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Meeting of the Board of Directors
To be held in public

Thursday 24 September 2015 from 1:30pm

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

AGENDA

1.	**Welcome and introductions:-**	Chairman	
2.	Apologies for Absence:- Victoria Pickles, Company Secretary Welcome:- Peter Middleton, Publicly Elected Membership Councillor Dianne Hughes, Publicly Elected Membership Councillor Dawn Stephenson, Nominated Stakeholder Membership Councillor	Chairman	
3.	Declaration of interests	All	**VERBAL**
4.	Minutes of the previous meeting held on 27 August 2015	Chairman	**APP A**
5.	**Action Log and Matters arising:**	Chairman	**APP B**
6.	Patient/Staff Story	Executive Director of Nursing & Operations	
7.	**Chairman's Report:-** a. Joint Board/Membership Council Healthfair and AGM – 17.9.15	Chairman	**VERBAL**
8.	**Chief Executive's Report**	Chief Executive	**VERBAL**
Keeping the base safe			
9.	Board Assurance Framework	Executive Director of Nursing & Operations	**APP C**
10.	Risk Register	Executive Director of Nursing & Operations	**APP D**
11.	Governance Report a. Annual Review of NED roles b. Quarter 1 Feedback from Monitor c. Workforce Committee - Terms of Reference d. Remuneration and Nominations Committee (Execs) – Terms of Reference	Board Secretary	**APP E**
12.	Director of Infection Prevention and Control Report	Executive Medical Director	**APP F**
13.	Security Management Annual Report	Executive Director of PPEF	**APP G**

14.	Nursing and Midwifery Staffing – Hard Truths Requirement	Executive Director of Nursing	**APP H**
15.	Quarterly Quality Report	Executive Director of Nursing	**APP I**
16.	Update on CQC Action Plan – Actions	Executive Director of Nursing	**APP J**
17.	**Integrated Board Report** - Responsive - Caring - Safety - Effectiveness - Well Led - CQUINs - Community - Monitor Indicators - Finance	Executive Director of PPEF/Associa Director of Community/Operations Executive Director of Nursing Executive Director of Nursing Executive Medical Director Interim Director of Workforce and OD Associate Director of Community/Operations Executive Director of Finance “	**APP K**
Financial Sustainability			
18.	Month 5 – August 2015 – Financial Narrative	Executive Director of Finance	**APP L**
Transforming and Improving patient care			
No items			
A Workforce for the future			
No items			
19.	**Update from sub-committees and receipt of minutes** ▪ Quality Committee (Minutes of 25.8.15 and verbal update from meeting held 22.9.15) ▪ Finance and Performance Committee (Minutes of 18.8.15 and verbal update from meeting held 15.9.15)		**APP M** **APP N**
Date and time of next meeting Thursday 29 October commencing at 1.30 pm Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital HX3 0PW.			

Resolution

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

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 24th September 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 27.8.15 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 27 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:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 27 August 2015.

Main Body

Purpose:

Please see attached.

Background/Overview:

N/A

The Issue:

N/A

Next Steps:

N/A

Recommendations:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 27 August 2015.

Appendix

Attachment:

DRAFT BOD MINS - PUBLIC BOD MINS - 27 8 15.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 27 August 2015 in the Boardroom, Sub Basement, Huddersfield Royal Infirmary

PRESENT

Jan Wilson	Non-Executive Director (Acting Chair)
Dr David Anderson	Non-Executive Director
Dr David Birkenhead	Executive Medical Director
Julie Dawes	Executive Director of Nursing and Operations/Deputy Chief Executive
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

IN ATTENDANCE/OBSERVERS

Kirsty Archer	Assistant Director of Finance
Helen Barker	Associate Director of Community Services and Operations
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
Amanda McKie	Matron – Complex Needs Care Co-ordinator (for part of meeting)
Victoria Pickles	Company Secretary

Item

116/15 APOLOGIES FOR ABSENCE AND INTRODUCTIONS

Apologies were received from:

Andrew Haigh	Chairman
Keith Griffiths	Executive Director of Finance
Julie Hull	Executive Director of Workforce and Organisational Development
Dr Linda Patterson	Non Executive Director
Owen Williams	Chief Executive

The Chairman welcomed everyone to the meeting.

117/15 DECLARATION OF INTERESTS

There were no declarations of interest to note.

118/15 MINUTES OF THE MEETING HELD ON THURSDAY 30 JULY 2015

The minutes of the meeting were approved as a true record subject to an amendment to Page 5, penultimate paragraph 'Failure to meet CIP' to read "would be discussed by the Finance and Performance Committee **and Audit and Risk Committee** and flagged appropriately".

119/15 MATTERS ARISING FROM THE MINUTES

109/15 – Risk Register – Winter Pressures – The Executive Director of Nursing reported that this had been discussed and had been included in the Risk Register.

120/15 ACTION LOG

There were no items outstanding on the Action Log.

121/15 PATIENT STORY – "Bethany's Story"

Amanda McKie, Matron – Complex Needs Care Co-ordinator attended the meeting and presented the story of Bethany as told by her Mother. The Board heard about Bethany's admissions and discharges over the last 17 years and the families' challenges and fight to keep her alive. Bethany's most recent episode of admission was to an adult ward due to no high dependency beds being available on the paediatric ward. This had been a distressing experience for both Bethany and her family. As part of the complaints process it had been agreed to share Bethany's experience with staff to provide a better understanding of what parents of children with complex needs have to cope with and the issues in relation to the quality of life of people with severe disability.

The Board thanked Debbie, through Amanda McKie for sharing their family story. The Executive Director of Nursing reminded the Board that there are a number of patients who have been in the care of the Trust for many years. Trust staff become part of their lives and become involved in their personal sacrifices and have a significant impact on both patients and carers lives.

122/15 CHAIRMAN'S REPORT

On behalf of the Board Jan Wilson, Vice-Chair wished to formally record the Board's condolences to Andrew Haigh on his recent bereavement.

a. Improving and Sustaining Cancer Performance Standard.

Jan Wilson reported that a letter had been received from the Chair of Leeds Teaching Hospitals Trust regarding the 62 day Cancer Performance Standard. The letter requested CHFT support in helping to achieve the target by ensuring referrals are made within the appropriate timescale. Helen Barker, Associate Director of Community Services and Operations reported that there was an action plan in place to support this work and that this would be reported to Leeds.

b. Translation and Interpreter Services

The Vice-Chair reported that she had attended an event for members of the Deaf Community in relation to the provision of translation and interpreting services. The event had highlighted a number of issues for the Trust to take into account when providing services to deaf patients.

123/15 CHIEF EXECUTIVE'S REPORT

Julie Dawes, Acting Chief Executive had no items to bring to the attention of the Board.

124/15 INTEGRATED BOARD REPORT

The Associate Director of Community Services and Operations introduced the Integrated Board report as at 31 July 2015 and explained that key areas would be presented in detail.

Summary

Further refinement to the Integrated Performance Report had taken place since the previous month. A performance management framework, with an associated accountability framework, was in development and would be presented to the Board in the near future.

The report showed a positive performance in July building on the improvement seen in June. It was noted that there continued to be significant

micro-management therefore further improvement work was needed to ensure sustainable delivery and optimal patient and staff experience across all pathways..

The key areas to note were:

Responsiveness

- The Trust delivered the 4 hour emergency care standard
- 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 had 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. The Executive Director of Nursing thanked staff for handling the backlog and dealing with recent increased number of complaints.
- Friends and Family Test responses remains challenging and different ways to increase response rates were being developed.

Safety

- Falls continue to be a concern and a deep dive with revised action plan has been commissioned. A Safety Group had been established to look at the root cause analysis work.
- Full compliance with the Duty of Candour requirements
- Continued improvement of the WHO checklist

Effectiveness

The Executive Medical Director reported:-

- 1 MRSA attributable to the Community Division in July.
- Excellent performance on CDiff continues.
- Emergency readmissions within 30 days remains a challenge, and a meeting had been planned with other local providers to look at improvements.
- HSMR has further increased and is a key source of concern with specific improvement actions ongoing.
- Fractured Neck of Femur, time to theatre deteriorated again in July however there had been improvement against the other elements of the best practice tariff.

Well Led

The Interim Director of Workforce and OD reported:-

- Sickness remains higher than target in all but two areas with the majority of Divisions/Directorates showing a deterioration in month around long term absence. The new Attendance Management Policy was being adopted and a deep dive taking place in Medicine to look at the potential for significant improvement.
- Appraisal and mandatory training metrics remain a concern and have been the focus of individual Divisional meetings led by HR. The revised appraisal report would give a planned trajectory.
- Only 3 areas are delivering good sickness rates with poor performance seen across the majority of clinical areas
- Hard Truths data has improved. .

Financial Activity

The Assistant Director of Finance agreed to report on the financial position later in the meeting when she delivered the Month 4 – July 2015 financial narrative.

Community

The information contained within the report was received and noted.

Data Quality Assessment

The information contained within the report was received and noted.

RESOLVED: The Board approved the report and thanked the Associate Director of Operations and Community for her work in improving the Integrated Board Report.

125/15 RISK REGISTER

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

- Progression of service reconfiguration impact on quality and safety
- Poor clinical decision making in A&E
- Failure to meet CIP
- Outlier on mortality levels
- Staffing risk, nursing and medical
- Ability to deliver service transformation risk

Risks with increased score:-

- There were no risks with an increased score

Risks with reduced score:-

- CQC inspection outcome/non regulatory compliance, decreased from 20
- to 16. (This risk was incorrectly increased to a 20 following the last Risk & Compliance Group meeting.
- NHS E-referral – IT system failure, decreased from 20 to 12.

New Risk added:-

- Medical Device failure levels – new risk with a score of 15. The Executive Director of Nursing reported that this was around training and appropriate maintenance of devices. Action plans were being put in place.

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

126/15 DIRECTOR OF INFECTION PREVENTATION AND CONTROL (DIPC)

a. Monthly Report

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

- **C.Diff** – 4 cases had been reported to date (2 avoidable and 2 unavoidable). The ceiling was 21 cases for the year to March 2016.
- **MRSA** – 2 cases had been reported to date and both assigned to the Trust
- **ANTT compliance –** On-going training being provided and an increase in number of assessors. Plan in place for training of newly trained junior doctors.

RESOLVED: The Board received the report.

b. Annual DIPC Report

The contents of the Annual Director of Infection, Prevention and Control was received and noted. The Executive Medical Director reported that the Board had received the information contained within the Annual Report through the monthly DIPC reports.

RESOLVED: The Board received the report.

The Executive Director of Nursing and Operations asked how the Trust compares with other Trusts and whether it horizon scanned for new infections which need to be planned for in the future. The Executive Medical Director advised that there was a

robust plan in A/E for the treatment of Middle East Respiratory Syndrome – (MERS) 'CoV Corrona Virus' but in the future Trusts may be challenged with the detection and treatment of patients with antibiotic resistance to Carbapenem.

127/15 GOVERNANCE REPORT

The Company Secretary presented the Governance Report which included:-

a. **Board Workplan Update** – received and approved
b. **Monitor's New Risk Assessment Framework (RAF)** – this had previously been circulated to Board members. The key changes to the RAF included:-
   - 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 Company Secretary explained that the changes would be incorporated into the Integrated Board Report for the next month.
c. **Board Meeting Dates 2016** – received and agreed, subject to a meeting being arranged at Todmorden Health Centre.

ACTION: Board Secretary

d. **Use of Trust Seal** – One entry received and noted.
e. **Declaration of Interest** – Two pieces of work being undertaken were noted. Update to Declaration of Interest Registers prior to October Audit and Risk Committee (ARC) Meeting and the exercise commissioned by the ARC for Counter Fraud Services to review the Trust's arrangements for capturing all staff interests.
f. **Feedback from Monitor – Q4 2015/16 and Annual Plan Review** – received and noted
g. **Workforce Committee** - The Board approved the creation of a Workforce Committee initially for a 12 month period. Full terms of reference would be brought to the next meeting.

ACTION: Agenda Item – September BOD Meeting

g. **Well Led Governance Review Action Plan** – was received and approved. This had now been subject to independent review. The delivery of the plan would be monitored through the Programme Management Office.

RESOLVED: The Board received the report and approved the Terms of Reference for the Workforce Committee being submitted to the next meeting.

ACTION: BOD Agenda Item – September 2015.

128/15 CARE OF THE ACUTELY ILL PATIENT REPORT

The Executive Medical Director presented the updated Care of the Acutely Ill Patient Report. The key highlights included:-

HSMR - The most recent rolling 12 months data for HSMR, Apr'14 – Mar'15, indicated a score of 110.47, which was an increase from the previous release and placed the Trust as an outlier. There had 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 were unclear and further analysis was being undertaken however an independent review of 100 cases had identified only one instance where there was a possible preventable death.

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. A written process/guidance has been developed. David Anderson and Peter Roberts

asked whether any 'go see' work had been undertaken on mortality rates and end of life research on patients dying out of the hospital setting. The Executive Medical Director reported that we were working with the AHSM. The Acutely Ill Programme had been developed with the support of Liz Rob and reflected similar work done in other organisations with a high HSMR. The Trust were inviting Brian Gill, Medical Director at Bradford to review the programme along with Professor Mohamed from Bradford University to review the data.

Deteriorating Patient Workstream - Implementation of 'Nervecentre' had commenced. This was an electronic observation and handover tool to improve accuracy of National Early Warning Score assessment and standardisation of escalation. This was 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.

DNACPR - A new theme, end of life care, had been added to the revised CAIP plan. This incorporated Do Not Attempt CPR arrangements 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 report explained that the 'Integrated Care of the Dying Document' (ICODD) is currently in place in the hospitals and hospices, and would be implemented in the community.

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

Frailty - A task and finish group had been set up to define how this group of patients are identified. There had been discussions with Sheffield Teaching Hospitals and their use of a "Frail-safe" bundle.

Coding – Further work was being undertaken. Phil Oldfield enquired whether there was any checking of coding against mortalities. It was noted that this was not routinely undertaken.

129/15 MONTH 4 – JULY 2015 FINANCIAL NARRATIVE

The Assistant Director of Finance presented the finance month 4 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 18 August 2015:-

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 day case activity is significantly behind planned levels in month. Non-elective Long stay activity has slowed.
- Pay expenditure had 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 £7.92m against a planned £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 restricting 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 on-going 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.

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

130/15 UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES

The following information was received and noted:-

- **Quality Committee** – The Board received the minutes of the 28.7.15 and a verbal update from Jeremy Pease on the meeting held on 25.8.15. Matters arising from the meeting included:-
  - Q1 Monitor Submission – received
  - Medical Workforce paper 'Recruitment, Retention and Vacancies'. Actions noted including
    - The development of a Workforce Group.
    - Baseline of consultants in post
    - Rota management
    - Job planning review
    - Hospital at Night
    - Shared work with West Yorkshire
    - International recruitment
  - Divisional Patient Safety and Quality Board reports had been received and reviewed in detail. A detailed report to the Committee on the progress made against the Best Practice Tariff for Fractured Neck of Femur had been shared with all Non Executive Directors.

- **Finance and Performance Committee** - The Board received the minutes of the 21.7.15 and a verbal update from Phil Oldfield on the meeting held 18.8.15. The main issue considered by the Committee had been the forecast financial position. In addition the Committee had discussed:

  - Workforce management opportunities
  - National pressures.
  - Pharmacy Manufacturing Unit – changed governance and quality issues
  - Strategic Review and the progress to develop the strategic turnaround plan
  - Report from the Interim Turnaround Director received and will be circulated to Monitor at the end of September
  - Commissioner Contracts – update received.

The Acting Chair thanked everyone for their attendance and contributions, particularly Jackie Green, Interim Director of Workforce who was due to complete her period of cover at the end of the month and would be providing support through project work in the future.

131/15 DATE AND TIME OF NEXT MEETING

Thursday 17 September 2015 Healthfair and AGM commencing at 5.00 pn and 6.00 pm respectively. Venue: 3rd Floor, Acre Mill Outpatients Building, Acre Street, Lindley.

Thursday 24 September 2015 at 1.30 pm in the Boardroom, Sub-basement, Huddersfield Royal Infirmary.

The Chair closed the meeting at 3.15 pm.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 24th September 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: ACTION LOG - PUBLIC BOARD OF DIRECTORS - SEPTEMBER 2015 - The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 September 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 Action Log for the Public Board of Directors Meeting as at 1 September 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 Action Log for the Public Board of Directors Meeting as at 1 September 2015

Appendix

Attachment:

DRAFT ACTION LOG - BOD - PUBLIC - As at 1 SEPTEMBER 2015.pdf

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 September 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 27.8.15 – Bethany's Story – Complex Needs Care	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	August 2015		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 September 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
			24.4.14 – Update received. 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 27.8.15 – 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, 24th September 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: BOARD ASSURANCE FRAMEWORK - The Board is asked to receive and comment on the Board Assurance Framework	
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 Assurance Framework (BAF) is a strategic document that the Board uses to obtain assurance on the achievement of the organisation's principal objectives.The Board is asked to receive and approved the Board Assurance Framework

Main Body

Purpose:

The Board Assurance Framework (BAF) is a strategic document that the Board uses to obtain assurance on the achievement of the organisation's principal objectives and was last presented to the Board in March 2015.
The revised BAF builds on the risks identified at that time, which have been re-structured against the revised 1 and 5 Year strategic plan, and new risks have been identified.

Background/Overview:

Following feedback from the March meeting, the BAF format has been simplified. It follows good practice in that it:
- sets out the risks to the delivery of the Trust's strategic objectives
- articulates the three lines of assurance
- makes the links to risks on the risk register
- includes clear actions, timescale and lead for those actions.

The Issue:

The Board is asked to review the BAF and consider:
- whether the risks are appropriately described and scored
- whether any risks are missing
- what further assurance may needed.

Next Steps:

Given the number of actions that are due during September and October, it is proposed that an updated Board Assurance Framework comes back to the Board in November. Further work will also be done to strengthen the detail around what has been reported to the Board and what the Board should expect to see on its work plan / agendas over the coming months to provide assurance against the risks.

Recommendations:

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

Appendix

Attachment:

15.16 Board Assurance Framework v2.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK
2015/16

Contents:

compassionate care

REF	RISK DESCRIPTION	Current score	Lead	Link to RR
Transforming and improving patient care				
001	Trust falls below national standards for mortality levels due to not delivering appropriate standards of care for acutely ill patients and incorrect clinical coding	20	DB	4783
002	Failure to deliver large-scale transformational service change due to insufficient capacity and capability across the organisation to manage the many schemes (EPR, CIP, CQC preparation and service reconfiguration)	20	OW	6346
003	Faliure to progress service reconfiguration caused by an inability to agree a way forward across health and social care partners	20	AB	6131 2827 4783
004	Inability to deliver appropriate services across seven days resulting in poor patient experience, greater length of stay and reduced quality of care.	12	DB	NEW
005	Failure to successfully implement the trust's electronic patient record that supports the delivery of high quality, efficient and cost effective patient care	15	MG	6230
006	Failure to secure patient and public involvement into transformational change due to lack of clear process and capacity within the trust	12	LH	NEW
Keeping the base safe				
007	Failure to maintain the quality of patient care and comply with internally and externally set standards on quality and safety	15	JD	6300 6299
008	Failure to implement robust governance systems and processes across the Trust	12	OW	NEW
009	The Trust does not deliver the necessary improvements required to achieve full compliance with Monitor	20	OW	4706
010	Failure to achieve local and national performance targets	12	HB	2828
011	Failure to maintain current estate and equipment and to develop future estates model to provide high quality patient care	16	LH	6300 5806
A workforce fit for the future				
012	Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical and nursing staff caused by an inability to attract, recruit, retain, reward and develop collegues.	20	JD / DB	6345
013	Failure to attract and develop appropriate clinical leadership across the Trust.	16	JH	
014	Failure to appropriately engage all colleagues and embed the culture of the organisation across all sites.	16	JH	
Financial sustainability				
015	Failure to deliver the financial forecast position for 2015/16 due to non-delivery of CIP, reduced activity and increased expenditure on additional capacity	20	KG	4706
016	Failure to develop a robust financial plan for 2016/17 including identification of CIP	20	KG	4706
017	Failure to progress and agree a five year strategic turnaround plan across the local health economy	15	AB	NEW
018	The Trust is unable to grow due to inability to increase clinical income opportunities	16	AB	

LIKELIHOOD (frequency)	CONSEQUENCE (impact / severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Rare (1)					
Unlikely (2)					
Possible (3)				6. PPI 8. Governance 10. National and local targets	5. EPR 7. Compliance with quality standards 17. Five year turnaround plan
Likely (4)			4. Seven day services	11. Estate fit for purpose 13. Clinical leadership 14. Staff engagement 18. Income loss	15. Financial delivery 15/16 16. Financial plan 16/17 12. Staffing levels 9. Breach of monitor licence
Highly likely (5)				1. Mortality 2. Large scale transformation	3. Service reconfiguration

Assessment is Likelihood x Consequence

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
1.1516	Quality Committee	Executive Medical Director	**Risk** 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. **Impact** - Inaccurate reporting of preventable deaths - Increased regulatory scrutiny as become CQC outlier - Inability to learn lessons - Increased risk of litigation and negative publicity. - Possible increase in complaints and litigation	• Safety thermometer in use on wards • Safety huddles being implemented • Clinical Outcomes Group review of progress • Mortality review process redesigned and rolled out • Tighter process in place in relation to SI reporting and investigation • 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 • Nervecentre roll out across the trust	First line Mortality dashboard in divisions Second line Care of the Acutely Ill patient report to Board PSQB reports to Quality Committee Third line Independent review of cases	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. Gaps in capacity / capability to undertake reviews	• HSMR position has worsened • Regulation 28 reports from Coroner received	**Initial** 5x4 = 20	**Current** 5x4 = 20	**Target** 4x4 = 16

Action	**Timescales**	**Lead**
To complete the work in progress	December	DB
CQUINS to be monitored by the Trust	Ongoing	JC
Review Care of the Acutely Ill Patient plan	October	AH
External review of data and plan to take place	October	DB
Fully implement new mortality review process	October	AH

Links to risk register:
Risk 4783 - Outlier on Mortality
Risk 2827 - Clinical decision making in A&E

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
2.1516	Board of Directors	Chief Executive	Risk Failure to deliver large-scale transformational service change due to insufficient capacity and capability across the organisation to manage the many schemes (EPR, CIP, CQC preparation and service reconfiguration) Impact - Delivery of safe clinical care - Financial sustainability - Low staff morale. - Viability and competitiveness of Trust is compromised	• Programme Management Office established to manage schemes •Turnaround governance arrangements in place including weekly Turnaround Executive • Joint EPR governance arrangements in place with BTHT • Moderisation WEB and report to F&P Committee on progress with delivery of EPR • Weekly CQC steering group • Risk reporting and review arrangements • Executive team undertaking review of capacity and responsibilities	<u>First line</u> WEB report on EPR CIP plan on track for 15/16 EPR implementation programme Strategic turnaround plan development progress <u>Second line</u> Integrated Board Report EPR report to Finance and Performance Committee Turnaround Executive scrutiny weekly Monthly report on turnaround to Finance and Performance Committee Quality Committee review of quality impacts of CIP <u>Third line</u> PRM meetings with Monitor demonstrate progress Turnaround director report highlighted areas of improvment Well Led Governance Review showed some areas of good practice	• Lack of clarity in servie redesign and improvement responsibilities • Need clearly articulated clinical development plan • Job plans to be reviewed to include time for clinical leadership responsibiltiies • Accountability framework to be developed	• Well Led Governance review identified a need to review capacity and capability • Gateway assurance review for EPR programme to be undertaken • Assurance that schemes can be delivered in totality	**Initial** 4x4 = 16	**Current** 4x5 = 20	**Target** 3x3 = 9

Action	**Timescales**	**Lead**
Well Led Governance review action plan to be implemented	September - March	AB
Executives to complete work to consider capacity and capability	September	OW
Nominations and Remuneration Committee to consider executive and non-executive capacity	September	JE

Links to risk register:
Risk 6346 - Capacity and capability to deliver service transformation

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE									
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**	
3.1516	Board of Directors	Director of Transformation and Partnerships	Risk Faliure to progress service reconfiguration caused by inability to agree way forward across health and social care partners Impact - 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 - Inabilty to recruit and retain workforce in particular medical workforce (increased reliance on Middle Grades and Locums) - Potential loss of service to other areas	• Participation in Hospital Services Board by key senior staff and ongoing discussion with CCGs around progress to a decision on consultation • CCGs and NHS England representatives included in roundtable discussion with Monitor • Clinicians from the Trust particpated in workshops to agree future clinical model • Monitor support for development of 5 Year Strategic plan • ED business continuity plan developed • Additional consultant posts agreed for ED • Interim actions to mitigate known clinical risks including areas identified for service redesign where this will not impact on co-adjacencies e.g. cardio & respiratory / EPAU & Gynae • Nurse led service managing Paediatrics • Critical care still being managed on both sites • Frequent hospital to hospital transfers to ensure access to correct specialties • Assistant Director of Finance from the Trust seconded to work jointly across the Trust and CCGs	First line Vanguard work in Calderdale showing an impact Second line 5 Year plan progress report to Finance & Performance Committee and Board Urgent Care Board and System Resilience Group in place Third line Recent Trauma review shows positive position for CHFT PRM meeting with Monitor tracks progress	• Financial plans not yet finalised with CCG • Difficulty in recruiting Consultants, Middle Grade and longer term locums • Estate limitations inhibit the present way of working • Consultant rotas cannot always be filled to sustain services on both sites	• High use of locums • High sickness rates among • 5 Year Strategic Plan support still to be appointed • CCGs to agree plan for consultation	**Initial** 5x5 = 25 **Current** 5x5 = 25 **Target** 3x5 = 15	

Action	**Timescales**	**Lead**
More detailed ED business continuity plan to be developed and presented to Board	September	HB
Business case for support for 5 Year strategic plan to be approved	September	AB
Tender process for support for 5 Year strategic plan to be secured	September	AB

Links to risk register:
Risk 6131 - large scale service change
BAF risk 2.1516

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref	**OWNER** Board committee		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
4.1516	Quality Committee	Executive Medical Director	Risk Inability to deliver appropriate services over seven days resulting in poor patient experience, greater length of stay and reduced quality of care. Impact - Reduced quality of care - Increased length of stay - Increased HSMR / SHMI - Delayed discharges	• Working group set up and workshop held with senior colleagues to develop plan • Perfect week learning shared • Governance systems and performance indicators in place	First line Improvement in performance against some key indicators including delayed discharges & green cross although still behind trajectory Second line Integrated Board report Third line Independent review of mortality cases	• Gap analysis and action plan to be followed up • National consultant contract negotiations outcomes awaited • Work to be done on job planning • Capacity to deliver 7 day service action plan	• Not yet meeting a number of indicators in the IBR including pre-11am daily discharges; outliers; bed movements; • Internal Audt report on OBC identified some actions to be undertaken not yet completed	4x3 = 12	4x3 = 12	2x3 = 6

Action	**Timescales**	**Lead**
Work with the FourEyes team 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.	October	HB
7 day service action plan to be finalised	October / November	SU

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

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref	**OWNER** Board committee		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
5.1516	Finance and Performance Committee	Interim Director of The Health Informatics Service	Risk Failure to successfully implement the trust's electronic patient record that supports the delivery of high quality, efficient and cost effective patient care Impact - Inability to realise the benefits - Non delivery of improvements in clinical outcomes - inability to realise return on investment or financial value for money	• 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. • A detailed project plan and timelines has been agreed with Cerner (EPR Provider) and Bradford for the roll-out of the EPR. • Current state gap analysis completed • Communications and engagement capacity secured	<u>First line</u> Improvement in performance against some key indicators including delayed discharges & green cross although still behind trajectory <u>Second line</u> Joint Transformation Board with BTHT meets on a monthly basis chaired at Chief Executive level. Assurance Board that includes Non-Executive directors. Report to Finance and Performance Committee <u>Third line</u> Gateway assurance process agreed Monthly update to Monitor as part of PRM reporting arrangements	• Future state gap analysis to be completed • Engagement work yet to commence • Delays in appointments to key project position resulting in delay in the start of the programme	• EPR assurance process to be undertaken	3x5 = 15	3x5 = 15	1x5 = 5

Action	**Timescales**	**Lead**
Final appointments to be made	September	MG
Future state review to be signed off	September	MG
Engagement plan to be implemented	Ongoing starting in September	MG
System testing to be completed	February	MG
Integration testing to be completed	April	MG

Links to risk register:
Risk 6230 - Non delivery of EPR
BAF risk 2.1516

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE										
Ref	**OWNER** Board committee		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
								Initial	**Current**	**Target**
6.1516	Quality Committee	Executive Director of Planning, Performance, Estates and Facilities	Risk Failure to secure patient and public involvement into transformational change due to lack of clear process and capacity within the trust Impact - inability to make require service change impacting on the delivery of safe clinical care - reputational damage with stakeholders	• Patient and public involvement plan implemented for development of SOC / OBC and used as template for other engagement activity • Full engagement and consultation commissioned from CSU for movement of child development services from Princess Royal Health centre • EPAU and Gynae engagement plan in place with CCG scrutiny and OSC oversight • Particpation in communication and engagement strategic oversight group with CCGs.	First line Some PPI activity included in divisional patient experience reports to Patient Experience Group each quarter Second line Contribution to CCG Annual Statement of Involvement Third line OSC oversight and approval of Child Development Unit and EPAU / Emergency Gynae engagement plan	• No identified capacity to deliver co-ordinated approach to PPI • Membership Strategy requires review and appropriate action plan putting in place • PPI Strategy out of date and requires review with clear supporting implementation plan • Require clarity on process for engagement and consultation sign off for service redesign with CCGs	• Patient and Public involvement activity, learning and gaps not routinely reported within the Trust	3x4= 12	3x4 = 12	2x3 = 6

Action	**Timescales**	**Lead**
Paper to go to Directors on capacity and capability gaps for PPI delivery	September	VP
Membership Strategy to be reviewed and action plan in place	October	RM
PPI Strategy to be written with supporting implemetnation plan	December	LH
Process to be agreed with CCG for engagement and consultation sign off for service redesign	October	VP / CR

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

TRUST GOAL: 2 KEEPING THE BASE SAFE

Ref	OWNER Board committee	Exec Lead	RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING Initial	Current	Target
7.1516	Quality Committee	Executive Director of Nursing / Executive Medical Director	**Risk** Failure to maintain the quality of patient care and comply with internally and externally set standards on quality and safety **Impact** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale -	• Quality governance arrangements revised and strengthened • Revised SI investigation and escalation process in place • Improved risk management arrangements • Weekly CQC Steering Group in place overseeing self assessment of compliance with CQC domains and delivery of 90 day plans • Use of e-rostering in place. • Framework for identifying wards potentially unsafe (under-resourced or under performing) and placing in special measures • Leadership walkrounds implemented	First line Staffing levels reported to WEB CQC Steering Group reports Clinical audit plan reviewed Assessment of compliance with NICE guidance Second line Quarterly Quality Report to Quality Committee and Board 6 monthly Hard Truths report to Board KPIs in Integrated Board Report. PSQB reports to Quality Committee CQC Action plan progress reported to Quality Committee DIPC report to Board Care of the Acutely Ill Patient plan report to Board Third line Quality Account reviewed by External Auditors and stakeholder bodies Trauma Review results PWC mock CQC inspection feedback Well Led Governance review Independent assurance on clinical audit strategy	• Mandatory training compliance • Out of date policies and guidelines • Scale of change and pace impacting on staff morale and engagement • Operational priorities impacting on capacity • Not fully compliant with NICE guidance where appropriate • Clinical audit plan to be reviewed to map to challenged services and Internal Audit recommendations	• Further work required on ED Business Continuity plan; • Internal Audit report on discharge planning has outstanding actions • Internal Audit report on learning lessons has outstanding actions • Internal Audit report on Medical Devices has outstanding actions HSMR position continues to worsen • National Clinical Advisory Team recommendations not fully addressed • Self assessed as requires improvement across a number of areas • Staff FFT response to recommendation as a place to work and place to be cared for declining	3x5 = 15	3x5 = 15	2x5 = 10

Action	Timescales	Lead
Review of Care of the Acutely Ill Patient plan	October	DB
Complete outstanding actions from internal audit reports	December	HB /JD / LH
Delivery of 90 day plans	November	

Links to risk register:
Risk 6300 - Estates
Risk 6299 - Medical devices

TRUST GOAL: 2. KEEPING THE BASE SAFE									
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**	
8.1516	Board of Directors	Chief Executive	Risk Failure to implement robust governance systems and processes across the Trust Impact - Potential to affect the quality of patient care. - Reputational damage - Risk of regulatory action - Learning opportunities missed	• Quality governance review undertakend and implemented • Review of Board level sub-committees • Imrpoved board level risk managemenr reporting arrangements • PMO in place and improved governance in relation to CIP planning	<u>First line</u> Divisional governance arrangements in place with Executive attendance Improved PSQB reporting Self assessment undertaken against Board Governance Assurance Framework template Mock CQC inspection for Community <u>Second line</u> Self assessment for Well Led Governance review approved by the Board <u>Third line</u> PRM meeting with Monitor showing progress Foresight assessment of Board governance PWC Mock CQC Inspection Well Led Governance Review identified no red flags	• BAF process not full embedded • Risk management arrangements to be strengthened at divsional level and below • Accountability framework to be developed	• Well Led Governance review actions to be implemented across a number of areas • Assessment of divisional governance to align to Well Led Governance review • CQC Self assessment identified a number of areas as requires improvement	**Initial** 3x4 = 12	**Current** 3x4 = 12	**Target** 2x4= 9

Action	**Timescales**	**Lead**
Well Led Governance review action plan to be implemented	September - March	AB
Accountability framework to be developed and agreed	October	HB
Divisional governance assessment to be undertaken	October - December	VP

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

TRUST GOAL: 2. KEEPING THE BASE SAFE									
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**	
14.1516	Board of Directors	Chief Executive	Risk The Trust does not deliver the necessary improvements required to achieve full compliance with Monitor Impact - Risk of further regulatory action - Reputation damage - Financial sustainability	• PRM meeting with Monitor • Corporate compliance register in place • Review of monthly Monitor bulletins to assess any required actions • PMO in place with Turnaround Executive governance around CIP • Clear process for development of 5 Year strategic plan with oversight from Monitor • Well Led Governance review completed	<u>First line</u> Clear PMO reporting from Divisions <u>Second line</u> Integrated Board report showing CIP delivery CIP report to Finance and Performance Committee Well Led Governance review report to Board Board approval of business case and tender documents for support for 5 Year Strategic Turnaround Plan <u>Third line</u> Monthly PRM with Monitor Round table meetings being held with CCGs, NHS England and Monitor Monitor two day assurance visit KPMG Report on Cash management Turnaround Director report on PMO arrangements PWC report on financial control	• 16/17 CIP plan to be finalised • Approval awaited for business case for support for 5 Year Strategic Turnaround Plan	• Internal Audit report on PMO arrangements • KPMG report on Cash management actions to be implemented • Forecast deficit position has worsened to £22M	Initial 5x5 = 25	Current 4x5 = 20	Target 2 x 5 = 10

Action	**Timescales**	**Lead**
Well Led Governance Review action plan to be implemented	September 15 - March 16	AB
Cash management actions to be implemented	December 15	KG
Focus to remain on delivery of forecast financial plan	Ongoing	KG
Development of 16/17 CIP schemes to be completed	October 15	AB

Links to risk register:
Risk 4706 - Financial plans

TRUST GOAL: 2. KEEPING THE BASE SAFE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
10.1516	Finance and Performance Committee	Associate Director of Operations	Risk Failure to achieve local and national performance targets Impact - Poor quality of care and treatment - Poor patient experience - Regulatory action - Reputational damage with stakeholders	• Strengthened performance monitoring and management arrangements • Bed modelling work and additional investment made in to bed capacity • Plan for every patient programme and board rounds • Theatre productivity work adn Theatres perfect week • Learning from Perfect Weeks • Work wtih Foureyes to improve delivery of pre-11am discharges • CQUINS compliance monitored by Quality directorate • Broze, silver and gold command arrangements and escalation process • Appointment slot issues action plan • Qlikview information	First line Weekly performance review with divisions. Divisional board and PSQB reviews of performance with executive attendance Activity reporting discussed at WEB Intergrated Board report focus of one WEB each month for detailed scrutiny wtih wider representation from divisions 'Deep dive' discussions into areas of under performance Second line Enhanced Integrated Board Report discussed at Quality Committee and Board Finance and Performance Committee monthly report on activity Report on compliance with #NOF best practice tariff Third line Urgent Care and Planned Care Boards and System Resilience group NHS England review of delayed discharges	• Funding for winter plan and system resilience plans not yet agreed Appointment slot issues action plan not yet delivered • Delivery of activity remains behind plan and action plans do not set out full recovery • Achievement of 4 hour emergency care standard requires micro-management. • Lack of detailed capacity and demand information and monitoring. • No independent assurance and validation team to divisions • Not delivering or appropriately tracking patients referred to tertiary centre by day 38 for cancer pathway.	• External Audit unable to give assurance around 18 week data • A number of indicators remain off track including Appointment slot issues; delayed discharges. • Lack of robust system surge plans.	Initial 4x4 = 16	Current 3x4 = 12	Target 2x3 = 6

Action	**Timescales**	**Lead**
Theatre action week to identify potential for additional activity	October	LH
Funding for winter plan and system resilience plan to be aagreed	September	HB
Implementation of appointment slot issues action plan	October	HB
Further improvement work around patient flow and discharges to be implemented	Ongoing	HB

Links to risk register:
Risk 2828

TRUST GOAL: 2. KEEPING THE BASE SAFE									
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**	
11.1516	Quality Committee	Executive Director of Planning, Performance, Estates and Facilities	Risk Failure to maintain current estate and equipment and develop future estates model to provide high quality patient care Impact - Poor quality of care and treatment - Poor patient experience - Poor staff experience and negative impact on their health and wellbeing - Regulatory action - Inability to implement service change - Reputational damage with stakeholders	• System for regular assessment of Divisional and Corporate compliance • Policies and procedures in place • Quality Governance assurance structure revised • Estates element included in development of 5 Year Strategic plan • Close management of service contracts to ensure planned aintenance activity has been performed • Categorisation / risk analysis of medical devices (high, medium, low) to prioritise maintenance • Development of Planned Preventive Maintenance (PPM) Programme • Audit of medical devices by independent assessor to identify any further actions needed	<u>First line</u> CQC compliance reported in Quarterly Quality and Divisional Board reports Weekly strategic CQC meetings <u>Second line</u> Health and Safety Committee monitors medical devices action plan to address recruitment issues, database, risk analysis of devices Monitor review of PFI arrangements <u>Third line</u> PLACE assessments CQC Compliance report	• Capital funding scaled back which has impacted on ability to deliver estates schemes • PPM Programme not yet complete • Medical Device database needs to be reviewed to ensure accurate formation on medical devices needing maintenance. • Lack of information on what proportion ofequipment has accurate recording of location on medical devices database • Medical Devices Assessor final report and action plan not yet received meaning further actions required not yet known • Full divisional and corporate self assessments to be completed • There remains some out of date policies and procedures	• Internal Audit report on medical devices has a number of outstanding actions • Mandatory training figures remain below plan for both health and safety and fire • Completed self assessments show 'requires improvement'.	**Initial** 4x4 = 16	**Current** 4x4 = 16	**Target** 2x4 = 8

Action	**Timescales**	**Lead**
Complete self assessments at divisional and corporate level	October	LH
Work to improve compliance with mandatory training	Ongoing	ALL DIVISIONS
Implementation CQC Compliance action plan	November	LH
Ensure all relevant policies and procedures reviewed and up to date	September	LH
Implement actions from PLACE assessment	December	LH

Links to risk register:
Risk 6300 - estates risk
Risk 5806 - estates schemes
Risk 6299 - medical devices

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE

Ref	OWNER Board committee Exec Lead		RISK DESCRIPTION *(What is the risk?)*	KEY CONTROLS *(How are we managing the risk?)*	POSITIVE ASSURANCE & SOURCES *(How do we know it is working?)*	GAPS IN CONTROL *(Where are we failing to put controls / systems in place?)*	GAPS IN ASSURANCE *(Where are we failing to gain evidence about our system/ controls?)*	RATING		
								Initial	Current	Target
12.1516	Quality Committee	Executive Director of Nursing / Executive Medical Director	**Risk** Risk of not being able to deliver safe and effective high quality care and experience for patients due to insufficient medical and nursing staff caused by an inability to attract, recruit, retain, reward and develop collegues. **Impact** - Quality and safety of patient care and Trust's ability to deliver some services. - Ability to deliver national targets and CQUINS. - Increased risk of litigation and negative publicity. - poor staff morale - Increased sickness absence - Continued financial pressure due to use of locums / agency staff	• Weekly nurse staffing escalation reports; • Ongoing multifacted recruitment programme in place, including international recruitment; • Use of bank, agency and overtime in place to cover gaps with CIP plan to reduce reliance on this in the future; • ED business continuity plan drafted; • Vacancy review process in place; • Use of e-rostering in place. • Framework for identifying wards potentially unsafe (under-resourced or under performing) and placing in special measures • Risk assessments in place	<u>First line</u> Staffing levels reported to WEB Report on delivery of training and education Divisional business meetings and PSQBs consider staffing levels IBR shows slight decrease in sickness levels <u>Second line</u> Quarterly Quality Report to Quality Committee and Board 6 monthly Hard Truths report to Board KPIs in Integrated Board Report. PSQB reports to Quality Committee <u>Third line</u> Nurse staffing report on the internet CQC report .	Current hotspots are: Emergency Care; Radiology; Hisotpathology; vascular surgery; opthalmology; gastroenterology; respiratory;elderly medicine; dermatology; SALT; Additional beds open meaning that although nursing recruitment has almost achieved full establishement, there is still significant use of bank and agency to support additional bed capacity. Bed planning required review for the winter period. Clear workforce strategy / plan and recruitment and retention strategy required Continued spend on locums and agency leading to financial pressures in year.	• Further work required on ED Business Continuity plan; • Medical workforce paper to Quality Committee highlighted particularly difficult areas for recruitment. • Internal Audit report on bank and agency has outstanding actions • Need clear workforce plan	4x4 = 16	4x5 = 20	3x3 = 9

Action	Timescales	Lead
Medical staff tool to be developed and rolled out		DB
Workforce Strategy / plan to be developed		JH
Recruitment and retention strategy to be finalised		JH
ED Business continuity plan to be finalised and approved at Board		HB

Links to risk register:
Risk 6345 overall staffing risk

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE										
Ref	**OWNER** Board committee	Exec Lead	**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING** Initial	Current	Target
13.1516	Quality Committee	Executive Medical Director	Risk Failure to attract and develop appropriate clinical leadership across the Trust. Impact - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale. - Non–achievement of key Trust priorities	• Devolved clinical structure • Work together get results programme in place • Positive feedback from Junior doctors on medical training • Performance appraisal based around behaviours • Coaching circles process • All CIP schemes have clinical lead • Development of new roles across professional groups • Good revalidation compliance	<u>First line</u> Established escalation frameowrk to prioritise action to address week areas Clinicians leading of transformation programmes e.g. cardio /respiratory Engaged leaders toolkit in place Clinical lead particpation in star chamber approach <u>Second line</u> Integrated Board Report Revalidation report to board <u>Third line</u> IIP Accreditation Internal Audit report and Turnaround Director report on PMO arrangements and inclusion of clinicians and Quality Imapact Assessment processes in governance arrangements.	• Lack of clarity in service redesign and improvement responsibilities • Need clearly articulated clinical development plan • Job plans to be reviewed to include time for clinical leadership responsibiltiies • Accountability framework to be developed	• Well Led Governance review identified some actions relating to accountability framework between corporate and divisions • Assessment of divisional governance to align to Well Led Governance review • Acquire independent assessment of clinical leadership arrangements • Staff FFT / Survey results deteriorating • Appraisal compliance away from target	4x4 = 16	4x4 = 16	3x3 = 9

Action	**Timescales**	**Lead**
Well Led Governance review action plan to be implemented	September - March	AB
Service redesign process to be formalised	TBC	AB
Clinical leadership review to be undertaken	TBC	DB
Bring together medical and non-medical training and development teams	December	JD

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

TRUST GOAL: 3. A WORKFORCE FIT FOR THE FUTURE										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
14.1516	Weekly Executive Board	Executive Director of Workforce and Organisational Development	Risk Failure to appropriately engage all colleagues and embed the culture of the organisation across all sites. Impact - Ability to deliver transformational change compromised. - Potential to affect the quality of patient care. - Low staff morale. - Non–achievement of key Trust priorities - Poor response to staff survey / staff FFT	• Colleague engagement plan signed off by WEB • Leadership visibility increasing • Quarterly staff FFT in place • Work together get results programme in place • 'Ask Owen' button launched and being responded to • Good evidence of colleague engagement in SOC / OBC development • Celebrating success annual awards • Staff survey action plan • Health and wellbeing strategy	<u>First line</u> Divisional leadership approach CQC preparation for self assessment shows some areas reporting GOOD in well led domain <u>Second line</u> Integrated Board report shows sickness absence slightly improved CQC Mock inspection feedback from focus groups <u>Third line</u> Staff FFT / staff survey provides some positive feedback IIP accrediation	• Divisional engagement plans not yet completed • Leadership walkaround and feedback process to be further embedded • Cultural barometer indicators to be developed • Continued difficulty in engaging clinical staff • Colleague recognition scheme not yet in place	• Staff FFT response rate deteriorating along with number of staff who would recommend the Trust as a place to work • Still a number of well led indicators on the IBR showing red • Number of areas in self assessment for CQC preparation showing REQUIRES IMPROVEMENT • Falling number of entries into Celebrating Success	Initial 3x4= 12	Current 4 x 4 = 16	Target 1x4 = 4

Action	Timescales	Lead
Divisional engagement plans to be finalised and implemented	End September	ADDs
Focus groups to be carried out	October	JC
Leadership walkabout process to be embedded	October	JC
Full roll out of WTGR programme	December	Greengage
Colleague recognition scheme to be agreed and delivered	End September	VP

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

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY									
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**	
15.1516	Finance and Performance Committee	Executive Director of Finance	**Risk** Failure to deliver the financial forecast position for 2015/16 due to non-delivery of CIP, reduced activity and increased expenditure on additional capacity **Impact** - financial sustainability - increased regultory scrutiny - insufficient cash to meet revenue obligation - inability to invest in patient care or estate	• Financial recovery and cost improvement programme plan in place • PMO tracking of delivery against CIP plan • Budgetary control process • Detailed income and activity contract monitoring • Bottom-up forecasting process • Star chamber process to support CIP schemes off track • Quality directorate overview of progress against delivery of CQUIN • Application made to ITFF for funding	First line Divisional Board reports Second line Turnaround Executive Reports Monthly scrutiny at Finance and Performance Committee and Board Integrated Board report including CQUIN delivery reporting Third line Monthly return to Monitor PRM meeting with Monitor Two day assurance visit from Monitor PWC report from December Turnaround Director report Well Led Governance Review Internal Audit Report on divisional performance management arrangements	• £2M away from forecast position • Have included all contingency funding • Temporary staffing remains a cost pressure due to additional capacity remaining open • There remain outstanding contract challenges on PBR contract • Awaiting decision on ITFF funding	• Internal Audit report on budgetary control had limited assurance opinion • Cash report from KPMG identified some actions	**Initial** 3x5 = 15	**Current** 4x5 = 20	**Target** 2x5 = 10

Action	**Timescales**	**Lead**
Actions from KPMG Cash Management report to be completed	• October 2015	KG
Finance and Performance Committee effectiveness review to be undertaken	• October 2015	VP
Further work to be done with divisions to identify in-year savings opportunities	• September / October 2015	ADFs

Links to risk register:
Risk 4706 - failure to achieve financial plans

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY									
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**	
16.1516	Finance and Performance Committee	Executive Director of Finance	Risk Failure to develop a robust financial plan for 2016/17 including identification of CIP Impact - financial sustainability - insufficient cash to meet revenue obligation - inability to invest in patient care or estate	• PMO in place with clear tracker and 'ideas' hopper process to identify and follow up potential saving schemes • Turnaround executive weekly scrutiny of progress • Turnaround scrutiny arrangements replicated at divisional level • Workshops held with divisions to identify potential savings • Colleague communication and engagement plan in place to encourage flow of ideas and share scale of the challenge • Particpation in WYAAT and WY Urgent Care vanguard enabling discussions on collboration and sharing on a wider footprint • Star chamber process to unblock any issues and identify further potential for schemes	<u>First line</u> Divisional Board reports <u>Second line</u> Turnaround Executive Reports Monthly scrutiny at Finance and Performance Committee and Board WYAAT meeting minutes DH approval of WY Vanguard <u>Third line</u> Monthly return to Monitor PRM meeting with Monitor Two day assurance visit from Monitor PWC report from December Turnaround Director report	• £12M of savings identified against a plan of £14M but not yet been through assurance process • Risks to the delivery of some of the 15/16 schemes which could impact on 16/17 • Ongoing pressures in Trust may result in continued expenditure and therefore need to identify additional savings	• Well Led Governance review identified some actions relating to accountability framework between corporate and divisions • Turnaround Director report identified some actions for implementation	**Initial** 4x5 = 20	**Current** 4x5= 20	**Target** 2x5 = 10

Action	**Timescales**	**Lead**
Complete assessment of all ideas in hopper	September / October	AB
Develop accountabililty framework with divisions	October	HB
Implement actions identified in Turnaround Director report	December	AB / KG

Links to risk register:
Risk 4706 - failure to achieve financial plans
BAF risk 16.1516

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY									
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**	
17.1516	Board of Directors	Director of Transformation and Partnerships	Risk Failure to progress and agree a five year strategic plan across the local health economy Impact - financial sustainability - viability of certain services - inability to compete or collaborate with other WY acute trusts	• PRM process • Roundtable discussions introduced including Monitor, CCGs and NHS England • Assessment completed against Monitor strategy checklist • Business case developed and submitted to Monitor for approval • Tender released for support	First line WEB assessment of direction of travel Second line Board scrutiny and approval of business case and tender specification Hospital Services Programme Board discussions Third line PRM meetings with Monitor and Roundtable discussions Monitor assurance process for business case Monitor oversight of strategy development process	• Resources not yet identified to work with the external support. May place additional pressure on divisions at a time when going in to winter period.	• Monitor yet to approve business case • Awaiting confirmation from Monitor on how the costs of external support can be accounted for	Initial: 4x5 = 20 Current: 3x5 = 15 Target: 2x5 = 10	

Action	**Timescales**	**Lead**
Approval of business case to be followed up	By 18 September	AB
Complete tender process and appoint independent support	By 30 September	AB
Identify resources to support the work from within the Trust	By 30 September	AB
Agree process for monitoring progress and assessing KPIs	October	AB

Links to risk register:
Risk 6131 - mortality standards
Risk 2827 - clinical decision making in A&E

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY										
Ref	**OWNER** Board committee Exec Lead		**RISK DESCRIPTION** *(What is the risk?)*	**KEY CONTROLS** *(How are we managing the risk?)*	**POSITIVE ASSURANCE & SOURCES** *(How do we know it is working?)*	**GAPS IN CONTROL** *(Where are we failing to put controls / systems in place?)*	**GAPS IN ASSURANCE** *(Where are we failing to gain evidence about our system/ controls?)*	**RATING**		
18.1516	Finance and Performance Committee	Director of Transformation and Partnerships	Risk The Trust is unable to grow due to inability to increase clinical income opportunities as a result of an inability to attract and deliver addiditional activity or to compete in competitive market Impact - financial sustainability - viability of certain services - inability to offset cost pressures	• Clearly artculated and understood corporate strategy • Services identified where changes could be made without impact on other co-adjacent services e.g. cardio / respiratory • Governance arrangements enable risks to be identified and tested • Theatre productivity work • Service line reporting and detailed activity monitoring • Joint working with GP federations in Calderdale and Kirklees	<u>First line</u> Activity reporting discussed at WEB <u>Second line</u> Integrated Board report Finance and Performance Committee monthly report on activity <u>Third line</u> Three tenders recently secured NHS Calderdale CCG decision not to go out to tender on community services Particpation in two successful vanguard applications Audit of coding	• Loss of CC2H Kirklees tender has resulted in destabilisation of some services • Delivery of activity remains behind plan and action plans do not set out full recovery • LLP not progressed • Delivery of activity remains behind plan and action plans do not set out full recovery • Depth of clinical coding to be improved to ensure trust is paid appropriately for activity	• Lost CC2H Kirklees tender • Internal Audt report on OBC identified some actions to be undertaken not yet completed	**Initial** 3x4 = 12	**Current** 4x4 = 16	**Target** 2x4 = 8

Action	**Timescales**	**Lead**
Theatre action week to identify potential for additional activity	October	LH
1:1 with consultant body taking place	October / November	ALL DIRECTORS
Clinical coding review to be completed and business case for further resource to be considered	October	DB
Further review of disinvestment opportunities	October	AB
Continued work with WYAAT to look at sharing opportunities	Ongoing	OW

Links to risk register:
Risk 4706 - failure to achieve financial plans
BAF risk 16.1516

ACRONYM LIST

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

INITIALS LIST

AB	Anna Basford, Director of Transformation and Partnerships
DB	David Birkenhead, Executive Medical Director
HB	Helen Barker, Associate Director of Operations
JC	Juliette Cosgrove, Assistant Director of Quality
JD	Julie Dawes, Executive Director of Nursing and Deputy Chief Executive
JE	Jason Eddleston, Deputy Director of Workforce and OD
KG	Keith Girffiths, Executive Director of Finance
MG	Mandy Griffin, Interim Director of the Health Informatics Service
AH	Alex Hamilton, Assisociate Medical Director
LH	Lesley Hill, Executive Director of Planning, Performance, Estates and Facilities
RM	Ruth Mason, Associate Director of Engagement and Inclusion
VP	Victoria Pickles, Company Secretary
CR	Catherine Riley, Assistant Director of Strategic Planning
SU	Sal Uka, Consultant Paediatrician and 7 day services clinical lead
OW	Owen Williams, Chief Executive

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, 24th September 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 14 September 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 8 September 2015 meeting.	
Governance Requirements: .	
Sustainability Implications: None	

Executive Summary

Summary:

There are 13 risks on the Corporate Risk Register as at 14 September 2015.

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 the Corporate Risk Register as a true reflection of the Trust's risk position, following recommendation from the Risk & Compliance Group.

Appendix

Attachment:

Risk Register Papers.pdf

CORPORATE RISK REGISTER – SEPTEMBER 2015 Summary of Risks

Risk Ref	Strategic Objective	Risk	Executive Lead (s)	Current Risk score and change
		Strategic Risks		
6346	Transforming & Improving Patient Care	Capacity and capability to deliver service reconfiguration	Director of Nursing (JD)	**20 =**
		Safety and Quality Risks		
6131	Transforming & Improving Patient Care	Progress of reconfiguration, impact on quality and safety	Director of Commissioning and Partnerships (AB)	25 =
4783	Transforming & Improving Patient Care	Outlier on mortality levels	Medical Director (DB)	20 =
2827	Developing Our workforce	Poor clinical decision-making in A&E	Medical Director (DB)	20 =
6299	Keeping the base safe	Failure of high risk medical devices	Director of Estates and Performance (LH)	15
5806	Keeping the base safe	Urgent estate work not completed	Director of Estates and Performance (LH)	16 =
		Financial Risks		
4706	Financial sustainability	Failure to meet cost improvement plans and not adhere to financial governance	Director of Finance (KG)	20 =
6230	Transforming & Improving Patient Care	Failure to deliver expected financial benefits of Electronic Patient Record	Director of Finance (KG)	20 =
6130	Financial sustainability	Loss of income / service due to commissioner procurement decisions	Director of Commissioning and Partnerships (AB)	15=
		Performance and Regulation Risks		
6300	Keeping the base safe	CQC Inspection Outcome	Director of Nursing (JD)	16 =
6078	Keeping the base safe	Insufficient Appointment Slots	Director of Nursing (JD)	16 =
2828	Keeping the base safe	Slow patient flow and breach of A&E targets	Director of Nursing (JD)	16 =
		People Risks		
6345	Keeping the base safe	Ability to deliver service transformation	Medical Director (DB) , Director of Nursing (JD), HR Director	20 =

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

RISK REGISTER REPORT

Risks as at 14 September 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
No risks have reduced in score.
NEW RISKS
No new risks have been added.
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 14 September 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 and not adhere to financial governance
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

	Risk No	Div	Dir	Dep	Opened	Status	Strategic Objectives	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Further Actions	Review	Target	RC	Exec Dir	Lead
Extreme	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 (through the joint Hospital Board) to revisit the clinical model, activity, workforce and financial modelling of options for hospital reconfiguration. The Trust is required by Monitor to develop a 5 year strategic plan that will improve the Trust's financial and clinical sustainability. This plan will be completed by December 2015 and will include plans for reconfiguration of services across hospital sites. The Trust's five year plan will inform and enable CCG's to commence public consultation. The Trust has developed and is discussing with CCGs options for progressing interim actions to mitigate known clinical risks (paediatric service provision at HRI, cardiology and respiratory service configuration, Emergency Pregnancy Assessment configuration).	Sep-2015	Dec-2015	WEB	Anna Basford	Catherine Riley
Major	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

Major	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
Major	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	The unpredictability of Commissioners tendering process and possible decommissioning of services. Impact of decisions in wider local health and social care system on capacity driven expenditure requirements in Trust.	15 5 x 3	20 5 x 4	10 5 x 2	Plans to be agreed to manage gains or losses following tendering process. September update: Clinical contract with main commissioners signed by all parties in early September. This will operate on a full PbR basis.	Oct-2015	Mar-2016	FPC	Keith Griffiths	Kirsty Archer

Major	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 Written mortality review process agreed to clarify roles and to facilitate a greater number of reviews being completed, process for escalation, linking with other investigation processes e.g. SI panel review. August reviews of July deaths (using new process) compliance 70% - highest since Feb'15 Monthly report of findings to CEAM and COG from Sept 2015 (Aug reviews of July deaths) Revised investigation policy clarifies process for learning from all investigations, including mortality reviews, and monitoring of actions CAIP plan revised Aug 2015 and now focusing on 6 key themes: investigating mortality and learning from findings; reliability; early recognition and response to deterioration; end of life care; frailty; and coding. Care bundles in place	Mortality reviews to assess preventable deaths which is indicating there isn't a problem but not yet performed for long enough or to sufficient depth to determine causes Mortality case notes review may not pick up all factors relating to preventability Coding improvement work not yet complete Improvement to standardized clinical care not yet consistent. To be completed by Dec 15 Care bundles not reliably commenced and completed	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 - External review of data and plan to take place - assistance from Prof Mohammed (Bradford) August update: Further information received with increased risks to mortality. Action plan reviewed and presented to WEB. PMO approach to be adopted for reliable implementation of care bundles Sept update: Compliance with mortality reviews for last month significantly increased.	Dec-2015	Aug-2016	COB	David Birkenhead	Juliette Cosgrove

Major	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

Major	2828	Medical	Emergency Network	Accident & Emergency	Apr-2011	Active	Keeping the base safe	There is a risk of slow patient flow and breaches against the ED national standards due to bed blockages across the Trust, resulting in harm to patients through delayed treatment, increased external scrutiny for the Trust and financial penalties against the contract.	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. September update: Beds paper and presentation delivered at BoD - recommendation approved. Operational plan in development and additional beds will be brought on line as per plan. Work underway with SRG to ensure a robust system level response to cope with peak season demand. ED nurse staffing paper in development and will be presented to Medical Division Business Meeting. Senior decision makers on site from 5-8pm 4 days per week due to commence from mid- September. Achieved compliance with . ED 4 hour standard in August	Sep-2015	Dec-2015	CG	Julie Dawes	Sajid Azeb

Major	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

Major	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/reduced available capacity to manage demand. Resulting in: - 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) - impact on Trust ability to attract income	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 Specialty developed actions plans to reduce ASIs. - Weekly cross-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. This will be reviewed in November.	Nov-2015	Jan-2016	PCB	Julie Dawes	Rob Aitchison / Katharine Fletch
Major	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 catchment 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. September 2015 Update: Greater Huddersfield CCG has selected Locala Community Partnerships as the preferred provider of Care Closer to Home services in Kirklees. This represents a £5m loss of income to the Trust (and a potential further £20m in the future). The Trust and its bidding partners have submitted a formal complaint to Monitor regarding the procurement process. The Trust is awaiting update from Kirklees Council regarding the next steps related to the procurement of sexual health services.	Jul-2015	Dec-2015	CISC	Anna Basford	Rob Aitchison & Lisa Williams

Major	6300	Trustwide	All Divisions	All Departments/Wards	May-2015	Active	Keeping the base safe	Clinical, operational and estates risks in:Children and young people, maternity and family planning, out patients and diagnostic imaging, A&E, Medical care, end of life care, surgery causing increased risks to patients and possible 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	Nov-2015	Feb-2016	WEB	Julie Dawes	Juliette Cosgrove
Major	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 regular agenda item at the Trust Finance and Performance Committee. September update: Tactical implementation reviewed by Star Chamber in September 2015	Oct-2015	Apr-2016	FC	Keith Griffiths	Kirsty Archer
Major	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

Extreme + Major Risks =

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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, 24th September 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: GOVERNANCE REPORT - SEPTEMBER 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:
1. Re-appointment of non-executive director to specific roles
2. Q1 Feedback from Monitor
3. Nominations and Remuneration Committee terms of reference
4. Well Led Committee terms of reference
5. Board work plan

Main Body

Purpose:

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

- Re-appointment of non-executive director to specific roles
- Q1 Feedback from Monitor
- Nominations and Remuneration Committee terms of reference
- Well Led Committee terms of reference
- Board work plan

Background/Overview:

-

The Issue:

1. Re-appointment of Non-Executive Directors to specific roles
Following the annual appraisal process and annual review of Non-Executive Director roles the Chair of the Board recommends that Jan Wilson be re-appointed as Deputy Chair and the David Anderson be re-appointed as the Senior Independent Non-Executive Director.
The Board is asked to APPROVE the recommended re-appointments.

2. Q1 2015-16 submission to Monitor
The Trust received feedback form Monitor in relation to the Q1 15/16 submission on 15 September. A copy of the letter is attached.

3.Nominations and Remuneration Committee terms of reference
The Trust currently has in place two Nominations Committees and two Remuneration Committees. In line with the Foundation Trust Good Governance Handbook, it is recommended that these Committees be brought together to form a Nominations and Remuneration Committee (Board of Directors) and a Nominations and Remuneration Committee (Membership Council). This will enable the streamlining of the consideration of new executive and non-executive appointments.

Following initial review by the Deputy Director of Workforce and OD and the Non-Executive Directors, the terms of reference for the Nominations and Remuneration Committee (Board of Directors) are presented here for approval. The main change is that only Non-Executive Directors and the Chief Executive will be members of the Committee.

The Nominations and Remuneration Committee (Membership Council) will go to the next Membership Council meeting for consideration and approval.

The Board is asked to APPROVE the terms of reference for the Nominations and Remuneration Committee (Board of Directors).

4. Well Led Committee
At its August meeting, the Board of Directors approved the creation of a Well Led Committee as a formal sub-committee in recognition of the challenges facing the recruitment, retention and wellbeing of our workforce. The Committee would provide assurance to the Trust Board on key workforce and organisational development indicators and effectiveness of workforce management within the Trust as well as overseeing the development of the workforce strategy and plan.

Following that meeting further discussion has taken place and the draft terms of reference are attached here for consideration and approval.

The key points to note are:
- It is proposed that this Committee begin as a formal sub-committee of the Board with a Non-Executive Chair. This would be reviewed in 12 months and if sufficient progress made, consideration be given to stepping down to a sub-group of one of the Board committees in a similar way to the Health and Safety Committee.
- The Committee will meet every 2 months with a minimum of five meetings per year.
- The Committee will have a sub-structure to focus on particular areas such as colleague engagement. This sub-structure will be agreed at the first meeting of the Committee.

The Board of Directors is asked to APPROVE the terms of reference for the Well Led Committee.

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

Next Steps:

-

Recommendations:

The Board is asked to receive the report and:
- Approve the re-appointments to Non-Executive Director specific roles
- Note the feedback from Monitor Q1 15/16
- Nominations and Remuneration Committee terms of reference
- Well Led Governance terms of reference
- Review the Board work plan

Appendix

Attachment:

COMBINED GOVERNANCE REPORT - 24.9.15.pdf

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15 September 2015

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

Monitor
Making the health sector work for patients

Wellington House
133-155 Waterloo Road
London SE1 8UG

T: 020 3747 0000
E: enquiries@monitor.gov.uk
W: www.gov.uk/ monitor

Dear Owen

Q1 2015/16 monitoring of NHS foundation trusts

Our analysis of your Q1 submissions is now complete. Based on this work, the trust's current ratings are:

- Continuity of services risk rating: 1
- Governance rating: Red

These ratings will be published on Monitor's website later in September.

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 Q1 submissions as part of our regular Progress Review Meetings.

A report on the FT sector aggregate performance from Q1 2015/16 will be available in due course on our website (in the News, events and publications section) which I hope you will find of interest.

For your information, we will be issuing a press release in due course setting out a summary of the key findings across the FT sector from the Q1 monitoring cycle.

Monitor is currently reviewing the responses of all NHS foundation trusts to David Bennett's letter dated 3 August 2015 as well as the outcome of the contract dispute resolution process. We will be writing to all NHS foundation trusts in due course to inform them of the outcome of our review. As a result, the content of this letter and our regulatory position only relates to our Q1 2015/16 monitoring process.

If you have any queries relating to the above, please contact me by telephone on 0203 747 0484 or by email (Kemi.Oluwole@monitor.gov.uk).

Yours sincerely

Kemi Oluwole
Senior Regional Manager

cc: Mr, Andrew Haigh, Chair,
Mr, Keith Griffiths, Director of Finance

NOMINATION AND REMUNERATION COMMITTEE (BOARD OF DIRECTORS)

TERMS OF REFERENCE

Version:	1.1 (first draft circulated for review to Chair / Non-Executives) 1.2 Draft submitted to Board for approval
Approved by:	Board of Directors
Date approved:	08.09.15
Date issued:	
Review date:	

NOMINATION AND REMUNERATION COMMITTEE TERMS OF REFERENCE

1. Constitution

1.1 The Trust hereby resolves to establish a Committee to be known as the Nomination and Remuneration Committee. The Committee has no executive powers other than those specifically delegated in these terms of reference.

2. Authority

2.1 The Nominations and Remuneration Committee is constituted as a standing committee of the Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings.

2.2 The Nominations and Remuneration Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Nominations and Remuneration Committee.

2.3 The Nominations and Remuneration Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from both within and outside the Trust with relevant experience and expertise if it considers this necessary to the exercise its functions.

3. Purpose

3.1 To be responsible for identifying and appointing candidates to fill all the executive director positions on the board and for determining their remuneration and other conditions of service. When appointing the chief executive, the committee shall be the committee described in Schedule 7, 17(3) of the National Health Service Act 2006. When appointing the other executive directors the committee shall be the committee described in Schedule 7, 17(4) of the Act.

4. Nominations role

The Committee will:

4.1 Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board and make recommendations to the Board with regard to any changes.

4.2 Give full consideration to and make plans for succession planning for the Chief Executive and other Executive Board Directors, taking into account the challenges and opportunities facing the Foundation Trust and the skills and expertise needed, in particular on the Board in the future.

4.3 Keep the leadership needs of the Trust under review at executive level to ensure the continued ability of the trust to operate effectively in the health economy.

4.4 Be responsible for identifying and nominating for appointment candidates to fill posts within its remit as and when they arise.

4.5 When a vacancy is identified, evaluate the balance of skills, knowledge and experience on the Board, and its diversity, and in the light of this evaluation, prepare a description of the role and capabilities required for the particular appointment. In identifying suitable candidates the committee shall use open advertising or the services of external advisers to facilitate the search; consider

candidates from a wide range of backgrounds; and consider candidates on merit against objective criteria.

4.6 Ensure that a proposed Executive Director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the board as they arise.

4.7 Be responsible for identifying and nominating a candidate for approval by the Membership Council, to fill the position of Chief Executive (in line with the Constitution).

4.8 Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest are reported.

4.9 Consider any matter in line with Trust procedures relating to the continuation in office of any Board Executive Director at any time including the suspension or termination of service of an individual as an employee of the Foundation Trust.

5. Remuneration role

5.1 Establish and keep under review a remuneration policy in respect of Executive Board Directors (and senior managers on locally determined pay).

5.2 Consult with the Chief Executive about proposals relating to the remuneration of other executive directors.

5.3 In accordance with all relevant laws, regulations and Trust policies, decide and keep under review the terms and conditions of office of the Trust's executive directors (and senior managers on locally-determined pay), including:

- Salary, including any performance-related pay or bonus;
- Provisions for other benefits, including pensions and cars;
- Allowances;
- Payable expenses; and compensation payments.

5.4 In adhering to all relevant laws, regulations and Trust policies:-

- Establish levels of remuneration which are sufficient to attract, retain and motivate executive directors of the quality and with the skills and experience required to lead the trust successfully, without paying more than is necessary for this purpose and at a level which is affordable for the trust.
- Use national guidance and market benchmarking analysis in the annual determination of remuneration of executive directors (and senior managers on locally determined pay) while ensuring that increases are not made where trust or individual performance do not justify them.
- Be sensitive to pay and employment pay and conditions elsewhere in the trust.

5.5 Monitor and assess the output of the evaluation of the performance of individual directors, and consider this output when reviewing changes to remuneration levels.

5.6 Advise upon and oversee contractual arrangements for executive directors, including but not limited to termination payments (including redundancy), taking account of national guidance where appropriate, always ensuring that poor performance is not rewarded.

5.7 Delegate responsibility to the Chief Executive and Director of Workforce and OD

for the determination of the Trust's Pay and Reward Strategy as it affects all other staff – working within national frameworks where required.

6. Membership and attendance

6.1 The membership of the committee shall consist of:

- The Trust Chair
- The other non-executive directors on the Board (excluding the Chair of the Audit and Risk Committee for remuneration business)
- The Chief Executive shall be a member but will withdraw from the meeting during any discussions regarding his/term terms of condition and remuneration.

6.2 The Trust Chair shall chair the committee.

6.3 A quorum shall be three members which must include either the Chair or Deputy Chair.

6.4 The Executive Director of Workforce and OD shall normally be invited to attend meetings in an advisory capacity.

6.5 Other members of staff and external advisers may attend all or part of a meeting by invitation of the committee chair where required.

6.6 Members unable to attend should inform the Committee Secretary at least 7 days in advance of the meeting.

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

7. Administration

7.1 The Board Secretary shall be the secretary to the Committee and will provide administrative support and advice. The duties of the Board Secretary in this regard include but are not limited to:

- Agreement of the agenda with the chair of the committee and attendees together with the collation of connected papers;
- Taking the minutes and keeping a record of matters arising and issues to be carried forward;
- Agreeing the action schedule with the Chair and ensuring circulation within 48 hours of each meeting; and
- Maintaining a record of attendance.

8. Frequency of meetings

8.1 Meetings shall be held as required but at least twice in each financial year,

9. Reporting

9.1 Formal minutes shall be taken of all Committee meetings. Once approved by the committee, the minutes will go to the next Board of Directors meeting unless it would be inappropriate to do so.

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

9.3 The Committee shall receive and agree a description of the work of the committee, its policies and all Executive Director emoluments in order that these are accurately reported in the Trust's Annual Report.

10. Review

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

10.2 The terms of reference of the committee shall be reviewed by the Board of Directors at least annually.

WELL LED COMMITTEE

TERMS OF REFERENCE

Version:	1.1 (first draft circulated for review to Chair / Julie Dawes) 1.2 Amendments prior to Board
Approved by:	
Date approved:	
Date issued:	
Review date:	

WELL LED COMMITTEE TERMS OF REFERENCE

1. Constitution

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

2. Authority

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

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

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

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

3. Purpose

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

- Human Resource management
- Employee engagement including health and wellbeing
- Organisational learning and development
- Workforce planning and productivity

These four headings represent the cornerstones of the Trust's People Strategy

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

3.3 The Committee is supported by four subgroups aligned to the areas set out in 2.1 above. The terms of reference for the subgroups are attached as appendix 1.

4. Duties

4.1 The objectives of the Committee are to:-

4.1.1 Consider and recommend to the Board of Directors, the Trust's overarching People strategy and plan.

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

4.1.3 Review the workforce risks of the workforce risk register and the corporate risk register and to specifically review individual workforce risks rated 15 and above.

4.1.4 Hold the Executive Director of Workforce and OD to account for keeping the

Committee informed on risk mitigation and future activity/plans.

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

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

4.1.7 Monitor and approve all Trust workforce policies and ensure existing policies are received in a timely manner.

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

In regard of objective 4.1.7 the Well Led Committee gives delegated approval authority to the Chair of the Committee to take Chair's action in respect of policy documents in appropriate circumstances.

5. Membership and attendance

5.1 The Committee shall consist of the following members:-

- Two Non-Executive Directors, one of whom will Chair the Committee and one of whom will be the Deputy Chair of the Committee.
- Executive Director of Workforce and Organisational Development
- Deputy Director of Workforce and Organisational Development
- Chief Nurse and Deputy Chief Executive/Deputy Director of Nursing
- Chief Operating Officer
- Medical Director
- Each of the Chairs of the four sub groups
- Divisional Director
- Assistant Divisional Director
- Deputy Director of Finance
- Company Secretary

5.2 The Committee shall consist of the following attendees:-

- Membership Councillor
- Chair – Staff Management Partnership
- Chair – Local Negotiating Committee
- Secretary, Workforce and Organisational Development (notes)

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

5.4 A quorum will be seven members and must include at least one Non-executive and one executive director.

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

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

substitute or replacement.

6. Administration

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

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

7. Frequency of meetings

7.1 The Committee will meet every two months and at least 5 times per year.

8. Reporting

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

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

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

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

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

9. Review

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

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

BOARD WORK PLANWORKING DOCUMENT – SEPTEMBER 2015 - LATEST update TO BOD 24.9.15

Date of meeting	23 April 2015	28 May	25 June	30 July	27 Aug	24 Sept	29 Oct	26 Nov	17 Dec	28 Jan 2016	25 Feb 2016	31 March 2016
Date of agenda setting/Paper Review of drafts						14.9.15	19.10.15	6.11.15	7.12.15	18.1.16	15.2.16	21.3.16
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	20.1.16	17.2.16	23.3.16
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 – SEPTEMBER 2015 - LATEST update TO BOD 24.9.15

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			✓									✓
Quarterly 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 Quality Accounts		✓										
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 – SEPTEMBER 2015 - LATEST update TO BOD 24.9.15

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 (tbc)												
Registration of Nurses (from May 15) – date tbc												

BOARD WORK PLANWORKING DOCUMENT – SEPTEMBER 2015 - LATEST update TO BOD 24.9.15

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 Board development workshop			✓									
Urgent Care Board Minutes (to rec)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
EPR update						✓		✓			✓	

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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, 24th September 2015	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Monthly DIPC Report - Monthly DIPC report - report on the position of healthcare associated infections	
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 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:

as per report (appendix)

The Issue:

as per report (appendix)

Next Steps:

Actions required to be included in the Trust HCAI action plan

Recommendations:

for the Board to note the content

Appendix

Attachment:

Monthly DIPC Report September 2015.pdf

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

Performance targets

Indicator	Month agreed target	Current month (August)	YTD agreed target	YTD performance	Actions/Comments
MRSA bacteraemia (trust assigned)	0	**0**	0	**2**	
C.difficile (trust assigned)	3	**3**	21	**7**	Year-end projection = 17 2 avoidable 5 unavoidable
MSSA bacteraemia (post admission)	1	**2**	12	**5**	Year-end projection = 12 Both cases thought to be unavoidable and unrelated
E.coli bacteraemia (post admission)	3	**3**	29	**15**	Year-end projection = 36
MRSA screening (electives)	95%	**96.17%**	95%	**95.16%**	July validated data
Central line associated blood stream infections (Rate per 1000 cvc days)	1.5	**0.37**	1.5	**0.67**	
ANTT Competency assessments (doctors)			95%	**62.2%**	Work is on-going to validate the data
ANTT Competency assessments (nursing and AHP)			95%	**70.8%**	
Hand hygiene	95%	**99.74%**	95%	**99.66%**	

Quality Indicators

Indicator	Current month (August)	YTD performance	Comments
MRSA screening (emergency)	**89.67%**	**90.75%**	July validated data
Isolation breaches	**38**	**122**	
Cleanliness	**97.39%**	**97.3%**	

HCAIs/Areas of Concern/Outbreaks

- **Isolation breaches** recorded by the Infection Control Team during August were 38, compared to 12 in July. Of these 38 isolation breaches,
    - 31 of the breaches occurred in the medical division
        - 15 on MAU at HRI
        - 8 on MAU at CRH
    - 5 breaches occurred on surgical wards
    - 2 breaches occurred on the Gynaecology ward

- **Analysis of the isolation breaches** - The IPCN's identify the isolation breaches and follow up daily until the patient is isolated and also assist the ward staff by risk assessing the available side rooms and ensuring control measures are in place
    - Of the 14 breaches at CRH, all were patients with MRSA. On 7 occasions the staff had not acknowledged the infection alert and were prompted by the IPCT to isolate the patient. On 2 occasions there was no side room available and on one occasion the patient was risk assessed against other patients in the side rooms and deemed the lower risk
    - Of the 24 breaches at HRI, 15 were patients with MRSA and 4 were patients with ESBLs. On 10 occasions the staff had not acknowledged the infection alert and were prompted by the IPCT to isolate the patient. On 5 occasions there was no side room available and on 7 occasions the patients were risk assessed against other patients in the side rooms and deemed the lower risk
    - The IPCT will continue to monitor isolation breaches and actions to reduce breaches to be included in the HCAI annual action plan
- **MRSA acquisition** – there were **no cases** of hospital acquired MRSA identified in August. There have been 8 cases in total since April.
- **Pertussis** – a staff member working on the SCBU was treated for suspected pertussis, confirmation is awaited. Prophylaxis was given to 10 in patients and 7 outpatients with guidance from PHE.
- **MRSA bacteraemia** – there was one post 48 hour case that has been investigated by the PIR investigation. This case was re-assigned to the CCG. The summary of the case is in table 1 below.
- **C.difficile** – there were three cases in August and are summarised in the table 2 below

Table 1

Case details	Summary of C.difficile case	Key issues identified from RCA
07.08.15 **H22** MESS Datix	Admitted to ED on 7th August with haematuria and UTI. Transferred to ward 22 and commenced Tazocin. Patient has prostate cancer and has a long-term catheter. He pulled out his catheter on two occasions but was assessed by bladder scan to require the catheter. MRSA screening swabs and CSU positive on admission. MRSA was not identified on his previous admission screening swabs and it was unclear whether the carers had been trained on ANTT. Blood cultures taken on 9th August.	• No causative factors were attributed to CHFT • Following a meeting with Locala and Huddersfield CCG representative this case has been re-assigned to the CCG • Review of sepsis triggers for frail patients (blood cultures were not taken on admission as did not fit the criteria)

Table 2

Case details	Summary of C.difficile case	Key issues identified from RCA
10.08.15 **H6** MESS 429063	Admitted to ED after a fall, mild head injury sustained. Moved to MAU and then ward 6 on the 5th August. One	• Agreed as an unavoidable case • Improved education to staff regarding

Datix 19148	episode of loose stools and two small vomits on the 4th August prior to admission. Patient treated for a urine infection in July 2015 with Trimethoprim. No reference to loose stools in the community.	Duty of Candour. • Gaps in nutritional recording. • Normal stool type and frequency not recorded on admission.
20.08.15 **H4** MESS 432659 Datix 19573	Patient admitted on the 27 July with reduced mobility and new incontinence for urine and faeces (these improved on reduction of her antipsychotic treatment). Developed sepsis on 30 July and commenced on IV antibiotics, diagnosed with E.coli bacteraemia and changed to Ertapenem following discussed with microbiologist	• Agreed as an unavoidable case • Ensure cleaning of nerve centre equipment • Discuss RCA at team meetings
21.08.15 MESS 432661 Datix 19641	Patient admitted on 28th July with reduced mobility ?sepsis, known diagnosis of MS and epilepsy and previous stroke, patient commenced on IV antibiotics. Had a history of diarrhoea for 2 days prior to admission.	• Agreed as an unavoidable case • Record on Bristol stool chart inconsistent • delay in obtaining stool sample • patients bowel pattern to be recorded on admission

Quality Improvement Audits

Four Quality Improvement Audits were performed in August

- Pain Clinic CRH – 93% green
    - some out of date stock – needles and blood bottles and the storage area was dusty
    - The fridge seal was dirty, bin feet were dusty, edges of the floor were gritty

- GAU CRH – 91% green
    - The storage area was dusty, lots of overstock items
    - The toilet floor was gritty in the edges
    - Storeroom floor dusty under the shelf

- Ward 7AD CRH – 90% amber
    - 7A – dust behind the beds and also under the beds, high and low dust
    - 7D – The day room was dusty
    - The ledges in the domestic room were dusty and the machinery needed wiping.

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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, 24th September 2015	**Sponsoring Director:** Lesley Hill, Director of Planning, Performance, Estates and Facilities
Title and brief summary: LSMS Annual Report - The Local Security Management Specialist ("LSMS") is required to provide a written report, at least annually, to the Board and NHS Protect on violence and aggression and security activities which have been undertaken.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: This paper has not been presented at any other forum/meeting.	
Governance Requirements: None.	
Sustainability Implications: None	

Executive Summary

Summary:

The Local Security Management Specialist (“LSMS”) is required to provide a written report, at least annually, to the Board and NHS Protect on violence and aggression and security activities which have been undertaken. The report provides details of the work understaken in realtion to NHS Protects key principles within 2014/15.

Main Body

Purpose:

The report provides details of the work understaken in realtion to NHS Protects key principles within 2014/15.

Background/Overview:

The paper provides an annual overview of violence and aggression and security related incidents and provides an assurance the that Trust is meetings it's requirements to NHS Protect.

The Issue:

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Next Steps:

Subsequent reports will be provided on an annual basis.

Recommendations:

The Board is asked to note the report.

Appendix

Attachment:

LSMS Annual Report 2014-15.pdf

Local Security Management Specialist
Annual Report for 1 April 2014 to 31 March 2015

1. Introduction

All NHS organisations have a requirement under the Standard Commissioning Contract for providers (Service Condition 24) to undertake work in support of the national NHS Security Management Strategy published by NHS Protect. NHS Protects "*Standards for Providers 2014/15 Security Management*" embodies the four key section of NHS Protects strategy:

- Strategic Governance;
- Key Principle 1: Inform and Involve;
- Key Principle 2: Prevent and Deter; and
- Key Principle 3: Hold to Account.

This report provides an overview to the Board on the work carried out within the Trust in relation to these key principles during 2014/15.

2. STRATEGIC GOVERNANCE

Reporting Arrangements – Trust Wide
All Security management matters are reported thorough the Trust's Health & Safety Committee. This is achieved through regular reports provided by:

- Head of Security/Local Security Management Specialist ("LSMS")
- Health & Safety Manager
- Fire Officer

Reporting Arrangements - National
The LSMS is responsible for reporting violence and aggression and security incidents to NHS Protects Security Incident Reporting System ("SIRS").

Local Security Management Specialist Annual Work Plan
The LSMS work plan details the work conducted by the Trust to meet the Security Management Standards. It includes policy development and review, investigations, incident analysis, liaison within Trust services and external organisations. The Work Plan is reviewed and updated in conjunction with the Security Management Director and /or Trust Secretary.

Security Management Policies
The following Trust policies relate to security management:

- Security Policy
- Management of Violence & Aggression Policy (incorporates Lone Worker Guidance and compliance with the CCTV Code of Practice statement)
- Missing Patients Policy

Quality Assurance Framework
The Trust is required to complete an online Security Management Self Review Tool against the thirty-one NHS Protect Standards to identify areas of non-compliance and further development. Areas of non-compliance/further development form the LSMS's work plan for the next year. Compliance is graded on a Red/Amber/Green system as

follows:

Red The Trust does not have anything in place in relation to that standard.
Amber The Trust can demonstrate actions in place to meet the standard.
Green The Trust can demonstrate actions in place to meet the standard which are monitored and reviewed on a regular basis and that any changes are put in place where those monitoring arrangements identify deficiencies/room for improvement.

In January 2014 the security management provision during the year 2012/13 was self-reviewed against the NHS Protect standards and the Trust declared the following against the 31 standards: 15 Green; 11 Amber and 5 red. For the Amber and Red standards, actions were identified to mitigate the risk and are included in the work plan. Our overall rating was **Amber**.

The Security Management Standards will next be required to be submitted in November 2015. The self-assessment will be reviewed and signed off by the Security Management Director ("SMD") and submitted to NHS Protect to provide the appropriate level of assurance and compliance required.

Quality Assurance Assessment
On 28 April 2015 the Trust's security management arrangements in relation to NHS Protect Standards 1 and 2, Strategic Governance and Inform and Involve were externally assessed by NHS Protect. This assessment was conducted in line with the requirements of security management standards for providers.

As set out above, we are required, on an annual basis, to provide a self-assessment against the standards to NHS Protect. In relation to the two standards assessed, our own assessment was that we were compliant (green) with standard 1 and partially complaint (amber) with standard fully. The assessment concluded that we were in fact in a better position than that declared (green for both standards). However, there were two areas where further work was identified. An action plan to address these two areas was developed.

