Meeting of the Board of Directors
To be held in public
Thursday 5 January 2017 from 9:00 am

Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital

AGENDA

REF	ITEM	LEAD	PAPER	PURPOSE OF PAPER/ UPDATE
1	**Welcome and introductions:** Rosemary Hedges, Publicly Elected Membership Councillor Lynn Moore, Publicly Elected Membership Councillor	Acting Chair	**VERBAL**	**Note**
2	**Apologies for absence:** Mr Andrew Haigh, Chair – Mrs Jan Wilson to attend as Acting Chair Mr Owen Williams, CE – Mr Brendan Brown to attend as Acting CE and Mrs Juliette Cosgrove as Acting DoN	Acting Chair	**VERBAL**	**Note**
3	**Declaration of interests**	All	**VERBAL**	**Receive**
4	**Minutes of the previous meeting** held on 1 December 2016	Acting Chair	**APP A**	**Approve**
5	**Matters arising and review of the Action Log:**	Acting Chair	**APP B**	**Review**
6	**Patient/Staff Story:** To receive a 'Patient Story' – Mrs Andrews re: Delayed Transfer of Care	Chief Operating Officer	**You-tube presentation**	**Note**
7	**Chairman's Report** a. WYAAT Meeting Update b. MC Workshop re Annual Plan/Quality Accounts 2017 c. CE/CEO Meeting – 13.12.16	Acting Chair	**VERBAL**	**Note**
8	**Chief Executive's Report:**	Acting Chief Executive	**VERBAL**	**Note**
Transforming and improving patient care – no items				
Keeping the base safe				
9	Risk Register report	Acting Executive Director of Nursing	**APP C**	**Approve**

10	Risk Management Strategy	Acting Executive Director of Nursing	**APP D**	**Approve**
11	Governance report - Workforce (Well Led) Committee Terms of Reference	Company Secretary	**APP E**	**Approve**
12	Care of the Acutely Ill Patient Report	Executive Medical Director	**APP F**	**Approve**
13	CQC Update	Acting Executive Director of Nursing	**APP G**	**Note**
14	Public Sector Equality Duty Report	Executive Director of Workforce & OD	**APP H**	**Approve**
15	Integrated Performance Report	Chief Operating Officer	**APP I**	**Approve**
Financial Sustainability				
16	Month 8 – 2016 – Financial Narrative	Executive Director of Finance	**APP J**	**Approve**
A workforce for the future				
17	Workforce Strategy	Executive Director of Workforce & OD	**APP K**	**Approve**
18	**Update from sub-committees and receipt of minutes & papers** ▪ Quality Committee – minutes of 29.11.16 and verbal update from meeting of 3.1.17 ▪ Finance and Performance Committee – minutes of 29.11.16 and verbal update from meeting 3.1.17 ▪ Workforce Well Led Committee draft minutes – 8.12.16 ▪ Draft Membership Council Minutes – 9.11.16		**APP L**	**Receive**
Date and time of next meeting Thursday 2 February 2017 commencing at 9.00 am **Venue: Discussion Room 1, Learning Centre, HRI**				

Resolution

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

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 5th January 2017	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 1.12.16 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 1 December 2016.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 1 December 2016.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 1 December 2016.

Appendix

Attachment:

draft BOD MINS - PUBLIC - 1.12.16.pdf

Minutes of the Public Board Meeting held on Thursday 1 December 2016 in the Board Room, Huddersfield Royal Infirmary.

PRESENT

Andrew Haigh	Chairman
Dr David Anderson	Non-Executive Director
Helen Barker	Chief Operating Officer
Gary Boothby	Executive Director of Finance
Brendan Brown	Executive Director of Nursing
Lesley Hill	Executive Director of Planning, Estates and Facilities
Richard Hopkin	Non-Executive Director
Phil Oldfield	Non-Executive Director
Dr Linda Patterson	Non-Executive Director
Prof Peter Roberts	Non-Executive Director
Jan Wilson	Non-Executive Director
Ian Warren	Executive Director of Workforce & OD
Owen Williams	Chief Executive

IN ATTENDANCE

Anna Basford	Director of Transformation and Partnerships
Mandy Griffin	Director of The Health Informatics Service
Victoria Pickles	Company Secretary
Dr Alex Hamilton	Associate Medical Director (For the Executive Medical Director)
Juliette Cosgrove	Assistant Director of Quality (for part of meeting – items 181/16 and 185/16)

OBSERVER

Annette Bell	Membership Councillor
Brian Moore	Membership Councillor
Mike George	Insource Limited
Nasim Esmail	Membership Councillor – public member

177/16 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting.

178/16 APOLOGIES FOR ABSENCE

Apologies were received from:
Dr David Birkenhead, Medical Director.
Karen Heaton, Non-Executive Director

179/16 DECLARATIONS OF INTEREST

There were no declarations of interest to note.

180/16 MINUTES OF THE MEETING HELD ON 3 NOVEMBER 2016

The minutes of the meeting were approved as a correct record subject to amendments being made to items 160/16 and 167/16.

160/16 PATIENT/STAFF STORY – SAFER PATIENT PROGRAMME

Richard Hopkin requested that the minutes be amended to read "Age UK' and confirmed that Age UK run the Hospital from Home service.

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167/16 PERFORMANCE MANAGEMENT FRAMEWORK
Helen Barker requested that the minutes be amended to read that the report was an update and was no longer a pilot.

OUTCOME: The minutes of the meeting were approved subject to the above changes.

181/16 MATTERS ARISING FROM THE MINUTES / ACTION LOG

165/16 BOARD ASSURANCE FRAMEWORK
The Company Secretary confirmed that a review of other Trusts Board Assurance Frameworks had shown similar risks were captured as those described on the Trust's own Board Assurance Framework. It was agreed that the Company Secretary would undertake a deep dive of the top themes and bring back any changes to the Board Assurance Framework to the Board in February 2017.

ACTION: COMPANY SECRETARY

166/16 RISK APPETITE STATEMENT
It was noted that this statement had been shared with the Risk and Compliance Group. The Chief Operating Officer agreed to share this with the Divisions.

ACTION: CHIEF OPERATING OFFICER

169/16 WELL LED GOVERNANCE REVIEW
The Executive Director of Finance reported that governance arrangements for the Pharmaceutical Manufacturing Unit and THIS Management Board would be circulated to Board Members outside the meeting.

ACTION: EXECUTIVE DIRECTOR OF FINANCE

182/16 PATIENT / STAFF STORY – UPDATE ON THE SEPSIS REVIEW
The Assistant Director of Quality gave a presentation highlighting the actions of the Trust in the treatment and prevention of Sepsis.

Benchmarking and data available was shared with the Board. The work included:
- Ongoing improvements through the establishment of an improvement group;
- Matrons to ensure timely response and completion of mortality reviews;
- Relaunch of the sepsis care bundle (BUFALO) to all staff.
- Two professors were helping the Trust undertake detailed analysis of data available.
- A case note review to provide insight into why patients were dying in our care).

The Board discussed the work being undertaken and the importance of changing the culture of staff to see sepsis as a priority area. Dr Linda Patterson suggested that sepsis should be given the same degree of urgency by staff as when dealing with a cardiac arrest.

The Board welcomed the interventions being undertaken to understand the prevalence of sepsis in the organisation and where possible the actions to prevent sepsis. The Board acknowledged the importance of saving of lives through timely recognition and management of sepsis.

It was reported that further work was underway with the Electronic Patient Record (EPR) implementation to standardise care bundles associated with sepsis.

The Chairman thanked the Assistant Director of Quality for the informative presentation.
OUTCOME: The Board **AGREED** that the Quality Committee would receive detailed reports on the progress the sepsis work and this would then be fed back to the Board

via routine Quality Committee meeting minutes.

183/16 CHAIRMAN'S REPORT

a. Membership Council Meeting – 9.11.16

The Chairman reported on the key issues discussed at the Membership Council Meeting on the 9 November which included the following:

- Presentation on the audit of Clinical Audit
- Update on progress against delivery of the 1 Year Plan
- Update on the next steps following Consultation on hospital service reconfiguration
- Update on the West Yorkshire Association of Acute Trusts (WYAAT) work and its contribution to the overall West Yorkshire Sustainability and Transformation Plan (WYSTP).
- Quality Accounts
- Nomination and Remuneration Committee (MC) meeting – extension of Chair role from 7 July 2017 to 6 July 2018

b. MC/BOD Workshop – 16.11.16

The Chairman reported that the Membership Councillors present had received an update on progress against the 1 Year Plan. It was noted that this had been a disappointing turnout by the Membership Council.

c. NHS Improvement Courses and Conferences

The Chairman advised that he had recently attended two NHS Improvement courses regarding transformation and delivery of sustainability.

He had also attended the first day of the NHS Providers Conference in Birmingham on the 30 November 2016.

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

184/16 CHIEF EXECUTIVE'S REPORT

a. National Audit Office report into Financial Sustainability of the NHS

The Chief Executive presented the report produced by the Comptroller and Auditor General of the National Audit Office. Detailed discussion took place reflecting on how the NHS market was changing with the increased deficit in both Trusts and CCGs. The likely impact on the NHS with the changing financial arrangements for local authorities were discussed.

The Board acknowledged that all stakeholders, Trusts, CCGs and Local Authorities were in this together and this was reflective of the 'Right care, Right time, Right place consultation work.

It was agreed that the Chairman and Chief Executive should host a conversation with key players to discuss the implications for the future. Consideration would also be given to commissioning an independent think tank organisation to help pull together the outcomes from this.

ACTION: CHAIRMAN AND CHIEF EXECUTIVE

OUTCOME: The Board NOTED the update from the Chief Executive and supported a meeting of key players taking place in the near future.

185/16 **QUARTER 2 – QUARTERLY QUALITY REPORT**

The Assistant Director of Quality gave a presentation to summarise the document previously circulated with the Board papers. The presentation included highlights of the details on the progress within the 5 domains:- Safety, Effectiveness, Experience, Responsive and Well-led.

The Board were asked if this highlight report was of a sufficient level for the Board to gain assurance and it was agreed that in future the Board would receive the summarised information and the full details would be monitored and overseen by the Quality Committee.

OUTCOME: The Board NOTED and RECEIVED the Quarter 2, Quarterly Quality Report and agreed that the detailed report would be monitored and overseen by the Quality Committee in the future with a summary presentation coming to Board.

186/16 **RISK REGISTER**

The Executive Director of Nursing reported on the top risks scoring 15 or above within the organisation. These were:-
2827 (20): Over-reliance on middle grade locum doctors in A&E
6345 (20): Staffing risk, nursing and medical
5806 (20): Urgent estates schemes not undertaken
6503(20): Delivery of Electronic Patient Record Programme
6721 (20): Non delivery of 2016/17 financial plan
6722 (20): Cash flow risk

Risks with increased score
There were no risks with increased risk scores.

Risks with reduced scores
There was one risk that had been reduced in score on the corporate risk register during November: Risk 6131 – There is a risk that the Trust will not be able to quickly progress service reconfiguration due to the requirements of a consultation process.

This risk had been reduced from 20 to a 15 as a result of the Clinical Commissioning Group (CCG) decision in October to approve the development of the full business case.

New risks
The following new risk was agreed at the 8th November 2016 Risk and Compliance Group and was added to the corporate risk register:

- Risk 6886 - risk of non-compliance with seven day services requirements, scored as a risk of 15.

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

Prof. Roberts commented that the Audit and Risk Committee had requested that 'Staff Declarations' be included on the Risk Register. The Company Secretary confirmed that this was due to go to the next Risk and Compliance Group meeting however it was unlikely that it would score 15 at this stage. This would be reviewed once the new policy is published by NHS England.
OUTCOME: The Board **RECEIVED** and **APPROVED** the corporate risk register subject to the removal of Julie Dawes from the Register.

Brian Moore asked for information regarding the urgent estates work which had not

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been completed. The Executive Director of Planning, Estates and Facilities confirmed that a number of schemes had been delayed but these were for a variety of operational reasons and not just financial constraints. It was noted that the risks had been mitigated.

187/16 GOVERNANCE REPORT

The Company Secretary presented the report which brought together a number of items that evidenced or strengthened the corporate governance arrangements and systems of internal control within the Trust. This included:-

1. Board Skills/Competencies Self-Assessment

It was noted that the Board of Directors had all undertaken a self-assessment of their skills and competencies as part of an annual review. An anonymised composite report was presented. It was noted that this document would be used to help identify any required developments and also the assessment of what skills were required when consideration is given to future board vacancies.

OUTCOME: The Board NOTED the self-assessment.

2. Review of Board of Directors' Work plan

The Board work plan had been updated and was presented to the Board for review. The Board was asked to consider whether there were any other items they would like to add for the forthcoming year.

OUTCOME: The Board APPROVED the work plan.

3. Use of Trust Seal

Two documents had been sealed since the last report to the Board in September. These were in relation to:
- Transfer of the ATM machine to a different provider
- Lease of a police pod in the A/E department at HRI.

OUTCOME: The Board NOTED the use of the Trust Seal.

4. Integrated Performance Reporting and Risk Management reporting processes

It was noted that at the workshop on 16 November, the Board reviewed the reporting processes for the Integrated Performance Report to ensure that there is robust scrutiny and assurance of performance. It was agreed at the workshop to update the process to reflect the input of the Membership Council and to map out the governance arrangements relating to risk alongside.

OUTCOME: The Board NOTED the updated IPR and risk management reporting processes.

188/16 WINTER PLANNING

The Chief Operating Officer presented the Winter Planning paper.

The winter plan described the structure within which operational pressures during the winter period will be anticipated and managed. It provided a framework for managers and clinicians in the Trust to work together and with other organisations.

The objectives of the Plan were to support existing plans by increasing the operational focus on winter as an issue that challenges the resilience of the Trust:

- to provide a framework for the management of the winter response,
- to provide a framework for the development of other plans,
- to provide the basis for agreement and working with other organisations,
- to provide reference material for use in the Trust and to set out the information systems to be used to manage the response.

The Chief Operating Officer highlighted the key points from the report:

- No additional external winter money was available from the Commissioners
- There was significant impact and challenge for Divisions
- New escalation levels had been published nationally – known as Operational Pressures Escalation Levels. It was noted that these would need to be amended in the plan from the existing REAP alert levels. Formal review to be undertaken by commissioners on the resilience of the winter plan
- Avoidance of using additional beds unless essential
- Dashboard being developed to show nursing staff available vs bed allocations – information to be shared with partners.
- Community place ward – actions on going
- Norovirus – problems of infections still on going.
- Significant pressures with increased attendances being seen across the Region.

OUTCOME: The Board APPROVED the Winter Planning arrangements subject to the amendment to the escalation levels.

ACTION: CHIEF OPERATING OFFICER

189/16 INTEGRATED PERFORMANCE REPORT

The Chief Operating Officer highlighted the key points of operational performance for October 2016. It was noted that this report had been discussed in detail at the Executive Board, Quality Committee and Finance and Performance Committee. The key highlights from the report were noted:

- October's performance score has remained static at 68% for the Trust.
- 3 of the 6 domains improved in month with responsive nearing a green rating.
- The overall score for Workforce peaked at 64% having achieved its overall sickness rate of below 4% for the first time this year.
- Emergency Care – currently 95% - November level expected at 94.02%. Team working hard to deliver the best possible patient experience. CHFT currently in the upper quartile nationally on performance.
- Carter report – Fractured Neck of Femur improving outturn of patients through theatre within 36 hours. Work on going to focus on clinical exceptions and deep-dive to be presented to Executive Board.
- Referral to treatment waiting time was a concern and a detailed analysis was to be undertaken and will be brought to the next Board.
- Length of stay – improving position particularly in medical specialties.
- Direction of travel for cancer performance targets of concern with two tertiary providers reporting capacity issues. Discussions were on going.

The formatting of the document was discussed and it was agreed that a revised, formatted copy would be circulated to Prof. Roberts.

OUTCOME: The Board RECEIVED the Integrated Board Report and NOTED the key areas of performance for October 2016.

190/16 MONTH 7 – 2016 - FINANCIAL NARRATIVE

The Executive Director of Finance reported the key financial performance areas. It was noted that this had been discussed in detail at the Finance and Performance Committee held on the 29 November 2016.

The year to date financial position stands at a deficit of £10.06m, a favourable variance of £1.07m from the planned £11.13m of which £0.94m is purely a timing difference on the accrual of Strategic Transformation Funding (STF) versus the planned quarterly profile. The underlying position is £0.13m favourable variance from year to date plan.

The in-month clinical contract activity position is above plan at a similar level to that seen last month. This drives an overall income position at Month 6 which is

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£2.68m above planned levels in the year to date. The in-month over-performance is seen across non electives, outpatients, day cases and A&E attendances. It continues to be the case that, in order to deliver activity and access standards across the Trust with high vacancy levels, there is reliance upon agency staffing. It was recognised that the actions put in place to curb the use of agency staffing have started to impact positively. As a result total agency spend in month was £1.79m, a stable position from the previous month which compares with expenditure in excess of £2.1m each month in the year to August. This improvement brings the agency expenditure in line with the revised trajectory submitted to NHS Improvement.

Summary:-

- EBITDA of £4.43m, a favourable variance of £0.65m from the plan. Of this operating performance £0.94m is driven by a timing difference on the accrual of Strategic Transformation Funding versus the planned quarterly profile.
- A bottom line deficit of £10.06m, a £1.07m favourable variance from plan.
- Delivery of CIP of £8.35m against the planned level of £6.16m.
- Contingency reserves of £1.0m have been released against pressures.
- Capital expenditure of £9.14m, this is below the planned level of £14.94m.
- Cash balance of £2.62m; this is above the planned level of £1.95m, supported by borrowing.
- Use of Resources score of level 3, in line with the plan.

Discussion took place regarding the cash position and financial constraints in the system as a whole including the likely impact on the Trust not being able to pay suppliers and the possible repercussions of this. It was noted that this was being reviewed at the next Finance and Performance Committee and if felt appropriate would be included on the Risk Register.

OUTCOME: The Board **APPROVED** the Month 7 financial narrative and **NOTED** the continued financial challenges.

191/16 UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES

The Board received an update from each of the sub-committees that had met in the previous month.

a. Quality Committee

The Chair of the Quality Committee reported the items discussed at the meeting held on 29.11.16 not previously covered on the Board's agenda:

-
- Divisional Quality Reports – received
- Partnership Working - continued to be a concern regarding flow to acute wards.

OUTCOME: The Board RECEIVED the verbal update and the minutes of the meeting held on 31.10.16.

b. Finance and Performance Committee

Phil Oldfield, Chair of the Finance and Performance Committee reported on the items discussed at the meeting held on 29.11.16:

- Annual Plan and EPR concerns
- Forecast – still challenging
- The impact of the divisional performance review meetings was being seen
- CNST presentation received – 10% increase in premiums for CHFT this year compared to a 17.5% rise across the region. Work being done with Divisions on improving the quality of complaints responses and hopefuly reducing the number of claims. Feedback requested from Divisions via the Quality Committee.

OUTCOME: The Board RECEIVED the verbal update and the minutes of the

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meeting held on 1.11.16.

c. Workforce Committee
OUTCOME: The Board **RECEIVED** draft minutes from the meeting held on 19.10.16.

d. Draft Nomination/Remuneration Committee Minutes (MC) – 18.10.16
OUTCOME: The Board **RECEIVED** the draft minutes from the meeting held on 18.10.16. It was noted that the Chair position had been extended until June 2018 and a further meeting was scheduled for 8 March 2017 to consider the tenures of the three Non-Executive Directors due to expire in 2017.

192/16 DATE AND TIME OF NEXT MEETING

Thursday 5 January 2017 commencing at 9.00 am in the Large Training Room, Learning Centre, Calderdale Royal Hospital.

The Chair gave the Membership Councillors present an opportunity to ask any questions. Mrs Esmail asked for advice on trust policy regarding relatives bringing in food and the safe storage of this. The Executive Director of Nursing confirmed relatives were able to bring in food for patients as in some cases it was beneficial to the health and wellbeing of the patient, however it was not possible to store food for patients on the ward. It was agreed that this issue should be referred to the Quality Committee.

The Chair closed the public meeting at 11:40 am.

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Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 5th January 2017	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: ACTION LOG - PUBLIC BOARD OF DIRECTORS - The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 January 2017.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

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

Appendix

Attachment:

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

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 January 2017 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
33/16 25.2.16	**QUARTERLY QUALITY REPORT** The Board agreed that the level of detail being reported to the Board should be reviewed by the Quality Committee. Juliette Cosgrove agreed to ascertain the level of information required for the various sub-committees and make recommendations accordingly.	DoN	Initial review of information across all Quality metrics complete. Refreshed presentation of Quarterly quality report to commence in December 2016. **1.12.16** Q2 summary received. Agreed that the detailed report would be monitored and overseen by the Quality Committee in the future with a summary presentation coming to Board.	1.12.16		1.12.16
165/16 3.11.16	**BOARD ASSURANCE FRAMEWORK** It was agreed to bring the Board Assurance Framework to the Board in February and for the Company Secretary to review other organisations' BAFs to assess the types of risks included	VP	**1.12.16** It was agreed that the Company Secretary would undertake a deep dive of the top themes and bring back to the Board anything which would benefit changing on the BAF in February 2017.	2.2.16		
169/16 3.11.16	**REVIEW OF PROGRESS AGAINST STRATEGY – PMU/THIS** Discussion took place regarding the governance arrangements for the PMU commercial strategy and THIS Management Board and the Executive Director of Finance agreed to circulate a briefing note to the Board explaining the governance arrangements for the two ventures.	GB	**1.12.16** The Executive Director of Finance reported that governance arrangements for the Pharmaceutical Manufacturing Unit and THIS Management Board would be circulated to Board Members outside the meeting.			
168/16 3.11.16	**WELL LED GOVERNANCE ASSESSMENT** As part of new oversight arrangements, NHSI are looking to align their well led governance assessment	VP	**1.12.16** It was noted that the workshop had not taken place.			

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 January 2017 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	more closely with the CQC well led assessment. The Company Secretary was due to attend a workshop on this in November and will provide further feedback to the Board at a future meeting.					
175/16 3.11.16	**UPDATE FROM SUB-COMMITTEES** **Audit and Risk Committee** The Company Secretary explained that there would be a change to the declarations of interest policy as new guidance was due to be published in December. An update would be brought to a future Board meeting.	VP				
166/16 1.12.16	**RISK APPETITE STATEMENT** It was noted that this statement had been shared with the Risk and Compliance Group. The Chief Operating Officer agreed to share this with the Divisions.	GB				Completed 6.12.16
184/16 1.12.16	**FINANCIAL SUSTAINABILITY OF THE NHS REPORT** The Board acknowledged that all stakeholders, Trusts, CCGs and Local Authorities were in this together and this was reflective of the 'Right care, Right time, Right place consultation work. It was agreed that the Chairman and Chief Executive should host a conversation with key players to discuss the implications for the future. Consideration would also be given to commissioning an independent think tank	OW		March 2017		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 January 2017 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
	organisation to help pull together the outcomes from this.					
188/16 1.12.16	**WINTER PLANNING** New escalation levels nationally – reap to be updated on document.	HB				Completed 6.12.16
193/16 1.12.16	**SAFE STORAGE OF PATIENT FOOD** Mrs Esmail asked for advice on trust policy regarding relatives bringing in food and the safe storage of this. The Executive Director of Nursing confirmed that the Trust would not be looking to discourage any relatives from bring in food as it could be beneficial for patients to have 'home food', but would check on an individual basis regarding storage of the food. It was agreed that this issue should be referred to the Quality Committee to oversee this.	BB/LH				7.12.16 Referred to Quality Committee

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Andrea McCourt, Head of Governance and Risk
Date: Thursday, 5th January 2017	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: High level Risk Register - Presentation of the significant risks facing the Trust as at December 2016	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Risk and Compliance Group reviewed the corporate risk register on 13 December 2016	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

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

Background/Overview:

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

On a monthly basis the Risk and Compliance Group consider all risks that may potentially be deemed a corporate risk, with those with a risk score of 15 or more, prior to these being presented to the Board.

The Issue:

The attached paper includes:

i. A summary of the Trust risk profile as at December 2016 which identifies the highest scoring risks (between 15 and 25), risks with either an increase or decrease in scores, new and closed risks.

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

There are no new risks this month. Discussion of the risk relating to the implications of Brexit took place at the Risk and Compliance Group in December and the risk score was confirmed as 12, with the Director of Workforce and Organisational Development confirmed as the lead. The risk will be managed within the Workforce and Organisational Development risk register, with input from the Finance directorate.

Risk 6131,relating to reconfiguration, has been increased in score from 15 to 20 due to on-gong discussion with the Overview and Scrutiny Committee regarding their recommendations.

Next Steps:

The high level risk register is a dynamic document and will continue to be reviewed on a monthly basis and presented to the Board to ensure it is aware of all significant risk facing the organisation.

Recommendations:

Board members are requested to:

I. Consider, challenge and confirm that potential significant risks within the Corporate 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:

COMBINED RISK REGISTER (2) (3).pdf

HIGH LEVEL RISK REGISTER REPORT

Risks as at 16 December 2016

TOP RISKS
2827 (20): Over-reliance on locum middle grade doctors in A&E 6345 (20): Staffing risk, nursing and medical 6131 (20) : Service reconfiguration 5806 (20): Urgent estates schemes not undertaken 6503(20): Delivery of Electronic Patient Record Programme 6721 (20): Non delivery of 2016/17 financial plan 6722 (20): Cash flow risk
RISKS WITH INCREASED SCORE
There is one risk with an increased risk score, risk 6131 regarding service reconfiguration. This risk had reduced in score to 15 but has now increased to a risk score of 20.
RISKS WITH REDUCED SCORE
There are no risks that have been reduced in score on the high level risk register during December.
NEW RISKS
There are no risks that have been added to the high level risk register during December.
CLOSED RISKS
None

Risk Ref	Strategic Objective	Risk	Executive Lead (s)	July 2016	September 2016	October 2016	November 2016	December 2016
		Strategic Risks						
6503	Transforming & Improving Patient Care	Non delivery of Electronic Patient Record Programme - transformation	Director of THIS (MG)	20 =	20 =	20 =	20 =	20 =
		Safety and Quality Risks						
6131	Transforming & Improving Patient Care	Progress of reconfiguration, impact on quality and safety	Director of Commissioning and Partnerships (AB)	20 =	20 =	20 =	↓15	↑20
6886	Transforming & Improving Patient Care	Non compliance with 7 day services standards	Medical Director (DB)	-	-	-	**!15**	**=15**
4783	Transforming & Improving Patient Care	Outlier on mortality levels	Medical Director (DB)	20=	↓16	16 =	16 =	16 =
2827	Developing Our workforce	Over –reliance on locum middle grade doctors in A&E	Medical Director (DB)	=20	=20	=20	=20	=20
6822	Keeping the Base Safe	Not meeting sepsis CQUIN	Medical Director (DB)	-	-	!16	=16	=16
5862	Keeping the Base Safe	Risk of falls with harm	Director of Nursing	-	-	!16	=16	=16
6829	Keeping the Base Safe	Aspetic Pharmacy Unit production	Director of Nursing	-	-	!15	=15	=15
6841	Keeping the Base Safe	Not being able to go live with the Electronic Patient Record – operational readiness	Chief Operating Officer (HB)	-	15!	15=	15=	15=
5806	Keeping the base safe	Urgent estate work not completed	Director of Estates and Performance (LH)	=16	=16	↑20	=20	=20
6300	Keeping the base safe	Risk of being inadequate for some services if CQC improvement actions not delivered	Director of Nursing (BB)	=16	=16	=16	=16	=16
6598	Keeping the base safe	Essential skills training data	Director of Workforce and OD	=16	=16	=16	=16	=16
6694	Keeping the base safe	Divisional Governance arrangements	Director of Nursing (BB)	=16	=16	=16	=16	=16
6715	Keeping the base safe	Poor quality / incomplete documentation	Director of Nursing (BB)	=15	=15	=15	=15	=15
6753	Keeping the base safe	Inappropriate access to person identifiable information	Director of THIS (MG)	16!	=16	=16	=16	=16

Risk Ref	Strategic Objective	Risk	Executive Lead (s)	July 2016	September 2016	October 2016	Nov ember 2016	December 2016
		Financial Risks						
6721	Financial sustainability	Non delivery of 2016/17 financial plan	Director of Finance (KG)	=20	=20	=20	=20	=20
6722	Financial sustainability	Cash flow risk	Director of Finance (KG)	=20	=20	=20	=20	=20
6723	Financial sustainability	Capital programme	Director of Finance (KG)	=20	↓15	15 =	15 =	15 =
		Performance and Regulation Risks						
6658	Keeping the base safe	Inefficient patient flow	Chief Operating Officer (HB)	=20	↓16	16=	16=	16=
6596	Keeping the base safe	Timeliness of serious incident investigations	Director of Nursing (BB)	=16	=16	=16	=16	=16
6693	Keeping the base safe	Failure to comply with the Monitor cap rules	Director of Workforce (IW)		=15	=15	=15	=15
		People Risks						
6345	Keeping the base safe	Staffing - ability to deliver safe and effective high quality care and experience service	Medical Director (DB) ,Director of Nursing (BB), Director of Workforce (IW)		=20	=20	=20	=20

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

Trust Risk Profile as at 16 December 2016

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Highly Likely (5)			= 6693 - Failure to comply with monitor staffing cap = 6715 - Poor quality / incomplete documentation	= 6345 - Staffing risk, nursing and medical	
Likely (4)				= 4783 Outlier on mortality levels = 6658 Inefficient patient flow = 6300 Clinical, operational and estates risks outcome = 6596 Serious Incident investigations = 6598 Essential Skills Training Data = 6694 Divisional governance arrangements = 6753 Inappropriate access to patient identifiable data = 6723 capital programme = 5862 Falls risk = 6822 CQUIN sepsis	= 2827 Over reliance on locum middle grade doctors in A&E = 6503 Non delivery of EPR programme = 6721 Not delivering 2016/17 financial plan = 5806 Urgent estate work not completed ↑ 6131 – service reconfiguration
Possible (3)					= 6722 Cash Flow risk = 6814 EPR operational readiness = 6829 Pharmacy Aseptic Unit = 6886 Non compliance with 7 day services standards
Unlikely (2)					
Rare (1)					

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

High Level Risk Register

Significant risks Scores of 15+

Dec-16

Risk No	Div	Opened	Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Further Actions	Review	Target	RC	Exec Dir	Lead
2827	Medical	Apr-2011	Developing our workforce	There is an over-reliance on locum Middle Grade Doctors at weekends and on nights in A&E due to staffing issues resulting in possible harm to patients, extended length of stay and increased complaints ***It should be noted that risks 4783 and 6131should be read in conjunction with this risk.	Associated Specialist and Regular locums for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Part-time MG doctors appointed Where necessary other medical staff re-located to ED Consultants act down into middle grade roles to fill gaps temporarily	Difficulty in recruiting Consultants, Middle Grade and longer term locums Relatively high sickness levels amongst locum staff.	20 4 x 5	20 5 x 4	12 4 x 3	Expedite Outline Business case for reconfiguration of services across sites to afford better deployment of medical staff Explore use of ANP to fill vacant doctor posts Business Continuity Plan awaiting approval of Urgent care Board covering ability to provide safe services for varying periods of time Sept 2016 Update: 2 Substantive consultants have resigned. Senior Clinical fellow appointed to Consultant level position. Currently 10 on consultant rota. One additional Specialty Doctor has been recruited November 2016 Advert out for specialty doctors and ED Consultants **December 2016**: The Trust continues to advertise vacancies for specialty doctors and ED consultants.	Jan-2017	Aug-2017	WEB	David Birkenhead	Dr Mark Davies/Mrs Bev Walker

6345	Trustwide	Jul-2015	Keeping the base safe	Staffing Risk Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to: lack of nursing staffing, unable to recruit to substantive posts, not achieving recommended nurse staffing levels. Inability to adequately staff flexible capacity ward areas, lack of medical staffing as unable to recruit to Consultant / middle grade doctor / junior doctor vacancies across a number of specialties over-reliance on middle grade doctors, dual site working and impact on medical staffing rotas, lack of workforce planning / operational management process and information to manage medical staffing gaps, lack of therapy staffing as unable to recruit to Band 5 and 6 Physiotherapists, Occupational Therapists, Speech and Language Therapists and Dieticians in both hospital and community. resulting in an increase in clinical risk to patient safety, negative impact on staff morale, motivation, health and well-being and patient experience, negative impact on staff mandatory training and appraisal, cost pressures due to increased costs of interim staffing and delay in implementation of key strategic objectives (eg Electronic Patient Record)	Nurse Staffing To ensure safety across 24 hour period: - use of electronic duty roster for nursing staffing, approved by Matrons - risk assessment of nurse staffing levels for each shift and escalation process to Director of Nursing to secure additional staffing - staff redeployment where possible -nursing retention strategy - flexible workforce used for shortfalls (bank/nursing, internal, agency) and weekly report as part of HR workstream Active recruitment activity, including international recruitment Medical Staffing Medical Workforce Group chaired by the Medical Director. Active recruitment activity including international recruitment. -revised approvals process for medical staffing to reduce delays in commencing recruitment. -HR resource to manage medical workforce issues. - Exit interviews for Consultants being conducted. -Identification of staffing gaps within divisional risk registers, reviewed through divisional governance arrangements Therapy Staffing - posts designed to be as flexible as possible - review of skill mix and development of Assistant Practitioners. - flexible working - aim to increase availability of flexible work force through additional resources / bank staff	Medical Staffing Lack of: - workforce plan / strategy for medical staff identifying level of workforce required - dedicated resource to develop workforce model for medical staffing - centralised medical staffing roster/ workforce planning for medical staff - system /process to identify, record and manage gaps in planned medical staffing, - measure to quantify how staffing gaps increase clinical risk for patients Therapy staffing Lack of: - workforce plan / strategy for therapy staff identifying level of workforce required - dedicated resource to develop workforce model for therapy staffing - system to identify changes in demand and activity, gaps in staffing and how this is reflected through block contract - flexibility within existing funding to over recruit into posts/ teams with high turnover	16 4 x 4	20 4 x 5	9 3 x 3	Continue to recruit to vacant posts / skill mix review, progress international recruitment of medical staff, consider incentive schemes. (Director of Nursing, Medical Director) Divisions have identified opportunities where Specialty Doctors may be able to bridge the gap with Consultant vacancies. TTM are working with us to create an international recruitment plan to appoint Specialty doctors. The long term intention is to progress these doctors to Consultant level vis the CESR route. A deputy medical director is being recruited to support the Executive Medical Director with operational management of the medical workforce. November 2016 Update Divisions have identified opportunities where Specialty Doctors may be able to bridge the gap with Consultant vacancies. TTM are working with us to create an international recruitment plan to appoint Specialty doctors. The long term intention is to progress these doctors to Consultant level vis the CESR route. A deputy medical director is being recruited to support the Executive Medical Director with operational management of the medical workforce. **December 2016 Update** Active recruitment to vacant nursing, medical and AHP posts continues. From a nursing perspective this includes local, national and international recruitment events. A confirm and challenge process is now in place at Divisional level, which reviews the quality, professional, safety and financial elements of staffing. A further 'Hard Truths' review of ward nursing establishments is currently underway, alongside the introduction of a peripatetic team to manage the organisations response to the needs of specialing (1:1) nursing improvements to the recruitment process and the Flexible Workforce departments also continue, in line with National and arm's length bodies recommendations.	Nov-2016	Nov-2016	WLG	David Birkenhead, Brendan Brown, Ian Warren	Lindsay Rudge, Jason Eddleston & Claire Wilson

6131	Corporate	Oct-2014	Transforming and improving patient care	There is a risk that the Trust will not be able to quickly progress service reconfiguration due to the requirements of a consultation process initiated by local CCG's resulting in delays to important clinical quality and safety issues e.g: Compliance with A&E National Guidance Compliance with Paediatric Standards Compliance with Critical Care Standards Speciality level review in Medicine Unable to meeting 7 day standards Difficulties in recruiting and retaining a medical workforce (increased reliance on Middle Grades and Locums) Increased gaps in Middle Grade Doctors Dual site working is one of the causes of the Trust;s underlying deficit. Delays in being able to reconfigure services will impact on the Trust's financial recovery plan. During the period of public consultation there is a risk of an impact on the Trust's reputation. ***It should be noted that risks 2827 and 4783 should be read in conjunction with this risk.	The continued funding of medical staff on both sites Nurse led service managing Paediatrics Critical care still being managed on both sites High usage of locum doctors Frequent hospital to hospital transfers to ensure access to correct specialties The Trust has developed a contingency plan should it not be able to provide sufficient medical staffing to provide safe A&E services on two sites. Consultant rotas cannot always be filled substantively to sustain services on both sites but locum arrangements used 5 year plan completed in December 2015 and agreed with CCGs. Emergency Pregnancy Assessment and Emergency gynae clinic both changed to be delivered from CRH following public engagement and engagement with Kirklees Overview and scrutiny Committee. Change implemented January 2016. Dual site working additional cost is factored into the trust's financial planning.	Interim actions to mitigate known clinical risks need to be progressed.	25 5 x 5	20 5 x 4	10 5 x 2	The Trust has developed and is discussing with CCGs options for progressing interim actions to mitigate known clinical risks. A change in consultant recruitment process (that commenced during January 2016) will reduce time to appointment. October 2016 update Commissioner approval on 20.10.16. for development to full business case. JOSC decision on 16 November on referral of decision to secretary of state December 2016 Update: On the 16th November the Joint Scrutiny Committee decided that if the CCG's do not satisfactorily address their concerns the Committee will consider referral to the Secretary of State. The Committee will meet in February 2017 to assess progress of the development of the Full Business Case.	Jan-2017	Feb-2017	WEB	Anna Basford	Catherine Riley
5806	Estates & Facilities	May-2015	Keeping the base safe	Risk of the current HRI Estate failing to meet required condition due the age and condition of the building resulting in a failure of the Trust achieving compliance in a number of statutory duties. This could result in closure of some areas which will mean stopping of patient care, suspension of services, delays and stoppage of treatment, closure of buildings, services and wards, harm caused by slips, trips and falls and potential harm from structural failure.	Each of the risks above has an entry on the risk register and details actions for managing the risk. Many of these risks could lead to injury of patients and staff, closure of essential services, and inability for the Trust to deliver vital services. The estate structural and infrastructure continues to be monitored through the annual Authorising's Engineers (AE)/ Independent Advisors (IA) report and subsequent Action Plan. This report details any remedial work and maintenance that should be undertaken where reasonably practicable to do so to ensure the Engineering and structural regime remains safe and sustainable. Statutory compliance actions are prioritised, then risk assessment of other priorities. When any of the above become critical, we can go through the Trust Board for further funding to ensure they are made safe again.	The lack of funding is the main gap in control. Also the time it takes to deliver some of the repairs required. In terms of the structure of HRI, this is beyond repair, so no further major structural work can now be undertaken.	16 4 x 4	20 5 x 4	6 3 x 2	October 16 The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so. The level of risk to the services at HRI is increasing as the number of major building risks increases Nov 16 The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so. The sub basement area is currently undergoing an environmental clean to enable various projects to recommence after a significant delay in the capital programme. **Dec 16** The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so. The sub basement area is currently undergoing an environmental clean to enable various projects to recommence after a significant delay in the capital programme.	Jan-2017	Mar-2018	RC	Lesley Hill	Paul Gilling / Chris Davies

6503	Corporate	Dec-2015	Transforming and improving patient care	RISK of: non - delivery of Electronic Patient Record Programme due to failure to deliver the transformation associated with not achieving the key deliverables around timescales, engagement and financial targets causing CRB to not be realised, significant cost overruns which ultimately could make the programme unsustainable. The Trust along with its partners BTHFT (Bradford Teaching Hospitals Foundation Trust) and Cerner are implementing an EPR system that will enable service transformation whilst improving patient safety and patient and clinician experience. This is a summary risk, EPR risks escalated at Transformation Group will be brought to R&C by exception. This will impact on patient care, safety and patient experience and mean the expected financial benefits of EPR programme will not be realised.	A Well-developed Governance Structure in place underpinned by a contract between CHFT and Cerner and a partnership agreement between CHFT and BTHFT. Management of EPR programme risks using Best Practice MSP (Managing Successful Programmes) methodology and EPR specific risk register Executive sponsorship of the programme with CEO's chairing the Transformation Board Separate assurance process in place Clinical engagement from divisions Clearly identified and protected funding as identified in the Full Business Case. All Risk and issues are recorded on the programme risk and issue register and managed by the EPR Risk Review Board.	- Further divisional engagement required - A more in depth understanding of the transformational change is required within the clinical divisions. The impact on activity during go live will be significant and the changes in processes post go live will be equally significant. An understanding, acceptance and support will be essential to success. - Financial offsetting for 16/17 to mitigate against the reduction in activity during go live and short term post go live. - Sign off the Operational Readiness plan by division - Lack of divisional engagement in some areas as raised at the EPR Operational Group.	20 5 x 4	20 5 x 4	5 5 x 1	Continual monitoring of actual programme risk and issues log Any risks escalated to the Transformation Board brought to this committee Access to the full EPR Risk Log will be made available to N7&C group via the Cerner Portal if required, any escalations from transformation group will be brought to R&C by the programme leads. Nov Update: Following the re-planning phase referenced above, the timeline for the programme will be based around the successful exit of Trial Load 3 (end of November). If this phase is successful then CHFT will continue to head towards a March go-live, the consequence of failure is the need for a Trial Load 4 (circa 8 weeks). We have met the entry criteria for TL3 and early indicators are positive. The December update will give revised proposed go-live month. The risk score cannot be reduced at this point, further work is required on the Gaps in controls. **December 2016 Update** In relation to the process described in the above update, TL3 is now complete and whilst the results were good, we didn't meet the exit criteria (primarily due to OrderComms and E-referrals) There is a need for a Trial Load 4, but not a full TL. It is estimated that this TL will be circa 7 weeks giving a potential go-live date in April 17. This plan is still being worked through and discussed with both the EPR programme and the two trusts involved. Further (more timely) updates via Programme Board, Ops Group and EB with the next risk update in Jan.	Dec-2016	Sep-2017	RC	Mandy Griffin	Mandy Griffin

6721	Corporate	May-2016	Keeping the base safe	The Trust is planning to deliver a £16.1m deficit in 2016/17. There is a risk that the Trust fails to achieve its financial plans for 2016/16 due to: - clinical activity and therefore income being below planned levels - income shortfall due to commissioner affordability - income shortfall due to contract sanctions / penalties based on performance measures or failure to achieve CQUIN targets - non receipt of Sustainability and Transformation Funding due to performance - failure to deliver cost improvements - expenditure in excess of budgeted levels - agency expenditure and premia in excess of planned and Monitor ceiling level	Standing Financial Instructions set spending limits Project Management Office in place to support the identification of CIP Turnaround Executive meeting weekly to identify CIP shortfalls and drive remedial action Accurate activity, income and expenditure forecasting Finance and Performance Committee in place to monitor performance and steer necessary actions Executive review of divisional business meetings Budget reviews hold budget holders to account Realistic budget set through divisionally led bottom up approach	Further work ongoing to tighten controls around use of agency staffing. For 2016/17 the Trust has been given a £14.95m ceiling level for agency expenditure by NHS Improvement. Agency spend must be reduced considerably if the Trust is to deliver the financial plan, not exceed the ceiling and secure the Strategic Transformation Funding.	20 5 x 4	20 5 x 4	15 5 x 3	November update: At Month 7, the year end forecast position is to deliver the planned £16.1m deficit (excluding exceptional costs). In addition, it continues to be assumed that the Trust will achieve the necessary conditions to secure the £11.3m Sustainability and Transformation Funding which is intrinsic to delivery of the planned deficit. Divisional financial recovery plans and additional savings plans must be implemented to ensure delivery of the Trust's forecast financial position. December update: At Month 8, the year end forecast position is to deliver the planned £16.1m deficit (excluding exceptional costs). In addition, it continues to be assumed that the Trust will achieve the necessary conditions to secure the £11.3m Sustainability and Transformation Funding which is intrinsic to delivery of the planned deficit. Divisional financial recovery plans and additional savings plans must be implemented to ensure delivery of the Trust's forecast financial position. The Trust must drive the necessary reductions in agency expenditure whilst striving to maintain safe staffing levels and deliver standards and access targets. Against the £14m CIP target, £15.19m delivery is forecast and the risk profile of this has been reviewed, £1.02m of schemes remain as high risk. In addition, the new EPR system brings heightened risk of lost productivity through the implementation phase. Commissioner affordability challenges, CQUIN performance and seasonal operational challenges may bring further unplanned pressure.	Jan-17	Mar-2017	FPC	Keith Griffiths	Kirsty Archer

6722	Corporate	May-2016	Keeping the base safe	Risk that the Trust will not be able to pay suppliers, staff, PDC and loans due to cash flow timing or an overall shortfall of cash resulting in external scrutiny, significant reputational damage and possible inability to function as going concern.	* Agreed £5m capital loan from Independent Trust Financing Facility received in April 2016 * Cash forecasting processes in place to produce detailed 13 week rolling forecasts * Discussed and planned for distressed funding cash support from Monitor * Trust's Standing Operating Procedures for Treasury Management and Accounts Payable give authority to withold payments to suppliers * Cash management committee in place to review and implement actions to aid treasury management * Working capital loan facility in place (at 3.5% interest rate) for £13.1m to support cash in advance of progression of revenue support loan (at 1.5% interest rate)	Distressed cash support through "Revenue Support Loan" not yet formally approved by NHS Improvement. The level of outstanding debt held by the Trust is increasing on a monthly basis, the majority of this is owed by other NHS organisations, this has increased the borrowing requirement in the year to date.	15 5 x 3	20 5 x 4	15 5 x 3	November update: Borrowing has been drawn down at a higher level than originally planned to allow settlement of outstanding creditor payments. Further action is being taken to maximise collection of receivables and the profile of cash management has been raised at Divisional level and agreement has been reached with the Trust's main commissioners to settle in-year contract activity overtrades in a more timely manner. Cash continues to be a high risk due to the knock on impact of I&E risks; the ongoing reliance on availability of commissioner cash funding; and the fine balance required in managing working capital. The latest understanding from discussions with NHSI to convert our loan from a Working Capital Facility (at 3.5% interest) to a Revenue Support loan (at 1.5% interest), is that we will only move to the lower rate loan once the working capital facility has reached the level equivalent to 30 days operating costs. This will be in March 2017 based on current projections. **December update:** At Month 8, the year end forecast position is to deliver the planned £16.1m deficit (excluding exceptional costs). In addition, it continues to be assumed that the Trust will achieve the necessary conditions to secure the £11.3m Sustainability and Transformation Funding which is intrinsic to delivery of the planned deficit. Divisional financial recovery plans and additional savings plans must be implemented to ensure delivery of the Trust's forecast financial position. The Trust must drive the necessary reductions in agency expenditure whilst striving to maintain safe staffing levels and deliver standards and access targets. Against the £14m CIP target, £15.19m delivery is forecast and the risk profile of this has been reviewed, £1.02m of schemes remain as high risk. In addition, the new EPR system brings heightened risk of lost productivity through the implementation phase. Commissioner affordability challenges, CQUIN performance and seasonal operational challenges may bring further unplanned pressure. December update: Borrowing has been drawn down at a higher level than originally planned to allow settlement of outstanding creditor payments. Further action is being taken to maximise collection of receivables and the profile of cash management has been raised at Divisional level. Cash continues to be a high risk due to the knock on impact of I&E risks; the ongoing reliance on availability of commissioner cash funding; and the fine balance required in managing working capital.	Jan-17	Mar-2017	FPC	Keith Griffiths	Kirsty Archer

6753	Corporate	Jun-2016	Keeping the base safe	The Risk of:- Inappropriate access to PID and CHFT Organisational data on some Trust PC's. This risk is increased by the inability to audit access either pre or post any incident. Due to :-Data being saved under Web-station log ins on communal PCs and associated network drives (wards etc) Resulting in:-Breach of confidentiality of patient or staff internally and organisational risk from a CHFT data breach.	- Only trust staff can access the PCs under the web-station login - Only PC's that are a member of a specified group will allow the use of web-station login - Policy mandates that no Data (especially PID) to be saved to local drives - Reduction of generic logons where possible (low impact) - Sophos encryption of disk drives for encrypted local disk data	- Process to wipe the local drive on web-station PCs daily (Begin Comms after audit) - Removal of generic logons through roll out of single sign-on/VDI (Oct 2016) - Password for web-station does not change (currently set in 2010) every 3 months as per other user accounts - Ability to save information to shared network drives associated with web-station account. This information is accessible by all who use the account. - Not all PC's have Sophos Encryption installed (Ongoing)	16 4 x 4	16 4 x 4	4 4 x 1	Clarity around the extent of the problem through audit of PCs and network saved data - End of July 2016 Understand potential completion dates for SSO and VDI - October 2016 July Update: Work is continuing with the Audit of the situation/PC's, once complete short term mitigation can be put in place to reduce the score while we are waiting for SSO/VDI to be implemented in October. Sept Update: Short term - Unprotected PC's have been encrypted. Longer term - SSO/VDI hardware is in place, Configuration is underway, Ward 3 at CRH will be the initial test area in October. Roll out will commence in November. October Update - As above, no further mitigation to the risk until VDI/SSO is rolled out from November. **November/December Update** VDI/SSO project is still on track for this month. Mitigation will be reported in the next update.	Jan-2017	Jan-2017	RC	Mandy Griffin	Rob Birkett
6822	Medical	Aug-2016	Keeping the base safe	CQUIN target at risk of not being met for 2016/17 based on current compliance for screening for sepsis, time to antibiotic and review after 72 hours and risk of non - compliance in line with new NICE guidelines for sepsis. This is due to lack of engagement with processes, lack or process for ward staff to follow and lack of joined up working between nursing and medical colleagues. The impact is the increased deterioration in patients condition and increased mortality if sepsis not recognised and treated within the hour and all of the sepsis 6 requirements delivered impact and financial penalties.	Sepsis CQUIN matron employed Awareness and new controls for ward areas Divisional plan, medical leads identified in all divisions -Improvement action plan in place, improvements seen in data for Q2 -stop added to nerve centre to prompt screening -new screening tool and sepsis 6 campaign to be launched ASAP, introducing the BUFALO system -matrons promoting the and challenging for screening in the 9-11 time on wards NICE guidelines - Cerner currently testing qSOFA and new NICE cut offs	Lack of engagement with processes Lack of clear process for ward staff to follow Lack of joined up working between nursing and medical colleagues Compliance with NICE guidelines - sepsis matron to seek clarity and confirm compliance and noncompliance and add in improvement action plan if needed	15 5 x 3	16 4 x 4	12 4 x 3	Sepsis matron to set immediate controls for ward staff Deep dive into the causes of sepsis and barriers to implementing clinical standards to be presented at Quality Committee 31.10.16. Details action plan to be developed by 18 November 2016 by deputy associate divisional nurse. November update Deep dive report into the causes of sepsis and barriers to implementing clinical standards completed and now being presented to the quality Committee on 29-11-16 December update. DD/ADN lead for new collaborative, monthly sepsis collaborative with strong medical leadership/involvement. Roll out BUFALO, daily monitoring by performance triggering ward level response/escalation of omissions to CD/improve divisional processes/Governance. Joint working across Medicine and Surgery. Targeted mortality review for sepsis patients to inform quality improvement. Clear c0mmunicatio/education strategy for clinicians. Test of sepsis trolleys in A&E, MAU and Wd 12. Quality improvement support to create culture change sustainability. Cop-ordinate action plan with deteriorating patient work.	Jan-2017	Mar-2017	PSQB	David Birkenhead	Tracy Fennell

5862	Medical	Aug-2013	Keeping the base safe	There is a risk of significant patient falls due to poor level of patient risk assessment which is not being completed to support clinical judgement, failure to use preventative equipment appropriately and staff training, failure to implement preventative care, lack of equipment, environmental factors, staffing levels below workforce model exacerbated by increased acuity and dependency of patients, resulting in a high number of falls with harm, poor patient experience and increased length of hospital stay.	Falls bundles; Vulnerable adult risk assessment and care plan. Falls monitors,falls beds/chairs, staff visibility on the wards, cohort patients and 1:1 care for patients deemed at high risk. Falls collaborative work on wards deemed as high risk; Staff education. All falls performance (harm and non harm) reported and discussed at Divisional PSQB meetings.	Insufficient uptake of education and training of nursing staff, particularly in equipment. Staffing levels due to vacancies and sickness. Inconsistent clinical assessment of patients at risk of falls. Inconsistency and failure to recognise and assess functional risk of patients at risk of falls by registered practitioners. Environmental challenges in some areas due to layout of wards. .	12 4 x 3	16 4 x 4	9 3 x 3	Spread of falls improvement work and further staff education and training. Safety huddles to be embedded on all in patient areas with the co-operation of the whole multi -disciplinary team. Continue to undertake RCA on harm falls and ensuring learning is embedded. Embed falls 5 across all areas and monitor quality improvements against this. . November update Medical division has undertaken a deep dive into falls and is presenting this at their divisional performance meeting on 25-11-16 Implementing new methods of care delivery to support managing vulnerable patients. December update. Deep dive into all areas of Medicine identifying key themes. Divisional roll out of Falls 5. Targeted working in high risk areas focusing on intentional rounding, tag bay nursing. Audit undertaken of quality of safety huddles. Targeted work on individual areas to improve quality/engagement with Safety huddles.	Jan-2017	Mar-2017	PSQB	Brendan Brown	Maggie Shepley

4783	Corporate	Aug-2011	Transforming and improving patient care	Risk of adverse publicity and regulatory intervention due to Trust falling below national standards for mortality as Trust SHIMI position is now outside the expected range; this may be due to issues regarding delivering appropriate standards of care for acutely ill patients/frail elderly patients and failure to correct accurate co-morbidity data for coding and may result in inaccurate reporting of preventable deaths, increased external scrutiny and a possible increase in complaints and claims. ***It should be noted that risks 2827 and 6131 should be read in conjunction with this risk.	2 invited service reviews undertaken by Royal College of Physicians on Respiratory Medicine and Complex Medicine which will give guidance on areas of further improvement. Action plans for these areas being developed based on preliminary report findings. Outlier areas are monitored (e.g. Stroke, Sepsis and COPD) Outliers are investigated in depth to identify the cause. Improvement work is implemented via an action plan Mortality dashboard analyses data to specific areas Monitoring key coding indicators and actions in place to track coding issues Written mortality review process agreed to clarify roles and to facilitate a greater number of reviews being completed, process for escalation, linking with other investigation processes e.g. SI panel review. August reviews of July deaths (using new process) compliance 70% - highest since Feb'15 Monthly report of findings to CEAM and COG from Sept 2015 (Aug reviews of July deaths) Revised investigation policy clarifies process for learning from all investigations, including mortality reviews, and monitoring of actions CAIP plan revised Aug 2015 and now focusing on 6 key themes: investigating mortality and learning from findings; reliability; early recognition and response to deterioration; end of life care; frailty; and coding. Care bundles in place	Mortality reviews to assess preventable deaths which is indicating there isn't a problem but not yet performed for long enough or to sufficient depth to determine causes Mortality case notes review may not pick up all factors relating to preventability Coding improvement work not yet complete Improvement to standardised clinical care not yet consistent. Care bundles not reliably commenced and completed	20 4 x 5	16 4 x 4	12 4 x 3	To complete the work in progress CQUINS to be monitored by the Trust External review of data and plan to take place - assistance from Prof Mohammed (Bradford) September update A new mortality review process will be implemented which will lead to a consultant led review into each death. Progress continues to be made with the management of sepsis and a lead nurse has commenced in post October update The action plans for the elderly and respiratory ISR's will be presented to the Medical Director this month. Dates for the stroke ISR have been agreed. November update The Medical Director to meet with Medicine Division to sign off ISR action plans, the division have appointed a manager to oversee implementation of the plans. A deep dive into sepsis to be taken to Quality Committee in November. A revised care of the Acutely Ill action Plan to be taken to Clinical Outcomes Group in November **December 2016 update:** Care of the acutely ill patient plan agreed by Clinical Outcomes Group in November and will be monitored by the group on a monthly basis. HSMR dropped to 102 based on September data, SHIMII remains outside of expected range.	Jan-17	Mar-2017	COB	David Birkenhead	Juliette Cosgrove

6598	Corporate	Jan-2016	Keeping the base safe	There is a risk of being unable to provide essential skills training data for some subjects and where data is available this is not always set against a target audience. Therefore the organisation cannot be assured that all staff have the relevant essential skills to practice safely. This is due to the data being held in a devolved structure with no required target audience setting mechanism or central gathering/recording process. This will result in a failure to understand essential skills training compliance against set targets across the whole of the organisation. Further essential skills subjects are been identified and added to the list with increasing frequency. This obviously not only extends the period of time the roll out project will take but also leads to a re-prioritisation exercise around establishing which are the key priority essential skills to focus on first.	There is an agreed essential skills matrix now in place and an essential skills project plan to describe and implement the target audience for each essential skills subject - the project timeline extends until February 2017, however the risk will remain after this date as changes to the way essential skills are recorded and reported are presently under discussion and review. Compliance measurement will be enabled as each TA is set although this is a lengthy process within the confines of the current Learning Management System. The business plan to commission an alternate learning management system has been approved therefore the tendering process is underway. The Education and Learning Group (ELG) has recently been established and any new requests for addition to the essential skills list need to be approved by this group which should help apply some control to the content of the list.	1/ Essential skills training data held is inconsistent and patchy. 2/ target audiences setting to allow compliance monitoring against a target is inconsistent and patchy 3/ Functionality of the OLM system is limited and cannot facilitate disaggregated target audience setting. A manual system to facilitate the actions above will be require1/ Essential skills training data held is inconsistent and patchy. 4/ There are issues with PC settings which leads to completed e-learning not been recorded as complete.	16 4 x 4	16 4 x 4	12 4 x 3	**December Update** List reviewed by Director of Nursing. Request for further information around renewal periods and relevance to different nursing groups was requested. This has been completed and a meeting for next steps is scheduled for early January. The rust continues to debate the need for a new learning management system. Until a decision is made, emphasis is been placed on completing TA's for priority identified subjects. These are: FGM and MCA/DoLS. November Update A date of 11.11.16 has been agreed to discuss the list of essential skills with the director of nursing. October Update It has been recognised that the list of essential skills (currently in excess of 40) needs a refresh with a view to significantly reducing this number. The list has therefore been forwarded as requested to the director of nursing for review. The outcome is awaited. September Update Essential Skills emphasis is currently on aspects identified within the CQC report, mostly in relation to maternity. These are now priority actions which has led to delays in the progress of other planned essential skills work.	Dec-2016	Dec-2016	NA	Interim Director of Workforce and Organisational D	Pamela Wood

6658	Medical	Mar-2016	Keeping 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 CRH. This results in the following: patient harm and death, increase in mortality of 1.5% per hour wait for a bed; poor patient experience from inability to access an appropriate clinical area for their care, waiting in hospital corridors within the ED with poor privacy and dignity; Risk to delivery of a safe ED service due to lack of capacity to manage and risk assess undifferentiated new ED patients; increased risk of violence and aggression towards staff and other patients; poor staff morale due to frustration of inability to undertake the work for which they are employed; poor compliance with reportable clinical indicators: 4 hour emergency access target; time to initial assessment; ambulance turnaround, resulting in financial penalties	1 Patient flow team supported by on-call Management arrangements to ensure capacity and capability in response to flow pressures. 2 Employed an Unplanned Care Lead to focus across the Organisation bringing expertise and coaching for sustainable improvement .3 Daily reporting to ensure timely awareness of risks. 4 4 Hourly position reports to ensure timely awareness of risks 5 Surge and escalation plan to ensure rapid response. 6 Discharge Team to focus on long stay patients and complex discharges facilitating flow. 7 Active participation in systems forums relating to Urgent Care. 8 Phased capacity plan to ensure reflective of demand therefore facilitating safer flow. 9 Weekly emergency care standard recovery meeting to identify immediate improvement actions 10 Daily safety huddles to pro-actively manage potential risks on wards with early escalation. 11. Programme governance including multi Director attendance at Safer Programme Board and monthly reporting into WEB. 12. Single transfer of care list with agency partners	1. Capacity and capability gaps in patient flow team 2. Very limited pull from social care to support timely discharge 3. Limited used of ambulatory care to support admission avoidance 4. Tolerance of pathway delays internally with inconsistency in documented medical plans 5. Unable to enhance winter resilience in a timely manner due to external funding reductions from 2014/15 levels as escalated to Board, Monitor and local System Resilience Group 6. Roving MDT (which supports discharge of complex patients) ceased pending Systems Resilience Group funding decision. 7. Lack of system resilience funding and a risk that previously agreed funding will be withdrawn. Action internal assessment meeting to understand the risk of this (September w/c 19.9.19.)	20 4 x 5	16 4 x 4	9 3 x 3	September 16 Update Single transfer of care list in place and finalised with agency partners meaning that there is consistent prioritisation of discharge planning. Integrated the discharge and social care teams on both sites. New process in SAS and Medicine for matron reviews every morning identifying and actioning discharge planning. Associate Director in place focusing on urgent care and safer flow. Active participants in the NHS I Improvement Programme for Emergency Care. October 2016 Continued progress on SAFER Programme improvement work. CHFT part of the WYATT Accelerator Zone- to deliver the ECS 95% standard. This is about system resilience, improved patient flow, creating capacity by improved discharge with social care involvement. December 2016 As CHFT continue to experience a high number of patients on a green cross pathway this impacts on flow out of the ED. The A&E Delivery Board, chaired by CCG and all partners are members has made improving discharge and reducing patients on a green cross pathway as their main priority for the system. The accelerator zone funding has been received and actions are bing taken to introduce a frailty team from the begining of January 2017. Staff the Medical Ambulatory Area over 7 days with the necessary equipment purchased.	Jan-17	Mar-2017	BOD	COO Helen Barker	Bev Walker

ID	Division	Date	Objective	Risk	Controls	Gaps	Initial	Current	Target	Actions / Updates	Review date	Due date	Committee	Lead	Owner
6300	Trustwide	May-2015	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.	- System for regular assessment of Divisional and Corporate compliance - Routine policies and procedures - Quality Governance Assurance structure - CQC compliance reported in Quarterly Quality and Divisional Board reports -Action plans in place for areas that have been identified as requiring improvements including those areas identified by the CQC during and after the inspection -A fortnightly meeting is being held to monitor progress with the action plans chaired by the Chief Executive - An external review of the maternity service, by the Royal College of Obstetricians and Gynaecologists, has been conducted	The inspection report has shown us to be in the "requires improvement" category An action plan is being developed but not yet approved	16 4 x 4	16 4 x 4	8 4 x 2	CQC compliance Steering Group Implementation CQC Compliance action plan CQC Operational Group Further embedding of CQC assurance into the Divisions and Corporate Governance structures October update The action plan has been reviewed at the Trust Board meeting in September. Core service improvement plans are also in development and expected to be completed at the end of October. The report from the RCOG relating to maternity services is due in month. November update RCOG report has been received and the maternity service are incorporating recommendations into their plans. A number of actions are completed that were due for October. All core services have approved or drafted action plans. Quality summit didn't identify areas for improvement that weren't already included in the action plan. A number of "Go See" visits have occurred including from the CQC and the CCG. **December 2016 Update** Work continues on delivery of actions, "go see" visits and reportting on progress with actions to the CQC response group .	Dec-2016	Mar-2017	WEB	Brendan Brown	Juliette Cosgrove
6694	Trustwide	Mar-2016	Keeping the base safe	Risk that the divisional governance structures are not sufficiently standardised and mature to provide assurance on quality and safety due to inconsistent divisional governance systems and processes and lack of application of agreed terms of reference and divisional and directorate Patient Safety Quality Boards (PSQB) resulting in the Quality Committee having a lack of assurance on quality and safety at divisional and directorate governance level	Divisional PSQB terms of reference used for each divisional PSQB. Supplementary governance manager resource within divisions.Quarterly quality and safety report from divisional PSQB to quality committee and hoc reports to Quality committee on specific quality issues eg, Stroke, # Neck of Femur Action plan in place to deliver improvements	Consistent application of PSQB terms of reference at Divisional and Directorate level.Variable quality quarterly PSQB reports to Quality Committee.Varied model of governance support into and within Divisions. Varying structures and processes for quality governance at Directorate and Speciality level.	16 4 x 4	16 4 x 4	8 4 x 2	Review of governance support to divisions Application of standardised governance approach to PSQBs October update The Director of Nursing has met with 3 divisions to understand where some of the gaps are and to agree specific areas of improvement. Actions continue to be implemented. November update A set of Governance Standards are being developed for ward and departments. Sessions on the Ward Managers Development Programme in October have covered areas relating to governance. A review of divisional risk registers is to be undertaken in November.	Dec-2016	Dec-2016	QC	Director of Nursing Brendan Brown	Juliette Cosgrove

