

Members of the public wishing to submit questions are required to submit these to the Board Secretary by close of play the day before the meeting.

Meeting of the Board of Directors

To be held in public

Thursday 25 February 2016 from 1:30 pm

Venue: Boardroom, Sub-basement, Huddersfield Royal Infirmary

AGENDA

REF	ITEM	LEAD	PAPER	PURPOSE OF PAPER/ UPDATE
019/16	Welcome and introductions: Mr Ken Batten, Publicly Elected Membership Councillor Mr Brian Moore, Publicly Elected Membership Councillor	Chair	VERBAL	Note
020/16	Apologies for absence: Julie Dawes, Executive Director of Nursing (Lindsay Rudge, Deputy Director of Nursing attending) Dr David Birkenhead, Executive Medical Director (Juliette Cosgrove, Assistant Director for Quality attending)	Chair	VERBAL	Note
021/16	Declaration of interests	All	VERBAL	Receive
022/16	Minutes of the previous meeting held on 28 January 2016	Chair	APP A	Approve
023/16	Matters arising and review of the Action Log 8/16 – “In One Place” – South Wales initiative 10/16 - Calderdale Support & Independence Team 11/16 – EPR – Risk Register/BAF update 12/16 – Risk Register – Heatmap 13/16 – F&P Committee Agenda item – Commercial Plan 14/16 – Equality and Diversity – Prevent Training Evaluation 180/15 – Performance Management Framework Updates	Chair	APP B VERBAL VERBAL VERBAL VERBAL VERBAL APP C	Review
024/16	Patient/Staff Story ‘Research Improves Lives at CHFT’ presentation by Asifa Ali, Research & Development Lead		Presentation	Receive

025/16	Chairman's Report: a. NHS Improvement launch – Provider Roadmap Conference 11.2.16 b. MC Activities - MC/NED Workshop - 18.2.16 - 5 Year Strategic Plan Extraordinary Meeting – 4.2.16 - NED Appointments	Chair	Verbal	Receive
026/16	Chief Executive's Report: a. Implementing the Forward View – Summary b. Mental Health – 5 year Forward View - Summary	Chief Executive	APP D	Receive
Transforming and improving patient care				
027/16	Consultation Process - Update	Director of Transformation and Partnerships	VERBAL	Receive
Keeping the base safe				
028/16	Board Assurance Framework	Company Secretary	APP E	Approve
029/16	Risk Register	Assistant Director for Quality	APP F	Approve
030/16	Risk Management Policy	Assistant Director for Quality	APP G	Approve
031/16	Director of Infection Control, Prevention	Assistant Director for Quality	APP H	Receive
032/16	Care of the Acutely Ill Patient	Assistant Director for Quality	APP I	Approve
033/16	Quarterly Quality Report	Assistant Director for Quality	APP J	Approve
034/16	End of Life Report	Deputy Director of Nursing	APP K	Receive
035/16	Integrated Board Report - Responsive - Caring - Safety - Effectiveness - Well Led - CQUINs - Monitor Indicators - Finance	Chief Operating Officer Assistant Director of Quality “ Deputy Director of Nursing “ Executive Director of Finance	APP L	Approve

Approved Minute

Cover Sheet

Meeting: Board of Directors	Report Author: Kathy Bray, Board Secretary
Date: Thursday, 25th February 2016	Sponsoring Director: Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 28.1.16 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 28 January 2016.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 28 January 2016.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 28 January 2016.

Appendix

Attachment:

DRAFT BOD MINS - PUBLIC - 28 1 16(2).pdf

**Minutes of the Public Board Meeting held on
Thursday 28 January 2015 in the Large Training Room, Learning Centre,
Calderdale Royal Hospital HX3 0PW**

PRESENT

Andrew Haigh	Chairman
Helen Barker	Chief Operating Officer
Dr David Birkenhead	Executive Medical Director
Julie Dawes	Executive Director of Nursing /Deputy Chief Executive
Keith Griffiths	Executive Director of Finance
Jan Wilson	Non-Executive Director
Philip Oldfield	Non-Executive Director
Jeremy Pease	Non-Executive Director
Prof Peter Roberts	Non-Executive Director
Owen Williams	Chief Executive

IN ATTENDANCE/OBSERVERS

Tracy Fennell	Associate Director of Nursing (for part of meeting)
Anna Basford	Director of Transformation and Partnerships
Kathy Bray	Board Secretary
Rev Wayne Clarke	Publicly Elected Membership Councillor
Mandy Griffin	Interim Director of the Health Informatics Service
David Himelfield	Huddersfield Examiner Reporter
Victoria Pickles	Company Secretary
Dawn Stephenson	Nominated Stakeholder Membership Councillor
Caroline Wright	Communications Manager

Item

1/16 WELCOME AND INTRODUCTIONS

The Chairman welcomed everyone to the meeting and particularly welcomed Helen Barker in her new role as Chief Operating Officer.

2/16 APOLOGIES FOR APOLOGIES were received from:

Dr David Anderson	Non-Executive Director
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities
Dr Linda Patterson	Non-Executive Director

3/16 DECLARATION OF INTERESTS

There were no declarations of interest to note.

4/16 MINUTES OF THE MEETING HELD ON THURSDAY 17 DECEMBER 2015

The minutes of the meeting were approved as a true record.

5/16 MATTERS ARISING FROM THE MINUTES/ACTION LOG

a. 161/15 – CARE OF THE ACUTELY ILL PATIENT – GO AND SEE VISIT TO TYNE & WEAR – It was noted that arrangements had not been made between Prof. Roberts and the Medical Director to visit Tyne and Wear to obtain information around End of Life care. It was agreed that further discussion would take place between them to agree whether to take this forward and would be updated within the next Care of the Acutely Ill Patient Report.

ACTION: Executive Medical Director

OUTCOME: Closed

b. 185/15 – IBR - GREEN CROSS PATIENTS – The Chief Operating Officer reported that this had been reported in detail at the Quality Committee.

OUTCOME: Closed

c. 183/15 – HARD TRUTHS – The Executive Director of Nursing confirmed that a report had been presented to the Commercial Investment and Strategy Committee. Support had been given for additional nursing bank staff to be funded for patients with respiratory disease. Further information regarding a clinical specialist post had been required by the Committee.

OUTCOME: Closed

d. 198/15 – BOARD WORKPLAN – Minutes from the last Risk and Compliance Group had been added to the work plan each meeting.

e. 202/15 – IBR – CARING – REAL TIME MONITORING – The Executive Director of Nursing reported that the Real Time Monitoring project would re-commence with the help of volunteers and Membership Councillors to collate patient feedback.

f. WELL LED GOVERNANCE REVIEW – UPDATED ACTION PLAN

The Company Secretary presented an updated Action Plan. It was noted that actions were progressing with particular continuing focus on risk management work, the clinical leadership model and ongoing board development programme.

OUTCOME: It was agreed that an update would be brought to the Board in March 2016.

6/16 STAFF STORY

Tracy Fennell, Associate Director of Nursing – Medical Division attended the meeting to share her experiences as a new employee recently appointed to the Trust.

The Board received positive feedback of her first impressions having worked in the Trust for 3 weeks. She had received a warm and friendly welcome from everyone and was impressed by the care and compassion shown by the workforce together with a visible leadership that listened, acted and connected with staff. Tracey commented that nursing staff were working extremely hard, particularly in light of the additional beds currently open. She was impressed by the huge amount of data available in the Trust and reflected that there was a need to strengthen systems and processes to make the best use of this information. This would follow particularly with the introduction of the electronic patient record.

The Board thanked Tracy for the positive messages and felt that the Trust would appreciate her 'fresh pair of eyes' approach. The Executive Director of Nursing advised that Tracy would be leading on the work to reduce patient falls in the Trust.

7/16 CHAIRMAN'S REPORT

a. Membership Council Meeting – 19.1.16 – The Chairman updated the Board on the Membership Council Meeting held on Tuesday 19 January 2016. The key issues included:-

- **5 Year Strategic Plan** – Membership Councillors had received details at a private meeting held on the 11 January 2016. A further session for those unable to attend this meeting had been scheduled for 4 February 2016.

- **Nominations and Remuneration Committee (MC)** - The process for the recruitment of two Non-Executive posts was underway with shortlisting planned for 9 February and interviews on the 19 February 2016.
- **Membership Council Vacancies** – It was agreed that a bi-election would be deferred and the existing vacancies would be appointed in the summer elections. The Chairman reported that since the Membership Council Meeting Locala had nominated a Stakeholder.
- **Membership Strategy** – A task and finish group was to be established to develop the strategy.
- **CQC Preparedness** – Arrangements had been made for the Membership Councillors to receive a briefing on the CQC inspection on the 3 March 2016.
- **Food and Nutrition Event** - The Chairman agreed to report the work undertaken within the Trust to raise awareness regarding food and nutrition. The Trust had given support to this initiative and the support from all the Board was welcomed.

b. Nominations and Remuneration Committee (BOD) – The Chairman reported that a meeting had been held earlier that day which approved the replacement of two Executive Director roles going forward.