3. KEY PRINCIPLE 1: INFORM AND INVOLVE

Security Management Investigations
In 2014/15, the LSMS reviewed all incidents reported in relation to violence and aggression and security issues (i.e. thefts, damage, unlawful entry etc). Where appropriate, interventions were initiated to ensure the safety of Trust staff and others and property.

These have included, for example, individual lone worker arrangements, the issuing of warnings, including verbal and written communications, sharing of information with other organisations and reporting of crimes to the Police.

Health and Safety Committee
The Health and Safety Committee's overall purpose is to provide, monitor and review safety policies and procedures which include security management. As part of the terms of reference, issues relating to the security of the premises and safety of staff are a standing agenda item. Regular updates in relation to security and actions taken, local and national initiatives and policy development are discussed.

Security Awareness
Little work was undertaken in 2014/15 to promote security awareness. The current

LSMS is also the Patient Safety Risk Manager, having responsibility for ensuring that incidents are identified and investigated appropriately. The time spent on this role over the last year has had a negative impact on the time available to undertake the LSMS role and has impacted on security management awareness raising. This has been addressed as part of the self-assessment and the Quality assessment undertaken by NHS Protect in April 2015.

4. KEY PRINCIPLE 2: PREVENT AND DETER

TRAINING:

Prevention of Violence and Aggression Training
The Trusts Conflict Resolution Training is currently being reviewed to ensure it meets the objectives contained within new guidance issued by NHS Protect. This revision is looking at providing a more bespoke "risk based" training package rather than a standardized program. This package is being developed with input from specialist nurses including the Matron for Complex Needs and Nurse Consultant to ensure all aspects of learning disabilities/dementia/delirium and other clinical/medical complexities as well as the Mental Health Act requirements are incorporated. The focus of the program will be to ensure participants gain the essential knowledge, skills and confidence to prevent and de-escalate crisis situations reducing the risk to staff from violence and aggression.

In the meantime, a new e-learning package has been developed (with thanks to North West) which will be mandatory to all staff from September 2015. This training package will form the basic level awareness session for all staff.

Dementia Awareness Training
A significant number of violence and aggression incidents on staff were due to medical factors including patients with dementia. To help reduce the incidence of both physical and non-physical assaults by patients with dementia towards staff, and to improve patient care, Dementia Awareness training is available to staff.

Breakaway Training
Breakaway training was provided to staff through the conflict resolution training. However, as with conflict resolution, this program is under review. A suitable level of training needs to be agreed to ensure that the appropriate training is provided to staff to meet the new national guidance.

Safe Holding Techniques
Introduction of the Restrictive Physical Interventions Guidelines has introduced a need for appropriate levels of intervention and training for all staff to ensure safe and dignified outcomes for our patients. This is being considered as part of the new conflict resolution training package.

No training is currently provided to staff in the use of Control & Restraint and/or Safe Holding Techniques.

GENERAL SECURITY ARRANGEMENTS:

Lone Working Arrangements
Lone Working continues to be a key area of activity and monitoring of processes and compliance in relation to the safety of staff.

Security Assessments
Security Assessments to reduce the risk of security incidents are on-going Trust-wide to ensure the Trust provides a safe and secure environment. Each year each department/ward completes a generic risk assessment to help identify any trust-wide issues. Individual risk assessments are undertaken where a specific issue or concern is raised.

A report, pulling together the key themes/issues identified within the annual risk assessments are presented to the Health & Safety committee. The last 2 years reports have not identified any areas of concern in relation to safety and the environment. This year's findings did not highlight any concerns to be addressed.

Where appropriate, where security risks have been identified in a number of buildings/departments/wards, action plans are compiled to mitigate or reduce these risks where possible.

POLICIES:

Security Policy
The Trust's Security Policy details the requirements for the provision of a safe and secure environment minimising and preventing violence and aggression against those providing services and the protection of Trust property and assets, both financial and non-financial. It also aims to:

- Protect the safety, security and welfare of staff, service users and visitors whilst on Trust property;
- Provide safe systems and safeguards against crime, loss, damage, or theft of property, equipment or other assets; and
- Minimise disruption or loss of services to service users and to the Trust core activities.

Management of Violence and Aggression (Incorporating Lone Worker Guidance)
National reporting by NHS Protect continues to show that violent and aggressive incidents at work are escalating within the healthcare services and that employees may encounter physical or verbal aggression during the course of their normal duties.

There is a significant risk of violence and aggression to staff safety due to the services we provide, for example but not restricted to, the Accident and Emergency Departments, and in the care of the elderly presenting in the both the acute and community setting when presenting with challenging behaviour due to medical factors.

A full review of the Violence and Aggression Policy is due to be completed by December 2015. It is key that this review takes into account new guidance from NHS Protect on the prevention and management of clinically-related challenging behaviour. This is a key area of work to carry forward into the LSMS work plan.

National and Local Alerts
A Security Management alert process ensures arrangements are in place to receive, record, risk assess, disseminate and share information on security related issues and individuals who may pose a significant, present or potential, threat to NHS staff, NHS service providers or NHS property assets. Any national and local alerts received by the Local Security Management Specialist are circulated in accordance with NHS Protect policy guidance.

Medicines Security
This relates to the storage of all prescription and non-prescription drugs in approved containers and is monitored by the pharmacy service. The main pharmacy at both our hospitals and Acre Mill has physical security measures in place to reduce likelihood of a security related incident. All incidents are reported through the Trust's incident reporting system and followed up as appropriate.

NHS Protect has provided a self-assessment tool designed to support chief pharmacists in their evaluation of organisational policies and procedures against guidance and legislative requirements for the secure management and storage of medicines.

The LSMS as part of the Security Management Work Plan 2015/16 – 16/17 will review the self-assessment tool and provide advice and guidance to the Pharmacy Service. This will include a review by the LSMS, together with the Fire Officer of the current physical security measures.

5. KEY PRINCIPLE 3 - HOLD TO ACCOUNT

Security Incidents
The Trust is committed to an open reporting and learning process for all security incidents and near misses that occur. The understanding of incidents reported informs training programs, capital improvements, equipment purchases and development of safer ways of working.

In 2014/15 198 security incidents were reported. Compared to 2013/14 this represents a decrease of 3% (7 incidents). The table below shows the number and types of incidents reported.

	13/14	14/15
Access - Unauthorised access or use of password	1	1
Accidental damage	2	0
Accidental damage to premises	4	2
Breach of confidentiality of staff records or information	1	1
Damage caused by vandalism (other than ARSON)	3	4
False fire or intruder alarm	5	1
Illegal Drugs found on person/in locker	2	1
Intruders, Break-ins, Trespassers, Intruder alarms	4	11
Lost/missing property/damaged property	121	117
Other breach of security or public order	23	13
Other incident related to Security	23	22
Proven, alleged or suspected theft	16	23
Suspected bogus person	0	2
Totals:	205	198

Physical and Non-Physical Assaults
The NHS Protect definition of Physical Assault against staff is as follows:

"*The intended application of force to the person of another, without lawful justification, resulting in physical injury or personal discomfort*."

The NHS Protect definition of a Non-Physical Assault against staff is as follows:

"The use of inappropriate words or behaviour causing distress and/or constituting harassment."

The table below demonstrates that in 2014/15, there were 143 reported incidents of Physical Assault and 244 Non-Physical Assaults against staff, this representing a 15% increase and 14% decrease respectively in the number reported in 2013/14.

	13/14	14/15
Non-Physical - Disruptive, aggressive behaviour - other	112	111
Non-Physical – Racial	6	4
Non-Physical - Threats to harm/threatening behaviour	7	3
Non-Physical - Verbal abuse or disruption	158	126
	283	**244**
Physical - Physical abuse, assault or violence	119	143
Physical – Sexual	2	0
	121	**143**
Totals:	**404**	**387**

Security Incident Reporting System

NHS Protect commissioned a national Security Incident Reporting System to better understand the scale of security incidents within the NHS which is a key step towards building of a safer NHS where people and property are protected. Security Incident Reporting System enables health bodies to report incidents electronically making reporting easier and more efficient. LSMS are required to report the following all types of security incidents, including physical assault against staff, non-physical assaults, theft or damage (including burglary, arson, and vandalism) to NHS property or equipment issued to staff, as well as information on theft or damage to staff or patient personal property arising from these types of security incident onto SIRS.

NHS Protect have invested a lot of time and money over the past few years in simplifying the system and working with risk management database organizations (such as Datix) to introduce ways of capturing this data without in effect double reporting. This has now been perfected and our Trust is going to work with NHS Protect to introduce direct reporting.

Details reported on SIRS form part of the national annual Physical Assault data collection undertaken by NHS Protect.

Sanctions and Criminal Prosecutions

A range of sanctions against those responsible for security incidents and breaches can be applied through a combination of procedural, disciplinary, civil and criminal actions as appropriate.

In 2014/15 two letters were written to patients whose behavior was deemed such to be unacceptable. This is a significant reduction on previous years. It should be noted that an anti-social behavior order remains in place for a particular problematic patient who added our both our A&E departments last year. This patient been imprisoned on two occasions as a result of breaching this order.

6. Conclusions

Whilst the LSMS has not been able to commit fully to the role over the last 12 months, the Trust continues to have a good security awareness culture in that the number of incidents reported stays similar to that of the previous year. Annual risk assessments are also not identifying any concerns as to their safety or security of their working environment. That said it is recognised that further work is required to improve the Trust's overall compliance with the NHS Protect Security Management Standards.

The external assessment highlighted that the function of the LSMS role was different within our Trust as, in all other Trusts within Yorkshire and the Humber, this function is held either by the Head of Security or the Health & Safety advisor.

To this end the role of the LSMS is transferring to the Estates & Facilities Division and a full-time LSMS/Health & Safety advisor is to be appointed. This provides an excellent opportunity to re-launch the role of the LSMS; security awareness and to provide a commitment to achieving full compliance against the standards which, in turn, will provide not only a safe a secure environment for all staff, patients and visitors but will reinvigorate the security culture in the organisation.

7. Next Steps

For the remainder of 2015/16:

- to ensure that the action plan developed following the NHS Protect assessment be implemented;
- to submit our self-assessment in November 2015, as per NHS Protects requirements;
- upon completion of the above, develop an LSMS work plan with a view to improving compliance, in turn raising the profile of security within the organization;
- to appoint a full-time LSMS/Health & Safety Advisor.

Author: Claire Gruszka, Local Security Management Specialist
Approved by:
Julie Dawes, Security Management Director

Dated: 18 August 2015

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Vicki Drummond, Workforce Assurance Manager
Date: Thursday, 24th September 2015	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: Nursing & Midwifery Safe Staffing Report - To provide the Board of Directors with: • An overview of the current size and shape of the Nursing and Midwifery Workforce. • The current reality of the Nursing and Midwifery workforce Recruitment and Retention Strategy. • An overview of the findings from June 2015 Ward Based Staffing Review. • An assessment against the National Quality Board 10 expectations and NICE guidance for safe staffing. • The year to date temporary and substantive workforce expenditure. • To bring to the attention of the Board any workforce risks.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: None	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

• Achieving safe staffing levels in nursing and midwifery are essential to provide safe and compassionate care.
• This paper demonstrates compliance with National Quality Board expectations.
• A further paper is to be presented to Board in November 2015 which will recommend any adjustment to Nursing and Midwifery workforce models.

Main Body

Purpose:

To provide the Board of Directors with:

• An overview of the current size and shape of the Nursing and Midwifery Workforce
• The current reality of the Nursing and Midwifery workforce Recruitment and Retention Strategy
• An overview of the findings from June 2015 Ward Based Staffing Review
• An assessment against the National Quality Board 10 expectations and NICE guidance for safe staffing
• The year to date temporary and substantive workforce expenditure
• To bring to the attention of the Board any workforce risks

Background/Overview:

The following paper presented to the Board of Directors is the fourth in a series of reports / updates on the Nursing and Midwifery workforce. The Board also receive monthly performance updates on Nursing and Midwifery staffing within the Integrated Board Report.

The importance of ensuring nursing and midwifery staffing levels has been reinforced through a number of publications:

• National Quality Board – How to ensure the right people, with the right skills, are in the right place at the right time. (NHS England, 2013)
• Hard Truths: The Journey to putting patients first. (Department of Health, 2014)
• Safe Staffing for nursing in adult inpatient wards in acute hospitals. (NICE guidelines [SG1], 2014)
• Safe Midwifery Staffing for maternity settings. (NICE guidelines [NG4], 2015)

This paper addresses our compliance with the recommendations within these reports, and provides an overview of progress within the nursing and midwifery workforce following the actions agreed in the last report accepted by the Board of Directors in April 2015.

The Issue:

Please see report for detail.

Next Steps:

This 6 monthly review provides assurance to the Board that the Trust has a growing nursing and midwifery workforce committed to supporting patients and families. The Nursing Workforce Strategy Group is developing the workforce to ensure healthcare is provided by a multi professional workforce including roles such as advanced practitioners; cancer co-ordinators to ensure the right skill mix is in place.

Workforce models have been reviewed utilising recognised tools to inform staffing requirements.

A panel chaired by the Director of Nursing will further review all workforce models in October 2015 to inform business planning. A short paper will be provided to Board in November 2015 which will include any recommendations required to continue to achieve nursing and midwifery safe staffing levels.

There remains significant risk to the workforce due to the national shortage of qualified nurses and current immigration challenges. Sustained recruitment and retention of the nursing workforce is a key priority.

Current areas of risk to be prioritised:
• Red flag event reporting
• Workforce models for community nursing
• A&E

Potential areas of risk being monitored / developed:
• Insufficient headroom in workforce models
• Impact of increased number of long days
• Increase in wte retiring as technology increases within the workforce
• Investment in Critical Care
• Investment in endoscopy due to bowel scope

Recommendations:

The Board of Directors is asked:
• To note the challenges around recruitment and retention of the nursing workforce
• To note the increased metrics informing recommended workforce models
• Review and be satisfied that the appropriate level of detail and assessment has been undertaken or planned to review the nursing and midwifery workforce to ensure safe staffing levels are achieved.
• Note the next six monthly staffing review and recommendations will be presented to the Board in February 2016.

Appendix

Attachment:

Hard Truths Nursing Staffing Report - BoD - September 2016 v6 - FINAL VERSION.pdf

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Report to:	Board of Directors – September 2015
Subject:	**NURSING AND MIDWIFERY SAFE STAFFING**
Sponsored by:	Julie Dawes, Director of Nursing
Prepared by:	Jackie Murphy, Deputy Director of Nursing Vicki Drummond, Assistant to the Director of Nursing – Workforce Assurance Manager
Purpose of the Report:	To provide the Board of Directors with: • An overview of the current size and shape of the Nursing and Midwifery Workforce • The current reality of the Nursing and Midwifery workforce Recruitment and Retention Strategy • An overview of the findings from June 2015 Ward Based Staffing Review • An assessment against the National Quality Board 10 expectations and NICE guidance for safe staffing • The year to date temporary and substantive workforce expenditure • To bring to the attention of the Board any workforce risks
Key Points for Trust Board Members:	• Achieving safe staffing levels in nursing and midwifery are essential to provide safe and compassionate care. • This paper demonstrates compliance with National Quality Board expectations. • A further paper is to be presented to Board in November 2015 which will recommend any adjustment to Nursing and Midwifery workforce models.
Next Steps Future action:	The Board is asked to note the information contained in this report and the actions we have in place.
Strategic Aim	Keeping the Base Safe
Risk Register	
CQC Reference	

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1.0 INTRODUCTION

1.1 The following paper presented to the Board of Directors is the fourth in a series of reports / updates on the Nursing and Midwifery workforce. The Board also receive monthly performance updates on Nursing and Midwifery staffing within the Integrated Board Report.

1.2 The importance of ensuring nursing and midwifery staffing levels has been reinforced through a number of publications:

- National Quality Board – How to ensure the right people, with the right skills, are in the right place at the right time. (NHS England, 2013)
- Hard Truths: The Journey to putting patients first. (Department of Health, 2014)
- Safe Staffing for nursing in adult inpatient wards in acute hospitals. (NICE guidelines [SG1], 2014)
- Safe Midwifery Staffing for maternity settings. (NICE guidelines [NG4], 2015)

1.3 This paper addresses our compliance with the recommendations within these reports, and provides an overview of progress within the nursing and midwifery workforce following the actions agreed in the last report accepted by the Board of Directors in April 2015.

2.0 NATIONAL QUALITY BOARD EXPECTATIONS

2.1 The National Quality Board published 10 expectations in relation to nursing, midwifery and care staffing capacity and capability in 2013 to support NHS organisations in making the right decisions to provide high quality, compassionate care.
Table 1 demonstrates CHFT current compliance with those expectations and planned next steps.

2.2 To date CHFT are fully compliant with nine of the National Quality Board expectations. The one area in which we have assessed ourselves as partially compliant is in the area of nurses and midwives having sufficient time to fulfil responsibilities, which are additional to their direct caring duties.

Whilst ward based establishments received an increase in supervisory time to 100% in 2014 and an increase in headroom to 20%, it has remained challenging to achieve supervisory status due to vacancy levels and supporting additional capacity demand.

A review of headroom is currently being undertaken by the Nursing Workforce Strategy Group. We expect a review of the direct and indirect contact time results (study completed in June 2015) to provide valuable intelligence informing areas of responsibilities, which could be carried out by non-registered nurses resulting in nurses and midwives having sufficient time to fulfil all responsibilities.

Table 1: CHFT compliance against National Quality Board Expectations

Focus	Expectation	CHFT Current Status	Evidence of Compliance	Next Steps
Accountability & Responsibility	1. Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective responsibility for nursing, midwifery and care staffing capacity and capability	Achieved	• Board actively involved in agreeing staffing establishments (March 2015 and September 2015) • Board regularly updated on recruitment, training and key quality outcome measures • Integrated Board report provides monthly update on safe staffing levels achieved, current areas of concern and action taken to address (accessible to patients and staff).	• Site view of daily staffing levels providing both current and prospective for next 24hours due to launch electronically September 2015. • This will increase the information currently shared to include additional safe staffing indicators including red flag events and proportion of substantive to temporary workforce in any one area.
	2. Processes are in place to enable staffing establishments to be met on a shift-to-shift basis	Achieved	• Process in place to alert Flexible Workforce when additional staff required due to shortfall. • All areas reviewed with real-time monitoring to address absence, unplanned activities and change in skill mix as a result of temporary workforce use. • Matron of the day role commenced August 2015 to ensure senior nurse monitoring shift to shift staffing at all times • Promotion of escalating staffing concerns to Site Co-ordintor and Matron completed April 2015 through red flag event initiatives.	• Safe Staffing incorporated into nursing and midwifery induction from September 2015 to ensure all staff aware of how to raise concerns

Focus	Expectation	CHFT Current Status	Evidence of Compliance	Next Steps
Evidence-Based Decision Making	3. Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability	Achieved	• Acuity and Dependency studies completed utilising NICE approved tool SNCT • Professional Judgement recorded daily on the web based safe staffing tool • Additional staffing indicators utilised (see section 8.0)	• Update / training session on classification of patients utilising SNCT scheduled for November 2015 • Review of electronic systems (SNCT APP and Nerve centre) underway to review possible use to complete SNCT.
Supporting and Fostering A Professional Environment	4. Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff fell able to raise concerns.	Achieved	• All areas have supervisory status built into their workforce models to provide structured and support within teams • All staff encouraged to raise concerns (guidance on how to do this included on nursing workforce induction)	• Additional support for newly qualified nurses due to commence October 2015 in response to concerns that nurses did not all receive preceptorship and level of support they required. • Preceptorship register to commence September 2015 • Nurses joining CHFT to be informed of their preceptor prior to arrival September 2015
	5. A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments	Achieved	• Reviews are completed with ward managers, matrons and members of the multidisciplinary team. • The Nursing and Midwifery Strategy Group receive and endorse any recommendations to Board. • Membership of the Nursing and Midwifery Strategy Group include Workforce and Finance colleagues.	
	6. Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties.	Partially achieved	• Establishments incorporate supervisory time, but this is not always currently achieved due to vacancy levels and additional capacity demand. • Headroom has been set at 20%	• Review of headroom to be completed (see section 4.5) • Matron's to review contact time results and identify areas of focus to increase efficiency of nursing time. • Review of additional roles contact time results through the Matrons to identify any areas which can be further developed to assist with maximising efficiency of the nursing workforce.

Focus	Expectation	CHFT Current Status	Evidence of Compliance	Next Steps
Openness and Transparency	7. Boards receive monthly updates on workforce information, and staffing capacity and capability is discussed at a public Board meeting at least every six months on the basis of a full nursing and midwifery establishment review	Achieved	• Monthly report provided (Integrated Board Report) comparing the planned staffing level, reason for any gap and action taken. • Establishment review provided to Board 6 monthly	• Quality dashboards have been developed within the last 6 months to provide trend analysis on key quality and outcome measures which will provide additional information regarding the impact potentially related to staffing levels. • Quality dashboards to provide month on month view for each ward area expected October 2015
	8. NHS providers clearly display information about the nurses, midwives and care staff present on each ward, clinical setting, department or service on each shift.	Achieved	• Boards are in place and managed to display staff on duty. • Information booklets including how to raise concerns for red flag nursing events and the staff and roles in place available.	
Planning for the Future Workforce Requirements	9. Providers of NHS services take an active role in securing staff in line with their workforce requirements	Achieved	• Recruitment and Retention strategy in place and monitored through Nursing and Midwifery Strategy Group • Workforce planning completed to inform Future Workforce Forecast and LETBs July 2015	
The Role of Commissioning	10. Commissioners actively seek assurance that the right people, with the right skills, are in the right place at the right time within the providers with whom they contract.	Achieved	• Commissioners updated quarterly through quality report in relation to safe staffing • Commissioners updated monthly on planned against actual staffing levels • Engagement with commissioners incorporated into workforce plans for proposed changes to workforce models	

3.0 FINANCIAL UPDATE

3.1 In terms of Hard Truths investment, the opening budgets in April 2015 incorporate the full year effect of the Hard Truths investments made in 14/15 and no further investment has been made in this financial year.

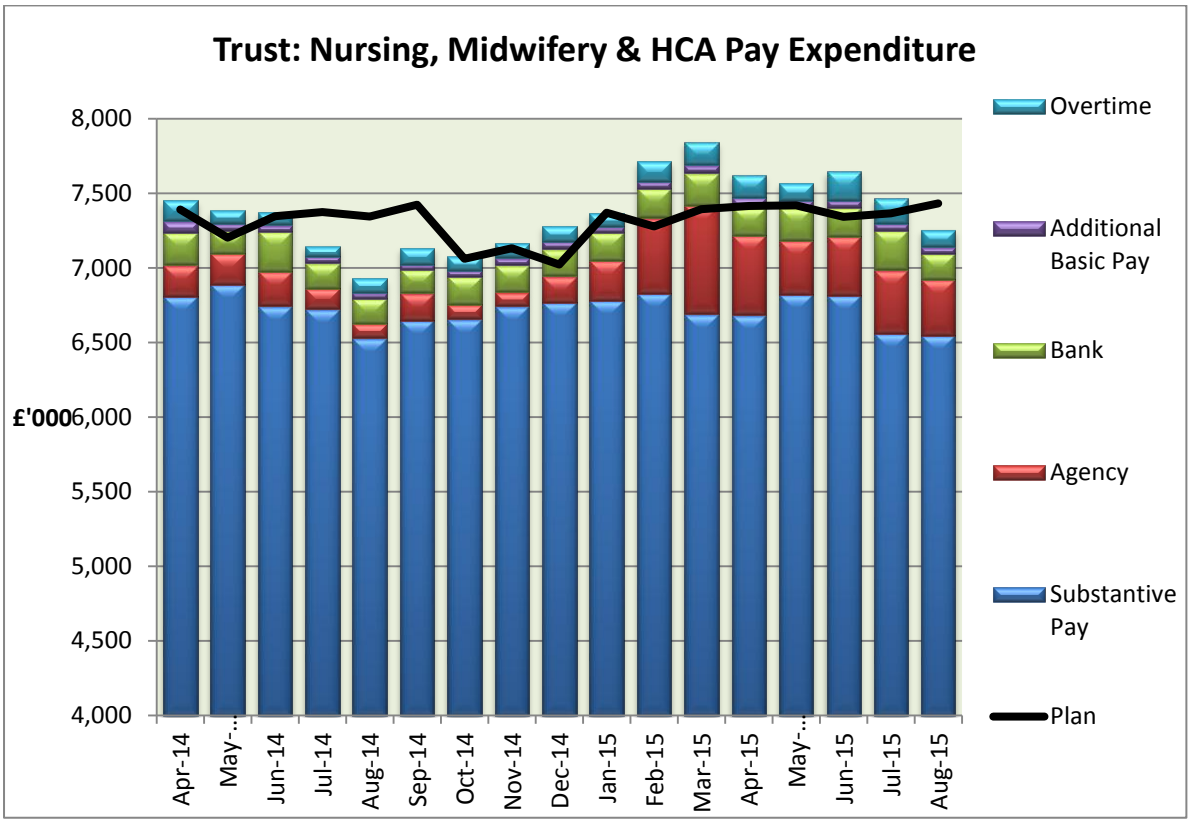
Current expenditure has been impacted upon by an increased use of agency and flexible workforce primarily to address increased planned staffing levels balanced against vacancy levels, additional capacity demand and headroom factors.

Table 2: August 2015: Pay expenditure on Nursing, Midwifery and HCA including Agency.

*The total budgeted amount does include the adjustment for Vacancy factor and any budgets identified as CIP have been taken out.

	Nursing, Midwifery & HCAs Pay Expenditure including Agency							
	M05 YTD Budget	M05 YTD Actual						M05 YTD Variance
	Total Budget	Total Actual	Substantive Pay	Agency	Bank	Additional Basic Pay	Overtime	
	£	£	£	£	£	£	£	£
MEDICAL DIVISION	12,835,395	14,270,148	11,468,692	1,673,221	651,685	82,281	394,269	1,434,753
SURGERY & ANAESTHETICS	9,838,929	9,617,943	8,786,555	341,142	210,417	58,557	221,272	-220,986
FAMILIES & SPECIALIST SERVICES	8,844,929	8,582,028	8,217,016	56,106	140,317	82,884	85,706	-262,901
COMMUNITY	4,822,401	4,479,715	4,381,469	5,830	26,305	31,036	35,074	-342,686
ESTATES & FACILITIES	24,535	36,177	24,833	11,344	0	0	0	11,642
CORPORATE SERVICES	607,979	563,901	555,507	0	5,298	1,692	1,404	-44,078
CENTRAL & TECHNICAL		0	0	0	0	0	0	0
HEALTH INFORMATICS		5,770	0	0	5,770	0	0	5,770
PMU	859		0	0	0	0	0	-859
RECHARGES		24	0	0	24	0	0	24
TRUST TOTAL	**36,975,027**	**37,555,705**	**33,434,071**	**2,087,644**	**1,039,816**	**256,450**	**737,725**	**580,678**

Table 3: Demonstrates the total Nursing Workforce pay trends by month 2014 – 2015.



3.2 Temporary Spend

Increased planned staffing levels following the Hard Truths investment in 2014, vacancies and additional capacity demand has led to an increased average agency spend in the last quarter of 2014 / 2015 of £500k per month compared with an average for the same period in 2013/14 of £250k per month (see Table 4 for detail)

Table 4 : NURSING AGENCY COSTS 2013 – 2014 COMPARED TO 2014 - 2015

13/14 Nursing, Midwifery & HCA Pay	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Total
	£	£	£	£	£	£	£	£	£	£	£
Agency Costs	301,886	324,660	190,590	186,542	373,479	209,701	207,696	231,764	138,323	94,574	2,259,216

14/15 Nursing, Midwifery & HCA Pay	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Total
	£	£	£	£	£	£	£	£	£	£	£
Agency costs	93,391	179,309	266,641	504,656	725,955	529,957	360,517	393,637	426,887	376,646	3,857,596

Increase / (decrease)	(208,495)	(145,351)	76,051	318,113	352,476	320,256	152,821	161,872	288,564	282,072	1,598,380

3.3 Within the last 12 months the single source agency agreement previously held for the nursing workforce ceased due to fill rates from the agency resulting in fill rates below 20% of those requested for qualified nurses.

Additional agencies were sourced through the procurement team, and a tiered level of agencies introduced with any request to the top tier agencies (high cost) requiring director approval. This has resulted in an increasing fill rate via temporary workforce solutions resulting in an increased spend.

As vacancy levels have reduced and the demand of additional capacity reduced use of the highest cost agency stopped on 30.6.15. A further Tier 3/ 4 (highest cost) agency stopped in August 2015 in all but the most exceptional cases. In August 2015 the length of time provided to Tier 2 agencies to fill shifts was also reduced with the intention of filling unfilled shifts with Tier 1 / 2 agencies to the maximum.

Table 5: Comparative hourly cost (day rate) for agency tiers.

Substantive band 5 Nurse	£14.79
Tier 1 qualified nurse	£28-30
Tier 2 qualified nurse	£36-37
Tier 3 qualified nurse	£38
Tier 4 qualified nurse	£53

An additional five Tier 1 agencies have been recruited in August 2015 with the aim of increasing fill rates through Tier 1 agencies.

3.4 A review of the Internal Flexible Workforce Service indicated that current service provision is not as effective or efficient as required to meet current demand. An options appraisal was completed which identified four potential options which are being considered.

We anticipate that a move to a managed bank service available 24 hours a day, 365 days of the year will improve the efficiency of providing temporary staffing solutions, in addition to improved governance of the temporary workforce utilised.

3.5 An increase in temporary spend may also be as a result of the current 20% headroom built into the workforce models for nursing and 21% for midwifery. The current headroom split for nursing is demonstrated in Table 6.

Table 6: Headroom in Nursing

Sickness	4.5%	
Annual Leave	11.23%	
Mandatory Training	1.01%	2.01% in Midwifery
Other	1.01%	

A review of the headroom calculations has identified that the split of 20% is required to change to accommodate demand. The Nursing and Midwifery workforce models are recommended to be modified to include the headroom split as detailed in Table 7.

Table 7: Revised allocation of 20% headroom in Nursing

Sickness	3.5%
Annual Leave	14.23%
Mandatory Training	1.28%
Other (inc. maternity leave)	0.99%

3.6 Improved reporting through the e-rostering system has recently led to increased management information indicating the current headroom split. Matrons and Associate Directors of Nursing have committed to overseeing the rosters to ensure avoidable risks such as over allocation of annual leave do not occur placing additional strain on staffing levels.

Early indications from headroom reports suggest suggest 20% headroom may be insufficient (particularly in relation to sickness level of 3.5%) and thus contribute to an increased temporary spend. A national review of headroom is currently being completed and the Nursing and Midwifery Strategy Group will review the findings when completed. Meanwhile provisional scoping to explore the cost of raising the headroom to 23% to reduce temporary spend has been requested and a review of the estimated time mandatory and essential skills training requirement will result in.

The estimated investment and training time requirements and any recommended actions will be presented to Board following business planning in November 2015.

3.7 Recruitment initiatives to increase the number of Health Care Assistants (HCA's) have been completed, particularly targeting second year student nurses resulting in 56 HCA's being recruited to the bank. Recruitment to qualified nurses has also been advertised on a monthly basis, but with a limited response (15 qualified nurses).

For the month of June an enhanced rate of pay was offered to flexible workforce members (qualified and unqualified) with the aim of increasing fill rates through this method of temporary workforce. This resulted in an increase of 142 hours additional coverage. Evaluation indicated that regular flexible workforce staff booked at short notice to receive the enhanced rate of pay. This initiative was discontinued for HCA's, but is currently still in place for qualified staff to ensure we maximise use of flexible workforce against high cost agency.

This resulted in 51 Staff being paid additional pay through the incentive totalling an additional cost of £8,086.95 in July and August.

3.8 In September 2015 new Agency Rules were received from Monitor and the NHS Trust Development Authority (TDA). The rules result in an annual ceiling for total nursing agency spending (qualified nurses / midwives / health visitors only) and mandatory use of approved

frameworks for procuring agency staff.

CHFT are in the process of agreeing the ceiling to be applied at CHFT. The Nursing Workforce Strategy Group will respond to the new agency rules which will be effective from October 2015.

4.0 NURSING AND MIDWIFERY PROFILE

4.1 The contracted whole time equivalent (WTE) nursing and midwifery workforce in post has reduced in comparison from July 2014 and July 2015 by a total of 32.86 WTE (15.07 WTE qualified and 17.79 unqualified).

Table 8: Nursing and Midwifery Contracted WTE

	July 2014	July 2015
Contracted Qualified wte	1661.87	1646.8
Contracted Unqualified wte	696.75	678.96
Total wte	2358.62	2325.76

4.2 The reduction in WTE can in part be attributed to the transfer of the school nursing service to an alternative provider which resulted in 11.95 WTE qualified and 2.94 WTE unqualified leaving CHFT, and the introduction of long days into planned workforce models. Across the divisions the long day initiative reduced the required WTE qualified by 29.63 and 21.8 unqualified.

Table 9: Current Vacancies (WTE) September 2015

*Information received from the Matrons and verified by Associate Directors of Nursing

	Current Vacancies	Pipeline of Candidates Awaiting start date	Remaining Vacancies
Qualified	181.86 wte	144.26 wte	37.6 wte
Unqualified	26.15 wte	12 wte	14.15 wte

4.3 Vacancies within the Nursing workforce will increase from October 2015 despite a focused recruitment strategy due to additional staffing required following bed remodelling for the Trust.

Table 10: Forecast vacancy position qualified nurses

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16
Current Vacancies	37.6	132.6	141.6	143.6	143.6	147.6
Starters	*	18	18	20	16	16
Leavers	20	20	20	20	20	20
Staffing for additional beds	75	7	-	-	-	-
Resulting vacancies	132.6	141.6	143.6	143.6	147.6	151.6

*starters for October are included in current vacancy position of 37.6 wte calculation as part of the pipeline due to arrive between Sept / Oct 2015

*forecast position includes an element of international recruitment resulting in an additional 33 recruits.

The Nursing Workforce Strategy Group do not anticipate any difficulties in recruiting to unqualified vacancies and have a scheduled event on 19.9.15 with over 80 confirmed candidates attending to address the additional requirements for unqualified nurses.

4.4 Significant work has continued to achieve greater clarity with regard to the vacancies within the nursing and midwifery workforce. The matrons for each area identify their vacancies monthly through meeting with the ward / area managers, and identify potential leavers prior to termination forms being completed. This information is then verified by the Associate Directors of Nursing for each area.

The vacancies reported by the nursing staff do not always correlate to the financial ledger position, but recently finance has ensured all nursing and midwifery staff are coded correctly on ESR. Early indications from a trial in August identified further work between ESR and finance was required to ensure the accuracy of this data is maximised. The vacancy information will be provided by ESR from September 2015.

A triangulated approach between the collated vacancies verified by the matrons, finance and ESR will continue until we are confident in the data provided.

4.5 Turnover in May 2015 was lower than it had been for the previous 6 months, however data received from ESR indicates that turnover has increased recently for both qualified and unqualified staff. The turnover trend for the last 6 months is evidenced in table 11.

Table 11: Turnover

	Nov 14	Dec 14	Jan 15	Feb 15	March 15	Apr 15	May 15	Jun 15	Jul 15
Turnover Qualified %	0.98	1.13	1.63	1.06	2.46	1.40	0.80	1.45	1.05
Turnover Qualified WTE	16.59	19.01	27.21	17.67	40.45	22.09	16.69	23.87	18.19
Turnover Un qualified %	1.42	0.55	0.44	0.51	2.50	1.08	0.84	0.64	1.06
Turnover Un Qualified WTE	10.94	3.32	1.80	3.35	13.57	9.07	6.14	5.13	7.79

*Increased turnover in March included the transfer of school nursing service to an alternative provider.

Reducing turnover remains a key focus for the Nursing and Midwifery Strategy Group.

4.6 Sickness and absence for qualified nurses is currently at the lowest level since March 2015, but this remains significantly higher than the 3.5% level the Trust requires (Table 12).

Absence rate for unqualified nurses has reduced from the peak reached in December and January, but also remains higher than the Trust standard (Table 12).

Table 12: Absence rates

	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	April 15	May15	June 15	July 15
Absence rate Qualified %	4.77	5.44	5.19	4.74	4.90	5.30	5.27	5.33	5.09
Absence Rate Unqualified %	7.75	8.19	8.45	7.61	7.45	7.09	7.75	7.31	6.69

4.7 Each division has identified the top 3 reasons for absence and the number of working days lost as a result which are from August 2014 – July 2015.

Table 13: Top 3 reasons for sickness August 2014 – July 2015

Division	Reason for Sickness	FTE Days Lost
372 Community L3	S10 Anxiety/stress/depression/other psychiatric illnesses	738.20
	S98 Other known causes - not elsewhere classified	704.96
	S28 Injury, fracture	436.81
372 Corporate L3	S10 Anxiety/stress/depression/other psychiatric illnesses	69.00
	S12 Other musculoskeletal problems	40.00
	S13 Cold, Cough, Flu - Influenza	23.36
372 Estates & Facilities L3	S12 Other musculoskeletal problems	809.87
	S10 Anxiety/stress/depression/other psychiatric illnesses	392.33
	S19 Heart, cardiac & circulatory problems	305.87
372 Families & Specialist Services L3	S10 Anxiety/stress/depression/other psychiatric illnesses	3647.12
	S98 Other known causes - not elsewhere classified	1911.83
	S25 Gastrointestinal problems	1471.97
372 Medical L3	S10 Anxiety/stress/depression/other psychiatric illnesses	3792.92
	S12 Other musculoskeletal problems	2864.62
	S98 Other known causes - not elsewhere classified	1969.09
372 Surgery & Anaesthetics L3	S10 Anxiety/stress/depression/other psychiatric illnesses	3138.96
	S25 Gastrointestinal problems	1736.57
	S12 Other musculoskeletal problems	1212.51

*Information provided by Workforce and Development September 2015

4.8 A revised attendance management policy is due to be completed in September 2015 which will be supported by divisional actions which include:

- Importance of attendance at work being recognised and highlighted to result in a change in culture regarding expectations to attend work regularly.
- Ensuring individuals notify managers early of support required and a proactive approach to early discussions and increased speed of referrals to and interventions from Occupational Health.
- Increased focus on levels of sickness absence in each area and increased accountability for management of this.
- Direct intervention and a personalised plan for each member of staff currently off sick.
- Improved guidance for managers and support to manage sickness absence cases directly without the need for workforce and organisational development intervention at early stages.
- Increased competency of managers to manage absence effectively and resolve issues early, therefore preventing escalation to more formal stages of the process.

- Consideration on a case-by-case basis redeployment or dismissal where attendance has failed to respond to intervention.

4.9 Additional resource in the form of an Attendance Management team has been supported and will be recruited to soon who will lead on the implementation of the revised attendance management policy.

4.10 Retirement forecast through ESR demonstrates that 516 WTE of our current Nursing and Midwifery workforce are currently over 55 years of age with a split of 245 wte qualified and 271 unqualified which is increase of 42 WTE from our position in November 2014.
Within the next 12 months a further 100 WTE will reach the age of 55 years.
It remains difficult to predict retirement trends particularly following pension changes and changes to the retirement laws.
A potential risk to the workforce has been identified though as a significant proportion of the nursing workforce choose to retire with some returning on a part time basis. With the introduction of revalidation and Electronic Patient Record (EPR) this may reduce and could also see an increase in the number of retirees.

5.0 RETENTION OF THE NURSING WORKFORCE

Retaining staff to ensure our workforce remains stable and sustainable continues to be a focus for the Nursing and Midwifery Strategy Group. The group remain committed to improving the support, training and preceptorship available to all members of the nursing workforce.

5.1 Increased focus to identify the reasons for leaving the workforce provided has been completed within the last 6 months for qualified nurses and midwives with a view to further informing our retention strategy.

5.2 The number of WTE leavers from the nursing and midwifery workforce (qualified) increased between October and April 2015 in comparison to April to October 2014. (Table 14)

Table 14: Qualified nurse leavers 2014 – 2015

April – October	November - April	Total wte
121.43 wte	143.01 wte	264.44 wte

*Information received from Workforce and Development May 2015

5.3 Analysis of the reasons for leaving indicated that the largest number of leavers had no reason for leaving recorded. Table 15 demonstrates an overview of reasons for leaving recorded across the organisation for the nursing and midwifery workforce between October 2014 and April 2015. Greater analysis at ward and divisional level was provided to inform divisional priorities.

Table 15: Reasons for leaving October 2014 – April 2015

*Information received from Workforce and Development May 2015

Ranked	Reason for leaving recorded	Headcount	Comments
1	Other / not known	50	
2	Retirement	27	
3	Employee Transfer	28	Includes school nursing service Potentially some inaccuracies in how information recorded with nurses leaving been logged as transfers if moving to another organisation.
4	Promotion	15	
5	Work Life Balance	11	
6	Relocation	10	
7	Health	8	
8=	MARS	7	
8=	Child Dependants	7	
8=	Voluntary Resignation – better rewards	7	
9	Has not worked	5	These are not leavers – they are recruited candidates who have been set up on ESR but dropped out of the recruitment process before starting
10=	Voluntary Redundancy	4	
10=	Voluntary Early Retirement	4	
10=	Dismissal / Early Retirement	4	
10=	End of Fixed Term contract	4	

5.4 An Action plan to increase retention rates and decrease turnover of nursing and midwifery workforce was agreed at the Nursing Workforce Strategy Group in June 2015 and is provided in Table 16.

Table 16: Action Plan to increase retention rates

Action	How and When	Further Action Required
Facilitate internal transfers – prioritising own staff where possible	Commenced December 2014	To promote this option (nursing page on intranet; nursing workforce updates; induction and joint sisters meeting to cascade)
Increased support for existing staff and new starters	• Preceptorship policy renewed and relaunched • Interactive training for preceptors offered from May 2015 • Clinical Skills offering all new starters a skills assessment and development plan (commenced January 2015) • Action Learning sets for new starters providing 1 day per month of structured study and support. • Develop 1 week induction programme for all new members of the nursing workforce (September 2015) • Invest in Band 6 Clinical Support Nurse (see outline below) (September 2015) on trial basis for 6 months	Promote on Nursing page of intranet. Preceptorship database to be developed to record preceptorship offered including ward based preceptor and preceptorship programme. Develop rolling programme of preceptorship and induction for the nursing workforce following evaluation.
Provide development opportunities	• Promote opportunities for development – such as NHS leadership academy further training opportunities through monthly PLF clinic, with success stories in weekly newsletter • Support for newly qualified nurses to complete their Masters (from Sept 15) • Scope opportunity to develop opportunities for HCA's to progress and Access to Higher Education Diploma (Health Care Professions) – September 2015 • Development opportunities within divisions to progress to be promoted and shared.	PLF team to develop drop in clinic for further information / guidance on professional development. Nursing workforce to link with training department to identify opportunities for HCA roles.
Increase understanding of retention strategies	• PLF to complete further education study with focus on retaining staff through support and development using newly qualified nurses commencing September 2015 as focus group.	Application to be made for September 2015
Increase understanding of reasons for leaving	• Workforce Assurance Manager and Flexible Workforce manger to offer face to face interviews with all qualified leavers(August 2015)	Trigger alert to Workforce Assurance Manager from Termination forms to be developed to increase number of leavers surveys complete (face to face) – August 2015
Review e-roster training and support	• Increase user group representation on the E-rostering board and operations group. • Review E-rostering to ensure the programme and ward managers are able to provide the best rosters possible within agreed timescales (September 15)	

5.5 Within the last 6 months an updated preceptorship policy has been launched which has resulted in preceptorship being mandatory for the first time.

The Nursing workforce started to offer new starters the name of their preceptor prior to commencing employment to improve the number of new starters who receive a named preceptor.

Support for preceptors has been developed in the form of an online training package and shared with the ward managers.

1 week induction programmes are due to commence for new starters in September and will then be offered every 3 months for members of the nursing and midwifery workforce. Whilst this will support the new starters it will also support the ward / area teams in providing training and support consistently.

An ongoing preceptorship programme has been developed and will form a rolling programme of half day events each month for nurses / midwives to attend.

5.6 From September 2015 all band 5 nurses joining CHFT will complete a programme of Band 5 competencies and maintain a record of their developing skills as part of their probationary period.

Similarly the Band 2 competencies for HCA's within the Trust and new to the Trust are scheduled to work towards completing competencies developed through the training group.

5.7 We recognise that providing support for nurses and midwives has been difficult in some areas due to the high level of vacancies and supporting additional capacity areas. With the introduction of a large number of newly qualified nurses in September and October we anticipate that there will be an additional need for support to ensure nurses develop in their skills and confidence.

We recommend a 6 month Band 6 secondment post is funded through the recruitment budget to provide additional support to the nursing workforce. This role would accept referrals from the nurses themselves and from ward managers and provide support working alongside nurses, offering support and guidance and opportunities for reflection.

5.8 It has proved challenging to develop an internal rotation programme for the nursing workforce and there has been little interest from both nurses or ward managers to rotate staff. The internal transfer scheme has worked increasingly well offering opportunities for nurses at CHFT to move easily between clinical areas through matching current vacancies to staff requesting opportunities to transfer or develop new skills in areas within the Trust.

6.0 RECRUITMENT

Sustained focus on recruitment has remained a key action and challenge over the last 6 months. The national shortage of nurses has continued to result in a challenging landscape further impacted by a shrinking pool of international resources. Both local and international recruitment campaigns have been completed with success for CHFT.

6.1 Recruitment events at four universities have been completed to raise the profile of CHFT and promote the support and development opportunities we offer for nurses completing their training this year. Further recruitment events within the UK are due to be completed within autumn 2015 which include attending a RCN Jobs Fair in London and completing an advertising campaign with the Guardian newspaper.

6.2 2015 has seen CHFT employ an alternative approach to recruiting nurses due to qualify in September 2015. Nurses have been actively recruited through value based assessment days from January 2015 onwards which is significantly earlier than previous years. Table 17 demonstrates the trend experienced in the nurse led recruitment events leading towards completion of university led training.

Table 17: Headcount of candidates attending band 5 recruitment days 2014 – 2015

Number Attended	Oct	Nov	Dec	Jan	Feb	March	Apr	May	June	July	August
	6	14	19	13	42	50	13	24	4	9	10

6.3 To retain soon to be qualified nurses recruited through the events each successful candidate has benefited from an allocated “keep in touch” nurse from CHFT, who was tasked with keeping in touch either by phone, email or in person with the candidate to ensure they remained engaged with CHFT. Examples of keep in touch events have included facilitating visits to wards or departments within CHFT and informal ward based events.

6.4 The Nursing Workforce held a welcome in June 2015 to which all nurses who had been offered positions were invited and 50 attended. The event evaluated well and provided an opportunity for the nurses to meet the Director of Nursing; receive an outline of support, induction and preceptorship available to them; and meet with nurses from the divisions which they are due to join.

6.5 Current predictions based on the pipeline of candidates due to join the nursing workforce suggest higher uptake of positions at CHFT from newly qualified nurses and midwives in comparison to 2014.

6.6 Increased recruitment through advertising has been reviewed within the last year, with dual adverts on NHS Jobs being placed now to ensure searches for either site “only” results in CHFT vacancies being identified.
A further advertising campaign through a national newspaper is scheduled to be completed in September / October 2015 with the aim of targeting Band 5 nurses; Emergency

Department nurses and dual trained nurses.

6.7 Return to practice campaigns regionally have had little success and CHFT has followed this trend. In a further change to CHFT recruitment practices an opportunity for nurses to receive a band 3 post whilst they completed their return to practice course has been offered. This has resulted in 2 nurses currently undertaking their return to practice course.

6.8 CHFT have continued to offer secondment opportunities to complete their training through the Open University with 5 HCA's offered places to complete this from 2015.

6.9 CHFT are currently working with Wakefield College and Health Education Yorkshire and Humber to scope the possibility of supporting HCA's to complete the Access to Health Education diploma (Healthcare Professions) to increase the capacity to grow CHFT nursing workforce.

6.10 A review of incentivised recruitment was completed late 2014, CHFT continued with their plan to offer increased support for new recruits in place of monetary support as did neighbouring trusts.

6.11 Recruitment to apprentice roles within the nursing and midwifery workforce has continued. All apprentices completing their training in July 2015 secured HCA posts within CHFT. A further 11 apprentices commenced their training in July 2015.

Since March 2015 all apprentices recruited have commenced the Cavendish Care Certificate. First evaluations are currently being collated, with the early findings indicating that the apprentices enjoy completing the certificate, but completion is taking 16 weeks as opposed to the planned 12 weeks.

6.12 Through the recruitment events we have currently offered substantive posts to over 80 newly qualified nurses and 30 midwives.

6.13 The Nursing Workforce Strategy Group are considering incorporating a strength based approach into our recruitment process. The Shelford Group have created profiles indicating the strengths required to be a great ward manager; staff nurse and health care assistant. Strengths are defined by the Shelford Group as "something a person loves doing; is good at and is energised by".

Coupling a strengths assessment with a competence assessment have been found to improve performance, patient experience and candidate experience. Further benefits have been realised in areas which have moved to a strengths approach in terms of cost saving and efficiency through recruitment and attrition cost savings.

The Nursing Workforce Group consider that incorporating this approach into our current recruitment process would provide additional assurance that we have the right people in the right positions to provide the safe and compassionate care we are committed to.

6.14 **International Recruitment update**

In May 2014 the Board of Directors agreed investment of £1.5m into the nursing workforce primarily to support ward establishments to achieve a 20% uplift for absence, a minimum of 1 to 8 patient ratio and supervisory ward sister role by quarter 4. The resulting need to recruit an increasing number of nurses was mirrored throughout much of the UK which has increased the challenge for CHFT in recruiting to vacancies.

In 2014 CHFT joined the 90% of NHS Trusts in England reportedly engaged in international recruitment campaigns to meet their individual demands.

6.15 Five recruitment campaigns have been completed, 4 in Spain and 1 in Romania between November 2014 and July 2015 resulting in 36 international nurses arriving at CHFT between January and June 2015 and a further 8 expected in September.

6.16 Retention rate for CHFT international recruits is currently 86.2% which compares favourably with regional feedback. A full review of the international recruitment campaign including regional benchmarking as of June 2015 can be found in Appendix A.

6.17 CHFT have considered recruiting qualified nurses from outside of the EU with the intention of securing nurses who may be increasingly likely to settle permanently with the Trust. As nursing failed to make it onto the government's shortage occupation list and CHFT have a limited number of certificates of sponsorship this approach to increasing the substantive nurses has not yet been developed further.

Following changes to the Governments migration cap rules, migrants from outside the EU will not be granted indefinite leave to remain and will be sent home after 6 years if they do not meet minimum earnings standards of £35k, which currently affects 3 members of our workforce. Nurses are unlikely to meet this minimum threshold. The Migration Advisory Committee is currently working with NHS Employers to assess the impact these new rules will have on the NHS and staff nurse shortages.

6.18 As an example, an NHS trust currently looking to fill around 200 nurse vacancies knows that the maximum number of UK trained newly qualified nurses they will be employing from the next cohort to qualify is 28. They have offered posts to 60 nurses from overseas all of whom had the certificates of sponsorship rejected at the June panel.

Another NHS trust has only been able to recruit 20 nurses from their EU recruitment efforts over the last 12 months and embarked upon recruitment in the Philippines earlier this year. They have offered posts to 72 individuals. All certificates of sponsorship were rejected at the June panel due to high demand from across business and the low points score gained for NHS professions. Basic salary being the proxy for priority.

The Nursing Workforce Strategy Group are currently assessing to what extent this will affect our current workforce and recruitment strategy.

7.0 SAFE STAFFING INDICATORS

CHFT have continued to record and publish staffing levels recording the planned nursing hours against the actual nursing hours worked are as one safe staffing indicator.

7.1 A number of inaccuracies in hours recorded are still evident in the fill rates recorded. This is largely within the division of medicine where approximately 50% of day shifts are now planned to be completed through 11.5 hour (long) shifts.

With current level of vacancy and sickness within the division actual hours worked regularly remain away from plan as to maintain the right number of nurses on the wards with the resources available an increasing number of 11.5 hour (long) shifts are being completed.

7.2 The impact of safely staffing additional capacity areas is not currently reflected in the staffing levels reported externally. Additional capacity areas are not reported in terms of staffing fill rates, but staffing these areas safely has at times reduced the fill rate on substantive ward areas where staff have transferred to support additional capacity.

7.3 Increased accuracy in reporting staffing levels and recording professional judgement has been achieved through the introduction of the web based staffing tool in January 2015.

7.4 The board receives a monthly report on the staffing levels achieved. In June 2015 it became apparent that an increasing number of areas are starting to experience an increase in achieving their supervisory status with 6 areas reporting over 100% fill rate for qualified day fill rates.

Table18 identifies the average fill rates for June 2014 in comparison to June 2015

Table 18: Average fill rates comparison June 2014 – June 2015

	June 2014	June 2015
Average Fill Rate Day Qualified Nurses / Midwives %	86%	90.07%
Average Fill Rate Day Unqualified Nurses / Midwives %	98%	95.68%
Average Fill Rate Night Qualified Nurses / Midwives %	84%	88.81 %
Average Fill Rate Night Unqualified Nurses / Midwives %	122%	113.16%

7.5 A daily staffing tool is has been developed and will be launched in September 2015 which will be used to record actual staff in place and highlight any workforce risks and actions taken each day. The tool will be completed on each site 3 times within a 24 hour period.

The additional information and support the tool will provide is:

- Acceptable staffing levels for each area are documented to assist with decision making when resources are stretched.
- Each area will be rag rated to provide an overview of the nursing workforce in place each day.
- A record of any temporary workforce members in place at CHFT will be evident and will provide the split between temporary and substantive workers in any one area.
- Record and provide a prompt of any nursing red flag events

The tool will be electronic and stored on a secure drive and therefore available if requested at a later date, and have the potential be circulated electronically to ensure key personnel are informed in a timely manner of the current nursing workforce position each day.

7.6 **Contact Time**

Safer Staffing: A Guide to Care Contact Time" was published by NHS England in November 2014, and sits alongside the NQB guidance, and NICE guidance to support decision making to ensure safe staffing care for patients and service users. "Care Contact Time" is recommended to be reviewed and included in staffing reviews as part of the drive to deliver safe and effective care. A baseline assessment of contact time was required by summer 2015 by all Trusts.

Following a trial in one area in April 2015, CHFT completed the Contact Time study on 04.06.2015 to enable areas to monitor the nursing care and contact time required by patients in all inpatient ward areas.

7.7 CHFT used a tool approved by NHS England referred to as the "Activity Clocks". All members of the nursing workforce on duty that day identified their tasks from a pre-approved list (see table 21) at 5 minute intervals from 7.00hrs to 19.30hrs.

The data was inputted and produced a report for each ward area which identified the direct and indirect time spent by qualified and unqualified staff. Additional information is also visible such as the proportion of time taken completing specific tasks such as discharges or medicines. Areas are also able to view how many interruptions were received during tasks.

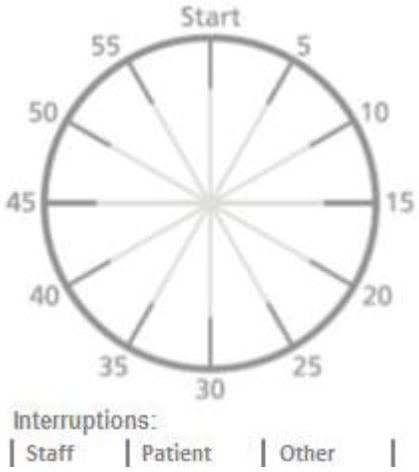
To reduce the risk of the study becoming a data set for reporting and not improvement of patient care, each area was also requested to review the contact time results and identify a quality improvement area to target at ward level.

Table 19 summarises the categories defined as indirect and direct contact time activities.

Table 19: Classification of Direct and Indirect Contact time activities

Direct Care (Nursing and process)	Indirect Care (Nursing and activities)
Meals	Shift Handover
Medications	Nursing Documentation
Patient Communication	Professional Discussion
Nursing Procedures	Relative Communication
Patient Hygiene	Environment / Cleanliness
Patient Observations	Ordering Patient Tests
Other	Student support
Off ward with patient	Break
Ward Round	Ordering stocks
Admissions	Searching for items
Discharges	Staff Training
	Off ward without Patient
	Other

The template below is an example of the clock each member of the nursing workforce member completed for each hour of their shift on 4.6.15



7.8 As we repeat the contact time study in December 2015 we will review how effective the quality improvements have been. The data will also be reviewed along with any training needs required to improve the quality of data collated.

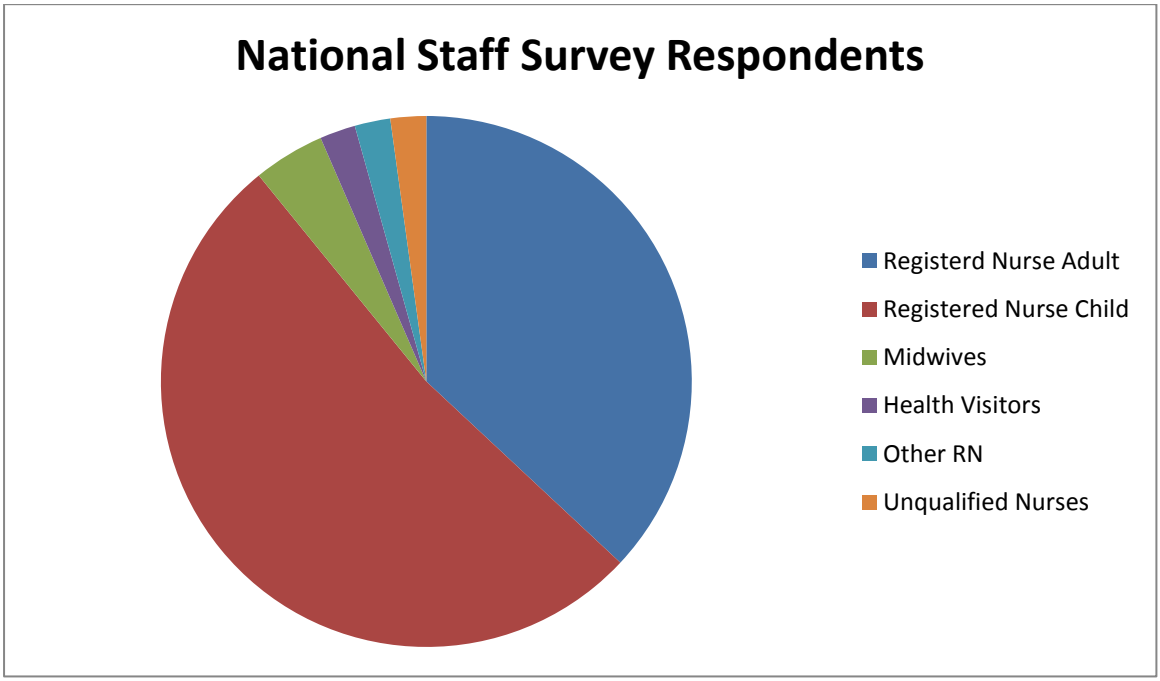
7.9 In April 2015 NHS England announced a new composite indicator for safe staffing which is expected to be launched this summer. This will sit alongside the staffing hour's data and contact time results as part of the safer staffing focus. The indicators are:

- Sickness absence data
- Rate of compliance with mandatory training
- Rate of appraisals in the previous 12 months
- Views on staffing from the national staff survey
- Views on staffing from patient surveys

Absence rates have been reviewed earlier within the paper. Mandatory training and appraisal compliance is monitored monthly within each division.

7.10 National Staff Survey (2014) results have been reviewed with reference to the nursing workforce group.

Responses received from the nursing workforce at CHFT resulted in:



Role	Number of responses	% of Survey respondents
Registered Nurse Adult	59	17%
Registered Nurse Child	8	24%
Midwives	6	2%
Health Visitors	5	1%
Other RN	3	1%
Unqualified Nurses	27	8%

7.11 The Nursing Workforce Group were reassured to find CHFT received above average scoring for the extent to which staff look forward to coming to work and that an increasing number of staff had been appraised in the last 12 months.

There was little change to the percentage of staff who felt satisfied with the quality of work and patient care they are able to deliver, but an improvement in the percentage of staff who felt their role was making a difference to patients.

67-69% qualified nurses felt satisfied with the quality of work and patient care they are able to deliver in comparison to 89% of unqualified nurses. The Nursing Workforce Group anticipate that through the retention strategy work, and increased staffing levels as our vacancies have reduced we will see an increase in the percentage of qualified nurses

satisfied with their quality of work.

Listening events in July 2015 indicated that in some areas ward managers are increasingly being able to fulfil their supervisory role which can contribute to both their own quality of work, and that of their team.

7.12 Whilst staff job satisfaction has improved since the 2013 survey alongside staff motivation the percentage of staff who felt work pressure was worse than average at CHFT.

This is consistent with some feedback from leaver's surveys and listening events. Vacancy levels coupled with safely staffing additional capacity has resulted in significant pressures in some areas within the last 6 months.

7.13 **Care Quality Commission Inpatient Survey 2014**

Five key areas which could be considered to be heavily influenced by safe staffing levels of the nursing workforce have been reviewed by the Nursing Workforce Group and action identified.

Area	Score	Action	Date for Completion
"Felt there were enough nurses on duty to care for them "	7.5 / 10	Review workforce models Review contact time studies to identify if direct patient care can be improved Review direct patient care time Ensure nurses ask patients "what is important to them" on a daily basis – cascade through divisions	July 2015 completed July 2015 completed December 2015 Ongoing
"Felt that they were given enough help from staff to eat their meals if they need this"	7.8 / 10	Review the role of the nutritional assistants and additional roles through the nursing workforce strategy group and make appropriate recommendations.	August 2015
"Felt they received help following activation of the call button quickly"	6.4 / 10	Review workforce models to ensure sufficient staff available at all times for timely response. Promote prompt response to all calls as a "must do" through divisions – "Beat the Buzzer " campaign to be led by group of ward sisters	July 2015 completed December 2015

"Felt they were well looked after by hospital staff"	8.9 / 10	Promote positive result to nursing and midwifery workforce. Ensure we recruit and retain the right workforce to provide the highest standard of care	August 2015 Ongoing
" Felt they had overall a good experience"	8.1 / 10	Promote and monitor high standards of care through quality dashboards and frontline leadership	Ongoing

7.14 Quality dashboards have been developed within the last 6 months to provide an overview of each ward including performance indicators which will ensure all indicators relating to patient care and safe staffing are visible and reviewed monthly as a minimum.

Reporting by exception outside of agreed parameters is reviewed monthly by the Nursing workforce strategy group and any further action required agreed.

7.15 The Nursing Workforce Group are working with the Risk team and nursing workforce to increase the knowledge and use of incident reporting and resulting data which can be produced through the DATIX system with the intention of reviewing all staffing incidents for themes and trends as a further indicator of safe staffing.

7.16 NICE safe staffing guidance for adult inpatient ward areas has been in place since July 2014 and for midwifery and maternity since February 2015. NICE suspended their work to determine safe staffing levels across the NHS in June 2015. Future work to develop safe staffing guidance will be led by a new body, NHS Improvement and the Chief Nursing Officer.

The work undertaken by NICE in relation to safe staffing in additional areas is now understood to be set to continue under NHS England within a series of wider service reviews and as such we no longer expect the publication of NICE guidance for Accident and Emergency departments to be imminent.

Future staffing guidance is expected to be published by the National Quality Board. Guidance will be reviewed by the Nursing and Midwifery Strategy Group and appropriate action taken to ensure CHFT achieve compliance.

The Nursing Workforce Strategy Group continues to review and progress the nursing workforce to achieve compliance with published NICE Guidance whilst we await further guidance from the National Quality Board.

Current areas which require focus to achieve 100% compliance with NICE Guidance are demonstrated in Table 20.

Table 20: CHFT compliance with NICE Safe Staffing Guidance (Nursing)

Priorities for Action from NICE Guidance	Progress against planned action March 2015	Progress against planned action August 2015
• A system in place for nursing red flag events to be reported by any member of the nursing team, patients, relatives or carers to the registered nurse in charge of the ward or shift. Management of red flag events. • Records of on the day occurrences of red flag events recorded	• Task and Finish Group has commenced to promote red flag events. • Work with Risk and Health Informatics is been undertaken to develop robust reporting. • Monitoring of Red Flag events is been developed through the task and finish group and will be utilised to inform future staffing reviews. • Red Flag incidents are been outlined in patient information leaflets to ensure patients, relatives and carers are aware of Red Flags and how to escalate concerns.	• All areas within nursing workforce have received posters; credit sized cards and cascaded information via both written and verbal presentations outlining red flag and how to report red flag events. • Reporting mechanism via Datix under review – monthly reports outstanding whilst this is developed • Red flag incidents reported included in data set for ward dashboards since July 2015 • patient information leaflets are available • Red flag prompts added to daily staffing tool currently being developed for completion by site co-ordinator to provide further prompt. Due for launch September 2015
• Approaches to support flexibility of the nursing workforce.	• Proposed long day implementation into workforce models in Medical division. • Long day proposal for Surgery in progress with scheduled completion of 30.3.15. • Review of support roles within nursing workforce utilising Calderdale Framework in progress.	• A proportion of long days in terms of shift patterns have been in place since April within Surgery, Medicine and FSS. • Additional roles providing support have been reviewed. • Project currently being completed to scope the opportunities for developing bands 1-4 with the Calderdale Framework.

7.17 In February 2015 the National Institute for Health and Care Excellence published guidance for Safe midwifery staffing for maternity settings (NICE 2015). Recommendations are made for organisational requirements for safe midwifery staffing levels, setting the midwifery staffing establishment, assessing differences in the number and skill mix of midwives needed and the number of midwives available and monitoring and evaluating midwifery staffing requirements.

7.18 Midwifery specific safer staffing 'Red Flags' are defined and a range of safe midwifery staffing outcome measures are described. These include: the proportion of women who are able to book for maternity care by 13 weeks gestation, breastfeeding rates, post-natal readmission rates, incidence of genital tract trauma, missed breaks, the proportion of staff

working extra hours, midwifery sickness rates and staff morale, compliance with mandatory training, the proportion of midwifery hours provided by bank or agency and the proportion of women in established labour who received one to one care.

7.19 Safe staffing outcome measure data is collected on a monthly basis provides assurance that staffing data is being measured against NICE standards; the first half year report is due to be presented to FSS Divisional Board and Business Meeting in October 2015. The report will then be presented to the Nursing Workforce Strategy Group in November 2015. In line with NICE guidance, CHFT use Birth-rate plus to set and to review the midwifery staffing establishment.

8.0 WARD BASED REVIEW AND RECOMMENDED STAFFING LEVELS

At CHFT we have continued to follow NICE guidance in systematically assessing at ward level a number of factors which inform the nursing establishment required to provide safe nursing care.

Table 21 summarises the processes followed to review and inform recommended staffing levels within the last 6 months.

Table 21: Process to inform nursing workforce establishments

Summary of the process of setting ward based nursing establishments	CHFT Update
1. Complete Acuity and Dependency study using NICE approved tool (Safer Nursing Care Tool)	Completed May – June 2015
2. Complete the Contact Time Study to identify current nursing time spent delivering direct patient care.	Completed June 2015
3. Associate Director of Nursing; General Manager; Finance Manager; Workforce Assurance Manager; Ward Manger and Matron review acuity and dependency results and contact time results to triangulate with professional judgement and nurse quality indicators and national guidance. Professional judgement included: • Clinical model • Staff capacity and capability • Organisational factors (such as ward layout, support roles, students) • Ward manager supervisory status time • Staff feedback • Complaints Nurse Quality Indicators included: • Falls • Pressure Ulcers • Medication errors • Mandatory training compliance • Family Friends Test • Harm Free Care	Completed for all areas June / July 2015

8.1 Results of the ward based staffing levels reviews June 2015 are evident in Table 22 which demonstrates:

- recommended WTE (combined qualified and unqualified) nurse to bed ratio from the acuity and dependency review
- current nurse to bed ratio for all areas
- contact time results

Please refer to table 21 (section 8.7) for definition of direct and indirect patient care in section.

Table 22: Results of ward based staffing indicators

SURGERY									
Ward	**Beds**	**AUKUH Nov 13**	**AUKUH Jan 14**	**SNCT Nov 14**	**SNCT June 15**	**Current n:b**	**Direct Patient Care % June 2015**	**Indirect Patient Care % June 2015**	**Comments**
3	15	1.10	1.20	1.65	1.61	1.37	71.2 Q 85.8 Un Q	28.8 Q 14.2 Un Q	
10	20	1.10	1.50	-	1.41	1.25	59.9 Q 71.8 Un Q	40.1 Q 28.2 Un Q	
15	27	1.20	1.50	1.32	1.22	1.02	55.2 Q 78.6 Un Q	44.8 Q 21.4 Un Q	
19	22	1.30	1.60	1.42	1.62	1.75	54.7 Q 73.6 Un Q	45.3 Q 26.4 Un Q	
20	30	1.30	1.50	1.15	1.26	1.37	52.2 Q 69.4 Un Q	47.8 Q 30.6 Un Q	
22	23	1.10	1.20	-	1.17	1.23	60.2 Q 66.1 Un Q	39.8 Q 33.9 Un Q	
SAU	25	1.00	0.92	1.05	1.15	1.31	64.7 Q 49 un Q	35.3 Q 51.0 Un Q	
ICU HRI	8	-	-	3.03	2.30	4.95	40.7 Q 58.2 Un Q	59.3 Q 41.8 Un Q	
8AB	26	0.80	-	0.68	0.97	1.22	50.7 Q 66.1	49.3 Q 33.9	

							Un Q	UnQ	
8D	14	-	-	-	0.91	1.29	59.9 Q 71.2 Un Q	40.1 Q 28.2 Un Q	
ICU CRH	5	-	-	-	2.45		61.6	38.4	No unqualified hours for contact time.

MEDICINE									
Ward	**Beds**	**AUKUH Nov 13**	**AUKUH Jan 14**	**SNCT Nov 14**	**SNCT June 15**	**Current N: B**	**Direct Patient Care % June 2015**	**Indirect Patient Care % June 2015**	**Comments**
6D	15	1.38	1.13	1.33	-	2.10	70.3 Q 62.1 Un Q	29.7 Q 37.9 Un Q	
7AD	26	1.59	-	1.54	1.55	1.50	59.7 Q 67.2 Un Q	40.3 Q 32.8 Un Q	
7BC	26	1.54	1.22	1.48	1.55	1.50	73.1 Q 71.1 Un Q	26.9 Q 28.9 Un Q	
21	18	1.43	1.29	1.25	1.44	1.34	54.7 Q 71.9 Un Q	45.3 Q 28.1 Un Q	
Mau hri	24	-	1.18	1.12	1.23	1.91	43.8 Q xxxxxx	56.2 Q	Did not complete activity clocks for unqualified
Mau crh	24	1.24	1.15	1.22	1.46	1.91	60.5 Q 81.3 Un Q	39.5 Q 18.7 Un Q	
6	23	-	1.35	1.26	0.98	1.46	43.5 Q 57.0 un Q	56.5 Q 43.0 Un Q	
2AB	31	1.28	1.24	1.24	1.14	1.31	54.7 Q 65.2 Un Q	45.3 Q 34.8 Un Q	
8	21	-	1.43	1.66	1.75	1.31	46.9 Q 61.7 Un Q	53.1 Q 38.3 Un Q	
4	15	1.70	1.54	1.31	1.36	1.7	71.2 Q 67.7	28.8 Q 32.3	

							Un Q	Un Q	
5AD	31	1.44	-	1.50	1.66	1.53	64.4 Q	35.6 Q	
							XXXX	XXXX	
17	24	1.21	-	-	1.21	1.32	62.5 Q	37.5 Q	
							80.9 Un Q	19.1 Un Q	
5C	16	1.42	1.42	1.59	1.59	1.42	62.8 Q	38.7 Q	
							85.0 Un Q	15.0 Un Q	
6BC / CCU		1.13	1.32	1.48	1.80	1.49	6B – 54.8% Q 6C – 51.5%	6B – 45.2% Q 6C – 48.5%	
							6B – 66.7 Un Q 6C – 81.1 Un Q	6B – 33.3 Un Q 6C – 18.9 Un Q	
12	20	1.23	1.45	1.31	1.43	1.38	55.1 Q	44.9 Q	
							65.9 Un Q	34.1 Un Q	
5	19	0.82	1.38	1.26	1.46	1.36	55.2 Q	44.8 Q	
							66.0 Un Q	34.0 Un Q	

FSS									
Ward	**Beds**	**AUKUH Nov 13**	**AUKUH Jan 14**	**SNCT Nov 14**	**SNCT June 15**	**Current N: B**	**Direct Patient Care % June 2015**	**Indirect Patient Care % June 2015**	**Comments**
3	25 + 10 assess beds					2.22	53.2 Q	46.8 Q	
							55.7 Un Q	44.3 Un Q	
18	8					2.42	49 Q	51 Q	No Unqualified for contact time
4C	16	-	-		1.02	1.50	55.4 Q	44.6 Q	
							71.8 Un Q	28.2 Un Q	
HBC / CBC	14					2.28	14 Q	86 Q	
							47.5 un Q	52.5 Un Q	
NICU	24					2.35	35.9 Q	64.1 Q	
							0 Un Q	100 Un Q	
1D	13					1.32	50.5 Q	49.5 Q	
							57.5 Un Q	42.5 Un Q	
9	14					1.32	63.4 Q	36.6 Q	

							26.1 Un Q	73.9 Un Q	
LDRP	16					4.16	62.7 Q	37.3 Q	

8.2 Analysis of the results has been completed within the Divisions. Scrutiny of the results will form part of the review presented to the Nursing Workforce Panel in October 2015. Recommendations from which will be presented to Board in November 2015.

8.3 **Surgical Division**

The Acuity and Dependency results indicated an average rise in the acuity of patients on wards 19, 20, 8AB and Surgical Assessment Unit (SAU) reported.

Analysis of current Nurse to Bed ratios for each of these areas remains higher than that indicated by the SNCT based on professional judgement.

All areas meet the NICE guidance for registered nurse to patient ratio of 1:8

Ward 8D is currently challenged to provide a second qualified nurse on night shift due to vacancies and has been supplementing the night shift with an experienced unqualified nurse at present.

Table 23: Current staffing levels – Surgical Division

		Current model	Current model	Current model
Area	**Beds**	**Early Qualified + Un Qualified**	**Late Qualified + Un Qualified**	**Night Qualified + Un Qualified**
ITU (HRI) **ITU (CRH)**	**8** **5**	**7+1** **4+1**	**7+1** **4+1**	**7+0** **4+0**
SAU	**25**	**5+2**	**5+2**	**4+1**
3	**15**	**3+2**	**2+1**	**2+1**
10	**20**	**4+2**	**3+1**	**3+1**
15	**27**	**4+2**	**4+2**	**3+1**
19	**22**	**4+3**	**4+3**	**3+3**
20	**30**	**5+4**	**5+3**	**3+3**
22	**23**	**3+3**	**3+3**	**2+2**
8AB	**26**	**4+4**	**4+2**	**3+2**
8D	**14**	**2+2**	**2+1**	**2+1**

8.4 Following the implementation of long days in the Nursing Workforce a number of areas have requested an increase in the proportion of long days included in their workforce model.

Ward 15 and Ward 8AB are currently trialling an additional number of long days prior to business planning in October 2015. Ward 8D is trialling utilising an additional health care assistant on the late shift when additional observations and theatre transfers are required instead of the night shift.

8.5 Critical Care potentially may require investment if expected guidance from NHS England is forthcoming regarding the service specification for adult critical care (D16). This guidance is expected to recommend each critical care unit with 6 beds of more (which would include the HRI site, but not the CRH site) to have a clinical co-ordinator 24/7.

Current indications within the skill mix of the current workforce model for critical care suggest a potential investment of further band 5 nurses could be required to allow current band 6 and 7 nurses to fulfil the clinical co-ordinator role.

8.6 A review of the operating department nursing workforce models has been completed within the last 6 months. Areas included in the review are: Admissions Unit HRI; Day Surgery HRI; Day Procedure Unit and Admissions CRH; HRI Theatres; CRH Theatres; Surgical Procedures Unit; Pre Assessment.

The review has been a challenging exercise to accurately capture and align the current workforce models and budgeted workforce models due to the current absorption of 7 lists, historically completed in 6 theatres being moved into alternative areas within scope. Previous workforce model data was limited in this area.

The review has been presented to the Nursing Workforce Strategy Group. Benchmarking is currently being undertaken and final recommendations will be made in the next nursing workforce paper due to Board in November 2015.

8.7 All areas within the medical division remain largely stable in terms of their acuity and dependency results.

Following the in-depth review of each workforce model as planned no changes to the current establishments are recommended by the Associate Director of Nursing for the division. Most areas continue to plan for approximately 50% of their workforce undertaking long days whilst further review of any impact from the introduction of long days is considered. Any impact will become increasingly transparent through monitoring of the quality dashboards across divisions.

8.8 Due to the level of vacancies within the division a number of areas continue to work an increased percentage of long days to ensure the right number of nurse remain on shift each day.

All areas meet the NICE guidance for adult inpatient wards and in addition to this areas also comply with professional guidance applicable to their area (Hyper acute stroke unit guidance; Older Persons Guidelines).

8.9 Further analysis of the Emergency Department workforce and workflow has been undertaken with nursing and consultant staff. A detailed nursing workforce model is in development and will be completed by October 2015 to inform business planning.

Recruitment to vacancies in the Emergency Department has continued with current vacancies across both departments been 3 qualified nurses. We continue to target Emergency Department nurses through both adverts on NHS Jobs; Guardian newspaper campaign and at the RCN jobs Fayre in London (September 2015).

Since the last report to Board in April 2015 paediatric nurse practitioners have increased the paediatric provision of nursing cover provided in the departments by basing themselves within the departments.

Table 24 demonstrates the current planned staffing levels Medical Division

Ward	Beds	Early Qualified + Un Qualified	Late Qualified + Un Qualified	Night Qualified + Un Qualified
6BC	48	5+2	5+2	4+2
CCU	8	4+1	4+1	4.0
6D	15	4+2	4+2	3+2
7AD	26	4+4	4+3	4+2
7BC	26	4+4	4+3	4+2
2AB	31	5+3	5+3	4+2
5C	16	3+2	2+2	2+1
MAU, CRH	24	6+3	6+3	5+2
5AD	31	6+3	5+3	4+3
MAU, HRI	24	6+3	6+3	5+2
A&E, HRI		7+3	9+4	7+1
A&E, CRH		6+2	8+3	6+1
4	15	3+3	2+2	2+2
12	20	4+2	4+2	3+1
6	23	5+2	5+2	3+2
8	21	4+3	3+3	3+3
17	24	4+3	4+3	3+1
5	24	5+3	5+3	4+1

8.10 Families and Specialist Services Division

Since the last update provided to the Board of Directors a new Division, Families and Specialist Services has been established by merging Children's Women's and Families Division and Diagnostic and Therapeutic Services Division. The new Division has taken

over responsibility for the operational management and nursing leadership of medical, surgical and orthopaedic outpatient nurses.

Where available, validated tools (such as Birth-rate Plus, British Association of Perinatal Medicine and Royal College of nursing nurse staffing ratio tools) have been used to review qualified and unqualified nurse staffing requirements.

8.11 In light of this review, the Associate Director of Nursing and Head of Midwifery for FSS recommends a number of refinements to workforce models which will be defined in a further paper to Board in November 2015.

8.12 **Paediatrics**

Previously paediatric areas on both acute hospital sites held separate workforce models. The workforce models are now combined into one providing cover for a total of 43 paediatric beds across site. This results in nurses working across both ward areas, to maintain competencies in paediatric assessment, medical and surgical nursing.

The Shelford Group are due to release their Safer Nursing Care Tool for Children's Services. CHFT have been accepted as an early implementer site and will be commencing data collection in September 2015.

Over the last 6 months nurses have used the RCN standards "Defining staffing levels for children and young people's services Guidance for General Children's Wards and Departments' (RCN, 2013) to assess qualified and unqualified nurse staffing requirements. Data continues to be collected on a four hourly basis to assist nurses in decision making about safe staffing levels and implementation of the children's ward escalation policy.

This data will be utilised to inform any adjustments to workforce models during business planning in October 2015. Currently the paediatric areas are trialling an increased ratio of long days and an increase in staffing levels when ward attendance trends have peaked.

Table 25: Current Workforce Models for Paediatric wards

Ward 18

	Early Qualified + Un Q	**Late Qualified + Un Q**	**Night Qualified + Un Q**
Monday	2+1	2	2
Tuesday	2+2	2	2
Wednesday	2+1	2	2
Thursday	2+1	2	2
Friday	2+1	2	2
Saturday	2	2	2
Sunday	2	2	2

Ward 3

	Early Qualified + Un Q	Late Qualified + Un Q	Twilight 3 – 11pm	Night Qualified + Un Q
Monday	8+3	8+2	0+1	7+1
Tuesday	8+3	8+2	0+1	7+1
Wednesday	8+3	9+2	0+1	7+1
Thursday	8+3	9+2	0+1	7+1
Friday	8+3	8+2	0+1	7+1
Saturday	8+4	8+2	0+1	7+1
Sunday	7+3	7+2	0+1	7+1

*The workforce model on ward 3 provides for 4 unqualified nurses on a Saturday to manage a day case work.

8.13 Paediatric Nurse Practitioners (PNP) are one example of the developing workforce who provide additional support. Currently CHFT have 6 qualified PNP's and 4 trainee PNP's. The PNP's have historically been based largely at HRI, but following the recent service changes are now providing increasing cover at CRH.

PNP's also provide support for children within the Emergency Department and support patient flow.

8.14 Gynaecology and Gynaecology Assessment Unit (GAU)

A detailed analysis of the nursing workforce for the gynaecology ward and gynaecology assessment unit has been undertaken, and nurses aligned to their place of work. The outcome is a well-defined staffing model.

Inaccurate fill rates for 4C have been reported over the last six months due to the previous complex workforce model which included planned hours for nurses in the assessment unit within the ward establishment and visa versa.

Ward 4C

	Early Qualified + Un Q	Late Qualified + Un Q	Night Qualified + Un Q
Monday	3+1	3+1	2+1
Tuesday	3+1	3+1	2+1
Wednesday	3+1	3+1	2+1
Thursday	3+1	3+1	2+1
Friday	3+1	3+1	2+1
Saturday	3+1	3+1	2+1
Sunday	3+1	3+1	2+1

GAU

	Early Qualified + Un Q	Late Qualified + Un Q	Night Qualified + Un Q
Monday	2+1	2+1	0+0
Tuesday	2+1	2+1	0+0
Wednesday	2+1	2+1	0+0
Thursday	2+1	2+1	0+0
Friday	2+1	2+1	0+0
Saturday	1+1	0	0
Sunday	0	0	0

8.15 Midwifery

Staffing requirements for the maternity service have been reviewed in line with NICE (2015). Approaches have included: analysis of crude Midwife to Birth Ratios; Birth-rate Plus; application of the NICE (2015) Safer Staffing Tool for Midwifery and the professional judgement of the Associate Director of Nursing and Head of Midwifery, General Manager, Senior Clinical Midwifery Managers and Midwifery Ward and Departmental Managers.

8.16 Crude midwife to birth ratios for 2014-2015 were 1:29.5 based on a wte budget of 194.5wte midwives. Four wte midwives were removed from the calculation (2wte Senior Clinical Managers, 1wte Divisional Patient Safety and Quality Lead and 1wte Divisional Patient Safety and Quality team member). Taking into account:

- The Trust is currently commissioned by the CCG to provide a midwife to birth ratio of no more than 1:30
- The current service model provides for two birth centres as well as home birth and a consultant led labour ward
- Inpatient ward areas each require two midwives per shift (due to their location and size)

It is not recommended that the midwife to birth ratio is increased at this time. The current ratio of qualified midwife to maternity support worker is 90:10. There are opportunities to develop maternity support workers from Band 2 to Band 3 and reduce this ratio to 85:15 or 80:20.

8.17 Birth-rate Plus calculations include a 21% uplift to provide for activities related to the statutory supervision of midwives. If this was to be reduce to 20% in line with the rest of the Trust, 1.5wte midwife posts would be released.

Bookings to date suggest a small increase in the birth-rate for 2015-2016 and so it is not anticipated that further investment will be required in midwifery workforce for the remainder of this financial year.

8.18 **NICU**

The Neonatal Unit are in the final stages of the NHS England Specialist Commissioning approved derogation plan. To inform workforce planning, the nursing team a complete four hourly analysis of nurse staffing requirements against BAPM guidelines This analysis informs decision making about escalation and use of agency and bank staff.

Taking both factors into account no changes to the current NICU workforce model are recommended at this time.

Table 26: Current staffing levels for NICU

	Early Qualified + Un Q	Late Qualified + Un Q	Night Qualified + Un Q
Monday	6+2	6+2	6+2
Tuesday	6+2	6+2	6+2
Wednesday	6+2	6+2	6+2
Thursday	6+2	6+2	6+2
Friday	6+2	6+2	6+2
Saturday	6+2	6+2	6+2
Sunday	6+2	6+2	6+2

CHFT have 7 Advanced Neo-natal Practitioners who provide additional support within the Neo Natal Intensive care unit.