6596	Corporate	Jan-2016	Keeping the base safe	Risk of not conducting timely investigations into serious incidents (SIs), due to not responding quickly enough to the new national SI framework introduced in March 2015, resulting in delayed learning from incidents, concerns from commissioners and delays in sharing the findings with those affected.	- Revised Incident Reporting Policy aligns with national framework, with template reports, clarity on process for divisional sign off and Trust sign off of SIs. - Director led panels held weekly to ensure quality assurance of final reports. Meet commissioners monthly on SIs - Patient Safety Quality Boards review of serious incidents, progress and sharing of learning - Accurate weekly information for divisions identifying serious incidents and timescales for completion of reports - Investigator Training - 1 day course held monthly to update investigator skills and align investigations with report requirements. - Recent introduction of Serious Incident Review group chaired by Chief Executive to ensure senior Trust wide oversight and peer challenge of SIs - Investigations Manager to support investigators with timely and robust Serious Incident Investigations reports and action plans - Learning summaries from SIs presented to Quality Committee, Serious Incident Review Group monthly and shared with PSQB leads for divsional learning	1. Lack of capacity to undertake investigations in a timely way 2. Need to improve sharing learning from incidents within and across Divisions 3. Training of investigators to increase Trust capacity and capability for investigation	16 4 x 4	16 4 x 4	8 4 x 2	1. Capacity - recruitment taken place for dedicated investigation resource in Governance and risk team - final stages of recruitment process being completed 1. Ongoing delivery of Effective Investigation Training Course (1 day, monthly) 2. Greater identification and sharing of learning from each SI, sharing within PSQBs and across division through reporting and SI review group October update There remains concerns about the timeliness of reports but the quality is improving. A business case is being developed to recruit staff with specialised investigation expertise. November update A training day was held for 14 staff in October. All SI investigations now have a trained investigator allocated. Business case for investigators still being developed. **December 2016 Update** Plan to explore option to increase investigator capacity with neighbouring organisations.	Dec-2016	Dec-2016	QC	Director of Nursing, Brendan Brown	Juliette Cosgrove
6723	Corporate	May-2016	Financial sustainability	Risk that the Trust will have to suspend or curtail its capital programme for 2016/17 due to having insufficient cash to meet ongoing commitments resulting in a failure to develop infrastructure for the organisation. There is a risk that NHS Improvement will not approve the Trust's capital programme for 2016/17 due to national funding pressure also resulting a failure to develop infrastructure for the organisation.	Agreed £5m capital loan from Independent Trust Financing Facility (ITFF) received in April 2016 to support capital programme, specifically the Electronic Patient Record (EPR) investment. Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling. Discussed with NHS Improvement and planned for distressed cash support.	.	20 5 x 4	15 5 x 3	12 4 x 3	November update: The forecast capital expenditure of £27.64m against the planned £28.2m is as per the submission made to NHSI in June, against which assurance has been received with regard to the availability of cash support. On this basis, after an internal review of our cash, operational, and legislative compliance requirements, the Trust continues to reprioritise spend within the overall value discussed with NHSI. Any changes to the make-up of the programme follow the completion of a full risk assessment. **December update:** The forecast capital expenditure is £27.65m against the planned £28.2m. A level of capital expenditure on EPR has now been pushed back to month 12 and a proportion of this expenditure is now forecast to be paid in cash terms the next financial year. This has reduced our loan drawdown requirements for 2016/17, but will need be added to the assessment of 2017/18 borrowing. The Trust is mindful of the limited availability of capital funding nationally. On this basis, the organisation continues to constantly review our capital programme whilst taking into account operational, and legislative compliance requirements	Jan-17	Mar-2017	FPC	Keith Griffiths	Kirsty Archer

6829	Family & Specialist Services	Aug-2016	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. Due to the HRI and CRH Aseptic dispensing facilities not being compliant with national standards as identified by stat external audits EL (97) 52. The audits are undertaken by the Regional Quality Control Service on behalf of NHSE. Critical findings would be reported to the MHRA who have statutory authority (under the Medicines Act 1968) to close the unit if it does not comply with the national standards. The 20 year old HRI unit is a maximum life-span up to the end of 2018.capital investment is required for the development of the capacity of the CRH unit and the compliance with national standards. Resulting in the lack of availability of high risk critical injectable medicines for urgent patient care.Non-compliance with national standards with significant risk to patients if unresolved.	Rigorous environmental and microbiological monitoring of the current facilities and the introduction of in- process controls to ensure no microbial contamination of final products. Self-audits of the unit External Audits of the units undertaken by the Quality Control Service on behalf of NHSE every 18 months. Audit findings and action plans are reported to the FSS Divisional Board with monitoring of non-compliance.	If a business case for the development of the Aseptic Service is not approved within this financial year then this will result in a 'critical non-compliance 'rating for the HRI unit by the external auditors in 2017 creating a major capacity problem in 2018.	15 3 x 5	15 3 x 5	0 3 x 0	The procurement of manufactured ready to administer injectable medicines when available from commercial suppliers. The first phase will be the procurement of dose- banded chemotherapy as soon as regional procurement contracts have been approved. This will create some capacity. The business case for the future provision of Aseptic Dispensing Services to be produced by November 2016 with a view to consideration and approval by the Commercial Investment Strategy Group taking into account commercial procurement of some products. If the business case is approved then the risk will be reduced. The target risk of 0 will be achieved on completion of the refurbishment of the CRH unit.	Jan-2017	Dec-2018	DB	Brendan Brown	Mike Culshaw

6841	Corporate	Sep-2016	Keeping the base safe	Risk of: Not being able to go live with the Electronic Patient Record due to: Lack of operational readiness,training issues, staffing levels (see risk 6345), vacancies, Lack of colleague ownership and engagement for the EPR at all levels of the organisation and availability of suitable IT equipment. During cut over, Lack of clear processes to carry out paper monitoring of the go-live period. Productivity and efficiency may reduce as colleagues defer to paper systems. POST GO LIVE: Inability to use the system effectively once support mechanisms reduce following Early Live Support. Lack of confidence of the system due to any quality and/or performance issues. Efficiency and productivity may reduce due to inexperience of system and Inability to report against regulatory standards. Resulting in: Reputational damage due to inability to go live with the EPR, financial impact, impact at every point of patient care and continued use of paper records. Also national and local targets may be put in jeopardy and Contractual Penalties for the Trust.	Pre go-live - A robust governance structure is in place to support the implementation of the EPR, including EPR specific risk register reviewed at weekly EPR meeting. - Weekly EPR operational board with direct escalation to WEB (and sponsoring group) - 90/60/30 day plans will aid control - 1:1 consultant plan Cut over: - Strong cut over plan with a developed support structure for BAU post ELS. - Command and control arrangements for cut over (Gold, Silver, Bronze) Post go-live: - gap	1. Training – need to monitor uptake of EPR training (EPR team and divisions by mid-September 2016) 2. Need to identify capacity and activity gaps through divisional operational readiness reporting 3. Number of EPR Friends/effectiveness of EPR friends.	15 5 x 3	15 5 x 3	10 5 x 2	Engagement and operational readiness sign off closer to go live date via operational readiness checklist and EPR passport. Closely monitor progress around training and staff feedback following the sessions. Further work with the divisions to clearly communicate the operational groups expectations and measure progress through the divisions reporting back to the operations group. **December 2016 Update:** - EPR Friends training underway raising awareness throughout the trust - Divisional Leads identified to help bridge the gap - SIM Centres and Demo Days running with good engagement numbers - Operational meetings back to weekly (divisional specific every 2nd week) Significant progress has been made against the gaps in controls but not enough to reduce the likely hood yet. A full training plan with dates is likely to help reduce the score pre-go live.	Jan-17	Sep-2017	RC	Helen Barker	Mandy Griffin
6715	Corporate	Apr-2016	Keeping the base safe	There is a risk to patient safety, outcome and experience due to incomplete or poor quality nursing and medical documentation. Poor documentation can also lead to increased length of stay, lack of escalation for when deterioration occurs, poor communication and multidisciplinary working.	Monthly clinical record audits (CRAS) with feed back available form ward to board A further qualitative audit is undertaken monthly by Matrons that includes patient understanding . Medical audits are undertaken Analysis and action planning is managed through divisional patient safety and quality board A multi professional clinical documentation group meets bi monthly to ensure new documentation is ratified, standards on documentation are addressed. This group also receives reports and audits with regard to documentation and identifies to the divisions areas (teams, wards departments) of concern as well as any specific areas of concern within a specific standard. Clinical records group monitors performance, highlighting best and worst performing wards and action plans are developed and managed through the divisions, including specific areas for improvement.	The number of audits undertaken can be low Unable to audit to allow and act on findings in real time The discharge documentation is under going review Fluid balance is being reviewed, the evidence base is being examined by the Deputy Director of Nursing	20 4 x 5	15 3 x 5	8 4 x 2	The Trust is developing an electronic patient record that will enable reports to be run in real time, audits can be undertaken by the ward or department lead when they deem it necessary (daily, weekly, monthly) There are alerts and stops within the system to prevent the user skipping documentation. October Update There is recognition that the improvement work required will take time to embed and therefore the CRAS audits have been suspended until January 2017. The revised falls documentation will be tested on wards 6 and 7 at Calderdale Royal Hospital, over this period compliance with the documentation will be audited. The Matrons will also continue to work with teams to make improvement with the fluid balance charts There will be no further date until January 2017 November Update The Clinical Record Audits remain suspended with the divisions focusing on improving falls and fluid balance documentation. Progress will be reported through divisional Patient Safety and Quality Boards The senior nurse team are reviewing the ward assurance framework which will include documentation; the anticipated timeframe to test the revised assurance is January 2017. **December Update** The improvement work and ward assurance remains in development.	Feb-2017	Mar-2017	QC	Brendan Brown	Jackie Murphy

6693	Corporate	Mar-2016	Keeping the base safe	Risk Of: Failure to comply with the NHS Improvement cap rules. Due to: Bed capacity – The Trust has opened a significant number of additional beds in response to service pressures requiring safe staffing levels. No. of vacancies in the workforce – The Trust has a high number of vacancies across its workforce resulting in the requirement to engage agency staff (including national shortages). Resulting in: High usage of externally sourced agency workers, utilising agency that breaches the cap rate and in circumstances uses off-framework agencies. Regulator sanction – The Trust receiving a regulatory sanction given the number of breaches the Trust currently reports against the NHS Improvement agency cap. Safety risk – The Trust is unable to fill vacant posts (Medical, Nursing, AHP, A&C) resulting in the risk of patient safety, quality and care.	The Trust collects weekly information on the number of breaches of the Monitor cap and reports this through to Monitor. Assurance via Finance and Performance and Well- led Group The Trust has performed a number of challenge sessions to review all existing long term breaches of the NHS Improvement cap. Following this one-off exercise the Trust has sought to integrate this review/challenge into the existing Divisional Business Meetings. An exercise has been carried out to write a letter to all agencies (across all staff groups) requiring agencies to comply with the NHS Improvement cap imposed. Nursing - The Trust has a centralised escalation process in place for the authorisation of requests to secure agency workers for Nursing staff (qualified and non-qualified), through to Nursing Director. The Trust has rich information on the Nursing workforce, covering bank, overtime and agency as a monitoring tool for spend/bookings. Medical – Exec authorisation of requests to secure agency workers/locums AHP's – Exec authorisation of requests to secure agency workers Admin & Clerical – Exec authorisation of requests to secure agency workers	Robust escalation and management information for all non-Nursing staff groups. Disparate data sets around agency use & spend making adequate overview difficult. Delays have occurred in implementation of systems to facilitate efficiencies in rostering , bank/agency use and job-planning. Recommendation to install programme approach for tighter project control of multiple workforce projects, including multi-system rollout to be taken to Workforce Well Led Committee 08/12/16.	15 3 x 5	15 3 x 5	9 3 x 3	**December 2016 update** A further paper to the Weekly Executive Board that requests gaps in controls are addressed and requests a directive from the Exec Board about absolute compliance with the agency cap and framework compliance guidance. The Safe Staffing Utilisation and Efficient Programme (NHS-I SMART Plan) has been signed off by Board and workstreams identified are to be implemented from within Divisions and by Corporate leads. November Update A Programme Board will be established to provide governance, support and structure to Trust wide initiatives to improve and embed a consistent model for medical, nursing, midwifery and AHP workforce utilisation and efficiency and subsequent reduction in the reliance on medical locums and overall use of agency medical and non-medical workforce. I.T. system implementation is scheduled to modernise the processes around job planning, Rostering and booking of flexible and interim workforce ensuring this is done through the most cost effective measures. Key leads will engage with agencies to ensure all agency/interim staff is engaged only where absolutely necessary. Pay rates and commission rates are being renegotiated with each agency. All mid-long term agency staff contracts are to be reviewed and renegotiated where possible. All Divisions are responsible for keeping an action log / task list to ensure all possible action is being undertaken to negate the need for agency workforce. The Trust will work to increase and optimise the availability of bank staff whilst simultaneously modernising access to the bank booking system. The wider NHS-I SMART Plan addresses a number of initiatives designed to improve upon the Trust's recruitment and retention strategy including; reviewing skill mix, embedding a rolling programme of HCA recruitment, advertising for Bank Doctor vacancies and other local, national and international initiatives.	Jan-2017	Mar-2017	WLG	Ian Warren,	Mark Borrington, Programme Manager

6886	Corporate	Nov-2016	Transforming and improving patient care	The seven day service compliance is a part of one of the five categories that the Single Oversight Framework is judged on. As the trust is an early adopter of the four priority standards (2, 4, 5 and 8) it is expected that full compliance will not be achieved by March 2017. At present the impact of not meeting this is not clear as NHS Improvement have not stated what (if) penalties are in place for un met targets. The panel discussed the likely outcomes of not meeting this deadline (financial? Monitoring? Greater oversight?). It was also mentioned that nationally the target is September 2020, and whether we would expect to be able to meet the standards by this date also. This is due to split site acute services, no additional investment for the extra consultants needed, consultant workforce vacancies and difficulties in recruiting. This will result in inconsistent service delivery over the 7-days and especially at weekends. In turn this may impact on clinical outcomes, patient flow and patient experience. Currently there is no contractual obligation or penalty in not achieving compliance with the four priority standards by March 2017. This may also impact on local and national reputational loss and be focus of future enquiry.	High level action plans are being reviewed with the aim of developing more detailed plans to review what can be achieved within current resources and current configuration of acute services. This will include details of workforce and skill mix, financial implications and full benefits such LOS and patient experience. This will need to take into account what can realistic be achieved with the scope of the 5-year plan. 7DS reports via the Safer Programme.	The main reasons for not achieving compliance include: • Lack of dedicated funding to recruit additional consultants to meet compliance • Existing difficulties in retaining and recruiting to consultant posts within certain specialties especially in Medicine and Radiology • Split-site configuration of hospital services. Whilst the completion of a more detailed action plan will help identify possible solutions towards achieving compliance it is doubtful that within current resources and current configuration of acute services that full compliance will be achieved. Note the national timeline for all trusts to achieve full compliance with the priority standards is 2020 which is before the likely 5-year timeline to reconfiguration of acute services. Also at present whilst there is no financial penalty in achieving compliance this may change in the future.	15 3 x 5	15 3 x 5	9 3 x 3	Impact and in particular response to non-compliance from NHSI will require further monitoring. **December 2016:** Work on plans ongoing	Jan-2017	Mar-17	BOD	David Birkenhead	Sal Uka

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Andrea McCourt, Head of Governance and Risk
Date: Thursday, 5th January 2017	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: Risk Management Strategy - To detail the organisation's strategic approach to risk management.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Risk and Compliance Group - 11.10.16 Quality Committee – 31.10.16. Audit Committee members – via e-mail Executive Board - 22.12.16.	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

A Trust Risk Management Strategy for the management of both clinical and non-clinical risk is presented to the Board of Directors for review and approval.

Main Body

Purpose:

At present there is a risk management policy in place but no risk management strategy, which is an identified gap.
The enclosed Risk Management Strategy has therefore been developed.

Background/Overview:

The Trust has a Risk Management Policy in place which combines largely operational information on risk management and risk registers.

The enclosed Risk Management Strategy details the objectives and organisational framework for risk management systems within the Trust.

It confirms roles, responsibilities and processes for risk management in order to reduce harm, create safer environments for care and achieve the Trust's strategic objectives.

The Issue:

The Risk Management Strategy cover the following areas:

1. Vision and Statement of Intent for risk management
2. Components of the Risk Management Strategy
3. Benefits of Managing Risk
4. The Way We Work
5. Risk Appetite
6. Organisational Structure for Risk Management
7. Accountabilities, Roles and Responsibilities and Organisational Framework
8. Systems and Processes for Managing Risk
9. Risk Management Training

Next Steps:

Following the approval of the Risk Management Strategy this will be communicated to staff and the Risk Management Policy will be revised.

Recommendations:

The Board of Directors is asked to approve the Risk Management Strategy.

Appendix

Attachment:

Board pdf Risk Management Strategy v 0.4 December 2016.pdf

Risk Management Strategy

Version 0.4

Important: This document can only be considered valid when viewed on the Trust's Intranet. If this document has been printed or saved to another location, you must check that the version number on your copy matches that of the document online.

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Risk and Compliance Group	Assistant Director of Quality, Juliette Cosgrove	11.10.16.
Quality Committee	Non Executive Director	31.10.16.
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Does this document map to other Regulator requirements?	
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NHS Improvement	Single Oversight Framework

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0.2	Second draft 20.10.16. amended for comments from Risk and Compliance Group members
0.3	Amendments from Audit Committee members
0.4	Amendments to incorporate Raising Concerns / Freedom to Speak Up

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1. Introduction

The purpose of this Risk Management (RM) Strategy is to confirm the objectives and organisational framework for risk management systems within the Trust. It details roles, responsibilities and processes for risk management in order to reduce harm, create safer environments for care and achieve the Trust's strategic objectives.

The underpinning risk management processes will ensure that risks are identified and managed, and reported appropriately through the organisation as part of the Trust's system of internal control. Definitions of risk and risk management are given at Appendix 1.

The strategy is relevant to all staff, including those on temporary contracts, contractors, membership councillors, and bank/agency staff, volunteers and Private Finance Initiative (PFI) partners. It is also relevant to all those who partner with or work with the Trust.

2. Vision and Statement of Intent

2.1 Risk Management and Strategic Objectives

The stated aim of Calderdale and Huddersfield Foundation Trust is:

Together we will deliver outstanding compassionate care to the communities we serve.

Our strategic objectives to deliver this aim are to:

- Transform and improving patient care
- Keep the base safe
- Have a workforce fit for the future
- Ensure financial sustainability

Risk management is central to implementing this strategy as the business of healthcare is by its very nature a high risk activity. The process of risk management is an essential control mechanism to identify and manage risks which may threaten the ability of the Trust to meet its objectives, and, as a consequence it increases the likelihood of the Trust achieving its objectives and strategic aim.

Risk and risk management is not about doing nothing for fear that we might make a mistake. Rather, risk policy and risk management are concerned with promoting an understanding of an organisation's strategy, operating environment and the associated risks and putting in place appropriate processes and procedures to identify, assess and manage risk. Risk identification, assessment, management and assurance is best understood as a constant cycle of activity: risks emerge, alter their significance and scale and may disappear without warning. Anticipation and early action to manage risk is the best defence. Her Majesty's Treasury offers guidance to all organisations in receipt of public funding as to how they may incorporate good practice. This guidance concludes it is essential that an organisation should:

- Understand the risks associated with all elements of its strategy and operating environment;

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- Have in place a framework for risk identification, risk assessment, risk management and assurance and the assignment of responsibilities;
- Have a clear policy and attitude to risk appetite and ensure that these are defined and communicated to all relevant parties;
- Review the adequacy and effectiveness of control processes for responding to risks

The Trust recognises that providing healthcare and the activities associated with the treatment and care of patients incurs clinical and non-clinical risk, both for the organisation and its stakeholders: our patients, staff, visitors, partners in the health and social care community and commissioners.

Risk Management is an integral part of the Trust's Board system of internal control and its effectiveness is reviewed annually by internal and external auditors. Key strategic risks are identified and monitored by the Board and operational risks are managed on a day to day basis by staff throughout the Trust. The Board Assurance Framework and Corporate / high level Risk Register provide a central record of how the Trust is managing its risks.

The Trust has a Maternity Risk Management Strategy within the Family and Specialist Services Division which sets out the strategic direction for risk management within maternity services. It details accountability, roles and responsibilities for the management of maternity risks to ensure that women and their families experience safe, clinically effective care at all times to ensure a positive birth experience and a healthy outcome for mother and baby.

2.2 Risk Management Three Lines of Defence

To ensure the effectiveness of the Trust's risk management processes the board and senior management team need to be able to rely on three lines of defence, including the monitoring and assurance functions with the organisation. This is depicted overleaf and explained below:

First line of defence – our front-line staff are the first line of defence. They must understand their roles and responsibilities for risk management using Trust processes and they must own and manage risk, as well as implementing operational management at directorate and divisional level. These are the teams with ownership, responsibility and accountability for directly assessing, controlling and mitigating risks.

Second line of defence – the second line of defence consists of the functions that reflect risk management, quality and compliance (which monitors and facilitates the implementation of effective risk management practices by operational management) and the processes that assist the risk owners to report adequate risk related information up and down the organisation. This line of defence includes the governance and management committees that provide assurance that risks are actively and appropriately managed.

3rd line of defence – the third line of defence is provided by independent audit, such as internal and external auditors, who through a risk-based approach provide independent assurance to Board and senior management team about how effectively the Trust assesses and manages its risks, how

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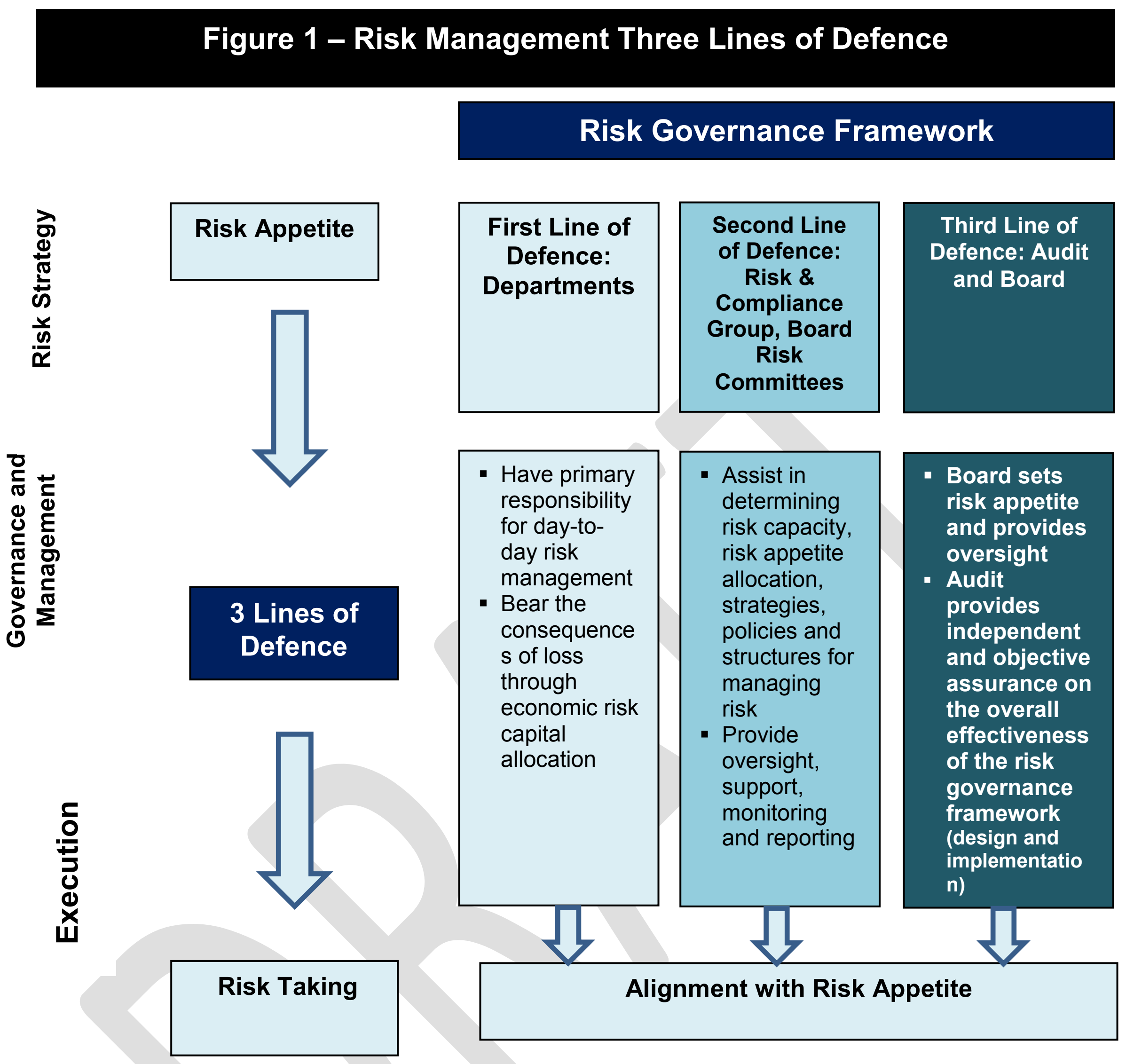
effective the first and second lines of defence are and looks at all aspects of risk across all organisational objectives.



The Trust will ensure that it's risk management arrangements meet the requirements of a number of national bodies including NHS Improvement, the Care Quality Commission (CQC), the Health and Safety Executive (HSE), Environmental Agency, the NHS Litigation Authority, our insurers, other agencies and systems supporting a safety culture, such as the National Reporting Learning System and all other regulatory and scrutiny bodies..

On behalf of the Board the Chief Executive signs annually a Governance Statement for the Department of Health which outlines how the organisation identifies, evaluates and controls risks together with confirmation that the effectiveness of the system of internal control has been reviewed.

2.3 Vision and Statement of Intent

The Trust's vision of this strategy is for risk management to be regarded as a highly valuable and useful tool to help the Trust achieve its objectives, with:

Risk management systems understood by staff
Risk management systems embedded into everyday working practice across all parts of the organisation
The Board and its committees assured that risks are managed to achieve the Trust's objectives

.
The Trust will aim continually to improve the content and maturity of the risk management framework.

2.4 Risk Management Objectives

The overall objectives for risk management at the Trust are to establish and support an effective risk management system which ensures that:

- Risks which may adversely affect patients, staff, contractors, the public and the fabric of buildings, are identified, assessed, documented and effectively managed locally to a level as low as possible, using a structured and systematic approach thereby providing a safe environment in which patients can be cared for, staff can work and the public can visit.

- Risks are managed to an acceptable level as defined in the Board's Trust risk appetite and staff have a clear understanding of exposure and the action being taken to manage significant risks

- Risks are regularly reviewed at team, directorate, division and corporate levels by accountable managers, ensuring that risks that are not able to be controlled locally are escalated, (a flowchart of risk escalation is given at section 9.4)

- All staff can undertake risk management in a supportive environment and have access to the tools they need to report, manage and monitor risks effectively – see section 9 for further details.

- All staff recognise their personal contribution to risk management

- Assurance on the operation of controls is provided through audit, inspection and gaps in control and risks are identified and actively managed

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2.5 Risk Scope

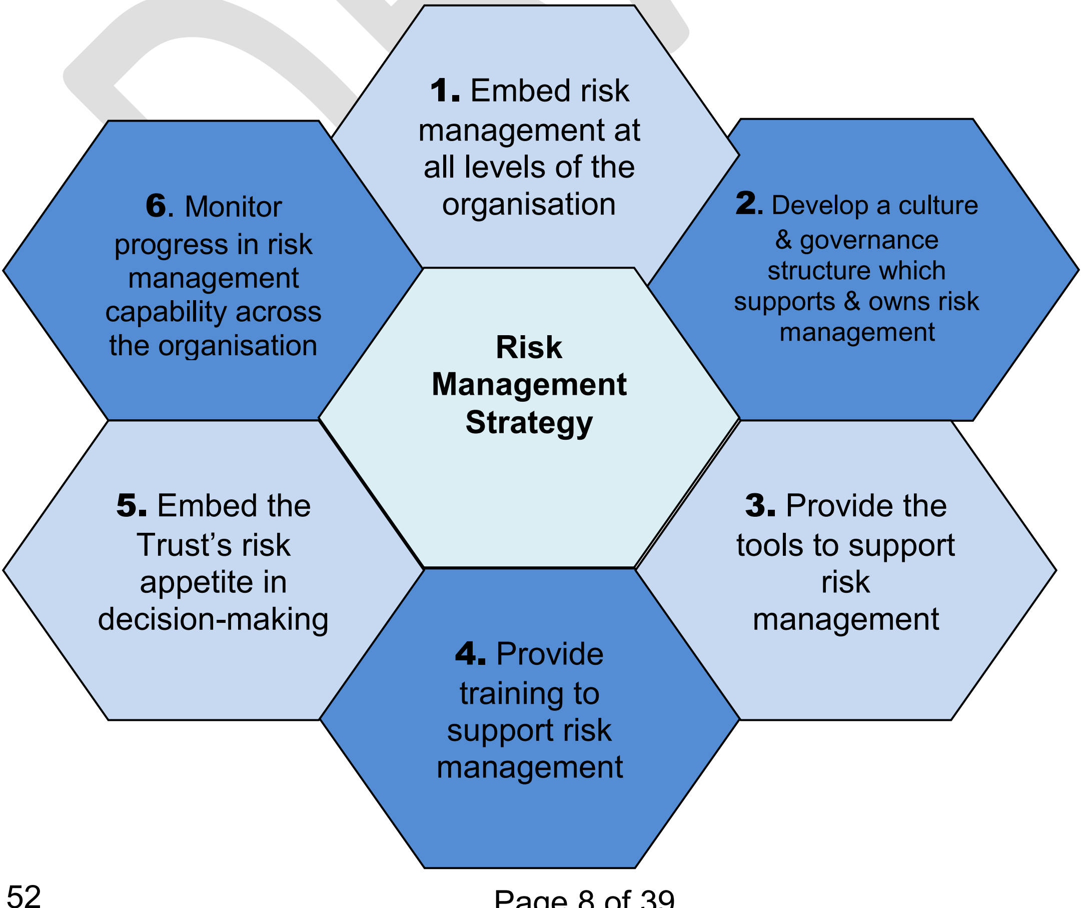
This Risk Management Strategy and the Risk Management Policy apply to all categories of risk, both clinical and non-clinical risks. These include, though are not limited to:

Clinical quality / patient safety risks	Operational / performance risks	Financial risks
Health and Safety Risks	Project Risks	Patient Experience Risks
Business Risks	Reputational Risk	Regulatory risks
Governance risks	Workforce Risks	Partnership risks
Information risks	External environment risks	Risks from political change / policy

3. Components of the Trust Risk Management Strategy

The components of the Trust's Risk Management Strategy to deliver this vision are given below.

These components will enable the organisation to manage inherent risks within the current systems and processes. The organisation will decide how to manage these risks in line with it's risk appetite (see section 6) and risk management processes, see Appendix 1. It is acknowledged that risks may emerge from external sources, particularly during times of change or when new systems or revised regulation is introduced, and the organisation will remain alert to these sources of risk.



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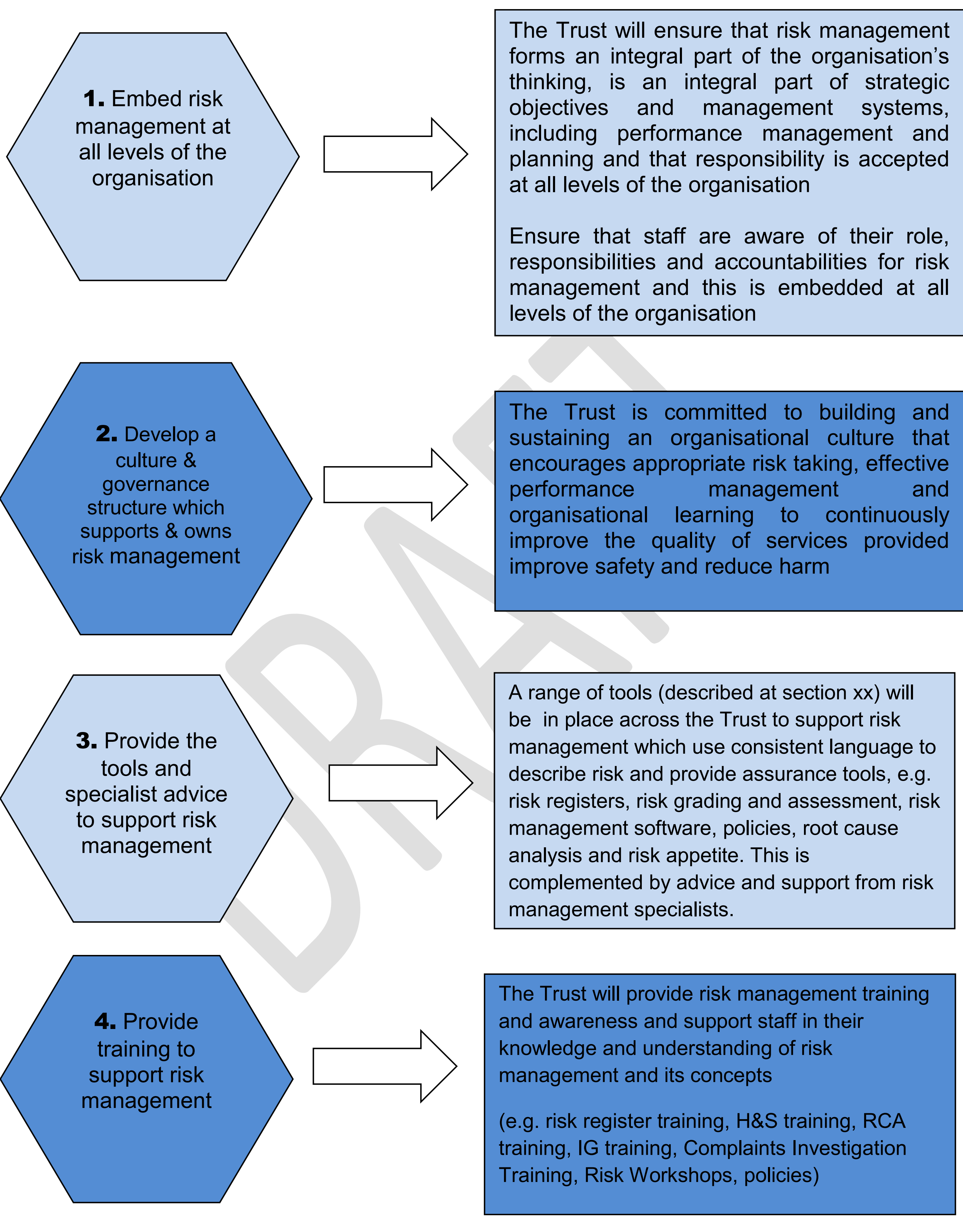
Details of each component are given below:



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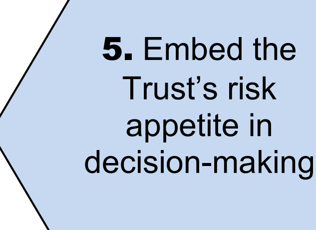
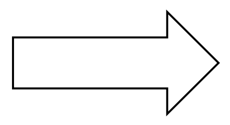
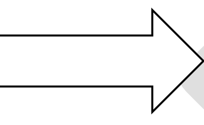




A Board approved practical and pragmatic risk appetite statement will enable decision-makers to understand risks in any proposal and the degree of risk to which the Trust can be exposed or extent to which an opportunity can be pursued.

6. Monitor progress in risk management capability across the organisation and effectiveness of control processes.



Ensure a review process is in place to assist in evaluating performance and progress in developing and maintaining effective risk management capability across the organisation and the effectiveness of risk

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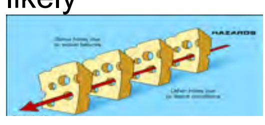
4. Benefits of managing risk

The Trust is committed to the effective management of risks which, among others, has the following benefits for the Trust:

Achievement of objectives is more likely

Adverse events are less likely



Opportunities can be better identified and explored

Outcomes are better: safety, effectiveness, efficiency.

We reduce firefighting and fewer costly surprises and re-work.

Performance is improved.

Decision-making is better informed, more open and transparent.

Reputation is protected and enhanced.

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5. The way we work

The four behaviours expected of all staff to deliver our strategic objectives are:

A pro-active approach to managing risk
The Trust aims to embed a culture in which true pro-active risk reduction takes place by aiming to anticipate and prevent risks, complementing the more traditional reactive approach to risk management by looking ahead and managing upcoming risks. This is achieved by staff and teams identifying pro-actively risks to avoid adverse events or by managing risks as far as reasonably practical to minimise the consequences of adverse events, for example for patient outcomes or preventing harm and reducing losses for the organisation. A key part of this pro-active approach to risk management is the use of risk assessment which is detailed as a key risk management tool in the organisation (see Appendix 4).

All members of staff have responsibilities and an important role to play in identifying, assessing and managing risk using the risk management strategy policy and supporting policies and procedures to guide them.

Staff should pro-actively identify and assess risks and manage these to avoid / minimise adverse events. *(We Do The Must Do's)*

To support staff in their role in managing risk the Trust seeks to provide an open, fair and consistent environment, encouraging a culture of openness and a willingness to admit mistakes and learn from them.

This means:

Staff are open about incidents they have been involved in and feel able to talk to their colleagues about any incident *(We Do The Must Do's)*

All staff, and others associated with the Trust, should report any situation where things have or could have gone wrong through the incident reporting process.

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Balanced with this approach is the need for the Trust to provide information, counselling, support and training for staff in response to such situation.

The organisation is open with patients, the public and staff when things have gone wrong and appreciates and explains what lessons can be learned (*We Put The Patient First)*

The Trust wants to learn from events and situations in order to constantly improve management processes, take a systems approach to learning, looking at contributory factors, including human factors to make changes to improve quality and safety. Where necessary and/or appropriate, changes will be made to the Trust's systems to enable this to happen.

The Duty of Candour and Being Open policy is a key tool to support this and to engage with families where things have gone wrong. Staff should be informed of feedback on actions taken as a result of an incident being reported.

Staff and organisations are accountable for their actions and are treated fairly and are supported when an incident happens (We Do the Must Do's)

In the interests of openness and candour, responding to concerns raised and learning from mistakes, formal disciplinary action will not usually be taken as a result of an investigation into an adverse event. However, the Trust's Disciplinary Policy outlines circumstances in which disciplinary action will be taken, e.g. professional misconduct. Should disciplinary action be appropriate this will be made clear as soon as the possibility emerges from an investigation and advice would be taken from the Workforce and Organisational Development department.

6. Risk appetite

No organisation can achieve its objectives without taking risks. An organisation's risk appetite is the amount and type of risk that the organisation is willing to take in the pursuit of its strategic objectives.

The risk appetite can help the Trust by enabling the organisation to take decisions based on an understanding of the risks involved. The organisation will communicate expectations for risk taking to managers.

The Trust uses the risk appetite matrix for NHS organisations developed by the Good Governance Institute to express its risk appetite.

There are 5 levels of risk appetite (excluding no risk appetite) which are detailed below.

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Risk level / appetite	Key Elements
MINIMAL (ALARP) – as little risk as possible	Preference for ultra-safe delivery options with a low degree of inherent risk and only for limited reward potential
CAUTIOUS	Preference for-safe delivery options with a low degree of inherent risk and limited potential for reward
OPEN	Willing to deliver all potential delivery options and choose while also providing an acceptable level of reward and value for money.
SEEK	Eager to be innovative and to choose options offering potentially higher business rewards, despite greater inherent risk
MATURE	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

Expressing the Trust's Risk Appetite

In line with best practice in corporate governance and risk management, the Trust will clearly express the extent of its willingness to take a risk in order to meet its strategic objectives through a risk appetite statement.

The risk appetite will be agreed by the Board and reviewed at least annually or as needed, as risk appetite levels may change depending on circumstances. Other parts of the organisation should not materially alter the Trust's risk appetite,

Risk Categories

Risks need to be considered in terms of both opportunities and threats and are not usually confined to clinical risk or finances – they are much broader and impact on the capability of the Trust, its performance and reputation. The risk appetite is also influenced by the overall objectives set by the Trust.

The Trust will agree categories of risk when defining its risk appetite and will publish these, which will cover the over-arching areas of:

- Quality, innovation and improvement, safety
- Financial
- Commercial
- Regulation
- Reputation
- Workforce

The risk appetite statement will be communicated to relevant staff and risks throughout the Trust should be managed within the Trust's risk appetite, or, where this is exceeded, action should be taken to reduce the risk.

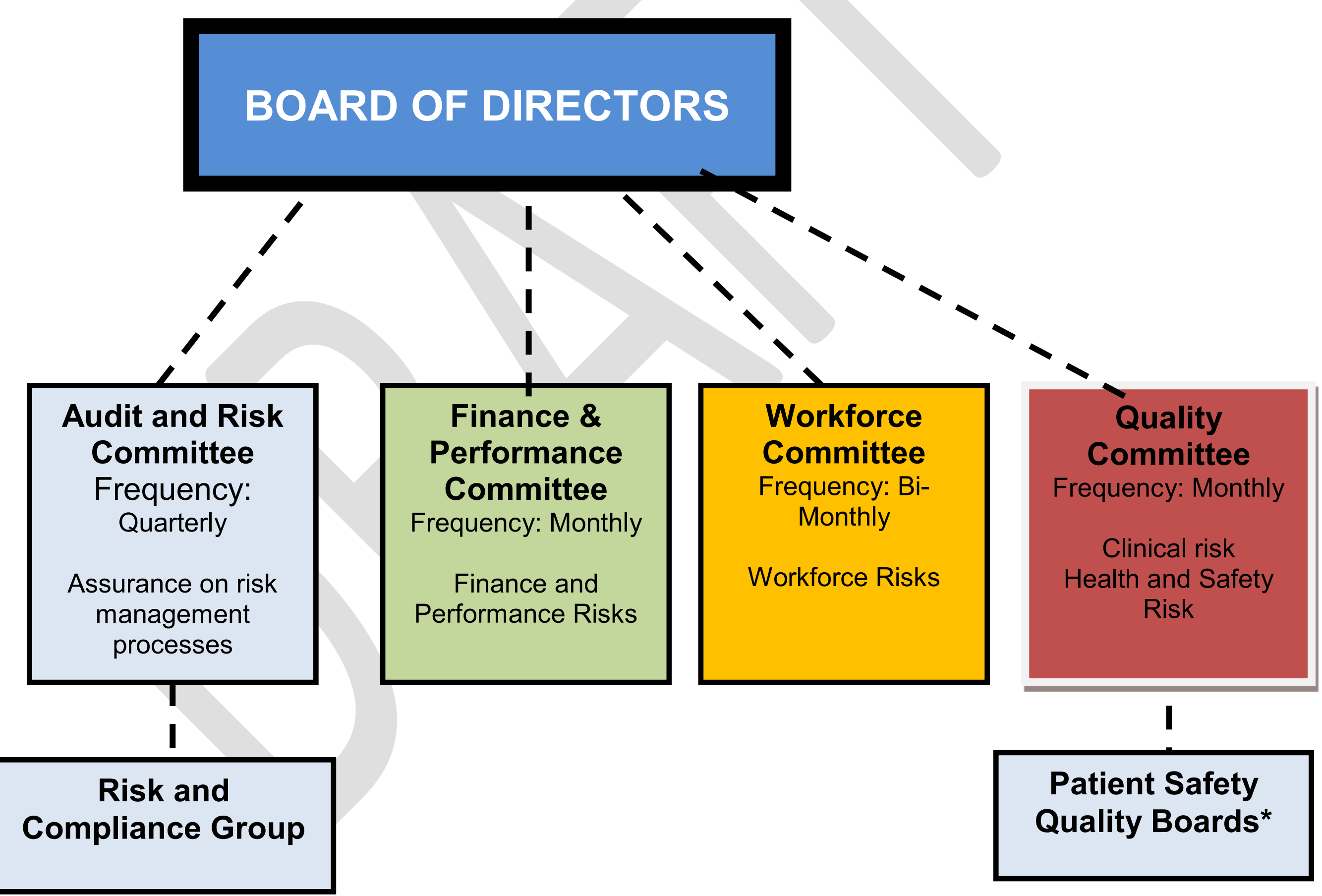
The Risk and Compliance Group will review the significant risks on the high level risk register to ensure that risks are acceptable within the Trust risk appetite.

The Quality Committee (for clinical risk), Audit and Risk Committee (for all clinical and non clinical risk) and the Board will also review significant risks and ensure that the Trust's overall portfolio of risks is appropriate, balanced and sustainable.

7. Organisational Structure for Risk Management

7.1 Organisational Structure

A full organisational structure, to help manage delegated responsibility for implementing risk management systems within the Trust is given at Appendix 2, with the key committees given below



*For a full list of sub groups reporting to Board Committees please refer to Appendix 2.

7.2 Roles and responsibilities of Committees responsible for risk

Trust Board

The Trust Board is responsible for ensuring that the organisation consistently follows the principles of good governance applicable to all NHS organisations. This includes the development of systems and processes for financial control, organisational control, governance and risk management.

Board members must ensure that the systems, policies and people that are in place to manage risk are operating effectively, focused on key risks and driving the delivery of objectives.

In the context of this Risk Management Strategy the Board will:

- Demonstrate its continuing commitment to risk management through the endorsement of the Risk Management Strategy, participating in the risk assurance process and ensuring that appropriate structures are in place to implement effective risk management

- Be collectively responsible for determining the Trust's vision, mission and values.

- Set corporate strategy and priorities and monitor progress against these; the Board must decide what opportunities, present or future, it wants to pursue and what risk it is willing to take in developing the opportunities presented.

- Routinely, robustly and regularly scan the horizon for emergent opportunities and threats by anticipating future risks.

- Set the Trust's risk appetite and review on an annual basis.

- Simultaneously drive the business forward whilst making decision which keep risk under prudent control

- Effectively hold those responsible for managing risk to account for performance through assurance processes and continuous improvement through learning lessons and ensuring these are disseminated into practice from complaints, claims, incidents and other patient experience data.

Audit and Risk Committee

On behalf of the Board the Audit and Risk Committee provides an independent and objective review of financial and corporate governance, assurance, systems of internal control and risk management. These activities apply across the whole of the Trust's clinical and non-clinical activities and they support the achievement of the Trust's objectives. The Audit and Risk Committee also ensures effective external and internal audit, monitors the performance of auditors and re-tenders for auditors services.

The Risk and Compliance Group, chaired by the Assistant Director of Quality, reports to the Audit and Risk Committee. It's role is to promote effective risk management and to establish and maintain a dynamic Board Assurance

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Framework and Risk Register through which the Board can monitor the arrangements in place to achieve a satisfactory level of internal control, safety and quality.

The Information Governance Group also reports to the Audit and Risk Committee.

To ensure that Board Committees are effectively managing risks within their remit, each Committee undertakes a self-assessment of performance annually and share these assessments with the Audit and Risk Committee.

Finance and Performance Committee

The Finance and Performance Committee has delegated authority from the Board to oversee, coordinate, review and assess the financial and performance management arrangements. This includes monitoring the delivery of the 5 Year Plan and supporting Annual Plan decisions on investments and business cases. It is responsible for identifying any financial and performance risks.

Workforce Committee

The Workforce (Well Led) Committee provides assurance to the Board of Directors on the quality of workforce and organisational development strategies and the effectiveness of workforce management in the Trust and is responsible for identifying any workforce and training risks.

Quality Committee

The Quality Committee provides assurance to the Trust Board that there is continuous and measurable improvement in the quality of the services provided and that the quality risks associated with its activities, including those relating to registration with the CQC are managed appropriately.

There are 9 groups that support the work of the Quality Committee and directly report to it, including the Health and Safety Committee, as depicted in the governance structure at Appendix 2.

The Company Secretary is responsible for the work of the Board and its Committees and for ensuring integration of their activities, particularly the governance and regulatory responsibilities.

8. Accountabilities, Roles and Responsibilities for Risk Management

8.1 The **Chief Executive** is the Accountable Officer of the Trust and as such has overall accountability for ensuring it meets its statutory and legal requirements and has effective risk management, health and safety, financial and organisational controls in place.

The Chief Executive has overall accountability and responsibility for:

- ensuring the Trust maintains an up-to-date Risk Management Strategy, is committed to the risk management principles in the Trust statement of intent and has a risk appetite endorsed by the Board

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- promoting a risk management culture throughout the organisation
- ensuring an effective system of risk management and internal control is in place with a framework which provides assurance to the Trust management of risk and internal control
- ensuring that the Annual Governance Statement contains the appropriate assurance requirements for risk management
- ensuring priorities are determined and communicated, risk is identified at each level of the organisation and managed in accordance with the Board's appetite for taking risk.

8.2 **The Chairman** is responsible for leadership of the Board and ensuring that the Board receives assurance and information about risks to the achievement of the organisation's strategic objectives.

8.3 Non-Executive Directors

All Non-Executive directors have a responsibility to challenge the effective management of risk and seek reasonable assurance of adequate control.

The Audit and Risk Committee, Quality Committee, Finance and Performance Committees and Workforce Committee are chaired by nominated Non-Executive directors.

The Senior Independent Non Executive Director is the Trust's Freedom to Speak Up Guardian in accordance with the Trust's Raising Concerns Policy.

8.4 Executive Directors

The following Executive Directors have particular responsibilities in respect of assurance and the management of risk summarised below. The Chief Executive will delegate responsibilities in relation to partnership working as appropriate.

Lead Executive Director	Risk Area
Director of Nursing The Director of Nursing is the Executive lead for risk management and patient safety in partnership with the Medical Director, ensuring organisational requirements are in place which satisfy the legal requirements of the Trust for quality and safety, patients and staff, including delivery of processes to enable effective risk management and clinical standards. The Company Secretary is the lead for the Board Assurance Framework	• Board lead for clinical risk management: – Risk Management Strategy and Policies – Risk appetite – Monitoring the management of risks across divisions and escalate as needed • Serious Incidents and Incident Reporting • Patient Advice and Complaints Service • Patient Experience • Quality and Quality Improvement • Safeguarding and Deprivation of Liberties • Quality regulatory compliance

Medical Director The Medical Director is the Executive lead for clinical risk and clinical governance, which is shared with the Director of Nursing and leads the quality improvement strategy. Responsible for informing the Board of the key risks from clinical activity, employment of doctors and their practice, training, supervision and revalidation.	• Clinical medical risk • Infection Prevention and Control • Caldicott Guardian information risks– delegated to the Associate Medical Director • Responsible Officer for GMC • Medicines Management – delegated to Chief Pharmacy Officer • Clinical audit and effectiveness • Compliance with NICE guidance • Quality Improvement • Research & Development
Director of Finance The Director of Finance has executive responsibility for financial governance and financial systems, is the lead for counter fraud and responsible for informing the Board of the key financial risks within the Trust and actions to control these.	• Financial risk • Procurement risk • Counter fraud and reporting to NHS Protect • Financial regulatory compliance
Chief Operating Officer The Chief Operating Officer has executive responsibilities, which include effective and safe delivery of clinical services through effective operational governance arrangements across the organisation and management of performance of all clinical services through divisional management teams.	• Performance risks • Performance regulatory compliance • Safe and sustainable operational services
Director of Workforce and Organisational Development The Director of Workforce and Organisational Development has executive responsibilities which include identification and assessment of risks associated with recruitment, employment, supervision, training, staff development and staff well – being.	• Staffing risks including training, workforce planning, recruitment and retention, • Workforce Policies • Professional registration • Staff Well Being
Director of Estates and Facilities The Director of Estates and Facilities: has executive responsibilities which include health and safety across the organisation, the estates and facilities infrastructure, including Medical Engineering and PFI sites.	• Health and Safety, including external reporting for RIDDOR • Security Management • Trust Resilience • Fire safety • Compliance with regulations / guidance on specialised building and engineering technology for healthcare • Estates and facilities and contractor risk • Medical Engineering • PFI contract

8.5 Board Directors

The following Board Directors also have responsibilities for assurance and management of risk.

Director of Transformation and Partnerships The Director of Transformation and Partnerships has lead responsibility for service redesign and reconfiguration and working together with our partners across the local health and social care economy.	• Risks in relation to service reconfiguration and transformation • Partnership risks
Director of Health Informatics Service The Director of Health Informatics promotes the need to manage information and IT risks, for the security of patient records and IT business continuity arrangements.	• Information governance risks and external reporting to the Information Commissioner • Senior Information Risk Officer – delegated to head of informatics, is responsible for ensuring the Trust manages its information risks, through the development of information asset owners and information asset administrators. • Electronic Patient Record.

8.6 Assistant Director for Quality

The Assistant Director for Quality supports the Director of Nursing and Medical Director in their clinical quality and safety and risk management responsibilities as well as quality improvement. This includes overseeing the risk management function, including the risk register and compliance with the requirements of CQC standards.

8.7 Clinical and Divisional Directors

Clinical and Divisional Directors have a specific responsibility for the identification and prudent control of risks within their sphere of responsibility. They are responsible for ensuring effective systems for risk management within their division and directorates and ensuring that their staff are aware of the risk management policy and their individual responsibilities.

In addition to Divisional Directors and Clinical Directors the divisional management team includes an Associate Director of Nursing and Associate Divisional Director.

They are responsible for demonstrating and providing leadership of risk management within their division, directorates and teams. They are accountable for:

- Pro-actively identifying, assess, managing and reporting risks in line with Trust processes
- Establishing and sustaining an environment of openness and learning from adverse events to prevent recurrence and creating a positive risk management culture
- Seeking assurance through their governance arrangements of the effectiveness of risk management

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- Ensuring clinical risks, health and risks, emergency planning and business continuity risks, project and operational risks are identified and managed.
- That general managers, operational managers, matrons, ward managers, departmental team managers are responsible for ensuring effective systems of risk management and risks registers are in place at all levels.

8.8 All Staff

All staff will:

- Accept personal responsibility for maintaining a safe environment, which includes being aware of their duty under legislation to take reasonable care of their own safety and all others that are affected by Trust business
- Be aware of, identify and minimise risks, taking immediate action to reduce hazards or risks
- Identify, assess, manage and control risks in line with Trust policies and procedures
- Be familiar with local policies, procedures, guidance and safe systems of work
- Be aware of their roles and responsibilities within the risk management strategy, policy and supporting policies, eg comply with incident and near miss reporting procedures
- Be responsible for attending mandatory and essential training and relevant educational events
- Undertake risk assessments within their areas of work and notify their line manager of any perceived risks which may not have been assessed

8.9 Contractors and Partners

It is the responsibility of any member of Trust staff who employ contractors, and their partners, to ensure they are aware of the Safe Management of Contractors policy and undergo Trust induction via the relevant Estates Department at either HRI or CRH. This will ensure that all contractors working on behalf of the Trust are fully conversant with CHFTs health and safety rules staff member responsible is fully aware of the contractors activity for which they are engaged and, if applicable, are in possession of the contractors risk assessment and method statement for their activity.

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9. SYSTEMS and PROCESSES for MANAGING RISK

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9.1 Policies

There are a number of key policies which support the effective management of risk, including the risk management policy which provides operational details of how we manage risk across the organisation. Other key policies include:

This policy/procedure should be read in accordance with the following Trust policies, procedures and guidance:

- Incident Reporting, Investigation and Management policy
- Complaints policy
- Claims policy
- Being Open / Duty of Candour Policy
- Major Incident policy
- Blood Transfusion policy
- Capability policy
- Claims Policy
- Complaints Policy
- Consent Policy
- DOLS
- Electronic Patient Record Standard Operating Procedures
- Emergency Preparedness, Resilience and Response Policy
- Falls Prevention and Management policy
- Fire Safety Strategy
- Freedom of speech/Whistleblowing policy
- Health and Safety policy
- Induction policy
- Infection Control policies
- Information Governance Strategy and associated policies
- Inquest Policy
- Mandatory Training Policy
- Managing External Visits Policy
- Maternity Risk Management Strategy
- Medicines Management policies
- Medical Devices policy
- Moving and Handling policy
- Patient Identification policy
- Personal Development Review
- Policy on the Appointment of Medical locums
- Policy for Developing Policies
- Policy on the implementation of NICE guidelines
- Promoting Good Health at Work Policy
- Race Equality Scheme
- Raising Concerns Policy
- Risk Management Policy
- Safe Management of Contractors
- Safeguarding
- Security Policy
- Waste Policy

All operational policies, procedures and guidance also support the effective management of risk.

9.2 Incident Reporting

The formal reactive method of identifying risks with the Trust is through the electronic risk management system, Datix where all staff can report incidents accidents and near misses in a timely way, with incidents graded for type and severity. This enables the organisation to investigate and identify learning to make quality improvements in patient safety at all levels of the organisation.

An Incident Reporting Policy is in place which details the processes for grading, reporting, investigating and learning from incidents and serious incidents and is a key part of our effective risk management processes.

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Staff wishing to raise concerns in accordance with the Raising Concerns Policy should utilise the reporting facility in that policy.

The Trust is committed to continue to improve its reporting culture throughout all professional groups of staff and others who work with it. It achieves this by ensuring that action is taken, changes in practice are implemented and services are improved as a direct result of the review and investigation of incidents and by identifying and reacting to themes.

9.3 Board Assurance Framework (BAF)

The Board Assurance Framework provides the Trust Board with an oversight of the strategic risks to meeting the Trust's objectives together with controls and methods of providing assurance that controls are effective. Risks on the BAF are owned by Trust Directors. .

The BAF maps out the controls already in place and the assurance mechanisms available so that the Board can be confident that they have sufficient assurances about the effectiveness of the controls. The risks are cross-referenced to the risks on the corporate risk register.

All risks from the BAF are presented to the Board at its public meetings. All other Board committees may make recommendations for including or amending strategic or significant risks. The BAF forms part of the evidence to support the Annual Governance Statement produced as part of the Annual Report and Accounts.

The assessment of risk within the Board Assurance Framework is reviewed at the Risk and Compliance Group. The risks on the Board Assurance Framework are scrutinised each quarter by the Board of Directors with input from the Quality Committee, the Finance and Performance Committee and the Workforce Committee, on the relevant risks. Oversight of the system of risk management, including the Board Assurance Framework, is provided by the Audit and Risk Committee.

The Board Assurance Framework is closely linked with the Corporate Risk Register (CRR), which reflects significant risks identified at both a corporate department and divisional level. The Company Secretary and the Head of Governance and Risk ensure that the link between the Corporate Risk Register and the Board Assurance Framework is maintained, and that the Audit and Risk Committee is satisfied that this is occurring.

9.4 Risk Registers

All areas assess record and manage risk within their own remit, reporting on the management of risks through the risk register, using the risk grading system detailed at Appendix 4. All risks are linked to strategic objectives.

A database is used to capture all risks to the organisation including clinical, organisational, health and safety, financial, business and reputational risks. A framework is in place for assessing, rating and managing risks throughout the Trust, ensuring that risks are captured in a consistent way. Risks can be analysed by risk score, division, directorate and team. Further detail on the process for populating the risk register is given in the Risk Management Policy.

It is the responsibility of each division to maintain and monitor their divisional

risk registers and ensure they feed into the Corporate Risk Register which is an integral part of the Trust's system of internal control.

The Corporate Risk Register includes those significant risks which may impact on the Trust's ability to deliver its objectives, with a risk score of 15 or above. These are reviewed on a monthly basis by the Risk and Compliance Group and presented to the Trust Board.

Divisional, directorate and team risk registers are managed and reviewed by the Divisions, with divisional risk registers reviewed on a regular basis by the Risk and Compliance Group. The performance framework for divisions also includes scrutiny of risks within divisions. The Risk Management Policy details the process for risk register reporting.

The diagram below depicts the flow of risks throughout the organisation from identification to assessment and management according to severity throughout the Trust.

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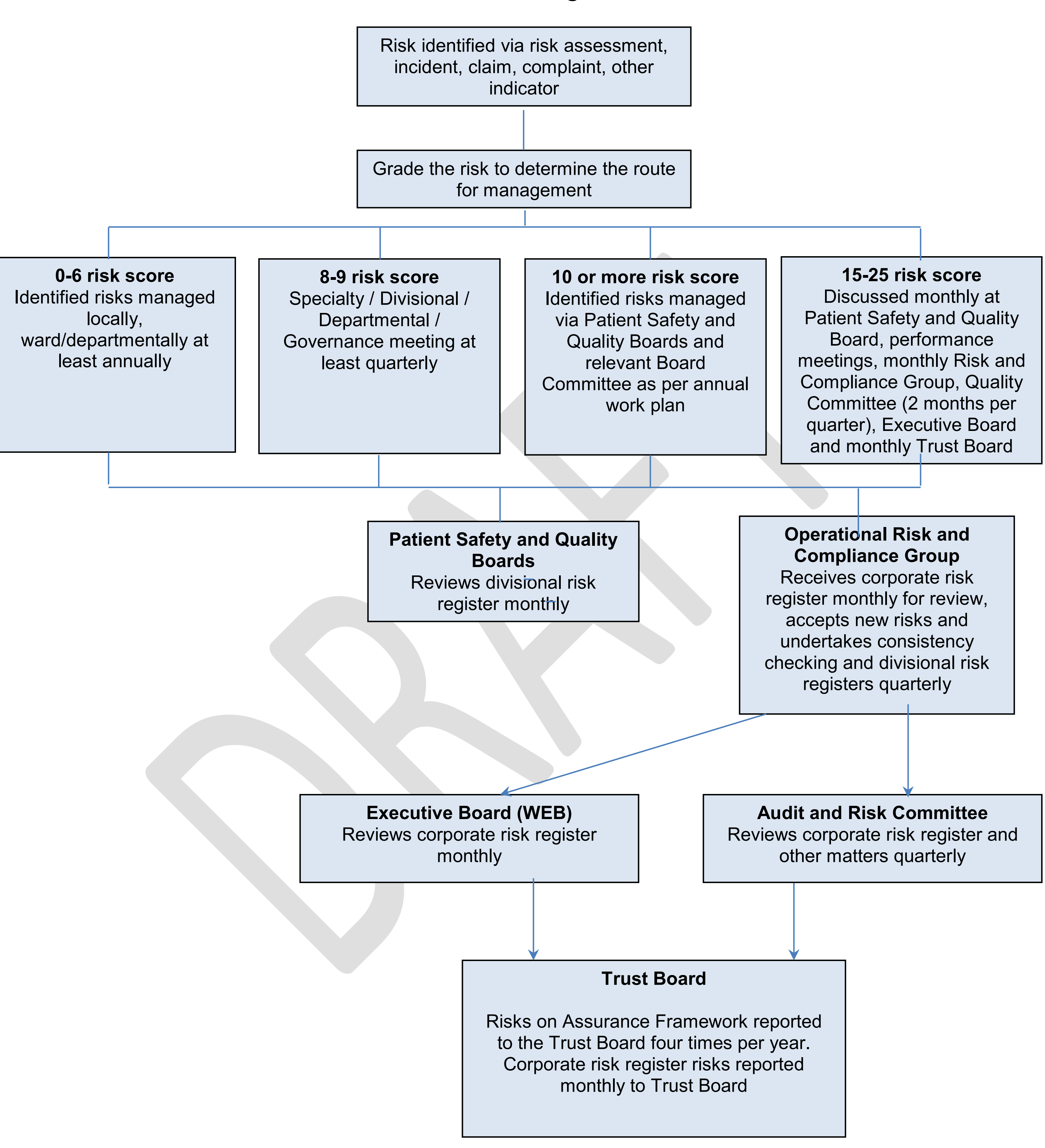
Structure and flow chart for the management of assurance and risk



9.5 Compliance Register

Each division will maintain a Register of Compliance, which records details of all external assessments, inspections and accreditations.

The register will include the due date of the inspection, and record whether any recommendations from previous visits are outstanding and identify any risk areas. These are reviewed every other month by the Risk and Compliance Group.

9.6 Risk Management Specialists

The Trust has risk management specialists who possess and maintain appropriate qualifications and experience so that competent advice is available to staff. As well as supporting staff manage risks, these specialists create, review and implement policies, procedures and guidelines for the effective control of risks.

Responsibilities of staff at all levels for risk are given at section 8.Details of Trust risk management specialists are given at Appendix 3.

Role	Responsibility
Caldicott Guardian Senior Information Risk Owner (SIRO) Information Governance Manager	Information Governance Risks
Company Secretary	Strategic Risks Foundation Trust risks Central alert systems risks
Director of Nursing	Clinical Risk
Director of Infection and Prevention Control (DIPC)	Infection Prevention risks
Medical Director	Safety incidents in NHS screening programmes
Head of Midwifery	Maternity Risks
Emergency Preparedness	Emergency Planning and business continuity risks
Fire Safety Manager Health and Safety Advisor Local Security Management Specialist (LSMS) Director of Estates and Facilities Director of Security	Fire Safety Advice Health and Safety risks Energy, all waste materials and sustainability Security Management
Controlled Drugs Officer Chief Pharmacist Medication Safety Officer	Medicines management Risks
Freedom to Speak Up Guardian	Raising Concerns risk
Patient Experience lead	Patient Experience Risks
Local Counter Fraud Specialist	Fraud Risks
Governance and Risk Team Assistant Director of Quality Head of Governance and Risk Risk Manager, Legal Services Manager Clinical Governance Support Managers / Quality and Safety lead	All risks and risk management tools, processes and training.
Head of Safeguarding / Safeguarding Team	Safeguarding Risks

9.7 Risk Management Software

The Trust uses a specialist risk management database, Datix, for incident reporting, complaints, concerns, claims and inquests to support identification, management and investigation into adverse events. The system allows the Trust to share information and triangulate data on an individual and aggregate basis, provides an easy way of staff to report and get feedback on incidents, ensure an appropriate level of investigation based on severity, capture actions and learning from adverse events and analyse data to identify themes and trends for the whole organisation.

A bespoke database is used for the management of the risk register, which allows reporting and analysis at directorate, divisional and Trust-wide level.

9.8 Risk Identification and Assessment

Risk assessment is a systematic and effective method of identifying risks and determining the most effective means to minimise or remove them. It is an essential part of risk management within the Trust.

The formal proactive method of identifying operational risks within the Trust us through the use of risk assessments. Clinical and non-clinical risk assessment is used to populate directorate, divisional and corporate risk registers. The Board of Directors is responsible for identifying strategic risks associated with the strategic direction of the organisation.

All risk assessments in all departments should be regularly updated and formally reviewed on an annual basis.

It is essential to identify the scale and significance of a risk. It is important to distinguish between these elements and to provide a clear and applied assessment; a risk may be extreme in scale without having great significance and vice versa. Equally it is important to assess and manage cumulative risk.

Guidance for staff on risk assessment is given in the Risk Management Policy.

