Meeting of the Board of Directors
To be held in public

Thursday 27 August 2015 from 1:30pm

Venue: Boardroom, Sub Basement, Huddersfield Royal Infirmary, HD3 3EA

AGENDA

1.	**Welcome and introductions:-**	Chairman	
2.	Apologies for Absence: Mr Andrew Haigh, Chairman Ms Julie Hull, Executive Director of Workforce and OD Mr Owen Williams, Chief Executive Mr Keith Griffiths, Executive Director of Finance Dr Linda Patterson, NED	Chairman	
3.	Declaration of interests	All	**VERBAL**
4.	Minutes of the previous meeting held on 30 July 2015	Chairman	**APP A**
5.	**Action Log and Matters arising:** a. 109/15 – Risk Register - Winter Pressures	Chairman Director of Operations	**APP B** **VERBAL**
6.	Patient Story "Bethany's Story presented by Amanda McKie, Matron – Complex Needs Care Co-ordinator	Executive Director of Nursing & Operations	
7.	**Chairman's Report:-** a. Improving and Sustaining Cancer Performance Standard	Chairman	**VERBAL**
8.	**Chief Executive's Report:-**	Acting Chief Executive	**VERBAL**
Keeping the base safe			
9.	**Integrated Board Report** - Responsive - Caring - Safety - Effectiveness - Well Led	Executive Director of PPEF/Associate Director of Community/Operations Executive Director of Nursing Executive Director of Nursing Executive Medical Director Interim Director of Workforce	**APP C**

	- CQUINs - Community - Monitor Indicators - Finance	and OD Associate Director of Community/Operations Assistant Director of Finance “	
10.	Risk Register	Executive Director of Nursing & Operations	**APP D**
11.	a. Director of Infection Prevention and Control Report b. Annual DIPC Report	Executive Medical Director “	**APP E** **APP F**
12.	**Governance Report** a. Board Workplan Update b. New Risk Assessment Framework c. Board Meeting Dates 2016 d. Use of Trust Seal e. Declaration of Interests Register f. Feedback from Monitor – Q4 2015/16 and Annual Plan Review g. Well Led Governance Review Action Plan	Company Secretary	**APP G**
13.	Care of the Acutely Ill Patient Report	Executive Medical Director	**APP H**
Financial Sustainability			
14.	Month 4 – July 2015 Financial Narrative	Assistant Director of Finance	**APP I**
Transforming and Improving patient care			
No items			
A Workforce for the future			
No items			
15.	**Update from sub-committees and receipt of minutes** ▪ Quality Committee (Minutes of 28.7.15 and verbal update from meeting held 25.8.15) ▪ Finance and Performance Committee (Minutes of 21.7.15 and verbal update from meeting held 18.8.15)		**APP J** **APP K**
Date and time of next meeting Thursday 17 September 2015 Healthfair and AGM commencing at 5.00 pm and 6.00 pm respectively Venue: 3rd Floor, Acre Mill Outpatients Building, Acre Street, Lindley, Huddersfield Thursday 24 September 2015 at 1.30pm			

Venue: Boardroom, Huddersfield Royal Infirmary

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).*

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 27th August 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 30.7.15 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 30 July 2015.	
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 30 July 2015.

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 30 July 2015.

Appendix

Attachment:

APP A - BOD MINS - PUBLIC BOD MINS - 30.7.15.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 30 July 2015 in the Large Training Room, Learning Centre, Calderdale Royal Hospital

PRESENT

Andrew Haigh	Chairman
Dr David Anderson	Non-Executive Director
Dr David Birkenhead	Executive Medical Director
Julie Dawes	Executive Director of Nursing and Operations/Deputy Chief Executive
Keith Griffiths	Executive Director of Finance
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities
Philip Oldfield	Non-Executive Director
Jeremy Pease	Non-Executive Director
Prof Peter Roberts	Non-Executive Director
Jan Wilson	Non-Executive Director
Owen Williams	Chief Executive

IN ATTENDANCE/OBSERVERS

Anna Basford	Director of Commissioning and Partnerships
Caroline Wright	Communications Manager
Kathy Bray	Board Secretary
Jackie Green	Interim Director of Workforce and Organisational Development
Nick Lavigueur	Huddersfield Examiner Reporter
Bob Metcalfe	Membership Councillor (Stakeholder)
Victoria Pickles	Company Secretary
George Richardson	Membership Councillor (Elected Publicly)

1 member of the public observer – Kathryn Horner

Item

101/15 APOLOGIES FOR ABSENCE AND INTRODUCTIONS

Apologies were received from:

Julie Hull	Executive Director of Workforce and Organisational Development
Dr Linda Patterson	Non Executive Director

The Chairman welcomed everyone to the meeting.

102/15 DECLARATION OF INTERESTS

There were no declarations of interest to note.

103/15 MINUTES OF THE MEETING HELD ON THURSDAY 25 JUNE 2015

The minutes of the meeting were approved as a true record with the inclusion of the word 'consultancy' on page 2 to read "cap on management consultancy spend".

104/15 MATTERS ARISING FROM THE MINUTES

a. Patient/Staff Story

The Chairman commented that the Board had not received a Patient/Staff Story for the last 2 months. The Executive Director of Nursing reported that one would be brought to the August meeting.

ACTION: JD – AUGUST BOD AGENDA ITEM

105/15 ACTION LOG

97/15 Workforce Race Equality Standards

It was noted that Jan Wilson had met with the Interim Director of Workforce and agreed a signed off version of this document.

There were no other outstanding issues.

106/15 CHAIRMAN'S REPORT

a. Board to Board Meeting with South West Yorkshire Partnership NHS Foundation Trust (SWYPFT) and Calderdale and Huddersfield NHS Foundation Trust (CHFT)

The Chairman reported that representatives of the SWYPFT and CHFT Boards had met on the 29 June 2015. The areas broadly covered included:-

- Liaison on Rapid Assessment, Interface and Discharge (RAID
- Child and Adult Mental Health Services (CAMHS) transfer work
- Estates Utilisation
- Nursing Revalidation, Recruitment and Retention
- SWYPFT Outline Business Case Update
- Calderdale Vanguard

b. Board to Board Meeting with Mid Yorkshire Hospitals NHS Trust (MYHT) and Calderdale and Huddersfield NHS Foundation Trust (CHFT)

The Chairman reported that representatives of the MYHT and CHFT Boards had met on the 30 July 2015. The areas broadly covered the following points and agreed action:-

- West Yorkshire collaboration
- Current collaboration projections
- Current joint tenders involving both organisations
- Regulatory Changes – Trust Development Authority (TDA) model
- It was agreed that MYHT and CHFT would host a meeting with GP Federations across the Kirklees, Calderdale and Wakefield footprint to talk about Winter Pressures and beyond.

107/15 CHIEF EXECUTIVE'S REPORT

The Chief Executive explained that he had shared the following reports to the Board to ensure that the Board gave consideration to how these reviews might affect the Trust.

- a. Kings Fund Report
- b. Carter Review
- c. Rose Review

The Board discussed the key issues arising from each review. It was acknowledged that the Kings Fund Report would bring significant challenges locally and nationally to the financial 5 year position. This would also affect the spending review for social care and there will be a need to review how this service is provided for the future.

The Carter report broadly affected the performance metrics of all hospital trusts with regard to standards for procurement and efficiency.

The Rose Review recommended a review of Leadership of the NHS with the TDA and Monitor being brought together as a National Improvement Agency.
Other recommendations included:

- Form a single service-wide communication strategy within the NHS
- Create a short NHS handbook/ passport/ map

- Performance Management
- Bureaucracy reduction
- Management Support and Training
- Move sponsorship of the NHS Leadership Academy from NHS England into Heatlh Education England.

The Chief Executive summarised the forecast as a systems re-organisation and regulator change - all against less money in the system.

Bob Metcalfe reported that Calderdale Council were finding it very challenging to provide social services due to recent reductions in funding levels. A new model had been developed which was to be rolled out over the next few months.

The Executive Director of Nursing commented that the Rose review recommended the move of NHS England to Health Education England and agreed to look at how the Trust is represented in this organisation.

ACTION: JD

d. Care Closer to Home Tender

The Chief Executive reported that the Trust was progressing information to present to Monitor to challenge the decision under the 2013 Act. This would be developed and agreed with Partners before submission. The Board wanted to ensure that the local population were getting the very best care in the future and felt this was the correct course of action.

108/15 INTEGRATED BOARD REPORT

The Executive Director of Planning, Performance, Estates and Facilities introduced the Integrated Board report as at 30 June 2015 and explained that each area would be presented in detail.

Summary - the Executive Director of Planning, Performance, Estates and Facilities highlighted the key issues from the executive summary commentary:-
The Trust had achieved all monthly targets in June, including A/E for the first quarter. Thanks were given to staff involved in ensuring this position.
All cancer standards had been achieved and the Trust had delivered on the fractured neck of femur target (#NOF). David Anderson enquired whether there had been one specific action which had achieved the #NOF position and it was confirmed that this had been due to work on all areas of the standard with concentrated effort being made to fill vacant theatre lists. Two laminar flow theatres had now opened at Huddersfield and further work was being undertaken to upgrade another. It was acknowledged that this could also have been affected by a seasonal downturn in the number of patients presenting with #NOF.

RESPONSIVE

- The Trust delivered the Emergency Care Standard for June and recovered to deliver the quarter at 95.08% with improved ambulance turnaround maintained
- Patient flow requires on-going focus with outlier numbers and patient movement still higher than acceptable
- All referral to treatment and cancer standards were met
- Appointment slot issues continue but actions have been identified and implementation plans are in progress
- Cancelled operations have improved to within contract levels
- Non elective activity remains high in June and some improvements have been seen in elective activity but particular focus is required on outpatients and day cases which is now monitored weekly

CARING

The Executive Director of Nursing and Operations reported:

- Complaint performance is improving with the backlog being cleared in month with teams focussed on designing new processes to rapidly turnaround newly received complaints and prevent recurrence of backlog
- Friends and Family test continues to be challenging as new areas are brought online with particular pressures following the introduction of day case and the on-going challenge of completion of the survey in A/E.

SAFETY

The Executive Director of Nursing and Operations reported:

- Falls had increased with 3 falls resulting in serious harm. The connections with this and increased lengths of stay was noted and it was report that a quality summit was to be undertaken to look at these issues.
- There had been 1 category 4 ulcer. Jan Wilson reported that she had been approached to assist the Trust with this work.

EFFECTIVENESS

The Executive Medical Director reported:-

- Overall HCAI delivery is good but a small peak in EColi noted within the Medicine Division for June
- Emergency Readmissions within 30 days is slightly above target relating to service changes within partner organisations. Trust delivered activity remains within target
- HSMR has further increased and is a key source of concern with specific improvement actions initiated
- Depth of coding has not improved as intended with some agreed processes not embedded and staffing still a concern. Finance and Performance Committee supported
  the recommendations to address staffing which are being implemented
- # Neck of Femur had delivered 85% for the month.

WELL LED/WORKFOCE

It was noted that the Well Led section of the report had been amended and circulated to Board Members.

The Interim Director of Workforce and Organisational Development reported:-

- Sickness remains higher than target in all but 2 areas with the majority of Divisions/Directorates showing deterioration in month around long term absence. It was reported that steady increases in long term sickness was a national shift. It was noted that further discussion would take place in the private Board meeting, with a view to setting up a Workforce Committee.
- All mandatory training metrics were red and a particular focus of local performance meetings. A letter had been circulated with payslips reminding staff of their duty to ensure compliance with mandatory training.
- Three divisions are showing above 80% for appraisal with trajectories requested from all departments. The workforce team were in the process of developing an appraisal tool to better plan appraisals.
- There had been deterioration in the number of staff who would recommend the Trust as a good place to work.
- Hard Truths staffing levels remain a significant concern and reflects both the additional capacity still in place and sickness levels. There remain on-going challenges in securing permanent and temporary nurses but overseas recruitment continues.

FINANCIAL ACTIVITY

The Executive Director of Finance agreed to report on the financial position later in the meeting when he delivered the Month 3 – June 2015 financial narrative.

- **Community**
  The information contained within the report was received and noted.
- **External Reported Framework**
  The information contained within the report was received and noted.

The Chairman reminded the Board that PWC had suggested that the Board examine the reporting trend/forecasting analysis provided and the Director of PPEF agreed that this would be reviewed for next month's report. The Chief Executive asked that focus be given to the key areas of greatest concern rather than all areas.

RESOLVED: The Board approved the Integrated Board Report

109/15 RISK REGISTER

The Executive Director of Nursing and Operations reported the top risks (scored 15+) within the organisation. The top seven risks were:-

- Progression of service reconfiguration impact on quality and safety
- Risk of poor patient outcomes due to dependence on middle grades
- CQC inspection outcome
- Failure to meet cost improvement programme targets
- HSMR & SHMI
- Staffing risk
- Service transformation risk

Risks with increased score:-

- CQC inspection outcome, increased from 16 to 20
- Failure to meet CIP, increased from 15 to 20

Risks with reduced score:-

- Infection control, reduced from 15 to 10

New Risk added:-

- NHS E-referrals, system outage – score of 16
- Staffing risk – score of 20
- Service transformation risk – score of 20

Other issues arising from the debate included:-

- The Chief Executive asked that the 'Service Transformation risk' be updated for next month with detailed mitigation/controls against the OBC and CC2H risks

- Peter Roberts questioned whether 'Failure to Meet CIP' was a realistic achievement and whether a 6 month target for an intermediate target would be more appropriate. It was agreed that this would be discussed by the Finance and Performance Committee and flagged appropriately.

- The Chief Executive requested that the Board have a discussion about Winter Planning. It was noted that the Associate Director of Community Services and Operations was undertaking some work across the system regarding a systems resilience plan. It was agreed that an update would be brought to the Board for discussion in August and more detailed risk worked up for the September Board Meeting.

ACTION: Winter Pressures - BOD Agenda Item – August and September 2015 - HB

RESOLVED: The Board received and approved the Risk Register report.

110/15 DIRECTOR OF INFECTION PREVENTATION AND CONTROL (DIPC) REPORT

The Executive Medical Director presented the report and specific discussion took place regarding:-

- **C.Diff** – 3 cases had been reported to date (2 avoidable and 1 unavoidable). The ceiling was 21 cases for the year to March 2016.
- **MRSA** – 1 case had been reported to date.
- **ANTT compliance –** On-going training being provided and increase in number of assessors. Plan in place for training of newly trained junior doctors.

RESOLVED: The Board received the report.

111/15 GOVERNANCE REPORT

The Company Secretary presented the Governance Report which included:-

a. Well Led Governance Review

The final report received from PWC had been circulated to Board Members. Over the next few months the Company Secretary would be liaising with PWC and Trust colleagues to develop an action plan to address the actions outstanding. It was agreed that the finalised action plan would be brought to the Board workshop on the 14 October 2015. The key themes stemming from the review were:

- Capacity
- Pace of change
- Performance management
- Data quality
- Ability to forecast

The Executive Director of Nursing reported that Mr Paul Moore had been appointed Associate Director of Nursing with effect from September 2015. It was requested that with his past experience and background he should be invited to help progress this issue.

b. Terms of Reference

As part of the work plan this document had been brought to the Board for approval. It was noted that a number of typographical amendments had been made, subject to which the document was approved by the Board.

c. Board Assurance Framework

The first draft of the strategic risks to reflect the revised strategy had been circulated to executive directors for comment and amendment. This could not be completed in time for this Board meeting and so will come to the August Board. These will also been updated to reflect the findings from the Well Led Governance Review. The draft Board Assurance Framework will be circulated to all Board members for comment in advance of the Board meeting. Work was also underway between the Company Secretary and the Head of Governance and Risk to articulate how the corporate risk register and Board Assurance Framework will link.

RESOLVED: The Board received the report and approved the Terms of Reference.

ACTION: BOD Agenda Item – August 2015.

112/15 SAFEGUARDING ADULTS AND CHILDREN UPDATE REPORT

The Executive Director of Nursing and Operations presented the updated report prepared by Vicky Thersby, newly appointed Safeguarding Lead. The contents of the report were noted and the Executive Director of Nursing and Operations outlined the key priorities and main focus for the safeguarding team over the next Quarter:- Continue Training, Supervision, Serious Case Reviews/Domestic Homicide Reviews, and Mental Capacity Act and Deprivation of Liberty Safeguards.

113/15 MONTH 3 – JUNE 2015 FINANCIAL NARRATIVE

The Executive Director of Finance presented the finance month 3 report (included within the Integrated Board). It was noted that this information had been discussed in detail at the Finance and Performance Committee held on the 21 July 2015:-

Summary Year to Date:

- The year to date deficit is £6.53m versus a planned deficit of £6.59m, this includes release of £0.1m contingency reserves.
- Elective and day case activity is behind planned levels whilst non-elective continues to be above plan in the year to date.
- The main area of on-going expenditure pressure is non-contracted pay, supporting vacancy cover and extra bed capacity.
- Capital expenditure year to date is £4.69m against the planned £5.10m with slippage primarily on Estates schemes.
- Cash balance is £10.97m against a planned £10.9m. £10m of loan funding for capital expenditure was drawn down in April.
- CIP schemes delivered £2.80m in the year to date against a planned target of £2.18m.
- The Continuity of Service Risk Rating (CoSRR) stands at 1 against a planned level of 1

Summary Forecast:-

- The forecast is to deliver the year end planned income and expenditure position in overall terms, however at present this relies on £1.5m contingency reserves being released unused and forecast delivery of £16m CIP against the originally planned £14m.
- The balance of contingency reserve has been ring-fenced against investment to enable transformation and other known commitments.
- This mitigation has been called upon due to financial pressures driven by the extra bed capacity open over the first quarter of the year and the locum and agency pay expenditure linked to both this capacity and covering substantive vacancies.
- Efforts must therefore be focussed on securing the full value of CIP including the 'stretch' target as this is now crucial to delivery of the plan.
- The year end cash balance is predicated on external cash support being received from September onwards.
- Year end capital expenditure is forecast to be £20.59m slightly below the planned £20.72m. The year end CoSRR is forecast to be at level 1.

RESOLVED: The Board received and approved the financial narrative for June 2015.

114/15 UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES

The following information was received and noted:-

- **Quality Committee** – The Board received the minutes of the 23.6.15 and a verbal update from Jeremy Pease on the meeting held on 28.7.15. Matters arising from the meeting included:-
  - Equality and diversity quarterly report
  - Integrated Board Report
  - Research and development report
  - Care of the Acutely Ill Patient programme, HSMR and SHMI
  - Cleaning Redesign Programme
  - CQC action plan and monthly report. It was likely that the Board of Directors would receive a report in September.

- **Audit and Risk Committee** - The Board received a verbal update from Prof. Peter Roberts on the meeting held on 21 July 2015. Matters arising from the meeting included:-
  - Update on Standing Financial Instructions to reflect recent government directives
  - Debt collection and write off of debt received and agreed
  - Regulatory Compliance Submission information - quarterly information to be received by ARC
  - Internal Audit – Outstanding Internal Audits - high priority/status – recommendation to invite lead personnel to future ARC meetings
  - Internal Audit Reports – two limited assurance (IT Modernisation, ISO Compliance)
  - Internal Audit Annual Report – Updated version to include updates
  - Counter Fraud Specialists – good progress and staff awareness
    Review of Declarations of Interests exercise to be undertaken.

The Chairman thanked everyone for their attendance and contributions.

115/15 DATE AND TIME OF NEXT MEETING

Thursday 27 August 2015 at 1.30 pm in the Boardroom, Sub Basement, Huddersfield Royal Infirmary HD3 3EA

The Chairman closed the meeting at 3.30 pm.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 27th August 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: ACTION LOG - PUBLIC BOARD OF DIRECTORS - AUGUST 2015 - The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 August 2015	
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:

Please see attached.

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 August 2015

Appendix

Attachment:

ACTION LOG - BOD - PUBLIC - As at 1 AUGUST 2015.pdf

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 August 2015 / 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
30.10.14 140/14	**PATIENT/STAFF STORY** 30.10.14 - 'Carol's Story' extract video. 27.11.14 – 'Mr P' – Drug Error 18.12.14 – Dr Sarah Hoye 29.1.15 – Dr Mary Kiely – Care of the Dying 26.2.15 – Catherine Briggs, Matron – Green Cross Patient 26.3.15 – Diane Catlow – Families Senior Locality Manager 23.4.15 – Dr Mark Davies – Perfect Week 28.5.15 – Stroke Team - Patient Story/FAST Awareness 25.6.15 – No information received 30.7.15 – No information received	Executive Director of Nursing	Regular item on BOD Agenda going forward.	Monthly Reports		
25.7.13 113/13	**HSMR/MORTALITY/CARE OF THE ACUTELY ILL PATIENT** Presentation received from BC & HT. Action Plan discussed. Update on actions to be brought to BOD Meetings on a bi-monthly basis.	Executive Medical Director	Regular Updates to be brought back to BoD as plan progresses (bi- monthly). 26.9.13 – Update on worsened position received. Key themes and actions identified. Agreed that an updated plan would be brought back to the October 2013 BoD Meeting. 24.10.13 – Update and Action Plan received and note. Board endorsed plan and supported its implementation. Regular Updates to be brought back to BoD as plan progresses (bi- monthly). 19.12.13 – Update on progress received. Agreed that updated Action Plan would be brought to the Board in February 2014. 27.2.14 – Further work being undertaken by Divisions – roll out of mortality review process from March 2014 24.4.14 – Update received.	August 2015		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 August 2015 / 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
			26.6.14 – Update received 25.9.14 – Update received 27.11.14 – Update received 29.1.15 – Update received 26.3.15 – Update received 28.5.15 – Update received			
30.7.15 109/15	**RISK REGISTER - WINTER PRESSURES** It was noted that the Associate Director of Community Services and Operations was undertaking some work across the system regarding a systems resilience plan. It was agreed that an update would be brought to the Board for discussion in August and more detailed risk worked up for the September Board Meeting.			August/September 2015		

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 27th August 2015	**Sponsoring Director:** Lesley Hill, Director of Planning, Performance, Estates and Facilities
Title and brief summary: INTEGRATED BOARD REPORT - The Board is asked to receive and note the Integrated Board Report	
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 - 20.8.15, Quality Committee 25.8.15	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

Please see attached

Main Body

Purpose:

The Board is asked to receive and note the Integrated Board Report

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive and note the Integrated Board Report

Appendix

Attachment:

There is no PDF document attached to the paper.

Board Of Directors Integrated Performance Report

Calderdale and Huddersfield NHS
NHS Foundation Trust

compassionate care

Contents

Report For: July 2015

Board of Directors

Integrated Board Report

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Executive Summary Commentary

This is a further refinement of the Integrated Performance Report taking into account feedback from Board members alongside a review of reports from other Trusts. A performance management framework, with an associated accountability framework, is in development and will be presented to the Board in the near future.

The report on July performance is positive with a solid month of delivery building on the improvement seen in June although this continues to require significant micromanagement so further improvement work needed to ensure sustainable delivery and optimal patient and staff experience across all pathways, recognising feedback from these two groups.

The key areas to note are:

Responsiveness

- The Trust delivered the Emergency Care Standard although continue to see daily variation in breach numbers
- All referral to treatment and cancer standards were met
- Appointment slot issues continue but actions have been identified and implementation plans are in progress
- Cancelled operations performance has deteriorated
- Elective activity continues to track below plan and a detailed review has been undertaken with plans for recovery developed

Caring

- Complaint performance continues to improve
- Friends and Family Test remains challenging

Safety

- Falls continue to be a concern and a deep dive with revised action plan has been commissioned
- Full compliance with the Duty of candour requirements
- Continued improvement of the WHO checklist

Effectiveness

- 1 MRSA attributable to the Community Division in July
- Excellent performance on CDiff continues
- Emergency Readmissions within 30days remains a challenge, a meeting with Locala is planned to look together at improvement
- HSMR has further increased and is a key source of concern with specific improvement actions ongoing
- # Neck of Femur, time to theatre deteriorated again in July

Well led

- Sickness remains higher than target in all but 2 areas with the majority of Divisions/Directorates showing a deterioration in month around long term absence
- Appraisal and Mandatory training metrics remain a concern and have been the focus of individual Divisional meetings led by HR
- Only 3 areas are delivering good sickness rates with poor performance seen across the majority of clinical areas
- Hard Truths data has improved however there was an increase in areas rag rated red by 1 in comparison to the month of June for qualified nurses (day) with average fill rates of less than 75%.

The weekly performance meetings continue with an increasing suite of reports reviewed and proactive actions agreed to improve delivery. The Divisional performance packs are currently being refined to compliment the IPR and enhance Ward to Board escalation

Calderdale and Huddersfield NHS
NHS Foundation Trust

Table of Risk

compassionate care

Monitor		Contract		Contract		NHSE		Quality		Other Internal	
Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator
→	A and E 4 hour target	↑	% Admitted Closed Pathways Under 18 Weeks	→	Number of Mixed Sex Accommodation Breaches	↓	Friends & Family Test (IP Survey) - % would recommend the Service	↓	Left without being seen	↓	% Elective Variance against Plan
↓	62 Day Gp Referral to Treatment	↓	% Non-admitted closed Pathways under 18 weeks	n/a	Nutrition and Hydration - Reducing Hospital Food Waste (reported quarterly)	→	Friends and Family Test A & E Survey - % would recommend the Service	↓	Time to Initial Assessment (95th Percentile)	↓	% Day Case Variance against Plan
→	62 Day Referral From Screening to Treatment	↑	% Incomplete Pathways <18 Weeks	n/a	Nutrition and Hydration - Patient Satisfaction (Reported quarterly)	↑	Friends & Family Test (Maternity) - % would recommend the Service	↑	Time to Treatment (Median)	↓	% Non-elective Variance against Plan
→	31 Day Subsequent Surgery Treatment	↑	Percentage of Completed VTE Risk Assessments	↑	Improving Medicines Safety – Reconciliation (Effective Transfer of Medicines)	↑	Friends and Family Test Community Survey - % would recommend the Service	↓	Unplanned Re-Attendance	↓	% Outpatient Variance against Plan
→	31 day wait for second or subsequent treatment drug treatments	→	Completion of NHS numbers within A&E commissioning datasets submitted via SUS	↑	Improving Medicines Safety Discharge Accuracy Checks	↑	Percentage of non-elective inpatients 75+ screened for dementia	↓	% of diabetic patients supported to self-care	↓	Theatre Utilisation (TT) - Main Theatre - CRH
↑	31 Days From Diagnosis to First Treatment	↑	Completion of NHS numbers within acute commissioning datasets submitted via SUS	↑	Emergency Readmissions Within 30 Days (With PbR Exclusions)	↓	Number of Trust Pressure Ulcers Acquired at CHFT	↑	End of Life Care Plan in place	↓	Theatre Utilisation (TT) - Main Theatre - HRI
↓	Two Week Wait From Referral to Date First Seen	↑	Number of MRSA Bacteraemias – Trust assigned	→	Never Events	↑	Acute Kidney Injury (Reported quarterly)	↓	% Harm Free Care	↑	Theatre Utilisation (TT) - HRI DSU
↓	Two Week Wait From Referral to Date First Seen: Breast Symptoms	→	Total Duty of Candour reported within the month	↑	Percentage of SI's investigations where reports submitted within timescale (45 days unless extension agreed)	n/a	Sepsis Screening (Reported quarterly)	n/a	Missed Doses (Reported quarterly)	↑	Theatre Utilisation (TT) - HRI SPU
→	Community care - referral to treatment information completeness	→	Total Duty of Candour outstanding at the end of the month	↓	Number of MSSA Bacteraemias - Post 48 Hours	n/a	Sepsis Antibiotic Administration (Reported Quarterly)	→	Local SHMI - Relative Risk (1yr Rolling Data Jan14- Dec 14)	↑	World Health Organisation Check List
↓	Community care - referral information completeness	→	RTT Waits over 52 weeks Threshold > zero			→	Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	→	Hospital Standardised Mortality Rate (1 yr Rolling Data Apr 14 - Mar 15)	↑	% Daily Discharges - Pre 11am
→	Community care - activity information completeness	↑	A&E Ambulance 30-60 mins					↓	Crude Mortality Rate (Latest Month July 15)	↑	Green Cross Patients (Snapshot at month end)
→	Total Number of Clostridium Difficile Cases - Trust assigned	↑	Delayed Transfers of Care					↑	Average Diagnosis per Coded Episode	↑	Number of Outliers (Bed Days)
		→	Respiratory Care Bundle - Improving management of patients attending A&E with pneumonia (Reported quarterly)					↓	Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	↑	First DNA Rate
		→	Respiratory Care Bundle - Improving management of patients presenting with Asthma in ED (Reported quarterly)					↓	Inpatient Falls with Serious Harm (10% reduction on 14/15)	↓	% Hospital Initiated Outpatient Cancellations
		→	18 weeks Pathways >=40 weeks open					↑	% Complaints closed within target timeframe	↑	No of Spells with > 2 Ward Movements
		↑	% Diagnostic Waiting List Within 6 Weeks					↓	All Falls	↑	% of Spells with > 2 ward movements (2% Target)
		↑	Community AHP - 18 Week RTT Activity					↓	Avoidable number of Clostridium Difficile Cases	n/a	No of Spells with > 5 Ward Movements
		↑	Paediatric Therapies - 18 Week RTT Speech Therapy					↑	Unavoidable Number of Clostridium Difficile Cases	n/a	% of spells with > 5 ward movements (No Target)
		↑	Paediatric Therapies - 18 Week RTT Occupational Therapy					↑	MRSA Screening - Percentage of Inpatients Matched	n/a	Total Number of Spells
		↑	Paediatric Therapies - 18 Week RTT Physiotherapy					↓	Number of E.Coli - Post 48 Hours	↓	18 weeks Pathways >=26 weeks open
		↑	% Last Minute Cancellations to Elective Surgery					n/a	Total Complaints received in the month	↑	Complaints acknowledged within 3 working days
		→	28 Day Standard for all Last Minute Cancellations					n/a	Total Concerns in the month		
		→	No of Urgent Operations cancelled for a second time					↓	Number of Patient Incidents		
		→	Appointment Slot Issues on Choose & Book					↓	Number of SI's		
		↓	62 Day Aggregated Gp Urgent Referral To Treatment And Screening Referral To Treatment					↓	Number of Incidents with Harm		
								↓	Number of Category 2 Pressure Ulcers Acquired at CHFT		
								↓	Number of Category 3 Pressure Ulcers Acquired at CHFT		
								↓	Number of Category 4 Pressure Ulcers Acquired at CHFT		
								↓	Number of Category 3 & 4 Pressure Ulcers Acquired at CHFT		
								↑	Safeguarding Alerts made by the Trust		
								↑	Safeguarding Alerts made against the Trust		
								↑	Percentage of SI's reported externally within timescale (2 days)		
								↑	% Hand Hygiene Compliance		
								↑	Mortality Reviews – May Deaths		

KEY

↑ Improvement on last month ↓ deterioration on last month → No change on last month

RAG rating = Green Achieving Target / Red = Currently not Achieving Target

Achieving and Improving = 23	Achieving No Change = 18	Achieving but Deteriorating = 24	Not Achieving No Change = 5	Not achieving but improving = 20	Not Achieving and Deteriorating = 11

n/a - New indicators currently no trend /No RAG rating = 10

Overall Rating: Red reflecting enforcement action in place.

CQC Status: No outstanding issues. Awaiting confirmation of date for full inspection.

		Threshold	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Access and Outcome Metrics	% Admitted Closed Pathways Under 18 Weeks	>=90%	91.65%	92.41%	92.67%	92.79%									92.40%
	% Non-admitted closed Pathways under 18 weeks	>=95%	98.35%	98.89%	98.63%	98.23%									98.52%
	% Incomplete Pathways <18 Weeks	>=92%	95.02%	95.85%	95.44%	95.55%									95.55%
	A and E 4 hour target	>=95%	95.01%	94.80%	95.44%	95.44%									95.17%
	Total Number of Clostridium Difficile Cases - Trust assigned	21	2	0	1	1									4
	62 Day Gp Referral to Treatment	>=86%	89.38%	92.31%	90.00%	88.95%									90.05%
	62 Day Referral From Screening to Treatment	>=90%	85.71%	100.00%	100.00%	100.00%									97.83%
	31 Day Subsequent Surgery Treatment	>=94%	95.45%	100.00%	100.00%	100.00%									100.00%
	31 day wait for second or subsequent treatment drug treatments	>=98%	100.00%	100.00%	100.00%	100.00%									100.00%
	31 Days From Diagnosis to First Treatment	>=93%	100.00%	100.00%	99.24%	100.00%									99.80%
	Two Week Wait From Referral to Date First Seen	>=93%	96.45%	98.43%	96.55%	95.64%									96.73%
	Two Week Wait From Referral to Date First Seen: Breast Symptoms	>=93%	93.33%	93.75%	94.92%	94.87%									94.55%
	Community care - referral to treatment information completeness	>=50%	100.00%	100.00%	100.00%	100.00%									100.00%
	Community care - referral information completeness	>=50%	98.05%	98.04%	97.83%	97.40%									97.84%
	Community care - activity information completeness	>=50%	100.00%	100.00%	100.00%	100.00%									100.00%

Third Party Reports	Local Supervisory Midwife Authority - visit completed, no serious concerns at verbal feedback. Awaiting final report. Haematology peer review (jointly with Leeds Teaching Hospital). Identified one immediate concern and one serious concern, both responded to within time and awaiting confirmation of downgrading of risk. Medical Microbiology full accreditation visit scheduled for August 15.
Quality Governance Indicators	**Patient Metrics - Patient Satisfaction** : Friends and Family Test feedback - positive across all areas ranging from 91% would recommend in A&E through to 97% in Maternity.
	Staff Metrics : Quarter 4 to Quarter 1 deterioration in staff recommending the Trust as a place to work. 59% to 51% with an 81% to 77% reduction in staff who would recommend the Trust to family and friends as a place to receive treatment.

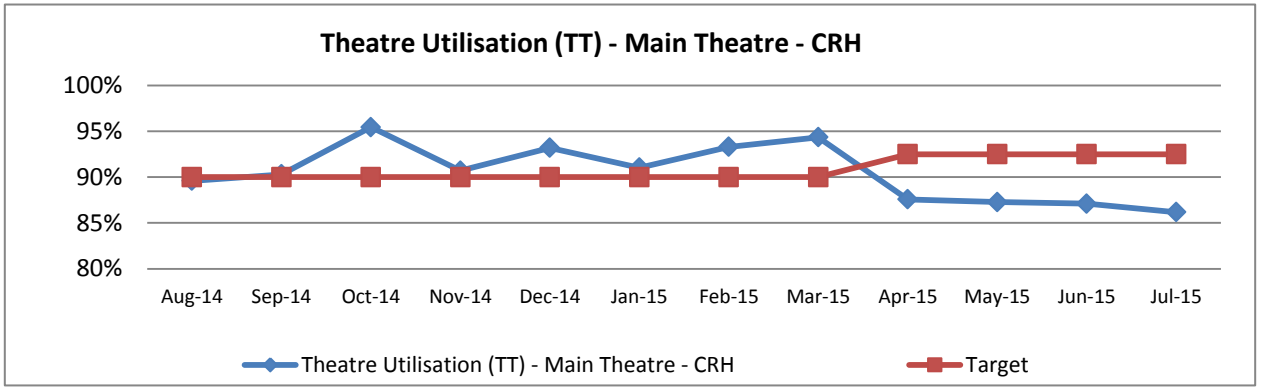
Finance	Continuity of Service Risk Rating	1	1
	Operational Performance (Debt service cover)	1	1
	Cash & Balance Sheet Performance (Liquidity)	1	1
	Use of Capital	£6.99m	£6.11m
	Income and Expenditure	(£7.15m)	(£8.23m)
	Cost Improvement Programme (CIP)	£3.30m	£4.00m

Report For: July 2015		Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Year To Date Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Direction of travel (past 4 months)	Year End Forecast	Data Quality
Activity	% Elective Variance against Plan	Local	0.00%	-6.18%	-10.02%	-20.65%	24.90%	-	0.00%	-3.39%	-5.41%	-8.27%	10.67%	-		↓		
	% Day Case Variance against Plan	Local	0.00%	-8.15%	-8.78%	-7.10%	-5.06%	-	0.00%	-3.86%	-4.01%	-5.11%	3.95%	-		↓		
	% Non-elective Variance against Plan	Local	0.00%	5.52%	0.26%	2.24%	16.26%	-	0.00%	3.58%	-2.42%	4.46%	5.93%	-		↓		
	% Outpatient Variance against Plan	Local	0.00%	-6.60%	-6.80%	-7.50%	-4.25%	-	0.00%	-2.20%	-2.06%	-3.09%	-0.96%	-		↓		
RESPONSIVE - Theatre Utilisation	Theatre Utilisation (TT) - Main Theatre - CRH	Local	92.50%	86.18%	84.77%	-	95.00%	-	92.50%	87.01%	85.37%	-	95.00%	-		↓		
	Theatre Utilisation (TT) - Main Theatre -HRI	Local	92.50%	93.73%	93.73%	-	-	-	92.50%	94.28%	94.28%	-	-	-		↓		
	Theatre Utilisation (TT) - HRI DSU	Local	92.50%	76.50%	75.08%	-	86.78%	-	92.50%	76.43%	75.12%	-	86.78%	-		↑		
	Theatre Utilisation (TT) - HRI SPU	Local	92.50%	85.03%	85.03%	-	-	-	92.50%	83.32%	83.32%	-	-	-		↑		
Exception Report - Patient Flow	% Daily Discharges - Pre 11am	Local	28.00%	11.44%	17.29%	6.68%	11.85%	-	28.00%	10.47%	13.92%	8.21%	10.26%	-		↑		
	Delayed Transfers of Care	Local	5.00%	7.04%	-	-	-	-	5.00%	6.71%	-	-	-	-		↑		
	Green Cross Patients (Snapshot at month end)	Local	40	96	-	96	-	-	40	96	-	96	-	-		↑		
	Number of Outliers (Bed Days)	Local	465	859	250	609	0	-	2172	3273	1033	2243	0	-		↑		
	% of Spells with > 2 ward movements (2% Target)	Local	2.00%	2.43%	1.36%	5.57%	1.09%	-	2.00%	2.27%	1.42%	4.98%	1.04%	-		↑		
	No of Spells with > 5 Ward Movements	Local	-	2	0	2	0	-	-	15	1	14	0	-		↓		
	% of spells with > 5 ward movements (No Target)	Local	-	0.03%	0.00%	0.11%	0.00%	-	-	0.06%	0.02%	0.20%	0.00%	-		↓		
	Total Number of Spells	Local	-	6212	1619	1758	2385	-	-	24663	6282	7063	11328	-		↑		
Exception Report - Patient Flow 2	A and E 4 hour target	National & Contract	95.00%	95.44%	-	95.44%	-	-	95.00%	95.17%	-	95.17%	-	-		→		
	Time to Initial Assessment (95th Percentile)	National	00:15:00	00:16:00	-	00:16:00	-	-	00:15:00	00:20:00	-	00:20:00	-	-		↓		
	Time to Treatment (Median)	National	01:00:00	01:00:00	-	01:00:00	-	-	01:00:00	00:58:00	-	00:58:00	-	-		↑		
	Unplanned Re-Attendance	National	5.00%	4.99%	-	4.99%	-	-	5.00%	5.04%	-	5.04%	-	-		↓		
	Left without being seen	National	5.00%	3.16%	-	3.16%	-	-	5.00%	3.29%	-	3.29%	-	-		↓		
	A&E Ambulance 30-60 mins	National	0	4	-	4	-	-	0	39	-	39	-	-		↑		
	A&E Trolley Waits	National	0	0	-	0	-	-	0	0	-	0	-	-		→		
	Improving recording of diagnosis in A&E	CQUINS	85.00%	86.34%	-	86.34%	-	-	85.00%	86.13%	-	86.13%	-	-		↓		
Exception Report - Elective Access	First DNA Rate	Local	7.00%	7.27%	7.33%	7.40%	6.98%	-	7.00%	6.77%	6.68%	6.58%	7.24%	2.70%		↑		
	% Hospital Initiated Outpatient Cancellations	Local	17.6%	14.10%	14.50%	14.50%	12.70%	-	17.6%	14.60%	15.00%	15.20%	12.70%	-		↓		
	Appointment Slot Issues on Choose & Book	Local	-	-	-	-	-	-	5.00%	15.00%	12.25%	22.56%	7.38%	-		→		
	No of Spells with > 2 Ward Movements	Local	-	151	22	98	31	-	-	558	88	352	118	-		↑		

	Report For: July 2015	Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Direction of travel (past 4 months)	Year End Forecast	Data Quality
									Year To Date									
RESPONSIVE - Elective Access	% Non-admitted Closed Pathways under 18 weeks	National & Contract	95.00%	98.23%	98.23%	97.78%	99.35%	-	95.00%	98.52%	98.55%	98.31%	98.92%	-		↓		
	% Admitted Closed Pathways Under 18 Weeks	National & Contract	90.00%	92.79%	92.07%	100.00%	96.17%	-	90.00%	92.40%	91.70%	100.00%	95.07%	-		↑		
	% Incomplete Pathways <18 Weeks	National	92.00%	95.55%	94.29%	99.23%	96.93%	-	92.00%	95.55%	94.29%	99.23%	96.93%	-		↑		
	18 weeks Pathways >=26 weeks open	Local	0	197	191	5	1	-	0	197	191	5	1	-		↓		
	18 weeks Pathways >=40 weeks open	National	0	4	4	0	0	-	0	4	4	0	0	-		→		
	% Diagnostic Waiting List Within 6 Weeks	National & Contract	99.00%	99.93%	100.00%	100.00%	99.90%	-	99.00%	99.87%	100.00%	100.00%	99.81%	-		↑		
	Community AHP - 18 Week RTT Activity	National	95.00%	97.80%	-	-	-	97.80%	95.00%	96.70%	-	-	-	96.70%		↑		
	Paediatric Therapies - 18 Week RTT Speech Therapy	National	95.00%	98.30%	-	-	-	98.30%	95.00%	97.80%	-	-	-	97.80%		↑		
	Paediatric Therapies - 18 Week RTT Occupational Therapy	National	95.00%	100.00%	-	-	-	100.00%	95.00%	94.00%	-	-	-	94.00%		↑		
	Paediatric Therapies - 18 Week RTT Physiotherapy	National	95.00%	100.00%	-	-	-	100.00%	95.00%	99.00%	-	-	-	99.00%		↑		
	% Last Minute Cancellations to Elective Surgery	National & Contract	0.60%	0.71%	1.10%	0.00%	0.60%	-	0.60%	0.67%	0.97%	0.03%	1.04%	-		↑		
	28 Day Standard for all Last Minute Cancellations	National & Contract	0	0	0	0	0	-	0	0	0	0	0	-		→		
	No of Urgent Operations cancelled for a second time	National & Contract	0	0	0	0	0	-	0	0	0	0	0	-		→		
RESPONSIVE: Cancer	62 Day Gp Referral to Treatment	National & Contract	85.00%	88.95%	89.09%	84.09%	100.00%	-	85.00%	90.05%	90.96%	88.39%	93.33%	-		↓		
	62 Day Referral From Screening to Treatment	National & Contract	90.00%	100.00%	100.00%	-	-	-	90.00%	97.83%	97.73%	-	100.00%	-		→		
	31 Day Subsequent Surgery Treatment	National & Contract	94.00%	100.00%	100.00%	100.00%	-	-	94.00%	100.00%	100.00%	100.00%	-	-		→		
	31 day wait for second or subsequent treatment drug treatments	National & Contract	98.00%	100.00%	100.00%	100.00%	-	-	98.00%	100.00%	100.00%	100.00%	100.00%	-		→		
	62 Day Aggregated Gp Urgent Referral To Treatment And Screening Referral To Treatment	National & Contract	86.00%	90.21%	90.77%	83.70%	100.00%	-	86.00%	90.66%	91.71%	87.75%	94.23%	-		↓		
	31 Days From Diagnosis to First Treatment	National & Contract	96.00%	100.00%	100.00%	100.00%	100.00%	-	96.00%	99.80%	99.68%	100.00%	100.00%	-		↑		
	Two Week Wait From Referral to Date First Seen	National & Contract	93.00%	95.64%	96.18%	94.17%	95.18%	-	93.00%	96.73%	97.89%	93.18%	98.18%	-		↓		
	Two Week Wait From Referral to Date First Seen: Breast Symptoms	National & Contract	93.00%	94.87%	94.87%	-	-	-	93.00%	94.55%	94.55%	-	-	-		↓		

Exception Report -Theatre Utilisation - Associate Director of Operations

Report For: July 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Theatre Utilisation (TT) - Main Theatre - CRH	92.50%	86.18%	84.77%	-	95.00%	-
Theatre Utilisation (TT) - HRI DSU	92.50%	76.50%	75.08%	-	86.78%	-
Theatre Utilisation (TT) - HRI SPU	92.50%	85.03%	85.03%	-	-	-



Theatre Utilisation:

Why off plan:

There are a number of factors as to why we are off plan:

- On the day cancellations.
- The scheduling process in place did not allow sufficient time for escalation.
- There is a challenge to delivery of 92% for day case lists due to high volume turnover of patients.
- There continues to be flow issues within the theatre process.

What are we doing about it?

- As part of the theatre work stream we have commenced a project looking at cancellations particularly on the day cancellations.
- A new scheduling process is now in place and we will see the benefits of this from September onwards.
- Split the target into a day case list and non-day case list target reflective following interrogation of data and review of best practice.
- Conduct a theatre activity week (akin to the perfect week) to assess what constraints there are in the theatre process .