9.0 E-ROSTERTING

9.1 From August 2015 all CHFT ward based Nursing and Midwifery workforce have been electronically rostered. In October 2015 all ward based staff will receive payment generated electronically from the information on the E Rostering system. All reporting of Sickness and Absence from the rosters will feed into the Trusts Electronic Staff Record (ESR). Over the next eight months the project team will be capturing other areas where our nursing and midwifery workforce are predominately placed, this will include both hospital and community teams.

9.2 Ongoing evaluation is informing the project team on both system and user errors and continuous work is being done to meet these challenges. The rostering team have undertaken a feedback survey within the nursing workforce to evaluate the impact of e-rostering on the workforce.

Key performance indicators have been agreed through the Nursing Workforce Strategy Group to ensure the roster works as efficiently and effectively for both our workforce and service. Key areas of focus which are a priority for the e-roster team at present are to ensure the system is developed to prevent part time colleagues working increased hours in some weeks and less hours the following week when this is not as a result of a request. A further key area is to ensure that the workforce is not working days and nights within short

turnaround periods following feedback from colleagues that this has been experienced. Work has already been completed to ensure that the roster system does not repeat patterns which have previously been reported and had led to some staff member's inequitable shifts particularly at a weekend.

9.03 A pilot of Centralised rostering will take place September to December 2015, for three medical wards at CRH. Centralised rostering is a process where each area has a roster coordinator who is an expert in the e rostering processes. They create the roster for the area working together with the area manager who will maintain ownership and management of the roster. Feedback sessions have been planned throughout the pilot study.

9.4 Key Performance Indicators will be monitored through the Nursing Workforce Strategy Group on:

- Roster compliance underpinned by the Roster protocol. Aimed at ensuring the roster is available to staff at least 4 – 6 weeks ahead.
- Number of unfilled shifts is forecast in advance to inform workforce planning.
- Roster Headroom reports are developed to assist ward managers, matrons and Associate Directors of Nursing in ensuring staffing levels are not adversely affected where avoidable

10.0 NON-WARD BASED STAFFING

10.1 A non-ward based and specialist nurse staffing review has been undertaken to record our baseline level from which we intend to benchmark and have identified any risks. Some areas have been addressed in further detail such as the operating department; critical care; community nursing, health visiting and emergency department within this paper. A summary of all non-ward based areas which have been reviewed has been included in Table 27

Table 27: Non-ward based staffing areas reviewed 2015

Safeguarding Team
Infection and Prevention Control Team
Endoscopy
Tissue Viability
Cancer Specialist Nursing Teams
Outpatients
Specialist nurses
Intermediate Care
Outreach Team
Trauma Co-ordinators
Bariatric Nurses

Matrons
Clinical Commanders
Clinical Skills Facilitators
Practice Learning Facilitators
Advanced Clinical Practitioners
Children's Community Team

10.2 Annual job planning was completed for all non ward based areas within the last 6 months and this will be repeated at the beginning of 2016.

10.3 An area of risk within the non ward based review identified was in relation to a number of single practitioners (for example a vascular nurse). The Associate Director of Nursing for medicine is currently completing all remaining specialist nurse reviews which will be presented to the Nursing Workforce Strategy Group and appropriate action agreed.

10.4 A further risk within the non ward based review was highlighted within the safeguarding team where 1.0 wte band 6 post is temporarily funded by the CCG. The safeguarding team would have a significant challenge in being able to meet the increasing demand for their services without this additional post.

The Head of Safeguarding will advise when a decision on funding via the CCG has been received.

11.0 NURSING WORKSTREAM

11.1 To date the Nursing Workstream CIP scheme is delivering ahead of target.

11.2 The project team have developed key areas of focus for 2016 – 2017 which include:

- Scoping the nursing workforce for roles which can be safely completed by non registered staff. This will result in a conversion of roles previously completed by for example a band 5 nurse being completed by a band 3 colleague.
- Increasing the skill mix ratio within midwifery
- Increasing the long days within the workforce models
- Reviewing the additional roles which support the nursing workforce and identifying areas where they may work across areas due to the geographical landscape of some areas.
- Review of training for external organisations provided with a view to charging for this service.

11.3 Enablers for the nursing workstream project team for 2016 – 2017
Include:

- Review of recruitment processes to minimize delays and attrition rate (Due for completion by Workforce and Development September 2015)

- Review of utilising model such as Calderdale Framework to develop non registered workforce safely.
- Reduction in the use of 1-1's through the review of additional roles working across areas.
- Conversion of high cost of agency to bank and substantive staff
- Introduction of NHS Professionals

12.0 COMMUNITY NURSING

12.1 Health Visiting

Health Visiting in Calderdale will successfully meet its trajectory in September 2015 with the recruitment of the newly qualified Health Visitors following completion of the Health Visitor Implementation plan.

12.2 The priorities for the Health Visiting team continue to be to deliver the four levels of Health Visiting: community, universal, universal and universal partnership plus.

Community involves working with communities and other professionals to identify health needs and empower communities through community capacity building. It is expected that Health Visitors in Calderdale will act as catalyst to identify and enable action by community groups and individuals to address needs that affect health and wellbeing. Recently Health Visitors have delivered health walks, sessions to provide low level support for women experiencing mild depression and targeted health promotion sessions.

Calderdale Health Visitors are currently working increasingly closer with the Local Authority and early year's providers to establish the Integrated 2 Year Review to identify children's needs earlier, prevent duplication and improve multi agency working.

12.3 Calderdale Health Visitors continue to deliver the Health Child Programme 0-5 years and the commissioners have set Key Performance Indicators for the mandated contacts which are an antenatal contact , a birth visit at 10-14 days, a 6-8 week visit, a contact by the first birthday and a review at 2-1 ½ years old.

For Ante-natal visits the table below indicates the number and percentage completed on time, with additional information and figures for instances where this was not achieved.

Table 28: Antenatal visits delivered on time (number and percentage) with instances where target not achieved provided (reason, number and percentage).

On Time	548	88%
Baby already born/ in hospital	28	4%
Movement into area	7	1%
No Access	20	3%

Parental Preference	6	1%
Total Accounted for	609	97%

Table 29: Birth visits delivered on time (number and percentage) with instances where target not achieved provided (reason, number and percentage).

567	91%	On Time
13	2%	Activity Captured in March Return
11	2%	No Access Visit (on time)
6	1%	Parental Preference
11	2%	Baby in Hospital
18	3%	Took Place on Day 15/16
626	100%	Total Accounted for

12.4 Health Visitors continue to work in partnership with parents and agencies in the provision of intensive multi-agency targeted packages where there are identified complex health needs or safeguarding needs.

12.5 Currently, the health visiting service is commissioned jointly by NHS England and the Public Health commissioners in the local authority. This is a transfer period leading to the service being fully commissioned by Public Health in October 2015.

12.6 **Immunisation team**

The Immunisation team is a new development at CHFT for 2015. The team are responsible for the planning and delivery of the Department of Health School aged immunisation programmes within Calderdale. This is according to current national campaigns. The vaccination programmes are primarily carried out in a school based setting; although these can also be offered in other community settings depending on individual need.

12.7 The team can also provide expert advice to children, families, schools and other professionals regarding vaccination and immunisation issues. Vaccinations currently being offered are as demonstrated in table 30.

Table 30: Vaccinations offered by CHFT Immunisation team

Year 8	Human Papilloma Virus (HPV)	Girl's only
Year 9	Diphtheria, Tetanus and Polio(Td/IPV)	Boy's and Girl's
Year 9	Meningitis ACWY (Men ACWY)	Boy's and Girl's
Year 1&2	Nasal Flu Spray	Boy's and Girl's
Year 10	Meningitis ACWY (catch up programme) (Men ACWY)	Boy's and Girl's

12.8 The immunisation team consist of 4 WTE band 5 nurses who work term time only supported by 1 WTE administrator.

12.9 The team is meeting the 90% value target on all immunisations offered.

12.10 **Community Nursing**

The district nursing (DN) team have strived to measure activity against workforce within the last 6 months to ascertain appropriate workforce models. In June the team received additional finance support to complete this work which is currently not available.

12.11 Recruitment into DN posts has been an issue nationally for the last 3 years. District nursing courses are not attracting the same number of applicants and with an ageing community workforce it is predicted that this position is unlikely to improve for some time.

Recruitment into band 5 posts has been positive with posts being filled outside of area as well as from internal candidates.

CHFT has been actively recruiting into DN posts and supporting training positions. There are 3 district nurses due to qualify from CHFT teams in September 2015. These DNs will be taking up their posts in Grange Dene, Nursery Lane and Northowram.

12.12 Activity has increased by 10% across district nursing sustainably in the last 12 months. The service specification lacks clarity and a review would be welcomed as more teams report:

- Large numbers of venepuncture requests for patients not on the caseload
- A difference in the spread of practice nurses as well as the tasks that they undertake
- Increasing number of requests for nursing reports
- No single agreement on the definition of housebound patients

12.13 In order to manage the service and maintain safety and quality the team composition across each locality is reviewed regularly. As part of this review the following factors are considered:

- Caseload size
- Complexity of caseload
- Skill mix in the team
- Experience of the district nurse
- Geography of each locality
- Forthcoming maternity leave and vacancies

12.14 Work to design a dependency tool has been started however with no IT support available this was being undertaken by a senior nurse within the team. This work is currently on hold due to long term sickness.

The teams have all been involved in providing information to a consultant brought in form the finance team to work through a community specific workforce model based on data collected through tasks recorded on S1.

12.15 The next steps for community nursing have been identified as:

- The housebound policy is in draft awaiting sign off by CCG and primary care. This is part of a larger piece of work which will support a move towards a reduction in the number of domiciliary visits and an increase in the number of patients treated in a clinic setting. A scoping exercise is planned through the PMO scheme to understand the impact this will have on capacity and demand.
  As part of the review the role of community matron is being looked at with a view to increasing their clinical support to the DN teams.

- The team are exploring working hours to improve efficiency and quality. A successful trial at Nursery Lane team of an 8-6 pm shift is being rolled out across all teams for a period of two months. This trial will be evaluated to measure the impact on service provision as well as health and wellbeing of teams. There is a requirement to understand where this fits with workforce model when approved. The 'half day' which is currently taken as time owing will cease as part of the trial and will not continue whichever model is approved going forward.

- Community Division will work with THIS and contracting to establish a process for counting activity in shadow to the Block contract.

- Community Division will review all areas of service creep, identifying impacts, for discussion with Commissioners to agree payment or notify cessation.

- A request has been made to recruit into staff bank for community staff to increase the number of staff available to work flexibly.

- Plan to work collaboratively with partners to use Vanguard as part of recruitment strategy for community services.

- Participate in community benchmarking exercise with 25 other community trusts to understand staffing position.

- Continue to work through locality hubs as part of Vanguard proposals and develop the multi- disciplinary team around each practice. This will include an understanding of the admin function in each of these teams.

13.0 NEXT STEPS

This 6 monthly review provides assurance to the Board that the Trust has a growing nursing and midwifery workforce committed to supporting patients and families. The Nursing Workforce Strategy Group is developing the workforce to ensure healthcare is provided by

a multi professional workforce including roles such as advanced practitioners; cancer co-ordinators to ensure the right skill mix is in place.

Workforce models have been reviewed utilising recognised tools to inform staffing requirements.

A panel chaired by the Director of Nursing will further review all workforce models in October 2015 to inform business planning. A short paper will be provided to Board in November 2015 which will include any recommendations required to continue to achieve nursing and midwifery safe staffing levels.

There remains significant risk to the workforce due to the national shortage of qualified nurses and current immigration challenges. Sustained recruitment and retention of the nursing workforce is a key priority.

Current areas of risk to be prioritised:

- Red flag event reporting
- Workforce models for community nursing
- A&E

Potential areas of risk being monitored / developed:

- Insufficient headroom in workforce models
- Impact of increased number of long days
- Increase in wte retiring as technology increases within the workforce
- Investment in Critical Care
- Investment in endoscopy due to bowel scope

14.0 CONCLUSION

No investment is required at this time.

The Board of Directors is asked:

- To note the challenges around recruitment and retention of the nursing workforce
- To note the increased metrics informing recommended workforce models
- Review and be satisfied that the appropriate level of detail and assessment has been undertaken or planned to review the nursing and midwifery workforce to ensure safe staffing levels are achieved.
- Note the next six monthly staffing review and recommendations will be presented to the Board in February 2016.

APPENDIX A

Calderdale and Huddersfield NHS
NHS Foundation Trust

A Review of the International Nursing Recruitment Campaign

2014 – 2015

1.0 Background

In May 2014 the Board of Directors agreed investment of £1.5m into the nursing workforce primarily to support ward establishments to achieve a 20% uplift for absence, a minimum of 1 to 8 patient ratio and supervisory ward sister role by quarter 4.

In May 2014 the Trust carried approximately 200 nursing vacancies in part due to the investment received.

The national shortage of nurses increased the challenge for CHFT in recruiting to the vacancies, as reported by other Trusts.

During 2014 over 90% of NHS Trusts in England reportedly engaged in international recruitment campaigns to meet their individual demands.

Four providers were reviewed in 2014 and with assistance from procurement and a task and finish group a series of international recruitment events commenced.

2.0 International Recruitment Campaign

2.1 Four recruitment campaigns have been completed in Spain between November 2014 and March 2015. Following a low number of candidates received from the first event and a review of the service provided CHFT changed provider from Medacs to Simply Health with improved results in terms of candidates sourced.

2.2 The panel for each campaign has consisted of a Deputy Director of Human Resources and two nurses at least one of which was a senior nurse.
The panel spent an intensive day interviewing candidates who also completed drugs calculation tests; multiple choice clinical test and an English test. In addition we included screening of a “empathy – compassion in practice” clip with a facilitated discussion following this which we utilise for our UK recruits.

2.3 CHFT offered one month accommodation free of charge which was sourced off site. Following feedback from the first cohort CHFT negotiated a 6 month contract for the international recruits to allow them longer to settle and locate their own accommodation.

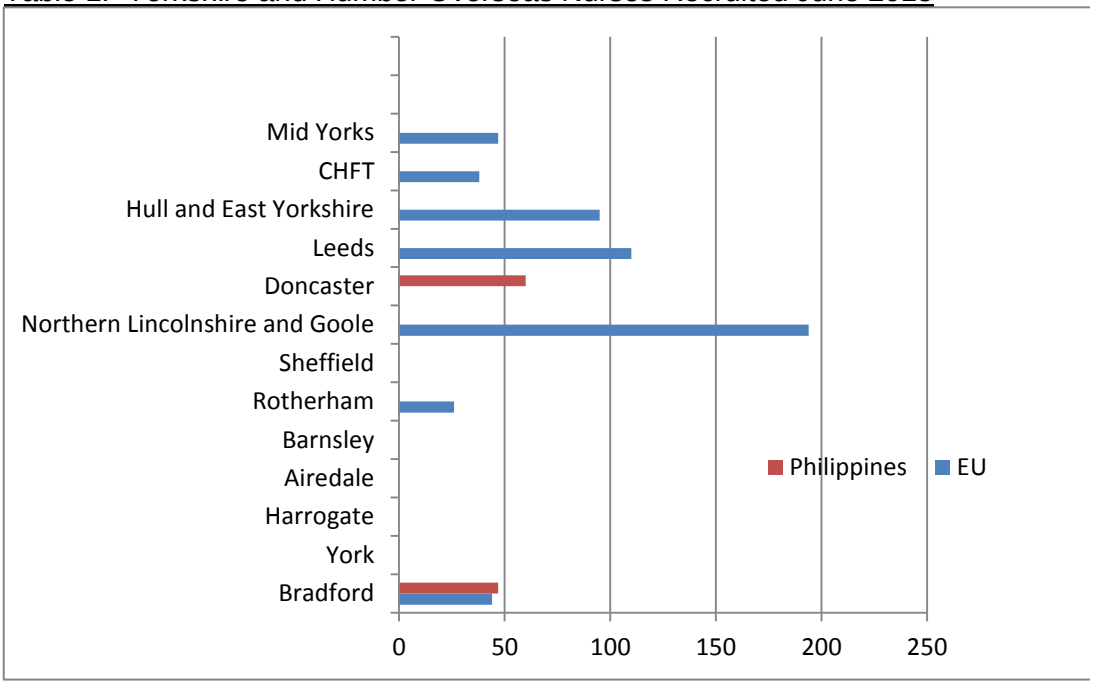
Whilst this proved popular for some, the majority of nurses advised that they would prefer a shorter period of accommodation. For the last cohort we returned to sourcing one month accommodation with a landlord who was happy to extend

the offer to the nurses on an individual basis.

3.0 Regional benchmarking

3.1 A review of current levels of overseas recruitment in the Yorkshire and Humber region is provided in table 1.

Table 1: Yorkshire and Humber Overseas Nurses Recruited June 2015



3.2 Three NHS Trusts within Yorkshire and Humber have reported undertaking campaigns within the Philippines. Data from Mid Yorks is yet to be shared and is therefore missing from Table 1.

York reported in June that they had tried to recruit in Spain in March 2015, but secured no nurses during their trip.

Northern Lincolnshire and Goole advise that they find it difficult to attract local nurses and therefore have had a greater need to recruit internationally.

The region share issues with accessing India / Philippines for recruitment due to NMC restrictions & the timescales for applicants getting their registration confirmed.

3.3 CHFT currently have a relatively small number of certificates of sponsorship which has been considered recently due to evidence that recruitment from the Philippines results in nurses who stay with the Trust for longer periods than EU recruits. Consideration for applying the labour market test had been commenced following other Trusts within the region successfully obtaining additional certificates of sponsorship.

We currently have concerns due to the visa limitations in place which result in nurses who are not earning over £35,000 after 5 years being required to return home. A call for evidence regarding this is currently under way with a result expected at the end of August which will be considered by Trusts across the region and nationally.

4.0 **Results 2014 – 2015 International Recruitment Campaign**

36 international nurses arrived at CHFT as a result of the 4 campaigns completed to date.

5 have now left resulting in a retention rate of 86.2 %

In comparison a neighbouring trust have reported that their retention rate for nurses recruited from Spain within the same time frame is less than 80%

Each nurse leaving has had a face to face interview with a senior nurse.

The reasons for leaving are:

Reason for Leaving	**Number of Nurses**
Secured post in Spain	2
Homesick	1
Struggling to complete probationary Period	2

5.0 **Investment**

Table 2: Estimated Costs of International Recruitment 2014 – 2015 (excluding VAT)

Phase 1

Description	**Cost (£)**	**Number of Nurses**
Medacs (5 nurses)	11,436	5
Simply Health (3 nurses)	6,480	3
CHFT travel costs Dec 14	1349.81	
CHFT travel costs Jan 15	623.23	
Crockery, Food, welcome packs for 20 nurses	186.40	
4 weeks free accommodation for 3 nurses (£100 / week)	1,200	
Total	**21,275.44**	**8**

Phase 2

Simply Health (28 nurses)	36,000	20
CHFT travel costs March 15	623.23	
Crockery / welcome pack	194.60	
Simply Health (10 nurses)	14,400	8
Crockery /welcome pack	69.50	
4 weeks free accommodation for 24 nurses (£100 / week)	9,600	
Total	**60,887.33**	**28**

Phase 1 and 2:

	Cost (£)	Number of Nurses
Grand Total	**82,162.77**	**36**

Procurement are currently processing rebates for the 5 nurses who have left CHFT in line with terms and conditions agreed.

An additional cost has been a Band 6 nurse supporting international recruits on 7.5 hrs / week for six months.

6.0 Support for success

6.1 Induction

The first cohort of 5 nurses arriving received a one week induction. The sessions took longer to complete than expected as the nurses required a slower delivery of the planned training than our UK recruits usually require.

The following cohorts of all received a comprehensive 2 week induction which included practical and theoretical sessions in addition to Occupational Health screening and appointments with a local bank.

6.2 Induction feedback from the international recruits:

- Induction was friendly and welcoming
- Important topics covered
- Catheterisation requested to be added
- Consistent venue for 2 weeks requested

6.3 Induction feedback from the ward managers:

- 2 week induction was comprehensive – practical skills still required development
- Thorough
- Induction did not fully prepare newly qualified nurse on new placement
- English lessons would be useful addition
- Working alongside a HCA to understand level of care expected
- Discharge planning and IT systems training would also be useful.

6.4 Pastoral support

Each cohort was met by Director of Nursing / Workforce Assurance Manager and welcomed to the trust.

An additional nurse provided pastoral care for 7.5hrs per week from January – July 2015 with the Workforce Assurance Manager providing support outside of these hours.

Estates management team have assisted in sourcing and supporting the nurses with accommodation requests and issues.

Pastoral support has been varied, but included travelling on buses to provide support in locating the hospital from the accommodation; offering a contact time each week for nurses to raise any queries; supporting with registering with a GP; meeting with the nurses at regular intervals for evaluation; arranging induction programmes.

6.5 Clinical area support

A presentation was provided at the joint sister's meeting in January 2015 to ensure that all ward managers were aware of the process and expectations for supporting international recruits.

The support requested was:

- A local induction

- A preceptor utilising the modified preceptorship materials for international recruits
- An identified “buddy” within CHFT with some similar interests
- A minimum of 4 weeks protected induction where the nurses work alongside their preceptor
- A programme to develop their skills
- A friendly and supportive team
- An early / day off on a Tuesday where possible.

In addition the international recruits have also been invited to new starter forum events on a monthly basis, English language support group for 6 weeks, and an “afternoon tea” event to celebrate their integration into CHFT..

6.6 Workforce and Development Support.

As with all new employees at the Trust the international recruitment has been completed and audited to ensure compliance with the NHS employment checks. This included 6 separate pre-employment checks including: identity checks, qualification and professional registration, employment history and reference checks all of which have to be the original documents not photocopies.

CHFT are audited formally by audit on an annual basis and In November 2014 were noted to be green. Additional internal audits are completed with the latest completed January/February 2015. The result of the audit was green on all NHS pre-employment checks, and the next one is scheduled for July 2015. Furthermore the resourcing team have all been trained in spotting fraudulent documentation.

All 36 internationally recruited nurses resourcing files were audited as compliant by a manager/assistant Director of HR on the NHS employment checks standards prior to contracts been issued. We did not rely on the agency to undertake these checks for the Trust

Resourcing attended all induction weeks to support the new arrivals in completing their contracts and ensuring all necessary documentation was completed and copied. Assistance was also provided in obtaining national insurance numbers.

7.0 Language Skills

Despite screening through the recruitment agency and CHFT recruitment panel some international recruits have expressed varied levels of difficulty in being able to communicate as quickly and effectively as they would like to.

Utilising the phone has been reported to be more difficult than face to face communication.

2 nurses recruited have requested English support, but none of the nurses recruited felt that they required formal English lessons.

A series of weekly communication groups has proved popular with nurses attending for a 1 hour session which has covered conversational English; medical terminology; scenarios and telephone practice.

7.1 Language feedback from the International Recruits:

- Improvement in language skills has been as a result of talking and

listening to staff and patients

- All nurses expressed pride in their continued development of speaking, writing and understanding English
- A number of nurses actively read English books and newspapers to assist in their development
- Some of the nurses feel frustrated when they do not fully understand immediately.
- The nurses have enjoyed the language sessions hosted at CHFT as they have found them useful in learning from each other.
- "Not English lessons, learning by listening and speaking"

7.2 Language skills feedback from the ward managers:

(This has been largely varied as expected as each nurse has been different)

- Consistent feedback has been that the nurses are less confident in utilising the phone and undertaking phone calls or processing discharges.
- Language skills have improved over time
- Local dialect and language skills have been cited as reasons for the nurses taking longer to practice independently.

7.3 Recruitment panel feedback:

Following the first cohort's arrival the panel increased the appointable standard for English language when recruiting for CHFT.

There was acknowledgement that a number of nurses were able to complete standard interview questions, and this did not always translate into being able to communicate fully in English.

A notable improvement in the level of English of those recruited from the latest 2 cohorts has been recognised by the nurse providing pastoral care who has had the overall view from meeting all the recruits.

8.0 Preceptorship

Preceptorship has been mandatory for each of the international recruits. Whilst all the nurses have reported feeling welcome some of the nurses have not received consistent preceptorship.

Probationary reviews have been advised to be completed as standard for all CHFT employees. There has been some confusion reported with some areas commencing the probationary review from the time the nurses received their NMC registration rather than their start date.

Clarification regarding the requirement for probationary periods to be commenced from each nurses start date was circulated in June 2015.

There is evidence from the ward managers feedback to suggest that effective use of the probationary period to ensure the nurses are developing and are reaching the expected standard has not always been applied.

One example from the feedback sought from ward managers has referred to medicine errors and a negative attitude towards patients – this has been escalated to the ward manager and matron for the area with support from the General Manager and HR colleagues to action.

Band 5 competencies have been utilised in some areas to provide records of

competencies completed, but this document has been in draft and not widely available yet.

8.1 Supernumerary

Further action is required to establish and define the supernumerary period for international nurses. Some confusion has arisen with ward managers advising that nurses are supernumerary as their NMC registration has not been received.

Consistent feedback from the majority of international recruits is that they are independently caring for patients. Those awaiting their NMC registration are not independently completing medicine rounds.

The ward managers feedback on supernumerary periods was requested from all areas which have supported international recruits in the last 6 months.

The average time taken for the international recruits to practice independently is 6-8 weeks. Two areas reported 3-4 months and one area 5-6 months.

The feedback also highlighted that assessment areas can be more challenging for the international recruits to become independent nurses.

9.0 Issues Log

Items of note on the Issues log have been:

- Delays in receiving NMC registration (longest has taken 4 months)
- Nurses offered posts in Spain (2) leaving immediately
- Sourcing accommodation of an acceptable standard
- Venues for induction training
- Compliance in managing probationary period
- Language barrier concerns
- Nurses with experience of nursing in Spain have usually settled and performed better than those with no experience

10 Next Steps

- Review completion of probationary periods for all international recruits
- Recruitment trip to Romania as the nurses available in Spain are all newly qualified.
- Excellent English and experience have been set as a criteria for recruitment.
- Deputy Director for HR scoping increasing certificates of sponsorship to allow CHFT to undertake non EU recruitment
- Workforce Assurance Manager liaising with NHS Professionals to scope the possibility of “leasing” a number of international nurses.
- Feedback to Joint Sisters Meeting, Grand Round, regarding supernumerary periods and expectation of standard required for international nurses to be completed,
- Recommendation that supernumerary period identified as 6-8 weeks with anything further being agreed with the Associate Director of Nursing
- Review the induction programme
- Avoid placing international recruits in Assessment areas for initial placements where possible.
- Await outcome of Call for Evidence (predicted to be August 2015) when

considering further international recruitment

11 Conclusion

The majority of the nurses have felt welcome and supported and “love it” at CHFT. A number of the nurses have expressed how much they enjoy coming to work.

Whilst some of the areas and recruits have found the process challenging, others have reported that the nurses have been a “fantastic asset to the team” and “It has worked surprisingly well, and would welcome further international recruits in the future.”

We consider this with our current retention rate to be a measure of success, but will continue with the next steps to refine the process and ensure the quality and safety aspects of utilising international recruitment within our nursing workforce are developed.

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Juliette Cosgrove, Assistant Director
Date: Thursday, 24th September 2015	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: Quarterly Quality Report - This quarterly quality report covers contractual, quality account, national and local quality priority requirements to provide a comprehensive overview of quality performance during the first quarter of 2015-2016 within Calderdale and Huddersfield NHS Foundation Trust (the Trust).	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Quality Committee on the 25th August 2015.	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

The report is structured into the five Care Quality Commission domains, with each section having a summary providing an overview of compliance with each indicator and highlights.

During quarter 1 2015/16, all CQUIN, Quality Account and Contract requirements were achieved, with the exceptions noted below:

Patient Safety Domain:
MRSA Bacteremia: (section 2.7)
Patient admitted on 10th April with vomiting and reduced appetite after recently discharged. History of MRSA since 2010 and screening and suppression treatment all performed as per policy. Developed signs of sepsis on 13th April; sepsis likely to have occurred from pneumonia acquired from endogenous flora. PIR meeting concluded this was an unavoidable case

Effective Domain:
SHMI: (section 2.1)
The latest SHMI shows the Trust to have a SHMI of 109 which although classified ‘as expected’ is above the 100 target. The HSCIC caution that it is inappropriate to conclude that a trust is performing better or worse than average based purely on whether or not there are more or less deaths than predicted. The trust has been placed in the ‘as expected’ range because any variation from the number of expected deaths is not statistically significant.

Partial Compliance

Areas showing partial compliance during quarter 1 are:

Patient Safety
• Pressure Ulcer reduction: quarter 1 trajectory not achieved (section 1.2)

Experience

• Friends and family test: low response rates

Effective
• A&E performance: 2 of 5 quality indicators not achieved (section 4.1)

Well-Led
• Mandatory training: 6 of 8 targets not achieved (section 5.2)
• Appraisal: 25% target for appraisal completion not met (section 5.3)

Main Body

Purpose:

Please see appendix

Background/Overview:

Please see appendix

The Issue:

Please see appendix

Next Steps:

The next report is due following quarter two.

Recommendations:

The Board is asked to note the contents of the report and support the actions contained within the report.

Appendix

Attachment:

Q1 Quality Report 15-16 Q1 FINAL Version for BOD.pdf

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Calderdale & Huddersfield Foundation Trust
Quarter 1 Quality Report
2015-16

Subject:	Quarterly 1 2015-2016 Quality Report
Prepared by:	Juliette Cosgrove – Assistant Director of Quality Andrea McCourt - Head of Governance and Risk Lisa Fox – Information Manager
Sponsored by:	Julie Dawes, Director of Nursing
Presented by:	Julie Dawes, Director of Nursing
Purpose of paper	Discussion requested by Trust Board Regular Reporting For Information / Awareness
Key points for Trust Board members	The report is structured into the five Care Quality Standards domains, with each section having a summary providing an overview of compliance with each indicator and highlights. During quarter 1 2015/16, all CQUIN, Quality Account and Contract requirements were achieved, with the exceptions noted below: **Patient Safety Domain:** **MRSA Bacteremia:** (section 2.7) Patient admitted on 10th April with vomiting and reduced appetite after recently discharged. History of MRSA since 2010 and screening and suppression treatment all performed as per policy. Developed signs of sepsis on 13th April; sepsis likely to have occurred from pneumonia acquired from endogenous flora. PIR meeting concluded this was an unavoidable case **Effective Domain:** **SHMI:** (section 2.1) The latest SHMI shows the Trust to have a SHMI of 109 which although classified 'as expected' is above the 100 target. *The HSCIC caution that it is inappropriate to conclude that a trust is performing better or worse than average based purely on whether or not there are more or less deaths than predicted. The trust has been placed in the 'as expected' range because any variation from the number of expected deaths is not*

	statistically significant. **Partial Compliance** Areas showing partial compliance during quarter 1 are: Patient Safety • Pressure Ulcer reduction: quarter 1 trajectory not achieved (section 1.2) Experience • Friends and family test: low response rates Effective • A&E performance: 2 of 5 quality indicators not achieved (section 4.1) Well-Led • Mandatory training: 6 of 8 targets not achieved (section 5.2) • Appraisal: 25% target for appraisal completion not met (section 5.3)

Contents

Domain Five – Well Led: The Leadership, management and governance of the organisation assure the delivery of high quality person centred care, supports learning and innovation and promotes an open and fair culture.

Appendices

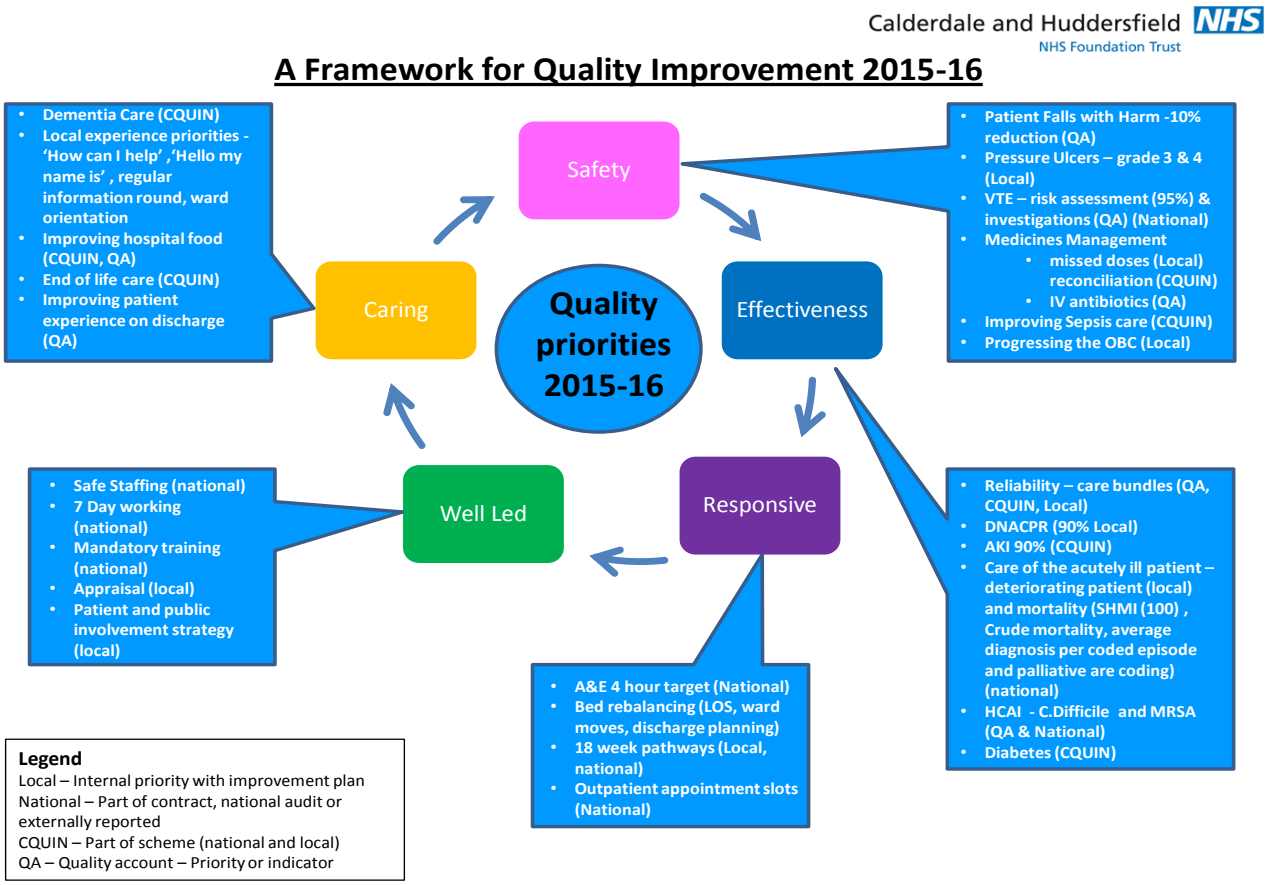
Introduction

This quarterly quality report covers contractual, quality account, national and local quality priority requirements to provide a comprehensive overview of quality performance during the first quarter of 2015-2016 within Calderdale and Huddersfield NHS Foundation Trust (the Trust).

Each year the Trust works with the commissioners to agree what should be included in the local contract including CQUIN priorities. These cover key clinical priorities and build upon our strategic aims.

The Care Quality Commission Intelligent Monitoring reports also provide a framework for determining quality priorities, a full inspection within 2015/16 is expected under the new regulations. In preparation for that we worked with Price Water House Cooper to conduct a self-assessment. As a result of that we have identified a number of areas where we will focus our improvement effort.

From all these sources the following diagram shows the Trust key priorities for 2015-16, these have been broken down into the 5 key CQC domains



Summary of Key Performance Frameworks:

2015/16 Quality Account:

There are four Quality Account priorities for 2015/16. These are listed below and further detail regarding progress can be found on the page number indicated

Domain	Focus/Priority	More Details
Safety	Improving Sepsis Care	Pg.19
Effectiveness	To ensure Intravenous antibiotics are given correctly and on time (continued from last year)	Pg.15
Effectiveness	Improving the discharge process	Pg.102
Experience	Better Food & Improving Nutrition	Pg. 66

2015/16 CQUINS:

There are nine CQUIN areas for 2015/16. These are listed below and further detail regarding progress can be found on the page number indicated. The information contained in the Q1 performance box provides a quick overview of target attainment during the first quarter, where applicable.

	Indicator Name	Q1 Performance	Page
1	Acute Kidney Injury	Baseline Gathered (21%)	**Pg. 45**
2a	Sepsis Screening	Baseline Gathered (83%)	**Pg. 19**
2b	Sepsis Antibiotics	N/A	
3	Urgent care	Performance above target (86%)	**Pg. 94**
4a	Dementia - Find, Assess, Investigate and Refer	Performance above target (91%, 99%,100%)	**Pg. 59**
4b	Dementia - Clinical Leadership	N/A	
4c	Supporting Carers of people with Dementia	N/A	
5a	Asthma Care Bundle	Performance above target (66%)	**Pg. 40**
5b	Pneumonia Care Bundle	Performance above target (70%)	**Pg. 40**
6	Diabetes - Inpatient	Performance on target (10 wards)	**Pg. 52**
7a	Medicines Reconciliation/E-Discharge	Performance on target (80%/73%)	**Pg. 15**
7b	Medicines Discharge - Improvement	Wards Identified and Baseline Gathered (38%)	**Pg15**
8	End of Life Care	N/A	
9a	Nutrition patient satisfaction	N/A	
9b	Nutrition reduce waste	N/A	
9c	Nutrition Vending	Report on Vending Facilities Written	**Pg. 66**

Domain One – Patient Safety

Patient Safety Compliance Summary

Indicator 2015-16	Compliance Q1
1.1 Falls Reduction	**Over Trajectory**
1.2 Pressure Ulcer Reduction	**Over Trajectory**
1.3 Reducing Hospital Acquired VTEs (Contract)	Achieved
1.4 Medication Management (CQUIN)	Achieved
1.5 Sepsis (CQUIN)	Achieved
1.6 Safeguarding Patients	Reporting only
1.7 Incident Reporting	Reporting only
1.8 Effective Investigations	Reporting only
1.9 Central Alerts System (CAS) Alerts	Achieved

Highlights:

1.3 Reducing Hospital Acquired VTEs	Hospital Acquired Thrombosis (HAT) target achieved in Q1
1.7 Incident Reporting	17% Increase in the number of incidents reported relating to the Trust showing an improvement in reporting following a reduction in 2014-15 No Never Events reported
1.8 Effective Investigations	Initial training on Serious Incidents delivered

1.1 Reducing patient falls with harm

Aims and Objectives of Work:

In 2015/16 the Trust is aiming for a further 10% reduction in harm falls, which is no more than 14 harm falls by the end of the year.

Whilst the total number of falls in the hospital will continue to be monitored, there will be no associated target for reduction as it is important to encourage transparency and maintain a positive culture of incident reporting.

Performance surrounding the prevention of falls is overseen by the Patient Safety Group.

Background

Falls are the most commonly reported type of patient safety incident in healthcare. Around 250,000 patients fall in acute and community hospitals each year (NHS England, National Reporting and Learning System, 2013, 2014). Although most falls do not result in injury, patients can have psychological and mobility problems as a result of falling.

The prevention and management of inpatient falls is described in The National Institute for Clinical Excellence – Guideline 161 (2013)/ Implementing FallSafe.

The Trust has detailed action plan to deliver the reduction in the number of harm falls. This plan focuses in on the following 6 areas:

1. Ensure all documentation supporting falls prevention and management in use is compliant with guidelines.
2. Ensure all patients being admitted are screened for risk of falls and the necessary preventative actions taken.
3. Ensure that following an in-patient fall patients get the best care to prevent harm and repeat falls.
4. Ensure falls data is robust by understanding where gaps in reporting are currently.
5. Undertake thematic review of inpatient falls causing harm rated as amber/red to capture learning.
6. Improve engagement with staff around falls prevention work to ensure impact of fall on the patient is understood by use of patient stories and training.

Current Performance

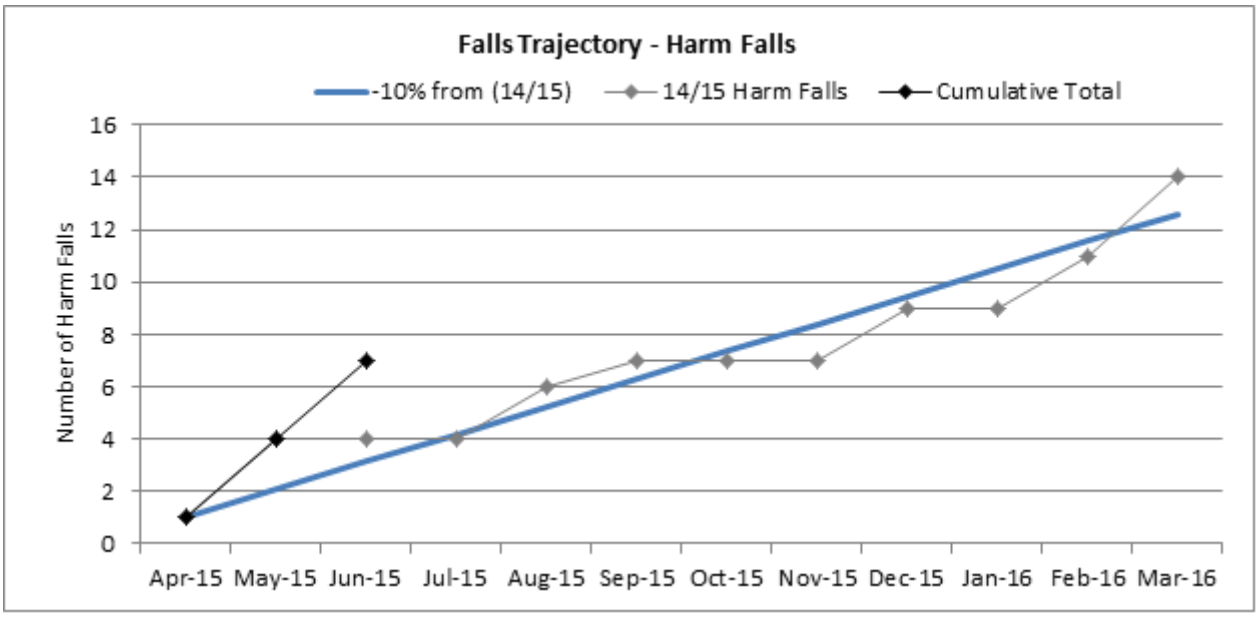
<u>Overall Summary of Q1 performance 2015/16 for falls prevention</u>

The target for falls prevention for 2015/16 is for a 10% reduction in falls that cause harm. The ceiling target is for 14 falls, a reduction from the total of 16 falls with harm in the previous performance year 2014/15.

During the first three months of 2015/16 the Trust has had 7 falls with harm, which is 3 above the trajectory target of 4. As this is naturally causing some concern, a paper will be

discussed at the Patient Safety Group on 3 September 2015, which will suggest appropriate next steps in response to this poorer than anticipated performance.

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
SAS		1											1
MED	1	2	3										6
FSS													0
Total	**1**	**3**	**3**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**7**
OBDs	**21669**	**22340**	**21564**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**65573**
Rate of Falls/ 1000 OBDs	0.05	0.13	0.14	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.11
Cumulative Total	**1**	**4**	**7**										**7**
-10% from 14/15)	1	2	4	5	6	7	8	10	11	12	13	14	14



NB - April 14 and May 14 performed at the same levels as last year and as such the grey dots are obscured.

Current Action Plan Areas:

1. Documentation

The Falls Collaborative 2013/14 completed the design and review of the documentation to reduce in-patient falls and harm from falls. This is ensuring compliance with the following national evidence:

- NICE clinical guideline 161 'Falls: assessment and prevention of falls in older people' June 2013 – anticipate update in October 2015.
- CG176 Head injury: full guideline 22 January 2014
- National Patient Safety Agency. *Essential care after an inpatient fall.* Rapid response report. London: NPSA, 2011.
- Implementing FallSafe. Royal College of Physicians (RCP) 2012.

The new documentation was launched in January 2015 and the following documents are available on the documentation repository:

- Nursing Assessment tool (identify all patients at risk of falls on admission)
- Falls Prevention Bundle
- In-patient Fall bundle
- Falls Prevention and Management Care Plan

Following on from a recent review (June 2015) of in-patient severe harm falls a trial of a revised falls care plan to promote individualised care will be trialled using service improvement methodology on ward 20 through August / September 2015

5. Learning from Incidents/Audit/Networking

Incidents:

During June 2015, a six monthly audit of moderate/severe harm falls (Red and Orange) was reviewed by a panel consisting of cross divisional representation and safeguarding leads. The audit identified the key themes as:

- High incidence of falls in bathroom areas.
- High correlation of patients falling with an acute delirium.
- High correlation of patients falling who had been admitted following a fall.

This process also identified a need to develop a robust system to support high quality post falls investigations. There is work going to link this with the work of the Effective Investigations Operational Group (see section 1.8).

Audits:

During May 2015 (12th –13th May), the first National Inpatient Falls audit was undertaken. The results of the audit are currently being analysed and will be available in September 2015.

Networking:

Networking links have been maintained with the Yorkshire and Humber Falls Prevention Network (last attended in February 2015) and new links made locally with the Kirklees Falls Prevention Group. The first meeting at which the Trust will be represented is July 2015.

On 8 June, the Trust Fall's lead participated in a "Falls Prevention: Webinar hosted by NHS England's Patient Safety Lead. This session identified that there were no gaps in relation the approach taken by the trust in the management of falls.

6. Training

The RCP/NHS Preventing Falls in Hospitals e-learning course is now available via the NHS Electronic Staff Record. This has been developed primarily for registered nurses working in acute or community hospitals but any staff member with a clinical inpatient role should be encouraged to use it to improve falls prevention.

The training package includes patient risk factors, environmental risk factors and what to do following a fall.

Improvement Plans for Q2 onwards

1. Continue to maintain links with the Improvement Academy, with an aim to achieve 95% compliance in actions identified from the safety briefings. The Medical Division Falls Collaborative to take this piece of work forward August 2015.

2. The Vulnerable Adults Operational Group (VAOG) is the focus of future falls action planning. This will enable the agenda to link with other key areas impacting upon falls with a shared action plan – Dementia, Learning Disability, Mental Health, Safeguarding, Restrictive Practice and MCA/DoLs. The trust Falls Collaborative is now part of this group.

3. Action planning will take place in July/August 2015 following the completion of First National Inpatient Falls audit in May / June 2015.

4. To review Falls Care Plan by end September 2015 to enhance ability to make person centred.

5. Implementation of clear signage above all in-patient bed areas in July 2015, containing vital information about the patient including their preferred name, the consultant in charge of their care and the nurse looking after them. In addition there are a number of spaces to allow for the inclusion of further signage to indicate a patients key risks e.g. a yellow triangle to denote at risk of falls or information telling the team at a glance what walking aide is required. The evidence tells us that at a glance signage can significantly reduce the risk of falling when used as part of a package of care.

6. During July 2015 the development and trial of Falls Alarm tool to enable assessment of mental capacity and potential restriction / DoLS will take place.

1.2 Reducing Pressure Ulcers

Aims and Objectives of Work

Pressure ulcer prevention is an important measure of the quality of care provided to patients. Pressure ulcers are largely preventable and their prevention is included in domain 5 of the Department of Health's NHS Outcomes Framework 2014/15 (NICE CG, 179). They can have a significant impact on patient’s wellbeing and quality of life.

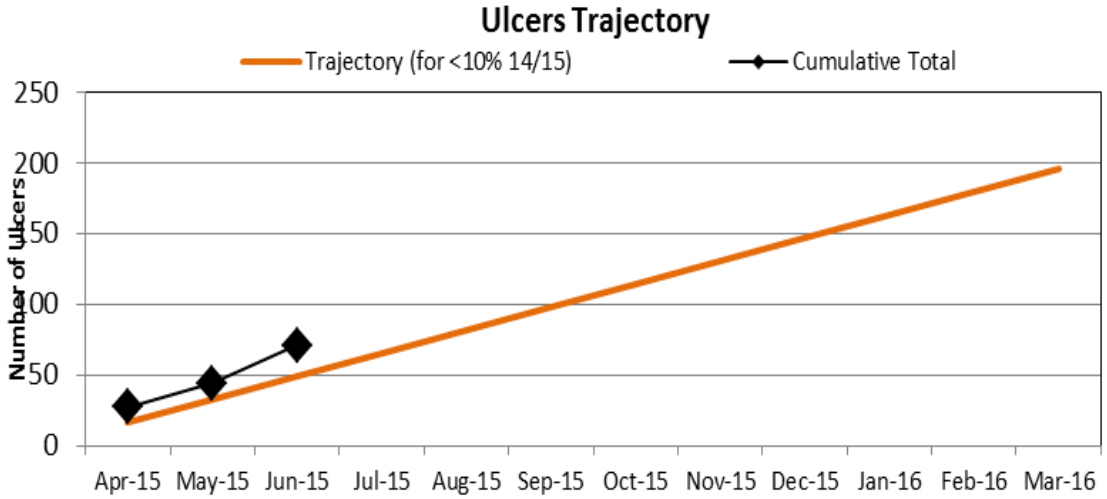
For 2015-16 a trajectory of 10% reduction for all hospital acquired category 2, 3 and 4 pressure ulcers has been agreed. (In 2014/15 we had 65 hospital acquired category 3 ulcers and 4 hospital acquired category 4 ulcers)

The pressure ulcer prevention and reduction programme is being overseen by the Patient Safety Group which received an action plan and progress reports.

Overall Summary of Q1 performance 2015/16

During 2014/15 the number of CHFT acquired pressure ulcer incidents increased from an average of 20 per month (April to October) to 32 per month (November to March). The current average for Q1 is 24.

CHFT hospital acquired pressure ulcer incidents are above the planned improvement trajectory for Quarter 1 with 71 in quarter 1 compared to a trajectory of 49.



This is related to the ongoing issues highlighted in 2014/15, which included extra unplanned capacity (particularly at CRH) and the associated use of agency staff.

A review of pressure ulcer incidents that was completed in April 2015 by the Tissue Viability team, revealed issues related to the accuracy of pressure ulcer reporting and timeliness of pressure ulcer validation. This included inaccurate reporting of pressure ulcer severity and the reporting of other wounds/ skin problems (such as moisture lesions and leg ulcers) as pressure ulcers. As such all severe (category 3 and 4s) CHFT acquired pressure ulcer investigations now have Senior Nursing approval at the completion stage.

A follow on review looking specifically at staffing data was completed in July 2015 (covering the time period January to May 2015). A key finding of which was that pressure ulcers were more prevalent in areas which had lower staff fill rates, with 23 acquired, in comparison to 5 acquired ulcer in those areas with the highest fill rate areas, however it should be noted that this information will also be affected by differences in patient dependency during the time periods examined.

Completed actions in Q1

- A higher specification pressure reducing mattress was been introduced in March 2015 across the hospital wards. Ongoing clinical support and training is being provided to ensure appropriate use of this equipment.

- All severe (category 3 and 4s) CHFT acquired pressure ulcer investigations now have Senior Nursing approval at the completion stage.

- Implementation of action plans for 5 highest reporting wards to support improvement. TVNs are offering/ providing support in terms of training and clinical advice. 2 other areas have now been identified that require the development of action plans.
    - For Quarter 1, 3 of the wards (19, 20, 11) are within trajectory to achieve a 10% reduction of pressure ulcers. However, 5ad & 6bc have exceeded the trajectory for this quarter.

- Specific targets have been set for the wards (in terms of numbers) in order to make improvement meaningful for staff.

- Training is being delivered to ensure that 95% of staff are trained and competency assessed on the selection and use of pressure relieving devices as per CHFT policy.

Improvement Plans for Q2 forward:

The Pressure Ulcer Collaborative has a detailed action plan overseen by the Patient Safety Group.

Actions ongoing:

- Introduction of a new pressure ulcer risk assessment tool. Work is ongoing to establish how this tool can be adopted in line with the introduction of the Electronic Patient Record. Lead TVN will attend the Electronic Patient Record Future State Event in September 2015 and will meet with colleagues from Bradford Teaching Hospitals Trust, to review processes across the 2 organisations.
- Competencies for the prevention and management of pressure ulcers will form part of the competency assessment for new nurses
- Doncaster model of training – expert nursing programme which saw a 30% drop in pressure ulcers (staffing support will be required to mirror this model) – competencies are assessed by the pressure ulcer nurses – staff have to achieve 90% pass. A review of this approach is to be completed, in terms of resources at CHFT, once the impact of the Care Closer to Home contract for the Tissue Viability Service is understood (November 2015).
- New equipment (Repose Wedge) is being evaluated that offloads the heel thereby reducing the risk of pressure ulcers to the heels. The evaluation commenced in July 2015 and is due to complete in September 2015.

1.3 Reducing Hospital Acquired VTEs

Venous Thromboembolism, or VTE as it is known, is a collective term for deep vein thrombosis (DVT) and pulmonary embolism (PE). VTE is a significant cause of mortality, long-term disability and chronic ill-health problems, many of which are avoidable. The incidence of Venous Thromboembolism is 1-2 per 1,000 of the population and the risk increases with age.

It has been estimated that the management of hospital associated VTE costs the NHS millions per year. This includes the costs of diagnostic testing, treatment, prolonged length of stay in hospital and long term care. Long term complications that reduce the quality of life add to the human cost and overall burden of VTE. VTE Prevention is well served by national standards that facilitate high quality care and NICE guidelines for reducing risk in patients admitted to hospital.

The Trust achieved all its VTE targets for 2014/15 which were:

- 10% reduction in the number of Hospital Acquired Thrombosis (HAT*) from the baseline of 2013-14
- To go 300 days without an avoidable hospital acquired VTE death (last death February 2014, year-end 411 days since a death attributed to VTE
- To ensure over 95% of applicable patients undergo a VTE risk assessment

There was a a reduction of over 20% in the number of diagnosed cases. Seeing reduction from a monthly avergae of 14 cases down to 10.

All Cases are subject to a Root Cause Analysis which has determined that there were no avoidable HAT episodes

2015 /16 Targets

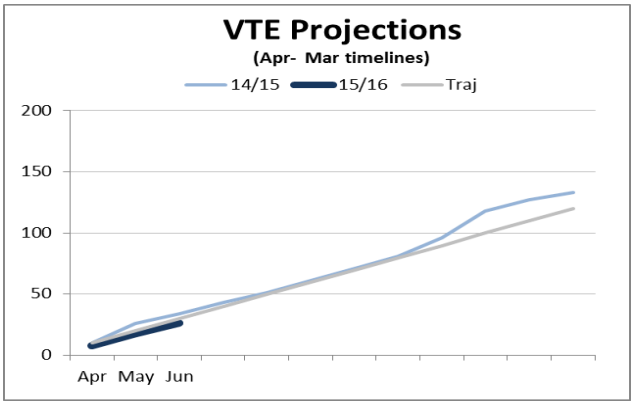
The VTE Committee agreed new trajectories for Quarter 1 2015/16 as follows:

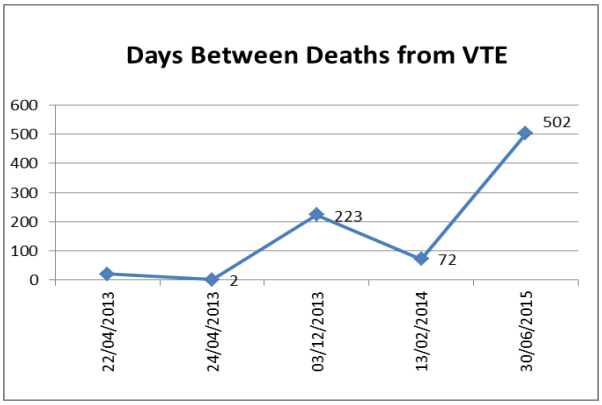
- To continues to see a 10% reduction in the number of HATS *(definition of a HAT is when a patient develops a VTE after the first 72 hours of their stay or had a previous surgical admission within the last 90 days)*
- To continue to monitor the number of days between deaths from HAT
- The VTE risk assements continue above the 95% target.

The VTE Committee will set improvement trajectories for the rest of 2015-16 following completion of the audit described below which will be confirmed in the quarter 2 report. A revised risk assessment and prescription chart is currently being implemented throughout the Trust (with the exception of paediatrics and maternity services), following which an audit will take place on its effectiveness in helping to reduce the numbers of HAT's.

Current Performance

The Trust achieved its HAT target in Q1, with 26 cases throughout Apr 15 – June15, against a ceiling of 30.





The VTE risk assements continue to be above the 95% target.

Improvement plans for Q2 2015/16

A new process has been designed for reviewing HAT cases. This will be signed off by the thrombosis committee and in place for Q3.

A revised risk assessment is to be implemented on all areas. An audit will be undertaken to identity improvement in prescribing mechanical and pharmacological prophylaxis.

1.4 Medicines management

Aims and Objectives of Work

Effective medicine management ensures that patients receive the correct medicine at the correct time which in turn expedites their return to good health, reduces the time spent in hospital, and prevent unnecessary hospital readmissions. Nationally the transfer of information about patients' medicines continues to be a significant risk to patient safety. Between 30 - 70% of patients can have either an error or an unintentional change to their medication when their care is transferred (Royal Pharmaceutical Society July 2011).

The medicine management work in the Trust has the following aims:

- To reduce unintentional missed doses to a target of 9% or less by April 2016.
- To improve the percentage of patients who had their medicine reconciled on admission – with a 2015/16 CQUINS target of 80% by the end of the year
- To improve the percentage of patients who had pharmacist approval of discharge prescriptions – with a 2015/16 CQUINS target of 70% by the end of the year.
- To look in detail at improving discharge processes as part of a local CQUIN.

Performance is driven by The Medication Safety Group, established in November 2014, and overseen by the Patient Safety Group.

Q1 Performance:

Missed Doses:

The Trust wide missed doses audit monitors intentional and unintentional missed doses (see table below for overview of the differences) with a focus on blanks, ticks and crosses which contravenes documentation on Prescription Charts & Administration Records - data taken from one 24 hour period each quarter.

Intentional missed doses	Unintentional missed doses
✓ Omitted at nurses discretion ✓ Prescriber requested omission ✓ Pharmacist/ Healthcare professional requested omission ✓ Patient refused	✓ Patient away from ward ✓ Patient could not take/ receive dose ✓ Dose not available ✓ Nil by mouth ✓ Blanks, Ticks, Crosses

There was a reduction in the number of all missed doses of 3.6%

	Q4 14/15	Q1 15/16
For all missed doses	16.98%	13.37%
Intentional missed doses	8.01%	5.57%
Unintentional missed doses	8.98%	7.80%
Blanks	283	216
Ticks/crosses etc	42	32

In order to ensure that performance continues to improve, the results are fed back to All Ward Managers/Matrons and to the Nursing and Midwifery Committee. Going forward, admissions areas continue to be targeted to encourage the transfer of medicines with patients.

There is an ongoing campaign to encourage patients to bring all their medicines into hospital with them.

Wards are encouraged to check prescriptions on each shift change/handover to check documentation and ensure doses have not been missed.

Medicine Reconciliation and Discharge Checking:

All targets were achieved, during the month of June there was a slight drop in the % medicines reconciliation on medical wards due to pharmacy staff vacancies and additional demands of extra capacity wards remaining open.

	Quarter 1			Q1
6 - Improving Medicines Safety Support the effective transfer of information about medicines when patients are being transferred from one provider to another following an unplanned admission to hospital	Apr-15	May-15	Jun-15	Total
The number of patients on acute medical wards having a medicines reconciliation process by pharmacist or pharmacy technician during hospital stay	644	634	675	1953
The total number of patients admitted to acute medical wards	797	788	862	2447
% Medicines following the reconciliation process	**80.8%**	**80.5%**	**78.3%**	**80%**
Target	**80.0%**			

	Quarter 1			Q1
Part 6.2 - Discharge Accuracy Checks	Apr-15	May-15	Jun-15	Total
The number of patients (admitted for longer than 24 hours) on acute medical wards having their e-discharge prescription approved and reconciled against the inpatient prescription chart by a pharmacist	797	788	862	2447
The number of patients (admitted for longer than 24 hours) on acute medical wards	1127	1064	1149	3340
Discharge Medication - total	**70.7%**	**74.1%**	**75.0%**	**73.3%**
Target	**70.0%**			

In order to maintain 80% medicines reconciliation throughout Q2, staff are being recruited to fill vacant positions. It is also anticipated that the extra capacity wards will close releasing some of the current pressures on existing pharmacy staff.

Improving Discharge Processes:

In addition to the standard e-discharge checking process being monitored above, there is a desire for the trust to further improve the quality of the medication element of the discharge processes. The Discharge Improvement CQUIN for 2015/16 seeks "*To improve the standards of discharge with a particular focus on accuracy of information relating to medicines on the e-discharge written by the junior doctor, ensuring patients leave the hospital with the correct medication and correct information on discharge"*

The aim of quarter one was to scope out how intensive audit work could be carried out to examine this in detail. Two wards on each hospital site needed to be identified and baseline data collated. The wards which have been identified to undertake this improvement work are 4 and 8 at HRI, 6b and 7d at CRH.

These wards performance at the following levels for the standard CQUIN elements,

Medicines reconciliation = 87%
Discharge accuracy checks = 96%

However it was noted that only 38% of e-discharge prescriptions, that is the medications being prescribed as per documentation in the case notes, were completed correctly. It is this reason that improvement targets will be set going into Q2.

There will need to be further work to assess reasons for errors and how improvement in the supply of discharge medication can be made. Quality of information on discharge has already been identified as an issue and junior medical staff have made suggestion to change the Drug prescription and Administration to include an simple tool for recalling what was required, as such the acronym 'PAN' was added to the prescription chart, standing for:

P =Pre-admission drug (PAD)
A =Amended dose of PAD
N =New Drug

During the quarter, a process of having a single nurse checking discharge medication has been introduced to also reduce any errors on discharge.

National Drug Safety Alerts

Safe and Secure Storage of Medicines - A tool has been developed for use by matrons and ward managers to assess compliance with national standards.

Nursing and pharmacy staffs are being more proactive in identifying areas of concern and risks addressed. Newsletters will be used to reinforce and remind staff about action required

Q2 planned improvement:

- Learning and Development:

FY1's requested feedback on prescribing errors for shared learning and this is now available on the intranet and via Ignaz. For a development at future meetings is the sharing of information and recommendations from the group using existing systems e.g. Patient Safety Newsletter/ Medicine Management Newsletter or meetings e.g./Divisional Patient Safety and Quality Boards

Safer Prescribing by FY1s.4 mandatory modules of the e-learning package SCRIPT will be introduced from August 2015

- Medication Safety:

A review of Insulin incidents highlighted recurring theme in relation to confusion between those insulins which had similar names. The Diabetic Collaborative has been asked to work on an aid memoir to improve understanding of the different insulins and duration of action.

Medication and Allergies continue to be a recurring theme. Given that reports involving penicillins are one of the most frequent there is a plan to reduce the inadvertent administration of Penicillins to patients with known Penicillin allergy by 50% by March 2016.

It is important to note that none of the incidents involving penicillins have resulted in serious harm.

Clinical areas are to be issued with a laminated poster which is to be applied to the medicines trolleys and displayed where intravenous medicines prepared. Information for new prescribers on medicine incidents seen includes allergies as does teaching sessions for FY1's and medical students

- Improving Discharge:

Now the baseline has been gathered further work is being undertaken to understand the root causes of the issues identified. Non-compliant cases often involve patients on multiple medications who have either started or stopped certain drugs during their stay. An action plan and associated improvement trajectory is in development.

Training with Drs on wards to ensure that doctors understand how to completed the e-discharge and the importance of ensuring GPs receive accurate information

Pharmacists will check the EDS against the drug chart and the notes on the improvement wards wards will correct any inaccuracies at this point (so the EDS will be correct) and also provide continuous feedback to the junior Drs and consultants.

1.5 Improving Sepsis Care

Aims and Objectives of Work:

Sepsis is a complex disease process associated with multiple pathologies, and high mortality rates. Sepsis causes about 37,000 deaths per year in the United Kingdom alone, as such accounting for more deaths than lung cancer alone, or breast and bowel cancer combined (Survive Sepsis, 2010).

Early identification and intervention improves both morbidity and mortality from sepsis. The UK Sepsis Trust, working with Health Education England (HEE) have produced a number of clinical tools to support consistent recognition and response across primary and secondary care.

We have had a sepsis collaborative for 6 years that includes clinical staff from all admitting areas (emergency department, medical/surgical assessment units etc), intensive care, pharmacy, microbiology, informatics and governance. The work has been focussed on improving identification and early treatment of patients with sepsis across the organisation.

In 2015/16 a new national CQUIN has been introduced which aims to have:

- 90% by Quarter 4 of emergency admissions being screen for sepsis where appropriate. ***Quarter 1 target was to establish a baseline position.***

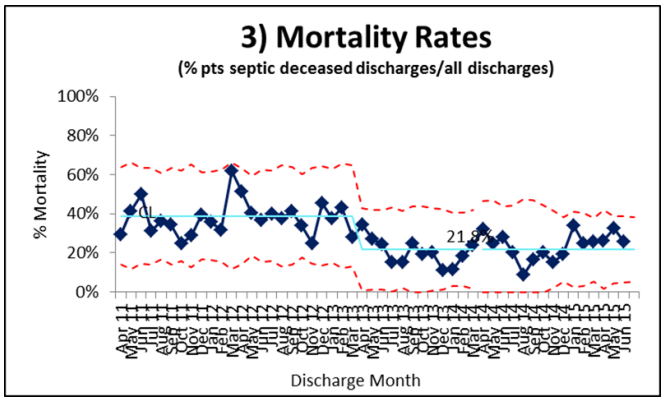
- 90% by Quarter 4 those patients who have been identified as Septic having received antibiotics within an hour of admission. ***There is not target for Q1, the target occurs***

at the end of Q2 when a baseline position over the first 6 month of the year should have been established.

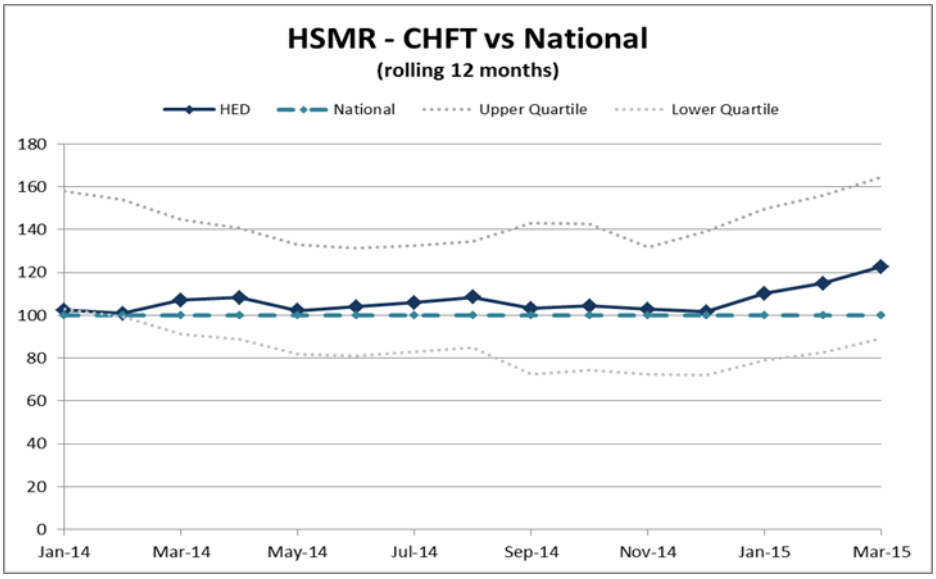
Q1 Performance:

Over the last Quarter the mortality rate been higher than the 14/15 average. This trend has become apparent since January 2015,
See Below.

	14/15 Performance	Q1
Number of Discharged	599	144
Number of deaths	136	41
Mortality Rate %	22.7%	28.5%



There has been a corresponding rise in the trust HSMR for this condition.
At present the trust remains in the as expected range, with a HSMR of 120 (LCI 95, UCI 160)



At present there is no obviously reason for the rise, a trust has recently begun a mortality case note review process. During Q1, 8 out of the 41 deaths have undergone review, 6 score a Hogan score of 1 which indicates no evidence of preventability, the other 2 were given a Hogan score of 2 on first review, and these are now undergoing a second level

review which includes looking much deeper into the case. It is important to notes that he Hogan scale runs from 1 – 6, with 6 being the definite evidence of preventability.

Screening for Sepsis:

Performance for Q1 was 88% of applicable patients being screened, which give us a baseline for improving into Quarter 2. The CQUIN aim for Q1 was to gather enough data to have a baseline to work from going forward – this was achieved as indicated by the green box below.

	Quarter 1			Q1
2.2a - Sepsis Screening	Apr-15	May-15	Jun-15	Total
Number of emergency patients who had a NEWS score of 5 and above and were screened for sepsis	5	5	5	**15**
The total number of emergency patients who require screening for sepsis according to the agreed local protocol (NEWS of 5 and above on admission)	6	6	5	**17**
% Eligible patients screened for Sepsis	**83.3%**	**83.3%**	**100.0%**	**88%**
Target	**Baseline**			

Antibiotics within an hour:

The CQUIN aim for Q1 was to gather enough data to have a baseline to work from going forward – this was achieved, and above is indicated by the green box in the performance table below.

	Quarter 1			Q1
2.2b - Sepsis Antibiotic Administration	Apr-15	May-15	Jun-15	Total
Number of patients in the sample with severe sepsis, red flag sepsis and septic shock who received IV antibiotics within 1 hour	3	3	4	**10**
Patients who, in the reviewers view, had recorded evidence of severe sepsis-Red Flag Sepsis- Septic Shock on emergency presentation who should have been administered IV antibiotics within 1 hr	6	11	5	**22**
% Patients with severe sepsis, red flag sepsis and septic shock that received Iv antibiotics within 1 hour.	**50.0%**	**27.3%**	**27.3%**	**45%**
Target	**Baseline**			

**Some cases are still outstanding so the performance below is subject to update*

Improvement plans for Q2 going forward:

In recognition of the current performance, a proposal has been made on how best to support the collaborative going forward in the delivery of a new sepsis screening protocol.

- During Q1 finalised the new sepsis protocol which will now include a new trigger to identify high risk/red flag sepsis at an early stage and initiate treatment. This will be rolled out in September to coincide with world sepsis day. Expect to see an impact into Q3

- The GP referral criteria have now changed for admissions into MAU and SAU, to again capture early indicator of sepsis. GPs will now be asked to complete initial observations on referrals. This started in May and is being rolled out during Q2.

- Tested process for the collection of CQUIN data, recognition that support will be needed to ensure this process is as smoother and therefore more effective in both the collection of the information and the learning from any findings.

1.6 Safeguarding Patients

Aims and Objectives of Work

Aims for the work are to:

(i) Safeguard children and adults at risk through further development of the partnership between health and social care in Calderdale and Kirklees.
(ii) To ensure effective communication and engagement with staff and the public in respect of the work of the Trust and the wider safeguarding agenda

It is vital that Safeguarding standards are maintained, continue to improve and accountability remains clear and unambiguous. With this is mind safeguarding remains a key priority within the Trust for 15/16 and that staff are fully supported in delivering safe and quality services.

(i) Quarter 1 Progress.

Safeguarding Adults and Children remains an integral aspect of patient care, and requires services to work effectively together across boundaries to either prevent harm or intervene when harm, neglect, or abuse is suspected.

There has been an increase in the number of safeguarding level 1 concerns identified across the Trust, which may reflect increasing awareness and willingness to report such concerns. This reflected an increase from 54 referrals in quarter 4 2014/15 to 77 in 2015/16 equating an increase of 42%.

The Trust has recruited a new Head of Safeguarding to Lead the Adults and Children's Team. Work is continuing to embed a safeguarding culture across all divisions and departments by ensuring that the Trust follow the principles into practice ethos of ensuring safe patient care, which applies knowledge and skills into nursing practice; and that the four behaviours expected of all employees are followed. There is development of a safeguarding strategy ongoing to ensure that CHFT policies and procedures in relation to the Adults and Children's agenda seamlessly transfer information from admission to discharge and beyond.

In March 2015 CHFT contributed to 'Safeguarding Week' on behalf of Calderdale Adults and Children's Safeguarding Boards. The aim of this week was to raise awareness of the role of 'everyone' in safeguarding vulnerable children and adults at risk to highlighted available support and intervention in Calderdale. As part of this week:

- CHFT hosted Hempson's Solicitors to present a 'Consent update.' This event was open to all professionals across Calderdale. This evaluated extremely well.
- CHFT in collaboration with the Police hosted an event surrounding Domestic Abuse and Clare's Law on two occasions.
- CHFT also held a stall in the canteen and main entrance of CRH.

A legal expert, Peter Edwards Law, spent a day at Huddersfield Royal Infirmary and presented a session in the morning and afternoon via video link to Calderdale Royal Hospital and presented a masterclass on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). This was extremely well attended by approximately 350 staff.

Internal lines of accountability and internal structures within the Trust have been strengthened to make sure that the organisation has a clear process in place for communicating with staff and to ensure safeguarding is at the heart of everything they do. The safeguarding team continues to work closely with the risk department to provide advice and support in relation to complaints and incidents where safeguarding concerns have been identified. Further governance work is ongoing in engaging with Divisions ensuring safeguarding continues to be a priority, and attendance at Divisional Patient Safety and Quality Boards is ongoing.

Further plans in the forthcoming year follow acknowledgement of:

- The introduction of The Care Act 2014 in April 2015
- The continuation of The Children Act 1989/2004

April 2015 saw the introduction into primary legislation of the Care Act 2014, which now legislates Adult Safeguarding and imposes a legal duty on NHS organisations. This legislation replaces the 'No Secrets' guidance (Department of Health and Home Office, 2000). It not only addresses and recognises stopping abuse or neglect, preventing harm and reducing risk, but promotes an approach that improves the life for the adult concerned. The principles and values of adult safeguarding are built on empowerment, protection, prevention, partnerships, proportionality and accountability. This includes such duties for care providers as:

- Providers of care regulated by the CQC have a duty to report any allegations of abuse or neglect.

- Where there is an employee involved with a Section 42 formal enquiry, there will need to be an investigation by the provider and the sharing of information sufficient to include all facts in a Case Conference report.
- Employers must report all findings of abuse to the Disclosure and Barring Service and professional bodies.
- There is a Duty of Candour for Care Providers
- Local Authorities must cooperate with relevant partners, and those partners must cooperate with the Local Authority (The Care Act specifies NHS Trusts and hospitals, amongst others).
- There is in addition a greater emphasis on making safeguarding personal for patients in helping them achieve the outcomes that they want.
- The Foundation Trust should ensure that they have the mechanisms in place to enable early identification of risk and collaborate and work together, whilst considering the wishes of the adult on whose behalf they are working.

The legislation confirmed that:

- Safeguarding Adult Boards became statutory.
- There is a requirement to conduct Safeguarding Adult Reviews.
- Information sharing duties.
    - The statutory organisations for the Safeguarding Adults Board are the Local Authority, the Police and the Clinical Commissioning Groups.
    - All statutory agencies to have a Designated Adult Safeguarding Manager (DASM). A DASM would be involved where concerns are raised about an employee, volunteer or student, paid or unpaid. This role is recommended for members of Safeguarding Adults Boards

In addition to this the Trust is required to comply with The Children Act 1989/2004 which imposes a legal duty on all professionals to safeguard and protect children. The 'Working Together 2015' statutory guidance further emphasises the collective interagency arrangements of how agencies including NHS organisations must work together, and how this is implemented locally. Members of the Trust's Safeguarding Children's team attend both Calderdale and Kirklees Safeguarding children's Boards and their sub-groups. They contribute to district wide strategies and work which is then disseminated within the Trust. An annual section 11 audit is carried out within Children's safeguarding services within the Trust which is sent to the Children's Safeguarding Boards. Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. It places a duty on NHS Foundation Trusts.

MCA and DoLS Audit June 2015

The increased number of Deprivation of Liberty Safeguards (DoLS) applications reflects increasing awareness of deprivation of liberty arising from the Mental Capacity Act (MCA) 'Principles into Practice' work on-going within the trust.

An audit carried out in June 2015 on all adult in patient wards has identified knowledge gaps on wards in relation to the assessments of patients capacity in relation to decision specific criterion; the lack of the identification of patients who are deprived of their liberty but without a legal safeguard on the wards, and a lack of comprehensive policy relating to the MCA and DoLS. The acid test arose from a Supreme Court Judgement last year which lowered the threshold for DoLS. Patients who lack capacity; who are under continuous supervision and control; and are not free to leave require a legal safeguard. There were 27 patients at Huddersfield Royal Infirmary and 8 patients at Calderdale Royal Hospital who met the acid test.

A more comprehensive report has been prepared to action this. This report has identified a clear action plan which includes the development of a separate Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Procedures which will be completed by the end of September, the production of a training plan, development of an action plan to increase knowledge and awareness in areas identified in the audit

ii) Training

The last quarter has seen a decrease in compliance for level 2 and level 3 safeguarding training. Training sessions have been consistently offered but poor attendance at sessions is clearly reflected. Level 3 training remains better attended.

The trajectory set for safeguarding training was agreed at the beginning of the year, in that 90% staff (in the relevant target groups) should have undertaken the relevant safeguarding training by the end of quarter 4 (March 2015) in order to demonstrate compliance with this important agenda. Whilst the safeguarding team have a comprehensive programme of training that is delivered on a monthly basis, often many of the sessions are not well attended. Divisions are asked to support safeguarding training and ensure their teams are compliant with safeguarding training.

- Level 1 safeguarding continues to be delivered via written updates and briefings across the workforce in the form of the safeguarding newsletter which is circulated twice a year. It not only gives relevant information to meet the criteria for level 1 training, but it also supports levels 2 and 3 training and is currently at **100%**

- Level 2 safeguarding training (Adults and Children) has seen a slight decrease of 52.8 to **51.9 %.** Training continues to be constantly reviewed and updated in order to maximise learning and meet the needs of the diverse workforce and overall evaluates well. This is now shortly being offered as an eLearning package which will be easier for staff to access and increase training compliance.

- Level 3 safeguarding children training has decreased in the last quarter from 82.8% **to 73.4%**

- Level 3 safeguarding adults training is not being recorded in %. Staff that require level 3 training have not been identified in a matrix and therefore further work is being carried out here.

- **Master classes** have been developed throughout 2015 in relation to the MCA and DoLS.

- **PREVENT** - Implementation of the PREVENT Strategy is now underway across the organisation, with significant progress being made. The Trust now had 9 accredited trainers and a clear training programme is currently underway**.** NHS England and commissioners are happy with our Implementation of this strategy and training continues to evaluate well. All staff are identified on ESR who require this one off training. This training is not yet captured as a percentage

- **Safeguarding Supervision** whilst safeguarding supervision is offered to staff there has been poor uptake on this. There are plans to address this through the Workforce Department to identify members of staff through ESR to ensure divisional managers are aware of members of staff who do not engage in regular mandatory supervision and that this is followed up. Community staff are better at attending supervision compared to acute sector staff.

Other work has included;

- Further update and development of the Foundation Trusts Intranet pages to facilitate easier access to safeguarding information. The safeguarding icon is now clearly visible on the intranet pages, and work continues to develop the content in order to make it easier for staff to access up to date safeguarding information.

- Publication of the 7th edition the safeguarding newsletter in June 2015 provided further updates and information for staff.

- Promotion of district wide events hosted by the local Safeguarding Boards

- Production of a safeguarding banner on the main intranet page which includes topical information evolving from serious case reviews, domestic homicide reviews and local and national guidance.

Improvement Plans for 2015/16 (Quarter 2)

CHFT continues to be represented at their planned regular meetings on both Children and Adult Safeguarding Boards and their subgroups in Calderdale and Kirklees, and work continues to ensure existing partnerships and collaborative work is maintained.

There is development of a safeguarding strategy and plan which has commenced and will be completed by November to ensure that CHFT policies and procedures seamlessly transfer information from admission to discharge and beyond whilst continuing to embed a safeguarding culture across all divisions.

Whilst safeguarding supervision is offered to staff there has been poor uptake on this.

The content of the level 2 training has been updated and the safeguarding team are awaiting the compilation of an eLearning package for staff in an attempt to address poor compliance at level 2.

There are plans to address this through the Workforce Department to identify members of staff using the Electronic Staff Record (ESR) system to ensure divisional managers are aware of members of staff who do not engage in regular mandatory supervision and that this is followed up. The safeguarding team is currently working with workforce development in relation to how target groups are defined and how training is recorded since a number of anomalies have been identified. An achievement plan is being developed to address this which will involve the further identification of divisional non-compliance and individual staff identification.

Reporting of Female Genital Mutilation (FGM) is in place within the Trust and there is ongoing development of a pathway. This pathway is expected to be completed by November 2015. The Safeguarding team engage with both strategic and operational groups relating to Child Sexual Exploitation and both these are being referred to in the safeguarding policies.

Datix Incident Reporting**:** Further ongoing work is continued to ensure that systems are in place where safeguarding concerns are reported through the Foundation Trusts internal reporting mechanism. This work also includes ensuring the Foundation Trust is meeting its obligations in relation to the Care Act 2014 by involving the Local Authority partner organisation.

Lessons learned from Serious Case Reviews/ Domestic Homicide Reviews and Serious Adult Reviews are being currently being collated to ensure that actions and lessons are disseminated and actioned Trust wide. This task and finish group is planning its commencement in September.

Overview of Current Performance KPIs

SAFEGUARDING DASHBOARD QUARTER 0NE 2015/16	**Trajectory**	**Q4 2014/5**	**Q1 2015/16**
TRAINING - LEVEL 1 %	100	100	100
TRAINING - LEVEL 2 (%)	90	52.8	51.9
TRAINING - LEVEL 3 (%)	90	82.8	73.4
Numbers - Prevent Trained	100	222	280
% LAC IHA WITHIN TIMESCALES	95	66	60
% LAC RHA WITHIN TIMESCALES	95	93	85
% SUPERVISION for HV's and ScN	90	85	89
% SUPERVISION for Specialist Midwives	90	100	75
% Supervision for others Children Services	50	44	40
Number of children currently Looked after (Calderdale)		323	327
Number of children subject to CP Plan (Calderdale)		231	227
Number of children currently Looked after (Kirklees)		627	616

Number of children subject to CP Plan (Kirklees)		346	362
NUMBER OF LAC HA		82	92
Numbers - Supervision for Adult Services		140	128
Referrals to FRT Acute Kirklees (Children)		11	17
Referrals to FRT Acute Calderdale (Children)		28	13
Referrals to FRT Calderdale Community (HV/SCN)		11	9
Adult Concerns reported Acute -Calderdale Category 1		54	77
Referrals to Gateway Acute - Calderdale Category 2		17	17
Adult Concerns reported Acute - Kirklees 1		44	75
Referral to Gateway Acute - Kirklees 2		22	16
Adult Concerns reported (community)- Calderdale 1		27	58
Referral to Gateway Community Calderdale 2		24	19
Number of CP Medicals - Calderdale		23	39
Number of CP Medicals - Kirklees		8	8
Number of DoLS(Actual) Kirklees		2	5
Number of DoLS (Potential) Kirklees		2	3
Number of DoLS (Actual) Calderdale		7	11
Number of DoLS (Potential) Calderdale		3	3
Number of children Kirklees attending A/E - Alcohol		2	6
Number of children Calderdale attending A/E - Alcohol		6	8
Number of children Kirklees attending A/E - Substances		2	7
Number of children Calderdale attending A/E - Substances		4	6
Number of children Kirklees attending A/E - self harm		21	10
Number of children Calderdale attending A/E - self harm		9	13
Number of Cause for Concern Forms in relation to - DV-Calderdale HV		3	7
Number of Cause for Concern Forms in relation to - DV-Kirklees HV		8	4
Number of FGM in Kirklees	Not collected		1
Number of FGM in Calderdale	Not collected		0

1.7 Learning from Incidents

Key messages:

- 17% Increase in CHFT incidents recorded in Q1
- Suspected falls is the top reported incident in Q1
- Medical Division is the highest reporter of incidents in Q1 (42% all incidents)
- Labour Delivery recovery Post Natal Unit is the highest reporting department (226 incidents)
- 40 pressure ulcer incident Serious Incidents (SIs) Q1, 5 other Sis
- No never events in Q1

Numbers of Incidents

For the period 1 April 2015 to 30 June 2015 a total of 2,940 incidents were reported by CHFT members of staff. Of these, a total of 2,331 were CHFT related incidents.

Incidents by Organisation and Quarter

	2014/15	2015/16	Movement
Bradford Teaching Hospital Trust	0	1	⇧
Calderdale & Huddersfield NHS Trust	1938	2331	⇧
Calderdale CCG was Calderdale PCT	34	149	⇧
Coop Pharmacy	3	9	⇧
External Agencies	139	28	⇩
GP Surgeries Calderdale (Health Informatics)	0	1	⇧
Greater Huddersfield CCG was Kirklees PCT	131	134	⇧
Leeds Teaching Hospitals	5	6	⇧
Mid Yorkshire Hospitals NHS Trust	1	2	⇧
NLA Embankment Leeds (Health Informatics)	0	1	⇧
Nursing Agency	0	1	⇧
Nursing/Care Home	110	167	⇧
Out of area patients	3	0	⇩
South West Yorkshire Mental Health Trust	1	2	⇧
Yorkshire Ambulance Service	14	20	⇧
Totals:	**2379**	**2852**	⇧

The above table shows that the number of incidents report has increased (increase of 473 incidents, 17%).