9.9 Risks Grading Matrix

Staff should use the risk grading matrix, adapted from a national model by the National Patient Safety Agency for the NHS, to ensure a consistent approach to assessing risks.

The risk grading matric provides a description of risk types and defines an impact score from 1 – 5 and a likelihood score from 1 – 5. The impact score x the likelihood score determines the actual grading of the risk – refer to Appendix 4 for details.

The information produced from the risk assessment is used to populate the risk register.

For assessment of the severity of incidents, the Trust uses the grading scale given at Appendix 9 which grades no harm incidents as green, incidents with minimal harm as yellow, incidents with moderate or short term harm as orange and incidents where there is severe or long term harm or death as red incidents.

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Complaints are assessed in line with the grading policy within the complaints policy.

9.10 Root Cause Analysis / Learning

Formal root cause analysis is used throughout the Trust providing a structured approach for the analysis and identification of learning from incidents, complaints and claims. This is used in investigations to identify how and why incidents occur and inform actions and learning to prevent harm.

The Trust uses the Yorkshire and Humber contributory factors framework, a tool from the Improvement Academy with an evidence-base to optimise learning and address causes of patient safety incidents from incidents within hospital settings. It takes a systems approach and identifies situational factors, local working conditions, latent / organisational factors and latent / external factors and general factors that contribute to error, providing an opportunity to learn from error and prevent factors that cause harm to patients.

The Trust has a clear framework for undertaking root cause analysis for all moderate harm and severe harm incidents. This ensures that action is taken to prevent the potential for recurrence locally and at a corporate level. Specific root cause analysis processes have been developed for specific incidents, i.e. pressure ulcers, infection related incidents. These are detailed in the Incident Reporting Policy.

10. Risk Management Training

In order to develop a risk aware culture and to ensure successful Implementation of this strategy there needs to be training for staff.

Risk management training and awareness already occurs in a number of different methods, eg Board workshops, risk register training, root cause analysis training, complaints investigation training, Datix training as well as ad hoc training.

In order to successfully implement this strategy we will need to develop a more structured risk management training programme to increase staff knowledge and understanding of risk management for specific groups. A training needs analysis will be undertaken and further training developed and delivered to address any needs.

11. Equality Impact Statement

Calderdale and Huddersfield NHS Foundation Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their age, race, faith, culture, gender, sexuality, marital status or disability.

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12. Monitoring the Effectiveness of this Strategy

The strategy will be reviewed on a three year basis or sooner as required.

A review process will be developed to assist in evaluating performance and progress in developing and maintaining effective risk management capability within divisions and corporate functions across the organisation and the effectiveness of risk management control processes. This will include leadership for risk management, local ownership of risk, equipping staff to manage risk well, governance arrangements to support the risk management framework, policies and procedures.

13. Associated Documents/Further Reading

The relevant policies and procedures listed in section 9.1 should be read in accordance with this strategy.

APPENDICES

1. Definitions of Risk, Risk Management. Risk Management Process
2. Governance Structure
3. Risk Management Specialists
4. Risk Grading matrix
5. Incident Grading Matrix

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Appendix 1 **Definitions**

Risk is the chance that something will happen that will have an impact on the achievement of the Trust's aims and objectives. It is measured in terms of likelihood (frequency or probability of the risk occurring) and severity (impact or magnitude of the risk occurring). See section 9.8 and Appendix 4.

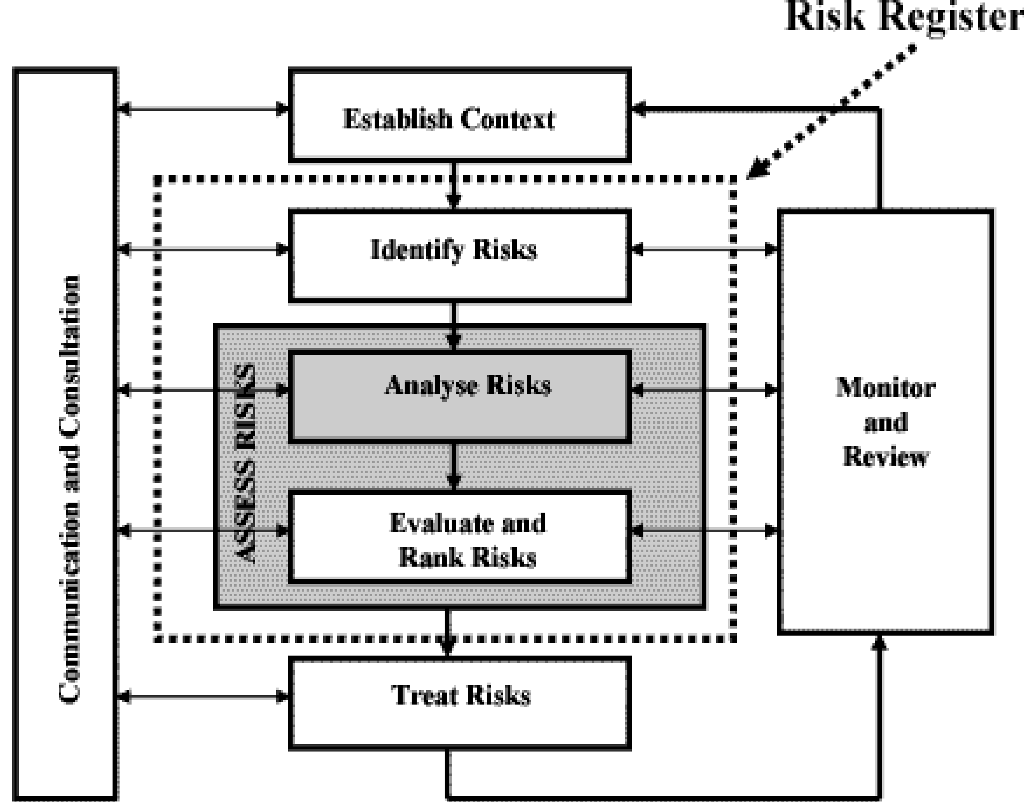
Risk management is the culture, processes and structures that are directed towards the effective management of potential opportunities and adverse effects.

The **risk management process** is the systematic application of management policies, procedures and practices to the task of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk. It is described in the diagram below.

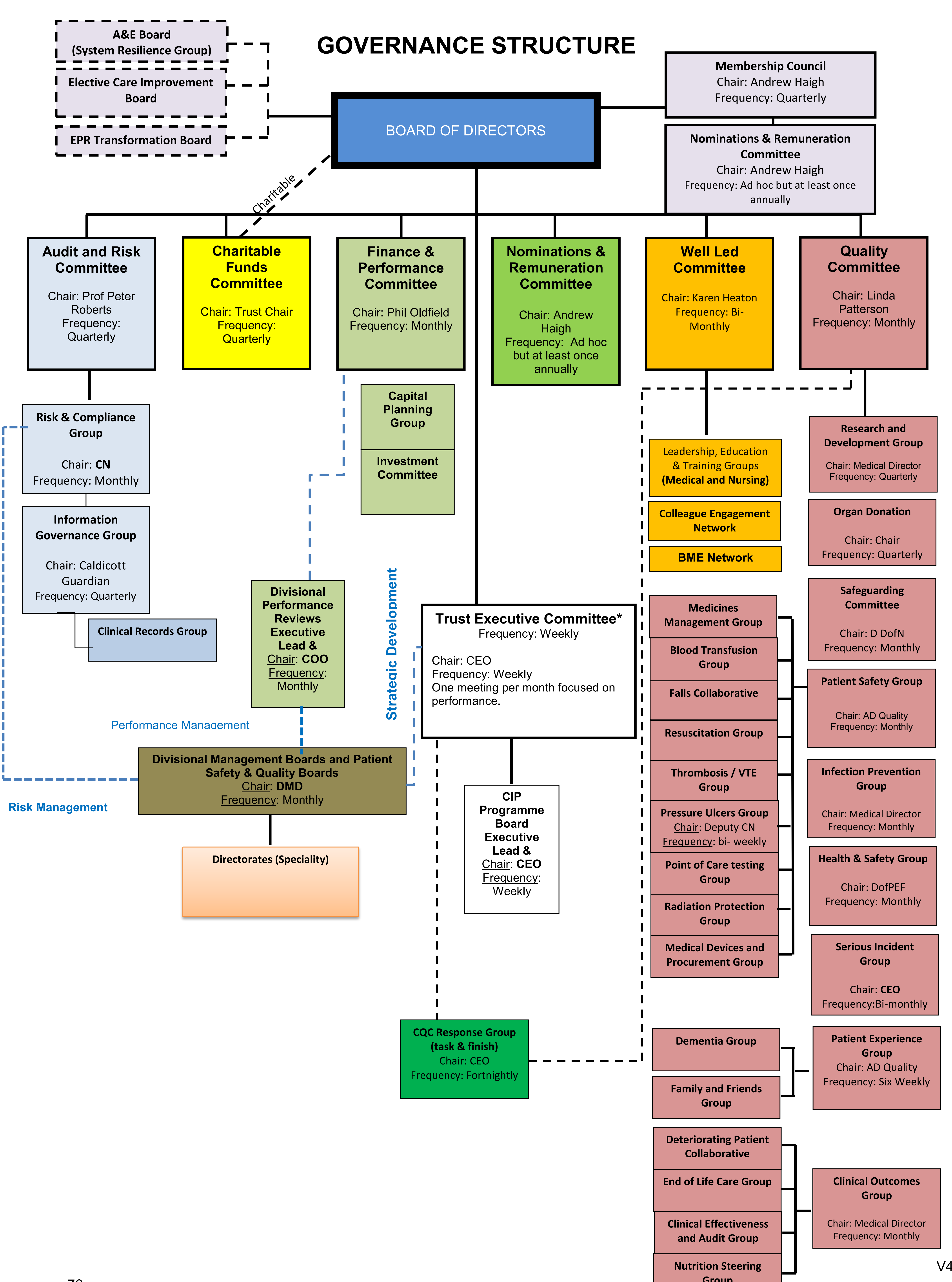
Significant risks are those which, when measured according to the grading tool at Appendix 9, are assessed to be significant, with a risk score of 15 or more. The Board will take an active interest in the management of significant risks.

Cumulative risks are individual risks from different areas which, when added together, may combine to become a significant risk.

Risk Management Overview from AS/NZS 4360:1999



Appendix 2 – Organisational Structure for Risk Management and Assurance



Appendix 3

RISK MANAGEMENT SPECIALISTS

Role	Responsibility
Caldicott Guardian Senior Information Risk Owner (SIRO) Information Governance Manager	Information Governance Risks
Company Secretary	Strategic Risks Foundation Trust risks Central alert systems risks
Director of Nursing	Clinical Risk
Director of Infection and Prevention Control (DIPC)	Infection Prevention risks
Medical Director	Safety incidents in NHS screening programmes
Head of Midwifery	Maternity Risks
Emergency Preparedness	Emergency Planning and business continuity risks
Fire Safety Manager Health and Safety Advisor Local Security Management Specialist (LSMS) Director of Estates and Facilities Director of Security	Fire Safety Advice Health and Safety risks Energy, all waste materials and sustainability Security Management
Controlled Drugs Officer Chief Pharmacist Medication Safety Officer	Medicines management Risks
Freedom to Speak Up Guardian	Raising Concerns risk
Patient Experience lead	Patient Experience Risks
Local Counter Fraud Specialist	Fraud Risks
Governance and Risk Team Assistant Director of Quality Head of Governance and Risk Risk Manager, Legal Services Manager Clinical Governance Support Managers / Quality and Safety lead	All risks and risk management tools, processes and training.
Head of Safeguarding / Safeguarding Team	Safeguarding Risks

Caldicott Guardian
The Caldicott Guardian is a senior health professional who oversees all procedures affecting access to person-identifiable health data, protecting the confidentiality of patient and service user information.

Senior Information Risk Owner
As the Trust Senior Information Risk Owner (SIRO), the Chief Information Officer is responsible for ensuring that the Trust creates and manages its information risks, through the development of a network of Information Asset Owners (IAA's) and Information Assess Administrators (IAAs).

Information Governance Manager
The Information Governance Manager is responsible for ensuring that the Trust has a robust Strategy of policies and procedures for the management of the Trust's information, both corporate and clinical/patient.

The Information Governance Manager liaises with the Trust's Caldicott Guardian and Senior Information Risk Owner to ensure that the Trust meets and complies with the standards set out in the Information Governance Toolkit.

Company Secretary
The Company Secretary is responsible for ensuring the strategic risks for the organisation are captured in the Board Assurance Framework and that there are effective processes in place for managing central alerts. The role also ensures that the supporting Committee structure of the Board and their terms of reference reflect the Committee's risk responsibilities system. This role also ensures that compliance issues, i.e. NHS Improvement. are appropriately reported throughout the organisation.

Director of Nursing

The Director of Nursing is the Executive lead for risk management and patient safety in partnership with the Medical Director, ensuring organisational requirements are in place which satisfy the legal requirements of the Trust for quality and safety, patients and staff, including delivery of processes to enable effective risk management and clinical standards.

Director of Infection Prevention and Control
The Director of Infection Prevention and Control (DIPC) has the following role and responsibilities: oversee local control of infection policies and their implementation; responsibility for the Infection Prevention and Control Team within the healthcare organisation, report directly to the Chief Executive and the Board, challenge inappropriate clinical hygiene practice as well as antibiotic prescribing decisions; assess the impact of all existing and new policies and plans on infection and make recommendations for change; be an integral member of the organisation's clinical governance structures.

Medical Director
The Medical Director is the Executive lead for clinical risk and clinical governance, which is shared with the Director of Nursing and leads the quality improvement

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strategy. The Medical Director is responsible for informing the Board of the key risks from clinical activity, employment of doctors and their practice, training, supervision and revalidation.

The Medical Director is also responsible for managing safety incidents in NHS screening programmes where the Trust is involved.

Head of Midwifery
The Head of Midwifery is the professional and management lead for midwives and is responsible for the co-ordination of clinical risk, providing expert advice for risk management within maternity services and responsible for supporting and embedding the implementation of risk management within maternity services. A Maternity Risk Management Strategy supports the continual improvement of the quality of clinical care through effective management of clinical risks and details roles and responsibilities for maternity risk management.

Fire Safety Manager
In relation to fire safety. This includes the provision of a fire safety strategy and fire training for all staff in terms of prevention, fire precautions and safe evacuation. The role also includes ensuring each area has a current fire risk assessment. They also provide specialist advice to design consultant / architects in respect of statutory structural fire safety incorporating the requirements of health technical memorandum 05 Fire Safety requirements.

Health and Safety Advisor
The Health and Safety Advisor is responsible for monitoring all staff related incidents on a regular basis and ensuring this is reported to the relevant commitees and Divisions via their integrated performance reports. They will organise health and safety training and education of staff to support CHFTs compliance with health and safety requirements. Duties of all employees are detailed in the health and safety policy.

Trust Resilience & Security Management Specialist
The overall objective of the Trust Resilience and Security Management Specialist is to serve two separate functions as a designated Emergency Planning/Business Continuity Manager and the Local Security Management Specialist (LSMS) is to identify the work programs required to comply with both the Civil Contingencies Act (2004) and the NHS Protect Security Management Standards, as dictated by national service provision contract standards. The associated corporate work programs will form the basis of ongoing developmental work and an implementation plan to deliver compliance against legislation and standards.

Local Security Management Specialist (LSMS) and SIRS
The LSMS undertakes the duties of a Local Security Management Specialist in accordance with Secretary of State Directions to health bodies on measures to tackle violence and general security management measures and any subsequent advice issued by the NHS Security Management Specialist.

The LSMS is responsible for ensuring the reporting violent and aggressive incidents through the Security Incident Reporting Systems.

Director of Estates and Facilities
The Director of Estates and Facilities has executive responsibilities which include health and safety across the organisation, security management, the estates and facilities infrastructure, including Medical Engineering and PFI sites.

Controlled Drugs Officer
The Clinical Director of Pharmacy is the controlled drugs accountable officer for the Trust (CDAO) in line with the Controlled Drugs (Supervision of Management and Use) Regulations 2006) and has responsibility for all aspects of controlled drugs management within the Trust, including standard operation procedures for controlled drugs, procurement and storage arrangements and oversight of the safe practices for prescribing and administration of controlled drugs, investigation of medication incidents.

The Clinical Director of Pharmacy is also the Chief Pharmacist and is responsible for policy and strategy in respect of medicines management.

Medication Safety Officer
The Trust has a Medication Safety Officer who oversees medication error incident reporting and learning to improve medication safety.

Radiation Protection
The Trust has a Radiation Protection Board chaired by the divisional Director, with specialist and technical advice on radiation provided by the Radiology department and external radiation protection advisors.

Freedom to Speak Up Guardian

The Guardian acts as an independent and impartial source of advice for staff on raising concerns and will signpost staff to other sources of advice where necessary. In addition, the Guardian will help to support the Trust to become a more open and transparent place to work.

Head of Risk & Governance - has day-to-day responsibility for risk management process, quality governance and safety management including:

- the development of risk management strategy and policies;
- administration of risk management systems;
- oversight of risk exposures facing the business;
- provision of risk management training and support to divisions
- the maintenance of the corporate risk register
- support the development of local risk registers
- lead in triangulating and sharing lessons for learning from adverse events
- risk management training
- management of legal services

Head of Safeguarding - has day-to-day responsibility for ensuring risks relating to safeguarding adults and children are managed in line with local policies and through collaborative working with other agencies and safeguarding practitioners. .

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Appendix 4 Risk Grading Matrix

	Impact /Consequence score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million

Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

2 Likelihood score

What is the likelihood of **the impact / consequence** occurring?

Likelihood score	**1**	**2**	**3**	**4**	**5**
Descriptor	**Extremely Unlikely**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently
How often might or / does this happen	Not expected for years	Possible Annual Occurrence	Possible Monthly	Possible to occur weekly	Expected to occur daily
Probability	< 1 in 1000 chance	≥ 1 in 1000 chance	≥ 1 in 100 chance	≥ 1 in 10 chance	≥ 1 in 5 chance

Table 3 Risk scoring = Impact / Consequence x likelihood

	Likelihood				
Consequence	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

1 - 3	Very Low risk
4 - 6	Low Risk
8 - 12	Medium Risk
10-12	High Risk
15-25	Significant

Appendix 5

Incident Grading Matrix

Degree of Harm (	Description	Severity grading
No harm / near miss Impact prevented (near miss)	An incident that might have had the potential to cause harm but was prevented, resulting in no harm	Green
No harm Impact not prevented	An incident that occurred but no harm resulted	Green
Low / Minimal harm	An unexpected or unintended incident where patient (s) required extra observation or minor treatment and caused minimal harm to one or more persons	Yellow
Moderate / Short term harm	An unexpected or unintended incident where patient(s) required further treatment or procedure which caused significant but not permanent harm (e.g. increase in length of hospital stay by 4-15 days)	Orange
Severe / permanent or long term harm	An unexpected or unintended incident that appears to have resulted in permanent harm	Red
Death caused by the patient incident	An unexpected or unintended incident that directly resulted in death	Red

APPENDIX E

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 5th January 2017	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: Well Led Workforce Committee Terms of Reference - The Well Led Workforce Committee terms of reference have been reviewed and a number of amendments made.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Well Led Workforce Committee	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Well Led Workforce Committee terms of reference have been reviewed and a number of amendments made to reflect the scrutiny of the delivery of the Workforce Strategy. The membership of the Committee has also been reviewed and amended to ensure there is clarity between members of the Committee and attendees.

The Committee recommends the terms of reference to the Board for approval.

Main Body

Purpose:

-

Background/Overview:

-

The Issue:

-

Next Steps:

-

Recommendations:

The Board is asked to APPROVE the terms of reference.

Appendix

Attachment:

WORKFORCE (WELL LED) COMMITTEE

TERMS OF REFERENCE

Version:	1.1 (first draft circulated for review to Chair/Executive Director of Nursing) 1.2 Amendments prior to Board 2.1 Amendments after submission to Workforce (Well Led) Committee 2.2 Further amendments 2.3 Amendment following Well Led Workforce Committee (December)
Approved by:	Board of Directors
Date approved:	
Date issued:	
Review date:	February 2018

WORKFORCE (WELL LED) COMMITTEE TERMS OF REFERENCE

1. Constitution

1.1 The Trust hereby resolves to establish a Committee to be known as the Workforce (Well Led) Committee. The Workforce (Well Led) Committee has no executive powers other than those specifically delegated in these terms of reference.

2. Authority

2.1 The Workforce (Well Led) Committee is constituted as a Standing Committee of the Board. Its constitution and terms of reference are subject to amendment by the Board.

2.2 The Committee derives its power from the Board and has no executive powers, other than those specifically delegated in these terms of reference.

2.3 The Committee is authorised by the Board to investigate any activity within its terms of reference – it is authorised to seek any information it requires from any member of staff and all members of staff are directed to co-operate with any request made by the Committee.

2.4 The Committee is authorised by the Board to request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

3. Purpose

3.1 The purpose of the Workforce (Well Led) Committee is to provide assurance to the Board of Directors on the quality of workforce and organisational development strategies and the effectiveness of workforce management in the Trust. For these purposes Workforce (Well Led) includes but is not limited to:-

- Recruitment
- Retention
- Workforce planning – availability, utilisation and effectiveness
- Agency spend – both in terms of cost and number
- Attendance Management
- Colleague Engagement
- Organisation Development and Leadership

3.2 In particular, the Committee will assure the Board of Directors of the achievement of the objectives set out in the 'A workforce fit for the future' section of the Trust's five year strategy.

3.3 The Committee will set up subgroups aligned to key areas of the Strategy as required.

4. Duties

4.1 The objectives of the Committee are to:-

4.1.1 Consider and recommend to the Board of Directors, the Trust's overarching Workforce Strategy and implementation plan.

4.1.2 Consider and recommend to the Board of Directors the key workforce performance targets for the Trust. To receive regular reports to assure itself that these targets are being achieved and to request and receive exception reports where this is not the case.

4.1.3 Review the workforce risks of the high level risk register and the Board

Assurance Framework

4.1.4 Hold the Executive Director of Workforce and OD to account for keeping the Committee informed on risk mitigation and future activity/plans.

4.1.5 Receive and consider the Trust's annual Workforce Equality Report and monitor the implementation of the workforce aspects of the Trust's Workforce Race Equality Scheme and Public Sector Equality Duty Report.

4.1.6 Receive regular reports in relation to internal and external quality and performance targets relating to workforce, including but not limited to CQC safe staffing standards. To assure that these targets are being achieved and to request and receive exception reports where this is not the case.

4.1.7 Recommend to the Board the Trust's Colleague Engagement Strategy and monitor implementation.

4.1.8 Receive assurance on the effective management of the flexible workforce arrangements.

5. Membership and attendance

5.1 The Committee shall consist of the following members:-

- Three Non-Executive Directors, one of whom will Chair the Committee and one of whom will be the Deputy Chair of the Committee.
- Executive Director of Workforce and Organisational Development
- Executive Director of Nursing
- Chief Operating Officer
- Executive Medical Director
- Staff Side Chair

5.2 The following shall be required to attend meetings of the Committee:

- Deputy Director of Workforce and Organisational Development
- Membership Councillor
- Deputy Director of Finance
- Company Secretary
- Secretary, Workforce and Organisational Development (notes).

5.3 The Executive Members of the Committee must nominate a named deputy to attend in their absence.

5.4 Other members/attendees may be co-opted or requested to attend as considered appropriate.

5.5 A quorum will be four members and must include at least one Non-Executive and one Executive Director.

5.6 Attendance is required at 75% of meetings, Members unable to attend should indicate in writing to the Committee Secretary at least 7 days in advance of the meeting and nominate a deputy except in extenuating circumstances of absence. In normal circumstances any members who are unable to attend must nominate a deputy who is appropriately briefed to participate in the meeting.

5.7 A register of attendance will be maintained and the Chair of the Committee will follow up any issues related to the unexplained non-attendance of members. Should continuing non-attendance of a member jeopardise the functioning of the Committee, the Chair will discuss the matter with the member and, if necessary, select a substitute or replacement.

6. Administration

6.1 The Committee shall be supported by the Secretary, whose duties in this respect will include:-

- In consultation with the Chair develop and maintain the reporting schedule to the Committee
- Collation of papers and drafting of the agenda for agreement by the Chair of the Committee
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the group of scheduled agenda items
- Agreeing the action schedule with the Chair and ensuring circulation within 48 hours of each meeting
- Maintaining a record of attendance.

7. Frequency of meetings

7.1 The Committee will meet monthly.

8. Reporting

8.1 The Committee Secretary will produce and maintain a standard agenda; any additional agenda items must be sent to the Secretary no later than 10 working days prior to the meeting, urgent items may be raised under any other business.

8.2 An action schedule will be articulated to members 48 hours following each meeting and must be duly completed and returned to the Secretary for circulation with the agenda and associated papers.

8.3 The agenda will be sent out to the Committee members 5 working days prior to the meeting date, together with the updated action scheduled and other associated papers.

8.4 Formal minutes shall be taken of all committee meetings. Once approved by the committee, the minutes will go to the next board of directors meeting.

8.5 A summary report will be presented to the next board meeting.

9. Review

9.1 As part of the Trust's annual committee effectiveness review process, the Committee shall review its collective performance.

9.2 The terms of reference of the Committee shall be reviewed by the Board of Directors at least annually.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Carole Hallam, Senior Nurse Clinical Governance
Date: Thursday, 5th January 2017	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Care of the Acutely Ill Patient (CAIP) Programme Report - This report provides an update of progress of the CAIP programme	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Reporting is provided monthly to the Clinical Outcomes Group and Quarterly to the Quality Committee	
Governance Requirements: Transforming and improving patient care	
Sustainability Implications: None	

Executive Summary

Summary:

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

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

HSMR is reducing and currently 102.94

Main Body

Purpose:

This progress report is intended to keep the BOD informed of the work of the CAIP Programme

Background/Overview:

As per the executive summary

The Issue:

Although mortality remains a concern there is evidence that the improvement work has helped towards the reducing HSMR

Next Steps:

Monthly monitoring of the CAIP themes at the COG

Recommendations:

To note the content and support the improvement plan

Appendix

Attachment:

CAIP programme summary for BoD Dec 16.pdf

Care of the Acutely Ill Patient programme

Progress Report for Board of Directors December 2016

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

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

A CAIP improvement plan has been revised (appendix 1). This is updated monthly and reported by exception monthly to Clinical Outcome Group and quarterly to the Quality Committee. Performance is measured in the CAIP dashboard (appendix 2) and a brief progress against themes noted below.

	Progress to Date	Future Plans
1) Investigating causes of mortality and learning from findings	**SHMI** The latest release for SHMI is for Apr 15 – March 16 is **113.8.** **HSMR** The latest HSMR release is for October 15 to September 16, and has shown a fall to **102.9**. **Mortality Reviews** The total number of mortality reviews has fallen over the last 3 months. Consultants have been invited to join the mortality review process ahead of the job planning next year. **Alerting Conditions** There are currently no HSMR or SHMI	The next SHMI is expected to reduce slightly, as it reflects a delayed period of time when the HSMR also started to reduce. HSMR performance continues to be monitored The process for consultants to perform mortality reviews has been developed. Training is being provided for the initial screening process. There is a training day for the National Mortality review programme on 16th January. This is a train the trainer approach being delivered by the Improvement Academy. All alerts are presented to the

	alerts. There is a CUSUM alert for Urinary tract Infections (Score 3.6)	Mortality Surveillance Group to agree level of further investigation
2) Reliability in clinical care	There are five conditions where evidence-based care bundles have been developed to improve patient outcomes. These are; • Asthma • Acute Kidney Injury (AKI) • Sepsis • Chronic Obstructive Pulmonary Disease (COPD) • Community Acquired Pneumonia (CAP) There remains variation in completion of the bundles.	Sepsis bundle has been prioritised for improvement work. A systems approach for improvement work to understand the barriers for implementation. Sepsis trolleys to be provided for A&E and MAU. Matrons providing a check on all patients with a NEW >5 Bundle leads to be invited to present progress updates to COG bi-monthly Liaison with the EPR team to seek assurance on reliable care built into the EPR
3) Early recognition and treatment of deteriorating patients.	The NerveCentre is fully operational in all areas including Paediatrics. Improving metrics suggest reduced mortality in patients with NEWS >5 Hospital out of hours (HOOP) team established at CRH and runs from 5pm to 8am weekdays and all weekend Code purple implemented as a process to give all staff the opportunity to raise concerns about individual patients	Further work looking patients for one month who have a NEWS score of 5 being referred to outreach team to understand impact and benefit HOOP to commence at HRI in February An action plan to be submitted to NHSI by 31st January 2017
4) End of life care	An End of Life Care co-ordinator has been appointed on a 1-year secondment and supported by the ADN in the Community Division. An improvement plan and strategy has been developed End of life questions now included in the mortality review form to be able to assess the quality of the EoL care	Quality Indicators to be set and will be measured and will report to the COG quarterly and also the Patient Experience Group. Information to be collected on how many patients should be on the ICODD and the percentage of these patients that are actually on the ICODD
5) Caring for frail patients	A clinical manager and virtual ward team identify patients on the wards that are suitable for community interventions.	Further work to increase knowledge and understanding of services available to avoid admissions

		Focus admission avoidance work in community and include in the elderly medicine action plan Identify quality measures and add to the CAIP dashboard
6) Clinical coding	Improvement works shows 0.05 off achieving the upper quartile for average diagnosis and 0.3 off for average Charlson score but acknowledge specialities differences	Clinical engagement work needs to continue to provide consistency is documentation

CAIP Improvement Plan

CARE OF THE ACUTELY ILL PATIENT 2016-17

Updated 19/12/16

Result	No	Response	Date to Complete	Clinical Lead	Overseeing group	Measure of success	RAG	Progress
Theme 1: Investigating Mortality and Learning from the findings								
Mortality reviews are all patient deaths are undertaken and finding reported with appropriate actions and shared learning	1.1	Mortality review protocol to be revised to include Consultant led process	Dec-16	Alex Hamilton	Mortality Surveillance Group	Approved protocol		14/12/16 - protocol revised and unclear if this needs to go back to WEB but to go to MSG in January
	1.2	Level one mortality review form to be revised and tested to incorporate speciality specific elements and developed into an E-form	Jan-17			Completed e-form		14/12/16 - form completed and access database changes completed
	1.3	All consultants to undertake Mortality Reviews once this has been agreed within their job plan	Apr-17			95% of consultants to have mortality reviews in JP		14/12/16 - request gone out to consultants prior to the job planning process
	1.4	Regular Learning from Mortality Review Reports shared at Mortality Surveillance Group and Divisional PSQB	Immediate			Minutes of the MSG and PSQBs		

	1.5	Develop a process to review post discharge 30 day deaths	Jan-17			Agreed process included into the Mortality review Protocol		14/12/16 - Second pilot being arranged with an EMIS practice
	1.6	Agree a team to access the Improvement Academy train the trainer with the Bradford team and to deliver in house training	Jan-17			Register of staff who have completed the training		14/12/16 - training arranged for 16th January with the Improvement Academy. 8 people booked
	1.7	All alert conditions are identified via HED and discussed at the Mortality Surveillance group and further action, if required, is agreed.	Nov-17			Minutes of the Mortality Surveillance Group		14/12/16 - HED alerts presented at MSG, agreed to add responses for the next meeting
	1.8	Develop processes to provide assurance that learning themes are being acted upon in a timely manner	Jan-17			Improved outcomes on CAIP dashboard		14/12/16 - CAIP dashboard revised but still requiring some outcome measures
Theme 2: Reliability								
Development and robust performance of critical clinical pathways to be implemented and used conistently to achieve best patient outcomes	2.1	Identify and agree regular audit of care bundles to be performed and data shared with the relevant teams	Dec-16		Clinical Outcomes Group	COG Dashboard		19/12/14 - Sepsis prioritised

	2.2	Data is shared in a timely manner with the appropriate teams	Nov-16			COG Dashboard		14/12/16 - Dashboard revamped at shared at November COG
	2.3	Establish improvement programmes to be led by clinicians for all agreed care bundles and critical care pathways	Jan-17			Terms of reference of the improvement groups		
	2.4	Work closely with the EPR team to ensure the care bundles and critical care pathways are developed within the Millenium system	Apr-17			EPR		19/12/16 - Jackie Murphy and Alistair Morris to be invited to January COG meeting
Theme 3: Early recognition and treatment of deteriorating patients								
Accurate and timely monitoring and recognition of deteriorating patients leading to prompt and appropriate escalation	3.1	Audit of patients with NEWS score of 7 or more to provide assurance of escalation and focus for improvement as required	Dec-16	Sal Uka	Deteriorating Patient Group			19/12/16 - Improving metrics. Mortality reducing in patients with NEWS >5
	3.2	Establish 'Hospital out of hours' (HOOP) team at both hospital sites and evaluate outcomes	Feb-17			Quality Measures		14/12/16 - established at CRH and will start at HRI in February 2017

	3.3	Identify quality measures and add to the CAIP dashboard	Jan-17					
Theme 4: End of Life care								
Appropriate ceilings of care, as indicated by timely DNACPR decisions, to be completed and implemented where appropriate and the Intergrated Care of the Dying pathway to be provided at the end of life	4.1	Regular audit of DNACPR completion and reported by ward and consultant	Dec-16	Mary Kiely	End of Life group	Audit reports		
	4.2	Include end of life questions into the Mortality review level one form as part of the quality of care	Dec-16			Revised mortality review form		14/12/16 - EoL questions now included in the review form, commenced from December (November deaths)
	4.3	Analysis of the data collected in the mortality reviews and audit of DNACPR to form improvement work	Jan-17			Minutes and action log from End of Life Group		
	4.4	Identify further quality measures and add to the dashboard	Mar-17			Dashboard		
Theme 5: Fraility								
Frail patients are identified to prevent both unnecessary admission to hospital and to assure effective care pathways are established	5.1	A clinical manager and virtual ward team to identify patients on the wards that are suitable for community interventions.	Dec-16	Diane Catlow	Safer Programme			

	5.2	Work required to increase knowledge and understanding of services available to avoid admissions	Dec-16					
	5.3	Focus on admission avoidance work in community and to feed these actions into the action plan for elderly.	Dec-16					
	5.4	Identify quality measures and add to the CAIP dashboard	Dec-16					
Theme 6: Clinical Coding								
To improve the quality of the clinically coded data through improved clinical documentation	6.1	Provide information to new doctors in relation to clinical coding	Aug-16	Sam Ingram	Clinical Outcomes Group			
	6.2	Reports per directorate and speciality in relation to co-morbidity scores, diagnosis, signs and symptoms	immediate					
	6.3	Improve recruitment and retension of clinical coders	immediate					

	6.4	Evaluate the improvement work to assure sustainability and identify additional actions as required	Jun-17			Achievement of national upper quartile performance per specialty for the key coding KPI’s (depth, average Charlson score and % sign & symptom)		
	6.5	Continue clinical engagement process to improve documentation with focus being on specialties not achieving UQ Charlson/Depth	Aug-17					14/11/16 Nov figs showed us being 0.05 off achieving the upper quartile for average diags and 0.3 off for average Charlson score but acknowledge specialities differences

CAIP Dashboard

CARE OF THE ACUTELY ILL PATIENT (CAIP) PROGRAMME

	15/16	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	YTD	Target
Theme 1: Investigating Mortality and Learning from findings																	
Number of In Hospital Deaths		121	123	132	140	148	142	148	139	155	135	118	123	95	136	901	
Deaths within 30 days of Discharge		55	78	63	79	77	71	72	60	58	77	71	72	59	40	437	
Total Number of deaths (in hospital + Within 30 days of discharge		176	201	195	219	225	213	220	199	213	212	189	195	154	176	1338	
% of Deaths Occurring in Hospital vs within 30 days of discharge		68.75%	61.19%	67.69%	63.93%	65.78%	66.67%	67.27%	69.85%	72.77%	63.68%	62.43%	63.08%	61.69%	77.3%	67.3%	
% Mortality Reviews (Month behind)		64.10%	60.20%	62.60%	56.60%	46.20%	43.90%	46.20%	50.37%	46.98%	37.59%	33.30%	30.00%	19.10%	In arrears	37.60%	95%
In hospital Crude Mortality Rate (all Admissions)		1.22%	1.21%	1.33%	1.41%	1.53%	1.46%	1.49%	1.43%	1.60%	1.32%	1.17%	1.22%	0.94%	1.69%	1.28%	
Local SHMI - Relative Risk (12 months Rolling Data)		113.88	113.80	113.80	113.80	113.34	113.34	113.34	in arrears	in arrears	in arrears	in arrears	in arrears	in arrears	in arrears	113.34	100
Hospital Standardised Mortality Rate (12 months Rolling Data)		116.18	116.22	116.06	116.49	116.30	114.04	111.62	111.62	109.38	108.67	106.12	105.00	In arrears	In arrears	105.00	100
Hospital Standardised WEEKEND Mortality Rate (12 months Rolling Data)		124.54	124.54	122.49	121.45	117.86	116.71	114.04	113.06	112.71	112.17	111.87	108.03	In arrears	In arrears	108.03	100
Hospital Standardised WEEKDAY Mortality Rate (12 months Rolling Data)		113.41	114.43	113.55	114.44	115.19	112.25	110.07	108.84	108.22	107.36	104.34	104.08	In arrears	In arrears	104.08	100
SHMI - COPD		121.06	132.80	132.80	132.80	122.76	122.76	in arrears	in arrears	in arrears	in arrears	in arrears	in arrears	in arrears	in arrears	122.76	100
HSMR - COPD		127.41	131.92	133.22	131.12	120.11	130.47	130.31	135.65	130.65	125.76	122.71	in arrears	in arrears	in arrears	122.71	100
SHMI - Pneumonia		109.55	113.70	113.70	113.70	134.82	134.82	in arrears	in arrears	in arrears	in arrears	in arrears	in arrears	in arrears	in arrears	134.82	100
HSMR - Pneumonia		119.70	121.46	120.54	122.52	123.65	116.96	115.24	118.86	111.12	110.98	108.87	in arrears	in arrears	in arrears	108.87	100
SHMI - Sepsis																	100
HSMR - Sepsis		123.46	125.25	126.70	136.20	133.14	127.63	121.67	123.12	117.71	106.34	102.82	in arrears	in arrears	in arrears	102.82	100
SHMI - AKI																	100
HSMR - AKI		106.96	109.18	108.68	108.01	109.80	111.40	112.39	117.75	117.60	118.01	111.94	in arrears	in arrears	in arrears	111.94	100
Theme 2: Reliability																	
AKI - Bundle Started		76.00%	53.00%	n/a	n/a	33.00%	71.00%	91.00%	58.00%	62.00%	79.00%	67.00%	82.00%	45.00%	100.00%	71.00%	95.00%
AKI - Bundle Completed		32.00%	70.00%	n/a	n/a	0.00%	67.00%	40.00%	39.00%	38.00%	48.00%	19.00%	44.00%	33.00%	13.00%	36.00%	95.00%
Sepsis - Bundle Started		70.00%	58.00%	n/a	n/a	89.00%	70.00%	63.00%	88.00%	91.00%	86.00%	77.00%	70.00%	93.00%	90.00%	85.00%	95.00%
Sepsis - Bundle Completed		38.00%	58.00%	n/a	n/a	50.00%	71.00%	60.00%	41.00%	45.00%	39.00%	22.00%	47.00%	43.00%	37.00%	39.00%	95.00%
COPD - Bundle Started		63.00%	47.00%	n/a	n/a	47.00%	48.00%	78.00%	43.00%	65.00%	77.00%	100.00%	100.00%	100.00%	100.00%	84.00%	95.00%
COPD - Bundle Completed		53.00%	60.00%	n/a	n/a	60.00%	62.00%	57.00%	85.00%	33.00%	48.00%	50.00%	30.00%	11.00%	10.00%	34.00%	95.00%
Pneumonia - Bundle Started		100.00%	50.00%	n/a	n/a	0.00%	38.00%	50.00%	40.00%	23.00%	43.00%	30.00%	27.00%	40.00%	40.00%	35.00%	95.00%
Pneumonia - Bundle Completed		100.00%	100.00%	n/a	n/a	0.00%	100.00%	33.00%	66.60%	20.00%	77.00%	67.00%	50.00%	83.00%	67.00%	68.00%	95.00%
Theme 3: Early recognition and treatment of deteriorating patients																	
NEW MEASURES																	
NEW MEASURES																	
NEW MEASURES																	
Theme 4: End of Life Care																	
DNACPR % Discussion completion		82.80%	92.30%	93.67%	89.70%	90.30%	96.20%	96.00%	89.20%	87.60%	91.00%	93.50%	94.20%	90.20%	90.40%	91%	95.00%
DNACPR Review date completion %		68.10%	84.60%	77.22%	78.20%	68.80%	76.90%	90.70%	79.50%	76.40%	80.90%	79.30%	82.70%	78.40%	74.00%	79%	95.00%
% of patients on the ICODD		45.30.%	46.61.%	40.46.%	35.29.%	45.52.%	42.45.%	42.07.%	46.67.%	40.27.%	37.59.%	35.96.%	42.50.%	50.00.%	37.78.%	41.25.%	Monitoring
Theme 5: Frailty																	
NEW MEASURES																	
NEW MEASURES																	
Theme 6: Coding																	
Average Diagnosis		4.38	4.42	4.53	4.73	4.72	4.84	4.89	4.90	5.05	5.10	5.05	5.14	5.11	5.06	5.08	5.27
Average Charlson Score		3.66	3.86	3.92	4.18	4.03	4.30	4.25	3.78	4.17	3.96	3.93	4.08	3.92	3.92	3.98	4.43
Co-morbidity capture		24%	30%	47%	41%	44%	44%	41%	45%	51%	61%	64%	63%	42%	53.00%	56.00%	90.0%
% Sign and Symptom		10.90%	10.10%	9.90%	9.60%	9.10%	9.10%	9.40%	9.10%	8.70%	9.58%	9.40%	8.20%	8.10%	8.90%	8.70%	9.4%
% Coded with Specialist Pall Care		0.70%	0.70%	0.70%	0.60%	1.00%	1.00%	0.90%	0.80%	0.90%	0.90%	0.80%	1.00%	0.90%	0.90%	1.00%	NA

APPENDIX G

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Shelley Adrian, PA to Medical Director
Date: Thursday, 5th January 2017	**Sponsoring Director:** Brendan Brown, Executive Director of Nursing
Title and brief summary: CQC Update - The Board is asked to receive and note the contents of the CQC update paper.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Quality Committee	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive and note the contents of the CQC update paper.

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:

Combined CQC papers for January 2017 BOD.pdf

BOARD OF DIRECTORS

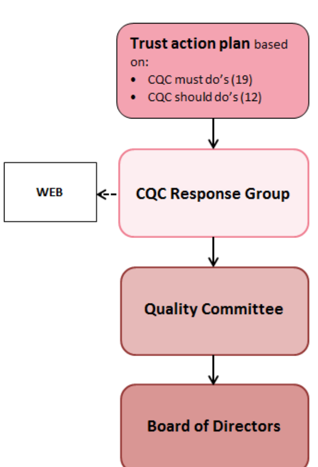
PAPER TITLE: CHFT CARE QUALITY COMMISSION (CQC) INSPECTION	**REPORTING AUTHOR:** Alison Lodge
DATE OF MEETING: 5th January 2017	**SPONSORING DIRECTOR:** Brendan Brown
STRATEGIC DIRECTION – AREA: Keeping the base safe Transforming and improving patient care	**ACTIONS REQUESTED:** To approve
PREVIOUS FORUMS: None	
EXECUTIVE SUMMARY: This paper provides an update on the delivery of the Trust's response to the CQC report. The plan is based on the 19 must do and 12 should do actions detailed in the CQC report which was published on 15th August 2016. The report focuses on the movements of individual actions in line with the 'BRAG' rating methodology. The Board of Directors are asked to approve the movements in the plan as recommended by the CQC Response Group and approved by the Trust Quality Committee. The links to the evidence files to support the move to a blue rating for action SD4 have been circulated separately.	
FINANCIAL IMPLICATIONS OF THIS REPORT: None	
RECOMMENDATION: The Board of Directors are requested to: 1. Approve the movements in the plan (detailed in section 2) from November 2016 and December 2016 as recommended by CQC Response Group and approved by the Trust Quality Committee. 2. Approve the revised completion dates (section 3) for the actions currently not delivering against the plan.	
APPENDIX ATTACHED: Green to blue proposal form – SD4: *The trust should ensure that relevant staff have received training in root cause analysis to enable them to provide comprehensive investigations into incidents.*	

CHFT Care Quality Commission (CQC) update December 2016

1. Context / Background

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

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



Rating	*Must do*	*Should do*	*Total*
Delivered and sustained	*0*	*1*	***1***
Action complete	*19*	*10*	***29***
On track to deliver	*1*	*2*	***3***
No progress / Not progressing to plan	*0*	*0*	***0***
Total	***20***	***13***	***33***

Please note *actions Must do 7 (safeguarding) and Should do 6 (children cared for outside Paediatric services) have both been split into 2 elements, therefore the total number of individual actions being monitored via internal processes are 20 must dos and 13 should dos. External reporting will remain at 19 and 12 respectively.*

2. Action Plan – movements

The plan was considered and challenged at the CQC Response Group on 30th November 2016 and 13th December 2016 and the Group agreed to recommend the following BRAG rating movements in the plan:

MD1	Staffing	BRAG rating from **Amber** to **Green**
MD2	Governance processes	BRAG rating from **Amber** to **Green**
MD7a	Safeguarding training	BRAG rating from **Amber** to **Green**
MD10	Falls and pressure ulcers	BRAG rating from **Amber** to **Green**
MD11	Maternity patient experience	BRAG rating from **Amber** to **Green**
MD15	Critical care capacity and demand	BRAG rating from **Amber** to **Green**
MD16	CDU	BRAG rating from **Amber** to **Green**
MD17	Complaints	BRAG rating from **Amber** to **Green**
MD19	Paediatric assessment unit	BRAG rating from **Amber** to **Green**
SD1	Medical Devices (Cty)	BRAG rating from **Amber** to **Green**
SD4	RCA training for investigations	BRAG rating from **Green** to **Blue**
SD5	End of Life strategy / vision	BRAG rating from **Amber** to **Green**
SD6a	Paediatric provision - OPD	BRAG rating from **Amber** to **Green**
SD6b	Paediatric provision - ED	BRAG rating from **Amber** to **Green**
SD7	Signage – HRI & Acre Mill	BRAG rating from **Amber** to **Green**
SD9	Therapy Service Provision (Children Cty)	BRAG rating from **Amber** to **Green**
SD10	Midwifery / Health visiting pathway	BRAG rating from **Amber** to **Green**

3. Actions currently not achieving / not on track to achieve the 'embedded' dates - proposed new target timescales

Extension requests have been made for 4 of the embedded dates (MD6, MD18, SD6a and SD7). The CQC Response Group meeting on 13th December 2016 considered the reasons for the delays and proposed the following extension to the deadlines and recommended the further actions to be taken:

MD6	Mortality reviews (embedded date)	**Issue:** this action is due to be 'embedded' by the end of December 2016, however the CQC published a report on 13th December 2016 - *Learning, candour and accountability - A review of the way NHS trusts review and investigate the deaths of patients in England* and it was agreed that this should be reviewed to ensure our action plan has addressed any relevant recommendations in the report **Further actions:** During January 17 review the report and identify any additional actions ***Recommendation: Move embedded deadline from 31.12.16 to 31.1.17, BRAG rating remain green***
MD18	GI bleed rota (embedded date)	**Issue:** the CQC Response group had agreed a blue (embedded) rating for this action, however a review of the evidence demonstrated that the Endoscopy rota was not completed a month in advance as required in the SOP – the embedded deadline was initially extended from 31.10.16 to 31.12.16; arrangements have now been agreed that from January 2017 the Flexible Workforce Team will produce a central rota which will achieve the 'four weeks in advance' requirement **Further actions:** Test out the process in January 2017 ***Recommendation: Move embedded deadline from 31.12.16 to 31.1.17, BRAG rating remain green***
SD6a	Paediatric provision OPD adult services – suitably skilled staff (embedded date)	**Issue:** this action is due to be 'embedded' by the end of December 2016 – whilst a plan is now in place for the delivery of Children's paediatric life support training to adult OPD staff, the training dates run to March 2017 **Further actions:** Ensure each shift is covered by a staff member with the relevant skills; continue to progress opportunities to bring forward the training dates ***Recommendation: Move embedded deadline from 31.12.16 to 31.3.17, BRAG rating remain green***
SD7	Signage – HRI and Acre Mill (embedded date)	**Issue:** this action is due to be 'embedded' by the end of January 2017 - whilst new signage installation will commence in January 2017, the estimated completion date is 10th February 2017. **Further actions:** Complete installation against the agreed schedule and also complete the review and update of OPD letters in line with any changes. ***Recommendation: Move embedded deadline from 31.1.17 to 28.2.17, BRAG rating remain green***

The Board of Directors are requested to approve the recommendations made by the CQC Response Group and approved by the Trust Quality Committee: to move the BRAG ratings for the actions listed under section 2 and support the revised completion dates detailed in section 3.

4. Monitoring arrangements

Monitoring of the plan follows the governance arrangements described below:

Governance arrangements

CQC Response Group: Oversee the delivery of the plan, monitor progress, sign off actions, agree submission of sustained position to the Trust Quality Committee (must and should do actions)

Trust Quality Committee: Provide assurance to the Board that the plan is achieving the expected impact and give final sign off for sustained actions.

WEB: Receive a monthly report ahead of the Quality Committee, in order to be informed of any emerging concerns and agree any actions required by WEB.

Divisional PSQBs: Oversee the delivery of the core service plans; escalate to Divisional performance meetings by exception any impacts on performance requiring Executive support, provide progress updates to the CQC Response Group.

BOARD OF DIRECTORS

PAPER TITLE: CHFT CARE QUALITY COMMISSION (CQC) INSPECTION	**REPORTING AUTHOR:** Alison Lodge
DATE OF MEETING: 5th January 2017	**SPONSORING DIRECTOR:** Brendan Brown
STRATEGIC DIRECTION – AREA: Keeping the base safe Transforming and improving patient care	**ACTIONS REQUESTED:** To approve
PREVIOUS FORUMS: None	
EXECUTIVE SUMMARY: This paper provides an update on the delivery of the Trust's response to the CQC report. The plan is based on the 19 must do and 12 should do actions detailed in the CQC report which was published on 15th August 2016. The report focuses on the movements of individual actions in line with the 'BRAG' rating methodology. The Board of Directors are asked to approve the movements in the plan as recommended by the CQC Response Group and approved by the Trust Quality Committee.	
FINANCIAL IMPLICATIONS OF THIS REPORT: None	
RECOMMENDATION: The Board of Directors are requested to: 1. Approve the movements in the plan (detailed in section 2) from October and November 2016 as recommended by CQC Response Group and approved by the Trust Quality Committee. 2. Approve the revised completion dates (section 3) for the actions currently not delivering against the plan.	
APPENDIX ATTACHED: None	

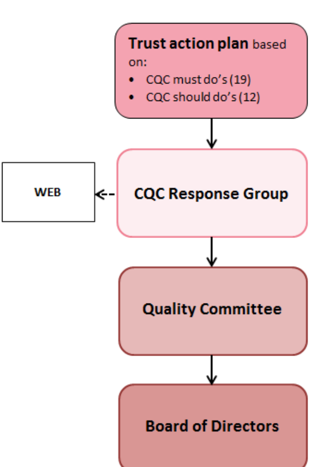
CHFT Care Quality Commission (CQC) update November 2016

1. Context / Background

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

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

Rating	Must do	Should do	Total
Delivered and sustained	0	0	**0**
Action complete	10	4	**14**
On track to deliver	10	9	**19**
No progress / Not progressing to plan	0	0	**0**
Total	**20**	**13**	**33**



Please note *actions Must do 7 (safeguarding) and Should do 6 (children cared for outside Paediatric services) have both been split into 2 elements, therefore the total number of individual actions being monitored via internal processes are 20 must dos and 13 should dos. External reporting will remain at 19 and 12 respectively.*

2. Action Plan – movements

The plan was considered and challenged at the CQC Response Group on 31st October 2016 and 15th November 2016 and the Group agreed to recommend the following BRAG rating movements in the plan:

MD4	MCA & DoLs	BRAG rating from **Amber** to **Green**
MD5	Gillick competence	BRAG rating from **Amber** to **Green**
MD6	Mortality reviews	BRAG rating from **Amber** to **Green**
MD7b	FGM awareness	BRAG rating from **Amber** to **Green**
MD8	Medicines management	BRAG rating from **Amber** to **Green**
MD9	Interpreter and written information	BRAG rating from **Amber** to **Green**
MD12	Second emergency theatre	BRAG rating from **Amber** to **Green**
MD13	3rd and 4th degree tears / PPH	BRAG rating from **Amber** to **Green**
MD16	CDU	BRAG rating from **Red** to **Amber**
SD2	Psychological support - CC	BRAG rating from **Amber** to **Green**
SD3	Handover –CC (subject to out of hours team)	BRAG rating from **Amber** to **Green**
SD4	RCA training for investigations	BRAG rating from **Amber** to **Green**

3. Actions currently not achieving the 'actions complete/ embedded' dates - proposed new target timescales

Three actions have not met the deadline for completion of the actions (MD7a, MD16 and SD6a); a further action has not met the embedded date (MD18). The CQC Response Group meeting on the 15th November considered the reasons for the delays and proposed the following extensions to the deadlines and recommended the further actions to be taken:

MD7a	Safeguarding training	**Issue:** All staff groups have been reviewed against the intercollegiate document, this resulted in more staff requiring level 3 children's training and an additional session (level 3 adult) added. Whilst reporting into Divisions has improved and an e-learning package

		identified for PREVENT, there is still some technical work required to separate the training packages, assimilate externally delivered training and add the approved 'prevent' package to ESR **Further actions:** W&OD team have agreed to prioritise this to ensure the training packages on ESR are available in the revised format, and PREVENT is uploaded. There has been an agreed process for validating external training to enable this to be recorded correctly on ESR. ***Recommendation: Move action deadline from 31.10.16 to 31.12.16, BRAG rating remain amber***
MD16	CDU	**Issue:** Completed actions re concerns identified by CQC, however 'Go See' visits identified potential issues with use of social pathway for elderly frail patients **Further actions:** By the end of November undertake a deep dive into use for social pathway in ED, looking at age, LOS, comorbidity and holistic person centred care ***Recommendation: Move action deadline from 31.10.16 to 30.11.16, BRAG rating moved from red to amber***
MD18	GI bleed rota (embedded date	**Issue:** The CQC Response group had agreed a blue (embedded) rating for this action, however a review of the evidence demonstrated that the Endoscopy rota was not completed a month in advance as required in the SOP; also monitoring of admissions data shows that not all patient are being admitted via HRI ED / AMU. **Further actions:** Surgical Division reviewing process for compiling the rota, Medical division reviewing cases not following the admissions pathway ***Recommendation: Move embedded deadline from 31.10.16 to 31.12.16, BRAG rating moved from blue to green***
SD6a	Paediatric provision OPD adult services – suitably skilled staff	**Issue:** Childrens safeguarding training has been addressed, however there is a lack of capacity to provide paediatric life support training to adult OPD staff (37 staff members) **Further actions:** By end of November identify training provision and develop a plan which includes a date for delivery against each staff member ***Recommendation: Move action deadline from 31.10.16 to 30.11.16, BRAG rating remain amber***

The Board of Directors are requested to approve the recommendations made by the CQC Response Group and approved by the Trust Quality Committee: to move the BRAG ratings for the actions listed under section 2 and support the revised completion dates detailed in section 3.

4. Monitoring arrangements

Monitoring of the plan follows the governance arrangements described below:

Governance arrangements

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

CQC Recommendation: The trust should ensure that relevant staff have received training in root cause analysis to enable them to provide comprehensive investigations into incidents.	**Current BRAG Rating**	**Recommended BRAG Rating**
	Completed November 2016	January 17 Quality Committee

Action Ref	**Detail**
SD4	- For all serious incident investigations the lead investigator is always a colleague with RCA training - All new serious incidents are allocated a trained investigator at the SI panel; in order to support and develop colleagues, a member of staff involved in an investigation report for the first time is paired with an experienced investigator. - RCA training days have continued to be delivered, with multidisciplinary attendance – further dates are scheduled for 2017. - The effective investigations intranet page has information on RCA techniques, backing up information provided on the course. - Governance and risk team members, specifically the Senior Investigations Manager, support staff in developing their competencies in the use of RCA and investigation techniques - working with them on draft reports and ensuring the key questions in the investigation are addressed.

Supporting evidence:

- Investigators for the last 10 Serious Investigations (SD4.1)
- RCA training programme presentation (SD4.2)
- Course evaluation feedback examples (SD4.3)
- E-mail re attendance list for the October 16 training day and further dates (SD4.4)
- Positive feedback from CCG colleagues re quality of investigation reports (SD4.5a) and (SD4.5b)
- Positive feedback re support from SI manager (SD4.6)

Monitoring arrangements:
Compliance with the process is monitored by the Head of Governance and Risk

Executive Director Responsible:	Brendan Brown	**Responsible Assurance Committee:**	Quality Committee through the Serious Incident Review Group

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Ruth Mason, Associate Director of Engagement & Inclusion
Date: Thursday, 5th January 2017	**Sponsoring Director:** ian warren, Executive Director of Workforce and OD
Title and brief summary: Public Sector Equality Duty Annual Report 2016 - To meet the statutory duty to publish information to demonstrate compliance with the general equality duty, enabling service users, staff and other interested parties to assess the equality performance of the Trust.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: None	
Governance Requirements: Transform care, improve the patient experience, deliver the regulations, develop the organisation for the future.	
Sustainability Implications: Improve local conditions, especially in disadvantaged areas, eg encourage social inclusion, develop business and social enterprise or develop the workforce and labour market Reduce social and health inequalities	

Executive Summary

Summary:

As a public sector body, the Trust has a statutory duty to comply with the Equality Act 2010. In line with the specific duties of the Act, the Trust is required to publish an annual report, detailing the ways in which the Trust meets the general duties of the Act to:
- Eliminate unfair discrimination, harassment and victimisation
- Advance equality of opportunity between different groups
- Foster good relationships between different groups

This annual report, known as the Public Sector Equality Duty report, must be approved by the Board for publication by the end of January each year.

Main Body

Purpose:

The purpose of this paper is to present the latest PSED report, including the Equality in our Workforce report, to the Board for consideration. A copy is attached as Appendix 1.
The report contains information and evidence of activities throughout 2016 which have improved the patient experience and helped the Trust comply with equalities legislation.

Background/Overview:

This equality report is to show the progress the Trust has made during 2016 in meeting its equality duties. These duties refer to both the recruitment, retention and development of staff and to the delivery of care and services for patients. The report contains examples of activities, best practice and evidence that demonstrate the Trust's commitment to an equitable and diverse organisation.
Ultimately the Trust is striving to help colleagues feel confident and competent when caring for or dealing with people with any of the nine 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.

The Issue:

Equitable, fair and diverse services across the Trust for all patients and colleagues.

Next Steps:

Following Board approval the Trust is required to publish the PSED report by 31 January 2017. The report will be published on the Trust's website.

Recommendations:

The Board is asked to note the achievement of statutory timescales in relation to production of the PSED report and agree its publication before the end of January 2017

Appendix

Attachment:

PSED Report 2016_CHFT_final.pdf

Calderdale and Huddersfield
NHS Foundation Trust

CHFT Public Sector Equality Duty Annual Report 2016

Published January 2017

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Appendix 1
Equality in our Workforce Report

Appendix 2
Faith Card

Appendix 3
CQC Fact sheet

Appendix 4
Membership Engagement Data

1 Executive Summary

This equality report is to show the progress the Trust has made during 2016 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 of how the Trust is meeting the requirements of the Public Sector Equality Duty. This 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 for the Trust.

The Trust 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. Throughout the report there are examples of work/initiatives going on at the Trust 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.

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 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 Calderdale and Huddersfield NHS Foundation Trust (CHFT) to publish relevant information to demonstrate their compliance with the duty.

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 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 2012, 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 (E&D) 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 the findings around equality and diversity are referred to later in this report.

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 E&D 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 area, and will be presenting progress on two of its equality and diversity priorities to a panel of user representatives from each of the protected groups in Calderdale and Kirklees early in 2017. In line with the EDS2 framework, the Trust will assess itself and present its evidence to the panels, who will then grade the Trust based on the evidence presented.

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.

Progress in this area can be seen in Appendix 1, our Equality in our Workforce Report for 2016.

3 Our progress in 2016

3.1 Engagement

In line with the Trust's "Putting the Patient First" strategy for patient and public involvement and E&D, and in order to strengthen engagement with users and other members of our local communities, for the first time in 2016, the Trust appointed Engagement Champions from across all its divisions.

There have been two workshops in 2016 at which the Engagement Champions defined their role and the tools they required to fulfil the role.

The Engagement Champions will act as the conduit between the Equality and Diversity function and the divisions, cascading information, offering training and awareness for colleagues working with patients and coordinating engagement activities. They will be fully supported by the Equality and Diversity function and will be offered training on how to run focus groups, carry out surveys and undertake other engagement activities.

The Trust's Director of Nursing is the nominated executive Lead for the Engagement Champions project, and has pledged his support to the Engagement Champions in undertaking their role.

As a Foundation Trust, CHFT has a council of governors, known as its "Membership Council". The Membership Council is actively engaged through divisional reference groups and corporate sub-groups with members and service users about quality improvement and service change.

In addition, Membership Councillors 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 Membership Councillors and public members in recruitment panels for the appointment of hospital consultants and senior nursing staff.

The Trust has a large membership which is compared with its local population (see Appendix 4) to ensure that we are engaging with the diverse communities that we serve. The data shows that we 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 during 2017.

3.2 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 are doing to achieve these outcomes are shown below:

Protected Characteristic	What we are doing
All	We have reviewed our process for carrying out equality impact assessments and launched a new electronic process which includes a mechanism to ensure that assessments are always carried out before new policies or service changes are introduced. This has enabled us to achieve outcome 4.2 above.
	Prior to our CQC inspection, in January 2016, each ward, community and clinical area received an information pack containing a series of fact sheets, including one for equality and diversity. The fact sheet can be seen at Appendix 3.
Age	The Trust is purchasing "dementia friendly" crockery for wards that typically care for dementia patients at HRI. 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.
	The Estates and Facilities Division is working on the introduction of picture menus for dementia patients across both sites.
	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 2016 HRI scored 84.4% (an increase of 4% on 2015) and CRH 75.5% (an increase of 1.2% on 2015).
	Any child under the age of 12 having their blood taken now goes to the Children's Outpatient Department rather than the main Phlebotomy Department, making it a less traumatic experience for them.
	A prompt sheet has been introduced to make colleagues aware of the needs of younger patients in predominantly adult clinical areas.

Protected Characteristic	What we are doing
Age/Disability (visual impairment)	Bedside table child-friendly sheets are now available in yellow print for children with a visual impairment.
Disability (visual impairment)	As a result of Friends and Family test feedback, the size of the card issued prior to a specific day case procedure in the Eye Clinic has been increased.
Disability (hearing impairment)	A review of the provision of hearing loops for patients with a hearing impairment has been carried out. The review revealed that the Trust has a range of hearing loops, both fixed and portable, at both hospital sites. All fixed loops on the HRI site were checked and repaired, and portable loops were procured for all wards on that site.
	Following consultation with our local deaf community, we have changed our service provider for BSL to a small, local company that has worked with us to design our own BSL booking website and only provides BSL services, thus ensuring a high quality service for our deaf patients. A 6-month review of the service has recently been carried out, which has shown that the service provided is of high quality and patient experience has improved.
Disability (mental health)	In the Community division, to reduce the incidence of post-natal depression in new mums, a "buggy walk" initiative has been introduced to bring mums together in groups and reduce feelings of isolation. This initiative was recently shortlisted for the Trust's staff awards scheme.
Disability	The plans to upgrade the public toilets on the HRI site during 2016/17 include the provision of accessible toilets.
Disability (Learning)	The Matron Complex Care Coordinator has been involved in planning the patient pathway for patients with a learning disability undergoing a certain orthopaedic procedure, to ensure their, and their relatives' needs, are met.
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, the Trust's Chief Executive has led on a programme of focus groups for BME colleagues. This has produced a strategy and action plan.
Religion/belief	A "Faith Card" has been produced by our Coordinating Chaplain and the steering group working on building bridges with the Muslim community, to raise colleagues' awareness of the needs of patients from different faiths. The Faith Card (see Appendix 2) is to be distributed to all clinical areas.

3.3 CQC feedback

In their report following the inspection in March 2016, the CQC described the following initiatives as “areas of outstanding practice”:

The trust had vulnerable adult’s leaders to ensure the vulnerable adult care principles and process was embedded into practice.

Engagement support workers had been appointed to provide engagement, socialisation and companionship, cognitive and physical support for patients with dementia and/or delirium. The team supported patients during the day with either group or one-to-one activities which promoted sleep at night. Through providing suitable engaging activities during the day, less 1:1 care was required during the day and night. This also helped other patients experience by reducing sleep disruption on the wards.

4 Strengthening Equality & Diversity

4.1 Equality & Diversity Training

The Trust 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.

Equality and diversity training is now mandatory for all colleagues. In terms of compliance, statistics show that as at 1 December 2015, 63.3% of colleagues had undertaken their training. By the end of March 2016 further progress had been made and the compliance rate had reached 86%. As at 1 December 2016, the compliance rate for the Trust stood at 88%.

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

4.2 Learning from Experience

The Trust sees learning from patient experience as an important way of improving care, quality and experience.

Managers dealing with complaints are required to complete a "Capturing the Learning" report at the conclusion of a complaint, which ensures that valuable lessons are recorded and shared appropriately.

Senior managers produce "patient stories" where lessons have been learned, and these are used to educate staff and improve services as necessary.