8/16 CHIEF EXECUTIVE'S REPORT

The Chief Executive advised the Board that he had circulated the Sustainability and Transformation Plan for the Board to consider the future changes required in healthcare. It was noted that the Trust was being offered funding from the Sustainability and Transformation Fund and that agreement would need to be reached on this and its impact on the Trust's financial planning by 8 February. The Board agreed to delegate this decision to sub-group. Further discussion about this offer and agreement of the sub-group would take place in the private Board meeting to be held later that day.

Prof Peter Roberts reported that he was due to visit South Wales Board within the next couple of months regarding the 'In One Place' integrated delivery of healthcare. After that time it may be appropriate for the Board to invite a representative from the 'In One Place' initiative to share their experiences and best practice with the Board. The Board welcomed this proposal which would ensure that all options are considered in the future.

ACTION: Prof Peter Roberts

9/16 CCG PRE CONSULTATION BUSINESS CASE AND DECISION

The Chief Executive explained that the Clinical Commissioning Groups had published a pre-consultation business case document and announced their decision to go out to public consultation beginning in early February. The pre-consultation business case built on the Trust's 5 Year Strategic Plan. The Board noted the significant media and social media attention on the decision and agreed that everyone should be encouraged to contribute to the Consultation. Details regarding the Consultation Events were awaited.

Discussion took regarding the communication plans for the Trust. It was noted that conversations were taking place with Trust staff prior to the consultation period commencing and that an Overview and Scrutiny Meeting was scheduled for Friday 29 January 2016. The Non-Executives present offered their support in speaking with staff.

10/16 CALDERDALE SUPPORT AND INDEPENDENCE TEAMS UPDATE

The Director of Transformation and Partnerships presented a paper which had been discussed by the Calderdale Council Cabinet in December 2015 which related to the delivery of a range of intermediate care services through an integrated model of working within a joint management structure. The report summarised developments during the past 12 months and recommended the continuation of the partnership agreement between the Council and CHFT for the delivery of these services for a further 12 months which would allow time for Care Closer to Home and Vanguard to be progressed. This will influence future arrangements as part of a whole system approach.

The Board discussed the line management arrangements for staff. It was noted that the paper did not make clear who would employ and line manage the teams delivering the service. The Chief Operating Officer agreed to follow up on this point.

ACTION: Chief Operating Officer

OUTCOME: The Board agreed the recommendation within the report.

11/16 EPR UPDATE – GATEWAY REPORT

The Interim Director of The Health Informatics Service presented a paper updating the Board on the progress in developing an electronic patient record and the results of the first Gateway assessment. She apologised that the full report had been omitted from the combined file, but this would be circulated to the Board for information prior to its submission to Monitor. Further work was being undertaken on the scope, benefits and recommendations.

ACTION: Board Secretary

As discussed at the last Audit and Risk Committee, Professor Roberts highlighted that discussion had taken place regarding the Risk Register and Board Assurance Framework (BAF) accurately reflecting the risks associated with the operational and deliverability issues of this project. It was agreed that more work would be undertaken on this issue before the issue of the next versions of the Risk Register and BAF.

ACTION: Interim Director of Health Informatics

12/16 RISK REGISTER

The Executive Director of Nursing reported that the top risks (scored 15+) within the organisation remained the same as the previous month. The **top risks** were:-

- Progression of service reconfiguration impact on quality and safety
- Over-reliance on middle grade doctors in A&E
- Failure to meet cost improvement programmes
- Outlier on mortality levels
- Staffing risk, nursing and medical
- Ability to deliver service transformation risk
- Delivery of Electronic Patient Record Programme

Risks with increased score:-

- No risks had increased score over the previous month.

Risks with reduced score:-

- Two risks had reduced in score over the previous month.
 - CQC standards in the community division has been revised and has a lower score on the community division risk register.
 - potential loss of training grade posts, scored at 12, has been removed from the corporate risk register and will be managed within the divisional risk register.

New risk added:-

The following new risks have been added to the Corporate Risk Register in January 2016.

- Radiology Risk re: not acting on findings from diagnostic tests, score of 16 – It was noted that a serious incident group had been convened. It was agreed that the introduction of the EPR would help reduce the risks to the Trust.
- Essential skills data training risk, score 16 – A centralised system was being developed.
- Timeliness of serious incident investigations, risk score of 16 - New guidelines had been received and there are capacity issues within the team. Further training of staff was underway and a central investigation team to help the Trust with the backlog was being appointed.

The Chairman thanked the team for the update of the Risk Register. It was agreed to look to reformat the heat map.

ACTION: Executive Director of Nursing.

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

13/16 REVIEW OF PROGRESS AGAINST STRATEGY

The Director of Transformation and Partnerships presented the updated progress against the strategy which had been prepared by the Company Secretary. It was noted that significant progress had been made against all of the priorities in the plan.

Of the 22 deliverables:-

- None were rated red i.e. off track with no plan in place.
- 2 were rated amber / red i.e. off track with a plan in place.
- 17 were rated amber / green i.e. on track but not yet delivered.
- 3 have been fully delivered or rated green

The Chairman questioned whether the Trust would require a commercial plan separate to the 5 Year Strategic Plan. It was agreed that this would be discussed at the next Finance and Performance Committee meeting.

ACTION: KG - F&P Agenda

Jeremy Pease asked what assurance the Trust had regarding the two amber rated issues:- Roll out of 7 day working and strategic framework to articulate and govern a value driven people focussed approach using work together to get results. The Board were advised that there was national and local ambiguity around 7 day working. A clinical fellow had been brought in to work through the 7 day working priorities. Through the implementation of the 5 Year Strategic Plan there would be work to address the value driven people focussed approach.

Concern was expressed that the progress around SHMI was rated as amber / green and yet the Care of the Acutely Ill Patient was not delivering a reduction in the SHMI position. The Executive Medical Director reported that data over the last few months was showing that HSMR may be reducing. It was acknowledged that although the programme may not improve the SHMI position it will improve patient care. As discussed at the November Board Meeting, the Executive Medical Director reported that he had invited Professor Mohammed to present his findings again to the Board and was awaiting his response. The Executive Medical Director agreed to follow up on this issue.

ACTION: EXECUTIVE MEDICAL DIRECTOR

The Company Secretary reported that the plan would be refreshed over the next few weeks, in line with the Annual Planning process, to prepare the one year plan for 2016/17. An update of the progress against strategy would be available to the Board in April 2016 as outlined on the Annual Business Plan.

OUTCOME: The Board received and approved the updated review of progress against strategy and agreed that an update would be provided to the April 2016 Board of Directors Meeting

14/16 EQUALITY AND DIVERSITY REPORT AND PUBLIC SECTOR EQUALITY DUTY COMPLIANCE EVIDENCE

The Executive Director of Nursing presented a report on the Trust's progress against, and achievement of, agreed equality and diversity objectives. The Board received and approved the report. It was noted that at the moment the Trust had a patient and public involvement plan that linked to the delivery of the equality objectives

Jan Wilson asked for information regarding a £10K funding from NHS England for a national BME project. The Executive Director of Nursing agreed to investigate this further and feed back to Jan Wilson outside the meeting.

The Chief Executive reported that recent data showed an increase in the headcount of self-declared BME staff within the Trust. The Board felt that this was an encouraging trend bearing in mind the context of Trust numbers reducing. It was agreed that more conversation was required around other protected characteristics to include other groups of people.

Discussion took place regarding whether the Trust had any system of evaluation in place to monitor the impact of training with regard to Prevent Training. The Executive Director of Nursing agreed to investigate and ensure that systems/processes were in place. It was felt that this issue could be addressed by the Well-led Workforce Committee.

ACTION: Executive Director of Nursing

OUTCOME: The Board received and approved the Equality and Diversity Report.

15/16 CQC READINESS UPDATE

The Executive Director of Nursing presented the Trust's self-assessment of CQC compliance as requiring improvement. The dates for the inspection had been confirmed as Tuesday 8th March 2016 to Friday 11 March 2016 and the Trust was now moving into the final phase of preparation ahead of the inspection.

OUTCOME: The Board received the self-assessment and the work being undertaken.

16/16 INTEGRATED BOARD REPORT

The Chief Operating Officer introduced the Integrated Board Report as at 31 December 2015 and explained that key areas would be presented in detail by the appropriate Executive leads.

Key issues arising from the report were:

Responsiveness

- In month there have been several areas of overtrade against plan with a positive impact on financial forecasts despite periods of reduced activity for the Christmas period. In particular there continues to be a significant over-trade against the non-elective activity in Medicine which is 4% above planned levels.
- Emergency Care Standard delivered in December and in quarter 3.

- Pressures continue in key elements of patient flow meaning performance secured through additional capacity rather than pathway improvement.
- Elective access - All 18 week referral to treatment targets and 6 week diagnostic targets have been achieved in month.
- Appointment Slot Issues reporting remains problematic. Focus required on clinical and non-clinical validation
- Stroke standards have been revised to better reflect national stroke audit standard 'A' rating with improvement required to achieve these; both the TIA and Thrombolysis targets were delivered.
- All regulatory cancer targets were achieved, Day 38 standard improved and no patients had a pathway in excess of 104 days.

Caring

- Complaints response times remain a challenge with focussed activity in January to close high volumes.
- Friends and Family Test – those who would recommend in Community and Accident and Emergency Department has reduced. The Chair expressed concern regarding the percentages shown.
- There have been increased concerns raised by women in labour.