It is positive to note the number of CHFT incidents reported has increased by 393 (17%), following a drop in the reporting of CHFT incidents by 8% in 2014-15, indicating an improvement in reporting culture.

CHFT Incidents

The top 20 reported incidents for Quarter 1 are given below with suspected fall accounting for just under a third of these:

2015-16 Incidents : Top 20 reported incidents	Q1
Suspected fall	410
Lack of suitably trained /skilled staff	139
Simple complication of treatment	93
Fall on level ground	74
Pressure Sore Grade 2	73
Delay	54
Breach of Isolation Policy	49
Hospital Acquired Pressure Sore Grade 2	43
Accident of some other type or cause	40

Physical abuse, assault or violence	40
Failure to note relevant information in patient's record	34
Suspected bogus person	30
Documentation - misfiled	28
Fall from a height, bed or chair	28
Patient incorrectly identified	27
Breach of CD drug recording/storage policy	27
Medicine not administered	26
Wasted blood products	26
Lost/missing property/damaged property	25
Struck against furniture/object/fitting	25
Totals:	**1291**

Incidents by Divisions:

The tables below show that the number of incidents reported in Quarter 1 per Division, with the Medical Division reporting 42% of total incidents

Incidents reported by Division 2015-16	Q1
Corporate Division	9
Children's Women's and Families Services Division	519
Community	185
Diagnostic and Therapeutic Services Division	152
Estates and Facilities	27
Medical Division	993
Surgical & Anaesthetics Services Division	446
Totals:	**2331**

Incidents by Department:

The table below identifies the highest reporting ward/department (Top 20):

Labour Delivery Recovery Post-natal Unit	226
Patient's Home	142
Accident and Emergency	93
HRI MAU	92
Operating Theatre	78
HWD8	77
C3ABCD Paeds	60
CWD2C MAU CRH	58
HWD19 Trauma	56
HWD6	54

Pharmacy Manufacturing Unit	46
CWD6A	42
Outpatient Department	39
HWD15 General Surgery	38
Acute Stroke Unit CRH6D	37
Health Centre/Clinic	37
CWD2B	37
CWD5C	35
CWD6C Cardiology CRH	34
CWD2D MAU CRH	33
Totals:	1314

Incidents by Severity:

The numbers of incidents by severity are:

2015-16	**Q1**
Green	1624
Yellow	645
Orange	16
Red	46
Totals:	2331

Learning from Incidents

Examples of learning from incidents – shared at ward meeting 22 July 2015 (ward 5)

Incident	**Investigation Highlighted**	Actions
Datix 98868 Patient found in bathroom (walked to bathroom with zimmer) . sustained fall and fractured right ankle. Investigation highlighted the following: • Staff to clearly document if patients are being supervised to bathroom • Patients to be supervised whilst using bathroom and shown how to use nurse call buzzer		ALL patients to have documented review of mobility in falls care plan / moving and handling care plan All patients to have intentional rounding
Datix 117566 Aa mortality review highlighted an unexpected death. Patient with COPD was triggering high on NEWS – not escalated at night. Patient found deceased the following morning	Lack of escalation of a patient triggering high NEWS	Addition to safety huddle to identify patients with high NEWS and escalation plans. Robust huddles daily and at weekends

		Nerve centre roll out in first cluster
Datix 112505 Patient acquired category 3 pressure ulcer	Patient was not transferred onto appropriate pressure relieving mattress in a timely manner Lack of documentation in waterlow care plan and SKIN bundle	Addition to daily safety huddle regarding pressure area care All training completed with staff regarding pressure ulcer / mattresses Increased records audits (CRAS) at ward level to review documentation Closely working with Tissue Viability Nurse (TVN) to trial new audit tool TVN attending safety huddles

Incidents Classed as "Serious" Reportable to the CCG:

In Quarter 1, 45 incidents were identified as being "serious" and required reporting to the CCG/NHS England via STEIS. The types of incidents were:

Pressure Sore Grade 3	38
Pressure Sore Grade 4	2
Maternal resuscitation	1
Failure to act on adverse symptoms	1
Failure to follow protocol	1
Abuse - other	1
Implementation & ongoing monitoring/review - other	1
Totals:	45

All but 1 incident was reported on STEIS within the 48hr timescale.

The Executive team were provided with a brief description of the non-pressure ulcer related incidents at the time the incidents were identified.

Never Events

There were no Never Events reported within Quarter 1.

Improvements:

An update against improvement areas for 2015/16 is given below:

Improvement	Progress
To improve and increase the number of incidents reported	Number for Quarter 1 show a 17% increase in the number of incidents reported.
To increase the number of trained investigators	A number of training sessions have now been provided. Further dates were available within July.
To improve quality of investigation reports (through the action above)	Linked to above. This will become more evidence in future investigations.
To improve the timescale for booking 48hr incident panels	This is still a challenge. This is being reviewed as part of the Incident Reporting and Management Policy review (see below).
To develop mechanisms to report: Investigation themes/ Learning themes	In development
To develop linkages with Complaints/ Coroners cases to ensure appropriate incidents/investigations are highlighted and undertaken.	This is an ongoing development. However, all new cases as discussed and linked via Datix and our investigation process.
Work continues on reducing harm from falls and pressure ulcers	This work continues with the nominated leads.

Additionally, a review of the Incident Reporting and Management Policy is underway and will become the Incident Reporting, Management, and Investigation Policy (Incorporating the Serious Incident Process). This is to incorporate new sections in line with the recommendations from the Staff Survey review, and internal audit "Learning to Improve" review in relation to learning and feedback, which are also incorporated into the Trust's CQC action plan.

The revised policy will focus on:

- clarifying procedures (particularly relation to incorporating complaints, mortality review, inquest and claims investigations into the overall process);
- clarifying process for escalation of incidents and commissioning formal reports;
- developing effective investigations, including training and support for staff, standards for completed RCA reports and arrangements for sign-off;
- improving learning from experience, and
- explicitly stating the process for monitoring arrangements of any actions arising from investigations.

The policy also introduces the NPSA's Incident Decision tree to assess staff decision-making and actions. Implementation of the policy will be supported by review of all templates and other relevant documents.
The policy is currently at consultation stage and the aim is for it to be approved by September 2015.

1.8 Ensuring Effective Investigations

Aims and Objectives of Work

Whilst a high level of resources are utilised by the Trust to investigate complaints and incidents, (often from senior clinical staff), it is difficult to evidence positive change as a result. Improving the efficiency of the investigations process was the focus for establishing the Effective Investigations group in January 2015.

The group aims to:

- Advise the corporate and clinical divisions of CHFT on their CDP investigations processes.
- Incorporate human factors and evidence based methodology to service delivery problems (SDP) and care delivery problems (CDP) investigations
- Streamline reporting of incidents and near-misses
- Design, pilot and make available SDP/CDP investigative tools across CHFT.
- Develop educational material (e.g. written, eLearning and workshop materials as appropriate) to train CHFT staff in incident investigations

The implementation these investigations would ultimately lead to an increase in the number of incidences reported in line with the national average by the December 2015 and reduce the number of complaints by March 2016

Current Performance

The last three months have been focusing on establishing the group. Initial discussion with key staff has highlighted the following points that need addressing:

- Variance in the quality and depth of investigations being completed
- There are different tools in use and little standardisation.
- Investigators have not been formally trained
- Often investigations do not reveal the root causes, contributory factors & latent conditions
- There is a mismatch between recommendations which tend to be far reaching rather than actions generated which tend to be easier to implement
- There is a lack of shared learning from investigations
- Reporters do not feel they receive any feedback and this adversely affects their willingness to report.
- It is difficult to evidence change as a result of investigations.
- Implementation of the duty of candour reliably will need a robust structure and guidance and support for staff.

Improvement Plans for 2015/16

- A detailed action plan has been written, progress against this will be reported as part of the CQC dashboard and actions plan on a monthly basis.

- Kate Beaumont (ex-ICU nurse, ex-NPSA), investigations trainer for SI training based on NPSA toolkits has delivered 4 full training days with good feedback. These were 8

May (CRH), 22 May (CRH), 5 June (HRI) and 26 June (Acre Mill). Each day could only accommodate 20 people. Outcomes Group discussed who should attend (currently over-prescribed). EIG welcomed Kate's input and incorporated the CHFT NPSA based toolkit to it.

- Trust wide awareness and communication for the Effective Investigation group is being developed for dissemination by September 2015.

- Appetite for further training has been identified. Further training days are being planned (10 per year) with in house expertise. Current barriers to timely roll-out include lack of availability of training rooms. The situation is being monitored over Sept/Oct and will be escalated to Education Department should difficulties arise.

1.9 Central Alerts System (CAS) Alerts

Aims and Objectives of Work

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care

Current Performance

There were 15 Alerts received between April 2015 and June 2015. 10 did not require any action. Of the five that did require completed – See detail below – All were closed on time.

Reference	Alert Title	Originated By	Issue Date	Response	Deadline	Closed within Deadline
EFA/2015/004	Grundfos - Conlift Pumps - Limited Recall	DH Estates and Facilities	10-Jun-15	Action Completed	17-Jul-15	
MDA/2015/021R	Philips ventilators: BiPAP autoSV, BiPAP autoSV Advanced, OmniLab Advanced, OmniLab Advanced + and ...	MHRA Medical Device Alerts	22-May-15	Action Completed	09-Jun-15	
MDA/2015/019	All Birdie mobile hoists (lifters) manufactured by Invacare	MHRA Medical Device Alerts	28-Apr-15	Action Completed	29-Jun-15	
MDA/2015/018	All posture or safety belts fitted to supportive seating, wheelchairs, hoists and bathroom equipment.	MHRA Medical Device Alerts	21-Apr-15	Action Completed	22-Jun-15	

There is one alert current ongoing that was received before Q1; however the deadline is not until Q2.

Reference	Alert Title	Originated By	Issue Date	Response	Deadline	Trust Lead
MDA/2015/012	INRatio® and INRatio®2 PT/INR coagulation monitor and test strips used at home and at poin ...	MHRA Medical Device Alerts	19-Mar-15	Action Required: Ongoing	21-Sep-15	Luke Whitley

Domain Two – Effective

Effectiveness compliance summary

Indicator	Compliance
2.1 Learning from Mortality	Partial Compliance
2.2 Improving Reliability – Implementing Care Bundles (CQUIN)	Reporting Only
2.3 Improving the Management of Acute Kidney Injury (CQUIN)	Achieved
2.4 Improving the Management of Stroke	Reporting Only
2.5 Improving the Management of Fracture Neck of Femur Patients	Reporting Only
2.6 Improving Diabetes Care (CQUIN)	Achieved
2.7 Reducing Hospital Acquired Infections (Contract)	Partial Compliance
2.8 Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR)	Reporting Only

Highlights:

2.3 Improving Reliability – Implementing Care Bundles	Quarter 1 CQUIN target achieved for asthma and pneumonia
2.4 Improving the Management of Stroke	Outcome 2 - On track, with % of stroke patients spending more than 90% stay on stroke unit Outcome 4 - exceeded 20% reduction in length of stay (25% achieved)
2.6 Improving Diabetic Care	Quarter 1 CQUIN target achieved

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2.1 Learning from Mortality

Through understanding our hospital mortality the Trust is able to both gain assurance and learning relating as to current care processes and further identify any areas requiring improvements.

The main outcome measure is the Summary Hospital Mortality Index (SHMI) calculated by the Health and Social Care Information Centre (HSCIC). The SHMI 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.

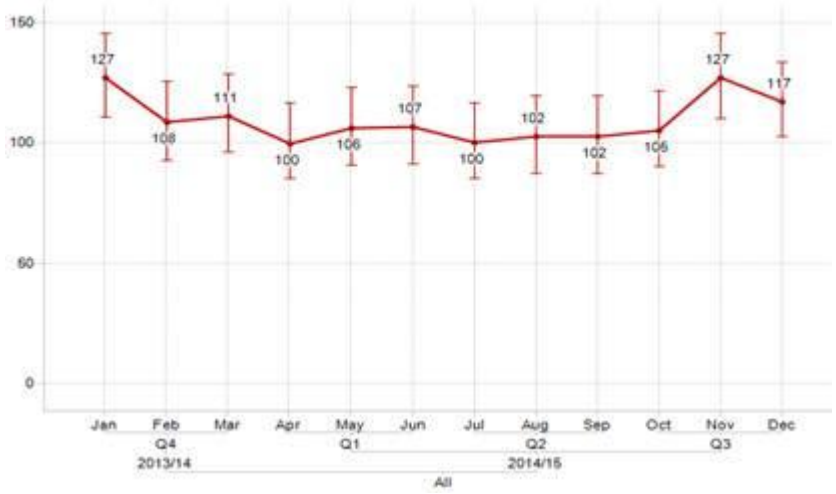
The Trust aims to:

- Reduce the SHMI to 100
- To review 100% of all in hospital deaths each month by the March 2016

Current Performance

The Trust's SHMI for the latest period published (Jan 14 – Dec 2014) is 109.4, this is in the category of "as expected", however I higher than the aim of having a SHMI closer to the national average of 100. The HSCIC caution that it is inappropriate to conclude that a Trust is performing better or worse than average based purely on whether or not there are more or less deaths than predicted. The Trust has been placed in the 'as expected' range because any variation from the number of expected deaths is not statistically significant

The trend data below shows how each month in the year has contributed to the overall performance.



The SHMI data can be tracked to specific conditions where the actual number of deaths exceeds expected, where this occurs cases are investigated and reports presented to clinical outcomes group with actions where necessary.

The latest SHMI was released during Quarter 1 and the following areas were noted to have higher than expected mortality rates:

Cancer of the Colon
Contusions
Skin Ulcer

These cases are undergoing case note review; initial findings indicate that there is no evidence to suggest a reason for concern. However the case note review process is recognised as a useful tool in gaining insight in around the processes of care being delivered. Many of these processes will not have a direct impact on preventing mortality; however where concerns are noted action plans will be put in place.

As the Trust consistently performs at the “as expected” level, the Trust needs a mechanism by why they could understand the quality of the care being delivered, especially for those patients who died in our care. It was decided to embed a mortality case note review programme across the board and not just for those conditions which triggered an alert.

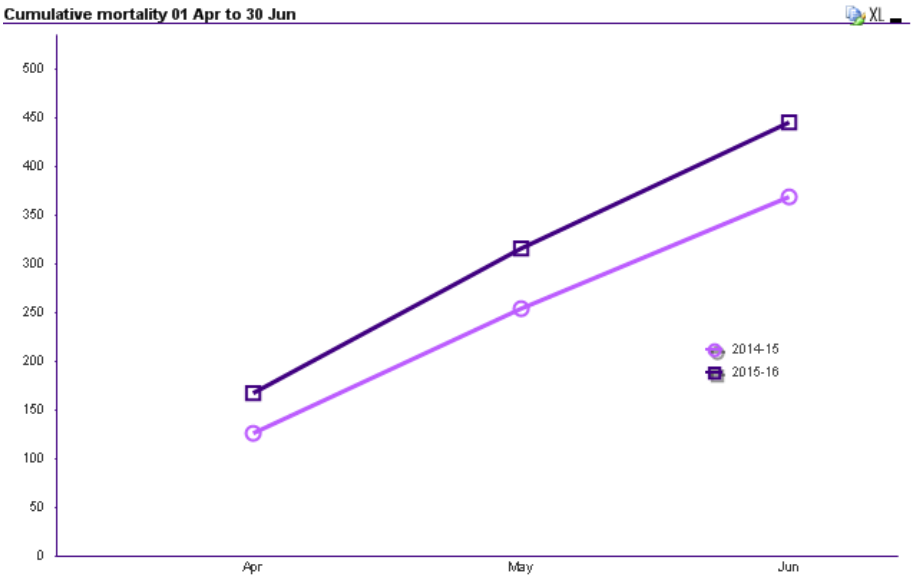
This work commenced in December 2014 with the aim of reviewing all in patient deaths. The process does require expert resource, and as such the 100% target has been difficult to attain but this will be examined going forward.

	Apr 2015	May 2015	Jun 2015	**Total**
Adult deaths	163	147	129	439
Reviews	49	33	22	104
Compliance	**30.1%**	**22.4%**	**17.1%**	**23.7%**

A full review has been undertaken (please see Appendix A for full overview of findings) as to the potentially preventability of the deaths that have occurred. This has highlighted care processes that the Trust would like to improve, such as ensuring all patients get a consultant review with 12 hour of admission.

There are also a small percentage (10%) which may have benefited from having there end of life care delivered in the community and avoiding an admission to hospital. This will lead to work with our partners to see how best to manage those types of cases going forward.

The Trust noted a higher than anticipated crude mortality rate, and work is underway to understand the drivers behind that.



Improvement Work is being delivered primarily through the Care of the acutely ill Patient programme, which was revised in September 2014 and consists of 8 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

During June 2015 the CAIP programme underwent a further review, and a more detail report will be in place in the next quarterly report. Theme 3 - Delivering high standard of care through reliable delivery of care bundles, was raised as needing some more focused attention.

Improvement for Q2

Implementation of a new mortality review policy.

A written process for mortality reviews has been completed and approved by COG). 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.

The role of the Clinical Effectiveness, Audit and Mortality (CEAM) group is to be reviewed and refreshed; including a review of membership to ensure representation from all divisions, and this group will receive mortality review information, make recommendations, and report to COG as necessary.

Alongside the introduction of new policies, the trust has sought the expertise from outside the organisation to have an impartial look into our performance. There will be further engagement with external support agencies, in the form analytical expertise from the university of Bradford and Clinical Support from previous MD of Quality at a local trust.

2.2 Improving Reliability – Implementing Care Bundles

Aims and Objectives of Work

Care bundles are being implemented in health care as a way of focusing improvement efforts on a defined set of factors and actions which contribute to achievement of a clearly specified aim. Care bundles are a simple way of focusing improvement efforts on a set of actions which contribute to achievement of a clearly specified aim. Improvement theory suggests that care bundles allow clinical teams to focus their efforts on a small number of measurable strategies aimed at improving specified outcomes (BTS/NHSI; 2012). Protocol-based care also enables staff to quickly see what action should be taken, when and by whom. They allow practice to be standardised and reduce variation in the treatment of patients. They are also an important tool in improving the quality of care, as variance from the agreed care pathway can be measured easily, allowing systemic factors that inhibit provision of best care to be identified

There is some evidence from single pilot sites in the UK that the implementation of in-patient care pathways or bundles can improve clinical outcomes such as mortality, hospital re-admission rates and hospital length of stay (Robb E; BMJ 2010).

The Trust is working on implementing evidence based care bundles for the following conditions

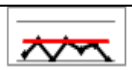
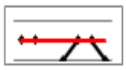
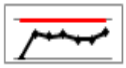
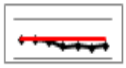
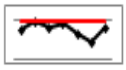
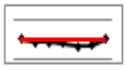
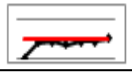
- Sepsis (See Sepsis Section)
- Acute Kidney Injury (See AKI Section)
- COPD
- Community Acquired Pneumonia
- Asthma

The aim of this work is initially to ensure the existing care bundles are being used reliably (95% and above) and are having the desired impact on clinical outcomes.

Current Performance

Data is collection focuses on uptake and whether the elements of the bundles, when present, are being completed.

Data relating to the month of June 2015 is shown below.

Asthma - Bundle Started	95%	0%	95%	67%		All bundle performance trends are from December 2014 June bundle had **1** identified patient who required a bundle - **0** started the bundle
Asthma - Bundle Completed	95%	n/a	95%	100%		Of those **0** started, **0** were completed
AKI - Bundle Started	95%	65%	95%	53%		June bundle had **17** identified patients who required a bundle - **11** started the bundle
AKI - Bundle Completed	95%	45%	95%	50%		Of those **11** started, **5** were completed
Sepsis - Bundle Started	95%	59%	95%	57%		June bundle had **44** identified patient who required a bundle - **26** of them started the Bundle
Sepsis - Bundle Completed	95%	58%	95%	60%		Of those **26** started, **15** were completed
COPD - Bundle Started	95%	80%	95%	54%		June bundle had **5** identified patient who required a bundle - **4** of them started the Bundle
COPD - Bundle Completed	95%	25%	95%	43%		Of those **4** started, **1** were fully completed
Pneumonia - Bundle Started	95%	100%	95%	69%		June bundle had **4** identified patient who required a bundle - **4** of them started the Bundle
Pneumonia - Bundle Completed	95%	100%	95%	89%		Of those **4** started, **4** were fully completed

Work has been undertaken to ascertain the causes for not achieving a higher proportions patients having started a bundle, and poor compliance with the overall elements. Findings have been as follows:

- Fast turnaround of junior medical staff making it difficult to ensure key messages around bundles and their use are communicated.
- Confusion re which bundle to prioritise
- Duplication and contradictory actions across the bundles in use.
- Lack of real time data around implementation so poor compliance can be challenged.

Three of the bundles now form part of the 2015/16 CQUINS, asthma, pneumonia and sepsis screening and further information regarding each of these for quarter 1 is given below.

Asthma (CQUIN) – The aim of improving the management of patients presenting with Asthma in A&E, by achieving 75% of compliance with the bundle complete in the final quarter.

This CQUIN is applied to Emergency Department (ED) attenders with Asthma who are treated and who are subsequently discharged home. The data for compliance with CQUIN is taken from the ED EDIS system, looking at the relevant fields and measuring compliance with each CQUIN element and the care bundle as a whole for each patient.

The data collection for the CQUIN is 50 consecutive cases within the quarter. Q1 performance was 66%.

	Quarter 1		
5.1 Respiratory Care Bundle - Improving management of patients presenting with Asthma in ED	Apr-15	May-15	Jun-15
Number of patients (<18) attending ED/PAU and the Number of patients (over 18) attending ED/MAU with asthma discharged home/not admitted with completed care bundle	33		
Number of patients (<18) attending ED/PAU and the Number of patients (over 18) attending ED/MAU with asthma discharged home/not admitted with / without completed care bundle	50		
% patients receiving care bundle	66%		
Target	**65.0%**		

Q2: Performance Plan: Having achieved 66% in Q1, improvements are needed to further improve and achieve the Q2 target of 70%. At present there is weekly monitoring in the unit which is allowing any noncompliance to be reviewed, lessons learned and processed to be put in place to improve.

Q2: Improvement Plan:

The Division build on the previous year's action, this will be used to gain the further improvements needed in Q2

ACTION PLAN

Issue	Current State	Future Plan and action	Timeframe
Performance, failure to meet CQUIN target	The under-performance has been communicated to the senior A&E team on both sites to highlight the situation.	The message around performance will be re-iterated to staff via Directorate Management Team meetings, Sister and Staff meetings.	May 2015
Staff compliance of the Asthma Bundle	Staff compliance variable, though addressed as a department, no performance addressed with individuals.	Daily monitoring of the compliance to begin on all asthma presentations. Weekly performance will go to the Turnaround Meetings. Targeted training and performance management of staff who fail to comply.	27 April 2015, to review at weekl

		Main issues to be recorded to identify common barriers and themes. Issue resolution to be put in place. **Following each patient case review any gaps noted are addressed with individual nurses/doctors.**	y interv als **Upda te July 2015** **Actio ns conti nue**
Staff understanding of the Asthma bundle detail	Training has been delivered to all staff; it is believed that there is a good understanding that staff are aware of the elements required.	Spot check of understanding to take place across both sites. **Staff awareness good for both medical and nursing. Spot checking monthly continues**	May 2015 **Upda te July 2015** **Actio ns conti nue**
Administering medications within timeframe	The difficulty in getting medications administered in time has be explored in more detail by the A&E consultant nurse, to look for process barriers and changes that can be made to increase compliance.	Work is underway to make the process more nurse led getting senior nurses to sign off the bundles as completed before patients leave the department. This will help ensure actions particularly around the discharge elements are more robustly followed but in addition will allow real time challenge of non-compliance and better understanding of delivery issues. Monitor compliance and take action where performance is poor. **Performance much improved, monitoring continues.**	May 2015 **Upda te July 2015** **Actio ns conti nue**
Compliance with recording Peak Flow scores	Review of supplies and access to equipment was completed – all necessary equipment in place.	Continue to monitor monthly and check the number of peak flow meters and access to other essential equipment.	Ongoi ng
Asthma Bundle visible within EDIS	Reception staff not fully compliant with including 'finish bundle' alongside presenting complaint.	Message to be re-iterated to all reception staff. To inform them that this will now be monitored on a daily basis. Staff to be informed once and if non-compliant then performance management will commence. **Monitoring closely**	1 May 2015 **Upda te July 2015** **Actio ns conti nue**
Current and visible data available for all.	Data is pulled on a weekly basis as part of the A&E quality indicators' by the nursing team. Issues identified quickly	Repeat audit required, to work in conjunction with the daily monitoring of staff compliance. Visible up to date displays in both departments. **New screens in each department providing up to date data on all quality indicators and CQUINs**	May 2015

	and rectified.		
Evaluation of current work		To consider the effectiveness of the new measures to be put in place. Senior team to consider if some dedicated resources for this work is a possibility, to incorporate other quality improvement work focusing around education and support for new/junior staff and real time data collection. **Whilst this CQUIN is on track to be delivered the other national/local CQUINs are heavily dependent on ED and additional support will be required.** **Request to QB via HM submitted.**	June 2015 **Update July 2015** **Actions continue**

Pneumonia (CQUIN)

Q1 Performance: The Community Acquired Pneumonia Care bundle (CAP) was introduced in 2014/15 for patients admitted with a Community Acquired Pneumonia. As one of the Trusts key care bundles this work is designed to reduce harm and improve identification and response to deterioration. The work reports to Clinical Outcomes Group on a monthly basis and through this route to the Quality Committee and Board.

The CQUIN consists of 4 measures which should be achieved within 4 hours:

1) C-XRAY
2) CURB Score recorded
3) Antibiotics given
4) Oxygen given

CURB Scoring was the lowest performing element. Q1 performance was 70%

	Quarter 1		
5.2 Respiratory Care Bundle - Improving management of patient attending A&E with pneumonia	Apr-15	May-15	Jun-15
Number of patients attending A&E with pneumonia who receive the CAP care bundle within 4 hours of admission	35		
Number of patients attending A&E with pneumonia who are admitted.	50		
% patients receiving care bundle	70%		
Target	**60.0%**		

Q2 Performance Plan: Performance was above target or Q1 and is expected to continue into Q2. There is an action plan in development which will address the difficulties with capturing CURB scores, and over the next 6 months compliance with this element is expected to improve.

Sepsis Screening (CQUIN) – See Sepsis Section 1.5 which shows achievement of quarter 1 target.

Improvement Plans for Q2 going forward:

During Q2 there is going to discussion on how best to proceed with this area of work. It is likely that the work will be managed using PMO methodology and support. This is likely to bring forward new plans for measurement and support going forward.

2.3 Improving Management of Acute Kidney Injury

Aims and Objectives of Work

Acute kidney injury (AKI) has now replaced the term acute renal failure and is characterised by a rapid reduction in kidney function, potentially resulting in a failure to maintain fluid, electrolyte and acid-base homeostasis. Recently it has been recognised that even relatively small rises in serum creatinine in a variety of clinical settings are associated with significant adverse outcomes, including increased mortality and prolonged length of stay.

Recognising the frequency and relative serious nature of AKI, NCEPOD surveyed the management of the condition in UK hospitals. The subsequent report (Adding Insult to Injury, NCEPOD, June 2009) identified serious shortcomings in the management of AKI in hospitals. NICE also published a clinical guideline for the management of AKI in hospital in August 2013.

As part of its response to this report and other information the Trust decided to design a care bundle for the treatment of patients with AKI either on admission or during their stay. This bundle has been in place now for 18 months, it has not yet been reliably implemented.

The aim of the work is to reduce the number of deaths whereby Acute Kidney Injury was stipulated as the primary, secondary or other diagnosis.

Targets for improvement:

1) Maintain HSMR below 100 – Target met.
2) Delivery of the national CQUIN, target of 90% compliance with specific elements on discharge to form part of the electronic discharge summary by Q4.

Q1 Performance: This CQUIN focuses on AKI diagnosis and treatment in hospital, and the plan of care to monitor kidney function after discharge. It is measured through the percentage of patients with AKI treated in an acute hospital whose discharge summary includes each of four key items of information listed below:

1. Stage of AKI (a key aspect of AKI diagnosis);
2. Evidence of medicines review having been undertaken (a key aspect of AKI treatment);
3. Type of blood tests required on discharge for monitoring (a key aspect of post discharge care);
4. Frequency of blood tests required on discharge for monitoring (a key aspect of post discharge care).

Each item counts separately towards the total i.e. review of four items in each of 25 discharge summaries creates a monthly numerator total of up to 100.
All stages of AKI (1, 2 or 3) are included in the denominator data.

Performance for Q1 was 21.3% of the required elements being captured on the discharge summary.

	Quarter 1			Q1
2.1 - Acute Kidney Injury	Apr-15	May-15	Jun-15	Total
The number of key items found in discharge summaries for patients in the sample of 25	25	21	18	**64**
4 key items in discharge summaries for 25 inpatients randomly selected from pathology system with AKI *	100	100	100	**300**
% key Items included	**25.0%**	**21.0%**	**18.0%**	**21.3%**
Target	**Baseline**			

Improvements for Q2 onwards:

In order to ensure that we consistency collect the elements listed above, a change is required to be made to the Electronic Discharge Summary (EDS). This work has been scheduled into the system enhancement diary and will is expected to be delivered at the beginning of Q3.

There are some additional actions taking place to address the current compliance, these include:

1. Ensuring that the CQUIN requirements are communicated to the junior doctors starting in August 2015 as part of junior doctor induction. This will complement the existing training provided around the importance of accurately completing the EDS
2. There will be ongoing monitoring of Q2 performance, which will enable feedback to clinical teams who are not compliant with CQUIN to challenge their practice and further improve reliability going into Q3.

2.4 Improving Management of Stroke

Aims and Objectives of Work

Strokes affects between 174 and 216 people per 100,000 population in the UK each year (Mant et al 2004), and accounts for 11% of all deaths in England and Wales. It is accepted that 85% of strokes are due to cerebral infarction, 10% due to primary haemorrhage and 5% due to subarachnoid haemorrhage. The risk of recurrent stroke is 26% within 5 years of a first stroke and 39% by 10 years (Mohan et al 2011). By focusing in improvement in stroke care, patient outcomes can be vastly improved,

The Trust has the following aims to strengthen and improve stroke services

- Reduce stroke mortality to a SHMI of less than 100,
- Improve functional outcomes for patients
- Reduce the length of stay by 20%
- Improve overall SSNAP score to “A”

To do this we will:

- Ensure all stroke patients are admitted directly to a stroke bed
- Ensure all patients received 45 minutes of therapy 5 times a week
- Ensure all appropriate patients receive thrombolysis within 60minutes of arriving at hospital

Current Performance

The Directorate and Division monitor Stroke performance each month at Board and at the monthly stroke governance meeting. The Division were asked to work with Greengage, an external consultancy, to review the approach to action planning and develop new ways of working. This was to ensure delivery of agreed actions in time and in full. The Division introduced bimonthly meetings with the Stroke Team that are on-going. One of the first meetings was led by Greengage and focussed on Creating the Success Story, Engaging the Stroke multidisciplinary Team and development of the Must Do’s

The must do’s were:

1. All suspected stroke patients to have FAST test
2. Improve patient flow by ensuring 90% compliance with PFEP
3. Write SOP for patient flow
4. Undertake RCA on patients who breech the 90% time on the stroke unit
5. Agree SOP with radiology
6. Write joint rehabilitation pathway
7. Ensure 45 min of therapy at least 5 times a week across 7 days
8. Increase clinical time for therapists and consultants with data officer for SSNAP

Each was linked to a desired outcome and progress against the actions monitored:

Result - Overal Outcome Wanted	Reality as of Nov 14	Must Do (enabler)	Completion of Enablers RAGd and date
100% of all suspected stroke patients brought to ED at CRH	13% of stroke patients taken to HRI ED by YAS	1) All suspected stroke patients to have FAST test	19th January 2015
90% of stroke patients admitted directly to ASU within 4 hrs 80% of stroke patients spend >90% of their time of the stroke unit	55% of stroke patients admitted directly to ASU within 4 hrs 85% of stroke patients spend >90% of their time of the stroke unit	2) Improve patient flow by ensuring 90% compliance with PFEP	16th February 2015
		3) Write SOP for patient flow	Final version Feb 9th 2015
		4) Undertake RCA on patients who breech the 90% time on the stroke unit	Repeat RCA done by 1st March
100% of appropriate patients receive thrombolysis within 60min	15% of appropriate patients receive thrombolysis with 60 min	5)Agree SOP with radiology	February 1st 2015
Reduce LoS by 20%	Mean LoS for stroke and stroke rehab patients 28days	6)Write joint rehabilitation pathway	Final version: 1st April 2015
	Therapy once a week	7)Ensure 45 min of therapy at least 5 times a week across 7 days	Therapy x3 weekly by March 1st
Improve SSNAP Case ascertainment and data quality		8)Increase clinical time for therapists and consultants with data officer for SSNAP	February 1st 2015

The following is an update from the report received in March 2015

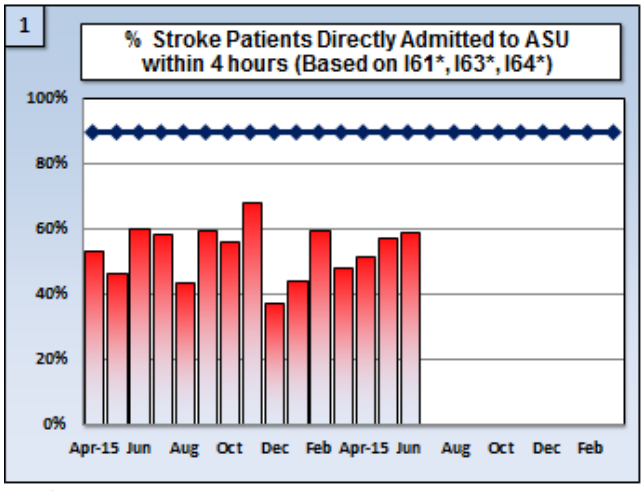
Outcome 1 - 100% of all suspected stroke patients brought to ED at CRH

Outcome 2 - 90% of stroke patients admitted directly to ASU within 4 hrs;

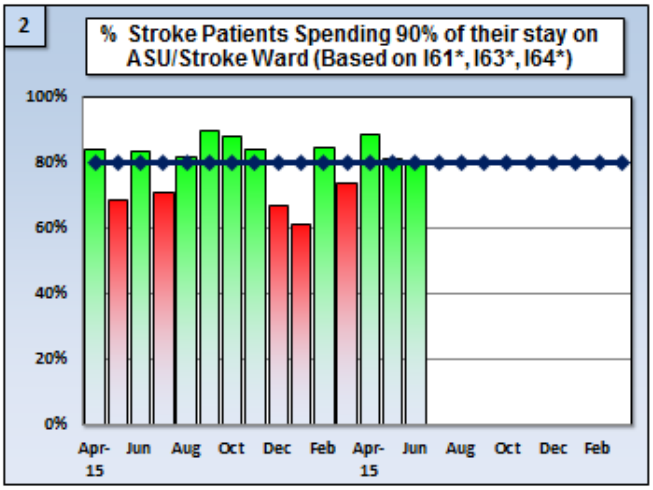
And 80% of stroke patients spend >90% of their time of the stroke unit

2a) Current 4hr and 90% stay performance.

Current 4hr performance remains challenging although has started to improve and stands at 60%. We remain on track with the 90% LoS target. We continue to focus on improving direct admissions to the stroke unit with 4hrs.



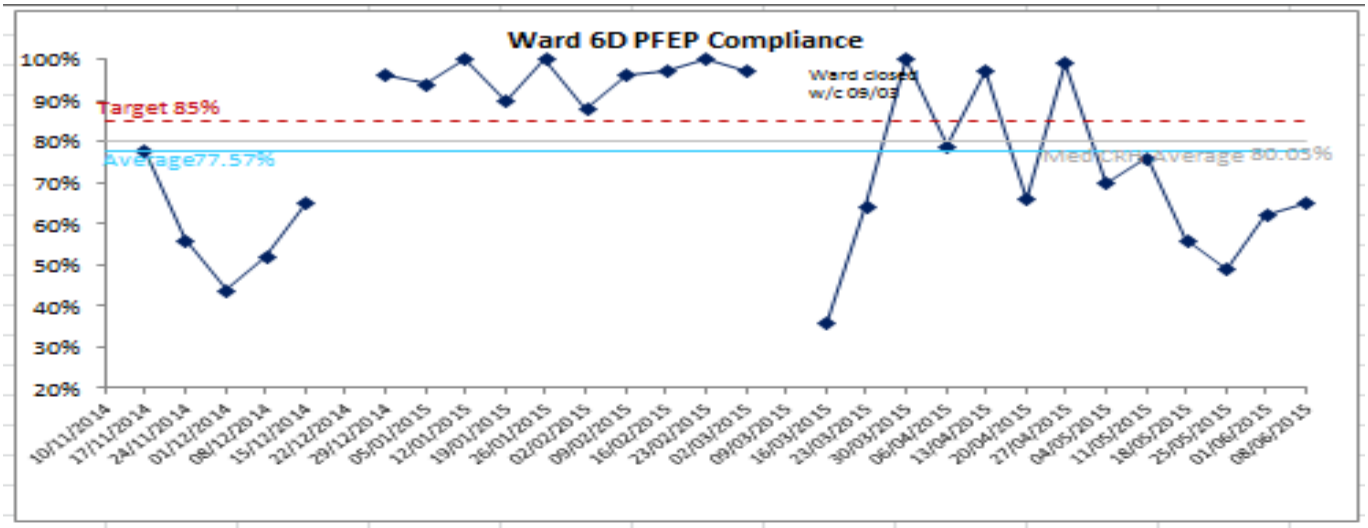
* Based on All Patients with a Primary Diagnosis of Stroke (I61*, I63*, I64*) - Any FCE in Spell - Excluding patients who have a stroke whilst in hospital

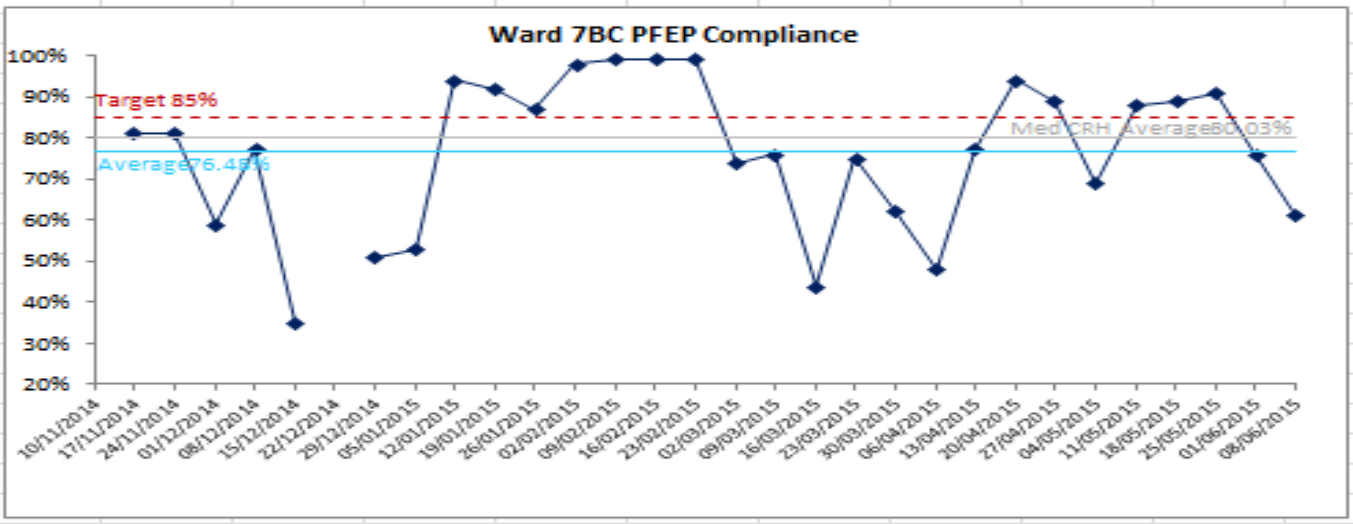


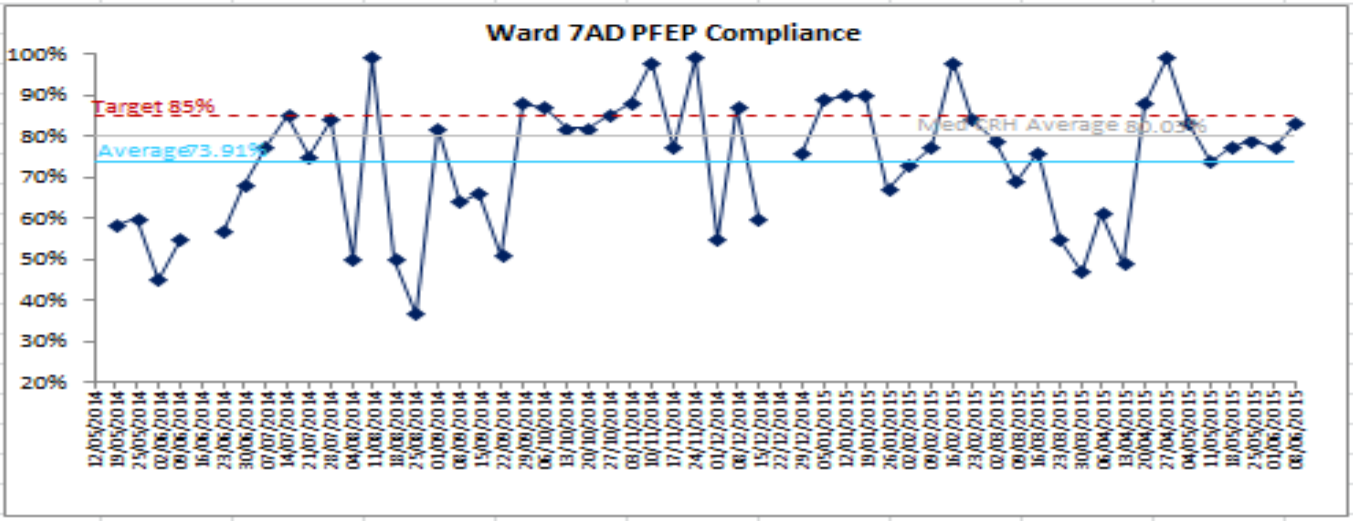
* Based on All Patients with a Primary Diagnosis of Stroke (I61*, I63*, I64*) - Any FCE in Spell

2b) Improve patient flow by ensuring 90% compliance with PFEP (Plan for Every Patient):

Performance with PFEP remains inconsistent. There have been changes in nurse leadership and nurse staffing. We continue to review performance at our meetings to ensure a sustainable performance.

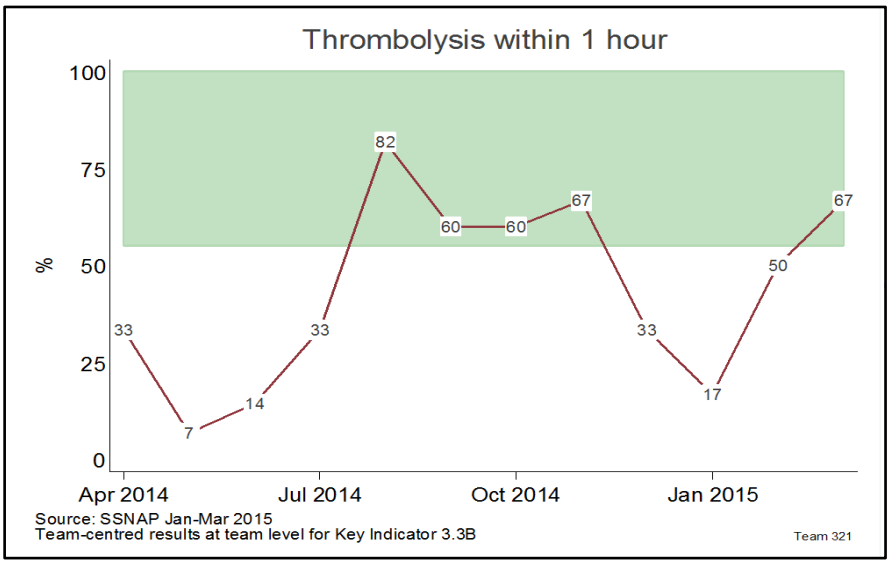






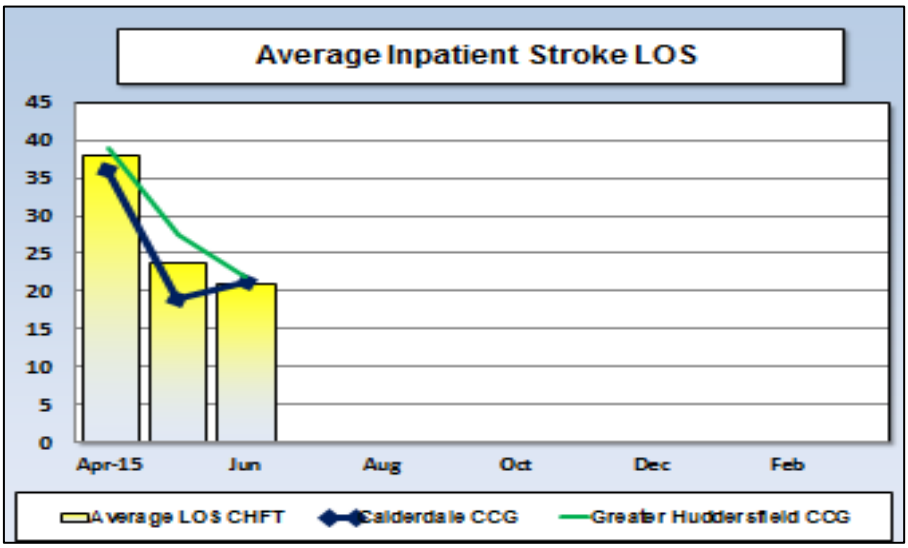
Outcome 3 - 100% of appropriate patients receive thrombolysis within 60min

Over the winter period performance deteriorated but has started to improve. A joint audit is planned between the stroke team and radiology to understand the delays that prevent thrombolysis within 60min.



Outcome 4 - Reduce LOS by 20%

Current LoS has reduced from 28.1 days to 21 days reflecting a 25% reduction in LoS.



Outcome 5 - Improve SSNAP Case ascertainment and data quality

Data collection has changed since May 2015 – this will start to show in SSNAP reports later in the year. SSNAP data is analysed and released approximately 6 months in arrears.

2.5 Improving Management of Fracture Neck of Femur

Introduction:

The Best Practice Tariff (BPT) was introduced in 2010. It aims to act as a financial incentive for hospitals to optimize management of patients with neck of femur (NOF) fractures.

Where all the factors associated with best practice have been delivered a supplement of just over £1300 is added to the tariff.

We expect to receive between 450 and 500 patients who have sustained a fractured NOF each year.

Aims and Objectives of Work:

Seven factors have been identified by NICE and require inputting into the National Hip Fracture Database (NHFD). Each of these seven factors relates to either patient experience or outcome.

The first of the factors relates to getting patients to theatre within 36 hours of admission, this target was set to ensure no patient ever spent more than one night in a hospital bed with a broken hip.

The Directorate will be delivering 85% of patients to theatre within 36 hours by October 2015.

Quarter1:

The NHFD shows that 66% of patients got to theatre in 36 hours, and 51% of patients got all components of BPT. (Patients from the very end of June may not yet be included in this data set)

84% of the patients admitted in June got to theatre in 36 hours, and 81% of patients received full BPT. Some of this improvement will show in July data, as the NHFD is based on discharge date.

The rest of the year:

In order to deliver 85% of BPT the Directorate will be looking to deliver at least 3 more trauma lists a week, which will restore the volume of trauma prior to the laminar theatre breaking down.

The staff on the wards have been successful in chasing down all the individual components and allocating them to named individuals where a medic is required.

A plan is in place to carry out total hip replacements on the HRI site. Historically these are carried out in CRH and this cohort of patients do not get to theatre in time, or get the post op Ortho

geriatric care. There is also a consequence on Elective patients as we have had to cancel them to fit these trauma patients onto lists.

Trauma Coordinators are working weekends from July, which will improve quality or all trauma patients, and hopefully improve Monday performance.

Improvement Plans for 2015/16

- Over the next 12 months the Directorate is going to be involved with the PERFECTED research study. PERFECTED (Peri-operative Enhanced Recovery hip Fracture Care of patients with Dementia) is a National Institute for Health Research (NIHR) funded Applied Research Programme aiming to improve hospital care for patients with Dementia who break their hip.
- The Directorate has appointed Advanced Clinical Practitioners and by autumn three of the four will be working autonomously on the elective unit. This will reduce the vacancies on the Junior Doctor rota, and increase the visibility of these staff on the trauma wards, concurrently improving the completeness of medical tasks and contributing to a reduced length of stay.

2.6 Improving Diabetic Care

Aims and Objectives of Work

People with diabetes admitted to hospital benefit most when they are cared for by appropriately trained staff, provided with access to a specialist diabetes team, and given the choice of self-monitoring and managing their own insulin (NICE quality standard). In order to ensure high standards of care for diabetic patients the Trust aims to:

- Enable patients on insulin to self-manage – CQUIN target 50% of diabetic patients completing the self-care bundle on a number of ward in the Trust by Q4

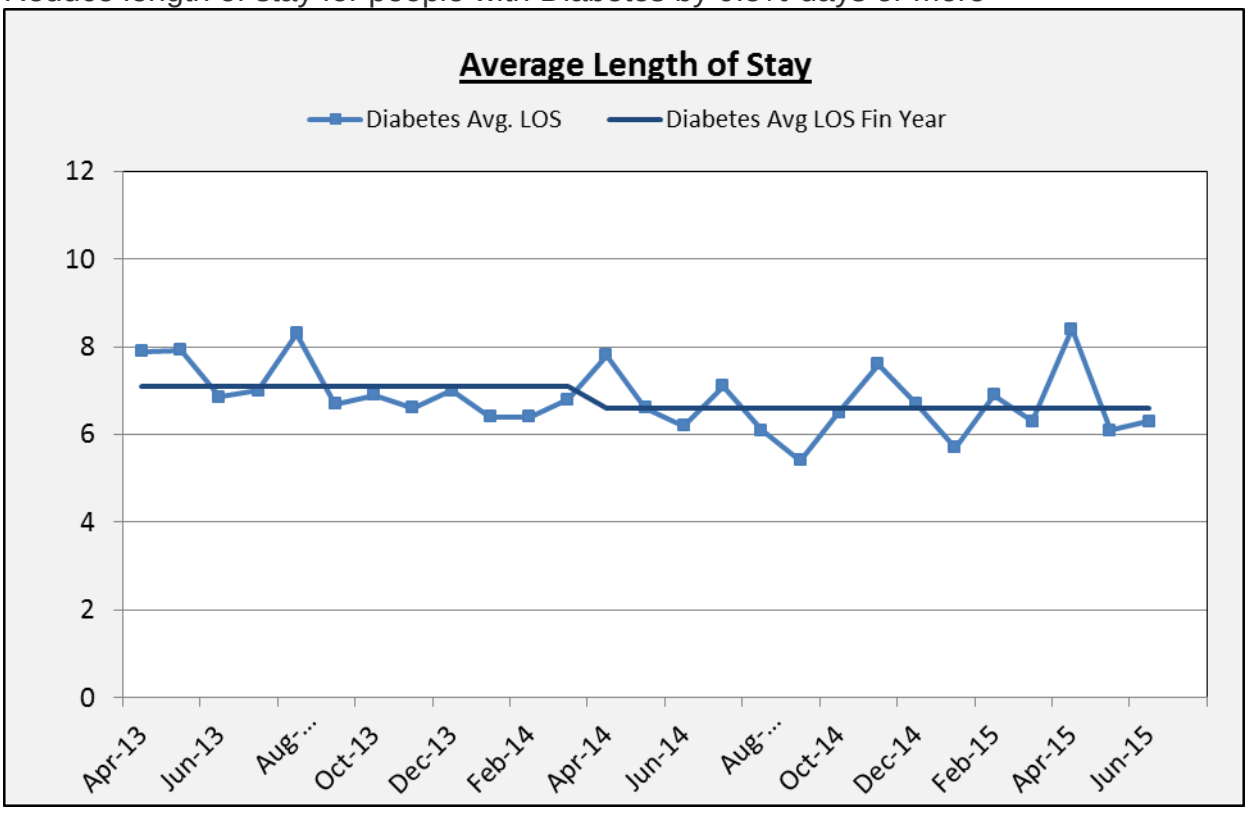
- Reduce length of stay for people with Diabetes by 0.5% days or more

Current Performance

The diabetic CQUINS were achieved for Q1, with 74.3% of patients who are able to self-care doing so.

6.1 Diabetes Self Care - Number of wards included in the audit	Quarter 1			Q1
	Apr-15	May-15	Jun-15	Total
Number of patients admitted with Diabetes who are treated with insulin and assessed as being competent to self care who are supported to have an agreed care plan - own glucose testing / self medicating with insulin inc dose adjustment / adequate food choice & timing	4	10	12	26
Number of patients who are admitted with secondary diagnosis of Type 1/2 Diabetes or as a comorbidity who are treated with insulin and assessed as being competent to self care	8	13	14	35
% eligible patients receiving care bundle	**50.0%**	**76.9%**	**85.7%**	**74.3%**
Target	**On 10 wards**			

Reduce length of stay for people with Diabetes by 0.5% days or more



Work continues to implement the self-care process for Insulin dependent patients on the nine collaborative wards, with the introduction of two further wards at the beginning of quarter 1. The improvement work has continued to focus on identifying the number of patients potentially suitable to self-care as well as the delivery of the individual elements of the self-care indicator.

As the extra wards were included, nursing staff undertook a program of training in the elements of self-administration and self-management and the use of associated documentation. Training is continual in order to implement the process on each new ward area.

This work stream is clinically led by one of the Trust's senior Diabetologists/Clinical Director and supported by other clinical, nursing and pharmacy colleagues. Project support is provided by the Clinical Governance Support Unit and The Health Informatics Service.

The outcome aims for this work is to reduce harm and also the length of stay for diabetic patients.

Work in this quarter has focused on bringing further wards into the collaborative whilst ensuring overall compliance with the bundle is maintained.

A campaign launched in June around self-management of medications, which involves a poster/media campaign for primary and secondary care which will include public buildings, schools etc.

Improvement Plans for 2015/16

- We are currently training another 2 wards in the process, they will be brought on line in Q1 and a further 2 in each quarter
- We will continue to monitor the data so we can increase compliance in all the ward areas and through the collaborative team.
- Camapign poster and launch of self management in June/July Liasion with Yorkshire Ambulance Service and Calderdale and Huddersfield CCG's has taken place.
- Working with the ambulance service for them to ensure patients bring all their medication and diabetic equipment into hospital.
- Work with pharmacy, A+E, MAU and SAU staff to ensure diabetes medication and equipment are brought in if the patient is staying in hospital
- Add onto e-dischage information about bringing diabetes related equipment into hospital if coming back in.
- Add to pre assessment letters about bringing diabetes related equipment into hospital.
- Recent tender completed and due to be introduced over the next 3-4 months.
  Every capillary BG will be Wi-Fi linked to central system to allow DSN team to remotely monitor every patient with diabetes on the wards

2.7 Reducing Hospital Acquired Infections

Aims and Objectives of Work

The Trust is committed to providing a safe environment for patients including preventing healthcare associated infections. Although the Trust has made significant reductions in healthcare associated infection in the last 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)

In 2015/16 the Trust aims are to:

- Have 0 Trust assigned MRSA bacteraemias
- Have no more than 21 Clostridium difficile (Post 48 admission) infections
- Improve on the previous year's outturn of 12 MSSA Bacteraemias
- Improve on the previous year's outturn of 29 E.Coli infections
- Screen more than 95% of all elective in-patients for MRSA

Current Performance

Performance at the end of Q1;

Indicator	Quarter End Target	Q1 Performance
Meeting the MRSA bacteraemia (Trust Assigned)	0	1
Meeting the Clostridium difficile (Post 48 hours)	6	3
MSSA Bacteraemias	3	3
E-Coli rates	9	9
Screening all elective in-patients for MRSA	95.0%	97.00%

MRSA (Meticillin-resistant *Staphylococcus aureus*) bacteraemias - there was one case reported in April. This case was investigated by a 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.

MSSA (Meticillin-sensitive *Staphylococcus aureus*) bacteraemias – there have been 3 reported cases in Q1. These cases have not been linked.

E.coli bacteraemias – Of the 9 cases in Q1, the most likely source of the infection is urinary tract. Although not all related to urinary catheters, there is on-going work to reduce the risk of infection from urinary catheters by use of intermittent catheters for retention of urine and prompting early removal of indwelling catheters.

***Clostridium difficile* (*C. difficile*)** is one of the major causes of infective diarrhoea. In Q1, there have been three post admission cases of C. difficile which is a significant reduction compared to the same period last year when there were 8 cases. Following full investigation of the three cases, two cases were deemed avoidable cases and have been followed up with action plans for improvements.

Improvement Plans for 2015/16

The Trust has a comprehensive programme and action plan to reduce healthcare associated infections.

- There is ongoing work to updating the training for aseptic non-touch technique with competency assessment for all clinical staff who come into contact with invasive devices

- There has been an external review of cleaning services which has led to setting up a working group to deliver the recommended changes

- Work has been done to improve the timeliness of isolation of patients with infective diarrhoea, this has involved use of the new nerve centre technology and support from the matrons

2.8 DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation)

Aims and Objectives of Work

This work aims to ensure Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions are taken in an appropriate and timely manner, documented accurately and wherever possible communicated with the patient.

In June 2014 the Court of Appeal handed down a judgement regarding the duty of clinicians to consult patients when making a DNACPR decision. The Court of Appeal ruled that patients should be consulted in relation to advance DNACPR decisions save in exceptional circumstances.

Current Performance

The table below shows the Trust percentage of DNACPR decisions that have been discussed with the patient or where the patient is unavailable (i.e. dementia, unconscious) it was discussed with a relative/carer. This data is collected by the clinical audit team as a monthly point prevalence audit. The target is 90% to allow some leeway when decisions need to be taken in critical situations and there is no opportunity to communicate with the patient or carer.

		2014/2015												2015-2016			
	Ward	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Trend
Total		80.5%	67.5%	75.9%	85.5%	83.5%	84.3%	81.9%	77.8%	82.3%	83.7%	84.3%	89.7%	90.5%	83.1%	85.7%	

A Trust wide point prevalence audit was carried out in January which provided baseline data of all patients with a DNACPR decision and provides detailed reasons for non-discussion, this led to further consultant engagement and ward level and consultant information being made readily available. Improvements since January 2015 have been noted. Data is reported monthly at the

Trust Clinical Outcomes Group and ward level data will be sent to individual wards and Consultants. A further Trust wide point prevalence audit will take place in September 2015.

Improvement Plans for 2015/16

- Full point prevalence audit to be repeated in September 2015.
- Compliance audit documentation has been updated to capture if both the patient and the family have been spoken to by a clinician regarding DNACPR. This data will be sent to divisions for discussion at their PSQBs.
- DNACPR status is included as part of the handover module of the new electronic 'Nerve Centre' platform. Roll out is complete at CRH and will begin at HRI in July.
- Work with the intensivists regarding the decision making process in relation to patients not suitable for escalation to ICU. Intensive care consultants have been briefed about a process for flagging up the need for DNACPR and family discussions.
- Outreach staff and other specialist nurses to support conversations where the parent team are struggling to meet with family members (and consent allows).
- DNACPR bundles are currently being trialled on 3 Medical and 1 Surgical ward
- Monthly reports on compliance to be reported at the Trust Clinical Outcomes Group and Divisional PSQBs.

Domain Three – Experience (Caring)

Patient experience compliance summary

Indicator	Compliance
3.1 Dementia (CQUIN)	Achieved
3.2 Mixed Sex Accommodation	Reporting Only
3.3 Improving Hospital Nutrition (CQUIN, Quality Account)	Achieved
3.4 Improving care for end of life patients and their relatives	Achieved
3.5 Improving In Patient experience - Inc Friends and Family Test (contract)	Partial
3.6 Claims and Complaints	Reporting only

Highlights:

3.1 Dementia (CQUIN)	Dementia Find, Assess, Investigate, Refer CQUIN achieved in Q1, 91.7% against target of 80%
3.2 Improving the In Patient Experience	Progress with five projects in programme for wards to improve in patient experience
3.4 End of Life Care –	Education and training target on respiratory wards achieved in Q1
3.5 Claims and Complaints	Clinical claims in General and Specialist Surgery Services reduced 10% increase in number of complaints 206 complaints closed in quarter 1 33 complaints overdue at end of Quarter 1, an improved position, with most overdue by up to one month

3.1 Dementia

Aims and Objectives of Work:

Improving services for patients with dementia has the potential to enhance the quality of their care experience as well as shortening their length of stay and reducing unnecessary costs. Dementia is not generally the prime reason for admission to hospital and therefore it can become difficult to factor into a patient's care programme.

The dementia quality improvement work has 3 objectives:

1) To improve early diagnosis of dementia in order that people can live well with dementia and receive the care and treatment they need
2) To work in partnership with carers to ensure that we understand and meet the specific needs and preferences of people with dementia
3) To deliver training and clinical leadership to all staff to ensure that people with dementia receive person centred and appropriate care whilst in hospital

There are also 3 CQUIN requirements which support the aims above:

1) Dementia Assessment and Referral
2) Clinical Leadership & Training
3) Carers Support

Current Performance:

Improved Diagnosis:

The dementia assessment is completed by the doctors on the ward for patients age 65 and over. This is a 3 part process which each part must achieve 90%.

- Part 1: How many patients have been asked the following question "Has the person been more forgetful in the past 12 months, to the extent that it has significantly affected their daily life?" If the answer is yes, part 2 must then be completed.

- Part 2: For patients that were yes in part 1, an abbreviated mini mental test score (AMTS) must be completed.

- Part 3 For those patients that had an AMTS score of 8 or below they must now be referred to their GP

We consistently achieve 90% or above in each element.

The assessment is included in the clerking in document. The assessment is then included as a mandatory field on the electronic discharge system with the option to refer those appropriate back to their GP for further assessment.

Performance in this area also fulfils the first national CQUIN requirement.

Dementia and Delirium - Find, Assess, Investigate, Refer and Inform (FAIRI)	Quarter 1 Apr-15	Quarter 1 May-15	Quarter 1 Jun-15	Q1 Total
No. of patients > 75 years admitted or accepted for emergency unplanned care to hospital or community services, who are reported as having known diagnosis of dementia or clinical diagnosis of delirium, or been asked the case fining question	452	430	452	**1334**
No. of patients > 75 non elective admissions with a LOS >72 hours (excl those for whom the case finding question is not applicable or answered positively on the dementia case finding question/underwent a diagnostic assessment for dementia in whom the outcome was either positive or inconclusive)	490	474	490	**1454**
% asked the Question*	**92.2%**	**90.7%**	**92.2%**	**91.7%**
Target	**90.0%**			

* Data require validation and is reported a month in a

Dementia AMTS - Emergency Admission 75 Years & Above	Quarter 1 Apr-15	Quarter 1 May-15	Quarter 1 Jun-15	Q1 Total
No of Non Elec patients admitted aged 75 and above, who have scored positively on the Case finding questions reported as having had a dementia diagnostic assessment. (AMTS)	81	66	61	**208**
No of Non Elective patients > 75 admitted as inpatients, who have scored positively on the caser finding question	82	66	62	**210**
% of patients aged 75 and over admitted as inpatients who were appropriately risk assessed	**98.8%**	**100.0%**	**98.4%**	**99.0%**
Target	**90.0%**			

* Data require validation and is reported a month in a

Dementia Referral - Emergency Admission 75 Years & Above	Quarter 1 Apr-15	Quarter 1 May-15	Quarter 1 Jun-15	Q1 Total
No of Non Elec Patients admitted >75 who have had a positive diagnostic assessment who are referred on for further diagnostic advice.	41	33	39	**113**
No of Non Elec patients > 75 and above admitted as inpatients, who underwent a diagnostic assessment (in whom the outcome is either "positive" or "inconclusive")	41	33	39	**113**
% appropriately referred on to GP	**100.0%**	**100.0%**	**100.0%**	**100.0%**
Target	**90.0%**			

Partnership Working:

A mental health liaison team employed by the mental health trust support assessment of people with dementia, and provide expert advice for patients and their families, and for staff. The principle aim of the service is to prevent unnecessary admission to hospital, often activating appropriate community services for support and care closer to, or at, home. The team also support timely discharge of people with dementia, activating appropriate community care as above.

5 Action plans to meet national requirements

- Assessment and diagnosis
- Training plan
- Carer support – designated projects to support carers and people with dementia
- Dementia friendly environments
- Person centred care – Butterfly scheme and POD (prevention of delirium) programme

Dementia friendly ward and department refurbishments and upgraded

Training

A training strategy addresses 3 levels of training. These are dementia awareness, dementia competent and dementia expert.

Dementia awareness is currently delivered to wards and departments by request. The plan for 2015-2016 is to introduce an e-Learning dementia package as part of Trust mandatory training.

Dementia competent is currently delivered through education, ward/department based support, and care pathways:-

- Vulnerable adult leaders training
- Vulnerable adult champion training
- Person centred dementia training
- Butterfly scheme in place on all relevant adult wards, supported with training
- Memory care assessment tool to facilitate person centred care
- Prevention of delirium pathway (POD) included in clinical documentation
- Recruitment of volunteers – rolling programme whereby A level students receive training and induction each year to support people with dementia and delirium on the POD pathway (student enrichment scheme)
- Engagement and Care Support workers in post on wards 19 and 20.
- MYLIFE software to promote social engagement. 6 units now in use, 3 on each hospital site

Dementia now included in a newly formed Vulnerable Adult Network – operational group embraces dementia, delirium, LD, safeguarding adults, person centred care, dignity and mental health, and links with groups for nutrition, falls, and end of life care. This operational group oversees the dementia action plan and reports to the Patient Experience Group and Safeguarding Committee.

Training performance supports the second element of the CQUINs requirement

Improvement Plans for Q2 onwards

Delivery of person centred care training – 250 work books funded by HEE for further training 2015
Support to POD students on wards 4, 8, 19, 20 and 21 at HRI, and ward 5AD at CRH –
With designated support from key ward members and 3 Student leads

POD and supporting roles – social engagement and care support workers and intergenerational student enrichment scheme, enhances care and outcomes, staff experience, patient and carer experience, reduce incidents and need for 1:1. Resources including MYLIFE software and recruitment of more students in October 2015

Butterfly scheme promotes person centred care and ensures people receive care relevant to their needs and choices – uptake would improve care and outcomes, patient and carer satisfaction, staff satisfaction, reduce incidents and need for 1:1

Principles into Practice ward based support from the vulnerable adult strategic leads is providing direct education and support regarding the care of people with dementia and/or delirium on adult wards

3.2 Improving the Inpatient Experience

Aims and Objectives of Work

It is important that we measure patient experience, not only in terms of their satisfaction with the care they received but also giving them the opportunity to tell us how we can make it better. This may often be about the small things as well as any large system changes.

The primary method of measuring the patient experience in the trust is through the Friends and Family test (FFT) which is now well established across all inpatient areas and is becoming embedded as a performance measure and indicator for improvement at ward level.

The 2014 /15 CQUIN target was focused on achievement of a high response rate, with a recognition that a high response rate links to more reliable results. All inpatient targets were achieved, including the Quarter 4 stretch target of 40%.

This is no longer a CQUIN, however is now incorporated into the trust contract with an expectation to at least maintain the 14/15 position in relation to a response rate of 40% or more.

In addition to this the trust is aiming for a local target of 95% of respondents stating they would recommend the care they received.

Q1 Update

Feedback from the FFT comments has been used to influence the Inpatient Experience Improvement Programme, with 5 key projects being carried over from the end of 2014/15. These commenced during last year and are now being formalised as a programme for all wards to participate in.

A summary of each project is detailed below:

1) **Hello my name is** … This is aimed at reminding staff of the importance of introducing themselves to patients, carers and visitors and to always include their role in any proposed care or treatment with them. ….

Most the work under this programme was carried out during 14/15. More work is planned for Q2, see Q1 improvement section for more details.

2) **Ward orientation.** This project has three components:

- Orientation of patients to the ward supported by a welcome to the ward leaflet. Our patient feedback has told us that patients do not always feel welcomed onto the wards and that once they are there, they would like more information about the ward routines.
- Availability of individual 'about me' information for all patients. These aim to provide an 'at a glance' source of information for staff about individual patient care needs and a personal 'what is important for me' statement
- Provision of a public facing information board for patients / visitors about the ward. The public facing board will provide consistent information for patients and visitors across all wards.

Quarter one has focused on ensuring that the content and display of this information is appropriate and accessible, needing to remain mindful that in some areas there will be ward specific information that needs to be incorporated i.e telephone number, meal time ect.

Whilst undertaking this piece of work, it became apparent that there was variation between the wards in terms of their visiting hours, as such there is now open visiting between 10am – 8pm in the majority of areas.

The behind the bed boards which contain the 'about me' information are now in situ. Ward staff are currently undergoing training in how to update the boards with appropriate and relevant information on them is kept up to date and relevant for the patient.

3) **Reducing Noise at night.** Noise at night is something patients continue to raise with us through our patient feedback. Research tells us that quiet hospitals help healing – we have therefore made this our message in a campaign to reduce avoidable noise.

During Q1 four wards per month were visited and assessments of any contributory factors were noted and how/what improvements could be made. A number of environmental factors, such as door, bins squeaky trolley have been raised however it was noted that it would be more beneficial if a member of the estates team was present on the ward visit and be on hand to say what changes were possible.

It was also recognised that staff have a role to play, and some behaviours can affect noise levels at night. Staff are being encourages to reflect on this and work will commence in Q2 to address this.

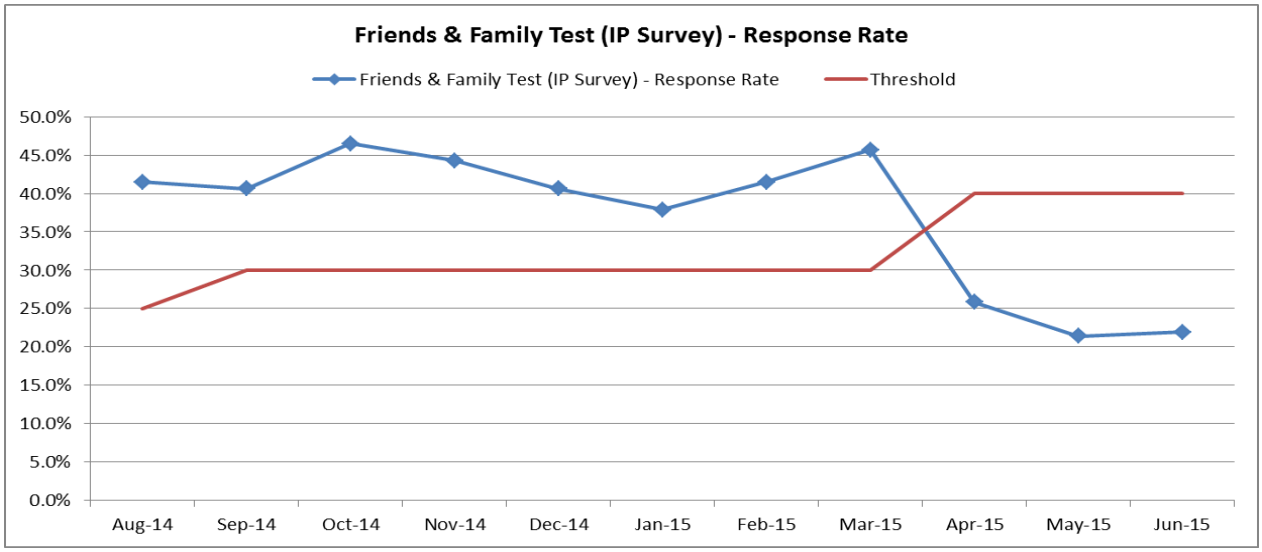
4) **How can I help?** Patients have expressed a view that staff are not always empowered or enabled to respond to solve problems for them. During Q1 a project has been evaluated and recognised the following as being key to achieving a culture of 'How can I help you?' within a team:

    - Sharing experiences of helping

- Troubleshooting on behalf of patients and colleagues
- Taking actions to solve problems, no matter how large or small

5) **Regular information round.** Surveys of patients' views have revealed that doctor/patient communication is not always as good as it could be and in some cases it is judged by patients to be extremely poor. The areas where we seem to consistently fail relate to communication between doctors and patients about a patient's clinical condition, the treatment plan, and expected outcomes. This project is being linked to a set of 'always events' and a learning package in the style of a short DVD based on some good practice examples of communication on the ward.

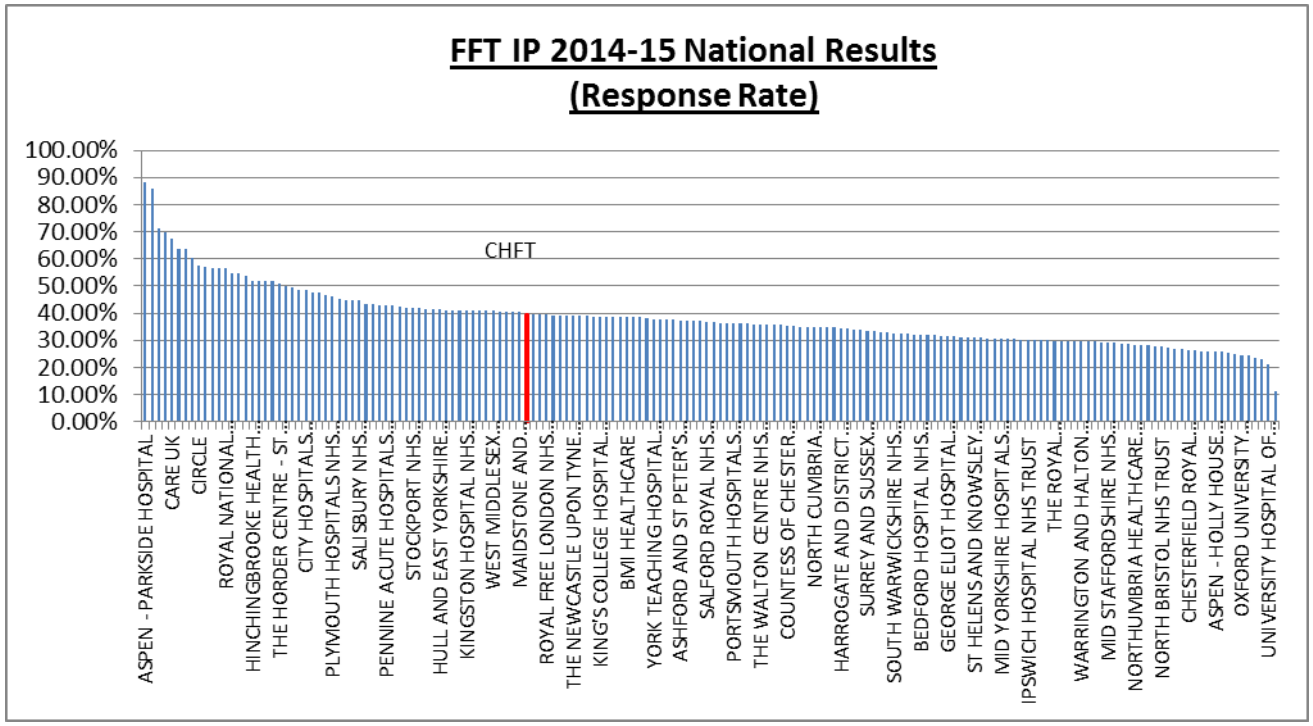
Some changes have been introduced in April 2015 for the inpatient FFT that have resulted in a significant drop in response rate. See below.



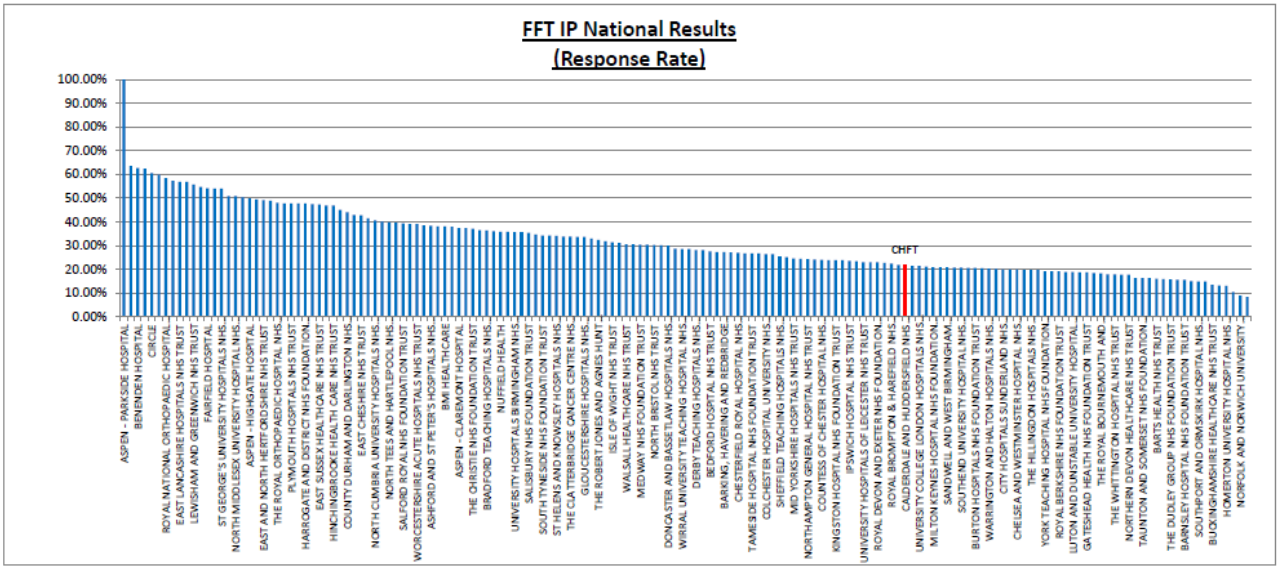
From the 1st April 2015 patients who are admitted into any inpatient area regardless of whether they have an overnight stay are now included. Prior to April 2015 this was not the case.

The two charts below show the difference between the response rates for 2014 /15 and the individual month of May 15. Not only has the response rate dropped, but also our ranked position. It is worth noting that national there are less trusts achieving the high levels of response rates which had been seen last year.

14/15 Year End Position:

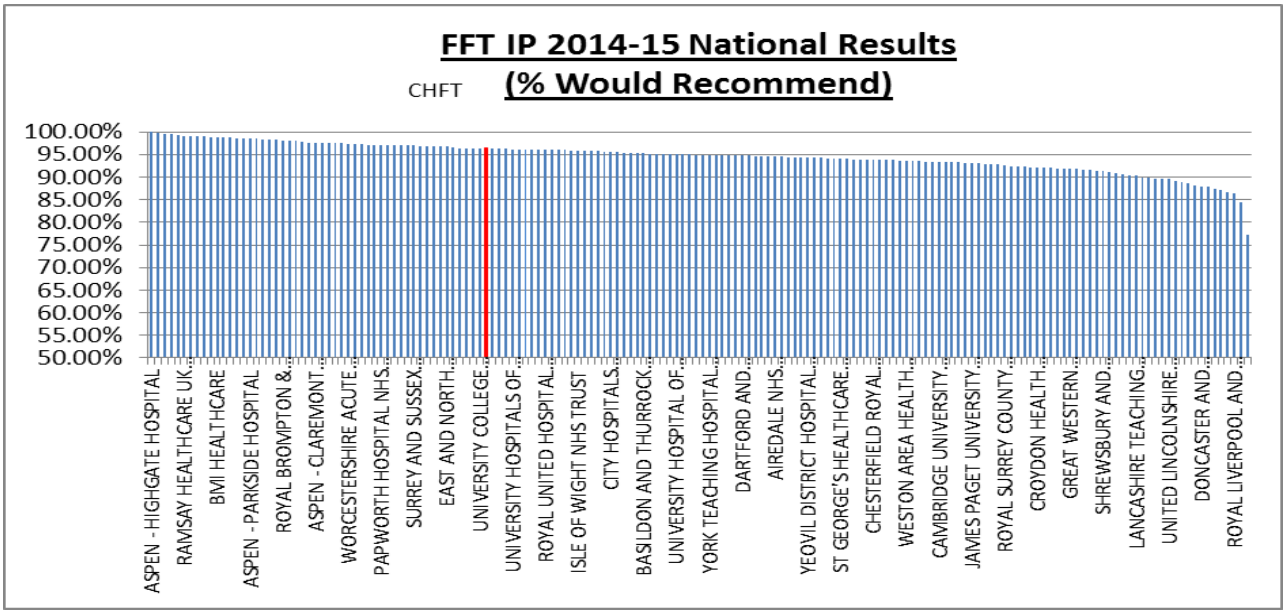


May 2015:



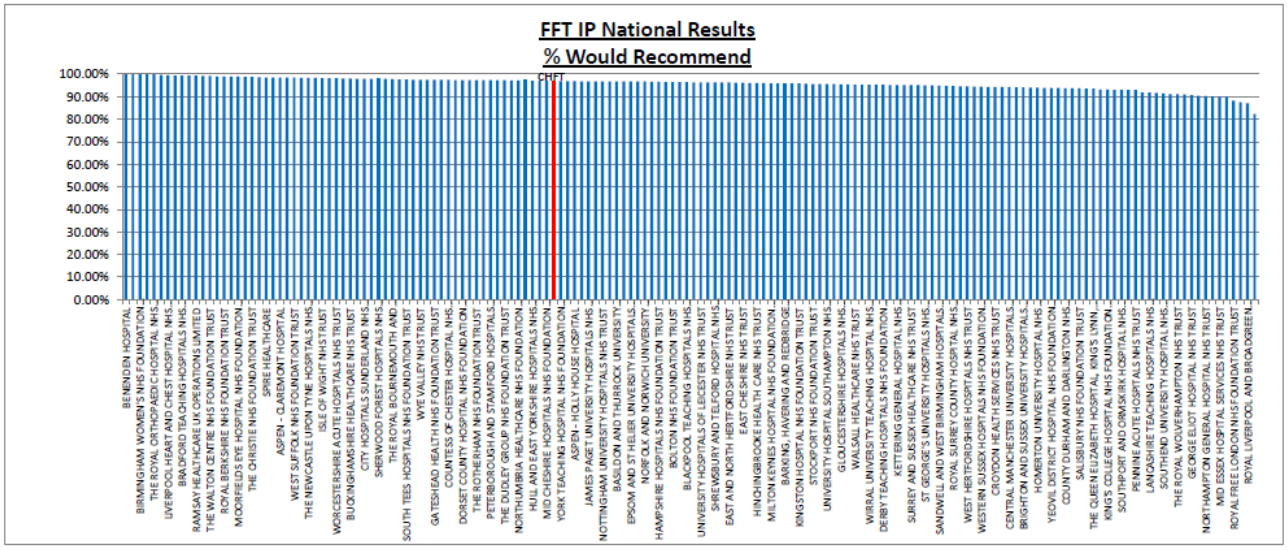
Having dropped in the rankings, coupled with the low response rate, the Trust Friends and Family Group have been tasked with establishing a recovery plan; this includes thoroughly investigating and understanding the gaps. Divisional FFT leads are liaising with the relevant teams to notify them of the need to commence the FFT process for this patient group.

Whilst it is important to maintain a high response rate, an additional key measure for the trust is to have our patients stating that they would be happy to recommend the care they received. During 2014/15, this averaged at 96.3%, which placed us in the top half of Trusts when compared nationally



It is reassuring to note that we have remained in the top 50% as seen in the chart below for May 15, with scores across the quarter being: April 97.3%, May 96.9%, June 97.4%

May 2015



Plans for Improving the Inpatient Experience from Q2 onwards:

1) **Hello my name is** …

A significant campaign was run in 2014/15. The work in Q2 will look to revisit the effectiveness of that campaign by carrying out observations on the wards and clinical areas to see whether the campaign has resulted in a sustained change in practice with staff reliably and regular introducing themselves to the patients they are caring for.

2) Ward orientation.

There will be significant progress in relation to the generation and placement of public facing boards which will have key performance metrics and ward based information clearly displayed to help patients and visitors.

3) Regular information round.

A learning package in the style of a short DVD, based on some good practice examples of communication, will be available on the ward.

4) Reducing Noise at night.

In Q2 a member of the Estates team will go on the ward visits assessing the contributory factory to noise at night.

It was also recognised that staff have a role to play, and some behaviours can affect noise levels at night. Staff are being encourages to reflect on this and work will commence in Q2 to address this

5) How can I help

Further work will follow on from the evaluation of how the 'How can I help you?' culture with a team. Work will look at how teams can, share experiences of helping, troubleshooting on behalf of patients and colleagues and take actions to solve problems, no matter how large or small

During the next quarter this programme will be formalised and linked to the four behaviours expected of all Trust employees.

3.3 Improving Hospital Nutrition

Aims and Objectives of Work

The Trust has a responsibility to provide the highest level of care possible and this includes the quality of the food that is provided for patients. Nutrition is an agreed priority for the trust in the annual Quality Account.