Patient stories are presented to the Trust's Membership Councillors at Divisional Reference Group meetings. This provides our governors with an assurance that lessons are learned and action is taken where shortcomings in our systems or processes have been uncovered.

An area of good practice is in the Children's directorate where learning from experience is a standing monthly item on the directorate agenda and a divisional risk newsletter is produced to capture and share learning. A review of concerns/compliments and complaints is incorporated into divisional forums to inform service development and three examples of this from 2016 are:

- the development of a patient information leaflet for a child with abdominal pain - this was implemented following investigation of a complaint;
- following a clinical incident there is now joint working between the children's ward and the CAMHS service to enhance care planning and staff training for young people with mental health needs;
- information about the use of Cryogesic spray or local anaesthetic cream in the Children's Outpatient Department is now provided following feedback from families

Any complaint received by the Trust relating to, or from, a patient with a protected characteristic is routinely escalated to the recognised expert for that protected characteristic, and also to the Equality and Diversity function. All such complaints are reviewed by the E&D function to establish the nature of the complaint and whether there is any suggestion that the patient feels they were discriminated against because of their protected characteristic.

In the period 1 December 2015 to 30 November 2016, 28 complaints were referred to the E&D function. On review it was established that one of the complainants had suggested that the patient had been treated differently because of their protected characteristic. The complaint was successfully resolved and the E&D function will continue to monitor this area of service.

5 Conclusions

The Trust has now refreshed its approach under a wider strategy "Putting Patients First – a strategy for involvement and equality". This 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 nine 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, eg large print, braille, languages other than English, please contact Vanessa Henderson, Business Manager for Membership and Inclusion, on 01484 347342 or e-mail our dedicated inbox at 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 2016. 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 2016. 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 BME staff, and in so doing, help lead improvements in the quality of care and satisfaction for all patients.

2. Staff profile

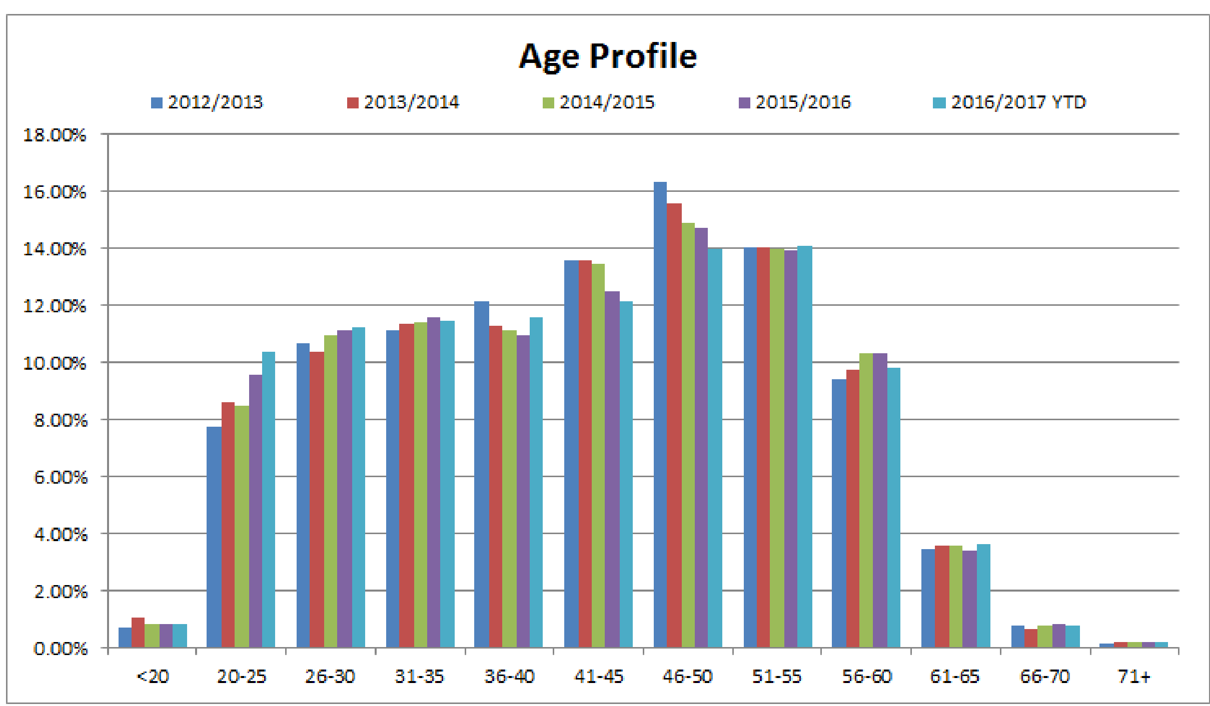
The staff profile shown in the graphs below are based on a 'snapshot' of all the staff working for the Trust as at 30 November 2016 against the same date in the previous four financial years.

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

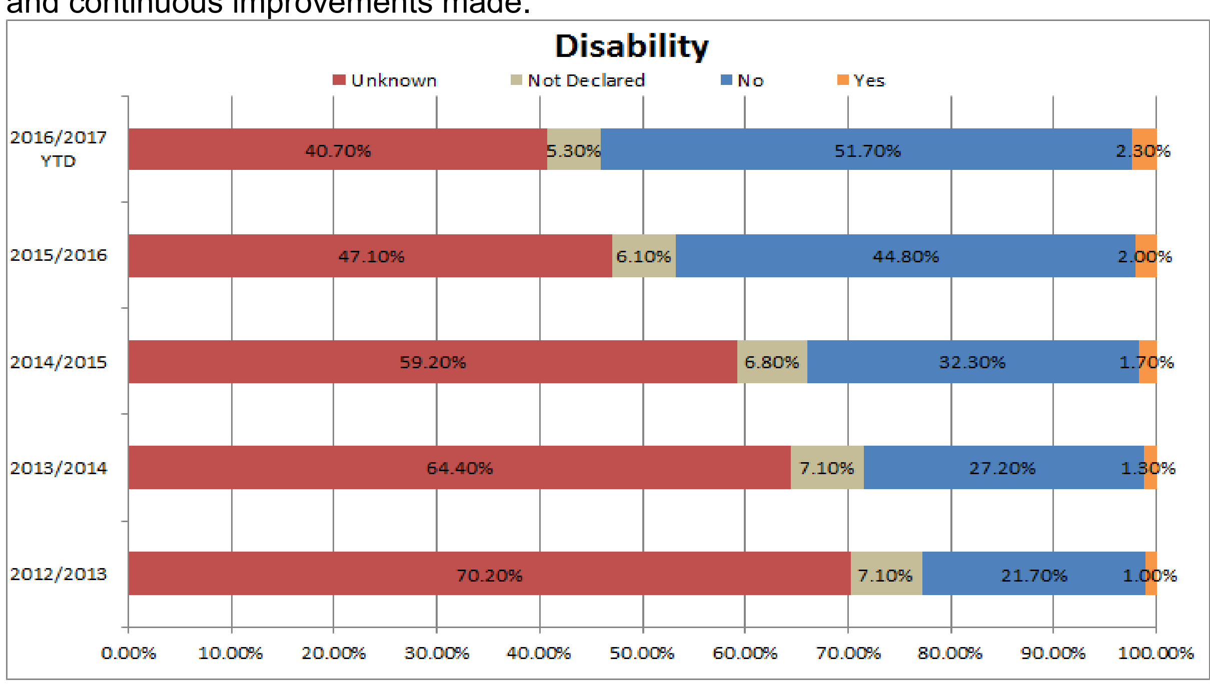
We have analysed the Trust's workforce information from the last four years using key equality and diversity indicators to try and identify any significant trends in the data. The categories used are:

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

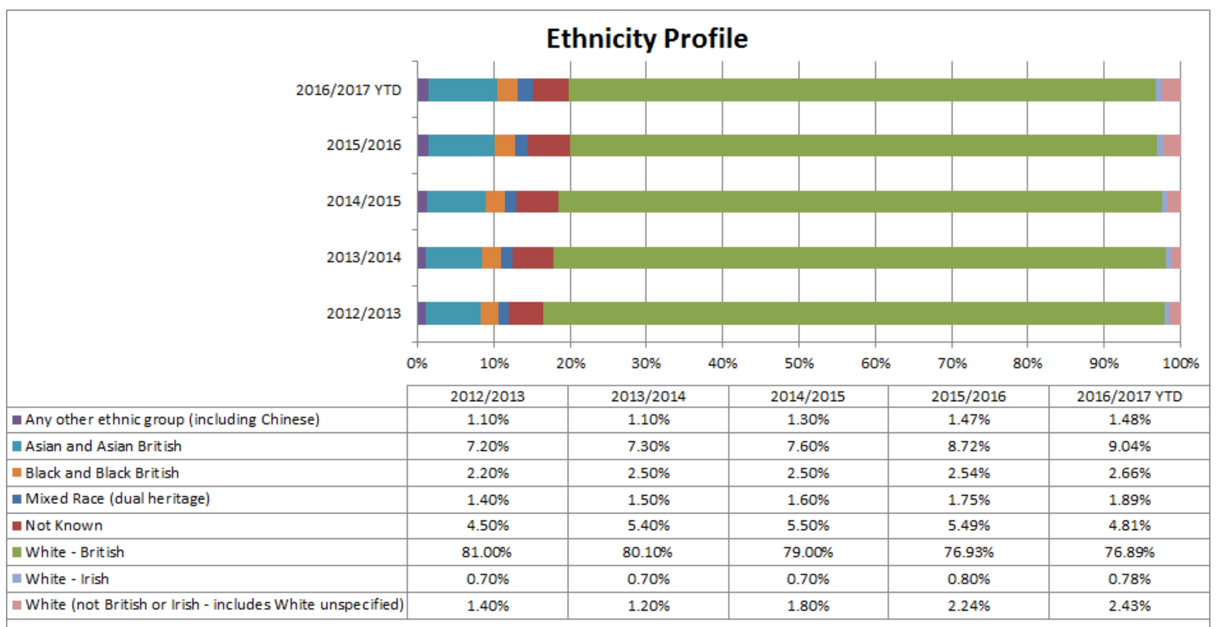
Age Profile
The highest proportion of Trust employees are in the age bracket 51-55. The age bracket showing the most growth during this financial year was 20-25, with an increase of 0.77% from the previous year.



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 40.7% 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.

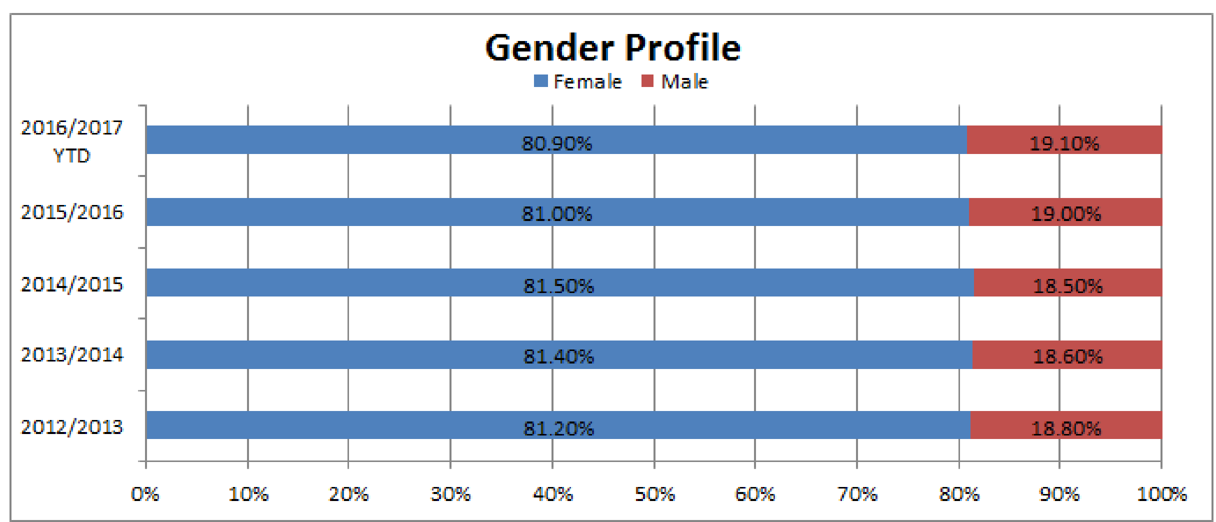


Ethnicity Profile
The ethnicity profile of the Trust has not shown much change over the last 4 years, the biggest profile remain white British (76.89%)

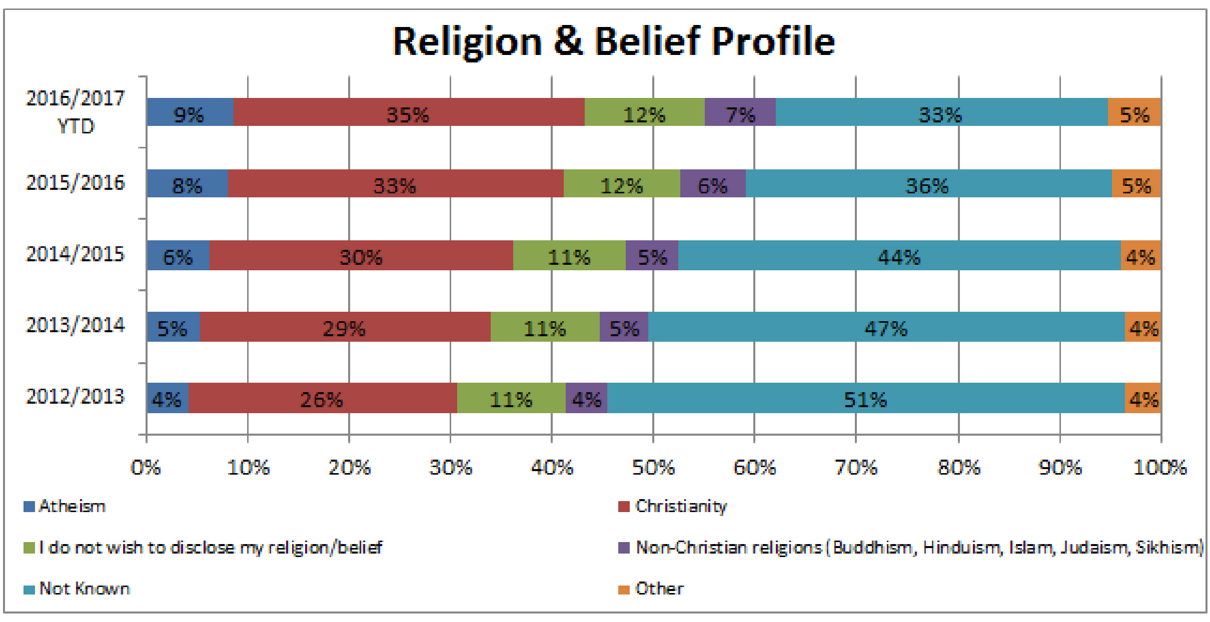


	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017 YTD
Any other ethnic group (including Chinese)	1.10%	1.10%	1.30%	1.47%	1.48%
Asian and Asian British	7.20%	7.30%	7.60%	8.72%	9.04%
Black and Black British	2.20%	2.50%	2.50%	2.54%	2.66%
Mixed Race (dual heritage)	1.40%	1.50%	1.60%	1.75%	1.89%
Not Known	4.50%	5.40%	5.50%	5.49%	4.81%
White - British	81.00%	80.10%	79.00%	76.93%	76.89%
White - Irish	0.70%	0.70%	0.70%	0.80%	0.78%
White (not British or Irish - includes White unspecified)	1.40%	1.20%	1.80%	2.24%	2.43%

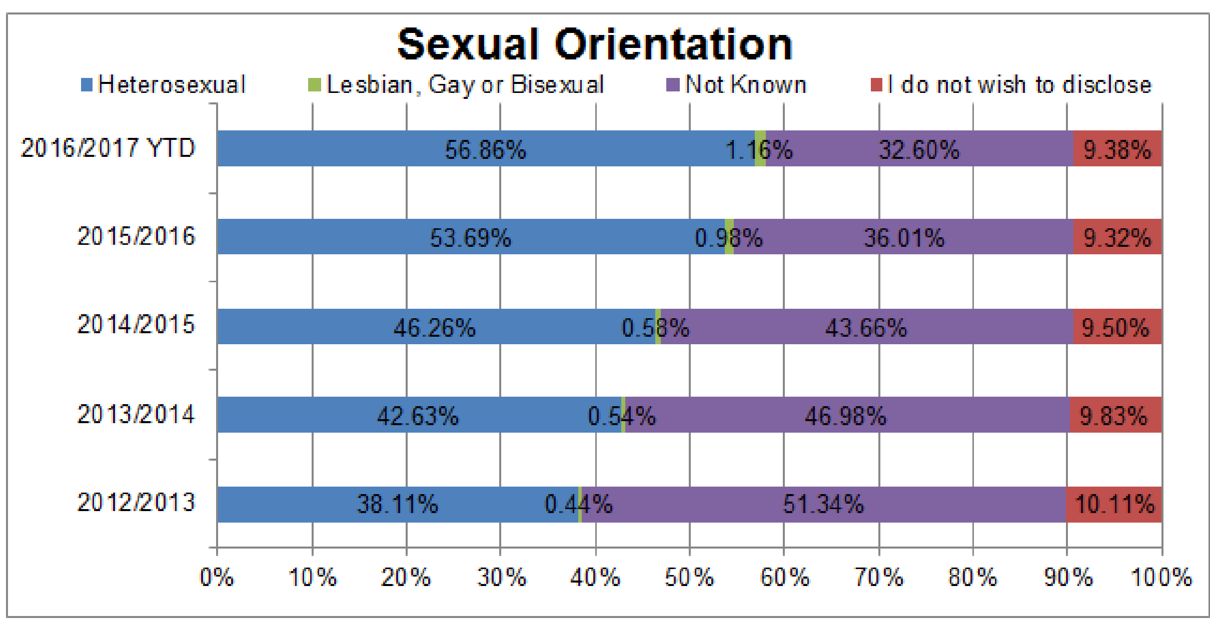
Gender Profile
The proportion of men working for the Trust is significantly lower than the national workforce. However, the health and social care sector traditionally employs more women than men.



Religion & Belief
Data quality has continued to improve; however there is still 33% of the workforce where information around religious belief is unknown.



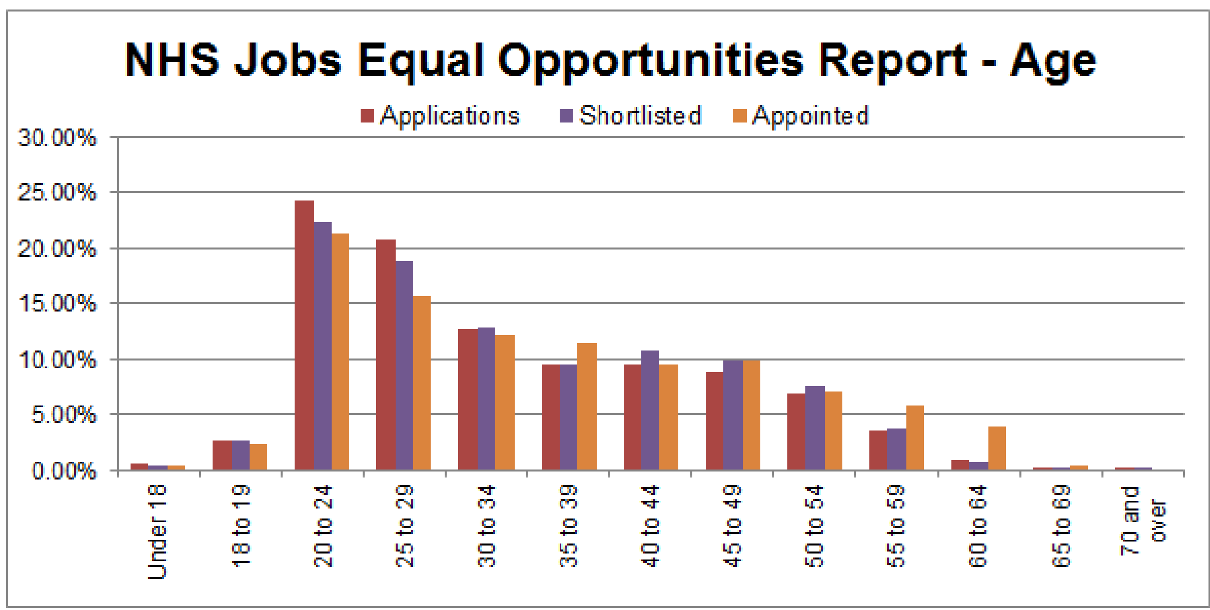
Sexual orientation
Data quality has continued to improve; however there is still 32.6% of the workforce where information around sexual orientation is unknown.

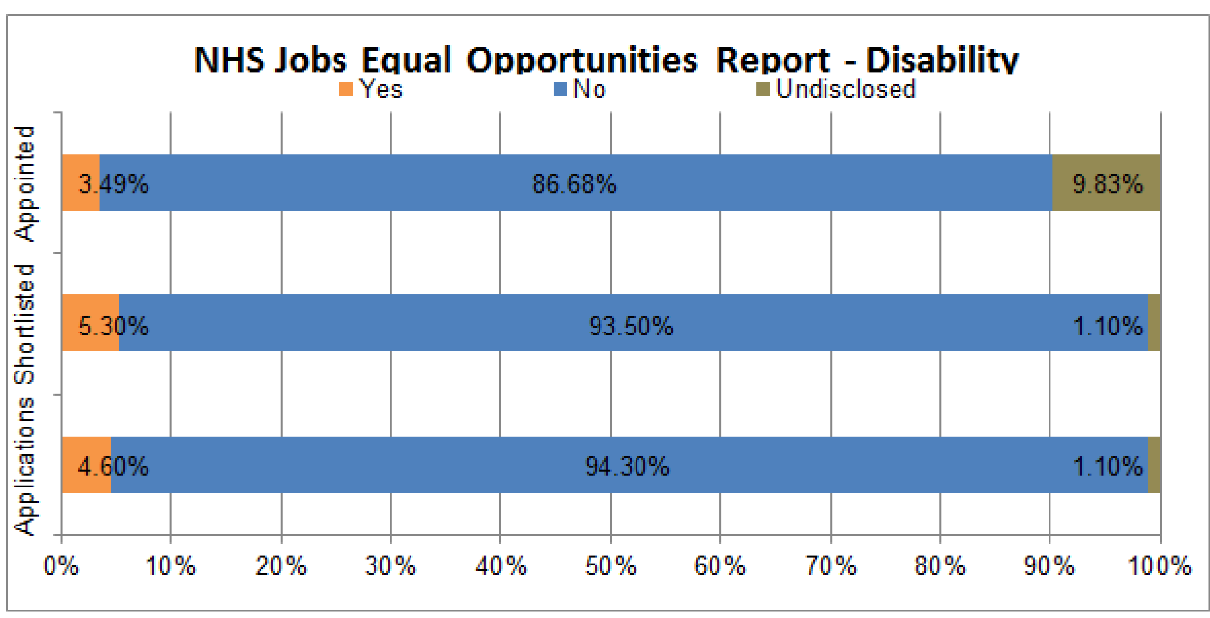


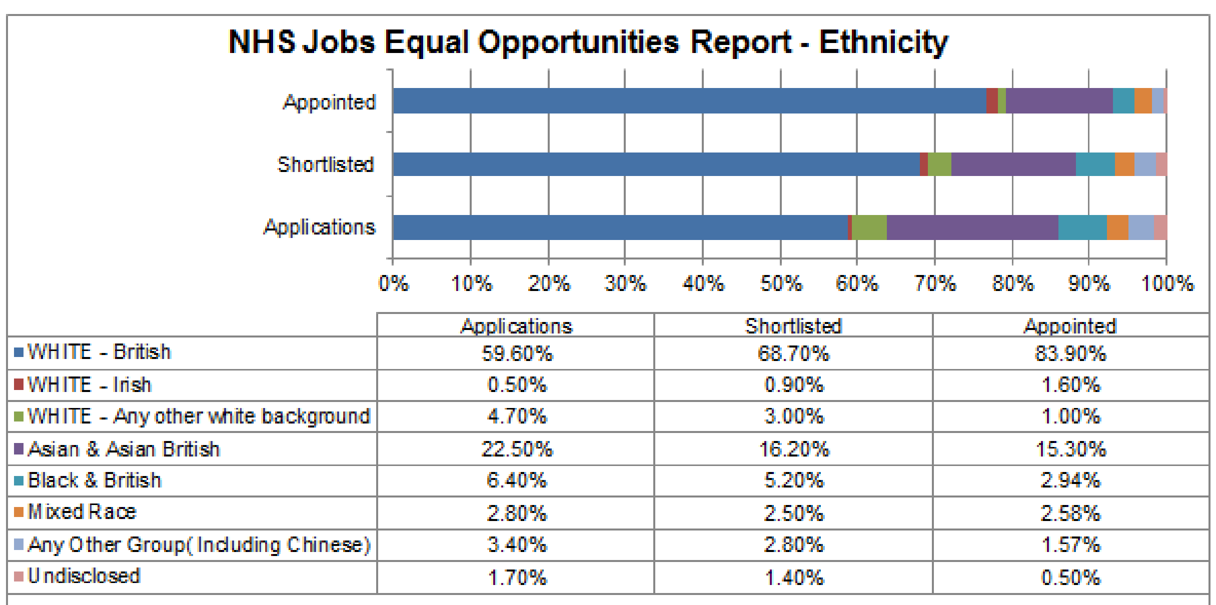
3. Staff joining the Trust

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 NHS Jobs, an online recruitment tool used by all NHS organisations.

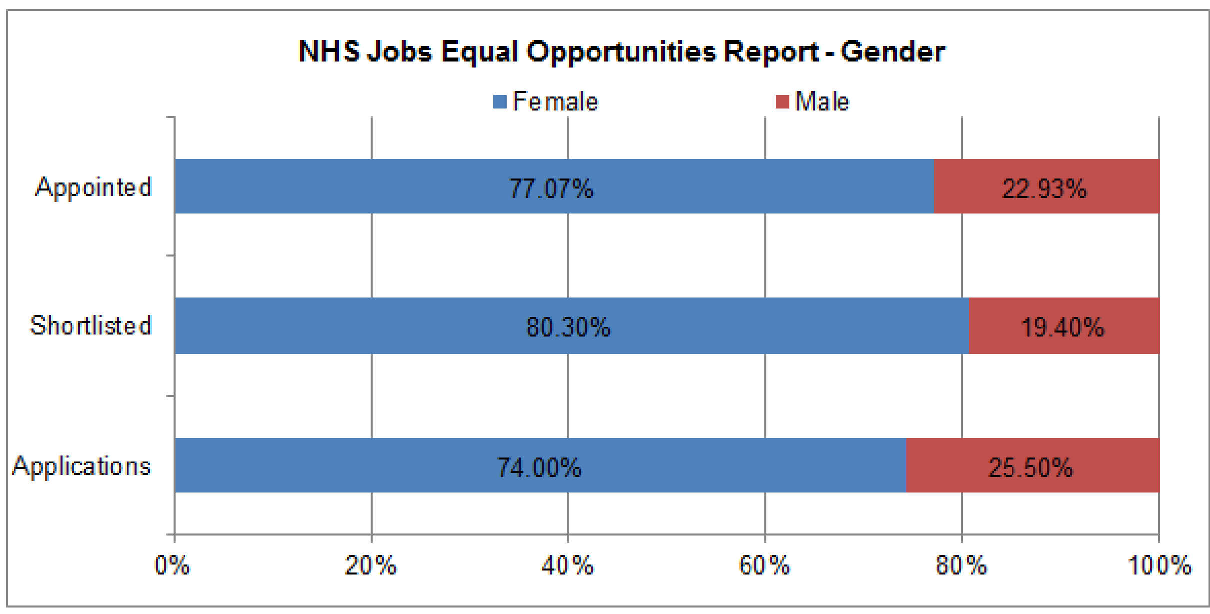
The data shown reflects all recruitment activity for the period 1 December 2015 to 30 November 2016, and provides a breakdown of number of applicants, number of applicants shortlisted and number of applicants appointed.

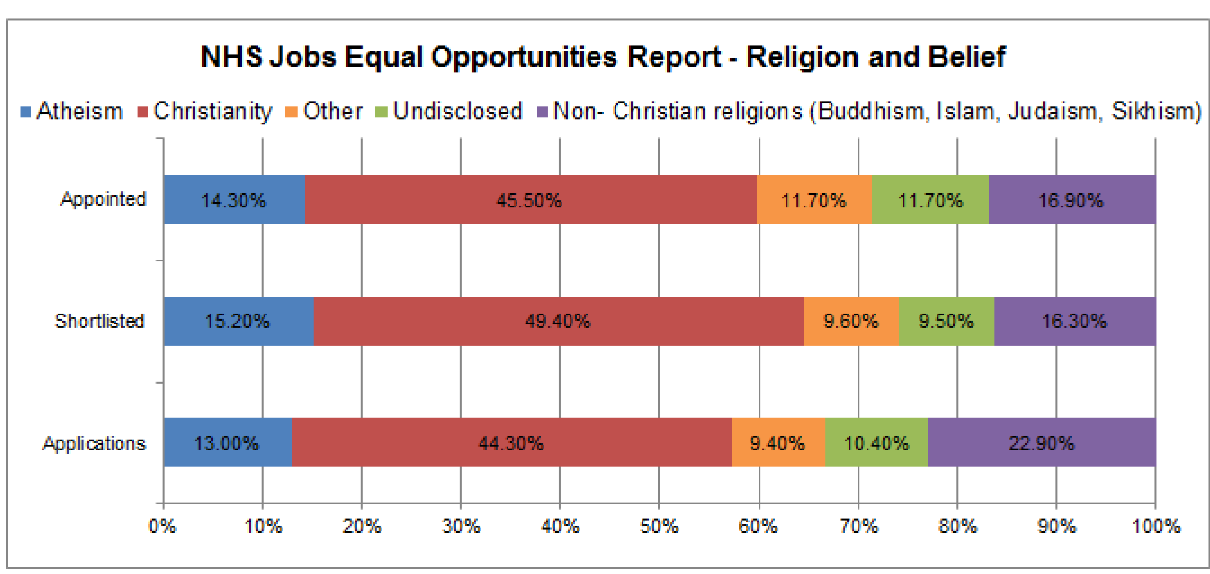


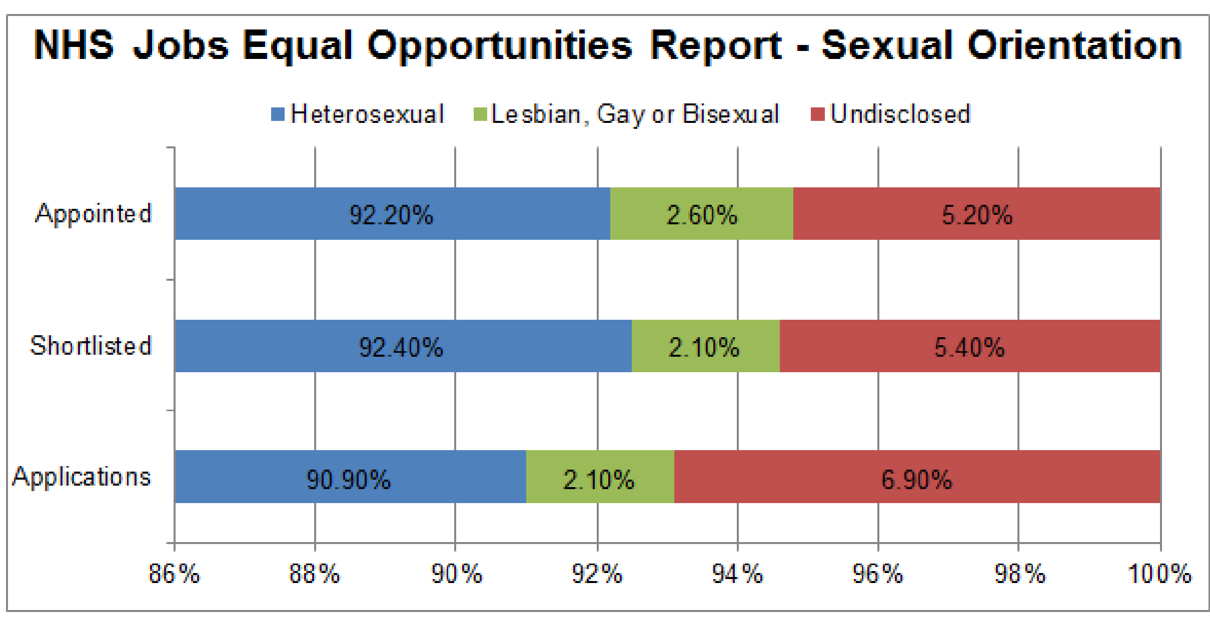




	Applications	Shortlisted	Appointed
WHITE - British	59.60%	68.70%	83.90%
WHITE - Irish	0.50%	0.90%	1.60%
WHITE - Any other white background	4.70%	3.00%	1.00%
Asian & Asian British	22.50%	16.20%	15.30%
Black & British	6.40%	5.20%	2.94%
Mixed Race	2.80%	2.50%	2.58%
Any Other Group(Including Chinese)	3.40%	2.80%	1.57%
Undisclosed	1.70%	1.40%	0.50%





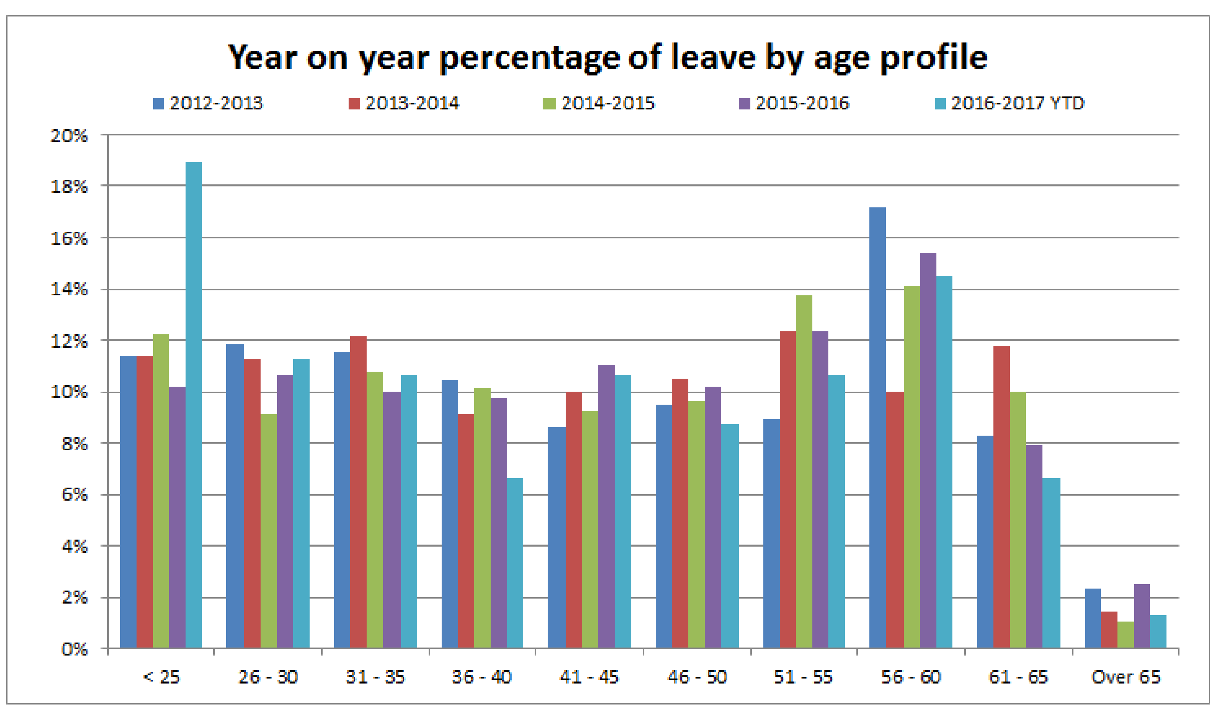


4. Staff leaving the Trust

This section shows data regarding staff that left the Trust between 1 April 2012 and 30 November 2016; broken down using the equality and diversity indicators.

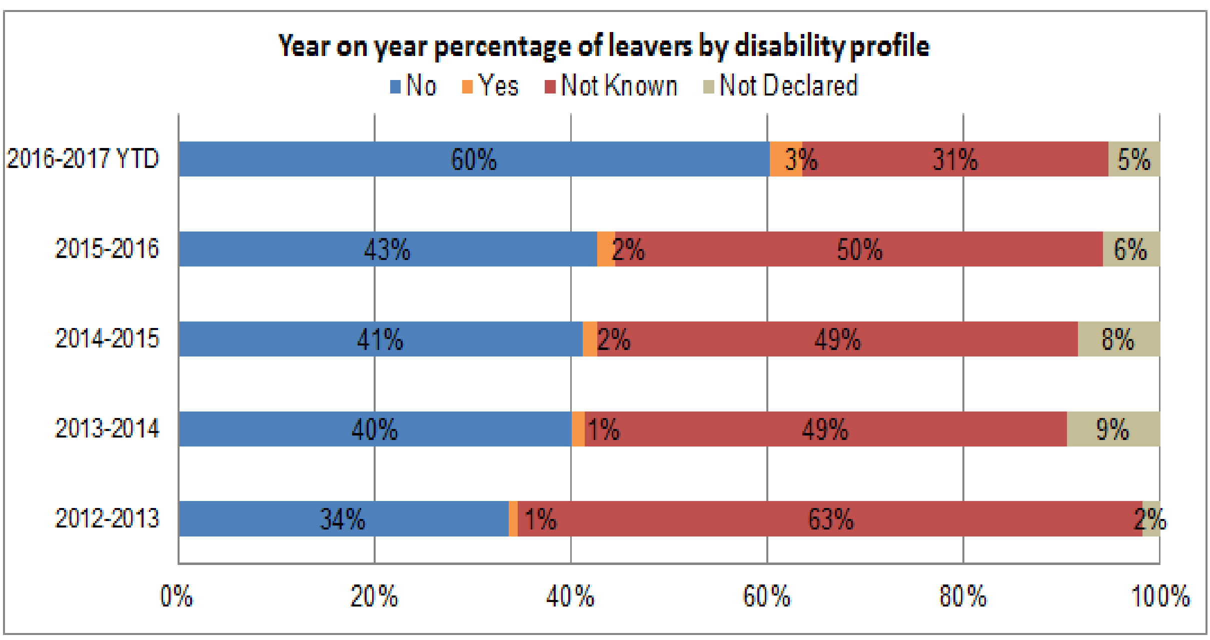
Age

During the current year to date, turnover is highest amongst staff aged 25 and under (19%).



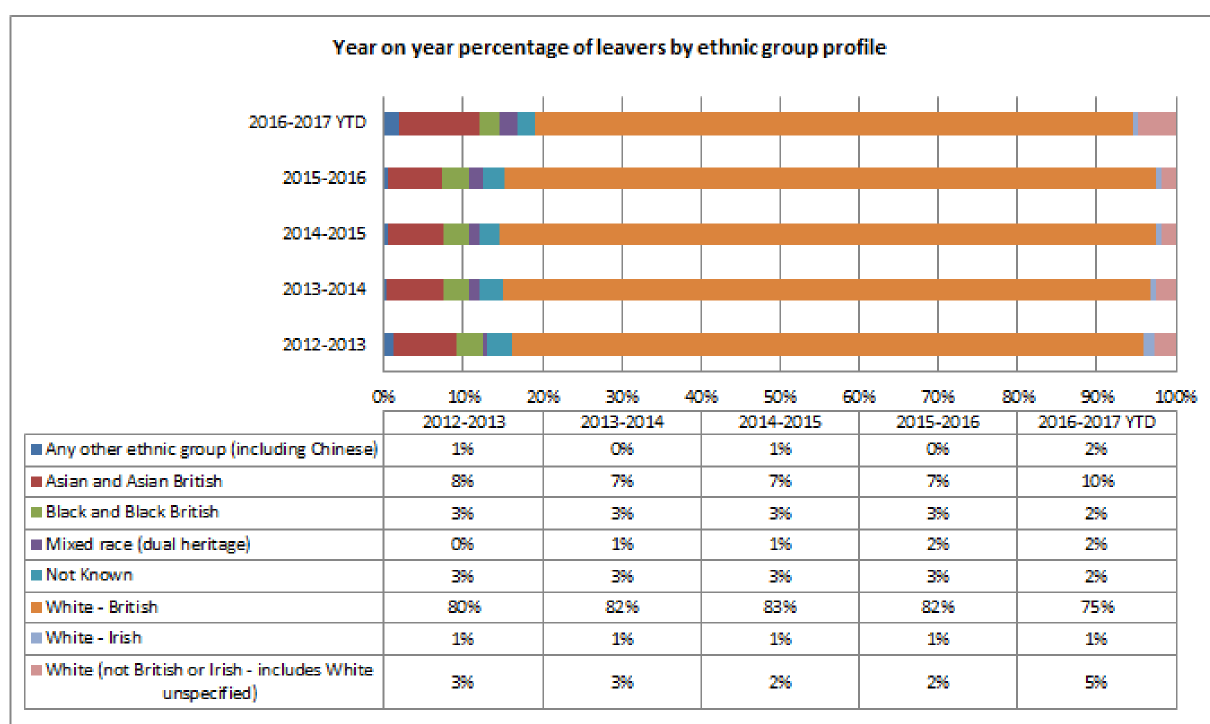
Disability

Data quality has improved in this area with a reduction of 19% in the in the 'not known' category.



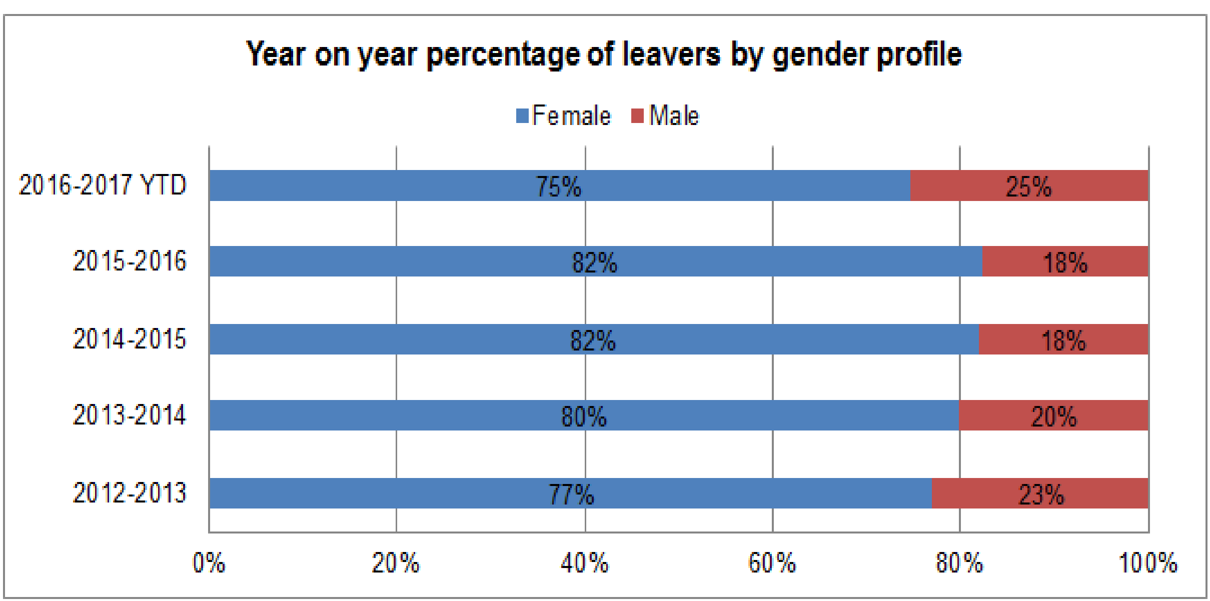
Ethnicity Profile

In the current financial year there has been a slight decrease in 'White British' leavers in the Trust. The other ethnic categories that showed a significant change are 'Asian & Asian British' and 'White (not British or Irish – includes White unspecified) which have both had a 3% increase. All other categories remained around similar levels as previous years.

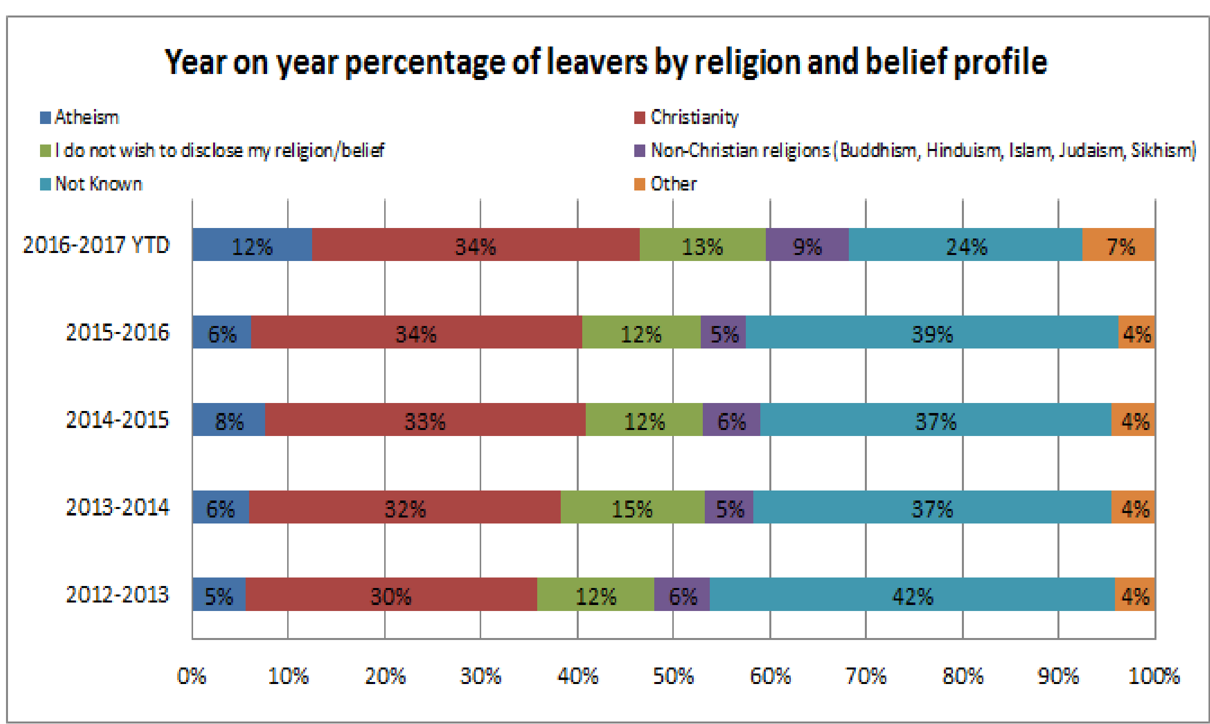


	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017 YTD
Any other ethnic group (including Chinese)	1%	0%	1%	0%	2%
Asian and Asian British	8%	7%	7%	7%	10%
Black and Black British	3%	3%	3%	3%	2%
Mixed race (dual heritage)	0%	1%	1%	2%	2%
Not Known	3%	3%	3%	3%	2%
White - British	80%	82%	83%	82%	75%
White - Irish	1%	1%	1%	1%	1%
White (not British or Irish - includes White unspecified)	3%	3%	2%	2%	5%

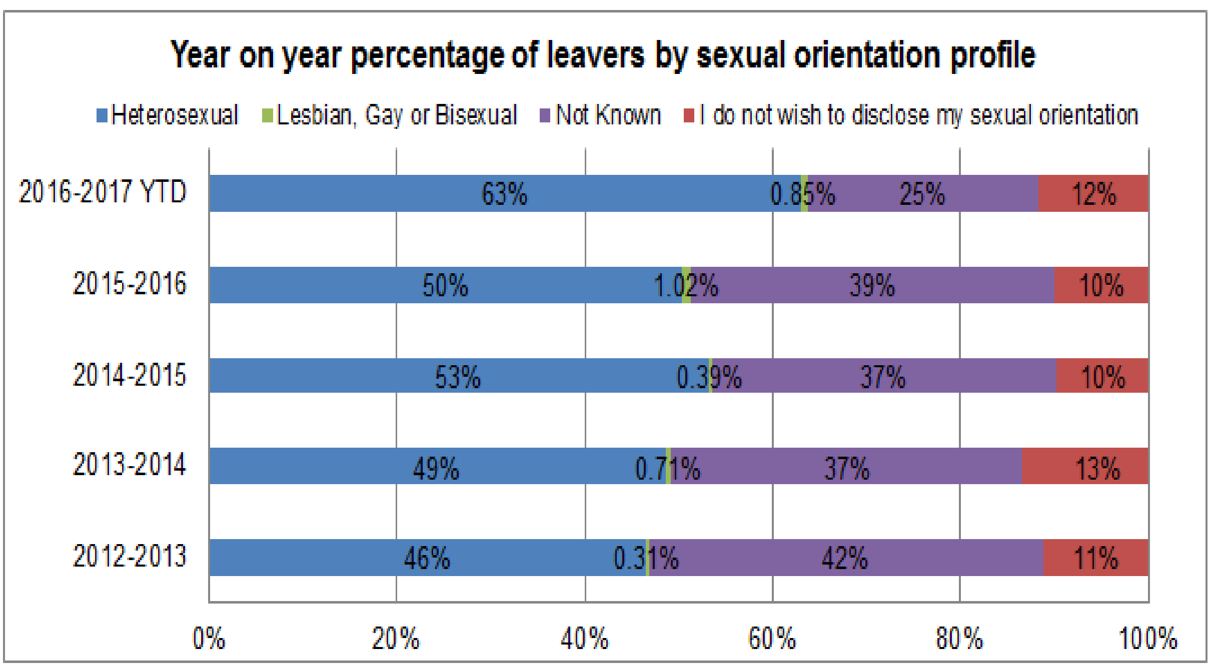
Gender
Again turnover is higher amongst female employees (75%) with the Trust employing a significantly higher amount of female employees to male. Therefore, this is expected.



Religion & Belief
In the current year there has been a 15% decrease in the 'not known' category this is something the Trust will try to continue to improve over the next 12 months.



Sexual Orientation
In the current year there has been a 14% decrease in the 'not known' category. This is something the Trust will try to continue improve over the next 12 months.



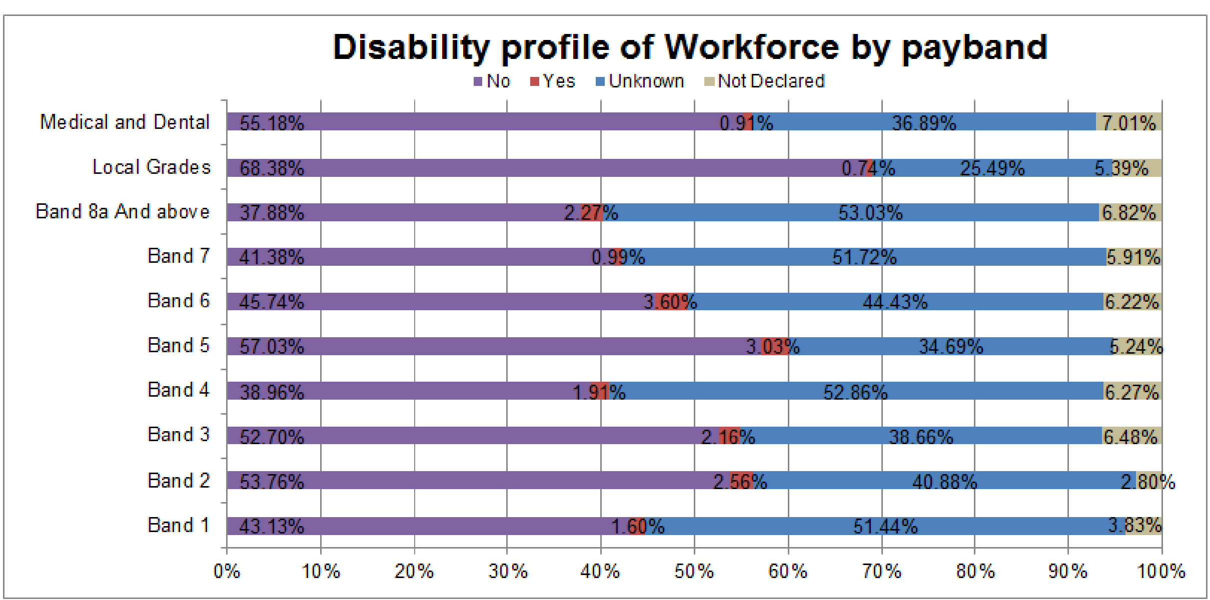
5. Staff profile by pay

The data below is a 'snapshot view' of the pay levels for all Trust employees as at 30 November 2016. 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. 15.31% 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	7.99%	14.96%	5.62%	6.54%	15.31%	3.71%	0.49%	0.00%	6.62%	15.55%
26 - 30	5.75%	11.36%	10.37%	7.08%	14.76%	10.48%	5.17%	1.52%	18.14%	6.40%
31 - 35	4.15%	9.36%	10.15%	8.72%	13.59%	15.50%	10.34%	6.06%	19.36%	3.66%
36 - 40	7.35%	7.44%	11.02%	12.26%	11.38%	14.30%	15.52%	10.61%	17.89%	14.02%
41 - 45	8.31%	11.36%	12.10%	11.99%	11.31%	15.28%	14.53%	18.94%	9.07%	19.21%
46 - 50	18.21%	11.52%	15.33%	19.62%	11.17%	15.94%	24.88%	21.97%	12.25%	15.85%
51 - 55	21.09%	14.48%	17.49%	19.07%	12.69%	14.08%	19.46%	25.76%	9.31%	13.11%
56 - 60	16.29%	13.12%	13.82%	11.72%	7.86%	7.75%	7.88%	11.36%	3.92%	6.71%
61 - 65	8.95%	5.60%	3.24%	3.00%	1.59%	1.97%	1.48%	3.79%	2.21%	3.96%
Over 65	1.92%	0.80%	0.86%	0.00%	0.34%	0.98%	0.25%	0.00%	1.23%	1.52%

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 40.7% 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.

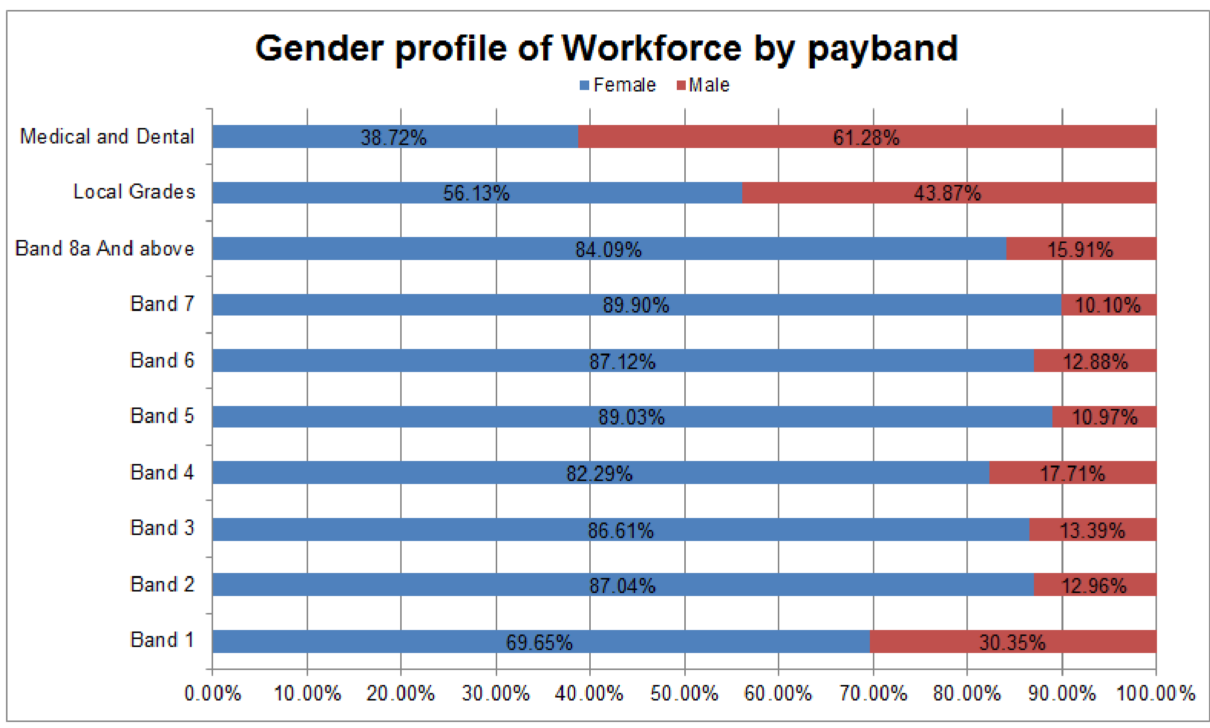


Ethnicity
Overall the Agenda for Change pay scales, the majority of staff were White British. While Medical and Dental have a more even split between White and other ethnic backgrounds, with a large proportion of those being Asian/Asian British.

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%	0.64%	0.43%	0.27%	1.52%	1.09%	0.25%	1.52%	3.71%	8.62%
Asian and Asian British	9.58%	9.77%	5.83%	6.28%	9.00%	4.37%	2.96%	0.76%	27.48%	35.38%
Black and Black British	1.28%	0.88%	0.65%	0.27%	1.18%	0.98%	0.25%	0.00%	2.23%	2.46%
Mixed race (dual heritage)	3.51%	2.72%	1.30%	1.37%	1.73%	0.55%	2.22%	0.76%	2.23%	1.23%
Not Known	3.19%	2.16%	1.94%	1.64%	2.63%	1.97%	1.97%	1.52%	4.70%	2.46%
White - British	77.96%	81.91%	87.04%	89.07%	79.31%	88.43%	91.87%	95.45%	56.19%	42.46%
White - Irish	0.96%	0.72%	0.86%	0.27%	0.76%	1.31%	0.49%	0.00%	0.74%	0.31%
White (not British or Irish - includes White unspecified)	3.51%	1.20%	1.94%	0.82%	3.88%	1.31%	0.00%	0.00%	2.72%	7.08%

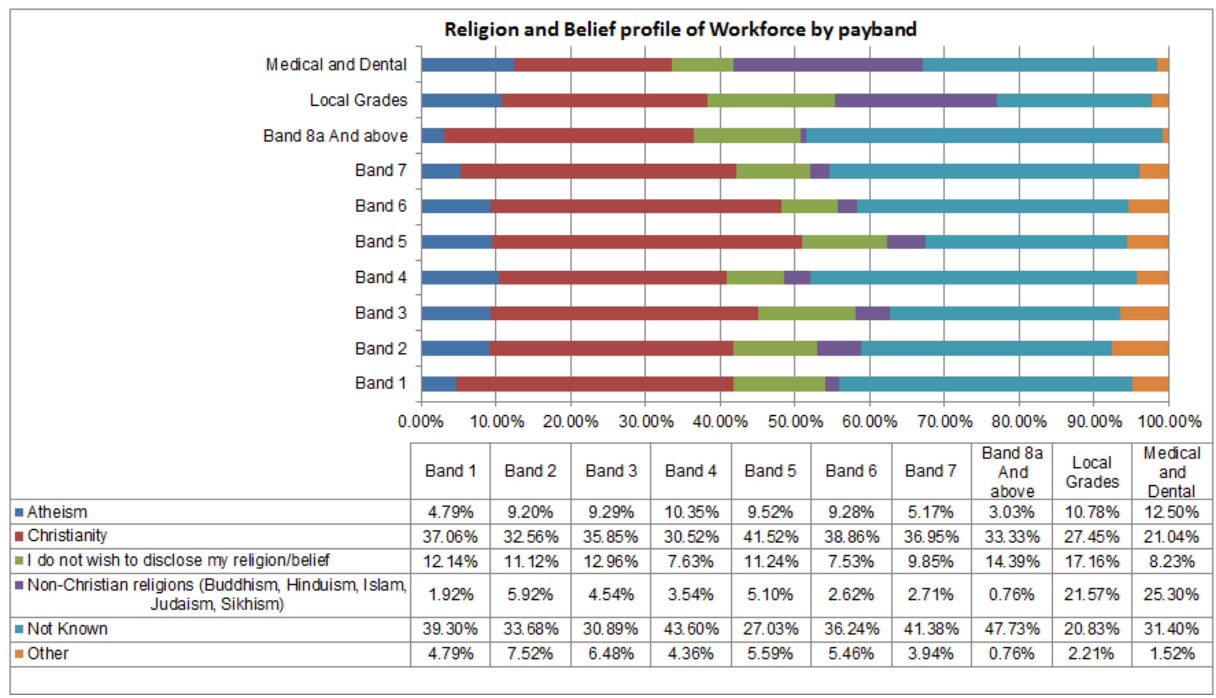
Gender

Men are over-represented in the Medical and Dental pay band (61.28%) compared with the workforce profile as a whole.



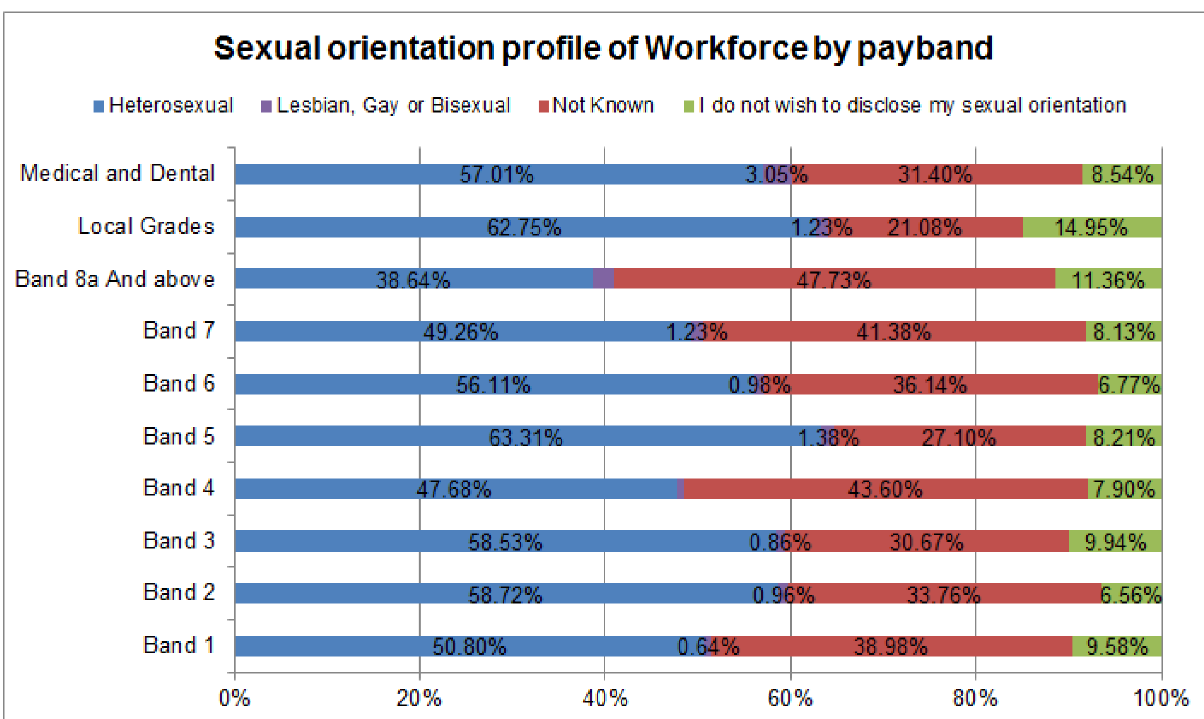
Religion and belief

'Not known' information is predominant in all pay bands with the most significant being in Band 8a and above (47.73%). 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.