Effectiveness

- Hand Hygiene compliance has improved in December
- Mortality remains a concern and is the focus of significant work
- Fractured Neck of Femur (# NoF) performance in relation to Theatre within 36 hours has improved again and reached the 85% target.

Safety

- There remain a high proportion of serious incident reports out of time
- Duty of Candour is 100% across both metrics
- The predicted improvement has not been achieved for 'falls with harm'.

Discussion took place regarding some of the metrics within the safety indicators and the Executive Director of Nursing agreed to look into the anomalies and circulate corrected information to the Board.

ACTION: Executive Director of Nursing

Well led

- Sickness has increased in 5 of the 7 service areas reported and 5 out of 8 staff categories with overall % sickness at its highest point in current service year.
- Staff in post and FTE is static
- Over 96% of colleagues have now started their mandatory training programme.
- Appraisal activity plans are in place with divisions now RAG rated against these plans CQUINs
- Sepsis and Acute Kidney Injury CQUINs remain a challenge to deliver. The threshold is set nationally and the Trust is in a similar position to peers on delivery.

It was noted that the Investors in People analysis and Action Plan would be received by the Board at the February meeting.

OUTCOME: The Board received and approved the contents of the Integrated Board Report.

ACTION: Agenda Item – February 2016 BOD.

17/16 MONTH 9 – DECEMBER 2015 FINANCIAL NARRATIVE

The Executive Director of Finance presented the finance month 9 report (including the contents of the Integrated Board Report). It was noted that this information had been discussed in detail at the Finance and Performance Committee held on the 26 January 2016:-

The key issues included:-

Summary Year to Date:

- The year-to-date deficit (excluding restructuring costs) is £16.42m versus a planned deficit of £15.34m
- The overall deficit is £17.50m against a planned £18.34m, due to restructuring costs not being incurred.
- Outpatient activity was above plan in month and there was an improvement in levels of day case and elective activity.
- High pay expenditure including significant levels of agency expenditure, some of which is above the Monitor price cap.
- Capital expenditure year to date is £13.64m against the planned £16.54m due to timing differences mainly on IT spend
- Cash balance is £7.60m against a planned £1.91m, due predominantly to securing cash payments in advance for clinical activity
- CIP schemes delivered £12.65m in the year to date against a planned target of £9.57m
- The new Monitor performance measure Financial Sustainability Risk Rating (FSRR) stands at 2 against a planned level of 2.

Summary forecast:

- The forecast year-end deficit (excluding restructuring costs) is £20.54m against a planned £20.01m, an adverse variance of £0.53m. This position includes full release of remaining contingency reserves and delivery of £17.93m CIP against the original planned £14m
- Whilst this is a slight improvement on the £20.93m deficit (excluding restructuring) reforecast plan submitted to Monitor in Month 7, risks remain against the settlement of commissioner contracts and winter expenditure pressures and junior doctor strike action.
- The overall forecast deficit position shows a favourable variance of £1.37m from plan due to a reduction in forecast restructuring costs of £1.9m. Reliance on external cash support has come down from a planned £14.90m to £12.90m due to reduced Capital expenditure and restructuring costs.
- It has been decided to reduce capital expenditure by £1m, to reduce reliance on external cash support. The year end FSRR is forecast to be at level 2.

OUTCOME: The Board received and approved the financial narrative for December 2015.

18/16 UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES

The following information was received and noted:-

a. Quality Committee – The Board received and noted the minutes from the meeting held on 15 December 2015 and verbal update from meeting held on 26 January 2016. Matters arising in this meeting Board included:-

- CQC visit preparation

- Medical Devices – update on training programme, staff awareness, maintenance plans, replacement programme
- NICE Compliance – update on guidance received and work ongoing on non-compliant positions.
- Regulation 28 – A Regulation 28 had been issued by the Coroner. An action plan was in place. A number of serious incidents had occurred in the last 18 months and a paper was being prepared for the next Quality Committee to update on the actions being undertaken.

b. Finance and Performance Committee – minutes of the meeting held on 15 December 2015 were received and noted and a verbal update from the meeting held on the 26 January 2016 was received from Phil Oldfield.
Matters arising in this meeting included:-

- Due to time commitments some items on the agenda had been deferred to the next meeting
- CNST triangulation
- Trading performance
- Budget and budget timelines
- CIP progress
- EPR update
- Sustainability and Transformation Fund.

c. Remuneration and Nomination Committee (Membership Councillors) – The minutes from the meeting held on 7 December 2015 were received and noted.

d. Audit and Risk Committee – Prof. Peter Roberts gave a verbal update from the meeting held on 20 January 2016.

The main issues discussed at the meeting included:-

- Audit Effectiveness Self-Assessment Template to be completed by attendees
- Note evolving internal audit arrangements
- Internal Audit Follow-up Recommendations – Review areas to focus on at April Meeting
- Internal Audit Progress Report – 2 Limited Opinion Reports - Emergency Preparedness, Resilience and Response, Information Governance Toolkit - plus discussion on EPR Assurance
- Noted review of effectiveness of internal audit and agreed this should be subject to peer review
- Local Counter Fraud Services Progress Report
- Technical Update
- External Audit Plan
- Risk Management Policy – more work required especially on non-clinical risk
- Whistleblowing response – noted changes to draft response and agreed final version.

The Chairman thanked everyone for their attendance and contributions.

19/16 DATE AND TIME OF NEXT MEETING

Thursday 25 February 2016 at 1.30 pm in the Boardroom, Sub Basement, Huddersfield Royal Infirmary HD3 3EA

The Chairman closed the meeting at 5.00 pm.

Approved Minute

Cover Sheet

Meeting: Board of Directors	Report Author: Kathy Bray, Board Secretary
Date: Thursday, 25th February 2016	Sponsoring Director: Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS ACTION LOG AS AT 1.2.16 - The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 February 2016	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 February 2016

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 February 2016

Appendix

Attachment:

DRAFT ACTION LOG - BOD - PUBLIC - As at 1 FEBRUARY 2016.pdf

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 February 2016 / 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
29.10.15	CAIP/MORTALITY REVIEWS The Executive Medical Director reported that Brian Fill and Professor Mohamed from Bradford University were working within the Trust to review the Trust's data and this would be brought back to the Board at a future date.	Executive Medical Director	26.11.15 DB to contact Prof. Mohammed with a view to him presenting to the Board again on his return from leave in the New Year.	TBC		
29.9.15	NURSING & MIDWIFERY STAFFING – HARD TRUTHS REQUIREMENT – WORKFORCE MODELS Update received. Agreed a further paper be presented to the Board in November 2015 which will recommend any adjustment to Nursing and Midwifery workforce models.	Executive Director of Nursing	26.11.15 Paper to be submitted to Commercial Investment and Strategy Committee and summary then provided to Board re. size of investment and how it is structured. 17.12.15 The paper presented had now been submitted to the Commercial Investment and Strategy Committee and further information had been requested from them. This would be taken to the Executive Board for discussion in January 2016 prior to discussion at the Board of Directors. 28.1.16 Report presented to Commercial Investment & Strategy Committee. Closed.	?Feb 2016		
29.10.15 (161/15)	CARE OF THE ACUTELY ILL PATIENT Consideration to be given to a 'go-see' in Tyne and Wear	Executive Medical Director / PR	Liaison through Prof. Roberts and DB to visit – update to December 2015 Board. 17.12.15 It was noted that arrangements had yet to be made between Prof. Roberts and the Medical Director to visit Tyne and Wear to obtain	?Feb 2016		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 February 2016 / 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
			information around End of Life care. 28.1.16 Agreed that further discussion would take place between Prof Roberts and Executive Medical Director to agree whether to take this forward. Closed.			
29.10.15 (165/15)	INTEGRATED BOARD REPORT Review to take place on how information is presented and summarised	Chief Operating Officer	17.12.15 The Associate Director of Community Services and Operations and the Executive Director of Planning, Performance, Estates and Facilities (DPPEF) reported that they had met to discuss the level of detail required in the IBR to ensure that the Board receives information at the correct level from the various committees. It was suggested that a summarised version of the Integrated Board Report would be developed in the future and a more formal reporting back system from the various Board sub-committee Chairs put in place. This would allow the Board to be more forward focussed going forward.	26.5.16		
26.11.15 (177.15)	BOARD ASSURANCE FRAMEWORK – WINTER RESILIENCE Reference to Winter Resilience in Risk Register to be recorded to create an overarching statement in BAF,	Company Secretary		25.2.16		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 February 2016 / APPENDIX B