When will we be on track:

- We would expect to see improvements in main theatres through September.
- Overall trajectory will be confirmed following the Theatre Activity Week

Report For: July 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Daily Discharges - Pre 11am	28.00%	11.44%	17.29%	6.68%	11.85%	-
Delayed Transfers of Care	5.00%	7.04%	-	-	-	-
Green Cross Patients (Snapshot at month end)	40	96	-	96	-	-
Number of Outliers (Bed Days)	465	859	250	609	0	-
% of Spells with > 2 ward movements (2% Target)	2.00%	2.43%	1.36%	5.57%	1.09%	-

Delayed Transfer of Care:

Why off plan:
1: Capacity changes in nursing home provision in July has increased delays; these are a combination of providers exiting the market and recovery plans in response to inspections.
2: Workforce constraints for Packages of care, a volume of patients remaining in reablement as a consequence which is causing exit block.
3: Lack of consistent escalation &/or active management of blockages.

Actions to improve:
1: Constructive meeting of system leaders across Calderdale attended by CQC to work collectively on options to minimise the on-going risks of nursing home provision Options in development include:
- Alternative nursing workforce model across health and social care – linking to vanguard
- Enhanced residential home provision for patients requiring minimal support
- Potential for an alternative ward model reflecting of Community bed
- Kirklees have met internally and awaiting outcome of their discussions with a full system meeting scheduled for September 15
2: Pathway for reablement review undertaken and criteria for entry amended to reflect national position.
- Future capacity requirement currently being mapped with potential to move some reablement capacity to Package of Care (reflecting analysis identified consistently more patients awaiting exit from reablement than delays into the service).
- A new provider of package of care commissioned
- Models to flex capacity across the localities to be developed
3: Urgent meeting with key accountable officers responsible for daily management of DTOC scheduled to agree further internal actions to improve performance.

When will this be back on track: Aiming to improve performance trend in September if no further Nursing home risks materialise. A detailed exception report will be provided in September for further assurance.

Attended Health Overview & Scrutiny Committee with CMDC in July and have been asked to attend with NHS partners in six months following which expectation is demonstrable improvement.

Pre 11 am discharges – performance is currently below the 28% target of all discharges by 11am.

Why off plan : Patient flow processes and the advanced planning for TTOs, transport and utilisation of discharge lounge is not robust or standardised across all ward areas demonstrated by variation at ward level.
The criteria for the utilisation of the discharge lounge requires review so that there is absolute clarity on the patients that can / cannot use this area.
Performance management at ward level is not consistently applied therefore driving improvement

Actions to get back on plan: Work with the four eyes team is currently at scoping / PID phase a key component of this improvement work is to try and achieve delivery of early morning discharges across the wards that are in scope. Learning from these pilot wards will then be spread across other areas.

Green X patient tracking has been formally separated from DTOC management reflecting these are a very different cohort however there is further work to do to now determine the patients identified as Green X who are actually ready for discharge. This is required as there will always be patients who are medically stable for discharge but are not ready for discharge and further transparency of this is essential to ensure actions are appropriately focussed and the target is appropriate.

The 'Plan For Every Patient' is not yet fully rolled out with Medical staff yet to be included (as per the original plan); this is being picked up with Four Eyes as they develop the roll out of the efficiency work.
The process for escalation and management of key themes was discussed at project board and guidance being developed for circulation to all wards and departments ensuring timely escalation and response to themes supported by a revised process for the performance management of teams that are contributing to high volumes of delays

No of outliers

Why off plan – The number of outliers in month from medicine into the surgical bed base equates to 19 beds worth and is directly linked to the bed availability and the increased non-elective admissions above the planned level.

Actions to get back on plan - The bed modelling analysis has highlighted the number of beds required in order to deliver a 90% occupancy, which will allow the reduction in number of outliers into the surgical bed base. The bed modelling is currently being converted into an operational plan which we would have in place from September onwards.

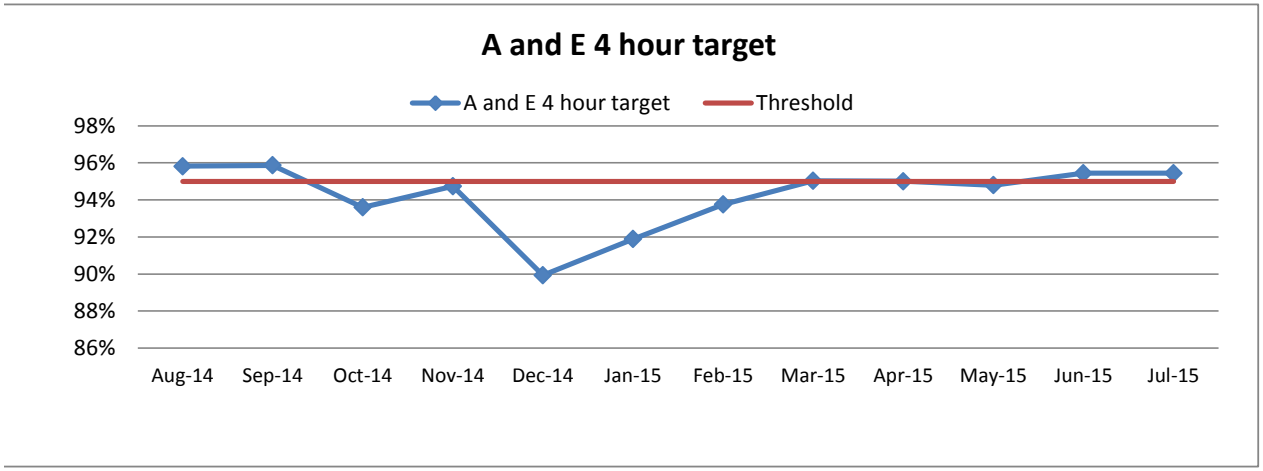
>2 moves – Performance is currently 2.43% against a target of 2.00%

Why off plan : The data collected identifies all patient moves both for clinical and non-clinical reasons. Bed pressures lead to transfers of patients for non-clinical reasons in order to ensure adequate capacity for newly admitted acute patients.

Actions to get back on plan: The bed modelling work identifies the required bed base to minimise the number of patients who are moved into surgical beds. The operational plan for which beds are opened up and by when is currently being worked up. Four eyes have been commissioned to work with the trusts bed efficiency work stream the project is currently being scoped out however it is anticipated that it will lead to earlier discharges of patients and a reduction in LoS. It is expected that this will lead to a reduction in the number of patients who are moved from one ward to another for non-clinical reasons. Some improvement expected from September 2015 onwards.

Exception Report - Patient Flow - Associate Director of Operations

Report For: July 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
A and E 4 hour target	95.00%	95.44%	-	95.44%	-	-
A&E Ambulance 30-60 mins	0	4	-	4	-	-



Emergency care standard

July position compliant with the 95% standard and delivered at 95.4% although not sustainable with daily variation in breach numbers particularly Monday/Tuesday

Risk continues with ongoing delivery requiring close monitoring and micro-management via ED action plan which is presented to the divisional management team on a fortnightly basis.
Main area of risk associated with 'Exit Block' with the key reasons for breaches due to awaiting beds. Bed modelling work completed and presented at WEB and due to be presented to board of directors at the end of August. Actions being put in place to formalise the beds plan.

Report For: July 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
First DNA Rate	7.00%	7.27%	7.33%	7.40%	6.98%	-
18 weeks Pathways >=40 weeks open	0	4	4	0	0	-
% Last Minute Cancellations to Elective Surgery	0.60%	0.71%	1.10%	0.00%	0.60%	-

Cancelled Ops:

Why the target is away from plan: Some cancellations relate to bed pressures and whilst we are trying to manage these proactively, they are still occurring. Session overrun linked to a combination of late start, late decision making around bed availability and the drive to increase theatre through put volumes. Some concerns regarding the current level of authorisation of cancellations contributing to the performance.

What are we doing to get it back to plan:

1 Decisions around medical bed base will have a step benefit in performance.
2 Increased focus and structure to theatre scheduling meetings with active participation of Theatre Team Leaders.
3 Authorisation for cancellation protocol being developed ; ADD level only .
4 Theatre utilisation project to focus on pragmatic first patient process in pararel to bed allocation.
When will this be achieved: Looking to bring this back in line by the end of quarter 2.

First DNAs have increased slightly across the 3 divisions in comparison to previous months, this is a seasonal trend.

18 Weeks Pathways > = 40 weeks open:

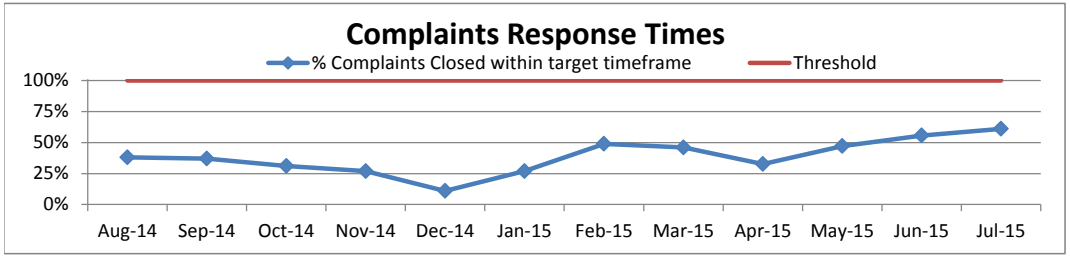
Current process for reporting of waiting list still requires a manual connection between diagnostics and admitted incompletes following validation. A query has been raised by the Divisional team regarding the validation process which is currently being investigated as risk of over reporting long waiting patients. Review to be completed and update at next meeting
Where patients are identified as long waiters dates are immediately agreed.

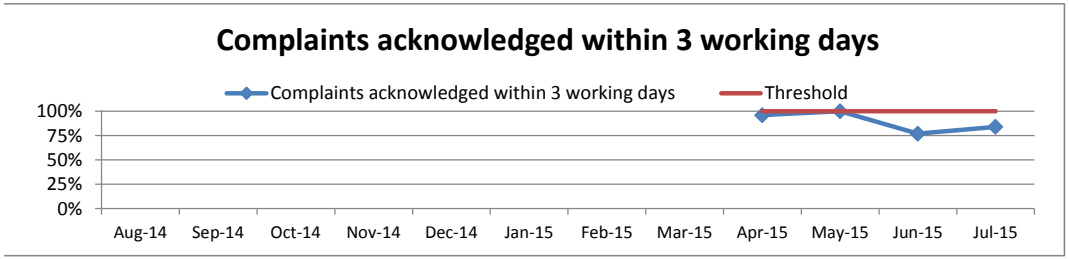
Appointment Slot Issues :

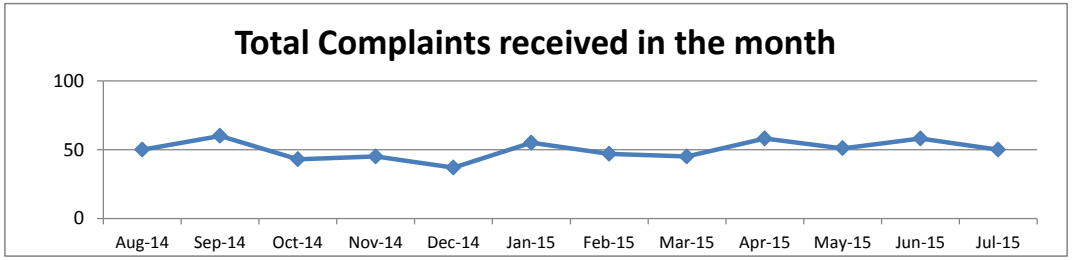
Details of action plan shared with Trust Board in July and now in progress; monitoring established through weekly meeting but will be a timelag to improvement. Next update scheduled for September.

	Report For: July 2015	Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Direction of travel (past 4 months)	Year End Forecast	Data Quality
									Year To Date									
Complaints	Number of Mixed Sex Accommodation Breaches	National & Contract	0	0	0	0	0	-	0	0	0	0	0	-		↑		
	% Complaints closed within target timeframe	Local	100.00%	61.11%	58.33%	64.71%	75.00%	25.00%	100.00%	50.38%	44.68%	45.92%	70.21%	22.22%		↑		
	Total Complaints received in the month	Monitor	-	50	19	13	15	3	-	222	75	73	48	9		↓		
	Complaints acknowledged within 3 working days	Local	100.00%	84.00%	74.00%	87.00%	93.00%	100.00%	100.00%	81.00%	76.00%	86.30%	81.25%	20.00%		↑		
	Total Concerns in the month	Monitor	-	64	25	19	8	7	0	227	74	73	45	11		→		
	% of diabetic patients supported to self-care	CQUINS	50.00%	54.55%	-	54.55%	-	-	50.00%	69.57%	-	69.57%	-	-		↓		
	End of Life Care Plan in place	CQUINS	-	44.83%	-	-	-	-	-	37.86%	-	-	-	-		↑		
	Percentage of non-elective inpatients 75+ screened for dementia	CQUIN	90.00%	92.24%	-	-	-	-	90.00%	91.75%	-	-	-	-		↑		
	Nutrition and Hydration - Reducing Hospital Food Waste (reported quarterly)	CQUINS	-	-	-	-			-	5.70%	-	-						
	Nutrition and Hydration - Patient Satisfaction (Reported quarterly)	CQUINS	-	-	-	-			-	-	-	-						
Friends & Family Test	Friends & Family Test (IP Survey) - Response Rate	Contract	40.00%	26.50%	30.60%	21.40%	25.70%	-	40.00%	23.80%	26.30%	26.60%	22.70%	-		↑		
	Friends & Family Test (IP Survey) - % would recommend the Service	Contract	95.00%	96.60%	97.00%	95.10%	98.50%	-	95.00%	97.00%	97.90%	95.80%	98.30%	-		↓		
	Friends and Family Test A & E Survey - Response Rate	Contract	30.00%	5.70%	-	5.70%	-	-	30.00%	7.70%	-	7.70%	-	-		↓		
	Friends and Family Test A & E Survey - % would recommend the Service	Contract	95.00%	91.10%	-	91.10%	-	-	90.50%	90.80%	-	90.80%	-	-		→		
	Friends & Family Test (Maternity) - % would recommend the Service	Contract	95.00%	97.80%	-	-	97.80%	-	95.00%	93.80%	-	-	93.80%	-		↑		
	Friends and Family Test Community Survey - % would recommend the Service	Local	95.00%	92.00%	-	-	-	92.00%	95.00%	90.69%	-	-	-	90.69%		↑		

Report For: July 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Complaints closed within target timeframe	100.00%	61.11%	58.33%	64.71%	75.00%	25.00%
Complaints acknowledged within 3 working days	100.00%	84.00%	74.00%	87.00%	93.00%	100.00%







% Complaints closed within target timeframe

1. Why off plan? The performance rate remains in line with the improvements seen in the previous month, however still remains below target. There are no longer any complaints overdue by 3 months or more. Of note, there has been an overall increase in volume of complaints (10% increase compared to same period in 2014/15), this coupled with the drive to close the older complaints has had an effect on performance.

2. Actions to get on plan? The drive now continues to conclude all cases ongoing over timescale. At the end of July, 37 complaints are overdue by up to one month, 8 by 1 to 2 months and 2 by 2 - 3 months). The weekly performance report continues to support Divisions in recognising their overdue cases and increased monitoring and support both within Division and the Patient Advice and Complaints team will begin help to improve this position further.

3.Achieved by date: All cases ongoing over target to be completed by divisions as a matter of urgency. All new and remaining cases to be managed in target.

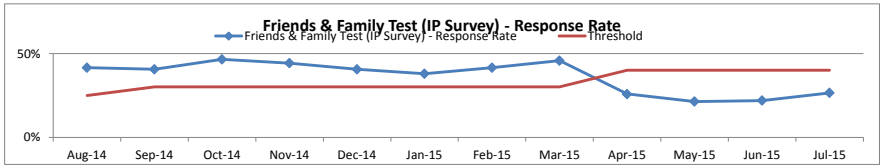
Complaints acknowledged within 3 working days

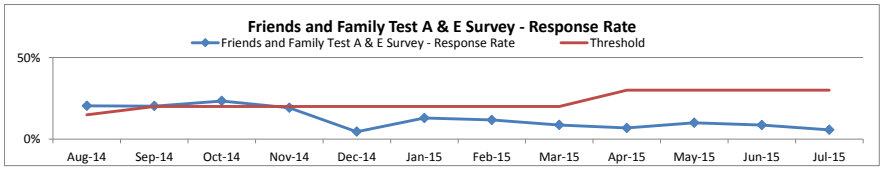
1. Why off plan? Whilst this is an improved position against June's performance of 77%, there is still a residual effect of staffing pressures , coupled with with an increased workload in reference to the number of complaint which were received in June. 6 of 50 complaints missed acknowledgment target by 1 day.

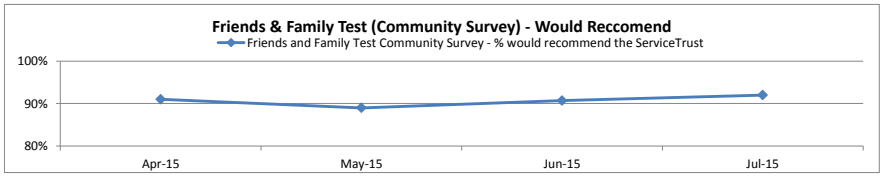
2. Actions to get on plan? Continue the plan to be flexible with the use of the administrative staff to improve resilience during the holiday period.

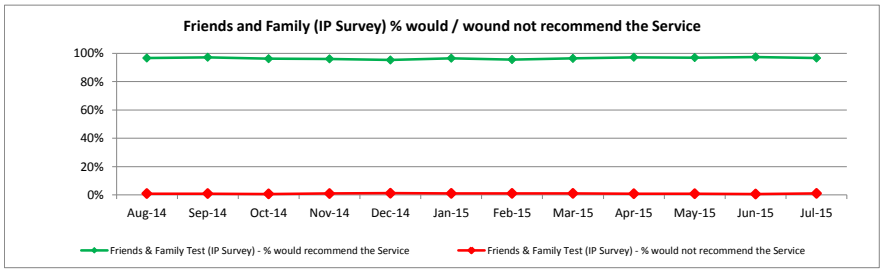
3.Achieved by date: Performance expected to continue to improve next month.

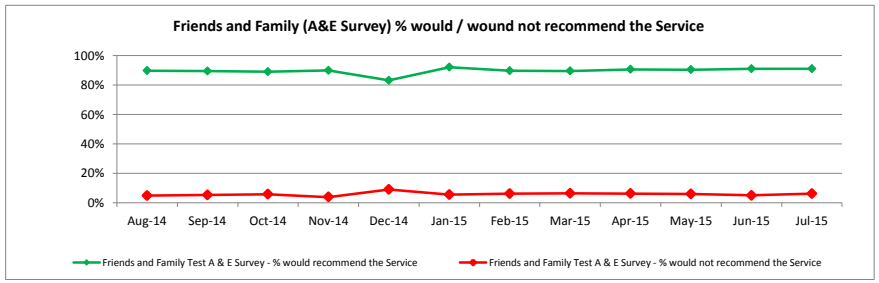
Report For: July 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Friends & Family Test (IP Survey) - Response Rate	40.00%	26.50%	30.60%	21.40%	25.70%	-
Friends and Family Test A & E Survey - Response Rate	30.00%	5.70%	-	5.70%	-	-
Friends and Family Test A & E Survey - % would recommend the Service	95.00%	91.10%	-	91.10%	-	-
Friends and Family Test Community Survey - % would recommend the Service	95.00%	92.00%	-	-	-	92.00%











Inpatient FFT Response Rate:

1.Why off plan: As predicted last month ,some improvement has been seen in the response rate. 26% compared to 21% last month. The initial reduction in performance was related to the requirement for including all admissions regardless of whether there has been an overnight stay, prior to April 2015 this was not the case.

2.Actions to get back on plan: Divisional FFT leads are continuing to liaise with the relevant teams to ensure they are aware of the need to commence the FFT process for this patient group.

A&E FFT - Response Rate & Would Recommend:

1.Why off plan: The A&E response rate continues to be a challenge and current methods are not eliciting high response rates.

2.Actions to get back on plan: The planned implementation of SMS text messaging is due in September 2015, after which a higher response rate is expected to be seen. In the mean time staff continue to promote the use of feedback using the post card approach.

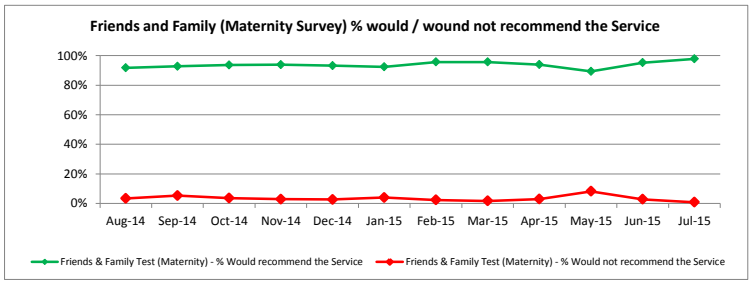
3.Achieved by date: It is anticipated that improvements will be seen from

Community FFT - Would Recommend:

1.Why off plan: Performance continues to increase however remains below targets. The current method of data collection is the use of SMS text messaging. This method does not allow comments to be related back to the individual service which makes targeting improvements more difficult.

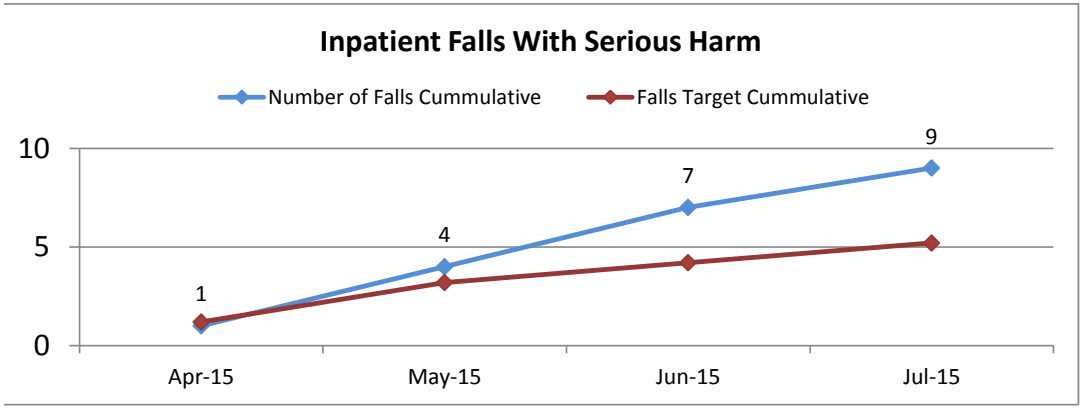
2.Actions to get back on plan: The decision has been made to move to a variety of data collection methods which will run alongside the text service. This will include a web based method which staff can ask patients to input directly onto a mobile device such as staff lap tops or mobile phones. This may be a challenge where connectivity issues have been identified but the teams will also have access to postcards which they can distribute to patients and collect on a follow up visit. These methods will enable further examination to see where patients are not yet feeling that they would recommend the service and why.

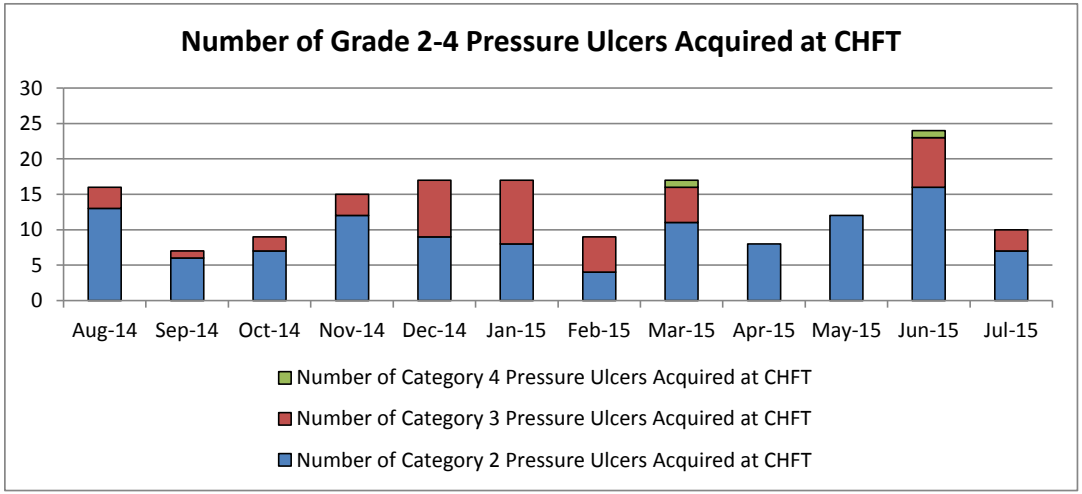
3.Achieved by date: The new data collection methods are expected to be embedded during September with improvements seen shortly after.



	Report For: July 2015	Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Year To Date: Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Direction of travel (past 4 months)	Year End Forecast	Data Quality
Safety	Inpatient Falls with Serious Harm (10% reduction on 14/15)	Local	1	2	0	2	0	-	5	9	1	8	0	-		↓		
	All Falls	Local	-	139	19	119	1	-	-	641	105	524	12	-		↓		
	Number of Trust Pressure Ulcers Acquired at CHFT	Local	16	10	3	7	0	-	63	79	20	57	2	-		↓		
	Number of Category 2 Pressure Ulcers Acquired at CHFT	Local	11	7	0	7	0	-	45	55	13	40	2	-		↓		
	Number of Category 3 Pressure Ulcers Acquired at CHFT	Local	5	3	3	0	0	-	20	22	7	15	0	-		↓		
	Number of Category 4 Pressure Ulcers Acquired at CHFT	Local	0	0	0	0	0	-	4	2	0	2	0	-		↓		
	Number of Category 3 & 4 Pressure Ulcers Acquired at CHFT	Local	0	3	3	0	0	-	0	24	7	17	0	-		↓		
Safety 2	Percentage of Completed VTE Risk Assessments	National & Contract	95.00%	95.90%	94.90%	96.20%	98.10%	-	95.00%	95.40%	94.90%	94.90%	97.30%	-		↑		
	Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	Local	100.00%	100.00%	100.00%	100.00%	-	-	100.00%	100.00%	100.00%	100.00%	-	-		→		
	% Harm Free Care	CQUIN	95.00%	93.96%	92.21%	94.34%	96.20%	94.22%	95.00%	94.37%	92.74%	94.56%	99.71%	94.88%		↓		
	Safeguarding Alerts made by the Trust	Local	-	29	-	-	-	-	-	77	-	-	-	-		↑		
	Safeguarding Alerts made against the Trust	Local	-	10	-	-	-	-	-	34	-	-	-	-		↑		
	Improving Medicines Safety – Reconciliation (Effective Transfer of Medicines)	CQUINS	80.00%	80.00%	-	-	-	-	80.00%	80.02%	-	-	-	-		↑		
	Improving Medicines Safety Discharge Accuracy Checks	CQUINS	70.00%	86.27%	-	-	-	-	70.00%	75.98%	-	-	-	-		↑		
	World Health Organisation Check List	National	100.00%	98.60%	-	-	-	-	100.00%	97.72%	-	-	-	-		↑		
	Missed Doses (Reported quarterly)	National	-	-	-	-	-	-	-	7.80%	9.63%	7.10%	6.55%	-				
Safety 3	Never Events	National	0	0	0	0	0	0	0	0	0	0	0	0		→		
	Total Duty of Candour reported within the month	National & Contract	100.00%	100.00%	100.00%	100.00%	-	100.00%	-	-	-	-	-	-		→		
	Total Duty of Candour outstanding at the end of the month	National & Contract	0	0	0	0	-	0	0	5	3	4	0	0		→		

Report For: July 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Inpatient Falls with Serious Harm (10% reduction on 14/15)	1	2	0	2	0	-
Number of Category 3 & 4 Pressure Ulcers Acquired at CHFT	0	3	3	0	0	-





Falls with Serious Harm

1.Why off plan: There have been 9 falls in the year so far, against a 10% reduction target of 5. (There have been 8 falls in medicine and 1 in surgery)

2.Actions to get back on plan: There is now a risk to achieving the year end target. A paper will go to the September Patient Safety Group with recommendations for next steps . Following a thematic review of the falls to date, the Medical Division Falls collaborative has been reconvened to focus upon improvements in medicine and will meet in August 2015 .

3. Achieved by date: Improvements are expected from the end of August 2015 in light of the recommendations given to the Patient Safety Group and the Medicine Falls

Pressure Ulcers:

Please note that the number of pressure ulcer incidents appears to have fallen this month, however due to system upgrades and the resulting down time of the Incident reporting system, some delays in processing validations have taken place. This will be rectified shortly and performance data refreshed in subsequent reports.

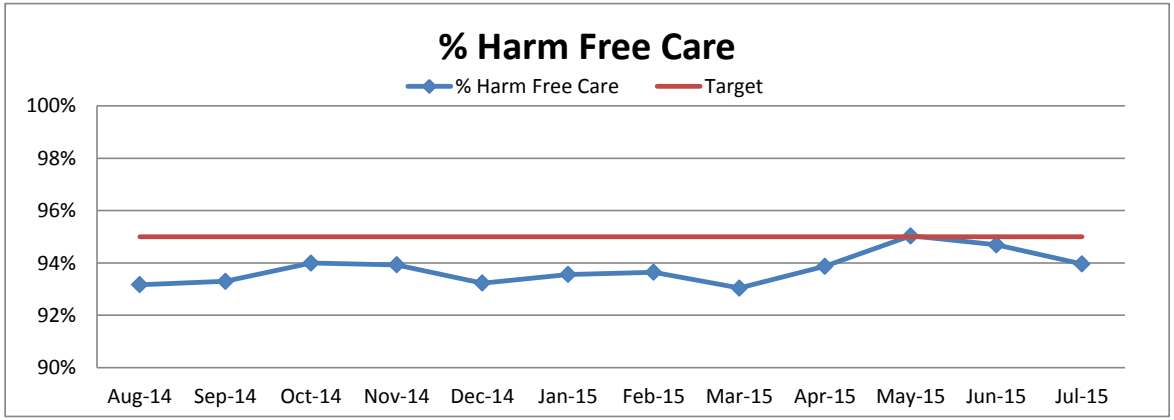
Pressure Ulcers - Category 3 & Category 4.

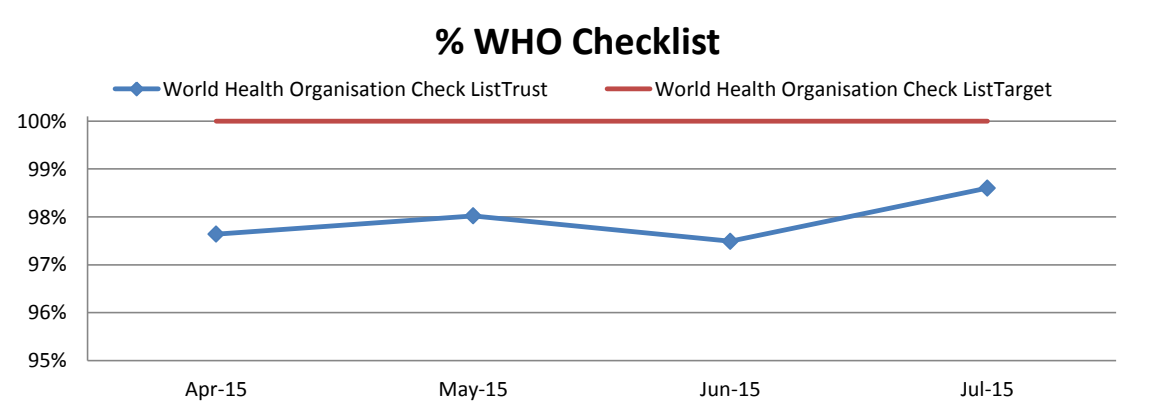
1.Why off plan? There are 3 category ulcers so far noted for July.

2. Actions to get back on plan: The outcome of the thematic review which took place through out July is awaited, following this actions will be put in place to address any issues which have emerged .

3. Achieved by date: As described in the previous month, once the thematic review and action plan is put in place, improvements are expected from September 2015 onwards.

Report For: July 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Harm Free Care	95.00%	93.96%	92.21%	94.34%	96.20%	94.22%
World Health Organisation Check List	100.00%	98.60%	-	-	-	-





Harm Free Care:

1. Why off plan? Harm free care for the trust is at 93.96%. With all divisions seeing a poorer position that the previous month. The harm events contributing to this are primarily old pressure ulcers, these are ulcers which are present on admission or developed within the first 72hours of admissions, alongside this were 6 new ulcers, 4 Falls, 9 UTIs in patients who had catheters and 6 VTEs

2. Actions to get back to plan: Work is ongoing to improve the trust position in relation to the number of Ulcers and Falls occurring in the trust (Please see detail on page 16). Phase two of the improvement work focusing on the appropriate use of indwelling catheters began in July 2015 and will see 6 wards becoming engaged in the work., as well as one community area. VTEs risk assessment compliance continues to be monitored.

3.Achieved by date: See individual subject areas for Ulcers and Falls (page 16).

World Health Organisation Check List

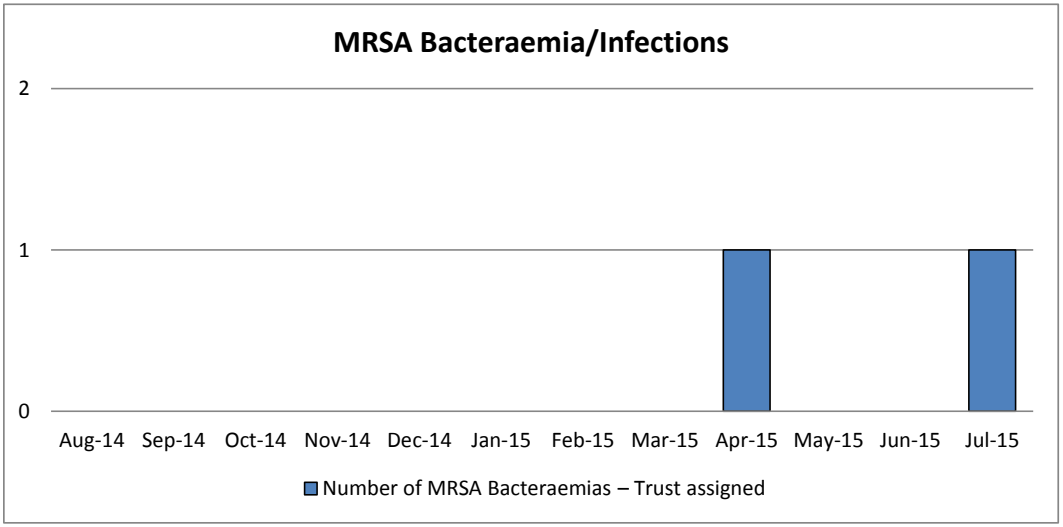
1. Why off plan? There are groups of patients who don't require the WHO checklist. The current theatre system is unable to exempt these cases. There are also a few technical issues where part of the form is not saved which leads to an uncompleted case being noted. It is very rare event that a person does not have a checklist completed. Engagement work undertaken in May/June is contributing to the slight improvement this month.

2. Actions to get it back on plan: Performance monitoring for the small number of non-compliant cases, leading to engagement work in the clinical teams. For the exempt patients a theatre system upgrade has been requested to have a N/A option included.

3. Achieved by date: The next system upgrade will be in September 2015.

Report For: July 2015		Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Year To Date Target	Year To Date Trust	Year To Date Surgical	Year To Date Medical	Year To Date Families and Specialist Services	Year To Date Community	Trend (Rolling 12 Month)	Direction of travel (past 4 months)	Year End Forecast	Data Quality
Effectiveness	Number of MRSA Bacteraemias – Trust assigned	National & Contract	0	1	0	0	0	1	0	2	0	1	0	1		↑		
	Total Number of Clostridium Difficile Cases - Trust assigned	National & Contract	2	1	0	1	0	-	8	4	1	3	0	-		→		
	Avoidable number of Clostridium Difficile Cases	National & Contract	0	0	0	0	0	-	21	2	1	1	0	-		↓		
	Unavoidable Number of Clostridium Difficile Cases	National & Contract	2	1	0	1	0	-	8	2	0	2	1	-		↑		
	Number of MSSA Bacteraemias - Post 48 Hours	National	1	0	0	0	0	-	4	3	1	2	0	-		↓		
	% Hand Hygiene Compliance	Local	95.00%	99.65%	98.85%	99.95%	100.00%	100.00%	95.00%	99.66%	99.07%	99.79%	99.80%	100.00%		↑		
	MRSA Screening - Percentage of Inpatients Matched	Local	95.00%	96.78%	95.16%	99.72%	92.68%	-	95.00%	95.64%	93.76%	99.30%	94.81%	-		↑		
	Number of E.Coli - Post 48 Hours	Local	3	3	1	2	0	-	10	12	3	9	0	-		↓		
Effectiveness 2	Emergency Readmissions Within 30 Days (With PbR Exclusions)	National	7.44%	7.82%	4.82%	11.62%	6.06%	-	7.60%	8.24%	4.59%	12.67%	6.52%	-		↑		
	Emergency Readmissions Within 30 Days (With PbR Exclusions) - Calderdale CCG	Local	7.80%	7.80%	-	-	-	-	7.80%	8.40%	-	-	-	-		↓		
	Emergency Readmissions Within 30 Days (With PbR Exclusions) - Greater Huddersfield CCG	Local	7.40%	8.30%	-	-	-	-	7.40%	8.63%	-	-	-	-		↑		
	Local SHMI - Relative Risk (1yr Rolling Data Jan14- Dec 14)	National	100	109	-	-	-	-	100	109	-	-	-	-		→		
	Hospital Standardised Mortality Rate (1 yr Rolling Data Apr 14 - Mar 15)	National	100	110.00	-	-	-	-	100.00	108.53	-	-	-	-		→		
	Mortality Reviews – May Deaths	local	100.00%	21.10%	46.20%	18.70%	-	-	100.00%	42%	46.90%	41.70%	-	-		↑		
	Crude Mortality Rate (Latest Month July 15)	National	0.98%	1.08%	0.21%	2.74%	0.03%	-	1.16%	1.32%	0.40%	3.20%	0.07%	-		↓		
	Completion of NHS numbers within acute commissioning datasets submitted via SUS	Contract	99.00%	99.90%	99.90%	99.90%	99.90%	-	99.00%	99.90%	99.90%	99.90%	99.90%	-		→		
	Completion of NHS numbers within A&E commissioning datasets submitted via SUS	Contract	95.00%	99.10%	-	99.10%	-	-	95.00%	99.10%	-	99.10%	-	-		→		
	Average Diagnosis per Coded Episode	National	4.90	3.98	3.45	5.54	2.19	-	4.90	3.96	3.39	5.52	2.24	-		↑		
Effectiveness 3	Acute Kidney Injury (Reported quarterly)	CQUINS	Baseline	22.00%	-	-	-	-	-	21.50%	-	-	-	-				
	Sepsis Screening (Reported quarterly)	CQUINS	Baseline	100.00%	-	-	-	-	-	88.24%	-	-	-	-				
	Sepsis Antibiotic Administration (Reported Quarterly)	CQUINS	Baseline	80.00%	-	-	-	-	-	50.00%	-	-	-	-				
	Respiratory Care Bundle - Improving management of patients attending A&E with pneumonia (Reported quarterly)	CQUINS	60.00%	70.00%	-	-	-	-	60.00%	70.00%	-	-	-	-				
	Respiratory Care Bundle - Improving management of patients presenting with Asthma in ED (Reported quarterly)	CQUINS	65.00%	66.00%	-	-	-	-	65.00%	66.00%	-	-	-	-				
	Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	National	85.00%	71.43%	71.43%	-	-	-	85.00%	69.87%	69.87%	-	-	-		↓		

Report For: July 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Number of MRSA Bacteraemias – Trust assigned	0	1	0	0	0	1



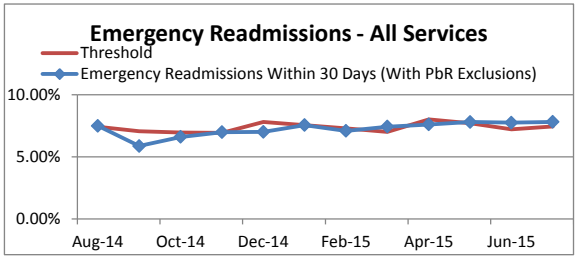
MRSA Bacteraemia

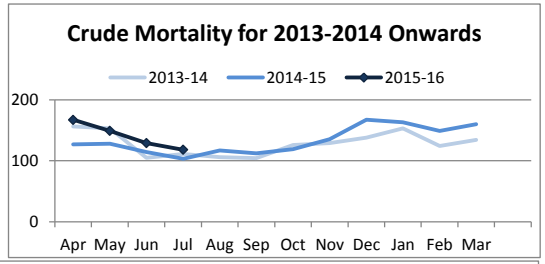
1.Why off Plan: A pre admission MRSA case was assigned to the acute trust ,due to their being missed opportunities, by the community nursing team, to swab the wound, prior to the septic event on admission.

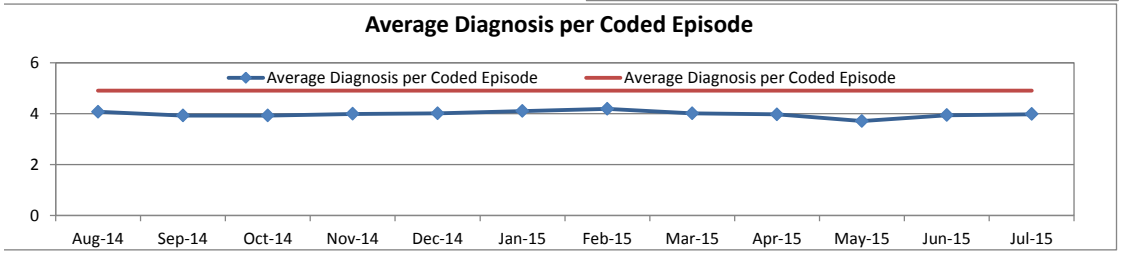
2.Action to get back on plan: The community nursing team are implementing actions which will ensure appropriate wound swabbing is carried out in the future..

3. Achieved by date: September 2015

Report For: July 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Emergency Readmissions Within 30 Days (With PbR Exclusions)	7.44%	7.82%	4.82%	11.62%	6.06%	-
Emergency Readmissions Within 30 Days (With PbR Exclusions) - Calderdale CCG	7.80%	7.80%	-	-	-	-
Emergency Readmissions Within 30 Days (With PbR Exclusions) - Greater Huddersfield CCG	7.40%	8.30%	-	-	-	-
Local SHMI - Relative Risk (1yr Rolling Data Jan14- Dec 14)	100	109	-	-	-	-
Hospital Standardised Mortality Rate (1 yr Rolling Data Apr 14 - Mar 15)	100	110	-	-	-	-
Crude Mortality Rate (Latest Month July 15)	0.98%	1.08%	0.21%	2.74%	0.03%	-
Mortality Reviews – May Deaths	100.00%	21.10%	46.20%	18.70%	-	-
Average Diagnosis per Coded Episode	4.90	3.98	3.45	5.54	2.19	-







Emergency Readmissions Within 30 Days (With PbR Exclusions)

Concerns raised by Locala regarding cause and effect of Kirklees readmission data as reported in previous report. Audit trail of both Virtual Ward teams being reviewed and a meeting between Operational Director of Locala and Associate Director of Operations at CHFT agreed to establish the optimal model to secure delivery across the system.

SHMI/HSMR/Crude Mortality

1. Why it is off plan? The most recent release indicated a SHMI which was maintained at 109 the 12 months of Jan 14 to Dec14. It remains in the "as expected" category, indicating that there are not significantly more deaths than would be expected for the trusts patient population. The most recent 12 months data for HSMR indicates a score of 110.59, which is an increase from previous release and is an outlying position. The July 2015 crude mortality is also higher than the same point in the previous year (please note the target has been changed to be a comparative measure as to the previous years mortality rates as opposed to a fixed value. This lends itself to being more informative when looking at any potential reduction/increase in crude mortality). The number of mortality reviews carried out on May's deaths is also under target.

2.Action to get back on plan: A draft of the revised Acutely ill Patient (CAIP) plan was discussed at COG in August, and will be finalised for September 2015 with external support assisting in further understanding why the HSMR position appears to be deteriorating . A mortality review process has been written, which clarifies the processes including a new process of getting deceased's' case notes delivered to clinical reviewers to get more timely learning and a greater number of reviews carried out. This will enable identification of key problem areas to focus improvements.

3.Achieved By: Improvements in Mortality Review compliance expected next month.