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a And above	Local Grades	Medical and Dental
Atheism	4.79%	9.20%	9.29%	10.35%	9.52%	9.28%	5.17%	3.03%	10.78%	12.50%
Christianity	37.06%	32.56%	35.85%	30.52%	41.52%	38.86%	36.95%	33.33%	27.45%	21.04%
I do not wish to disclose my religion/belief	12.14%	11.12%	12.96%	7.63%	11.24%	7.53%	9.85%	14.39%	17.16%	8.23%
Non-Christian religions (Buddhism, Hinduism, Islam, Judaism, Sikhism)	1.92%	5.92%	4.54%	3.54%	5.10%	2.62%	2.71%	0.76%	21.57%	25.30%
Not Known	39.30%	33.68%	30.89%	43.60%	27.03%	36.24%	41.38%	47.73%	20.83%	31.40%
Other	4.79%	7.52%	6.48%	4.36%	5.59%	5.46%	3.94%	0.76%	2.21%	1.52%

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



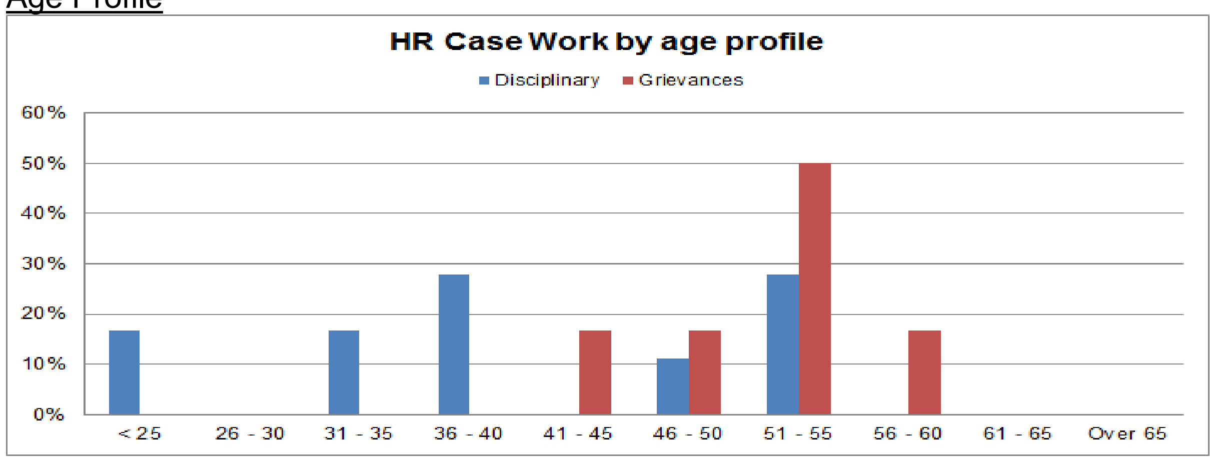
6. Disciplinary, grievance and bullying and harassment

Overall, between December 2015 and November 2016 there were:

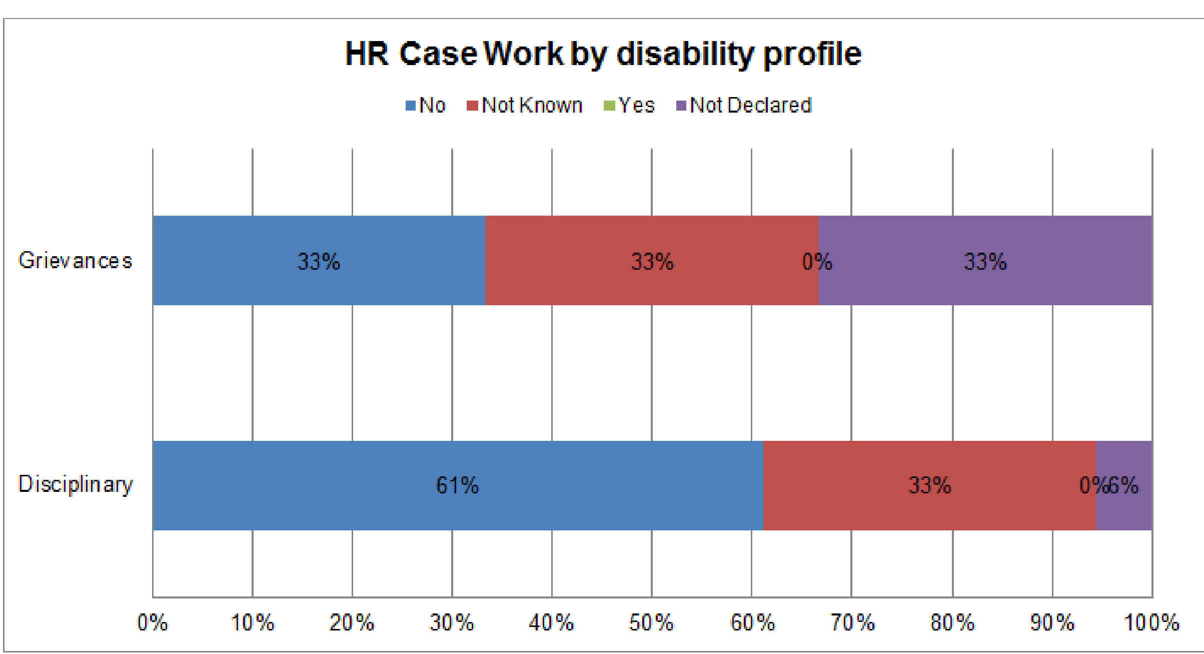
- 18 disciplinary investigations.
- 4 grievance investigations
- 2 bullying and harassment investigations

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.

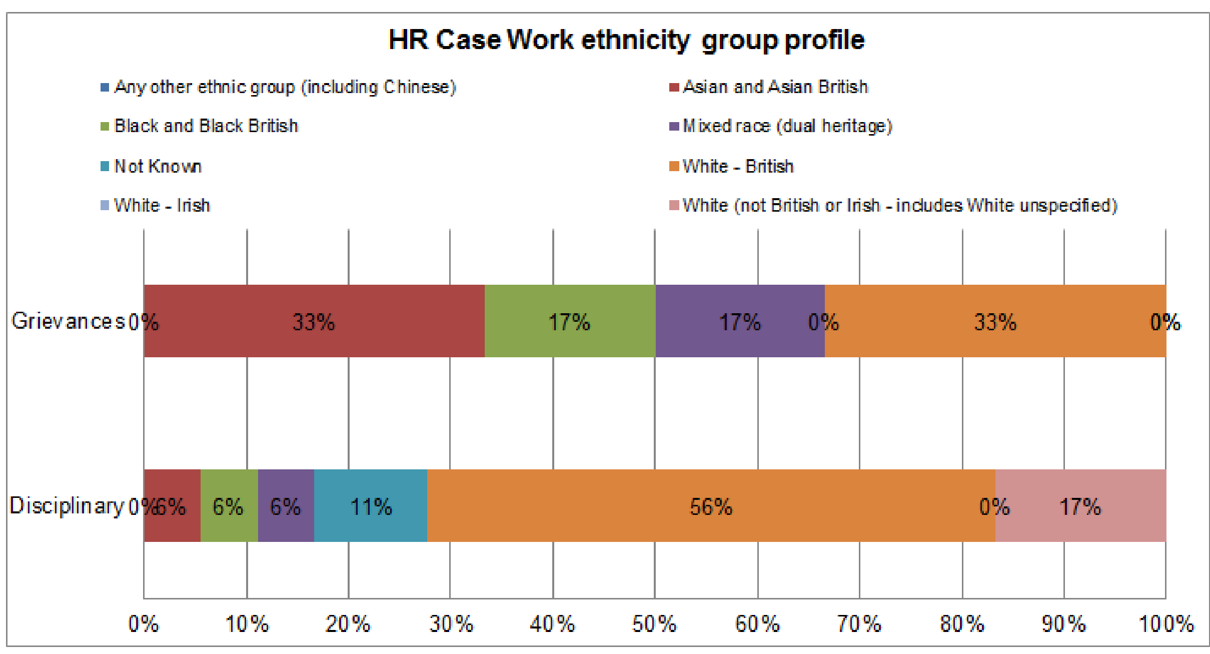
Age Profile



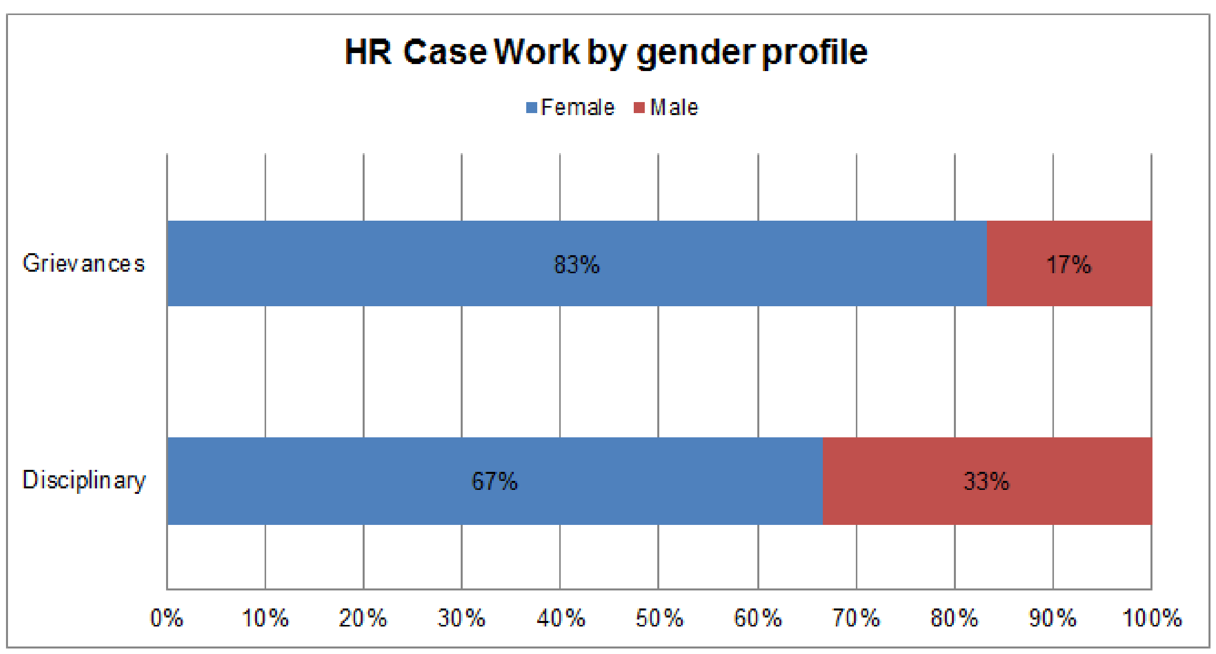
Disability



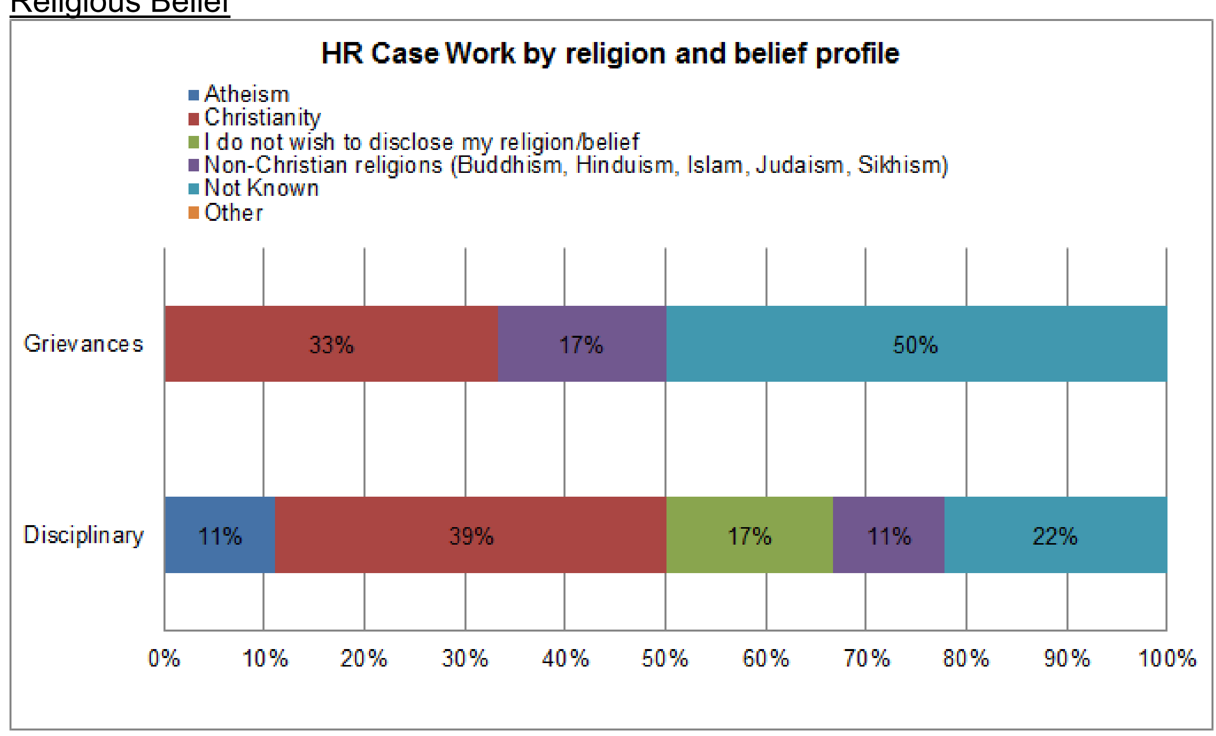
Ethnicity



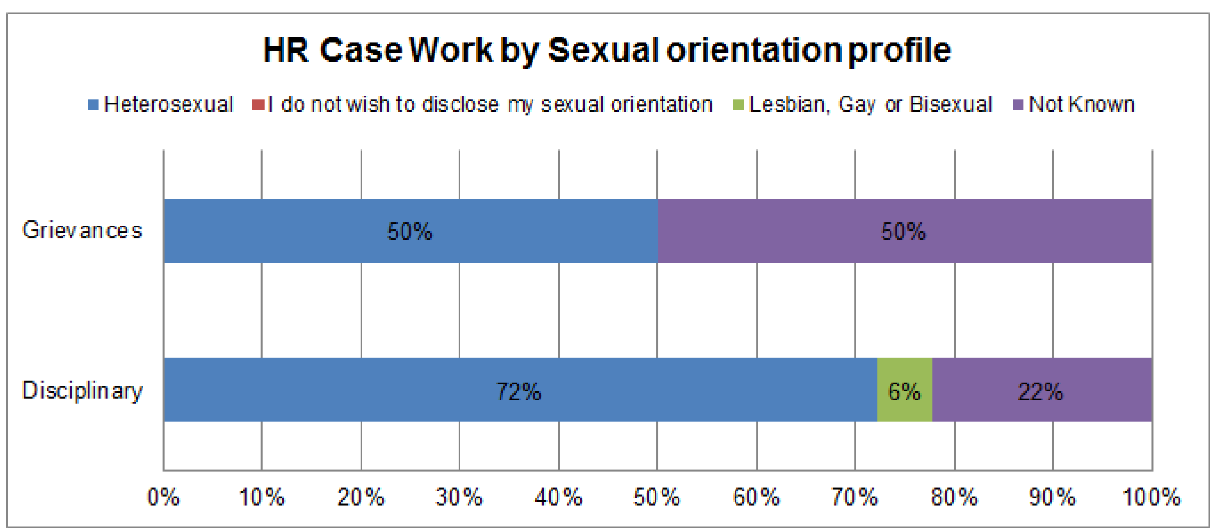
Gender



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 will ensure that all policies are assessed for their impact on patients/colleagues with a protected characteristic. No policies will be 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 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.

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 and gardeners using the scheme but has expanded the types of roles over the past 12 months to include therapy assistants, phlebotomists and radiography assistants. Whilst the Trust recruits to all roles a key success has been through the cohort recruitment approach for healthcare assistants. The first cohort of 14 employees commenced in July 2013 with 12 further cohorts recruited as at 30 November 2016. Seven cohorts have successfully completed their training and have been recruited into substantive posts.

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 2016. 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 BME 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 January 2016, the Trust's Chief Executive invited BME colleagues to attend a focus group. A total of 7 focus groups were held between January and March 2016 and 47 colleagues from across all staff groups attended.

Focus group participants were asked to comment on what their experience was of working in the Trust, how they would like things to be in the future and what the Trust

needed to do to improve. Feedback from each focus group was collated and consistent themes used to formulate an action plan. An executive lead is responsible for each action and works with BME colleagues who volunteered to work on the actions in task and finish groups. One of the actions was to create a BME Network which was established and had its first meeting in September 2016.

The Trust conducts a leavers survey where employees leaving the organisation are given an opportunity the complete the survey. The response rate is 30%. The top three reasons for leaving the Trust are better career opportunity, change in career and retirement.

All new starters to the Trust are invited to complete a 'New Starter Feedback Form' when they have been with the Trust for 3 months. The response rate is 27%, with the majority of new starters reporting a positive start to working at the Trust and 98% agree that they are aware of and recognise the four pillars of behaviour the Trust expects of new colleagues.

8. Improving workforce equality data

In 2016, we have:

- Improved the quality of data stored within the Electronic Staff Record (ESR) around ethnicity, sexual and religious beliefs for all new starters since April 2010. This is in line with the ESR central team and the Health and Social Care Information Centre validation and data quality reporting system, and the Workforce Validation Engine (WOVEN). Reports are received on a monthly basis and highlight improvements within ESR.
- Introduced ESR employee self-service which means that employees can update their personal data including protected characteristics on ESR which will improve accuracy.
- Improved processes with the recruitment of applicants through NHS Jobs to make sure demographic information is captured in a timely manner.
- The Trust continued to support and recruit staff using the apprenticeship scheme.
- Published the Workforce Race Equality Standard (WRES) in July 2016
- Improved our exit survey process to ensure all staff have the opportunity to offer feedback

APPENDIX 2

Faiths and Practice

A practical guide to help in responding to patients with different religions and cultural backgrounds within our demographic area

It is best practice to ask all patients if their faith might have any bearing upon the way they are treated during their stay.

Please note that this is intended as a **brief guide only** and is by no means exhaustive It is the responsibility of staff to ensure that the wishes of all patients are respected where at all possible. We wish to ensure that patients have a positive experience during their care within our Trust.

	Diet (always ask)	Festivals	Hygiene, etc
Christians	No restrictions generally. Some will fast in Lent and may abstain from meat on Fridays.	Advent, Christmas, Lent, Holy Week, Good Friday, Easter, Pentecost, Saints Days. Some people may wish to celebrate whilst others may not.	No special needs.
Buddhist	Always ask patient first. Often vegetarian or vegan. Salads, rice, vegetables and fruit are usually acceptable.	They may want to have quiet, or time with another Buddhist chanting sacred texts.	No special requirements
Hindus	Many are vegetarian. Some eat eggs. Dairy produce free from animal fat. Even the use of utensils used for meat would be offensive. Hindus do fast: Always Ask.	Divali (Oct/Nov variable) Holi (Mid March)	Water for washing required in same room as WC. Water required if bedpan has to be used. Hindus prefer free flowing water to baths.
Jewish people	Kosher meals. No flour at Passover time. May request vegetarian. Pork is forbidden. No milk and meat at same meal No animal rennet or gelatine. Eggs and white fish. No fish without scales or fins.	Passover (early April), Pentecost (late May), New Year (mid September), Yom Kippur (late September/early October) Succoth (early October) Chanucah (Mid December) **Sabbath – Fri – Sat p.m.**	Wash and say brief blessing before eating. Jewish men prefer to be bearded and use electric razor. Orthodox women keep their hair covered.
Muslims	No pork. Most other meats from Muslim (Halal) butcher. Muslims are strict on Halal food. No alcohol even in chocolates. No animal fats to be used even in food preparation. Fish and eggs are allowed, but not when cooked where other non Halal meats are cooked.	Dates vary with lunar calendar. **Fast during month of Ramadan** – no feed or drink during daylight hours but may be relaxed for those who are sick. Other festivals: Eid-Al-Fitr, Eid-Al-Adha, New Year. Friday is Muslim holy day. Dates vary annually.	They attach great importance to cleanliness. Toilet paper is adequate, but many prefer water. They require a container of water after a bedpan. Ablution is necessary before prayers.
Sikhs	Most are vegetarian. (Please ask patient)	Vaisakhi (April).	Prefer to wash in free flowing water. Water in same room as WC or with a bedpan when used. They wash hands and rinse mouths before meals.
Humanist	No particular requirements. Some Humanists are vegetarian or vegan. Ask patient.	Humanists may value open and rational conversation. Human dignity is valued.	No special requirements.

	Language	Modesty	Protocol on Death (always ask)
Christians	Any.	No special needs apart from observation of personal dignity- as with any patient.	Should be offered spiritual care by the appropriate chaplain at the time of death. (e.g. If Roman Catholic please ask if Catholic chaplain is needed for End of life prayers.) This also applies to relatives. There are no formal objections to autopsy or cremation. They believe the bodies of the dead whatever faith should be treated with the same respect as if alive.
Buddhist	English, Cantonese, Hakka, Japanese, Thai, Tibetan, Sinhalese	No special requirements. Always check with patient.	Many Buddhists wish to maintain a clear mind when dying. They may want to have quiet. Buddhists believe in rebirth/reincarnation. The body of the deceased may be handled by non-Buddhists.
Hindus	Punjabi, Hindi, Gujurati, Urdu, Bengali.	Most Hindu women would prefer a female doctor for examination or treatment. Respecting person's modesty of dress is particularly appreciated.	Prior to death, a Hindu's relative may bring money and clothes for him to touch before distribution to the needy. May like having a Holy book read to them. After death the body should be left covered. Believe body should be cremated.
Jewish people	Language of resident country, Hebrew, Yiddish, Ladino.	Please check that patient is prepared to be treated by male doctors.	Funeral should take place within 24 hours and cremation is forbidden. No mutilation of body allowed unless there has to be a post mortem. Prayers are said. Family mourning for 7 days. For Orthodox Jews: ask family for preferred Rabbi.
Muslims	Arabic, Punjabi, Bengali, Hindu, Urdu, Turkish, Iranian, Gujarati, Pushto, etc.	Generally Muslim women are not allowed to be examined or surrounded by male medical staff. A female member of medical staff should be present. Sometimes a woman may not agree to examination or treatment by a male clinician. In Islam sexual segregation depends on degree of adherence to tradition. In women head and chest requires modesty, but both sexes to dress modestly.	Expect a high volume of visitors. In Islam one is required to bury the body as quickly as possible. Post mortems are to be avoided unless legally necessary. The next of kin will want to arrange the washing of the body before burial. It is expected that emotions will be freely expressed when a relative dies, and space should be provided for this to occur. Same sex preparation of body for burial.
Sikhs	Punjabi, Hindi	Women prefer to be examined by female doctors. A male doctor will do in an emergency as long as a female member of staff is present. Personal dignity to be respected. Men have the 5 k's which should not be removed.	Do not like post mortems but will accept them if legally necessary. The body is washed and white clothes put on before cremation. Sikh Priest can be contacted at the nearest Gurdwara (two Sikh temples in Huddersfield**). Contact Chaplaincy for advice if needed**. Always cremation.
Humanist	Any known language	No specific requirements.	Humanists may prefer to have family or close friends with them. They might object to prayers being said or reassurance given based on belief in God or afterlife. Many Humanists request a non-religious celebration for their dead.

APPENDIX 3
CQC FACTSHEET

WHAT YOU NEED TO KNOW ABOUT……….*Equality and diversity*
Reality We all have a responsibility to ensure that the care we provide is responsive to the individual needs of our patients. The trust must also comply with the Equality Act. The Equality Act 2010 makes it unlawful to discriminate against people with a "protected characteristic". The protected characteristics are: Age; Disability; Gender reassignment; Marriage or civil partnership; Pregnancy or maternity; Race; Religion or belief; Sex; Sexual orientation. You're disabled under the Equality Act 2010 if you have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on your ability to do normal daily activities.
Response It's **everyone's responsibility** to ensure that the needs of patients and colleagues with a protected characteristic are taken into account and met. You need to make sure you take the appropriate action to meet the individual's needs, or seek advice from your line manager if you are unsure what to do. Equality and diversity training is **mandatory** so make sure you complete yours.
Result **Supporting physical disability:** A wheelchair user and WH Smith have worked in partnership to 'test drive' a new layout of hospital shop **Older people/Dementia:** We now have an award-winning volunteer led programme to assist with mobility and movement, eating and drinking and social engagement skills **Our workforce:** Since 2012 the number of black and minority ethnic colleagues has increased by more than 2.5%
Where to find more information Mandatory training e-learning module: Home/divisions/corporate/workforce-and-organisational-development/mandatory-training/your-mandatory-training-packages/equality-diversity-and-human-rights/ Dedicated intranet pages: Home/divisions/Trust-wide information/equality and human rights
Key contacts Associate Director of Engagement & Inclusion, Ruth Mason ruth.mason@cht.nhs.uk or call 01484 355007.

APPENDIX 4

MEMBERSHIP ENGAGEMENT DATA

Membership Representation as at December 2016 by Age, Ethnicity & Gender

	Members	% of total members	Eligible membership*	% of eligible membership
Age (years)				
0-16	1	0.0%	10398	1.6%
17-21	832	4.4%	52215	8.2%
22+	8218	95.5%	573203	90.2%
Ethnicity				
White	7429	86.4%	529668	83.3%
Mixed	166	1.9%	9659	1.5%
Asian or Asian British	736	8.6%	79829	12.6%
Black or Black British	233	2.7%	10162	1.6%
Other	37	0.4%	3935	0.6%
Gender				
Male	3033	35.3%	309248	48.6%
Female	5567	64.7%	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: Board of Directors	**Report Author:** Sue Laycock, PA to Chief Operating Officer
Date: Thursday, 5th January 2017	**Sponsoring Director:** Helen Barker, Chief Operating Officer
Title and brief summary: Integrated Board Report - Integrated Board Report - the Board are asked to note the contents of the report and the overall performance score for November.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Weekly Executive Board, Quality Committee, Finance and Performance Committee	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

To note - November's Performance Score is 65% for the Trust. 3 of the 6 domains improved in month. Within the Safe domain, the Never Event has contributed significantly to the RED rating.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board are asked to note the contents of the report and the overall performance score for November.

Appendix

Attachment:

Board Report - November 2016.pdf

Board Report

November 2016

Performance Summary

November

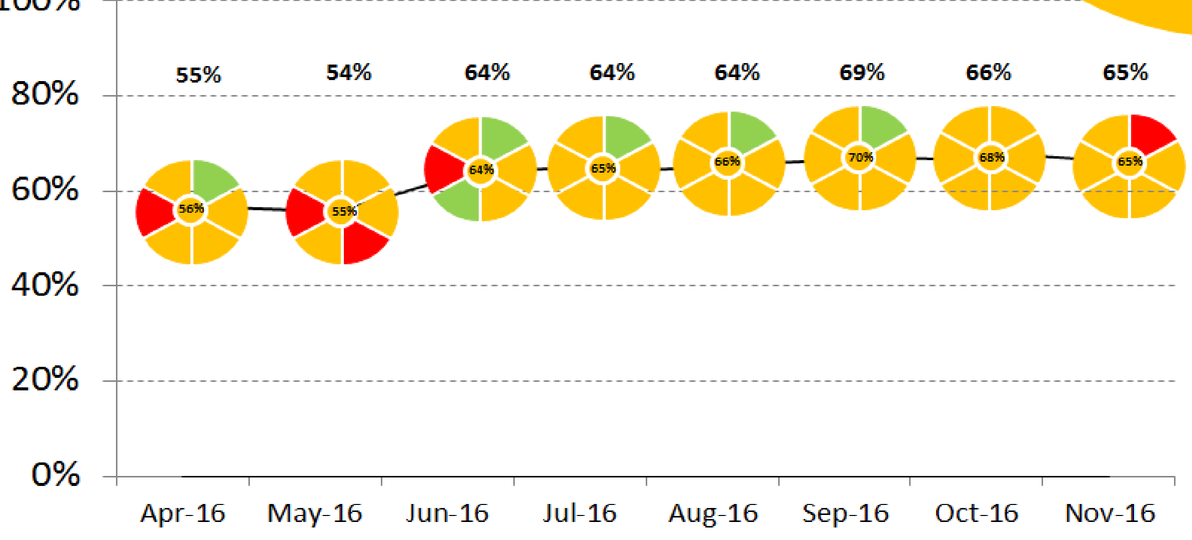
RAG Movement

November's Performance Score is 65% for the Trust. 3 of the 6 domains improved in month. Within **Safe** Never Event contributed significantly to RED rating.

CHFT

Efficiency & Finance
Safe
Workforce
Performance Score 65%
Caring
Responsive
Effective

Total performance score



November Score by Domain

Domain	Score
Safe	46%
Caring	70%
Effective	64%
Responsive	69%
Workforce	64%
Efficiency & Finance	67%
Performance Score	65%

Regulatory Targets

CDiff Cases	Cancer 62 day Referral to Treatment
Avoidable Cdiff	Cancer 62 day Screening to Treatment 84.6% (90%)
ECS 4 hours 94.02% (95%)	Cancer 31 day targets x3
RTT Incomplete Pathways	Cancer 2 Week Referral to Date first seen
Data Completeness Community Care x3	Cancer 2 week Breast Symptoms

Other Key Targets

VTE Assessments	FFT targets x7
Never events 1 (0)	FFT A&E 89.4% (90%)
MRSA	FFT Community 86.5% FFT OP 90.9%
SHMI 113.8 (100)	Stroke % admitted 4 hours 69.5% (90%)
HSMR 102.94 (100)	Diagnostics 6 weeks
Emergency Readmissions GHCCG 8.26% (7.05%)	Net surplus/ (deficit) £120k
% Complaints closed 38% (100%)	Sickness 4.15% (4%)

Carter Dashboard

		Current Month Score	Previous Month	Trend	Target
CARING	Friends & Family Test (IP Survey) - % would recommend the Service	97.6%	97.3%	↑	96%
	Inpatient Complaints per 1000 bed days	2.2	2.2	↔	TBC
EFFECTIVE	Average Length of Stay - Overall	5.2	5.1	↓	5.17
	Delayed Transfers of Care	2.07%	2.80%	↑	5%
	Green Cross Patients (Snapshot at month end)	83	100	↑	40
	Hospital Standardised Mortality Rate (12 months Rolling Data)	102.94	105.00	↑	100
	Theatre Utilisation (TT) - Trust	85.1%	85.8%	↓	92.5%
RESPONSIVE	% Last Minute Cancellations to Elective Surgery	0.68%	0.52%	↓	0.6%
	Emergency Care Standard 4 hours	94.02%	94.86%	↓	95%
	% Incomplete Pathways <18 Weeks	96.13%	95.60%	↑	92%
	62 Day GP Referral to Treatment	89.6%	88.1%	↑	85%
SAFE	% Harm Free Care	93.92%	95.78%	↓	95.0%
	Number of Outliers (Bed Days)	284	840	↑	495
	Number of Serious Incidents	8	9	↑	0
	Never Events	1	0	↓	0

MOST IMPROVED	MOST DETERIORATED	ACTIONS
Improved: Hospital Standardised Mortality Rate (12 months Rolling Data October 15 - September 16) has improved again to 102.94. The Trust HSMR has fallen below 80 for the first time in an individual month - September.	Deteriorated: % Harm Free Care - The Trust performance is 93.92% which was below the target of 95% . The Medical division was the only area where this target was not met, with performance at 89.19%. The Safety Thermometer audit where the % of harm free care is measured showed an increase in all catagories contained in the audit within the Medical Division.	Action: % Harm Free Care - Deep dive was presented at November PRM where areas for improvement were identified at Individual ward level.
Improved: Number of Hospital admissions avoided by Community Nursing services have almost doubled in November to 119.	Deteriorated: Never Event - assigned to the Surgical Division in November, this was in Operating Services, Anaesthetics, Pain and Critical Care.	A serious incident investigation is underway and will be completed within 60 days. Early learning has identified which is being implemented and monitored.
Improved: % PPH ≥ 1500ml - all deliveries has improved in month to 1.3%. This is the best performance this year and takes YTD performance to 3.1% - just above the internally set target of 3%.	Deteriorated: 62 Day Referral From Screening to Treatment has dropped below the 90% target for the last 2 months.	Action: Target has been missed for the last 2 months where low numbers of breaches caused the failure of the target as there were only a small number of patients in total. Cross divisional action plans between FSS and Surgery in place to avoid future breaches.

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.

Arrow direction count 1 11 ↓ 7

PEOPLE, MANAGEMENT & CULTURE: WELL-LED	Current Month Score	Previous Month	Trend	Target
Doctors Hours per Patient Day				
Care Hours per Patient Day	7.9	7.6	↑	
Sickness Absence Rate	4.15%	3.94%	↓	4.0%
Turnover rate (%) (Rolling 12m)	12.41%	12.93%	↑	12.3%
Vacancy	355.07	402.49	↑	NA
FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q4	79%	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) Q4	60%	Different division samples each quarter. Comparisons not applicable		

OUR MONEY	Current Month Score	Previous Month	Trend
Income vs Plan var (£m)	£2.80	£2.68	Green
Expenditure vs Plan var (£m)	-£3.29	-£3.11	Amber
Liquidity (Days)	-14.90	-14.20	Red
I&E: Surplus/(Deficit) var (£m)	£0.12	£0.13	Green
CIP var (£m)	£2.03	£2.08	Green
FSRR	3	3	Red
Temporary Staffing as a % of Trust Pay Bill	15.79%	16.26%	Green

Executive Summary

The report covers the period from November 2015 to allow comparison with historic performance. However the key messages and targets relate to November 2016 for the financial year 2016/17.

Area	Domain
Safe	• **% Harm Free Care -** The Trust performance 93.92% which was below the target of 95% . The Medical division was the only area where this target was not met with performance at 89.19%. The Safety Thermometer audit where the % of harm free care is measured showed an increase in all catagories contained in the audit within the Medical Division. Deep dive was presented at Medical Division November PRM where areas for improvement were identified at Individual ward level. • **Percentage of SI's investigations where reports submitted within timescale (60 days unless extension agreed) -** 67% of reports were submitted within 60 days. The capacity of the investigators is still an issue. Additional support is available from the Risk team when timescales become challenging. The Risk team are meeting with trained investigators at key touch points throughout the process to identify any barriers to completion within timeframe. • **Never Event -** A serious incident investigation is underway and will be completed within 60 days. Early learning has identified improvements that are being implemented. All staff in the relevent departments have been made aware and Duty of Candour has been completed. • **Antenatal Health Visiting Contact by 32 Weeks** - fell below 90% target at 81% - visits were missed due to premature births, no access visits and parental preference. • **Number of Category 4 Pressure Ulcers Acquired at CHFT -** There was 1 Category 4 pressure ulcer recorded in October which has been validated and re-classified as a Category 3. All wards will have an allocated Tissue Viability Link Practitioner who will participate in the new quarterly programme (first session January 2017) and disseminate best practice.
Caring	• **Complaints closed within timeframe** - 109 complaints were closed in November, which is a 56% increase from October. Of the 109 complaints that were closed 38% were closed within target timeframe, same as October. The total number of overdue complaints has been reduced to 5 which is is an impressive 93% reduction from October. Should 10% of a Division's complaints become overdue a report will be sent to Executive Director of Nursing and Assistant Director for Quality for discussion in the Weekly ADN meeting. • **Friends and Family Test Outpatients Survey** - % would recommend has maintained last month's performance at 91% which is still below the target of 95%. Further work to continue as part of directorate action plan to achieve Q3 improvement trajectory (December 16). Each department with 3 or more consecutive months of < 95% performance has developed an action plan. • **Friends and Family Test Community Survey** - FFT reports 4% of people would not recommend services. An options paper for FFT recording was presented at November PRM. An analysis of negative voice and SMS messages showed that a high percentage of them were not about CHFT Community services but about other parts of the patient pathway. The division plans to reduce the method of collecting data from voice messages in response to feedback. There are plans to increase the number of teams using the webform or paper collection tool with a view to these being the only data collection methods for all teams from April 2018.
Effective	• **Total Number of Clostridium Difficile Cases/Avoidable number of Clostridium Difficile Cases -** There has been 1 Clostridium Difficile case reported in month which was unavoidable. This takes the total number of cases to 21 as at the end of November against last year's total of 25 which is a higher run rate however the number deemed avoidable at 5 is well below the full year tolerance of 21. • **Hospital Standardised Mortality Rate** (12 months Rolling Data October 15 - September 16) - has shown a further improvement to 102.94. The Trust HSMR has fallen below 80 (79.55) for the first time in an individual month - September. The weekday/weekend split shows a 2 point difference with an improvement in both measures. • **Mortality Reviews** - The completion rate for Level 1 reviews stands at 26% of October deaths having had a corporate level one review. This reduction was anticipated as internal processes are adapted to capture more robust data from Q3 onwards. A number of new reviwers have been recruited and there is a focus on reviewing sepsis related deaths. • **Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge** - In November the number of patients operated on within 36 hours of admission for fragility hip fracture was 36 out of a total of 46. Performance was 78.3% against a target of 85%. YTD performance is 71.3%. The use of Theatre 6 is expected to progress this position with the introduction of 3 additional Trauma lists per week. A 'go-see' is planned to Pilgrim Hospital, Boston, Lincolnshire in January 2017 to identify best practice elements that can be introduced at CHFT. A deep dive has been requested for January's PRM following the visit. • **Emergency Readmissions Within 30 Days (With PbR Exclusions) - Calderdale CCG/Greater Huddersfield CCG** - In October there was an increased rate for both CCGs. Divisions continue to support the readmissions work lead by Community with the first audit planned for December.

Background Context

During November all Divisional teams have been finalising the 17/18 annual plan and working to develop CIP schemes for 17/18.

AED has seen activity continue to over-perform in month 8 but at a lower level than seen in month 7. Activity is 1.7% above the month 8 plan and cumulatively 3.3% above plan and peaks on Sundays and Mondays continue. Discharges at a weekend and Monday are causing pressure points in relation to bed capacity.

Non-elective activity overall is 3.5% below the month 8 plan. This is a decrease in activity when compared to month 7 when activity was 2.6% above plan. The in-month under-performance is mainly due to a reduction in emergency General Surgery admissions and Accident & Emergency. Cumulatively activity is 0.7% below planned levels due to emergency long stay activity.

Patients on a Green Cross pathway remain high and excess bed days is tracking higher than previous years. Despite this the number of beds open is lower than previous years and flow remains problematic on particular days.

Additional capacity was required in November in the form of HRI wards 14 and 4, partly due to the impact of Norovirus on both sites. Overall Trust level bed numbers are 6 above the November planned levels which is an improvement on the position seen in October and better than 15/16. Surgery has continued with 12 beds above plan while Medicine have improved further to be 6 beds below planned levels in November.

Planned day case and elective activity combined has improved in month 8 with activity 4.6% above plan. This is driven by an over-performance in day cases offset by a continued under-performance within elective inpatients. The improvement from month 7 is mainly within Gastroenterology, Oral Surgery which was under plan last month and General Surgery. Elective under-performance continues mainly within General Surgery, Paediatrics and Gynaecology. Interventional Radiology has a continued under-performance due to the shift to day case activity.

A Paediatric workshop was held at the end of November to review future models of care relating to acute Paediatric Surgery. The meeting involved representatives from all elements of the existing service. A programme of work has been agreed for January with an option appraisal due mid-February.

The Trust's Appointments and Outpatient services has received very positive coverage after been featured at a recent conference. A number of Trusts have asked to come and visit CHFT to learn from the work done in relation to clinic utilisation and efficiency. The success of the Trust's services has been supported by the innovative work done via its

Executive Summary

The report covers the period from November 2015 to allow comparison with historic performance. However the key messages and targets relate to November 2016 for the financial year 2016/17.

Area	Domain
Responsive	• **Emergency Care Standard 4 hours -** November's position was 94.02% which was in the Upper Quartlie nationally but still breaches occuring that are avoidable. An Emergency Care improvement plan has been developed by the Directorate which focusses on ECS and quality indicators. • **Stroke -** Patients admitted to a stroke ward within 4 hours maintained the 70% performance in November. Patients scanned within 1 hour of arrival however dropped in month. Discussions are ongoing between Medicine and FSS to improve scanning with FSS agreeing to prioritise Stroke patients. Stroke Invited Service Review (ISR) took place in December and early reports are positive regarding the quality of the service with areas for improvement identified. • **% Last Minute Cancellations to Elective Surgery -** just failing to meet target at 0.68%. Main reasons for cancellations were list overruns, unavailable beds and emergencies/Trauma, • **RTT pathways over 26weeks** - numbers continue to reduce and now stand at 79. Further validation resource is being recruited to validate all pathways highlighted in recent analysis. • **38 Day Referral to Tertiary** remains a concern. FSS provided their approach to improvements and programme of work at their November PRM. Full RCA's carried out on every breach and discussed at the Clinicians' monthly education session. Scoping the possibility of moving the local MDT, currently held on the same day as the central MDT causing a delay of 7 days in most cases. Criteria being established to enable some cases to bypass the local MDT to reduce time between MDT discussions. Regular meetings with pathway tracking team to review all ongoing cases and escalate as appropriate. • **62 Day Referral From Screening to Treatment** - Target has been missed for the last 2 months where low numbers of breaches caused the failure of the target as there were only a small number of patients in total.
Workforce	• **Sickness Absence rate** - long term sickness is now achieving target for the first time this year. Slight deterioration in short term sickness in month. • **Return to work Interviews** have reached 72% following the drop in performance in September. However still some way short of 100% target. • **Mandatory Training and Appraisal -** Mandatory training compliance has changed to a rolling 12 month reporting period and is RAG rated against performance at the same point last year. Only Information Governance is below last year's performance. Workforce summit is taking place w/c 12th December where a deep dive will take place and an action plan created. Appraisal compliance is now reported as both year to date and rolling 12 months and has hit the year to date target for October.
Efficiency/ Finance	• **Finance:** Year to date: The financial position stands at a deficit of £12.48m, a favourable variance of £0.12m from the planned £12.60m. This is positive news as the Trust is continuing to maintain the financial position in the second half of the financial year where there was always acknowledged to be a greater challenge in terms of the timing of CIP delivery, alongside seasonal pressures. Operational performance linked to the Sustainability Transformation Funding has also been maintained in the year to date however, in early December the organisation has faced considerable operational challenges including dealing with Norovirus in the face of continued high clinical activity. It continues to be the case that, in order to maintain safety and secure and regulatory access standards across the Trust with high vacancy levels, there is a reliance upon agency staffing. Total agency spend in month was £1.47m; this is an improved position from last month which compares favourably with expenditure in excess of £2.1m each month in the year to August. This improvement brings the agency expenditure beneath the revised trajectory submitted to NHSI. The impact of this operational position is as follows at headline level: • EBITDA of £3.95m, an adverse variance of £0.49m from the plan. • A bottom line deficit of £12.48m, a £0.12m favourable variance from plan. • Delivery of CIP of £9.65m against the planned level of £7.62m. • Contingency reserves of £1.0m have been released against pressures. • Capital expenditure of £10.66m, this is below the planned level of £17.93m. • A cash balance of £3.97m, this is above the planned level of £1.94m, supported by borrowing. • **Theatre Utilisation** has maintained its 86% performance. There have been improvements in some of the key specialties that have struggled to achieve the targets in month; namely Ophthalmology, Urology and ENT.
CQUIN	• **Staff Well Being Flu Vaccination** - As at the end of November performance stands at 66.3% with almost 4,000 colleagues vaccinated, just over 2,800 of these were classified as frontline. The Trust has already met the partial payment threshold, further campaign work for December is planned including performance data being sent to relevant areas and further awareness raising being led by the Director of Nursing. Divisional leads are using flu data to challenge lower uptake areas, and a refreshed view of the data broken down to staff groups is being undertaken to see if further opportunities can be identified.
Activity	• **Activity** in-month is above planned levels in all of the main points of delivery apart from elective and non-elective inpatients. Cumulatively elective inpatients and day cases combined are above plan however waiting lists are still high reflecting ongoing demand.

Background Context

November has seen a high demand on hospital beds and the Community division has been supporting the inpatient teams in facilitating discharge and undertaking additional assessments where possible.

There has been an increased focus on discharge delays from external partners which has supported the Trust in gaining traction regarding the challenges of moving people into packages of care. As a result additional packages of care have been commissioned by CMBC in December.

The 0-5 Public Health Early Years bid was released in November and the completed tender was submitted 14th December.

Cancer waiting times continue to be challenging, a mixture of early pathway pressures with increased referral via fastrack, MDT arrangements and diagnostic pressures. The Divsions are working together on improvements and closer support to the Patient Flow team.

On 21st November Theatre 6 came back into clinical use. This allowed Surgery to increase its Trauma lists by 2 per week on a sustainable basis. The additional theatre has led to a significant reduction in the number of patients waiting on the Trauma list. This will also allow better flow during the week as specialties respond to ongoing demand pressures.

The Medicine division is now preparing to hand over a ward to the Community Division at the CRH site. The plan is to pilot an innovative ward configuration promoting independance and supporting active discharge called the Community Place. This has been developed in collaboration with Calderdale social care and is now planned to "go live" in January.

Diagnostics has been extremely busy responding to internally and externally driven demand but still maintaining access standards.

Demand continues to be high driving increased outpatient activity and work continues to ensure reductions in follow-up waiting times.

Outpatient activity overall has continued to see an increase and is 7.6% above the month 8 plan. The over-performance in-month is across both first and follow-up attendances including procedures. The specialties with the more significant over-performances within first attendances are Oral, ENT, Paediatrics, Rheumatology, Gynaecology, Dermatology and Urology. General Surgery and Ophthalmology have continued to under-perform. Cumulatively outpatient activity is now 3.5% above plan however with demand continuing at high levels this is not resulting in a reduced waiting list size.

The Commissioner Contract includes all NHS Standard Contract Operational Standards and any applicable financial sanctions. Some of these are included within the Sustainability Transformational Fund (STF) performance trajectories and so will not be subject to 'double jeopardy' within the Contract. No further sanctions have been incurred in month 8. Cumulatively there have now been sanctions of £12.9k of which there are 3 Duty of Candour breaches, a Never Event and a Mixed Sex Ward breach.

Safe, Effective, Caring, Responsive - Community Key messages

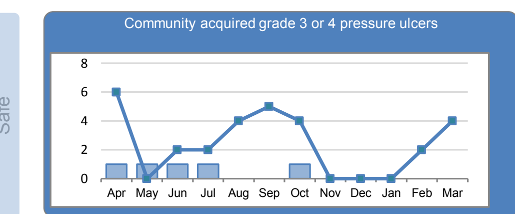
Area	Reality	Response	Result
Safe	**Falls reduction , reduction cat 3/4 community acquired PU's ,Early Detection of Sepsis** Maintained reduction in 3/4 pressure ulcers. The team continues to focus on these 3 areas to improve outcomes - Work on the sepsis model within community is the area that now requires further development and model design.	The orange incident panel meets weekly to review orange and red incidents Robust PU pathway in place Falls prevention and collaboration work continues Working with Mel Johnson re AKI and sepsis - early identification and indicators particularly in care homes and once modeled to roll out across community services	Learning from falls investigation fed into the division via PSQBs QUEST matrons to work collaboratively to identify tools and develop education packages for care homes and community staff and develop training packages for community staff to support the quality agenda **By when: March 2017** **Accountable: Associate Director Nursing**
Effective	**Flow through intermediate services:** There are continued challenges across Calderdale, particularly in Upper Valley, for access to packages of care. This continues to impact on the flow through reablement and intermediate care services.	**Flow through intermediate services:** additional packages of care have been commissioned by social care in December to support flow though Reablement. The Trust is undertaking a review of all parts of the intermediate tier to understand where the blockages are and what could be done differently. A proposal for running a rapid process improvement intervention has been developed and now looking for support from social care senior managers to undertake this jointly.	**Flow through intermediate services:-** To have an agreed redesigned intermediate tier process following the rapid process improvement intervention and an agreed action plan for implementing changes. **By when: February 2017** **Accountable: DO**
Caring	**Health Visitor core contact visits**: 39 core contacts have been reported as exceptions with valid reasons why the visit did not take place within timescale. There are 24 clients who did not receive an antenatal visit and 4 babies that did not receive a birth visit within 14 days that have no exception report completed. These will be followed up by the service lead and investigated.	**Health Visitor core contact visits:** The service lead is aware of all clients that have not received the core contact within the mandated timeframe. This is being followed up with individual health visitors to understand if there are practice issues or other reasons and then will develop actions that can improve performance.	**Health Visitor core contact visits:** The peformance of mandated visits will improve month on month. Expect target to be achieved by end March 2017. **By when: March 2017** **Accountable: DO**
Responsiveness	**ASI's for MSK** Issue is generally in spinal pathway. Whilst capacity has remained there has been an increase in demand for this service in the last year. **MSK responsiveness - Typing turnaround** There has been an issue identified where letters that have been typed are backed up waiting for the practitioner to sign them.	**ASI's for MSK** The spinal MSK post has been recruited to. The person leaving post has agreed to bank shifts. Additional MSK practitioners to be appointed following business case approval for 2017/18 **MSK responsiveness - Typing turnaround** New typist has started within team. A template is being agreed within the service. A plan has been implemented with the MSK practitioners	**ASI's for MSK** Reduce the number of ASI's in MSK. **Accountable: Head of Therapies** **By when: February 2017** **MSK responsiveness - Typing turnaround** Backlog for signing will be removed by end December 2016. **By when: End December 2016** **Accountable: Head of Therapies**

Safe | Effective | Caring | Responsive | Workforce | Efficiency/Finance | CQUIN | Activity

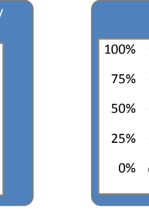
Dashboard - Community

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

Safe



One month in arrears



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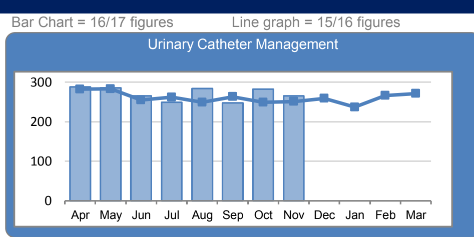

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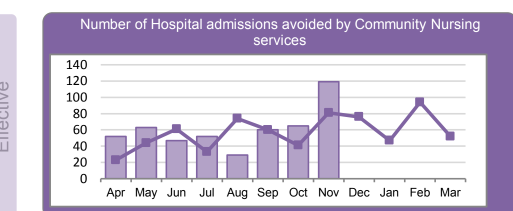

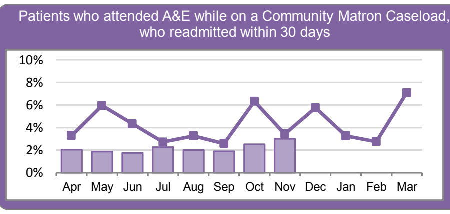

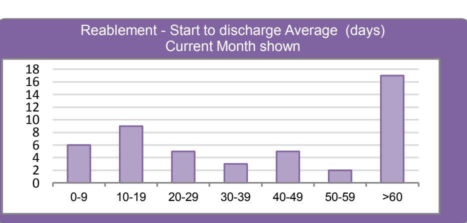

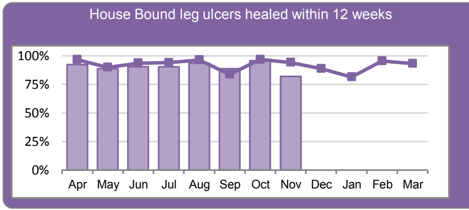

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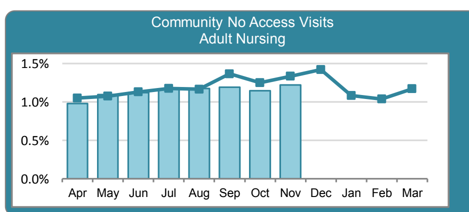

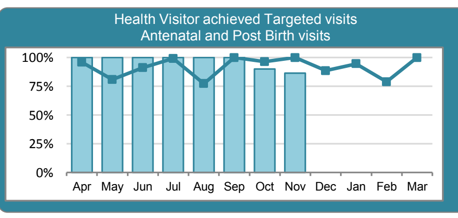

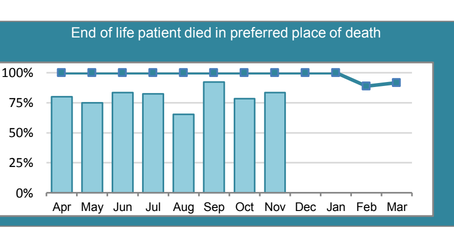

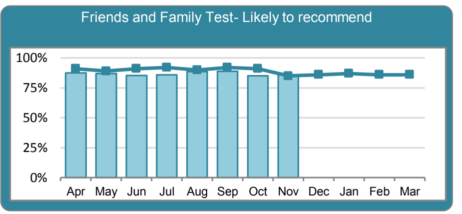

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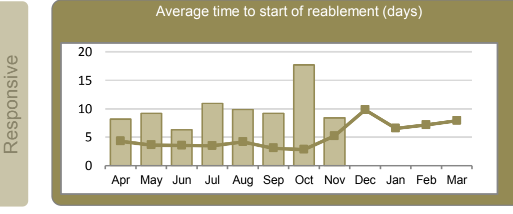
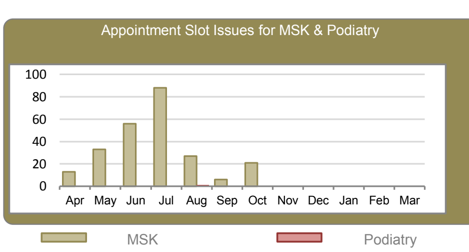
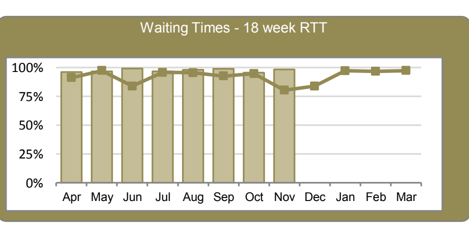
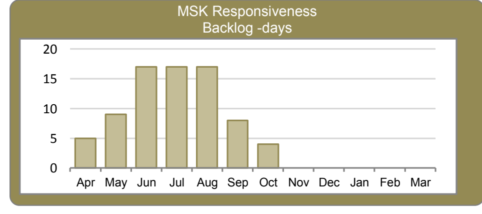
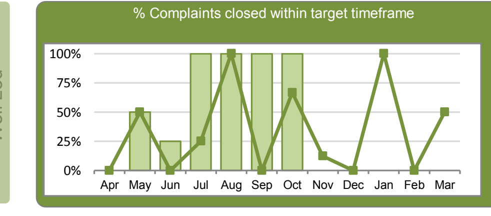


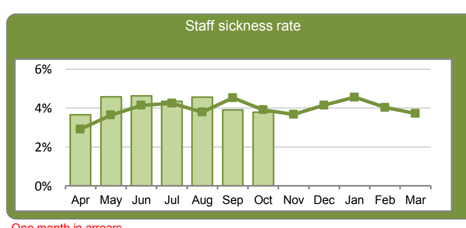




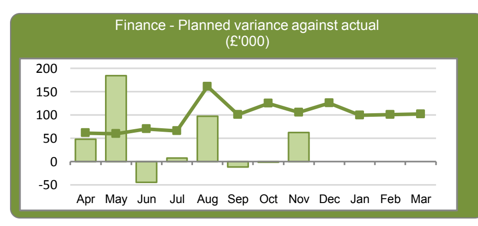


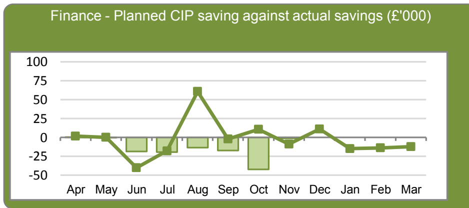
Well Led

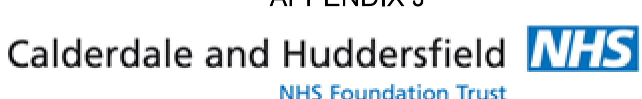




One month in arrears







Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 5th January 2017	**Sponsoring Director:** Gary Boothby, Deputy Director of Finance
Title and brief summary: FINANCIAL COMMENTARY TO NHS IMPROVEMENT - MONTH 8 - The Board is asked to approve Month 8 Financial Commentary	
Action required: Approve	
Strategic Direction area supported by this paper: Financial Sustainability	
Forums where this paper has previously been considered: Finance and Performance Committee - 3.1.17	
Governance Requirements: Financial Sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve Month 8 Financial Commentary attached.

Management commentary on the financial position of Calderdale and Huddersfield NHS Foundation Trust at the end of October 2016 for submission to NHS Improvement.

The report is structured into three sections to describe:
- Key messages
- Detailed commentary for the period with variance analysis against the plan as submitted to NHS Improvement
- Use of Resources rating (UOR) and forecast.

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 Month 8 Financial Commentary attached.

Appendix

Attachment:

NHSI Financial Commentary Month 8 1617(2).pdf

MONTH 8 NOVEMBER 2016, 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 November 2016.

The report is structured into three sections to describe:
- Key messages;
- Detailed commentary for the period with variance analysis against the annual plan as submitted to NHSI;
- Use of Resources rating and forecast.

1. Key Messages

The year to date financial position stands at a deficit of £10.60m, a favourable variance of £2.00m from the planned £12.60m of which £1.88m is purely a timing difference on the accrual of Strategic Transformation Funding (STF) versus the planned quarterly profile. The underlying position is a £0.12m favourable variance from year to date plan. This is positive news as the Trust is continuing to maintain the financial position in the second half of the financial year where there was always acknowledged to be a greater challenge in terms of the timing of CIP delivery, alongside seasonal pressures.

Operational performance linked to the STF has also been maintained in the year to date however, in early December the organisation has faced considerable operational challenges including dealing with Norovirus in the face of continued high clinical activity. It continues to be the case that, in order to deliver activity and access standards across the Trust with high vacancy levels, there is reliance upon agency staffing. However, operational actions that have been put in place to curb the use of agency have started to impact positively, total agency spend in month was £1.47m, an improved position from last month which compares favourably with expenditure in excess of £2.1m each month in the year to August. This improvement brings the agency expenditure beneath the revised trajectory submitted to NHSI.

Month 8, November Position (Year to Date)

Income and Expenditure Summary	Plan £m	Actual £m	Variance £m
Income	246.13	250.81	4.68
Expenditure	(241.69)	(244.84)	(3.15)
EBITDA	**4.44**	**5.98**	**1.53**
Non operating items	(17.05)	(16.44)	0.61
Deficit excluding restructuring costs	**(12.60)**	**(10.46)**	**2.14**
Restructuring costs	0.00	(0.14)	(0.14)
Deficit including restructuring costs	**(12.60)**	**(10.60)**	**2.00**

- EBITDA of £5.98m, a favourable variance of £1.53m from the plan.
- Of this operating performance £1.88m is driven by a timing difference on the accrual of Strategic Transformation Funding versus the planned quarterly profile.
- A bottom line deficit of £10.60m, a £2.00m favourable variance from plan.
- Delivery of CIP of £9.65m against the planned level of £7.62m.
- Contingency reserves of £1.0m have been released against pressures.
- Capital expenditure of £10.66m, this is below the planned level of £17.93m.
- Cash balance of £3.97m; this is above the planned level of £1.94m, supported by borrowing.
- Use of Resources score of level 3, in line with the plan.

2. Detailed Commentary for the Reporting Period

Statement of Comprehensive Income (SOCI)

The year to date activity over performance sits alongside strong CIP delivery, achieving £2.03m in advance of the planned timescale. The combined benefit has not flowed through in full to the bottom line but has rather absorbed the activity related expenditure pressures and one off issues such as the Junior Doctors' strike action. However, of the £2m contingency reserves planned for in the year to date, £1m has not been released but rather has been held back to mitigate against pressures in the latter part of the year. This lesser reliance on contingency reserves in the year to date continues to be supported by the income over performance and CIP delivery.

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

Operating income	£4.68m favourable variance
Operating expenditure	(£3.15m) adverse variance
EBITDA	**£1.53m favourable variance**
Non-Operating items	£0.61m favourable variance
Restructuring costs	(£0.14m) adverse variance
Total	**£2.00m favourable variance**

Operating Income

There is a £4.68m favourable variance from the year to date plan within operating income. Of this operating performance £1.88m is driven by a timing difference on the accrual of Strategic Transformation Funding (STF) versus the planned quarterly profile. The £1.88m STF represents full achievement of financial and operational criteria in the year to date. There has been a slight under-performance against the A&E trajectory in individual months but this is overridden by the cumulative year to date performance which is above the agreed year to date trajectory. This will remain a challenging target for the Trust due to increases in A&E attendances and non electives increase, exacerbated by the volume of 'Green Cross' (medically fit for discharge) numbers and seasonal pressures. The Trust is however seizing this challenge having been selected as an 'Accelerator' site for A&E performance and will continue to strive to deliver the trajectory as originally submitted to NHSI.

NHS Clinical Income

Within the £2.80m favourable income variance (excluding the timing difference on STF), NHS Clinical income shows a favourable variance of £4.06m. As described above, overall activity has again had a strong performance in month which augments the position seen in the year to date. The breakdown by point of delivery is as follows:

- Planned day case and elective inpatient performance is 4.6% (184 spells) above the month 8 plan which is an improved position from month 7. Cumulatively, the aggregate performance across day case and electives is also above plan, driven by strong day case activity.

- Non-elective activity overall is 3.5% (153 spells) below the month 8 plan. In the year to date non elective activity just slightly below planned levels by 0.7% with fluctuation in individual months.

- A&E activity has continued to over-perform but at a lower level than month 7. The month 8 activity is 1.7% (204 attendances) above plan and cumulatively is 3.3% (3,209 attendances) above plan.

- Outpatient activity overall has continued to see a further increase above plan of 7.6% (2,268 attendances). The over-performance in month is across both first and follow-up attendances, including procedures. Cumulatively activity is 3.5% (8,140 attendances) above plan.

- Adult critical care bed day activity and NICU activity are both above plan in the year to date, most significantly the latter by 13.5% (525 spells).

The clinical contract PbR income position is driven by these areas of activity over performance as well as Rehabilitation and Diagnostic testing & imaging. The non-elective activity level belies the favourable income position which is boosted by case mix.

This position continues to reflect an over-performance against the Trust's year to date plan and a greater over-performance against contracts with the Trust's Commissioners. The 2016-17 contracts with the Trust's commissioners incorporated a lower level of activity and income to the Trust plan in the main due to the CCG QIPP plans, Trust CIP plans and a differing view of baseline activity levels. The Trust remains in close contact with commissioners to highlight this position both from a point of view of securing cash relating to the overtrades in a timely manner and also to guard against unexpected challenges. Whilst the Trust is mindful of the affordability pressures to the health economy as a whole, it continues to be the case that no provision against PbR contractual challenges is reflected within the year to date position. This risk has heightened in recent days with the commissioners having raised the likelihood of a challenge to changes to counting and coding practices driven through the Trust's CIP. This will require further mitigating actions to be developed in order that the forecast delivery of the control total can be sustained.

The 2016-17 plan was inclusive of £1.97m of System Resilience funding which in previous months had been reflected in line with planned levels. Whilst the Trust is continuing to pursue this full value, commissioners are looking to hold back this funding on the grounds of affordability. The projects that are supported within the Trust with this funding are committed and embedded recurrently to aid improved patient flow and capacity in the context of pressures in the social care sector. Receipt of this funding is now not assumed in full in the forecast, placing a health economy risk entirely with the Trust and forcing the need for further compensating recovery actions to be implemented.

Other income

Overall other income is below plan by £1.26m in the year to date. This is mainly due the transfer of the West Yorkshire Audit Consortium to another host provider, which has reduced income by £0.57m cumulatively. The Trust also planned for Bowel Scope income as part of non-NHS Council funding which changed contractually to be funded through NHS England, showing below plan within non-NHS Clinical income, offset by over-performance within NHS Clinical income at a cumulative value of £0.57m.

<u>Operating expenditure</u>

There was a cumulative £3.15m adverse variance from plan within operating expenditure across the following areas:

Pay costs	(£1.60m) adverse variance
Drugs costs	£1.26m favourable variance
Clinical supply and other costs	(£2.81m) adverse variance

Employee benefits expenses (Pay costs)

Pay costs are £1.60m higher than the planned level in the year to date. The high vacancy levels in clinical staff groups continues to causing reliance on agency staffing with the associated premium rates driving contributing to the overspend.

For 2016/17 the Trust was originally given a £14.95m ceiling level for agency expenditure by NHSI. In the course of the year, the Trust was given the opportunity to restate the agency trajectory with the clear expectation that this would form a commitment by the Trust to reducing the agency costs. The revised full year position is to reduce the run rate in the second half of the year and contain spend within a £24.31m total. The Trust understands that it will now be held to this commitment.

The drive to recruit staff is ongoing including advertising new types of roles to aid recruitment potential. The work to push down the contractual rates paid to Medical agencies and develop a tiered approach to bookings is now beginning to impact. The actions to curb agency usage are of the highest priority to the Trust with a weekly Executive Director level meeting focussing purely on this agenda and continuing to work with colleagues in NHSI to ensure the implementation of best practice. Total agency spend in month was £1.47m, an improved position from last month which compares with expenditure in excess of £2.1m each month in the year to August. This improvement brings the agency expenditure beneath the revised trajectory submitted to NHSI.

It should be noted that £2.0m of contingency reserves are planned against pay across the first six months of the financial year. This contingency has been released against the pay position; meaning that the underlying divisional year to date pay overspend was £2.6m. In overall terms, there has been a year to date benefit from releasing reserves of £1m to the bottom line, a provision has been made against the £1m balance of the available contingency for potential future risks. The accounting treatment for provisions is as a non-pay cost and as such this drives an overspend against this element of the plan.

Drug costs

Year to date expenditure on drugs was £1.26m below the planned level. The income and corresponding spend on 'pass through' high cost drugs is £1.19m below plan. Underlying drug budgets are therefore further underspent by £0.07m.

Clinical supply and other costs

Clinical supply and other costs, including PFI costs, are £2.81m above the plan. This overspend reflects activity related factors such as ward consumables and diagnostic test costs. There has been a considerable increase in MRI usage driving hire costs and outsourced reporting charges, with growth in internal diagnostics demand outstripping the overall activity increase. Another factor is high cost devices which are 'pass through' costs are £0.43m above the planned level, compensated directly by income.

As was the case last month, an element of the overspend in this area is driven by purely technical reasons. The annual plan includes £2.0m of contingency reserves all of which was planned as pay spend. There has been a release of £1.0m contingency reserves to the bottom line in the year to date position; a provision has been made against the £1m balance for potential future risks and commitments. The accounting treatment for provisions is as a non-pay cost and as such this drives an overspend against this element of the plan. The accounts for £1m of the total £2.81m overspend against clinical supply and other costs.

Non-operating Items and Restructuring Costs

Non-operating items and restructuring costs are £0.61m below the planned level. This is driven by a combination of lower than planned depreciation charges and Public Dividend Capital payable. The adoption of a different valuation method for the PFI site and a review of equipment asset lives have reduced the asset value upon which both depreciation and PDC are chargeable.

The year to date has also seen £0.06m gain on disposal against the sale of the old Occupational Health building which was surplus to Trust requirements. In full year forecast terms, the Trust also anticipates recognition of a loss on disposal £0.3m relating to Princess Royal Hospital due to the sale price being lower than the carrying Net Book Value. Both of these technical accounting movements are excluded from the measurement against the control total.