Nutrition designed to meet patients' individual needs is central to a good recovery. The Trust aims to provide patient choice which is both hot and appetising and nutritionally balanced.

The trust is involved in 3 CQUINs during 15/16. These aim to:

- Measure and Increase patient satisfaction with food
- Show a reduction in the amount of food which is wasted.
- Improve the Hospital vending facilities.

Current Performance

- Patient Satisfaction:

8.1 Nutrition and Hydration - Patient satisfaction	Quarter 1			Q1
	Apr-15	May-15	Jun-15	Total
No. of patients reporting satisfaction with hospital food (Very Good & Good)	*137*	*146*	165	**448**
Number of patients audited in quarter *	*185*	*177*	210	**572**
% patients reported satisfaction with Hospital Food (Very Good & Good)	*74%*	*82%*	*79%*	**78.3%**
Target	**Patient feedback (400 survey's per quarter)**			

- Food Waste

Performance below related to HRI only, data has been gathered for CRH and is currently being converted into monetary terms, given that the supplier system does not measure in this way. An update will be in available for Q2.

Indicator 8.2 Nutrition & Hydration - Reducing Hospital Food Waste	Quarter 1		
	Apr-15	May-15	Jun-15
HRI - No of Meals delivered to Wards (Bulk System)	16986	21786	17290
HRI - Amount of untouched portions returned (in monetary terms)	£971	£1,165	£1,060
HRI - % Returned	5.72%	5.35%	4.77%

- Vending Facilities : The following report was submitted in support of achieving the third CQUIN element

VENDING MACHINE PROVISION HUDDERSFIELD ROYAL INFIRMARY
CURRENT VENDING FACILITIES

Remit: - Huddersfield Royal Infirmary (HRI) is reviewing their vending service offered to patients, visitors and staff across the HRI Site.

Current Services: - The current available service is detailed below in table 1. Traditionally the 9 available machines have provided snacking and beverages options within the HRI site in three

dedicated locations, the current vending service provision is from two companies, LTT vending, who provide 4 cold beverage machines stocking a range of traditional cola and sugar based branded products, water, fruit juice, and energy drinks. Wilkes Group operate the 2 hot drinks machines offering tea, coffee, and 3 snack machines providing a range of traditional branded products.

The Trust has worked with service providers to ensure the machines are not just based on traditional sugary drinks, confectionary bars and unhealthy snacks, the cold drink offerings now include a range of juice drinks and water. Snack machines are marked with green circles these are linked to a spot the dot campaign highlighting hand-picked healthier snacks.

Table.1

LTT Vending		
Machine Locations	**Machine type**	**Current retail offering**
Hospital main entrance Sub-basement lobby (block 2) Orthopaedics OP Reception lower ground floor (block 2) Accident & Emergency entrance lower ground floor (block 2)	Glass fronted Beverage	A mixture of bottled & canned beverages, including water, fruit juice related products and energy drinks.
Wilkes Group Services		
Machine Location	**Machine type**	**Current retail offering**
Hospital main entrance Orthopaedics OP Reception lower ground floor (block 2) Accident & Emergency entrance lower ground floor (block 2)	Glass fronted snack machine Green stickers indicate healthier options	Range of snacks & savory products including traditional branded lines & healthier options, rice and corn products reduced fats and baked products. Confectionary count lines, sweets, mints and cereal biscuit and breakfast bars.
Accident & Emergency entrance lower ground floor (block 2)	Hot beverage machine	Tea, coffee, hot chocolate and varieties from these base ingredients

The two companies currently provide a fully managed vending service for the Trust this include loan of the equipment repair and breakdown cover, maintaining stock levels, cleaning and full cash handling for all machines.

The Trust receives a royalty payment which is based on a percentage of the takings from each machine royalty payments totaled £ 26,438 in 2014. (Figs from CHFT Finance)

Table 2 details income and royalty payments from LTT during the period July 2014 – June 2015

Table 2

LTT Cold Drinks Breakdown.			
Machine Location	**Type**	**Total income**	**Rebate**
A & E	Glass fronted	£14,400	£4,200
Dining Room Foyer	Glass fronted	£1,418	£414
Main Entrance	Glass fronted	£9,948	£2,901
Out Patients	Glass fronted	£5,937	£1,732
Period July 2014 – June 2015		£31,703	£9,247

Table 3 details income and royalty paid by Wilkes period 2014

Wilkes Group Services Income for period 2014				
Location	**Machine Type**	**Machine No.**	**Cash**	**Rebate**
Orthopaedics Dept	Hot Drinks	550	£6,586.64	£2,552.36
Orthopaedics Dept	Snack	* 1024	£5,504.41	£1,146.81
A & E Dept	Hot Drinks	127	£9,144.79	£3,543.61
A & E Dept	Snack	* 1157	£10,788.11	£2,247.59
Main Entrance	Snack	* 1148	£7,037.24	£1,466.16
			£39,061.19	**£10,956.53**

Best Selling Products

* Figure 1 illustrates the best-selling snack products from Wilkes.

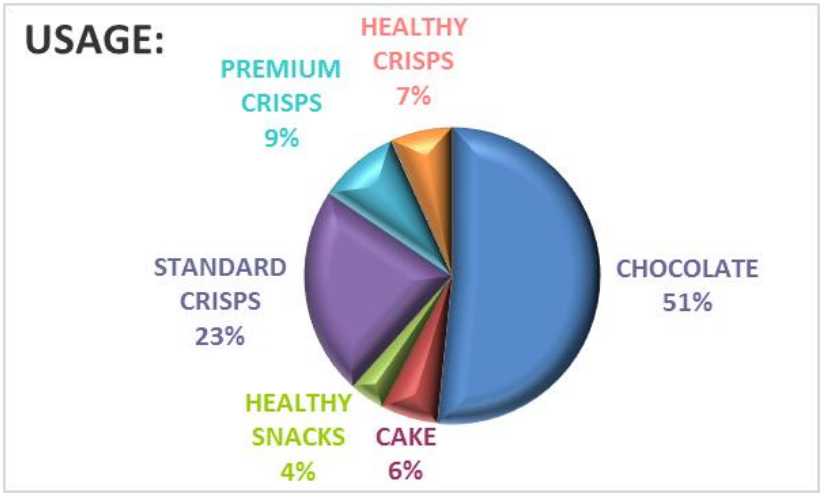


Figure 1 - Wilkes Best Selling Products (from 3 snack machines)
TOP 6 LINES CHOC/CAKE/HEALTHY

- *GALAXY CARAMEL*
- *BELVITA*
- *KIT KAT CHUNKY*
- *FRUIT PASTILLES*

- *YORKIE MILK*
- *FLAPJACK*

TOP 6 LINES STANDARD CRISPS/PREMIUM CRISPS/HEALTHY CRISPS

- *MINI CHEDDAR CHEESE*
- *WALKERS PRAWN*
- *MINI CHEDDAR CRINKLE CHEESE & ONION*
- *MAX PAPRIKA*
- *WALKERS CHEESE AND ONION*
- *WALKERS BAKED CHEESE AND ONION*

Proposal: A full review of HRI's vending services is being undertaken to improve customer satisfaction and ensure ongoing income generation.

This will be achieved the following next steps:-

1. **Engagement of Food For Life** (Support courtesy of J Harvey)
2. **Update of FFLP Survey** (test & trial on limited staff)
3. **Site evaluation**
   a. *Review the current locations and look for any potential new locations to site machines, enhancing the product availability.*
   b. *Review potential locations in Community premises.*
   Action: J Harvey (FFLP) / A Donegan (CHFT FM Catering Manager)
4. **Feedback from Manchester Vending Event**
   Action: J Harvey / S McWilliam (FFLP)
5. **Networking**
   Use learning from other NHS and public sector organisations (Royal Brompton / Liverpool ISS)
6. **Hot Food**
   Continue to explore the option of offering food that is nutritious healthy with the ability to re-heat offering a genuine alternative to current out of hours feeding arrangements.

3.4 Improving End of Life Care

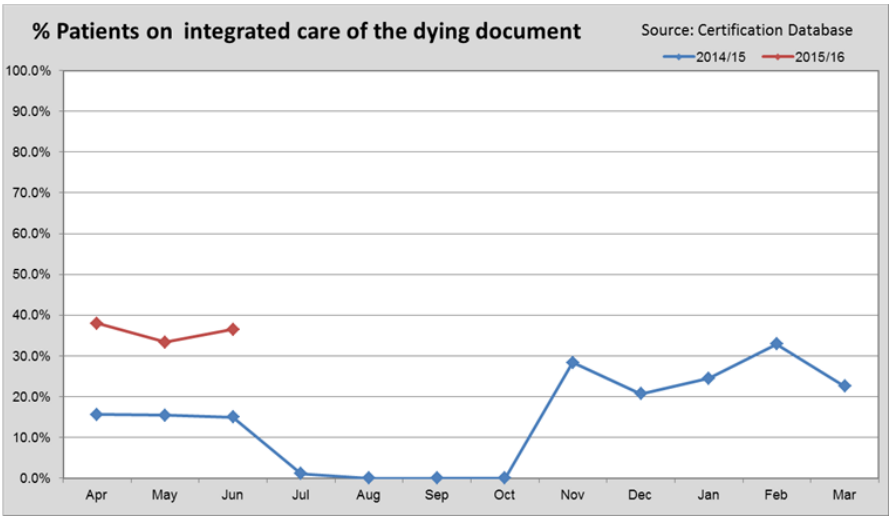
Aims and Objectives of Work

End of life care provides particular challenges, not only because of the special needs of many at the end of life but also because of the need to coordinate and integrate a wide range of services across different sectors. However the rewards for getting it right are huge. Personalised, integrated care at the end of life can transform that experience for the individual, their family, and the staff caring for them (source: NHSIQ)

Current Performance

The number of patients who died whilst being supported by an end of life care plan - The Liverpool Care Pathway (LCP) was withdrawn from use in July 2014 following an independent review, published in July 2013. The individualised Care of the Dying Document (ICODD) was implemented in the Trust at the beginning of November 2014. The ICODD is a care plan that helps clinical staff who are caring for patients who are dying and in the last hours or days of their lives. It guides them in delivering the best care that they can in order to meet the needs of

patients and their families. It should be used when the patient is dying from an irreversible condition, and a decision has been made that the focus of care is now on quality and comfort.



The chart shows the percentage of patients who are supported by an end of life care plan who then go onto die, since the ICODD was implemented in November 2014 (currently 36%).
The introduction of comfort bags has received warm feedback from both families and clinicians. The bags contain little essentials, such as bed socks, tissues, a dental kit, and a notebook and pen, to ease time spent at a bedside if a relative needs to stay overnight.

Progress against Improvement Plans for last 12 Months

- Education and training in end of life care on respiratory wards achieved the CQUIN target of 90% of staff trained. The training has evaluated really well. The training is now being rolled out to Cardiology and complex care wards.

- Funding received from Health Education for Yorkshire & Humber for training. – CHFT has commissioned Kirkwood Hospice to deliver a series of free one day courses for doctors and registered nurses working in the Trust. There has been one session in June and three more planned later this year.

- Continue to identify and review end of life related complaints using the criteria of death during admission or within 3 months of discharge. Identify any themes. -This will give a focus to the need for training/action specific to each area, and in particular whether there are nursing or medical actions required. Reports will be produced every 2 months and trends identified.

- Continue to monitor use of the ICODD - . This is an individualised plan of care which helps to support and care for people who are dying. Compliance should increase as staff attend the organised training sessions.

- Registered to participate in the National End of Life Care Audit which will look at the progress acute hospitals have made addressing the 'five priorities of care' for people in their last hours, days of life.

- Commissioned 10 training days on advanced communication skills and end of life care - There are 4 organised for 2015 and 6 in 2016. The first session took place on 16th June 2015 and has evaluated very well.

Plans for improvement 2015/2016

- More training days on advanced communication skills and end of life care - organised for 2015/2016.
- Purchase of more comfort bags for use with the ICODD
- Further improvement in review of decisions for DNACPR
- Participation in the national end of life care audit - looking at the 5 priorities of care as well as key recommendations from the 2014 audit. Data collection is 1st July – 30th September and will include patients who died during May 2015.
- Further improvement in the use of the ICODD

3.5 Claims

Claims

Key points Quarter 1, 2015 -16

Clinical Claims	Activity Q1 2015 -16	Comment
New Claims opened during quarter	44	3 claims linked to a complaint 1 claim linked to a reported incident Consistent level with Q1 2014-15
Claims closed in quarter	17	35% cases liability accepted 65% cases liability denied
Services with highest level of clinical claims Q1	61% claims relate to 3 service areas: Emergency Network Orthopaedics Women's Services	Consistent pattern with 2014-15

Non Clinical Claims	Activity Q1 2015-16	Comment
New Claims during quarter	6	Consistent level with Q1 2014-15
Claims closed in quarter	3	2 case liability accepted

To note:

- Significant reduction in clinical claims in General and Specialist Surgical Services
- Incident form raised for only one of the six clinical claims where liability was accepted in quarter 1

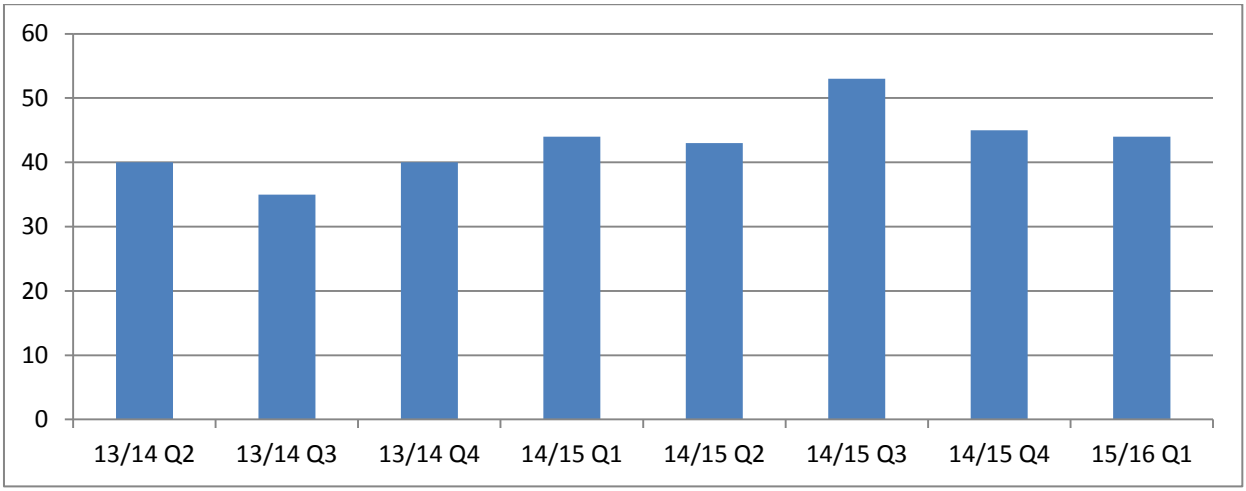
Clinical Claims

Opened Claims

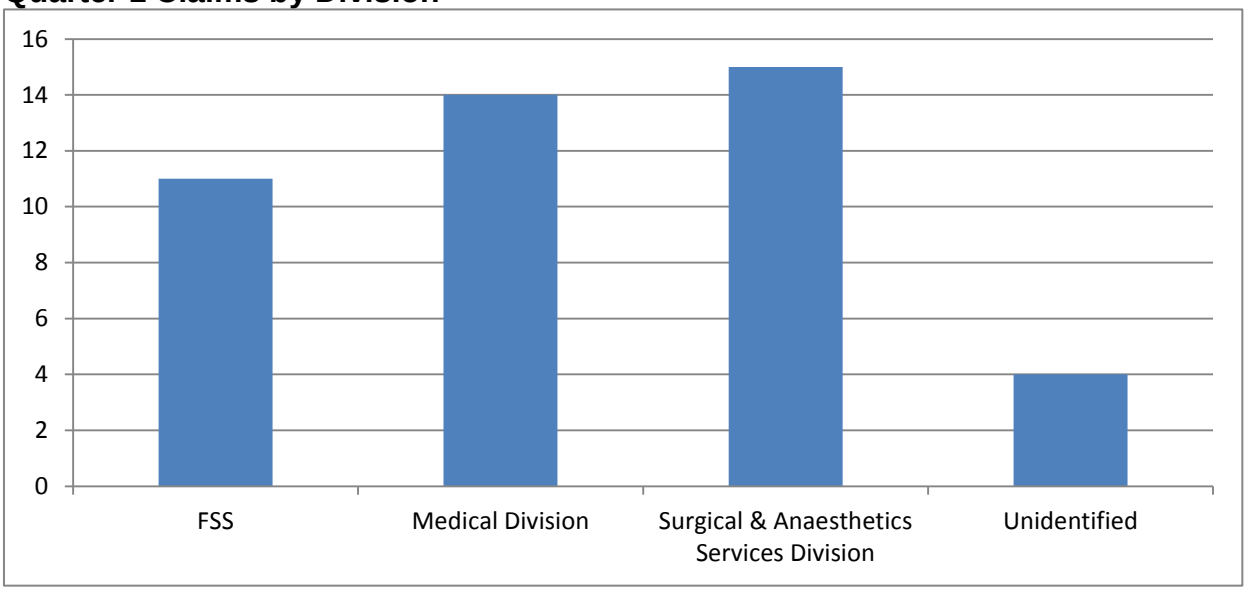
44 new clinical claims were opened in Quarter 1 of 2015/16. This is very similar to the new claims received the previous quarter and the same quarter last year.

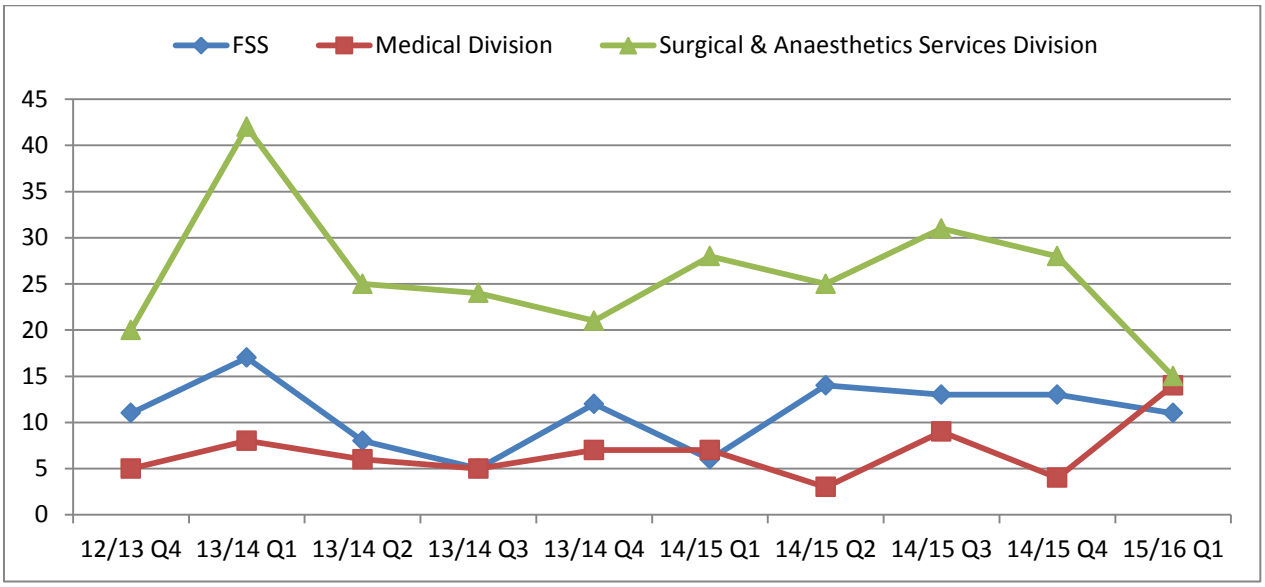
The bar chart below illustrates a relatively stable number of new clinical claims being received quarter on quarter, with the exception of quarter 3 last year.

Opened Claims by Financial Quarter



Quarter 1 Claims by Division

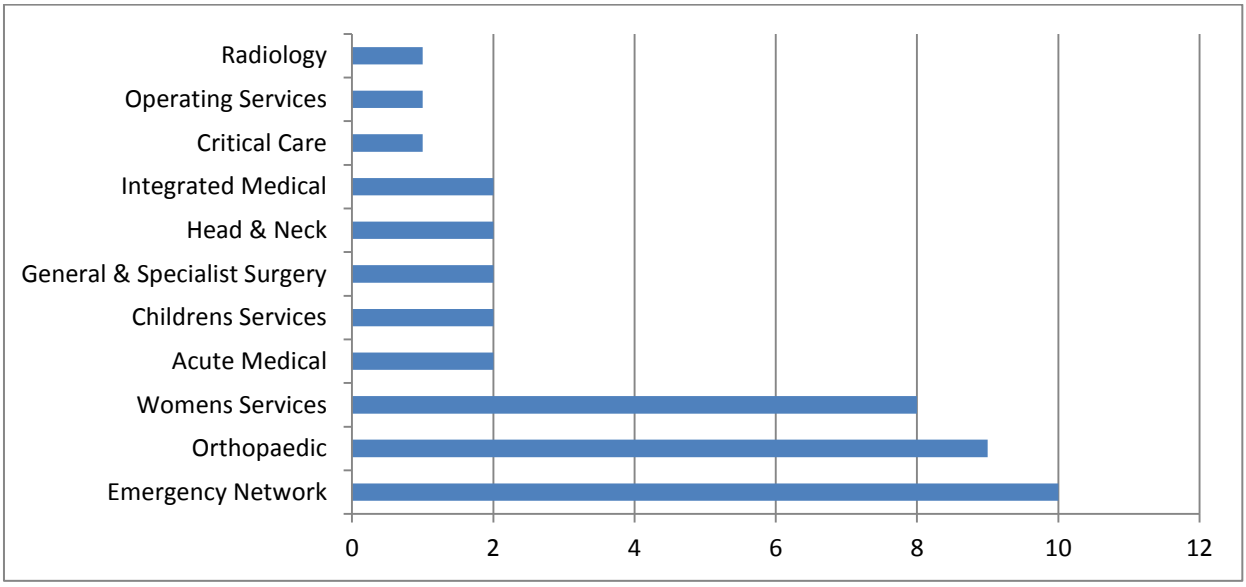


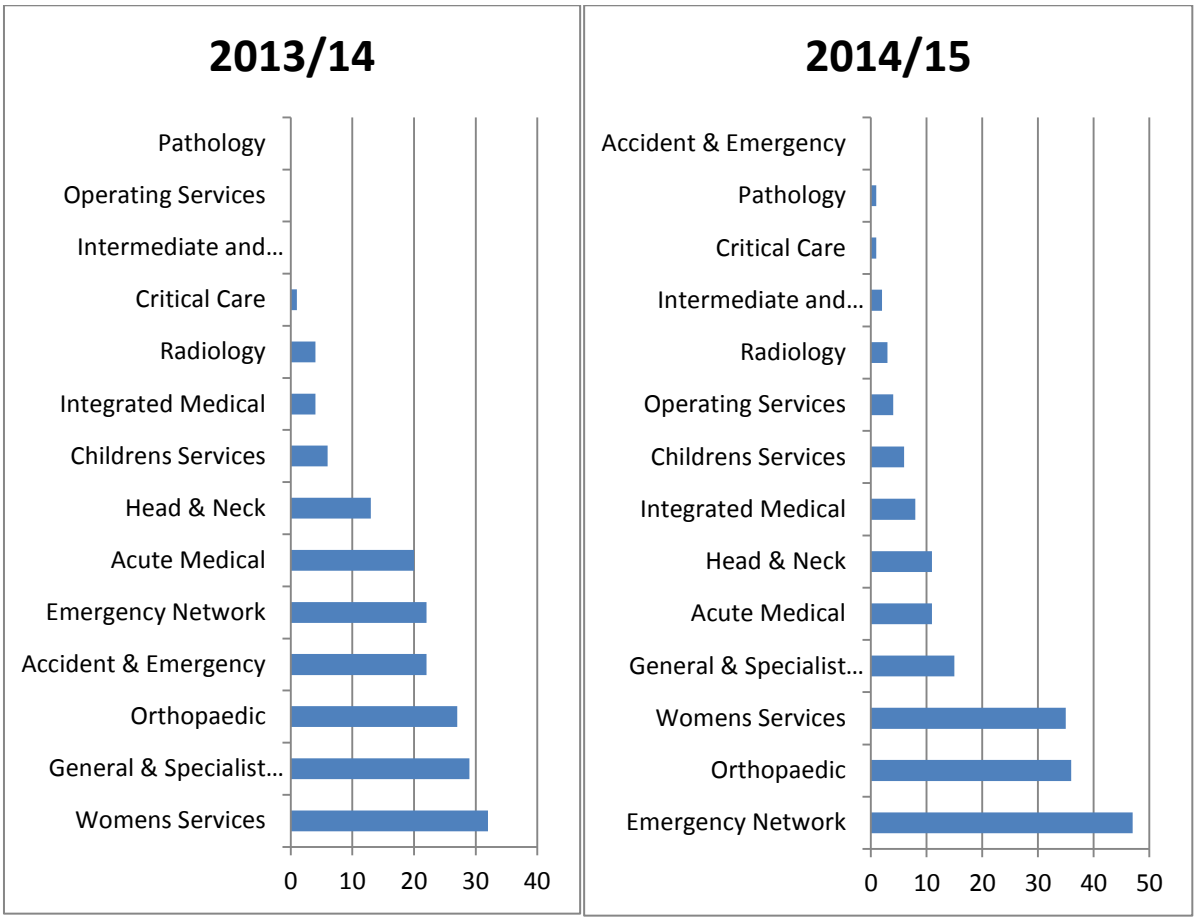


The significant increase in claims opened in the Division of Medicine and with a significant reduction in claims opened in SAS illustrated in the above graph, represents the transfer of Accident & Emergency between the two Divisions.

Claims by Directorate

Reviewing claims opened in the quarter by Directorate confirms that the Emergency Network; Orthopaedic Services and Women's Services are the three significant areas for receipt of clinical claims and account for 61% of new claims opened in the quarter.





Comparing claims received by Directorate illustrates the different 'spread' of the claims that have been received. Last year there was a concentration of claims in three main areas; Emergency Network; Orthopaedic Services and Women's Services. This has continued in Quarter 1 of this year.

Bringing together Accident & Emergency and the Emergency Network into one Directorate has combined two previously high receiving areas.

There is a significant reduction in the number of claims received for General and Specialist Surgical Services which has continued in Quarter 1 of this year.

Clinical Claims linked to Incidents and Complaints

Of the 44 new claims opened in Quarter 1, 3 were linked to a complaint and 1 to an incident.

Closed Claims

17 clinical claims were closed in the quarter. 65% (11) of these did not succeed, with 2 cases being withdrawn and liability successfully denied in 9 cases. 35% (6) succeeded and liability was accepted.

Summary of the claims where claimant was successful:

Directorate	Issue of Claim	Damages	Treatment Date	Incident Raised
A&E	Treatment to burn on arm caused additional pain and more extensive scarring.	£30,000	April 2012	No
Orthopaedics	In adequate treatment of fracture to wrist	£64,000	May 2012	No
Orthopaedics	Insufficient bone resected	£38,500	May 2007	No
Operating Services	Administered Rocuronium instead of Midazolam	£24,200	March 2013	Identified and investigated as an incident – see learning below
Gen & Specialist Surgery	perforation to colon during a colonoscopy resulting in peritonitis, emergency laparotomy, washout and colostomy .	£11,000	February 2010	No
Obstetrics	Non-dissolvable stitches not removed following caesarean section	£7,000	December 20111	No

Learning from a Claim in Operating Services

Issue: Administered Rocuronium instead of Midazolam

Learning: Medications were drawn up appropriately, but used in the wrong order.

Actions: A larger tray to be used when there are multiple syringes of drugs drawn up for a general anaesthetic; this would allow the syringe labels to be more visible and reduce the risk of incorrect syringe selection.

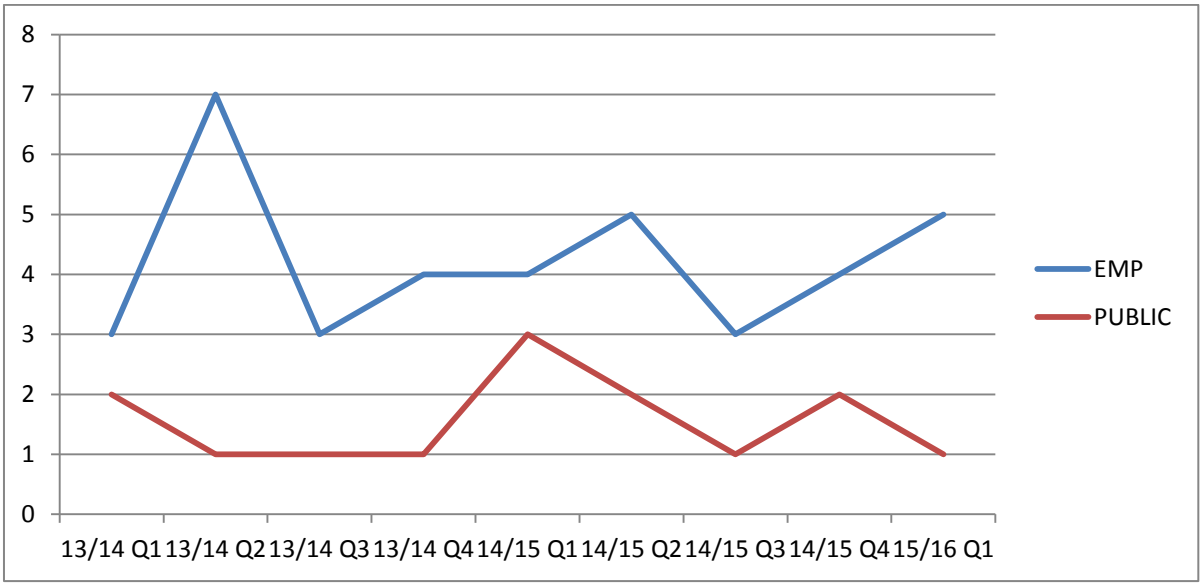
The labels on syringes should always be visible particularly if paper packets are being used for the purposes of ANTT

To raise awareness about drug errors, thus reminding all anaesthetists to be extra vigilant with respect to this.

Non Clinical Claims

The number of claims received relating to non clinical claims is much lower than for clinical claims with a total of 6 claims being received in Quarter 1.

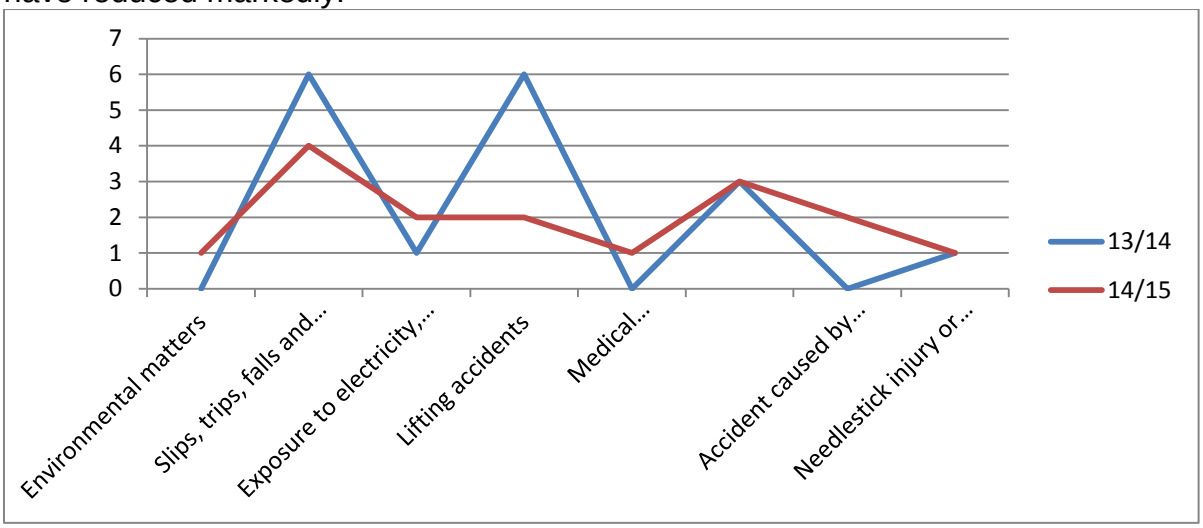
Five claims were Employee claims with one claim from a member of the public. Employee claims continue to show an increase as in the previous quarter.



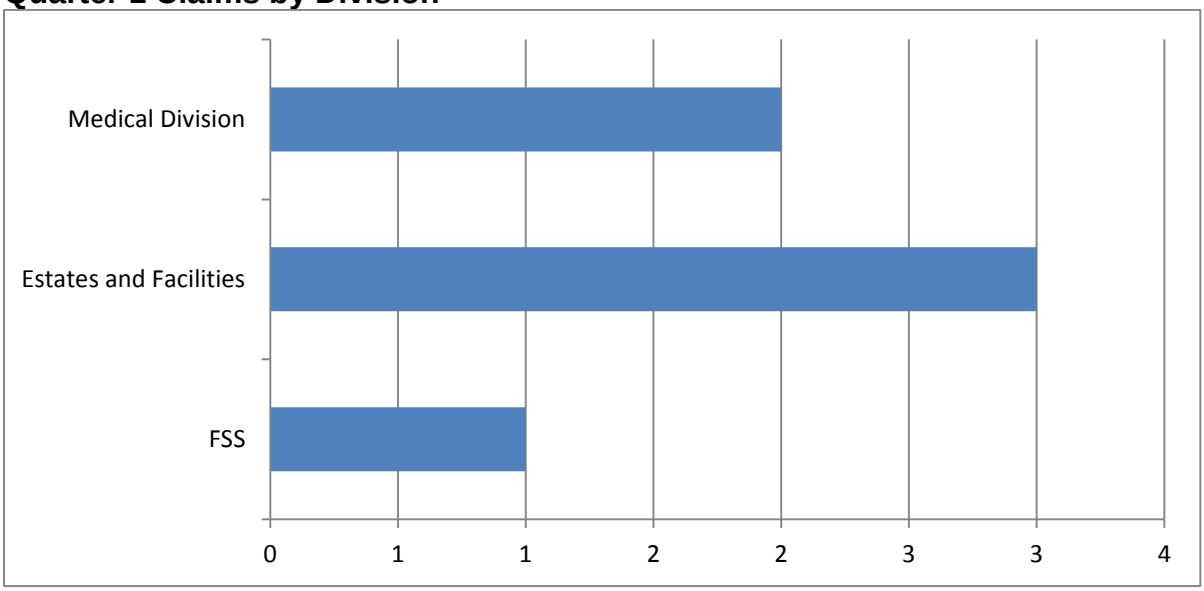
The non clinical claims opened this quarter relates to:

Slips, trips, falls and collisions	4
Lifting accidents	1
Infrastructure or resources - other	1
Totals:	6

A review of reasons for employee claims being received over the previous two years illustrates that although falls and moving and handling account for the majority of claims received, numbers have reduced markedly.



Quarter 1 Claims by Division



Closed Claims

3 non clinical claims were closed in the quarter. 33% (1) of these did not succeed and was withdrawn. The remaining 2 cases 66% succeeded and liability was accepted.

Summary of the successful cases:

Public/Employee	Issue of Claim	Damages	Incident Date	Incident Raised
Public	Tripped over hole in pavement	£3,600	April 2013	Yes
Employee	Needlestick injury	£1,500	December 2014	ISS – provider for facilities at CRH

3.6 Complaints

COMPLAINTS

Complaints are a vital source of information for the Trust, helping to identify where the quality and safety of services and care require improvement for service users.

This section includes information on:

- Performance re: complaints management in Quarter 1 2015-16
- Learning from complaints
- Key publications in the quarter
- Areas for improvement

Formal complaints are investigated thoroughly following the Trust's Complaints Policy. Complaints data is reported across the organisation in a number of ways:

- via the quarterly quality report to the Quality Committee and Trust Board
- via the Patient Experience Group
- via Divisional Patient Quality and Safety Boards
- via key performance information in the monthly Board Integrated Performance Report.

1. Complaints Performance Quarter 1, 2015-16

The Trust received 169 complaints between 1 April 2015 and 30 June 2015, an increase of 10% on the same quarter in 2014/15. This continues the upward trend of an increasing number of complaints per month, averaging 56 complaints per month (previously 51 per month).

Key Performance Indicators

Complaints and Concerns 2015/16	Quarter 1	Q2	Q3	Q4
Number of complaints received Cumulative total	169 169			
% increase / decrease on same period 2014/15	10%			
Number of complaints acknowledged within 3 working days - target 100%	93%			
Number of complaints closed within the quarter	206			
Number of complaints overdue at end of quarter.	33			
Number of complaints re-opened within the quarter following final response	25			
% complaints upheld	Tbc Q2			
Number of complaints referred to Ombudsman during quarter	3			
Number of complaints upheld by Ombudsman in quarter	0			
Number of concerns in quarter	158			

Number of concerns cumulative	158			

Acknowledgement time
100% complaints in April and May were acknowledged within three working days, however in June this figure dropped to 78%. This was due to the drive to close overdue complaints and leave within the team.

Action has been taken in early July to develop resilience across the Governance and Risk team to ensure a wider group of staff are able to acknowledge complaints, though administrative capacity continues to be an issue.

Overdue Complaints
There has been considerable effort by all divisions to reduce the number of overdue complaints in the quarter leading to a reduction in numbers overdue. A number of the overdue complaints relate to complex cases or cases where a serious incident investigation is ongoing.

At the end of quarter 1 there are 33 complaints overdue as follows:

0 – 1 month overdue: 23 complaints
1 – 2 months overdue: 7 complaints
2-3 months overdue: 1 complaint
3-4 months overdue: 1 complaint
Over 5 months overdue: 1 complaint

Weekly monitoring reports are now provided by division to ensure that all cases overdue are clearly identified and timescales for completion of complaints that are due are clear, seeking to prevent further cases becoming overdue.

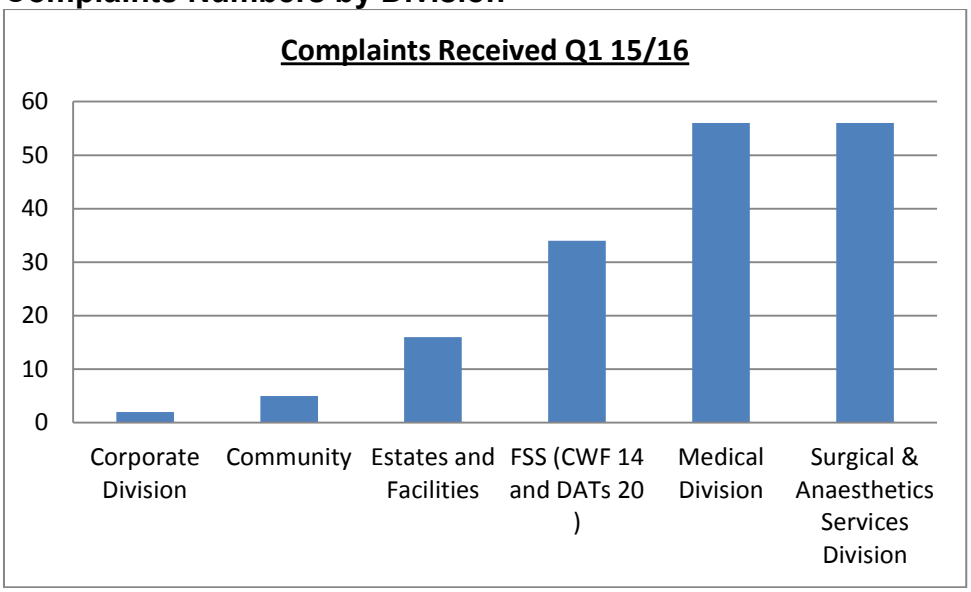
Outcome of Complaints
Information on the number of complaints which are upheld, partially upheld or not upheld is collected as part of the management of each complaint. Analysis of this information will be included in the quarter 2 report, as due to the focus on overdue complaints in quarter 1, the information has not yet been completed on the system to allow for analysis.

Ombudsman Complaints
During quarter 1 the Trust is aware of three complaints that have been raised with the Parliamentary and Health Service Ombudsman following final response.

There are currently 16 complaints cases with the Ombudsman.
During the quarter no Ombudsman complaints have been closed.

National Quarterly Complaints Returns
For the first time national complaints information, KO41 returns, which monitor written hospital and community health services complaints in the NHS, are required to be submitted on a quarterly rather than an annual basis to the Health and Social Care Information Centre. The return also requires a greater level of detail than previous returns, such as age of the person who is the subject of the complaint. This information has not previously been recorded within the complaints process and has required further work to ensure that information is available for the quarter 1 return for 2015/16 which will be submitted on 28 August 2015. Summary information from this report will be included in future reports.

Complaints Numbers by Division



The split of complaints by Division by month was as follows:

Division	2014/15	April	May	June	Total Q1 2-15-16
Corporate	3	2	0	0	2
Family and Specialist Services	146	16 (CWF 6) (DATS 10)	11 (CWF 5) (DATS 6)	7 (CWF 3) (DATS 4)	34 (CWF 14) (DATS 20)
Estates and Facilities	12	6	1	9	16
Community	N/A	2	1	2	5
Medical	174	21	16	19	56
Surgical & Anaesthetic Services (SAS)	282	14	21	21	56
Total	617	61	50	58	**169**

The top 3 directorate areas that received complaints in Quarter 1 are:

General Specialist Services (SAS) - 30 complaints
Emergency Department (SAS) - 25 complaints
Acute Medical (Medical) - 21complaints

Emergency Department complaints are now included within the Medical Division figures following re-organisation during 2014-15.

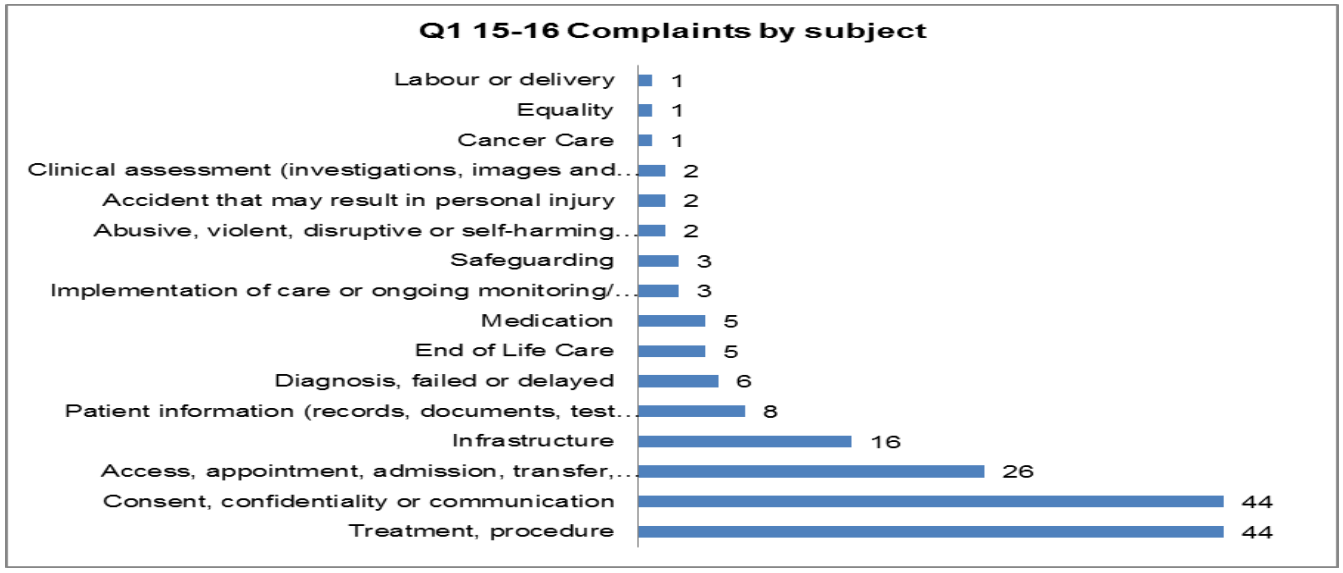
Analysis of Complaints By Theme
Complaints are analysed in two ways below, by primary subject code and by CQC standard. Care and treatment are the main cause for complaint in each analysis.

Complaints By Primary Subject Code
The top three subjects of complaints remain clinical treatment, communication and appointments as shown below, consistent with 2014/15:

Subject	2014/15	2015-16 Q1
Treatment, procedure	30%	26%
Consent, confidentiality, communication	25%	25%
Access, appointment, admission, transfer, discharge	14%	15%

The spread of complaints in Q1 by division is:

	Access, appointment, admission, transfer, discharge	Consent, confidentiality or communication	Treatment, procedure	Total
Corporate	0	1	0	1
FSS	9 (*DATs*)	8 *(CWF 3 DATs 5)*	5 *(CWF 4 DATs 1)*	22
Estates and Facilities	0	3	0	3
Medical Division	10	18	16	44
SAS	7	14	23	44
Total	26	44	44	114



2. Learning From Complaints

The feedback we receive from complaints gives the Trust a wealth of information that can be used to improve services as an individual complaint provides detailed insight into a patient's experience.

As an organisation we need to ensure that we learn from complaints so that we can:

- Share good practice
- Increase patient safety
- Improve the patient experience
- Reduce the number of complaints

It is therefore essential that information on learning from complaints is captured and shared across the organisation. Each service and division needs to be clear:

- How the services records learning from complaints
- How this learning is disseminated within the service / directorate / division
- How it can point to changes arising from learning from complaints

The complaints process includes a form to document learning from each individual complaint, known as learning from experience form.

A review of completion levels of these forms shows that completion of the forms is variable. There is a good volume of complaints for which the forms are completed in the Family Specialist Services Division, Community Division and Acute Medical Unit within the Medical Division.

There is a low level of completion of the learning forms in the Surgical Division, with only 10 of 68 learning from experience forms completed for complaints closed during quarter 1.

Learning forms for Emergency Network complaints, which is one of the top three services which patients complain about, is also low, with 12 of 39 complaints in the quarter having the learning form completed.

Further work is needed to work with staff to help identify and share the learning from complaints more widely across the organisation. Discussion on how to develop and capture learning from complaints more robustly and share this took place at the Patient Experience Group in July.

Information on learning from complaints in quarter 1 is given below, with samples of learning taken from the returned learning forms in quarter 1 is given below:

Learning the Lessons

Childrens. Womens & Families – Women's Services

Q1 2015-16, 15/18 Learning from Experience Forms Completed

Issue: Delay in reviewing wound swab results after C-section.

Finding: Process for checking swab results is not robust

Action: Review of process for checking investigation results

Issue: Review scan of cyst was not undertaken by Registrar

Finding: Patient notes were not read and follow up was not organised

Action: Staff reminded to fully review notes to ensure follow up required is arranged.
Learning shared through: Midwifery Learning Event (Sept 2015), Divisional newsletter

Issue: Bowel problems / infection after C-section:

Finding: No debrief following birth or post natal care before discharge home caused anxiety for patient

Action
Importance of communication and debrief of patients before discharge

Issue: Perineal tear – patient unaware of previously suffering 3rd degree tear 2013 and not attending follow up.

Finding: Case notes and copy letter to patient /GP confirm information sent to patient's address re: tear

Action
Raise awareness of communications and referral processes to women.

Share with staff via Learning from Experience newsletter

Learning the Lessons

Emergency Network

Q1 2015-16 12/39 Learning from Experience Forms Completed

Issue: Patient discharged home with cannula in arm.

Finding: Nurse did not undertake appropriate clinical checks prior to discharge

Action: Awareness raising with ward team and introductions of "safety huddles" and prompts / nursing documentation checks re; removal of cannula immediately prior to discharge.

Issue: Poor staff attitude

Action:
Discussion with staff member / reflection on attitude

Issue: Inconsistent messages re: visiting times outside of set visiting times.

Action
Identify and negotiate with individual patient/ families if need for visiting outside set times.

Issue: Child on Medical Assessment Unit with feeding peg that staff were unfamiliar with, medication wrongly administered in peg, causing it to come out and require urgent replacement.

Action
1:1 discussion and monitoring of member of staff. Training in gastrostomy/enteral feeding system.

Learning the Lessons

Surgical Division General Surgery

Q1 2015-16: 6/28 Learning from Experience Forms Completed

Issue: Poor written and verbal communication re: patient transfer. Not supporting patients to go home with a catheter

Action: Improve written and verbal communication when patients transferred. Ensure timely TTCS for outliers on ward. Order catheter packs to support going home. Learning: Share Patient story through Divisional Management Team

Issue: Lack of timely communication to family about patient's discharge (Ward 11) and not enough support on discharge

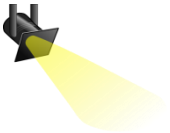
Action:
Discussion with ward sister and discharge nurses re: importance of ensuring family aware of plans for discharge.

Issue: Communication about patient specific needs

Action
Need for clear documentation of patient specific needs

Issue: Need for follow up of biopsy for cancerous lesion missed – patient had to chase.

Action
Results book introduced to ensure system in place so that patients are not lost in the system.



ACUTE MEDICAL UNIT, MEDICAL DIVISON:
Learning from Complaints Q1 2015-16

In quarter 1 2015 – 16 there were 34 complaints closed in the quarter relating the Acute Medical Unit. The Acute Medical Unit (AMU) is one of the top 3 services which the Trust receives complaints about, with 21 complaints received during quarter 1.

Of the 34 complaints closed during quarter 1, 24 learning from experience forms were completed.

15 completed forms identify communication as an issue for learning. These 15 complaints have been analysed to summarise the type of communication issue which shows:

- Most communication complaints are about verbal communication with staff not communicating information with patients and relatives (9 out of 15)
- A small number of learning from experience forms do not make it clear what the learning / communication issue is (3 out of 15) from the complaint
- Communication between teams (2 out of 15)
- Written communication (1 out of 15)

Communication between staff and patients and relatives (Information extracted from Learning from Experience form)
Communication with next of kin
Communication between staff and relatives
Communication and lack of full details to all family members re: expectations
Communication between nursing staff, patients and relatives re: deteriorating patients end of life care
Need for better communication with patient /relative whilst medical condition being diagnosed
Clear that not everything communicated between patient and their representative
Communication with patient and relative on what happened to patient and when medication given
Clear communication with patients / significant others re: discharge planning / safe timely discharge
Clear lines of communication with patient by medical & nursing staff re: diagnosis, treatment, investigation (Shared complaints actions MAU/Ward 5c)

Communication – unclear from Learning from Experience form what issue is
That clear communication is very important
Communication
Communication issue raised – procedure and process needs clear instruction

Communication between teams about patient care (extracted from Learning from Experience form)
Communication and recording re: DNAR form
Poor communication between patients and nursing team re: clopidogrel protocol

Written Communication (extracted from Learning from Experience form)
Poor written communication (leaflet from angiography service) not written from patient perspective – learning involve patient in improvements to written communication

Action in Response to Complaints relating to Sign Language Interpreters

An unexpected number of complaints were received during the period January to April 2015 relating to the services provided by the Big Word, with 8 complaints in total received and a petition from the Calderdale Deaf Community. The complaints relate to the skill level and availability of British Sign Language Interpreters employed by the Big Word.

In response to the issues raised an engagement event for the deaf communities of Calderdale and Kirklees is planned for August. Additionally the agreement to transfer services over to the preferred new provider, Pearl Linguistics, has been paused to enable the Trust to consider the feedback from the engagement event and commission the most appropriate service for this client group.

Key Publications in Quarter 1 2015-16

"Dying without Dignity"
The Parliamentary Health Service Ombudsman (PHSO) in May 2015 published a report , "Dying without Dignity" which looked at complaints they had received about the care and treatment that someone has received in the last 12 months of their life, to highlight where things are going wrong to help improvements be made. It highlights cases where people's suffering could have been avoided or lessened with the right care and treatment. The report identified six themes from the cases it has reviewed:

- Not recognising that people are dying or responding to their needs
- Poor symptom control / pain management
- Poor communication
- Poor care planning leading to uncoordinated care
- Inadequate out of hours service
- Delays in diagnosis / referrals for treatment

Within the Trust in quarter 1 there were five end of life care complaints received. The End of Life Group, led by Consultant in Palliative Medicine, has undertaken a review of end of life care, including incidents and complaints and developed a programme of work.

With regard to the management of end of life complaints, the group identified the following:

- The need for a clearer process to capture / categorise End of Life complaints – work on this has begun

- Complaints about communication have now overtaken complaints about procedures/treatment (consistent with PHSO finding)

- The need for speedier handling of concerns / complaints and the need to encourage earlier face-to-face meetings with complainants

The group has a programme of work underway; including a series of training sessions arranged around enhancing communication skills and improving recognition of and care for dying patients.

Patients Association NHS Benchmarking Complaints Survey 2014-15
The Trust participates in a national complaints survey that helps Trusts monitor their handling of complaints against the Patient Association good practice standards. Surveys are sent out to patients for each complaint considered closed (post 10 weeks).

In 2014-15 44 completed survey forms were returned relating to complaints handled by the Trust. Data is benchmarked against other organisations and in 2014-15 1527 survey forms have been returned by participating Trusts. Taken as a percentage of overall complaints received (617 in 2014/15) the number of completed survey forms is low, which is typical of this type of survey. Of the forms received approximately 52% people were complaining about their own care.

The Trust was in the top 5 Trusts for:

- complaint being resolved
- complaint handled well/ very well
- staff helpful when concerns were raised
- easy to make a complaint
- where complaint involved Trust staff, explained how Trust had dealt with this
- understanding the explanation given in the complaint response
- told the truth in the complaint response

Where complainants sought further action the Trust had a higher number of complainants seeking further medical advice and contacting the Ombudsman and a lower number seeking legal advice.

The Trust was at the lower end of responses for:

- responsiveness, 68% said complaints could have been dealt with quicker
- 46% complainants said the Trust hadn't explained what action would be taken to prevent the same happening again
- updating complainant on changes to be made as a result of the complaint
- dissatisfied with the final response

The Trust will work to continue to improve the response time to complaints, improve the quality of final response and be clear what actions will be taken to prevent issues recurring.

Areas for Improvement
An update against the key priorities for 2015-16 for the patient advice and complaints service are:

- to eradicate overdue complaints – work continues to reduce the numbers of overdue

complaints, with 33 overdue at end of quarter 1
- to respond to all complaints within agreed timescales – close monitoring via weekly reports highlighting complaints due dates and any overdue
- to establish processes to routinely capture information for quarterly KO41 reports – preparing return has required identification of further information for each complaint
- to continue to encourage meetings/discussions with complainants at the early stage of the complaints process
- to develop systems to share learning from complaints across the Trust – discussion with Patient Experience Group has begun with further reporting on lessons learned from complaints for Q2

A Complaints Task and Finish Group was established in late June to progress developments to improve the management of complaints. There is representation from each division, including matrons and operational managers, and the Governance and Risk team. Areas of work are:

- to develop support materials to enable staff to manage complains effectively and in line with Trust standards
- to ensure an effective interface between divisions and the corporate complaints team
- to ensure the complaints service is accessible for complainants
- to ensure the Trust learns from complaints
- to encourage and support a culture that empowers staff to handle concerns and complaints effectively

3.7 Ensuring Privacy and Dignity - Mixed Sex Accommodation

Aims and Objectives of Work

Being in mixed-sex hospital accommodation can be difficult for some patients for a variety of personal and cultural reasons. Therefore all providers of NHS-funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient or reflects their personal choice

A breach is said to occur when a member of the opposite sex shares sleeping accommodation. The breach takes into consideration how many patients were affected by that breach.

Current Performance

During quarter one there were no mixed sex breeches within the organisation. However, we continue to enact our improvement plan by revising trust policy and raising awareness particularly in critical care areas.

Performance continues to be monitored and reporting within the Integrated Board Report which is review monthly by the Executive Team.

Our real time patient monitoring and patient survey demonstrate that some patients feel they are being cared for in mixed sex accommodation.

We monitor all mixed sex breaches and this demonstrates that we rarely breach this standard, over the entire of 2014/15 there were 2 instances of mix sexed accommodation breaches which affected 15 patients (double check). These exceptions occurred due to patients being stepped down from critical or high dependency care

We measure compliance monthly and undertake root cause analysis to understand if the breach has occurred and share any learning. The main learning points have been around recognising a need to improve the planning and discharge of patients from high dependency areas.

We want to understand why our patients perceive this differently and have instigated some work to educate volunteers on the guidance and policy so they can investigate the patient perception by surveying patients in order to formulate an action plan which will be available in September 2015

Domain Four – Responsive

Responsive compliance summary

Indicator	Compliance
4.1 A&E Performance	Partial Compliance
4.2 18 week pathway RTT (referral to treatment)	Achieved
4.3 Bed Efficiency and Rebalancing	Reporting Only
4.4 Outpatients – Focus on DNAs	Reporting Only
4.5 Diagnostic Waits	Achieved
4.6 Cancer Waiting Times	Achieved
4.7 Theatre Utilisation	Reporting Only

Highlights:

4.1 A & E Performance	Achieved 3 of 5 quality indicators Achieved CQUIN target for improving recording of diagnosis in A&E of 80% in Q1
4.4 Out Patient DNA	Target of 7% for first appointment DNA's achieved q1 - year to Date performance is 6.1%, i.e. target met Target of 7.5% is in place for Follow-Up DNA's achieved q1, year to date performance is at 6.4%, i.e. target met
4.6 Cancer Waiting Times	All 8 standards achieved in quarter 1.

4.1 A&E Performance

Aims and Objectives of Work

NATIONAL PERFORMANCE INDICATORS

Total Time in A&E: This is measured on 95th percentile, stating that 95% of the patients should be discharged from A&E within 4 hours.

Unplanned re attendances: The target for this is that no more than 5% of A&E attendances should re-attend within 7 days of the original attendance.

Left without being seen: The target for this is no more than 5% of A&E attendances should leave the department without having been treated by a nurse or Doctor.

Time to Initial Assessment: This is an indicator only for patients brought in via Ambulance. The aim is that 95% of the patients attending via ambulance should have been assessed by a qualified member of staff within 15 minutes of arrival at A&E.

Time to Treatment: This indicator is measured by the median (middle) time. Aim is that all patients attending the A&E Department should wait no more than 60 minutes before commencing treatment by a doctor.

CQUINS

Improving A&E diagnosis: This indicator aims to improve diagnosis recording in the A&E HES data set so that the proportion of records with valid codes (either A&E 2 digit diagnosis codes or 3 digit ICD-10 codes) is at least 85%.

Current Performance

Q1 saw 2 out of the 5 quality indicators not achieved: unplanned re-attendances and time to initial assessment. There is recognition that the whole system has been under significant pressure during Q1.

A&E Quality Indicators for 2014/15

Indicator Name	Indicator Detail	Target	Site	Apr-15	May-15	Jun-15	Qtr 1
Unplanned Re-Attendances	Unplanned re-attendances within 7 days of origional attendance	5%	Trust	5.32%	4.82%	5.04%	5.06%
			CRH	5.75%	4.89%	5.57%	5.40%
			HRI	4.87%	4.75%	4.50%	4.71%
Left without being seen	% of patients who leave the department without being seen	5%	Trust	3.65%	3.09%	3.27%	3.34%
			CRH	4.72%	3.22%	3.18%	3.71%
			HRI	2.52%	2.96%	3.36%	2.95%
Time to initial assessment	95th Percentile of time spent from arrival at A&E to initial assessment (999	15 mins	Trust	00:25	00:20	00:17	00:21
			CRH	00:30	00:22	00:17	00:24
			HRI	00:15	00:16	00:19	00:16
Time to Treatment	Median time spent from arrival at A&E to Treatment	60 mins	Trust	01:00	00:56	00:58	00:58
			CRH	01:12	00:54	00:59	01:01
			HRI	00:47	00:59	00:56	00:54
A and E 4 hour target	Numerator	95%	TRUST	11656	11935	11751	35342
	Denominator			12268	12590	12313	37171
	%			95.01%	94.80%	95.44%	95.08%

For 4.92% of patient who breached the four hour waiting time, the main reasons related to the following:

Breach Reason:	%
Wait for a medical bed	25.0%
A&E majors delay	23.5%
Continuing Care in dept	18.0%
Waiting for medical doctor	6.5%
Waiting for side room	3.1%

Unplanned re attendances

The 5% target was missed this quarter; there was an the increase in the number of attendances which may have an impact on other patients deciding to leave before being seen, this then can then result in the following situations:

- patients decide not to wait and come back later
- patients move between sites when one department is busy
- exit block causes patients to have lengthy waits

Each of the scenarios above can result in an attendance being recorded.
Through monthly validation, some performance issues are related to administration errors in how attendances are noted. These are being addressed with reception/admin staff.

Despite the pressure there were some significant improvements noted for Q1.

- The safety huddle, which is delivered at the start of each shift, is working well with staff were made aware of issues in a timely fashion with an opportunity to put any correctively action in place.

- The introduction of large electronic performance TV screens, which are now visible in the patient waiting areas, has enable staff to see at a glance what the current assessment time is and the unit is functioning.

- There is now a daily review of patient's assessment times, so any issues can be rectified at the time.

CQUIN performance:

Performance for Q1 was 86.1%, above 80% target.

Improving Recording of Diagnosis in A&E (Improving diagnoses & re attendance rates of patients with mental health needs)	Quarter 1			Q1
	Apr-15	May-15	Jun-15	Total
Number of records with a invalid diagnosis code	1828	1783	1570	**5181**
All records of A&E attendances within the last month	12268	12590	12313	**37171**
% with Valid Diagnosis Code	**85.1%**	**85.8%**	**87.2%**	**86.1%**
Target	**80% Coded**			

Improvement Plans for Q2 onwards:

Total time in A & E

- Admission Avoidance: Medical Consultants/Medical Registrars are working in each A&E unit from 1pm - 8 pm to support clinical decision making and provide admission avoidance support. This was initially for 5 days a week, but is to be extended during Q2 to 7 days.

- The daily review of patients will include noting those patients who are on a “green cross pathway” whereby they are waiting for a package of care to be arranged via social services and clinical teams. A lead person will be identified for each patient to expedite delays and the discharge process.

- There will be the full introduction of Plan for Every Patient (PFEP) to enable better planning for timely discharges and any issue resolutions plan can be commenced.

- Alongside this there will be the introduction of Standard Operating Procedure (SOP) for A&E clinical co-ordinators to aid decision making and standardisation.

- A review of the assessment pathway work will commence in Q2, this will follow a 90 day PMO plan methodology.

Time to Initial Assessment

1 Increase in attendances:
- awareness of this issue to commissioners so that a review of capacity of services
- Local Care Direct streaming service review
- Out of area attendances appear to be increasing
- Appropriateness of ED presenting complaints
- Workforce model to reflect the demand

2 ‘Exit block’:
- daily meetings to review green cross patients
- increased focus and work ensuring EDD for all patients
- introduction of the discharge improvement meeting (all health economy partners involved)
- clinical commanders in post to take control of site and improve flow

- bed modelling to ensure correct capacity available
- discharge levelling

3 Lack of nursing staff
- new workforce model being developed in line with NICE hard truths for emergency medicine

CQUIN

Q2 Performance is expected to maintain above target in quarter 2.

The CQUIN requirements for the first 2 quarters are:

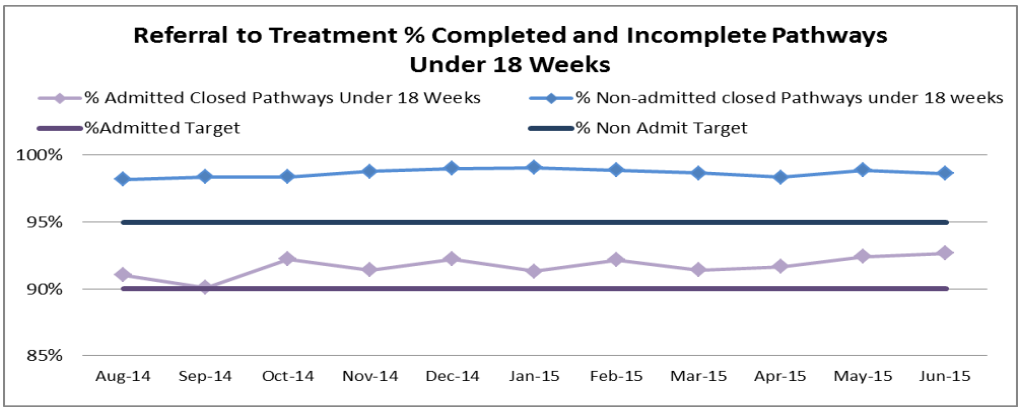
Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)
Quarter 1	Baseline audit to ensure 80% of all A&E attendances are coded correctly
Quarter 2	TBC after baseline

4.2 18 Week Pathway (RTT)

Aims and Objectives of Work

The NHS Constitution gives patients the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. This right is a legal entitlement protected by law, and applies to the NHS in England.

- 90% target for admitted treatment within 18 weeks
- 95% target for patients having outpatient treatment within 18 weeks



Below is a report to the Executive Board of the output of the Intensive Support Team (IST) engagement with the Trust in relation to the Referral to Treatment pathway elective access and other associated reports. The report provides assurance that a comprehensive deep dive into delivery of the referral to treatment standards has been undertaken, with an action plan agreed.

Executive Summary

In July 2014 the Trust invited the Intensive Support Team (IST) to undertake a high level assurance review of the systems in place to deliver the referral to treatment (RTT) standards. This included an assessment of the robustness of the Trust's performance management structure, data quality and information reporting, administrative processes and policies.

In May 2015 the Trust requested the newly appointed Associate Director of Community Services and Operations to review this and the current position on elective access and performance management which included input to the External Assurance audit on the Quality Report by KPMG.

The overall assessment by the IST was good, however there were several key observations that required focus and which have yet to be concluded. The internal assessment confirms overall delivery on the reportable performance metrics are solid but further work is required to ensure delivery aligns with the NHS Constitution and non-reportable access is afforded the required focus to ensure optimal patient experience. KPMG informed the Audit Committee that they were unable to give an opinion, with specific focus on the validation element of reporting.

The recommendations from IST have been accepted in full and actions are described below, including additional actions on the wider elective access issues identified and a proposed revision to operational and performance management structures to enhance assurance.

IST Report

Whilst the IST's overall assessment of assurance of the Trust's RTT systems and processes was good, there were some key observations noted during the visit that require further investigation and resolution, namely:

1. Reasonable notice – the definition of reasonable notice in the Trust's Access Policy is not in line with the national RTT definition and this may impact the organisation's ability to make legitimate adjustments on the admitted pathway.

2. TCI booking – there is varying confidence in the system that offers of reasonable notice are being recorded in cases where consultants are responsible for managing their majors lists.

3. Fuzzy matching – although the process described appeared sound, the underpinning business rules have not been reviewed for approximately two years, which is overdue.

4. RTT audit programme – although there are occasional audits, there is no formal rolling programme of RTT data auditing across the organisation.

5. Follow-up booking – there is poor visibility of follow-up waiting times although noted that the organisation is planning to implement partial booking of follow-ups.

6. Confirmation of doctor rotas – there is poor organisation and timeliness of communication around doctor rotas and this is having a negative impact on patient experience and capacity due to late cancellations and unfilled lists/clinics.

7. Demand and capacity modelling work – this has just commenced in some of the specialties but the organisation needs to accelerate this work to make the most of the opportunities around the outpatient template review work being undertaken with Newton.

8. Appointment slot issues (ASIs) – the Trust's ASI rate is high at 13-14%, and very high in some specialties (>50% in ophthalmology). Whilst there is a plan to address this by October 2014, this highlights the need to accelerate the demand and capacity modelling work.

9. Paediatric orthopaedics – there is inequity of service on the Calderdale site as patients may still have to go to the Huddersfield site to see a consultant.

10. Pooling of referrals and work – there is more opportunity for pooling, especially in orthopaedics.

11. Fracture clinic service – there are concerns around poor patient experience due to hidden waits in the treatment room.

There was reference to several meetings and reporting processes that were in place at the time of the IST visit but no longer exist.

The report was received in 2014; hence some of the comments reflecting a 2014 completion date, however there is little documented to evidence progress. It is important to note that the Trust continues to report good compliance with the three core metrics of admitted, non-admitted and incompletes. Lack of documented progress was identified by the Director of Nursing and Operations who requested a review of progress along with an internal review of the current position which is reported in section 4.

3. External Assurance

KMPG review had a mandated indicator to review which was:

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period.

They were 'unable to give an opinion' on this indicator due to:

- Patient records not all being available
- Data not agreeing to patient notes
- Evidence of duplicate episodes

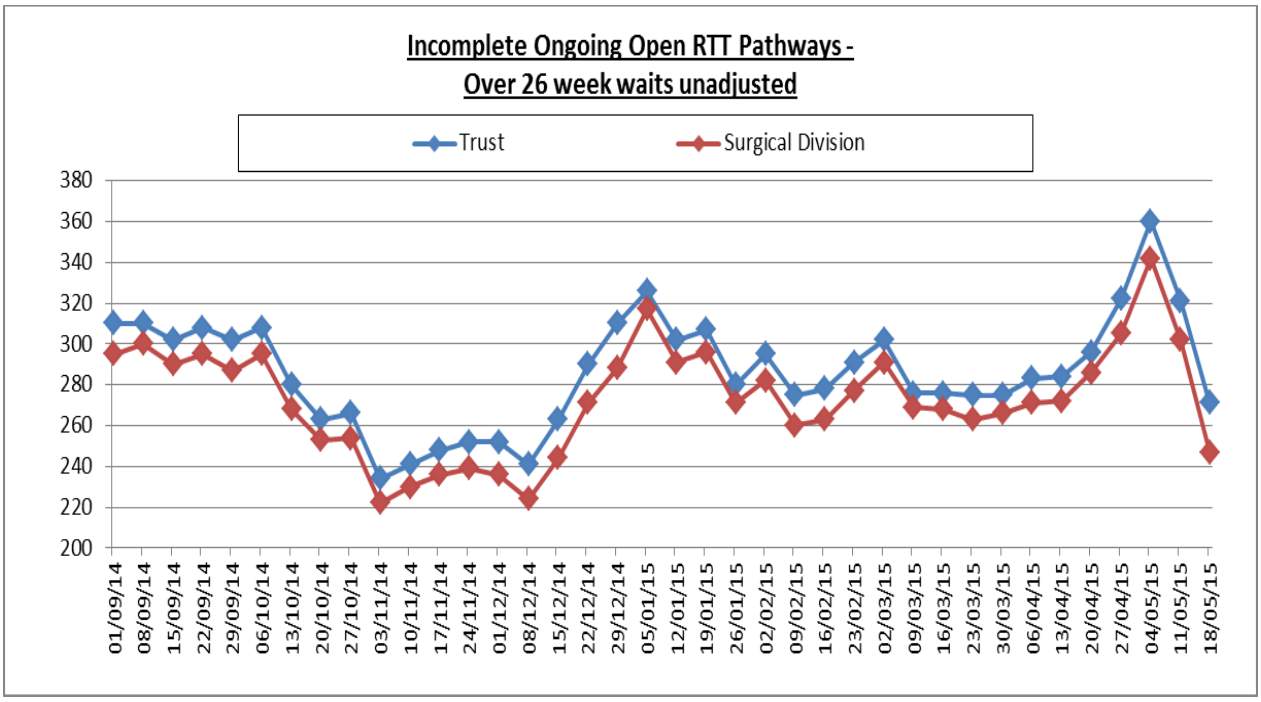
They identified areas for improvement in relation to accuracy and timeliness of recording and validation with the following recommendations:

■ When validation of data is undertaken, a sample of patient records should be checked to ensure the data which is being reported is consistent with the medical records.
■ Validation checks require improvement to identify the types of errors identified within our testing.

4. Internal Review

The Trust has delivered excellent performance against the admitted, non-admitted and incomplete standards however for those patients waiting longer than 18 weeks the main reason for the delay is capacity. This does not conform with our NHS Constitution responsibilities where patients should only wait if by choice or clinically contra-indicated.

More recently there has been a reliance on local validation to secure performance with a mismatch between the weekly and monthly PTLs, which is a concern both for sustainable delivery and contract penalties. This validation is retrospective and whilst secures performance delivery does not provide assurance of any potential performance risk and also means patient pathways are not accurate leading to a poorer experience. There is little movement on the reduction of over 18 week waiters with the 'clearance' and 'tip' being almost equal but the length of wait over 18 weeks appearing to grow and over 26 having significant peaks as seen in the following graph:



Getting absolute clarity on the picture is difficult and compounded by the current process of 'fuzzy matching' which now needs to be urgently reviewed.

The current approach to 18 weeks management represents a reactive rather than proactive approach to the management of waiting times. Information reporting needs to be reviewed to provide for dashboards that alert operational managers to risks and provide the Board with greater assurance on compliance. With improved, proactive management of waits, the current high level of RTT performance can be sustained.

As highlighted by the IST further work is required on Capacity and Demand to ensure business planning builds in sufficient headroom to manage within defined waiting times for all patients, there is an ability to flex demand to meet peaks in referrals and, where there is too much capacity, plans can be implemented for a reduction with associated cost savings.

Performance is delivered and managed at specialty level with variable waiting times when reviewed at Consultant level. Waiting lists and associated capacity needs to be used flexibly to ensure equitable access for patients. Booking for admitted is undertaken by Medical Secretaries and there is no apparent proactive look at booked activity. With specialties and Divisions managing independently of each other this is a performance risk as whilst there is sufficient headroom on incompletes this does need monitoring to avoid contract penalties at specialty or Trust level.

Whilst there is good delivery and awareness of RTT there is less visibility of non-reportable activity at Trust level and variable awareness within Divisions, including planned waiting lists and follow up activity. Some of the current reporting mechanisms are detailed and allow good interrogation by operational managers, however there is a requirement to have a high level dashboard to facilitate early identification of risks and a weekly performance meeting to ensure timely corrective actions. In addition there needs to be weekly visibility of non-reportable access metrics to ensure all patients access services at the optimal time with an urgent review of the input, reporting and management of follow up appointments

Finally all RTT and elective access activity is undertaken at Divisional level with no central access team. As highlighted in the KPMG report, and in learning from other organisations, this reduces the assurance the organisation and commissioners have on the accuracy of delivery and reporting. With no central function there is limited ability to proactively understand the risks at Trust level and therefore support Divisions to collectively secure optimal delivery at corporate level; be that managing peaks or using the overall resources to most optimal efficiency.

5. Actions

The feedback has been reviewed and an action plan developed to address the recommendations within the three reviews.

6. Summary

The Trust has a solid record of delivery against the reportable elective access standards of RTT, however needs to review compliance with the NHS Constitution. New reporting and performance standards have recently been proposed but should be reviewed with caution to avoid deterioration in overall waiting times and have not been considered as part of this paper.

The devolved reporting arrangements within the Trust ensure good ownership of delivery but do not provide the requisite assurance required. An independent access team should be established in conjunction with the development of revised weekly performance meetings and more formalised Divisional Performance reviews.

Data is comprehensive, however is retrospective and does not highlight promptly areas of risk for operational investigation and management. A review of the reporting suite and associated performance framework will be undertaken and will secure greater assurance of sustainable improvement.

6. Recommendations (made to the Executive Board)

- The Executive Board is asked to note the recommendations and confirm the actions are sufficient and priority rating is sufficient to improve assurance and sustainable delivery.

- Divisional and relevant Directors are asked to confirm acceptance of the actions within their remit and commit to provide regular updates to inform the Executive Board of progress, including the submission of business cases where investment or reconfiguration changes are identified.

- The Executive Board is asked to agree for monitoring of the action plan to be overseen by the Associate Director of Community Services & Operations.

- The Executive Board to consider the key messages for escalation to Quality Committee and the Board of Directors.

4.3 Bed Efficiency and Rebalancing

Aims and Objectives of Work

The programme commenced in 2014/15 with enabling work but continues into 2015-16. Further work will progress into 2016-17 .The need to ensure an appropriate bed base within CHFT is crucial. Work undertaken through existing trust schemes such as Care of the Acutely Ill Patient and the Courage to Put the Patient First programme have highlighted the link between patient safety, efficiency and the optimum bed occupancy level. This work stream will aim to further improve efficiency / LOS, standardise occupancy and seek to deliver improved care, reduced reliance on temporary nursing cost avoidance and delivery of the 2015/2016 financial plan. The project will aspire to a 90% occupancy level (16/17) across the adult bed base in this way ensuring patients can access the right bed at the right time. Significant improvement in LOS and Day case rates in order to ensure that we are best in class nationally and ultimately leading to improvements in quality, performance and financial performance.

Current Performance / Improvement Plans for 2015/16

The 2015/2016 Programme has six key work streams:

1. Bed Plan - A detailed bed model built upon contracted activity for elective work and based on trends from the last 3 years for non-elective activity. This work seeks to identify the required beds by week, by division at various occupancy levels. Having this bed model allows us to ensure early planning for flex bed capacity to deal with key pressure points. This will allow smoother patient flow ensuring our patients who need to be admitted have timely access to the right speciality bed as early as possible.

2. Emergency Department / Admission Management-The aim of the ED work stream is to redesign the internal processes of the Emergency Department to facilitate pathways that deliver the assessment and initial treatment of patients on an 'On time, In Full' basis. The work stream will introduce standardised processes for treatment around assessment, treatment and handover in the ED. By this design the organisation can be more confident of its ability to meet the 4 hour target and dovetail ED to the larger hospital economy. In addition to the ED redesign, this work stream will look at the relationship between ED and hospital avoidance, both through redesign of Ambulatory Assessment and initiatives such as ESD and the introduction of the enhanced respiratory service.

3. Ward Efficiency-This will maximise efficiency of inpatient ward areas by designing and embedding a range of processes. These will include;
    - A continued embedding of Plan For Every Patient (PFEP) and an extension of this to include real and measureable problem solving to minimise the common delays to patient journeys.
    - PFEP will be extended to include the Consultant teams in the planning of care and the review of the plan. This will be done using a 'Board Round' model in conjunction with existing ward rounds.
    - Although largely facilitated by the 'In Hospital Flow' work stream, discharging patients at the most appropriate time of day will also form a part of the work stream, with ward areas taking responsibility for planning discharges throughout the day, avoiding batching of discharges for the later part of the afternoon.
    - There will also be an OD element where process will be designed to help the staff on the wards (of all professions) to feedback success in efficiency, and also to voice any concerns or frustrations.
    - Divisional projects such as Enhanced Recovery after surgery will also fall within this work stream.

4. In Hospital Flow- This work stream will design the role and practice of the Clinical Commanders (along with the wider patient flow team) as allow full operational management of patient flow, both internally within the hospital and when patients are being discharged. This will incorporate standardised procedures and processes for bed meetings, ensuring actions are planned and reviewed to completion. This work stream will also look at management of the patient flow by use of levelling discharges and escalation of any potential problems that cannot be solved operationally by the clinical commanders. To facilitate the flow, the discharge coordinators will have a standardised process for planning discharge and using a check/adjust model to ensure actions have been completed.

5. Improvement of Reportable Delays in Transfers of Care- This work will focus on the ongoing projects in which CHFT is working with Local Authority's and CCGs to reduce the number of patients whose discharge/transfer of care is delayed due to sluggish process or lack of necessary social or ongoing health support. The work looks at both internal process and the interface between internal processes and the wider community.

6. External System Capacity- This piece of work is again a collaborative initiative with Local Authority and CCG colleagues. The aim is to carry out an assessment of what community resource is needed to meet demand for services.

4.4 Outpatients – Focus on DNA's

Aims and Objectives of Work

National Context -
The NHS has made good progress over the last year to reduce the number of missed outpatient appointments by over 250,000, against a background of rising demand.

However, during 2011/12 (more recent figure) there were still around 5.5 million missed appointments in the NHS. Overall, the NHS carried out nearly 53 million outpatient appointments – meaning more than one in ten appointments were did-not-attends.

The NHS Constitution makes clear that patients have the right to access NHS services, but patients have responsibilities too – it is important to keep appointments, or cancel within a reasonable time. Otherwise, it can jeopardise patients starting treatment within 18 weeks of a referral.

Figures for 2011/12 show more than 1.5 million of the missed appointments were for first outpatient appointments and nearly four million missed appointments were for follow-up treatment.

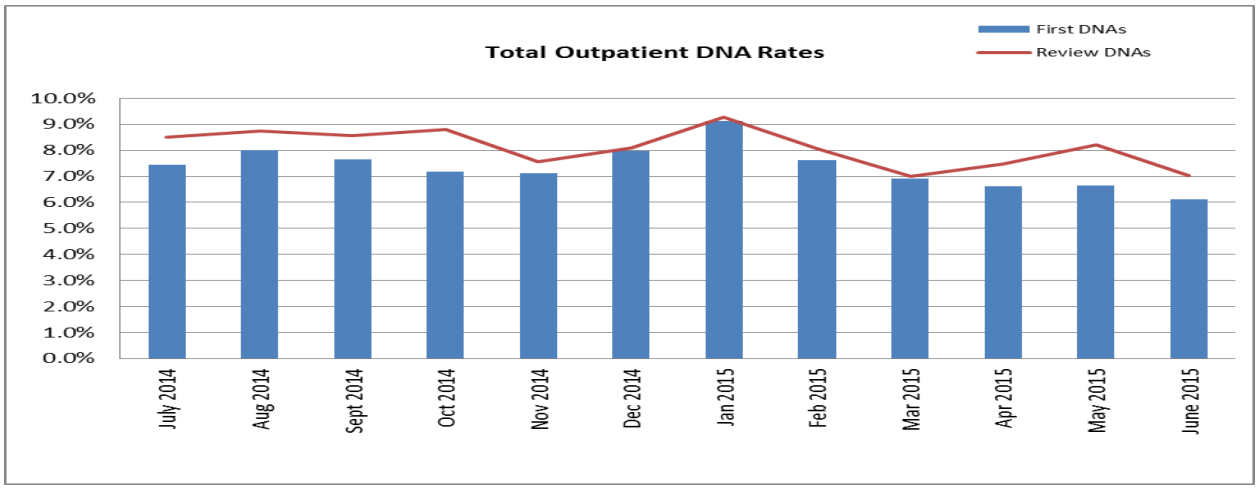
Local Context

Last year in the Trust, (2014-15) 36,099 patients failed to attend their outpatient appointment; this is a reduction on the previous year when 40,880 appointments were missed. Applying an average outpatient tariff of £127 this equates to £4.5m.

As at the end of June, 36,842 patients have missed their outpatient appointment at a cost of £4.6m

Current Performance

The Trust has set a target of 7% for first appointment DNA's. Year to Date performance is 6.1%. A target of 7.5% is in place for Follow-Up DNA's, year to date performance is at 6.4%



DNA Policy

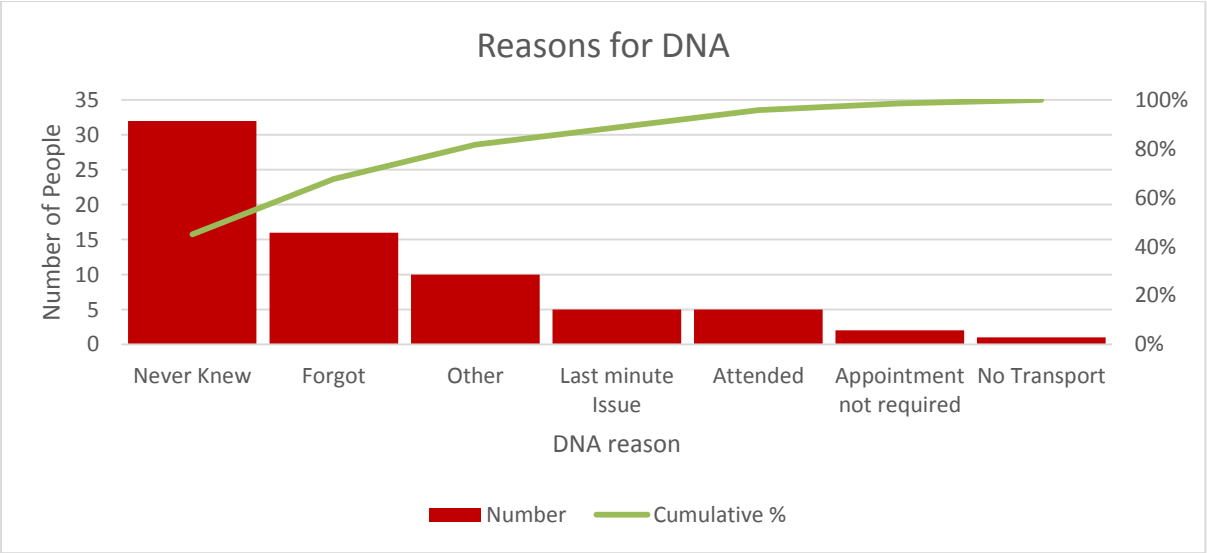
Patients that fail to attend their outpatient appointment are managed via the terms of the Trust Patient Access Policy.

Patients who do not attend their first outpatient appointment should be discharged back to the referrer and their 18 week clock will be stopped. In terms of Follow-Up Appointments no more than two consecutive DNAs should be permitted except in exceptional circumstances.