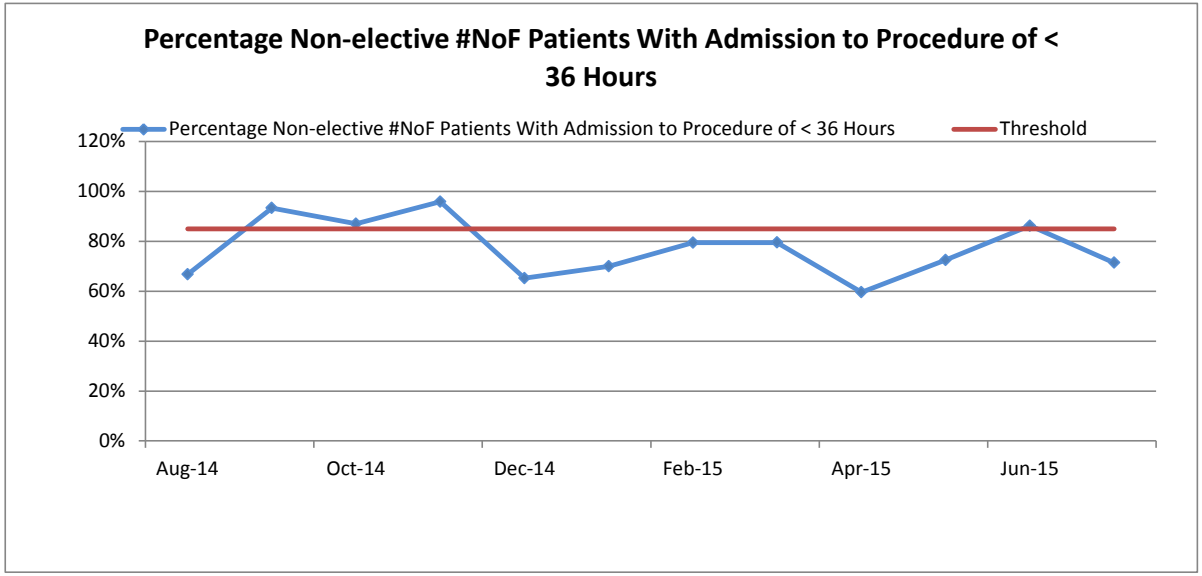
Average Diagnosis per Coded Episode

1. Why off plan? CHFT depth of coding is less than plan due to missed or undocumented relevant comorbidities within the coding source documentation. May also be due to incomplete coding documentation at the time of coding. Clinical Coding depth is falling largely due to the result of changes to coding rules at the start of April 2015. Prior to April 2015 patients admitted for blood transfusions, drug infusions, terminations, pain injections, eye injections codes were included to specify admission for drug therapy or admission for blood transfusion. From April 2015 under the new national coding rules these codes should not be included in the coding of the stay. Consequently the average diagnoses per episode has dropped quite dramatically. Omission of the codes does not affect the comorbidity score or income.

2. Action to get it back on plan: Clinical engagement and presentations continue around importance of complete and accurate documentation including work to develop existing documentation to assist coding process. Co-morbidity form compliance continues to be monitored on a fortnightly basis. The recruitment process is now underway.

3. Achieve by date: End of FY 2015/16

Report For: July 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	85.00%	71.43%	71.43%	-	-	-



Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours

1. Why off plan?

The variation in demand for trauma theatre is not matched with flxeible enough capacity causing sporadic blockages and delays. The current process to respond is not timely enough to secure access to thetare within 36 hours as seeks theatre capacity for the #NOF patient not the elective.

This miss match and flaws in the process were highlighted in July and compounded by poor escalation from the local team. This picture has been repeated in August with existing monitoring systems not picking this up in a timely manner

2. Actions to get back on plan:

- Requirement to prioritise #NOF patients at Trauma meeting re-iterated
- Process for additional theatre capacity changed so that additional capacity is found for displaced elective work thereby prioritising access for the most vulnerable patients
- Increased daily monitoring implemented within the Division
- Extraordinary meeting with clinical leads arranged to ensure clarity on roles and responsibilties scheduled for 20th August 15
- From this month forward, all patients missing >1 component of best practice guidance (of which this is one component) will have an RCA completed

3. Achieved by date: The Directorate is expecting to meet 85% of this standard by September 2015.

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Workforce indicators

The row of tables below show sickness absence rates for CHFT during May and June 2015, broken down by division, identifying movement from the previous month, performance against the 4% threshold.

The second row of tables show the average length of a sickness episode, identifying movement from the previous month. The next tables look at the year to date performance of CHFT and the divisions against the 4% target. The final table looks at staff in post by headcount and full time equivalent (FTE).

FTE Days Lost is calculated by taking the FTE of the employee and multiplying by the length of sickness (in days). For example an employee on 0.5 FTE who is sick for 4 days would equate to an FTE Days Lost of 2.0

FTE Days Available is calculated by taking the FTE of the employee and multiplying by the number of days in the reporting period. For example during May an employee on 0.5 FTE would have 15.5 FTE Days Available.

Sickness Absence rate (%) (1 Month Behind)

Division	May-15	Jun-15	Movement
Surgery	4.13%	4.45%	↑
Medical	5.53%	5.05%	↓
Community	3.66%	3.68%	↑
FSS	5.36%	5.05%	↓
Estates	5.79%	6.05%	↑
Corporate	2.26%	1.68%	↓
THIS	3.47%	3.86%	↑
Trust	4.72%	**4.58%**	↓

Sickness Absence rate (%) (1 Month Behind)

Division	Short Term	Long Term	Overall %	RAG
Surgery	1.20%	3.25%	4.45%	🔴
Medical	1.18%	3.87%	5.05%	🔴
Community	0.56%	3.12%	3.68%	🟢
FSS	1.26%	3.80%	5.05%	🔴
Estates	1.71%	4.34%	6.05%	🔴
Corporate	0.50%	1.18%	1.68%	🟢
THIS	0.39%	3.47%	3.86%	🟢
Trust	**1.09%**	**3.49%**	**4.58%**	🔴

Sickness Absence full time equivalent (FTE) breakdown (1 Month Behind)

Division	Available FTE	Short Term FTE	Long Term FTE	FTE Days Lost
Surgery	32311.14	388.46	1049.12	1437.58
Medical	37826.93	447.46	1463.22	1910.68
Community	18314.97	101.78	572.31	674.09
FSS	39006.14	490.26	1480.50	1970.76
Estates	8227.31	140.79	357.17	497.96
Corporate	8289.77	41.16	98.00	139.16
THIS	5358.80	21.00	186.00	207.00
Trust	**149335.06**	**1630.91**	**5206.32**	**6837.23**

Sickness Absence rate (%) (1 Month Behind)

Staff Group	May-15	Jun-15	Movement
Add Sci & Tech	2.55%	2.17%	↓
ACS	7.27%	6.93%	↓
Admin & Clerical	4.10%	3.88%	↓
AHP	3.60%	2.98%	↓
Estates & Ancil.	5.85%	4.99%	↓
Healthcare Scientists	2.23%	2.32%	↑
Medical and Dental	0.96%	0.57%	↓
Nursing & Midwifery	5.15%	5.12%	↓

Sickness Average FTE Lost per Episode

Division	May-15	Jun-15	Movement
Surgery	10.59	10.20	↓
Medical	9.72	9.41	↓
Community	9.77	11.23	↑
FSS	10.96	9.52	↓
Estates	9.58	11.32	↑
Corporate	6.97	8.19	↑
THIS	10.63	12.94	↑
Trust	10.14	9.94	↓

Sickness Absence full time equivalent (FTE) breakdown Year to Date

Division	Available FTE	FTE Days Lost	YTD Sicknes %	RAG
Surgery	398178.15	17346.64	4.36%	🔴
Medical	471863.31	24244.48	5.14%	🔴
Community	231493.02	8800.47	3.80%	🟢
FSS	495604.13	23037.98	4.65%	🔴
Estates	107078.77	5456.27	5.10%	🔴
Corporate	101407.80	1726.20	1.70%	🟢
THIS	68791.40	2392.76	3.48%	🟢
Trust	**1874416.60**	**83004.80**	**4.43%**	🔴

Staff in Post Full Time Equivalent

Division	Jun-15	Jul-15	Movement
Surgery	1076.87	1064.89	↓
Medical	1257.76	1256.48	↓
Community	608.01	596.30	↓
FSS	1297.78	1297.43	↓
Estates	273.67	265.67	↓
Corporate	276.49	272.57	↓
THIS	179.33	180.33	↑
Trust	**4969.89**	**4933.66**	↓

Staff in Post Headcount

Jun-15	Jul-15	Movement
1201	1188	↓
1406	1404	↓
748	734	↓
1522	1520	↓
359	350	↓
316	312	↓
186	187	↑
5738	**5695**	↓

Sickness Absence/Attendance Management at work

Why are we away from plan -
Community and Corporate are the only divisions with a % below the 4% threshold identified . Short term sickness absence for the Trust is at 1.09% long term absence at 3.49% . The June 2015 figure compares to a June 2014 figure of 1.34% short term absence and long term absence of 2.52%. The 2015-16 year to date sickness rate of 4.43% compares to a 2014-15 outturn sickness rate of 4.26%.
e a number of key interventions planned to address the current rate of sickness absence:
dedicated absence manager resource to support divisional activity/line managers
promotion increasing awareness of health and lifestyle
Evidence based data driven – target action (BI)
Clear and simple attendance management policy
Joined up approach – Line manager/HR/Occupational Health/Staff Side
Fast access to Occupational Health and Physiotherapy
Robust return to work process – Meetings and plans
Training for Managers – " how to ….."
Realistic improvement targets
Case management approach
Early intervention
Active management

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Training indicators

Mandatory Training Indicators completetd since April 2015								
Division	Prevent	Equality & Diversity	Information Governance	Infection Control	Health & Saftey	Manual Handling	Safe Guarding	Fire safety
Surgery	7.0%	24.50%	26.80%	20.70%	20.50%	20.30%	11.4%	20.00%
Medical	3.5%	24.20%	29.30%	23.60%	22.40%	23.20%	13.9%	19.40%
FSS	4.3%	24.40%	29.30%	22.80%	21.30%	21.40%	11.2%	33.60%
Community	4.6%	23.20%	26.30%	19.10%	17.40%	19.10%	9.3%	30.90%
Estates	1.2%	11.00%	13.60%	13.10%	12.80%	12.50%	8.6%	29.40%
Corporate	3.7%	27.30%	29.70%	27.70%	28.00%	27.30%	19.7%	40.30%
THIS	14.6%	33.70%	27.50%	29.80%	28.70%	30.30%	16.9%	19.70%
Trust	**4.8%**	**23.90%**	**27.50%**	**22.10%**	**21.10%**	**21.40%**	**12.2%**	**26.70%**

Appraisal- Completeted Since April 2015		
Division	Compliance	YTD Target (32%)
Surgery	5.90%	
Medical	12.60%	
FSS	10.40%	
Community	18.80%	
Estates	8.00%	
Corporate	4.80%	
THIS	14.00%	
Trust	**10.74%**	

Medical Devices Training		
Division	Compliance	100% Target
Surgery	73.00%	
Medical	65.00%	
FSS	79.00%	
Community	83.00%	
Estates	-	-
Corporate	88.00%	
THIS	-	-
Trust	**78.00%**	

Mandatory Training Indicators completetd in last 12 Months								
Division	Prevent	Equality & Diversity	Information Governance	Infection Control	Health & Saftey	Manual Handling	Safeguarding	Fire safety
Surgery	19.60%	67.50%	64.40%	65.00%	65.00%	65.00%	62.10%	53.00%
Medical	27.30%	70.00%	71.70%	69.10%	68.40%	68.90%	66.60%	59.40%
FSS	41.70%	75.20%	76.20%	72.70%	71.80%	72.20%	68.70%	71.00%
Community	75.10%	79.00%	76.40%	78.00%	77.20%	77.20%	75.30%	73.90%
Estates	15.10%	92.60%	89.00%	92.30%	92.00%	92.00%	91.70%	68.00%
Corporate	28.00%	83.30%	73.00%	73.70%	73.70%	73.70%	69.70%	65.70%
THIS	21.30%	81.50%	75.80%	80.90%	80.30%	80.90%	75.30%	65.70%
Trust	**33.6%**	**74.40%**	**73.30%**	**72.30%**	**71.70%**	**72.00%**	**69.2%**	**64.00%**

Appraisal- completetd in last 12 Months		
Division	Compliance	100% Target
Surgery	62.60%	
Medical	68.60%	
FSS	80.30%	
Community	73.80%	
Estates	91.30%	
Corporate	79.60%	
THIS	65.30%	
Trust	**73.50%**	

Appraisal

Why are we away from plan

Absence of appraisal activity plans which spread activity across a 12-month period and / or non-delivery of appraisal activity plans

Action to get on plan including timescales

From September 2015 the IBR Well Led slide will report actual activity vs. planned activity. Using an appraisal planning tool developed by THIS and Workforce Information colleagues, divisional teams are now able to log planned activity and measure in real time actual activity against plan. The activity plan for each division will be shared in the September IBR. A 'comply or explain' approach has been adopted requiring divisional colleagues to identify barriers to improved performance/delivery of activity plans in support of the 100% compliance target.

NB: ESR is the only accepted reporting tool for appraisal compliance. The deadline for inputting appraisal activity data each month is 1st working day of month for previous months appraisals. Activity recorded after this data will only be included in compliance reports in the following months.nth.

Mandatory Training

Why are we away from plan?

The new mandatory training approach (the Core Skills Training Framework or CSTF) has been in operation since 1st June 2015. Colleagues are still becoming familar with the new approach and this will factor into the complaince data reported through the IBR.

Action to get on plan including timescales

An intranet portal has been established giving access into the Electronic Staff Record (ESR) to complete the mandatory training elements. In addition, classroom based Prevent training sessions are scheduled. The web pages contain comprehensive support materials including vidoes and scripts which are to be used by colleagues enabling them to access the training and complete it satisfactory. A series of meetings across the organisation have been orgainsed with divisional management teams, line managers and colleagues generally in order to publicise the approach we have adopted and to deal with any problems that have arisen in using the system. Additionally, a help facility has been established as well as an FAQ which sets out issues colleagues have raised in using the system and the solutions to them.

Medical Devices

Medical Devices Training is currently at 79% compliance across the Trust.

Action to get on Plan - (1) Regular reminders to all staff re Medical Devices training requirements via newsletter, intranet notices, link nurse, matrons and department managers group emails (2)Discuss and remind Medical Devices training group and link nurse meeting members to cascade Medical Devices Training requirements throughout divisions. (3) Organise and promote medical devices training events (4) Contact all areas below 75% compliance (in the red) to develop an action plan to improve training compliance

By Who- (1) Director of Planning, Performance, Estates & Facilities, ADN's, Matrons, General Managers, Department Heads, Line Managers and link nurses (2) Medical Devices Training Coordinator and Medical Devices Training support .

When- (1) On-going throughout the year

Well Led indicators

The first row of tables below show the performance against the Friends and Family test scores for the quarter 4 identifying movement from the previous quarters performance.

The second row of tables show the Hard Truths staffing level indicators.

FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly)			
Division	Quarter 4	Quarter 1	**Movement**
Surgery	**79.00%**	**79.00%**	→
Medical	**80.00%**	**76.00%**	↓
FSS	**74.00%**	**76.00%**	↑
Community	-	**77.00%**	
Estates	**89.00%**	**83.00%**	↓
Corporate	**79.00%**	**82.00%**	↑
THIS	**75.00%**	**72.00%**	↓
Trust	**81.00%**	**77.00%**	↓

FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly)			
Division	Quarter 4	Quarter 1	**Movement**
Surgery	**55.00%**	**55.00%**	→
Medical	**54.00%**	**49.00%**	↓
FSS	**49.00%**	**47.00%**	↓
Community	-	**49.00%**	
Estates	**53.00%**	**45.00%**	↓
Corporate	**57.00%**	**52.00%**	↓
THIS	**66.00%**	**72.00%**	↑
Trust	**59.00%**	**51.00%**	↓

Hard Truths Summary Day - Nurses/Midwives		
Division	Jul-15	95% Target
Surgery	93.18%	
Medical	85.32%	
FSS	89.65%	
Trust	**88.33%**	

Hard Truths Summary - Day Care Staff		
Division	Jul-15	95% Target
Surgery	96.74%	
Medical	95.02%	
FSS	96.32%	
Trust	**95.80%**	

Hard Truths Summary - Night Nurses/Midwives		
Division	Jul-15	95% Target
Surgery	86.35%	
Medical	92.49%	
FSS	88.02%	
Trust	**89.36%**	

Hard Truths Summary - Night Care Staff		
Division	Jul-15	95% Target
Surgery	115.66%	
Medical	109.93%	
FSS	82.23%	
Trust	**113.73%**	

Hard Truths Staffing Levels

Why we are away from plan

The overall average fill rate for qualified nurses (day and night) has been maintained at 91.64% for HRI site and 86.6% for CRH Site.
For unqualified staff the average fill rate (day and night) has been 104.36% for HRI site and 105.4% for CRH site.

	Day		Night		
	Qualified	Unqualified	Qualified	Unqualified	Combined
Red (less than 75% fill rate)	3	3	3	1	10
Amber (75 – 89% fill rate)	12	7	9	1	29
Green (90-100% fill rate)	15	10	20	8	53
Blue (greater than 100%)	4	14	2	20	40

There was an increase in areas rag rated red by 1 in comparison to the month of June for qualified nurses (day) with average fill rates of less than 75%.
There was also an increase in the areas rag rated red for qualified nurses (night) from 1 area in June to 3 in July. The Associate Nurse Directors are reviewing rosters to ensure there is parity across all shifts and that nights and weekends are appropriately covered.
40 areas in comparison to 43 in June 2015 had either qualified or unqualified average fill rates of 100% or more
The highest fill rate for any area qualified was 104.8% (day or night) in July 2015.
The average fill rate the highest fill rate for unqualified nurses was 216% due to increased unqualified useage.
The overfill rate of Health Care Assistants on the night shifts is of concern. The senior nurse team have agreed to reduce the usage of another 2 high cost agencies, are reviewing annual leave and implementing a process of overtime sign off by the Associate Nurse Director only. Over 300 one- one support shifts were requested to support areas within July 2015 which has contributed to the increased average fill rate for unqualified staff. See Table 2 for analysis.

Table 2: Analysis of areas with highest over fill July 2015

Area	Day	Night	Reason
SAU		216.1%	• Supporting reduced fill rate – 72.1% for qualified nurses
5AD	136.2% (unqualified)	152.1% (unqualified)	• 72 shifts required additional support for 1-1 requests. • Qualified fill rate on days 69.7% therefore additional unqualified supporting area.
6BC		140.4% (unqualified)	• 84 shifts required additional support for 1-1 requests. • Qualified fill rate for nights reduced to 91.7%
7AD		148.4% (Unqualified)	• Supporting qualified staff whose fill rate reduced to 76.6%
7BC		134.2% (Unqualified)	• Supporting qualified fill rate reduced to 92.5% • Additional 5 shifts required for 1-1 support
10	133.4% (unqualified)		• Supporting qualified (fill rate 91%, number of new starters who were

We continue to utilise temporary nursing workforce solutions and transfer substantive nurses within the trust to maintain safe staffing levels on additional capacity areas which have had up to 62 additional beds open within July at any one time.

Action Plan

Short term

ADNs to oversee rosters with immediate effect

Matron of the day to oversee staffing- to commence 17th August

Further reducing high cost agency- immediate effect

ADNs only to sign off overtime- immediate effect

Longer Term

Robust recruitment with particular focus on completing successfully the recruitment process for the cohort of newly qualified nurses and midwives due to qualify in September 2015 continues.

Support for newly qualified and new starters to the nursing workforce including a one week induction programme; competency document and preceptorship programme are being completed to commence in September.

A successful recruitment trip to Romania in July has led to 8 nurses been offered positions within CHFT. Workforce and Development are completing compliance checks and we anticipate the nurses will arrive at the end of September 2015.

Recruitment to Band 2 posts currently underway for both substantive and flexible workforce positions to reduce the reliance on agency suppliers.

Increased focus on areas requesting 1-1 support and increasing fill rates is being completed by matrons and Associate Directors of Nursing to ensure that shift fill remains within planned and safe parameters.

Achieved by Date

The Trust continues to expect fill rates to increase particularly in October and September to some extent, as newly qualified nurses and midwives reach their start dates within CHFT.

Increased fill rates will be monitored weekly by the Associate Directors of Nursing and reported by exception through the Nursing Workforce Strategy Group.

Calderdale and Huddersfield NHS
NHS Foundation Trust

INTERMEDIATE CARE AND COMMUNITY DIRECTORATE

DIRECTORATE PERFORMANCE DASHBOARD

MONTH : JULY 2015

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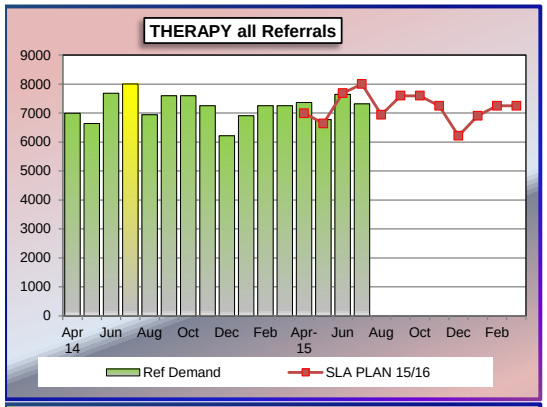
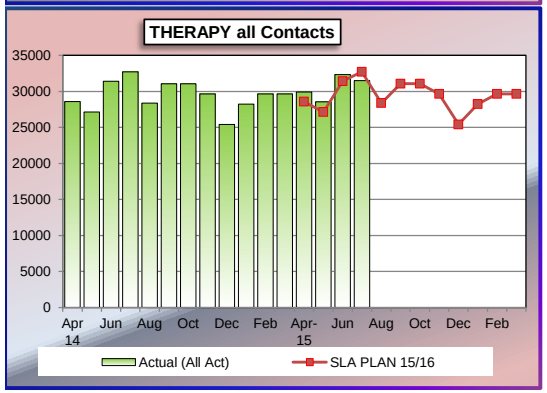
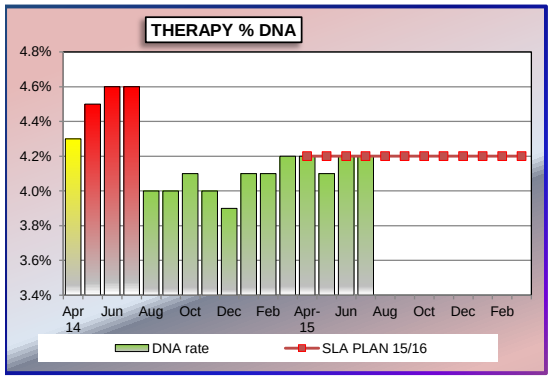
CLINICAL THERAPY SERVICES







ACTIVITY EFFICIENCIES - PERFORMANCE v PLAN

ALL THERAPY CONTACTS (includes Inpatients & All Commissioners)

CLINICAL THERAPIES : Activity Metric	Curr Month	YTD actual	YTD PROFILE	Actual 14/15	POSITION
Referral Demand	7,320	29,230	29,332	86,372	-0.3%
Initial Contacts	5,558	22,148	23,133	68,118	-4.3%
Follow Up Contacts	25,046	96,774	93,483	275,273	3.5%
Telephone Contacts	892	3,538	3,237	9,531	9.3%
THERAPY CONTACTS - including Inpatients	**31,496**	**122,460**	**119,852**	**352,922**	**2.2%**
CTR Podiatry	5,987	23,752	25,008	73,640	-5.0%
CTR Therapies Outpatients	6,061	23,299	23,460	69,082	-0.7%
CTR Inpatient Therapies	9,601	37,156	32,039	94,342	16.0%
CTR Long Term Conditions and Rehab	5,741	21,128	21,741	64,018	-2.8%
CTR Acute & Planned Care is 'Other Outpatients'	1,748	6,769	6,973	20,534	-2.9%
CTR Childrens Therapies	1,466	6,818	7,395	21,775	-7.8%
Telephone Contacts	892	3,538	3,237	9,531	9.3%
THERAPY CONTACTS - including Inpatients	**31,496**	**122,460**	**119,852**	**352,922**	**2.2%**

First DNAs	244	994
First DNAs % Rate	4.2%	4.3%
Total DNAs	1441	5430
Total DNA % Rate	4.4%	4.2%

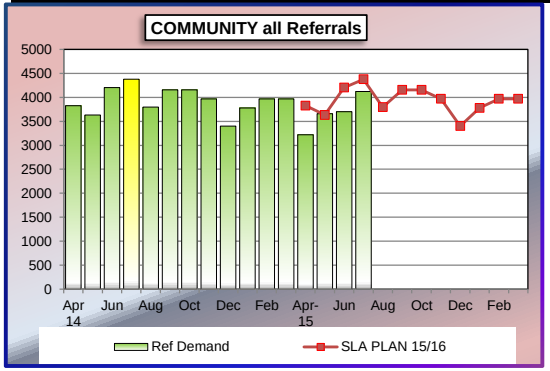
COMMUNITY ADULT : Activity Metric	Curr Month	YTD actual	YTD COMM	COMM PLAN	POSITION
Referral Demand	4,121	16,426	16,036	47,219	2.4%
Initial Contacts*	2,783	10,521	11,758	34,624	-10.5%
Follow Up Contacts	24,324	91,558	88,120	259,482	3.9%
Telephone Contacts	3,198	12,151	11,117	32,735	9.3%
ALL Clinical Contacts - Face to Face & Telephone	30,305	114,230	110,995	326,841	2.9%

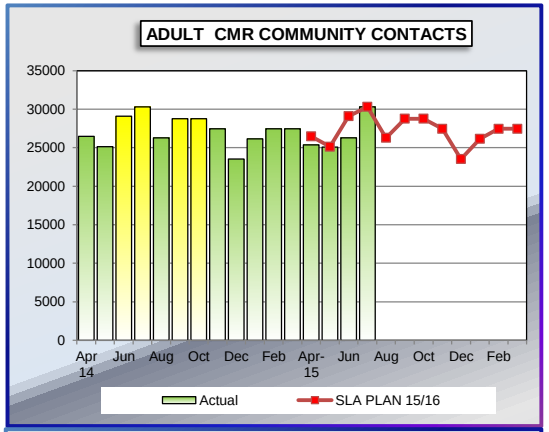
* From changes to recording of referrals introduced this financial year - this will reduce the number of initial contacts

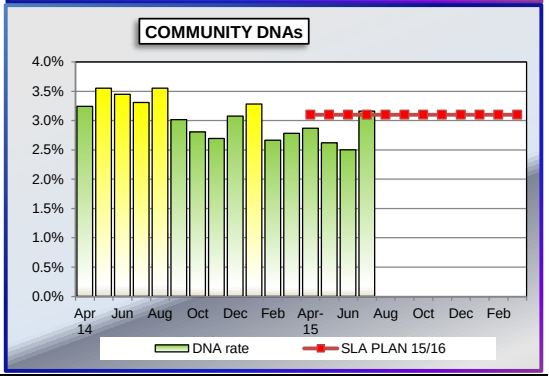
Total DNAs - No Access Visits + DNAs	989	3177
Total DNA (No Access) % Rate	3.16%	2.71%

DIRECTORATE SUMMARY KPIs	Curr Month	YTD actual	YTD COMM	Actual 14/15	POSITION
Referral Demand	11,441	45,656	45,368	133,591	0.6%
Total Contacts	57,711	221,001	216,494	637,497	2.1%
Telephone Contacts	4,090	15,689	14,354	42,266	9.3%
TOTAL CONTACTS - ALL SERVICES	**61,801**	**236,690**	**230,848**	**679,763**	**2.5%**
Total DNAs	2430	8607			
Total DNA % Rate	4.0%	3.7%			
Snapshot : Waiting List - Waiting for First Appt	1,268				

CALDERDALE COMMUNITY ADULT







Calderdale and Huddersfield NHS
NHS Foundation Trust

COMMUNITY DIVISIONAL PERFORMANCE REPORT & DASHBOARD

PROVIDING AN ASSESSMENT OF QUALITY ACROSS THE DOMAINS OF THE NHS OUTCOMES FRAMEWORK

JULY 2015

compassionate care

Key Points

July 2015
Performance Summary

A - Why the target is away from plan
B - What are we doing to get it back to plan
C - When will this be achieved

(4a) Pressure ulcer screening
A - Work to do around how we report this as the screening is reflected in the holistic assessment in all cases and in the care plans where there is an issue.
B - Developed outcome measures for completion when a pressure ulcer care plan has been performed, however, as these are new we need to push completion and compliance.
C - 31st August

(4b) Community acquired pressure ulcers
There was a breakthrough session in July with DNs to re look at our action plan and feed into the wider organisational action plan which is going to CCG.

(4f) Safeguarding training
A - Recording is over a 36 month period therefore the target for the year is not in line with the current calculation methodology
B - Investigations around how best to represent this indicator with the current information available is ongoing
C - 31st August

(5a) Community DNA rates
A - Number of patients have multiple DNAs and therefore inflate the percentage
B - Trial the use of proactive methods such as contacting the patient prior to the visit
New 'Housebound policy' being developed.
The housebound policy is in draft and has gone to CCG and primary care for comments. We need to sign up to a clear position around discharge from the caseload for repeat non attenders and the policy for clinic compliance is referenced in the housebound policy. We also need a decision around transport and to understand the potential impact on transport.
C - 31st August

	1 Enhancing quality of life for people with a Long Term condition (LTC)	Target	Current Month	YTD	YTD 14/15	Var
a	Home equipment delivery < 7 days	95%	99.8%	99.2%	96.6%	4.2%
b	% Patient died in preferred place of death	95%	100.0%	100.0%	100.0%	5.0%
c	% of people that died who were expected to die and had an advance care plan	Indicator suspended pending new pathway				
d	% District Nursing Patients with a care plan	90%	99.0%	98.0%	94.5%	8.0%
e	% of patients with a LTC with a Calderdale Care Plan	90%	100.0%	89.8%	59.0%	-0.3%
f	% of patients under the care of the community specialist matron who have been readmitted to hospital with the same LTC in less than 30 days	<10%	6.5%	8.3%	1.7%	1.7%

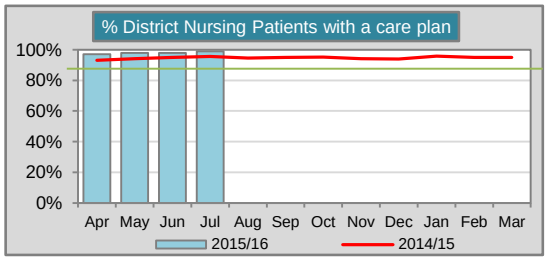
	2 Helping people to recover from episodes of ill health or following injury	Target	Current Month	YTD	YTD 14/15	Var
a	% of leg ulcers healed within 12 weeks from diagnosis	75%	94.1%	94.5%	97.9%	19.5%

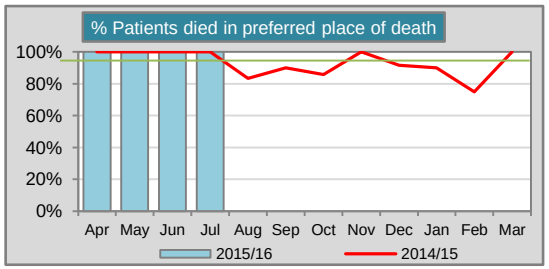
	3 Ensuring people have positive experience of care	Target	Current Month	YTD	YTD 14/15	Var
a	Number of complaints	n/a	TBC	5	10	
b	Number of complaints about staff attitude	n/a	TBC	0	0	
c	Community AHP - 18 week RTT Snapshot at month end	95%	95.8%	96.7%	90.2%	1.7%
d	Community Friends and Family Test	n/a	92.0%	90.8%	N/A	N/A

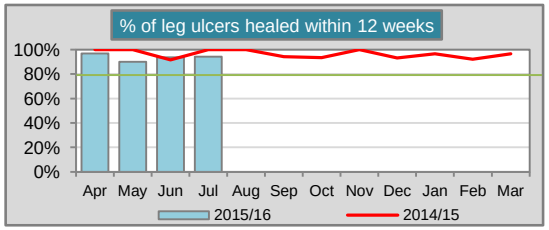
	4 Treating and caring for people in a safe environment; and protecting them from avoidable harm	Target	Current Month	YTD	YTD 14/15	Var
a	% of patients in receipt of community nursing services that have had a pressure ulcer screening and this is documented in their care plan	90%	85.0%	87.2%	89.8%	-2.8%
b	Number of community acquired grade 3 or 4 pressure ulcers	<1.8	2	10	4	0.2
c	Number of falls that caused harm whilst patient was in receipt of Comm Services	<1.1	3	12	8	1.9
d	Patient safety thermometer - coverage - Harm free	>95%	94.2%	95.1%	93.9%	0.1%
e	Patient safety thermometer - No of Harms Reported	<22.1	20	78	103	-2
f	% of staff that have undertaken safeguarding / mental capacity act training	95%	TBC	76.4%	66.3%	-18.6%

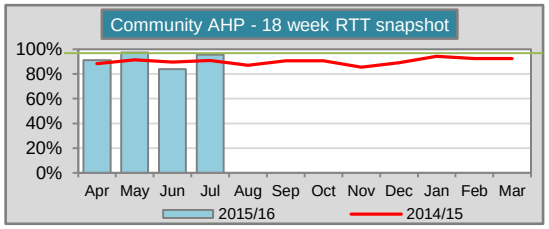
	5 Activity & Resource efficiency	Baseline	Current Month	YTD	YTD 14/15	Var
a	Community DNA Rates	<1%	1.2%	1.1%	1.1%	0.1%
b	Sickness Absence rate	<4%	TBC	3.4%	4%	-0.6%

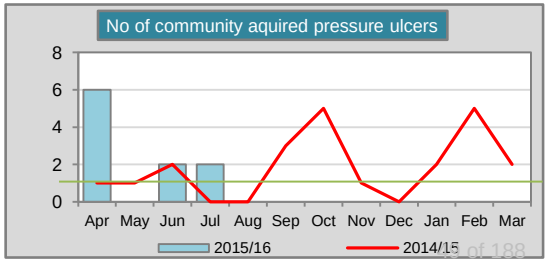
Target











Trust Financial Overview as at 31th Jul 2015 - Month 4

INCOME AND EXPENDITURE COMPARED TO PLAN SUBMITTED TO MONITOR IN MAY 2015

YEAR TO DATE POSITION: M04

CLINICAL ACTIVITY

	M04 Plan	M04 Actual	Var
Elective	2,893	2,796	(97)
Non Elective	16,243	16,832	589
Daycase	14,055	13,512	(543)
Outpatients	110,182	108,581	(1,601)
A & E	50,642	49,556	(1,086)

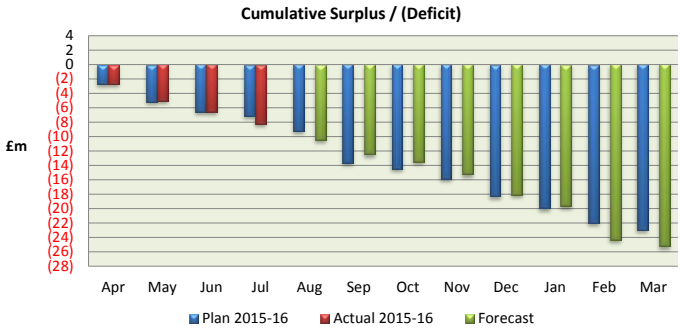
TRUST: INCOME AND EXPENDITURE

	M04 Plan	M04 Actual	Var
	£m	£m	£m
Elective	£7.42	£7.14	(£0.28)
Non Elective	£26.56	£27.63	£1.07
Daycase	£9.53	£8.74	(£0.79)
Outpatients	£13.24	£13.16	(£0.08)
A & E	£5.33	£5.34	£0.01
Other-NHS Clinical	£38.83	£39.33	£0.50
CQUIN	£2.24	£2.26	£0.01
Other Income	£12.45	£11.98	(£0.47)
Total Income	**£115.60**	**£115.57**	**(£0.03)**
Pay	(£74.25)	(£74.71)	(£0.46)
Drug Costs	(£10.45)	(£10.39)	£0.06
Clinical Support	(£10.38)	(£10.18)	£0.19
Other Costs	(£15.24)	(£16.12)	(£0.87)
PFI Costs	(£3.97)	(£3.94)	£0.04
Total Expenditure	**(£114.29)**	**(£115.34)**	**(£1.05)**
EBITDA	**£1.31**	**£0.24**	**(£1.08)**
Non Operating Expenditure	(£8.47)	(£8.39)	£0.08
Deficit excl. Restructuring	**(£7.15)**	**(£8.15)**	**(£1.00)**
Restructuring Costs	£0.00	(£0.08)	(£0.08)
Surplus / (Deficit)	**(£7.15)**	**(£8.23)**	**(£1.08)**

DIVISIONS: INCOME AND EXPENDITURE

	M04 Plan	M04 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	£6.74	£6.20	(£0.54)
Medical	£9.05	£8.04	(£1.01)
Families & Specialist Services	(£0.85)	(£0.90)	(£0.05)
Community	£2.04	£2.15	£0.11
Estates & Facilities	(£9.48)	(£8.78)	£0.70
Corporate	(£6.85)	(£7.26)	(£0.41)
THIS	£0.10	£0.05	(£0.05)
PMU	£0.96	£0.57	(£0.39)
Central Inc/Technical Accounts	(£7.62)	(£7.66)	(£0.03)
Reserves	(£1.25)	(£0.65)	£0.60
Surplus / (Deficit)	**(£7.15)**	**(£8.23)**	**(£1.08)**

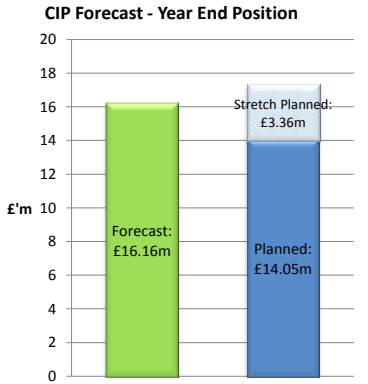
TRUST SURPLUS / (DEFICIT)

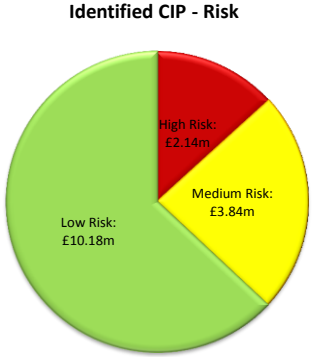


KEY METRICS

	Year To Date: M04 Plan	Year To Date: M04 Actual	Year To Date: Var	Year End: Forecast: Plan	Year End: Forecast: Forecast	Year End: Forecast: Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	(£7.15)	(£8.23)	(£1.08)	(£23.01)	(£25.23)	(£2.22)
Capital (forecast Plan)	£6.99	£6.11	£0.88	£20.72	£20.72	£0.00
Cash	£7.57	£7.92	£0.35	£1.92	£1.06	(£0.86)
CIP	£3.30	£4.00	£0.71	£14.05	£16.16	£2.11
	Plan	Actual		Plan	Forecast	
Continuity of Service Risk Rating	1	1		1	1	

COST IMPROVEMENT PROGRAMME (CIP)





Total Planned: £14.05m Total Forecast £16.16m

YEAR END 2015/16

CLINICAL ACTIVITY

	Plan	Forecast	Var
Elective	9,185	8,439	(746)
Non Elective	49,263	51,048	1,786
Daycase	43,731	41,647	(2,084)
Outpatients	327,200	325,122	(2,078)
A & E	146,774	144,508	(2,266)

TRUST: INCOME AND EXPENDITURE

	Plan	Forecast	Var
	£m	£m	£m
Elective	£23.39	£21.88	(£1.51)
Non Elective	£79.89	£83.57	£3.68
Daycase	£30.25	£27.11	(£3.14)
Outpatients	£39.45	£39.39	(£0.06)
A & E	£15.49	£15.53	£0.04
Other-NHS Clinical	£117.49	£116.24	(£1.25)
CQUIN	£6.69	£6.80	£0.11
Other Income	£38.90	£39.64	£0.74
Total Income	**£351.55**	**£350.17**	**(£1.38)**
Pay	(£224.98)	(£228.14)	(£3.16)
Drug Costs	(£32.05)	(£31.33)	£0.71
Clinical Support	(£31.15)	(£29.60)	£1.55
Other Costs	(£45.94)	(£46.19)	(£0.25)
PFI Costs	(£11.92)	(£11.83)	£0.09
Total Expenditure	**(£346.04)**	**(£347.09)**	**(£1.05)**
EBITDA	**£5.51**	**£3.08**	**(£2.43)**
Non Operating Expenditure	(£25.52)	(£25.31)	£0.21
Deficit excl. Restructuring	**(£20.01)**	**(£22.23)**	**(£2.22)**
Restructuring Costs	(£3.00)	(£3.00)	£0.00
Surplus / (Deficit)	**(£23.01)**	**(£25.23)**	**(£2.22)**

DIVISIONS: INCOME AND EXPENDITURE

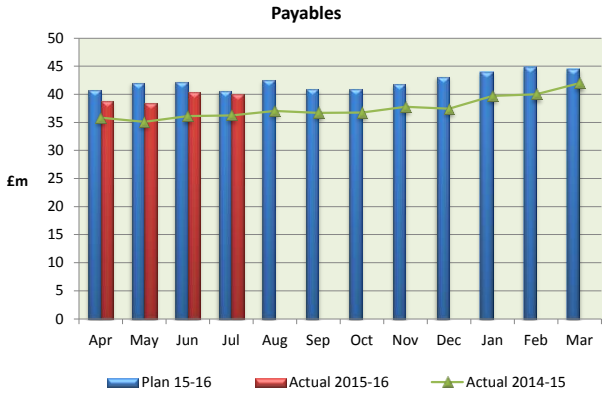
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	£21.33	£19.15	(£2.18)
Medical	£26.04	£21.75	(£4.30)
Families & Specialist Services	(£1.58)	(£1.30)	£0.27
Community	£5.90	£6.33	£0.43
Estates & Facilities	(£28.64)	(£27.74)	£0.90
Corporate	(£20.19)	(£21.26)	(£1.07)
THIS	£0.53	£0.34	(£0.19)
PMU	£3.16	£3.16	£0.00
Central Inc/Technical Accounts	(£25.23)	(£25.66)	(£0.43)
Reserves	(£4.35)	£0.00	£4.35
Surplus / (Deficit)	**(£23.01)**	**(£25.23)**	**(£2.22)**

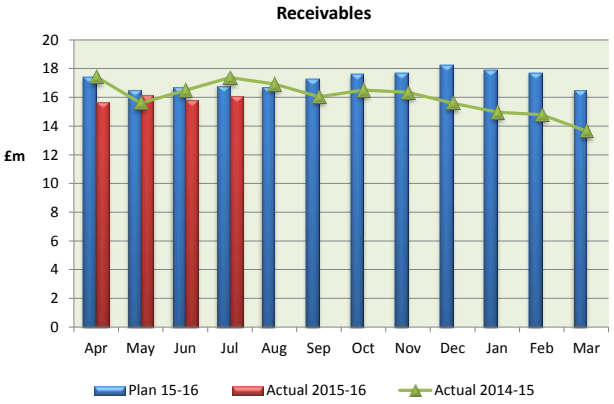
Trust Financial Overview as at 31th Jul 2015 - Month 4

CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO MONITOR IN MAY 2015

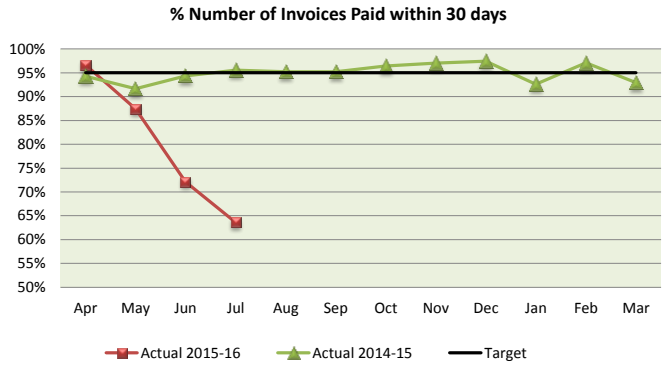
WORKING CAPITAL

	M04 Plan £m	M04 Actual £m	Var £m	M04
Payables	(£40.65)	(£40.06)	(£0.59)	
Receivables	£16.83	£16.08	£0.75	



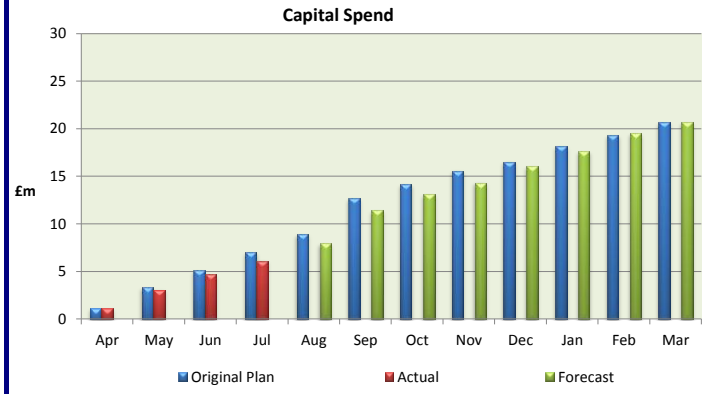


BETTER PAYMENT PRACTICE CODE



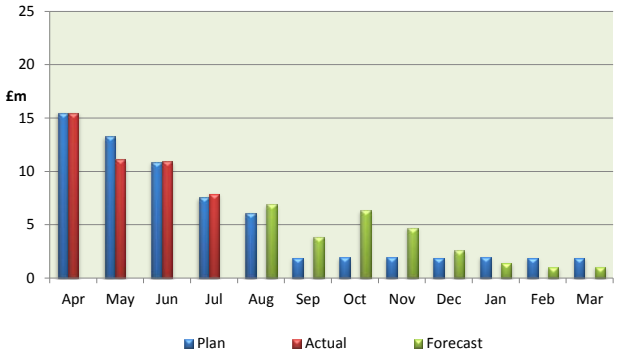
CAPITAL

	M04 Plan £m	M04 Actual £m	Var £m	M04
Capital	£6.99	£6.11	£0.88	

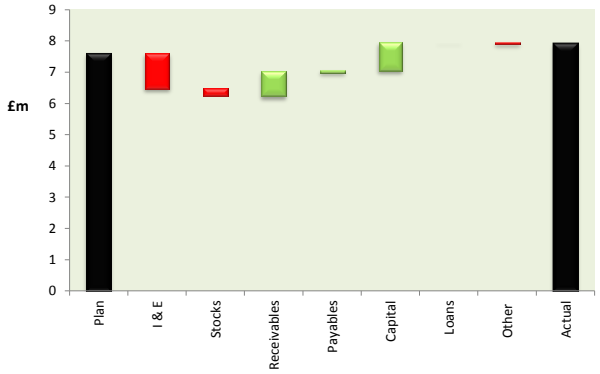


CASH

	M04 Plan £m	M04 Actual £m	Var £m	M04
Cash	£7.57	£7.92	£0.35	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The year to date deficit is £8.23m versus a planned deficit of £7.15m, this includes release of £0.35m contingency reserves.
- The adverse variance of £1.08m from plan is due to clinical activity underperformance and high pay spend.
- Elective and daycase activity is significantly behind planned levels in month. Non-elective long stay activity has slowed.
- Pay expenditure has not followed the activity downturn, remaining high in spite of a reduction in open bed capacity.
- Capital expenditure year to date is £6.11m against the planned £6.99m with slippage primarily on Estates schemes.
- Cash balance is £7.92 against a planed £7.57m. £10m of loan funding for capital expenditure was drawn down in April.
- CIP schemes delivered £4.00m in the year to date against a planned target of £3.30m.
- The Continuity of Service Risk Rating (CoSRR) stands at 1 against a planned level of 1.