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Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
26.11.15 (177/15)	BOARD ASSURANCE FRAMEWORK – MORTALITY Following changed position in the Trust, rewording of Mortality section of BAF to be undertaken before its next update.	Medical Director		25.2.16		
26.11.15 (178/15)	RISK REGISTER – TRANSFER OF SERVICES Agreed that financial and service risks would be clarified on the Risk Register	Chief Operating Officer		28.1.16		
26.11.15 (179/15)	WELL LED GOVERNANCE REVIEW Milestones to be built in against each action	DoN/Co Sec	28.1.16 Agreed a report would be brought back to Board in March 2016.	31.3.16		
26.11.15 (180/15)	PERFORMANCE MANAGEMENT FRAMEWORK (PMF) – TROLLEY WAITS Over 4 hour trolley waits to be included	COO		25.2.16		
26.11.15 (180/15)	PERFORMANCE MANAGEMENT FRAMEWORK – UPDATE ON PMF PILOT Update on pilot to be brought in February 2016.	COO		25.2.16		
26.11.15 (185/15)	INTEGRATED BOARD REPORT – GREEN CROSS PATIENTS Further assurance about direction of discharges to be provided to December BOD Meeting	COO	17.12.15 The Associate Director of Community Services and Operations reported that a ‘deep dive’ would be undertaken in the January 2016 Board report, taking up comments from Linda Patterson and Jeremy Pease. 28.1.16 Reported in detail to Quality Committee. Closed	28.1.16		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 February 2016 / APPENDIX B

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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
202/15 17.12.15	IBR – WELL LED – Sickness Policy The Chief Executive asked whether revalidation of the Sickness Policy had been included in the BoD Workplan. It was agreed that this should come back to the Board at the End of March 2016.	DoN		31.3.16		

Approved Minute

Cover Sheet

Meeting: Board of Directors	Report Author: Kathy Bray, Board Secretary
Date: Thursday, 25th February 2016	Sponsoring Director: Helen Barker, Associate Director of Community Services and Operations
Title and brief summary: PERFORMANCE MANAGEMENT FRAMEWORK - UPDATE - The Board is asked to note progress on the implementation of the Performance Management Framework	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Board of Directors Meeting - November 2015	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board received and approved a Performance Management Framework with associated accountability in November 2015 that was developed in consultation with corporate departments and Divisional teams.

Whilst work commenced there was insufficient expertise and capacity to ensure full implementation to the required timeline therefore additional interim capacity has been secured with a Head of Performance in place from 8th February.

The Head of Performance is undertaking a diagnostic exercise to ensure the Divisions are ready for implementation along with a review of the structure for the production and management of performance information.

A further update will be provided to the March Board of Directors

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board of Directors are asked to note the progress on implementation.

Appendix

Attachment:

PMF update Feb 16.pdf

Performance Management Framework Implementation Progress update February 2016

Introduction

Further to the approval of the Performance Management Framework in November 2016 work has commenced on the implementation. Following on from discussions with THIS, the chair of the Finance & Performance (F&P) Committee and operational teams it is clear that there are both practical and cultural developments needed to fully implement and embed the framework at all levels within the organisation

To facilitate this we have appointed an Interim Head of Performance, initially for 3months (commenced in February 2016), with the remit of ensuring implementation of the key recommendations of the framework and identification of the structure and process required to sustain effective performance management and reporting within CHFT.

In their initial 4 weeks they are meeting with Directors, managers and their teams undertaking a diagnostic on the key issues to be resolved to secure implementation along with the development of the solutions and the remaining time will be focussed on implementation.

This paper describes some of the practical steps taken to date incorporating some initial observations of the Interim Head of Performance

Weekly Performance Meetings

The weekly performance reviews combined with the Performance review pack means that the basics for performance management are in place. In that senior managers are receiving regular performance information, having regular integrated reviews and being held to account for their divisions performance in the presence of their peers.

This means that:

- We have established a single source of truth across all divisions.
- There is a clear escalation from the weekly meeting to WEB
- Managers are accustomed to receiving data/information regarding performance, assimilating this and being answerable for performance.
- Conversations about performance are occurring at senior strategic levels across divisions.
- Actions, Strategies, plans and decisions can be based on, supported and informed by performance information.

- Data that was already in the business is now being used to understand performance and through the performance meetings various disparate measures and data are being drawn together and combined to provide a narrative which describes how the organisation is working and performing.
- CHFT is moving towards an evidenced based approach.
- We are becoming more self-aware and there is greater transparency and accountability.

Further development:

The process has more to do in terms of a move from reactive to proactive, analysis needs to focus more on what the data is telling us about the future and the destination not just retrospectively informing us of how we have performed to date.

The data pack needs to develop into one that clearly highlights the exceptions to allow a more focussed action based discussion with clear ownership and timelines by Divisions

Documentation and action tracking of the weekly meetings needs to be more robust

Monthly Divisional & Directorate Performance Meetings

A review of the datapacks and performance templates has been undertaken with THIS, these have been broken down to Directorate level and are currently out with Divisions for them to propose thresholds and ensure all KPIs relevant for their areas of responsibility are included. This will be discussed with Directors through the Annual Planning sign off process to ensure KPIs in place at Directorate and Divisional level will deliver the objective of 'Keeping the Base Safe' and associated accountability is clear.

There is a misalignment with the data publication and the timings of performance meetings to support rapid Ward to Board reporting. The interim Head of Performance is reviewing this and will be making recommendations for implementation from 1st April 16.

The framework has been developed with the intention of replication into Divisions with the DD's holding similar meetings with their Directorates, holding them to account and getting from them the assurance, explanations and actions that will ensure that performance is being addressed at operational levels. The development of this within Divisions remains variable and the Interim Head of Performance is currently meeting with each ADD to co-produce the Terms of Reference for performance meetings at Directorate level, this will include a greater focus on the access agenda and will encompass CIP and annual planning delivery.

Board Reporting

A meeting has been held with the Non-Executive chair of the Finance and Performance Committee the forum which will, going forward, be responsible for the detailed review of

operational performance, a similar meeting with the chair of the Quality Committee will take place. The reporting suite has been discussed and the key components of a dashboard have been identified. The Interim Head of Performance has started to mock up a dashboard and is currently meeting with individual Directors to discuss and refine. This is on track for implementation with April 2016 KPIs.

The current detailed IPR, with exception reports will be presented to F&P and Quality Committee as appropriate in February with a summary report to Board of Directors.

Next steps

Interim Head of Performance to:

- meet directly with Chairs of the relevant committees to agree final dashboards;
- support the Chief operating Officer in the production of a Business Case for a substantive Head of Performance;
- meet with Director of THIS and Senior Information Officer to develop a performance function that supports the PMF;
- review all existing data produced with a view to rationalising production and the aim of understanding what the production of the data is costing us (In time, cost and resources) and what benefit it is likely to deliver and
- Commence coaching of operational teams to ensure consistency of approach.

A further update with more detail of the diagnostic will be presented in March 2016

Approved Minute

Cover Sheet

Meeting: Board of Directors	Report Author: Kathy Bray, Board Secretary
Date: Thursday, 25th February 2016	Sponsoring Director: Victoria Pickles, Company Secretary
Title and brief summary: CHIEF EXECUTIVE'S REPORT - The Board is asked to receive and note the Chief Executive's Report	
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 and note the updates:-

- a. Implementing the Forward View - Summary
- b. Mental Health - 5 Year Forward View

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 updates:-

- a. Implementing the Forward View - Summary
- b. Mental Health - 5 Year Forward View

Appendix

Attachment:

COMBINED CE REPORT.pdf



IMPLEMENTING THE *FORWARD VIEW*: Supporting providers to deliver SUMMARY

Implementing the *Forward View*

Supporting providers to deliver

SUMMARY

Version number: 1

First published: 11 February 2016

Prepared by: NHS Improvement in collaboration with a range of provider leaders, NHS Providers, NHS Confederation, NHS Clinical Commissioners, NHS Partners and the Local Government Association.

This document is for: Boards, senior leaders and clinicians, and interested staff in NHS trusts and NHS foundation trusts as well as their commissioners.

This document is designed for NHS provider organisations. It is part of a series of roadmaps that draw on messages from the [NHS Planning Guidance](#) and set out the key priorities for specific audiences that are responsible for delivering high quality health and care this year and beyond. Each roadmap draws on a shared vision for the health and care sector as set out in the [Five Year Forward View](#) (5YFV) – about the challenges ahead and the choices we face about the kind of health and care service we want and need in 2020. This is not just about stabilising services for today, but about driving the necessary scale of transformation required to meet the needs of future patients in a sustainable way and to help close the three gaps identified in the 5YFV: health and wellbeing; care and quality; and finance and efficiency.

The solutions to today's problems lie in a radical upgrade of prevention and new models of service delivery. This means working differently, and collaboratively, on identifying solutions and sharing problems, at both national and local levels and with wider stakeholders, such as local government, individuals and community partners. This will be increasingly important as we move further towards place-based planning, commissioning and delivery of preventative, person-centred and co-ordinated care in which individuals are increasingly empowered to take responsibility for their own care where relevant, thereby reducing pressure on existing services. Success will require us all to think beyond our statutory and organisational borders to meet the needs of the people we serve. Further strengthening of collective system leadership at both national and local levels is essential to ensure that we succeed.

1 Introduction

All providers of NHS services have been under increasing pressure in recent years, most acutely from slowing growth in the NHS budget, but also from rising expectations, an ageing population and an expanding range of treatments and therapies. Managing this increase in demand during a period of limited funding growth was the key challenge identified in the NHS Five Year Forward View (5YFV).

In response to the 5YFV, the government has pledged an additional £8.4 billion of real-term investment in the NHS by 2020, heavily weighted to the earlier years of the spending period. This gives NHS providers a window in which to invest in lasting improvements in the quality and efficiency of care, so they can sustain higher standards as funding growth slows later in the period.