The exception to this will be where, in the clinical judgement of the consultant the patient needs to be offered another appointment

Reasons for DNA

A recent survey of patients that have DNA'd appointments have provided the following reasons for DNA:



Reminder Service

In June 2013, the Trust moved to a new service provider for appointment reminders. The new service now includes 2-way text and Interactive Voice Messaging; the latter went live early September. The service offers:

- Interactive Voice Messaging with human voice to landline
- 2-way SMS Text to mobile
- Partial Booking Contacts
- Email Reminder
- Ability to inform a group or individual patients of changes to clinic or appointment.
- Ability to identify available clinic slots and offer appointment to patient via SMS, Interactive or email and connecting to CHFT Appointment Centre on acceptance.
- Ability to cancel or change with the option of rebooking by auto connection to CHFT Appointment Centre
- Ability to target specific patient groups utilising Qlikview intelligence

SMS Reminders

An SMS reminder is sent to the patient 7 days prior to the appointment with the following message:

You have an appt @ Huddersfield Royal on 21/09/13@15:30.To rebook call 01484 355370 to cancel reply "CANCEL 2473" Cancelling will result in discharge.

A second reminder is sent the day before the appointment.

Interactive Voice Message (IVM)

The software firstly checks for a mobile number, and if not found will use the landline number. The IVM includes a patient verification, asking the call receiver to confirm they are the person the reminder is intended for. Eight attempts are made to contact the patient via the landline number.

On confirmation, the IVM enables the patient to confirm attendance, or to be put directly through to the Appointment Centre at CHFT, to rebook.

Reminder Performance Data

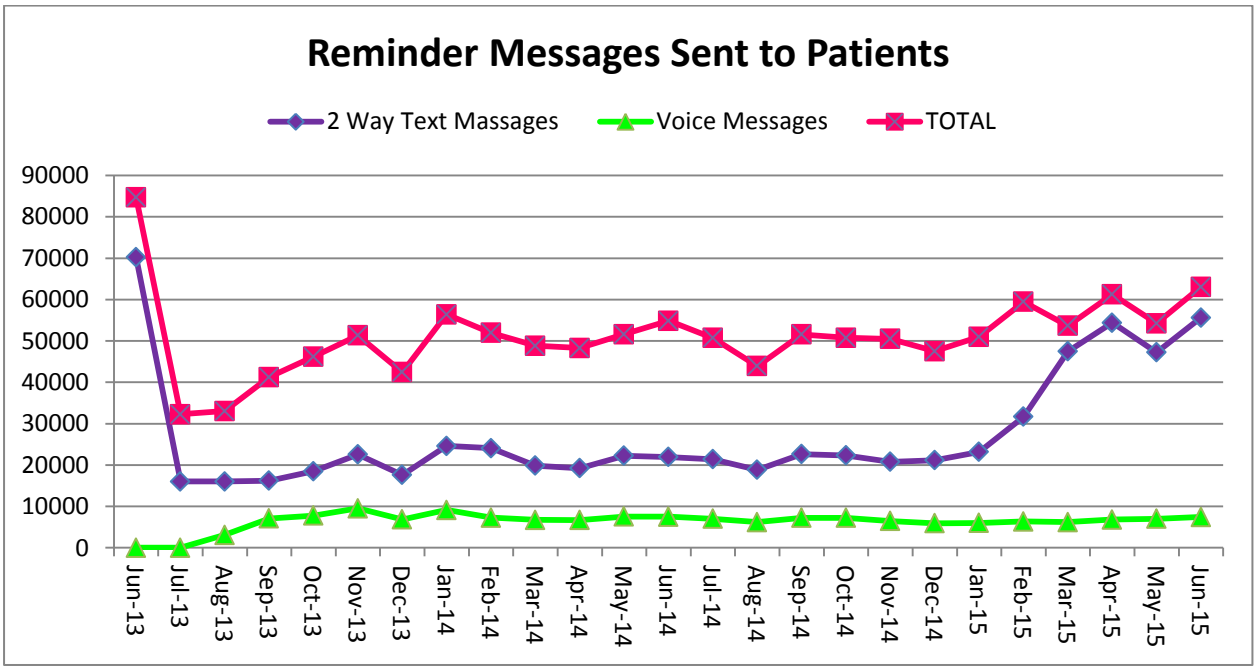
The software includes detailed reports of activity, including failed reminders. This will greatly assist with data quality improvements. The table and graphs below show performance to date.

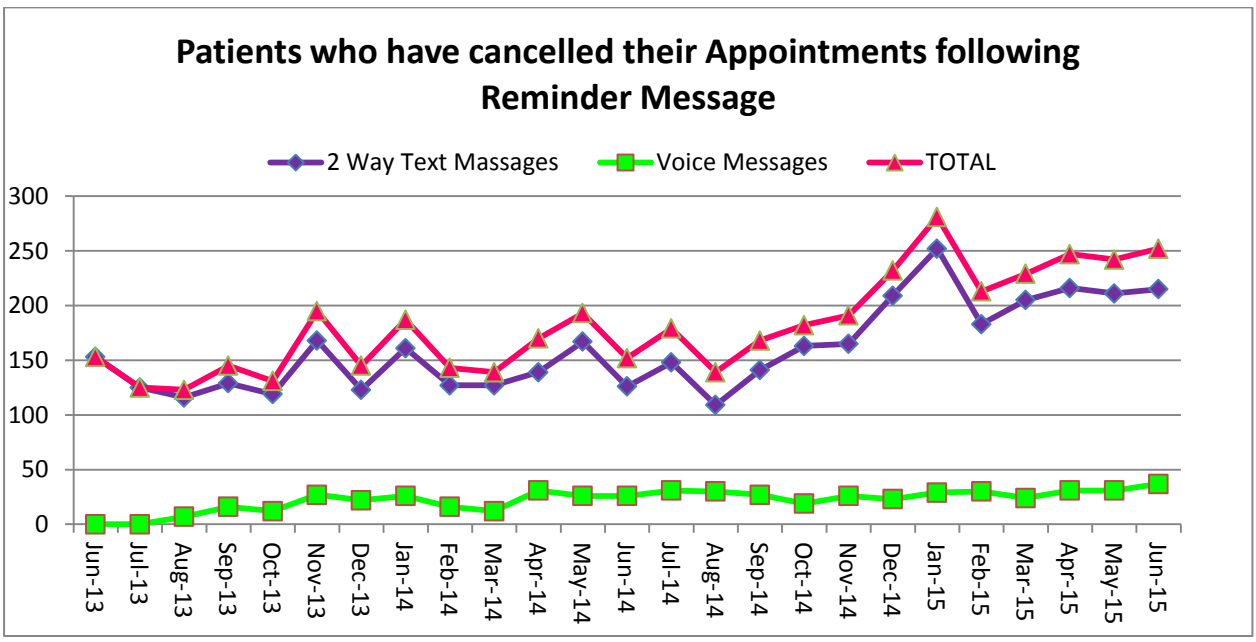
TOTAL – SMS

	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
In Transit	397	189	143	286	351	22710	1631	148	519
Delivered	19092	17854	18374	19853	27612	21723	45922	41085	47953
Failed	2859	2756	2671	3029	3740	3036	6844	6022	7145
Cancel	163	165	209	252	183	205	216	211	215
Total Sent	22348	20799	21188	23168	31703	47469	54397	47255	55617

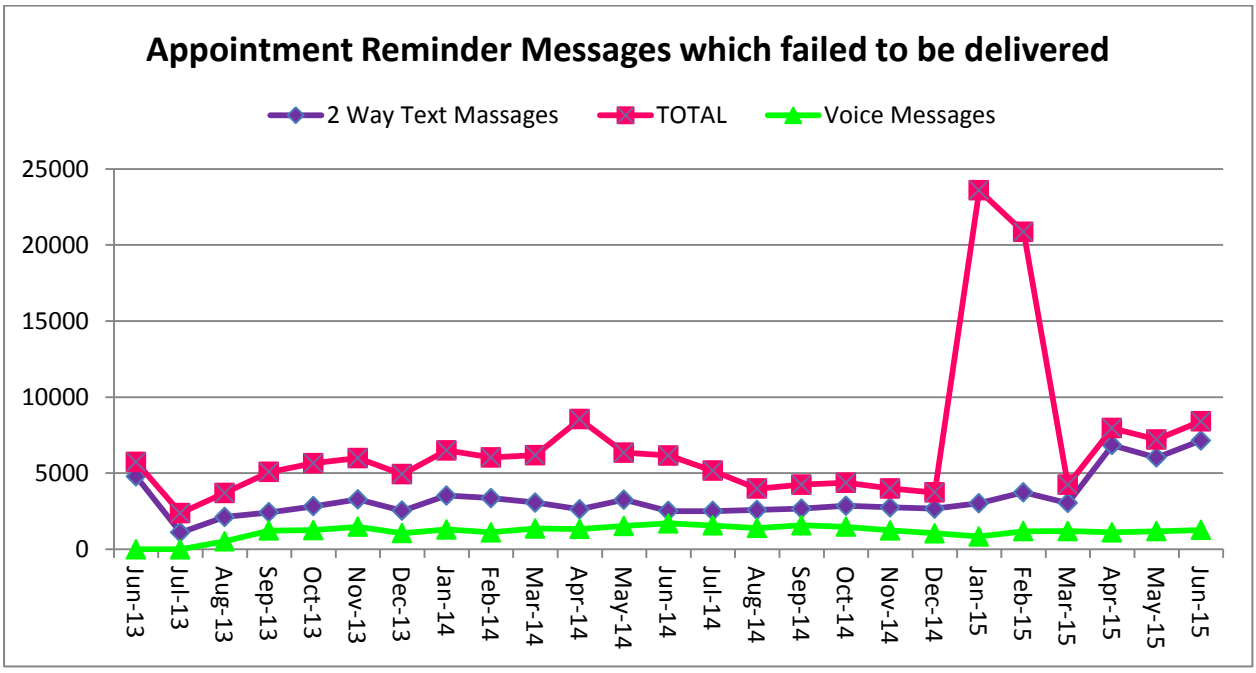
TOTAL – IVM

	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
In Transit	6	1	0	7	27	37	9	3	6
Delivered	5757	5260	4897	5164	5162	4957	5705	5811	6161
Failed	1481	1235	1045	833	1186	1194	1114	1188	1265
Cancel	19	26	23	29	30	24	31	31	37
Total Sent	7244	6496	5942	6004	6375	6188	6828	7002	7432





The SMS informs the patient that if they choose to cancel the appointment via SMS they will be discharged. In order to ensure that the clinical care is not compromised, monthly reports of cancellation messages are sent to each Clinical Manager, and the episode is not closed on PAS until the Manager is satisfied that the discharge outcome is appropriate.



*** Please note that the January and February 2015 second reminders failed due to changes with NHS Mail ***

Where a SMS or IVM message has failed to deliver, a list by Clinic Code is generated each day for the relevant Outpatient Clinic so that the details can be checked with the patient at the next visit. Our efforts are now being focussed on failed messages, and improving our data quality and we have Change of Contact Details forms for all outpatient areas and the Self Check In software has been upgraded to enable patients to update their personal contact information. This has been a huge success and the results are evident in the increase in SMS reminders.

Other Initiatives to reduce DNAs

In order to continue to improve the DNA performance standard a number of other initiatives have been agreed and are underway:

- **Partial Booking for >6week Follow-Up Appointments**

All Services have now moved to partial booking and patients now book an appointment within 3-4 weeks of the due date, thus reducing the risk of DNA.

A number of enhancements have been added to PAS to provide robust reporting information to support partial booking. This ensures that each specialty is aware of the capacity and demand requirements.

- **Cancelling / Rebooking On Line**

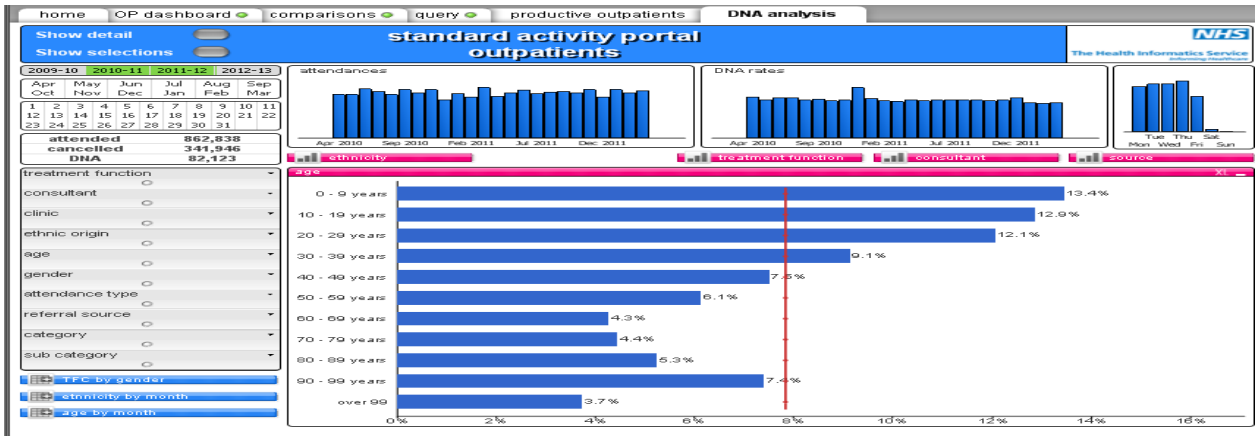
Recognising that patients may wish to contact us to cancel or rebook their appointment, thus avoiding a DNA, the Trust public website includes an On-Line form for patients to complete and discussions are underway to develop email communication with patients. This service is well utilised.

- **Appointment Letters**

The style and content of appointment letters has been reviewed and a new clearer design and format has been introduced. The service provided by the downstream mail provider includes mail piece tracking so that the source of delayed/lost mail can be traced.

- **Qlikview Intelligence**

By utilising collated DNA data from within the HIS Qlikview software, by age, ethnicity, treatment function, source, we can now identify those patients most likely to DNA (As per the screen shot below), and those less likely, therefore not requiring a reminder.



Additional staff have been recruited to contact patients in the high risk category (males aged 21-35) the evening before the appointment as an additional reminder to the automated reminder systems.

- **Compliance with DNA management procedures**

Continuing adherence to the DNA policy (Patient Access Policy 2014) will minimise repeat DNA offenders. Patients who do not attend their first outpatient appointment should be discharged back to the referrer and their 18 week clock will be stopped. In terms of Follow-Up Appointments no more than two consecutive DNAs should be permitted except in exceptional circumstances. Compliance with policy is being monitored at Divisional level.

Improvement Plans for 2015/16

Reminder Service

The SMS and Interactive Voice Messaging continue to deliver a reduction in missed appointments, and patients are now able to update contact numbers at the self-checking kiosks.

Evening staff have now been recruited to support the extended working in OP reception, the role includes telephoning potential DNAs as an added precaution - the work will focus on high DNA clinics and age ranges.

Outpatient Restructure

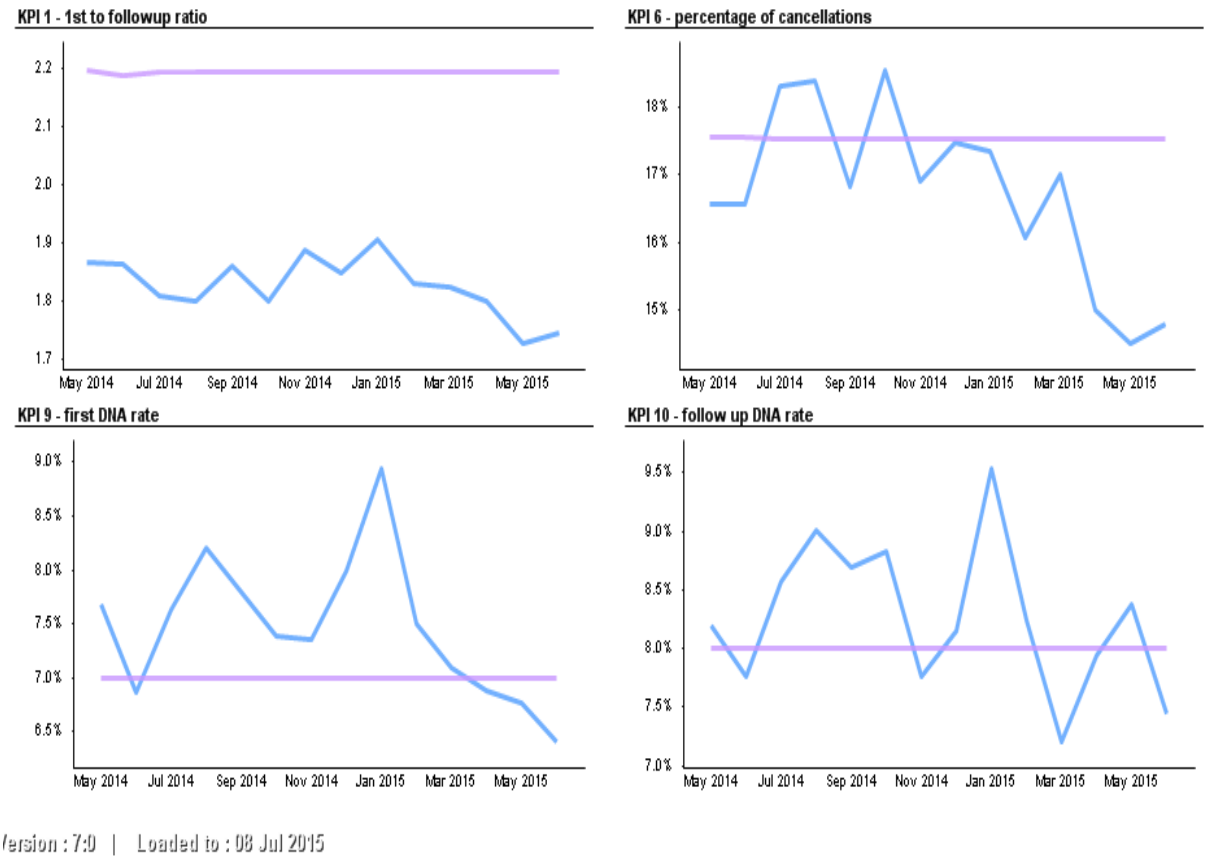
With effect from 1st April Surgical, Medical, Orthopaedic and ENT outpatient services have been centralised under the umbrella of the Family and Specialist Service Division and now form part of the Outpatient and Records Directorate. A Matron has been appointed specifically for outpatients with a focus on visible, accessible and strong clinical leadership; service quality and development; and the patient's experience of safe, timely and effective care in outpatients.

Outpatient Productivity

A number of performance measures have been agreed with clinical divisions, to improve outpatient performance and productivity and specifically focus on:

- New to Follow-up Ratios
- Hospital Cancellations
- DNA's
- Clinic Utilisation.

The screenshot below shows the May 14 – June 15 performance.



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4.5 Diagnostic Waits

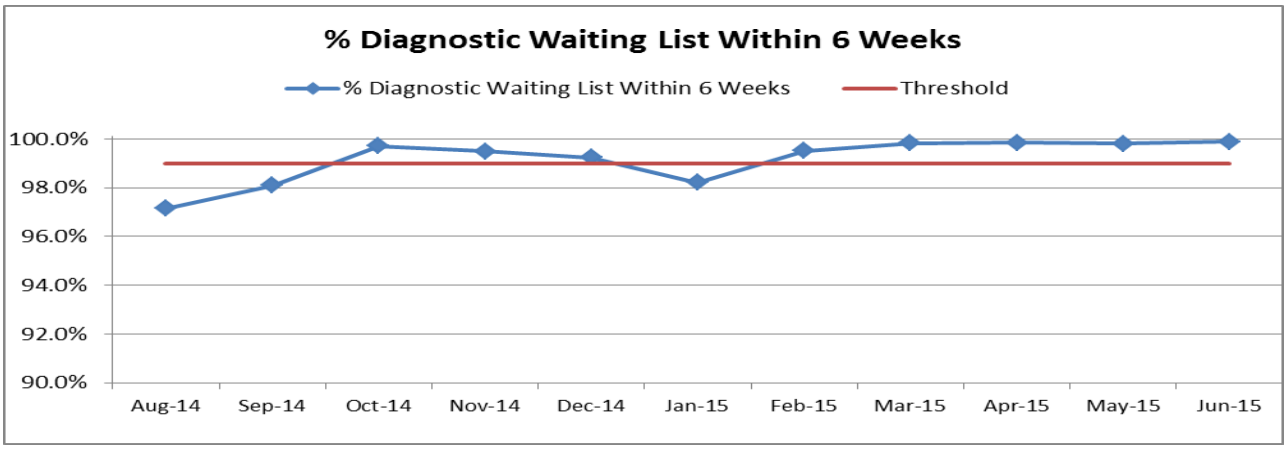
Aims and Objectives of Work

There is a national target set for all diagnostics to ensure initial diagnostic tests are delivered within 6 weeks or less. The target was initially introduced to assist with the delivery of 18 week referral to treatment initiative as diagnostics are integral to the majority of pathways,

The threshold for performance is >99% in any month.

Current Performance

The Radiology diagnostic 6 week target continues to be met in as shown below:



Apr-15	May-15	Jun-15
99.98%	**99%**	99%

- Additional mobile MRI capacity is still secured for the remainder of the financial year.
- The third MRI scanner which will see additional capacity benefits is on target for installation February 2016 - further reducing patient waiting times and thereby improving the patient experience
- Monthly capacity and demand meetings are held within radiology to track performance across all modalities and ensure corrective actions are put in place to avoid any breach of the target.
- Performance on waiting list is actively monitored on a daily basis

4.6 Cancer Waiting Times

Aims and Objectives of Work

Delivery of the National Cancer Targets is a key part of cancer care and the Trust's performance around these key targets is a significant indicator of the quality of cancer services delivery.

High quality and accurate data is key to improving services and positive outcomes for patients, the Trust continues to be committed to supporting Cancer Outcomes and Services Dataset (COSD).

The Trust seeks to ensure all patients are treated with dignity, respect and in a timely manner ensuring that any delays are removed from the pathway where ever possible.

There are seven National Cancer Waiting Times Targets:

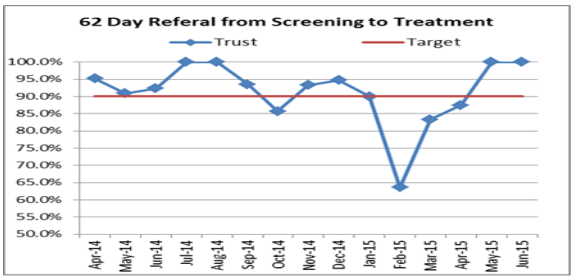
Target	Description
Two Week Wait Standard:	All patients urgently referred by their GP with a suspicion of cancer should wait no longer than 14 calendar days from the date the referral is received by the hospital to the date they are first seen in hospital.
31 Day Standard:	All patients who are newly diagnosed with a cancer should wait no longer than 31 calendar days from the date of decision to treat to receiving their first treatment.
62 Day Standard:	All patients who are urgently referred by their GP with a suspicion of cancer (Two Week Wait Standard) who are subsequently diagnosed with cancer should wait no longer than 62 calendar days from the date the referral is received by the hospital to the date of their first treatment.
Two Week Wait Symptomatic Breast Standard:	In addition to all patients with suspected cancer, all patients referred with any breast symptoms should have their first hospital appointment with 14 calendar days of the referral being received at the hospital even if cancer is not suspected.
31 Day Treatment Standard:	The 31 Day Standard applies to all cancers, irrespective of whether they are new or recurrent, relapsed or metastatic. In addition all surgical and drug therapy treatments (not just first treatment) are subject to a 31 Day Standard, e.g. a patient receiving surgery post radiotherapy must receive their surgery within 31 days of the decision to treat surgically being made.
62 Day National Screening Standard:	The 62 Day Standard now applies to referrals from National Screening Services (Bowel, Cervical and Breast screening). So patients diagnosed with a cancer that has been detected via the screening programme will need to start their treatment within 62 days of the screening referral.
31 Day Standard:	All subsequent treatments (not just surgery and drug therapy) will be subject to the 31 Day Standard, so every new and subsequent treatment is required to be delivered within 31 calendar days of a decision to treat date or an 'earliest clinically appropriate date'.

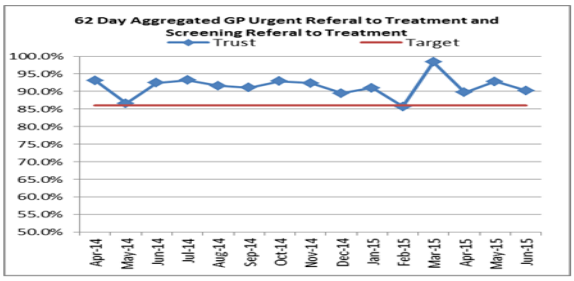
Current Performance

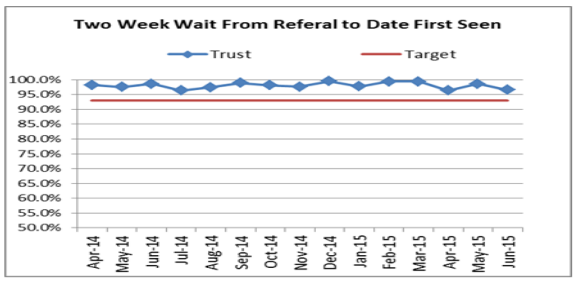
The Trust has achieved all 7 of the national standards for Quarter 1. An 8th measure which aggregates all the 62 day performance indicators are therefore also been met.

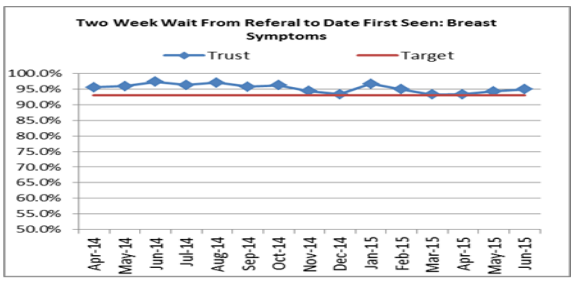
Significant progress has been made in delivering important aspects of cancer services leading to falling mortality rates and consistent achievement of the cancer waiting times.

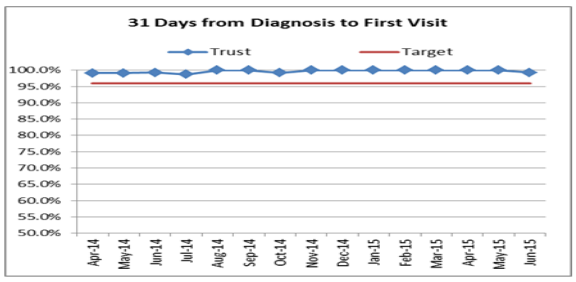
All issues have been regularly discussed at the Cancer Locality Board and Planned Care Board so that the GPs receive feedback along with ourselves and Ppublic Health; so that we can education patients in the importance of being treated early.

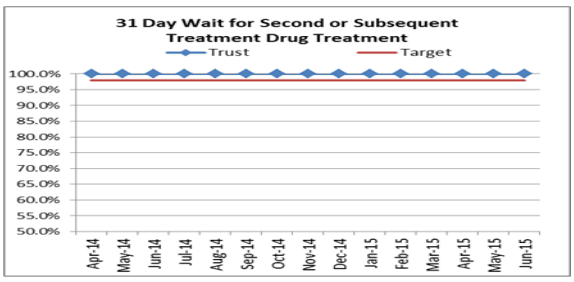


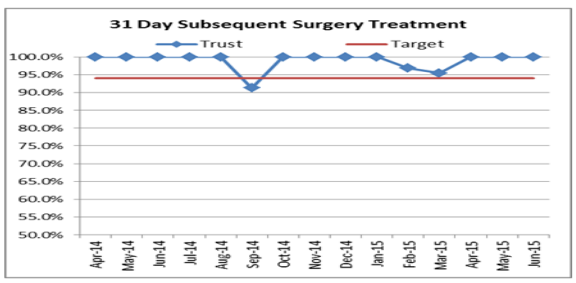


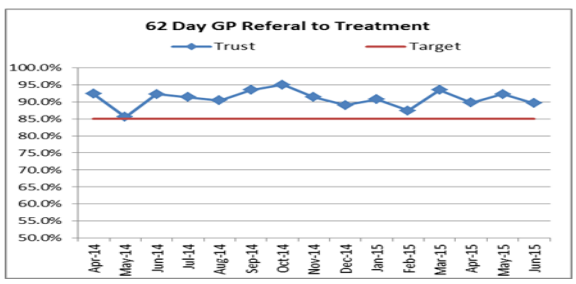












Alongside the national standards the trust is looking to report on regional targets to ensure patients are transferred to specialist hospitals in a timely fashion. This will aim to:

- See Fast Track patients within 7 days

  At present, 71% of patients are being seen within 7 days of referral which is excellent compared to the 30% we were achieving in April 2014.

- Provide diagnostics tests within 7 days

Unfortunately the 7 days to Diagnostics target which was an aspiration of WEB has not been successful and needs continued action to ensure this is achieved so that the measures become sustainable.

- Carry out any Inter Provider Transfers (IPT) by day 38

The Trust has issues meeting the target of referring 85% of patients to Tertiary centres by day 38 of their pathway. For February the Trust only managed to send 42% of patients by this target which is much lower than we would wish to have achieved at this point in the year.

Improvement Plans for Q2 forward

A further review with the Divisions is to take place during June/July 2015 to address how the teams can operate differently to meet the 38 day referral to Tertiary centre. An action plan has been put in place by each division as to how they are going to rectify the poor performance and this will have to be closely monitored throughout the year.

From the Improvement plan set out by NHS England, NHS TDS and Monitor the Trust has completed their self-assessment and put together an action plan to achieve all the eight key priorities for the Cancer Waiting Time Standards within this financial year.

4.7 Theatre Utilisation

Aims and Objectives of Work.

The Trust Operating Theatre Utilisation can fluctuate and the data used to collect information around the theatre pathway was historically paper-based. In 2014 Bluespier was launched in theatres providing a system which could time the patient journey from admissions unit through anaesthetic start, procedure start, into recovery area and discharge. The system also provides electronic pre-operative assessment and has a stock module which will enable us to more accurately keep the stock we need when we need it. Reducing cancellations on day, ensuring patients are optimised for their procedures and providing a seamless and high quality experience is what we are committed to deliver and with this in mind, further work has commenced around actual surgeon 'touch time' in theatres (that is the time spent actually operating) and reducing the wasted time waiting between cases. It has been identified that there are opportunities to optimise theatre space further. The theatre refurbishment at HRI is progressing well and is planned to be completed in December 2016.

We were committed to ensuring that any changes to our Patient Pathway were aligned to the CQC standards for patient care and that the safety and the quality of care was paramount in all we did.

Current Performance

Trust Theatre Utilisation	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	YTD
Trust	92%	92%	93%	91%	90%	90%	95%	91%	93%	91%	93%	94%	92%
Surgical	92%	92%	92%	91%	90%	90%	96%	97%	93%	91%	93%	93%	92%
CWF	94%	94%	101%	93%	92%	93%	94%	90%	99%	100%	105%	110%	98%

Improvement Plans for 2015/16

Throughout the coming year we will continue to focus on efficiencies and the quality of service that we will be delivering for our patients.

We are continually reviewing best practice, monitoring our Theatre productivity and utilisation on a weekly basis via a Theatre Scheduling and Activity group utilising Bluespier to ensure that our theatres are optimised. This will enable us to treat patients more quickly and safely.

We have commenced work with an external agency Four Eyes who have identified further 'in theatre' opportunity for our surgical specialties.

We continue to use technology to harness some theatre efficiencies; working closely with our clinical teams, this will ensure that patients we treat; receive the best possible care during their stay with us.

We are redesigning our Surgical Pre-Operative Assessment Service Model to provide a more seamless service without the need for patients to travel all over the hospital and included in this will be early morning or evening sessions for patients to attend.

We have changed our Management Structure in the Directorate of Operating Services which will enable us to drive through standardisation of systems and process around the patient journey.

We are re-locating our Admissions Unit at HRI to a more patient-friendly area and plan to make this a place where patients can be relaxed and looked after prior to their surgery.

We are re-locating Pre-Assessment to a more patient-friendly area also which will include a treatment room and better facilities.

Domain Five – Well Led

Well Led Compliance summary:

Indicator	Compliance
5.1 Safe Staffing	Reporting Only
5.2 Mandatory Training	Partial Compliance
5.3 Appraisal	Partial Compliance
5.4 Patient and Public Involvement (6 month review)	Reporting Only
5.5 Sickness/Absence	Reporting Only
5.6 Staff Experience and Engagement	Reporting Only

Highlights:

5.1 Safe Staffing	Some improvement in qualified fill rates for nursing and midwifery staff.
5.2 Mandatory Training	Training targets for Q1 achieved for Equality and Diversity and Health and Safety
5.5 Sickness / Absence	Two divisions within 4% threshold for low levels of sickness absence rates: - 1.97% in the corporate division. - 3.2% in the community division

5.1 Safe staffing

Aim and Objectives of Work

The Nursing and Midwifery workforce group implement and lead the Nursing and Midwifery Workforce Strategy, providing monitoring and assurance of the Nursing and Midwifery Workforce across the Trust.

Objectives include:

- To set direction of the Nursing and Midwifery Workforce including defining, monitoring and continually updating the Trusts policies and procedures to ensure that the workforce is safe, effective and able to deliver high quality compassionate care consistently;
- To monitor and manage the Hard Truths requirements ensuring data is accurate, utilised to provide assurance and incorporated into workforce planning;
- To define standards for the workforce;
- To oversee nursing establishments which are linked to acuity and dependency studies, activity follows and NICE guidance on Safe Staffing

Current Performance

Within the last quarter the Nursing workforce have continued to record and publish staffing levels recording the planned nursing hours against the actual nursing hours worked as one safe staffing indicator. Compared to the same point in time last year the Qualified fill rates are improving but there is still some way to go.

Average fill rates comparison June 2014 – June 2015

	June 2014	June 2015
Average Fill Rate Day - Qualified Nurses / Midwives	86%	90.07%
Average Fill Rate Day - Unqualified Nurses / Midwives	98%	95.68%
Average Fill Rate Night - Qualified Nurses / Midwives	84%	88.81 %
Average Fill Rate Night - Unqualified Nurses / Midwives	122%	113.16%

The web based daily staffing tool has been adopted in all acute inpatient ward areas for recording staffing levels since January 2015. The comments added on a daily basis provide evidence of the reasons for actual levels being away from plan. In order to cover shifts safely within the bed base and the flexible capacity areas, within the medical division nurses have been working long days to cover shifts, despite the workforce model recommending shorter shifts. This has the result of appearing that the fill rates are lower than plan; however the number of nurses was adequate.

In May 2015 the safe staffing section of the Integrated Board Report was extended to provide greater analysis of the staffing position reported to Board on a monthly basis.

In May 2015 ward dashboards were commissioned from the Health Informatics team by the Nursing Workforce Strategy Group to monitor the impact of changes made to workforce

models in April 2015, and clearly present month on month data for key performance indicators such as vacancies; red flag staffing events and probationary reviews. The first dashboards were received in July and will be reviewed monthly within divisions. The data will be monitored over the next 3 months with plans to benchmark and RAG rate to ensure performance is managed.

In June 2015 the current workforce models were systematically assessed at ward level using a number of factors to inform the nursing establishment required to provide safe nursing care.

Contact time studies were completed in all inpatient ward areas as part of the staffing review as recommended by NHS England. The results provided the percentage of direct and indirect patient contact time for both qualified and unqualified staff alongside analysis of the tasks which were completed.
Each area has identified a quality improvement initiative to focus upon following the contact time study results such as reducing the handover time. The study will be repeated in December 2015.

Acuity and Dependency studies were repeated in June using the NICE approved tool - Safer Nursing Care Tool. A multi-agency review of the Safer Nursing Care Tool Acuity study results, contact time results, fill rates and nurse quality indicators combined with professional judgement has enabled the Associate Directors of Nursing to recommend to the Nursing Workforce Strategy Group workforce models required to provide safe care. Recommended changes to workforce models resulting from the June reviews will be made to Board from the Nursing Strategy Group in September 2015.

Acuity and Dependency studies in paediatrics remain outstanding as we await an adapted Safer nursing care tool for paediatrics which, whilst expected in May 2015, has been delayed.

Nursing safe staffing red flag events have been promoted since April 2015. Information sessions have been provided alongside posters and credit sized information cards which have been provided for all members of the nursing workforce group. The cards provide a reminder of the red flag events and the process for escalation and recording on Datix. Datix has yet to be fully developed to allow red flag incidents to be easily and accurately recorded, but a prompt to ascertain if the incident is a red flag event is now in place.

Recruitment

Recruitment has remained a key focus through quarter 1 with a number of initiatives completed including:

- Recruitment events at 4 local universities
- 3rd year student nurses recruited earlier than in previous years
- Nurses recruited offered “keep in touch” events from CHFT nurses
- Welcome event hosted 50 soon to be qualified nurses due to start at CHFT in September
- Newly developed preceptorship programme to support induction and first six months at CHFT
- International recruitment campaigns to both Spain and Romania

The success of the recruitment initiatives will not be fully realised and evaluated until October when the number of new recruits are confirmed starters at CHFT.
A positive review of the international recruitment campaign completed has been completed and will form part of the nursing workforce paper due to be presented to Board in September 2015.

Retention of the nursing workforce remains a priority for the Nursing Workforce Strategy Group. Increased facilitation of internal transfers for Band 5 posts have been completed within the last 3 months with feedback indicating that this is preferred to rotational programmes.

Completing face to face interviews for colleagues leaving CHFT has remained a challenge for senior nurses to complete. The Nursing Workforce Strategy Group have worked with the ESR team to create an alert when termination forms are completed. This will provide a trigger for a face to face leaver's survey to be offered by a senior nurse.

Analysis of leavers surveys between November 2014 – June 2015 has been reviewed by the Nursing Workforce Strategy Group and an action plan agreed.

Improvement plans

- Review ward based dashboards to monitor compliance with key quality indicators including completion of probationary reviews
- Preceptorship register to commence September 2015 to provide record of preceptorship offered to each new starter within the nursing workforce
- Temporary Band 6 role to commence September 2015 to support newly qualified nurses in their transition to their new posts within CHFT
- Preceptorship programme including a one week induction and scheduled monthly events to commence September 2015
- Clinical Supervision policy to be completed and Clinical Supervision to be offered to the nursing workforce
- Introduction of revised local induction tool
- Review of recruitment processes with Workforce and Development colleagues
- Launch of Daily Site Staffing View. This will replace the current site co form and provide the current staffing position for the nursing and midwifery workforce and the forecast for the next 24 hours. It will also provide a record of any risks; action taken; and the number of temporary staff utilised in each are per shift.

5.2 Mandatory Training

Aims and Objectives of Work

From 1 June 2015 a new mandatory training framework was introduced in CHFT. It is called the core skills training framework (CSTF). Here is a link to more information about the framework
http://www.skillsforhealth.org.uk/services/item/146-core-skills-training-framework

This approach brings a number of key benefits for the Trust.

These include:

- Clarity of the mandatory suite of learning
- Extended refresher periods reducing repeat training for individuals
- Use of shared e-learning packages reducing the need to create CHFT specific learning
- Access to learning packages from many devices and locations reducing the need to bring colleagues into limited classroom Shared learning objectives with all other CSTF aligned organisations allowing 'passporting' of colleague learning from organisation to organisation thus reducing unnecessary re-training
- Release of subject matter experts from numerous classroom sessions allowing their time to be spent on more high risk learning tasks

The subjects covered by the framework are as follows:-

- Equality, diversity and human rights
- Fire safety
- Health, safety and well being
- Infection prevention and control
- Information governance
- Moving and handling
- Prevent
- Safeguarding children and adults

Two further subjects are in development and will be available later in the year. They are as follows:-

- Conflict resolution
- Dementia awareness

Current Performance

Mandatory Training Indicators completetd since April 2015								
Division	Prevent	Equality & Diversity	Information Governance	Infection Control	Health & Saftey	Manual Handling	Safe Guarding	Fire Saftey
Surgery	4.9%	13.60%	16.50%	8.90%	8.90%	8.40%	5.4%	13.60%
Medical	1.8%	9.00%	16.60%	7.30%	7.00%	7.00%	3.3%	11.80%
FSS	2.9%	11.10%	17.30%	8.90%	7.80%	8.30%	3.3%	25.70%
Community	3.6%	10.50%	14.80%	6.40%	5.10%	6.60%	3.0%	18.20%
Estates	0.6%	4.40%	9.10%	5.60%	5.00%	5.30%	2.6%	25.30%
Corporate	3.9%	14.30%	17.20%	13.00%	11.70%	12.00%	8.1%	31.80%
THIS	16.8%	19.00%	14.50%	14.50%	15.60%	15.10%	6.1%	14.50%
Trust	**3.5%**	**11.10%**	**16.10%**	**8.50%**	**7.90%**	8.10%	**4.0%**	**19.00%**

The renewal periods for the mandatory subjects are of various lengths, some being annual where the subject matter experts feel that colleagues need very regular updating. Other

subjects have a stretched renewal period of two or three years. In this case the target number of colleagues expected to adhere to new training each year will vary from the 100% target. For example; equality and diversity has a three year renewal and therefore only 33% of colleagues will be expected to attain compliance on this module each 12 month period.

Given that understanding, the following table shows the organisation's performance for the first quarter. Those subjects achieving training targets are shown as green and those failing to achieve the target in red.

Subject	Renewal Period In Years	Percentage Of Staff To Achieve Compliance Per Year	Quarter Target	Quarter Compliance	RAG
Equality & Diversity	3	33%	8%	11%	
Fire Safety	1	100%	25%	19%	
Health & Safety	3	33%	8%	8%	
Infection Control	1	100%	25%	9%	
Information Governance	1	100%	25%	16%	
Manual Handling	2	50%	13%	8%	
Prevent	1	100%	25%	4%	
Safeguarding	3	33%	8%	4%	

Improvement Plans for 2015/16

Elements of the improvement plan already achieved in quarter one. These include;

- Mandatory training elements clarified and supported by the Executive Board April 2015
- E-learning packages introduced for most elements of mandatory training from May 2015
- Data capture and reporting mechanisms standardised from May 2015
- ESR Business Intelligence tool roll out into clinical divisions from May 2015
- CHFT declaration of alignment to the CSTF achieved in May 2015
- Mandatory training portal on the intranet established in May 2015
- CHFT induction portal on the intranet established in June 2015

Work to embed the CSTF and to increase colleague awareness of their responsibilities will continue throughout 2015/2016.

From August a 'comply or explain' approach will be adopted requiring divisional colleagues to identify the barriers to improved performance and plans to move into compliance.

The timelines for improvement through 2015/2016 includes the following items:

- Monthly enhancements to the web portal
- Continued communications interventions including CHFT Weekly and Line Manager Bulletin articles. Trust-wide e-mails and payslip briefing sheets for all colleagues. Displays in the dining room and Acre Mill (admin block) lobby areas and personal briefings by the Head of Workforce Development via divisional and speciality set-piece meetings. This activity will occur throughout July to September 2015
- Desk top sessions scheduled for the year to support individual colleagues with their e-learning

- From late July 2015 Divisional/Corporate Function leads will receive the appraisal and mandatory training planning tool that has been developed by THIS and Workforce Information. This will enable Divisional/Corporate Function leads to plan in the 8% month on month activity required to achieve compliance targets
- Improved staffing levels with newly qualified nurses and midwives recruited from September 2015

5.3 Appraisal

Aims and Objectives of Work

A formal annual appraisal process provides employees with information around how they may be perceived within their team and organisation and offers constructive feedback about their performance at work. A good appraisal also helps colleagues understand the strengths they should capitalise on and the weaknesses where improvement may be required. This helps to ensure that each individual in the team understands how their input contributes to the whole and how achieving their goals will ensure the organisations vision of compassionate care is delivered.

The aims of appraisal are

- To ensure all colleagues have access to a simple and effective appraisal structure
- To maximise progress using that simplified structure towards the 100% annual target
- To facilitate effective and timely reporting for the organisation to ensure compliance

Current Performance

7.24% of appraisals were completed in the first quarter against a target of 25%. No division met their target.

Appraisal- Completeted Since April 2015		
Division	**Compliance**	Quarter Target (24%)
Surgery	5.70%	
Medical	9.00%	
FSS	7.40%	
Community	9.40%	
Estates	1.80%	
Corporate	2.00%	
THIS	5.60%	
Trust	**7.24%**	

Improvement Plans for 2015/16

Throughout 2014/15 work continued with divisional colleagues to standardise the data capture and reporting mechanism for appraisal compliance. There is now an agreed model in place,

with ESR as the prime data source for this measure. Divisions have struggled with continuity of data capture due to sickness and staffing issues. In most cases new colleagues to perform this function have now been identified and trained.

In order to deliver 100% compliance in the period 1 April to 31 March at least 8% of colleagues must be appraised each month. In 2015/16 work with the divisions will focus on making more robust plans to spread appraisal activity over the 12 month period as the bulk of appraisal activity is currently focussed into the last quarter of the year. To assist with this an appraisal planning tool has been developed by THIS and workforce information colleagues. The tool has been tested in Workforce and OD and will be available for use by divisional colleagues in late July. The tool will enable an assessment to be made of planned activity against actual activity each month facilitating a forecast position to be determined month by month. From August a 'comply or explain' approach will be adopted requiring divisional colleagues to identify the barriers to improved performance/delivery of the monthly 8% compliance target and plans for moving performance into compliance. Individual meetings with divisional leads are being scheduled about the appraisal planning tool and compliance reporting approach.

Line manager resources and information available through dedicated appraisal web pages are being further enhanced.

A new e-learning package is in design to further support the achievement of this target by creating greater flexibility and structure to the process in terms of the required documentation and recording of the discussion.

The timelines for these improvements are as follows:

- Data capture and reporting mechanisms standardised from May 2015
- ESR Business Intelligence tool roll out into clinical divisions from May 2015
- Divisional/Corporate Function leads to produce schedule of planned activity July/August 2015
- Appraisal planning tool available from late July
- Refresh training for managers during 2015
- Improved staffing levels with newly qualified nurses and midwives recruited from September 2015

5.4 Patient and Public Involvement

Aims and Objectives of Work

Involving patients and the public in planning, monitoring and developing health services enables the Trust to ensure that services are responsive to individual needs, are focused on the needs of our patients and the local community local community and support us in improving the quality of care that we provide. On a one to one basis patients feel involved in their care when they are treated as equal partners, listened to and properly informed, making them feel valued and appreciated

Due to being a foundation trust, we have a legal required to involve our patients in:

- How we plan and provide our services
- How we develop and consider proposals to change the way we provide our services
- Decisions that affect how we operate our services.

A detailed report into patient and public involvement work will be available as part of the Q2 report.

5.5 Sickness and Absence

Aims and Objectives of Work

The Trust has a strong emphasis on the well-being of colleagues to allow them to fulfil their roles effectively in an environment conducive to their welfare. The Trust's Attendance Management Policy supports the regular attendance of staff at work and enables managers to manage attendance fairly, with the focus on rehabilitation and return to work wherever possible.

The Trust aims to keep the % of Full Time Equivalents (FTE) on sick leave in any one period below 4%, which is the threshold set by the Trust.

The table below shows the Trust's performance against the agreed 4% threshold for Quarters 2, 3 and 4 in 2014/2015 and Quarter 1 for 2015/2016.

Quarter	CHFT (%)	Trust Threshold	RAG
2014/2015 Q2	4.11%	4.00%	🔴
2014/2015 Q3	4.66%	4.00%	🔴
2014/2015 Q4	4.61%	4.00%	🔴
2015/2016 Q1	4.43%	4.00%	🔴

Current Performance

The sickness absence rates for Quarter 1 in 2015/2016 are broken down by division in the table below.

The highest sickness absence rates occur in the Estates and Facilities Division with 6.12%. The lowest rates occur in Corporate Division with just 1.97%.

Division	Quarter to date Sickness %	RAG
Surgery	4.25%	🔴
Medical	5.30%	🔴
Community	3.20%	🟢
FSS	4.96%	🔴
Estates	6.12%	🔴
Corporate	1.97%	🟢
THIS	4.77%	🔴
Trust	**4.62%**	🔴

Improvement Plans for 2015/16

There are a number of key interventions planned to address the current rate of sickness absence:

- In-depth analysis of attendance management issues and key findings to be taken to the Board of Directors on 30 July 2015
- Attendance management policy updated – to be taken to Policy Sub-Group and Staff Management Partnership Forum in July 2015
- A comprehensive Health and Wellbeing Strategy is currently being developed and will be ready by the end of August 2015
- Enhanced line manager resource toolkit including short videos to be launched August 2015
- Line manager briefings/breakthrough sessions timetabled for September and October 2015
- ESR Business Intelligence tool roll out into Medical Division as a pilot towards the end of August 2015

5.6 Staff Experience and Engagement

Aims and Objectives of Work

The Staff Friends and Family test aims to provide a simple, headline metric which can be used to drive cultural change and continuous improvements in the quality of the care received by NHS patients and the working conditions of its staff. The survey questions are:

A – Would you recommend your Trust as a place to receive treatment?
B – Would you recommend your Trust as a place to work?

The Trust's 2014 Strategy was built around the vision of providing 'Compassionate Care'. This is supported by 14 key objectives, progress against which is reviewed and scrutinised by the Board of Directors on a quarterly basis. An annual refresh of the strategy for 2015 has been completed and will form the basis of the annual appraisal system. Quality and quality impact is embedded within the strategy.

Current Performance

The 2015/16 Q1 results show that 77% of staff would recommend the Trust as a place to receive treatment and 51% would recommend the Trust as a place to work. A highlight report is produced each quarter identifying a selection of responses. These are available on the Trust's intranet.

There is an open dialogue between staff and the Chief Executive through his regular blog. Staff are encouraged to respond direct to his key messages. A cascade message is issued each month from the board of directors/executive board to update staff on key discussions during the month. A CHFT weekly is issued each Thursday, introduced by an Executive Director, informing staff of key messages and items of interest. The "Big Brief" is held each month to give staff an opportunity to hear from our Directors about key issues affecting the Trust and the Divisions. A Line Managers' Bulletin is also published regularly.

The colleague engagement strategy is being delivered and showing results. 10% of staff have been through the Work Together Get Results (WTGR) programme and participate in coaching circles and associated development such as Authentic Conversations. We've set out the 4 key behaviours (4 pillars) we want to see throughout the organisation ("put the patient first", "go see", "work together to get results" "we do the must do's"). Through our WTGR programme we've also developed a consistent approach to managing change in the organisation. Our WTGR approach is about engaging with colleagues and getting their ideas about what improvements could be made to services and working conditions. It is also about setting out appropriate behaviours for leaders and managers to underpin our 4 key behaviours.

The most recent staff survey indicates that 63% of staff could recall the 4 pillars and in terms of the golden thread over 91% of staff recalled having an appraisal which was well above national average this time around.

Improvement Plans for 2015/16
The number of respondents has been decreasing each quarter, therefore the Well-Led Organisation Group, which is leading on action planning from the Staff FFT and the Staff Survey, will consider actions to improve response rates.

The Trust has developed quality indicators which cover the Care Quality Commission's five key questions around healthcare – safe, caring, reliable, effective, well-led. Three of the Trust's key areas of focus are care of the acutely ill patient, infection control and safe staffing. Following the "Hard Truths" report, which sets out recommendations on staffing levels, we have made a commitment to significant investment in increasing nursing numbers.

A comprehensive approach to colleague health and wellbeing, designed together with employees, is currently under development. Colleagues are involved in identifying what stress factors exist in the Trust, following feedback given through the staff survey, so that we're able to deal with these to ensure good outcomes for patients as well as colleagues.

A leadership visibility programme has been developed and is currently being implemented. This will provide staff with an opportunity to discuss issues with Executive and Non-Executive Directors.

NHS STAFF SURVEY 2014

1 2014 Survey

The Trust participated in the 2014 NHS Staff Survey, which was the 11th national annual survey. A total of 850 staff were included in our sample, of which 822 were eligible to complete the survey. Our Survey Contractor was Picker Institute Europe. 370 staff completed the survey giving us a response rate of 45%. The national average response rate was 42%. This year, for the first time, staff on maternity leave were eligible to take part in the survey.
There were minor changes to some questions, including the question around hot water, soap and paper towels and a change to the question about malpractice and wrongdoing, this is now being referred to as 'unsafe clinical practice'.

2 The National Picture

The results show growing pressure on those working in the NHS, but also that the vast majority of staff remain positive about their work and the service they provide.
Of the 29 key findings, 11 have shown improvement since 2013, one has remained the same, 15 have deteriorated and two cannot be compared due to changes in the questions.

There are some positive improvements in the perception of quality of care. For example, 67% of staff said they thought patient care was the top priority for their organisation compared to 66% in 2013. More than three quarters of staff reported that patient experience measures are collected in their organisation and 50% said such feedback is used to improve patient care.
A new question on raising concerns shows that 68% of staff would feel safe to raise a concern about unsafe clinical practice and 93% would know how to do so.

3 The Local Picture

Despite pressures on the Trust, we have maintained our staff engagement score at 3.77 out of 5, which is above the national average.

3.1 Improvement/Deterioration since 2013

Scores that show improvement since the 2013 survey are:

- Staff receiving an appraisal review in last 12 months

There has been no change in all other scores although by national comparison we have scored "worse than average" in the following areas:

- Work pressure felt by staff
- Staff receiving health and safety and equality and diversity training
- Fairness and effectiveness of incident reporting procedures
- Staff experiencing physical violence from staff/patients and relatives
- Staff reporting that communication between senior management and staff is not effective

A brief synopsis of results over the last three years appears below:

Category	**2014**	**2013**	**2012**
Best 20%	5	1	7
Better than average	6	11	6
Average	10	6	9
Worse than average	6	9	6
Worst 20%	2	1	0

4 Next Steps

An action plan has been developed and will be monitored by the Well-Led Organisation Group.

GMC Survey results

The results of the General Medical Council (GMC) annual national trainee survey for 2015 were published in June 2015. The survey is used to measure the quality of postgraduate medical education and training, and helps employers find out how junior doctors view training within their trust.
There has been an improvement in the Trust's performance compared with last year. The overall satisfaction rate for the Trust has gone up from 79.03 to 81.19 and we are now 5th out of 14 Yorkshire and Humber Trusts in terms of overall satisfaction compared with 6th last year. The Trust is one of two Trusts in the region to show sustained improvement each year over four years.
We are positive outliers for Emergency Medicine FY1 (for the third year in a row) and GP FY2.

The Trust has been rated as negative outliers for Obstetrics and Gynaecology. Last year, Medicine FY2 and Ophthalmology were negative outliers and they have shown both shown excellent improvement

College Tutors are currently in the process of analysing results for each specialty with a view to compiling action plans (deadline of 11th August 2015).

Further information can be found online in the GMC Survey Results at http://www.gmc-uk.org/education/national_summary_reports.asp?WT.mc_id=EMSRVP150527

APPENDIX A

Mortality Reviews

Analysis of reviews - December 2014 and May 2015

Background

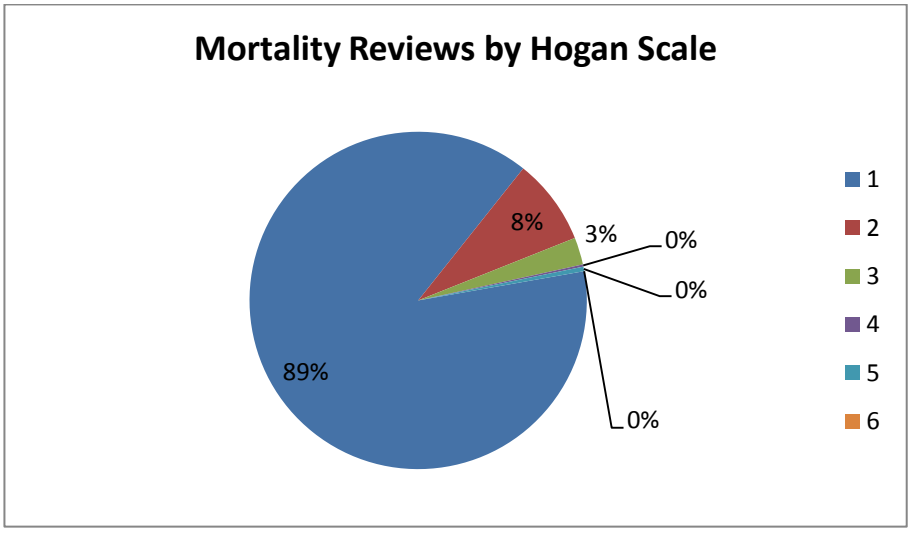
The mortality reviews are performed on a number of case notes of adult patients following a patient's death by a team of 'mortality reviewers'. These are doctors and senior nurses who have been nominated to perform the reviews. Each reviewer assesses the case notes and completes a first stage review form. At the end of the review the reviewer assesses the case using the Hogan Score. This is a nationally-recognised scale of the "preventability" of the death following a mortality case review. The scale ranges from 1 to 6.

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.

Stage one review

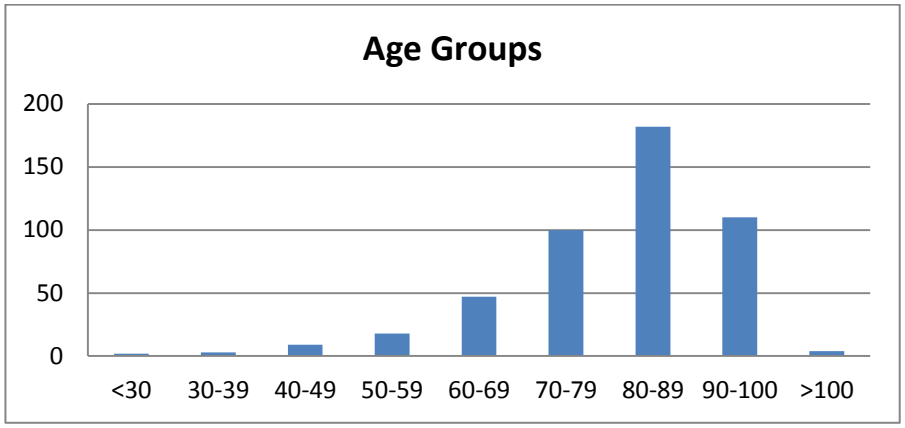
Analysis of review performed for deaths between December 2014 and May 2015 identified 460 reviews performed out of a total of 956 deaths during the 6 month period. Of these 89% (408) were assessed as 'definitely not preventable' using the Hogan scoring. Where the reviewer assessed the mortality as preventable using the Hogan score 2 – 6, these were requested for a second review. A total of 11% (52) were requested for a second review. Chart one shows the percentage of preventability using the Hogan scale.

Chart 1



The ages of the patients ranged from 24 – 103 years old. Chart two shows the age distribution of the patients

Chart 2



Analysis of the 460 first stage case reviews showed the following information

- 13% (59) were patients in surgical wards
- Of the 13% of patients in surgical wards 7% (4) were stated to be 'medical outliers'
- One patient was an elective surgical patient and the rest were acute admissions
- 87% (402) of patients were on medical wards
- 6% (28) of cases were assessed as an 'outlier'
- 4% (18) were assessed as not in the appropriate speciality
- Length of stay ranged from 0 to 128 days
- 16% (72) of cases were assessed with 'patient expected to die within 24 hours
- 12% (55) patients 'death was not expected when it occurred'
- 15% (68) were assessed as 'death not in the appropriate place', reasons provided in the chart 3 below

Chart 3

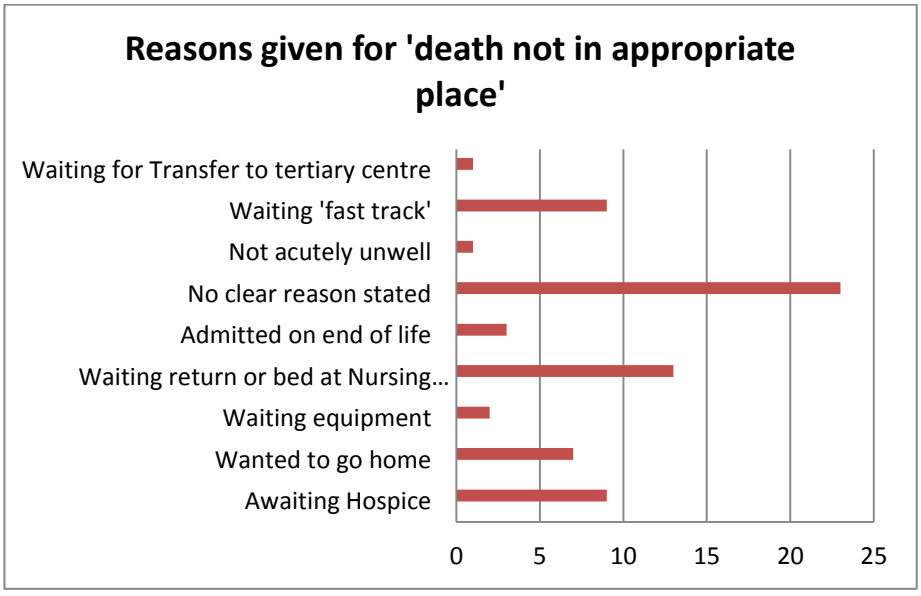
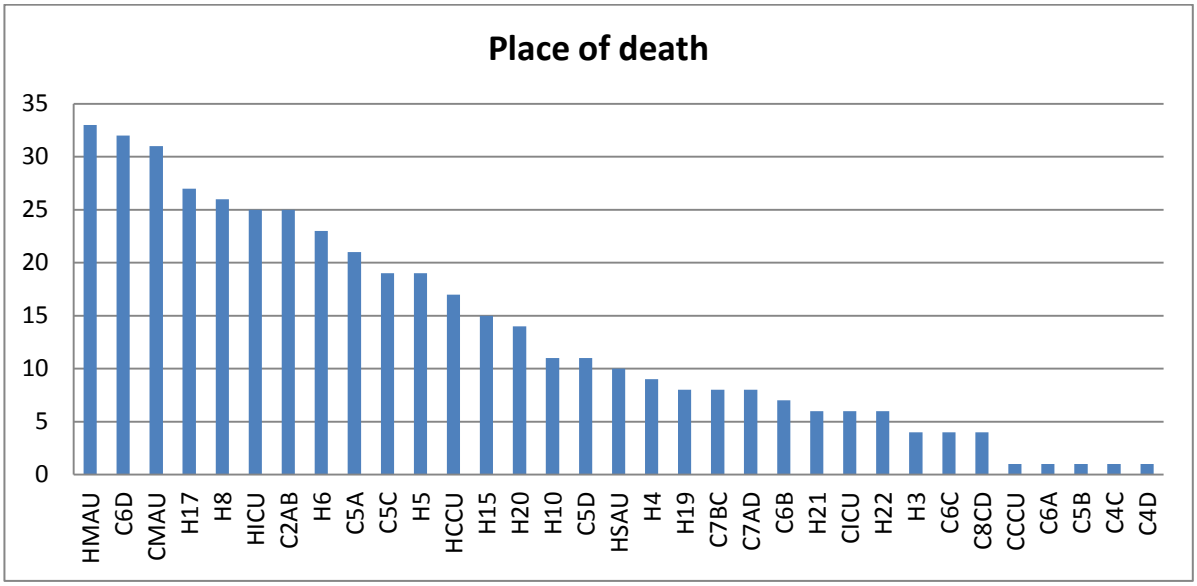


Chart four shows the top 14 wards were death occurred.

Chart 4



Summary of cases assessed as Hogan 2

A total of 38 cases were assessed as slight evidence for preventability

The primary diagnosis of the 38 cases included

- 42% (16) had a pulmonary related primary diagnosis, including pneumonia, COPD, acute LRTI and pneumonitis
- 8% (3) had a urinary tract infection
- 8% (3) had fractures, including #shaft of femur, #radius and #pubis
- 5% (2) cardiac related (Congestive Cardiac Failure and Myocardial Infarction)

Cause of Death

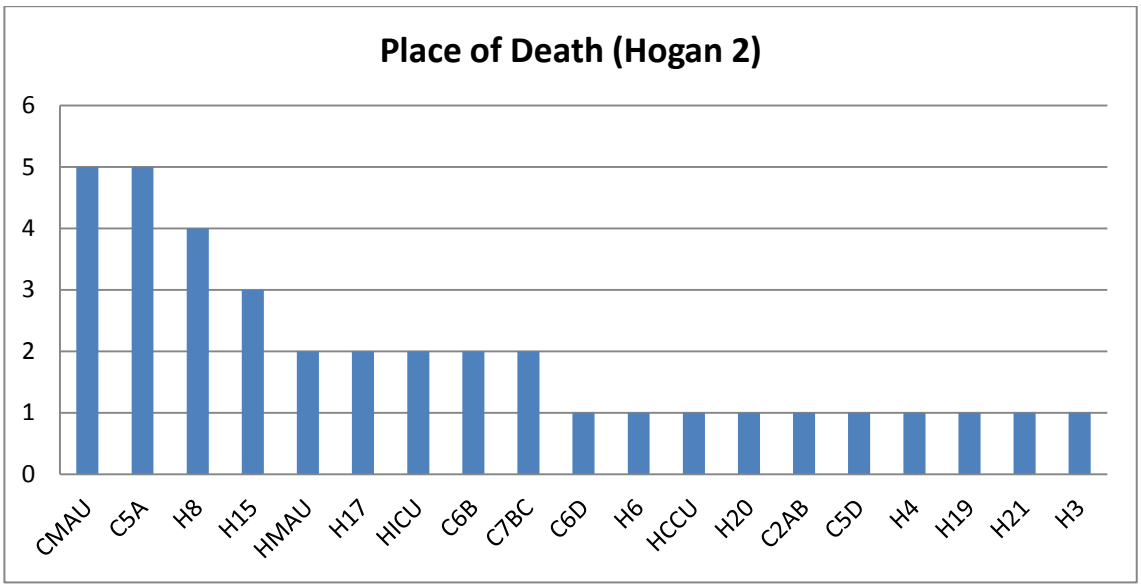
- 2 referred to the Coroner
- 32% (12) respiratory related
    - Aspiration pneumonia (2)
    - Bronchopneumonia (8)
    - Community acquired pneumonia (1)
    - Chronic Obstructive Pulmonary Disease (1)
- 18% (7) cardiac related
    - Acute left ventricular failure (1)
    - Congestive Cardiac Failure (3)
    - Cardiac failure (1)
    - Myocardial Infarction (1)
    - Complete heart block (1)
- 16% (6) sepsis

Main Key themes for requesting a second review

- Delay in senior review = 13% (5)
- Delay in administering medications (including antibiotics) = 18% (7)
- Observations not performed as per policy = 18% (7)
- Delay or lack of escalation to Outreach = 9% (3)
- Bundles not completed (Fall x1 and sepsis x2) = 9% (3)

Chart five shows the place of death for the cases assessed as Hogan 2.

Chart 5



Summary of cases assessed as Hogan 3

A total of 12 cases were assessed as 'possibly preventable but not very likely, less than 50–50 but close call'

Two were surgical patients and 10 were medical patients. 3 were classed as 'outliers' by the assessors.

Length of stay

Range = 1 – 37 days; average 14 days

Death expected when occurred = 8 out of 12 cases it was expected.

- DNACPR in place of 8 out of the 12 cases

The primary diagnosis of the 12 cases included

- 58% (7) had a pulmonary related primary diagnosis, including pneumonia, COPD, acute LRTI and pneumonitis
- 8% (1) malaena
- 8% (1) fractured calcaneus
- 8% (1) disorientation

- 8% (1) syncope and collapse
- 8% (1) gastroenteritis

Cause of Death

- 2 referred to the Coroner
- 58% (7) respiratory related
    - Aspiration pneumonia (1)
    - Bronchopneumonia (5)
    - Chronic Obstructive Pulmonary Disease (1)
- 8% (1) Myocardial Infarction
- 8% (1) Dementia
- 8% (1) Subarachnoid haemorrhage

Themes for requesting a second review (more than one theme was noted for some of the cases)

- Delay in medical review = 25% (3)
- Delay in administering medications (including antibiotics) = 25% (3)
- Observations not performed as per policy = 16% (2)
- Delay or lack of escalation to Outreach = 16% (2)
- Inappropriate ward = 16% (2)
- Poor nutrition due to delay of PEG insertion = 8% (1)
- Fall = 8% (1)
- Poor discharge arrangements = 8% (1)

Further details are provided in the table below

Division	Ward	LOS	Certification Description	Primary Diagnosis	Preventability Comments
Medical	H17	23	Spontaneous Subarachnoid Haemorrhage	Melaena	Re-admission 7-12-11-14 (anaemic alcoholic cirrhosis) 8/12/14 fall on ward - hit head. Bleed CT - ICU but died D/c Leeds - not for tx
Surgical	H20	8	*Referred to the coroner*	Fracture of calcaneus	Patient on long term Warfarin. Prescribed dalteparin 5000 units D/A - not given by nursing staff on 15/12/14 - reason for admission 'for theatre' medical notes on 16/12/14 state restart Warfarin - however this was not prescribed or given until 17/12/14 al
Medical		15	Pneumonia	Pneumonia, unspecified	Small GI bleed ?oesophagitis OGD 16/02/2015.Nursing LFT 17th Feb - ongoing 24/02/2015. Nursing today function diagnosis HDP on

	C7D				levoflatacin
Medical	H5	2	Chronic obstructive pulmonary disease	Chronic obstructive pulmonary disease with acute exacerbation, unspecified	NEWS7 at 2100 - no further obs done at all. Nursing entry at 0700 settled, appears to have slept. 0800 found to have died - cold ?Failure to rescue
Medical	H10	4	Myocardial Infarction	Other and unspecified gastroenteritis and colitis of infectious origin	NEWS score of 8 on 19/12/14 - escalated by nursing staff and reviewed by on call. However following this entry patient not reviewed on 20/12/14 or 21/12/14 by medical team. Was next seen by locum consultant on 22/12/14. please note unable to comment on pa
Medical	H6	7	Bronchopneumonia	Chronic obstructive pulmonary disease with acute lower respiratory infection	Patient has repeated admissions to 4 SOB/infection ex of COPD. She was treated and had community support. DNACPR. Very frail. End stage COPD death was very sudden (however expected with end stage COPD and **) Plan re escalation + DNACPR could have been ma
Medical	H4	2	Bronchopneumonia	Pneumonia, unspecified	Clerking notes and nursing documentation both state DNACPR form may be appropriate due to comorbidities. HB In A&E 80, following day 70 given dalterparin 5000 u documented in plan to have dalterparin as no evidence of bleeding with the x-match - never got
Surgical	H20	16	*Referred to the coroner*	Disorientation, unspecified	Delay in being clerked in and plan established was originally admitted to CDU and then stayed in CDU for 3 days before being admitted to ward 20. Urinary catheter inserted with little evidence of review and delay in removal of catheter. Seen by outreach o

Medical	H8	33	Bronchopneumonia	Pneumonitis due to food and vomit	DNACPR in place from 11/10/14. 26/11/14 WR sleepy - accidently had 2x. Temazepam last night. Coughing today ++ likely ASPIRATION. 12/12/14 WR plan of care in place. No medical review recorded from this part until death certified on 14/12/14 @ 0740hrs

Summary of cases assessed as Hogan 4 – 6

There were two mortality review cases assessed as 5, and no cases assessed as either 4 or 6. The two cases are summarised below along with the second review comments.

	Brief summary of 1st stage review	2nd stage review
Hogan 5 LOS = 5 days	94 year old patient admitted on 31st January to the surgical Division with a primary diagnosis of pertrochanteric fracture. Patient died on 5th May and the death was not expected and a crash team were called. Patient suffered post arrest cardiac ischaemia and a DNACPR was completed. Death certification stated spontaneous bowel perforation. Assessor requested a 2nd review due to 'a key clinical intervention was missed, patient had chest xray done in A&E – no evidence this was reviewed'	2nd review performed and reassessed as Hogan 2 Room for improvement - Not reviewed often enough towards the end. Poor record keeping of medical input
Hogan 5 LOS = 6 days	76 year old patient admitted on 23rd March under the Medics with a primary diagnosis of hypothermia. Died on 28th March. Death was referred to the corner. The assessor stated no reason for 2nd review	2nd review stated 'The staff were clearly unable to cope with the impact of this patient's learning and behavioural problems - to the extent that his CT was delayed, bloods not done, obs not done, and when outreach found him hypotensive and bradycardic he had no IV access, no fluids, no catheter etc' Concern over DNAR highlighted and referred to SI panel

Stage 2 reviews

Second reviews were requested on 57 cases that were with a Hogan score of 2 or above. These are ideally performed with two assessors but due to workload commitments and to avoid delay some of the second reviews were performed by one experienced assessor.

A total of 36 (63%) second reviews were performed. Of the 36 second reviews, 60% (21) of the cases the preventability was reassessed to 'definitely not preventable'. On four occasions the second review increased the Hogan score, on 3 occasions the Hogan score was lowered to a 2. The remaining 7 cases were assessed the same at second review.

The table below summarises of all the cases assessed as Hogan 2 or above following second review.

1st stage review Hogan Score	2nd stage review Hogan Score	Concerns documented at second review
5	5	Patient with learning disabilities with delayed investigations and delayed escalation (as described in in the above table). Referred to SI panel
3	5	Poor discharge to NH including failure to prescribe antibiotics patient readmitted and died rapidly (orange investigation)
2	5	Patient was medically fit when they had a fall resulting in death (this had already triggered an orange investigation)
2	4	Delayed senior review and failure to follow NEWS policy and not acting upon increased respirations
2	3	Delay in antibiotics being given for sepsis and sepsis bundle not used. Failure to act upon concerns raised by the family. Referred to the weekly Quality Team Meeting
3	2	Delay in stoke bed and delay in PEG insertion
3	2	Problem with PEG on admission and issues not resolved resulting in delayed feeding and treatment
5	2	Not reviewed often enough towards the end. Poor record keeping of medical input
2	2	Poorly coordinated diabetic care
2	2	Probably impossible to tell whether compression from the cot side could have precipitated the ischaemia of the left leg. Referred to the weekly Quality Team Meeting
2	2	Might not have developed hospital acquired pneumonia if admission avoided in the first place by use of existing community resources
2	2	12 hour delay in antibiotics.
2	2	Delay in antibiotics, sepsis bundle not used. Also concerns regarding catheter and cannula care. Referred to the weekly Quality Team Meeting
2	2	Patient had CCF and was difficult to assess and treat due to delirium, refused to have observation prior to arrest. Learning shared at clinical effectiveness committee

Conclusions

The number of reviews each month has been variable. First stage reviews are performed by either a doctor or a nurse. Many of the questions are subjective and there is variability on the response which can be affected by the background and specialist knowledge of the assessor. The second reviews are more time consuming and require 2 assessors which often results in delays and hence some cases these were performed by one assessor. There is useful learning to be gained from the reviews and these needs to be shared in a timely manner to ensure corrective actions are instituted. The second reviews have assured that where there are major concerns these have been escalated appropriately.

Recommendations

1. The process for mortality reviews needs to be formalised to ensure the reviews are performed in a timely manner with a clear escalation process, a draft document is ready to go to WEB
2. Review of the 1st and 2nd stage review forms to ensure they are simple to follow and capture quality of care
3. Move to an electronic review form to speed up the process for identifying cases requiring 2nd review
4. Ensure there are mechanisms for reporting learning themes to the appropriate forums to facilitate actions as required.

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Juliette Cosgrove, Assistant Director
Date: Thursday, 24th September 2015	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: Action plan in preparation for the CHFT Care Quality Commission inspection - As part of the Trusts on-going assurance on the quality of services it provides, and in preparation for a Care Quality Commission inspection, a number of self-assessments aganst the CQC standards have been undertaken in order to understand what improvement work is required. The inspection date is yet to be announced but will be in February or March 2016 and we will be informed 12 weeks in advance of the inspection date. Based upon assessments made to date, the overall Trust position is "requires improvement" and working towards "good".	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Received at the Quality Committee on the 25th August 2015	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

As part of the Trusts on-going assurance on the quality of services it provides, and in preparation for a Care Quality Commission inspection, a number of self-assessments aganst the CQC standards have been undertaken in order to understand what improvement work is required. The inspection date is yet to be announced but will be in February or March 2016 and we will be informed 12 weeks in advance of the inspection date.

Based upon assessments made to date, the overall Trust position is "requires improvement" and working towards "good".

Main Body

Purpose:

The purpose of the paper is to inform the Board of progress with the delivery of the CQC Preparation Action Plan and an estimate of the compliance of the organisations core services according to the criteria set out by the CQC in their inspection framework.

Background/Overview:

The weekly CQC Senior Steering Group has received core service presentations from Accident and Emergency, Critical Care, Children and Young People, Community, End of Life Care, Medical Care, Surgical Care, Maternity and Family Planning and Out Patients services. These are the core services that the CQC will inspect. Each Division has also presented their self-assessment including their core services where appropriate

Following the completion of the self-assessment, each core service and Division is preparing a 90-day plan to drive forward the areas for improvement. These will be performance managed within the appropriate Division. Some services were already working towards 90 day improvement plans as risks had already been identified, these services have presented what they have achieved to date and what outstanding concerns and risks they still have.

In addition to core service presentations, the Group is provided with updates against the Trust wide plan, which covers the 5 domains of a CQC inspection. The Steering Group has seen all 5 of the domains Safe, Effective, Caring, Well Led and Responsive. Safe, Caring and Effective have all had plans in place for some time, these were based upon findings from the mock inspection in September 2014. The Well Led plan is being revised following a self-assessment in June and July and the Responsive plan has been reviewed and revised by the Assistant Director of Operations.

The assessments to date show that the overall Trust position is that of “requires improvement” except in the Caring domain which is “good”, see appendix. This is driven by the majority of core services declaring a position of “requires improvement” across most domains. However there is now a shift being seen towards a number of core service domains being rated as good, this position can be seen on the dashboard in the appendix.

The dashboard contains the top 3 or 4 risks contributing to the “requires improvement” rating, or remaining concerns where a rating of “good” has been declared. It is expected that the majority of these risks will be addressed over the next 3 months, so enabling a rating of good to be more achievable, however there remain a number of challenges for some of these areas of risks which include:

- Children and Young People: the current model of running cross site services means that some of the key standards for paediatric care are not achievable. Whilst there are arrangements in place to mitigate any risks, it is possible that the situation may be viewed as requires improvement or inadequate (safe / responsive / effective).
- Maternity and family planning: this is the only core service currently reporting a rating of “requires improvement” for caring. This is influenced by the current challenges to increase the FFT response rate and a lower than expected percentage that “would recommend” the postnatal care service. Steps are being put

in place to improve the response rate, including the use of tablets and smart phones at the point of care rather than relying on text messaging. There is an expectation that the risks listed for the other domains will be addressed over the next 3 months.
- Outpatients and diagnostic imaging: “Responsive” is the only domain currently not rated as “good”, the majority of risks have a plan in place to be addressed by November 15. Challenges remain regarding the effective use of Electronic Document Management Ststem and the timely production of clinic letters.
- Accident and emergency: Recruitment, 24/7 service delivery, flow and achievement of key targets remain challenging for the service. All have been thoroughly assessed with plans to keep the current service safe and have been shared with the executive Team at Divisional Business Meetings.
- Medical care: Workforce staffing remains a real challenge with both medical and nursing vacancies, this has been escalated to the executive team, who have acknowledged this significant risk. The risks relating to mortality alerts, and national audits are being managed through improvement plans, including the development of business cases where required. To improve the position with the national targets there has been some recent recruitment and use of locum medical staff. The requirement for psychology support in some services remains unresolved.
- End of Life care: processes have been put in place across all domains to deliver any risks and concerns identified. “Responsive” is the only domain that is currently not rated as “good”, this relates to there being no designated social worker to support rapid discharge, this also has an impact on achieving the preferred place of death for patients.
- Surgery: there are 90 day plans in place to address the identified risks, however a number of challenges remain. These include: the delivery of the new national guidance for gastro-intestinal bleeds, which will require significant system redesign in order to comply with the guidance; recruitment to Clinical Director roles within the Division; achievement of the recovery plans to address capacity and demand across services
- Critical care: the main issue outstanding for this service is compliance with the D16 - Adult Critical Care Service Specification; this is due for publication November 15. An early discussion has commenced based on the consultation version of the document.
- Community adults and children: following a comprehensive mock inspection and self-assessment, 90 day plans have been developed to address the risks and concerns identified. There are ongoing issues regarding some of the estates in terms of the buildings and maintenance schedules, these are unlikely to be resolved in the short term. Continued work is taking place to establish the management arrangement for the new Division and to communicate this across the workforce.

The Issue:

See above

Next Steps:

Actions for the next month;
Where services assess themselves as “good” assurance reviews will take place to test the assessment with the intention of providing assurance and focus on sharing learning.
Implement the 90 day plans as they are developed.
Continue with the Engagement Plan with a focus on sharing good practice, increasing colleague engagement and preparing staff for the inspection.
Each Division will rate themselves each month as to their current status and expected timescale to become “good”. They will also identify risks that they believe they cannot resolve within Division and escalate to the CQC Senior Steering Group.

Recommendations:

The Board is asked to note the contents of the report.

Appendix

Attachment:

CQC Rating Dashboard for all divisions and domains- Board Report September.pdf

CQC Rating Dashboard (18.8.15)

Key ● Inadequate ● RI = Requires improvement ● Good ★ Outstanding

Division	Core Service	Safe	Caring	Responsive	Effective	Well-led
Families & Specialist Service	Children & Young People	**Requires Improvement** **Key risks:** - A&E and stabilisation of the critically ill child: challenge of cross site working, care environment, meeting RCN nurse staffing levels for A&E, flow in PAU) - Staffing (including time to recruit) - Training (APLS and HDU)	~~**Requires Improvement**~~ **→ Good** **Concerns:** - Red flags - Inpatient environment on ward 18 and NICU	**Requires Improvement** **Key risks:** - PAA and patient flow; - Medical children in A&E - Surgical provision: surgery provided on a site with no HDU facility, paediatric surgical standards not all met - Paediatric mental health services	**Requires Improvement** **Key risks:** - Service model – split site - HDU Provision and expansion / contraction of bed base	~~**Requires Improvement**~~ **→ Good** **Concerns:** - Absence
	Maternity & Family Planning	**Requires Improvement** **Key risks:** - Maternity staffing levels (including time to recruit) - Increasing intervention rates (including PPH, c sections)	**Requires Improvement** **Key risks:** - FFT response rates and postnatal percentage would recommend	**Good** **Concerns:** - Maternity assessment centre: patient flow, responsive staffing	**Good** **Concerns:** None	**Requires Improvement** **Key risks:** - Service user involvement in service improvement - Establishing and maintaining effective teams
	Outpatients & Diagnostic Imaging	**Good** **Concerns:** - Uptake of mandatory training - Awareness of DoLs and safeguarding	**Good** **Concerns:** - Environment: HRI site presents privacy and dignity challenges - Clinic waiting times and being kept informed of delays	**Requires Improvement** **Key risks:** - Access in OPD (ASI and follow ups) and to cancer diagnostics (working towards 7 days) - Waiting areas - Availability of timely clinical information: EDMS / production of clinic letters	~~**Requires Improvement**~~ **→ Good** **Concerns:** - Staff knowledge and competency re MCA / DoLs - Improved ownership of clinic outcomes	~~**Requires Improvement**~~ **→ Good** **Concerns:** - Front line staff awareness of / engagement with the Trust's vision and strategy - Improved attendance management - Establishing and maintaining effective teams
Medicine	Accident & Emergency	**Requires Improvement** **Key risks** - High usage of non-contracted staff (locum doctors and agency nurses) - ED business continuity plan – ability to maintain both departments 24 / 7 - Mandatory training compliance	**Good** **Concerns** - Department layout: doesn't allow for full visibility of patients; small cubicles; sluice areas - Communication with patients and relatives - Friends and family performance: response rates andpercentage would recommend	**Requires Improvement** **Key Risks:** - Patient flow /achievement of targets: 4 hour target, 15 min assessment (ambulance patients), long waits for beds - Facilities for individual patient needs	**Good** **Concerns:** - Effective pain management - Challenges in performance in RCEM audits - Training for junior staff around Manchester Triage	**Good** **Concerns:** - Front line staff awareness of / engagement with the Trust's vision and strategy - Directorate risk management - Completion of staff appraisals
	Medical Care	**Requires Improvement** **Key risks:** - Workforce staffing: medical and nursing - Mortality: Heart failure, stroke, respiratory - MCA / DoLs: staff knowledge and competency	~~**Requires Improvement**~~ **→ Good** **Concerns:** - Noise at night - FFT response rate: additional areas (day case areas) - Patients moved for non-clinical reasons	**Requires Improvement** **Key risks:** - Patient flow: delayed transfers of care, bed occupancy, outliers - Achievement of National targets: Rheumatology, Dermatology, Cardiology, Gastroenterology - Complaints / incident management: responsiveness and learning from experience	**Requires Improvement** **Key risks:** - Mandatory and role specific training - Compliance with National stroke audit - Documentation - Psychology support	**Requires Improvement** **Key risks:** - Front line staff awareness of / engagement with the Trust's vision and strategy - Wards in special measures - Directorate governance and risk management

	End of Life Care	**Good** **Concerns:** - Availability of opioid analgesia when required - DoLs implications at EoL - ICODD full implementation	**Good** **Concerns:** - Side rooms and facilities for relatives	**Requires Improvement** **Key risks:** - No team to discharge quickly: no designated social worker (also impacts on preferred place of death)	**Good** **Concerns:** - 7 day face to face assessment by specialist in palliative care (plan in place via additional roles) - National audit compliance - Ability to contribute to the national minimum data sets for specialist palliative care activity	**Good / Outstanding** **Concerns:** - Front line staff awareness of strategy, board members and strategy

Division	Core Service	Safe	Caring	Responsive	Effective	Well-led
Surgery	Surgery	**Requires Improvement** **Key risks:** - #NOF pathway: delivery of care in line with best practice tariff - Pre assessment & admissions: require protocols and pathways to be designed and implemented, lack of robust nurse staffing rota - GI bleeds: not achieving new national guidance re protocols and access to key services	**Good** **Concerns:** - FFT performance in day case and outpatients - Admission and pre-op environment - Outpatient environment - Patient and public involvement	**Requires Improvement** **Key risks:** - Capacity and demand all services: ENT and ophthalmic key concerns - Timeliness in responding to complaints and learning from experience	**Requires Improvement** **Key risks:** - Record keeping - DNA CPR - Mortality reviews	**Requires Improvement** **Key risks:** - Communication and engagement strategy - Restricted ability to recruit to CD and leadership roles - Junior doctor induction and adherence to protocols
	Critical Care	**Good** **Concerns:** - Management of clinical incidents / risk registers - Staff knowledge and competency re MCA / DoLs	**Good** **Concerns:** - Learning from patients / relative feedback	**Requires Improvement / Good** **Key risks:** - Time to discharge from ICU within 4 hours. - Surges in demand	**Requires Improvement / Good** **Key risks:** - Increase in audits and reviews: non-clinical transfers, readmissions, mortality reviews - Compliance with D16 service specification (guidance due out Nov 15)	**Requires Improvement / Good** **Key risks:** - Front line staff awareness of / engagement with the Trust's vision and strategy
Community	Adults	**Good** **Concerns:** - Estates issues (also impacts on some infection control practice): maintenance schedules, building ownership - Pressure ulcer rates	**Good** **Concerns:** - Poor response rate to FFT - Some Estates issues (covered in safe)	**Requires Improvement** **Key risks:** - Waiting times for some services and links with capacity and skill mix	**Requires Improvement** **Key risks:** - Lack of outcomes measures and KPIs - Care plans not available in patient homes (now electronic)	**Requires Improvement** **Key risks:** - Formation of new division and structure - Visibility of Board and senior managers
	Children			**Good** **Concerns:** None		
	End of life care	Hasn't been assessed separately, covered within the adult / children community assessment and linked to the acute service review				
Estates & Facilities	Estates	Not assessed as a core service. Local self-assessment results awaited.				