SUMMARY FORECAST

- The forecast year end deficit (excluding restructuring costs) is £22.23m against a planned £20.01m, an adverse variance of £2.22m. This position includes full release of remaining contingency reserves and delivery of £16.16m CIP against the original planned £14m.
- The worsening in the year end forecast is driven the ongoing impact of the activity, income and pay expenditure pressures as seen at Month 4, alongside a decision taken to invest £1.9m in bed capacity over forthcoming months.
- No further contingency reserves remain to cover other pressures and risks.
- Efforts must therefore be focussed on delivering planned activity, containing pay spend and securing the maximum CIP opportunity.
- The year end cash balance is predicated on external cash support being received at a higher level that previously planned.
- Year end capital expenditure is forecast to be in line with the planned £20.72m. The year end CoSRR is forecast to be at level 1.

RAG KEY: (Excl: Cash)

- Actual / Forecast is on plan or an improvement on plan
- Actual / Forecast is worse than planned by <2%
- Actual / Forecast is worse than planned by >2%

NB. In addition to the above rules, if Capital expenditure <85% of that planned then Red, (per Monitor risk indicator).

RAG KEY - Cash:

- At or above planned level or > £18.6m (20 working days cash)
- < £18.6m (unless planned) but > £9.3m (10 working days cash)
- < £9.3m (less than 10 working days cash)

Performance is formally assessed quarterly

High Risk	
Moderate Risk	
No known Risk	

Goals - CCG CQUINs **6,270,712**

Goal Number	Goal Name	Value of CQUIN (£)	Q1	Q2	Q3	Q4
1	Acute Kidney Injury	627,071	62,707	125,414	125,414	313,536
2a	Sepsis	313,536	78,384	78,384	78,384	78,384
2b	Sepsis	313,536		62,707	125,414	125,414
3	Urgent care	1,254,142	125,414	376,243	376,243	376,243
4.1	Dementia	250,828	62,707	62,707	62,707	62,707
4.2	Dementia	125,414		62,707		62,707
4.3	Dementia	250,828		125,414		125,414
5.1	Respiratory - Asthma	250,828	62,707	62,707	62,707	62,707
5.2	Respiratory - Pneumonia	376,243	94,061	94,061	94,061	94,061
6	Diabetes	627,071	156,768	156,768	156,768	156,768
7.1	Improving Medicines Safety	125,414	31,354	31,354	31,354	31,354
7.2	Improving Medicines Safety	501,657	125,414	125,414	125,414	125,414
8	End of Life Care	627,071		313,536		313,536
9.1	Hospital Food	250,828		125,414		125,414
9.2	Hospital Food	250,828		50,166	100,331	100,331
9.3	Hospital Food	125,414				125,414
	TOTAL	6,270,712	799,516	1,852,995	1,338,797	2,279,404

NHS England **421,193**

	Goal Name	Value of CQUIN (£)	Q1	Q2	Q3	Q4
	NICU	38,051	9,513	9,513	9,513	9,513
	Oncotype DX	38,051	9,513	9,513	9,513	9,513
	QIPP	126,836	31,709	31,709	31,709	31,709
	Vac and Immunisations	90,860	22,715	22,715	22,715	22,715
	National CQUIN	22,715	5,679	5,679	5,679	5,679
	Health Visitor Building Community Capacity	104,680	26,170	26,170	26,170	26,170
	TOTAL	421,193	105,298	105,298	105,298	105,298

Grand Total	**6,691,905**	**904,814**	**1,958,294**	**1,444,095**	**2,384,702**

Data Quality Assessment

A "Data Quality Assessment" is now being made for each indicator. These assessments are being provided by those responsible for the indicator's information provision each month, and then signed off by the indicator's lead manager.

It is a Red, Amber, Green (RAG) rating based on the evaluation of the following three questions -

1.What is the overall view for the robustness of the indicator documentation regards construction and completeness (RAG)?
2.What is the overall view regards the timeliness of the information for this indicator (RAG)?
3.What is the overall view regards the robustness of the collection for this indicator (RAG)?

The final rating for an indicator of Red Amber Green is assessed as follows -

Answers to the 3 Questions :	3 Green or 2 Green, 1 Amber	Final rating Green
	1 Green, 2 Amber or 3 Amber or 2 Green 1 Amber or 1 Green 1 Amber 1 Red	Final rating Amber
	Any other combination	Final rating Red

Any indicator that has its data quality assessment currently white has yet to be assessed or have its assessment signed off by the lead manager for the indicator.

Indicator	Description	Source
% Variance against Plan	The actual activity levels against the planned activity levels. (Plan based on previous activity, financial / clinical constraints)	Trust reporting tool - Knowledge Portal.
Theatre Utilisation	The utilisation of theatre capacity, indicating how much time in theatre is lost due to lack of utilisation	Bluespier
% Daily Discharges - Pre 11am	% patients discharged from hospital prior to 11 am	Sophia database
Delayed Transfers of Care	% patients who discharge from hospital has been delayed	Sophia database
Green Cross Patients (Snapshot at month end)	Count of patients on wards who are recorded on the Visual Hospital as medically stable for discharge.	Visual Hospital (HRI and CRH)
Number of Outliers (Bed Days)	Number of inpatients occupying a hospital bed, but situated within the wrong ward due to no beds within the correct ward	Bed Occupancy Cube from Sophia warehouse. Patients with a Treatment Function Code other than the Ward Divisions are classed as an outlier.
First DNA Rate	Patients that did not attend their first outpatient appointment, the threshold is less than or equal to 10% of all first appointments	Sophia database
% Hospital Initiated Outpatient Cancellations	% outpatient appointments cancelled by the Trust	Trust reporting tool - Knowledge Portal. Target 17.6% based on previous years outturn.
Appointment Slot Issues on Choose & Book	% of patients who experience an appointment slot issue when attempting to use Choose and book to book an appointment	Choose & Book Website
No of Spells with Ward Movements	Patients on all wards who have moved from one ward to another more than twice in their stay. Excludes specific wards to account for diagnostic tests etc.	Sophia data warehouse (APCEncounter, WardStay, LastWardStayInSpell and WardStay)
% Non-admitted closed Pathways under 18 weeks	Patients that are referred for treatment that doesn't involve an admission receive their first definitive treatment within 18 weeks of referral. The threshold is 95%.	Sophia database
% Admitted Closed Pathways Under 18 Weeks	Patients that have a decision to treat should be admitted within 18 weeks of their decision to admit them to hospital. The threshold is 90%.	Sophia database
% Incomplete Pathways <18 Weeks	Incomplete pathways are waiting times for patients still waiting to start treatment. The threshold is 92%	Sophia database
18 weeks Pathways >=26 weeks open		Sophia database
18 weeks Pathways >=40 weeks open		Sophia database
% Diagnostic Waiting List Within 6 Weeks	Patients referred into the hospital for a diagnostic test will wait no longer than 6 weeks for that test as the percentage of the total volume waiting. Target 99%	Sophia database
Community AHP - 18 Week RTT Activity	% Patients who have completed an 18 weeks pathway for community services	SystmOne reporting tool
Cancellations to Elective Surgery	Patients who are listed for a surgical procedure who are cancelled by the Hospital with less than 24 hours' notice. The threshold is less than or equal to 0.8% of elective procedures.	Sophia database
Two Week Wait From Referral to Date First Seen	Patients that have a suspected cancer diagnosis and sent on a 2 week wait faxed proforma should receive an appointment within 2 weeks of the date of the referral. The threshold is 93%	PPM

Indicator	Description	Source
Two Week Wait From Referral to Date First Seen: Breast Symptoms	Patients that have a suspected breast cancer diagnosis and sent on a 2 week wait faxed proforma should receive an appointment within 2 weeks of the date of the referral. The threshold is 93%	PPM
31 Days From Diagnosis to First Treatment	Patients that have a cancer diagnosis should have a date for treatment within 31 days of the decision to treat them. The threshold is 96%	PPM
31 Day Subsequent Surgery Treatment	Patients that have a decision to treat them surgically for a cancer diagnosis should have a date for their treatment within 31 days of the decision to treat them. The threshold is greater than or equal to 94%.	PPM
31 day wait for second or subsequent treatment drug treatments	Patients that have a decision to treat with medication for a diagnosis of cancer should receive their first definitive treatment of drugs within 31 days of the decision to treat them. The threshold is greater than or equal to 98%	PPM
62 Day Aggregated Gp Urgent Referral To Treatment And Screening Referral To Treatment	Patients that are referred via the screening service with a suspected cancer diagnosis should receive their first definitive treatment within 62 days of the date of the referral. The threshold is 86%	PPM
62 Day Gp Referral to Treatment	Patients [illegible] referred to the hospital with a suspected diagnosis of cancer should be treated within 62 days of the date of the referral. The threshold is 85%	PPM
62 Day Referral From Screening to Treatment	Patients that are referred via the screening service with a suspected cancer diagnosis should receive their first definitive treatment within 62 days of the date of the referral. The threshold is 90%	PPM
A & E Targets	Measures the length of time the patients wait to be seen, have a decision to treat and spend in the department prior to either being discharged or admitted.	EDiS
Number of Mixed Sex Accommodation Breaches	Patients should be accommodated in single sex accommodation unless clinically indicated. Target is zero breaches of this indicator	Sophia database
Complaints	All complaints received by the hospital from a patient or relative	Datix
Total Concerns in the month	The number of patient concerns that have been raised	Datix
CQUINS - % of diabetic patients supported to self-care	Commissioning for Quality innovation	Various sources
CQUINS - Nutrition and Hydration		
CQUINS - Improving Medicines Safety		
CQUINS - Acute Kidney Injury (Reported quarterly)		
CQUINS - Sepsis Screening		
CQUINS - Respiratory Care Bundle		
CQUINS - End of Life Care Plan in place		

Indicator	Description	Source
Percentage of non-elective inpatients 75+ screened for dementia	Assesses the proportion of patients aged 75+ who are at risk of dementia and ensures they are referred onward appropriately	Sophia Database
Friends & Family Test	% of patients who complete a friends and family questionnaire following an inpatient admission	Ward Audits
Falls	The number of patients who have fallen during their stay in hospital	Datix
Pressure Ulcers Acquired at CHFT	The number of pressure ulcers reported as developed during a patients stay in hospital	Datix
Percentage of Completed VTE Risk Assessments	% of Admissions in month that have had a VTE Risk Assessment on Admission.	PAS / K2 Maternity System / Manual Validations. (Future data source to include nerve centre forms)
Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	The stage 1 process for RCA's is to identify any Hospital Acquired Thrombosis (HAT) and investigate the episode of care to ensure the trusts VTE prevention policy has been followed correctly.	Episodes are identified from the certification database and reports from Radiology on positive PE's and DVT's
% Harm Free Care	A tool which is used by clinician to monitor and record the presence and absence of pressure ulcers, falls, Urinary tract infections and new venous thromboembolisms (VTEs)	
Safeguarding Alerts	An alert is the formal raising with Social Services of a concern, suspicion or allegation of potential abuse or harm or neglect which may have arisen	Alerts recorded on Datix whether received by the Trust from Social Services or made by the Trust to Social Services
World Health Organisation Check List	The WHO Surgical Safety Checklist was developed after extensive consultation aiming to decrease errors and adverse events, and increase teamwork and communication in surgery. The 19-item checklist is now used by a majority of surgical providers around the world.	
Missed Doses	Where medicine doses have been omitted, delayed or missed during shifts.	Ward Audits
Patient Incidents	A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients	Datix
Never Events	An event that should never happen, for example wrong site surgery or an instrument left in the patient post-surgery. The threshold is zero cases per year.	Datix
Duty of Candour	To ensure that providers are open and transparent with people who use their services and that Trusts act lawfully on their behalf when things go wrong with care and treatment	Datix and Risk Mangement incident register.
Number of MRSA Bacteraemias – Trust assigned	Methicillin-resistant Staphylococcus aureus, This is no longer a monitor requirement however continuing to work to a de minimus of 6 cases after which contract penalties apply.	Infection Control Net (IC Net)
Total Number of Clostridium Difficile Cases	The Foundation Trust has a target of no more than 21 cases per year attributable to the organisation.	Infection Control Net (IC Net)
Number of MSSA Bacteraemias - Post 48 Hours	The number of MSSA infections acquired after 48 hours of a hospital stay	Infection Control Net (IC Net)

Indicator	Description	Source
% Hand Hygiene Compliance	The percentage of monthly hand hygiene observations which have been done to the required standard.	Hand Hygiene System
Number of E.Coli - Post 48 Hours	The number of E.Coli infections acquired after 48 hours of a hospital stay	Infection Control Net (IC Net)
Central Line Infection rate per 1000 Central Venous Catheter days	The number of infection acquired in patient with a CVC line in situ. Each day a line is in is counted as one calendar day. This is scaled up to the number of patients with a line present	Departmental Audits
Emergency Readmissions Within 30 Days	% patients readmitted (unplanned) back into hospital within 30 days of their discharge	Sophia database
Local SHMI - Relative Risk (1yr Rolling Data Oct 13- Sept 14)	The SHMI (Summary Hospital Mortality Index) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days (inclusive) of discharge	HSCIC and summary analysis via HED (www.hed.nhs.uk)
Hospital Standardised Mortality Rate (1 yr Rolling Data Apr 14 - Mar 15)	The HSMR (Hospital Standardised Mortality Rate) is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 diagnosis groups in a specified patient group. The expected deaths are calculated from logistic regression models with a case-mix of: age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge.	HED (www.hed.nhs.uk)
Mortality Reviews – April Deaths	The number of in hospital adult deaths which have been reviewed using the local mortality proforma	Mortality Knowledge Portal
Crude Mortality Rate (Latest Month June 15)	Crude mortality is the number of inpatient and Daycase deaths as a proportion of all discharges	Knowledge Portal
Average Diagnosis per Coded Episode	The average number of clinical codes that each inpatient spell attracts based on the information that can be coded from the clinical record	Knowledge Portal
Completion of NHS numbers within commissioning datasets submitted via SUS	The activity submitted to the Secondary Care User Service is fully complete with the patient NHS number	Knowledge Portal
Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	% of hip fracture patients who are receive surgery within 36 hours as a percentage of those receiving surgery.	The National Hip Fracture Database
↑ ↓ →	Flow of direction of activity	
RAG Rating (Also called Traffic light rating)	RED – Worse than Target GREEN – On or Better than Target	-

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Claire Gruszka, Patient Safety Risk Manager - LSMS
Date: Thursday, 27th August 2015	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: Risk Register - The attached papers provide details of the organisational risks scoring 15 or higher as at 18 August 2015.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: These papers were presented at the Risk & Compliance Group 11 August 2015 meeting.	
Governance Requirements: .	
Sustainability Implications: None	

Executive Summary

Summary:

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Main Body

Purpose:

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Background/Overview:

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The Issue:

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Next Steps:

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Recommendations:

To note.

Appendix

Attachment:

Risk Register report heat map as at 18 8 2015 (2 files merged)[1].pdf

RISK REGISTER REPORT

Risks as at 18 August 2015

TOP RISKS
6131 (25): Progression of service reconfiguration impact on quality and safety 2827 (20): Poor clinical decision making in A&E 4706 (20): Failure to meet CIP 4783 (20): Outlier on mortality levels 6345 (20): Staffing risk, nursing and medical 6346 (20): Ability to deliver service transformation risk
RISKS WITH INCREASED SCORE
No risks have increased in score.
RISKS WITH REDUCED SCORE
6300 - CQC inspection outcome/non regulatory compliance, decreased from 20 to 16*. 6224 – NHS E-referral – IT system failure, decreased from 20 to 12. *This risk was incorrectly increased to a 20 following the last Risk & Compliance Group meeting.
NEW RISKS
The following new risks have been added/have been carried over since/from the meeting: 6229 – Medical Device failure levels – new risk with a score of 15
CLOSED RISKS
No risks have been closed.
RISKS TO BE DISCUSSED AT NEXT RISK & COMPLIANCE COMMITTEE:
No specific risks have been identified for discussion at the next meeting.

Trust Risk Profile as at 18 August 2015

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Rare (1)					
Unlikely (2)					
Possible (3)					= 6230 – Failure to deliver expected benefits of EPR ! 6299 – Medical Device failure levels
Likely (4)				= 2828 – Slow patient flow & breach of A&E targets due to bed blockages / transport = 5806 – Urgent estate work not completed = 6078 – AIS, insufficient appointment slots = 6130 = Loss of income/services due to commissioner procurement decisions ↓ 6300 – CQC inspection outcome	= 2827 – Poor clinical decision-making in A&E = 4706 – Failure to meet CIP
Highly Likely (5)				= 4783 – Outlier on morality levels = 6345 – Staffing risk, nursing and medical = 6346 – Ability to deliver service transformation	= 6131 – Progression of service reconfiguration impact on quality and safety

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

Extreme and Major Risks (15 or over)

NHS
The Health Informatics Service
Informing Healthcare

Risk No	Div	Dir	Dep	Opened	Status	Strategic Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Further Actions	Review	Target	RC	Exec Director	Lead
6131	Corporate	Commissioning & Partnerships	Commissioning & Partnerships	Oct-2014	Active	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 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. ***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.	Financial plans of associated reconfiguration not yet completed or agreed with CCG's Estate limitations inhibit the present way of working Consultant rotas cannot always be filled to sustain services on both sites Interim actions to mitigate known clinical risks need to be progressed.	25 5 x 5	25 5 x 5	15 5 x 3	Joint working is in place with Commissioners to revisit the clinical model, activity, workforce and financial assumptions in the OBC. A joint Hospital Review Board has been established and external support arranged to refresh the OBC. A number of clinical workshops have been held. A Trust Assistant Director of Finance has been seconded to work jointly across the Trust and CCG. Update: June 2015 Monitor is advising the Trust on the review and development of the business case that will be submitted to Monitor and DH in September. The business case will be an important part of the Trust's longer term financial and sustainability recovery plan. It will be used to request funding support from the DH. A key issue related to refresh of the OBC is capital requirements and use of the PFI site. CCGs are keen to include GP led urgent care in the clinical model. The CCGs are developing a pre-consultation business case (that will be consistent with the Trust's business case) and aim to commence public consultation in Autumn 2015. Continue to ensure compliance with current estate pending a decision. Medical Workforce Plan to be developed by end of August 15 examining overseas recruitment. Interim actions to mitigate known clinical risks need to be progressed (paediatric service provision at HRI, cardiology and respiratory service configuration, Emergency Pregnancy Assessment configuration).	Sep-2015	Dec-2015	WEB	Anna Basford	Catherine Riley

6346	Trustwide	All Divisions	All Departments/Wards	Jul-2015	Active	Transforming and improving patient care	Capacity and Capability of Delivering Service Transformation Risk of not achieving service transformation due to insufficient capacity and capability across the organisation to deliver the many transformation schemes underway (Electronic Patient Record (EPR), clinical administration review, financial turnaround and cost improvement schemes, CQC preparation, service reconfiguration, i.e. consultation and planning for Outline Business Case, Care Closer to Home Proposal) resulting in impact on delivery of safe clinical care for patients in the right setting and financial imbalance.	Programme Management Office established to managing schemes Strategic and Financial Turnaround Plan, 2015/166 financial plans and cost improvements Integrated Board report details Trust financial position monthly Well Led Governance Review identifies areas to strengthen governance across the Trust CQC Steering Group reviews progress with CQC action plan preparation to identify areas of risk of non-delivery EPR implementation programme	Assurance that the totality of transformation schemes can be delivered	16 4 x 4	20 4 x 5	9 3 x 3	To consider adding the risk to the Board Assurance Framework. July update: Workshop held with Executive team to consider this conflicting priorities. A number of proposals developed to be discussed at next Directors meeting.	Sep-2015	Mar-2016	WEB	Julie Dawes	Director of Nursing, Julie Dawes
2827	Medical	Emergency Network	Accident & Emergency	Apr-2011	Active	Developing our workforce	There is a risk of poor clinical decision making in A/E due to a dependence on locum Middle Grade Doctors at weekends and on nights 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 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 4 Consultant posts advertised currently. Closing date end of June 15 Business Continuity Plan awaiting approval of Urgent care Board covering ability to provide safe services for varying periods of time	Oct-2015	Oct-2015	WEB	David Birkenhead	Dr Mark Davies/Mrs Bev Walker
4706	Corporate	Finance	Corporate Finance	Jun-2011	Active	Financial sustainability	There is a risk that the Trust fails to achieve it's financial plans for 2015/16 thereby breaching it's Monitor licence due to failure to deliver cost improvement plans or not adhering to good financial governance, resulting in compromised patient safety and increased external scrutiny.	Standing Financial Instructions set spending limits Turnaround structure in place which has created a more robust Project Management Office and the rigorous administration of cost improvement schemes Implementation of Turnaround Governance procedures (i.e. accurately reporting and projecting financial performance) Divisions can respond to activity targets on a specialty basis (e.g. additional theatre sessions/outsourcing if necessary) Formal Finance Our Future training Board to Budget Holders in place Budget reviews hold budget holders to account Accurate Income and Expenditure forecasting CIP target greater than actual savings required and contingency reserve established by the Director of Finance	Signed contracts not yet in place with main Commissioners for 2015/16. The unpredictability of Commissioners tendering process and possible decommissioning of services.	15 5 x 3	20 5 x 4	10 5 x 2	Contracts to be agreed and signed following mediation Plans to be agreed to manage gains or losses following tendering process August update: Contract believed to be close to point of signing.	Sep-2015	Mar-2016	FPC	Keith Griffiths	Kirsty Archer
4783	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Aug-2011	Active	Transforming and improving patient care	There is a risk that the Trust falls below national standards for mortality levels due to not delivering appropriate standards of care for acutely ill patients/frail elderly patients and possible incorrect clinical coding resulting 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.	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	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 Coding improvement work not yet complete Improvement to standardized clinical care not yet consistent. To be completed by Dec 15	20 4 x 5	20 4 x 5	16 4 x 4	- To complete the work in progress - CQUINS to be monitored by the Trust - Plan is being revised - External review of data and plan to take place August update: Further information received with increased risks to mortality. Action plan reviewed and presented to WEB.	Sep-2015	Dec-2015	COB	David Birkenhead	Juliette Cosgrove

6345	Trustwide	All Divisions	All Departments/Wards	Jul-2015	Active	Keeping the base safe	Staffing Risk Risk of not being able to deliver safe and effective high quality care and experience for patients due to: - lack of nursing staffing as unable to recruit to substantive posts, i.e. not achieving recommended nurse staffing levels (as per Hard Truths workforce model) - lack of medical staffing as unable to recruit to Consultant / middle grade doctor / junior doctor vacancies across a number of specialties (A&E, Opthalmology, Anaesthetics, Paediatrics, Histopathology, Radiology, Gynaecology/Urology Oncology, Acute Oncology Service) - over-reliance on middle grade doctors meaning less specialist input - dual site working and impact on medical staffing rotas - lack of workforce planning / operational management process and information to manage medical staffing gaps resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives (eg Electronic Patient Record)	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 - staff skill mix, eg extend roles of nursing / Allied Health professionals - medical rotas (organised by division) - use of flexible labour where identified staffing shortfalls - bank/ additional hour payments (nursing), internal / agency locum cover - weekly report on usage of agency / bank staff and review of interim resource costs as part of control workstream by Director of HR Active recruitment activity, including international recruitment Retention strategy for nursing Integrated Board Report /Hard Truths report identifies nursing staffing levels below requirements Divisional management:specific staffing gaps identified on Risk Register and reviewed through governance structures, divisional business meetings identify staffing risks and plan to mitigate risk Contribute to Health Education England survey to inform future commissioning / provision of education / training	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 (currently divisional) / workforce planning for medical staff - system /process to identify, record and manage gaps in planned medical staffing, particularly for junior doctors - measure to quantify how staffing gaps increase clinical risk for patients International recruitment for medical staff yet to take place	16 4 x 4	20 4 x 5	9 3 x 3	Nursing recruitment - investigate the possibility of outsourcing flexible workforce department Continue to recruit to vacant posts / skill mix review, progress international recruitment of medical staff, consider incentive schemes. (Director of Nursing, Medical Director) Secure resource to develop medical staffing workforce planning (Medical Director) Improved operational management of medical staffing workforce (Medical Director) Set up a Task and Finish Group led by Assistant Director of Operations to agree the response to manage the medical workforce risk (September 2015). August update: Medical staffing paper to be presented to August Quality Committee to understand the full extent of the problem and further mitigations to be considered.	Oct-2015	Mar-2016	WLG	David Birkenhead, Julie Dawes & Jackie Green	Jackie Murphy, Jason Eddleston & Juliette Cosgrove

6078	Family & Specialist Services	Appointments & Records	Appointment Services	Aug-2014	Active	Keeping the base safe	Appointment Slot Issues – A failure to provide sufficient appointment slots to manage demand. Caused by an increase in referrals to services or reduced available capacity to manage demand. Resulting, poor patient experience, inability to access referral letter as e-referrals cannot be accessed until an appointment is allocated, increased administration (reliance on spreadsheets to track capacity requirements).	Process: Daily spreadsheet to Clinical Divisions highlighting capacity requirements. Regular communications with Specialty capacity leads. Reallocation of cancelled slots to maximise capacity.	Variations in capacity and demand plans. Consultant vacancy factor. Manual process in place to record ASIs extracting information from ERS and PAS. THIS are working on a live document that clinical and administrative leads can access to eliminate the emailing and filtering of spreadsheets on a daily basis.	16 4 x 4	16 4 x 4	4 4 x 1	Capacity issues reported at Planned Care Board, and Clinical Specialties developed actions plans to reduce ASIs. Weekly x-divisional Access Meetings established (at ADD level) to monitor performance. Recruitment of locum / substantive Consultant posts underway. Review of clinic templates undertaken which is providing increased capacity for new patient slots Additional Clinics to continue to address shortfall. Call wrap up time halved from 20 seconds to 10 seconds • Increased staffing at peak times • Monitoring downtime of call handlers • Reviewing hot spots (by hour) and flexing across core tasks as required • Reallocating and monitoring evening activity • Reviewing call handler KPIs and stretch targets • Review of call messages In addition to the call centre actions above an action plan to enhance administration services has been developed which include short notice clinics, reallocation of cancelled slots, conversion of "special slots", removal of named clinician. •	Nov-2015	Nov-2015	PCB	Julie Dawes	Rob Aitchison
2828	Medical	Emergency Network	Accident & Emergency	Apr-2011	Active	Keeping the base safe	There is a risk of too slow patient flow and breaches of national targets in A/E due to bed blockages across the Trust, resulting in harm to patients through delayed treatment and increased external scrutiny for the Trust.	Escalation protocol in place which requires ED Co-ordinator to link with Patient Flow/Clinical Site Commander to ensure patients are moved from ED to a bed within national guidelines Site Commander can authorize additional beds by using flexible capacity Level discharges (required discharges at certain points of the day) plan in place. Site Commander to work with Ward Managers at 2 hourly meetings to ensure these happen All patients have a personal plan established by their Ward which includes discharge arrangements Medically stable patients are reviewed daily by the Discharge Team and Local Authority Surge and escalation plan in place to escalate to higher levels of authority (e.g. cancel next day surgery)	Despite the controls, the bed base in still insufficient at certain times The night period is particularly vulnerable. There is a reliance on locum middle grade doctors due to vacancies	20 4 x 5	16 4 x 4	12 4 x 3	Bed modeling review underway as part of the ED Action Plan. To be completed by mid-June 15 Capacity and demand modeling being undertaken (matching resources to peak activity periods). To be complete by mid-June 15 Urgent Care Board is accessible to consider new initiatives and act as an escalation decision making body in the case of very urgent situations. The Board has reserve resources Update: June 2015 - Silver Command put in place and escalation discussions re: whole system specific issues and creating more capacity. - Business case being developed for 10 additional step down beds at Oakmoor. Bed modelling to be presented to Star Chambers in June. August update: Star Chamber held, outputs validated by PMO who supported the suggested cost pressures and change to year end forecast, particularly in relation to bed capacity. Bed modelling paper presented to WEB and on agenda for August Trust Board meeting with recommendations to support bed cost pressures.	Sep-2015	Dec-2015	CG	Julie Dawes	Sajid Azeb

5806	Estates & Facilities	Estates, Planning & Contracting	Capital Team	May-2015	Active	Keeping the base safe	There is a risk that the following urgent Estates schemes cannot be undertaken due to insufficient resources, resulting in a poor patient experience, possible ward closures and harm caused by slips, trips and falls A) Failure to maintain privacy and dignity on the Chemotherapy Unit at HRI B) Poor/unsafe flooring in ICU at HRI C) Environmental/safety standards on Ward 18 at HRI D) Temperature control in winter on Ward 4 at HRI E) Poor environmental conditions on Ward 5 at HRI F) Uneven floor surface on Ward 19 G) Poor fitting windows on Ward 6 at HRI H) Damaged floor on CCU at CRH	A) Chemo unit- currently still on ward 3 but will be moving to new facilities on ward 7 in September 15 B) ICU- temporary repairs carried out as & when required but decant necessary for full floor replacement. C) Ward 18- Discharge lounge re-located onto Ward 18 which has been decorated & patient entertainment fitted. Ongoing concerns with Ward 18 (Childrens Area). Estates working with AM Henshaw to provide action plan for intermediate repairs (ward upgrade necessary) - ACTION COMPLETE D) Ward 4- heaters were available for cold rooms. Ward 4 has now been connected to existing vent plant The heating system has been set up to enable the BMS system to control BMS valves within the ward to give better heating control within the area. ACTION COMPLETE E) Ward 5- now moved to ward 11 whilst the ward has works done and a minor upgrade. G) Windows repaired (temporary) H) Cofley aware of CCU Flooring which is being monitored prior to decanting ward to refurb under lifecycle. F) Staff aware of issue; decant to be planned to enable re-skimming of floor G) Ward 6- temporary solutions in place with the windows and heaters for cold rooms	A) The privacy & Dignity Issues are being managed by the ward until move onto new Ward. B) Situation monitored by Estates until opportunity to decant ward and fully replace,. C) No Gaps, work complete. D) No Gaps, work complete E) Issues highlighted for inclusion in the minor upgrade will be addressed prior to the Ward returning to Ward 5. F) Situation monitored by Estates until opportunity to decant ward and fully repair. G) Superficial repair of Ward 6 windows (carried out Site Wide); windows will be monitored by Estates. H) Cofley aware of CCU Flooring at CRH, on lifecycle replacement however monitored prior to decant.	16	4 x 4	16	4 x 4	8	4 x 2	A) Chemo Unit to transfer to upgraded area in Sept 15. B) ICU floor to be monitored until decant possible. F) Ward 19 flooring will be monitored until decant possible G) Windows on Ward 6 will be managed by Estates H) CCU Flooring at CRH will be monitored until decant possible. I) ED resus area at HRI. August update: Further work to improve estates on ward 18 has been completed and therefore risk in relation to this specific estates risk has been reduced.	Nov-2015	Mar-2016	RC	Lesley Hill	Paul Gilling
6300	Trustwide	All Divisions	All Departments/Wards	May-2015	Active	Keeping the base safe	A number of clinical, operational and estates risks causing increased risks to patients and non-regulatory compliance which may result in CHFT not achieving a CQC rating of good or outstanding (e.g. Estates risks; Paediatric Standard compliance; A&E National Standards compliance), which could cause the Trust to have breach of licence.	- 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 - Weekly strategic CQC meetings	- Full Divisional and Corporate self-assessment still to be completed - Some out of date policies and procedures - Assessments show us to be be in the "requiring improvement" category	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	Sep-2015	Dec-2015	WEB	Julie Dawes	Juliette Cosgrove

6130	Corporate	Commissioning & Partnerships	Commissioning & Partnerships	Oct-2014	Active	Financial sustainability	There is a risk of loss of income to the Trust due to Greater Huddersfield CCG and Kirklees and Calderdale Councils undertaking competitive procurements. This could have negative impact by increasing the Trust's underlying deficit and on the clinical resilience and stability of retained services. The two areas this relates to are procurement of Care Closer to Home and the Integrated Sexual Services in Kirklees.	There is a robust system of horizon scanning in place to identify when services are to be tendered both within and beyond the catchement area to ensure the Trust is able to respond and make decision of whether to submit tenders. New models of care have been developed in response to the requirements of tenders.	Need to anticipate weaknesses and gaps in services through risk assessments prior to tender processes to make service model changes rather than wait for pressure of a tender to force changes Use of Service Line Reporting needs to be strengthened to identify profitability of services and whether to bid against tenders or disinvest. Need to develop appropriate market exit strategies (disinvestment) to eliminate costs where income is lost.	16 4 x 4	16 4 x 4	12 4 x 3	Develop new models of care in advance of Commissioner tendering processes with advance notice of services likely to be tendered in the future Update: December 2015 Ensure where income is lost there is a managed and clear reduction in cost to minimise residual cost pressure. July Update: Care Closer to Home tender awarded to Locala. Work currently being undertaken to understand the impact on staff, service delivery and finance.	Jul-2015	Dec-2015	CISC	Anna Basford	Rob Aitchison & Lisa Williams
6230	Corporate	Finance	Corporate Finance	Feb-2015	Active	Transforming and improving patient care	There is a risk that the Trust will not be able to deliver the expected financial benefits of the Electronic Patient Record (EPR) system due to the implementation being impeded by financial and operational constraints (eg additional costs incurred due to time delays or lack of appropriate resource being made available) resulting in a failure to demonstrate return on investment or value for money. There are two elements to this risk: Implementation of tactical solutions (e.g. e-rostering; nerve centre; maternity; voice recognition; EDMS); and Project management delays, changes to specification and lack of capacity; clinical engagement and complexities with working jointly with Bradford Teaching Hospitals.	• Agreed loan from Independent Trust Financing Facility (ITFF) received in April 15 to support capital programme, specifically Electronic Patient Record (EPR). • Financial appraisal and selection of preferred supplier that included full benefits realisation and implementation plan. • Modernisation Programme Management and Governance structure to manage the implementation and roll-out of the EPR system within the Trust-wide IT Modernisation Programme. • Transformation Board meets on a monthly basis chaired at CEO level. • Creation of an Assurance Board that includes Non-Executive directors. • A detailed project plan and timelines has been agreed with Cerner (EPR Provider) and Bradford for the roll-out of the EPR.	The full gap analysis of EPR processes against current working practices to be completed with the requirement to develop an associated change management programme.	15 5 x 3	15 5 x 3	5 5 x 1	Regular updates from EPR Benefits Realisation now agended at the Trust Finance and Performance Committee.	Sep-2015	Apr-2016	FC	Keith Griffiths	Kirsty Archer

6299	Trustwide	All Divisions	All Departments/Wards	May-2015	Proposed for Acceptance	Keeping the base safe	Patient Safety Risk Risk of failure of high risk medical devices (patient monitoring infusion devices, incubators, phototherapy equipment) due to lack of routine maintenance, staffing capacity and systems in Medical Engineering, resulting in potential patient harm and inability to meet CQC requirements for medical devices.	* Health and Safety Committee monitors medical devices action plan to address recruitment issues, database, risk analysis of devices. * Close management of service contracts to ensure planned maintenance activity has been performed *Categorisation / risk analysis of medical devices (high, medium, low) to prioritise maintenance * Development of Planned Preventive Maintenance (PPM) Programme * Recruitment of administrator and 1 Medical Engineer * Audit of medical devices by independent assessor to identify any further actions needed	1. PPM Programme not yet complete 2. Medical Device database needs to be reviewed to ensure accurate information on medical devices needing maintenance. 3. Lack of information on what proportion of equipment has accurate recording of location on medical devices database 4. Medical Devices Assessor final report and action plan not yet received, meaning further actions required not yet known 5. Newly recruited Medical Engineer not yet in post.	15	5 x 3	15	5 x 3	5	5 x 1	1. PPM Programme to be competed by end October 2015 by V. Wotherspoon 2/3. Medical devices database audit by V. Wotherspoon, completion August 2016 to ensure accurate picture of devices needing maintenance and location of devices.. 4. Review final report and actions of independent assessor (due September 2015) and amend plans accordingly. 5. Newly recruited Medical Engineer to start September 2015 6. Medical Engineering team to move to Estates from end of September 2016 to ensure systems and processes for medical devices are closely monitored.	Oct-2015	Aug-2016	DB	Lesley Hill	V Wotherspoon

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 27th August 2015	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: MONTHLY DIPC REPORT - Report on the position of Healthcare-associated infections	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Weekly Executive Board	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The DIPC report is provided monthly to keep the Executive Board members and the Board of Directors informed of the current position of HCAI and to highlight areas of concern and progress of prevention work.

Main Body

Purpose:

For information

Background/Overview:

Monthly update on the state of HCAI in the Trust - please see attached

The Issue:

Monthly update on the state of HCAI in the Trust - please see attached

Next Steps:

Report to be taken to the Infection Control Performance Board for action as required

Recommendations:

For the Board to note the content

Appendix

Attachment:

MONTHLY DIPC REPORT .pdf

Report from the Director of Infection Prevention and Control to the Weekly Executive Board August 2015

Performance targets

Indicator	Month agreed target	Current month (July)	YTD agreed target	YTD performance	Actions/Comments
MRSA bacteraemia (trust assigned)	0	**0**	0	**2**	
C.difficile (trust assigned)	2	**1**	21	**4**	2 avoidable 2 unavoidable
MSSA bacteraemia (post admission)	1	**0**	12	**3**	
E.coli bacteraemia (post admission)	3	**3**	29	**12**	The probable source in all cases was urinary tract with one patient having a catheter
MRSA screening (electives)	95%	**96.78%**	95%	**97%**	May validated data
Central line associated blood stream infections (Rate per 1000 cvc days)	1.5	**0.7**	1.5	**0.7**	
ANTT Competency assessments (doctors)			95%	**69.4%**	On-going training being provided and increase in number of assessors. All FY1 have been competency assessed.
ANTT Competency assessments (nursing and AHP)			95%	**75.3%**	
Hand hygiene	95%	**99.65%**	95%	**99.66%**	

Quality Indicators

Indicator	Current month (July)	YTD performance	Comments
MRSA screening (emergency)	**90.55%**	**90/75%**	June validated data
Isolation breaches	**12**	**74**	
Blood cultures Competency assessments		**54.3%**	Data only available for RN
Cleanliness	**97.42%**	**97.3%**	

HCAIs/Areas of Concern/Outbreaks

- **Isolation breaches** recorded by the Infection Control Team during July were 12, compared to 17 in June. Of these 12 isolation breaches,
    - All 12 of the breaches occurred in the medical division, 7 at HRI and 5 at CRH

- **MRSA acquisition** – there was 2 cases of hospital acquired MRSA identified in July; one on ICU CRH and one on 5AD. There have been 8 cases in total since April.
- **MRSA bacteraemia** – there was one pre 48 hour case that has been attributed to the Trust following the PIR investigation. Care of the patient was provided by the District Nursing and Intermediate Care teams in Calderdale.

  There was one post admission case in July; the summary of the case is below.

Case details	Summary of C.difficile case	Key issues identified from RCA
13.07.15 **HRI 4** MESS 423979 Datix 221890	Patient has a history of incurable pancreatic cancer and admitted on 9th July from respite care following being found on the floor, history of not opening bowels for 5 days, treated for ?UTI and prescribed IV antibiotics, but these were stopped as raised inflammatory makers were attributed to pancreatic cancer. First episode of type 6 on 13th July, patient isolated immediately.	• Agreed as an unavoidable case • Gaps in documentation – stool chart not fully complete

Quality Improvement Audits

- Six Quality Improvement Audits were performed in July (only 5 fully reported)
  - HRI Haematology Outpatient – Scored Green (97%)
    - Small panel on fire door needs painting
    - Small piece of grit on waiting room floor
    - 2 blood collection bottles out of date
  - HRI Phlebotomy – Scored Green ()
    - Wall protection required in some areas
    - Sky lights need cleaning
    - 2 ceiling tiles need replacing
    - High level dust on 2 shelves
  - HRI ward 20 – Scored Green (92%)
    - Some patient chairs need replacing
    - Microwave condemned – plastic coating peeling away
    - High and low level dust
    - Some painting required in various areas of the ward
  - HRI ward 8 – Scored Amber (89%)
    - Some minor wall and floor damaged noted
    - Dusty noted on the shelving units in the clean utility
    - High and low level dust
  - CRH Theatres – scored Green
    - Evidence of trolley mattress checking need to be in place.
    - The drug fridge was unlocked
    - Low level dust

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Carole Hallam, Assistant Director of Infection Prevention Control
Date: Thursday, 27th August 2015	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Annual Director of Infection Prevention and Control Report 2014-15 - The Annual DIPC Report provides an overview of healthcare associated infections and the work to prevent HCAI during 2014-15	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: WEB	
Governance Requirements: Improving Patient Experience - reducing healthcare associated infections	
Sustainability Implications: None	

Executive Summary

Summary:

The report is provided as outlined by the Department of Health (Winning Ways) and includes the mandatory surveillence data and the prevention and improvement work that has been delivered during the year across the whole organisation. A comprehensive executive summary is included within the report.

Main Body

Purpose:

The purpose of the report is to provide an annual overview of healthcare associated infections and the work to prevent HCAIs in the trust

Background/Overview:

A monthly DIPC report is provided on a monthly basis and actions taken as appropriate, this annual report summarises the surveillance of HCAI and the prevention work during the year (2014-15)

The Issue:

As above

Next Steps:

The Annual DIPC report will be published on the Trust website as per the Department of Health (Winning Ways) recommendations

Recommendations:

For the Board to note the content of the report

Appendix

Attachment:

DIPC Report 2014-15 final.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Director of Infection Prevention and Control Annual Report 2014-15

Executive Summary

This report provides information about the infection prevention and control arrangements and activity during the period 2014-15. The Director of Infection Prevention and Control (DIPC) who leads the infection prevention and control team reports directly to the Chief Executive.

The governance arrangements for infection prevention and control are as follows; infection prevention performance is reported monthly to the Board of Directors by the DIPC. The Board is a well-represented infection control committee (ICC) that meets quarterly to manage the infection control programme. The ICC also receives reports from Divisional work streams that atre managed through divisional patient safety and quality boards. Performance of healthcare associated infections (HCAI) is monitored by the Infection Control Performance Board (ICPB) that meets monthly. In addition, the ICPB also manages the HCAI action plan. HCAI data is shared monthly by means of a comprehensive dashboard and discussed further at divisional performance meetings.

The trust reported one case of meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia assigned to the trust compared with two cases in the previous year. This case was investigated and no lapses in care were identified.

There were 27 cases of *Clostridium difficile* infection identified more than 48 hours after admission.. All of the 27 cases were investigated using root cause analysis by a multidisciplinary team; 17 cases there were no lapses in care that had contributed to the infection and were thought to be unavoidable infections. Where there has been increased incidence of C. difficile this has been investigated to establish the underlying problems and actions required. This has prompted the use of hydrogen peroxide vapour (HPV) for high level disinfection of affected areas.

There was also a reduction in meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia cases with 12 cases compared to 15 in the previous year but there was an increase in E. coli bacteraemia cases with 29 cases compared to 23 cases in the previous years.

The Health and Social Care Act (2008) sets out a code of practice for health and adult social care on the prevention and control of infections. The Trust ensured compliance by means of a HCAI programme of work for 2014/15 to include the 10 criteria identified in the code and was able to demonstrate self-assessed evidence in all criteria.

Activity to prevent HCAI continued to include hand hygiene as a top priority with regular audit and a zero tolerance approach to non-compliance with staff working in clinical areas. Hand hygiene was also monitored by the Real Time Patient Monitoring team where patients are asked the question of whether, in their opinion, doctors and nurses wash their hands showing a good level of compliance throughout the year.

Aseptic non-touch technique (ANTT) is fundamental to the prevention of infection when inserting and caring for invasive devices. A standard approach is used in the Trust and both competency and compliance are monitored. Evidence showed a 78% compliance with all the key elements of ANTT.

There has been on-going work during the year to reduce the risk of harm from invasive devices. This has included training sessions and competency assessments and audit of practice. A project to reduce catheter associated infections commenced in July 2014 to reduce the risks associated with urinary catheters and to use intermittent catheters instead of indwelling catheters for first line management of retention of urine.

The trust has instituted RCA investigations for all central venous access device infections. This process has enabled an understanding of the causes of infection and appropriate learning to prevent further cases.