Implementing the Forward View: supporting providers to deliver, summarised below, describes for provider boards and leadership teams the task they face, how to build the capability they need to achieve it, and what NHS Improvement and other arm's length bodies will do to support them.

2 The provider task to 2020

The challenge facing providers to 2020 is to deliver patient care of outstanding quality, regain NHS Constitution access standards, return to financial balance and eliminate unwarranted variation across all these areas, while at the same time making the transformation needed to ensure long-term sustainability.

Getting the 'quality, access, finance' triangle right while transforming care adds up to an ambitious and stretching task. Provider boards will need clear strategies for achieving it, using their local Sustainability and Transformation Planning process to plan elements needing action across local health systems. Providers will also need to develop a new partnership with patients and their families.

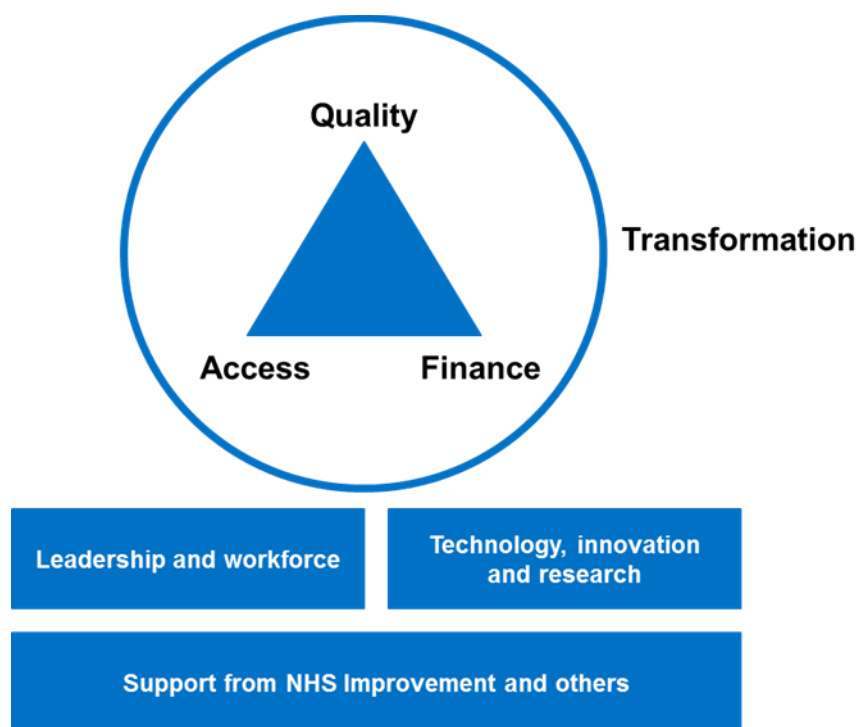
Quality: The vision for 2020 is that the vast majority of NHS providers will have an 'Outstanding' or 'Good' CQC rating and no trusts will be in special measures. At the same time, all providers will have made the improvements specified by national taskforces in the priority areas of cancer, mental health, maternity, dementia, and urgent and emergency care. They will also have made significant progress in eliminating unwarranted variation in clinical performance. Patient safety will have consistently improved and all providers will be delivering seven-day services in line with the priority clinical standards.

Access: The vision is that by 2020 all NHS providers will be delivering the agreed NHS Constitution access standards for urgent and emergency care, elective care and cancer care, and be meeting the new access standards for mental health services. Providers' recovery plans will include measures such as better demand and capacity planning, better use of better quality data, better operational management

within providers and across local systems, and improved referral management, responding to patient choice.

Finance: The vision for 2020 is that all NHS providers will have balanced their books and released significant efficiency savings, maximising value for patients and improving the quality of care. Fortunately, quality and efficiency are two sides of the same coin in healthcare. To start with, providers need to achieve the best possible outturn position in 2015/16 and develop a plan for 2016/17 based on agreed control totals. Providers are expected to become less reliant on temporary staff by sticking to recent guidance on agency staff controls. Acute trusts will need to plan to achieve the savings of up to 10% of their expenditure identified in Lord Carter's recent report. All providers may need to take action to release the value in surplus NHS estate: for example, by co-locating primary and secondary care where possible.

Transformation for sustainability: The vision for 2020 is of providers joining up with other organisations to transform services in ways that best meet the needs of their local population. Providers will drive a shift of emphasis in NHS financial, regulatory and performance management processes from individual organisation performance to the performance of whole local health and care systems, recognising that the success of individual organisations remains important. NHS Improvement and NHS England will support this shift by increasingly engaging jointly with local health and care economies, encouraging joint planning and collaboration across boundaries. All local health and care systems will need clear plans to move to new care models – such as the five the sector is currently testing – and to reconfigure services where required. Providers will play a big part in developing these plans, and a more prominent role in prevention, early intervention and improving life expectancy.



3 Building capability for the task

Providers do not yet have enough capability to achieve the task to 2020, summarised above. Provider boards will need to increase their capability by investing in workforce and leadership, and in technology, innovation and research.

Workforce and leadership: A highly skilled, motivated and healthy workforce, deployed in the right place and at the right time, will continue to be the driving force behind high quality, innovative, patient-centred care. Providers will need to equip staff to deliver even greater value and the shape of the workforce will change.

So provider boards will need to devote significantly more time and focus to strategic workforce issues. First, providers will need to recruit, develop and retain the right workforce for the future. Far more care will be delivered closer to home, by multiprofessional teams with more generalist skills, able to operate between different care settings and with more specialist colleagues. Staffing levels will be appropriate to the needs of patients and care models, and providers will be using tools such as e-rostering and caring hours per patient day to ensure their services are both safe and efficient.

Providers will also need to improve their performance on equality and diversity, so NHS organisations have leadership teams that more closely resemble the communities they serve. They should make sure the workforce plans they submit to Health Education England match staff projections in local Sustainability and Transformation Plans, so the supply of suitably trained staff is more likely to meet future patient needs.

Providers will need to help staff increase their productivity, especially by developing managers and leaders, including clinical leaders. Their NHS culture will recognise and value the role and importance of provider leadership and management. In line with growing evidence of a strong correlation between organisational performance and staff engagement, providers will foster a culture in which staff feel valued and engaged, where bullying and harassment are not tolerated, and staff health and wellbeing are paramount. This goes hand in hand with creating the culture of learning and improvement that underpins achieving the task to 2020.

To support these developments, NHS Improvement is working with arm's length bodies and other expert organisations on several workforce measures, including a national strategy for leadership development and improvement. This will also cover talent management in the NHS, from graduate to board level.

Investing in technology, innovation and research: The vision for 2020 is of providers fully exploiting the benefits of technology to interface between different parts of the health and care system and to enable efficient, patient-centred ways of working. Clinicians and patients will benefit from improved information, less paper and rapid access to services facilitated by new technology.

Provider boards will therefore consider technology investments to support, for example, basing staff and asset management on real-time supply and demand information to improve patient flows, or enable complete and up-to-date records to accompany patients around the health and care system. Providers should engage in and lead on the development of digital roadmaps by local health economies, as well as broader strategic planning for innovation. NHS Improvement and NHS England plan jointly to appoint a chief information and technology officer to support local joint working.

Advances in the use of data and technology are also critical to research and innovation. Providers need to support high quality research and innovation and its rapid translation into clinical practice, so patients and the population benefit from leading-edge, cost-effective care. Academic health science centres and networks lead on diffusing such innovations. Provider boards should therefore clearly define their role in science, education and training, and research and innovation, including how they will work with their local academic health science network.

4 Support from NHS Improvement

NHS Improvement's first and most important purpose is to support providers to deliver their task to 2020, summarised above. To support providers we will:

Develop a new oversight model. In the short term, the scale of financial and operational challenges faced by many providers will necessitate more involvement than we intend long term. But we recognise the limitations of such an approach. Our ambition is to develop an oversight model where we support first, building deep and lasting relationships with providers, and working alongside them to help them to improve, and only intervene when we have to.

Develop the right relationships. In our relationships with providers and local health and care systems we will put patients' interests first, respect and empower provider boards and hold them to account against a single, clear definition of success. We will give leaders space to innovate and take well-managed risks. Our practical, evidence-based support will recognise and share good practice to drive continuous improvement. We will strive to eliminate unnecessary data reporting requirements and lighten other regulatory burdens.

With our national system partners, we aim to create an environment for provider and system success through national policy, pricing and other levers. We will collaborate instinctively and naturally with NHS England and CQC at national, regional and local levels, so we all speak with one voice to the service.

Create a single definition of success. We will align with CQC and NHS England to create a single, simple definition of success for providers. It will cover quality, finance and use of resources, operational performance, leadership and strategic change.

Allow autonomy for good performers. Providers that meet the definition of success will earn greater autonomy, while those that do not will receive more intensive support from NHS Improvement in line with the scale of the challenges they face. Providers facing the biggest challenges – including foundation trusts in breach of their licence, NHS trusts in similar circumstances and providers in special measures – will receive more directive support.