Overall Domain Rating	**REQUIRES IMPROVEMENT / GOOD**	**GOOD**	**REQUIRES IMPROVEMENT / GOOD**	**REQUIRES IMPROVEMENT**	**REQUIRES IMPROVEMENT / GOOD**

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 24th September 2015	**Sponsoring Director:** Helen Barker, Associate Director of Community Services and Operations
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 - 17.9.15 Quality Committee - 22.9.15	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

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

Appendix

Attachment:

APP K2 - IBR Report August 15.pdf

Board Of Directors Integrated Performance Report

Calderdale and Huddersfield NHS
NHS Foundation Trust

compassionate care

Contents

Report For: August 2015

Board of Directors

Integrated Performance Report

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Executive Summary Commentary

The report on August performance highlights continued good progress against the Monitor metrics however there is a general deterioration across several contractual metrics that have been and continue to be scrutinised with Division and appropriate improvement plans developed. As the report is developing new metrics are being included and will be developed in addition Cancer performance is now reported by tumour site pathway as required nationally.

The key areas to note are:

Responsiveness

- The Trust delivered the Emergency Care Standard with reduction in length of overall wait for those patients in the department over 4hours
- National cancer standards were met at Trust level but not yet delivering transfer to other providers by Day 38 and target performance in each tumour site group
- Delayed discharge improvement is slow but green cross delays are reducing
- Cancelled operations performance was achieved in August
- Elective activity continues to track below plan, exception report taken through F&P Committee
- No ASI data available due to production issues from the national centre, actions plan currently being refined based on local knowledge.

Caring

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

Safety

- Falls continues to be higher than acceptable
- Harm free care is running below Contract standard
- 3 Duty of candours remained open at month end

Effectiveness

- Slight increase in C Difficile cases in August
- Excellent performance on CDiff continues
- Emergency Readmissions within 30days delivered
- HSMR remains a key area of concern
- # Neck of Femur, time to theatre deteriorated significantly in August as predicted in the July report

Well led

- Sickness has improved in 5 of the 8 areas reported
- Staff in post, FTE, remains static
- Appraisal and Mandatory training remains red but significant actions taken in month to ensure improvement
- No reds noted in summary hard truths data however 14 individual shifts in the month were rated red, 9 qualified and 5 unqualified cover

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		Quality		Other Internal	
Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator
↓	A and E 4 hour target	↓	% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival	↓	Access to Imaging - % Stroke patients scanned within 12 hours of hospital arrival	↑	Friends & Family Test (IP Survey) - % would recommend the Service			↑	Unavoidable Number of Clostridium Difficile Cases	↑	% Elective Variance against Plan
↑	62 Day Gp Referral to Treatment	↓	% Patients Presenting with AF Anti-coagulated on Discharge	→	28 Day Standard for all Last Minute Cancellations	↓	Friends and Family Test A & E Survey - % would recommend the Service	n/a	End of Life Care Plan in place	↓	MRSA Screening - Percentage of Inpatients Matched	↑	% Day Case Variance against Plan
→	62 Day Referral From Screening to Treatment	↑	% Stroke patients spending 90% of their stay on a stroke unit	→	No of Urgent Operations cancelled for a second time	↓	Friends & Family Test (Maternity) - % would recommend the Service	↑	Local SHMI - Relative Risk (1yr Rolling Data Jan14- Dec 14)	→	Number of E.Coli - Post 48 Hours	↓	% Non-elective Variance against Plan
→	31 Day Subsequent Surgery Treatment	↑	% Stroke patients scanned within one hour of hospital arrival	↓	% Harm Free Care	↓	Friends and Family Test Community Survey - % would recommend the Service	↑	Hospital Standardised Mortality Rate (1 yr Rolling Data Jul 14 - Jun 15)	↑	% Hand Hygiene Compliance	↑	% Outpatient Variance against Plan
→	31 day wait for second or subsequent treatment drug treatments	↑	Management of High Risk TIA	↑	62 Day Aggregated Gp Urgent Referral To Treatment And Screening Referral To Treatment	↑	Friends & Family Test (IP Survey) - Response Rate	↑	Crude Mortality Rate (Latest Month Aug 15)	→	Avoidable number of Clostridium Difficile Cases	↓	Theatre Utilisation (TT) - Main Theatre - CRH
→	31 Days From Diagnosis to First Treatment	↑	% Low-Risk TIA patients investigated and trated withn 7 days of first contact with a health professional	→	Number of Mixed Sex Accommodation Breaches	↓	Friends and Family Test A & E Survey - Response Rate	↑	Mortality Reviews – July Deaths	↑	Number of MSSA Bacteraemias - Post 48 Hours	↓	Theatre Utilisation (TT) - Main Theatre -HRI
↓	Two Week Wait From Referral to Date First Seen	↓	% Stroke patients Thrombolysed	↓	Emergency Readmissions Within 30 Days (With PbR Exclusions)	→	Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	↑	Average Diagnosis per Coded Episode	↓	% Complaints closed within target timeframe	↓	Theatre Utilisation (TT) - HRI DSU
↑	Two Week Wait From Referral to Date First Seen: Breast Symptoms	↓	Percentage of Completed VTE Risk Assessments	→	Never Events	n/a	Percentage of non-elective inpatients 75+ screened for dementia	↓	Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	n/a	Total Complaints received in the month	↓	Theatre Utilisation (TT) - HRI SPU
→	Community care - referral to treatment information completeness	→	Completion of NHS numbers within acute commissioning datasets submitted via SUS	→	Percentage of SI's investigations where reports submitted within timescale (45 days unless extension agreed)	n/a	Acute Kidney Injury (Reported quarterly)	↑	Left without being seen	n/a	Total Concerns in the month	↑	World Health Organisation Check List
↓	Community care - referral information completeness	↓	Completion of NHS numbers within A&E commissioning datasets submitted via SUS	→	A&E Trolley Waits	n/a	Sepsis Screening (Reported quarterly)	↑	Time to Initial Assessment (95th Percentile)	n/a	Complaints acknowledged within 3 working days	↓	% Daily Discharges - Pre 11am
→	Community care - activity information completeness	↓	Number of MRSA Bacteraemias – Trust assigned	↓	Emergency Readmissions Within 30 Days (With PbR Exclusions) - Calderdale CCG	n/a	Sepsis Antibiotic Administration (Reported Quarterly)	↓	Time to Treatment (Median)	n/a	Percentage of SI's reported externally within timescale (2 days)	↓	Green Cross Patients (Snapshot at month end)
↑	Total Number of Clostridium Difficile Cases - Trust assigned	↓	A&E Ambulance 30-60 mins	↓	Emergency Readmissions Within 30 Days (With PbR Exclusions) - Greater Huddersfield CCG			↑	Unplanned Re-Attendance	n/a	Number of Patient Incidents	↓	Number of Outliers (Bed Days)

Monitor		Contract		Contract		NHSE		Quality		Quality		Other Internal	
Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator
↓	7 Day Referral to First Seen	↑	Delayed Transfers of Care	n/a	Nutrition and Hydration - Reducing Hospital Food Waste (reported quarterly)			→	Inpatient Falls with Serious Harm (10% reduction on 14/15)	n/a	Number of Incidents with Harm	↓	First DNA Rate
↑	38 Day Referral to Tertiary	→	Total Duty of Candour reported within the month	n/a	Nutrition and Hydration - Patient Satisfaction (Reported quarterly)			n/a	All Falls	n/a	Number of SI's	↓	% Hospital Initiated Outpatient Cancellations
↑	54 Referral to Treatment	→	Total Duty of Candour outstanding at the end of the month	n/a	Improving Medicines Safety – Reconciliation (Effective Transfer of Medicines)			n/a	Missed Doses (Reported quarterly)	↓	Number of Trust Pressure Ulcers Acquired at CHFT	↓	18 weeks Pathways >=26 weeks open
		n/a	Respiratory Care Bundle - Improving management of patients attending A&E with pneumonia (Reported quarterly)	n/a	Improving Medicines Safety Discharge Accuracy Checks			n/a	% of diabetic patients supported to self-care	↓	Number of Category 2 Pressure Ulcers Acquired at CHFT	n/a	Total Number of Spells
		n/a	Respiratory Care Bundle - Improving management of patients presenting with Asthma in ED (Reported quarterly)	↑	% Diagnostic Waiting List Within 6 Weeks			n/a	Safeguarding Alerts made by the Trust	↓	Number of Category 3 Pressure Ulcers Acquired at CHFT	n/a	No of Spells with > 2 Ward Movements
		↑	% Non-admitted Closed Pathways under 18 weeks	↓	18 weeks Pathways >=26 weeks open			n/a	Safeguarding Alerts made against the Trust	↓	Number of Category 4 Pressure Ulcers Acquired at CHFT	↓	% of Spells with > 2 ward movements (2% Target)
		↓	% Admitted Closed Pathways Under 18 Weeks	↓	18 weeks Pathways >=40 weeks open					↓	Number of Category 3 & 4 Pressure Ulcers Acquired at CHFT	n/a	No of Spells with > 5 Ward Movements
		↓	% Incomplete Pathways <18 Weeks	→	RTT Waits over 52 weeks Threshold > zero							n/a	% of spells with > 5 ward movements (No Target)
		↓	Community - 18 Week RTT Activity	↓	% Last Minute Cancellations to Elective Surgery								

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

RAG rating = GREEN Achieving Target / AMBER = missing target by a small margin / RED = Currently not Achieving Target

Achieving and Improving	Achieving No Change	Achieving but Deteriorating	Not Achieving No Change	Not achieving but improving	Not Achieving and Deteriorating
14	19	24	1	16	23

n/a - New indicators currently no trend /No RAG rating 27

Monitor Risk Assessment Framework

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%	92.03%								92.33%
	% Non-admitted closed Pathways under 18 weeks	>=95%	98.35%	98.89%	98.63%	98.23%	98.55%								98.53%
	% Incomplete Pathways <18 Weeks	>=92%	95.02%	95.85%	95.44%	95.55%	95.44%								95.44%
	A and E 4 hour target	>=95%	95.01%	94.80%	95.44%	95.44%	95.36%								95.21%
	Total Number of Clostridium Difficile Cases - Trust assigned	21	2	0	1	1	3								7
	62 Day Gp Referral to Treatment	>=86%	89.38%	92.31%	90.00%	88.95%	93.94%								90.45%
	62 Day Referral From Screening to Treatment	>=90%	85.71%	100.00%	100.00%	100.00%	100.00%								98.15%
	31 Day Subsequent Surgery Treatment	>=94%	95.45%	100.00%	100.00%	100.00%	100.00%								98.86%
	31 day wait for second or subsequent treatment drug treatments	>=98%	100.00%	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%	100.00%								99.84%
	Two Week Wait From Referral to Date First Seen	>=93%	96.45%	98.43%	96.55%	95.64%	93.78%								96.16%
	Two Week Wait From Referral to Date First Seen: Breast Symptoms	>=93%	93.33%	93.75%	94.92%	94.87%	98.60%								95.33%
	Community care - referral to treatment information completeness	>=50%	100.00%	100.00%	100.00%	100.00%	100.00%								100.00%
	Community care - referral information completeness	>=50%	98.05%	98.04%	97.83%	97.40%	97.42%								97.75%
	Community care - activity information completeness	>=50%	100.00%	100.00%	100.00%	100.00%	100.00%								100.00%

Third Party Reports	Yorkshire Ambulance Service are undertaking an audit which required a self-assessment to be completed prior to the site visit on 4th September. No feedback yet received The National Hip Fracture Database dashboard 2014/15 has been received and will be considered by the Division of Surgery A System Resilience Self-assessment has been completed via the System Resilience Group and submitted to NHSE, this concluded only partial assurance for winter 2015/16. Background, context and the CHFT analysis of actions required was discussed in detail at SRG but agreed outcomes not yet defined. Regional Stroke data review undertaken driven by the network, actions require by CHFT to improve overall performance across the suite of metrics. Report requested from Division for review at October Divisional Performance meeting.
Quality Governance Indicators	**Patient Metrics -Narrative on Friends and Family included within Exception reports.**
	Staff Metrics : Reported quarterly – no further update from previous report

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	£8.92m	£7.77m
	Income and Expenditure	(£9.24m)	(£10.56m)
	Cost Improvement Programme (CIP)	£4.45m	£5.38m

Responsive Executive Summary - Helen Barker Associate Director of Operations

	Report For: August 2015	Indicator Source	Target	Trust	Year To Date: Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Directon of travel (past 4 months)	Financial Penalities/Non Financial Impact	Year End Forecast	Data Quality
Activity	% Elective Variance against Plan	Local	0.00%	3.59%	2.55%	-13.46%	23.07%	-	0.00%	-2.49%	-3.98%	-9.50%	10.71%	-		↓			
	% Day Case Variance against Plan	Local	0.00%	-4.38%	-4.64%	-6.97%	11.52%	-	0.00%	-3.95%	-4.13%	-5.44%	5.37%	-		↓			
	% Non-elective Variance against Plan	Local	0.00%	-3.96%	-5.36%	1.17%	-12.04%	-	0.00%	2.15%	-3.04%	3.85%	2.47%	-		↓			
	% Outpatient Variance against Plan	Local	0.00%	-4.05%	-4.45%	-7.03%	2.98%	-	0.00%	-2.62%	-2.59%	-4.03%	-0.07%	-		↓			
RESPONSIVE - Theatre Utilisation	Theatre Utilisation (TT) - Main Theatre - CRH	Local	92.50%	85.64%	84.17%	-	95.28%	-	92.50%	86.75%	85.15%	-	98.26%	-		↓			
	Theatre Utilisation (TT) - Main Theatre -HRI	Local	92.50%	89.87%	89.87%	-	-	-	92.50%	93.50%	93.50%	-	-	-		↓			
	Theatre Utilisation (TT) - HRI DSU	Local	92.50%	75.31%	73.96%	-	86.29%	-	92.50%	76.23%	74.91%	-	86.88%	-		↓			
	Theatre Utilisation (TT) - HRI SPU	Local	92.50%	84.41%	84.41%	-	-	-	92.50%	83.52%	83.52%	-	-	-		↓			
Exception Report - Patient Flow	% Daily Discharges - Pre 11am	Local	28.00%	10.83%	12.33%	10.77%	10.03%	-	28.00%	10.53%	13.61%	8.69%	10.21%	-		↑			
	Delayed Transfers of Care	Local	5.00%	7.45%	-	-	-	-	5.00%	6.86%	-	-	-	-		↑			
	Green Cross Patients (Snapshot at month end)	Local	40	62	-	62	-	-	40	62	-	62	-	-		↓			
	Number of Outliers (Bed Days)	Local	401	803	236	567	0	-	2573	4076	1269	2815	0	-		↑			
	No of Spells with > 2 Ward Movements	Local	-	135	18	91	-	-	-	693	106	443	118	-		↑			
	% of Spells with > 2 ward movements (2% Target)	Local	2.00%	2.28%	1.18%	5.29%	0.97%	-	2.00%	2.27%	1.37%	5.04%	1.02%	-		↑			
	No of Spells with > 5 Ward Movements	Local	-	2	0	2	0	-	-	17	1	16	0	-		↓			
	% of spells with > 5 ward movements (No Target)	Local	-	0.03%	0.00%	0.12%	0.00%	-	-	0.06%	0.01%	0.21%	0.00%	-		→			
	Total Number of Spells	Local	-	5917	1528	1721	2668	-	-	30590	7808	8784	13998	-		↓			

	Report For: August 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)	Financial Penalities /Non Financial	Year End Forecast	Data Quality
Exception Report - Patient Flow 2	A and E 4 hour target	National & Contract	95.00%	95.36%	-	95.36%	-	-	95.00%	95.21%	-	95.21%	-	-		↑			
	Time to Initial Assessment (95th Percentile)	National	00:15:00	00:17:00	-	00:17:00	-	-	00:15:00	00:20:00	-	00:20:00	-	-		↓			
	Time to Treatment (Median)	National	01:00:00	00:55:00	-	00:55:00	-	-	01:00:00	00:58:00	-	00:58:00	-	-		↑			
	Unplanned Re-Attendance	National	5.00%	5.34%	-	5.34%	-	-	5.00%	5.10%	-	5.10%	-	-		↑			
	Left without being seen	National	5.00%	3.36%	-	3.36%	-	-	5.00%	3.30%	-	3.30%	-	-		↑			
	A&E Ambulance 30-60 mins	National	0	2	-	2	-	-	0	41	-	41	-	-		↓			
	A&E Trolley Waits	National	0	0	-	0	-	-	0	0	-	0	-	-		→			
Exception Report - Elective Access	First DNA Rate	Local	7.00%	6.66%	6.73%	6.53%	6.59%	-	7.00%	6.79%	6.74%	6.60%	7.05%	2.70%		↑			
	% Hospital Initiated Outpatient Cancellations	Local	17.6%	13.40%	14.20%	14.40%	9.60%	-	17.6%	14.40%	14.90%	15.00%	12.10%	-		↓			
	Appointment Slot Issues on Choose & Book	Local	-	-	-	-	-	-	5.00%	15.00%	12.25%	8.33%	7.38%	-					
Exception Report - Elective Access 2	% Non-admitted Closed Pathways under 18 weeks	National & Contract	95.00%	98.55%	98.56%	98.50%	98.63%	-	95.00%	98.53%	98.55%	98.34%	98.86%	-		↓			
	% Admitted Closed Pathways Under 18 Weeks	National & Contract	90.00%	92.03%	91.38%	100.00%	94.76%	-	90.00%	92.33%	91.64%	100.00%	95.01%	-		↓			
	% Incomplete Pathways <18 Weeks	National	92.00%	95.44%	93.90%	99.22%	98.80%	-	92.00%	95.44%	93.90%	99.22%	98.80%	-		↓			
	18 weeks Pathways >=26 weeks open	Local	0	174	166	3	5	-	0	174	166	3	5	-		↓			
	18 weeks Pathways >=40 weeks open	National	0	3	3	0	0	-	0	3	3	0	0	-		↓			
	RTT Waits over 52 weeks Threshold > zero	National & Contract	0	0	0	0	0	-	0	0	0	0	0	-					
	% Diagnostic Waiting List Within 6 Weeks	National & Contract	99.00%	99.48%	99.29%	99.86%	99.45%	-	99.00%	99.48%	99.29%	99.86%	99.45%	-		↓			
	Community - 18 Week RTT Activity	National	95.00%	95.50%	-	-	-	95.50%	95.00%	97.20%	-	-	-	97.20%		↓			
	% Last Minute Cancellations to Elective Surgery	National & Contract	0.60%	0.51%	0.72%	0.00%	1.06%	-	0.60%	0.64%	0.92%	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	-		→			

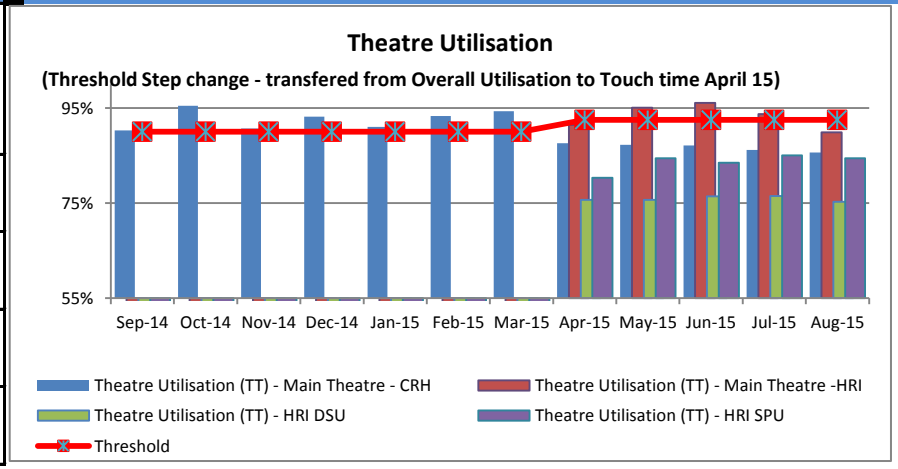
	Report For: August 2015	Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Year To Date: Target	Year To Date: Trust	Year To Date: Surgical	Year To Date: Medical	Year To Date: Families and Specialist Services	Year To Date: Community	Trend (Rolling 12 Month)	Direction of travel (past 4 months)	Financial Penalties/Non Financial Impact	Year End Forecast	Data Quality
Exception Report - Elective Access 3	% Patients Presenting with AF Anti-coagulated on Discharge	National & Contract	60.00%	40.00%	-	40.00%	-	-	60.00%	72.34%	-	72.34%	-	-		↓			
	% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival	National & Contract	90.00%	47.70%	-	47.70%	-	-	90.00%	53.60%	-	53.60%	-	-		↓			
	% Stroke patients spending 90% of their stay on a stroke unit	National	80.00%	73.40%	-	73.40%	-	-	80.00%	78.20%	-	78.20%	-	-		↓			
	Access to Imaging - % Stroke patients scanned within 1 hour of hospital arrival	Local	50.00%	42.22%	-	42.22%	-	-	50.00%	42.22%	-	42.22%	-	-					
	Access to Imaging - % Stroke patients scanned within 12 hours of hospital arrival	National	50.00%	89.13%	-	89.13%	-	-	50.00%	80.30%	-	80.30%	-	-					
	Management of High Risk TIA	National & Contract	60.00%	83.80%	-	83.80%	-	-	60.00%	78.40%	-	78.40%	-	-		↑			
	% Stroke patients Thrombolysed	National & Contract	5.00%	19.20%	-	19.20%	-	-	5.00%	19.20%	-	19.20%	-	-		↑			
	% Low-Risk TIA patients investigated and trated withn 7 days of first contact with a health professional	National	100.00%	94.34%	-	94.34%	-	-	100.00%	87.69%	-	87.69%	-	-		↑			
	% Stroke patients scanned within one hour of hospital arrival	National & Contract	100.00%	75.00%	-	75.00%	-	-	100.00%	67.39%	-	67.39%	-	-					
Exception Report - Elective Access 4	62 Day Gp Referral to Treatment	National & Contract	85.00%	93.94%	91.89%	96.43%	100.00%	-	85.00%	90.45%	91.24%	89.08%	95.31%	-		↑			
	62 Day Referral From Screening to Treatment	National & Contract	90.00%	100.00%	100.00%	-	-	-	90.00%	98.15%	98.08%	-	100.00%	-		→			
	31 Day Subsequent Surgery Treatment	National & Contract	94.00%	100.00%	100.00%	100.00%	-	-	94.00%	98.86%	100.00%	95.45%	-	-		→			
	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%	94.37%	92.68%	96.43%	100.00%	-	86.00%	91.05%	91.94%	89.08%	96.00%	-		↑			
	31 Days From Diagnosis to First Treatment	National & Contract	96.00%	100.00%	100.00%	100.00%	100.00%	-	96.00%	99.84%	99.74%	100.00%	100.00%	-		→			
	Two Week Wait From Referral to Date First Seen	National & Contract	93.00%	93.78%	97.36%	86.82%	90.67%	-	93.00%	96.16%	97.82%	91.76%	96.79%	-		↓			
	Two Week Wait From Referral to Date First Seen: Breast Symptoms	National & Contract	93.00%	98.60%	98.60%	-	-	-	93.00%	95.33%	95.33%	-	-	-		↑			
	7 Day Referral to First Seen	National & Contract	50.00%	29.08%	32.22%	22.48%	28.00%	-	50.00%	37.33%	41.36%	28.01%	35.06%	-		↓			
	38 Day Referral to Tertiary	National & Contract	85.00%	59.26%	56.25%	63.64%	-	-	85.00%	49.11%	46.15%	56.76%	44.44%	-		↑			
	54 Referral to Treatment	National & Contract	85.00%	74.24%	78.38%	67.86%	100.00%	-	85.00%	73.02%	75.69%	69.01%	72.97%	-		↑			

Calderdale and Huddersfield NHS Foundation Trust

Exception Report -Theatre Utilisation - Associate Director of Operations

compassionate care

Report For: August 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Theatre Utilisation (TT) - Main Theatre - CRH	92.50%	85.64%	84.17%	-	95.28%	-
Theatre Utilisation (TT) - Main Theatre -HRI	92.50%	89.87%	89.87%	-	-	-
Theatre Utilisation (TT) - HRI DSU	92.50%	75.31%	73.96%	-	86.29%	-
Theatre Utilisation (TT) - HRI SPU	92.50%	84.41%	84.41%	-	-	-

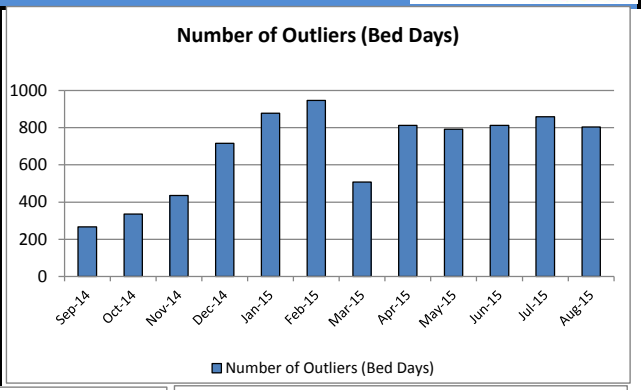


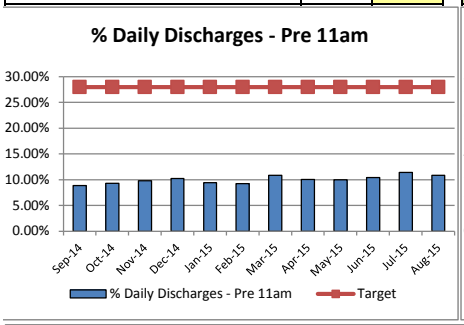
Theatre Utilisation:

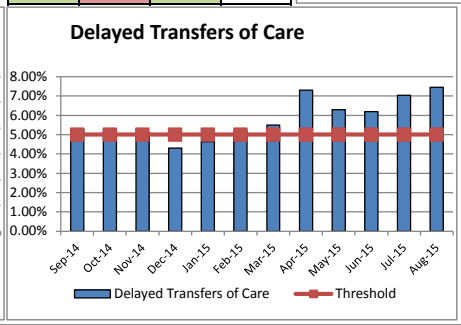
The Theatre Productivity Team continue to work on improving the number of patients going through theatres. Foureyes Consultancy are in helping us reset the required numbers by Consultant. This will be used to understand how many patients each surgeon should be treating, on average, each week. This is being followed by the theatre action week , W/B 5th Oct, which will identify and resolve many of the small problems which lead to inefficiencies in theatre flow. The expectation is that this will lead to another step change in the numbers of patients being treated in each operating session. The focus will be in day case theatres at HRI, with an aim of getting to 90% touch-time by the end of October, and CRH theatres, as these have the most opportunity to improve.

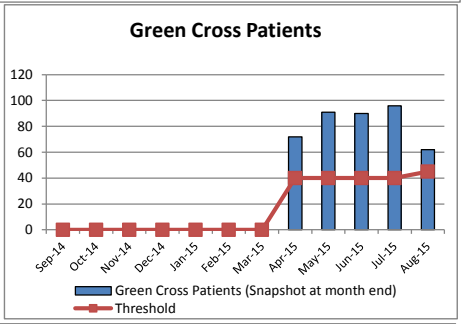
A more detailed update will be provided in the October report reflecting the recent Theatre 'Star Chamber' and the output from the Theatre Action Week

Report For: August 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Daily Discharges - Pre 11am	28.00%	10.83%	12.33%	10.77%	10.03%	-
Delayed Transfers of Care	5.00%	7.45%	-	-	-	-
Green Cross Patients (Snapshot at month end)	40	62	-	62	-	-
Number of Outliers (Bed Days)	401	803	236	567	0	-
% of Spells with > 2 ward movements (2% Target)	2.00%	2.28%	1.18%	5.29%	0.97%	-









Pre 11 am discharges

Why off Plan: Insufficient focus on the requirement to deliver this at ward level compounded by continued requirement to outlie patients which disjoints discharge planning. Clinical site commanders /patient flow continue to work with ward areas to ensure the use of discharge lounge is maximised, where clinically appropriate and safe to do so

Actions to get back on plan: . Acute physician presence on the MAU on both sites up until 8pm, 4 days a week has commenced in September which will facilitate early identification of patients, as well as supporting the evening discharge of a patient cohort the evening before. The impact of this will be closely monitored within the division of Medicine.

A KPI with Foureyes is ensuring early morning discharges with the project having an aspiration to achieve 40% of discharges prior to midday on an initial three target wards. The initial engagement with Foureyes is for a 12 week period the methodology will be rolled out across other wards after this period.

Specific issues in Gynaecology relating to their enhanced recovery programme (for those patients going to theatre in the afternoon 24/48 discharge occurs in the afternoon/early evening in the majority of cases). This work has delivered LOS benefit but does impact negatively on discharge pre11am

The patient Flow programme Board has been restructured with enhanced performance management and clear accountability.

When will we be back on track: An improvement trajectory that sees marked improvement through Quarter 3

Green X

Why the target is away from plan? There continues to be significant focus on these patients with clarity of definition and requirements at ward level in place. Whilst the target remains away from plan, there has been a significant reduction in recent weeks.

What are we doing to get it back to plan For those patients who require actions from partner this improvement continues to be managed through weekly operational meetings overseen by the DTOC Governance group.

When will this be achieved? Considerable work is underway with clinical teams to refine processes at ward level and across supporting services to minimise the number of patients on Green X pathways. Much of this work focussed on Plan for Every Patient ensuring this is embedded with an emphasis on the quality of the plan alongside medical input. This work is being facilitated by Foureyes Insight and whilst currently at a planning stage, is due to start in earnest in late September. The number of Green Cross patients have fallen in recent weeks as some of the efficiency work has begun to take effect. It is planned that this improvement should continue, to achieve target by the end of October.

Delayed Transfer of Care:

Why off plan: Since March the Trust has been working with partners in social care, community and NHS commissioners on a programme of work aimed to reduce the number of DTOCs. An improvement trajectory was set to achieve a target of 5% of occupied bed days by the end of September. However, performance in July and August has been off-track with changes across a variety of drivers evidenced in the August sitrep which shows a shift in the categorisation of delays. Whereas in previous months the most common cause of the delay was waiting for assessment, in August patients were more likely to be waiting for a package of care and delays waiting for patient or family choice.

Actions to get back to plan: The current DToC improvement action plan has been revised to reflect the changed reason for delay. The DToC Improvement group has undertaken two “go and see” visits to high-performing organisations and identified learning and a series of actions that will see a reduction in reportable delays. These include a review of the discharge pathway, implementing a case worker model for discharge, timely escalation and resolution of delays and more integrated working with social services teams. The Trust is also working with NHS commissioners and the Local Authorities to create a plan to tackle capacity issues in nursing care home beds and home care.

When will this be back on track The revised action plan responds to the changed causation factors and is being managed via a further focussed performance process. Assurance regarding the performance processes within partner organisations has also been requested giving greater system improvement and a WTGR workshop is taking place before end of September to further embed improvement at local level. By the end of November 2015 is it expected that delays waiting for assessment, patient or family choice, disputes and equipment are minimised which should bring performance closer to the 5% of occupied bed days. However, there is a risk that streamlining processes and systems in hospital will result in patient waiting longer for a package of care or placement at the end of the pathway where workforce availability is a problem

No of outliers

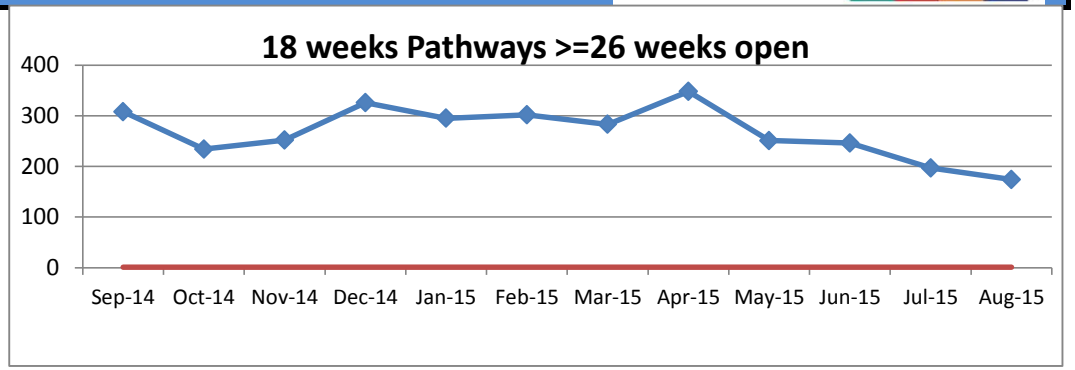
Why the target is away from plan? Bed pressures continue in the organisation, most acutely in the Medical Division with challenges of flow to support timely transfer from AED.The nerve centre is a key enabler to the reduction in outliers through better identification of bed capacity and the accuracy of the ‘outlier’ list. As this programme embeds more specific actions for improvement will be identified and actioned

What are we doing to get it back to plan Considerable work has been done to redesign the bed stock to minimise the need for outlying patients. This work is now at an advanced planning phase and should shortly lead to a bed reconfiguration, primarily in the Medical Division. This, coupled with ongoing improvements in efficiency will reduce occupancy rates and, wherever possible, make a clinically appropriate bed available in a more responsive manner.

When this will be achieved (a specific date) Based on forecasts of the likely occupancy, this should continue to improve in October however reflecting the onset of winter and need to ensure appropriate winter planning delivery may be volatile over the next 2 quarters

Exception Report - Elective Access - Associate Director of Operations

Report For: August 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
18 weeks Pathways >=26 weeks open	0	174	166	3	5	-
18 weeks Pathways >=40 weeks open	0	3	3	0	0	-



For the 26 & 40 week Pathways

Why off plan

There are 3 main causes for patients waiting longer than 26weeks

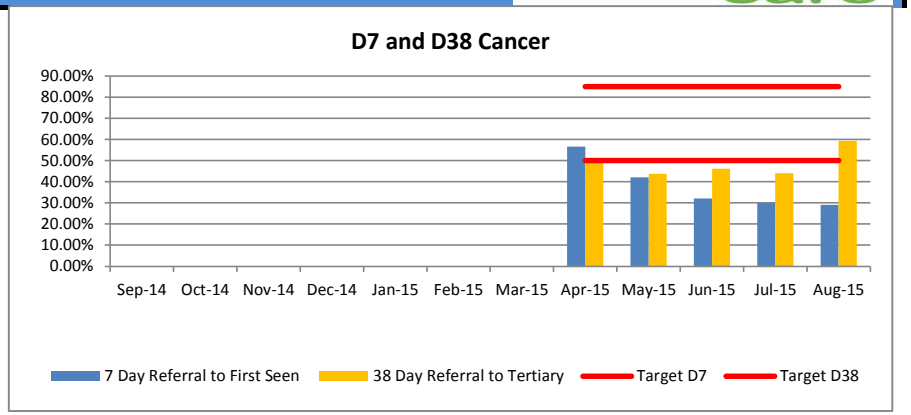
- The process for tracking of RTT pathways is complicated for those patients requiring diagnostic tests between outpatient and addition to waiting list which relies on manual matching of open pathways and can also lead to pathways inadvertently remaining open. These are validated weekly by the Medical Secretaries but the themes have not been collated to support improvement to process.
- There are some subspecialties/Consultant with a specialist skill set that have longer waiting lists and therefore some patients waiting a prolonged period of time due to capacity constraints
- There are patients who either choose a specific Consultant (who may have capacity constraints) or themselves choose to wait for surgery

Actions to get back on plan

A more formalised validation process is being established with collation of themes into an improvement plan. Some of this forms part of the process redesign to support new Clinical Admin Teams and some will need to wait for the EPR as would be inappropriate to recommend a PAS change at this stage in the EPR development. It is accepted therefore that a degree of manual validation will need to continue however we are seeking, as part of the review of operational structures, to develop an independent 'access' role that will provide greater assurance.
Waiting lists are being looked at by Consultants and the shapes of these reviewed to ensure strict chronological dating along with identification of opportunities to develop a more generic waiting list profile

Improvement can already be evidenced from the enclose graph and this trend is expected to continue.

Report For: August 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Two Week Wait From Referral to Date First Seen	93.00%	93.78%	97.36%	86.82%	90.67%	-
7 Day Referral to First Seen	50.00%	29.08%	32.22%	22.48%	28.00%	-
38 Day Referral to Tertiary	85.00%	59.26%	56.25%	63.64%	-	-
54 Referral to Treatment	85.00%	74.24%	78.38%	67.86%	100.00%	-



2WW: This indicator is delivering at Trust level but masking a specific pressure point in Dermatology. The service is currently fragile with a volume of Consultant vacancies and changes to outpatient nurse staffing that have created some capacity issues compounded by system capacity pressures in other providers

An element of the service currently sub contracted to a partner organisation transfers in October and a clearer demarcation on referral thresholds is being established from which further improvement actions can be identified.

Day 7 referral to first seen & Day 38 transfer to Tertiary provider: The former is an internal indicator developed to facilitate delivery of the 62day standard but also a key contributor to the delivery of referral to Tertiary provider by D38. The requirement to deliver 85% of transfer by D38 is nationally recognised as a requirement to support cancer centres in the delivery of their 62performance and reflects the complexity of multi-provider pathways.
Divisions have been challenged with developing bespoke action plans to secure delivery of both these indicators and to establish more robust weekly tracking of delivery. To support this, timed pathways have been developed an agreed for each tumour site with triggers and escalation embedded.
Leeds Teaching Hospital have been informed of progress of these plans and advised that we aim to secure improvement throughout Quarter 3. A meeting is scheduled this month with Assistant Divisional Directors to ensure accountability is clear.

Performance by tumour site: Cancer is reported nationally using the terminology of Tumour site reflecting that some specialties may have several tumour pathways e.g. General Surgery can have Upper and Lower pathways. Due to continued pressure nationally on the delivery of cancer performance all Trust have been instructed to ensure Board level visibility at tumour site with recovery plans developed to ensure equity of access regardless of presentation. For CHT this has identified that whilst overall performance is very positive there are some patients not receiving the optimal pathway. Whilst some of this will be due to the complex nature of their presentation there remains some element of avoidable delays that teams have reviewed and used to inform the timed pathways that will allow closer scrutiny and earlier escalation.
An improvement trajectory is to be established with each Division and will be managed through Divisional Performance process

The improvements required to secure D7 and D38 performance will have a positive impact on D54 delivery.

Cancer by Tumour Site

14 Day Referral to Date First Seen	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Trust	96.37%	98.58%	96.58%	95.79%	93.78%								96.16%	97.10%	94.80%		
Target	93.00%	93.00%	93.00%	93.00%	93.00%								93.00%	93.00%	93.00%		
Acute Leukemia	-	-	-	-	-								-	-	-		
Brain	100.00%	100.00%	80.00%	100.00%	100.00%								97.14%	94.12%	100.00%		
Breast	98.41%	100.00%	96.84%	93.17%	98.53%								97.16%	98.37%	95.68%		
Childrens	100.00%	100.00%	100.00%	100.00%	-								100.00%	100.00%	100.00%		
Gynaecology	100.00%	100.00%	97.96%	94.87%	90.67%								96.79%	99.17%	93.33%		
Haematology	100.00%	100.00%	93.75%	90.91%	100.00%								95.95%	97.87%	92.59%		
Head & Neck	98.06%	100.00%	98.29%	97.94%	95.08%								98.06%	98.60%	97.18%		
Lower GI	100.00%	99.14%	99.31%	96.83%	98.18%								98.59%	99.51%	97.59%		
Lung	100.00%	100.00%	100.00%	100.00%	100.00%								100.00%	100.00%	100.00%		
Sarcoma	100.00%	100.00%	100.00%	80.00%	100.00%								96.67%	100.00%	91.67%		
Skin	84.92%	95.15%	91.32%	93.29%	83.33%								89.87%	90.99%	88.40%		
Testicular	100.00%	100.00%	100.00%	100.00%	100.00%								100.00%	100.00%	100.00%		
Upper GI	93.48%	97.10%	98.94%	96.00%	95.18%								96.15%	96.47%	95.70%		
Urology	98.88%	100.00%	98.95%	100.00%	97.00%								98.92%	99.24%	98.51%		
Others	-	-	-	-	-								-	-	-		

14 Day Referral to Date First Seen: Breast Sympt	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Trust	93.41%	94.31%	94.92%	94.90%	98.60%								95.33%	94.40%	96.46%		
Target	93.00%	93.00%	93.00%	93.00%	93.00%								93.00%	93.00%	93.00%		
Breast	93.41%	94.31%	94.92%	94.90%	98.60%								95.63%	94.40%	96.92%		

31 Day Diagnosis to First Treatment	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Trust	100.00%	100.00%	99.29%	100.00%	100.00%								99.84%	99.74%	100.00%		
Target	96.00%	96.00%	96.00%	96.00%	96.00%								96.00%	96.00%	96.00%		
Acute Leukemia	-	-	-	-	-								-	-	-		
Brain	100.00%	100.00%	-	100.00%	100.00%								100.00%	100.00%	100.00%		
Breast	100.00%	100.00%	100.00%	100.00%	100.00%								100.00%	100.00%	100.00%		
Childrens	-	-	-	-	-								-	-	-		
Gynaecology	100.00%	100.00%	100.00%	100.00%	100.00%								100.00%	100.00%	100.00%		
Haematology	100.00%	100.00%	100.00%	100.00%	100.00%								100.00%	100.00%	100.00%		
Head & Neck	-	100.00%	66.67%	100.00%	-								85.71%	75.00%	100.00%		
Lower GI	100.00%	100.00%	100.00%	100.00%	100.00%								100.00%	100.00%	100.00%		
Lung	100.00%	100.00%	100.00%	100.00%	100.00%								100.00%	100.00%	100.00%		
Sarcoma	-	-	-	-	-								-	-	-		
Skin	100.00%	100.00%	100.00%	100.00%	100.00%								100.00%	100.00%	100.00%		
Testicular	-	-	-	-	-								-	-	-		
Upper GI	100.00%	100.00%	100.00%	100.00%	100.00%								100.00%	100.00%	100.00%		
Urology	100.00%	100.00%	100.00%	100.00%	100.00%								100.00%	100.00%	100.00%		
Others	100.00%	100.00%	100.00%	100.00%	-								100.00%	100.00%	100.00%		

62 Day Referral to Treatment	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Trust	89.76%	92.25%	88.37%	89.13%	93.94%								90.45%	90.00%	91.14%		
Target	85.00%	85.00%	85.00%	85.00%	85.00%								85.00%	85.00%	85.00%		
Acute Leukemia	-	-	-	-	-								-	-	-		
Brain	-	-	-	-	-								-	-	-		
Breast	100.00%	100.00%	100.00%	100.00%	100.00%								100.00%	100.00%	100.00%		
Childrens	-	-	-	-	-								-	-	-		
Gynaecology	66.67%	88.89%	100.00%	100.00%	100.00%								91.89%	84.21%	100.00%		
Haematology	66.67%	80.00%	100.00%	85.71%	71.43%								85.71%	89.29%	80.95%		
Head & Neck	0.00%	33.33%	72.73%	75.00%	100.00%								69.23%	56.25%	90.00%		
Lower GI	100.00%	84.62%	100.00%	96.15%	100.00%								96.74%	96.08%	97.56%		
Lung	70.83%	88.24%	75.86%	91.67%	100.00%								83.81%	77.14%	97.14%		
Sarcoma	-	-	-	0.00%	0.00%								0.00%	-	0.00%		
Skin	100.00%	100.00%	92.31%	76.19%	100.00%								94.85%	97.59%	90.57%		
Testicular	-	100.00%	100.00%	-	-								100.00%	100.00%	-		
Upper GI	81.82%	84.62%	100.00%	87.50%	100.00%								88.68%	87.88%	90.00%		
Urology	91.89%	100.00%	66.67%	79.41%	85.71%								85.35%	87.95%	82.43%		
Others	100.00%	-	66.67%	100.00%	-								66.67%	80.00%	50.00%		

62 Day Screening Referral to Treatment	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Trust	87.50%	100.00%	100.00%	100.00%	100.00%								98.15%	96.15%	100.00%		
Target	90.00%	90.00%	90.00%	90.00%	90.00%								90.00%	90.00%	90.00%		
Breast	80.00%	100.00%	100.00%	100.00%	100.00%								96.77%	93.33%	100.00%		
Gynaecology	100.00%	-	-	-	-								100.00%	100.00%	-		
Lower GI	100.00%	100.00%	100.00%	100.00%	100.00%								100.00%	100.00%	100.00%		

7 Day Referral to First Seen	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Trust	56.54%	42.12%	32.13%	29.99%	29.08%								37.33%	42.76%	29.54%		
Target	50.00%	50.00%	50.00%	50.00%	50.00%								50.00%	50.00%	50.00%		
Acute Leukemia	-	-	-	-	-								-	-	-		
Brain	14.29%	60.00%	40.00%	37.50%	44.44%								37.14%	35.29%	38.89%		
Breast	52.38%	24.83%	9.49%	9.94%	13.97%								21.01%	27.27%	13.26%		
Childrens	50.00%	100.00%	100.00%	100.00%	-								92.31%	83.33%	100.00%		
Gynaecology	37.50%	38.57%	31.63%	32.05%	28.00%								33.33%	35.42%	30.30%		
Haematology	35.71%	29.41%	25.00%	27.27%	38.46%								29.73%	29.79%	29.63%		
Head & Neck	66.02%	72.73%	32.48%	46.39%	59.02%								52.48%	53.85%	50.28%		
Lower GI	77.93%	54.31%	17.24%	13.23%	20.00%								33.85%	49.51%	16.84%		
Lung	0.00%	0.00%	0.00%	0.00%	0.00%								0.00%	0.00%	0.00%		
Sarcoma	100.00%	50.00%	60.00%	20.00%	60.00%								53.33%	66.67%	33.33%		
Skin	15.08%	18.79%	26.86%	17.07%	18.63%								20.15%	21.58%	18.27%		
Testicular	60.00%	75.00%	100.00%	88.89%	100.00%								88.24%	81.25%	94.44%		
Upper GI	57.61%	46.38%	38.30%	30.67%	25.30%								39.46%	47.45%	28.49%		
Urology	80.90%	71.79%	76.84%	73.12%	58.00%								71.77%	76.72%	65.35%		
Others	-	-	-	-	-								-	-	-		

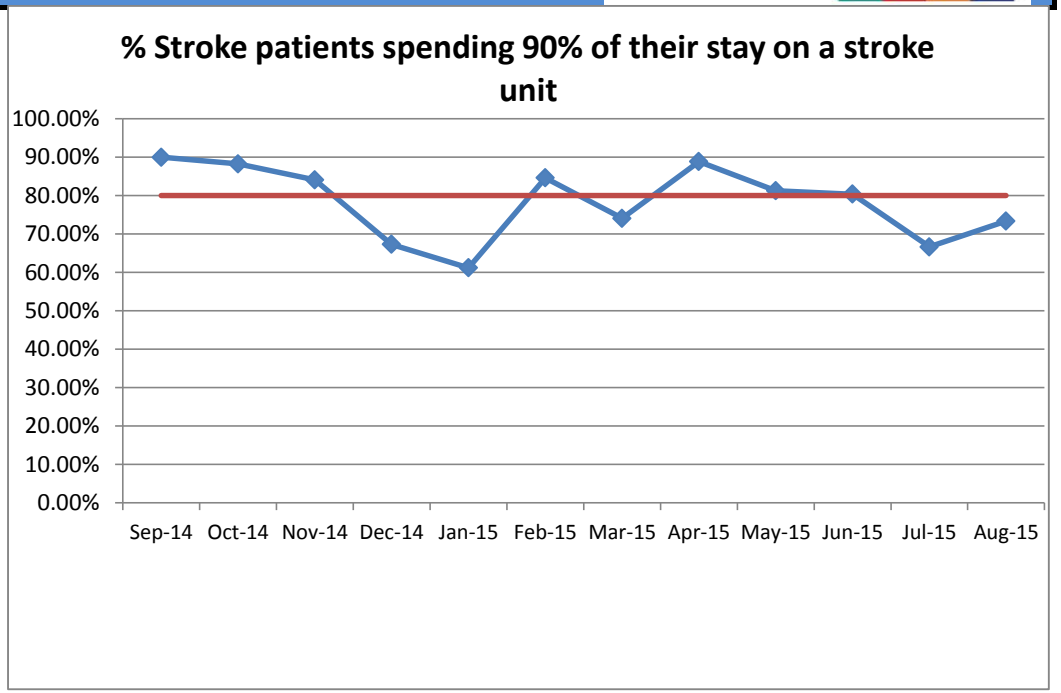
38 Day Gp Referral to Referral to Tertiary	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Trust	50.00%	43.75%	46.15%	44.00%	59.26%								49.11%	46.67%	51.92%		
Target	85.00%	85.00%	85.00%	85.00%	85.00%								85.00%	85.00%	85.00%		
Acute Leukemia	-	-	-	-	-								-	-	-		
Brain	-	-	-	-	-								-	-	-		
Breast	-	-	-	-	-								-	-	-		
Childrens	-	-	-	-	-								-	-	-		
Gynaecology	-	33.33%	50.00%	50.00%	-								44.44%	40.00%	50.00%		
Haematology	0.00%	-	100.00%	-	66.67%								60.00%	50.00%	66.67%		
Head & Neck	-	-	-	-	-								-	-	-		
Lower GI	75.00%	100.00%	-	33.33%	100.00%								57.14%	80.00%	44.44%		
Lung	25.00%	40.00%	66.67%	75.00%	66.67%								55.17%	50.00%	63.64%		
Sarcoma	-	-	-	100.00%	0.00%								66.67%	-	66.67%		
Skin	100.00%	-	-	0.00%	50.00%								60.00%	100.00%	50.00%		
Testicular	-	-	-	-	-								-	-	-		
Upper GI	0.00%	66.67%	0.00%	-	-								40.00%	40.00%	-		
Urology	60.00%	0.00%	28.57%	33.33%	63.64%								45.45%	38.46%	50.00%		
Others	-	-	0.00%	-	-								0.00%	0.00%	-		

54 Day Referral to Treatment	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Trust	77.11%	80.28%	64.53%	70.81%	74.24%								73.02%	73.54%	72.24%		
Target	85.00%	85.00%	85.00%	85.00%	85.00%								85.00%	85.00%	85.00%		
Acute Leukemia	-	-	-	-	-								-	-	-		
Brain	-	-	-	-	-								-	-	-		
Breast	100.00%	100.00%	100.00%	100.00%	90.91%								98.67%	100.00%	96.77%		
Childrens	-	-	-	-	-								-	-	-		
Gynaecology	66.67%	66.67%	100.00%	68.75%	100.00%								72.97%	73.68%	72.22%		
Haematology	66.67%	80.00%	73.33%	57.14%	42.86%								65.31%	75.00%	52.38%		
Head & Neck	0.00%	33.33%	36.36%	50.00%	50.00%								46.15%	31.25%	70.00%		
Lower GI	92.86%	76.92%	33.33%	61.54%	40.00%								57.61%	60.78%	53.66%		
Lung	54.17%	58.82%	65.52%	58.33%	73.68%								63.81%	60.00%	71.43%		
Sarcoma	-	-	-	50.00%	0.00%								33.33%	-	33.33%		
Skin	78.79%	83.33%	76.92%	66.67%	70.00%								74.26%	79.52%	66.04%		
Testicular	-	-	-	-	-								-	-	-		
Upper GI	36.36%	69.23%	66.67%	62.50%	100.00%								62.26%	57.58%	70.00%		
Urology	81.08%	88.89%	47.83%	64.71%	82.86%								73.29%	74.71%	71.62%		
Others	100.00%	-	0.00%	100.00%	-								44.44%	40.00%	50.00%		

Exception Report - Access Stroke - Associate Director of Operations

Report For: August 2015

	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Patients Presenting with AF Anti-coagulated on Discharge	60.00%	40.00%	-	40.00%	-	-
% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival	90.00%	47.70%	-	47.70%	-	-
% Stroke patients spending 90% of their stay on a stroke unit	80.00%	73.40%	-	73.40%	-	-
Access to Imaging - % Stroke patients scanned within 1 hour of hospital arrival	50.00%	42.22%	-	42.22%	-	-
% Low-Risk TIA patients investigated and trated withn 7 days of first contact with a health professional	100.00%	94.34%	-	94.34%	-	-
% Stroke patients scanned within one hour of hospital arrival	100.00%	75.00%	-	75.00%	-	-



Stroke Activity:

Why is the target off plan? Delivered against the High risk TIA and Thrombolysis target. Failed to deliver against the 80% of stroke patients spending 90% of their time on a stroke ward and the % of stroke admissions directly onto a stroke ward within 4 hours. Ward relocated from 6D over the course of the last month for decoration and minor works which impacted on available capacity leading to a deterioration in performance. SSNAP national average performance for direct admissions into a stroke ward is 56.8%. The two site model presents a particular problem particularly where a stroke was not initially suspected. Capacity constraints have meant that stroke patients awaiting intermediate / nursing home care have moved off onto the step down facility (ward 5B) to allow acute capacity for new stroke admissions. The time spent on a step down facility is counted in the total patients LoS which means that for these patients we will breach the 90% stay standard.

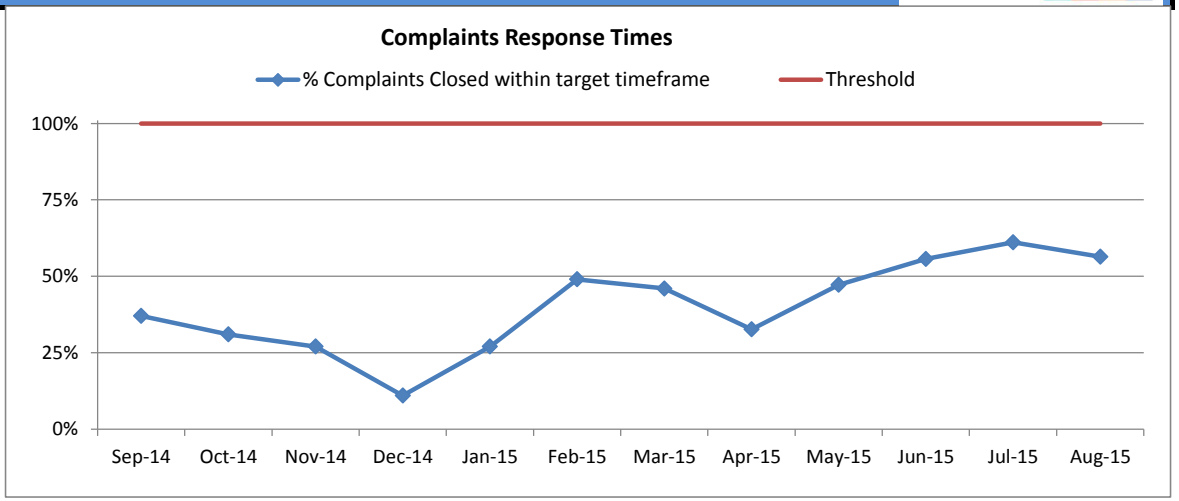
What are we doing to get it back to plan? Stroke action plan in place and being monitored within the fortnightly improvement group.
YAS audit of patients taken to the wrong site has been undertaken and will be fed back to clinical teams.
SOP for repatriation of non-stroke patients from stroke ward developed and in use within patient flow.
Protocol to allow stroke nurses the ability to request scans has been developed

When will we be back on track? Improvement trajectory to 70% for direct admissions established for end of October 2015

	Report For: August 2015	Indicator Source	Target	Trust	Year To Date: 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)	Financial Penalties/Non Financial Impact	Year End Forecast	Data Quality
Complaints	Number of Mixed Sex Accommodation Breaches	National & Contract	0	0	0	0	0	n/a	0	0	0	0	0	n/a		↑			
	% Complaints closed within target timeframe	Local	100.00%	56.41%	63.64%	40.00%	70.00%	100.00%	100.00%	51.17%	46.67%	45.13%	70.18%	69.23%		↑			
	Total Complaints received in the month	Monitor	-	41	13	14	9	4	-	263	88	87	57	13		↓			
	Complaints acknowledged within 3 working days	Local	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	83.59%	79.55%	88.51%	84.21%	69.23%		→			
	Total Concerns in the month	Monitor	-	48	15	16	9	6	0	275	89	89	54	17		↑			
Friends & Family Test	Friends & Family Test (IP Survey) - Response Rate	Contract	40.00%	28.10%	29.00%	24.70%	35.60%	-	40.00%	24.60%	27.00%	26.10%	25.10%	-		↓			
	Friends & Family Test (IP Survey) - % would recommend the Service	Contract	95.00%	97.10%	97.70%	96.00%	97.50%	-	95.00%	97.00%	97.40%	95.90%	98.10%	-		↑			
	Friends and Family Test A & E Survey - Response Rate	Contract	30.00%	2.70%	-	2.70%	-	-	30.00%	6.70%	-	6.70%	-	-		↓			
	Friends and Family Test A & E Survey - % would recommend the Service	Contract	95.00%	84.80%	-	84.80%	-	-	95.00%	90.30%	-	90.30%	-	-		↓			
	Friends & Family Test (Maternity) - % would recommend the Service	Contract	95.00%	95.20%	-	-	95.20%	-	95.00%	94.30%	-	-	94.30%	-		↑			
	Friends and Family Test Community Survey - % would recommend the Service	Local	95.00%	90.00%	-	-	-	90.00%	95.00%	90.55%	-	-	-	90.55%		↑			

Exception Report - Complaints- Director of Nursing

Report For: August 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Complaints closed within target timeframe	100.00%	56.41%	63.64%	40.00%	70.00%	100.00%

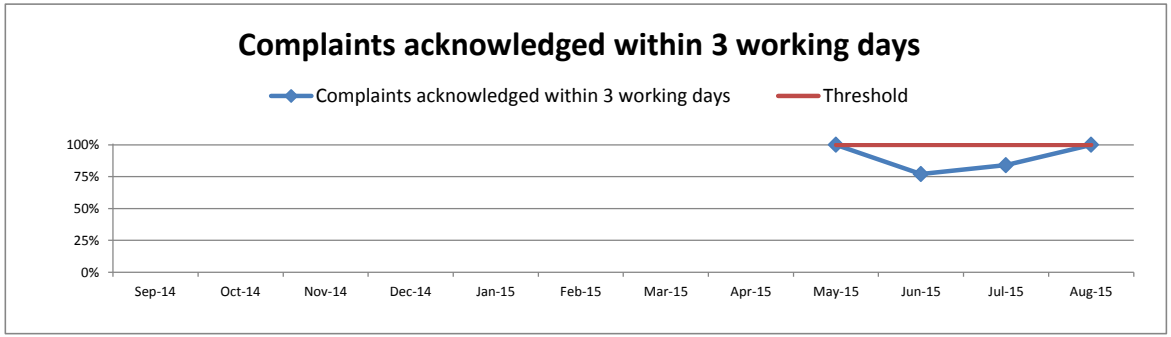


% Complaints closed within target timeframe

1. Why off plan? The 5% reduction in performance in August compared to July ,reflects high levels of annual leave in the trust during the month, meaning fewer complaint files were received back centrally for final review. This was further impacted upon by the focused effort on ensuring complaints were acknowledged in 3 days . The overall number of open complaints fell from 125 at 1..8.15. to 111 at 28.8.15.

2. Actions to get on plan? The drive continues to conclude all cases ongoing over timescale. At the end of August, 28 complaints are overdue by up to one month, 14 by 1 to 2 months and 6 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.



Exception Report - Friends and Family Test - Director of Nursing

Report For: August 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Friends & Family Test (IP Survey) - Response Rate	40.00%	28.10%	29.00%	24.70%	35.60%	-
Friends and Family Test A & E Survey - Response Rate	30.00%	2.70%	-	2.70%	-	-
Friends and Family Test A & E Survey - % would recommend the Service	95.00%	84.80%	-	84.80%	-	-
Friends and Family Test Community Survey - % would recommend the Service	95.00%	90.00%	-	-	-	90.00%

A&E FFT - Reponses Rate & Results:

Why off plan: There has been a continued deterioration of the response rates since the removal of the token system . This month has been particularly poor due to pressures on the unit resulting in staff being unable to engage patients with the postcard feedback processes.

Actions to get back on plan: To aid the improvement in response rates the text message feedback system is being introduced in September. This will be in place alongside patient postcards being given out by staff. In order to make this much more successful a task & finish group will be set up within the Emergency Medicine Directorate to ensure all staff groups are engaged with the process of providing postcards and how to get patients/relatives to understand the importance of their feedback.
Recent results have been analysed which show that there are 3 specific themes in the patients feedback 1) Delays in waiting time 2) Poor Communication 3) Staff attitude/professionalism. The task & finish group will provide an updated action plan focusing improvement work on these 3 themes.

When will we be on track: Early indications show an improved position for September. A trajectory for further improvement and achievement of the response rate target will be set once the text message baseline is known.

Community FFT - Would Recommend:

1. Why off plan? Performance remains below target. A meeting has taken place with Envoy (supplier of the SMS text service) to enhance the process which will enable identification of the service area being commented on and their individual response rates. On review of the comments it is possible to see that clients /patients are confused in respect to which service they are being asked to feed back on. Some also chose to opt out of the feedback process which then excludes them from future texts

2. Actions to get back on plan: There are planned changes to the way in which feedback is gathered for this group of patients, with the addition of a web based FFT tool. This will enable practitioners to ask clients to complete the feedback immediately after a face to face contact, ensuring any confusion around which service they are being asked about is removed from the process . Feedback can then be reviewed against the correct service and targeted improvement made to increase the likelihood of patients recommending our services. A review of the trends within responses is taking place this month and actions plans devised within service areas

3. Achieved by date: The new data collection methods are expected to be embedded during September/October . The actions within the plans are thought to impact from October onwards.

Inpatient FFT Response Rate:

1.Why off plan: Further improvements have been achieved in the August response rate, with a shift from 26.5% to 28.1%. The Trust is aware that this low response rate is associated with the spread to all 'day case' areas in April 2015. Using the pre April 15 criteria for inpatients FFT, the Trust would continue to score above 40%.

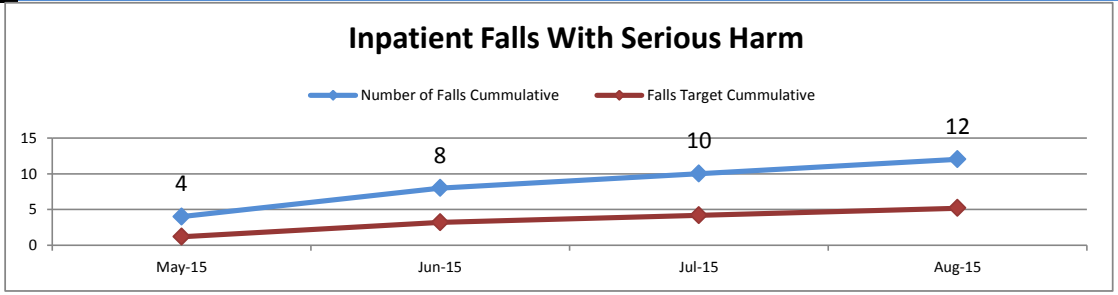
2.Actions to get back on plan: Divisional FFT leads are continuing to liaise with the relevant teams to ensure they are progressing the FFT process for this patient group. The 'day case' category covers a number of areas where a patient does not have an overnight stay, e.g. admissions / decisions units as well as all areas where a procedure is carried out, 27 in total. Whilst there has shift in the right direction, the drive for improvement continues focusing on the day case areas where a very low response performance is being noted. This has proved to be more challenging than initially anticipated as the majority of these areas have never been involved in issuing the FFT cards. Examples being the ophthalmology day procedures and the pain management day cases. For these areas the processes are being setup including the availability of the cards and post boxes along with staff briefings. In the main day surgery units FFT information points have been set up in the waiting grooms, including files with previous comments, directions to the post box and you said we did information. Clip boards and pens have also been provided for ease of completion

3. Achieved by date: The level of improvement required will require some time to embed the changes and ensure all potential areas have been identified, there is a trajectory in place to achieve this by Quarter 3.

	Report For: August 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)	Financial Penalities/Non Financial Impact	Year End Forecast	Data Quality
											Year To Date								
Safety	Inpatient Falls with Serious Harm (10% reduction on 14/15)	Local	1	2	0	2	0	0	5	12	1	11	0	0		↓			
	All Falls	Local	-	138	23	113	0	2	-	798	128	643	12	15		↓			
	Number of Trust Pressure Ulcers Acquired at CHFT	Local	25	20	7	6	0	7	125	248	29	64	2	153		↓			
	Number of Category 2 Pressure Ulcers Acquired at CHFT	Local	17	15	7	5	0	3	85	187	21	46	2	118		↓			
	Number of Category 3 Pressure Ulcers Acquired at CHFT	Local	7	5	-	1	0	4	35	55	7	16	0	32		↓			
	Number of Category 4 Pressure Ulcers Acquired at CHFT	Local	1	0	0	0	0	0	5	6	1	2	0	3		→			
	Number of Category 3 & 4 Pressure Ulcers Acquired at CHFT	Local	8	5	0	1	0	4	40	61	8	18	0	35		↓			
Safety 2	Percentage of Completed VTE Risk Assessments	National & Contract	95.00%	95.60%	95.20%	94.90%	97.20%	-	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%	n/a	-	100.00%	100.00%	100.00%	100.00%	100.00%	-		↑			
	% Harm Free Care	CQUIN	95.00%	92.19%	90.91%	91.13%	98.46%	93.04%	95.00%	93.89%	94.95%	91.40%	99.75%	94.40%		↓			
	Safeguarding Alerts made by the Trust	Local	-	12	-	-	-	-	-	89	-	-	-	-		↓			
	Safeguarding Alerts made against the Trust	Local	-	6	-	-	-	-	-	40	-	-	-	-		↓			
	World Health Organisation Check List	National	100.00%	98.67%	-	-	-	-	100.00%	98.09%	-	-	-	-		↑			
	Missed Doses (Reported quarterly)	National	-	-	-	-	-	-	-	7.80%	9.63%	7.10%	6.55%	-					
Safety 3	Number of Patient Incidents	Monitor	-	525	107	246	145	27	-	3296	595	1536	872	285		↑			
	Number of SI's	Monitor	-	5	0	0	1	4	-	66	9	19	3	35		↑			
	Number of Incidents with Harm	Monitor	-	111	17	56	29	9	-	905	112	398	215	179		↓			
	Never Events	National	0	0	0	0	0	0	0	0	0	0	0	0		→			
	Percentage of SI's reported externally within timescale (2 days)	Local	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	-	-	-	-	-	-		→			
	Percentage of SI's investigations where reports submitted within timescale (45 days unless extension agreed)	Local	100.00%	100.00%	100.00%	100.00%	100.00%	-	100.00%	45.45%	25.00%	46.15%	100.00%	-		↑			
	Total Duty of Candour reported within the month	National & Contract	100.00%	100.00%	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	0	4	-	-	-	-		→			

Exception Report - Safety - Director of Nursing

Report For: August 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	0



Falls with Serious Harm

1.Why off plan: There have been 12 falls in the year so far, against a 10% reduction target of 5. (There have been 11 falls in medicine and 1 in surgery). The Safety thermometer data indicated that there was a higher fall rate of 0.8% compared to 0.5% in the previous month.

2.Actions to get back on plan: The risk remains in the achievement of the year end target. Medical division falls collaborative is continuing to work with the Improvement Academy to move forward with patient safety briefings which are being introduced to ward 1 HRI (MAU) and ward 7b (CRH). Continued focus on completion of the falls bundle by clinical teams. Recommendation to the Patient Safety Group included facilitation of a 'safety summit' to include Falls Prevention in the intinery.

3. Achieved by date: Meeting to organise safety summit in September.

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.

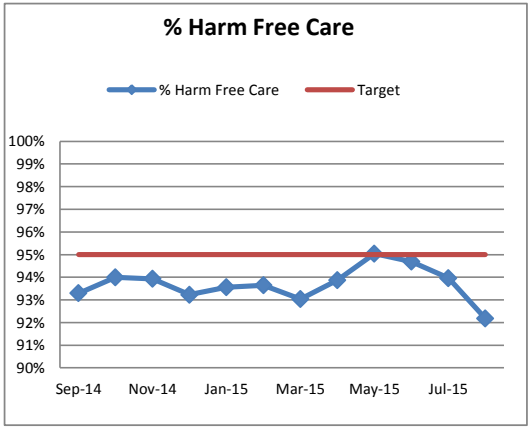
1.Why off plan? There are 5 category 3 ulcers so far noted for August, 4 of which occurred in community.

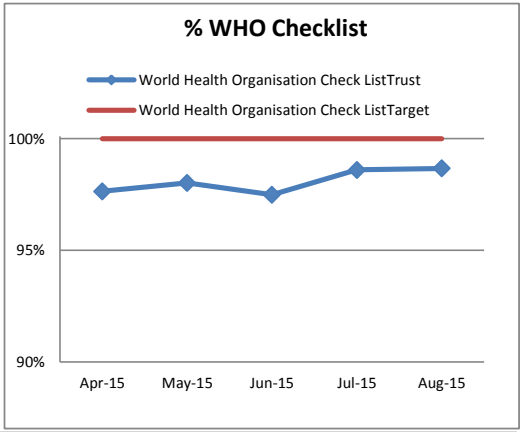
2. Actions to get back on plan: Due to not seeing the required reduction in the number of pressure ulcers a thematice review took place in July. following this, there are plans to hold a safety summit (this includes falls, pressure ulcers & medications) in order to engage with staff and ensure that current action plans address identified needs & concerns. All wards have been set individual targets and those off target have been asked to submit improvement plans .

3. Achieved by date: Improvements are expected from September2015 onwards.

Exception Report - Safety - Director of Nursing

Report For: August 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Percentage of Completed VTE Risk Assessments	95.00%	95.60%	95.20%	94.90%	97.20%	-
Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	100.00%	100.00%	100.00%	100.00%	n/a	-
% Harm Free Care	95.00%	92.19%	90.91%	91.13%	98.46%	93.04%
Missed Doses (Reported quarterly)	-	-	-	-	-	-
World Health Organisation Check List	100.00%	98.67%	-	-	-	-





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 Q1 is contributing to the improvements being seen.

2. Actions to get it back on plan: Performance monitoring for the small number of non-compliant cases. For the exempt patients a theatre system upgrade has been requested to have a N/A option included, this was originally planned for September 2015 but has been delayed by the system supplier.

3. Achieved by date: Awaiting confirmation of system upgrade date from supplier.

Harm Free Care:

1. Why off plan? Harm free care for the trust is at 92.19%. With all divisions seeing a poorer position that the previous month. The harm events contributing to this are primarily old pressure ulcers, of which there were 55. These are ulcers which are present on admission or developed within the first 72hours of admissions, alongside this were 5 new ulcers, 8 harm Falls, 11 UTIs in patients who had catheters and 3 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 p16) In relation to the UTIs, phase two of the indwelling improvement work continues and an associated drop in infection rates is anticipated when the work in more wide spread at the end of the year.

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

Effectiveness Executive Summary

	Report For: August 2015	Indicator Source	Target	Trust	Year To Date: 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)	Financial Penalties/Non Financial Impact	Year End Forecast	Data Quality
Effectiveness	Number of MRSA Bacteraemias – Trust assigned	National & Contract	0	0	0	0	0	0	0	2	0	1	0	1		→			
	Total Number of Clostridium Difficile Cases - Trust assigned	National & Contract	3	3	0	3	0	0	11	7	1	6	0	-		↑			
	Avoidable number of Clostridium Difficile Cases	National & Contract	0	0	0	0	0	0	21	2	1	1	0	-		→			
	Unavoidable Number of Clostridium Difficile Cases	National & Contract	3	3	0	3	0	0	11	5	0	5	1	-		↑			
	Number of MSSA Bacteraemias - Post 48 Hours	National	1	2	0	2	0	0	5	5	1	4	0	-		→			
	% Hand Hygiene Compliance	Local	95.00%	99.72%	99.24%	99.85%	100.00%	100.00%	95.00%	99.72%	99.11%	99.81%	99.90%	100.00%		↑			
	MRSA Screening - Percentage of Inpatients Matched	Local	95.00%	95.64%	94.10%	99.00%	96.30%	n/a	95.00%	96.64%	93.76%	99.30%	94.81%	-		↓			
	Number of E.Coli - Post 48 Hours	Local	3	3	1	2	0	0	13	15	4	11	0	-		→			
Effectiveness 2	Emergency Readmissions Within 30 Days (With PbR Exclusions)	National	7.41%	6.50%	3.92%	9.50%	6.28%	-	7.56%	8.01%	4.51%	12.25%	6.43%	-		↓			
	Emergency Readmissions Within 30 Days (With PbR Exclusions) - Calderdale CCG	Local	7.99%	6.35%	-	-	-	-	8.25%	8.16%	-	-	-	-		↓			
	Emergency Readmissions Within 30 Days (With PbR Exclusions) - Greater Huddersfield CCG	Local	7.09%	7.21%	-	-	-	-	7.18%	8.47%	-	-	-	-		↓			
	Local SHMI - Relative Risk (1yr Rolling Data Jan14- Dec 14)	National	100	109.3	-	-	-	-	100	109.1	-	-	-	-		↑			
	Hospital Standardised Mortality Rate (1 yr Rolling Data Jul 14 - Jun 15)	National	100.00	113.00	-	-	-	-	100.00	113.00	-	-	-	-		↑			
	Mortality Reviews – July Deaths	local	100.00%	75.20%	62.50%	76.10%	n/a	n/a	100.00%	45.90%	48.40%	45.70%	n/a	-		↑			
	Crude Mortality Rate (Latest Month Aug 15)	National	1.21%	1.18%	0.41%	2.88%	0.00%	n/a	1.17%	1.30%	0.40%	3.14%	0.06%	-		↓			
	Completion of NHS numbers within acute commissioning datasets submitted via SUS	Contract	99.00%	99.90%	99.90%	99.90%	99.80%	n/a	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%	98.80%	-	98.80%	-	n/a	95.00%	99.10%	-	99.00%	-	-		↓			
	Average Diagnosis per Coded Episode	National	4.90	4.11	3.51	5.75	2.32	n/a	4.90	3.99	3.45	5.56	2.26	-		↑			
Effectiveness3	Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	National	85.00%	58.33%	58.33%	-	-	-	85.00%	58.94%	58.94%	-	-	-		↑			

Exception Report - Effectiveness - Medical Director

Report For: August 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Number of MSSA Bacteraemias - Post 48 Hours	1	2	0	2	0	0

MSSA Bacteraemia - Post 48 Hours

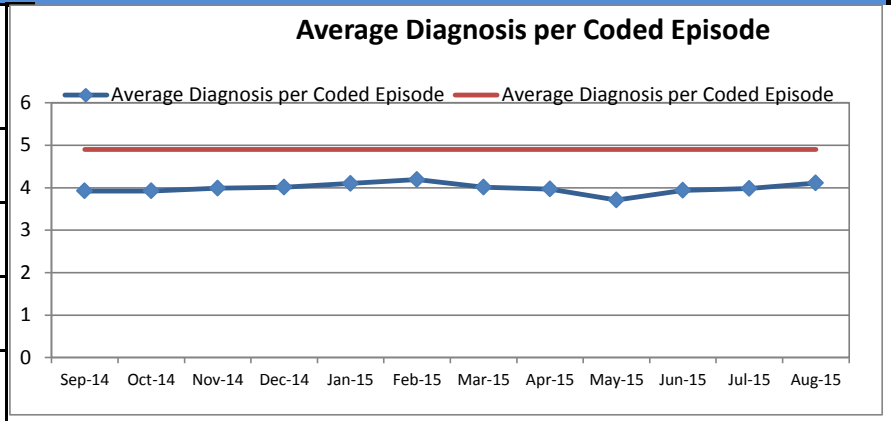
Why off plan: The trust has an internal target to have no more than 12 cases by year end, at present there have been 5 cases to date and the trust remains on trajectory. however, two of these occurred in August. Both cases are thought to be unavoidable. One case was related to an ulcer in a patient known to be colonised with MSSA already. The other case was related to an undrainable collection in an end of life oncology patient.

Actions to get back on plan: Due to the unavoidable nature of these cases, there are no plans in place to mitigate against this happening in the future. Consideration is being given to how the infection control team might be able to do PIR for all post-48 hour MSSA bacteraemias to ensure robust learning mechanisms are in place should an avoidable case occur

When will we be on track: Current processes will remain in place and performance expected to average out at no more than 1 case per month over the rest of the year.

Exception Report - Effectiveness - Medical Director

Report For: August 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Local SHMI - Relative Risk (1yr Rolling Data Jan14- Dec 14)	100	109.3	-	-	-	-
Hospital Standardised Mortality Rate (1 yr Rolling Data Jul 14 - Jun 15)	100	113	-	-	-	-
Mortality Reviews – July Deaths	100.00%	75.20%	62.50%	76.10%	n/a	n/a
Average Diagnosis per Coded Episode	4.90	4.11	3.51	5.75	2.32	n/a



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. Work continues to develop existing documentation to assist coding process e.g. inclusion of co-morbidity pro-forma in T&O, paediatric and Surgical assessment clerking in documentation. Co-morbidity form compliance continues to be monitored on a fortnightly basis. The recruitment process is now underway. Additional processes have been put in place to ensure complete capture of SPC codes.

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 trust's patient population. The most recent 12 months data for HSMR indicates a score of 113, which is an increase from previous release and continues to be an outlying position. The August 2015 crude mortality is however lower than the same point in the previous year

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. It focuses on six areas: mortality reviews and learning; reliability; deteriorating patients; end of life care; frailty; and coding.
The mortality review process has been approved and is now implemented. This clarifies the processes including a new process of getting the deceased patients' case notes delivered to clinical reviewers to get more timely learning and a greater number of reviews carried out. The latest figure of the number of mortality reviews carried out in August (July's deaths) is 75.2%. Whilst this is still under target it is a significant improvement on previous months. A greater number of reviews being undertaken will enable identification of key problem areas to focus improvements.
Additionally, The need for a number of focused reviews has been identified: first a review of all patients who died in HRI in March is to be undertaken during September as a result of a sharp rise in the HSMR in March. This is expected to completed by the end of September.

3.Achieved By: Further improvements in Mortality Review compliance is expected in September (deaths occurring during August) as initial difficulties in the process have been resolved. A summary report of the findings of all the mortality reviews has been presented to CEAM, and will be presented to COG in September. A regular report of the review compliance, findings, learning and actions is now scheduled each month

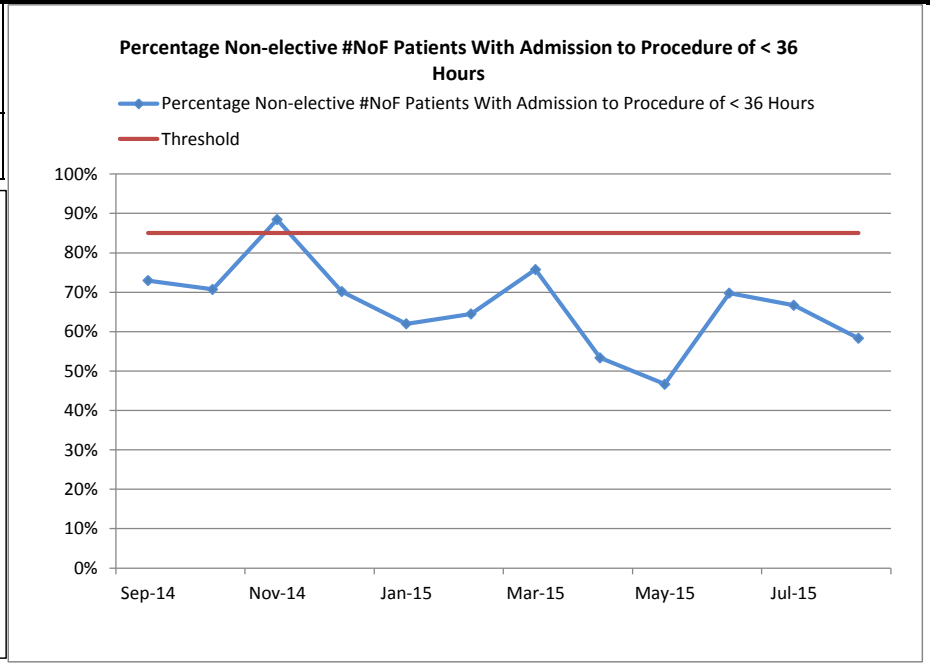
Report For: August 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	85.00%	58.33%	58.33%	-	-	-

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

Why off plan
As reported in August the issues highlighted in July impacted into early August. There was an initial surge at the beginning of August (10 of the first 14 patients with #NOF breached during this time) and whilst performance slowly improved this was not sufficient to bring this back into an overall improvement position compounded by some surgical availability. 8 of the delays were for clinical reasons.
In Total there were 34 admission, 19 of which were delivered in time.

Actions to get back on plan: Significant discussion at the Trust outcomes meeting and again at the Divisional Performance review with more specific actions identified; to be documented with clear accountabilities to facilitate a more rapid and sustained improvement Performance continues to be closely managed through the Divisional Management Board. All patients who fail the metric will be reviewed to provide assurance that this is for clinical rather than operational reasons. A review of the fallow theatre lists is expected to release additional capacity in September.

When will we be on track: The Directorate will be proposing an improvement trajectory along with the revised delivery plan by the end of September 2015.