The year to date benefits are offset in part by higher than planned interest payable due to both the timing of drawing down borrowing and higher than planned interest rates. The greater impact of this interest pressure is included in the full year forecast where a continuing to bear the current interest rate of 3.5% for a Working Capital Loan as opposed to the planned switch to a Revenue Support Loan at 1.5% will cost £0.5m more than plan.

Restructuring costs of £0.14m have been incurred in the year to date to fund redundancy costs which will deliver savings in the future periods.

Cost Improvement Programme (CIP) delivery

In the year to date, £9.65m of CIP has been delivered against a plan of £7.62m, an over performance of £2.03m. As was highlighted in previous months, whilst the level of over performance is positive news it should be noted that the over performance in early months is counterbalanced by under delivery in the latter half of the year. The £2.19m over performance against CIP plans in the year to date has not translated to an equivalent benefit to the Trust's bottom line financial performance but has rather offset other pressures. The issue that has been foreseen as a result of this is budgetary pressure in the remainder of the year which requires mitigation through the divisional recovery plans. This recovery has been realised in-month, with the lower CIP delivery versus plan in November having been sufficiently offset to maintain the overall financial position.

The year end forecast CIP delivery remains stable from last month at £15.19m, this over performance against plan is offsetting other pressures and therefore the increase in the CIP forecast does not translate to an improvement in the overall year end forecast. It should also be noted that over £4m of the total forecast CIP has been identified non-recurrently and this is creating an additional burden which has had to be accommodated in next year's financial plans.

Work is ongoing to ensure that CIP delivery in the latter part of the year can be secured, this is where the highest risk schemes are due to commence in earnest, for example the complex SAFER programme focussing on operational productivity through improved patient flow which remains under close review. Additional savings opportunities also need to be delivered in support of the divisional recovery plans that are required to deliver the overall financial control total of £16.1m deficit. An Executive Director time-out was held in early September to generate ideas; these have progressed through the gateway process to delivery stage alongside the balance of the divisional recovery plans.

Statement of Financial Position and Cash Flow

At the end of November 2016 the Trust had a cash balance of £3.97m against a planned position of £1.94m, a favourable variance of £2.03m. This is due to receiving 70% of the STF related cash on the final day of the month, meaning there was no opportunity to make further payments to suppliers. The key cash flow variances against plan are shown below:

Cash flow variance from plan		Variance £m
Operating activities	Deficit including restructuring	2.00
	Non cash flows in operating deficit	(0.52)
	Other working capital movements	(7.73)
	Sub Total	**(6.24)**
Investing activities	Capital expenditure	7.34
	Movement in capital creditors	(1.03)
	Sub Total	**6.32**
Financing activities	Drawdown of external DoH cash support	2.45
	Other financing activities	(0.49)
	Sub Total	**1.96**
	Grand Total	**2.03**

Operating activities

Operating activities show an adverse £6.24m variance against the plan. The favourable cash impact of the I&E position of £1.48m (£2.0m favourable I&E variance offset by £0.52m non-cash flows in operating deficit) is counter to a £7.73m adverse working capital variance from plan. The working capital variance reflects the catch up of payments to suppliers, coupled with the accrued STF. The performance against the Better Payment Practice Code has seen an improvement in month with 96.12% of invoices paid within 30 days against the 95% target, as many of the older outstanding invoices have flushed through in previous months and we are now paying recent invoices in the main.

Total aged debt based on invoices raised is £5.12m which is a reduction on last month as some material invoices have been settled, the remaining value includes; charges for Care Packages to local CCGs; contract overtrade invoices to local and other commissioners; and System Resilience Funding. As previously described, with the exception of the System Resilience Funding, these do not represent a risk of non settlement but rather a timing delay.

Investing activities (Capital)

Capital expenditure in the year to date is £10.66m which is £7.27m below the planned level of £17.93m.

Against the Estates element of the total, year to date expenditure is £3.19m against a planned £6.49m. The main area of spend in month was on the continuation of the Theatre refurbishment programme with a year to date spend of £1.74m, this is coupled with spend on backlog maintenance including the continuation of fire compartmentation, fire detection and roofing work.

IM&T investments total £4.84m against a plan of £5.72m. The main areas of spend in month were the continuation of the Electronic Patient Record (EPR), and EDMS projects. The main reason for the underspend against plan is due to the delay in go live of EPR, however, this project is now forecast to spend £12.24m versus a plan of £4.74 due to the additional costs of the delay.

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

The favourable cash impact of the £7.34m (£7.27m capital expenditure variance plus £0.07m funded by donated assets) under spend is offset by a £1.03m adverse variance against capital creditors as invoices have been forthcoming and paid in a timely way.

Financing activities

Financing activities show a £1.96m favourable variance from the original plan, of which £2.45m is due to additional cash support through borrowing. This position includes borrowing brought forward in earlier months to settle supplier invoices; a position which is being maintained versus the planned position which was to extend creditor payments. Extending creditor terms was not sustainable in operational terms in order to maintain key lines of supply.

Continuing to borrow at the current planned levels at an interest rate of 3.5% for the remainder of the year will bring a pressure of £0.5m, included in forecast, against the original plan which assumed a switch to the lower interest rate in-year. The latest understanding from discussions with NHSI to convert our loan from a Working Capital Facility (at 3.5% interest) to a Revenue Support loan (at 1.5% interest), is that we will only move to the lower rate loan once the working capital facility has reached the level equivalent to 30 days operating costs.

3. Use of Resources (UOR) rating and forecast

UOR

Against the UOR the Trust stands at level 3 in both the year to date and forecast position, in line with plan. This is equivalent to the Trust's previous rating of 2 against the Financial Sustainability Risk Rating, on the new inverted rating scale.

Forecast – Income and Expenditure

The year end forecast position continues to be delivery of the planned £16.1m deficit and control total, prior to consideration of costs associated with EPR implementation.

As described last month, the reported forecast year end deficit is £16.35m but includes exceptional costs of a loss on disposal of £0.3m relating to the disposal of Princess Royal. These exceptional technical accounting costs are excluded from the deficit for control total purposes and therefore have no impact on our STF allocation or UOR metric.

This position assumes delivery of £15.19m CIP and that recovery plans are delivered to offset ongoing pressures and risks. In addition, it continues to be assumed that the Trust will achieve the necessary conditions to secure the £11.3m STF which is intrinsic to and contingent upon delivery of the planned deficit.

It has been acknowledged in discussion with NHSI, both at the time of setting the plan and subsequently, that the £16.1m control total excluded any I&E or cash pressures for EPR 'go live'. The revised timescale for implementation, now being into early 2017/18 means that the implementation costs will cross the financial years. The split of the overall assessed impact of £5m across the two financial years is currently being worked up based upon the evolving operational plans. As recently discussed with NHSI, this assessment will be shared as soon as it is available. The Trust looks to NHSI to continue to support this position in 2016/17 and in the plans for 2017/18 which currently follow the same principle of excluding these exceptional one off costs.

There have inevitably been other areas of underlying pressure and risk emerging in year, including areas that have impacted in the year to date which are beyond the organisation's direct control, such as the Junior Doctor's strike action and the higher than planned rate of interest being borne on current borrowing. This pressure intensifies in the remainder of the financial year as the Trust plans to deal with the combination of EPR implementation; delivery of complex CIP schemes with greater returns; managing winter pressures alongside quelling agency staff usage; and the commissioners taking a stance that they will not support £1.97m of System Resilience funding to the Trust, against which expenditure commitments cannot be released.

All of these issues were acknowledged last month and the Trust has in train recovery plans to mitigate these risks. These include a range of divisional plans, rigorous budgetary control and innovative solutions. Under the latter heading the Trust has sought to negotiate with the soft FM provider on the PFI site to secure a favourable agreement. This is currently being tested independently to ensure value for money. The Trust will progress this initiative subject to best value being evidenced.

As described earlier in this report, a further risk has very recently emerged with regard to commissioner challenge to the Trust's counting and coding of clinical activity. The risk of full achievement of CQUIN targets has also heightened despite the best endeavours of the Trust to meet all targets. If these risks crystallise further mitigation will have to be found to secure the year end forecast deficit. The Trust will continue to strive to capitalise upon all opportunities to deliver this.

Forecast – Capital and cash

In overall terms the capital expenditure is currently forecast at £27.64m, £0.56m below the planned full year value of £28.22m. Due to the delay in go live of EPR which is forecast to increase spend against this element of the original plan by £7.5m, there has been some further re prioritisation of capital plan, resulting in reduced spend on the Estate and Equipment to offset the additional EPR cost.

A level of capital expenditure on EPR has now been pushed back to month 12 and a proportion of this expenditure is now forecast to be paid in cash terms the next financial year. This has reduced our loan drawdown requirements for 2016/17, but will need be added to the assessment of 2017/18 borrowing. Alongside this, in year, the cash benefit of the sale of Princess Royal Hospital at £1.2m is offsetting the non-cash I&E benefit of lower than planned depreciation and supporting working capital pressures.

The Trust is mindful of the limited availability of capital funding nationally. On this basis, the organisation continues to constantly review our capital programme whilst taking into account operational, and legislative compliance requirements. The Trust will complete the Project Appraisal Unit report and the final 2017/18 planning submission as required in the next week which will confirm the capital requirement across the two years.

Owen Williams **Chief Executive**	**Gary Boothby** **Executive Director of Finance**

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Samantha Lindl, PA to Deputy Director of Workforce & OD
Date: Thursday, 5th January 2017	**Sponsoring Director:** ian warren, Executive Director of Workforce and OD
Title and brief summary: WORKFORCE STRATEGY - In accordance with the vision of the future of the health sector across the region, we clearly face significant challenges in terms of the ever-increasing and complex demands placed upon the Trust.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: WORKFORCE (WELL LED) COMMITTEE 19 OCTOBER 2016 AND 8 DECEMBER 2016 EXECUTIVE BOARD 17 NOVEMBER 2016	
Governance Requirements: As described in the Executive Summary.	
Sustainability Implications: None	

Executive Summary

Summary:

In accordance with the vision of the future of the health sector across the region, we clearly face significant challenges in terms of the ever-increasing and complex demands placed upon the Trust.

As part of the ongoing need to develop our services, we are further challenged by the need to re-configure our services to meet these increasing demands across a multi-site organisation. We firmly believe that our workforce needs to be fully engaged in developing our approach to meet these future, and often unclear, requirements.

The Workforce Strategy is the key document that draws together the approaches we require to attract, retain, support, engage and reward our people in order to meet this challenge.

Our vision is to have an engaged and healthy organisational culture, supported by a sustainable and capable workforce working in an integrated and co-ordinated approach with all of our partners. This requires us to ensure that our leadership and management, with our colleagues, is undertaken and delivered in a manner which firmly demonstrates our values and behaviours – and that we put these into action through everything we do.

The Strategy themes are identified below:-

- Recruitment
- Retention
- Workforce planning – availability, utilisation and effectiveness
- Agency spend – both in terms of cost and number
- Attendance Management
- Colleague Engagement
- Organisation Development and Leadership.

The Workforce (Well Led) Committee approved the strategy at its meeting on 8 December 2016.

Main Body

Purpose:

As described in the Executive Summary.

Background/Overview:

As described in the Executive Summary.

The Issue:

As described in the Executive Summary.

Next Steps:

As described in the Executive Summary.

Recommendations:

The Board of Directors is asked to approve the adoption of the Workforce Strategy.

Appendix

Attachment:

Workforce Strategy and Appendices BoD 5.1.17.pdf

WORKFORCE STRATEGY

2016 – 2021

Approved by the Board of Directors
5 January 2017

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1. **Workforce Submission to NHS Improvement 2017/2019**
2. **Plan on a Page**
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   - **4.2 Project Status Report**
   - **4.3 Programme Status Report**

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CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

WORKFORCE STRATEGY

Foreword

In line with the vision of the future of the health sector across the region, we clearly face significant challenges in terms of the ever-increasing and complex demands placed upon the Trust.

As part of the ongoing need to develop our services, we are further challenged by the need to re-configure our services to meet these increasing demands across a multi-site organisation. We firmly believe that our workforce needs to be fully engaged in developing our approach to meet these future, and often unclear, requirements.

The Workforce Strategy is the key document that draws together the approaches we require to attract, retain, support, engage and reward our people in order to meet this challenge.

Our vision is to have an engaged and healthy organisational culture, supported by a sustainable and capable workforce working in an integrated and co-ordinated approach with all of our partners. This requires us to ensure that our leadership and management, with our colleagues, is undertaken and delivered in a manner which firmly demonstrates our values and behaviours – and that we put these into action through everything we do.

IAN WARREN

Executive Director of Workforce and Organisational Development

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CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

WORKFORCE STRATEGY

1. Introduction

This Workforce Strategy is grounded in our vision:-

"Together we will deliver outstanding compassionate care to the communities we serve"

and underpinned by the fundamental behaviours which guide the way we work, and which are set out in the Trust's People Management Framework as highlighted in our 4 pillars below:-

These behaviours will continue to guide and sustain us over the next five years as we strive to balance the dimensions of quality, people and money.

There are a number of explicit challenges we need to address within our strategy and it is necessary to keep these in focus as we deliver the changes to our services throughout the next five years and beyond.

The focussed areas within our strategy can be listed simply, but we are clear there are significant workforce issues to be addressed when dealing with these. The areas of focus are:-

- Recruitment
- Retention
- Workforce planning – availability, utilisation and effectiveness

- Agency spend – both in terms of cost and number
- Attendance Management
- Colleague Engagement
- Organisation Development and Leadership

We will ensure that through effective engagement of our colleagues, across the Trust and beyond, we maximise the opportunity of working for CHFT. As with all NHS Trusts, we are dealing with a shortage of professionals in many areas such as Emergency Care, Interventional Radiology, and many nursing areas. We will make certain that through marketing career opportunities in the Trust, developing our workforce, creating career pathways and through effective engagement of our staff that we will equip them to deliver the care required for all of our patients. It is essential we maximise the opportunity and desire to want to work with us as we deliver our future services in keeping with the commitment made in Right Care, Right Time, Right Place.

Further, we will need to consider how new competencies, roles and careers are developed to ensure we have a future workforce capable and enabled to deliver within a more demanding and complex future service. Put simply, we will be the employer of choice and will work with our workforce to ensure we deliver this.

As our Clinical Commissioning Groups have agreed to progress to a Full Business Case which would reconfigure services between our two main sites, we are presented with an opportunity to develop and deliver a future service, which will enable our vision of a sustainable quality service, supported by a workforce who clearly understand their role, and are clear on their career opportunities within, allowing us to work with our clinical colleagues to further develop their own careers with us.

Patient safety and workforce sustainability are at the forefront of our thinking, as we embark on this journey. We recognise that the scale of financial challenge we face will only be met by taking a whole system perspective, that avoids the trap of a purely reductionist approach; which attempts to 'do the same things in the same way', with less people year on year. We know that this is not realistic, neither is the assumption that the required scale of reduction in our cost base can be achieved solely through improvements in productivity and greater efficiencies.

We are wholly committed to reducing waste and improving efficiency within our organisation, and maximising the availability, utilisation and effectiveness of our workforce, and it is our strategic intention to work across traditional organisational boundaries. We aspire to a leadership role which is collaborative, inclusive and directive; acting in the collective interest, to deliver the needs of our patients, whilst making a positive contribution to system-wide choices. We acknowledge that at this point decisions regarding many such choices remain outstanding, and therefore we must be agile in our thinking and our planning needs to be both flexible and responsive to the emerging agenda.

Throughout this journey we will keep the interests of our patients and staff at the forefront of our thinking, ensuring that we are able to support our colleagues through, what is undoubtedly, significant transformational service change along with specific financial and workforce challenges. First and foremost we will drive real service change and improvement, building a resilient workforce with the capability and capacity to thrive and so continue to meet the challenges of the modern NHS.

1.1 This Workforce Strategy sets out the Trust's approach to working with our people and partners in health and social care to build a 'Workforce for the Future'' – by this we mean:-

'A workforce of the right shape and size with the commitment, capability and capacity to deliver safe, efficient, high quality patient care.'

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It provides a framework for plans at health economy, Trust and service level, describing how we will design and deliver the workforce change which is integral to the success of our Five Year Strategic Plan. We aim to create a sustainable future for the Trust and its patients as part of a vibrant local and regional health economy. In striving for this future we know that we must plan, manage and sustain the required transformational change effectively. In doing so we do not underestimate the scale of these challenges or the associated risk, to both our services and our workforce. However, the Board is clear that the combination of a strong clinical case for change together with the requirement to significantly reduce our running costs means that the status quo is not an option for the Trust or the NHS

1.2 It is in this context that this Workforce Strategy must:-

- Deliver the future vision for patient services and CHFT.
- Be grounded in Trust values and aim to reconcile the key dimensions of quality, people and money.
- Create the future of being an employer of choice, allowing for collaborative and flexible working, in support of delivering excellent patient care and treatment.
- Develop a future workforce vision and plan, enabling development of both existing and future roles and careers.
- Develop from a strategic 'whole system' perspective, bringing visibility and transparency, ensuring that short-term in year savings do not compromise longer term strategic aspirations.
- Deliver safe efficient, high quality services within the available resource, underpinned by innovative approaches to our future workforce requirements ensuring that we avoid the problems a purely reductionist approach would create
- Look forward to implementation, continuously assessing and stress testing the impact on staff and structures at any one time to avoid the risk of destabilisation and 'Keep the base safe'.
- Engage and secure collaboration and ownership across the Trust and the wider Health Economy.
- Align with and deliver the workforce impacts of the Five Year Strategic Plan.
- Actively support and enable organisational and service change, to ensure we maintain colleague engagement and effectiveness

2. THE FIVE YEAR STRATEGIC PLAN

2.1 The Five Year Strategic Plan published in January 2016 noted that the Trust currently faces considerable workforce challenges to the detriment of the resilience of clinical services, staff satisfaction and health and wellbeing and to Trust finances. As such, workforce is one of the key factors driving the need for reconfiguration.' Put simply the challenge of maintaining qualified, trained staff in all posts is a definite risk to the quality of patient services.

Specific risks and workforce challenges were noted as including:-

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- Non-compliance with Royal College of Emergency Medicine's recommendations on Children and Young People in Emergency Care settings, Critical Care workforce standards and emergency department consultant cover.

- Intense, fragile clinical rotas where unplanned services are provided at two sites.

- Recruitment, retention and vacancy challenges

- Long-term sickness absence challenges primarily relating to anxiety, stress and depression

- Inability to fill the substantive posts in the funded establishment creating heavy reliance on agency staff with a £21.2m forecast expenditure for 2016/2017

2.2 Workforce assumptions included that:-

- The challenges arise specifically due to the current clinical service, and are addressed through the proposed reconfiguration of clinical services which is now in the final stages of consultation.

- Further to the reconfiguration, the Trust will employ broader strategic workforce initiatives to improve the quality and resilience of clinical services and improve opportunities for the future workforce and workforce modernisation, including development of existing roles, as well as maximising new roles, including apprentices, to ensure we maximise the opportunity presented by the Apprentice Levy

- The Trust's financial position is strongly constrained by CIP and QIPP requirements and an overall financial envelope.

- Business as usual turnover of staff, 12.91% (October 2016) will be sufficient to achieve the necessary reduction in WTEs without the need for redundancy, and presents an opportunity through detailed workforce planning to ensure we deliver workforce changes including new roles.

- No assumption was made regarding re-investment in the community workforce model as the preferred provider of these services.

2.3 In the period since publication of the Five Year Plan, changes in activity levels and the further development of the workforce agenda continues to test the assumptions underpinning the profiling of staff groups. Factors influencing this position include:-

- The potential for improvements in operational productivity and performance as referenced in the Carter report, in terms of efficiency and utilisation of staff. Specifics include consideration of back office support, e-rostering, sickness and other areas of staff productivity.

- The opportunities to create new or advanced roles to address medical workforce shortages, and support roles to meet gaps in non- medical workforce. We will continue to assess where other roles can be developed for the future workforce to enable qualified staff to maximise patient facing time.

- The need to respond to the Workforce Race Equality Standard data analysis (2016), whilst we ensure we develop a fully inclusive approach to our recruitment and development, to ensure that we are the employer of choice.

- Focussing further on our health and wellbeing of our colleagues, supported by a fully integrated engagement approach, to ensure continuing reduction in absence levels.

- To deliver a reduction in turnover rates we will develop our engagement approach focussing upon the delivery of a fully effective and quality appraisal for all of our staff.

- Feedback from the CQC visit in May 2016 included many of the areas set out above and also referenced the need to ensure delivery of key development for staff. Specifically, we will concentrate on improving all mandatory training areas with an emphasis particularly on Mental Capacity, Safeguarding and Root Cause Analysis training.

- Changes in activity assumptions, which see significant increase in demand for acute services.

- Improvements in income levels built on increased activity.

- 2017/18 £16.8m agency ceiling

3. 'A WORKFORCE FOR THE FUTURE'

3.1 The financial operational, clinical and system wide challenges confronting the Trust are faced in a difficult financial environment for health and social care. It is in this context that the Trust must embark on the journey to reshape its workforce, building 'A workforce of the right size and shape with the commitment, capability and capacity to deliver safe, efficient, high quality patient care within the available resource'.

By this we mean a workforce where:-

Colleagues are clear about the Trust's priorities, feel valued, confident that their voice is heard; and able to take an active part in decisions which affect the Trust, its patients, carers and the community.

Colleagues are value driven and work together in pursuit of Trust priorities, the right teams are in the right place at the right time collaborating to deliver safe, efficient, high quality patient care within the available resource.

Colleagues are professional and capable, feel equipped to make an effective contribution to Trust priorities and are actively supported by a directive and inclusive leadership community.

Colleagues are resilient, feel supported to improve and maintain their health and wellbeing, sustaining their availability for work to the benefit of patients and fellow team members.

Colleague development will be supported by focus upon the Investors in People standards and will be underpinned by delivery of an effective appraisal. We will continue to strive for improvement utilising the Investors in People Standard as a key approach for driving and analysing our delivery.

4. ENVIROMENTAL ANALYSIS and POSITION STATEMENT

This section highlights known factors both external and internal to the organisation, that underpin and shape the requirement for workforce change; and which have influenced and shaped our thinking. It also summarises current workforce status utilising the latest available quantitative and qualitative data.

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The complexity of the external environment and data from a range of sources reveals a workforce under significant pressure, working in an increasingly demanding environment; with an unsettling level of uncertainty about the future. Turnover indicates that significant numbers of clinical staff are making the decision to leave the Trust whilst those that remain are looking for greater clarity about the future and our journey to get there. We are alive to the challenge of maintaining and where required improving staffing levels during this period of change.

As Lord Carter's report states clearly, we firmly believe that our employees are integral to delivering the future service required by ever increasing complexities – indeed they present the best solution in identifying and delivering on our strategy and plans.

We believe that the Trust is already on this journey, and that our approach to people articulated in 'working together to get results' evidences a positive mind-set that recognises people as our greatest asset. However we also recognise the challenges we face, the need to 'take our people with us', and that our approach has to be focussed around engagement, inclusivity and involvement. to build resilience in our workforce and our services supporting an ability and readiness for transformation.

4.1 **Available Resource**

It is increasingly clear that healthcare systems cannot sustain current rates of spending. The Trust's Five Year Plan includes the requirement for a reduction in workforce costs over the five year period to ensure that we are sustainable. These point to a different clinical service model and a workforce of a different size and shape, with potentially a variety of new roles – some of which are yet to be developed. In particular, there is an imperative to get best value from every pound spent on pay and this is at the forefront of our thinking; as is the need to avoid a purely reductionist approach - 'doing the same things in the same way with less people year on year'. Workforce planning, including the ability to focus on future services and roles, is a priority in this area.

The 2016/17 financial plan is to deliver a deficit of £16.1m. This requires the delivery of £14m CIP, and assumes that non recurrent STF funding of £11.3m is received. Receipt of the STF fund is conditional upon delivery of the overall £16.1m control total, delivery of agreed access improvement trajectories, engagement with the Carter Report, progress towards 7 day working and agency expenditure being within the agreed £15m ceiling. The plan does not allow for any revenue impact relating to the introduction of EPR.

The Trust recognises that the financial position is strongly constrained by the underlying recurrent deficit, the need to identify ongoing CIP and the Commissioner's requirements to deliver QIPP. In addition the Trust faces challenges linked to the financial position regarding cash, and the continuing capital investment requirements relating to the aged building stock at HRI.

4.2 **CIP Performance**

The Trust has a well-established governance processes for the development of CIP schemes. The process has governance oversight provided by the Trust's monthly Finance and Performance Committee and weekly meetings of the Turnaround Executive. This process includes the initial idea scoping stage, to Gateway 1 (GW1) where schemes are required to have a project brief including stage 1 Quality Impact Assessment (QIA) and executive sponsor. Schemes progress to Gateway 2 (GW2) only when there is a full project workbook including stage 2 QIA panel sign off and full Programme Management Office and executive sponsor approval. For these reasons GW2 approved schemes are better developed and therefore carry less risk. However, all schemes are assigned a risk rating.

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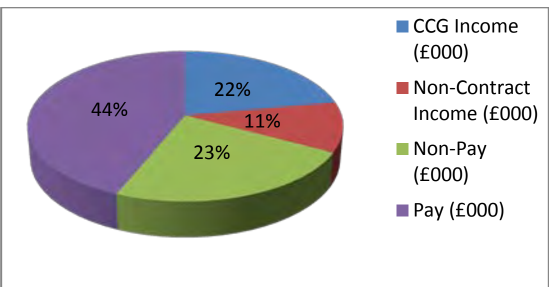
As of mid-July, £14.1m of scheme opportunities have been identified with £14.0m at Gateway 2. The risk levels are reviewed each month and in July, the high risk proportion of the £14m is £3.7m. 44% (£6.1m) is associated with reduction in the pay bill. This is illustrated below.



The latest forecast actual delivery against existing schemes slightly exceeds the £14m target.

The Trust recognises that the approach set out in this Workforce Strategy requires a fundamental shift from more traditionally focussed in year CIPs to an organisation wide transformational agenda for service and workforce change over the next five years. In October 2016, our Clinical Commissioning Groups announced the decision to re-configure the services between HRI and Calderdale. The key priority within the Workforce Strategy has to be the establishment of the future workforce requirements and the workforce, resourcing and development plans to deliver the vision.

4.3 Impact of Clinical Reconfiguration

As part of a whole system approach, the Trust's Five Year Strategy describes a clinical model underpinning the future model of care for hospital services in Calderdale and Greater Huddersfield. The proposed model of care will address service sustainability issues strengthening the care and quality received by patients. This model of care proposes co-location of planned care services, and unplanned care services. There is strong evidence that the proposed model of care will deliver clinical benefits. In particular, through improvements in paediatrics, emergency medicine and critical care staffing, as well as more general quality benefits from service co-location. The model has been endorsed by the Yorkshire and Humber Clinical Senate.

Formal public consultation on these proposals for major reconfiguration has been undertaken and concluded in June. Clinical Commissioners in Greater Huddersfield and Calderdale announced their decision to proceed to Full Business Case and this is now progressing. Our workforce strategy has to consider this and ensure we have the plans to deliver.

We fully believe that collaboration is required across West Yorkshire to achieve the best for our patients, and, as such, we participate with the West Yorkshire Association of Acute Trusts (WYAAT).

Alongside this the Trust is working hard, and in collaboration with WYAAT, to support the development of a shared vision for transformed health and care delivery for West Yorkshire through development of the West Yorkshire Sustainability and Transformation Plan (STP). The vision is aimed squarely at tackling all three gaps in the Five Year Forward View (i.e. health & wellbeing, care and quality, funding and efficiency).

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The proposals for the reconfiguration of services across Calderdale and Huddersfield are based on the need to address significant quality and safety concerns particularly relating to the provision of urgent and emergency care.

The Trust recognises that the plans across West Yorkshire are not sufficiently well developed at this stage to provide a clear solution to these concerns. Progressing the local plans for reconfiguration will put Calderdale and Huddersfield in a good position to address safety and quality issues that will enable and support the wider West Yorkshire model as it develops. In addition in terms of contribution to the required reductions in workforce costs, the burden falls on a combination of annual efficiency savings and strategic initiatives not directly associated with reconfiguration.

4.4 **Opportunity for Productivity Gains**

The opportunity for productivity gains set out in the Carter Report are seen as directly relevant to shaping the agenda for workforce change at CHFT to focus on productivity improvements across all services – provision of high quality clinical care and good resource management go hand in hand. It is recognised that there is significant potential to improve productivity in the areas of:-

- Improving deployment and optimising our current resource, through focus upon availability. utilisation and effectiveness
- Simplifying existing structures and systems in alignment with EPR implementation.
- Standardising good management practice across the organisation

The Trust recognises the need to support and enable changes in both front line services and back office functions to improve efficiency and reduce waste. To this end it is our intention to revisit current organisational structures, and processes to better align services, eliminate duplication, remove management layers and reduce costs. Key to achieving this will be out ability to bring together clinicians, other healthcare and technology professionals to collaborate in the development of EPR which will underpin the successful delivery of safe, efficient, high quality services.

4.5 **Reshaping the Workforce**

The Nuffield Report 'Re-Shaping the workforce to deliver the care patients need' states that role re-design is 'essential if we are to find a sustainable balance between available funding, patient needs and staff needs'. The Trust's approach to workforce change reflects this and recognises that there is significant opportunity to create new roles and extend existing roles to address medical workforce shortages; and develop new support roles to meet gaps in non-medical professions. Such roles can offer a rewarding clinically facing career option for experienced staff. However, re-shaping the workforce also carries risk. There is evidence that without careful role and service re-design, new and extended roles can: increase demand, supplement rather than substitute for other staff (cost more), compromise quality and fragment care. The lack of statutory regulation also limits the availability of roles such as physicians assistants to work autonomously. We also believe there are opportunities through effective future workforce planning to deliver employee development opportunities including those generated through apprentice levy to deliver both new roles and competencies.

The Trust recognises these challenges and intends to drive an integrated approach utilising the Calderdale framework as a robust methodology, rather than starting from existing notions of sectors, settings, services and professions. This will require careful planning improvements in

collaboration across professional groups, a realistic view of time and capacity needed to support change, and further investment in training and education.

4.6 **Colleague Engagement**

The direct link between staff engagement and quality of outcomes as Carter states is 'well understood and evidenced across high performing organisations' – Evidence from other industries has shown that good staff wellbeing leads to increased productivity. The Trust understands this and is alive to the risks also articulated by Carter who observed a naturally high resilient NHS workforce 'feeling jaded from consistent pressure to do more with less and the relentless scrutiny of performance'. Importantly Carter offers the following insight 'whilst NHS staff, in the main work extremely hard, often going beyond the call of duty, and are truly dedicated to the NHS and delivery of care to patients, we need a mind-set shift from seeing people as the problem to seeing them as the solution'.

This is reinforced by a recent McKinsey report which concludes 'workforce is by far the bigger component of healthcare spending. Automation and task shifting can dramatically reduce cost and improve care, but the biggest challenge is changing mind-sets'.

By focussing clearly on our values and behaviours, alongside the development of our workforce, we will improve capability and capacity for transformational change. This will be underpinned by direct focus on delivering an effective appraisal to continuously improve our performance against the Investors in People Standard.

The Trust recognises that improving and sustaining levels of job satisfaction, engagement and wellbeing is key to its ability to deliver transformational change; and that given the scale of that change, this presents a real challenge and as such is a top priority requiring focussed leadership and grip across the organisation.

4.7 **Organisation Development and Leadership**

Effective leadership working collaboratively to create an engaged and inclusive environment is an established pre-requisite to achieving successful change. Carter articulates the need to 'raise people management capacity and achieve greater engagement by significantly improving leadership capability from 'ward to board' so that transformation and change can be planned more effectively and sustained'. The report goes on to summarise that this will require a 'Board sponsored leadership strategy – based on business need and a clear set of expectations and encompassing all leaders from Board to frontline; including recruitment, engagement, development, talent management and succession planning'.

We know that there is wider need to equip every individual in the Trust to contribute to the best of their ability which in turn requires an individual performance management system which is capable of 'appraising both task and behavioural performance and has a range of feedback mechanisms'.

We will develop our workforce and leaders at all levels of the Trust to build capability, capacity and resilience. This will be critical in delivering real transformational change in our service and delivery to our patients.

The Trust recognises that it has an established and effective set of tools deployed in support of engaged leadership - 'Work together to get results'. However, given the challenges facing the Trust

there is an urgent need to re-visit this agenda to further inform and focus the future approach to organisational development and leadership.

4.8 Focus on the Future

There is a consensus between external commentators that the nature of work is changing, and 'how people want to work' is changing with it. The number of people choosing to be self-employed is increasing year on year. The traditional relationship between employers and employees is changing and becoming more complex with more links in this chain and more insecure terms of employment on the increase.

Demographic trends indicate that by 2025, three quarters of the workforce will be 'millennials' with entirely different expectations. There is also a new information savvy generation of healthcare users who want to 'book' their healthcare like they book a restaurant. Multiple websites provide the information on which to base choice, which is driving ever greater transparency revealing huge variations in treatment and outcomes. At the same time the care needs of our elderly population are putting the NHS under unprecedented pressures as other parts of the system fail.

Technology and automation is transforming healthcare and the requirement for and nature of the resource required to deliver it. As a recent McKinsey report notes 'The potential impact on costs, speed of service, and patient empowerment are quite phenomenal'. The report goes on to comment '15 years ago, no politician would dare to support investment in computers over investment in nurses and doctors. Now every country wants to know how they can accelerate healthcare technology adoption'. Collaboration between clinicians and informatics professionals will be key to bring together expert knowledge of patient care and operational processes with understanding of healthcare informatics methods and tools. We believe success in this endeavour will be key to securing sustainability as we move forward.

The Trust recognises that in driving workforce change it has to design for a different future, at the same time as securing the present and 'keeping the base safe'. The scale of change combined with the complexity of the environment demands an approach where 'transformational change can be planned more effectively, managed and sustained'. The implementation of EPR in 2017 is seen as a critical enabler. At an operational level – driving new ways of working and upskilling our people to maximise the contribution of technology, and strategically; facilitating real progress towards achieving Joint Governance arrangements and closer working with partners.

4.9 Management of Workforce Change

The Nuffield Report 'Re-shaping the workforce to deliver the care patients need' concludes with the statement 'it takes time, investment and skill to re-imagine the workforce and successfully implement change. Implementation can be particularly time consuming and organisations that have successfully transformed their workforce have often embarked on long multi-year journeys, adopting a systematic approach to workforce development and change'.

The Trust recognises the complexity of the wider environment, specifically the need for a systematic evidence based approach within a robust governance structure that brings grip, visibility and transparency. Thus avoiding duplication between different elements and ensuring that shorter term responses to in-year savings plans do not compromise longer term strategic aspirations. We will always look forward to implementation, continuously assessing and stress testing the impact on service staff and current organisational structures at any one time to avoid the risks to destabilisation and business continuity. The establishment of a programme infrastructure

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supported by robust governance arrangements and the application of the Trust's QIA process will support our priority to 'keep the base safe' through this period of change.

4.10 **Labour Market – Demand and Supply**

Shortages in the supply of labour for key roles in the NHS are well documented at a national level. The World Health Organisation has projected a global deficit for skilled health service professionals (midwives, nurses, physicians) by 2035; reporting 'an increasing competition between OECD countries to attract and retain highly skilled staff in general and health professionals in particular [because] population ageing and changing technologies are likely to contribute to increase in the demand for health workers, while workforce ageing will decrease the supply'. Managing the uncertainty in future demand for highly specialised medical and dental staff is also seen as a critical challenge in this workforce system.

The Centre for Workforce Information (CWI) has reported that the demand for health and care workers could grow more than twice as fast as the rate of overall population growth by 2035. Over 80% of additional demand being driven by increasing healthcare and support needs which are associated with long-term conditions. This relates both to the ageing population and a projected prevalence across age groups.

The initial results from the CWI Horizon 2035 Study suggest that the future profile of demand may be very different to the picture of demand we see today. A key driver for this difference is the growth in demand for lower levels of skill – those associated with unpaid care support workers, and in paid roles, NHS bands 1-4 staff are projected to substantially outstrip growth in demand for higher staff levels associated with medical and dental professionals.

It is against this background that the Five Year Forward View identifies the risk that given the time it takes to train skilled staff the 'NHS will lock itself into outdated models of delivery unless we radically alter the way in which we plan and train our workforce'. In response we have a stated commitment from Health Education England to 'Commission and expand new health and care roles ensuring we have a more flexible workforce that can provide high quality care wherever and whenever the patient needs it'.

The Trust recognises that the uncertainty and transitional status of the wider health care system adds a level of complexity to formulating its future approach to its people. It is clear that Trust aspirations about both wider future and service models must be considered against the reality of supply; and that in the present a robust recruitment and retention strategy is key to securing areas where vacancies are high. It is clear we need to focus on our ability to consider new models of care and the impact on the traditional view on what roles exist to deliver this. Effective workforce planning and consideration of how we deliver new competencies and roles is becoming increasingly importance – simply replacing like-for-like roles is not sustainable. The competition for the limited pool of clinical professionals is well rehearsed and needs specific attention including longer term planning and considerations for future educational requirements. This will need careful consideration with external stakeholders such as Health Education England.

4.11 **Workforce Status 2016/17**

4.11.1 **Staff Survey 2015**

We firmly believe that staff engagement is critical to the successful delivery of our future services and we will pay significant attention to developing our workforce.

With this in mind, the results of the 2015 Staff Survey were disappointing for the Trust. The overall response rate of 40% is below Trust expectations but reflects the national average. The overall indicator for staff engagement was worse than average when compared with Trusts of a similar type.

Overall Staff Survey results put the Trust in the bottom 20% of all acute trusts, although there are some positive indications from staff relating to reporting of incidents, witnessing potential harm, experiencing violence, confidence in reporting unsafe practice and appraisal. The bottom five ranked scores when compared to the national average for acute trusts are a significant cause for concern relating as they do to the quality of the relationship between employees and their employer on key issues of flexible working, work related stress, pressure to return to work when unwell, lack of management interest in health and wellbeing, recognition and valuing of staff.

Led by the CEO the Trust has engaged a wide range of people in constructing an immediate and combined response to this dissatisfaction which addresses the range of issues in both the 2015 Staff Survey and the 2015 Workforce Race Equality data report , and sees this as integral to its work on improving engagement.

Comprehensive and effective staff engagement will be a key area of focus within the first year of the Workforce Strategy and will continue to receive priority attention throughout our reconfiguration agenda. We believe it is critical to staff health and wellbeing, resilience, recruitment and retention.

The Trust recognises that instilling value driven engaged leadership at all levels of the Trust to ensure that the day to day experience of staff is positive and supported by directive, inclusive and accountable leadership is key to its future success and sustainability .

4.11.2 **Staff Friends and Family Test**

The Staff FFT running since 1 April 2014 has generally consistently positive themes around:-

- Good quality care from caring health professionals
- Staff work hard and are committed to the patients
- Friendly staff

The summary also highlighted staff priorities for improvement as:-

- Poor staffing levels
- Low staff morale
- Management support

The Trust recognises that its response to colleague feedback provided through the Staff FFT frames the opinion of existing and prospective employees. We know that our effectiveness in retaining and attracting high calibre workers in this competitive labour market is directly linked to our reputation and ability to brand ourselves as an Employer of choice. Therefore meaningful engagement with colleagues in the design of simple solutions that are valued and improve the overall staff experience is critically important to our future success and sustainability. Our plans will also include clear engagement and involvement with all colleagues, to ensure everyone understands what is being done. This is critical in the areas of recruitment and retention as clearly our staff have identified they feel staffing is low, albeit they

report being unclear what our plans are. It is important they are involved in developing solutions and are kept informed of progress.

4.11.3 **On-line Leavers Survey**

The on-line leavers survey provides valuable insight into reasons for leaving the Trust, albeit only 23% of leavers completed the survey in 2016.

Of particular note is staff leaving the Trust in order to further their career, dissatisfaction with opportunities to achieve work-life balance and a significant level of retirements.

Number of Leavers/Surveys completed in 2016		
Leavers	Surveys	Percentage
892	203	23%

Reasons for Leaving	
Reason	Jul-05
Better Benefits	2
Better Career Opportunity	40
Career Change	11
Closer to Home	13
Conflict with Managers	5
Conflict with employees	2
Deanary Rotation	3
End of FTC	5
Family and/or Personal	10
Higher Salary	7
Improved Work Life Balance	23
Organisational Change	10
Other	31
Redundancy	5
Retirement	36

Colleague Behaviours			
We put the Patient First		We Work Together to Get Results	
Strongly Agree	74	Strongly Agree	57
Agree	98	Agree	79
Disagree	25	Disagree	51
Strongly Disagree	6	Strongly Disagree	16
We Go See		We Do the Must Dos	
Strongly Agree	50	Strongly Agree	56
Agree	108	Agree	116
Disagree	37	Disagree	25
Strongly Disagree	8	Strongly Disagree	6

The Trust recognises that improving current retention rates for highly skilled healthcare workers is key to sustaining local services and safe and high quality patient care. The significant investment in recruitment and development is being compromised by the loss of colleagues to both NHS organisations and those in the private and third sector. There is an imperative to improve staff experience, increase retention and reduce turnover in the medical and nursing workforce in order to avoid the potential for adverse impacts on service standards and the delivery of the strategic plan.

4.11.4 **Investors in People (IIP)**

The Trust has been a recognised organisation since 2001. The latest assessment took place between October and December 2015, and concluded that the Trust met the necessary evidence requirements to achieve the IIP Bronze award, which is a progression from the core standard maintained since 2001.

The Assessor's report identified strengths and areas of good practice which were viewed positively by staff as:-

- Opportunities to be involved in business planning
- Results from the practical application of 'working together to get results'
- On-line learning for mandatory training
- Examples of good line management and recognition of team and individual achievements
- Commitment to the aims of the Trust
- Support for new members of staff

Areas for improvement were also detailed as:-

- Recruitment to become an employer of choice
- Appraisal (focus on quality)
- Individual responsibility and commitment (for team communications, appraisal and recognition)
- Strategy development (OD, Education and training)
- Evaluation (developing metrics to demonstrate return on investment in people)

The report concludes that there is still much work to be done in terms of organisational development but importantly that the Trust has commenced on this journey.

The Trust recognises the need to have a fully co-ordinated OD strategy to maintain momentum in developing its people management practice and retaining accreditation against this well-recognised external quality mark provides assurance. We are also encouraged by the alignment with current thinking. We will continue to work with our Investors in People colleagues to develop this agenda, as we know that our ability to develop our people and in particular grow our leadership and management capability is key to securing the present and future workforce and competing in a difficult labour market.

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4.11.5 **Workforce Race Equality Standard Data Analysis 2016**

The Workforce Race Equality Standard was introduced in April 2015. The standard has nine indicators aimed at improving Workforce Race Equality across the NHS. It aims to improve opportunities, experiences and the working environment for BME staff, and in doing so, help lead improvements in the quality of care and satisfaction for all patients. The Trust WRES submission in July 2015, which was shared with Clinical Commissioning Groups, highlighted a number of areas where improvement was required in relation to BME staff feeling :-

- That the Trust did not provide equal opportunities for career progression or promotion.
- That they were bullied and harassed by other staff.
- That they experienced discrimination at work, from their manager /team leader or colleagues.
- That there was less likelihood that as a BME member of staff they would be appointed from shortlisting processes in the Trust.

Led by the CEO the Trust has responded to these concerns and between January and March 2016 seven focus groups were constituted for BME staff throughout the Trust to collaborate to develop an action plan aimed at improving the position of BME colleagues throughout the workforce by responding to their concerns. This plan was approved in late May 2016 by the senior leadership of the Trust and is being led by a partnership of Executive and Non-Executive Directors working with members of the Trust's BME workforce.

We have established a BME network, which now meets quarterly, and forms a major step of our aim of ensuring a fully inclusive workforce model. We will continue to develop other areas, to ensure we consider and develop across the Trust to maximise inclusivity, and continue to be the employer of choice.

The Trust recognises the critical importance of building a workforce that is both representative of the communities it serves and responsive to the diverse needs of those accessing its services. We are committed to identifying and developing the best talent across all professional groups. This will enable the Trust to fulfil its obligations as a community partner and provide employment opportunities to drive improvements in the health of the local population.

4.11.6 **Mandatory Training**

Mandatory training helps employees achieve safety and efficiency in a timely manner. The mandatory training programme, which largely comprises e-learning, enables the Trust to demonstrate that employees regularly have mandatory training designed to ensure they can undertake their job roles safely and maintain a safe and healthy work environment. The Trust's approach identifies what training employees are required to complete, how often they are required to complete the training and how to access the training. Compliance continues to be a focus for the Trust and it presents a challenge to compliance rates varying between 65% and 89% across the 10 elements of the programme.

The Trust recognises that the provision of learning and development opportunities throughout employment is key to enhancing the quality of patient care, and that comprehensive, easily accessible Mandatory Training underpins the ability of colleagues to provide safe efficient high quality care. The implementation of EPR requires the Trust to focus on pre go-live training for an eight week period prior to launch in Spring 2017. To enable this and maintain staff

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availability for service those elements of Mandatory Training that are not subject to annual/two year refreshers have been deferred for 2016. Requirements for compliance with fire safety, infection control, information governance and manual handling will continue. The procurement of a new learning management system in 2017 will improve the Trust's ability to report compliance in this key area of training.

4.11.7 **Appraisal**

A quality driven formal annual appraisal process provides employees with information around how they may be perceived within their team and organisation and offers constructive feedback about their performance at work. We believe that a good appraisal is the vital component in developing our workforce, helps colleagues understand the strengths they should capitalise on and where development opportunities can aid improvement as well as career development. We firmly believe this is a key pillar in our becoming employer of choice and have firmly committed to developing this area. Appraisal rates continue to improve, albeit we are targeting an acceleration of this, and now forms part of our regular discussions with our managers and leaders throughout the Trust. We are slightly below trajectory but have improvement plans from all areas to ensure we hit our target at the end of this service year. We will now focus on the actual appraisal discussion to ensure it is undertaken in line with our desired outcomes.
We have a stated aim to improve our performance and:-

- ensure all colleagues have access to a simple and effective appraisal structure
- maximise progress using that simplified structure towards the 100% annual target (90% by 31 December)
- facilitate effective and timely reporting for the organisation to ensure compliance
- provide access to a high quality appraisal interaction

The Trust recognises the importance improving performance on appraisal. This is a must do given the challenges ahead. Leaders need to be in continuing and positive dialogue with their people about work priorities, objectives and personal/professional development. To this end appraisal plans have been developed by each division and corporate directorate to deliver compliance and these plans are monitored through the Trust's Integrated Performance Report and Divisional Performance Meetings. The quality of appraisals is reported as an issue within the Trust by colleagues and a study of current practice is being commissioned through an external partner to test our approach and deliver improvements to the overall appraisal experience.

4.11.8 **Vacancies**

Vacancy rates are of concern and drive unacceptable levels of agency costs. The Trust's vacancy outturn rate for 2015/2016 was 8.9%. As at 31 October 2016, the Trust's vacancy position is 402.49 fte (7.2%). This comprises 73.5 fte in the Medical and Dental group and 186.5 fte in the Nursing and Midwifery group. The Trust is engaged in recruitment of qualified practitioners in the UK and the EU and is extending its search internationally.

The Trust recognises that it must secure and retain high calibre and skilled healthcare workers and be an employer of choice offering attractive career pathways and opportunities, professional and personal development, work life balance and high levels of job satisfaction if it to ensure that it is able to develop services as well as deliver safe and high quality care to patients. Given the significant level of change over the next five years achieving these aspirations must be acknowledged as presenting very real challenges for the Trust. We firmly

believe that we can improve our marketing and recruitment to professional roles. This will be supported by improvements in our actual times to recruit enabling us to maximise the market opportunity to attract and employ new colleagues.

4.11.9 **Turnover**

Latest benchmarking information for Yorkshire and the Humber (August 2016) reveals the Trust to have a high level of turnover when compared to the average for large acute trusts (14.52% v. 10.01%). This is in part explained by transfers of staff out of the Trust. Turnover for the 12 month period up to 31 October 2016 is 12.7%, still higher than the average though a ninth consecutive reduction from a high of 16.76% in January 2016. Of particular concern is the challenge to recruit qualified nurses at a rate which matches and exceeds leavers. This creates a pressure on the retained and existing workforce leading to the potential for higher incidence of stress and sickness absence; a reduction in the quality of patient care; and the increased likelihood of harm to patients. The situation also increases the likelihood of a reliance on bank and agency workers with a resulting increase in non-contract spend.

The Trust recognises that it must ensure its existing workforce is valued and recognised for the contribution it makes. This means the Trust has to maintain a positive dialogue with staff to understand what the overall experience is of working in the Trust, what needs to improve and what staff believe are the areas where improvement will have the biggest impact. This necessarily informs the approach to colleague engagement and communication, reward and recognition. The current and future context will challenge the Trust's ability to maintain and where required improve existing staff levels.

4.11.10 **Sickness**

We continue to focus on the health and wellbeing of our employees, and have seen improvements across the Trust, in relation to absence The impact of absence both on the morale of colleagues who are in work and the cost of covering gaps continues to be an area of focus. We will continue to support employees and develop this area to maximise attendance, supported by effective health and wellbeing.

In response an investment was made in December 2015 to create a dedicated team focussed on supporting managers to manage attendance more effectively. This has resulted in reductions in both short and long-term absence levels. In October 2016 overall absence stood at 4.14% against a Trust target of 4.07%. Work is continuing to drive down absence and improve and maintain availability.

The Trust recognises that maintaining availability of its workforce underpins the ability to deliver safe, efficient high quality care. Improving colleague health and wellbeing is key to this and is important to ensuring staff feel valued and supported. This is particularly important when absent due to sickness. We recognise the need for a focussed and supportive approach to this underpinned by a clear process to managing both long and short term absence which enables colleagues to sustain their attendance in work.

4.11.11 **Deployment**

The efficiency of deployment across the Trust is a cause for concern specifically in terms of the impact on the quality of service, efficiency and productivity, and as a stated reason for nurses leaving the Trust. We acknowledge that the lack of a strategic approach, management, system

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issues and a shortage of sufficient expert support for implementation and maintenance has combined to undermine progress, limit benefit realisation and create negativity amongst colleagues.

The Trust recognises that achieving improvements in the efficiency of its deployment of key staff is a priority and to this end a Safe Staffing Board under the leadership of the Executive Director of Nursing has been established with a cross staff –group brief.

4.11.12 **Role Reshaping**

Work on the development of new support roles has commenced, with notable progress in Nursing and Therapies, albeit there has been a lack of working across existing professional boundaries. Currently new roles tend to be positioned within recognised staff groups, and progress within the medical workforce is limited.

This will form a key part of our workforce planning discussions and will be critical as we establish our future workforce.

The Trust recognises that the rate of progress needs to be ramped up and we need to be more ambitious. Given the transitional status of these changes we will take a considered and purposeful multi-disciplinary approach across the Trust led by the Director of Nursing. We aim to widen this to all clinical workforce planning discussions to ensure we maximise the opportunities available to us. Other areas we are currently reviewing are Physician Associates and we will continue to review all areas where we can consider differing future roles.

5. THE STRATEGIC WORKFORCE FRAMEWORK

5.1 Whilst fully recognising the scale of the challenge this Workforce Strategy is unashamedly ambitious, designed to actively support the achievement of the Trust's vision and strategic direction set out in the Five Year Strategic Plan through the delivery of a coherent Trust-wide approach to working with our people and partners in health and social care to build a 'workforce for the future'.

The strategy provides a framework for plans at health economy, Trust and Divisional level, describing how the Trust will design and deliver the workforce change which is integral to the success of the Five Strategic Year Plan.

In the context of the wider Health economy and Social Care developments and our plans for clinical reconfiguration, we are progressing towards a more focussed strategic position for the Trust. This means clarifying the need for and focus of our hospital and community services, and how we can continue to provide these services by exploring new models of care to meet the needs of our population.

5.2 We recognise that there is significant risk in the scale and complexity of workforce change associated with the Five Year Strategic Plan. Against this background we are clear that this Strategy must:-

- Firmly embed and advocate our vision and behaviours
- Balance the dimensions of quality, people and money
- Prioritise patient safety and workforce sustainability
- Promote a systematic whole system perspective
- Avoid a purely reductionist mind-set
- Maximise the opportunity for efficiency and productivity gains to reduce unit cost

- Innovate and lead across traditional professional, structural and organisational boundaries
- Champion inclusiveness and diversity
- Engage and secure cross system ownership
- Include a robust Recruitment and Retention Strategy, underpinned by a fully effective engagement culture
- Be fully supported by a Workforce Business Intelligence approach, which provides contemporary data in support of key action planning and decision making.
- Progress in a purposeful and managed way with robust governance structures
- Recognise that the current model of providing 'everything to everyone' as is traditional in a DGH is not sustainable

6. IMPLEMENTATION PLAN

6.1 The organising method for this Strategy and the plans that follow aims to ensure that interventions and actions at system, hospital and service level are linked with the Trust Workforce goals and strategic objectives; making all activity transparent and ensuring that linkages are in place and understood, thus creating a golden thread of connectivity from Ward to Board.

Level 1 - Workforce Strategy
Level 2 - Trust Workforce Plan
Level 3 - Divisional Workforce Plans

6.2 Workforce change is organised around four goals which provide the cornerstones of this Agenda at the Trust for the next five years. Each goal is supported by a set of strategic objectives designed to provide a framework for the interventions and actions which will be required at Trust and service level to achieve Trust workforce goals. These are set out below and summarised in the 'Plan on a Page' in Appendix 2 and further detailed in the Trust Implementation Plan Appendix 3.

Goal – Engagement

'We aspire to a workforce where colleagues are clear about the Trust's priorities, feel valued, confident that their voice is heard; and able to take an active part in decisions which affect the Trust, its patients, carers and the community.'

Trust KPIs

- CHFT in top 20% overall of acute Trusts for Staff Survey outcomes by 2017 survey results
- Reductions in turnover in nursing workforce to 13.5%
- Reductions in short-term absence levels -1.3% by 31/03/17
- 100% compliance with 4 x priority mandatory training requirements by 31/03/2017
- Consistent year on year improvement in overall staff engagement (key finding 4 in Annual Staff Survey)
- Consistent year on year improvement in staff recommending CHFT as a place to work or receive treatment (key finding 1 in Annual Staff Survey)

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Strategic Objectives

To achieve this Goal we will:-

- Create and deploy communications machinery that connects Ward to Board, improving the ability of all colleagues – to feed their views upward (have a voice) know what's going on and feel connected with their immediate managers and Trust leadership
- Deploy a clear narrative about values and priorities, making it the job of every manager to 'tell the story' of Trust aims and priorities so that colleagues can see how their job fits in and participate in decisions which affect them and their service
- Create opportunities to demonstrate that colleagues are valued in their role by recognising and rewarding contribution – individual and team
- Support and promote consistently good management practice across the Trust, and hold leaders at every level accountable for their people

Goal – Modernisation

'We aspire to a workforce where colleagues are value driven and work together in pursuit of Trust priorities, the right teams are in the right place at the right time collaborating to deliver safe, efficient, high quality patient care within the available resource.'

Trust KPIs

- Implementation programme for design and deployment of new roles in place by 31/12/16
- Absenteeism due to sickness stable between 3% and 3.5%
- Nursing absenteeism due to sickness no greater than 4% by 31/03/17
- Continuing sustained reduction in vacancy levels for Consultants and qualified nurses during 2017/2018
- Reduction in turnover to 12.5% by 31/03/17
- New job planning framework fully implemented by 31/03/2017
- Maximum of 2.5 SPA allocations for individuals by 31/03/2017
- Contractual maximum of 12 PAs (10 + 2 APAs) by 31/03/2017
- New performance management framework fully implemented, objectives set at team and individual level via Appraisal by 31/3/17
- Reduction in agency costs to agency costing of £15m in 2016/2017
- Achievement of year on year reduction in workforce WTEs as set out in Five Year Plan

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Strategic Objectives

To achieve this Goal we will:-

- Implement a service led multi-disciplinary approach to the design and deployment of new advance roles to address continuing medical workforce shortages; and create new competency based support roles to meet gaps in non-medical professions

- Improve the efficiency of staff deployment across all staff groups to maximise the availability of permanent staff and reduce the unacceptable dependencies on agency staff

- Reduce absenteeism to 3% across the Trust and maintain this level consistently reducing demand for agency staff

- Achieve demonstrable improvements in efficiency and productivity(%)by eliminating any waste of skills and money across the Trust

- Actively support and enable Service transformation across the Trust ensuring that workforce impact is understood and requirements for workforce change are clearly articulated and managed.

- Target of 130 apprentices, and utilisation of the apprenticeship Levy.

Goal – Organisational Development and Leadership

'We aspire to a workplace where colleagues are professional and capable, feel equipped to make an effective contribution to Trust priorities and are actively supported by a directive and inclusive leadership community.'

Trust KPIs

- Annual staff survey results in following key indicators above 'lowest 20% in 2017
  - Effective team working
  - Support from immediate managers
  - Good communication between managers and staff

- Improvement in appraisal rates -90% (Dec 2016) 100% (April 2017)

- Consistent year on year improvement in overall staff engagement (key finding 4 in Annual Staff Survey)

- Consistent year on year improvement in staff recommending CHFT as a place to work or receive treatment (key finding 1 in Annual Staff Survey)

- Compliance with mandatory training targets by 31/03/2017

- Deployment of new Performance Management Framework evidenced at team and individual level by 31/12/16

- Assessment centres for leaders programmes in place by 31/03/17

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Strategic Objectives

To achieve this Goal we will:-

- Build leadership capability and capacity from Ward to Board, co-creating an organisational environment that actively supports an engaged and inclusive culture

- Develop an integrated cross Trust approach to role re-design assessing workforce requirements using the common currency of skills and competence utilising the Calderdale Framework; rather than starting from existing notions of sectors, settings services and professions

- Develop and bolster personal and team resilience equipping staff to work across organisational and sector boundaries, so creating readiness for change

- Build the Trust healthcare support workforce (Bands 1-4) into a highly skilled and flexible workforce that is able to support the Trust in meeting healthcare challenges

- Improve and sustain performance in relation to appraisal and mandatory training, and implement a consistent cross Trust approach to regular performance reviews

Goal – Health and Wellbeing

'We aspire to a workforce where colleagues are resilient, feel supported to improve and maintain their health and wellbeing, sustaining their availability for work to the benefit of patients and fellow team members.'

Trust KPIs

- Reduction in sickness absence levels due to stress – move out of lowest 20% in Annual Staff Survey by 2017 Survey
- Reduction in short-term absence levels to 1.3% by 31/03/2017
- Reduction in turnover 12.5% by 31/03/17
- Annual Staff Survey results in following key indicators above 'lowest 20%' in 2017
    - Staff satisfied with opportunities for flexible working
    - Staff feeling pressure in last 3 months to attend work when feeling unwell
    - Organisation and management interest in action on health and wellbeing
- Demonstrable improvements in utilisation of feedback from Exit interviews by 31/03/2017

Strategic Objectives

To achieve this Goal we will:-

- Collectively embed new and enhanced approaches to health and wellbeing which are linked to Trust values and priorities, fully integrated into our ways of working and contribute to improved performance.

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- Co-create a broad programme of health promotion activities which reach out to those who are least active, improving health and wellbeing, so optimising availability and reducing premium cost.

- Ensure that the health and well-being of colleagues is at the heart of changes in the Trust, and that this is visible and recognised by all.

- Create and promote a Trust-wide employee benefits and assistance programme that supports the Trust as a good employer in the eyes of its Workforce.

7. MOBILISATION - DELIVERING THE WORKFORCE STRATEGY

7.1 Workforce Modernisation Programme Board

7.1.1 In recognition of the scale and complexity of the workforce agenda over the next five years the Trust has put in place robust arrangements to ensure that workforce change across the organisation is managed effectively and risk minimised. Key to this is the establishment of a Workforce Modernisation Programme Board chaired by the Director of Workforce and Organisational Development (SRO) as the Executive Lead for workforce change.

The Programme Board will report to Executive Board. It allows for the escalation and discussion of project performance, progress against plan and associated risks and issues. The outputs are used to produce programme reports and inform WEB of progress and achievements against plan. The Programme Board also acts as a buffer to ensure that any risk or issue that has a significant rating or agenda item that cannot be properly resolved by the Programme Board are escalated to WEB.

7.1.2 The prime purpose of the Programme Board is to scope, initiate and sign off all workforce related projects in the Trust, to ensure that these are supported by the necessary expertise, and that all proposed service change considers workforce impact at an early stage. The Board will provide strategic oversight, direction and corporate governance for all projects, acting as the driving force ensuring that individual projects deliver the outcomes and benefits as specified.

7.1.3 Membership

Executive Lead – Director of Workforce and Organisational Development
Workforce Programme Manager
Director of Transformation and Partnerships
Deputy Director of Workforce and Organisational Development
Deputy Director of Finance
Associate Medical Director (Workforce)
Deputy Director of Nursing
Chief Operating Officer
Company Secretary

Chairs of the Medical Workforce Group and Nursing and Midwifery Workforce Group will also attend to account for project performance within the remit of their group.

7.1.4 Members of the Programme Board are individually and collectively accountable to the Executive lead for their areas of responsibility and project deliver as follows:-

- Define the acceptable risk profile and risk thresholds for individual projects and the programme as a whole (see Appendix 4.1 for Workforce Projects – Master Schedule)

- Ensure projects deliver within their agreed parameters (cost, organisational/workforce impact, expected/actual benefits realisation) (see Appendix 4.2 for Project Status Report)

- Resolve strategic and directional issues between projects which need the input and agreement of senior stakeholders to ensure the progress of the programme

- Ensure the integrity of benefit priorities and realisation plans and ensure there is no double counting of benefits

- Provide assurance for operational stability and effectiveness (keeping the base safe) through programme delivery

- Ensure that all key elements of The Workforce Strategy: OD and leadership, engagement and health and wellbeing are aligned with and actively support workforce modernisation

8. GOVERNANCE OF THE TRUST WORKFORCE AGENDA

8.1 In developing this strategy the Trust recognises the risk associated with this level of transformational challenge and in particular the demands it will place on colleagues. In recognition of this we have committed to 'look forward to implementation, continuously assessing and stress testing the impact on staff and structures at any one time to avoid the risk of destabilisation and 'keep the base safe'.

Responsibility for this lies with the Workforce Modernisation Programme Board and are clearly articulated.

8.2 The Workforce Modernisation Programme Board will be supported by the Workforce (Well Led) Committee, which is a sub-committee of the Trust Board will act on behalf of the Board to gain assurance from the Executive Director of Workforce and OD, as Accountable Officer; on the overall status of the Workforce Modernisation Programme, and associated risks and issues. This will be provided via a consolidated Programme report on a monthly basis. (see Appendix 4.3)

8.3 In addition to the above, all programmes and projects which have the potential to significantly impact the workforce will be subject to the Trust Quality Impact Assessment process.

The purpose of the QIA is to provide assurance that all risks to quality and performance have been considered at the planning stage of any service change and periodically refreshed throughout the business cycle. This will ensure that the impact of the service change on quality and performance will be accurately assessed and managed. This impact may be positive or negative.