Norovirus has again presented some challenges to the Trust as the virus has affected a number of patients and staff during the winter months.

The Trust has a proactive Antimicrobial Management Team (AMT) that meets monthly. The AMT includes in its membership the Trust Antibiotic Stewardship Lead, Director of Infection Prevention and Control, Consultant Microbiologists, Senior Clinicians from Medicine and Surgery, Antimicrobial Pharmacists and Divisional Clinical Pharmacy Services Manager. A programme of training, audit, awareness campaigns and review of antibiotic prescribing guidelines has been used to improve practice. The consultant microbiologists continue to perform regular antibiotic ward rounds to advise on antimicrobial stewardship.

Decontamination and sterilisation of re-usable surgical instruments is performed by BBraun Sterilog which has validated processes and certified as compliant with the British Standards Institute.

The provision of cleaning services continues to be delivered by both an in-house service at Huddersfield Royal Infirmary (HRI) and a contracted out service at Calderdale Royal Hospital (CRH) and Princess Royal Community Hospital (PRCHC). 24-hours Rapid Response Teams are provided at both hospital sites providing out of hours cleaning and continue to be extremely well received by staff.

The trust carried out a number of environmental upgrades during 2014/2015 to both public and clinical areas. Improvement works included replacement of flooring, refurbishment of lift lobby areas, window replacement, redecoration works, staff dining and office areas

The infection prevention and control team have participated in a number of audits as part of their programme of work. These include an audit of sharps management and safety, hand hygiene compliance with the hand hygiene policy (no wrist watches, stoned rings, long nails and nail polish), urinary catheters, peripheral venous cannula, isolation facilities and commodes.

All core policies, as required by the Hygiene Code 2008, have been reviewed and have been published on the Trust Intranet and Internet sites. Twelve policies have been approved at Executive Board during 2014/15.

Training and education are a core activity key to the success of ensuring a knowledgeable workforce and effective infection prevention on clinical practice, therefore, the infection prevention and control team continue to deliver a comprehensive programme. Content is tailored to specific staff group needs that are identified through our training strategy as well as audit and surveillance outcomes.

Link Infection Prevention Control Practitioners are available in all areas across both the acute provider services and community provider services. They help to narrow the gap between theory and practice by passing on their knowledge to other staff in their areas of work.

Contents

1. Infection Control Arrangements

The Infection Prevention and Control Team (IPCT) provide specialist advice on matters relating to the identification, prevention and management of infection within the Trust. The team works to an agreed annual programme of work, approved by the Infection Control Committee and the Executive Board.

The IPCT is also supported by two antibiotic pharmacists (1 WTE) who are led by a Consultant Microbiologist with responsibility to improve antibiotic prescribing.

The IPCT comprises of an Infection Control Doctor, Lead Infection Prevention and Control Nurse, Senior Infection Prevention and Control Nurses, Infection Prevention and Control Nurses, support and administration staff.

The Director of Infection Prevention and Control (DIPC) is both the Medical Director and a Consultant Microbiologist. The specific role and responsibility of the DIPC is to:

- oversee local control of infection policies and their implementation;
- be responsible for the Infection Prevention and Control Team within the healthcare organisation;
- report directly to the Chief Executive and the Board and not through any other officer;
- have the authority to 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;
- produce an annual report on the state of healthcare associated infection in the organisation and release it publicly via the Calderdale and Huddersfield NHS Foundation Trust website.

Reporting arrangements

- Infection prevention is the responsibility of everyone in the organisation;
- The Infection Prevention and Control Doctor oversees the implementation of the Infection Prevention programme through the role as chair of the Infection Control Committee (ICC) and reports directly to the DIPC;
- The infection prevention and control nursing team is managed by the Lead Nurse;

- The DIPC is a member of the Executive Board and reports directly to the Chief Executive;
- Through reports received at the ICC and Executive Board the DIPC is able to challenge infection prevention and control practice;
- Exception reporting from the ICC is made to the Infection Control Performance Board.

Infection Control Committee

The ICC meets quarterly and is chaired by the Infection Prevention and Control Doctor. It has senior representatives from each clinical division, pharmacy, support services, occupational health and the Public Health England. Its remit is as follows:

- To ensure that Calderdale and Huddersfield NHS Foundation Trust provides a safe environment, in terms of infection risk and within the sphere of current knowledge, for patients, staff and visitors.
- To oversee the organisation and development of infection control services across the Trust, including surveillance, audit, education and the development and review of policies.

The ICC reports to the Patient Safety Group and onward to the Quality Board which reports to the Executive Board and Board of Directors.

Infection Control Performance Board

The Infection Control Performance Board meets monthly to monitor healthcare associated infection (HCAI) performance and the implementation of the Trust HCAI Action Plan. It also provides a forum for strategic decision making and ensures that the Trust does all it can to meet national HCAI targets, and is compliant with the Health and Social Care Act and associated core standards of the Care Quality Commission. This Board is chaired by the DIPC and membership includes the Director of Estates, Director of Risk Management and senior members of the Trust's clinical divisions.

Healthcare Associated Infection (HCAI) Operations Group

This group meets monthly to deliver the actions of the Trust HCAI Action Plan ensuring these were dealt with in a timely manner. It meets monthly with representatives from each of the divisions, clinical groups, health informatics team and estates and facilities. The outcomes from this group are reported to the Infection Control Performance Board.

Board to Ward

Board to ward reporting is achieved primarily through the HCAI dashboard which is compiled on a monthly basis. The DIPC reports monthly to the Executive Board (EB) and Board of Directors (BOD) a number of key indicators and performance of HCAI; this information is cascaded via the Trust EB Briefing and is reported in the staff newsletter, Trust News. A monthly DIPC report is provided for the Executive Board and Board of Directors and is also widely shared with the HCAI Clinical Champions, members of the ICPB and the HCAI Operations Group.

Healthcare Economy-Wide Meetings

The economy-wide group meets on a quarterly basis with executive level representation from the Trust, Public Health England (PHE), South West Yorkshire Partnership Trust (SWYT), Locala and Directors of Public Health Calderdale & Kirklees and representative from the Clinical Commissioning Groups (CCG). Recognising that reduction in preventable infection requires the highest standards of hygiene practice in all sectors of health care, this group ensures that there is a co-ordinated approach to improvement and facilitates communication and the sharing of best practice.

Infection Prevention and Control representative at relevant groups

To provide infection and prevention advice and ensure liaison between the IPCT and key groups, representation is provided at the following:

- Infection Control Performance Board
- Healthcare economy wide meetings
- Divisional management boards
- Quality Improvement Steering Group and collaborative
- Medical devices and clinical product review
- IV Strategy Group
- Community Infection Control Committees
- Matron and Sisters Forums
- Water management and air quality group
- Non clinical governance committee
- Estates and Facilities Capital planning group

Infection Control Budget 2014/15

The Infection Control Team has a budget of £474,151 per annum. Of this £30,327 is for non-pay including ICNet licensing, training expenses as well as travel and mobile phone costs. The Lead Nurse is both the budget holder and budget manager. Excess costs

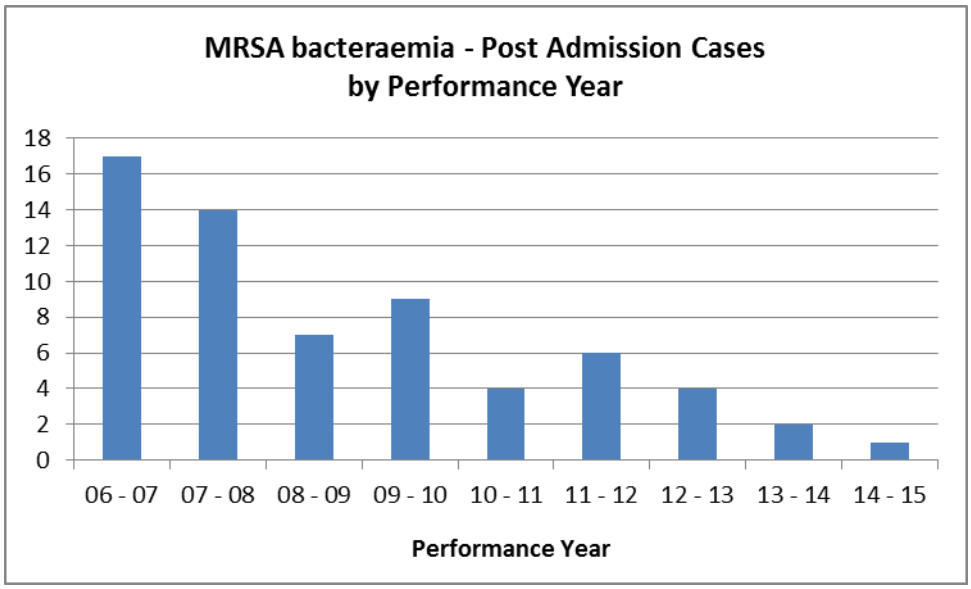
associated with outbreaks are funded separately from within the Trust. One WTE band 6 IPCN post has been lost to the voluntary redundancy scheme at the end of this financial year.

2. Mandatory reporting of HCAI

The Trust is committed to providing a safe environment for patients including preventing healthcare associated infections. Although the Trust has made significant reductions overall in healthcare associated infection in the few years it also recognises that continued focus and effort is required to sustain the changes and meet the targets set for Healthcare Associated Infections (HCAI)

Meticillin-resistant Staphylococcus aureus

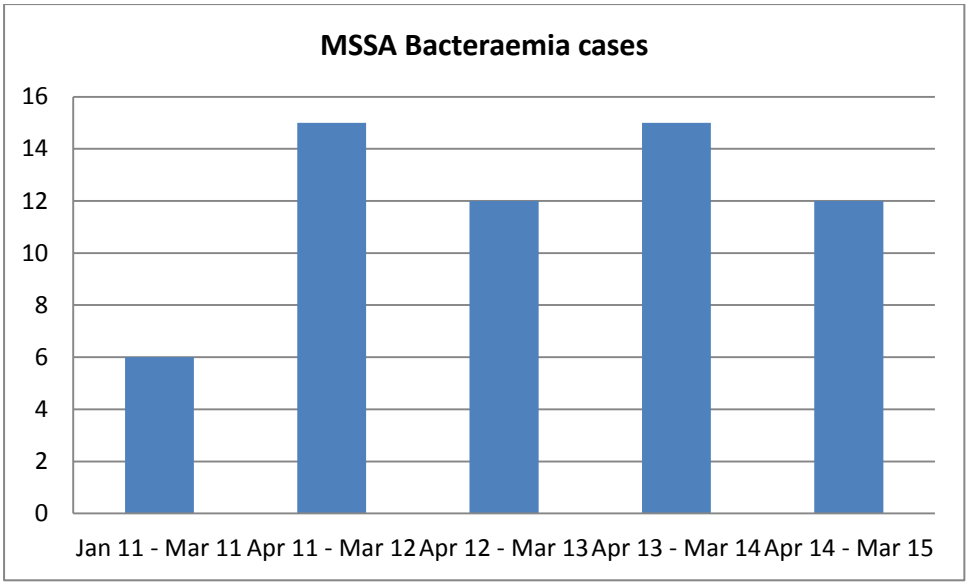
MRSA (Meticillin-resistant *Staphylococcus aureus*) bacteraemias are reported nationally and the Trust has seen a significant reduction over the last few years. There is a zero tolerance to avoidable cases and last year there was one case. This case was investigated by both doctors and nurses caring for the patient along with a representative from the CCG. There were no lapses of care attributed to the trust that would have contributed to the infection.



Meticillin-sensitive Staphylococcus aureus

MSSA (Meticillin-sensitive *Staphylococcus aureus*) bacteraemias are reported nationally but there is no national set target. A local target was set mid-term using the 2013-14 out turn of 15 cases. This target was achieved.

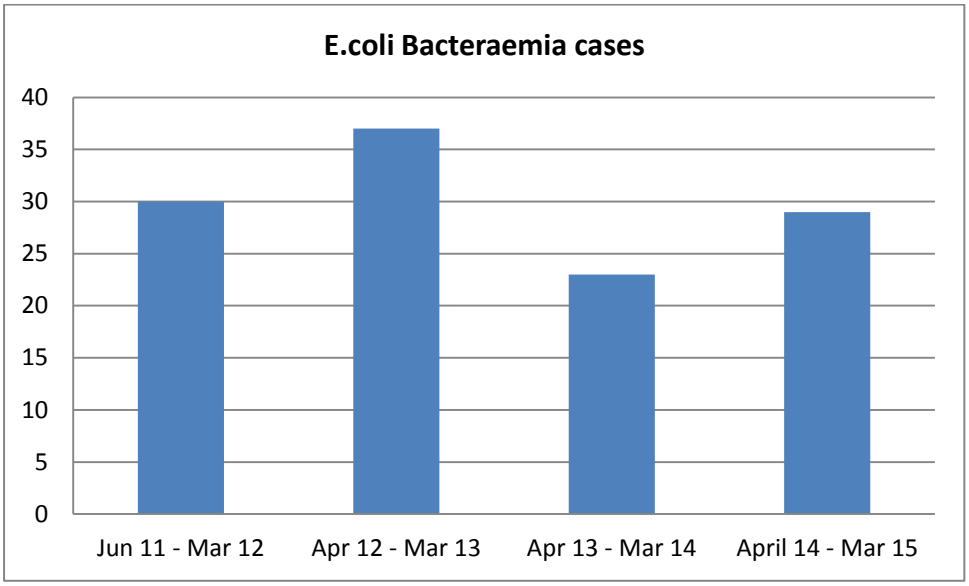
The chart below shows the number of post admission cases.



E.coli Bacteraemia

There is no national set target for E.coli. A local target for E.Coli was set mid-term using the 2013-14 out turn of 23 cases. There were a total of 29 cases therefore the target was missed by 6 cases, a review of these cases highlighted that almost half of the cases were associated UTI and around 25% of these had a urinary catheter.

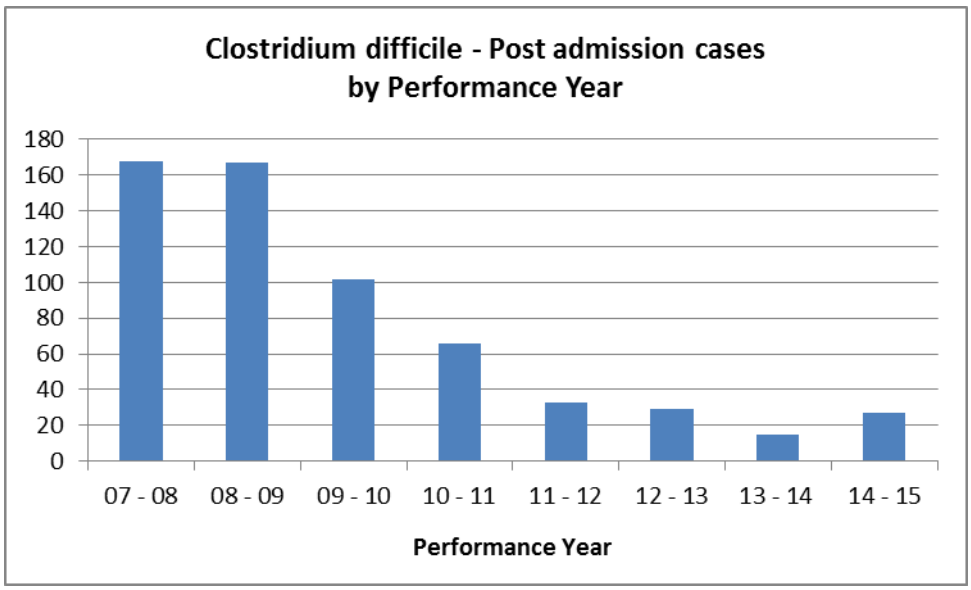
The chart below shows the number of post admission cases.



Clostridium difficile

Clostridium difficile (*C. difficile)* is one of the major causes of infective diarrhoea. The target set for the trust in 2014-15 was a ceiling target of 18. In the last year there was an

increase in cases compared to the previous year. All the cases were investigated by a both doctors and nurses caring for the patients along with a representative from the CCG. Following investigations of the 27 cases, 10 showed lapses in care which were followed up with actions plans. In the remaining 17 cases there were no lapses in care that had contributed to the infection and were thought to be unavoidable infections.



3. Health and Social Care Act (2008)

The Health and Social Care Act (2008) sets out a code of practice for health and adult social care on the prevention and control of infections. The main purpose of the code is to make the registration requirement for cleanliness and infection control clear to providers of health and social care services so they know what is needed to comply. There are 10 criteria within the code, as set out below. Providers of care must be able to demonstrate and evidence compliance with each of the criterion.

Compliance criteria	What the registered provider will need to demonstrate
Criterion 1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them
Criterion 2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection
Criterion 3	Provide suitable information on infections to service users and their visitors
Criterion 4	Provide suitable accurate information on infections to any persons concerned with providing further support or nursing/medical care in a timely fashion
Criterion 5	Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people
Criterion 6	Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection
Criterion 7	Provide or secure adequate isolation facilities
Criterion 8	Secure adequate access to laboratory support as appropriate
Criterion 9	Have and adhere to policies, designed for individual's care and provider organisations, that will help to prevent and control infection
Criterion 10	Ensure, so far as reasonably practicable, that care workers are free from and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care

The Trust developed the HCAI programme of work for 2014/15 around the 10 criteria and was able to demonstrate self-assessed evidence of compliance in all criteria. The Trust has not received inspection visits at either hospital sites from the Care Quality Commission in the last 12 months.

4. Preventing Healthcare Associated Infections

Hand Hygiene

Hand hygiene is the most important intervention to prevent healthcare associated infections and therefore remains a high priority for the Trust. Observational audits are performed on all wards and clinical departments on a weekly basis. Effective hand hygiene is achieved by staff working in clinical areas complying with 'bare below the elbow' and a zero tolerance is exercised towards non-compliance.

In addition, hand hygiene is also monitored by the RTPM (Real Time Patient Monitoring) team who ask a number of patients on a monthly basis, as far as they are aware, do the doctors and the nurses wash their hands. Chart 1 shows the RTPM responses for the doctors hand hygiene and chart 2 shows the RTPM responses for the nurses hand hygiene during the year.

Chart 1

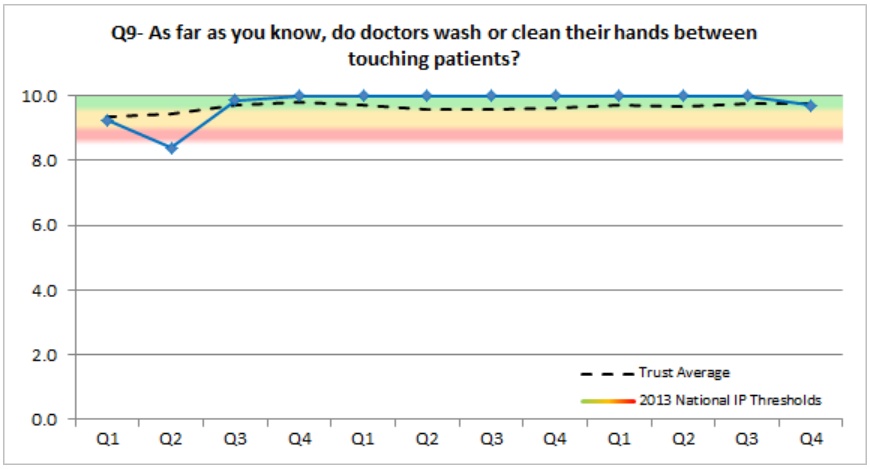
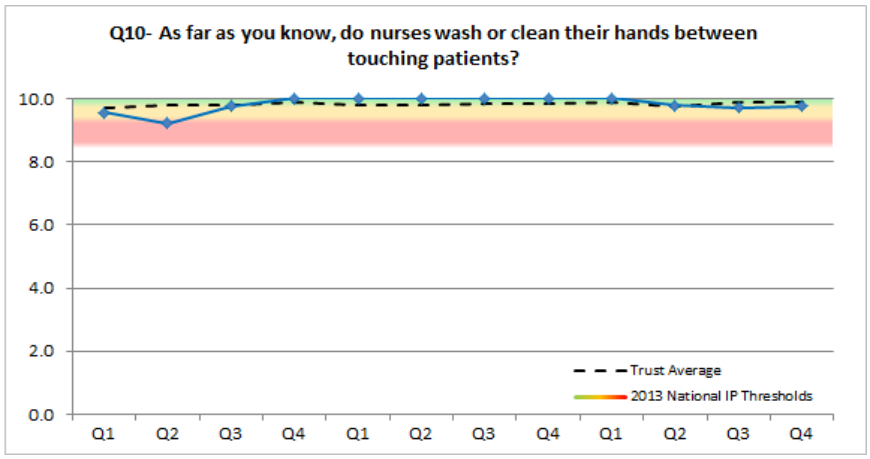


Chart 2



Aseptic Non-Touch Technique (ANTT)

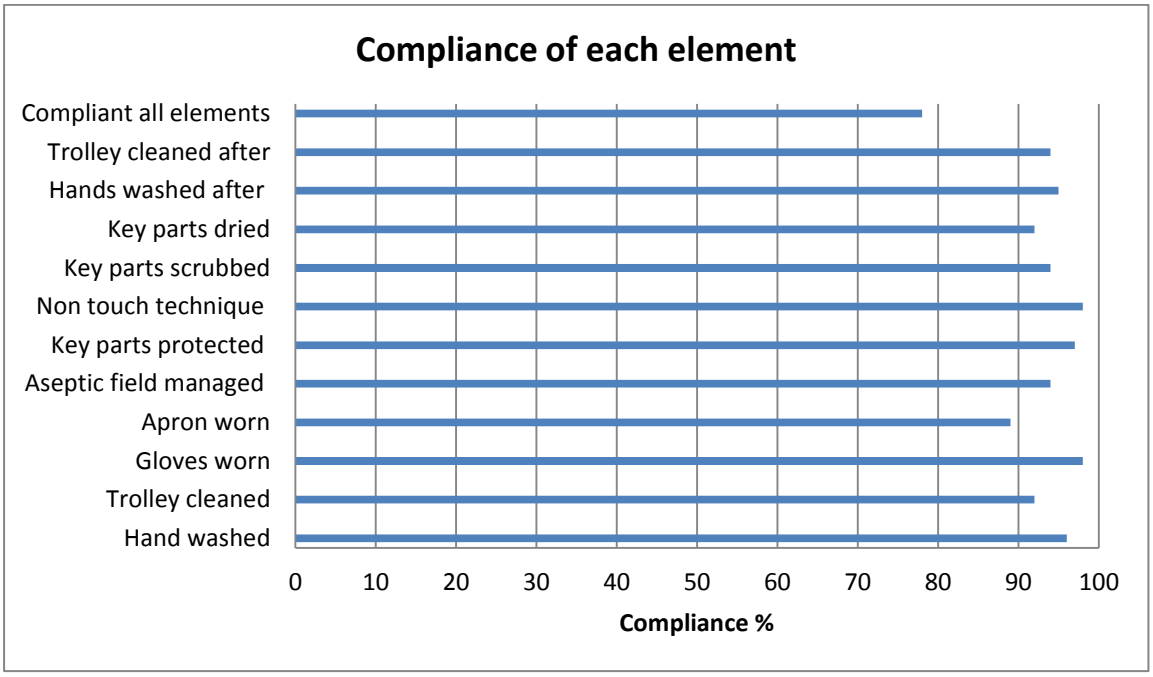
Aseptic Non Touch Technique (ANTT) was introduced to the Trust in April 2010. Regular audit of ANTT has been completed to assess on-going clinical staff using aseptic practice correctly in the organisation. A baseline audit was completed in May 2010 with post implementation audits being completed every year since.

In December 2014 ANTT practice was randomly observed by frontline staff. All divisions across both CRH and HRI have been represented. A total of 93 staff were observed practicing ANTT by volunteer observers in 53 different clinical areas.

The audit has shown a sustained level of compliance from the previous year with 78% compliance (77% in 2013) in staff completing all elements of ANTT during a single procedure.

The chart below shows the compliance with each individual element as well as compliance with all the elements.

Chart 3



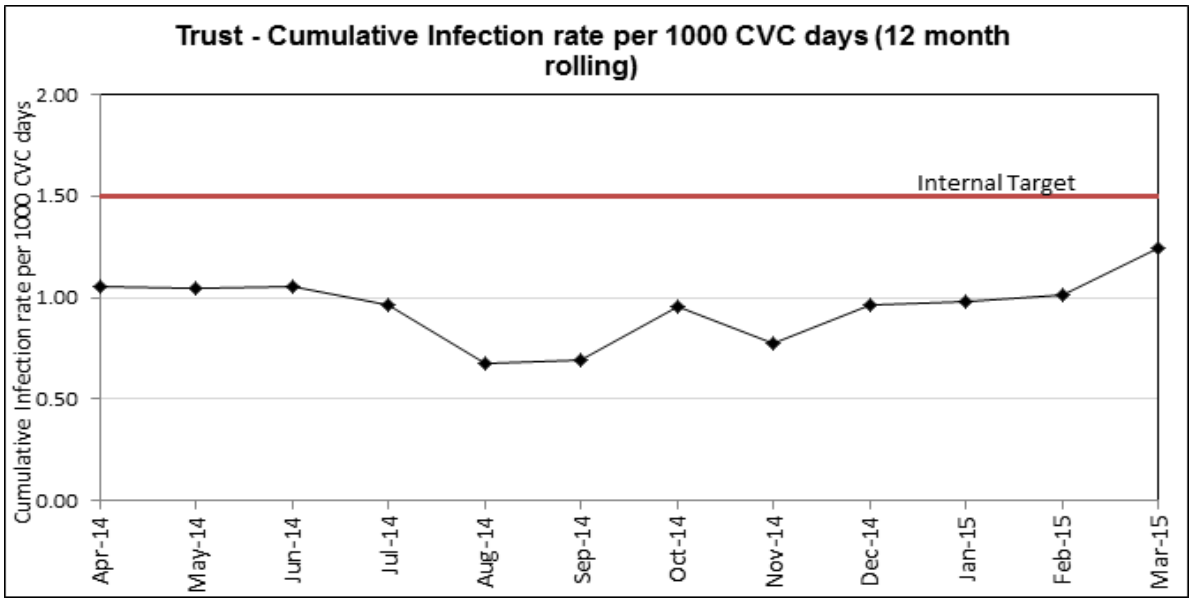
Invasive Devices

Effective practice and care of invasive devices is of greatest importance to reduce the risk of harm from these devices. The commonest three devices are peripheral venous cannulae (PVC), central venous access devices (CVAD) and urinary catheters.

There are training and competency programmes for the all the vascular access devices (PVC and CVAD) and urinary catheters with regular audit of practice. The rate of CVAD infections are measured and reported monthly. Since November 2014 an internal ceiling target has been set of 1.5 cases per 1000 device days. Each CVAD infection is investigated and actions implemented to prevent further cases.

The chart below shows that the CVAD rate of infection remains below the internal target and the slight increase in cases is due to the inclusion of cases from community that had previously been excluded from the surveillance.

Chart 4



In 2014 we were successful in obtaining some project funding to support a project nurse to reduce the number of indwelling catheters used in the trust and to introduce intermittent catheters as first line management of urinary retention and thus reducing the risks associated with indwelling catheters.

The project has raised the profile of safe catheter care, prompted education and training for ward staff in the use of bladder scanners, continence assessment and intermittent catheterisation. The Project Nurse has been able to influence existing culture, behaviour and practice about the use of indwelling catheters as a first line intervention for people with urinary retention.

Sepsis Collaborative

Focused work has continued around the recognition and management of sepsis has continued through the year it is recognised that improvements still need to be made in the reliability of screening and in particular ongoing care after sepsis 6 is delivered.

A new technology 'Nervecentre' was introduced to the medical wards at CRH in January to aid identification of deteriorating patients including sepsis with in-patients and facilitate early intervention.

HCAI Dashboard

A comprehensive monthly report is compiled by The Health Informatics Service. This report includes a number of key performance indicators which enables the Trust to be aware of both the levels of infections in terms of MRSA and *C. difficile* as well as compliance with the interventions in place to ensure that rates remain low. Hand hygiene and MRSA screening data are available at ward level, as well as details around any isolation room breaches and individual cleaning scores. This report is used across the organisation as a point of focus and is disseminated widely across divisional leads, with a subset of information being used to keep the executive team fully briefed

MRSA screening

The Trust monitors screening and reports compliance on a monthly basis via the HCAI dashboard. The Trust achieved 96.5% compliance with the MRSA screening of elective patients and 89.4% for emergency admission patients.

Investigations of cases of infection

Root cause analysis (RCA) continues to be used to investigate the cases of *Clostridium difficile* and CVAD infections. These investigations have been vital to allow understanding of the root causes and to allow the necessary learning to prevent further infections occurring from the same cause. RCA investigations are managed by the clinical staff responsible for the patient and their findings then shared both within the divisions and across the divisions.

Since April 2013 MRSA bacteraemias cases have been investigated using the NHS England's post infection review (PIR) process. PIR for MRSA cases and a summary of *C. difficile* RCAs are presented to the Infection Control Performance Board. The key learning points are reported to the Executive Board and Board of Directors via the monthly DIPC report.

Leadership

The programme of leadership walk-rounds has continued through the year, as well as wards, other non-clinical areas have been visited. The focus of these walk-rounds is to speak to front line staff and patients so any concerns can be raised and taken forward by the leadership team, as well as collecting and highlighting areas of good practice. Infection prevention and control has always been one of the key areas discussed.

Infection Prevention and Control at Divisional level

Each of the divisions has continued to support the infection control agenda through the divisional processes in line with the Health and Social Care Act 2008, with progress reported to the Infection Control Committee. Divisional support has been essential to embed good practice in all areas.

Surgery and Anaesthetics Division

This year the Division of Surgery have found infection prevention and control more challenging, however we have gone another year without a hospital acquired bacteraemia which is over 780 days since the last infection. We have had 9 cases of Clostridium difficile and we continue to learn through route cause analysis.

This year we have experienced some difficulty achieving our ANTT target; however we now have plans to address this issue and will monitor performance.

Performance is monitored through the clinical directorates, Divisional Patient Safety and Quality Board reporting also to the Infection Control Committee and the Infection Control Performance Board.

The Matrons continue to undertake the FLO (frontline ownership audits) and quality audits to ensure cleaning and environmental standards are maintained. They have more recently commenced peer review and assessment to provide 'fresh eyes' to the audits that are routinely undertaken.

Children's and Women's Services Division

The Division continues to recognise and understand the absolute importance of infection prevention and control in meeting the Divisional and Trust performance

outcomes. It maintains its commitment to working on continuous improvement. There are Link Infection Control and Prevention Practitioners within all services.

Performance is monitored through the clinical forums and the CWF Divisional Patient Safety and Quality Board as well as being integral to all nursing, midwifery and consultant agendas. We have sustained our position in having no cases of MRSA bacteraemia.

Designated clinical colleagues in the Division have again provided immunisation of the flu vaccine to the divisional team and others to contribute to meeting the Trusts target. We have also continuing to offer and sign post the flu vaccine to pregnant women.

The Division has continued to work towards the divisional trajectory for ANTT to achieve 100%.

Medical Division

The Division of Medicine has continued to progress its infection control agenda to support the trust's action plan and has seen a marked improvement in its infection control practice and management. Medical and nursing staff have demonstrated improved compliance which has been reflected in improved patient care and management. There have been no MRSA bacteraemia cases and 15 post admission cases of C*. difficile* throughout the whole of the year.

Thematic reviews of the cases of C-difficile have highlighted the need to improve isolation practice for diarrhoeal patients. There have been continued challenges to comply with side room isolation requirements for all our patients however proactive management from wards and teams have worked hard to minimise risks for our patients. Work is also being undertaken in partnership with the IPC team including the use of the nerve centre technology that is being implemented across all ward areas to monitor stool type.

The Division has an infection control group although attendance has been a challenge throughout the year and the format for this has now been revised. We have taken action to improve the performance levels of nurses and medical staff who have completed ANTT training following a period where these levels were below the standard expected.

The Division is working closely with ISS and the service performance team to monitor and improve standards of cleaning at the CRH site.

To improve consistency with reporting standards for the Matrons FLO audits the process has changed by which all FLO audits to be submitted on the 15th of every month to match with safety thermometer process. Infection prevention and control remains a fundamental part of the matron's role and as such they play a key role in improving standards at ward level with strong partnership working with the ward sister.

Multidisciplinary action plans are devised following the RCA meeting and continue to be shared from ward to board with the learning shared across all teams. Infection prevention and control is integral to the safe high quality care we deliver and it is on the agendas of all Directorate and Divisional patient safety and quality boards.

Specific action plans have been put in place, where required, to improve standards of infection control practice including cleanliness, training and leadership. Supportive monitoring of clinical compliance is undertaken by the ward matron and infection prevention and control nurses and has also facilitated important educational opportunities for staff and patients alike.

Diagnostic and Therapeutic Services

The division continues to promote an ethos of high values around infection control issues and has developed a culture of expected high standards. All areas have infection control notice boards and key parameters are presented and discussed at the Divisional and Directorate Board meetings. Learning is shared at quality and health and safety committees and service operational procedures are regularly reviewed and updated.

All areas in the division continue to show consistently good results for all audited parameters including dress code and hand hygiene. There are regular Frontline Ownership (FLO) audits and spot checks made by the matron in departmental areas for cleanliness. Where non-compliances have occurred, investigations have been carried out and actions taken. In addition, leadership walk rounds and PLACE visits are performed.

Aseptic non-touch technique (ANTT) training has full compliance in phlebotomy and radiology.

5. Untoward Incidents

Every year the infection prevention and control team (IPCT) recognise and respond to many incidents and potential outbreaks. Some are real but others are found to be chance clusters not caused by cross infection. It is not unusual to see variation in surveillance data, and the IPCT has to be alert to all potential outbreaks, and investigate them accordingly.

Month	Incident
April 14	Nil
May 14	Mumps exposure on SAU Influenza exposure ICU
June 14	Chickenpox exposure on SAU TB case contact tracing
July 14	Shingles exposure on ward 9 & SCBU CRH MRSA acquisition (2 cases) SCBU CRH
August 14	Nil
September 14	Pseudomonas isolates on ICU
October 14	VRE isolates on ICU
November 14	Nil
December 14	Nil
January 15	Pseudomonas isolates on ICU
February 15	Nil
March 15	Pertussis exposure ward 3 CRH

There were 17 outbreaks of diarrhoea and vomiting suspected or confirmed to be viral gastroenteritis in the Trust in 2014/15. Control measures, which included restrictions to admission and discharge in line with national guidance, were enforced.

All outbreaks were managed by the Trust Infection Prevention and Control Team and reported to Public Health England (PHE).

As a matter of routine good practice, the Trust closely monitors cases of both *Clostridium difficile* and MRSA acquisitions and investigates periods of increased incidence. During 2014/15 sporadic cases of *Clostridium difficile* were identified, investigated and managed. Each of these incidents was examined and any relevant lessons identified and acted upon. A programme for high level disinfection using Hydrogen Peroxide Vapour (HPV) was put in place for any wards that had two or more cases as a proactive measure to prevent environmental transmission.

6. Antimicrobial Prescribing

Antimicrobial Management Team

The Trust Antimicrobial Management Team (AMT) continues to meet monthly and comprises the Trust Antibiotic Stewardship lead, Director of Infection Prevention and Control, Consultant Microbiologist, Senior Clinicians from Medicine and Surgery, Antimicrobial Pharmacists and Divisional Clinical Pharmacy Services Manager.

Antibiotic Prescribing Guidelines

Adult antibiotic prescribing guidelines have been updated on a rolling programme and approved by Medicines Management Committee (MMC) to include minor amendments. These guidelines are now web-based.

As part of an antibiotic Quality Improvement project in paediatrics at CRH, guidelines for managing common paediatric infections were drafted and approved by MMC in April 2014.

Antibiotic App – The antibiotic guidelines have been put onto the Ignaz smartphone application (purchased by Medical Education and available on iPhone and Android devices). An intranet based version was completed. There were some initial compatibility issues which have been resolved.

Monthly Antibiotic Audits

Antibiotic audits are undertaken regularly, based on a rolling programme agreed for 2014-15:

- Audit of Restricted antibiotics in November showed 100% compliance for prescribing of Carbapenem antibiotics according to Trust guidelines, culture and sensitivity results or recommendation by microbiology
- Clinical Indication/Stop review for antibiotic prescribing. Trust-wide audit in May 2014 showed adherence to indication specified on inpatient prescription chart 85% and stop/review 80.5%. Trust-wide audit in November 2014 showed adherence to indication specified on inpatient prescription chart 90% and stop/review 69%. Historical data collected in May 2011 showed adherence to indication specified on inpatient prescription chart 59% and stop/review 63%. Between 2011 and 2015 adherence to Indication specified has shown a sustained improvement from 50% to 90%, however stop/review specified has fluctuated from 63-80.5%.

- MRSA Suppression treatment – January 2015 showed all patients audited had appropriate suppression treatment prescribed promptly and good use was made of the Infection Control Nurses PGDs (Patient Group Directive)
- Audit of Antibiotic Surgical prophylaxis in Urology patients undertaken by a pre-registration pharmacist, and results presented at Urology Clinical Audit meeting September 2014. Results showed that fewer than 25% of gentamicin doses were correct (4mg/kg IBW) as per guideline. 22% of patients received a co-amoxiclav & gentamicin combination which is not according to Trust guidelines.
- Audit of Antibiotic Surgical Prophylaxis in Caesarean Section patients undertaken by two of the Obstetric and Gynaecology doctors. Results presented at Obstetrics and Gynaecology Clinical Audit meeting July 2014. Results showed antibiotics were prescribed 93% in accordance with Trust policy (compared with 63% in 2010)
- Audit of prescribing of antibiotics for Urinary Tract infections undertaken by Clinical pharmacist and results presented at Clinical audit meetings between December 2014 and March 2015. Results showed 58% antibiotics prescribed empirically in line with Trust Guidelines. Most poor compliance was around treatment duration and not changing antibiotics following results from sensitivity tests.

Results are disseminated in the form of an Antibiotic Dashboard to the Trust Executive Board, Medicines Management Committee, DATS Management Board, Directorate Management Boards and HCAI Clinical Champions.

Quality Improvement work for Antibiotic Prescribing

Quality improvement work around antibiotic prescribing was undertaken in 4 ward areas.

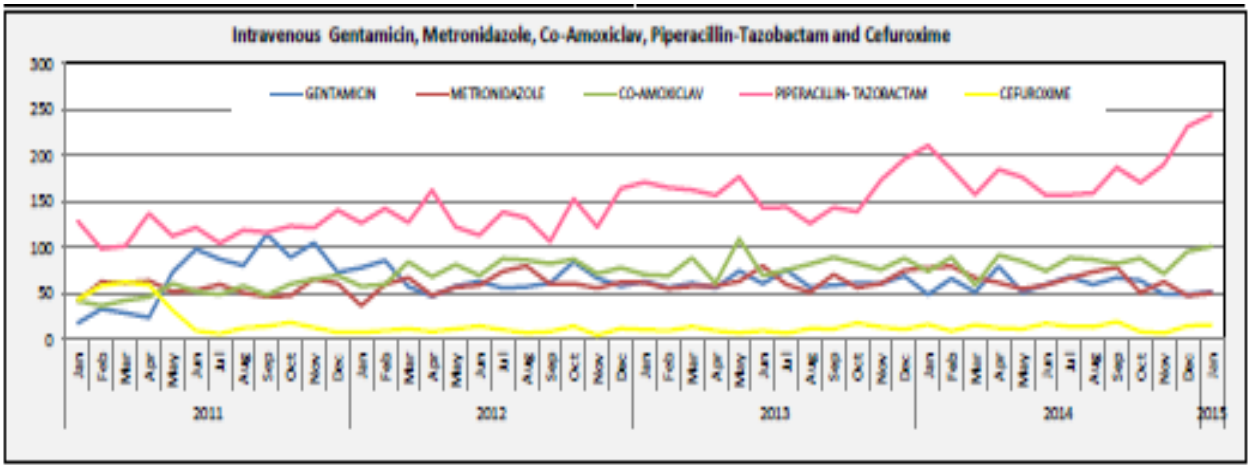
- Paediatrics CRH – QI initiative Paediatric antibiotic guidelines produced and posters put in paediatric ward areas
- Short stay Medicine (2ab) CRH – QI initiative implemented to improve the incidence of sending appropriate samples prior to starting antibiotic treatment. A subsequent re-audit showed increase from 66% to 85% of appropriate samples being taken
- MAU HRI – QI initiative to improve adherence to Antimicrobial Stewardship "Start Smart-then focus" implemented. "Don't be a DISMAL Prescriber"
- Ward 5, HRI – Audit of Antimicrobial Stewardship "Start Smart – then Focus"

Outpatient Parenteral Antibiotic Therapy (OPAT) antibiotics

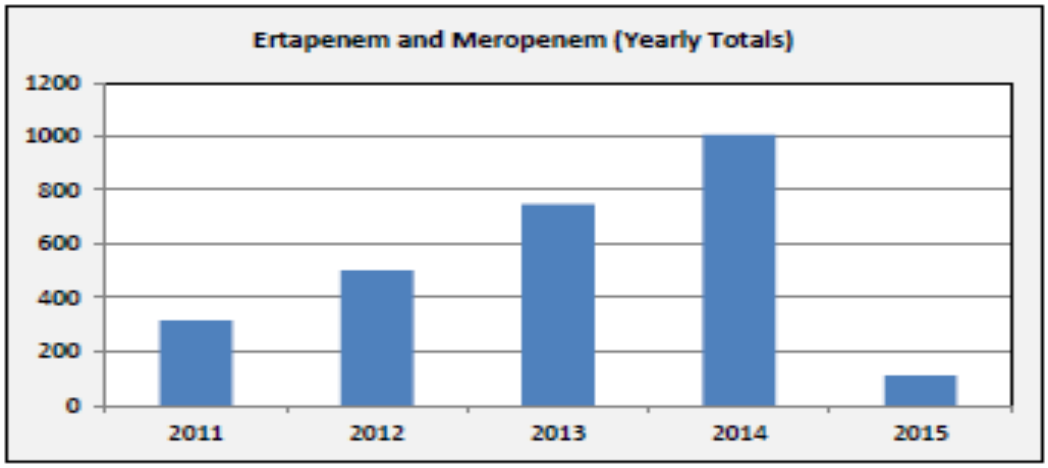
Commissioners continued to fund an OPAT service for Kirklees and Calderdale patients 2014-15. This has provided a service for up to 12 antibiotic administrations per day in each community area. A multi-disciplinary health economy-wide project group has continued to meet regularly. Nine pathways have been approved by MMC and ten antibiotics are approved for use for OPAT patients.

Monitoring antibiotic usage

We continue to monitor our inpatient antibiotic usage quarterly, in particular the use of high risk antibiotics (cefuroxime) and our use of co-amoxiclav and piperacillin-tazobactam (see graph below)



In addition, due to concerns regarding Carbapenemase producing Enterobacteriaceae (CPE), we are monitoring our use of the carbapenems (ertapenem and meropenem) – see the Graph below, and review of patients on these antibiotics has also become a focus of the antibiotic ward rounds.



Education and Training

- Trust-wide Junior Doctor Induction - Antibiotic prescribing is included in the medicines management information provided to all junior doctors on induction to the Trust.
- Regional Foundation Year (FYs) and Core Trainee (CT) doctors - Sessions on appropriate antibiotic prescribing are carried out as part of the generic skills induction course
- Medical students - The antibiotic pharmacists provide regular antibiotic teaching to third and fifth year medical students as part of their training at the Trust.
- Infection Control Link Practitioners - The antibiotic pharmacists provide regular antibiotic updates to the infection control link practitioners
- Non-medical Prescribers – In March 2015 the antibiotic pharmacists provided training on the "ARHAI Antimicrobial Stewardship Prescribing Competencies" to non-medical prescribers, who prescribe antibiotics, in the Trust
- Pharmacy staff - The antibiotic pharmacists provide regular teaching and updates on antibiotic prescribing to pharmacy staff

Antibiotic Awareness Week - November 2104

Once again, to coincide with European Antibiotic Awareness Day on 18 November, an Antibiotic Awareness week was organised at the Trust in November. The antibiotic pharmacists and microbiologists worked in collaboration with the infection control staff and the quality improvement team. Campaign material focussing on Antimicrobial Stewardship "Start Smart- then Focus" was distributed to prescribers along with presentations on the principles of good prescribing at clinical audit meetings, articles in Trust newsletters and an antibiotic quiz.

Safety of Antibiotic Prescribing

The antibiotic pharmacists continue to review all Trust reported clinical incidents for antibiotics six monthly from the Trust DATIX (incident reporting) system, particularly those involving penicillins being administered to patients with a documented penicillin allergy, intravenous vancomycin and intravenous gentamicin. Reports are discussed at the AMT meetings.

There is Microbiologist and/or Pharmacist attendance at *C. difficile* root cause analysis (RCA) and MRSA post infection review (PIR) meetings. Learning related to antibiotic prescribing from these RCAs is disseminated, as required, via the Trust Antibiotic Dashboards.

Antimicrobial Ward Rounds

The microbiologists continue to carry out regular multi-disciplinary ward rounds with infection control and pharmacy staff with the aim of a targeted review of identified patients, improving antimicrobial prescribing, and providing interactive education on the wards.

7. Decontamination

The Choice Framework for Policies and Procedures (CFPP) is a suite of best practice guidance that has replaced the Health Technical Memorandum (HTM) and details principles on the management and decontamination of surgical instruments.