Support providers in adopting evidence-based improvement approaches. To help providers address unwarranted variations in quality, access and efficiency, NHS Improvement will support all trusts in developing the capability to apply evidence-based improvement approaches. The kind of approaches we want to test and develop going forward include the Sign up to Safety campaign, the Emergency Care Improvement Programme, the Virginia Mason Institute's work with five NHS trusts, and the NHS Leadership Academy's leadership development programmes.

Much of the expertise needed to address the challenges set out in this document already exists in the system. We will work collaboratively across the sector to support improvement and to broker support between providers. We will also share our analysis and insights, enabling more systematic sharing and adoption of best practice among providers.

We will continue to provide dedicated support and development for providers in, or at risk of being in, special measures. This includes expanding senior leadership capacity and buddying with high-performing providers at home and abroad, in health and other sectors. We will support acute providers in implementing the recommendations of the Carter Review and work with non-acute providers to apply similar methodologies and tools.

At the same time, NHS Improvement will embed the principle of continuous improvement in the way we work. We will monitor and evaluate the effectiveness of our support, and will refine our methods in line with evidence of what works, including the feedback we get from providers.

The top portion of the image features a complex, abstract background composed of overlapping squares and rectangles in various shades of blue, ranging from light sky blue to deep navy blue. This creates a mosaic-like effect. Below this patterned area is a solid white horizontal band.

#FutureNHS

14 February 2016

Good morning,

RE: Strictly confidential and not for forwarding: Publication date for the Mental Health Taskforce report for England

As you'll be aware, over the last few months, we have been working with many of you in developing a Taskforce report on mental health for the NHS and wider Government. I wanted to let you know that the report will be published on Monday 15 February (embargoed until 00:01).

Attached is a confidential electronic copy of the report. Please note this is highly confidential and I ask you not to forward on to anyone.

The taskforce gives a frank assessment of the state of current mental health care across the NHS, highlighting that one in four people will experience a mental health problem in their lifetime and the cost of mental ill health to the economy, NHS and society is £105bn a year.

In a wide ranging package of recommendations, it proposes a three-pronged approach to improving care through prevention, the expansion of mental health care such as seven day access in a crisis, and integrated physical and mental health care.

I am very appreciative of the input we have received from many of you over the course of the last few months, and look forward to working with you on its implementation.

Yours,



Paul Farmer CBE

Chief Executive, Mind

**All report and press
release material
embargoed to
00.01 hours on
Monday 15th February
2016**

CONFIDENTIAL

THE MENTAL HEALTH FIVE YEAR FORWARD VIEW

FOREWORD

For far too long, people of all ages with mental health problems have been **stigmatised and marginalised**, all too often experiencing an NHS that treats their minds and bodies separately. Mental health services have been **underfunded** for decades, and too many people have received no help at all, leading to hundreds of thousands of lives put on hold or ruined, and thousands of tragic and unnecessary deaths.

But in recent years, the picture has started to change. Public **attitudes towards mental health are improving**, and there is a growing commitment among communities, workplaces, schools and within government to change the way we think about it. There is now a cross-party, cross-society consensus on what needs to change and a real desire to shift towards prevention and transform NHS care.

This independent report of the Mental Health Taskforce sets out the start of a **ten year journey** for that transformation, commissioned by Simon Stevens on behalf of the NHS. We have placed the experience of people with mental health problems at the heart of it. **Over 20,000** people told us of the changes they wanted to see so that they could fulfil their life ambitions and take their places as equal citizens in our society. They told us that their priorities were prevention, access, integration, quality and a positive experience of care. Their voices are quoted in this report and their views are reflected in our recommendations.

First, we have made a set of recommendations for the six NHS arm's length bodies to achieve the ambition of **parity of esteem** between mental and physical health for children, young people, adults and older people.

Second, we set out recommendations where wider action is needed. Many people told us that, as well as access to good quality mental health care wherever they are seen in the NHS, their main ambition was to have a **decent place to live, a job or good quality relationships** in their local communities. Making this happen will require a cross-government approach.

Finally, we have placed a particular focus on **tackling inequalities**. Mental health problems disproportionately affect people living in poverty, those who are unemployed and who already face discrimination. For too many, especially black, Asian and minority ethnic people, their first experience of mental health care comes when they are detained under the Mental Health Act, often with police involvement, followed by a long stay in hospital. To truly address this, we have to tackle inequalities at local and national level.

We want to thank all the Taskforce members, and the tens of thousands of people who contributed to and helped to co-produce this report.



Paul Farmer, Chair



Jacqui Dyer, Vice-Chair

EXECUTIVE SUMMARY

THE CURRENT STATE OF MENTAL HEALTH

“The NHS needs a far more proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services “

Mental health problems are widespread, at times disabling, yet often hidden. People who would go to their GP with chest pains will suffer depression or anxiety in silence. **One in four adults** experiences at least one diagnosable mental health problem in any given year. People in all walks of life can be affected and at any point in their lives, including new mothers, children, teenagers, adults and older people. Mental health problems represent the largest single cause of disability in the UK. The cost to the economy is estimated at £105 billion a year – roughly the cost of the entire NHS.

Policy Context

There has been a **transformation in mental health** over the last 50 years. Advances in care, the development of anti-psychotic and mood stabilising drugs, and greater emphasis on human rights led to the growth of community based mental health services. In the 1990s, the Care Programme Approach was developed to provide more intensive support to people with severe and enduring mental illness. There was a new emphasis on promoting public mental health and developing services for children and homeless people. In 1999 the National Service Framework for Mental Health was launched to establish a comprehensive evidence based service. This was followed by the NHS Plan in 2000 which set targets and provided funding to make the Framework a reality. A National Service Framework for Children, Young People and Maternity Services was then launched in 2004.

In 2011, the Coalition government published a **mental health strategy** setting six objectives, including improvement in the outcomes, physical health and experience of care of people with mental health problems, and a reduction in avoidable harm and stigma. The strategy was widely welcomed. However, despite these initiatives, challenges with system wide implementation coupled with an increase in people using mental health services has led to inadequate provision and worsening outcomes in recent years, including a rise in the number of people taking their own lives.

Yet, over the last five years, public attitudes about mental health have improved, in part due to the Time to Change campaign. In turn, this increased awareness has heightened understanding of an urgent need to act on improving the experiences of people with mental health problems, both within and beyond the NHS. There is now a need to **re-energise and improve mental health care across the NHS** to meet increased demand and improve outcomes.

In this context, NHS England and the Department of Health **published Future in Mind** in 2015, which articulated a clear consensus about the way in which we can make it easier for children and young people to access high-quality mental health care when they need it. This strategy builds on these strong foundations.

Mental health has not had the priority awarded to physical health, has been short of qualified staff and has been deprived of funds. We must provide equal status to mental and

physical health, equal status to mental health staff and equal funding for mental health services as part of a triple approach to improve mental health care – a fresh mindset for mental health within the NHS and beyond.

Mental Health Problems in the population

Half of all mental health problems have been established by the age of 14, rising to 75 per cent by age 24. **One in ten children** aged 5 – 16 has a diagnosable problem such as conduct disorder (6 per cent), anxiety disorder (3 per cent), attention deficit hyperactivity disorder (ADHD) (2 per cent) or depression (2 per cent). Children from low income families are at highest risk, three times that of those from the highest. Those with conduct disorder - persistent, disobedient, disruptive and aggressive behaviour - are twice as likely to leave school without any qualifications, three times more likely to become a teenage parent, four times more likely to become dependent on drugs and 20 times more likely to end up in prison. Yet most children and young people get no support. Even for those that do the average wait for routine appointments for psychological therapy was 32 weeks in 2015/16. A small group need inpatient services but, owing to inequity in provision, they may be sent anywhere in the country, requiring their families to travel long distances.

One in five mothers suffers from depression, anxiety or in some cases psychosis during pregnancy or in the first year after childbirth. Suicide is the second leading cause of maternal death, after cardiovascular disease. Mental health problems not only affect the health of mothers but can also have long-standing effects on children's emotional, social and cognitive development. Costs of perinatal mental ill health are estimated at £8.1 billion for each annual birth cohort, or almost £10,000 per birth. Yet fewer than 15 per cent of localities provide effective specialist community perinatal services for women with severe or complex conditions, and more than 40 per cent provide no service at all.

Physical and mental health are closely linked – **people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people** – one of the greatest health inequalities in England. Two thirds of these deaths are from avoidable physical illnesses, including heart disease and cancer, many caused by smoking. There is also a lack of access to physical healthcare for people with mental health problems – less than a third of people with schizophrenia in hospital received the recommended assessment of cardiovascular risk in the previous 12 months.

In addition, **people with long term physical illnesses suffer more complications if they also develop mental health problems**, increasing the cost of care by an average of 45 per cent. Yet much of the time this goes unaddressed. There is good evidence that dedicated mental health provision as part of an integrated service can substantially reduce these poor outcomes. For example, in the case of Type 2 diabetes, £1.8 billion of additional costs can be attributed to poor mental health. Yet fewer than 15 per cent of people with diabetes have access to psychological support. Pilot schemes show providing such support improves health and cuts costs by 25 per cent.