Draft – v0.9 2/12/16

Executive Director of Workforce and Organisational Development

Workforce Submission to NHS Improvement 2017/2019

Appendix 1

WORKFORCE WHOLE TIME EQUIVALENT		01WTEPYE	01WTEM01	01WTEM02	01WTEM03	01WTEM04	01WTEM05	01WTEM06	01WTEM07	01WTEM08	01WTEM09	01WTEM10	01WTEM11	01WTEM12	01WTECYECH	01WTECYECH2	01WTENYE	01WTENYECH	01WTENYECH2	01WTECOMMENT
																				Commentary is mandated for all values greater than or less than 1
		Forecast Out-turn	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
	Expected	31/03/2017	30/04/2017	31/05/2017	30/06/2017	31/07/2017	31/08/2017	30/09/2017	31/10/2017	30/11/2017	31/12/2017	31/01/2018	28/02/2018	31/03/2018	31/03/2018	31/03/2018	31/03/2019	31/03/2019	31/03/2019	31/03/2018
		Year Ending	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Year Ending	Year Ending	Year Ending	Year Ending	Year Ending	Year Ending
	Sign	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE Change	% Change	WTE	WTE Change	% Change	FREE TEXT
ALL STAFF		5,499.5	5,607.0	5,582.6	5,574.9	5,559.7	5,574.0	5,581.3	5,602.1	5,619.1	5,615.4	5,618.4	5,620.4	5,620.7	121	2.2%	5,490.1	(131)	(2.3%)	
Bank	+	123.9	123.9	123.9	123.9	123.9	123.9	123.9	123.9	123.9	123.9	123.9	123.9	123.9	(0)	(0.0%)	121.1	(3)	(2.3%)	
Agency staff (including, Agency, Contract and Locum)	+	212.8	202.5	197.5	196.5	186.5	182.5	181.8	187.8	193.8	193.8	193.8	193.8	193.8	(19)	(8.9%)	189.4	(4)	(2.3%)	
Substantive WTE	+	5,162.8	5,280.6	5,261.2	5,254.5	5,249.3	5,267.6	5,275.6	5,290.4	5,301.4	5,297.7	5,300.7	5,302.7	5,303.0	140	2.7%	5,179.7	(123)	(2.3%)	
Total Substantive Non Medical -Clinical Staff	+	3,837.2	3,951.3	3,940.9	3,933.8	3,929.0	3,939.7	3,944.7	3,956.9	3,967.2	3,962.7	3,965.3	3,966.6	3,966.6	129	3.4%	3,874.9	(92)	(2.3%)	
Total Substantive Non Medical- Non-Clinical Staff	+	809.8	823.3	815.3	814.7	814.2	814.9	815.2	816.9	817.6	818.4	818.7	819.4	819.4	10	1.2%	799.7	(20)	(2.4%)	
Total Substantive Medical and Dental Staff	+	515.8	506.1	505.1	506.1	506.1	513.1	515.6	516.6	516.6	516.6	516.6	516.6	516.9	1	0.2%	505.0	(12)	(2.3%)	
Registered Nursing, Midwifery and Health visiting staff	+	1,666.0	1,708.4	1,709.9	1,705.9	1,702.9	1,705.9	1,710.5	1,719.5	1,728.5	1,724.5	1,726.5	1,726.5	1,722.5	57	3.4%	1,682.9	(40)	(2.3%)	
Acute, Elderly and General (adult nurses)	+	1,141.2	1,170.2	1,171.2	1,168.5	1,166.4	1,168.5	1,171.6	1,177.8	1,184.0	1,181.2	1,182.6	1,182.6	1,179.9	39	3.4%	1,152.7	(27)	(2.3%)	Increase in substantive nurses
Community Services (including district nurses)	+	203.4	208.6	208.8	208.3	207.9	208.3	208.8	209.9	211.0	210.6	210.8	210.8	210.3	7	3.4%	205.5	(5)	(2.3%)	Increase in substantive nurses
Education Staff	+	9.2	9.4	9.4	9.4	9.4	9.4	9.4	9.5	9.5	9.5	9.5	9.5	9.5	0	3.1%	9.3	(0)	(2.3%)	
Maternity Services (including SCBUs)	+	209.2	214.5	214.7	214.2	213.8	214.2	214.8	215.9	217.1	216.6	216.8	216.8	216.3	7	3.4%	211.3	(5)	(2.3%)	Increase in substantive nurses
of which Registered Midwives	+	171.1	175.4	175.6	175.2	174.8	175.2	175.6	176.5	177.5	177.1	177.3	177.3	176.9	6	3.4%	172.8	(4)	(2.3%)	Increase in substantive nurses
Paediatric Nursing (Child nurses)	+	95.1	97.5	97.6	97.4	97.2	97.4	97.6	98.2	98.7	98.4	98.6	98.6	98.3	3	3.4%	96.1	(2)	(2.3%)	Increase in substantive nurses
Psychiatry (MH nurses)	+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	-	0.0	0	-	
Learning Disabilities (LD nurses)	+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	-	0.0	0	-	
School Nurses	+	7.9	8.1	8.1	8.1	8.1	8.1	8.1	8.2	8.2	8.2	8.2	8.2	8.2	0	3.1%	8.0	(0)	(2.3%)	
Other Nursing	+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	-	0.0	0	-	
All Scientific, Therapeutic and Technical Staff	+	667.1	663.5	666.5	664.5	663.5	669.9	669.9	669.9	669.9	667.9	667.9	667.9	671.9	5	0.7%	656.4	(15)	(2.3%)	
Allied Health Professionals	+	368.3	366.3	368.0	366.9	366.3	369.8	369.8	369.8	369.8	368.7	368.7	368.7	370.9	3	0.7%	362.4	(9)	(2.3%)	
Art/ Music/ Drama therapy	+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	-	0.0	0	-	
Chiropody / Podiatry	+	16.7	16.6	16.7	16.6	16.6	16.8	16.8	16.8	16.8	16.7	16.7	16.7	16.8	0	0.6%	16.4	(0)	(2.3%)	
Dietetics	+	19.4	19.3	19.4	19.3	19.3	19.5	19.5	19.5	19.5	19.4	19.4	19.4	19.5	0	0.5%	19.1	(0)	(2.3%)	
Occupational Therapy	+	51.2	50.9	51.1	51.0	50.9	51.4	51.4	51.4	51.4	51.2	51.2	51.2	51.6	0	0.7%	50.4	(1)	(2.3%)	
Orthoptics / Optics	+	12.5	12.4	12.5	12.4	12.4	12.5	12.5	12.5	12.5	12.5	12.5	12.5	12.6	0	1.1%	12.3	(0)	(2.3%)	
Physiotherapy	+	129.0	128.3	128.9	128.5	128.3	129.5	129.5	129.5	129.5	129.1	129.1	129.1	129.9	1	0.7%	126.9	(3)	(2.3%)	
Radiography (Diagnostic)	+	106.9	106.3	106.8	106.5	106.3	107.3	107.3	107.3	107.3	107.0	107.0	107.0	107.6	1	0.7%	105.2	(2)	(2.3%)	
Radiography (Therapeutic)	+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	-	0.0	0	-	
Speech and Language Therapy	+	32.7	32.5	32.7	32.6	32.5	32.8	32.8	32.8	32.8	32.7	32.7	32.7	32.9	0	0.8%	32.2	(1)	(2.3%)	
Other Scientific, Therapeutic and Technical Staff	+	174.8	173.9	174.7	174.2	173.9	175.6	175.6	175.6	175.6	175.0	175.0	175.0	176.1	1	0.7%	172.0	(4)	(2.3%)	
Clinical Psychology	+	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	0	4.9%	1.0	(0)	(2.3%)	
Dental	+	9.2	9.1	9.2	9.2	9.1	9.2	9.2	9.2	9.2	9.2	9.2	9.2	9.3	0	1.2%	9.0	(0)	(2.3%)	
Multi-Therapies	+	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	0	0.7%	1.0	(0)	(2.3%)	
Operating Theatre's / ODPs	+	54.2	53.9	54.1	54.0	53.9	54.4	54.4	54.4	54.4	54.2	54.2	54.2	54.6	0	0.7%	53.3	(1)	(2.3%)	
Pharmacy	+	41.2	41.0	41.1	41.0	41.0	41.3	41.3	41.3	41.3	41.2	41.2	41.2	41.5	0	0.6%	40.5	(1)	(2.3%)	
Pharmacy Technicians	+	59.4	59.1	59.3	59.2	59.1	59.6	59.6	59.6	59.6	59.5	59.5	59.5	59.8	0	0.6%	58.4	(1)	(2.3%)	
Psychotherapy	+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	-	0.0	0	-	
Social Services (workers)	+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	-	0.0	0	-	
Other STT Staff	+	8.9	8.8	8.9	8.9	8.8	8.9	8.9	8.9	8.9	8.9	8.9	8.9	9.0	0	1.0%	8.8	(0)	(2.3%)	
Health Care Scientists	+	124.0	123.3	123.9	123.5	123.3	124.5	124.5	124.5	124.5	124.1	124.1	124.1	124.8	1	0.7%	122.0	(3)	(2.3%)	
Clinical Engineering & Physical Sciences	+	72.5	72.1	72.4	72.2	72.1	72.8	72.8	72.8	72.8	72.6	72.6	72.6	73.0	0	0.6%	71.3	(2)	(2.3%)	
Life Sciences / Pathology	+	11.5	11.4	11.5	11.5	11.4	11.5	11.5	11.5	11.5	11.5	11.5	11.5	11.6	0	0.8%	11.3	(0)	(2.3%)	

1 WORKFORCE WHOLE TIME EQUIVALENT			01WTEPYE	01WTEM01	01WTEM02	01WTEM03	01WTEM04	01WTEM05	01WTEM06	01WTEM07	01WTEM08	01WTEM09	01WTEM10	01WTEM11	01WTEM12	01WTECYECH	01WTECYECH2	01WTENYE	01WTENYECH	01WTENYECH2	01WTECOMMENT
																					Commentary is mandated for all values greater than or less than 1
			Forecast Out-turn	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
		Expected	31/03/2017	30/04/2017	31/05/2017	30/06/2017	31/07/2017	31/08/2017	30/09/2017	31/10/2017	30/11/2017	31/12/2017	31/01/2018	28/02/2018	31/03/2018	31/03/2018	31/03/2018	31/03/2019	31/03/2019	31/03/2019	31/03/2018
Physiological Sciences		+	40.0	39.8	40.0	39.8	39.8	40.2	40.2	40.2	40.2	40.0	40.0	40.0	40.3	0	0.8%	39.3	(1)	(2.3%)	

WORKFORCE WHOLE TIME EQUIVALENT	Expected	01WTEPYE Forecast Out-turn 31/03/2017	01WTEM01 Plan 30/04/2017	01WTEM02 Plan 31/05/2017	01WTEM03 Plan 30/06/2017	01WTEM04 Plan 31/07/2017	01WTEM05 Plan 31/08/2017	01WTEM06 Plan 30/09/2017	01WTEM07 Plan 31/10/2017	01WTEM08 Plan 30/11/2017	01WTEM09 Plan 31/12/2017	01WTEM10 Plan 31/01/2018	01WTEM11 Plan 28/02/2018	01WTEM12 Plan 31/03/2018	01WTECYECH Plan 31/03/2018	01WTECYECH2 Plan 31/03/2018	01WTENYE Plan 31/03/2019	01WTENYECH Plan 31/03/2019	01WTENYECH2 Plan 31/03/2019	01WTECOMMENT Commentary is mandated for all values greater than or less than 1 Plan 31/03/2018
Other	+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	-	0.0	0	-	
Qualified Ambulance Service Staff	+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	-	0.0	0	-	
Ambulance Paramedic	+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	-	0.0	0	-	
Ambulance Technician	+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	-	0.0	0	-	
Other Qualified Ambulance Staff	+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	-	0.0	0	-	
Support to clinical staff	+	1,504.1	1,579.4	1,564.5	1,563.4	1,562.6	1,563.9	1,564.4	1,567.5	1,568.8	1,570.3	1,571.0	1,572.3	1,572.3	68	4.5%	1,535.7	(37)	(2.3%)	
Support to nursing staff	+	759.0	796.9	789.4	788.8	788.4	789.1	789.3	790.9	791.6	792.3	792.6	793.3	793.3	34	4.5%	774.8	(18)	(2.3%)	Increase in support for clinical staff
Support to STT & HCS staff	+	282.1	296.3	293.5	293.3	293.1	293.3	293.4	294.0	294.3	294.6	294.7	294.9	294.9	13	4.5%	288.1	(7)	(2.3%)	Increase in support for clinical staff
Support to ambulance staff	+	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	(0)	(5.0%)	0.1	(0)	(2.3%)	
Support to Allied Health Professionals	+	50.7	53.2	52.7	52.7	52.6	52.7	52.7	52.8	52.9	52.9	52.9	53.0	53.0	2	4.5%	51.7	(1)	(2.3%)	Increase in support for clinical staff
Other clinical support staff	+	412.3	432.9	428.9	428.5	428.3	428.7	428.8	429.7	430.0	430.5	430.6	431.0	431.0	19	4.5%	420.9	(10)	(2.3%)	Increase in support for clinical staff
NHS Infrastructure Support	+	808.9	822.1	814.1	813.5	813.1	813.8	814.1	815.8	816.5	817.3	817.6	818.3	818.3	9	1.2%	798.6	(20)	(2.4%)	
Managers & senior managers	+	125.5	127.6	126.3	126.2	126.2	126.3	126.3	126.6	126.7	126.8	126.9	127.0	127.0	1	1.2%	123.9	(3)	(2.4%)	Expectation to be stable in this staff group
Admin and Estates staff	+	449.4	456.7	452.3	452.0	451.7	452.1	452.3	453.2	453.6	454.0	454.2	454.6	454.6	5	1.2%	443.7	(11)	(2.4%)	Expectation to be stable in this staff group
Other Infrastructure & Support Staff	+	234.0	237.8	235.5	235.3	235.2	235.4	235.5	236.0	236.2	236.4	236.5	236.7	236.7	3	1.2%	231.0	(6)	(2.4%)	Expectation to be stable in this staff group
Any others	+	0.9	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	1.1	0	22.8%	1.1	(0)	(2.3%)	
Total Medical and Dental Staff	+	516	506	505	506	506	513	516	517	517	517	517	517	517	1	0.2%	505	(12)	(2.3%)	
Career/Staff Grades	+	45.6	58.3	58.3	58.3	58.3	62.3	62.3	62.3	62.3	62.3	62.3	62.3	62.3	17	36.7%	60.9	(1)	(2.3%)	Increase in substantive appointments, less use of locum and agency workers
Trainee Grades	+	253.3	243.8	243.8	243.8	242.8	242.8	243.8	243.8	243.8	243.8	243.8	243.8	243.8	(10)	(3.8%)	238.2	(6)	(2.3%)	Expectation is to have reduced number of Junior Doctors from Health Education England
Consultants (including Directors of Public Health)	+	216.9	204.0	203.0	204.0	205.0	208.0	209.5	210.5	210.5	210.5	210.5	210.5	210.8	(6)	(2.8%)	206.0	(5)	(2.3%)	
Accident & Emergency	+	9.2	8.7	8.6	8.7	8.7	8.8	8.9	8.9	8.9	8.9	8.9	8.9	8.9	(0)	(3.1%)	8.7	(0)	(2.3%)	
Anaesthetics	+	36.6	34.4	34.2	34.4	34.6	35.1	35.4	35.5	35.5	35.5	35.5	35.5	35.6	(1)	(2.9%)	34.8	(1)	(2.3%)	Expectation to be stable in this staff group
Dentistry / Dental (NHS employed)	+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	-	0.0	0	-	
GP, Community & PH (NHS employed)	+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	-	0.0	0	-	
Medicine	+	58.4	54.9	54.6	54.9	55.2	56.0	56.4	56.7	56.7	56.7	56.7	56.7	56.8	(2)	(2.8%)	55.5	(1)	(2.3%)	Expectation to be stable in this staff group
Obstetrics and Gynaecology	+	15.6	14.7	14.6	14.7	14.7	15.0	15.1	15.1	15.1	15.1	15.1	15.1	15.2	(0)	(2.6%)	14.8	(0)	(2.3%)	
Paediatrics	+	14.3	13.4	13.4	13.4	13.5	13.7	13.8	13.9	13.9	13.9	13.9	13.9	13.9	(0)	(2.5%)	13.6	(0)	(2.3%)	
Pathology	+	15.0	14.1	14.0	14.1	14.2	14.4	14.5	14.6	14.6	14.6	14.6	14.6	14.6	(0)	(2.7%)	14.2	(0)	(2.3%)	
Psychiatry	+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	-	0.0	0	-	
Radiology	+	15.3	14.4	14.3	14.4	14.5	14.7	14.8	14.9	14.9	14.9	14.9	14.9	14.9	(0)	(2.5%)	14.5	(0)	(2.3%)	
Surgery	+	52.5	49.4	49.1	49.4	49.6	50.3	50.7	51.0	51.0	51.0	51.0	51.0	51.0	(1)	(2.9%)	49.9	(1)	(2.3%)	Expectation to be stable in this staff group
Bank	+	123.9	123.9	123.9	123.9	123.9	123.9	123.9	123.9	123.9	123.9	123.9	123.9	123.9	(0)	(0.0%)	121.1	(3)	(2.3%)	
Total Non Medical -Clinical Staff	+	110.0	110.0	110.0	110.0	110.0	110.0	110.0	110.0	110.0	110.0	110.0	110.0	110.0	(0)	(0.0%)	107.5	(3)	(2.3%)	
Registered Nurses	+	21.9	21.9	21.9	21.9	21.9	21.9	21.9	21.9	21.9	21.9	21.9	21.9	21.9	(0)	(0.2%)	21.4	(1)	(2.3%)	
Qualified Scientific, Therapeutic and Technical Staff	+	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	6.0	0	0.2%	5.9	(0)	(2.3%)	
Qualified Ambulance Staff	+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	-	0.0	0	-	
Support to clinical staff	+	82.1	82.1	82.1	82.1	82.1	82.1	82.1	82.1	82.1	82.1	82.1	82.1	82.1	(0)	(0.0%)	80.2	(2)	(2.3%)	
of which Support to nursing staff	+	57.4	57.4	57.4	57.4	57.4	57.4	57.4	57.4	57.4	57.4	57.4	57.4	57.4	(0)	(0.0%)	56.1	(1)	(2.3%)	
of which Support to Allied Health Professionals	+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	-	0.0	0	-	
Total Non Medical- Non-Clinical Staff	+	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	5.3	(0)	(0.6%)	5.2	(0)	(2.3%)	

1 WORKFORCE WHOLE TIME EQUIVALENT			01WTEPYE	01WTEM01	01WTEM02	01WTEM03	01WTEM04	01WTEM05	01WTEM06	01WTEM07	01WTEM08	01WTEM09	01WTEM10	01WTEM11	01WTEM12	01WTECYECH	01WTECYECH2	01WTENYE	01WTENYECH	01WTENYECH2	01WTECOMMENT
																					Commentary is mandated for all values greater than or less than 1
			Forecast Out-turn	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
		Expected	31/03/2017	30/04/2017	31/05/2017	30/06/2017	31/07/2017	31/08/2017	30/09/2017	31/10/2017	30/11/2017	31/12/2017	31/01/2018	28/02/2018	31/03/2018	31/03/2018	31/03/2018	31/03/2019	31/03/2019	31/03/2019	31/03/2018
Total Medical and Dental Staff		+	8.6	8.6	8.6	8.6	8.6	8.6	8.6	8.6	8.6	8.6	8.6	8.6	8.6	0	0.6%	8.4	(0)	(2.3%)	

1 WORKFORCE WHOLE TIME EQUIVALENT			01WTEPYE	01WTEM01	01WTEM02	01WTEM03	01WTEM04	01WTEM05	01WTEM06	01WTEM07	01WTEM08	01WTEM09	01WTEM10	01WTEM11	01WTEM12	01WTECYECH	01WTECYECH2	01WTENYE	01WTENYECH	01WTENYECH2	01WTECOMMENT
																					Commentary is mandated for all values greater than or less than 1
			Forecast Out-turn	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
		Expected	31/03/2017	30/04/2017	31/05/2017	30/06/2017	31/07/2017	31/08/2017	30/09/2017	31/10/2017	30/11/2017	31/12/2017	31/01/2018	28/02/2018	31/03/2018	31/03/2018	31/03/2018	31/03/2019	31/03/2019	31/03/2019	31/03/2018
Career/Staff Grades		+	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	1.6	0	2.6%	1.6	(0)	(2.3%)	
Trainee Grades		+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	-	0.0	0	-	
Consultants		+	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	7.0	0	0.1%	6.8	(0)	(2.3%)	
Agency staff (including, Agency, Contract and Locum)		+	212.8	202.5	197.5	196.5	186.5	182.5	181.8	187.8	193.8	193.8	193.8	193.8	193.8	(19)	(8.9%)	189.4	(4)	(2.3%)	
Total Non Medical -Clinical Staff		+	113.1	109.9	104.9	103.9	97.9	97.9	97.9	105.9	111.9	111.9	111.9	111.9	111.9	(1)	(1.0%)	109.3	(3)	(2.3%)	
Registered Nurses		+	69.9	87.5	82.5	78.5	75.5	75.5	75.5	83.5	89.5	89.5	89.5	89.5	89.5	20	28.1%	87.5	(2)	(2.3%)	Increase in agency until all substantive appointments are in place, there is a plan in place for overseas recruitment for nursing.
Qualified Scientific, Therapeutic and Technical Staff		+	3.6	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(4)	(100.0%)	0.0	0	-	The plan is to have no agency costs
Qualified Ambulance Staff		+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	-	0.0	0	-	
Support to clinical staff		+	39.6	22.4	22.4	25.4	22.4	22.4	22.4	22.4	22.4	22.4	22.4	22.4	22.4	(17)	(43.4%)	21.9	(1)	(2.3%)	Decrease in agency due to appointments in substantive roles
of which Support to nursing staff		+	37.6	22.4	22.4	25.4	22.4	22.4	22.4	22.4	22.4	22.4	22.4	22.4	22.4	(15)	(40.4%)	21.9	(1)	(2.3%)	Decrease in agency due to appointments in substantive roles
of which Support to Allied Health Professionals		+	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	-	0.0	0	-	
Total Non Medical- Non-Clinical Staff		+	23.2	38.0	38.0	38.0	38.0	38.0	38.0	38.0	38.0	38.0	38.0	38.0	38.0	15	63.7%	37.1	(1)	(2.3%)	Due to the implementation of EPR there will be an increase in agency staff, which will reduce over time as the plan is rolled out
Total Medical and Dental Staff		+	76.5	54.6	54.6	54.6	50.6	46.6	45.9	43.9	43.9	43.9	43.9	43.9	43.9	(33)	(42.6%)	42.9	(1)	(2.3%)	
Career/Staff Grades		+	27.8	16.9	16.9	16.9	13.9	9.9	9.9	9.9	9.9	9.9	9.9	9.9	9.9	(18)	(64.2%)	9.7	(0)	(2.3%)	Less reliance on agency staff
Trainee Grades		+	10.7	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	4.5	(6)	(57.6%)	4.4	(0)	(2.3%)	Less reliance on agency staff
Consultants		+	38.1	33.1	33.1	33.1	32.1	32.1	31.5	29.5	29.5	29.5	29.5	29.5	29.5	(9)	(22.7%)	28.8	(1)	(2.3%)	Less reliance on agency staff

1 Workforce Spend		02SPENDPYE	02SPENDM01	02SPENDM02	03SPENDM03	02SPENDM04	02SPENDM05	02SPENDM06	02SPENDM07	02SPENDM08	02SPENDM09	02SPENDM10	02SPENDM11	02SPENDM12	02SPENDCYE	02SPENDNYE	02SPENDPYEAV	02SPENDCYEAV	02SPENDNYEAV
																	Average Cost per WTE	Average Cost per WTE	Average Cost per WTE
		Forecast Out-turn	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Forecast Out-turn	Plan	Plan
	Expected	31/03/2017	30/04/2017	31/05/2017	30/06/2017	31/07/2017	31/08/2017	30/09/2017	31/10/2017	30/11/2017	31/12/2017	31/01/2018	28/02/2018	31/03/2018	31/03/2018	31/03/2019	31/03/2017	31/03/2018	31/03/2019
		Year Ending	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Year Ending	Year Ending	Year Ending	Year Ending	Year Ending
	Sign	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Total Pay Bill All Staff	+	240,105	20,351	20,353	20,355	20,343	20,442	20,442	20,401	20,403	20,408	20,394	20,394	20,403	244,689	241,561	44	44	44
Bank	+	4,474	286	286	286	286	286	286	286	286	286	286	286	286	3,432	3,372	36	28	28
Agency staff (including, Agency, Contract and Locum)	+	24,071	1,880	1,880	1,380	1,344	1,344	1,344	1,278	1,278	1,278	1,261	1,261	1,261	16,789	16,483	113	87	87
Total Pay Bill Substantive Staff	+	211,560	18,185	18,187	18,689	18,713	18,812	18,812	18,837	18,839	18,844	18,847	18,847	18,856	224,468	221,706	41	42	43
Total Non Medical -Clinical Staff	+	117,707	10,486	10,487	10,487	10,488	10,516	10,516	10,517	10,517	10,518	10,516	10,516	10,517	126,081	124,378	31	32	32
Total Non Medical- Non-Clinical Staff	+	39,712	3,081	3,082	3,584	3,588	3,584	3,584	3,588	3,590	3,594	3,589	3,589	3,597	42,050	41,480	49	51	52
Total Medical and Dental Staff	+	54,141	4,618	4,618	4,618	4,637	4,712	4,712	4,732	4,732	4,732	4,742	4,742	4,742	56,337	55,848	105	109	111
PAY BILL BY STAFF GROUP (Excluding Bank Staff, Locums and Agency Staff)																			
Total Pay Bill- Permanent Staff	+	211,560	18,185	18,187	18,689	18,713	18,812	18,812	18,837	18,839	18,844	18,847	18,847	18,856	224,468	221,706	41	42	43
Registered Nursing, Midwifery and Health visiting staff spend	+	67,733	6,213	6,213	6,213	6,213	6,213	6,213	6,213	6,213	6,213	6,213	6,213	6,213	74,556	73,568	41	43	44
All Scientific, Therapeutic and Technical Staff spend	+	31,605	2,781	2,782	2,782	2,783	2,811	2,811	2,812	2,812	2,813	2,811	2,811	2,812	33,621	33,165	47	50	51
of which Allied Health Professionals	+	14,623	1,300	1,300	1,300	1,300	1,329	1,329	1,329	1,329	1,329	1,329	1,329	1,329	15,832	15,620	40	43	43
of which Other Scientific, Therapeutic and Technical Staff	+	14,485	1,281	1,281	1,281	1,281	1,281	1,281	1,281	1,281	1,281	1,281	1,281	1,281	15,372	15,163	83	87	88
of which Health Care Scientists	+	2,497	200	201	201	202	201	201	202	202	203	201	201	202	2,417	2,382	20	19	20
Qualified Ambulance Service Staff spend	+	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Support to clinical staff spend	+	18,369	1,492	1,492	1,492	1,492	1,492	1,492	1,492	1,492	1,492	1,492	1,492	1,492	17,904	17,645	12	11	11
of which Support to nursing staff	+	17,854	1,445	1,445	1,445	1,445	1,445	1,445	1,445	1,445	1,445	1,445	1,445	1,445	17,340	17,088	24	22	22
of which Support to Allied Health Professionals	+	515	47	47	47	47	47	47	47	47	47	47	47	47	564	557	10	11	11
NHS Infrastructure Support spend	+	39,535	2,888	2,890	3,390	3,393	3,389	3,389	3,392	3,395	3,399	3,394	3,394	3,401	39,714	39,152	49	49	49
Any others spend	+	177	193	192	194	195	195	195	196	195	195	195	195	196	2,336	2,328	192	2,067	2,109
Career/Staff Grades spend	+	6,780	536	536	536	545	545	545	545	545	545	545	545	545	6,513	6,412	149	105	105
Trainee Grades	+	14,134	1,174	1,174	1,174	1,174	1,249	1,249	1,249	1,249	1,249	1,249	1,249	1,249	14,688	14,785	56	60	62
Consultants (including Directors of Public Health) spend	+	33,227	2,908	2,908	2,908	2,918	2,918	2,918	2,938	2,938	2,938	2,948	2,948	2,948	35,136	34,651	153	167	168
BANK SPEND BY STAFF GROUP																			
Total Pay Bill Bank staff	+	4,474	286	286	286	286	286	286	286	286	286	286	286	286	3,432	3,372	36	28	28
Non Medical -Clinical Staff Bank	+	2,481	190	190	190	190	190	190	190	190	190	190	190	190	2,280	2,246	23	21	21
Registered Nurses	+	710	59	59	59	59	59	59	59	59	59	59	59	59	708	698	32	32	33
Qualified Scientific, Therapeutic and Technical Staff	+	215	1	1	1	1	1	1	1	1	1	1	1	1	12	10	36	2	2
Qualified Ambulance Staff	+	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Support to clinical staff	+	1,556	130	130	130	130	130	130	130	130	130	130	130	130	1,560	1,538	19	19	19
of which Support to nursing staff	+	1,556	130	130	130	130	130	130	130	130	130	130	130	130	1,560	1,538	27	27	27
of which Support to Allied Health Professionals	+	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Non Medical- Non-Clinical Staff Bank	+	653	38	38	38	38	38	38	38	38	38	38	38	38	456	447	123	86	86
Medical and Dental Bank	+	1,340	58	58	58	58	58	58	58	58	58	58	58	58	696	679	157	81	81
Career/Staff Grades	+	163	5	5	5	5	5	5	5	5	5	5	5	5	60	58	104	38	37
Trainee Grades	+	159	4	4	4	4	4	4	4	4	4	4	4	4	48	46	0	0	0
Consultants	+	1,018	49	49	49	49	49	49	49	49	49	49	49	49	588	575	146	84	84
AGENCY STAFF SPEND BY STAFF GROUP (INCLUDING, AGENCY, LOCUM)																			
Total Pay Bill Agency and Locum Staff	+	24,071	1,880	1,880	1,380	1,344	1,344	1,344	1,278	1,278	1,278	1,261	1,261	1,261	16,789	16,483	113	87	87
Non Medical -Clinical Staff Agency	+	7,798	500	500	500	500	500	500	500	500	500	500	500	500	6,000	5,905	69	54	54
Registered Nurses	+	5,877	458	458	458	458	458	458	458	458	458	458	458	458	5,496	5,414	84	61	62
Qualified Scientific, Therapeutic and Technical Staff	+	905	0	0	0	0	0	0	0	0	0	0	0	0	0	0	253	0	0
Qualified Ambulance Staff	+														0		0	0	0
Support to clinical staff	+	1,016	42	42	42	42	42	42	42	42	42	42	42	42	504	491	26	23	22
of which Support to nursing staff	+	1,016	42	42	42	42	42	42	42	42	42	42	42	42	504	491	27	23	22
of which Support to Allied Health Professionals	+	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Non Medical- Non-Clinical Staff Agency	+	1,631	566	566	66	66	66	66	66	66	66	66	66	66	1,792	1,768	70	47	48
Medical and Dental Agency	+	14,642	814	814	814	778	778	778	712	712	712	695	695	695	8,997	8,810	191	205	205
Career/Staff Grades	+	4,945	288	288	288	276	276	276	276	276	276	276	276	276	3,348	3,284	178	337	339
Trainee Grades	+	1,579	68	68	68	68	68	68	68	68	68	68	68	68	816	796	148	180	180
Consultants	+	8,118	458	458	458	434	434	434	368	368	368	351	351	351	4,833	4,730	213	164	164

Workforce KPI's - Planned		08KPIPYE	08KPIM01	08KPIM02	08KPIM03	08KPIM04	08KPIM05	08KPIM06	08KPIM07	08KPIM08	08KPIM09	08KPIM10	08KPIM11	08KPIM12	08KPINYE	08KPICOMMENT
																Please provide commentary on the targets set
		Forecast Out-turn	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan	Plan
	Expected	31/03/2017	30/04/2017	31/05/2017	30/06/2017	31/07/2017	31/08/2017	30/09/2017	31/10/2017	30/11/2017	31/12/2017	31/01/2018	28/02/2018	31/03/2018	31/03/2019	31/03/2018
		Year Ending	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12	Year Ending	Year Ending
	Sign	%	%	%	%	%	%	%	%	%	%	%	%	%	%	FREE TEXT
In Month Staff Turnover %	+															No target set
In Month Short Term Sickness Absence Rate %	+	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	1.30%	
In Month Long Term Sickness Absence Rate %	+	2.70%	2.70%	2.70%	2.70%	2.70%	2.70%	2.70%	2.70%	2.70%	2.70%	2.70%	2.70%	2.70%	2.70%	
In Month Total Sickness Absence Rate %	+	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	
In Month Vacancy Rate %	+															No target set
% AfC Staff Appraisal Rate (12 Month Rolling)	+	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
% Medical Staff Appraisal Rate (report as reported to Board)	+	100.00%	8.33%	16.67%	25.00%	33.33%	41.67%	50.00%	58.33%	66.67%	75.00%	83.33%	91.67%	100.00%	100.00%	
% Mandatory Training Completed (report as reported to Board)	+	100.00%	8.33%	16.67%	25.00%	33.33%	41.67%	50.00%	58.33%	66.67%	75.00%	83.33%	91.67%	100.00%	100.00%	

Workforce Strategy 2016/2017 – 2020/2021
Plan on a Page

Appendix 2

AIM: A workforce of the right size and shape with the commitment, capability and capacity to deliver safe, efficient, high quality services within the available resource

	Engagement	Modernisation	Organisational Development and Leadership	Health and Wellbeing
GOALS	Colleagues are clear about the Trust's priorities, feel valued, confident that their voice is heard; and able to take an active part in decisions which affect the Trust, its patients, carers and the community.	Colleagues are value driven and work together in pursuit of Trust priorities. The right teams are in the right place at the right time, collaborating to deliver safe, efficient, high quality patient care within the available resource.	Colleagues are professional and capable, feel equipped to make an effective contribution to Trust priorities and are actively supported by a directive and inclusive leadership community.	Colleagues are resilient, feel supported to improve and maintain their health and wellbeing, sustaining their availability for work to the benefit of patients and fellow team members.
STRATEGIC OBJECTIVES	Create and deploy communications machinery that connects Ward to Board. Improving the ability of all colleagues to feed their views upward (have a voice) know what's going on and feel connected with their immediate managers and Trust leadership. Deploy a clear narrative about values and priorities, making it the job of every manager to 'tell the story' of Trust aims and priorities, so that colleagues can see how their job fits in and participate in decisions which affect them and their service. Create opportunities to demonstrate that colleagues are valued in their role by recognising and rewarding contribution – individual and team. Support and promote consistently good management practice across the Trust, and hold leaders at every level accountable for their people.	Implement a service led multi-disciplinary approach to the design and deployment of new and advanced roles to address continuing medical workforce shortages; and create new competency based support roles to meet gaps in non-medical professions. Improve the efficiency of staff deployment across all staff groups to maximise the availability of permanent staff and reduce the unacceptable dependencies on agency staff. Reduce absenteeism to 3% across the Trust and maintain this level consistently reducing demand for agency staff. Achieve demonstrable improvements in efficiency and productivity (%) by eliminating any waste of skills and money across the Trust. Actively support and enable transformation across the Trust ensuring that workforce impact is understood and requirements for workforce change are clearly articulated and managed. Target of 130 apprentices, and utilisation of the apprenticeship Levy.	Build leadership capability and capacity from Ward to Board, co-creating an organisational environment that actively supports an engaged and inclusive culture. Develop an integrated cross Trust approach to role re-design assessing workforce requirements using the common currency of skills and competence utilising the Calderdale Framework; rather than starting from existing notions of sectors, settings, services and professions. Develop and bolster personal and team resilience equipping staff to work across organisational and sector boundaries, so creating readiness for change. Build the Trust healthcare support workforce (Bands 1-4) into a highly skilled and flexible workforce that is able to support the Trust in meeting healthcare challenges Improve and sustain performance in relation to appraisal and mandatory training, and implement a consistent cross Trust approach to regular performance reviews.	Collectively embed new and enhanced approaches to health and wellbeing which are linked to Trust values and priorities, fully integrated into our ways of working and contribute to improved performance. Co-create a broad programme of health promotion activities which reach out to those who are least active, improving health and wellbeing, so optimising availability and reducing premium cost. Ensure that the health and wellbeing of colleagues is at the heart of change s in the Trust, and that this is visible and recognised by all. Create and promote a Trust-wide employee benefits and assistance programme that supports the Trust as a good employer in the eyes of its Workforce.

Workforce Strategy Implementation Plan 2016/2017 – 2020/2021

Red	Amber	Green	Blue
Overdue	**Due this month**	**Closed**	**Going Forward**

REF	IDENTIFIED RESPONSE	ACTION	KPI	ACTION LEAD	TIMESCALE	RAG RATING
RECRUITMENT						
REC 1	**Implement recommendations as set out by Step Change**	Various see individual project plan with KPIs and deadlines Working Project Plan 25Oct16.xls		Rachael Pierce	31 October 2017	
REC 2	**Develop a brand and offering – WOD Customer service**	Create tools for story telling – publicise the positives of working in CHFT, new starters experience Make candidates feel special – personalised communication throughout the process Consider the use of R&R premia Review Induction activities- corporate/local by 31 March 2017 Pilot of new system will need to be delayed until Sept 2017 to allow implications of Apprenticeship Levy to embed.	'Story' to be available demonstrating the recruitment process and what it's like to work for CHFT Set through Stepchange project plan	Rachael Pierce Pauline North Caroline Wright Bev France	31 December 2017	
REC 3	**Identify and implement marketing materials**	Liaise with Communications colleagues linked to safer staffing. Use of social media	Increased use of social media with all adverts and recruitment events	Rachael Pierce Pauline North Caroline Wright	30 June 2017	

REF	IDENTIFIED RESPONSE	ACTION	KPI	ACTION LEAD	TIMESCALE	RAG RATING
		Adverts placed in Defence (MOD) journals Attendance at recruitment fairs Communicate across divisions planned changes and the recruitment process Sell the trust – create benefits of organisation and local area	Visibility at recruitment fairs			
REC 4	**Standard Operating Procedures**	Consistent organisational advert/ Localised departmental advert Consistent Job Descriptions Implement a system for cross exposure "We go see" – option to allow employees to transfer between departments on a trial basis to improve retention. Improving access to bank assignments Explore different selection activities	Managers/HR and Recruitment all aware and following same process Improve retention and internal vacancy process Streamlined process to access bank work	Rachael Pierce Pauline North	31 March 2017 31 December 2016	
REC 5	**Planned recruitment activity**	Implement TRAC system Link with schools/colleges/universities Schedule of planned recruitment	Recruitment activity to be managed to reflect planned recruitment Increase use of apprenticeships	Rachael Pierce Pauline North Pam Wood	30 April 2017	

REF	IDENTIFIED RESPONSE	ACTION	KPI	ACTION LEAD	TIMESCALE	RAG RATING
		Clear apprenticeship strategy (see also ODL4) Development of new roles Overseas recruitment- Doctors / Nurses	Increased variety of roles available Reduction in gaps within services	Michelle Bamford Charlotte North		
RETENTION						
RET 1	**Flexible/Responsive workforce**	Clarify flexible working options with case study examples and staff/manager stories particularly for older staff who are coming up to retirement and apply a consistent approach across the Trust. Promote the in house preparation for retirement course more widely. Utilise the delegate list to have focussed discussions with individuals about their plans and retire and return opportunities. Review the rationale behind the traditional shifts patterns and consider changing them to make them less unsocial and more family friendly e.g. 8am start for nurses	Increase in supported applications for flexible working A reduction in non-flexible working hours being cited as a reason for leaving on the exit questionnaire Retention of staff in difficult to recruit to posts. Reduction in flexible working applications Reduced Trustwide sickness levels to	Diane Marshall Christine Bouckley	30 September 2017	

REF	IDENTIFIED RESPONSE	ACTION	KPI	ACTION LEAD	TIMESCALE	RAG RATING
		rather than 7am. Short and long term sickness reduced, support increased for RTW, alternative employment or flexible working	3.5%			
RET 2	**Payments to staff to remain with the Trust for staying in hard to recruit to posts**	Identify the hard to recruit to posts with high turnover/agency spend and develop a bonus payment scheme.	Reduction in agency spend Reduction in turnover	Azizen Khan Pauline North	30 June 2017	
RET 3	**Reward and recognise staff for the small things**	Promote the use of thank you messages/cards more locally by hand delivering them to managers to issue. Reward staff with the small things like free coffee or fruit by working in partnership with Costa or the fruit stall Promote and encourage colleagues to nominate each other for the star award. Review and simplify the nomination process.	Improvement in staff survey results indicating staff feel valued Improvement in FFT results Increased number of nominations for star award	Azizen Khan Caroline Wright	31 March 2017	
RET 4	**Develop our Trust brand with improved Communications and Marketing strategy embedded to enhance recruitment**	Use the new starter survey to build a story board for each Division and then use that to promote the services and opportunities at CHFT	Increase in number of new starter surveys being completed	Charlotte North Caroline Wright	30 September 2017	

REF	IDENTIFIED RESPONSE	ACTION	KPI	ACTION LEAD	TIMESCALE	RAG RATING
	potential and retention across all staff groups.	Increase the numbers of staff completing the new starter survey and build this into a performance measure for the line manager Develop an informal `buddy system' for new starters to have someone they can talk to in the first few months of starting in post. Use social media to promote and highlight CHFT. Staff champions identified regularly support recruitment, marketing and communication initiatives	Reduced turnover for staff with short length of service	Rachael Pierce		
RET 5	**Define career pathways and development programmes**	Provide mentoring and coaching including support to navigate training and development pathways and opportunities for job shadowing Develop a comprehensive programme for Bands 3/4 (Clinical & Administration staff) and Band 5/6 (Clinical staff) to support them in career progression/promotion	Increased uptake of apprenticeship pathways to facilitate this development. Improvement in staff survey results indicating staff have been offered development and career progression. Reduced turnover Improvement in	Azizen Khan Ruth Shaw Ruth Mason Pam Wood	31 March 2018	

REF	IDENTIFIED RESPONSE	ACTION	KPI	ACTION LEAD	TIMESCALE	RAG RATING
			WRES indicators			
RET 6	**Promote NHS benefits and non-pay benefits for staff**	Include non-pay benefits in the recruitment campaign for CHFT. Review and refresh the total rewards statement available annually to staff. Develop a brochure promoting employee benefits.	Improvement in staff survey results. Greater uptake of salary sacrifice schemes	Rachael Pierce Sarah Parkin Laurie Beckett	31 May 2017	
RET 7	**Development of an Internal transfer framework**	Offer opportunities for staff to have work trials in other areas so they can work in another area with the opportunity to transfer without the need for formal application. Identify and develop a framework for posts that could rotate between specialities / divisions	Improvement in staff survey results Reduction in turnover rates Reduction in lack of development being cited as reason for leaving in exit questionnaire.	Azizen Khan Michelle Bamforth	31 March 2017	
RET 8	**Have a new must-do which is to 'smile and be respectful' and use 'please and thank you' and 'be kind to each other'**	Add the 'must-do' value to those the Trust already has in place and communicate	Improvement in staff survey results Improvement in FFT results	Azizen Khan	31 January 2017	
WORKFORCE PLANNING – AVAILABILITY, UTILISATION AND EFFECTIVENESS						

REF	IDENTIFIED RESPONSE	ACTION	KPI	ACTION LEAD	TIMESCALE	RAG RATING
WP 1	**Review the option of sourcing NHS workforce planning specialists**	Understanding the external market to assess who the NHS Workforce Planning Specialist are and determine how to use their expertise (in-house)	To have sourced an "expert" in NHS Workforce planning.	Ian Warren	30 November 2016	
WP 2	**Training needs analysis of workforce planning within the Trust as a whole (including HR). Increasing the knowledge, skills and competences in workforce planning**	Undertake a Training Needs Analysis and have an associated action plan, to understand the skills and competences needed to develop a robust workforce plan.	Sign-off of Training Needs Analysis. Have a skills and competence training plan.	Ian Warren	31 December 2016	
WP 3	**Develop a Workforce Planning Toolkit for the Trust**	Produce a standardised toolkit that is user friendly for managers to use.	Production of workforce planning toolkit for the Trust	Ian Warren Claire Wilson Adam Matthews	31 March 2017	
WP 4	**Engage senior management (including clinicians) in the discussions and workshops in planning the workforce of the future.**	Board level commitment to involve colleagues at a senior level in the formulation of Workforce plans. To use clinical expertise to address challenges.	Engagement plan to include all senior and middle managers within the Trust in the formulation of workforce plans.	Ian Warren Claire Wilson Adam Matthews Mark Bushby	31 March 2017	
WP 5	**Encourage creativity and innovation of senior managers and teams to consider their workforce for their service requirements (including skills and competences).**	To have a Workforce Planning Workshop to launch the workforce planning toolkit and kick-off the preparation of the Workforce Plan – to align to the Workforce Strategy (2016/2017 – 2020/2021). A Trust,	To have dates of Workforce Planning workshops to launch the toolkit.	Claire Wilson	31 March 2017	

REF	IDENTIFIED RESPONSE	ACTION	KPI	ACTION LEAD	TIMESCALE	RAG RATING
		Divisional, Directorate and Service Plan.				
WP 6	**Role and Job redesign – what roles do we need for the future supporting the need for using qualified staff appropriately**	To review the new roles of working in the NHS (As per the Nuffield Trust – Reshaping the Workforce to deliver the care patients need).	The senior team across all Divisions understand the new roles and how they can address their future workforce challenges. The knowledge and understanding of this to occur before the launch of the workforce planning sessions (or as part of)	Claire Wilson Azizen Khan Charlotte North	31 January 2017	
WP 7	**Assess the option of the utilisation of the Calderdale Framework in service areas for the organisation**	Assess the Calderdale Framework and agree the use within the Trust so that there is consistency of the implementation.	To determine whether to utilise the Calderdale Framework as a model for Job analysis, role redesign and workforce plan	Claire Wilson Azizen Khan Charlotte North	31 January 2017	
WP 8	**Succession planning in the organisation (the future workforce)**	To have a workforce where there is a career structure in place for employees to have development to support future opportunities and to aid retention with the Trust.	A career development structure in place in all Divisions to support succession planning (for both current	Bev France	31 March 2018	

REF	IDENTIFIED RESPONSE	ACTION	KPI	ACTION LEAD	TIMESCALE	RAG RATING
			employees in existing roles as well as new roles that will come on stream in the future). Please note this element needs further clarification of both the output and timescale.			
AGENCY SPEND – BOTH IN TERMS OF COST AND NUMBER						
AS 1	**Job planning**	Job Plans and Rosters re-evaluated by Division to improve cover (middle grade) across all shifts. Job Plans and Roster re-evaluated from past metrics (6 quarters) to realigned number of staff in post against workload demand and Quality Impact Assessment (QIA) against statutory requirements (i.e. ED, 18 week/2 week) per division. Programme of Divisional Support meetings established to facilitate senior leadership involvement in process. Medical Workforce Group agrees	Trust agency spend & use weekly report and fiscal year trajectory.	Martin Debono/Ashwin Verma/Julie O'Riordan Azizen Khan/Charlotte Baldwin/Richard Metcalf	30 December 2016	

REF	IDENTIFIED RESPONSE	ACTION	KPI	ACTION LEAD	TIMESCALE	RAG RATING
		strategy to pool cover across medical specialities and adapt work plans accordingly. Short term and medium term sustainability plans review by Division in specialities with high vacancy levels. Short term action plan developed and agreed to limit activity which creates a long-term financial loss for the Trust. Sustainability plans reviewed by Division in specialities with high vacancy levels. Action plan developed and agreed to increase advanced nurse practice and/or trained staff to release medical time. Robust job planning for Consultants and Speciality Doctors to identify extra capacity.	Completed prospective job plans ready for April 2017.			
AS 2	**Junior doctor rotas**	Identify difficult to fill vacancies. Review rota frequencies to cover vacancies.	Trust agency spend and use weekly report and fiscal year trajectory.	Martin Debono/Ashwin Verma/Julie O'Riordan Azizen Khan/Charlotte	31 January 2017	

REF	IDENTIFIED RESPONSE	ACTION	KPI	ACTION LEAD	TIMESCALE	RAG RATING
				Baldwin/Richard Metcalf		
AS 3	**Agency Engagement**	All mid-long term agency contracts reviewed and discussions had around renegotiated rates (Nov 2016). Action log / task list embedded to ensure all possible action is undertaken to negate need for mid -long term agency workforce. 100% Compliance of SOP for Agency Use & Engagement. Continuous review of mid-long term agency contracts. Continuous review of action log and tasks undertaken (and modified where necessary).	All mid to long-term agency contracts have been reviewed & renegotiated (where possible). Alternative provision to agency use is continuously explored. Action log captures any areas of non-compliance and is reported back to confirm and challenge panel.	Mark Borrington Lisa Cooper	30 November 2016	
AS 4	**Paying internal shifts**	Simpler systems to capture and when people have worked	Internal locum shifts paid in a timely	Sarah Parkin	31 December 2016	

REF	IDENTIFIED RESPONSE	ACTION	KPI	ACTION LEAD	TIMESCALE	RAG RATING
		additional hours and increase the frequency of pay e.g. weekly	manner			
AS 5	**Internal locum rates**	Review internal locums rates; benchmarking across the region.	Ensure locum rates are consistent across the patch.	Pauline North	30 November 2016	
AS 6	**Risk assessment**	Robust locum confirm and challenge.	Reduced reliance on agency locums.	Martin Debono/Ashwin Verma/Julie O'Riordan Azizen Khan/Charlotte Baldwin/Richard Metcalf	31 March 2017	
AS 7	**Shared out of hours working**	Identify opportunities for junior doctor cross cover (across specialities).	Reduced reliance on agency locums	Martin Debono/Ashwin Verma/Julie O'Riordan Azizen Khan/Charlotte Baldwin/Richard Metcalf	31 January 2017	
AS 8	**Regional cover**	Collaboration with local Trusts for some services e.g. tele medicine for stroke services.	Reduce reliance on agency locums	David Birkenhead	30 April 2017	
AS 9	**Rota Planning**	Rotas to be written and released 3 months prior.	Reduced reliance on agency locums.	Lisa Cooper	31 December 2016	
AS 10	**Incentivise Divisions**	Provide Divisions with incentives to come up with alternative ways to	Reduced reliance on agency locums	David Birkenhead	31 January 2017	

REF	IDENTIFIED RESPONSE	ACTION	KPI	ACTION LEAD	TIMESCALE	RAG RATING
		'bridge the gaps'.				
ATTENDANCE MANAGEMENT						
ATD 1	**Maintaining Wellbeing of Staff to prevent ill health and minimise health related absence**	Fast-track wellbeing initiatives fast track Occupational health, rapid access to physiotherapy and availability of counselling services Promoting services provided by OH and Wellbeing Team (wellbeing champions) Implementation of the Wellbeing CQUIN Action Plan which includes: • Promoting physical activity • Building physical activity within workplace hours • Health and wellbeing benefits • Exploring partnerships for provision of mental and physical wellbeing • Direct referral to physiotherapy • Access to chronic pain management program • Access to therapeutic massage • Counselling services	Employees will be seen within 5 working days of referral Increased uptake of services Achieving CQUIN	Christine Bouckley	31 March 2017	

REF	IDENTIFIED RESPONSE	ACTION	KPI	ACTION LEAD	TIMESCALE	RAG RATING
		including sleep counselling • Mindfulness program • Mental health first aider • Resilience and stress management training				
ATD 2	**Accurate Recording System**	Developing ESR into a management tool for recording, reporting and implementation of the Attendance Management Policy. Develop the alternate learning management system that is currently in procurement into the management tool for recording, reporting and implementation of the mandatory and essential skills training across the organisation. Identification of staff on long term sickness absence. Identification of staff on Attendance	100% compliance with using ESR 100% compliance with use of the new LMS measured at 'Go-Live', and at 6 and 12 months post 'Go-Live' Reduction in sickness absence and 100% case management plans for long term absence cases	Claire Wilson/ Diane Marshall Adam Mathews	31 March 2017 Throughout the procurement, implementation and Go Live phases of the alternate LMS project. Go live anticipated at September 2017 therefore 12 month post 'Go-Live' at September 2018	

REF	IDENTIFIED RESPONSE	ACTION	KPI	ACTION LEAD	TIMESCALE	RAG RATING
		Management Process.				
ATD 3	**Workplace Adjustments to prevent absences and reduce length of absences**	Support and planned return to work by: • Flexible working options • Adjustment to current role and duties or temporary move to suitable alternatively role • Permanent redeployment to alternative role Appreciation Scheme for members of staff with nil absences: • Recognise members of staff for following a healthy life styles and being resilient.	Reduce LOA TO 9 days. 100% of staff receive a letter from the CEO	Diane Marshall Christine Bouckley	31 December 2016	
ATD 4	**Managers Capacity to Manage**	Empowering managers to make decisions and take responsibility. Promote "Line manager is the driver of creating a healthy workplace" by; • Recruiting Socially Sensible managers • Training programs Allocate time management and promoting healthy specifically for attendance workplace.	Audit that all managers have accessed and understand the resource toolkit online. Continue to promote divisional first point of contact	Diane Marshall Christine Bouckley	31 March 2017	

REF	IDENTIFIED RESPONSE	ACTION	KPI	ACTION LEAD	TIMESCALE	RAG RATING
		Provide managers with attendance management resource kit Provide dedicated and tailored divisional support.				
COLLEAGUE ENGAGEMENT						
CE 1	**Employee voice – ensure the employee has a voice**	Back to the floor Floor to board, work alongside colleagues outside own area	All management staff have 1 day per month back to the floor	Ruth Mason	31 March 2017	
		Workplace champions	Identify 1 workplace champion in each area	Ruth Mason	31 March 2017	
		Joined up approach for champions eg “colleague engagement champions, patient champions, E&D champions	Common approach	Ruth Mason	31 March 2017	
CE 2	**Create and agree engagement strategy**	Identify those with good/range/experiences. Use their experience to craft CHFT strategy.	Identify 15 colleagues for task and finish group to produce engagement strategy Sign off at WEB	Ruth Mason	31 March 2017	

REF	IDENTIFIED RESPONSE	ACTION	KPI	ACTION LEAD	TIMESCALE	RAG RATING
		Senior team "buy in" An inclusive Engagement plan - to include staff at all levels within the Trust in the formulation of engagement plans with backing from senior team. New staff will be aware of values and behaviours and adopt CHFT culture at induction	100% of staff have an induction	Ruth Mason Ruth Mason	31 March 2017 31 December 2016	
CE 3	**Communication plan to include roadshows, success stories**	Use a range of tools i.e. social media, Trust intranet development Mystery shopper – staff feedback Closing feedback loop – principles such as "you said we did" Research staff engagement tools – "go see"	Link with Media group to establish the Trusts approach to Social media Increase of 20% Hits via intranet	Laurie Beckett Laurie Beckett	31 December 2016 31 March 2017 (dependent upon launch of new intranet)	
CE 4	**Increase colleague engagement and change management capacity**	Increase the numbers of participants accessing the WTGR Programme Train 6 additional WTGR facilitators to enable delivery of additional WTGR programmes– divisions to nominate potential new facilitators to be trained – will require 6month lead in to enable novice to expert process	Increase annual uptake by 10% 6 new facilitators identified, trained and capable of delivering WTGR without supervision	Ruth Shaw Ruth Shaw/Bev France	31 July 2018 31 July 2017	

REF	IDENTIFIED RESPONSE	ACTION	KPI	ACTION LEAD	TIMESCALE	RAG RATING
		Expand the coaching offer available to all colleagues through promotion of MyE-coach regional on-line platform	Promoted via line manager bulletin	Ruth Shaw	31 December 2016	
			MyE-coach included within WD intranet pages	Ruth Shaw/Laurie Beckett	31 December 2016	
			Offered within new Leadership and Management programme	Bev France	30 September 2017	
		Identify common workplace issues/problems shared by participants on WTGR programmes with a view to offering 'themed' coaching circles on a monthly basis.	Themes identified by June 2017	Ruth Shaw & WTGR facilitators (Bev France, Ruth Mason, Christine Bouckley)	30 June 2017	
		Current coaches recruited to lead and support themed coaching circles	Coaches allocated to dates on coaching circle schedule	Ruth Shaw	30 June 2017	
			Schedule of appropriately themed monthly coaching circles included within OD offer by July 2017	Ruth Shaw	31 July 2017	

REF	IDENTIFIED RESPONSE	ACTION	KPI	ACTION LEAD	TIMESCALE	RAG RATING
CE 5	**Investment in change management and service improvement**	Investment in specialists	Staff in post	Ian Warren	31 March 2016	
ORGANISATIONAL DEVELOPMENT AND LEADERSHIP						
ODL 1	**Appraisal**	1.1 identify hotspot areas for poor quality of appraisal 1.2 test current 'reality' – pre-input (questionnaire methodology) 1.3 design appraisal quality 'result' (behaviour and task) 1.4 Deliver in-put (in-house programme v theatre based learning programme actors) 1.5 Identified hotspot post-input evaluative questionnaires 3 months later 1.6 Roll out to all divisions May 2017	Pulse check questionnaire re quality of appraisal April 2017	Bev France/Ruth Shaw	Pilot process in place Jan 2017 3 month post input evaluations completed June 2017. Roll out conjoined process commencing July 2017	
ODL 2	**Leadership**	2.1 define leadership and management standards 2.2 design/source leadership and management inputs to deliver standards (identify specific staff groups – BME,CD, professional	post programme pulse check – delegate and line manager	Bev France/ Ruth Shaw	First modules in May 2017 (consistent with the intro of apprenticeship Levy and new	

REF	IDENTIFIED RESPONSE	ACTION	KPI	ACTION LEAD	TIMESCALE	RAG RATING
		groups etc) 2.3 create full business case to support delivery of programmes including enhanced resource to support in-house delivered elements 2.4 Understand the commissioning needs through workforce planning NB explore opportunity for collaborative working with partner organisations 2.5 design formal application process 2.6 pre-input and line manager evaluation of task, achievement and behaviour 2.7 deliver/manage inputs 1.7 2.8post input programme evaluation			leadership standards) with initial evaluation of completed elements by 1 September 2017	
ODL 3	**Expand OD opportunities through blended learning (including masterclass approach) to support transformational change**	3.1 Review current OD offering/processes and change where required 3.2 Create expanded OD opportunities – to include: • Creative thinking • Cultural awareness/diversity awareness • Resilience • Service improvement • Emotional Intelligence	post programme pulse check – delegate and line manager	Bev France/ Ruth Shaw	Review completed by 31 March 2017 Roll out of changed offering May 2017	

REF	IDENTIFIED RESPONSE	ACTION	KPI	ACTION LEAD	TIMESCALE	RAG RATING
		(relationship building/understanding teams) • Coaching/mentoring • Email management • WTGR (See colleague engagement section also) 3.3 Business case as part of wider OD offer				
ODL 4	**Linking from Workforce Planning through recruitment and retention into learning opportunities. Any opportunity should be considered as an apprenticeship opportunity primarily**	Define as part of apprenticeship strategy (see also REC5)				
ODL 5	**Leadership Walk Rounds**	5.1 review leadership walkround process 5.2 Test Exec Team desire for walk arounds 5.3 ensure structured process for senior leadership walk rounds 5.4 Design and administer post walk around pulse check	Post walk around pulse test	Bev France/ Ruth Shaw. Ian Warren to test with Exec Team Directors office to co-ordinate process	31 December 2017	
ODL 6	**Learning Management System**	Procure and implement a new Learning Management System	Post roll out pulse test	Bev France	December 2017	

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

WORKFORCE PROJECTS AND OWNERSHIP - MASTER SCHEDULE 2016/2017 - 2020/2021

Project	Responsible Officer

Calderdale and Huddersfield
NHS Foundation Trust

PROJECT STATUS REPORT

Reporting Period	Delivery Confidence (RAG)	Last Period	This Period

Programme		**Project**	
Exec Sponsor *(Accountable Officer)*	Ian Warren	**Project Lead** *(Responsible Officer)*	

FINANCIAL PERFORMANCE

	2016/2017									2017/2018			TOTAL
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Forecast	0	0	0										
Actual	0	0	0										
Variance	0	0	0										

KEY RISKS & ISSUES

(refer to Programme Risk & Issue Log)

ID	RAG	Risk/Issue	Description	Mitigation	By whom, by when
1	A	Risk			
2	A	Risk			

PROGRESS THIS PERIOD

ITEMS REQUIRING ESCALATION TO PROGRAMME BOARD FOR RESOLUTION

PROGRESS PLANNED FOR NEXT PERIOD

Appendix 4.2

Calderdale and Huddersfield
NHS Foundation Trust

KEY MILESTONE SUMMARY											
2016/2017									2017/2018		
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

KPI Description - To Be Confirmed	KPI Performance		
	Target	Actual	RAG

SIGN OFF		
	Signature	Date
Project Lead *(Responsible Officer)*		

PROGRAMME BOARD COMMENT & SIGNATURE		
	Signature	Date
Programme Sponsor *(Accountable Officer)*		

Calderdale and Huddersfield
NHS Foundation Trust

PROGRAMME STATUS REPORT

Reporting Period	Delivery Confidence (RAG)	Last Period	This Period

Programme	Workforce Programme Board	Exec Sponsor *(Accountable Officer)*	

FINANCIAL PERFORMANCE

	2016/2017									2017/2018			TOTAL
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Forecast													
Actual													
Variance													

KEY RISKS & ISSUES

(refer to Programme Risk & Issue Log)

ID	RAG	Risk/Issue	Description	Mitigation	By whom, by when

PROGRESS THIS PERIOD

ITEMS REQUIRING ESCALATION TO TURNAROUND EXECUTIVE FOR RESOLUTION

PROGRESS PLANNED FOR NEXT PERIOD

Calderdale and Huddersfield
NHS Foundation Trust

KEY MILESTONE SUMMARY											
2016/2017									2017/2018		
Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar

KPI Description	KPI Performance		
	Target	Actual	RAG

PROGRAMME BOARD COMMENT & SIGNATURE		
	Signature	Date
Programme Sponsor *(Accountable Officer)*		

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 5th January 2017	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: UPDATE FROM SUB-COMMITTEES AND RECEIPT OF MINUTES - The Board is asked to receive the updates and minutes from each of the sub-committees	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive the updates and minutes from each of the sub-committees:-
- Quality Committee - 29.11.16 and verbal update from 23.1.17
- Finance and Performance Committee - 29.11.16 and verbal update from 3.1.17
- Workforce Well Led Committee - draft minutes from 8.12.16
- Membership Council Meeting - draft minutes from 9.11.16

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to receive the updates and minutes from each of the sub-committees:-
- Quality Committee - 29.11.16 and verbal update from 23.1.17
- Finance and Performance Committee - 29.11.16 and verbal update from 3.1.17
- Workforce Well Led Committee - draft minutes from 8.12.16
- Membership Council Meeting - draft minutes from 9.11.16

Appendix

Attachment:

COMBINED UPDATE FROM SUB CTTEES.pdf

QUALITY COMMITTEE

Tuesday, 29th November 2016
Board Room, Sub Basement, Huddersfield Royal Infirmary

PRESENT

Linda Patterson	Non-Executive Director **(Chair)**
David Anderson	Non-Executive Director
Helen Barker	Chief Operating Officer
Karen Barnett	Assistant Divisional Director, Community Division
Diane Catlow	Associate Nurse Director, Community Division
Juliette Cosgrove	Assistant Director of Quality
Martin DeBono	Divisional Director, FSS Division and Associate Medical Director
Tracy Fennell	Associate Nurse Director, Medical Division
Lesley Hill	Executive Director of Planning, Performance, Estates and Facilities
Terry Matthews	Clinical Governance Manager, FSS Division
Andrea McCourt	Head of Governance and Risk
Julie O'Riordan	Divisional Director, Surgical Division
George Richardson	Membership Councillor
Lynne Taylor	Clinical Governance Manager, Medical Division
Nicola Vallance	Clinical Governance Manager, Surgical Division
Jan Wilson	Non-Executive Director
Michelle Augustine	Governance Administrator **(Minutes)**

ITEM NO	
224/16	**WELCOME AND INTRODUCTIONS** The Chair welcomed members to the meeting.
225/16	**APOLOGIES** Rob Aitchison – Director of Operations, FSS Division Asif Ameen – Director of Operations, Medical Division David Birkenhead – Medical Director Gary Boothby – Deputy Director of Finance Brendan Brown – Executive Director of Nursing Anne-Marie Henshaw – Associate Nurse Director/Head of Midwifery, FSS Division Maggie Metcalfe – Matron for Operating Services Joanne Middleton – Associate Nurse Director, Surgery and Anaesthetic Services Peter Middleton – Membership Councillor Jackie Murphy – Deputy Director of Nursing, Modernisation Vicky Pickles – Company Secretary Lindsay Rudge – Associate Director of Nursing Kristina Rutherford – Director of Operations, Surgical Division Sal Uka – Divisional Director, 7 Day Service/Hospital at Night Ian Warren – Executive Director of Workforce and Organisational Development
226/16	**DECLARATIONS OF INTEREST** There were no declarations of interest to note

227/16	**MINUTES OF THE LAST MEETING** The minutes of the last meeting held on Monday, 31st October 2016 were approved as a correct record, with the exception that sepsis paragraph at item 202/16 is amended to read: ▪ Sepsis – Work is ongoing to improve sepsis care through documentation, and significant improvement with patients presenting with sepsis and being screened. A deep dive of data will be undertaken to understand the causes of sepsis, and also reviewing compliance with NICE guidance on sepsis. ***The report will be presented to the Quality Committee, in the first instance at the next meeting on 29th November 2016 and subsequently presented to the Board of Directors meeting on 1st December 2016.***
228/16	**ACTION LOG AND MATTERS ARISING** ▪ Invited Service Reviews – FSS Division See item 232/16 ▪ Clinical Audit Plan Juliette Cosgrove (Assistant Director for Quality) reported that learning and recommendations from clinical audits will now be collated from summary reports presented at the Clinical Effectiveness and Audit Group (CEAG) meetings and will be included in the annual summary report. The process that is currently in place to reference audits to national guidance is also being reviewed and the following report will reflect these changes. ▪ Terms of Reference The Chair reported that a meeting had taken place with Vicky Pickles (Company Secretary) and Juliette Cosgrove (Assistant Director for Quality) to review the membership of the Committee and the overlap of agenda items at various committees. Email correspondence is to be shared with the Committee explaining the re-organisation of the Committee which will come into effect from 30th January 2017. The work plan will also be reviewed. **ACTION**: Email to be circulated to the Committee explaining the proposed changes. ▪ Treatment and prevention of Sepsis at CHFT Juliette Cosgrove (Assistant Director for Quality) gave a presentation on the treatment and prevention of sepsis at CHFT. The presentation highlighted that sepsis is a recognised cause of mortality and morbidity in the NHS. Around 32,000 deaths are attributed to sepsis annually, and estimates suggest that 11,000 could have been prevented. There has been a noted increase in patients diagnosed with sepsis, from an average of 47 cases, to a new average of just over 70 discharges per month since July 2016. The crude mortality rate has remained steady at just under 20% of all coded cases of sepsis going on to die in the Trust. The Trust's Hospital Standardised Mortality Ratio (HSMR) for sepsis is 102.82 (between August 2015 and July 2016). This is improving in line with Trustwide HSMR. A national review found recurring shortcomings in relation to sepsis management: ➢ Failure to recognise severity of illness – Trust Policy states that all patients with a National Early Warning Score (NEWS) greater than or equal to 5 should be screened for sepsis. Results showed that for emergency admissions, 63% of eligible patients were screened during the Q1 CQUIN and 98% of eligible patients were screened during the Q2 CQUIN; and for existing inpatients, 7% of eligible patients were screened during Q1 and 15% of eligible patients were screened during Q2 ➢ Inadequate first-line treatment with fluids and antibiotics – for emergency admissions, patients should receive IV antibiotics within 60 minutes of diagnosis and have an antibiotic review within 72 hours. Q1 CQUIN performance was 50% and Q2

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performance was 68%. For existing inpatients, they should receive IV antibiotics within 90 minutes of diagnosis and have an antibiotic review within 72 hours. Q1 performance was 73% and Q2 performance was 77%

- Delays in administering first-line treatment – a monthly sepsis audit is in place, and to date 85% of septic patients on admission had a bundle in place, however, only 38% were completed.
- Delay in source control of infection
- Delay in senior medical input

An improvement group has now been set up and led by Dr Ashwin Verma (Consultant Gastroenterologist). It is hoped that clinical leadership will reinforce what needs to be done. The sepsis bundle is to be relaunched and matrons in the medical and surgical divisions have agreed to carry out mortality reviews on patients who die from a diagnosis of sepsis. Work is also being done with two professors to do a detailed analysis on barriers, and case notes will be reviewed to provide an insight into why patients get sepsis/die from sepsis in our Trust. It is hoped that this work will be completed within 6 months.