A safe decontamination service contributes to successful clinical outcomes and the wellbeing of patients and staff. The trust is required by law to comply with essential levels of safety and quality which are assessed by the CQC. These levels are set in law through registration requirements, one of which covers cleanliness and infection control.

CFPP draws on current advice to provide comprehensive guidance on the management and decontamination of surgical instruments used in acute care, which includes clear definitions of what constitutes Essential Quality Requirements (EQR) and Best Practice (BP)

The Trust receives it's decontamination service from a third party provider, BBraun Sterilog Yorkshire Limited. They use British and European Standards to demonstrate compliance with the essential requirements of the Medical Devices Directive (MDD 2007/47/EC) and have a quality system in place, ISO13485 against which they are independently audited by the British Standards Institute (BSI). This therefore offers assurance to the Trust that the service delivered is safe and achieves recognised standards.

Within the Decontamination Services Agreement (DSA) there are key performance indicators (KPIs) associated with logistics, quality outcomes and turnaround times that are embedded to ensure the delivered service continues to meet the Trust needs and expectations. The KPI's also ensure national and international guidelines and recommendations are met.

BBraun Sterilog Yorkshire Limited is recognised as having validated processes and as such is fully compliant against all guidelines as detailed via the National Decontamination programme where independent verification by the British Standards Institute (BSI) confirms compliance by a six-monthly review audit and certificated accordingly.

The operating reporting structure for the remainder of the contract term is as follows:

a) Joint Management Board (JMB) (strategic) comprising of the three partnering Trusts & Braun, currently Chaired by C&HFT.

b) Project Board (PB) (strategic) comprising of the partnering Trusts and Chaired as above.
c) Technical Review Committee (operational) comprising representatives of the three Trusts & Braun with the Contract Manager Chairing the committee.
d) Service Review Meeting (operational) comprising CHFT stake holders & Braun and is Chaired by the Decontamination Manager

Day to day service delivery is monitored within the organisation to ensure the service maintains a fit for purpose status.

Endoscopy

The centralised endoscopy units at HRI and CRH have been designed and built to meet all relevant and current standards of build including Mechanical and Electrical services.

These state of the art units provide a first class and compliant service to our patients who can be confident the level of care delivered is carefully supported by a rigorous audit regime associated with a compliant decontamination facility.

The environment in which decontamination is carried out should be one that minimises both the risk of recontamination of flexible scopes and the possibility of generating aerosols. This implies the use of a separate room or rooms for the accommodation of clean (output) and dirty (input) work. These rooms are built into the endoscopy units and are used for this purpose only and access restricted to those staff performing decontamination duties or maintenance regimes.

The policy and guidance specifically designed for flexible endoscope reprocessing CFPP 01 – 06 is driven by the aim of ensuring progressive improvement in decontamination performance both in centralised facilities and at a local level giving a continuous reduction in infection rates from both conventional (virus, bacterial fungi and spores) and prion infection disease.

The guidance provides options to flexible endoscope decontamination practices within which choices may be made and a progressive improvement programme established. Coordinated use of the guidance across the quality inspection processes will help the Trust to achieve a satisfactory level of risk control together with equivalent compliance with the “Essential Requirement” of the Medical Devices Regulations.

Additionally, further independent monitoring carried out by the Joint Advisory Group (JAG) which is recognised as a pathway of quality improvement, where acceptable standards for endoscopy units are continually met, and assurance that endoscopy

training and quality are consistently achieved and therefore the patient experience and outcomes are of the standard expected.

ENT

ENT Naso-endoscope reprocessing is carried out at the Huddersfield Royal Infirmary (Acre Mill) via a state of the art unit using automated processes with independent validation at the heart of the process. Calderdale Royal Hospital currently reprocess locally in the ENT OPD area where manual cleaning takes place after each patient use followed by a daily high level disinfection via the Endoscopy unit, which complies with the essential quality requirements of the CFPP guidance for this flexible scope type.

A project plan is being developed to replace the automatic endoscope reprocessors in the two main endoscopy units and a review of the manual cleaning of the ENT scopes at CRH are included in that review.

8. Cleaning Services

The provision of cleaning services continues to be delivered by both an in-house service at HRI and a contracted out service under the PFI (Private Finance Initiative) agreement by ISS Facilities Healthcare Services at CRH and Princess Royal Community Health Centre (PRCHC). A 24-hour Rapid Response Team continues to be provided at CRH and HRI for out of hours cleaning at both sites.

The Infection Prevention Quality Improvements audits continue to be successful in driving improvements across the Trust. This was updated 2014-2015 but through changes to PLACE (Patient led Assessments of the Care Environment) and CQC guidance the audit tool will again be updated in the financial year 2015-2016 incorporating recommended changes

The Front line Ownership (FLO) whereby nursing staff at three different levels assess compliance with 10 key infection control areas quickly using a standardised tool, continues to be used and has been adapted as needs required . Ward and Department Managers assess their areas weekly and report their finding to their Matron. Matrons provide a further monthly check. This helps to identify issues quickly and strengthens the assurance process.

Performance management systems are in place with key performance indicators produced on a monthly basis in line with the national specification for cleanliness. The monthly scores are displayed in each ward/department's infection control notice board for public viewing

Through the service performance report any concerns raised relating to cleaning are reported at the Estates and Facilities Quality and Safety Board and for the CRH site at the PFI Service Performance meeting.

The Trusts Service performance team also monitors cleaning on both the HRI and CRH site using an adapted version of the FLO. Schedule 2 monitoring audits are also performed by the Service Performance Team at CRH in accordance with the PFI concessions agreement but do not audit against the 49 elements

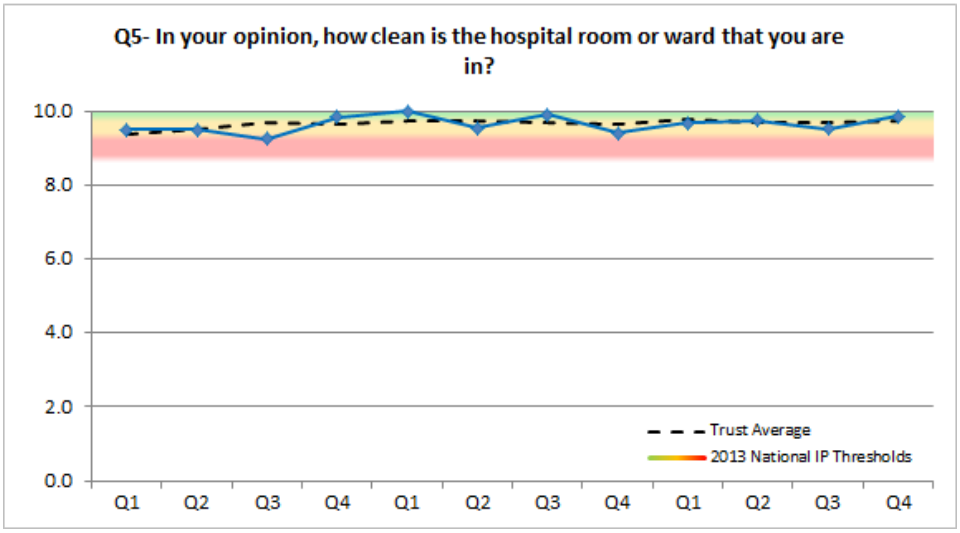
The Facilities Matron continues to work closely with all disciplines including cleaning services across both hospital sites and is the link between clinical and non-clinical teams. The matron attends the Trust Infection Control Committee as the Estates and Facilities representative.

Hydrogen Peroxide Vapour (HPV), a powerful bio-decontamination agent which reduces the biomass in the built environment, has continued to be used. The service continues to be funded this financial year and for 2015-2016. The reactive service remains to be operated in house by cleaning services staff on both hospital sites primarily to provide high level decontamination of isolation rooms. HPV is used in the final decontamination of a clinical area after discharge of an infected patient to ensure the room is safe for the next patient.

As part of a scheme to make further improvements to the work that Cleaning Services undertake, a study has been undertaken by ISS at CRH to find a product that could be used to improve the overall effectiveness of the chemical cleaning solution. They identified a company, Byotrol, who claimed to have developed a non-toxic, residual cleaning technology that continues to destroy micro-organisms for up to twenty-four hours after initial application. As part of the study, trials have been undertaken on a selection of wards around the CRH site to validate the use of Byotrol and sample the patient environment to monitor its effectiveness. The first report has just been finalised and results look promising. Further trialling may take place at HRI with a similar product.

Real time patient monitoring is performed on a monthly basis where patients are asked a number of questions by volunteers. One question relates to the cleanliness of the ward providing a patients view of cleanliness. The 2014-15 data is shown on the chart below

Q5, 'In your opinion, how clean is the room you are in?'
12 month Trust RTM and IP Survey 2013 – monthly scores



9. Estates

The trust continued with environmental upgrades during 2014/2015 to both public and clinical areas; improvement works include:-

- Replacement of flooring
- Refurbishment of lift lobby areas
- Window replacement
- Redecoration works
- Staff dining and office areas

In addition, work has continued on the site infrastructure in order to provide a safe environment that is compliant with HTM requirements, improvement works include:

- Asbestos removal
- Electrical switchgear and system infrastructure
- Roof repairs
- Repairs to the building façade
- Equality act compliance

Ward Upgrades Programme

The Ward refurbishment programme continued with works being carried out to ward 7 at HRI. This work was delayed until January 2015 due to required slippage in the capital programme to meet Trust financial challenges.

In addition, replacement flooring and redecoration was carried out on Ward 12 to provide an improved patient environment.

Theatre Upgrade Programme

The Theatre upgrading programme continued with Theatre 5, which was completed in January 2015. Theatre 3 also started in January 2015 and is due to complete in June 2015.

Acre Mill

Acre Mill Outpatient Centre was complete in January 2015 and provided a fully refurbished and compliant outpatient facility along with new office accommodation.

Environmental improvement works were undertaken on public thoroughfares including new flooring, lighting and decoration.

The Estates team have been focusing on ensuring compliance with HTM requirements and have now established a compliant governance structure including Authorising Engineers, Authorised Person and Competent Person which are now in place and staff have received the required training in accordance with HTM standards. An independent compliance audit has been carried out for engineering services and an action plan will be developed for 2015/16 to ensure full compliance with CQC requirements.

Waste management continues to be well managed across both CRH and HRI Sites. An audit was carried out by the Trusts Dangerous Goods Safety Advisor and an action plan produced to ensure compliance.

The Water and Air management group provide governance and scrutiny for both systems. Audits have been carried out by the associated Authorising Engineers to ensure compliance with HTM standards.

Patient-led Assessments of the Care Environmental (PLACE)

PLACE assessments see local people go into hospitals as part of teams to assess annually how the environment supports patient's privacy and dignity, food, cleanliness and general building maintenance. The results are reported publicly to help drive improvements in the care environment. The Division has continued to review and further improve performance across all criteria which will be reflected in the PLACE assessment for 2015/16. The findings from the PLACE inspection for 2014/15 were:-

Huddersfield Royal Infirmary (HRI)

Site	Cleanliness (%)	Food (%)	Privacy, Dignity and Wellbeing (%)	Condition, Appearance and Maintenance (%)
HRI	99.31	78.33	91.63	89.19
National Average	97.25	88.79	87.73	91.97
Variance	+2.06	-10.46	+3.9	-2.78

Calderdale Royal Hospital (CRH)

Site	Cleanliness (%)	Food (%)	Privacy, Dignity and Wellbeing (%)	Condition, Appearance and Maintenance (%)
CRH	97.94	88.77	94.59	94.17
National Average	97.25	88.79	87.73	91.97
Variance	+0.69	-0.02	+6.86	+2.2

10. Infection Prevention and Control Audit Programme

The audit programme for 2014/15 was completed and all action points were taken to the HAI Operational group for follow-up. This programme included:-

- Urinary Catheter annual prevalence audit
- Peripheral Venous Cannula prevalence audit
- Isolation audit
- Commode audit
- Sharps disposal

The Infection Prevention and Control Team (IPCT) are involved in the Quality Improvements audits which are undertaken on an unannounced basis to all clinical areas. The development of this process has interlinked services to provide a cohesive joined-up service; this is led by the Service Performance team.

The annual Hand Wash Road Show (HWRS) was carried out across the Trust in the acute settings of Huddersfield Royal Infirmary (HRI) and Calderdale Royal Hospital (CRH) during the weeks of 9th to 20th June 2014 by the Infection Prevention and Control (IPC) team. All wards and departments across both hospital sites were visited and in order to assess hand hygiene techniques, a new piece of technology called a 'Sure Wash' system was piloted. The Sure Wash system looks specifically at technique using motion sensor technology taking approximately 5 minutes per person; this was implemented as a trial for three months to visit all ward/department areas within our trust and is currently on a rolling programme. The aim of the IPC team is to highlight areas of good practice and by using the Sure Wash system this can be achieved, providing information and feedback to staff can reinforce compliance and adherence to the principles of Bare below the Elbows (BBE), as specified in the Hand hygiene Policy.

In this year's roadshow, 270 staff were reviewed at HRI and 220 at CRH, a total of 490 staff. The overall compliance with BBE across the trust was 81%.

11. Infection Prevention and Control Policies

All core policies as required by the Hygiene Code 2008 have been reviewed and have been published on the Trust Intranet and Internet. The following policies have been approved at Executive Board during 2014/15:

Section A	Infection Control Arrangements Policy
Section E	Major Outbreaks of Infection Policy
Section J	Multi Resistant Organism Policy
Section K	Isolation Policy
Section N	Viral Haemorrhagic Fever Policy
Section O	CJD Policy
Section P	Care of the Deceased Body
Section R	Specimen Collection Policy
Section T	MRSA including PVL Policy
Section U	MERS-CoV Policy
Section Y	Clostridium difficile Policy
Section Z	Blood Culture Policy

12. Education and training

Induction: - All staff, including medical staff, had Infection Prevention Control (IPC) training included within their induction. This includes instruction on hand washing, use of IPC guidance and accessing IPC advice.

CPD (Continued Professional Development) for all staff: - Annual updates on IPC are mandatory for all staff and are delivered via the 'risk DVD'. Compliance is monitored and for 2014/15 this was reported to be 70%.

The IPC team consider training and education a core activity key to the success of ensuring a knowledgeable workforce and effective infection prevention on clinical practice; this includes both clinical and non-clinical staff. Content is tailored to the needs of specific staff groups that are identified through the training strategy as well as audit and surveillance outcomes.

Face to face bespoke training is delivered by the IPC team as and when requested by wards and departments, enabling maximum opportunity for local learning to be fed back into training. IPC support is provided as and when required on wards and departments.

Link Infection Prevention Control Practitioners are recognised as important components of the organisational structure whereby skills, professional practice standards and knowledge are disseminated via motivated and active staff with an interest in IPC. There is a link worker available in all areas across both the acute provider services and community provider services. They help to narrow the gap between theory and practice by passing on their knowledge to other staff in their areas of work. Link workers perform regular audits of infection control standards. Quarterly educational workshops are held for link workers to enhance the knowledge and skills in order to fulfil the role. On-going support is provided to the link practitioners' as well as ward and department managers.

A training programme for third and fifth year student doctors was developed and will continue to run through the next year.

Training for IPC Specialists: - the IPC Team members attended national and local courses and updates as required.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 27th August 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: GOVERNANCE REPORT - AUGUST 2015 - This report brings together a number of governance items for review and approval by the Board.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

This report brings together a number of governance items for review and approval by the Board:-
a. Board Workplan
b. New Risk Assessment Framework
c. Board Meeting Dates 2016
d. Use of Trust Seal
e. Declaration of Interest Register
f. Feedback from Monitor - 2014/15 Q4 Monitoring and 2015/16 Annual Plan Review
h. Well Led Governance Review action plan

Main Body

Purpose:

The report sets out the main areas of corporate governance to bring to the attention of the Board. Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

It is recommended that the Board receives the report.

Appendix

Attachment:

There is no PDF document attached to the paper.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Meeting: **Board of Directors** **Report author:** **Victoria Pickles Company Secretary**

Date of meeting: **27 August 2015**

Title: **GOVERNANCE REPORT**

Brief Summary:

This report brings together a number of items that evidence or strengthens the corporate governance arrangements and systems of internal control within the Trust.

- Review of the Board work plan
- Update on the new Monitor risk assessment framework
- Meeting dates for 2016
- Use of the Trust seal
- Declarations of interest assurance process
- Monitor feedback on Q4 2014/15 and Annual Plan review 2015/16
- Development of a Workforce Committee
- Well Led Governance Review action plan

The Issue:

1. Board work plan

The Board work plan has been updated and is presented to the Board for review at Appendix 1.

The Board is asked to **RECEIVE** the work plan.

2. Monitor's Risk Assessment Framework

Monitor's risk assessment framework (RAF) sets out how they monitor financial sustainability and whether a foundation trust is well-governed.
During the summer, Monitor consulted on a new RAF and this has now been published.
The changes to strengthen the regulatory regime aim to

- help FTs live within their means
- support improvements in financial efficiency across the sector
- enable Monitor to take regulatory action earlier if an FT is:
  - in deficit
  - failing to deliver its financial plan
  - not providing value-for-money

The changes to the RAF include:

- monitoring in-year financial performance and the accuracy of planning
- combining these two measures with the previously used continuity of service risk rating to produce a new four-level financial sustainability risk rating
- introduce a value for money governance trigger.

The key differences are highlighted below:

Current RAF	New RAF
Continuity of service risk rating ▪ Capital service capacity ▪ Liquidity	Financial sustainability and performance risk rating ▪ Capital service capacity (unchanged) ▪ Liquidity (unchanged) ▪ I&E margin (new) ▪ Variance in I&E margin and capital expenditure (new)
Governance rating	Governance rating As today plus: new value for money measure to identify inefficient or uneconomical spend (actual or forecast) against published benchmarks for instance agency and consultancy spend

The financial sustainability risk rating is Monitor's view of the level of financial risk a foundation trust faces to the ongoing delivery of key NHS services and its overall financial efficiency. The rating ranges from 1, the most serious risk, to 4, the lowest risk. A rating indicating serious risk does not necessarily represent a breach of the provider licence. Rather it reflects the degree of financial concern Monitor has about a provider and therefore how frequent the monitoring will be.

The governance rating is generated by considering the following information and whether it is indicative of a potential breach of governance:

- performance against selected national access and outcomes standards;
- outcomes of CQC inspections and assessments relating to the quality of care;
- relevant information provided from third parties (such as the GMC, Ombudsman, HealthWatch or our auditors);
- a selection of information chosen to reflect organisational health (for example patient satisfaction, sickness rates, staff turnover, proportion of temporary staff);
- degree of financial sustainability risk and other aspects of risk relating to financial governance and efficiency (including a value for money measure which would trigger a governance concern if there was inefficient / uneconomical spend compared to published benchmarks);
- any other relevant information.

Some of these changes have been incorporated into the Integrated Board Report presented at today's meeting and will all be in place by the September Board meeting.

The Board is asked to **NOTE** the changes to Monitor's risk assessment framework.

3. Meeting dates

The Board meetings for 2016 have now been set and the dates will be published on the Trust's website. The dates of the sub-committee meetings will now be agreed to fit with the Board cycle.

The Board is asked to **NOTE** the dates of the meetings for 2016 Appendix 2.

4. Trust Seal

One document has been sealed since the last report to the Board and a copy of the register of sealing is attached for information at Appendix 3. This was in relation to the

commencement of improvement works to the Child Development Unit at Calderdale Royal Hospital in preparation for the transfer of the service from Huddersfield.

The Board is asked to **RATIFY** the sealing.

5. Declarations of interest

Following discussion at the Audit and Risk Committee in July, two pieces of work are being undertaken to ensure that current entries on the Staff Declaration of Interests Register are accurate. The Board Secretary contacting each member of staff with an entry on the register, asking them to confirm that the entry is correct and that they have no objections to this appearing on the Trust public website in the future in line with good practice. In addition, the Audit and Risk Committee have commissioned the Counter Fraud service to review the Trust's arrangements for capturing all staff interests.

As a reminder the Trust's Policy states:

> "All staff have an obligation to ensure that they do not abuse their position with the Trust for personal gain and/or seek to benefit family members, associates and/or friends. Staff are required therefore to declare any instance to the Board Secretary (**Appendix C**) where they, or any family member, associate and/or friend, has a controlling or significant financial interest in any business, activity or pursuit, which might compete for a Trust contract for the supply of goods and/or services.
>
> In each and every case where an employee makes a declaration, the Board Secretary will discuss the matter with the most appropriate Director. The Trust is committed to taking a 'common-sense approach' in determining whether there is a conflict of interest arises when a declaration is reviewed. Every declaration will be considered on its own merits.
>
> It is important to note that if an interest is declared and changes arise these must be clarified/declared at the earliest opportunity.
>
> If, after review of a declaration, a conflict of interest is identified the employee will be notified of the action required. A formal note of this will be retained on the employee's personal file and the centrally held confidential register."

A report on findings will be presented to the Audit and Risk Committee in October and shared with the Board.

The Board is asked to **NOTE** the work being undertaken on declarations of interest and **RECEIVE** a report at its meeting in November.

6. Monitor feedback on Q4 2014/15 and Annual Plan review 2015/16

The Trust has received feedback on the 2014/15 Quarter 4 return and the two day Annual Plan review which was undertaken in June. A copy is attached at appendix 4.

The Board is asked to **RECEIVE** the Monitor feedback.

7. Workforce Committee

At the Well Led Governance Review workshop in July, the Board discussed the development of a Workforce Committee in recognition of the challenges facing the recruitment, retention and wellbeing of our workforce. It is proposed that the Committee

would provide assurance to the Trust Board on key workforce and organisational development indicators and effectiveness of workforce management within the Trust. It would also oversee the development of the workforce strategy and plan. The work of the current Well Led Group would also be incorporated into the work plan of the new Committee.

The Committee would be a formal sub-committee of the Board, initially for 12 months at which point the position would be reviewed, meeting bi-monthly until April with a view to moving to quarterly meetings at that point. It would be chaired by the Deputy Chief Executive and have non-executive membership. If agreed, full terms of reference will be developed for approval at the September Board meeting.

The Board is asked to **APPROVE** the creation of a workforce committee and comment on the proposed structure and purpose in advance of full terms of reference being prepared.

8. **Well Led Governance Review**

At its meeting in July, the Board received the themes from the independent Well Led Governance Review. The full final report has now been received and circulated to Board members. The Report was also shared with Monitor who asked that the independent reviewers complete a prioritised action plan stemming from the recommendations within the report. This plan is attached at Appendix 5. Delivery of the plan will be monitored through the Programme Management Office.

The Board is asked to **RECEIVE** the Well Led Governance Review action plan.

BOARD WORK PLANWORKING DOCUMENT – AUGUST 2015 - LATEST update TO BOD 27.8.15

Date of meeting	23 April 2015	28 May	25 June	30 July	27 Aug Prov. mtg	24 Sept	29 Oct	26 Nov	17 Dec	Jan 2016	Feb 2016	March 2016
Date of agenda setting	During week before meeting date											
Date final reports required	15.4.15	10.5.15	17.6.15	22.7.15	19.8.15	16.9.15	21.10.15	18.11.15	9.12.15	TBC	TBC	TBC
STANDING PUBLIC AGENDA ITEMS												
Introduction and apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chairman's report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chief Executive's report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Integrated Board report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
DIPC report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of sub-committees	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
REGULAR ITEMS												
Board Assurance Framework				✓				✓			✓	
Risk Register	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Governance report: to include such items as: - Standing Orders / SFIs review - Non-Executive appointments - Board workplan - Board skills / competency - Code of Governance - Board meeting dates - Committee review and annual report - Annual review of NED roles - Use of Trust Seal - Quarterly Submission Feedback from Monitor			✓			✓			✓			✓
Care of the acutely ill patient report	✓		✓		✓		✓		✓		✓	

BOARD WORK PLANWORKING DOCUMENT – AUGUST 2015 - LATEST update TO BOD 27.8.15

Date of meeting	23 April 2015	28 May	25 June	30 July	27 Aug (Prov. Mtg)	24 Sept	29 Oct	26 Nov	17 Dec	Jan 2016	Feb 2016	March 2016
Patient Survey			✓									✓
Quality Report						✓						✓
Staff Survey						✓						✓
Staff Survey/Staff friends and family test results				✓			✓					
Nursing and Midwifery Staffing – Hard Truths Requirement						✓						✓
Safeguarding update – Adults & Children				✓				✓				✓
Patient Experience, Engagement & Improvement Plan (to include learning from experience and friends and family test)		✓				✓		✓			✓	
Review of progress against strategy (Qly)	✓			✓			✓			✓		
Quality Committee Update & Mins		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Audit and Risk Committee Update & Mins	✓	✓		✓	✓		✓	✓		✓	✓	
Finance and Performance Committee Update & Mins	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
ANNUAL ITEMS												
Annual Plan												✓
Annual Plan feedback from Monitor			✓									
Annual report and accounts (private)		✓										
Annual Governance Statement		✓										
Appointment of Deputy Chair / SINED						✓						
Emergency Planning annual report	✓	✓										
Health and Safety annual report		✓										
Capital Programme												✓
Equality & Inclusion update				✓ (update)							✓ (AR)	

BOARD WORK PLANWORKING DOCUMENT – AUGUST 2015 - LATEST update TO BOD 27.8.15

Date of meeting	23 April 2015	28 May	25 June	30 July	27 Aug Prov. mtg	24 Sept	29 Oct	26 Nov	17 Dec	Jan 2016	Feb 2016	March 2016
PLACE Report									✓			
Security Management annual report						✓						
DIPC annual report					✓							
Fire Safety annual report		✓										
Medical revalidation			✓						✓			✓
Nursing revalidation		✓						✓				
Annual Organ Donation plan				✓								
End of Life Report										✓		
ONE-OFF ITEMS												
Care Quality Commission												
Premises assurance model/Asbestos	✓											
Membership Council Elections	✓											
Calderdale Artefacts						✓						
Registration of Nurses (from May 15) – date tbc												

BOARD WORK PLANWORKING DOCUMENT – AUGUST 2015 - LATEST update TO BOD 27.8.15

Date of meeting	23 April 2015	28 May	25 June	30 July	27 Aug Prov. mtg	24 Sept	29 Oct	26 Nov	17 Dec	Jan 2016	Feb 2016	March 2016
STANDING PRIVATE AGENDA ITEMS												
Introduction and apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Private minutes of sub-committees	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
ADDITIONAL PRIVATE ITEMS												
Contract update										✓	✓	✓
Monitor quarterly submission	✓			✓			✓			✓		
Board development plan												
Feedback from March Board development			✓									
Urgent Care Board Minutes (to rec)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
EPR update						✓						

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

BOARD OF DIRECTORS MEETINGS – 2016

Unless otherwise stated all meetings will commence at 1.30 pm in the venues indicated below unless otherwise stated:

DATE OF BOD MEETING		VENUE
Thursday	28 January 2016	CRH – Large Training Room, Learning Centre
Thursday	25 February 2016	HRI – Boardroom, Sub-basement
Thursday	31 March 2016	HRI – Boardroom, Sub-basement
Thursday	28 April 2016	CRH – Large Training Room, Learning Centre
Thursday	26 May 2016	HRI – Boardroom, Sub-basement
Thursday	30 June 2016	CRH – Large Training Room, Learning Centre
Thursday	28 July 2016	HRI – Boardroom, Sub-basement
Thursday	25 August 2016 (PROVISONAL)	CRH – Large Training Room, Learning Centre
Thursday	29 September 2016	HRI – Boardroom, Sub-basement
Thursday	27 October 2016	CRH – Large Training Room, Learning Centre
Thursday	24 November 2016	CRH – Large Training Room, Learning Centre
Thursday	15 December 2016	HRI – Boardroom, Sub-basement

CRH - Lge TR, LC = Calderdale Royal Hospital Large Training Room, Learning Centre, HX3 0PW
HRI – Boardroom = Huddersfield Royal Infirmary, Boardroom, HD3 3EA

KB/BOD-MEETING DATES 2016 –
AUGUST 2016

Register of Sealings or Executions

126 of 188

Consecutive No.	Date of Sealing or Execution	Date of Authority	Sealing(s) or Execution(s)	Description of Documents Sealed or Executed	Persons attesting Sealing or Execution
232	3.6.15	3.6.15		DEED OF PRIORITY - BARCLAYS BANK, CMFT + HENRY BOOT + PENNINE PROPERTY PARTNERSHIP LLP	V L Pickles. Julie Davies.
233	25.6.15	25.6.15		LEASE + LICENSE FOR ALTERATIONS + STATUTORY DECLARATION - HVMH TENANT:- CMFT LANDLORD: NHS PROPERTY SERVICES RENT:- £2,790.25	J Davies V L Pickles.
234	25.6.15	25.6.15		LICENCE TO OCCUPY ON SHORT TERM BASIS THE LODGE, PARK VALLEY MILLS BETWEEN CMFT + OPCARE LTD	J Davies. V L Pickles
235	14.8.15			CDU REFURBISHMENT PROJECT OUTLINE TO ALLOW SERVICE FROM P.R. to transfer to CRH (CHILD DEVELOPMENT UNIT) £145,163.59 + VAT	J Davies. V L Pickles.

BO9

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Making the health sector work for patients

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03/08/2015

Mr Owen Williams
Chief Executive
Calderdale and Huddersfield NHS Foundation Trust
Trust Headquarters
Acre Street
Lindley
Huddersfield
West Yorkshire
HD3 3EA

Dear Owen

Calderdale & Huddersfield NHS Foundation Trust

2014/15 Q4 monitoring and 2015/16 Annual Plan Review (APR)

I am writing in response to the one-year 2015/16 operational plan and the 2014/15 Q4 return both submitted by the trust in May 2015.

As noted in the separate letter from David Bennett, we are asking all trusts to look at their 2015/16 plans again with the aim of reducing the unaffordable sector deficit. Therefore the purpose of this letter is to:

- Confirm the trust's current and forecast continuity of services risk ratings
- Confirm the trust's governance rating
- Feed back on any specific concerns identified from our review of your 2014/15 Q4 and 2015/16 operational plan review submissions (over and above those outlined in David Bennett's letter to the sector).

We appreciate the efforts undertaken by you and the sector as a whole during the planning round this year, especially given the introduction of a draft plan phase, the changes to the timetable, and the need to update plans with short timeframes to reflect the tariff.

As previously communicated in our 2015/16 guidance[1], the 2016/17 planning round is likely to include a multi-year strategic element and this is still our intention. These plans will need to both build on the strategy submitted to Monitor in June 2014 and reflect your response to the 'Five Year Forward View'.

Further guidance will be issued in due course, but in the meantime you may wish to refer to the Strategy Development Toolkit[2] made available last autumn.

---

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/390070/APR_guidance_Dec14.pdf
[2] https://www.gov.uk/government/publications/strategy-development-a-toolkit-for-nhs-providers

Foundation trust risk ratings

We are currently finalising our review procedures following the site visit at your foundation trust. We will feed back to you separately in due course with the outcome of this process. However, we can confirm that the Trust's current and forecast risk ratings are:

	Q4 14/15 (actual)	Q1 15/16 (plan)	Q2 15/16 (plan)	Q3 15/16 (plan)	Q4 15/16 (plan)
Continuity of service risk rating	2	1	1	1	1
Governance rating	Red				

Under the Risk Assessment Framework[3], the governance rating indicates whether Monitor is currently taking any action; this rating therefore reflects the outcome of both the operational plan review and Q4 monitoring.

As explained in our letter of 13 May 2015, governance ratings and continuity of services ratings will be published on Monitor's website for all trusts shortly.

Regulatory response

Quarterly monitoring

The trust is subject to formal enforcement action in the form of enforcement undertakings. In accordance with Monitor's Enforcement Guidance, such actions have also been published on our website.

Monitor will raise any concerns arising from our review of the trust's Q4 submissions as part of our regular Progress Review Meetings.

A report on the FT sector aggregate performance from Q4 2014/15 is now available on our website[4], which I hope you will find of interest.

We have also issued a press release[5] setting out a summary of the key findings across the FT sector from the Q4 monitoring cycle.

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[3] www.monitor.gov.uk/raf

[4] https://www.gov.uk/government/publications/nhs-foundation-trusts-quarterly-performance-report-quarter-4-201415

[5] https://www.gov.uk/government/news/foundation-trusts-face-challenging-year-as-pressures-mount

Annual plan review

As mentioned earlier due to the timing of the follow up meeting for the site visit, we will be responding separately with the outcome of our review of your 2015/16 operational plan.

In the meantime, as explained in the separate letter from David Bennett, given the unaffordable sector-wide deficit being forecast for 2015/16 all trusts are being asked to look at their plans again to determine whether the options outlined in that letter may present opportunities to improve their financial position. Please refer to the separate letter for further details and required actions.

If you have any queries relating to the above, please contact me by telephone on 02037470484 or by email Kemi.Oluwole@monitor.gov.uk

O. Oluwole.

Kemi Oluwole

Senior Regional Manager

CC. Keith Griffiths, Director of Finance

Andrew Haigh, Chair

Recommendations

Ref	Guidance Area	Action to be taken by the Trust	Suggested owner	Timeframe	Priority
1	Strategy: 1A	**Development of the strategy** The Trust should formalise the process for refreshing the strategy annually, ensuring involvement with external stakeholders, staff, patients and the wider public.	Chief Executive	1-3 months	High
2	Strategy: 1A	**Development of the strategy** Strategic development must include alignment of structures, processes and KPIs to the Trust's strategic priorities. The more robust planning process from 2015/16 should be embedded to ensure plans reflect capacity and workforce constraints, as well as the financial position.	Chief Executive	Ongoing	Medium
3	Strategy: 1A	**Communication of the strategy** The Board and those in leadership and managerial positions must consistently communicate strategic priorities to ensure the development and delivery of the operational plan.	Chief Executive	Ongoing	Medium
4	Strategy: 1B	**Divisional risk management** The Trust must strengthen risk management capability within the divisions as they are a foundation to manage and mitigate risk. The Trust should could consider using external support to engage with divisions to improve risk management culture, in the same way that this has been done at a Board level (see also action 16).	Director of Nursing	4-6 months	High

Recommendations

Ref	Guidance Area	Action to be taken by the Trust	Suggested owner	Timeframe	Priority
5	Strategy: 1B	**Risk and safety culture** The Trust should continue its focus on improving its risk management and safety culture. This should could include applying the "go see" methodology by observing an organisation with a strong risk management and safety culture. For example, Mid Cheshire Hospitals NHS Foundation Trust was the highest acute trust nationally for "Fairness and effectiveness of incident reporting procedures" in the 2014 staff survey. Salford Royal NHS Foundation Trust achieved outstanding for the well-led domain in a recent CQC inspection; risk management culture and processes were praised in a number of divisions by the CQC (see also action 16).	Director of Nursing	1-3 months	Medium
6	Capabilities & culture: 2A and Processes and structure: 3C	**Capacity** The Trust must assess and reflect on the capacity of the Board and staff at all levels to deliver operational improvement and future strategic priorities, and therefore the resilience of the organisation and individuals.	Chief Executive	1-3 months	High
7	Capabilities & culture: 2A	**Board development** In recognition of recent Board changes, and the changing context the Trust operates in, the Trust should consider the Board and organisational development needs to ensure that leadership, the desired behaviour and delivery capacity is optimised. This should reflect lessons learnt from previous development programmes, and how leadership can be enhanced at all levels in the Trust.	Chairman / Company Secretary	6-12 months[1]	Medium
8	Capabilities & culture: 2B	**Cultural barometer** The Board should seek assurance that the programme of work generated from the PwC review of quality of care in October 2014 is having the planned impact on the culture of care. The Trust should could consider the use of a cultural barometer or similar tool as a way of assessing this.	Director of Human Resources	4-6 months	Low

1: This action is dependent on the completion of action 6.

Recommendations

Ref	Guidance Area	Action to be taken by the Trust	Suggested owner	Timeframe	Priority
9	Capabilities & culture: 2C	**Clinical Leadership** The Trust should evaluate the current clinical leadership models as a means of strengthening leadership roles. The Trust should build on the leadership training provided to clinicians by clearly defining the job description and responsibilities of Divisional and Clinical Directors, and ensuring that there is sufficient ring-fenced time in their roles for this to be completed. There are several well established models of medical leadership that may provide further insight, for example, the Clinical Leadership Model developed at University Hospital of South Manchester NHS Foundation Trust.	Director of Operations	1-3 months	High
10	Capabilities & culture: 2C	**Multi-professional leadership** The Trust should consider how to ensure that all professions are included and represented in leadership across the Trust. This will be of particular importance as the service model of the Trust continues to develop.	Medical Director / Director of Nursing	4-6 months	Low
11	Processes and structure: 3A	**Executive Portfolios** To address a perceived lack of clarity over responsibility for planning, and to more closely align structures and processes relating to planning, the Trust should ensure that the responsibility and oversight for planning is clearly defined in Executive portfolios.	Chief Executive	1-3 months	High
12	Processes and structure: 3A	**Board sub-committees** The ongoing development of the Board sub-committees should be continued. This should focus on the strength of challenge from all members and the presentation and use of information, to ensure that appropriate scrutiny is applied and that assurance can be given to the Trust Board.	Company Secretary	4-6 months	Medium

Recommendations

Ref	Guidance Area	Action to be taken by the Trust	Suggested owner	Timeframe	Priority
13	Processes and structure: 3A	**Audit Committee** The private session of the Audit Committee should not include members of management, including the Director of Finance.	Chair of the Audit Committee / Company Secretary	Immediate	High
14	Processes and structure: 3B	**Accountability framework** The Trust should consider the introduction of a more formal accountability framework as an enabler to performance management and operational delivery. This internal contractual agreement between the Trust Board, divisions and directorates should be used as a basis to defined an appropriate level of devolution across the Trust.	Director of Operations	1-3 months	High
15	Processes and structure: 3B	**Turnaround Executive** The Trust should seek to adopt and adapt the lessons learnt from the Turnaround Executive structure within divisions and consider how this process, developed during turnaround, could be adapted to strengthen performance management more generally (that is, not just to facilitate CIP delivery), allowing the Trust to meet the ongoing challenges that it will face.	Chief Executive	1-3 months	High
16	Processes and structure: 3B	**Divisional risk management** The Trust should undertake an in depth review of risk management, incident reporting and escalation in the divisions to ensure that these processes are robust and aligned to the Trust's strategic priorities (see also actions 4 and 5).	Director of Nursing	1-3 months	High
17	Processes and structure: 3B	**Lessons learnt** The Trust should review the processes in place for sharing issues, lessons learnt and good practice between teams and consider whether further mechanisms at ward and service level might be required.	Director of Nursing	1-3 months	Medium

Recommendations

Ref	Guidance Area	Action to be taken by the Trust	Suggested owner	Timeframe	Priority
18	Processes and structure: 3C	**Community engagement** The Trust should consider the use of wider community networks to ensure that the diversity of the local population is reflected in its membership, Membership Council and Board.	Chairman	4-6 months	Low
19	Measurement: 4A	**Board challenge** Board debate and challenge could be enhanced by ensuring that all aspects of issues are considered, and that the debate "closes the loop" by identifying the actions to be taken, their expected impact, how this will be measured and under what timeframe.	Chairman / Company Secretary	1-3 months	High
20	Measurement: 4A	**Board reporting** The Board needs to be assured that the Trust is delivering its strategic priorities. Information presented to the Board should be integrated and triangulated to enable to the Board to make efficient judgements as to whether strategic and operational objectives are being achieved as expected. The Board should receive intelligence distilled from a more detailed review at the sub-committees.	Chairman / Director of Planning, Performance. Estates & Facilities	1-3 months	High
21	Measurement: 4B	**Data and data quality** Further development of the data quality kite mark will allow Board members to gain assurance over the reliability of each measure and could provide greater assurance that there are no unknown data quality issues. The Board should consider how the skills within the Trust (in particular, within the Health Informatics Service) could be leveraged to take a more transformation approach to data and data quality, and should consider the development of an information strategy to achieve this.	Director of Planning, Performance. Estates & Facilities	1-3 months	High

Recommendations

Ref	Guidance Area	Action to be taken by the Trust	Suggested owner	Timeframe	Priority
22	Measurement: 4B	**Board awareness of data quality** As the Board development programme is refreshed, the Trust should consider the inclusion of data quality and interpreting information to inform judgments as a subject for Board training, to ensure that the Board are equipped to identify potential indicators of poor data quality and challenge these.	Chairman / Company Secretary	4-6 months	Medium

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Katharine Thorley, Lead for Safety and Risk - Quality Directorate
Date: Thursday, 27th August 2015	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Care of the Acutely Ill Patient programme: progress report - This paper provides the Board with an update on the Care of the Acutely Ill Patient programme which is aiming to reduce avoidable mortality for our patients.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Some of the information was included in a report to the Quality Committee; July 2015	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The current CAIP programme was commenced in August 2014, with an overarching aim to reduce SHMI to 100 by August 2015, and to sustain this level. This has not been achieved: the latest figure, released in July, is 109 – the same as when the programme commenced.

Progress in each of the eight themes that were identified as part of the programme has been variable. Two themes: Effective (Courage to Put the Patient First); and Well-led organisation have become amalgamated into other work-streams. Improvements have been made with the implementation of “nervecentre”. Changes in coding processes have resulted in overall improvement in coding of co-morbidities, though performance within specialities is variable and improvements not always sustained. Compliance with care bundle implementation and completion is variable and requires improvement.

A Mortality Review protocol has been drafted and approved by COG: this clarifies responsibilities and procedures, and it is hoped will improve the mortality review rate (which is currently 46.6% of deaths since December 2014). This will result in more data being available for analysis and identification of areas for improvement.

The CAIP programme has been reviewed and updated, focusing clinical outcomes-related themes to reduce mortality (see appendix).

Main Body

Purpose:

To update the Board of Directors on progress of the Care of the Acutely Ill Patient plan, and to demonstrate the context for the revised CAIP plan.

Background/Overview:

A previous update was provided to the Board of Directors in May 2015

The Issue:

.

Next Steps:

Described in the paper

Recommendations:

The Board is asked to note the paper and the proposals

Appendix

Attachment:

CAIP programme summary for BoD_Aug 2015_final.pdf

Care of the Acutely Ill Patient programme

Progress Report for Board of Directors; August 2015

Introduction

The original Care of the Acutely Ill Patient (CAIP) programme was started in September 2013, and was focused on reducing HSMR. It was recommenced in August 2014 when the Standardised Hospital Mortality Index (SHMI) was 109 for the time period of January to December 2013. The overarching aim of the revised plan was to reduce Standardised Hospital Mortality Index (SHMI) to 100 by August 2015, and to maintain that standard. Unfortunately the figure for the period January to December 2014, show the Trust's SHMI score remains essentially unchanged at 109 – though this continues to be noted as "as expected" by the HSCIC.

The CAIP programme was set out in eight themes:

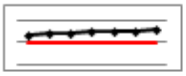
1) Reducing Mortality (overall outcome measures)
2) Ensuring the recognition and prompt treatment of our deteriorating patients.
3) Delivering high standard of care through reliable delivery of care bundles.
4) Frailty`
5) Effective (focus on the Courage to Put Patient First programme).
6) Focus on SHMI Conditions of Interest
7) Well Led Organisation
8) Coding

Overview of Progress to date

1. Reducing Mortality (Overall outcome measures)

1.1 Current Position

HSMR – The most recent rolling 12 months data for HSMR, Apr'14 – Mar'15, indicates a score of 110.47, which is unfortunately an increase from the previous release and is an outlying position.

Indicator	Month Agreed Target	Current Month Performance	Rolling 12 Month Target/YTD	YTD Performance	Performance Trends
Mortality Indicator	HSMR Latest =	Apr 14 - Mar 15	SHMI Latest =	Jan 14 - Dec 14	
HSMR	100	110.47	100	105.85	

However, the monthly figures show that HSMR climbs steeply from Jan-March, culminating in the March figure of 134. There has been an increase in the crude mortality rate but this has been less than the overall increase seen in the NHS. The reasons for these deaths occurring in hospital are unclear. The crude Trust's crude mortality rate is around the NHS average.

In order to understand the factors behind the rise fully, a review of all March deaths will be undertaken across the Trust to identify what it is about these cases which may have contributed to an increased HSMR. This review will aim to include an audit of the coding

accuracy: was all the necessary information captured in the notes for coding, or was some missing; and was the available information coded accurately.

There were 118 Deaths in July which resulted in a crude rate of 1.08%. This is above the crude rate seen in July 2014 of 0.98% (103 deaths).

SHMI – The most recent release shows a SHMI of 109.26 for the12 month period Jan-Dec 2014. This has increased slightly from 109 for the 12 months ending September 2014. The latest data point shows a levelling off of performance; prior to this each of the previous quarters had seen a one point reduction from a high of 111.

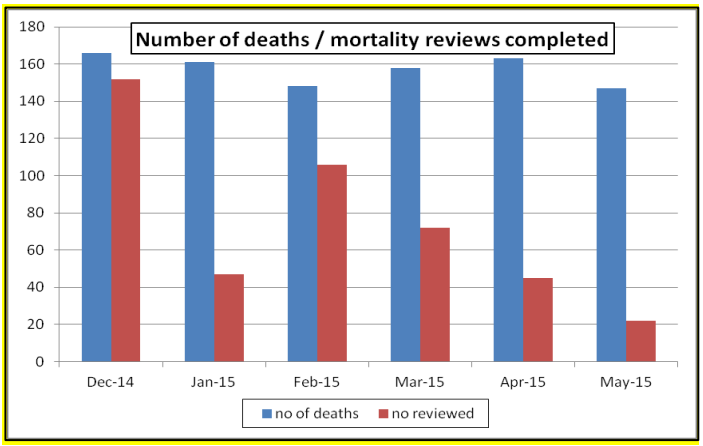
It does, however, remain in the "as expected" category indicating that there are not significantly more deaths than would be expected for the trust's patient population.