Fracture Neck of Femur	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
Number of fragility hip fracture discharges recorded on the National Hip Fracture Database	45	45	43	39	36								**171**
% achieving Best Practice Tariff	53.33%	46.67%	69.77%	66.67%	58.33%								**58.94%**
a) time to surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an admitted patient, to the start of anaesthesia.	73.33%	55.56%	76.74%	66.70%	63.90%								**67.84%**
(b) admitted under the joint care of a consultant geriatrician and a consultant orthopaedic surgeon.	97.78%	91.11%	100.00%	100.00%	100.00%								**97.08%**
(c) admitted using an assessment protocol agreed by geriatric medicine, orthopaedic surgery and anaesthesia.	100.00%	100.00%	97.67%	100.00%	100.00%								**99.42%**
(d) assessed by a geriatrician in the perioperative period (within 72 hours of admission).	93.33%	82.22%	95.35%	100.00%	97.20%								**91.81%**
(e) postoperative geriatrician-directed multi-professional rehabilitation team	82.22%	91.11%	93.02%	97.40%	94.40%								**87.72%**
(f i) fracture prevention assessments (Falls)	82.22%	82.22%	88.37%	92.30%	86.10%								**85.38%**
(f ii) fracture prevention assessments (Bone health)	100.00%	93.33%	100.00%	94.90%	94.40%								**97.08%**
(g i) two Abbreviated Mental Tests (AMT) performed and all the scores recorded in NHFD with the first test carried out prior to surgery and the second post-surgery but within the same spell - Pre-Op	93.33%	91.11%	97.67%	100.00%	94.40%								**95.32%**
(g ii) two Abbreviated Mental Tests (AMT) performed and all the scores recorded in NHFD with the first test carried out prior to surgery and the second post-surgery but within the same spell - Post-Op	91.11%	86.67%	90.70%	97.40%	97.20%								**91.23%**

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Workforce indicators

The first row of tables below show sickness absence rates for CHFT during June and July 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	Jun-15	Jul-15	Movement
Surgery	4.56%	4.23%	↓
Medical	5.28%	4.91%	↓
Community	3.87%	3.83%	↓
FSS	4.61%	4.43%	↓
Estates	4.22%	3.76%	↓
Corporate	1.74%	2.43%	↑
THIS	3.84%	3.78%	↓
Trust	**4.47%**	**4.26%**	↓

Sickness Absence rate (%) (1 Month Behind)

Division	Short Term	Long Term	Overall %	RAG
Surgery	1.21%	3.01%	4.23%	🔴
Medical	1.17%	3.73%	4.91%	🔴
Community	0.70%	3.13%	3.83%	🟢
FSS	1.36%	3.07%	4.43%	🔴
Estates	0.46%	3.30%	3.76%	🟢
Corporate	0.95%	1.48%	2.43%	🟢
THIS	0.68%	3.10%	3.78%	🟢
Trust	**1.10%**	**3.16%**	**4.26%**	🔴

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

Division	Available FTE	Short Term FTE	Long Term FTE	FTE Days Lost
Surgery	33163.63	402.89	998.93	1401.82
Medical	39058.07	458.74	1457.49	1916.23
Community	18547.46	129.18	581.15	710.33
FSS	40237.45	546.31	1236.77	1783.08
Estates	8324.91	38.24	274.61	312.85
Corporate	8464.22	80.40	125.00	205.40
THIS	5646.86	38.51	175.00	213.51
Trust	**153442.60**	**1694.27**	**4848.95**	**6543.22**

Sickness Absence rate (%) (1 Month Behind)

Staff Group	Jun-15	Jul-15	Movement
Add Sci & Tech	2.17%	2.60%	↑
ACS	6.68%	4.99%	↓
Admin & Clerical	3.87%	3.73%	↓
AHP	2.71%	1.51%	↓
Estates & Ancil.	5.35%	3.69%	↓
Healthcare Scientists	2.30%	1.76%	↓
Medical and Dental	0.75%	2.06%	↑
Nursing & Midwifery	6.32%	5.84%	↓

Sickness Average FTE Lost per Episode

Division	Jun-15	Jul-15	Movement
Surgery	9.96	9.41	↓
Medical	9.25	9.21	↓
Community	8.34	10.60	↑
FSS	8.72	9.05	↑
Estates	7.90	8.94	↑
Corporate	7.59	8.56	↑
THIS	12.88	10.68	↓
Trust	**9.10**	**9.35**	↑

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

Division	Available FTE	FTE Days Lost	YTD Sicknes %	RAG
Surgery	397394.05	17409.96	4.38%	🔴
Medical	470585.03	24961.10	5.30%	🔴
Community	229979.82	8514.56	3.70%	🟢
FSS	493644.24	22825.07	4.62%	🔴
Estates	105917.91	5478.18	5.17%	🔴
Corporate	101170.07	1801.11	1.78%	🟢
THIS	68140.21	2541.13	3.73%	🟢
Trust	**1866831.33**	**83531.10**	**4.47%**	🔴

Staff in Post Full Time Equivalent

Division	Jul-15	Aug-15	Movement
Surgery	1064.04	1071.61	↑
Medical	1258.49	1267.34	↑
Community	600.10	602.21	↑
FSS	1298.96	1276.00	↓
Estates	265.83	264.04	↓
Corporate	271.37	273.17	↑
THIS	183.66	186.06	↑
Trust	**4942.44**	**4940.43**	↓

Staff in Post Headcount

Jul-15	Aug-15	Movement
1201	1188	↓
1406	1406	→
749	738	↓
1520	1522	↑
359	351	↓
316	311	↓
186	190	↑
5737	**5706**	↓

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Training indicators

Mandatory Training Indicators completetd since April 2015

Division	Prevent	Equality & Diversity	Information Governance	Infection Control	Health & Safety	Manual Handling	Safeguarding	Fire Safety	Overall Compliance*
Surgery	8.9%	33.10%	33.70%	29.50%	29.50%	29.20%	18.7%	24.80%	0.60%
Medical	5.7%	33.20%	36.80%	32.00%	31.40%	32.20%	20.6%	23.10%	2.30%
FSS	5.2%	37.00%	40.00%	35.10%	34.90%	34.30%	19.8%	38.00%	0.30%
Community	5.7%	34.30%	35.10%	29.10%	28.30%	29.80%	16.6%	32.30%	0.90%
Estates	2.1%	14.30%	17.60%	16.70%	15.20%	15.80%	13.1%	46.70%	2.20%
Corporate	9.7%	32.00%	34.30%	32.00%	33.00%	32.30%	24.7%	47.00%	0.80%
THIS	21.3%	47.50%	38.80%	41.00%	41.00%	43.20%	27.3%	21.30%	0.90%
Trust	**6.7%**	**33.60%**	**35.70%**	**31.40%**	**31.10%**	**31.30%**	**19.6%**	**31.50%**	**0.90%**

Appraisal- Completeted Since April 2015

Division	Compliance	YTD Target (24%)
Surgery	6.50%	🔴
Medical	13.20%	🔴
FSS	17.80%	🔴
Community	20.80%	🔴
Estates	17.90%	🔴
Corporate	9.20%	🔴
THIS	24.60%	🔴
Trust	**14.46%**	🔴

Medical Devices Training

Division	Compliance	100% Target
Surgery	72.00%	🔴
Medical	64.00%	🔴
FSS	78.00%	🔴
Community	81.00%	🔴
Estates	100.00%	🟢
Corporate	81.00%	🔴
THIS	-	-
Trust	**79.00%**	🔴

Mandatory Training Indicators completetd in last 12 Months

Division	Prevent	Equality & Diversity	Information Governance	Infection Control	Health & Saftey	Manual Handling	Safe Guarding	Fire Saftey	All
Surgery	21.70%	65.70%	62.50%	62.90%	62.50%	63.10%	59.20%	51.50%	11.20%
Medical	29.70%	69.10%	71.50%	67.90%	67.30%	67.70%	63.50%	58.10%	18.30%
FSS	42.10%	76.00%	76.50%	72.20%	72.00%	72.10%	66.00%	70.20%	20.80%
Community	75.70%	76.20%	76.40%	75.10%	74.30%	74.30%	70.80%	71.30%	44.90%
Estates	16.10%	82.40%	82.10%	82.10%	81.50%	81.80%	81.50%	67.90%	12.50%
Corporate	35.70%	80.30%	71.70%	71.70%	72.00%	72.30%	68.00%	66.70%	19.30%
THIS	24.60%	82.00%	79.20%	79.20%	79.20%	79.20%	74.30%	65.00%	15.80%
Trust	**35.5%**	**73.00%**	**70.30%**	**70.30%**	**70.00%**	**70.20%**	**65.8%**	**62.90%**	**19.80%**

Appraisal- completetd in last 12 Months

Division	Compliance	100% Target
Surgery	60.60%	🔴
Medical	64.60%	🔴
FSS	79.80%	🔴
Community	68.60%	🔴
Estates	89.80%	🔴
Corporate	79.30%	🔴
THIS	74.30%	🔴
Trust	**71.40%**	🔴

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.

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 October 2015 (delayed from September 2015 due to a technical issue) 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 October IBR. With immediate effect 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.

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 familiar with the new approach and this will factor into the compliance data reported through the IBR. Steady progress has been made. 60% of colleagues have commenced completion of the new programme of mandatory training since 1st June 2015. However, increased participation and completion across all of the 8 available programme elements is low.
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. The web pages contain comprehensive support materials including videos and scripts which are to be used by colleagues enabling them to access the training and complete it satisfactory. 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. Particular focus is to be paid to the availability of PREVENT classroom sessions, provide home access for colleagues who wish to complete training outside of the workplace, dedicated time for training completion at work, publicise access to the training programme in ESR, share case studies of good compliance and continue to provide assistance to colleagues experiencing difficulty with the ESR tool.

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 on-going throughout the year

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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	Aug-15	95% Target
Surgery	89.60%	
Medical	80.79%	
FSS	87.71%	
Trust	**84.61%**	

Hard Truths Summary - Day Care Staff		
Division	Aug-15	95% Target
Surgery	95.10%	
Medical	95.09%	
FSS	87.90%	
Trust	**94.76%**	

Hard Truths Summary - Night Nurses/Midwives		
Division	Aug-15	95% Target
Surgery	87.48%	
Medical	87.93%	
FSS	84.40%	
Trust	**86.91%**	

Hard Truths Summary - Night Care Staff		
Division	Aug-15	95% Target
Surgery	112.51%	
Medical	117.78%	
FSS	80.30%	
Trust	**111.02%**	

Hard Truths Staffing Levels

Why we are away from plan

The overall average fill rate for qualified nurses (day and night) has been lower than July 2015 by around 3% on both sites. On the HRI site the average fill rate for qualified nurses was 88.85% and on the CRH site it was 83.3%

For unqualified staff the average fill rate (day and night) has increased from the July position on the HRI site to 104.7% and reduced on the CRH site to 102.1%The rag rating for average fill

	Day		Night		
	Qualified	Unqualified	Qualified	Unqualified	Combined
Red (less than 75% fill rate)	6	4	3	1	14
Amber (75 – 89% fill rate)	17	10	14	1	42
Green (90-100% fill rate)	12	9	15	12	48
Blue (greater than 100%)	0	12	3	16	31

Staffing in August has resulted in an increase by 3 areas rated red for qualified nurses (day and night) in comparison with July's position.
A decrease in the number of areas (31 in total) with average fill rates of above 100% has been achieved in August, in comparison to 43 in June and 40 in July.
Areas which have had an average fill rate of greater than 100% for qualified nurses (3 in total) have had minimal overfill with no area scoring greater than 102%.
The overfill of Health Care Assistants particularly on the night shifts remains a concern. The highest average fill rate for unqualified nurses was 220.5% in August 2015.
6 areas have been rated Blue due to average fill rates for unqualified nurses of between 100.3 % - 105.5%. For 4 areas this was due to greater than planned unqualified hours being utilised to support reduced fill rates for qualified nurses.
The introduction of nerve centre in one area resulted in a planned minimal overfill following challenges experienced to enable nurses to spend more time with the nerve centre team.
The use of one – one shifts to support areas has continued to contribute to the increased average fill rate for unqualified staff.

Area	Day	Night	Reason
Ward 11 -5		183.90%	· Additional HCA working on the night shift in a trial change to workforce model. The HCA has moved from the day shift. Planned hours have not been changed, but will be reviewed with the Matron and Associate Director of Nursing
5AD	135.20%	139.10%	· 42 additional shifts (1-1) required to support dependency of paitents · Supporting reduced qualified fill rate
6	120.20%	121.80%	· 60 shifts 1-1 required to support dependency of patients
6BC		135.10%	· 26 shifts (1-1) required · Supporting reduced fill rate for qualified hours of 86.5%
7AD		146.30%	· Increased fill rate to support qualified fill rate of 75.5%
7BC	108.00%	149.60%	· Increased use of 1-1 due to dependency of patients
8		114.80%	· Supporting reduced fill rate of 73.1% for qualified nurses
12		135.50%	· Supporting reduced fill rate of qualified nurses (88.2%) due to qualified nurses supporting additional capacity areas.
17		151.60%	· Supporting reduced fill rate for qualified nurses of 84.9%
21	121.80%		· Reduced fill rate (qualified nurses) of less than 75% day
8AB		111.50%	· Supporting reduced fill rate of qualified nurses of 82.5%
10	144.10%		· Supporting reduced fill rate of qualified nurses 81.5%
SAU	110.10%	220.50%	· To support reduced qualified nurses with reduced fill rates due to vacancies and sickness.
9	112.90%	123.40%	· Supporting reduced fill rate for qualified midwives

Table 3: Analysis of reduced fill rate for Qualified Planned hours

Area	Day	Night	Reason
MAU CRH	71%		Vacancies, Sickness
5AD	67.9%		Vacancies; Increased number of long shifts worked against planned resulting in decreased fill rate.
6BC	71.1%		Vacancies; Sickness
21	73.7%		Supporting additional capacity; sickness
4c	74.5%		Vacancies; Workforce model revised and vacancies have been advertised.
8		73.1%	Vacancies; supporting additional capacity; short term sickness. Supported by additional unqualified hours.
8D		56.5%	Vacancies have resulted in decreased fill rate for qualified nurses at night. Additional Unqualified support has been provided.
LDRP		74.7%	
9	72.7%		Vacancies;

We continue to utilise temporary nursing workforce solutions and transfer substantive nurses to maintain safe staffing across both sites.
Action Plan
Further reduction of higher cost agency use. An additional five tier 1 agencies have been recruited to supply nurses to CHFT and will begin supplying from September 2015.
Tier 2 agencies (currently we use two tier 2 agencies) have been approached to reduce their charges.
Associate Directors of Nursing and Matrons to continue to apply scrutiny and review rosters.
Matron of the day to oversee staffing on both sites on daily basis.
Increased support for newly qualified nurses who join CHFT. We expect over 100 newly qualified nurses, midwives and health v isitors to join CHFT within September and October and have a new programme of induction and preceptorship aimed at supporting and retaining them and existing members o f our workforce.
Recruitment to Band 2 positions is scheduled to be completed on 19.9.15 with over 70 confirmed candidates. We anticipate tha t we will be able to recruit to all band 2 vacancies.
Guardian newspaper advertising campaign to recruit to band 5 nurses for CHFT from 14.9.15 – 13.10.15
Recruitment stand at RCN jobs Fayre in London 9th and 10th September to recruit to nurse vacancies.
Achieved by Date
The Trust continues to expect fill rates to increase in September and October as a pipeline of 144 Nurses / Midwives are due to join CHFT.
Increased fill rates will be monitored weekly by the Associate Directors of Nursing and reported by exception through the Nur sing Workforce Strategy Group.

INTERMEDIATE CARE AND COMMUNITY DIRECTORATE

DIRECTORATE PERFORMANCE DASHBOARD

MONTH : AUGUST 2015

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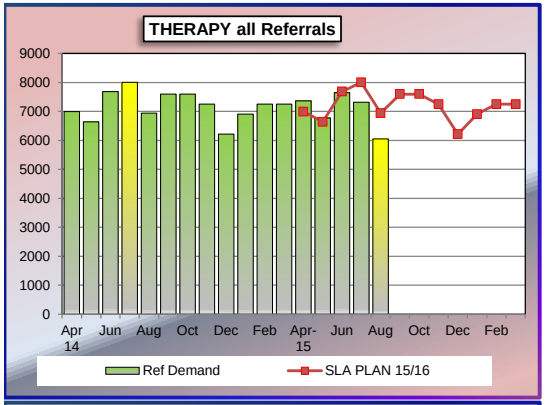
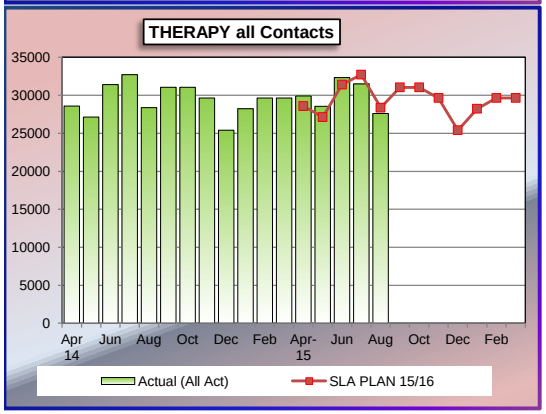
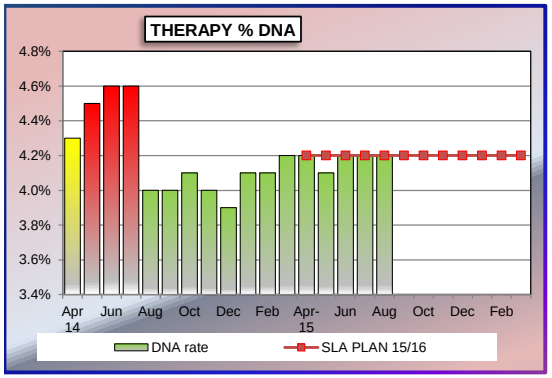
CLINICAL THERAPY SERVICES







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	6,052	35,391	36,276	86,372	-2.4%
Initial Contacts	4,587	26,741	28,610	68,118	-6.5%
Follow Up Contacts	22,321	119,022	115,615	275,273	2.9%
Telephone Contacts	700	4,239	4,003	9,531	5.9%
THERAPY CONTACTS - including Inpatients	**27,608**	**150,002**	**148,227**	**352,922**	**1.2%**
CTR Podiatry	5,063	28,817	30,929	73,640	-6.8%
CTR Therapies Outpatients	5,114	28,419	29,014	69,082	-2.1%
CTR Inpatient Therapies	9,395	46,442	39,624	94,342	17.2%
CTR Long Term Conditions and Rehab	4,976	26,126	26,888	64,018	-2.8%
CTR Acute & Planned Care is 'Other Outpatients'	1,282	8,050	8,624	20,534	-6.7%
CTR Childrens Therapies	1,078	7,909	9,146	21,775	-13.5%
Telephone Contacts	700	4,239	4,003	9,531	5.9%
THERAPY CONTACTS - including Inpatients	**27,608**	**150,002**	**148,227**	**352,922**	**1.2%**

First DNAs	209	1211
First DNAs % Rate	4.4%	4.3%
Total DNAs	1218	6651
Total DNA % Rate	4.2%	4.2%
Snapshot : Waiting List - Waiting for First Appt	8293	

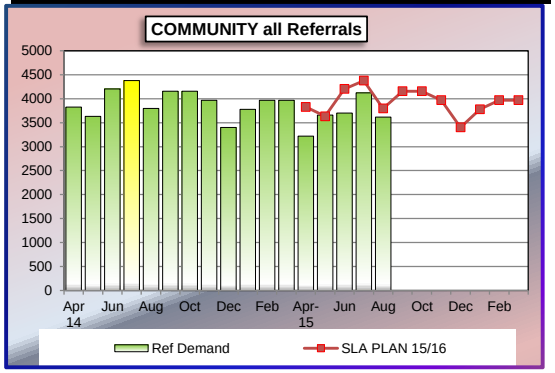
COMMUNITY ADULT : Activity Metric	Curr Month	YTD actual	YTD COMM	COMM PLAN	POSITION
Referral Demand	3,616	20,192	19,832	47,219	1.8%
Initial Contacts*	2,450	12,994	14,542	34,624	-10.6%
Follow Up Contacts	22,694	114,444	108,982	259,482	5.0%
Telephone Contacts	2,751	14,906	13,749	32,735	8.4%
ALL Clinical Contacts - Face to Face & Telephone	27,895	142,344	137,273	326,841	3.7%

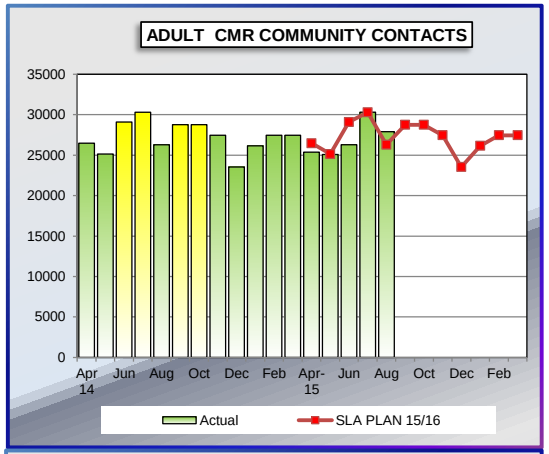
* From changes to recording of referrals introduced this financial year - this will reduce the number of initial contacts

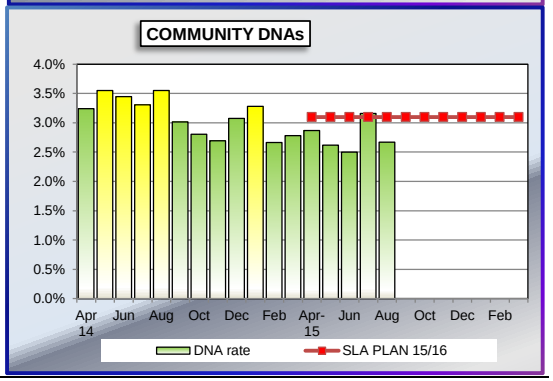
Total DNAs - No Access Visits + DNAs	765	3946
Total DNA (No Access) % Rate	2.67%	2.70%

DIRECTORATE SUMMARY KPIs	Curr Month	YTD actual	YTD COMM	Actual 14/15	POSITION
Referral Demand	9,668	55,583	56,108	133,591	-0.9%
Total Contacts	52,052	273,201	267,749	637,497	2.0%
Telephone Contacts	3,451	19,145	17,752	42,266	7.8%
TOTAL CONTACTS - ALL SERVICES	**55,503**	**292,346**	**285,500**	**679,763**	**2.4%**
Total DNAs	1983	10597			
Total DNA % Rate	3.7%	3.7%			
Snapshot : Waiting List - Waiting for First Appt	8,293				

CALDERDALE COMMUNITY ADULT







COMMUNITY DIVISIONAL PERFORMANCE REPORT & DASHBOARD

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

AUGUST 2015

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Key Points

August 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
d - provided by

(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

District Nursing referrals are off target, due to the way we changed the reporting of referrals. A patient is referred once and not a referral for each condition. Contacts still remain high as workload has not decreased.

	1 Enhancing quality of life for people with a Long Term condition (LTC)	Target	Current Month	YTD	YTD 14/15
a	Home equipment delivery < 7 days	95%	100.0%	99.4%	96.3%
b	% Patient died in preferred place of death	95%	100.0%	100.0%	96.7%
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%	98.2%	94.5%
e	% of patients with a LTC with a Calderdale Care Plan	90%	67.0%	85.2%	59.8%
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%	2.7%	4.1%	1.6%

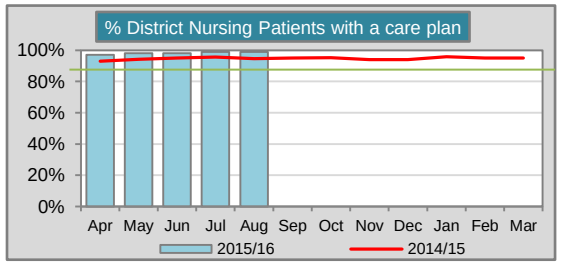
	2 Helping people to recover from episodes of ill health or following injury	Target	Current Month	YTD	YTD 14/15
a	% of leg ulcers healed within 12 weeks from diagnosis	75%	96.6%	94.7%	98.3%

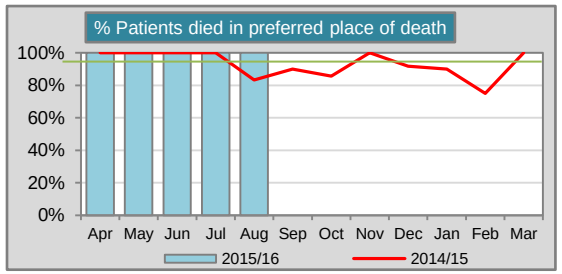
	3 Ensuring people have positive experience of care	Target	Current Month	YTD	YTD 14/15
a	Number of complaints	n/a	5	13	11
b	Number of complaints about staff attitude	n/a	0	0	0
c	Community AHP - 18 week RTT Snapshot at month end	95%	95.5%	92.3%	89.5%
d	Community Friends and Family Test	n/a	90.0%	90.6%	N/A

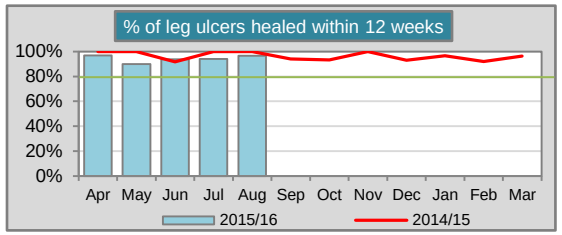
	4 Treating and caring for people in a safe environment; and protecting them from avoidable harm	Target	Current Month	YTD	YTD 14/15
a	% of patients in receipt of community nursing services that have had a pressure ulcer screening and this is documented in their care plan	90%	76.0%	85.0%	89.7%
b	Number of community acquired grade 3 or 4 pressure ulcers	<1.8	4	14	4
c	Number of falls that caused harm whilst patient was in receipt of Comm Services	<1.1	0	12	8
d	Patient safety thermometer - coverage - Harm free	>95%	93.0%	94.7%	94.1%
e	Patient safety thermometer - No of Harms Reported	<22.1	24	102	127
f	% of staff that have undertaken safeguarding / mental capacity act training	95%	56.5%	67.8%	67.0%

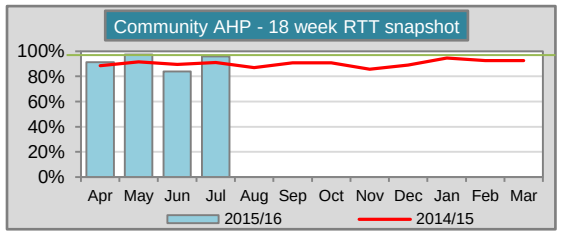
	5 Activity & Resource efficiency	Baseline	Current Month	YTD	YTD 14/15
a	Community DNA Rates	<1%	1.2%	1.1%	1.1%
b	Sickness Absence rate	<4%	TBC	3.5%	4%

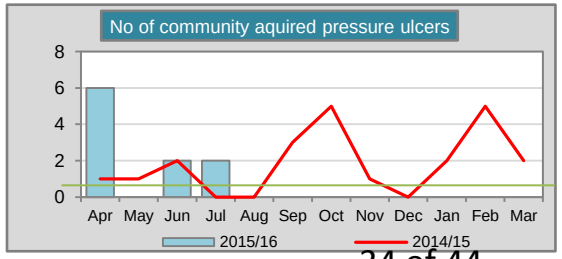
Target











Trust Financial Overview as at 31th Aug 2015 - Month 5

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

YEAR TO DATE POSITION: M05

CLINICAL ACTIVITY

	M05 Plan	M05 Actual	Var
Elective	3,705	3,494	(211)
Non Elective	20,312	20,747	435
Daycase	17,844	16,694	(1,150)
Outpatients	135,623	133,016	(2,607)
A & E	62,872	61,546	(1,326)

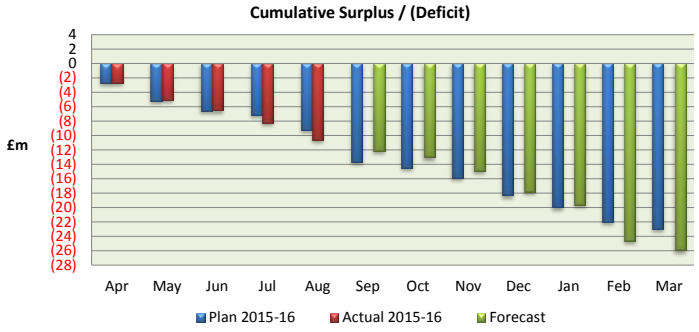
TRUST: INCOME AND EXPENDITURE

	M05 Plan	M05 Actual	Var
	£m	£m	£m
Elective	£9.31	£8.96	(£0.35)
Non Elective	£33.16	£34.20	£1.04
Daycase	£12.04	£10.75	(£1.29)
Outpatients	£16.31	£16.14	(£0.17)
A & E	£6.62	£6.65	£0.03
Other-NHS Clinical	£48.29	£48.57	£0.28
CQUIN	£2.78	£2.79	£0.01
Other Income	£15.59	£14.95	(£0.64)
Total Income	**£144.11**	**£143.02**	**(£1.09)**
Pay	(£92.93)	(£93.02)	(£0.09)
Drug Costs	(£13.00)	(£12.81)	£0.19
Clinical Support	(£12.85)	(£12.61)	£0.24
Other Costs	(£19.03)	(£19.64)	(£0.61)
PFI Costs	(£4.97)	(£4.92)	£0.04
Total Expenditure	**(£142.77)**	**(£142.99)**	**(£0.22)**
EBITDA	**£1.34**	**£0.02**	**(£1.32)**
Non Operating Expenditure	(£10.58)	(£10.49)	£0.09
Deficit excl. Restructuring	**(£9.24)**	**(£10.47)**	**(£1.22)**
Restructuring Costs	£0.00	(£0.10)	(£0.10)
Surplus / (Deficit)	**(£9.24)**	**(£10.56)**	**(£1.32)**

DIVISIONS: INCOME AND EXPENDITURE

	M05 Plan	M05 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	£8.37	£7.52	(£0.85)
Medical	£11.22	£9.73	(£1.48)
Families & Specialist Services	(£1.17)	(£1.41)	(£0.24)
Community	£2.47	£2.57	£0.10
Estates & Facilities	(£11.81)	(£10.71)	£1.10
Corporate	(£8.53)	(£8.95)	(£0.42)
THIS	£0.14	£0.08	(£0.06)
PMU	£1.20	£0.71	(£0.49)
Central Inc/Technical Accounts	(£9.70)	(£9.46)	£0.23
Reserves	(£1.44)	(£0.65)	£0.79
Surplus / (Deficit)	**(£9.24)**	**(£10.56)**	**(£1.32)**

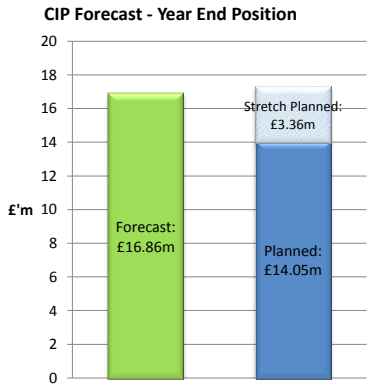
TRUST SURPLUS / (DEFICIT)

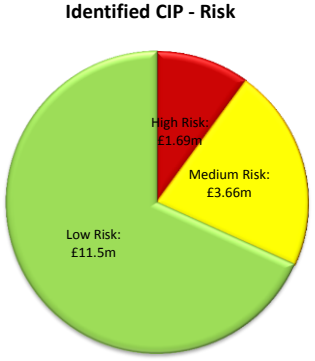


KEY METRICS

	Year To Date M05 Plan	Year To Date M05 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)	(£9.24)	(£10.56)	(£1.32)	(£23.01)	(£25.97)	(£2.96)
Capital (forecast Plan)	£8.92	£7.77	£1.15	£20.72	£20.72	£0.00
Cash	£6.13	£7.25	£1.12	£1.92	£1.02	(£0.90)
CIP	£4.45	£5.38	£0.93	£14.05	£16.86	£2.81
	Plan	**Actual**		**Plan**	**Forecast**	
Continuity of Service Risk Rating	1	1		1	1	

COST IMPROVEMENT PROGRAMME (CIP)





Total Planned: £14.05m **Total Forecast £16.86m**

YEAR END 2015/16

CLINICAL ACTIVITY

	Plan	Forecast	Var
Elective	9,185	8,488	(697)
Non Elective	49,263	50,700	1,437
Daycase	43,731	41,593	(2,138)
Outpatients	327,200	323,977	(3,223)
A & E	146,774	143,678	(3,096)

TRUST: INCOME AND EXPENDITURE

	Plan	Forecast	Var
	£m	£m	£m
Elective	£23.39	£22.00	(£1.39)
Non Elective	£79.89	£83.31	£3.42
Daycase	£30.25	£26.95	(£3.30)
Outpatients	£39.45	£39.96	£0.51
A & E	£15.49	£15.51	£0.02
Other-NHS Clinical	£117.49	£116.47	(£1.02)
CQUIN	£6.69	£6.80	£0.11
Other Income	£38.90	£38.49	(£0.41)
Total Income	**£351.55**	**£349.50**	**(£2.05)**
Pay	(£224.98)	(£227.55)	(£2.57)
Drug Costs	(£32.05)	(£30.84)	£1.20
Clinical Support	(£31.15)	(£29.87)	£1.28
Other Costs	(£45.94)	(£46.22)	(£0.28)
PFI Costs	(£11.92)	(£11.89)	£0.03
Total Expenditure	**(£346.04)**	**(£346.36)**	**(£0.32)**
EBITDA	**£5.51**	**£3.13**	**(£2.38)**
Non Operating Expenditure	(£25.52)	(£25.11)	£0.41
Deficit excl. Restructuring	**(£20.01)**	**(£21.97)**	**(£1.96)**
Restructuring Costs	(£3.00)	(£4.00)	(£1.00)
Surplus / (Deficit)	**(£23.01)**	**(£25.97)**	**(£2.96)**

DIVISIONS: INCOME AND EXPENDITURE

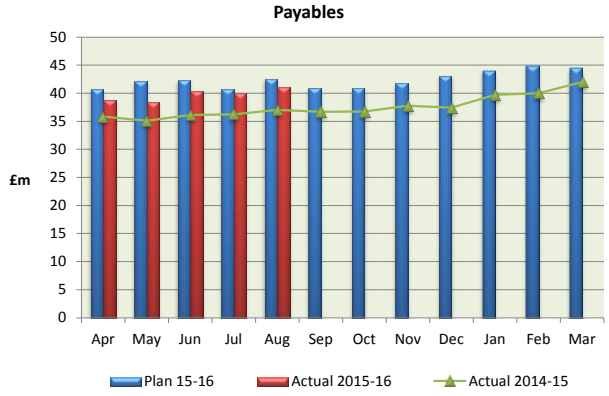
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	£21.30	£19.36	(£1.94)
Medical	£26.18	£21.81	(£4.37)
Families & Specialist Services	(£1.56)	(£1.56)	£0.00
Community	£5.77	£6.14	£0.38
Estates & Facilities	(£28.64)	(£27.58)	£1.06
Corporate	(£20.18)	(£21.29)	(£1.11)
THIS	£0.53	£0.41	(£0.12)
PMU	£3.16	£3.16	£0.00
Central Inc/Technical Accounts	(£25.20)	(£26.43)	(£1.23)
Reserves	(£4.38)	£0.00	£4.38
Surplus / (Deficit)	**(£23.01)**	**(£25.97)**	**(£2.96)**

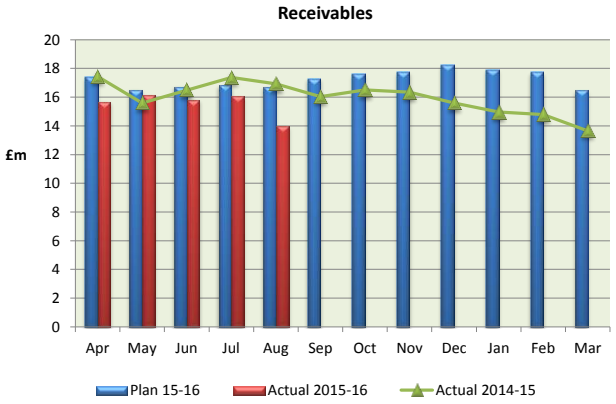
Trust Financial Overview as at 31th Aug 2015 - Month 5

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

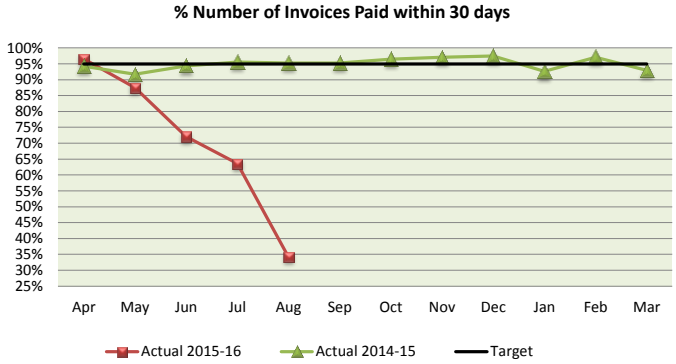
WORKING CAPITAL

	M05 Plan £m	M05 Actual £m	Var £m	M05
Payables	(£42.54)	(£41.14)	(£1.40)	
Receivables	£16.73	£13.99	£2.74	



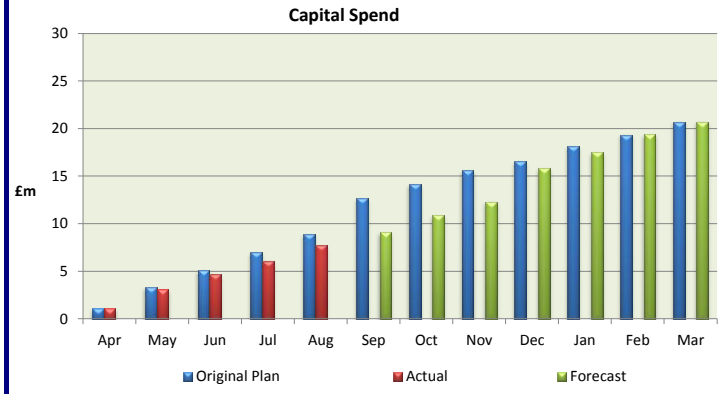


BETTER PAYMENT PRACTICE CODE



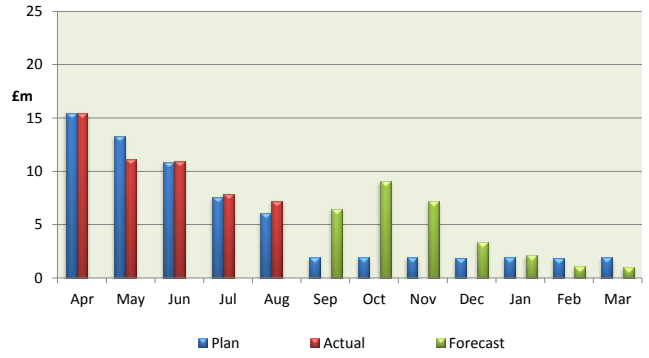
CAPITAL

	M05 Plan £m	M05 Actual £m	Var £m	M05
Capital	£8.92	£7.77	£1.15	

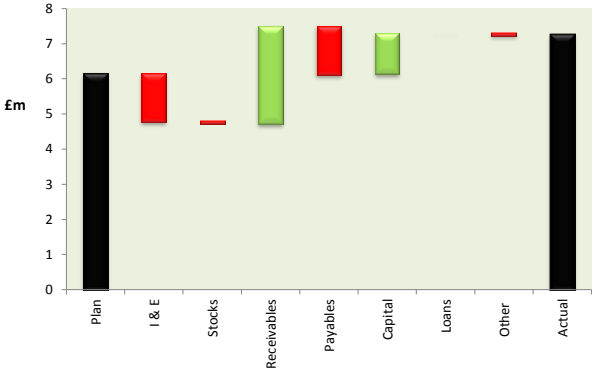


CASH

	M05 Plan £m	M05 Actual £m	Var £m	M05
Cash	£6.13	£7.25	£1.12	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The year to date deficit is £10.56m versus a planned deficit of £9.24m, this includes release of £0.60m contingency reserves.
- The adverse variance of £1.32m from plan is due to clinical activity underperformance and high pay spend.
- Elective and daycase activity remain behind planned levels in month. Non-elective activity is also below plan this month .
- Pay expenditure has not followed the activity downturn, remaining high including agency spend.
- Capital expenditure year to date is £7.77m against the planned £8.92m with slippage on Estates and IT schemes.
- Cash balance is £7.25 against a planed £6.13m. £10m of loan funding for capital expenditure was drawn down in April.
- CIP schemes delivered £5.38m in the year to date against a planned target of £4.45m.
- 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 £21.97m against a planned £20.01m, an adverse variance of £1.96m.

This position includes full release of remaining contingency reserves and delivery of £16.86m CIP against the original planned £14m.

- At EBITDA level, representing the organisations operational position, the forecast is in line with Month 4. This adverse position is driven by the ongoing impact of the activity, income and pay expenditure pressures seen in the year to date and costs associated with additional bed capacity.
- No further contingency reserves remain to cover other pressures and risks.
- Efforts must therefore be focussed on delivering planned activity by increasing productivity and containing pay spend particularly agency costs.
- 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)

CQUINS Performance Report 2015-16

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**

Best Practice Tariff / INDICATORS
FINANCIAL YEAR 2015/16

compassionate care

There are 18 Best Practice indicators nationally of which 17 are applicable to CHFT. The Fragility Hip Fracture guidance has been included on the Effectiveness 3 page. Of the remaining indicators we currently have information on 7 which are shown below and are reviewing the remaining indicators to establish the baseline.

For all indicators except Paedicatric Epilepsy improvement work is required to ensure patients receive the optimal care according to national guidance and maximum financial is secured.

	YTD Achieved BPT	YTD not Achieve BPT	Potential Achievement for BPT	% BPT Achieved
BP 01 Acute Stroke	106	69	175	60.57%
BP 02 Adult Renal Dialysis	Not applicable to CHFT			
BP 03 Daycase	396	300	696	56.90%
BP 04 Diabetic Ketoacidosis Hypoglycaemia				
BP 05 Early Inflammatory Arthritis	Monitoring required			
BP 06 Endoscopy				
BP 07 Fragility Hip Fracture (inc #nof)	122	85	207	58.94%
BP 08 Interventional Radiology				
BP 09 Major Trauma				
BP 10 Outpatient Procedures	1694	371	2065	82.03%
BP 11 Paediatric Diabetes	185	11	196	94.39%
BP 12 Paediatric Epilepsy	191	0	191	100.00%
BP 13 Parkinsons	Monitoring required			
BP 14 Pleural Effusion				
BP 15 Primary Total Hip and Knee Replacement				
BP 16 Same day Emergency Care	1430	2019	3449	41.46%
BP 17 Transient Ischaemic Attack	111	31	142	78.17%
BP 18 Heart Failure				

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	Target/Threshold
% 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.	Patients occupying a bed are recorded against each Division within the Trust and not the specialty the patient is under. i.e. a respiratory patient under the care of a medical consultant, yet occupying a bed within an Orthopaedic ward. This would be classed as a medical 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	

Indicator	Description	Source	Target/Threshold
% 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	
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 refer[illegible]ia the screening servic[illegible] with suspected cancer diagnosis should receive their first definitive treatment within 62 days of the date of the referral. The threshold is 86%	[illegible]	
62 Day Gp Referral to Treatment	Patients that are 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	

Indicator	Description	Source	Target/Threshold
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			
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 classification database and reports from radiology on positive PE 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)		

Indicator	Description	Source	Target/Threshold
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)	
% Hand Hygiene Compliance	The percentage of monthly hand hygiene observations which have been done to the required standard.	Hand Hygiene System	
MRSA Screening - Percentage of Inpatients Matched		Infection Control Net (IC Net)	
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	

Indicator	Description	Source	Target/Threshold
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	-	

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 24th September 2015	**Sponsoring Director:** Keith Griffiths, Director of Finance
Title and brief summary: MONTH 5 - FINANCIAL NARRATIVE - The Board is asked to approve the Month 5 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 - 15.9.15	
Governance Requirements: Financial Sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the Month 5 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 5 Financial Narrative.

Appendix

Attachment:

Financial Narrative Month 5 15_16 for BOD.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

MONTH 5 AUGUST 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 three sections:

- Key messages;
- Month 5, August, year to date performance;
- Forecast, risks and opportunities.

This paper has previously been discussed at the August 2015 Finance & Performance Committee.

1. Key Messages

The year to date financial position is in line with last month's forecast trajectory at a £1.32m year to date adverse variance from plan. The forecast year end position is also maintained at the level forecast last month at EBITDA level with some improvement in forecast non-operating expenditure leading to a forecast £21.97m deficit against a planned deficit of £20.00m excluding restructuring costs.

As reported last month, the downturn in the trading position seen in from July, coupled with the need to increase bed capacity has impacted on the year-end forecast.

Month 5, August Position

Income and Expenditure Summary	Plan £m	Actual £m	Variance £m
EBITDA	**1.34**	**0.02**	**(1.32)**
Deficit	**(9.24)**	**(10.56)**	**(1.32)**

- An EBITDA of £0.02m, an adverse variance from plan of 1.32m.
- A deficit of £10.56m, an adverse variance of £1.32m from the planned position.
- Delivery of CIP of £5.38m against the planned level of £4.45m.
- Contingency reserves released of £0.60m against year to date pressures.
- Capital expenditure of £7.44m, below the planned level of £8.92m.
- A cash balance of £7.25m, above the planned level of £6.13m.
- 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**	**3.13**	**(2.38)**
Deficit excluding restructuring	**(20.01)**	**(21.97)**	**(1.96)**
Restructuring costs	(3.00)	(4.00)	(1.00)
Deficit including restructuring	**(23.01)**	**(25.97)**	**(2.96)**

- An EBITDA of £3.13m, £2.38m adverse variance from plan.
- A deficit before restructure costs of £21.97m, an adverse variance of £1.96m from plan.
- Restructure costs of £4.00m against planned levels of £3.00m due to strategic turnaround costs.
- A deficit including restructure costs of £25.97m, an adverse variance of £2.96m from plan.
- CIP delivery of £16.86m 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 £1.12, below the plan of £1.92m, including external cash support of £18.0m.
- A Continuity of Risk Rating (CoSRR) of level 1, in line with plan.

2. Detailed Commentary for the Reporting Period

Statement of Comprehensive Income (SOCI)

The adverse variance from plan reported in the year to date has stabilised from the worsening seen in month 4. The month 5 position has come in line with the forecast projections made last month with an element of recovery seen in planned day case, elective and outpatient activity. Non-elective activity which by its nature fluctuates, is below projected levels in month, most notably in paediatrics but the Trust has been able to absorb the adverse income impact of this through other savings generated for example in non-pay.

Within the year to date, this additional planned capacity has been exceeded in every period including month 5. 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 and remains at a steady level from month 4. This continues to drive additional pay spend. In mitigation, £0.25m contingency reserves have been released in Month 5 in line with forecast requirements and in addition to the £0.35m already released.

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

Operating income	(£1.09m) adverse variance
Operating expenditure	(£0.22m) adverse variance
EBITDA for calculation of CoSRR	**(£1.32m) adverse variance**
Non-Operating items	£0.10m favourable variance
Restructuring costs	(£0.10m) adverse variance
Total	**(£1.32m) adverse variance**

Operating Income

There is a cumulative £1.09m adverse variance from plan within operating income.

NHS Clinical Income

Of the £0.03m adverse income variance, £0.45m is driven by NHS clinical income, In aggregate an underperformance against elective and day case activity in the year to date is offset financially by non-elective over performance. Also within this position, £0.42m relates to invoices raised to Calderdale CCG in the early part of the year for system resilience pressures (additional bed and medical capacity) and costs incurred following the closure of community Intermediate Care beds. As previously reported to Monitor, payment of these invoices remains in dispute with the CCG, in recognition of this stance a £0.42m bad debt provision has been made which is reflected within the non-pay position.

The clinical income contracts with the two main commissioners (Greater Huddersfield CCG and Calderdale CCG) were signed in early September and will operate on a full PbR basis which is in line with what had previously been assumed in valuing income in the year to date.

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

- Planned day case and elective activity has continued to perform below the month 5 plan by 9.7% (421 spells). This is however, an improved position from month 4.

- Non-elective admissions overall are below the month 5 plan by 3.7% (153 spells) which is a reduction from the over-performance of 5.5% (223 spells) seen in month 4. In-month both long and short stay admissions are below plan but to a larger extent within short-stay. Cumulatively activity is now 2.1% above plan (435 spells).

- A&E attendances are below the month 5 plan by 2% (241 attendances) which is an improvement in performance when compared to month 4 and in line with last month's forecast. Cumulatively attendances are now below plan by 2.1% (1,326 attendances).

- Outpatient attendances are 3.5% (892 attendances) below plan in month 5 which is still significantly below plan but an improvement from last month. Cumulatively outpatient activity is now 3.1% below plan (2,778 attendances).

- Both Adult Critical Care and NICU have seen an increase in Month 5.

- Pass-through high cost drugs have reduced and below plan in month 5.

As previously described the 2015-16 plan includes Urgent Care Board funding of £2.3m. Discussions with commissioners have concluded positively on this front with the funding being secured in full removing a previous element of risk from the position.

In line with plan and in recognition of the outstanding income risks, allowance to the value of £0.84m has been made in the year to date 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 £0.64m 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, this is expected to be rectified back to plan by year end. There are a number of smaller adverse variances across other areas in the year to date. 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 £0.22m adverse variance within operating expenditure across the following areas:

Pay costs	(£0.09m) adverse variance
Drugs costs	£0.19m favourable variance
Clinical supply and other costs	(£0.32m) adverse variance

Employee benefits expenses (Pay costs)

Pay costs are £0.09m above the planned level. However, within the pay position there is a benefit of £0.83m versus plan against contingency reserves. As previously described, the annual plan includes £3.0m of contingency reserves of which £2.0m was planned as pay spend. There has been a release of £0.6m contingency reserves to the bottom line in the year to date position as a provision has 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 £0.92m against year to date plan.

As previously reported, the largest single driver of the additional costs which have been incurred in the year to date is as a result of staffing additional bed capacity over and above the planned level. This is directly linked linked to dealing with the wider system resilience issues and is being supported by non-contracted medical and nursing staff. In addition, recruitment difficulties continue to be an issue in certain specialties for medical staff.

The Trust is progressing with contractual discussions to move to outsourced management of the flexible workforce 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 and increase bank staff numbers continues alongside this.

In addition, the forthcoming implementation of the Monitor regulations introducing a percentage cap on agency nursing expenditure is being used as a lever in negotiation with agency providers. The Trust has very recently contracted with new providers through procurement frameworks and successfully agreed lower rates with some existing suppliers. There will be a fine balance to be achieved, given the potential increase in availability of staff that this offers in support of ward nurse staffing ratios, to ensure that decision making appropriately considers both quality and best financial value.

Drug costs

Year to date expenditure on drugs was £0.19m 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 £0.32m 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 £0.23m 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. This is mainly due to the inclusion of £0.42m against additional charges levied to commissioners as described above which remain in dispute. The Trust continues to take a prudent view in not recognising any benefit against this whilst maintaining the negotiating stance with commissioners at present.

These costs and pressures from additional clinical activity are offset in part by the successful delivery of CIP over and above the planned level. There have been further benefits seen here this month through pro-active procurement work against telecoms and waste expenditure.

Non-operating Items and Restructuring Costs

Non-operating items show a favourable £0.10m variance from plan. In the year to date this continues to be due to 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 £5.38m achieved against a planned £4.45m. The over performance is seen in the same areas as in previous months; 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 August 2015 the Trust had a cash balance of £7.25m against a planned position of £6.13m, a favourable variance of £1.12m, summarised as:

Operating activities	(£0.56m) adverse variance
Investing activities	£1.66m favourable variance
Financing activities	£0.02m favourable variance

Operating activities

Operating activities show an adverse £0.56m variance against plan. This is driven by the adverse cash impact of the I&E position of £1.39m being compensated in part by positive working capital variances from plan. The outstanding level of receivables is now considerably below planned levels with the Trust's pursuit of NHS debtors alongside timely advance invoicing both 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 has fallen to 70% against the 95% target of invoices being paid within 30 days. Whilst balancing the need for careful treasury management, the Trust continues to understand the importance of meeting obligations to suppliers and maintaining good relationships, payments are being prioritised accordingly.

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. As described in last month's report, agreement has 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. The Trust is also exploring a number of other options to generate cash benefits.

The Trust now has an approved working capital loan facility in place with the Independent Trust Financing Facility which is available to draw against immediately up to a total value of £13.1m. The positive treasury management actions described above mean that this facility which will bring interest charges at 3.5% is not immediately required but will act as a 'safety net' in the short term.

Investing activities (Capital)

Capital expenditure in the year is £7.77m, £1.16m below the planned level of £8.92m. In aggregate across the range of schemes the latest forecast year end position is in line with planned expenditure.

Against the Estates element of the capital expenditure plan, £3.21m has been incurred in the year to date versus a planned £3.94m. The main areas of investment are the continuation of the ward and theatre upgrades on the Huddersfield Royal Infirmary site. As in previous months, 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. In aggregate across the range of Estates schemes the latest forecast year end position is in line with planned expenditure.

IM&T investments total £3.95m against a year to date plan of £4.17m. The main areas of expenditure are in the EPR, Electronic Document Management System (EDMS) and Electronic Observations software. The main area of underspend in month is against infrastructure work on the Calderdale Royal Hospital site which is offsetting increased cost for EDMS.

The favourable cash impact of this £1.16m under spend is coupled with a favourable variance against capital creditors, explaining the overall £1.66m positive cash variance against investing activities.

Financing activities

Financing activities show a £0.02m 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. Continuity of Service Risk Rating (CoSRR) and forecast

CoSRR

The CoSRR is at level 1 in line with the planned position in the year to date and forecast.

Forecast – Income and Expenditure

The forecast position which stood last month at £22.24m has been revised to a year end deficit of £21.97m against the planned £20.0m deficit (excluding restructuring costs). At EBITDA level this is in line with the forecast position described last month with £0.2m positive movement now anticipated against non-operating expenditure.

The reasons for the adverse variance to plan are as per last month's report. Firstly, the impact of the worsened trading position, particularly seen in July and recovered somewhat in August as projected. Secondly, system wide pressures in intermediate / residential care provision across Calderdale and Kirklees driving the need for a greater level of bed capacity within the Trust. 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.

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 £16.86m CIP against the original plan of £14m. The full £3m of contingency reserves is also forecast to be released.

There has been a further revision to the forecast position at bottom line this month to include £1m restructuring costs in respect of the specialist consulting resource to add capacity and capability to the development of the transformational Five Year Strategic Plan. As previously discussed and agreed with Monitor this will be included as an authorised increase to the year end deficit bringing the overall forecast to £25.97m including restructuring costs, against the originally planned £23.01m deficit.

Forecast – Cash

The deterioration in the year end I&E forecast will bring an equivalent increased requirement for external cash support. The total cash support now anticipated to be required is £18.0m against the planned £14.9m.

Conclusion – Risks and opportunities

Having brought to bear the full extent of the mitigation currently at our disposal, there continues to be a level of both risk and opportunity. The key areas that have been identified as opportunities are focussing on maximising productivity and curbing premium rate non-contracted pay expenditure. The Trust will continue to strive improve upon the year end forecast and minimise cash support required. The strong ambition remains to deliver the year end forecast as planned.

Keith Griffiths 16/09/15

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 24th September 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 22.9.15 and the minutes held on 25.8.15.	
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 22.9.15 and the minutes held on 25.8.15.

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 22.9.15 and the minutes held on 25.8.15.

Appendix

Attachment:

APP B - Minutes QC 250815 v1.pdf

Minutes of the QUALITY COMMITTEE held on Tuesday 25 August 2015, 2pm – 5pm in Discussion Room 1, Learning Centre, HRI

PRESENT:
David Birkenhead, Medical Director
Jan Wilson, Non-Executive Director
Jackie Murphy, Deputy Director of Nursing
Jeremy Pease, Non-Executive Director (Chair)
Julie Dawes, Executive Director of Nursing & Operations
Juliette Cosgrove, Assistant Director of Quality
Lesley Hill, Executive Director of Planning, Performance, Estates and Facilities
Lynne Moore, Membership Council Representative

IN ATTENDANCE:
Helen Barker, Interim Associate Director of Community Services and Operations
Helen Chauhan, Locality Manager, Community Services Division
Jason Eddleston, Deputy Director of Workforce and OD
Anne-Marie Henshaw, Head of Midwifery
Jenna McLoughland, Ward Sister (observing)
Julie O'Riordan, Divisional Director Surgery and Anaesthetics
Victoria Pickles, Company Secretary (minutes)
Lindsay Rudge, Associate Director of Nursing (Medicine)

01/08/15 **WELCOME AND INTRODUCTIONS**

The Chair welcomed members to the meeting. The meeting was confirmed as quorate. There were no declarations of interest.

02/08/15 **APOLOGIES FOR ABSENCE AND ATTENDANCE REGISTER**

Apologies for absence were received from:
Keith Griffiths, Finance Director
Linda Patterson, Non-Executive Director
Mike Culshaw, Clinical Director of Pharmacy

03/08/15 **MINUTES OF THE MEETING HELD ON 28 JULY 2015**

The minutes of the meeting held on 28 July 2015 were approved as a true record.

04/08/15 **ACTION LOG & MATTERS ARISING** (Items due this month)

Update on CQUINS
It was noted that this item was included in the quarterly quality report.

05/08/15 **MAIN AGENDA ITEMS**

5.1 QUARTER 1 QUALITY REPORT
The Executive Director of Nursing introduced the first of what would be a quarterly quality report. The report would contribute to the development of the Annual Quality Account. She explained that it would be presented at the quarterly Quality Board with clinical commissioners and then included on the agenda for the Board of Director's meeting.

The Assistant Director of Quality commented that there were minor errors which would be amended and asked for any feedback on content or structure of the report to be provided outside of the meeting. She explained that the report was structured into the five Care Quality Standards domains, with each section having a summary providing an overview of compliance with each indicator and highlights.

The Assistant Director of Quality highlighted that during quarter 1 2015/16, all Commissioning for Quality and Innovation (CQUIN) targets, Quality Account and contract requirements were achieved, with the exceptions noted below:

- Patient Safety - MRSA Bacteremia: There had been one Trust assigned case in Quarter 1. This case was a result of a patient's wound not being swabbed during their community care. When the patient presented at A&E, and had an MRSA screen the infection was picked up and subsequently assigned to the Trust as the pre admission care was delivered by the Trust's community services.
- Effective - SHMI: The latest data showed the Trust to have a SHMI of 109 which, although classified 'as expected' is above the 100 target.

The areas showing partial compliance during quarter 1 were:

- Patient Safety - Pressure Ulcer reduction: quarter 1 trajectory not achieved.
- Experience - Friends and family test: low response rates
- Effective - A&E performance: 2 of 5 quality indicators not achieved – unplanned re-attendance and time to initial assessment.
- Well-Led - Mandatory training: 6 of 8 targets not achieved. Appraisal: 25% target for appraisal completion not met

The Executive Director of Nursing highlighted the serious untoward incidents and the need to improve the standard of investigations and the capability within the Trust to carry them out. The Executive Medical Director highlighted the worsening HSMR position and the need to also build capacity and capability in undertaking mortality reviews.

It was agreed that the Care of the Acutely Ill Patient report information would be incorporated within the quarterly quality report going forward to prevent duplication.

The Chair of the Committee thanked the team for a comprehensive report.

5.2 MEDICAL WORKFORCE REPORT AUGUST 2015

The Executive Medical Director presented the report setting out the risks and challenges relating to the medical workforce. The paper showed that the Trust is operating a number of unfilled consultant vacancies particularly in certain core specialties. Whilst the true impact on patient safety and quality of care is not known there are concerns that increasing vacancies are contributing to the difficulties of consultant recruitment and retention. The paper included benchmarking information which would support the view that the Trust is understaffed in consultant posts.

The report also described the risks relating to the Trust's ability to deliver seven day services and the financial impact as a result of a dependency on locum staffing. It was also highlighted that up to 19% of the current consultant workforce could retire over the next five years.

Particular gaps in each division were noted as:

- Family & Specialist Services – radiology and histopathology.
- Surgery & anaesthetics – ophthalmology
- Medicine – emergency medicine, gastroenterology, elderly medicine, dermatology, rheumatology and oncology.

In addition 15 training posts had been lost resulting in consultants being required to do more frequent weekend rotas.

Discussion took place as to whether reconfiguring services on to a planned and unplanned site would help the position. The Executive Medical Director responded that it would help across many of the specialties and would have a positive impact on the on-call system. However this would not fully address the issues.

The Executive Director of Nursing highlighted that work was being done to look at alternative roes including advanced nurse and therapy practitioners. The business cases for hospital at night and hospital at weekend would provide an opportunity to introduce new roles however there was more work to do to develop a workforce plan that it is multi-disciplinary.

It was noted that the paper would be shared with Monitor and with Clinical Commissioners through the Quality Board.

The Chair thanked Sal Uka and Juliette Cosgrove for the comprehensive report.

06/08/15 **PATIENT SAFETYAND QUALITY BOARD (PSQB) DIVISIONAL REPORTS**

6.1 ESTATES AND FACILITIES DIVISION

The Executive Director of Planning, Performance, Estates and Facilities (PPEF) presented the report and highlighted the key points:

- The Trust was due to be inspected for fire safety and it was likely that this would identify areas where further work would be needed. In preparation for this inspection, work was being done to increase visibility and raise awareness across the Trust.
- Compliance with health and safety training remains behind plan.
- The results of the Patient Led Assessment of the Care Environment survey were awaited. These would be published and would include benchmarking information against other Trusts.
- An event had been arranged for October for a range of stakeholders to support the development of a nutrition and hydration strategy.

Discussion took place on the impact of the bed cleaning team introduced as part of the Perfect Week events to help with the rapid turnaround of beds to support patient flow. It was noted that this was not a 24/7 service but was well liked at both hospitals.
The Chair asked about patient transport to facilitate discharge, The Executive Director of PPEF explained that most patient transport is delivered by Yorkshire Ambulance Service (YAS) through a West Yorkshire-wide contract managed by the clinical commissioning groups. However contact had been made with YAS to discuss their capacity and plans were being agreed as part of the winter planning work to check whether private capacity would need to be brought in.

The Executive Director of Nursing asked that more assurance information on the quality metrics be provided in future reports and asked whether the linen bag issues had been resolved. The Executive Director of PPEF explained that a ‘bed a bag’ campaign had been run and this would be reviewed as it had a time implication for nursing staff. She suggested that the audit information about the quality of the linen coming in be shared in future reports.

The Chair also highlighted the need to ensure that all equipment is up to date and that assurance on this be provided.

The Committee received the report.

6.2 SURGERY AND ANAESTHETICS DIVISION

The Divisional Director for Surgery and Anaesthetics presented the report and explained that there had been a lot of work done to close complaints within the division and provide more timely responses. There had also been a workshop held with General Managers, Matrons and other senior staff to improve the quality of the risk register. This work was not yet complete but was part of a journey to make significant improvements.

The Divisional Director also presented a report showing progress against the action plan to improve performance against the best practice tariff. The Committee noted that there had been significant progress made against most elements of the tariff. The target of time to theatre within 36hrs remained challenging due to trauma theatre capacity. The Divisional Director explained that a scheduling meeting was held each Friday to identify capacity to treat these patients in a more timely manner. In addition, training was being delivered to enable hip surgery to be undertaken at Huddersfield as well as Calderdale.
She reported that the target would not be achieved in August but that the impact of the much more robust plan should be seen in September.

The Executive Director of Nursing asked that the Committee acknowledge the good work that had gone into improving performance against this tariff and the care of patients with a fractured neck of femur.

The Associate Director of Community Services and Operations highlighted that performance against the best practice tariffs would be included in the Integrated Board Report in future.

Discussion took place around the position in relation to falls. It was noted that agreement had reached on the routine use of the full falls assessment.

The Assistant Director of Quality asked that future reports include the mortality review outcomes.

The Deputy Director of Workforce and OD asked why the friends and family test response rate had fallen from 50% to 25% The Divisional Director responded that this was due to the recent inclusion of day case surgery patients which had impacted on the overall figure.

The Chair asked whether a more detailed breakdown was available in relation to the categories of the reasons why people complained. The Divisional Director explained that a breakdown had been requested and further analysis being done.

The Committee received the report and congratulated the division on the hard work on the fractured neck of femur best practice. It was agreed to circulate this report to other Board members.

6.3 MEDICAL DIVISION

The Associate Director of Nursing (Medical Division) presented the report and highlighted the main points:

- The gastro-intestinal protocol had been reviewed following a serious untoward incident investigation.
- As part of the bed modelling work there would be a proposal to ring-fence beds on the Calderdale site to support improvement in performance against the stroke indicators.
- The 4 hour A&E performance target for Quarter 1 had been met. This continued to be managed closely.
- There had been significant improvement in outcome data from major trauma – with the Trust being named as the best performing trauma unit in West Yorkshire
- An increase in falls and pressure ulcers had been seen. Work was being done with the

Academy in particular areas of high falls – MAU at Huddersfield and Stroke at Calderdale. This would then be rolled out across the Trust.

- A business continuity plan for the emergency department had been developed and would be complete by the end of the month.
- There had been a reduction in the number of nursing vacancies however nursing workforce remains a risk due to the open flexible bed capacity.
- Complaints handling had improved with the majority of the back log being cleared enabling better management of any new complaints.
- Friends and family test response rates affected by the introduction of day case however it was note that some wards had a better response than others and there was a need to share this learning and good practice. Text messaging would be implemented for the emergency department friends and family test.

The report included some of the 'you said we did' information demonstrating the actions that had been taken in response to comments made by our patients. Noise at night remains a consistent theme.

The Chair asked that information be included on the average length of stay and the numbers discharged before 11am. He also asked that the emergency department standards include of those who wait, how long are they waiting. The Associate Director of Nursing responded that this information was available and that a root cause analysis is undertaken for every patient waiting more than 8 hours. Matrons then follow these patients up to look at what it was like from an experience perspective. She added that HealthWatch were due to come in and support the Trust in talking to patients who have waited more than 4 hours.

Discussion took place on the impact of the closure of nursing home and community beds. The Executive Director of Nursing explained that this was being discussed as part of the Urgent Care board which included a number of options for commissioners to consider. A paper on this issue would be discussed at the Weekly Executive Board a meeting had been arranged with partners for September.

It was noted that further work would be done to look at turnover and the reasons behind it. This would be shared in a future report.

The Committee received the report.

6.4 FAMILY & SPECIALIST SERVICES DIVISION

The Head of Midwifery explained that the division continued to run separate quality reporting arrangement for both Diagnostic and Therapeutic Services and for Children's and Women's Services and therefore would presented two separate reports.

Diagnostic and Therapeutic Services

The Head of Midwifery explained that this was a draft report and the final version would be sent to the Quality Committee in September. She highlighted the key points of the report :

- Areas of non-compliance with NICE guidance were being reviewed and addressed.
- Appointment slot issues are significant. These had been mapped and a comprehensive action plan in place monitored weekly.
- Outpatients feedback from service users suggesting dissatisfaction (FFT and complaints) in relation to waiting times. A number of patient forums had been set up to look at how the service can be improved.
- There had been three external audits including a Human Tissue Authority inspection which had identified some minor shortfalls which had since been addressed and the Trust was accredited.

The Chair asked what number of patients were involved in relation to the nephrostomy guidance. It was agreed to include these numbers in the next report.

The Executive Medical Director asked whether the outpatient friends and family test responses related to specific areas. The Head of Midwifery explained that the next report would include more detail however particular areas of concern were surgical outpatients in Calderdale and medical outpatients and obstetrics in Huddersfield.

Children's and Women's Services
The Head of Midwifery highlighted the key points:

- There was a lack of specific feedback in the friends and family test responses. As a result the department had set up a task and finish group to improve the responses, to address issues quickly and to provide feedback to patients.
- There had been issues in relation to compliance with paediatric cover. These had been mitigated and changes made to paediatric assessment to improve flow. An audit would be undertaken and reported at the next meeting.
- Staff turnover rates had been of concern. Exit interviews were being undertaken to identify themes and a process being put in place to offer a person other than the line manager to carry out the exit interview.

Jan Wilson commented on the reference to translation services within the report and informed the Committee that a workshop had taken place with the deaf community to look at the arrangements for British Sign Language interpreters. This had highlighted a number of concerns which would be considered at the next Patient Experience group.

The Executive Medical Director asked about the compliance with NICE guidance and whether this would be achieved. The Head of Midwifery explained that of the 22 reviewed, 1 was compliant; the Trust was working towards compliance on 2; in 10 instances a decision had been made to not comply; and further information was awaited on the remaining 9. She added that in some instances business cases would be required to achieve compliance. The Divisional Director would be meeting with all the clinical leads to review this position.

Discussion took place on the Trust's performance in relation to post-partum haemorrhage. The Head of Midwifery explained that an audit was carried out for every case above 1500mls to see whether anything could have been done differently in the third stage of labour. In addition the Trust was participating in a West Yorkshire exercise to get benchmarking data. This remained a concern and had been built into the twice daily safety briefings to review any patient at risk and what could be done to mitigate.

The Committee **RECEIVED** the reports.

6.5 COMMUNITY SERVICES DIVISION
The Locality Manager for the Community Services Division presented the report and highlighted that the supporting infrastructure for the quality reporting was not yet fully in place. She highlighted the following points from the report:

- There had been an increase in reporting of category 2 - 4 pressure ulcers. An extraordinary Patient Safety and Quality Board was being held to look at this in more detail.
- Following the mock Care Quality Commission inspection, an estates review was being carried out.
- Consideration was being given to alternative ways of implementing the friends and family test in community in in line with national guidance.
- There was a risk relating to vacancies in the speech and language therapy team which

was being mitigated. Looking at assurance on reporting of reporting.

- The 90 day action plan following the CQC mock inspection was being delivered and monitored closely.

Jan Wilson asked whether the pressure ulcers were occurring in a patient's own home or in patient's in nursing homes. The Locality Manager responded that it was a mixture and that the review would consider ways of encouraging patients to recognise the risk of pressure ulcers occurring in their own home and the importance of complying with guidance. The Trust would also work with social care and independent providers to address this issue. Don't believe allocated time for carers is impacting on the care required to be carried out.

The higher incidence of witnessing harmful errors was noted. The Associate Director of Community Services commented that there was work with staff to look at what they consider to be an incident. It was noted that staff also don't feel they can raise concerns. A questionnaire had been shared with colleagues and the data analysed to identify what action could be taken to address this. Consideration would be given to benchmarking this information against other community trusts.

The Executive Director of Nursing asked whether anything was being done to influence the Local Education and Training Board in relation to the availability of Speech and Language Therapists. The Deputy Director of Workforce and OD explained that the issue had been flagged in the workforce return to the LETB to encourage the commissioning of more places. He agreed to follow this up further.

The Committee **RECEIVED** the report.

The Chair of the Committee asked for a view as to whether the cost improvement plans were impacting on the quality of care across the Trust. The Executive Director of Nursing responded that the quality impact assessments had been undertaken carefully and that the nursing quality indicators were being robustly monitored to identify any impact. It was noted that the theatre productivity scheme was the biggest scheme in surgery and this was not yet demonstrating an impact on quality. The consultant workforce were starting to report quality impacts as a result of the clinical administration work and voice recognition.

It was recognised that the scale of the turnaround would mean that there would be an impact on quality but that these risks would need to be mitigated as far as possible. The Trust need to bear in mind the perception of quality differs across different people. It was noted that some consultant colleagues were reporting quality impacts as a result of the medical secretary work and the implementation of voice recognition.

The Committee noted that the impact of the changes may not been seen for a while and recognised that staff sickness had increased demonstrating some of the impact of the changes on individuals. A significant amount of change was happening across the Trust, not all related to CIP, and this was having an impact on staff in responding to the change. The Executive Director of Nursing also highlighted that corporate functions had been impacted upon significantly and that this was starting to be visible.

The Committee **AGREED** to keep this in view over the coming months.

07/08/15 **CQC PREPARATION AND ACTION PLAN**

The Assistant Director of Quality presented the monthly update on preparation for CQC inspection. She explained that all divisions have undertaken their assessments and presented the position in each core service to the CQC Steering Group. Overall the Trust is showing a position of 'requires improvement' with the caring domain being the only one scored as predominantly good. Work was being done to review the 90 day plans and consider what risks would remain once these were complete.

The Assistant Director of Quality highlighted that the focus was on implementation. The Committee recommended that the independent support be sought from areas where they have received a rating of outstanding or good to review the Trust's self assessment and that divisions undertake a peer review.

The Committee **RECEIVED** the report and agreed to report this work to the Board in September 2015.

08/08/15 **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 27 August 2015:

- Quarterly quality report and that it would be presented to the Board in September.
- The Medical Workforce paper had been received and the work being done to mitigate the risks
- The Fractured Neck of Femur report and the positive progress made
- Preparation for a CQC inspection

09/08/15 **ITEMS TO NOTE**

9.1 QUALITY COMMITTEE WORK PLAN

The Committee **RECEIVED** the Quality Committee Work Plan for 2015/16 for information.

10/08/15 **ANY OTHER BUSINESS**

There were no other items of business.

DATE AND TIME OF NEXT MEETING

Tuesday 22 September 2015
2pm – 5pm
Board Room, HRI

DATE MINUTES APPROVED:

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 24th September 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: FINANCE AND PERFORMANCE COMMITTEE - UPDATE - The Board is asked to receive a verbal update from the Finance and Performance Committee held on 15.9.15 and the minutes held on 18.8.15.	
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 Finance and Performance Committee held on 15.9.15 and the minutes held on 18.8.15.

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 Finance and Performance Committee held on 15.9.15 and the minutes held on 18.8.15.

Appendix

Attachment:

Draft Minutes of the FP Committee 18Aug15 v1.pdf

Minutes of the Finance & Performance Committee held on Tuesday 18 August 2015 in Meeting Room, 3rd Floor, Acre Mill, Huddersfield Royal Infirmary commencing at 9.00am

PRESENT

Phil Oldfield	Non-Executive Director (Chair)
Anna Basford	Director of Commissioning and Partnerships
David Birkenhead	Executive Medical Director
Julie Dawes	Executive Director of Nursing
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities
Peter Roberts	Non Executive Director
Jan Wilson	Non Executive Director

IN ATTENDANCE

Kirsty Archer	Assistant Director of Finance
Stuart Baron	Assitant Director of Finance
Mandy Griffin	Acting Director of the Health Informatics Service
Andrew Haigh	Chair
Peter Middleton	Membership Councillor
Victoria Pickles	Company Secretary (minutes)

ITEM

188/08/15 WELCOME AND INTRODUCTIONS

Welcomed everyone to the meeting

189/08/15 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Jackie Green, Interim Executive Director of Workforce and OD
Keith Griffiths, Executive Director of Finance
Jeremy Pease, Non Executive Director
Owen Williams, Chief Executive

190/08/15 DECLARATIONS OF INTEREST

There were no declarations of interest.

191/08/15 MINUTES OF THE MEETINGS HELD 21 JULY 2015

The minutes were approved as a correct record.

192/08/15 MATTERS ARISING AND ACTION LOG

87/04/15 Complex discharge

It was confirmed that the deep dive review on this had been undertaken at a Weekly Executive Board meeting. It was agreed to close this action.

87/04/15 Bed modelling

It was noted that Foureyes had dome some work to validate the bed numbers that could be taken out. Further work would be undertaken as part of the business planning process. It was agreed to close this action.

103/05/15 Asthma Care bundle

It was confirmed that the deep dive had been completed and would be reported to the

Quality Committee. It was agreed to close this action.

91.04.15 Strategic Review

The Director of Transformation and Partnerships explained that since the previous meeting there had been a number of discussions with Monitor and the local Clinical Commissioning Groups (CCGs) on the timeline for the plan. She explained that Monitor requires the strategic plan to be developed in line with their toolkit which begins with a reframing of organisational ambition. A Board workshop had been arranged to discuss this on 27 August. The toolkit also sets out the process for baselining, forecasting, developing the strategic options and then the production of the final strategy. An assessment of the Trust's capacity and capability to complete this work had been completed demonstrating that there was not the capacity and some areas where there is not the capability. Monitor require that external support is sourced through a business case prior and short procurement process with the aim of selecting a provider and completing the work within 3-4 months. This has been shared with CCGs in relation to the impact on the readiness for consultation. CCGs are clear they want to consult on clinical model and preferred site and financial sustainability.

The Director of Transformation and Partnerships explained that the final scope would be shared with the Board for comment prior to submission to Monitor the first week of September. Discussion took place around the potential organisations to be invited to tender for the work with the need to robustly manage the procurement process to ensure that any selected organisation had a real track record of delivery and the capability to complete the work.

A further update on progress with this work would be given at the Board meeting on 27 August 2015.

ACTION: To share the scoping document and business case with Board members for comment. – Director of Transformation and Partnerships

159.06.15 Monitor return

The Company Secretary confirmed that a paper setting out the changes to the Monitor Risk Assessment Framework would be presented to the Board in August. It was agreed to close this action.

165.06.15 PMU business plan

The Committee received a paper setting out the results of a workshop around the PMU which had taken place on 5 August. The paper included the next steps and the need to finalise appropriate governance arrangements which would separate the PMU from the Family and Specialist Service Directorate. Professor Peter Roberts added that he would be meeting with the PMU and some outside support to move the unit to a more commercial footing. It was agreed that there needed to be robust controls around quality and safety and that these needed to be incorporated into the governance arrangements.

176.07.15 Month 3 Performance Summary

The Assistant Director of Finance explained that re-profiling payments to the Trust had

been agreed with the clinical commissioners which would provide a short term cash boost. She highlighted that the original plan also assumed pay out of restructuring costs in September but this had been pushed back to February and therefore impacted on the timing of when the Trust would be likely to need to financial support.

It was noted that a significant amount of work had been done to address theatre utilisation and the flow of patients through theatres. This had included a star chamber, resulting in targeted actions to address the bottle necks in the process. It was recognised that while there was improved efficiency in theatres, this was being impacted upon by flow and capacity issues.

Outcome from STAR chambers

The Executive Director of PPEF explained that the star chamber approach followed Monitor guidance and was a way of undertaking a deep dive into specific projects to help it progress and get a clear understanding of any blockages to be resolved. The Executive Director of Nursing added that the approach was still being developed and that the latest Monitor guidance is about the impact they have. This would be incorporated into future versions.

ACTION: It was agreed to share a summary of which areas have been subject to a star chamber and the learning that has resulted. – Director of Transformation and Partnerships.

177/07/05 Month 3 contract Activity and Income Performance

The Committee noted that the Well Led Governance Review prioritised actions would be presented to the Board at its meeting in August. The Chair of the Board highlighted that, in addition, the Board would be asked to approve the creation of a workforce focussed committee.

FINANCE AND PERFORMANCE

193/08/15 MONTH 4 PERFORMANCE

The Director of Transformation and Partnerships summarised the activity and contract performance. Total GP referrals to the Trust had increased by 1.1% for April to July 2015 when compared to the same period the previous year. This increase related to NHS Calderdale CCG where there was an increase of 6.6% mainly in oral surgery, trauma and orthopaedics and dermatology. GP referrals for NHS Greater Huddersfield were down 0.6%.

She also reported that activity underperformed against plan by 13.4% (658 spells) in Month 4 giving a cumulative total of 5.4% below plan for the year. The main specialties leading to the activity under-performance continue to be ophthalmology, trauma and orthopaedics, general surgery, cardiology, rheumatology, ENT and gastroenterology. These were partially off-set by over-performance within oral surgery and urology. It was noted that while recovery plans were in place, these would not recover back to the original plan and this had been factored into the forecast.

In addition, a decision had been made to invest in the medical beds to ensure that as winter approaches the risk of outlying patients is reduced and would therefore not impact on the surgical beds. These factors resulted in the full use of contingency reserves and a revised forecast deficit position of £22M.

Discussion took place on how much of the activity could have been predicted. It was agreed to provide a paper to the committee on some of the issues, what is being done to recover the position and any best practice taking place alongside.

ACTION: Director of Transformation and Partnerships / Executive Director of Nursing.

The Assistant Director of Finance highlighted that a divisional profit and loss report may be useful to give Committee members more information.

It was noted that the theatre productivity work had resulted in greater efficiency alongside qualitative improvements such as achievement of the fractured neck of femur best practice tariff. However this was being affected by capacity.

Discussion took place around the impact on patients. It was confirmed that the Trust was meeting the waiting time standards. The Committee asked that an update be given on cancelled lists and a patient story.

ACTION: Director of Transformation and Partnerships / Executive Director of Nursing.

The Assistant Director of Finance described some of the actions to mitigate the financial position including bringing forward any possible cost improvement schemes scheduled for 2016/17. The Executive Director of Nursing confirmed that nurse recruitment had gone well and that the Trust would be fully staffed however this was being impacted upon by the decision to maintain flexible capacity which would require some agency support. Work was being undertaken to look agency costs and make better use of the staff bank.

The Committee received the Month 4, Performance Summary, Contract Activity and Income Performance and the Financial Narrative & Monthly Dashboard reports. They noted the year end forecast deficit position, the risks associated and the actions to address this position.

194/08/15 MONTH 4 COMMENTARY ON MONITOR FINANCIAL RETURN

The paper provided confirmation that the reports to Monitor are consistent with what is reported to the Board.
The Committee approved the report.

195/08/15 CONTRACTUAL MEDIATION UPDATE

The Director of Transformation and Partnerships explained that the Centre for Effective Dispute Resolution had worked with the Trust and the local Clinical Commissioning Groups to agree a contract for 2015/16. She reported that this had been a constructive process and that it had been agreed by the Board to enter into a payment by results contract alongside the release of some system resilience funding. .

This had been confirmed this to the CCGs. It was noted that NHS Greater Huddersfield were discussing demand management with primary care colleagues in Huddersfield.
The Committee noted the contract had been agreed and asked to see the detail in relation to what had been forecast for activity and the provisions within the contract.

ACTION: Director of Transformation and Partnerships

STRATEGIC ITEMS

196/08/15 TURNAROUND PROGRAMME

The Director of Transformation and Partnerships presented the report which had been produced for the Trust by the Turnaround Director providing a summary of the progress made over the six months of his appointment. A formal response would be produced setting out the agreed actions to be taken forward.
The Executive Director of Nursing commented that there were lessons to be learned from the turnaround approach which had been incorporated into the programme management office arrangements. The Medical Director highlighted the need to robustly manage the quality impact assessments and ensure they are monitored appropriately.

The Committee received the report.

197/08/15 COST IMPROVEMENT PLAN (CIP) 15/16 £14/£18M PROGRESS AND PLANNING

The Director of Transformation and Partnerships presented the report showing progress of schemes and any areas of slippage. It was noted that the Trust had CIP plans of £17.3m signed-off at gateway 2 and that the annual plan submitted to Monitor to deliver a year end deficit of £20m (excluding restructuring costs) relied on delivery of £14.0m CIP.

As reported within the financial narrative, the Trust had over-delivered against the CIP plan for the year to date. The actual amount of CIP delivered was £4.0m against a planned level of £3.30m.

The latest assessment showed that it was likely that delivery against these schemes would total £16.16m and the year-end I&E forecast is currently predicated on the delivery of this value.

The risks in the delivery of some of the schemes were discussed, in particular clinical admin, outpatient productivity and the cardiology and respiratory schemes. It was noted that the focus of the Turnaround Executive was to get plans back to £17M.

The Committee received and noted the report.

198/08/15 EPR UPDATE

The Interim Director of the Health Informatics Service presented the report and highlighted the main points to note:

- Spend remains behind plan due to underspend on staff costs as a result of the delayed start to the programme.
- The project manager had been appointed.

- Assurance shortlisting would take place later in the week.
- Only one change had been made to the key project milestones where the future state review had been put back to end of September. The current state review was almost complete.

The Committee received the report and noted the progress made over the previous month.

199/08/15 MONITOR FEEDBACK FROM THE JULY PROGRESS REVIEW MEETING (PRM)

The Executive Director of Nursing provided feedback on the July PRM with Monitor. She explained that it had been a positive meeting and Monitor had been happy with the Trust's performance and the robustness of the plans. There would be increasing focus on the strategic turnaround plan. It was noted that all future PRM meetings would be held locally so that NHS England and CCG colleagues can be included.
It was felt that Monitor were genuinely supportive and that the Trust needed to deliver what we say we will and be clear about how we are managing the position we are in to maintain this good relationship.

200/08/15 REFERENCE COSTS

The Assistant Director of Finance presented the 2014/15 reference costs submission and explained that it had been prepared in accordance with the Department of Health guidance using the output of the 2014/15 Patient Level information and costing system (PLICS) costing model.

She explained that a draft submission had been prepared, which was then compared to the national average costs for 2013/14 and the average draft submissions of other trusts for the current year. This benchmarking analysis was shared with each clinical division and reviewed for material error. Early indications show that the submitted costs were, in total, within ±1% of the expected costs based on national averages.

The final submission was independently reviewed and submitted within the required deadline

A clinical coding and costing audit had been undertaken which identified one issue relating to the treatment of certain costs. These issues were proactively addressed.

Concern had been expressed that there isn't visibility of costing at a divisional level. A session on costings had been held for the divisions and a similar one would be held for the PMO team. It was noted that all divisions had access to the service line reporting system. More work was being done to be able to share patient level costing. In addition the 'finance our future' training programme had been launched for all budget holders which includes a section on costing.

The Director of Transformation and Partnerships highlighted that a paper was being prepared for Turnaround Executive in September looking at the viability of different services and what it would mean for the Trust to divest itself of some services.

The Chair of the Committee asked for a short presentation to be given on what the PLICS

and service line reporting looks like and how this is cascaded across the organisation.

ACTION: Assistant Director of Finance

The Committee received the report and noted the Trust's reference costs for 2014/15.

201/08/15 CASH FLOW

The Assistant Director of Finance presented the 13 week cash flow report and reported that the Trust was holding back on payment to suppliers to help with the cash position. Once the realigned payments had been received from the CCG, this would be reviewed. A Cash Committee had been setup with the first meeting to be held in September and an interim deputy director of finance appointed with a background in cash management.

GOVERNANCE

202/08/15 WORKPLAN

There were no items added to the work plan. The Committee noted the items for the next meeting.

203/08/15 MATTERS FOR THE BOARD AND OTHER COMMITTEES

- The revised forecast deficit of £22M
- The forecast CIP position of £16M.

204/08/15 ANY OTHER BUSINESS

There were no other items of business.

DATE AND TIME OF NEXT MEETING

Tuesday 15 September, 9.00am – 12.00noon, 3rd Floor, Acre Mill Outpatients

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