Discussion ensued on sepsis not being seen as a medical emergency and education and learning needed to differentiate between sepsis with a complication, and sepsis as an infection, which is treatable.

This report will also be presented to the Board of Directors on Thursday, 1st December 2016.
ACTION: An update on work done to be given in 6 months' time (June 2017)

- Calderdale Vanguard Programme

Karen Barnett (Assistant Divisional Director, Community Division) reported on the circulated paper (Appendix C) and gave and update on the development of supported self-management work as part of the Calderdale Vanguard programme.

The Supported Self-Management programme has been in existence since 2008, originally called Co-Creating Health. The co-creating health work centred on three elements:

- To train and support staff to better support patients to self-manage (Advanced Development Programme).
- To develop and deliver a Self-Management Programme (SMP) to patients run by a health professional and a patient tutor.
- To support service improvement to help teams maintain self-management approaches.

The focus now for the SMPs is for them to be delivered in community settings and to adapt the SMP so that it can be delivered to groups of patients with different conditions (i.e. generic rather than condition specific). Previously courses were delivered to people with specific conditions e.g. Chronic Pain, Chronic Obstructive Pulmonary Disease (COPD), Stroke, Multiple Sclerosis (MS), Falls.

Recent SMPs have provided evidence of the positive impact that a self-management programme has. A new long term condition support group has been established and want to maintain contact and support with other people who face the same challenges. A poem from an attendee of a recent self-management programme was attached to the report, which sums up the value such a programme can have in supporting people to achieve their potential whilst living with long term conditions.

The work describes a shift in focus for supported self-management from CHFT run services to a community focus. Moving forward without a programme office is a risk to

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	the work continuing to develop and flourish. The team have supported teams to develop the way they encourage self-management. Without a consistent model to work to and co-ordination of the self-management programme there is a risk that interventions will not benefit from the experience and skill of the team and we may see significant difference in the quality of the interventions provided. The programme benefits from the lived experience of a team of experienced patient volunteers who are well supported and committed to the work and to CHFT. The programme office provides support and a sense of identity for the volunteers, which is crucial to their ongoing commitment. **OUTCOME**: The Committee received and noted the content of the report.
229/16	**CARE QUALITY COMMISSION (CQC) REPORT** Juliette Cosgrove (Assistant Director for Quality) reported on the circulated paper (Appendix D). The report focussed on the movements of individual actions in line with the 'BRAG' rating methodology. 11 actions have moved from amber to a green rating and one action has moved from a red to an amber rating. Three actions have not met the deadline for completion, and one action has not met the embedded date. The report outlined the reasons for the delays and proposed extensions and further actions. **OUTCOME**: The Quality Committee noted the report and approved the movements in the plan and supported the revised completion dates for the actions currently not delivering against the plan.
230/16	**MEDICAL DIVISION PATIENT SAFETY AND QUALITY BOARD (PSQB) REPORT** Tracy Fennell (Associate Nurse Director for Medical Division) reported on the circulated paper (Appendix E) and summarised: ▪ Peak in harms falls during Q2 (July to September) – a deep dive was carried out on areas of concern and the Falls Five plan is being rolled out and tested on high risk wards. Ward 5AD has seen a significant reduction in harm falls and further work is ongoing to ensure appropriate equipment is available in the right areas with appropriate storage. This has led to a capital bid. ▪ Winter ward – plans have led to the opening of ward 4 for shorter stay and less complex medical admissions. Quality issues are monitored on a daily basis and quality reports have been requested to Acute and divisional Patient Safety and Quality Board (PSQB) meetings to ensure concerns are sighted and addressed early. ▪ Governance – the division has reviewed its governance processes and introduced new structures to allow directorates to take ownership of key quality issues and ensures time for discussion and action on key divisional priorities. During Q2, one PSQB agenda was focussed on the CQC report and monitoring actions from the CQC action plan. ▪ Quality Deep Dive – the division is currently undertaking a deep dive into quality across all wards and areas, which resulted from some deteriorating quality markers and a reduction in harm free care scores. This has identified some divisional-wide work to be undertaken which is being monitored via monthly divisional performance meetings. ▪ Deteriorating Patient – the division is working in partnership with the surgical division to initiate tests of change to provide response to deteriorating patients. Work is being tested across ten wards across both divisions. The project is currently in its infancy and expects to be able to report during Q3 (October to December). ▪ Clinical Decisions Unit (CDU) – during Q1 (April to June), concerns were raised in relation to CDU around the awareness of admission criteria, the appropriate escalation of patients on the CDU pathway and length of stay. These issues were confirmed following a 'go see' visit by the Chief Executive and Deputy Director of Nursing in early Q2. A

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follow-up 'go see' by the Deputy Director of Nursing has confirmed that the escalation process is effective; however an additional review is being undertaken on the suitability of frail patients to the unit. This report is expected to the forthcoming CQC response group and further monitoring of this area has been requested. In addition an unannounced "go see" is planned by the Divisional Director and the Associate Director of Nursing in Q3 to ensure processes remain embedded.

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

231/16 **SURGICAL DIVISION PATIENT SAFETY AND QUALITY BOARD (PSQB) REPORT**

Julie O'Riordan (Divisional Director for Surgical Division) reported on the circulated paper (Appendix F) and summarised:

- All risks reviewed on a monthly basis
- Focus on mandatory training and appraisals
- Patient Stories – will focus on regular smaller patient experience issues
- Red and orange incidents – Three red and four orange incidents closed during Q1 (April to June 2016)
- Complaints – 48 complaints closed in Q2 and now have a process for sign-off in division.
- Infection control – 3 infections were reported in Q2 (2 C.difficile cases and one line infection)
- Staffing levels – ICU is now at full establishment on both HRI and CRH sites.
- Safety huddles - Following the work carried out with the Improvement Academy, safety huddles are established on Ward 19 and due to start on Ward 20 in November 2016.
- Compliance with NICE - The Division is compliant with all NICE clinical guidelines except NICE Guidance 38 – Fractures: non-complex fractures. The guidance states that intra-articular wrist fractures should be operated on within 72 hours and extra-articular wrist fractures operated on within 7 days. The Trust does not differentiate between the two and operates on all wrist fractures within 7 days. The Trust has declared partial compliance as this practice will continue. The Surgeons, supported by the Royal College of Orthopaedics, maintain the patient has a better outcome if operated on by the right surgeon than if operated on quickly.

  Discussion ensued on the process of annual scrutiny on non-compliant guidelines, which are justified by the clinical leads. Explanations for non- or partial compliance may include, the service not being commissioned by local commissioners, the service not being a priority by the organisation, or there is a strong body of opinion regionally that is at variance with NICE. The Clinical Commissioning Groups and the Trust are in agreement on guidelines that are non-compliant. Martin DeBono (Associate Medical Director) stated that the NICE system at Mid-Yorkshire NHS Trust will be reviewed as their system is more robust and formal and auditable than the system at CHFT.

- Compliance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) – The division is partially compliant with NCEPOD: An age old problem (2010), and working through a solution in surgical areas through frailty work.
- Fractured Neck of Femur– the division's performance remained a challenge, but has seen an improvement at the end of Q2. Year to date, time to theatre within 36 hours was 72% and Best Practice Tariff was 67%. Planning visit to Pilgrim Hospital Boston, Lincolnshire in January 2017 as their figures have improved considerably

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

232/16 **FAMILIES AND SPECIALIST SERVICES DIVISION PATIENT SAFETY AND QUALITY BOARD (PSQB) REPORT**

Martin DeBono (Divisional Director) reported on the circulated paper (Appendix G1) and summarised:

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- Risk to Acute Kidney Injury (AKI) patients requiring nephrostomy and compliance with NICE guidance – service not provided until recruitment of further vascular radiologists.
- Pathology Information Technology (IT) projects are delayed due IT resources required on the Electronic Patient Record (EPR) project.
- Antenatal Ultrasound Scanning – national guidance has changed following publication of NHS England Stillbirth care Bundle. More women are recommended to have serial scans and demand has significantly outstripped capacity al maternity units across the UK due to the shortage of sonographers. Trying to have local policy to mitigate overall risks.
- During Q2, there have been 3 Children, Women and Families (CWF) Patient Safety and Quality Board (PSQB) meetings and 2 Diagnostic and Therapeutic Services (DaTS) PSQB meetings. The separate groups are more efficient from a governance perspective. The DaTS meetings are to be re-arranged from January 2017 to a suitable time for all senior management to be in attendance.
- Radiology Magnetic Resonance Imaging (MRI) – new machine on HRI site now working and putting in bid to increase hours of use. Now running 7 days a week for routine and emergency Computerised Tomography (CT) and MRI scans.
- Pathology Quality Assurance Dashboard (PQAD) – meeting scheduled with lead to look into the best option for data collection. Agreement has been made to report to the Trust on a quarterly basis and to PBSB meetings on a monthly basis.
- Pharmacy - Internal candidate appointed to Chief Technical pharmacy stores and procurement post; stores centralisation – now in position to commence project; E-prescribing – starting to identify and work through Standard Operational Procedures (SOPs) which will be required for ERP go-live
- Maternity – new Maternity Risk Management Strategy has been published and implemented – working to improve learning and complaints.
- Children's Services - NICE National Guidance 43: Transition to Adult Services – a bi-monthly task & finish group has been initiated to discuss areas of non-compliance, terms of reference and to review the transition policy
- Children's Services – readmissions - now being reviewed quarterly and action plan being developed
- Children's Services – paediatric resuscitation equipment - action plan completed and debate ongoing with Resuscitation Committee regarding upgrading equipment following CQC recommendation.
- High risks – There are two high rated risks, one relating to blood products and pharmacy aseptic dispensing service.

A copy of the Royal College of Obstetricians and Gynaecologists (RCOG) report following a review of the maternity services at the Trust was circulated (Appendix G2). The review in July 2016 resulted in 8 key recommendations, which were summarised and will be embedded as part of the CQC recovery plan and as a joint improvement plan.

Discussion ensued on whether there are any issues with the birthing unit. It was stated that there is increased visibility of high-risk outlying women choosing to give birth at HRI. It is impossible to stop women from giving birth at HRI without deviating from the choice agenda that the 5-year maternity service strategy sets out, but women are being made aware of the risk and why they are being advised against giving birth on a stand-alone unit. Usage of the HRI birthing unit has dropped to around 300-350 patients a year; this figure used to be 500. The challenge will be decreasing both emergency and elective Caesarean Sections, as an improvement in stillbirths has not been seen. Work has been commissioned from the maternity audit team to review 10 years' worth of work to see if there is any improvement.

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

233/16 **COMMUNITY DIVISION PATIENT SAFETY AND QUALITY BOARD (PSQB) REPORT**

Diane Catlow (Associate Nurse Director) reported on the circulated paper (Appendix H) and summarised:

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- The division is committed to developing its governance framework, due to the post being vacated by the divisional governance lead in April 2016 and not being replaced. There are areas that continue not to progress; these include audit, clinical guidelines development and review of NICE guidance.
- There have been challenges during this quarter in respect of capacity and demand within services and recruitment remains an issue for some specific posts.
- The health visiting service is preparing for tender and work has begun during the quarter to look at future workforce modelling
- The decision has been made by commissioners not to reissue the Family Nurse Partnership (FNP) contract (from March 2017) and therefore the staff in this team are being supported to find re-deployment and the families affected are being managed into universal services – with robust processes in place to ensure safe transfer of care
- Serious Incident (SI) Investigations – root cause analysis and investigation reports are completed for SIs and orange graded incidents. The division continues to hold weekly orange / Pressure Ulcer panels which are supported by the Tissue Viability Nurse team. There were no grade 3 or 4 pressures ulcers attributable to the division during this quarter.
- Complaints are monitored weekly. The division handled 7 complaints throughout this quarter and continues to work hard to ensure completion within time frames. The small number of complaints reflects the work being done within the division by front line staff and managers to resolve complaints before they become formal and the division is looking at ways to capture this work. There are currently no unresolved complaints within the division.
- The Division received a CQC rating of 'good' across all areas. Since the visit, the action plan has been monitored and reviewed via the PSQB meeting. In June 2016, it was highlighted at the CQC response group that targets were in danger of slipping due to capacity within the division to deliver the outcomes. A number of 'go sees' are to be arranged.
- The division has noted that sickness levels have risen slightly and retention and recruitment of staff is creating some challenges to staffing levels, however, progress has been made within internal recruitment processes which has supported this position. Reasons for staff leaving have been scoped and the division is committed to finding ways to support staff in their roles.
- Incidents – Staff incidents have identified safety issues in homes when visiting, e.g. aggressive dogs, abusive clients, etc. and staff are vigilant to these issues and the division has supported a number of zero tolerance actions and worked on issues specific to community working.
- Friends and Family Test (FFT) – This continues to provide some challenges. The response rate has improved but there is still a gap in the numbers that would recommend. The division and its services continue to receive a high number of compliments, which will be reported on in the next quarterly report.
- NICE and national guidance – The division currently have 5 guidelines awaiting assessment, and have developed a NICE group to discuss and review guidelines, however, this has not progressed due to divisional governance lead post being vacated, as mentioned earlier. This was reported to the Clinical Effectiveness and Audit Group (CEAG) and the division is actively seeking support.
- Risk register – there are currently 16 within the division.
- Celebrating Success - The Division had several entries into the Celebrating Success event with 3 community entries shortlisted to the final judging. A 'thank you' get together has been arranged for October 2016 for all staff to attend to recognise the hard work that goes on in the division.
- It was also reported that a lot of work is being done in the division with sepsis and early identification, and there is a clinical team leader who is supporting the frailty programme. This will be included in next quarterly report.

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

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234/16	**ESTATES AND FACILITIES PATIENT SAFETY AND QUALITY BOARD (PSQB) REPORT** Lesley Hill (Executive Director) reported on the circulated paper (Appendix I) and summarised: ▪ Training – Control of Substances Hazardous to Health (COSHH) training and risk assessments complete. Engagement programme to be rolled out Trust wide and embedded within each Division. – Fire safety training being rolled out. Staff reminded that 2016/2017 is face-to-face training. – Health and Safety training combining with Risk Management and will be cascaded in 2016/2017 Support and cooperation is requested from colleagues to recognise the importance of this training. ▪ Car parking - audit completed and action plan in place to improve the car parking process. Changes are being considered to improve the patient experience at Acre Mill and improve staff parking at Calderdale. ▪ Nasogastric Tubes – A risk exists relating to training for staff on the use of this medical device. This is being progressed by Director of Nursing and has been highlighted at the Health and Safety Committee. ▪ Shared learning developed arising from incorrect use of patient bed / strapping of mattresses. Learning cascaded via Patient Safety Group. ▪ Health and Wellbeing CQUIN making progress. Vending specification due out December 2016 and updates received from relevant external food and drink providers give assurance that they will be compliant by end of March 2017. ▪ “Bring me food” continues to be a success at Calderdale with orders and deliveries of food taken to families and friends who wish to remain with their loved ones. ▪ HRI Estates trialled new IT equipment and rolled out hand-held technology to manage estates tasks. Further work being undertaken to combine “Estates and Facilities” Help Desk and promote further use of technology. Further work planned to embed Electronic Patient Record (EPR) coordination within the Estates and Facilities help desk. ▪ Concern over lack of security related training for CHFT staff which is being explored with Local Security Management Specialist (LSMS) colleagues at East Lancashire Trust. ▪ High priority Estates and Facilities business continuity plans to undergo table top exercise to determine their effectiveness in the event of an emergency. ▪ The division had five entries shortlisted to the final judging of the Celebrating Success event with the refurbishment of HRIs main theatres winning the category of ‘We do the must dos’. **OUTCOME**: The Committee received and noted the content of the report.
235/16	**QUALITY AND PERFORMANCE REPORT** Helen Barker (Chief Operating Officer) reported on the circulated paper (Appendix J) and summarised that October’s performance score is 68% for the Trust. 3 of the 6 domains improved in month with responsive just short of a green rating. Within safe, maternity had the lowest performance this financial year for its 5 Key Performance Indicators (KPIs). Caring maintained its 70% performance, and workforce peaked at 64% having achieved its overall sickness rate for the first time this year. Regulatory targets scoring red this month were due to three Clostridium Difficile cases, one avoidable Clostridium Difficile case and Emergency Care Standards (ECS) 4 hours performance scoring to 94.86% against a target of 95%. The other key targets still scoring red are:

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	▪ Summary Hospital-level Mortality Indicator (SHMI) – latest figure is 113.8 against a target of 100; ▪ Friends and Family Test (FFT) Community – reporting 85% against a target of 96% ▪ Stroke – patients admitted to a stroke ward within 4 hours and scanned within 1 hour is reporting at 70.4% against a target of 90% ▪ Complaints – the percentage of complaints closed is reporting at 38% against a target of 100% Carter Dashboard - % of harm free care and % last minute cancellations to elective surgery are scoring green. The Safer programme continues with progress in ambulatory and frailty via the collaborative groups and our own internal teams enable effective management of some of the increased demand. **OUTCOME**: The Committee received and noted the content of the report.
236/16	**MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS** ▪ Sepsis report to be presented at meeting on 1st December 2016 ▪ Deep dive on harm falls ▪ Supported self-management integrating with hospital services ▪ Concern with radiology capacity regarding Acute Kidney Injury (AKI) patients requiring nephrostomy ▪ Lack of governance lead in Community division
237/16	**QUALITY COMMITTEE WORK PLAN** A copy of the Quality Committee work plan was circulated (Appendix K) for information. **OUTCOME**: The Quality Committee received and noted the content of the work plan
238/16	**ANY OTHER BUSINESS** There was no other business.
NEXT MEETING **Tuesday, 3rd January 2017** **2:00 – 5:00 pm** **Board Room, Sub-basement** **Huddersfield Royal Infirmary**	

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APP A

Minutes of the Finance & Performance Committee held on Tuesday 29 November 2016 at 9.00am in Meeting Room 4, Acre Mill, Huddersfield Royal Infirmary

PRESENT

Helen Barker	Chief Operating Officer
Anna Basford	Director of Transformation & Partnerships
Gary Boothby	Director of Finance
Lesley Hill	Director of Planning, Performance and Esates & Facilities (in part)
Richard Hopkin	Non-Executive Director
Phil Oldfield	Non-Executive Director (Chair)
Ian Warren	Director of Workforce & Organisational Development
Jan Wilson	Non-Executive Director

IN ATTENDANCE

Kirsty Archer	Assistant Director of Finance
Stuart Baron	Assistant Director of Finance
Mandy Griffin	Interim Director of Health Informatics
Andrea McCourt	Head of Governance & Risk (in part)
Victoria Pickles	Company Secretary
Betty Sewell	PA (Minutes)

ITEM

165/16 WELCOME AND INTRODUCTIONS

The Chair welcomed Andrea McCourt to the meeting.

166/16 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
David Birkenhead – Medical Director
Brendan Brown – Director of Nursing
Andrew Haigh – Chair of the Trust
Richard Hopkin – Non-Executive Director
Brian Moore – Membership Councillor

167/16 DECLARATIONS OF INTEREST

There were no declarations of interest.

168/16 MINUTES OF THE MEETINGS HELD 1 NOVEMBER 2016

The minutes of the last meeting were approved as an accurate record subject to the following amend:-
Page 5 – EPR Highlight Report. First paragraph should include the following: "…£3m for displaced IT systems and £0.8m for currently funded roles".

169/16 MATTERS ARISING AND ACTION LOG

Action Log

Clinical Negligence Scheme for Trusts (CNST) – The Head of Governance & Risk presented a paper which had previously been received at WEB. It was noted that the report included an overview of the insurance arrangements in place with CNST

within the Trust, a summary of information on the Trust's claims position over the last 5 years with a comparison of two neighbouring trusts, information on the current position of clinical claims and premiums at Q2, 2016/17 as well as work with the Divisions to share learning from claims.

With regard to our premium for next year, it was noted that this has increased by 10% which is less than the national average, however, following discussions at WEB we will be challenging the premium and the challenge process was described. It was reported that at the West Yorkshire Director of Finance forum a representative of CNST has been asked to join the January meeting to triangulate the methodology used to calculate premiums.

It was requested that specific work with Divisions should take place to ensure rigour is in the system to help mitigate claims in the future.

It was noted that as part of shared learning between trusts there is a Risk Management Network with the next meeting taking place in December. It was agreed that a collaborative approach should be pursued by CHFT and the Director of Finance was asked to raise this at the West Yorkshire Director of Finance meeting.

It was also noted that communication to a wider audience with regard to our success in defending claims should be considered and that the policy of face to face meetings with potential claimants should be followed to help mitigate potential claims.

The following actions came from discussions:

ACTIONS:
To ensure specific work with Divisions is in place to mitigate future claims – **HB/BB**
To pursue collaborative working between DoFs and Risk colleagues regionally – **GB/AMcC**
To discuss communication/marketing to a wider audience with regard to our policy of robustly defending claims – **AMcC/VP**
To review CNST again in 6 months' time - **AMcC**

113/16: Annual Review of Contracts - The Director of Finance presented a paper which aimed to provide the Committee with an overview of the mechanisms in place which trigger annual reviews with existing suppliers and the process to be followed as part of the annual review, to drive best value for money. The recent appointment of Matt Barker, Head of Procurement was noted, it is hoped that with his skills and expertise this will be driven forward. It was also noted that as part of 17/18 CIP, procurement have been given a £1m challenge to identify cost savings.

Discussions took place with regard to the procurement work stream of the West Yorkshire Association of Acute Trusts (WYAAT) which has committed to deliver 15% efficiency over the next 5 years. As part of 'working together' a clinical product reference group is also being set up to drive better value and we will ensure CHFT has representation.

It was acknowledged that working together should provide more benefit especially with regard to value chain analysis, however, with regard to open book accounting it would require a level of confidence between all parties.

To raise awareness of spend it was noted that as part of this year's annual planning, each budget holder/manager will sign off their plan to ensure it is 'owned' at local level. It was also confirmed that as part of the Finance session for Band 7s, they will be presented with the question "What spend have they been able to influence over the last 24 hours?"

Discussions then took place with regard to WYAAT and the individual 'working together' work-steams such as Estates & Facilities, THIS and Procurement and it was acknowledged that as governance arrangements strengthen, reports from the individual groups should be more transparent. It was agreed that reporting requirements for the organisation from these work-steams should be discussed with the full Board at a Workshop Day, it was also agreed that the Company Secretary should report back to the Finance & Performance Committee with regard to the progress of the Committee in Common.

ACTION: To report back to F&P with an update on the progress of the Committee in Common – **VP**
To schedule discussions at a Board Workshop day - **VP**

Matters Arising
No matters to discuss.

FINANCE AND PERFORMANCE

170/16 MONTH 7 FINANCE REPORT
The Assistant Director of Finance, Kirsty Archer, took the Committee through the Finance Report for Month 7, the following headlines were noted:
YTD

- The I&E position remains slightly ahead of plan with a favourable variance of £0.13m against a planned deficit of £11.13m.
- Driven by continued activity and, therefore income over-performance
- CIP is also over-performing which is also supporting the overall position.
- Planned reserves of £1m have been held back to mitigate against pressures in the latter part of the year.
- Cash balance is above plan at £2.62m this is due to receiving Learning & Development Agreement (LDA) income in advance of the anticipated timescale.
- Aged Debt position has increased but this is purely down to timing issues.
- Capital is in line with the forecast by year-end, however, there is a different profile of expenditure.
- Overall forecast position remains at £16.1m deficit, in line with the Control Total, excluding exceptional costs.

In terms of November, the Director of Transformation & Partnerships reported that with regard to activity we are still seeing an over-recovery of income based on the latest information. Operationally, the Director of Operations reported that from a

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non-elective perspective we are experiencing outflow pressures with our external providers. Work across the system with regard to excess bed day costs and income has taken place and agreement from the Chief Finance Officers has been received to do something different. With regard to Medicine, their length of stay reduction is doing well with a positive downward trend. Following the Surgical PRM, work to triangulate their activity profile, length of stay and bed utilisation will take place.

In terms of Workforce, the Director of Workforce & Organisational Development reported that agency is still a challenge and as part of divisional PRMs this is being micro-managed. The bigger challenge will be next year when trajectories reduce even further.

A question was raised about outpatient follow ups to first appointment and it was confirmed that a robust benchmarking exercise has taken place and Helen Barker confirmed she would share the presentation. It was also noted that a concerted effort to clear the follow up back log of patients waiting over 3 months for their follow up appointment has also taken place.

ACTION: To share benchmarking information with regard to outpatient follow ups to first appointment for next meeting – **HB**

171/16 FINANCIAL FORECAST AND RECOVERY PLANS AT MONTH 7

The Director of Finance introduced the paper which had already been seen by the majority of attendees at different forums prior to this meeting. In summary, the paper highlighted that against the original plan where we needed to identify £2m schemes to get us to the £16.1m deficit, we now need £1.3m worth of schemes to allow us to hit forecast. Work is progressing on the schemes identified, there are still risks and challenges, but we are in a stronger position to hit forecast.

In addition to the report included in the papers, the Director of Finance presented slides which provided information with regard to our expectations to achieve the forecast in the last 5 months of the year. The presentation which would be circulated following the meeting, was received by the Committee, it was acknowledged that there are still risks but the presentation gave clarity in terms of seeing the trends.

It was confirmed that the forecast assumes no Accelerator Zone income and no extra costs involved in delivering that funding, it also assumes full CIP delivery.

STRATEGIC ITEMS

172/16 CIP UPDATE

The Chief Executive reported that year to date we are delivering against plan. It was noted that one significant risk is the Change Control Notice (CCN) for EPR. With regard to the SAFER programme, there is an issue with Surgery and a STAR Chamber may take place. It was also noted that there had been an exercise around the 17/18 pipeline where Executive Sponsors had reviewed 10/12 schemes to test the robustness to get to a notional timeline with schemes to be at gateway by the end of the month. Confidence levels vary between schemes and the challenge is to ensure the SAFER programme does not slip and to ensure work continues on the 17/18 schemes to try to activate before 1 April 2017.

As a note of caution the Director of Transformation & Partnerships highlighted that although we have pipeline schemes of £17m further ideas would be required due to the fluctuation of values. It was noted that schemes are harder to find due to our rigour.

It was also noted that Commissioners have QIPP proposals for 17/18 which could be beneficial for us to take out costs. With regard to Income CIP, there is no contract income included within our £17m CIP. Following in depth discussions it was suggested that we should update the chart on page 21 of the Strategic Plan to include the actual position.

ACTION: To update the chart on page 21 of the Strategic Plan 'Comparison between Trust and Commissioners' income forecasts' to include the actual position – **GB/KA**

The Committee noted the CIP challenges for next year and the issues relating to Commissioners.

173/16 EPR

The Director of Health Informatics gave an update with regard to the current position of EPR and it was noted that there is a change in the go-live date from March to May 2017. The evidence for the three areas on the critical path so far shows that we have met all the criteria required with regard to e-prescribing to achieve a March go-live, however, due to lack of resourcing, Order Comms, will not hit the March go-live, Data Migration has shown excellent results on most criteria with the exception of e-referrals and out of slot. Trial load 3 highlighted that we are victims of our own success and the Cerner tool used cannot cope with the volume of e-referrals. Mandy confirmed that technically we would be ready for an April go-live and this will be put to the Transformation Board.

The risk areas around training have been mitigated and Broad Lea House will be used as a training hub with additional training to be held within the Trust.

Operational readiness is progressing well and once a go-live date has been decided this will be accelerated. The change in go-live date from March will have an impact on the timing of the revenue costs associated with the EPR deployment. The Trust has previously communicated a potential £5m cost in 2016/17 to support the go-live date, this was described as costs being in excess of the Trusts control total. The delay in go-live date will move these costs into 2017/18 and whilst this has been reported to NHSI, approval has not been received by the Trust. Liaison continues with NHSI through the PRM meetings.

Discussions took place with regard to the accounting treatment of costs within the EPR programme in relation to differing go-live dates across the two organisations with views to be sought from KPMG as to acceptable methodology to be adopted. The slippage in the programme was noted and it was agreed that a reivew of the project should be undertaken to update the business case financials and lessons learned.

The Assistant Director of Finance, Stuart Baron, reported on the financial forecast and it was highlighted that as this paper goes to the Transformation Board where Cerner are in attendance, it was noted that this report excludes any reference to any penalty costs associated with Cerner. The report is based on a March go-live date and the capital overspend against the original business case now stands at a £4.3m adverse variance, this excludes an estimate of penalties that Cerner may seek to recover. The internal capital plan has been re-planned to accommodate costs forecast costs including estimated penalties. The risk remains within the project to achieve a go-live in April/May and operational plans are being revised to support the planned go-live date. It was also noted that within the original business case it was assumed that we would be liable to pay VAT on agency costs following guidance from the Trusts VAT advisor, this is still the case and remains under review with HMRC.

Stuart described that the split of the go-live dates between CHFT and BTHFT had created an accounting challenge to ensure that CHFT are able to capitalise the costs associated with the project. A proposal has been made to BTHFT to mitigate this risk, though this would require agreement with the Trusts external auditors.

The following actions came out of EPR discussions:-
ACTIONS:

- A governance review with regard to the slippage of the go-live date will be reviewed by the Committee in January.
- A pre go-live baseline review and updated business case review looking at benefits and benefit realisation – **PO/GB to discuss the timing**
- A post- go-live review 6 months after go-live –**MG**
- An update of accounting treatment with KPMG for the next meeting – **SB**
- To get agreement with Bradford with regard to a governance point of view.

GOVERNANCE

174/16 INTEGRATED PERFORMANCE REPORT

The Chief Operating Officer reported the key points from a finance and performance perspective as follows:-

- The overall performance score for October is 68% with no 'reds' or 'greens'.
- Financially we are reporting £12.9k contractual penalties and sanctions
- Emergency Care Standard slightly under trajectory, still within the 1% and securing STF, the rest of the indicators are on line.
- Carter dashboard – length of stay better than target, green cross patients are in excess of 100 and sickness and absence has improved further in month, however, vacancies are a deterioration and this has been discussed at WEB and Workforce (Well Led) Committee.
- Endoscopy – to triangulate better with Divisions in terms of their assumptions and this will be picked up during the post-PRM process.
- Safety positive outcomes to focus on ambulatory.
- Community Place pilot scheme is coming on line on the 12 December, however, patients will remain on PAS for the rest of this year.

- Surgery SAFER programme, the assumption is that this will not go-live until 1 January 2017 as a result the Division have been asked to look at alternative ways to cover the financial impact.
- Divisional workshops have been arranged for next week to look at ward configuration, these workshops will be led by Brendan Brown, Lesley Hill and Helen Barker.
- Stroke, the IPR is reporting a better position this month. Work has taken place with Medicine to understand how they can achieve and sustain National Audit Data at a 'B'.
- CQUIN – 3 key areas of concern are:
    1. Flu
    2. Sepsis
    3. Antimicrobial Resistance
- Duty of Candour is being reviewed as part of the weekly Performance Review, still a lack of robustness within the Divisions and some Corporate functions and it is hoped with the weekly review a better position will be achieved.
- Fast-Track Referrals have been on an increase all year and the challenge is our diagnostics which is driving pressure around pathology and radiology.

It was noted that the FSRR risk rating is being used within the IPR and not the Use of Resources (UOR) risk rating, it was agreed that Kirsty Archer would provide some narrative to Peter Keogh so that an explanation can be put on the Trust website.

The Committee noted the contents of the report.

175/16 ANNUAL PLAN UPDATE

The Director of Finance shared with the Committee a presentation of the overview of the Draft Financial Plan submitted last week, the final version is due to be submitted prior to Christmas. The key messages were highlighted and the income and expenditure bridge for 2016/17 and 2017/18 were detailed and discussed along with the pressures and developments and planning assumptions. The capital plan highlighted the large increase over the next 2 years for the 'Built Environment' which is in line with the Full Business Case (FBC) at this stage, the key elements within the capital plans for 17/18 is the allocation of £2m for the development of the FBC and £2m for the EPR Programme.

It was noted that work continues with the Commissioners with regard to our Contract income and it was also noted that we have to decide by the 5 December if we are likely to require Contract Mediation which is due to start prior to Christmas.

The Director of Transformation and Partnerships commented that all elements of the plan are challenging and the achievement of £17m CIP was a particular challenge and this was acknowledged by the Chair.

The Committee received and noted the contents of the presentation.

176/16 MONTH 7 COMMENTARY TO NHS IMPROVEMENT

The Committee received the paper which provides the Management Commentary on the financial position of the Trust at the end of October 2016 which has been

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submitted to NHS I. It was noted that the external reported value at the end of the month differs from the internal reported value due to the timing of the STF.

The Committee noted the contents.

177/16 WORK PLAN

The Work Plan was received and noted by the Committee.

178/16 MATTERS FOR THE BOARD AND OTHER COMMITTEES

The Chair of the Committee highlighted the following items:-

- CNST presentation
- Procurement annual review contracts
- SAFER Programme delivery for CIP
- Issue with level of QIPP with Commissioners
- EPR – Private session
    - Governance Review
    - Re-stated Business Case before go-live
    - EPR 6 month review
    - Bradford agreement
- IPR on track
- Annual Plan – private session

179/16 ANY OTHER BUSINESS

The Chief Executive thanked financial colleagues for their input into the meeting.

DATE AND TIME OF NEXT MEETING

Tuesday 3 January 2017, 9.00am – 12.00noon, Meeting Room 4, Acre Mill Outpatients building.

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CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

Minutes of the WORKFORCE (WELL LED) COMMITTEE held on Thursday 8 December 2016, 1.00pm – 3.00pm in Syndicate Room 1, Learning and Development Centre, Calderdale Royal Hospital.

PRESENT:	
Brendan Brown	Executive Director of Nursing
Jason Eddleston	Deputy Director of Workforce and Organisational Development
Karen Heaton	Non-Executive Director (Chair)
Ian Warren	Director of Workforce and Organisational Development
Jan Wilson	Non-Executive Director
IN ATTENDANCE:	
Mark Borrington	Programme Manager – Safer Staffing Workforce Utilisation and Efficiency
Chris Burton	Staff Side Chair
Lois Mellor	Senior Clinical Midwifery Manager (Matron)
Tracy Rushworth	Personal Assistant, Workforce and Organisational Development
Claire Wilson	Assistant Director of Human Resources

84/16	**WELCOME AND INTRODUCTIONS:** The Chair welcomed members to the meeting.
85/16	**APOLOGIES FOR ABSENCE:** Helen Barker, Chief Operating Officer David Birkenhead, Medical Director Gary Boothby, Director of Finance Rosemary Hedges, Membership Councillor Anne-Marie Henshaw, Associate Director of Nursing, Families and Specialist Services Andy Lockey, Director of Medical Education Vicky Pickles, Company Secretary Kristina Rutherford, Director of Operations, Surgery and Anaesthetics Ashwin Verma, Divisional Director, Medical
86/16	**DECLARATION OF INTERESTS:** No declarations of interest were received.
87/16	**MINUTES OF MEETING HELD ON 19 OCTOBER 2016:** The minutes of the meeting held on 19 October 2016 were approved as a true record.

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88/16	**ACTION LOG (items due this month)** <u>Workforce Plan</u> Develop 12 workforce plan for each metric. **ACTION:** IW/ <u>Draft Workforce Strategy</u> See item 89/16 **ACTION:** IW <u>Terms of Reference and Structure</u> See item 93/16 **ACTION:** IW Share governance reporting structure with Committee **ACTION:** VP <u>Workforce (Well Led) Committee Workplan</u> Reshape workplan to align to Workforce Strategy **ACTION:** IW/JE <u>Workforce Monthly Trust Report</u> See item 93/16 and 97/16 **ACTION:** IW <u>Recruitment Improvement Plan</u> See item 95/16 **ACTION**: JE <u>Summary Sheet for all Committee papers</u> <u>Use of BoardPad for Committee papers</u> **ACTION:** TR
	MAIN AGENDA ITEMS
	FOR DECISION
89/16	**WORKFORCE STRATEGY** IW confirmed the Workforce Strategy had been shared with the Executive Board and the Committee in November 2016 for comment and feedback. IW had received positive feedback and constructive comments which had been incorporated into the document ahead of its circulation with December 2016 Committee papers. IW advised there was some revision to be made to the appendix 'Plan on a Page' so that it better aligned to the Strategy. The Workforce Strategy will be submitted to the January 2017 Board of Directors meeting with the recommendation of its approval. Ian wished to thank those involved in the development of the Workforce Strategy.

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	ACTION: IW to make revision to 'Plan on a Page' appendix. IW to submit the Workforce Strategy to January 2017 Board of Directors. **OUTCOME:** The Committee **RECEIVED** and **APPROVED** the Workforce Strategy.
90/16	**WORKFORCE (WELL LED) COMMITTEE TERMS OF REFERENCE** IW and VP had updated the Committee terms of reference in line with the Workforce Strategy. The Committee agreed the following amendments be incorporated into the terms of reference:- Job titles to be referenced (not individual names) front cover Executive Board approve and ratify workforce policies (4.1.7) Membership to include Staff Side (5.1) Members unable to attend to nominate a deputy who can decision make (5.5) The Committee will meet every month (this will be reviewed annually) (6) Include assurance of effective management of Flexible Workforce Subject to these amendments the Committee agreed to approve the terms of reference. **ACTION:** IW/VP to finalise Terms of Reference **OUTCOME:** The Committee **RECEIVED** and **APPROVED** the Terms of Reference.
91/16	**WORKFORCE (WELL LED) COMMITTEE SUB GROUPS AND TERMS OF REFERENCE** IW outlined a Committee sub structure which will align to key areas of the Trust's five year strategy. The sub structure comprises of 5 sub groups:- • Colleague Engagement, Health and Wellbeing Group • Education and Learning Group (*Future Workforce Group) • Medical Workforce Group • Nursing Workforce Group • *Workforce Programme Board IW advised that some of these groups* were yet to be established. The Committee agreed the terms of reference for each group should be reviewed in line with the Trust's Five Year Strategy and the Workforce Strategy. BB raised a suggestion that Allied Health Professionals be considered as a separate group. It was agreed that this group would be represented by the nursing workforce group. **ACTION:** IW/JE to progress establishment of sub groups and develop terms of reference. JE to liaise with existing group Chairs regarding review of terms of reference. **OUTCOME:** The Committee **RECEIVED** and **APPROVED** the sub structure.

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92/16	**WORKFORCE (WELL LED) COMMITTEE WORKPLAN 2016/2017** The Committee's Work Plan had been refreshed to reflect the Trust's Five Year Strategy and the Workforce Strategy. The Committee considered and approved the content of the Work Plan and agreed that this would need to remain under review as progress was made against the implementation of the Workforce Strategy. **OUTCOME:** The Committee **RECEIVED** and **APPROVED** the Work Plan.
93/16	**WORKFORCE PERFORMANCE REPORT – STRUCTURE AND FORMAT** CW outlined the format of the report which had been refreshed to show a more pictorial view of key workforce metrics. The Committee agreed structure and format of the report is much improved and more aligned to the delivery of the Workforce Strategy. The Committee agreed further amendments to the report:- 1. The report narrative needs to identify key themes and address the 'sort what' question. 2. Trajectories are needed for each KPI with actions to deliver targets (including past performance to aid identification of annual trends). 3. The employee engagement narrative should reflect what's happening in the organisation – for example, staff survey actions rather than communication to employees. 4. A glossary of terms should be provided. **ACTION:** IW to progress required amendments. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the Report.
	FOR ASSURANCE
94/16	**NHSI IMPROVEMENT SMART PLAN - UPDATE** MB attended the Committee meeting to provide an update on progress of the NHSI Improvement Smart Plan. MB reported that the key milestones appear on track but noted the need to monitor progress ahead of the baseline finish date. The Committee felt the rag rating colour system was confusing. MB advised this is based on NHSI's system but he would build in a number system for future clarification. The Committee agreed that where there are indications of Divisions being off trajectory, Divisional leads should be invited to attend a Committee meeting to update on the position and discuss the measures in place and the support required to get back on track. **ACTION:** MB to incorporate numbers into the RAG rating system. MB to provide monthly update report to the Committee.

	OUTCOME: The Committee **RECEIVED** and **NOTED** the report.
95/16	**RECRUITMENT PLAN** RP updated the group on the progress made following the 64 recommendations made by Stepchange. The key points of change being:- • Review of team structure • Training of team • Introduction of recruitment tracker • Establish KPIs • Improved process with Occupational Health • Use of NHS Jobs • Conditional and Unconditional offer letter Implementation of these changes has resulted in the reduction of the average time to hire of 21.6 weeks (December 2015) to 13.5 weeks currently. Both figures are inclusive of notice periods. RP confirmed that a follow up Stepchange review is to be commissioned to take place in March 2017. The Committee acknowledged the excellent progress the team had made and invited RP to give a further update to the Committee in 6 months' time. LM reported that the improvements had been noted in the FSS Division. This was important feedback for those involved. IW explained that vacancies are submitted to the Trust's weekly Vacancy Control Panel for approval before being made immediately available for the Resourcing Team to commence the advertisement process. IW and BB agreed to meet to explore how the first steps of the vacancy process can be expedited within the Divisions. KH requested information on the Trust pay scales and job roles to better understand the Trust's workforce. JW gave positive feedback on the style and content of the recent consultant advertisements which were published in the BMJ. The Committee asked for the advertisement to be shared with them. **ACTION:** TR to invite RP to June 2017 Committee meeting for progress update. TR to provide the Committee with a copy of the Consultant advertisements. TR schedule meeting for IW/BB to meet to discuss the vacancy process within the Divisions. TR to provide KH with job role and pay scale information. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the update.

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96/16	**WORKFORCE PLANNING** JE outlined the two elements of the workforce planning activity:- NHSI Annual Plan Submission Divisional workforce plans collated to create a Trust wide position which was reported to NHSI on 24 November 2016. Further work is required in the divisions ahead of the final submission deadline of 23 December 2016. Workforce Planning Capability Workforce plans continue to develop. Workforce and Organisational Development Team progressing developmental work to build capability to deliver effective workforce planning. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
	PERFORMANCE
97/16	**WORKFORCE PERFORMANCE REPORT (NOVEMBER 2016)** The content of the report was discussed and noted:- Sickness absence targets should align to the Workforce Strategy and not be within a range. IW wished to record the achievement of the Attendance Management Team in reducing the sickness absence levels across the Trust. Medical Appraisals – now being recorded on ESR will allow historic data going forward. Medical Appraisal profiler now established. Mandatory Training Compliance - Business case for replacement learning management systems approved. CW reported Electronic Staff Record learning management system is being procured with an estimated ‘go live’ date of August 2017. **ACTION:** The Committee agreed to identify dates to undertake a deep dive of specific areas to be included in the committee’s work plan. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
	INFORMATION
98/16	**2015 WORKFORCE RACE EQUALITY SCHEME (WRES)/STAFF SURVEY ACTION PLAN** JE reported that following the circulation of the action plan it had since been updated ahead of the BME network scheduled to meet on 13 December 2016. JW noted a concern that there may be a risk that the combined wider action plan could cut across the specific BME elements of the action plan. The Committee agreed the actions should be retained separately. **ACTION:** JE to identify separately the BME actions. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the action plan.

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99/16	**ANNUAL PLAN UPDATE** IW gave a brief verbal update. IW confirmed the key deadline for completion of final plans is 23 December 2016. The Committee agreed Finance should be invited to the February 2017 meeting to provide a detailed update. **ACTION:** TR to add Annual Plan Update to the February 2017 agenda. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
	ITEMS TO RECEIVE AND NOTE
100/16	**2017 MEETING DATES** The 2017 meeting dates were circulated for inclusion in calendars.
101/16	**ANY OTHER BUSINESS:** **1.** **2.** **Action:**
102/16	**MATTERS FOR ESCALATION:** There were no matters identified for escalation to the Board of Directors
DATE AND TIME OF NEXT MEETING: Thursday, 19 January 2017, 2.00pm – 4.00pm, Room 3, 3rd Floor, Acre Mill Outpatients, Huddersfield.	

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MINUTES OF THE FOUNDATION TRUST COUNCIL MEMBERS MEETING HELD ON WENESDAY 9 NOVEMBER 2016 IN THE BOARDROOM, SUB-BASEMENT, HUDDERSFIELD ROYAL INFIRMARY

PRESENT:

Andrew Haigh	Chair
Rosemary Hedges	Public elected – Constituency 1
Veronica Maher	Public elected – Constituency 2
Peter Middleton	Public elected – Constituency 3
Dianne Hughes	Public elected – Constituency 3
Nasim Banu Esmail	Public elected – Constituency 4
Stephen Baines	Public elected – Constituency 5
George Richardson	Public elected – Constituency 5
Annette Bell	Public elected – Constituency 6
Kate Wileman	Public elected – Constituency 7
Lynn Moore	Public elected – Constituency 7
Brian Moore	Public elected – Constituency 8
Michelle Rich	Public elected – Constituency 8
Charlie Crabtree	Staff-elected – Constituency 13
Bob Metcalfe	Nominated Stakeholder - Calderdale Metropolitan Council
Cath O'Halloran	Nominated Stakeholder - University of Huddersfield

IN ATTENDANCE:

Dr David Anderson	Non-Executive Director/SINED
Helen Barker	Chief Operating Officer
David Birkenhead	Executive Medical Director
Gary Boothby	Executive Director of Finance
Kathy Bray	Board Secretary
Brendan Brown	Executive Director of Nursing
Ruth Mason	Associate Director of Engagement & Inclusion
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities
Victoria Pickles	Company Secretary
Jan Wilson	Non-Executive Director/Deputy Chair - Trust
Martin Debono	Consultant Gynaecologist/Obstetrician (for part of meeting – item 6)
Michael George	Internal Audit Manager (for part of meeting – item 6)
Terry Matthews	Clinical Governance Support Manager (for part of meeting – item 6)
Bev Walker	Associate Director for Urgent Care (for part of meeting – item 20)
Dr Sarah Hoye	Consultant – Acute Medicine (for part of meeting – item 20)
Rachel Rae	Lead Matron for Discharges (for part of meeting – item 20)
Hannah Wood	Physiotherapist – Support and Independent Team (for part of meeting – item 20)

65/16 APOLOGIES:

Apologies for absence were received from:

Di Wharmby	Public elected – Constituency 1
Grenville Horsfall	Public elected – Constituency 4 (Reserve Register)
Brian Richardson	Public elected – Constituency 6
Mary Kiely	Staff-elected – Constituency 9

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Nicola Sheehan	Staff-elected – Constituency 10
Eileen Hamer	Staff-elected – Constituency 11
Linda Salmons	Staff-elected – Constituency 12
David Longstaff	Nominated Stakeholder – Clinical Commissioning Group
Dawn Stephenson	Nominated Stakeholder – SWYPFT
Carole Pattison	Nominated Stakeholder – Kirklees Metropolitan Council
Sharon Lowrie	Nominated Stakeholder – Locala
Anna Basford	Director of Transformation and Partnerships
Mandy Griffin	Director of The Health Informatics Service
Linda Patterson	Non-Executive Director
Owen Williams	Chief Executive

The Chair welcomed everyone to the meeting and particularly the number of recently appointed Membership Councillors.

66/16 DECLARATION OF INTERESTS

There were no declarations of interest at the meeting.

67/16 MINUTES OF THE LAST MEETING – 6 JULY 2016

The minutes of the last meeting held on 6 July 2016 were approved as an accurate record.

68/16 MATTERS ARISING

56/16 – WALKABOUT – Peter Middleton thanked the Trust for a very informative tour and asked that the Membership Council acknowledge the under-utilisation of the Birthing Centre at Huddersfield Royal Infirmary (HRI). Martin Debono reported that the Division acknowledged this under-utilisation and were looking at a number of initiatives to attract women with low risk pregnancies to the Huddersfield Birthing Centre.

47/16 - CONSTITUTIONAL AMENDMENTS

The Company Secretary reported that since the last Membership Council meeting two issues had arisen which required further clarity as the impact of these may mean further changes to the Constitution. The issues identified were the impact of the development of a Committee in Common across the West Yorkshire Association of Acute Trusts (WYAAT) and secondly the consultation being undertaken by NHS England on standardising all Trust declarations of interests from staff.

ACTION/OUTCOME: It was agreed that further information would be brought to the Membership Council Meeting on 17 January 2017.

All other matters arising were included within the agenda.

69/16 RESULTS OF THE AUDIT ON CLINICAL AUDIT

Martin Debono, Consultant, Michael George, Internal Audit Manager and Terry Matthews, Clinical Governance Support Manager attended the meeting to present the Internal Audit report undertaken on the Clinical Audit Department processes and the progress to date on the recommendations. Mr Debono reported that the final report would be presented to the Executive Board in January.

Michael George explained the content of the report. It was noted that the audit had found that the processes of the clinical audit department were effective and some recommendations had been made to enhance these processes.

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Terry Matthews outlined the range of audit work undertaken by the team. She highlighted that the recommended enhancements would systematise aspects of the approach to increase the assurance that clinical audit activity provides assurance in itself, is necessary and drives improvement. It was noted that the action plan had been produced to address the recommendations from the report and this was being monitored through the Clinical Audit Group.

Peter Middleton thanked the team for their enthusiastic and helpful presentation which gave assurance to the Membership Council that the output of the clinical audit team would be cascaded throughout the organisation and lead to more effective and efficient patient care. He suggested that the Divisional Reference Group (DRG) Chairs might wish to put clinical audit work on their future DRG agendas.

Discussion took place regarding the number of colleagues within clinical audit and the increasing workflow. Cath O'Halloran advised that there were a number of students at Huddersfield University who may be able to help the clinical audit team and this would also benefit the students in undertaking their third-year projects. Terry Matthews agreed to follow this up with the University.

70/16 CHAIR'S REPORT

The Chair reported that there had been a number of important issues discussed in the private session including:

- Update on issues discussed in the Private Board of Directors Meeting over the past 3 months.
- West Yorkshire Sustainability and Transformation Plan
- Resignation of Executive Director of Finance (Keith Griffiths) and appointment of Gary Boothby in the interim.

CONSTITUTION

71/16 MEMBERSHIP COUNCIL REGISTER

The updated register of members as at 22 September 2016 was received.

OUTCOME: The Membership Council approved the updated Register.

7216 REGISTER OF INTERESTS/DECLARATION OF INTERESTS

The updated Register of Interests/Declarations was received. Any amendments were requested to be notified to the Board Secretary as soon as possible. It was requested that the Board Secretary remind the members with outstanding declarations:- David Longstaff, Sharon Lowrie, Carole Pattison to complete and return their Declarations as soon as possible.

OUTCOME: All Membership Councillors present approved the Register of Interests.

ACTION: BOARD SECRETARY

73/16 STRATEGIC PLAN & QUALITY PRIORITIES 2016-17 UPDATE

In order to allow the Company Secretary to attend another meeting later that evening, the Chairman confirmed that this item would be moved up the agenda.

73/16a CONSULTATION UPDATE

The Chair and Company Secretary formally advised those present that the CCG had met on the 20 October 2016 and a decision made to progress to a full business case. It was noted that the Joint Overview and Scrutiny Committee (JOSC) feedback had contained 19

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recommendations, some of which could not be addressed until the full business case had been developed. It was noted that the Trust would be seeking external support to develop the business case.

The Chair advised that progress could be impacted by two issues:
- The JOSC could refer the decision to the Secretary of State for an independent review.
- The JOSC or another party could refer the decision for a judicial review on a matter of process.

The Company Secretary clarified that there was a set time limit for making a referral for judicial review of three months from the decision. There was no clear time limit on referral to the Secretary of State from the JOSC, however it would need to be within a reasonable timescale.

It was noted that discussions to allay concerns were taking place with the CCGs and the Huddersfield Local Medical Committee. A meeting between representatives of the Huddersfield LMC and Trust representatives was scheduled for Wednesday 16 November 2016.

OUTCOME: The Membership Council received the update.

73/16b CQC INSPECTION

The Executive Director of Nursing reported that the CQC Inspection had taken place in March 2016 and the report had been published in August 2016. A Quality Summit had taken place in October with representatives from CHFT, NHS Improvement, NHS England and members of the JOSC present, at which the CQC Action Plan had been approved. It was noted that the Action Plan had robust governance arrangements and actions could only be signed off following sight of clear evidence and independent testing that actions were implemented and embedded. It was noted that invitations had been extended and accepted by members of the CQC and Overview and Scrutiny Committee colleagues to have informal visits of the Trust to give assurance that actions were being undertaken. It was agreed that the rag-rated Action Plan which was being overseen by the Quality Committee would be shared with the Membership Council at the meeting on 17 January 2017.

OUTCOME: The Membership Council received the update.

ACTION: AGENDA ITEM 17.1.17 MC MEETING

73/16c UPDATE ON OVERALL STRATEGIC PLAN

The Company Secretary reminded those present of the 16 key issues to deliver within the Strategic Plan. It was noted that this had been shared with the Membership Council earlier in the year when a number of questions had been raised.

Arrangements were in hand to discuss the progress of the Strategic Plan at the MC/BOD Workshop to be held on the 16 November 2016 but the current progress was noted:-
- 0 – Red
- 11 – Amber – on track to deliver
- 5 - Green/Amber – underway
- 0 - Green – but this was expected so early in the year.

OUTCOME: The Membership Council received the update.

ACTION: AGENDA ITEM MC/BOD WORKSHOP – 16.11.16

73/16d WYAAT/STP

The Chair reported that the Membership Councillors present at the private session had discussed the impact on the Trust of the West Yorkshire Associate of Acute Trusts and the Sustainability and Transformation Plan.

73/16e QUALITY PRIORITIES UPDATE

The Executive Director of Nursing advised that work continued within the Trust on the five key quality priorities:-

- Safety
- Effective
- Experience
- Responsive
- Well Led

He highlighted that work continued to reduce falls through the Safety Bundles and the Hospital at Night programme which was in place at Calderdale Royal Hospital (CRH) and was to be rolled out to HRI in December. This used the 'Nervecentre system' to ensure deteriorating patients are cared for by the appropriate clinical staff immediately once deterioration is identified by the system. Community teams continued to measure real live information and getting feedback from patients.

OUTCOME: The Membership Council received the update.

74/16 UPDATE FROM BOARD SUB COMMITTEES

74/16a – AUDIT AND RISK COMMITTEE

Peter Middleton reported that the Audit and Risk Committee were progressing well. It was noted that where concerns regarding follow-up internal audit reports are highlighted, the lead personnel are being asked to give a presentation to the Committee. To date there had been two 'deep-dives' on Medical Devices and Payroll.

74/16b – ELECTRONIC PATIENT RECORD

Brian Moore reported that the 'Go Live' date for implementation of the EPR system had been deferred due to delays in migration of data. It was now proposed that CHFT would go live in March/May 2017 and Bradford some time during July 2017.

74/16c – FINANCE AND PERFORMANCE COMMITTEE

Brian Moore gave a brief update on the financial position which on a year to date position was favourable. It was noted that this would be discussed later in the meeting under the Trust Performance item to be presented by the Executive Director of Finance.

74/16d - QUALITY COMMITTEE

The Executive Director of Nursing reported that the Committee had focused on the CQC Inspection, information and complaints and how the Trust can move from the complaints figures to real and compassionate responses to patients and relatives.

74/16e – CHARITABLE FUNDS COMMITTEE

The Chairman reported that the Charitable Fund Committee was looking to become more of a fund raising environment. Discussions were taking place with two providers to explore the opportunities of a cash lottery system. Work was also underway with the University of Huddersfield undergraduates in the Business School exploring the opportunities of helping the Trust fund raising.

It was noted that work continued with the Calderdale Community Foundation regarding the allocation of charitable funds from the Abraham Ormerod funds which had been A significant donation had been made to the flood relief programme to help residents with the recent flooding.

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74/16f – WORKFORCE WELL-LED COMMITTEE
Rosemary Hedges reported on the key issues being discussed within the newly formed Workforce Committee:-

- Development of Workforce Strategy – to be signed off by the Board of Directors in January
- Review of Committee Terms of Reference
- Review of risk register and NHS Improvement submission regarding use of agency staff
- Reductions in absence with the implementation of Attendance Management Team
- Both vacancies and turnover had been reduced.

74/16g – NOMINATION AND REMUNERATION COMMITTEE MINUTES – 21.7.16 & 18.10.16
At this point the Chair left the meeting and Peter Middleton took over to chair the first part of this item. He updated the Membership Council regarding the matters discussed at the two Nomination and Remuneration Committees held this year and sought the ratification from the Membership Council on the decisions agreed.

- Following discussion by the Chair with Phil Oldfield and Dr Patterson regarding availability, the Committee approved the extension of both Non-Executive Director tenures to continue until 22 and 30 September 2018 respectively. At the meeting on the 18 October the Chair confirmed that both had confirmed their availability to continue their three-year tenures in the foreseeable future.

OUTCOME: The Membership Council ratified the decision of the Nomination and Remuneration Committee

- The Committee agreed that due to the challenges facing the Trust over the next 12 months that the offer of a further one-year tenure be made to Andrew Haigh, effective from July 2017.

OUTCOME: The Membership Council ratified the decision of the Nomination and Remuneration Committee

At this point the Chair returned to the meeting and he reported that.

- The Committee had agreed to defer the decision regarding the three Non-Executive Director tenures until the next meeting to be held in March 2017, but in order to maintain continuity and stability during a time of considerable challenge for the Trust it was agreed that a minimum of one Non- Executive Director would be recommended to roll over for a further 12 month period.

OUTCOME: The Membership Council ratified the decision of the Nomination and Remuneration Committee

OUTCOME: The Membership Council received and noted the updates from the Board sub committees.

75/16 ALLOCATION OF MEMBERSHIP COUNCILLORS TO SUB COMMITTEES/GROUPS
The Associate Director of Engagement and Inclusion presented the paper. She explained that as part of the governance and holding to account responsibility of Membership Councillors our Staff and publicly elected Membership Councillors work with Trust colleagues through

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involvement on Divisional Reference Group and Sub-Committees of the Board and the Membership Council.

All present received the allocations contained within the paper which were effective from 1 November 2016. Opportunity was taken to thank the Membership Councillors for the help and challenge they gave the Trust.

OUTCOME: The Membership Council received the report.

76/16 TRUST PERFORMANCE

a. Integrated Performance Report (IPR)

The Chief Operating Officer gave an overview of the key themes from the September IPR and the information was noted. It was reported that this was a new style shorter report prepared for the Board, but the full report was available on request. Discussion took place regarding the calculations used in developing the information and it was agreed that the Chief Operating Officer would circulate this to the Membership Council for information.

ACTION: CHIEF OPERATING OFFICER

b. Month 6 – September 2016 Finance Report

The Executive Director of Finance presented the finance month 6 report as at the 30 September 2016.
The key issues included:-

Summary Year to Date:

- The year to date deficit is £9.67m versus a planned deficit of £9.74m
- Year to date Elective activity remains behind plan but is offset by higher than planned Outpatient, A&E and Day Case activity.
- Capital expenditure year to date is £7.98m against a planned £11.82m.
- Cash balance is above plan at £2.95m against a planned £1.94m.
- The Trust has drawn down loans earlier than planned. The total loan balance is £57.93m against a planned £50.13m
- CIP schemes delivered £6.73m in the year to date against a planned target of £4.65m.
- The NHS Improvement performance measure Financial Sustainabillity Risk Rating (FSRR) stands at 2 against a planned level of 2.

Summary Forecast:

- The forecast year end deficit is £16.05m in line with the planned £16.10m. This position assumes delivery of £14.8m CIP and recovery plans being put in place at Divisional level against ongoing pressures and risks.
- Cash forecast is in line with plan at £1.90m.
- The Trust cash position relies on the Trust borrowing £37.63m in this financial year to support both Capital and Revenue plans.
- Forecast capital expenditure is £0.58m below plan at £27.63m.
- The year end FSRR is forecast to be at level 2 as planned.

c. Complaints for Q1

The Chair reported that Peter Middleton, Deputy Chair had requested that this be brought to the Membership Councillors in order that they were aware of the current position.

The Executive Director of Nursing explained that the Membership Council had been given an extract from the Quarterly Quality Report which had been circulated to the Board of Directors at the end of September. He re-iterated that a great amount of work was

underway to manage complaints more effectively and give true and compassionate responses to patients and relatives.

The backlog of complaints were being addressed and support given to Divisions regarding the management of complaints. The Membership Council were made aware that, as discussed with the Quality Committee, there were no quick fix remedies and it was important to get this right.

A huge amount of work was on going to encourage patients and relatives to feedback to the Trust and to support patients and families with their complaints rather than focus purely on the numbers. Initiatives which had been set in place included regular 'ward rounds' by the Matron/Ward Managers to offer the opportunity for patients and visitors to feedback and also pictures of the nurse in charge was being put at each ward/department entrance to provide a clear point of contact for patients.

OUTCOME: The Membership Council received the update on Trust performance.

77/16 CARE OF THE ACUTELY ILL PATIENT (CAIP) AND SAFER PATIENT PROGRAMME

Introductions were made to:-

Bev Walker, Associate Director for Urgent Care
Dr Sarah Hoye, Consultant – Acute Medicine
Rachel Rae, Lead Matron for Discharges
Hannah Wood Physiotherapist, Support and Independent Team

The team gave a presentation highlighting the Safer Patient Programme and the work of the Discharge Team.

Dr Hoye led the presentation by updating the Membership on the SAFER worksteam. The key issues were:-

- Bed Avoidance – Ambulatory Care, Frailty Care, Community Rehabilitation
- Bed Efficiency

Some of the work undertaken and outcomes realised by channeling appropriate patients into the Safer Patient Programme was shared and this included:

- "Think Home First" poster which explained to ward staff the use of ambulatory care facilities for safe and effective patient care without an overnight hospital stay.
- Review of potential to grow the programme.
- Exclusion criteria reviewed and extended to include long term conditions.
- Progress on pathways with partners with A/E Department identifying suitable patients i.e. cellulitis, self-harm, 6 hour blood test (Troponins), Iron Deficiency Anaemia.
- Communications – patient information leaflets, newsletters for staff and education packs for nursing teams.

For the future it was hoped that this programme could be rolled out to the CRH site, resulting in fewer admissions to A/E and fewer stages in the clinical review. Work was underway to look at reviewing the workforce and training and development of staff. Work is also underway to create an Ambulatory Care Unit on the HRI site.

Engagement with GPs was discussed and Dr David Anderson offered his support in liaising with fellow GP colleagues to promote this programme.

DRAFT

Hannah Wood and Rachel Rae gave an overview of the Discharge Team, highlighting their vision and providing information about their day to day tasks in ensuring discharges are managed effectively, together with their role in the End of Life Care pathway. Data was shown to demonstrate the reduction in the length of stay of patients from April to September 2016 and this included the Green Cross Patients in hospital due to delays in social care.

The team were enthusiastic to increase the focus on 'Home First' and bringing care closer to home through an efficient discharge process and shared working with social work and community colleagues.

Discussions were also taking place with the Commissioners as it was seen that the Safer Patient Programme and ambulatory care would be key to ensuring that patients are cared for safely, including a tool to reduce the length of stay in hospital.

Cllr Bob Metcalf commented that the work being undertaken by Calderdale Council fitted in with this programme, ensuring multidisciplinary teams are in place to allow patients to go home as soon as possible.

The Chair thanked the team for their input into the meeting which had been found interesting and stimulating by all present.

OUTCOME: The information regarding CAIP and Safer Patient Programme was received and noted.

78/16 INFORMATION TO RECEIVE

The following information was received and noted:

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

b. Draft MC/BOD Annual General Meeting Minutes – 15.9.16

The draft minutes were agreed as a correct record.

79/15 ANY OTHER BUSINESS

a. Shuttle Bus - HRI

Ruth Mason reported that with effect from Thursday 10 November 2016 arrangements were being made for the HRI Shuttle Bus Stop to move from the South Drive to the Main Entrance, HRI. This was to allow building work down the South Drive.

b. MC/BOD Workshop – Wednesday 16 November 2016

Those present were reminded that an agenda had been circulated for the Workshop on Wednesday 16 November and it was requested that RSVP's be returned to Kathy Bray, Board Secretary.

c. Training Session

Ruth Mason reminded all present that a training session was planned for Friday 25 November on "What does Quality Mean" and all were welcome to attend.

d. Smoking Shelters

Cllr Metcalfe identified that Calderdale Council had written to the Trust regarding supporting public awareness campaigns around smoking shelters and was awaiting a response.

DRAFT

e. **HRI Signage**

Membership Councillors identified that the signage on the HRI site could be improved. The Executive Director of Nursing reported that the Executive Director of Planning, Performance, Estates and Facilities (who had just left the meeting) was undertaking a large piece of work reviewing signage throughout the site.

f. Membership Council Email Box

The Chair reported that following the AGM when the question of consent regarding use of personal details during the consultation had been raised, the Membership Council email box had received a request that the Membership Council be made of aware of this. It was noted that a response had previously been sent to the complainant explaining that although the story used was based on real events, the details of the patient had been anonymised and no consent was therefore required. It was agreed that a response be sent back from the Membership Council Email box to advise that this had been raised with the Membership Council and would be minuted accordingly.

OUTCOME: The Membership Council noted receipt.
ACTION: RM

80/16 DATE AND TIME OF NEXT MEETING

Tuesday 17 January 2017 – Public Membership Council Meeting **commencing at 4.00 pm in the Boardroom, Sub-basement, Huddersfield Royal Infirmary**

The Chair thanked everyone for their contribution and closed the meeting at 6.40 pm.

DRAFT