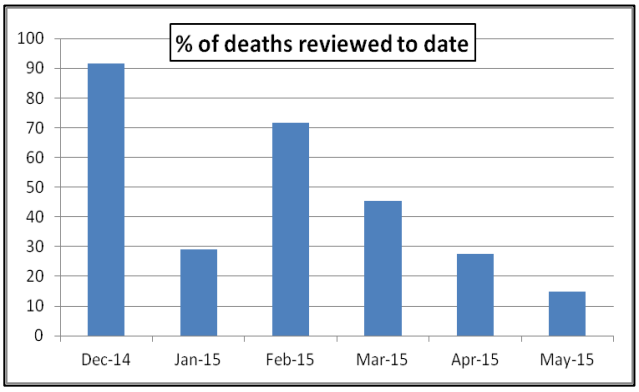
Indicator	Month Agreed Target	Current Month Performance	Rolling 12 Month Target/YTD	YTD Performance	Performance Trends
Mortality Indicator	HSMR Latest =	Apr 14 - Mar 15	SHMI Latest =	Jan 14 - Dec 14	
SHMI	100	-	100	109.26	

In light of the rising HSMR and the lack of significant improvement in the SHMI, the expertise of Professor Mohamed Amin Mohamed from Bradford University, a nationally recognised expert on modified mortality indices to support further analysis and understanding of these data.

Mortality Reviews:

The Trust is committed to undertaking reviews of all cases of mortality, though to date it has been consistently difficult to achieve this target. The charts below show the position for the first six months of mortality reviews.





On average, first reviews have been conducted on 460 (46.6%) of deaths, though monthly performance is variable. The completion of reviews of cases allocated for second review is also challenging. A review of the findings of the six months' reviews has been undertaken and key findings presented to the weekly executive board:

- 89% of cases assessed as "definitely not preventable" and needing no further review

- Main reasons for requesting second reviews:

    - lack of review by doctors;
    - delays in medicines administration;
    - insufficient observation; and
    - delays in escalation to Outreach.

- 61% (n = 35) of second reviews were completed
    - 21 reassessed as “definitely not preventable”
    - 4 cases score increased: one of these was escalated to panel review
    - 3 cases score decreased
    - 7 cases score remained the same

1.2 Planned developments

A written process for mortality reviews has been completed and approved by COG (see appendix for summary). This clarifies the procedures for review (including escalation for further review according to initial scoring) and reporting of findings. It includes guidance on prioritisation of the reviews, e.g. to include patients that have died over the weekend, those who were diagnosed with a “SHMI condition of interest,” below age 50, though the aim is still to review 100% of all mortalities.

It will be supported in its implementation with a review of all supporting documents and templates, a review of the list of staff currently identified as reviewers, and a process for delivery of case notes to reviewers. The new process also clarifies responsibilities in relation to cluster reviews: identification of need; agreeing terms of reference; and completion and reporting.

Additionally, the Trust’s Incident and Investigation Policy has been reviewed, and its scope widened, to incorporate learning from the mortality reviews with the aim that learning will help to focus actions to improve the quality of care. The revised policy will describe and clarify how lessons learnt from all investigations are to be shared local level and organisational levels.

A group to review data derived from mortality reviews has been convened with Mr Martin DeBono as chair. It will include clinical representatives from all Divisions. report to COG as necessary.

2. Ensuring the recognition and prompt treatment of our deteriorating patients

2.1 Current Position

The Deteriorating Patient work-stream incorporates Recognition and Response to the Deteriorating Patient – Observations, Training/education, and Escalation. In the last year the Trust has revised the Policy for Adult Physiological Observations and implemented National Early Warning Scores as the organisational standard across the Trust. Implementation of ‘Nervecentre’ has commenced. This is an electronic observation and handover tool to improve accuracy of NEWS and standardisation of escalation: it is automated and requires no decisions, phone calls or bleeps etc. This is now in place on every ward in Calderdale and implementation at HRI commenced at the end of July, with a target date for completion of October 2015.

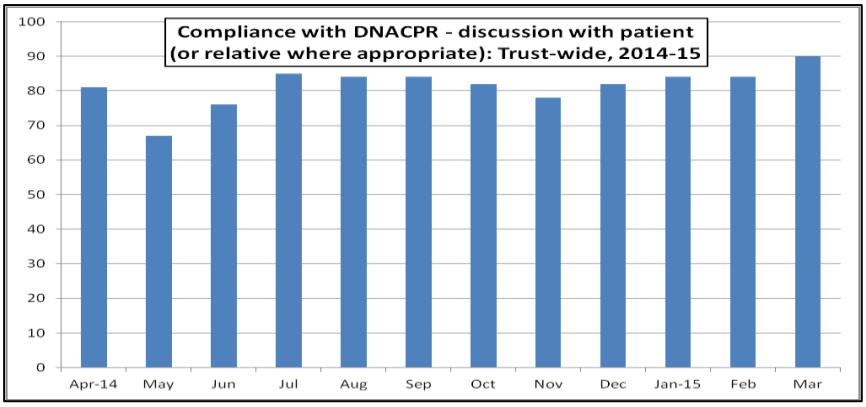
The outcome measures for this theme group are broad: cardiac arrests and ICU admissions. The chart below (June 2015 data) shows some reduction in cardiac arrests, though numbers are only small, but unplanned ICU admissions are above target.

	Indicator	Month Agreed Target	Current Month Performance	Rolling 12 Month Target/YTD	YTD Performance	Performance Trends
Theme 2: Ensuring earlier recognition & prompt treatment of deteriorating patients	Number of Cardiac Arrests per 1000 bed days	-	11	-	51	
	Number of Cardiac Arrests per 1000 bed days (Rate)	0.68	0.54	0.68	0.77	
	Unplanned Admission to ICU	-	45	128	143	

The other focus of the work is around DNACPR. The chart below is July 2015 data and shows slight improvement in both indicators.

	Indicator	Month Agreed Target	Current Month Performance	Rolling 12 Month Target/YTD	YTD Performance	Performance Trends
Theme 2: Ensuring earlier recognition & prompt treatment of deteriorating patients	DNACPR % Discussion completion	95%	88.4%	95%	86.9%	
	DNACPR Review date completion %	95%	74.4%	95%	71.8%	

The chart shows that compliance with discussion with patient or relative improved slightly over the last year to 90% in March 2015.



2.2 Planned developments

It is expected that the ongoing implementation nerve centre handover module will improve handover communication and procedures, within all professional groups. A business case has been developed for consideration of the implementation of the H@N Task Management module in Nervecentre. A decision is expected in November 2015.

A new theme, end of life care, has been added to the revised CAIP plan. This incorporates DNACPR (appropriate ceiling of care) and also aims to reduce unnecessary admissions for patients who are expected to die within 48 hours, that could have been managed in an alternative location. The 'Integrated Care of the Dying Document' (ICODD) is currently in place in the hospitals and hospices, and there is a plan for it to be implemented in the community.

The Resuscitation committee is considering developing a Medical Emergency Team, rather than Cardiac Arrest Team, and team drills / response to simulated crash calls as a training tool to improve communication and teamwork are to commence. All cardiac arrests will be reported as incidents from September to facilitate review of the cases and identification of cases of failure to escalate

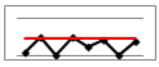
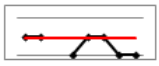
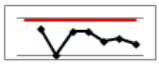
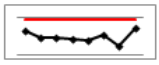
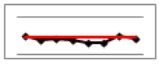
3. Delivering high standards of care through reliable delivery of care bundles:

3.1 Current position

Compliance with appropriate commencement of bundles for

- Asthma
- Acute Kidney Injury
- Sepsis
- COPD
- Community Acquired Pneumonia

is audited by the presence of the "stickers" in the notes. Where bundles have been commenced, completion is also assessed. Compliance is variable, as can be seen from the July 2015 CAIP dashboard shown below.

	Indicator	Month Agreed Target	Current Month Performance	Rolling 12 Month Target/YTD	YTD Performance	Performance Trends
Theme 3: High standards of care through reliable delivery of care bundles	Asthma - Bundle Started	95%	75%	95%	69%	
	Asthma - Bundle Completed	95%	0%	95%	73%	
	AKI - Bundle Started	95%	62%	95%	56%	
	AKI - Bundle Completed	95%	33%	95%	43%	
	Sepsis - Bundle Started	95%	66%	95%	60%	
	Sepsis - Bundle Completed	95%	51%	95%	57%	
	COPD - Bundle Started	95%	85%	95%	62%	
	COPD - Bundle Completed	95%	73%	95%	53%	
	Pneumonia - Bundle Started	95%	86%	95%	73%	
	Pneumonia - Bundle Completed	95%	100%	95%	92%	
	Heart Failure	Design Phase				

One problem is that some of the bundles contain elements of medical and nursing interventions, and therefore raise the question of ownership of the bundle.

3.2 Planned developments

In the revised CAIP plan, the bundles work has been combined with SHMI alerting conditions and site differences into a new overall "reliability" work-stream. The care bundles work is to adopt the PMO approach. Audit tools for bundles are to be reviewed and redesigned to capture compliance with the individual elements of the bundles in order to identify any specific difficulties, and focus areas of improvement.

Priority work-streams identified from review of information (e.g. SHMI alerts, findings of SIs and clinical audit etc) will be commissioned by Medical Director, to ensure an

appropriate investigation and response to findings. Where site differences are identified, these will be investigated to identify the causes.

4. Frailty

4.1 Current position

Overall, this work-stream has been slow to progress since August 2014. A task and finish group was set up to define how this group of patients is identified. There have been discussions with Sheffield Teaching Hospitals and their use of a “Frail-safe” bundle.

Appropriate metrics will be established once this is agreed, but currently being measured as the % of deaths occurring in patients 80+, with three or more co-morbidities, and three or more previous hospital admissions. July’s data showed the number of frailty deaths has dropped significantly from a average of 13% to 6.8%
.

4.2 Planned developments

A detailed action plan will be drafted in the light of the discussions with Sheffield Teaching Hospitals and the use of Frail-safe bundle.

5. Effective (focus on the Courage to Put Patient First programme)

5.1 Current position

These aims were primarily being delivered through the Courage to Put the Patient First programme which had their own measures dashboard. However, when the Trust reorganised its project structure into the PMO work streams, most of CPPFs elements were superseded by the Length of Stay and Bed Efficiency work-stream. They ran in parallel for a while, but the Director of Nursing took the decision to formally stand down CPPF in May.

The different CPPF elements have continued with:

- “Plan for Every Patient” (PFEP) being embedded, as indicated by compliance audits showing that staff now understand the process and see a value. The intelligence obtained from PFEP regarding delays has helped to facilitate some focused work on the causes of lack of patient flow.
- Timely discharge and delays due to partner organisation capacity has been highlighted with the pressures around delayed transfers which have increased as community and local authority capacity has been squeezed.
- ED and access, which has progressed in a limited way with some design of process in ED but is planned to be fully reinvigorated in the new efficiency structure which includes system capacity design.

5.2 Planned developments

The element of this theme relating to site differences has been incorporated into the “reliability” theme in the revised CAIP. Other elements are being managed directly elsewhere, as outlined above.

6. Focus on SHMI Conditions of Interest

6.1 Current position

This was included in the CAIP programme with the aim of focusing priority work-streams as and when required in response to concerns being raised, either locally or by the benchmarking software alerting the Trust that a condition appears to be outlying with a higher rate than expected. Any actions arising from this to improve the care of patients with these conditions would help to drive down the Trust's overall mortality.

There are a number of conditions alerting, and formal reviews of these have been commissioned by the Associate Medical Director:

- Complication of device; implant or graft
- Urinary tract infections
- Chronic obstructive pulmonary disease and bronchiectasis
- Cancer of colon
- Pneumonia (except that caused by tuberculosis or sepsis)

A standard reporting template for findings of these reviews has been produced alongside the Mortality Review Process.

6.2 Planned developments

This theme has been incorporated into an overall "reliability" theme in the revised CAIP programme.

7. Well Led Organisation

7.1 Current position

This theme encompassed a wide range of recommendations and actions, but since the CAIP programme began in August 2014 a well-led group has been established as part of the Trust's preparation for the CQC inspection, which has taken over the actions in this theme.

7.2 Planned developments

This theme is not included in the revised CAIP programme as it is being managed directly elsewhere.

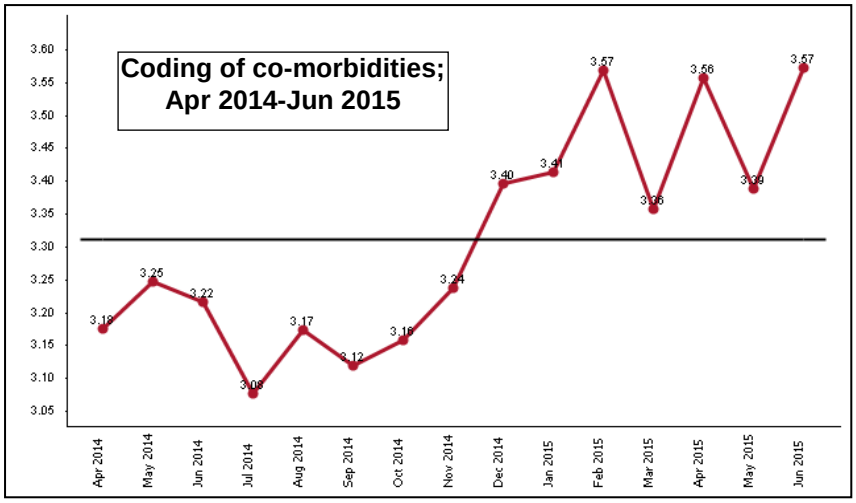
8. Coding

8.1 Current position

In relation to the CAIP aim of reducing SHMI and HSMR at the Trust, clinical coding is a key theme as it has a direct impact on the information which is collected in relation to patients who have died. A number of improvements have been made in coding over the last year:

- engagement with clinicians in relation to record-keeping;
- re-working of documentation, e.g. clerking proforma, to support the coding process; and
- reviewing systems, policies, and equipment (e.g. large computer screens for coders) to support timely and accurate coding.

Accurate coding of patients' co-morbidities is particularly important as it directly affects their assessed "likelihood of dying" and therefore the Trust's ratio of actual to expected deaths.



The Trust has significantly improved its coding of co-morbidities in the last few months, as demonstrated in the chart. This represents the overall Trust-wide position, and excellent improvement in some specialities is masking poor performance (or deterioration) in others.

However, the metrics from the July 2015 dashboard shown below indicate a deterioration in co-morbidity capture, and an increase in coding of "signs and symptoms" (where a diagnosis isn't clear in the notes).

	Indicator	Month Agreed Target	Current Month Performance	Rolling 12 Month Target/YTD	YTD Performance	Performance Trends
Theme 8: Coding	Average Charlson Score	4	3.40	4	3.48	
	% Sign and Symptom	9.5%	10.0%	9.5%	9.7%	
	Average Diagnosis	5	3.98	5	3.96	
	Co-morbidity capture	90%	11%	90%	24%	
	% Coded with Specialist Pall Care	-	0.62%	-	0.61%	

8.2 Planned developments

A short session on clinical coding and its importance is to be included on the FY1 and new doctors' induction programmes. This will focus on the importance of accurate documentation and the role of the doctor, to help improve clinical engagement to ensure clinical documentation is 'fit for purpose' for coding.
Palliative care coding is another key focus area, as the inclusion of a "specialist palliative care" (SPC) code, as opposed to "general palliative care" code (or no code), has a significant impact on the patient's mortality risk. The national rules relating to how SPC is coded have recently changed, and the team is exploring the impact of this for the Trust. Some queries have been raised with the HSCIC, and the Trust is awaiting their response which will clarify some of the details.

Another key challenge for coding is in relation to recruitment and retention of qualified coders, of which there is a national shortage. The Trust has employed trainee coders,

and is evaluating grading in line with qualifications and in comparison with other local Trusts.

Summary

Although there has been good progress in some areas of the CAIP programme over the last year, some themes have not progresses as anticipated, and overall the Trust has not improved its mortality figures as indicated by SHMI and HSMR. However, there is a time delay in the publishing of data and it may be that improvements in relation to actions completed become apparent as updated information is released.

Nevertheless, it was felt appropriate to review the CAIP programme, its themes and actions, and to allocate leads and realistic deadlines for each. A meeting was held at the end of June with the medical director, associate medical director, Governance & Risk leads, and information lead, to discuss proposals for the future programme. A revised plan has been drafted and is appended to the report.

The Board of Directors is asked to note the following:

- HSMR and SHMI have not improved over the last year
- On average, 46.6% of deaths have been reviewed in six months from December 2014. It is anticipated that clarification of roles and process, as defined in the new mortality review process document, will improve this figure.
- There will be a focus on learning from the review findings, and implementing targeted actions to make inprovements
- Nervecentre is now in place at Calderdale, and will be introduced at Huddersfield from the end of July
- DNACPR compliance has improved in relation to discussion with the patient / relative.
- Compliance with care bundles still requires improvement: this is to be managed in a PMO approach
- Changes in coding processes and overall improvement in coding of co-morbidities – though performance within specialities is variable and improvements are often not sustained.
- The CAIP programme has been reviewed and updated / streamlined to facilitate focused action within an agreed time-frame.

Care of the Acutely Ill Patient Action Plan: Revised August 2015 CAIP Lead: Alex Hamilton; Associate Medical Director				
Overarching aim ~ to contribute to the reduction of mortality rates within the Trust. **Timescale ~** actions to be completed August 2016.	AHam: Alex Hamilton AHar: Andy Hardy CH: Carole Hallam DDs: Divisional Directors	DV: Dimple Vyas HMcC: Heather McClelland JA: Jeena Ackroyd JM: Jackie Murphy	KT: Kath Thorley LF: Lisa Fox MK: Mary Kiley MH: Mary Hytch	MS: Marie Sullivan SI: Sam Ingram SS: Sue Shaw TM: Terry Matthews

The revised plan no longer includes the themes relating to Effective (focus on the Courage to Put Patient First programme, and Well Led Organisation which were part of the CAIP plan August 2014. The elements of the CPPF theme have been incorporated into the Length of Stay and Bed Efficiency work-stream, and CPPF was formally stood down in May 2015. The Well-Led organisation theme incorporated many different work-streams but oversight is now provided by the "Well-led" group which has been established to help the Trust prepare for the CQC inspection. However, the plan acknowledges that reduction in mortality within the trust is dependent upon the delivery of these work-streams in association with the CAIP plan.

Theme1: Investigating Mortality and Learning from findings
Lead: Alex Hamilton, Associate Medical Director

Action Plan Nº	Recommendations	Action Needed	Action Lead	Timescale	Verification of achievement	Evidence of impact	KPI	Oversight
1.1	Mortality reviews of all patient deaths to be undertaken and findings reported and actioned	Mortality review process to be written, ratified and implemented to ensure standardised approach to mortality reviews.	KT	Aug-15	Process agreed and available to users	Clarity as to roles and responsibilitites with relation to mortality reviews, with an increase in the number of reviews being conducted.	% of deaths having a Mortality Review. .	COG
		Review of Mortality review proformas.	AHam	Aug-15	Forms agreed and available to users	Streamline and clarify mortality review process	% of deaths having a Mortality Review. .	COG
		Regular monthly reports of mortality review findings to be submitted to C.E.A.M group and cascaded to Divisional PSQBs	AHam	Sep-15 (Jul-15 cases)	Reports as per C.E.A.M group agenda and work-plan	Staff are aware of mortality review findings Actions identified to address recommendations, and progress monitored.	Monthly report produced. Evidence of completion of previous actions.	COG

		Mortality data to be available on the Knowledge Portal for relevant and approved clinical staff	LF	Aug-15	Access to relevant site available	Consultants to be aware of their own, their speciality and the Trust's mortality data. Better engagement of consultants with mortality review process.	% of deaths having a Mortality Review. .	COG
1.2	Ensure that learning from the mortality reviews improve quality of care.	Lessons learnt to be shared at both a local level and an organisational level.	LF / DDs	Oct-15	Routine reports to COG	Evidence of changes to practice as a result of the reviews in divisional PSQB reports.	% of deaths reviewed. Evidence of completion of actions. Reduction in avoidable deaths	COG
Theme 2: Reliability **Lead: TBC**								
Action Plan Nº	Recommendations	Action Needed	Action Lead	Timescale	Verification of achievement	Evidence of impact	KPI	Oversight
2.1	Robust performance management to ensure that key pathways are being implemented and used consistently on all sites: clinicians to be accountable.	Audit tool, method and sample to be reviewed and agreed for each bundle. Audit to include uptake of care bundles when relevant, and quality / consistency / completeness / items routinely missed	AHar / TM	Sep-15	Plan to be approved by CEAM	Clarity as to how bundle compliance is audited, and improvement in quality and quantity of data available.	Audit plan and tools available	COG
		Audits completed as plan to provide data on bundle uptake and completion.	AHar / TM	Oct-15 and ongoing	Monthly bundle compliance reporting to COG	Identification of difficulties in completion of certain elements of bundles, and reasons. Benchmarks for improvement identified / set	% of audits and sample completed as plan. Audit results available	COG
		Audit data circulated to Divisional PSQBs and	DDs	Nov-15 and	Report to PSQBs	Clinicians aware of their teams' compliance with	% bundle compliance.	COG

		cascaded to clinical teams to drive improvement in compliance.		ongoing		relevant care bundles and to drive improvements	Improved outcomes, including shorter LoS and reduced mortality for those conditions relevant to care bundles	
		Performance management of bundle compliance	HB	Dec-15 and ongoing	Divisional business cycle / monthly IBRs	Improvement in compliance with implementing and completing care bundles		Ops board
2.2	Development of new bundles to be overseen by clinical experts in the field to ensure they meet best practice standards and will deliver improved outcomes. These should be evidence-based from national sources and other Trusts.	To have a robust process in place in each speciality to oversee and prompt the development and implementation of new care bundles where there is evidence to suggest they will be of benefit.	DDs	Sep-15	Divisional PSQB minutes COG meeting minutes	Bundles will be available where relevant and will be developed and updated in line with best practice	All bundles evidence-based and in line with best practice. Implementation of new bundles is audited	Care bundle group
Care bundles work is under review by PMO: project lead to be identified and new plan including measurement to be developed. Preliminary meeting 1st September								
2.3	Priority work streams, commissioned by Medical Director, identified from review of information (e.g. SHMI alerts, findings of SIs and clinical audit etc) and initiated to assure COG that issues are being resolved in a timely manner.	Clinical lead to deliver priority work stream findings and reports to agreed ToR and within agreed timescales. Non-delivery of milestones and work steams to be escalated to the QC via the COG.	DDs	Aug 2015 to agree process Individual timeframe for each ongoing	Report of findings to COG as necessary	Areas for improvement will be identified and action plan to improve is agreed.	Outcome targets met for work streams, and action plans completed	COG
						Improved adherence to clinical pathways as demonstrated via clinical audit and other quality indicators e.g. mortality rates, best practice tariffs etc.	Reduction in SHMI alerts	COG

2.4	To ensure an appropriate investigation and response to mortality outlier alerts (to include post discharge 30 day deaths)	Mortality review process to clarify how outlier alerts are reviewed, reported and actioned, with assurance for COG being obtained, to facilitate reviews being undertaken.	KT	Aug-15	Ad-hoc reports to the COG, in relation to alerts	Staff are aware of mortality review findings Actions identified to address recommendations, and progress monitored.	% outlier alerts investigated, analysed and reported appropriately, with response to regulatory organisations.	COG
		Work with GPs via CCG to determine a process to incorporate all deaths up to 30/7 after discharge into mortality reviews.	AH	Dec-15	Agreed process is in place	Information on post-discharge 30-day deaths included and reported to the CCG where appropriate.		
2.5	To maintain focus on any site differences that emerge as part of the on-going work of the programme. Where site differences are identified to investigate and identify the causes.	To break down all clinical information reports, where possible, by site to identify any differences requiring further exploration	LF	Sep-15 and ongoing	Information is available by site where possible and applicable	Identification of areas of concern and ad-hoc work commissioned as necessary	Reduction in site differences for key quality and mortality metrics	COG
		Where a concern is raised, to ensure any on-going work is addressing these or commission work if won't be addressed any other way	DDs	Aug 2015 to agree process Individual timeframe for each	Report of findings to COG as necessary	Improvement actions identified and implemented		COG
Theme 3: Early recognition and treatment of deteriorating patients Lead: Heather McClelland, Consultant Nurse Emergency Care								
Action Plan Nº	Recommendations	Action Needed	Action Lead	Timescale	Verification of achievement	Evidence of impact	KPI	Oversight
3.1	Accurate and timely monitoring and recognition of deteriorating patients leading to prompt and	Implement 'Nerve Centre' electronic observations and handover module across all wards of the Trust	HMcC	Oct-15	Nerve centre in place on all wards	Full implementation of nerve centre and increased availability of patients' clinical status	Nerve centre electronic observations and handover module implemented as plan.	Modernisation Board

	appropriate escalation					Early recognition of, and response to, the deteriorating patient.	Reduction in the nº of cardiac arrests Reduction in nº of unplanned admissions to ICU	Patient Safety Group
	Improve handover communication and procedures, within professional groups, for the MDT and out of hours.				nerve centre handover module operational on all wards	Improvement in handover of patient information	Reduction in the nº of incidents where miscommunication is a cause or contributory factor	COG
3.2	Fully implement recommendations from the Deteriorating Patient work stream relating to "responding to the deteriorating patients team" Work stream to make recommendations relating to the role of Critical Care Outreach, 'Hospital at Night' and the cardiac arrest team.	Outreach to extend hours to be available 8am-8pm on both sites, managing staffing issues.	MH	In place and ongoing	Outreach cover available 12 hours; 7 days	Improvement in early recognition of, and response to, the deteriorating patient.	Reduction in the nº of cardiac arrests Reduction in nº of unplanned admissions to ICU Monitoring response of Outreach to escalation requests calls from Medicus and Nervecentre.	Patient Safety Group
		Resuscitation committee to consider developing a Medical Emergency Team, rather than Cardiac Arrest Team.	Resus Group	Oct-15	Medical Emergency team in place, with clear escalation protocol and roles	Improvement in response to the deteriorating patient	Reduction in the nº of cardiac arrests Reduction in nº of unplanned admissions to ICU	Resus group / Patient Safety Group
		To commence team drills / response to simulated crash calls as a training tool to improve communication and teamwork	SS	Oct-15	Medical Emergency team operates effectively			

		Clarification of implementation of Hospital at Night in relation to the H@N Task Management module through Nervecentre.	HMcC	Nov-15	Plan for implementation of H@N management module	N/A	N/A	Nervecentre Board
		Appropriate staffing (coordinators) to be identified to implement H@N process	HMcC	Nov-15	Appropriate staff in post	N/A	N/A	
		Implementation of H@N management module roll-out as agreed plan.	TBA	TBA	Hospital @ night / 7 day working in place across both sites, as plan.	Improvement in early recognition of, and response to, the deteriorating patient.	Reduction in the nº of cardiac arrests Reduction in nº of unplanned admissions to ICU Monitoring response of staff to calls escalated by Nervecentre.	Patient Safety Group
Theme 4: End of Life care **Lead: Mary Kiely**								
Action Plan Nº	Recommendations	Action Needed	Action Lead	Timescale	Verification of achievement	Evidence of impact	KPI	Oversight
4.1	Appropriate ceiling of care, as indicated by timely DNACPR decisions, to be in place for patients where appropriate, and this to be communicated	Monthly audit data re DNACPR completion to include compliance with all indicators. To be reported by ward and consultant to EoL and COG for identification of appropriate action.	TM / LF	Sep-15 and ongoing	New-style reports available to identify areas for focused improvement	Better identification of patients needing end of life care.	Reduction in the nº of inappropriate cardiac arrest calls Improvement in % of appropriate DNACPR completed	End of Life Group
						Fewer complaints in relation to DNACPR	Reduction in nº of complaints relating to DNACPR	Patient Experience Group

		All cardiac arrests to be reported as clinical incidents	SS	Sep-15 and ongoing	Datix of all cardiac arrest calls	To identify areas for focused improvement in ceiling of care decisions.	Data from Datix compared with calls via switchboard	Resus group
4.2	Reduce unnecessary admissions for patients who are expected to die within 48 hours that could have been managed in an alternative location.	Analysis of 3/12 of cases (identified by mortality review) to identify numbers and causes.	AH / CH	Nov-15	Report of findings to COG	Report identifies causes and makes recommendations.	Relevant actions identified to progress	COG
		Participation in national EoL care audit of deaths in 2015, in relation to last episode of care.	MK / TM	Sep-15	Report of findings to EoL group, governance ½ days and COG	Report identifies causes and makes recommendations.	Relevant actions identified to progress	COG
		Improvement plan to be devised once findings of audits are known	TBC	TBC	TBC	A reduction in unnecessary admissions for patients who are dying that could have been managed in an alternative location, more appropriate to their needs.	Reduction in the nº of patients readmitted following a fast track discharge. Reduction in the nº of patients admitted from a nursing care facility who die.	COG
4.3	Ensure the full implementation of the Integrated Care of the Dying Document (a care-plan that has been designed to work in hospital, hospice and in community). Currently in place in the hospitals and hospices: to be implemented in the community.	Local audit being conducted alongside national audit to identify completion of ICODD	MK / JA	Dec-15	Audit report completed	To identify areas for improvement and focused actions	N/A	EoL group
		Complete programme of training within the community, to include care agencies, nursing homes etc	MS	Jul-16	Training completed	All staff will be trained and confident to use the ICODD. Patients will have care as ICODD appropriate for their needs	Training completed as plan	EoL group
		Three pilot teams to commence ICODD in September as pilot	MS	Dec-15	Pilot completed	To identify any areas of concern and focus for further action prior to full roll-out	Pilot completed as plan	EoL group

		Roll-out of ICODD to all community areas, commencing Jan'16	MS	Jul-16	Full implementation across the Trust	Patients nearing the end of their life receive care and treament appropriate for their needs, and in the right location.	Compliance measured (sample via certification database) re presence of care plan in records of patients expected to die. (CQUIN)	EoL group
Theme 5: Frailty Lead: Lindsey Rudge								
Action Plan Nº	Recommendations	Action Needed	Action Lead	Timescale	Verification of achievement	Evidence of impact	KPI	Oversight
5.1	Work to take place on refining how we identify this group of patients and therefore focus planned improvement work	Detailed action plan being drafted following discussions with Sheffield Teaching Hospitals and the use of Frailsafe bundle.	DV	Oct-15	Action plan for the management of Frail patients in place and agreed			COG
5.2		Additional actions TBC according to initial findings	TBC	TBC	TBC	Improved outcomes for Frail Patients. Additional evidence TBC	TBC	TBC
Theme 6: Coding Lead:								
Action Plan Nº	Recommendations	Action Needed	Action Lead	Timescale	Verification of achievement	Evidence of impact	KPI	Oversight
6.1	To improve the depth, extent and quality of clinical coding	Provision of information to new doctors so they know their responsibilities in relation to clinical record keeping for accurate coding	LF	Aug-15 In place and ongoing	Scheduled slot on doctors' induction day. Dedicated session on clinical coding as part of FY1s' education programme.	Improvement in clinical records to facilitate accurate coding	Increase in co-morbidity coding Reduction in S/S as primary diagnosis	COG

		To improve clinical engagement across all specialities and divisions	SI / AH	Nov-15	Clinical documentation is 'fit for purpose' for coding		Clinical Coding Steering group has clinical representation from all divisions Increase in co-morbidity coding Reduction in S/S as primary diagnosis	COG
		Reports by directorate and speciality in relation to co-morbidity scores, diagnosis, signs & symptoms etc	LF	Jan-15 In place and ongoing	Monthly reports to PSQBs	To enable identification of specific areas for improvement within teams to improve coding	Improvements demonstrated	COG
		Ongoing analysis of the coded data to identify focus areas for improvement	LF/ DDs	Apr-15 In place and ongoing	Monitoring report to the COG	Increase in the average number of diagnosis high predictive risk scores in the standardised mortality scores	Average number of diagnosis per spell SHMI score	COG
6.2	Focus on completion of Specialist Palliative Care coding as this is known to significantly impact upon mortality risk	Implement additional processes to ensure SPC codes aren't missed	SI	Aug-15 In place and ongoing		All patients will have a specialist palliative care code applied where applicable	Increase in nº of patients with specialist palliative care code	COG
		TBC following info on clarity of new process from HSCIC	SI	TBC	TBC			
6.3	Support for clinical coding to build improvements and efficiency: Improve recruitment and retention of coders	Re-band qualified clinical coders to retain existing team and attract staff from other areas	SI	Jul-15 In place and ongoing	Team structure and vacancies	Coding completed within timescales and within acceptable levels of accuracy	Nº of FCEs per coder reduced to below 7000	COG

Mortality Review Process: key extracts

5. Process for conducting mortality reviews

5.1 Reviews of individual patients

5.1.1 Identification of cases to be reviewed

A list of all deceased patients is generated by the Clinical Outcomes Information Team from the Mortality Knowledge Portal (which receives data from PAS.

The deceased patients' names are added to the spreadsheet of cases to be reviewed by the Clinical Governance Support Manager, and a reviewer is allocated to each case. Whilst the Trust target is that all mortality cases are reviewed, the cases associated with any of the following will be prioritised:

- SHMI "conditions of interest"
- Inquest
- Investigation / complaint
- Elective admission
- Death at the weekend
- Patient < 50 years

5.1.2 Initial review

This is done by a single reviewer, and is a review of the patient's case notes according to the criteria set out in the "level 1" mortality review form (appendix 1). This must be completed in the month following the month of the patient's death.

On conclusion, the reviewer will grade the case according to the Hogan score:

1. Definitely not preventable.
2. Slight evidence for preventability.
3. Possibly preventable but not very likely, less than 50–50 but close call.
4. Probably preventable, more than 50-50 but close call.
5. Strong evidence for preventability.
6. Definitely preventable.

If the reviewer is uncertain, they may request an additional review by an appropriate colleague, but this would be a second "level 1" review.

Cases that have not been reviewed at "level 1" by the end of the month after the month of death will not be carried forward to be included in the next month's reviews. The case notes are sent to base file, and the initial reviews of cases from the next calendar month will commence. This is to ensure that findings from the monthly reviews can be collated and reported in a timely manner.

If a reviewer has completed their allocated "level 1" reviews for the month and have capacity to do more and assist colleagues, they can contact the Governance & Risk

team who may be aware of staff who are struggling with their current reviews. If no colleagues need assistance, they may commence their own reviews of patients who have died within the current month, without waiting for the month end.

5.1.3 Follow-up / escalation according to Hogan Score

Cases scored as (1) will have no further action taken and the case notes are returned to base file.

Cases scored as (2) will have a second stage mortality review only if there is an associated complaint, inquest etc. However, a thematic review of the findings of all these cases will be undertaken and included as part of the mortality review report.

Cases scored as (3) and (4) will have a further more detailed review according to the criteria on the “level 2” mortality review form (appendix 2). These reviews must be done by two people:
neither of whom did the “level 1” review;
who are both independent of the patient’s care; and
ideally together to enable timely discussion of the findings to reach a conclusion.

Clinicians for “level 2” reviews will be allocated by the Clinical Governance Manager and notified individually. All “level 2” reviews must be completed by the end of the month following the month of death, and must be prioritised accordingly by the reviewers.

For cases scored as (5) and (6), a search of Datix is undertaken to see if concerns relating to the patient’s death have already been raised and being investigated at the appropriate level. If not, then the case is reported onto Datix, and escalated for panel review in accordance with the Incident Reporting, Management and Investigation Policy. A “level 2” mortality review will be conducted and incorporated as an appendix to the RCA investigation.

5.2 Reviews of clusters of cases as a result of alerts / horizon-scanning

5.2.1 Identification of cases

The Health Informatics team review the mortality database for early indications thatmortality is rising in a specific clinical classification area. It also reviews CUSUM charts contained within the HED system, to identify early trends that may indicate a future alert may arise.

Anticipation of HSMR / SHMI cases that may go on to trigger will be identified within the regular monthly report on current HSMR and SHMI position.

5.2.2 Scope of review

The informatics team will notify the Medical Director and Associate Medical Director with relevant information and a discussion is held to agree the level of review, terms of reference, sample etc.

Depending upon time-scale of alert, case note reviews may already have been undertaken as part of the routine mortality review process. The results of these can be used to provide information for the clinical classification reviews wherever possible

6. Reporting of findings

6.1 Formal reporting

6.1.1 The Governance & Risk team, with the Associate Medical Director, will produce monthly report of trust-wide mortality review findings. This report will include;
progress against previously identified actions compliance with the process within month, and achievement against the target;
themes and trends arising in month from the cases graded as “Hogan 2” (see section 5.1.2)
individual summary of all cases in month graded as Hogan 3-6
any recommendations and actions

The report is to be presented to the Divisional PSQBs, and to the CEAM and COG, and findings escalated to the Quality Committee as appropriate.

6.2.2 Findings of “cluster reviews” must be reported on the approved template (see appendix 5) and within the agreed time-scale. They will be presented to the committees / groups as above, and additionally to any other relevant speciality meeting as appropriate.

6.2 Action planning and learning

The COG will approve any recommendations identified in the monthly report, and any action plan including timescales and action owners.

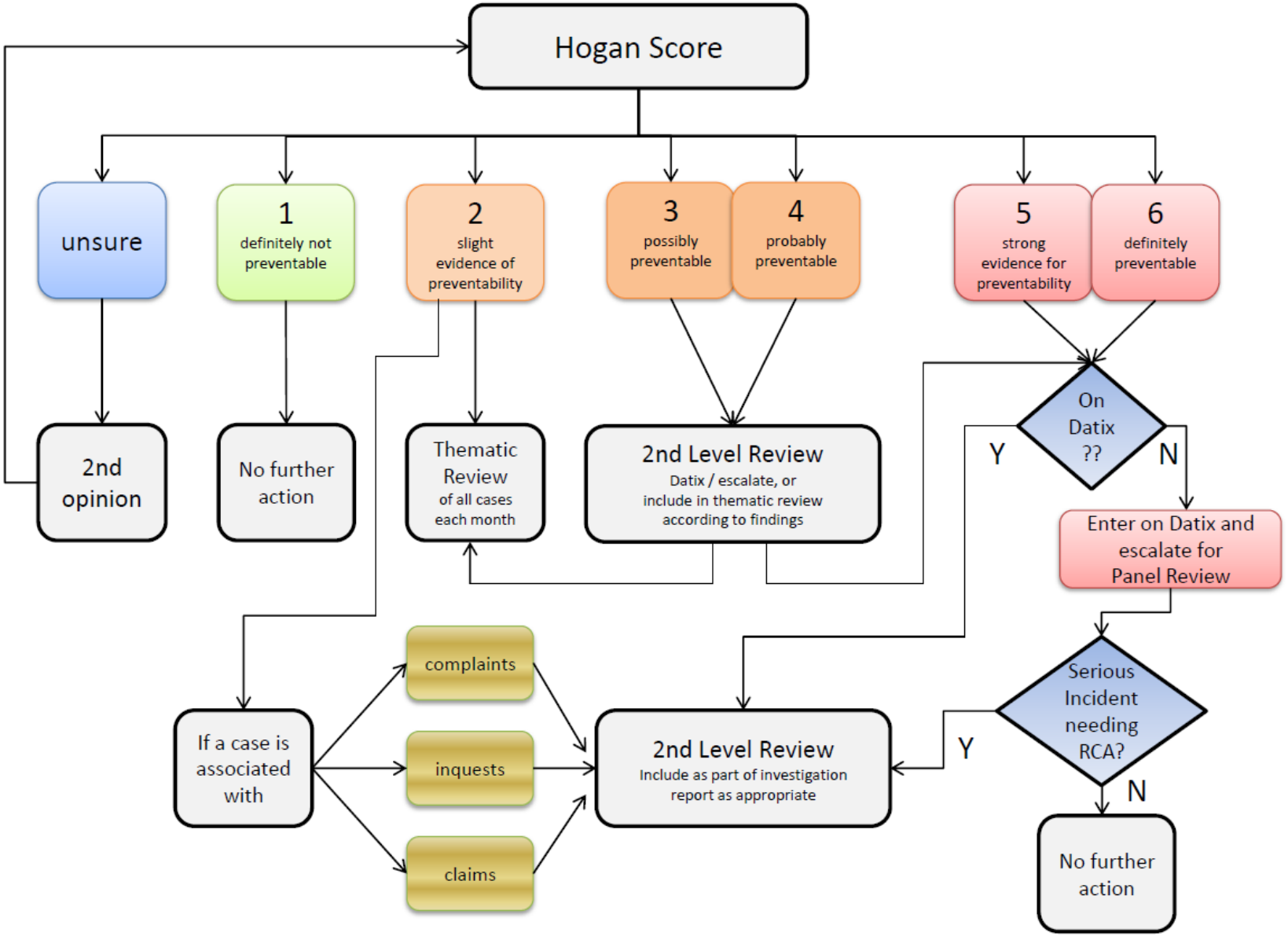
The Governance and Risk team will ensure the action plan is circulated to the action owners, and will monitor progress and completion, which will be included in the ensuing reports.

Relevant information will be incorporated into the Trust-wide “So What Happened Next?” newsletter which amalgamates learning from all experience and is circulated to all staff every month.

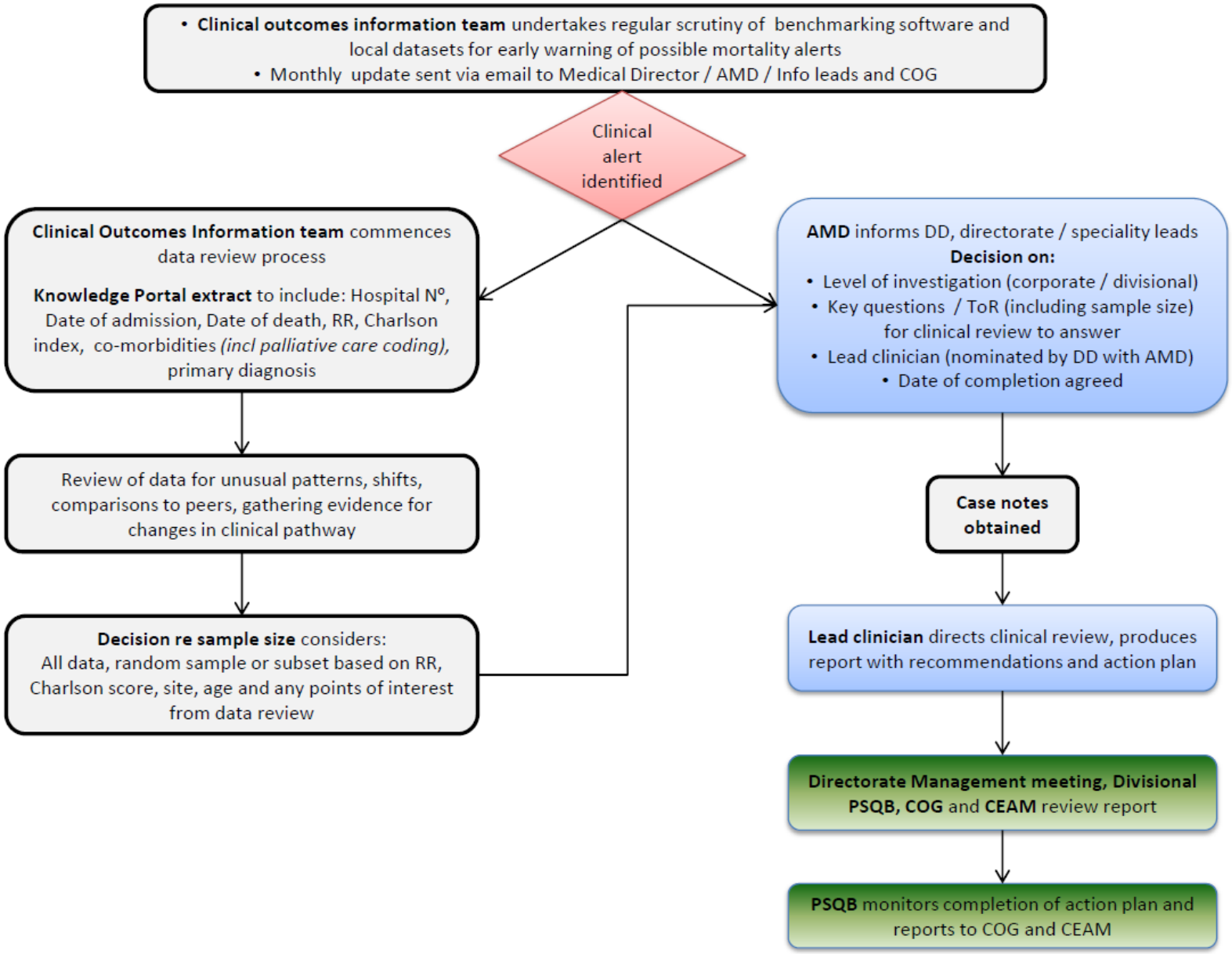
6.3 Real time data availability

Using the trusts Knowledge Portal platform, mortality review data is available in the Mortality Model. All Mortality reviewers will have access to this and will be able to view the outcome of the reviews which have been undertaken and inputted into the local database by the G&R team. This data is made available one day following the input of the review into the database.