Stable employment and housing are both factors contributing to someone being able to maintain good mental health and are important outcomes for their recovery if they have developed a mental health problem. Between 60–70 per cent of people with common

mental health problems are in work, yet few employees have access to specialist occupational health services. For people being supported by secondary mental health services, there is a 65 per cent employment gap compared with the general population. People with mental health problems are also often overrepresented in high-turnover, low-pay and often part-time or temporary work. Common mental health problems are over twice as high among people who are homeless compared with the general population, and psychosis is up to 15 times as high. Children living in poor housing have increased chances of experiencing stress, anxiety and depression.

Only **half of veterans of the armed forces** experiencing mental health problems like Post Traumatic Stress Disorder seek help from the NHS and those that do are rarely referred to the right specialist care. NHS England is currently consulting on the future of mental health support for this group and it is essential that more is done to ensure their needs are identified early and they are supported to access specialist care swiftly.

One in five older people living in the community and 40 per cent of older people living in care homes are affected by depression. Diagnosing depressive symptoms can be difficult, and we know that some clinicians believe treatment for depression is less effective in older people, despite evidence to the contrary.

People in **marginalised groups** are at greater risk, including black, Asian and minority ethnic (BAME) people, lesbian, gay, bisexual and transgender people, disabled people, and people who have had contact with the criminal justice system, among others. BAME households are more likely to live in poorer or over-crowded conditions, increasing the risks of developing mental health problems.

People of all ages who have experienced traumatic events, poor housing or homelessness, or who have multiple needs such as a learning disability or autism are also at higher risk.

As many as **nine out of ten people in prison** have a mental health, drug or alcohol problem.

Suicide is rising, after many years of decline. Suicide rates in England have increased steadily in recent years, peaking at 4882 deaths in 2014. The rise is most marked among middle aged men. Suicide is now the leading cause of death for men aged 15–49. Men are three times more likely than women to take their own lives - they accounted for four out of five suicides in 2013. A quarter of people who took their own life had been in contact with a health professional, usually their GP, in the last week before they died. Most were in contact within a month before their death.

More than a quarter (28 per cent) of suicides were among people who had been in contact with mental health services within 12 months before their death, amounting to almost 14,000 people in the ten years from 2003-2013. However, suicides among inpatients in mental hospitals have significantly declined over the same period, as a result of better safety precautions.

Current Experiences of mental health care

Nearly two million adults were in contact with **specialist mental health and learning disability services** at some point in 2014/15 – though we know little about the quality of their care and there remains extensive unmet need for mental health care. Three quarters of people with mental health problems receive no support at all. Among those who are helped, too few have access to the full range of interventions recommended by National Institute for Health and Care Excellence (NICE), including properly prescribed medication and psychological therapy.

Nine out of ten adults with mental health problems are supported in primary care. There has been a significant expansion in access to psychological therapies, following the introduction of the national IAPT programme (Improving Access to Psychological Therapies). However, there is considerable variation in services, with a waiting time of just over six days in the best performing areas and 124 days in the worst performing areas in 2014-15.

Of those adults with more **severe mental health problems** 90 per cent are supported by community services. However, within these services there are very long waits for some of the key interventions recommended by NICE, such as psychological therapy, and many people never have access to these interventions. One-quarter of people using secondary mental health services do not know who is responsible for coordinating their care, and the same number have not agreed what care they would receive with a clinician. Almost one-fifth of people with care coordinated through the Care Programme Approach (for people with more severe or complex needs) have not had a formal meeting to review their care in the previous 12 months.

In its recent review of **crisis care**, the Care Quality Commission found that only 14 per cent of adults surveyed felt they were provided with the right response when in crisis, and that only around half of community teams were able to offer an adequate 24/7 crisis service. Only a minority of hospital Accident & Emergency (A&E) departments has 24/7 cover from a liaison mental health service, even though the peak hours for mental health crisis presentations to A&E are between 11pm and 7am. Too often, people in mental health crisis are still accessing mental health care via contact with the police. The inquiry found that while adults were seen promptly where liaison mental health services were available in an A&E department and there were clear pathways through to community services, those aged under 16 were referred directly to children and young people's services but seen only when services were open during office hours. This could involve waiting a full weekend and lead to a significant variation in the quality of care on the basis of someone's age.

Admissions to **inpatient care** have remained stable for the past three years for adults but the severity of need and the number of people being detained under the Mental Health Act continues to increase, suggesting opportunities to intervene earlier are being missed. Men of African and Caribbean heritage are up to 6.6 times more likely to be admitted as inpatients or detained under the Mental Health Act, indicating a systemic failure to provide effective crisis care for these groups.

The number of adult inpatient psychiatric beds reduced by 39 per cent overall in the years between 1998 and 2012. For children and young people, average admissions per provider

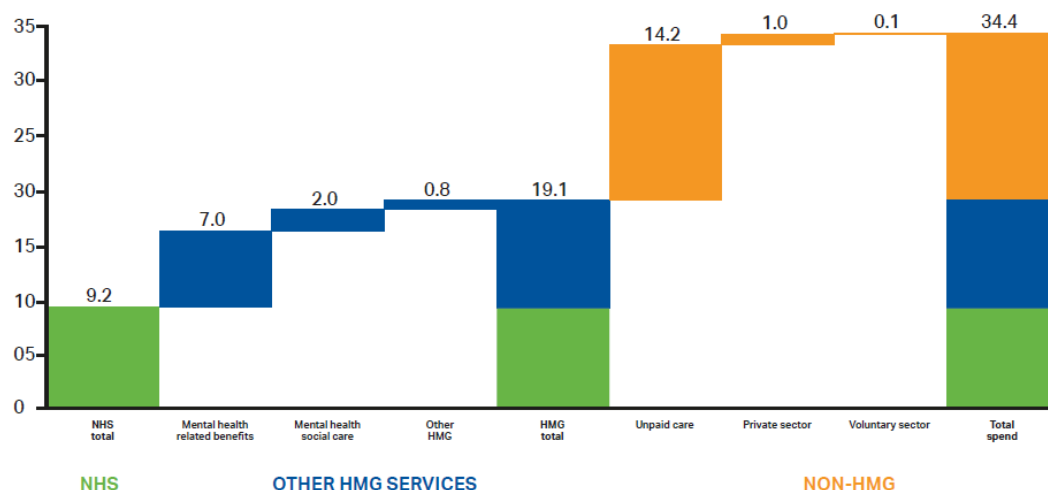
increased from 94 in 2013/14 to 106 in 2014/15. **Bed occupancy** has risen for the fourth consecutive year to 94 per cent. Many acute wards are not always safe, therapeutic or conducive to recovery. Pressure on beds has been exacerbated by a lack of early intervention and crisis care, and the resulting shortage leads to people being transferred long distances **outside of their area**.

Mental health accounts for 23 per cent of NHS activity but NHS **spending** on secondary mental health services is equivalent to just half of this. Years of low prioritisation have led to Clinical Commissioning Groups (CCGs) underinvesting in mental health services relative to physical health services but the degree of the disparity has largely been obscured by the way spending on mental health conditions is grouped together and reported, unlike spend on physical health care, which is disaggregated by specific conditions. Spending per capita across CCGs varies almost two-fold in relation to underlying need.

Poor mental health carries an **economic and social cost of £105 billion a year** in England. Analysis commissioned by NHS England found that the national cost of dedicated mental health support and services across government departments in England totals £34 billion each year, excluding dementia and substance use.¹

Government spend on mental health in England is £19bn

Total cost of mental health support and services in England 2013/14 (£bn)



Note: this analysis aims to capture direct spend on services provided to support those with mental ill-health; it does not factor in second-order costs in other public services or wider society Source: Programme Budgeting, Departments' finance data, HSCIC, DWP spend on benefits (see excel document for full detail)

£19 billion of this is made up of government spend, though there is little or no national data available for how up to 67 per cent of mental health funding is used at a local level. Most of the remainder (£14bn) is for the support provided by unpaid carers, plus a relatively small share that is funded through the private and voluntary sectors.

Given chronic underinvestment in mental health care across the NHS in recent years, efficiencies made through achieving better value for money should be **re-invested to meet**

¹ NHS England internal analysis

the significant unmet mental health needs of people of all ages across England, and to improve their experiences and outcomes.

WHAT NEEDS TO HAPPEN - A FRESH MINDSET

“We should have fewer cases where people are unable to get physical care due to mental health problems affecting engagement and attendance (and vice versa). And we need provision of mental health support in physical health care settings - especially primary care.”

People told us that their mental health needs should be treated with equal importance to their physical health needs, whatever NHS service they are using – this is a fundamental principle of the Taskforce recommendations.

All too often people living with mental health problems still experience stigma and discrimination, many people struggle to get the right help at the right time and evidence-based care is significantly underfunded. The human cost is unacceptable and the financial cost to government and society is unsustainable.

Leaders across the system must take decisive steps to break down barriers in the way services are provided to reshape how care is delivered, increase access to the right care at the right time, drive down variations in the quality of care on offer, and improve outcomes.

Our ambition is to deliver rapid improvements in outcomes by 2020/21 through ensuring that one million more people with mental health problems are accessing high quality care. In the context of a challenging Spending Review, **we have identified the need to invest an additional £1 billion in 2020/21**, which will generate significant savings. It builds on the £280 million investment each year already committed to drive improvements in children and young people’s mental health, and perinatal care.