Escalation of individual mortality cases according to Hogan Score



Process for Mortality Alert Review



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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 27th August 2015	**Sponsoring Director:** Kirsty Archer, Assistant Director of Finance
Title and brief summary: FINANCIAL NARRATIVE - MONTH 4 - The Board is asked to approve the Month 4 Financial Narrative.	
Action required: Approve	
Strategic Direction area supported by this paper: Financial Sustainability	
Forums where this paper has previously been considered: Finance and Performance Committee - 18.8.15	
Governance Requirements: Financial Sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the Month 4 Financial Narrative.

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 Month 4 Financial Narrative.

Appendix

Attachment:

Financial Narrative Month 4 15_16 final for BOD.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

MONTH 4 JULY 2015/16 FINANCIAL NARRATIVE

Purpose
This paper provides a narrative to accompany the monthly financial dashboard and will focus on the key messages within the month and year-end forecast and is presented in the following three sections:

- Key messages;
- Month 4, July, year to date performance;
- Forecast and risks.

This paper has previously been discussed at the Finance & Performance Committee on the 21 July 2015.

1. Key Messages

The reduction in non-elective activity and shortfall in elective activity in Month 4 has driven a £1.08m year to date adverse variance from plan. This downturn in the trading position, coupled with the need to consider an increase in bed capacity has impacted on the year-end forecast 2015/16 which stands at £22.2m against a planned deficit of £20.00m excluding restructuring costs. The commitment to deliver the agreed £20m deficit remains but in recognising now a potential £22m outturn, the appropriate corrective actions can be taken.

Month 4, (YTD) July Position

Income and Expenditure Summary	Plan £m	Actual £m	Variance £m
EBITDA	**1.31**	**0.24**	**(1.08)**
Deficit	**(7.15)**	**(8.23)**	**(1.08)**

- An EBITDA of £0.24m, an adverse variance from plan of 1.08m.
- A deficit of £8.23m, an adverse variance of £1.08m from the planned position.
- Delivery of CIP of £4.00m against the planned level of £3.30m.
- Contingency reserves released of £0.35m against year to date pressures.
- Capital expenditure of £6.11m, below the planned level of £6.99m.
- A cash balance of £7.92m, above the planned level of £7.57m.
- A Continuity of Risk Rating (CoSRR) of level 1, in line with plan.

Year-end Forecast Position

Income and Expenditure Summary	Plan £m	Actual £m	Var £m
EBITDA	**5.51**	**3.08**	**(2.43)**
Deficit excluding restructuring	**(20.01)**	**(22.23)**	**(2.22)**
Restructuring costs	(3.00)	(3.00)	0.00
Deficit including restructuring	**(23.01)**	**(25.23)**	**(2.22)**

- An EBITDA of £3.08m, £2.43m adverse variance from plan.
- A deficit before restructure costs of £22.23m, an adverse variance of £2.22m from plan.
- Restructure costs forecast to be at planned levels of £3.00m.
- A deficit including restructure costs of £25.23m, an adverse variance of £2.22m from plan.
- CIP delivery of £16.16m incorporated in the forecast position against planned CIP at £14.05m.
- Full balance of contingency reserves released unutilised to mitigate against financial pressures.
- Capital expenditure of £20.72m, in line with the plan and supported by the £10m capital loan.

- A cash balance of £1.06, below the plan of £1.92m, including external cash support of £17.1m.
- A Continuity of Risk Rating (CoSRR) of level 1, in-line with plan.

2. Month 4, July, year to date performance

Statement of Comprehensive Income (SOCI)

The adverse variance from plan reported in the year to date represents a deterioration in-month from the position seen at the end of quarter 1 which was in-line with plan. This is driven by a fall in clinical activity leading to a £1.2m income loss versus plan in-month. Coupled with this, pay expenditure has not tracked activity but has remained at the high level seen in recent months. These pressures have been offset in part by the release of £0.25m contingency reserves in Month 4, in addition to the £0.1m already released.

As described within the Annual Plan for 2015/16 additional bed capacity had been planned for over and above the levels experienced within 2014/15. Within the year to date, this additional planned capacity has been exceeded every month. The plan anticipated a reduction in the required bed capacity in quarter 2 based on the seasonality of demand. The actual number of beds has reduced proportionately with plan in month 4. In spite of this the pay expenditure has remained on a par with previous months with nursing fill rates being enhanced to meet previously agreed standards.

In summary the main cumulative variances behind the year to date position are:

Operating income	(£0.03m) adverse variance
Operating expenditure	(£1.05m) adverse variance
EBITDA for calculation of CoSRR	**(£1.08m) adverse variance**
Non-Operating items	£0.08m favourable variance
Restructuring costs	(£0.08m) adverse variance
Total	**(£1.08m) adverse variance**

Operating Income

There was a cumulative £0.03m adverse variance from plan within operating income.

NHS Clinical Income

Of the £0.03m adverse income variance, £0.44m is driven by NHS clinical income, predominantly driven by a non-elective over performance which has slowed in month but totals £0.99m in the year to date. In addition £0.42m relates to invoices raised to Calderdale CCG for April system resilience pressures (additional bed and medical capacity) and May costs incurred following the closure of community Intermediate Care beds. As previously reported, payment of these invoices remains in dispute with the CCG.

The clinical income contracts with the two main commissioners (Greater Huddersfield CCG and Calderdale CCG) continue to remain unsigned at present although progress is being made towards final resolution following mediation. In the meantime, until this is resolved, the Trust assumes operation under a full PbR contract in terms of activity, CQUIN delivery and penalties where relevant. The Trust has noted the latest Monitor communication detailing the agreement from NHS England to suspend fines and penalties relating to the RTT standard, however this risk was minimal to the Trust.

The activity position driving the reported PbR income is as follows:

- Planned day case and elective activity has performed below the month 4 plan by 13.4% (659 spells) which is a significant worsening from the month 3 position. Cumulatively activity is now 5.4% below plan (938 spells).

- Non-elective admissions overall are above the month 4 plan by 5.5% (223 spells). This is, however, all within emergency short stay admissions. A reduction in emergency long stay admissions has been seen in month 4 which is a shift from the over-performance in earlier months. In the year to date activity is 3.6% above plan (589 spells).

- A&E attendances are below the month 4 plan by 4.8% (624 attendances) which is a worsening in the under-performance seen in month 3. Cumulatively attendances are now below plan by 2.1% (1,086 attendances).

- Outpatient attendances have seen a significant worsening in performance in month 4 with activity below plan by 6.3% (1,889 attendances), this is predominantly within follow-up attendances in the year to date outpatient activity is now 1.4% below plan (1,601 attendances).

- Adult Critical Care and NICU are in line with plan in the year to date with high activity in the very early part of the year offset by a more recent reduction.

- Pass through high cost drugs are above plan whilst devices are below plan to a compensating level in the year to date.

It should also be noted that the 2015-16 plan includes Urgent Care Board funding of £2.3m. As we are still awaiting the resolution of Urgent Care Board discussions, the month 3 position assumes receipt of this in line with plan. Discussions with commissioners have progressed positively on this front, increasing our confidence of securing this funding in full.

In line with plan and in recognition of the income risks, allowance to the value of £0.65m has also been made in the anticipation of contract sanctions; any shortfall on CQUIN performance; and contract challenges under a full PbR contract.

Other income

Overall other income is £0.47m below the planned level. This continues to be driven in part by a shortfall in commercial revenue generation by the Trust's Pharmacy Manufacturing Unit against a plan to exceed their prior year surplus delivery. Plans are in place to recover this over the year and risks are being assessed. This sits alongside a number of smaller adverse variances across other areas in the year to date which we expect, along with the Pharmacy Manufacturing Unit income, to revert to plan in the remainder of the year. The Health Informatics Service which is also hosted by the Trust and operates commercially is achieving revenue generation in excess of plan in the year to date.

Operating expenditure

There was a cumulative £1.05m adverse variance within operating expenditure across the following areas:

Pay costs	(£0.46m) adverse variance
Drugs costs	£0.06m favourable variance
Clinical supply and other costs	(£0.65m) adverse variance

Employee benefits expenses (Pay costs)

Pay costs are £0.46m above the planned level. Additional costs have been incurred in the year to date as a result of staffing additional bed capacity over and above the planned level, linked to dealing with the wider system resilience issues, supported by non-contracted medical and nursing staff.

The continued requirement to use agency staffing has been seen in spite of the fact that the additional bed capacity pressures have reduced from their peak in quarter 1. The non-contracted pay spend remains at a high level in support of ward nurse staffing ratios and covering medical

vacancies in areas with recruitment difficulties. The former in particular is being challenged to ensure that decision making appropriately balances quality and best financial value.

The Trust is reviewing its management of flexible nursing workforce provision, considering in-house versus outsourced solutions with a view to being able to convert more agency and overtime usage to bank staff removing premium payments where possible. A drive to recruit substantive nursing staffing continues alongside this.

Within the pay position there is a benefit of £0.66m versus plan against contingency reserves. As described in previous reports the annual plan includes £3.0m of contingency reserves of which £2.0m was planned as pay spend. There has been a release of just £0.35m contingency reserves to the bottom line in the year to date position as a provision has already been made against the balance of the available contingency for potential future risks and commitments. The accounting treatment for provisions is as a non-pay cost and as such there is an underspend against this element of pay against plan. Excluding this benefit shows the true value of the pay pressures described above at £1.12m against year to date plan.

Drug costs

Year to date expenditure on drugs was £0.06m below plan. The spend on 'pass through' high cost drugs is below plan matched by a corresponding income reduction.

Clinical supply and other costs

Clinical supply and other costs, including PFI costs, are £0.65m above plan in the year to date position. This includes the creation of a provision against future risks and commitments to the contingency reserve as described above, driving £0.32m of the adverse variance and offsetting in part the pay benefit.

In addition, costs have been driven up by increasing the Trust's bad debt provision.

These costs and pressures from additional clinical activity are offset in part by the successful delivery of CIP over and above the planned level and further one-off non pay benefits driven out across areas of estates and facilities spend.

Non-operating Items and Restructuring Costs

Non-operating items show a favourable £0.08m variance from plan. This is predominantly driven by lower than planned inflationary charges on the PFI contract with actual RPI being lower than the projected level.

As previously reported, analysis also indicates that there is a potential benefit through lower than planned depreciation due to the impact of the year end asset revaluation exercise. As the Trust has a number of assets under review for disposal it is envisaged that there may be an adverse impact on capital charges. These issues will be considered in the round before any benefit is taken.

Cost Improvement Programme (CIP) delivery

The CIP and revenue generation schemes have delivered in excess of plan in the year to date with £4.00m achieved against a planned £3.30m. The over performance is seen in the same areas as last month; achieving additional revenue from pricing through greater depth of clinical coding; and delivery of additional non pay savings.

Statement of Financial Position and Cash Flow

At the end of July 2015 the Trust had a cash balance of £7.92m against a planned position of £7.57m, a favourable variance of £0.35m, summarised as:

Operating activities	£0.44m favourable variance
Investing activities	(£0.12m) adverse variance
Financing activities	£0.03m favourable variance

Operating activities

Operating activities show a favourable £0.44m variance against plan. This is driven by the adverse cash impact of the I&E position being exceeded by positive working capital variances from plan. The outstanding level of receivables is below planned levels with the Trust's active pursuit of NHS debtors in particular having been successful.

We are however continuing to stage our payments to suppliers in order to manage the cash position. Performance in the year to date against the Better Payment Practice Code was 81% against the 95% target of invoices being paid within 30 days, in month performance stands at 64%. Whilst balancing the need for careful treasury management, the Trust continues to understand the importance of meeting obligations to suppliers and maintaining good relationships.

In light of this, and the knowledge that the Trust will be unable to utilise distressed cash support to rebuild or improve a balance sheet position against creditors, pro-active steps are being taken to strengthen our cash profile. An example of this is the agreement that has recently been reached with our main commissioners to re-phase the contract income payments over eleven months rather than the standard twelve. This will bring a cash benefit in September.

Investing activities (Capital)

Capital expenditure in the year is £6.11m, £0.88m below the planned level of £6.99m.

Against the Estates element of the capital expenditure plan, £2.40m has been incurred in the year to date versus a planned £2.94m. The main areas of investment are the continuation of the ward and theatre upgrades on the Huddersfield Royal Infirmary site. The key reason for the variance is slippage on the ward upgrade works as a consequence of asbestos being found, costs are forecast to come back to plan by the completion date of October.

IM&T investments total £3.23m against a year to date plan of £3.44m. The main areas of expenditure are in the EPR, Electronic Document Management System (EDMS) and Electronic Observations software. The main area of underspend is against work planned on the switchboard which is now planned to take place later in the year.

The balance of the underspend is due to timing differences on planned investments in medical equipment.

The favourable cash impact of this £0.88m under spend is offset by an adverse £1.00m variance against capital creditors, explaining the overall £0.12m adverse cash variance against investing activities.

Financing activities

Financing activities show a £0.03m favourable variance from plan. The £10m loan to support capital expenditure was drawn down from the Independent Trusts Financing Facility (ITFF) in April in line with the plan.

3. Forecast and risks

Forecast – Income and Expenditure

The forecast position has been revised to a year end deficit of £22.2m against the planned £20.0m deficit (excluding restructuring costs). The reasons for this worsened position are twofold. Firstly, the impact of the Month 4 worsened trading position. Secondly, system wide pressures driving the need for a greater level of bed capacity. It has been determined that this brings the need to spend an additional £1.6m to avoid increased outlying of non-elective medical patients into elective surgical beds which would place at risk the delivery of planned activity and income and compromise quality.

As outlined in previous reports, a number of intermediate care nursing beds have recently been removed from the Calderdale community system until further notice. This is in addition to ongoing pressure within nursing / residential care capacity across both Calderdale and Kirklees which is impacting significantly on the CHFT bed base has been seen to impact on the Trust through increased levels of non-elective emergency admissions. The further expenditure is required to accommodate this operational pressure, particularly across the third quarter of 2015/16 when the capacity plans had anticipated bed requirements being at their lowest level.

Whilst some of the factors above are beyond the direct control of the Trust, it is recognised that there must be attention focussed on those areas that can be influenced. There is a significant amount of pro-active effort being placed on reducing delayed transfers of care. The overall capacity cost pressure is net of a bed contraction planned through this route. Hospital at Night and 7-day working are key programmes to prevent an ever increasing bed base.

The level of expenditure required is exacerbated by the difficulties in recruiting sufficient substantive staff into both qualified nursing and medical posts in certain key specialties, driving the need to contract locum and agency staff. The Trust is continuously reviewing these requirements, again to ensure that control is being exercised to deliver best value.

The revised forecast deficit has already called upon the additional ‘stretch’ CIP which had been conceived to guard against such risks. The forecast year end position includes delivery of £16.16m CIP against the original plan of £14m. The full £3m of contingency reserves is also forecast to be released. This leaves no resources to cover potential other pressures and risks that emerge later in the year.

Forecast – Cash

The deterioration in the year end I&E forecast will bring an equivalent increased requirement for external cash support. However, the Trust has been able to push back the timing of this required support. This is now anticipated to be required in quarter 4. This is due to the agreement with commissioners to re-phase the clinical contract income payments coupled with a revised scheduling on the pay out of restructuring costs, previously planned for September now anticipated in February.

Risks

As highlighted in previous reports, there will continue to be a variety of risks and opportunities within the forecast position. The utilisation of the full contingency reserves to support the forecast brings these into sharper focus with the need being to minimise the former and maximise the latter.

In addition, the forecast assumes CIP delivery of £16.16m. £2.14m of this remains rated as high risk, as illustrated on the dashboard report, and as such poses a further potential pressure.

Keith Griffiths 14/08/15

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 27th August 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: QUALITY COMMITTEE MINUTES - UPDATE - The Board is asked to receive a verbal update from the Quality Committee held on 25.8.15 and the minutes held on 28.7.15.	
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 a verbal update from the Quality Committee held on 25.8.15 and the minutes held on 28.7.15.

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 a verbal update from the Quality Committee held on 25.8.15 and the minutes held on 28.7.15.

Appendix

Attachment:

Minutes QC 280715 v2.pdf

Minutes of the QUALITY COMMITTEE held on Tuesday 28 July 2015, 2pm – 5pm in Discussion Room 1, Learning Centre, HRI

PRESENT:
David Birkenhead, Medical Director
Jan Wilson, Non-Executive Director
Jackie Green, Interim Director of Workforce and Organisational Development
Jackie Murphy, Deputy Director of Nursing/Interim ADN, Surgery & Anaesthetic Services Division
Jeremy Pease, Non-Executive Director (Chair)
Julie Dawes, Executive Director of Nursing & Operations (by telephone)
Juliette Cosgrove, Assistant Director to Nursing and Medical Directors' Offices
Lesley Hill, Executive Director of Planning, Performance, Estates and Facilities
Lynne Moore, Membership Council Representative
Sal Uka, Divisional Director, 7-day Services & Hospital at Night

IN ATTENDANCE:
Linda Cordingley, Executive Assistant (Minutes)
Anne-Marie Henshaw, Head of Midwifery (Full meeting)
Catherine Briggs, Matron, Medical Division (Full meeting)
David McGarrigan, Assistant Director of Estates & Facilities (Full meeting)
Sajid Azeb, Assistant Divisional Director, Medical Division (Item 5.1)

01/07/15	**WELCOME AND INTRODUCTIONS** The Chair welcomed members to the meeting. The meeting was confirmed as quorate. There were no declarations of interest.
02/07/15	**APOLOGIES FOR ABSENCE AND ATTENDANCE REGISTER** **Apologies for absence were received from:** Andrea McCourt, Head of Governance & Risk Helen Barker, Associate Director of Operations and Community Services Julie O'Riordan, Divisional Director, Surgery & Anaesthetic Services Division Keith Griffiths, Finance Director Linda Patterson, Non-Executive Director Lindsay Rudge, Associate Director of Nursing, Medical Division Martin DeBono, Divisional Director, Family and Specialist Services Division Victoria Pickles, Company Secretary
03/07/15	**MINUTES OF THE MEETING HELD ON 23 JUNE 2015** The minutes of the meeting held on 23 June 2015 were approved as a true record.
04/07/15	**ACTION LOG & MATTERS ARISING** (Items due this month) **PSQB report Children's, Women's and Families Division** Anne-Marie Henshaw advised members that the appraisal exemptions were those staff on maternity leave or on long-term sick who had worked at the beginning part of the year and by end of year were not at work. **Stepping Hill** – a report would be presented to the September meeting.

	Category 3 pressure ulcers – the 10% target reduction had not yet been amended in the IBR. This would be amended for the report to the August meeting. **DNA/CPR Compliance** – this would be considered at the August meeting.
05/07/15	**MAIN AGENDA ITEMS** **5.1 Emergency Services Department Quarterly Report** The Assistant Divisional Director for the Medical Division gave an update on the ED KPIs. The four-hour standard for Q1 had been achieved against a backdrop of 93.6% nationally. Ambulance handover (30-60 minutes) had improved (there was a charge to the Trust of £200 per patient waiting over 20 minutes). There had also been a reduction in over 60 minute waits. CQUINS – both in ED – Asthma and discharged patients who present with Asthma were eligible for the bundle. Q1 target had been achieved. There was confidence that Q2 would be achievable against the increased target. Urgent Care – this was improving. The mental health trust was putting in appropriate services to prevent re-attendance. Patient FFT in A&E – had a low response rate of 8.6%. Actions were being taken within the departments, with nurses being asked to distribute cards to patients. The department was also looking at a texting system and how this would be deployed. A stretch of 30% response rate in A&E had been agreed in the contract, although it should be noted that no trust was achieving this level. There would be renegotiation of the target with Commissioners. Early indications were that they were amenable to this. Work was continuing to achieve the Q2 plan, noting the consultant recruitment difficulties. Julie Dawes asked that the focus of the plan be reviewed to assess the impact on quality of care in terms of incidents, breaches and the impact on patients. It was noted that consultants were working down to cover gaps in middle grade doctors to ensure quality issues were not compromised. The escalation policy had been implemented and collection of breach information had commenced ie how long patients have waited, the impact on care and matrons discussing problems with patients. Quality and outcome measures would be put in place. In terms of middle grades the service was looking at different options, including use of ACP roles and international recruitment. These would be highlighted in report for the August meeting. ACTION: The Committee **RECEIVED** and **NOTED** the updated action plan. **5.2 Action Plan following Regulation 28 Letter from HMC (PRS)** The Trust was undertaking missed dose audits and providing training where necessary (online on a 3 year basis). Bespoke training would be made available in Maternity services. The importance of missed doses had been included in nurse induction and would be linked to competencies. It was noted that incidence of missed doses was high on the rehabilitation wards but there were complex reasons why this was the case. **5.3 Action Plan from the Cleaning Services Report** David McGarrigan, Assistant Director of Estates and Facilities, advised that a redesigned programme would be introduced with a clear management framework and accredited cleaning standards. A project team was in place and would meet in August with an anticipated project completion date of end of September. Two named nurses were part of the project team working closely with IPC colleagues. Clear KPIs would be agreed to form the basis of the performance management system. Julie Dawes expressed concern

over the timescale and felt there was a need to describe outcomes initially and monitor immediately as the results of current audits did not reflect the standards currently in place. David McGarrigan said that supervision and audit processes were in place but productivity rates in specific areas needed further scrutiny. Previous PLACE assessments had shown that cleaning was effective in most areas but some areas were under performing. The Project Team would report to the IPC Committee through the clinical effectiveness update. A full report would be available at end of October.

ACTION:

The Quality Committee would receive a report on the introduction of a management framework and accredited cleaning standards at the October meeting.

5.4 QIA Action Plan

The Executive Director of Nursing and Operations advised that the Turnaround Executive had asked for the process to be revised and taken through the quality directorate as there was concern about managing CIP risks. Julie Dawes asked that the top three risks for each of the schemes be included. A revised schedule would be circulated before the August meeting.

ACTION:

The Quality Committee would receive the revised QIA schedule at the August meeting.

5.5 R&D 6-monthly Report

The Executive Medical Director outlined the challenges in finding patients to enter clinical trials. Trials were becoming increasing complex and it was difficult to find patients who met the criteria. 1100 patients had been recruited from a target of 1300 giving a 67% achievement rate, therefore the Trust had seen a reduction in funding this year as our income was based on our accrual rate. The Trust's research profile was primarily in cancer, which was complex and relatively low numbers could be recruited. There had been 93 active research studies in 2014/15, with an expectation that 43 of these would be closed this year. The Trust was also trying to build commercial research income with support from the Research Network and was identifying interested consultants and the level of investment required. The Trust was also looking at its research nurse infrastructure to provide support more broadly across Trust, which would make it easier to open new studies. The Trust has a joint research fellow with Leeds.

The Trust's allocation for 2015/16 was £753K, £100K less than last year. To date 90 patients had been recruited, but there was a need to recruit 92 patients per month to meet the target of 1100.

ACTION:

To advise the Board of Directors of the R&D position within the Trust.

5.6 Action Plan from NHS Protect Focused Quality Assessment

Juliette Cosgrove, Assistant Divisional Director, advised that the NHS Protect standards had been in place for two years. Our annual self-assessment included two standards – Governance and Inform and Involve. The Trust had declared green for governance and amber for inform and involve. The final assessment found us as green for both standards. There are some areas still requiring improvement, which were included in the

	report and action plan submitted to NHS Protect. The Trust had received positive feedback on the report, with a slight concern that there was no strategy in place. NHS Protect had provided some draft strategies from other trusts as examples. It was noted that the LMSM role and function would shortly transfer to the Facilities Security team. Relevant training would be provided to support this role. ACTION: The Committee **RECEIVED** the report. **5.7 Well Led Governance Review Feedback** Jackie Murphy, Associate Director of Nursing, gave an update on the recent well-led governance review. Our self-assessment and the PwC assessment were compatible, which showed a high level of self-awareness. Work on further improvements would take place over the next 12 months, recognising the challenges involved. The overarching themes were: • capacity of Directors to take on roles and implement change management • Integrating data to provide more Board intelligence for future forecasting • Performance management framework • Ward to Board operation • Data quality – suggestion we kitemark ourselves and get an external view. An Information strategy would help us to do this.
06/07/15	**CQC PREPARATION AND ACTION PLAN** 6.1 Update on CQC Action Plan It was noted that the date for the inspection was as yet unknown. Our self-assessment suggested improvement was needed to achieve a "good" assessment, therefore the plan included core services as well as a focus on the five key domains. The CQC steering group met regularly and received data from across Trust. There had been a mock CQC assessment in July for community and their key lines of enquiry had been developed. The assessment supported their own findings with some additions around culture and risks. A revised data pack would be available for the September meeting. A number of awareness sessions had been delivered and more were scheduled. There was still a need for more communication. The leadership "Go See" events had been refocused to include DoLS, nutrition and pain management. It was noted that the CQC assessment had moved from 16 to 20 on the risk register. It was agreed that CQC readiness data should be included in the IBR. ACTION: The Committee **RECEIVED** and **NOTED** the updated action plan. The revised data pack would be received at the September meeting. It was agreed to update the Board of Directors on the CQC readiness position and how the outstanding issues would be addressed.
07/07/15	**RESPONSIVE** 7.1 Integrated Quality and Performance Report The Integrated Quality and Performance Report for June 2015 was presented and the following highlights were noted:

Responsive:

- A&E target delivered in Q1 in the context of a higher than planned number of acute patients. Not all targets on elective and day case activity were being achieved. Plans were being developed to deliver planned income and baseline on CIP targets. There were still ASI issues but work was ongoing to resolve these.

Caring:

- Complaints - acknowledgements within timescale were improving but there was more work to do. Well done to all. Julie Dawes agreed to look into the fall in 3-day acknowledgements.
- Patient FFT – looking at different methodologies to improve figures. Patient feedback would be included in the next report. There was a significant difference between outpatient and inpatient areas in terms of waiting, with outpatients being the least recommended. A deep dive into the comments would help to inform the outpatient improvement work. Boards were being introduced on wards to show FFT scores, comments and actions.
- Noise levels at night – work on wards was being undertaken to try to reduce noise levels
- Mixed sex accommodation – work was underway on the mixed sex policy via real time monitoring with volunteers. It was noted that this issue scored low nationally.

Safety:

- Pressure ulcers and falls – there had been an increase in harm-related falls and an increase in the number of pressure ulcers in the community. A quality summit would be held in those areas to look at further support to effect reductions.

Effectiveness:

- There had been one avoidable C.Diff case in Surgery related to the use of antibiotics, however the Trust was not likely to exceed its trajectory.
- E.Coli – 5 cases with urinary catheters being the significant source.
- #NOF – improvements had been made although there was still some vulnerability due to an excess of patients arriving in a short time frame. There were also challenges around theatre capacity.

Well Led:

- Sickness absence – the increase was noted. The key points of concern were the ratio of short to long term sickness. Long-term sickness now accounted for 69% of overall sickness. It was also noted that the Trust's benchmarking position had slipped. The main sickness absence reasons were mental health issues (anxiety, stress, depression, etc), musculoskeletal and gastroenterological conditions. There was significant under-reporting in some areas, particularly community and junior doctors. Whilst e-rostering may be considered a factor not all hospitals using the model had seen a similar level of increase. Although the Trust was offering a combination of long and shorter shifts, long-term sickness was increasing. It was noted that a change in our attendance and wellbeing approach would be presented to the Board of Directors.
- Appraisal – it was noted that the planning of appraisals was not effective, therefore an appraisal tool for line managers was due to be launched to assist with tracking on a monthly basis. The Trust could then focus on compliance.
- Mandatory training – launched in June 2015 and would be monitored on a monthly basis.
- Staff FFT – it was suggested that low job satisfaction may be linked to staff sickness issues and whether staff were feeling valued and recognised for their contribution by their manager. Leadership style was also considered a significant factor in the

	reductions. • Hard Truths – it was noted that the fill rate had improved in the last month mainly due to Sisters (who worked in a supervisory capacity) being taken out of the numbers. Some additional ward capacity had been closed and nursing staff had reverted back to their base ward. The Thornbury high cost agency costs had been suspended unless pre-agreed and other high cost agencies, other than for additional capacity in NICU and A&E, would be suspended. It was anticipated that a better fill rate should be observed going forward. • Community – compliance with pressure ulcers was being considered, particularly for patients in their own homes. The Committee **RECEIVED** and **NOTED** the report.
08/07/15	**SAFETY** <u>8.1 Serious Incident Register</u> Juliette Cosgrove presented the Serious Incident Register for the week ending 24 July 2015. 19 had been identified - mainly related to pressure ulcers – which was higher than normal in the month. Better reporting was being encouraged so this may account for the increase. All cases were under investigation, with 17 cases being closed. The supporting documentation around SI reporting was currently being revised. ACTION: The Committee **RECEIVED** and **NOTED** the content of the register. <u>8.2 Patient Safety Group Update</u> Jackie Murphy presented an update from the last meeting of the Patient Safety Group. The highlights from the meeting that were escalated to the Quality Committee were noted: • Incident policy • VTE – need to ensure we achieve 95% compliance by auditing notes • Pressure ulcers • Falls It was noted that sub-committees were being more action-oriented and this should be reflected in the minutes. The Committee **RECEIVED** and **NOTED** the update and the items that had been escalated to the Committee by the Patient Safety Group.
09/07/15	**COMPLIANCE** <u>9.1 Corporate Risk Register</u> The Corporate Risk Register was received. The key points were: • New staffing – there was further work to do to identify specific risks • NHS E-referrals – there had been a system outage which had been discussed as a service transformation risk. Training was in place to support staff in describing risk. Paediatrics and A&E were scheduled for the next meeting. The Committee **RECEIVED** and **NOTED** the content of the register.

10/07/15	**EFFECTIVENESS** 10.1 Clinical Effectiveness and Outcomes Group The Executive Medical Director presented the report from the Clinical Outcomes Group. SHMI was currently 109 and therefore the target of 100 by August had not been met. HSMR had recently increased and work was ongoing to understand this position. It was noted that the Trust was an outlier for HSMR but not for SHMI. The CAIP plan was being revised to improve its focus. The asthma care bundle had been introduced in ED and sepsis had fallen significantly. However bundle compliance was not where it needed to be, therefore metrics would be discussed at divisional quality boards. The top 10 outliers had been identified and case note reviews were being undertaken. However the mortality review process was being revised to improve assurance, led by Martin DeBono. Additional reviewers were being identified and notes were being pushed to reviewers. Nationally the mortality review process is known to be challenging and time consuming. There was a need to allocate more time for consultants to undertake reviews. Northumbria had seen an improvement in its HSMR in relation to ambulatory care. CHFT was undertaking more ambulatory care therefore this should impact positively on our HSMR. Work to improve coding performance was underway to make it an integral part of the clerking documentation. The Medical Director at LTHT was assisting us in our review of the process. Julie Dawes felt that there should be a 100% level of mortality reviews. Alex Hamilton and Carole Hallam would look at this. The Committee **RECEIVED** and **NOTED** the content of the report and in particular the items that were asked to be brought to the attention of the Committee.
11/07/15	**WELL LED ORGANISATION** 11.1 Themes and Lessons Learnt from the Jimmy Savile Inquiry It was noted that the recommendations had been reviewed. The impact and costs of introducing DBS checks for staff and volunteers on a 3-yearly basis would be considered by the Executive Board. This practice was not mandated but in terms of the CQC it would be expected. In terms of contractor staff there was a national system for trade representatives which trusts could check against. This would be picked up by the health and safety committee. It was agreed that more recommendations may emerge in the future which would be processed through the Well Led Organisation Group. Should this be the case there may need to be a review of its membership. 11.2 Well Led Organisation Group It was noted that the focus remained on preparation for the impending CQC inspection. The Committee **RECEIVED** and **NOTED** the content of the report.
12/07/15	**CARING** 12.1 Patient Experience and Caring Group The Patient Experience and Caring Group meets on a monthly basis and is well attended. Student volunteers had introduced “MYLIFE”, a programme which creates personalised stories about individuals suffering from dementia, which was working well. It was noted that there was no dementia matron. The Butterfly scheme required more promotion at ward level and it was anticipated that the new boards would raise its profile. The end of life care programme was now in place (replacing the Liverpool Care Pathway). It was noted that the number of complaints was increasing.

	The Committee **RECEIVED** and **NOTED** the content of the report.
13/07/15	**HEALTH AND SAFETY ISSUES RELATING TO QUALITY AND CARE** 13.1 Operational Health and Safety Group The Committee received the minutes from the Health and Safety Operational Group for information. The Director for PPE&F gave a verbal update: • Significant work was being undertaken on COSHH • There were some issues in terms of unwanted fire attendance at CRH ie false alarms, costing £350 per call out. The Trust was working with Cofely and ISS to address. • There were still some fire safety issues at HRI, particularly in the vacated outpatient space, creating a fire risk. • The medical devices audit was awaited, although it was known that routine checks of equipment had not been completed, which was a significant risk. Problems were being identified and actions were being put in place to address. • There were problems with representation from Medicine and Surgery on the Group. It was agreed that Lesley Hill should write formally to the divisional management teams and Julie Dawes would pick up informally on an opportunistic basis. The Committee **RECEIVED** and **NOTED** the verbal update.
14/07/15	**MATTERS TO BE ESCALATED TO THE BOARD OF DIRECTORS** The Committee agreed the following items would be highlighted to the Board of Directors meeting on 30 July 2015: • ED quarterly report • R&D report • CAIP, HSMR and SHMI • Cleaning Redesign Programme • CQC action plan
15/07/15	**ITEMS TO NOTE** 15.1 Quality Committee Work Plan The Committee received the Quality Committee Work Plan for 2015/16 for information. The Committee **RECEIVED** and **NOTED** the updated work plan.
16/07/15	**ANY OTHER BUSINESS** There was no other business.
17/07/15	**DATE AND TIME OF NEXT MEETING** Tuesday 25 August 2015 2pm – 5pm Board Room, HRI

	DATE MINUTES APPROVED:

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Minutes of the Finance & Performance Committee held on Tuesday 21 July 2015 in Meeting Room, 3rd Floor, Acre Mill, Huddersfield Royal Infirmary commencing at 8.30am

PRESENT

Peter Roberts	Non-Executive Director (Chair)
Anna Basford	Director of Commissioning and Partnerships
David Birkenhead	Executive Medical Director
Keith Griffiths	Executive Director of Finance
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities
Jeremy Pease	Non Executive Director
Owen Williams	Chief Executive
Jan Wilson	Non Executive Director

IN ATTENDANCE

Helen Barker	Associate Director of Community Services & Operations (for Julie Dawes)
Stuart Baron	Assistant Director of Finance – Financial Planning and Efficiencies
Mandy Griffin	Acting Director of the Health Informatics Service
Betty Sewell	PA (minutes)
Helen Wells	Assistant Director of Finance - FSS

ITEM

171/07/15 WELCOME AND INTRODUCTIONS

Peter Roberts Chaired the Committee in the absence of Phil Oldfield and welcomed attendees.

172/07/15 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Julie Dawes, Executive Director of Nursing
Phil Oldfield, Non-Executive Director
Andrew Haigh, Chiar
Julie Hull, Executive Director of Workforce & OD
Jackie Green, Interim Director of Workforce & OD
Peter Middleton, Membership Councillor
Victoria Pickles, Company Secretary

173/07/15 DECLARATIONS OF INTEREST

There were no declarations of interest.

174/07/15 MINUTES OF THE MEETINGS HELD 24 JUNE 2015

The minutes were approved as a correct record.

175/07/15 MATTERS ARISING AND ACTION LOG

91/04/15 – Strategic Review: The Chief Executive reported that an outline plan was going to come back to this forum in July but that this is would not be available. The Director of Commissioning and Partnerships informed the Committee that a meeting with Monitor was due to take place tomorrow to scope the expanded content and that an expected timeline would be clearer following this meeting.

ACTION : Verbal update at the next F&P Committee meeting – AB

103/05/15 – EDMS Lessons learnt/best practice: The Acting Director of Health Informatics confirmed that the paper had been shared with the Sponsoring Group, it was agreed that the paper should also be circulated to the members of the Finance & Performance Committee.

165/06/16 – PMU 5 Year Business Plan: It was confirmed that Wednesday 5 August would be the date for this session.

FINANCE AND PERFORMANCE

176/07/15 MONTH 3 PERFORMANCE SUMMARY REPORT

The Director of Commissioning & Partnerships presented the main highlights.

Referrals - In the month of June, there has been an 8% increase in GP referrals compared to last year this is mainly due to ENT, trauma and orthopaedics and dermatology, which gives us an increase of 0.9% YTD. It was noted that the usual pattern for the drop in activity covered two key holiday periods, namely August and December and it was suggested we should have a system in place where we could balance activity throughout the year.

In depth discussions took place regarding the Trust's profiling of activity and capacity and how we manage the outpatients and inpatients lists.

Helen Wells, Assistant Director of Finance - FSS was asked to describe the picture from a Divisional point of view and she agreed that we could get smarter with regard to outpatients and that within the FSS Division they are looking at the paediatrics department to profile the workforce to use the workforce more effectively but more can be done with regard to outpatients. It was confirmed the Divisions do hold weekly meetings to get a forward position for the next month

The Acting Director of the Health Informatics Service highlighted that the HSCSE went live between May and June and there were problems where GP referrals sat in the system between 3 and 4 weeks with a great proportion being Calderdale patients which could have had an impact on the numbers and this should be looked at.

Out of the discussions the following actions were agreed:

ACTIONS:

1. To understand the profile of capacity and demand

2. To have discussions with Commissions re the seasonal fluctuation in demand to enable us to balance and flex in the year

3. To be clear how many outpatients convert into inpatients to make sure we have a reasonable flow of patients.

4. To verify the increase in referral demand to ensure that this is not just a backlog of information.

AUGUST – LH/AB

Waiting Lists – The total number of patients on waiting lists including outpatients, diagnostics and surgery is 19,002 with the total number of patients waiting for surgery 4,363. The total number of patients waiting over 18 weeks was 866 with the main specialties with the highest level of 18+ weeks waiters being general surgery and trauma and orthopaedics.

Activity Performance – One of the headlines for June is that we continue to see an over-recovery of clinical income but there is a slow-down. The in-month increase is associated with Greater Huddersfield CCG. Clinical income YTD is ahead of plan by £1.6m but we need to be mindful that this is slowing down. In terms of actual activity in Month 3 for elective and daycase we have under-performed in month by 3.7% which is deterioration from Month 2 and at YTD we remain under plan at 2.1%. With regard to outpatient activity we are seeing an increase in month and YTD but although we have seen movement in Month 3 this is not being sustained and we are seeing a reduction in July. Non-elective activity continues to exceed plan but there is a slowing down, however, we remain ahead of plan compared to the same point last year. A&E remains under plan and is a lower level of activity compared to the previous year.

Overall we are positively ahead of plan in aggregate on clinical income but we have trends around daycase and elective activity that require action and a STAR Chamber session will be taking place this week to enable understanding. Also, it was noted that even though non-elective work is a positive trend there are cost pressures in delivering these services with very little I&E benefit evident.

ACTION : Specific action points from the STAR Chambers to be presented at next meeting - LH

177/07/15 MONTH 3 CONTRACT ACTIVITY AND INCOME PERFORMANCE

The Executive Director of Finance reported that at the end of Qtr 1 we have used reserves for the first time at £100k, and we are still expecting to deliver our deficit of £20m at the year end. However, with the pressures being called out from Medicine, Surgery and PMU, if those pressures materialise, we would need to fully utilise our reserves. As already noted STAR Chambers have/are taking place for Medicine and Surgery and discussions are taking place with PMU later today to review their recovery plans, the message back to divisions is that they must fix the pressures themselves and that reserves will not be used.

In terms of income and expenditure, which has already been referenced, income was falling in month and costs were slightly higher, we have had more people employed in June when activity has been falling and the challenge in the short term is to get agility between activity and non-contracted pay.

The CIP performance is ahead of plan by £600k at Qtr 1, which assumes delivery of approx. £16m CIP at year end, but there is a link to be made, there is a PMO programme for additional elective activity, therefore, included in the forecast of £16m CIP we are assuming an improvement in elective activity, by using reserves we have the shortfall covered but we must see an improvement. It was noted that within the workforce

strategy there is a need to control locum/agency spend and to understand our reliance on agency as opposed to substantive posts, we need to get a view as to whether we are running away with agency spend or whether this should have been predicted and a specific piece of work is being carried out by the PMO team.

It was also noted that the pipeline is not growing, adding the schemes at Gateway 2 to those in the pipeline schemes amounts to £17.9m, within the pipeline there is a £0.5m risk around medical staffing. The PMO and Finance teams have worked jointly on a piece of work to assess the Gateway 2 schemes. It was acknowledged that there will be a major focus on 16/17 schemes and workshops are diarised for the first week in August.

In terms of cash, the Director of Finance announced that there are a couple of actions we are looking at implementing which could have an effect on income and expenditure and cash. Clinical coding performance is below planned levels, the depth of coding across the specialties is variable but averages out at around 50%, if they are fully deployed the I&E position would improve and the cash position would also improve. We are also looking closely at non-contacted activity, where we get paid by invoice rather than the normal payment terms, ensuring we are capturing the activity and invoicing in real-time to help improve our cash flow. iProc compliance is being pushed by procurement teams and divisions are being encouraged to ensure compliance is being monitored. It was also noted that discussions have taken place with the Chief Finance Officer, at Calderdale CCG to make arrangements to be paid 12 months income over 11 or even 10 months, this would reduce the pace at which we would need to draw down cash from the DoH and would reduce our interest charges, appropriate recording of this advanced cash will be very closely monitored.

It was also noted that as we are in a PbR environment, we have received the first set of contract challenges from our Commissioners, which came in at £450k for month 1. The issues that are being called out have previously been challenged and we are working with the divisions to get a stronger clinical argument. It was acknowledged that some of the challenges do relate to the level of coding.

The Chief Executive picked up on the workforce point and reference the Workforce Returns for June which showed FTE has dropped below 5,000 and July data will be important. He also referenced the PwC benchmarking exercise where it had been found that the Trust was running on fewer staff than our peers and as a Trust we could be at optimum efficiency/workforce. In depth discussions followed with regard to workforce, recruitment, agency and sickness absence and the need for a Workforce Strategy.

ACTION: To get clarity as to where the Well-Led Governance Review had got to with regard to the need to link culture, colleagues and capacity and the development of a Peoples Committee - OW

178/07/15 MONTH 3 FINANCIAL NARRATIVE AND MONTHLY DASHBOARD

It was agreed that this has been covered and there was nothing more to add to discussions which have already taken place.

179/07/15 MONTH 3 COMMENTARY ON MONITOR FINANCIAL RETURN

The paper provides confirmation that what we report to Monitor is consistent with what we report to the Board.

180/07/15 CONTRACTUAL MEDIATION RELATING TO THE 2015/16 CONTRACT

The Director of Commissioning and Partnerships reported that an independent mediator had been appointed and that the first mediation meeting will take place Friday 24 June. A further update will be picked up at the Board meeting on the 30 July 2015.

STRATEGIC ITEMS

181/07/15 CIP 15/16 £14m/£18m PROGRESS AND PLANNING

The Director of Finance re-enforced the focus on 16/17 plans. It was requested that future monthly reports should show a split for recurrent and non-recurrent schemes.

ACTION: Split for recurrent and non-recurrent to be reported going forward - KG

The paper was received and noted by the Committee.

182/07/15 EPR UPDATE

The Acting Director of Health Informatics Service took the forum through the presentation which was noted by the Committee with the following observations:

- A universal repository should be created to enable easy access to review the lessons learnt.
- 'Go-live' is scheduled for August 2015 and concerns were raised with regard to financial implications with regard to a potential shortfall in clinical sessions, urgent analysis is required.
- The plan would be to schedule training as close to 'go-live' as possible but to ensure refresher training/new starter training is in place.
- Visits to external organisations have been critical for implementation and organisational readiness with 'go-live'.
- A paper with regard to Wi-fi access will be going back to WEB to provide assurance.

The Chief Executive confirmed that Monitor have requested, as part of the PRM which was held 17 June, that we hold a joint assurance session with Bradford. It was agreed that monthly updates re finances and human resources should continue to be discussed at Finance & Performance Committee.

183/07/15 MONITOR FEEDBACK FROM THE JUNE PRM

The Chief Executive referenced the Monitor correspondence dated 13 July. It was noted that the extension of the timeline for the turnaround plan is being reviewed by Monitor but we still await confirmation. We have been asked to provide assurance regarding the transition of the PMO function and to ensure we have sufficient divisional capacity arrangements with regard to programme management.

It was also noted that we are in the process of preparing the presentation for the 29th June which Anna Basford has also been asked to attend to discuss PMO. It was assumed that

this would be an extended meeting as there are 43 trusts nationally experiencing some sort of deep-dive exercise by Monitor. Monitor spent 2 days with the Trust testing communication into Divisions with regard to our financial position they seem to be reasonably assured and do not think this is a major issue.

Jan Wilson asked for the latest position with regard to Vanguard, the Chief Executive confirmed that we are working fully with our partners in Calderdale to realise the opportunities with Vanguard, it is still in the development stage and Commissioners are happy with our input. Jan was referenced to Appendix B of the Monitor correspondence.

184/07/15 CASH FLOW

The Director of Finance is still awaiting the report from KPMG and this will be circulated to the Committee once finalised. The Committee noted

It was also noted that an initial briefing with ITFF had taken place and a paper will be going to Trust Board to for approval.

185/07/15 WORKPLAN

There were no items added to the Workplan.

186/07/15 MATTERS FOR THE BOARD AND OTHER COMMITTEES

- Activity and implications with capacity.
- CIP progress
- Mediation Update to be picked up at the next Board meeting – 30 June
- EPR Update
- Monitor
- Development of a Peoples Committee

187/07/15 ANY OTHER BUSINESS

There were no items raised.

DATE AND TIME OF NEXT MEETINGS

Tuesday 18 August, 9.00am – 12.00noon, 3rd Floor, Acre Mill Outpatients