Priority actions for the NHS by 2020/21

1. A 7 day NHS – right care, right time, right quality

“If you feel unwell in the evening, during the night or at the weekends and bank holidays there is no choice but to go to A&E. There’s no support out there during these times. It’s crucial that this is changed for the benefit of service users, their families and carers.”

People facing a crisis should have access to mental health care **7 days a week** and 24 hours a day in the same way that they are able to get access to urgent physical health care. Getting the right care in the right place at the right time is vital. Failure to provide care early on means that the acute end of mental health care is under immense pressure. Better access to support was one of the top priorities identified by people in our engagement work. Early intervention services provided by dedicated teams are highly effective in improving outcomes and reducing costs.

The Care Quality Commission (CQC) found that just half of Community Mental Health Teams (CMHTs) are able to offer a 24/7 crisis service today. By 2020/21, NHS England should ensure that a 24/7 community-based mental health crisis response is available in all areas across England and that services are adequately resourced to offer intensive home treatment as an alternative to acute inpatient admission. For adults, NHS England should invest to expand Crisis Resolution and Home Treatment Teams (CRHTTs); for children and young people, an equivalent model of care should be developed within this expansion programme. **Out of area placements for acute care should be reduced and eliminated as quickly as possible.**

Good liaison mental health care is also needed in acute hospitals across the country, providing a 24/7 urgent and emergency mental health response for people attending A&E or admitted as inpatients to acute hospitals. Only a minority of A&E departments have 24/7 liaison mental health services that reach minimum quality standards, even though peak hours for people presenting to A&E with mental health crises are 11pm-7am. By 2020/21 no acute hospital should be without all-age mental health liaison services in emergency departments and inpatient wards, and at least 50 per cent of acute hospitals should be meeting the 'core 24' service standard as a minimum. **People experiencing a first episode of psychosis should have access to a NICE-approved care package within 2 weeks of referral.** Delay in providing care can lead to poorer clinical and social outcomes. The NHS should ensure that by April 2016 more than 50 per cent of this group have access to Early Intervention in Psychosis services, rising to at least 60 per cent by 2020/21.

People want care in the least restrictive setting that is appropriate to meet their individual needs, at any age, and is close to home. People living with severe mental health problems, such as schizophrenia or personality disorder, should not be held in restrictive settings for longer than they need to be. **The NHS should expand proven community-based services for people of all ages with severe mental health problems who need support to live safely as close to home as possible.**

More 'step-down' help should be provided from secure care, such as residential rehabilitation, supported housing and forensic or assertive outreach teams. By April 2017 population-based budgets should be in place for those CCGs who wish to commission specialised services for people of all ages, in partnership with local government and national specialised commissioners. The Taskforce welcomes the invitation set out in NHSE Planning Guidance 2016/17 – 2020/21 for providers of secondary mental health services to manage budgets for tertiary (specialised) services, to reduce fragmented commissioning and improve full community and inpatient care pathways.

Improving the 7 day crisis response service across the NHS will help save lives as part of a major drive to **reduce suicide by 10 per cent by 2020/21**. Every area must develop a multi-agency suicide prevention plan that demonstrates how they will implement interventions targeting high-risk locations and supporting high-risk groups within their population.

Some people experience unacceptably poor access to or quality of care. There has been no improvement in race inequalities relating to mental health care since the end of the 5-year Delivering Race Equality programme in 2010. **Inequalities in access** to early intervention and

crisis care, rates of detentions under the Mental Health Act 1983 and lengths of stay in secure services persist.

National and local commissioners must show leadership in tackling unwarranted variations in care. The Department of Health should address race equality as a priority and appoint a new equalities champion to drive change.

Measures must be taken to ensure all deaths across NHS-funded inpatient mental health services are properly investigated, and learned from to improve services and prevent repeat events. By April 2017, the Department of Health should establish an independent system for the assurance of the quality of investigations of all deaths in inpatient mental health services and to ensure a national approach to applying learning to service improvement.

2. An integrated mental and physical health approach

“Making physical and mental health care equally important means that someone with a disability or health problem won't just have that treated, they will also be offered advice and help to ensure their recovery is as smooth as possible, or in the case of physical illness a person cannot recover from, more should be done for their mental wellbeing as this is a huge part of learning to cope or manage a physical illness.”

People told us that mental health support should be made easily available across the NHS - for mums to be, children, young adults visiting their GP, people worried about stress at work, older people with long-term physical conditions and people receiving care for cancer or diabetes.

People with existing mental health problems told us that services should be integrated - for example, physical health checks and smoking cessation programmes should be made available for everyone with a severe mental illness.

The impact of mental health problems experienced by women in pregnancy and during the first year following the birth of their child can be devastating for both mother and baby, as well as their families. **By 2020/21, NHS England should support at least 30,000 more women each year to access evidence-based specialist mental health care during the perinatal period.** This should include access to psychological therapies and the right range of specialist community or inpatient care so that comprehensive, high-quality services are in place across England.

By 2020/21, at least 280,000 people living with severe mental health problems should have their physical health needs met. They should be offered screening and secondary prevention reflecting their higher risk of poor physical health. This will reduce the health inequalities gap. We know there is low take up of information, tests, and interventions relating to physical activity, smoking, alcohol problems, obesity, diabetes, heart disease and cancer. In England there are over 490,000 people with severe mental illness registered with a GP. The proportion receiving an annual physical health check ranges from 62 per cent to 82 per cent (this data does not include any information about how many people are being supported to access evidence based interventions as a result of these checks). People with a long standing mental health problem are twice as likely to smoke, with the highest rates

among people with psychosis or bipolar disorder. Current incentive schemes for GPs to encourage monitoring of physical health should continue and extra efforts should be made to reduce smoking - one of the most significant causes of poorer physical health for this group. Mental health inpatient services should be smoke free by 2018.

The provision of psychological therapies for people with common mental health problems has expanded hugely in recent years. But it is still meeting only 15 per cent of need for adults. NHS England should **increase access to evidence-based psychological therapies to reach 25 per cent of need so that at least 600,000 more adults with anxiety and depression can access care (and 350,000 complete treatment) each year by 2020/21**. There should be a focus on helping people who are living with long-term physical health conditions or who are unemployed. There must also be investment to increase access to psychological therapies for people with psychosis, bipolar disorder and personality disorder.

3. Promoting good mental health and preventing poor mental health– helping people lead better lives as equal citizens

“If I’d had the help in my teens that I finally got in my thirties, I wouldn’t have lost my twenties.”

Prevention matters - it’s the only way that lasting change can be achieved. Helping people lead fulfilled, productive lives is not the remit of the NHS alone. It involves good parenting and school support during the early years, decent housing, good work, supportive communities and the opportunity to forge satisfying relationships. These span across national and local government, so the Taskforce has a set of recommendations to build on the Prime Minister’s commitment to a “mental health revolution.”

Prevention at key moments in life

Children and young people are a priority group for mental health promotion and prevention, and we are calling for the *Future in Mind* recommendations to be implemented in full. Early intervention and quick access to good quality care is vital – especially for children and young people. Waiting times should be substantially reduced, significant inequalities in access should be addressed and support should be offered while people are waiting for care. **By 2020/21, at least 70,000 more children and young people should have access to high-quality mental health care when they need it.** This will require a fundamental change in the way services are commissioned, placing greater emphasis on prevention, early identification and evidence-based care. NHS England should continue to work with partners to fund and implement the whole system approach described in *Future in Mind*, building capacity and capability across the system so that by 2020 /21 we will secure measurable improvements in children and young people’s mental health outcomes. We need to ensure that good quality local transformation plans are put into action, invest in training to ensure that all those working with children and young people can identify mental health problems and know what to do, complete the roll-out of the Children and Young People’s Improving Access to Psychological Therapies (CYP IAPT) programme across England by 2018 and develop an access standard for Child and Adolescent Mental Health Services

(CAMHS) by the end of 2016/17. This should build on the standard for children and young people with eating disorders announced in July 2015.

In addition, some children are particularly vulnerable to developing mental health problems- including those who are looked after or adopted, care leavers, victims of abuse or exploitation, those with disabilities or long term conditions, or who are within the justice system. The Departments of Health and Education should establish an expert group to examine their complex needs and how they should best be met, including through the provision of personalised budgets. The Government should also review the best way to ensure that the significant expansion of parenting programmes announced by the Prime Minister builds on the strong-evidence base that already exists and is integrated with Local Transformation Plans for Children and Young People's mental health services.

The **employment rate for adults** with mental health problems remains unacceptably low: 43 per cent of all people with mental health problems are in employment, compared to 74 per cent of the general population and 65 per cent of people with other health conditions. Of people with 'mental and behavioural disorders' supported by the Work Programme, only 9.5per cent have been supported into employment, a lower proportion than for some proven programmes. There is a 65 per cent point gap between the employment rates of people being supported by specialist mental health services who have more severe health problems and the general population.

Employment and health form a virtuous circle: suitable work can be good for your health, and good health means that you are more likely to be employed.

By 2020/21, up to 29,000 per year more people living with mental health problems should be supported to find or stay in work through increasing access to psychological therapies for common mental health problems and expanding access to Individual Placement and Support (IPS).

Employment is vital to health and should be recognised as a health outcome. The NHS must play a greater role in supporting people to find or keep a job. Access to psychological support must be expanded to reach at least a quarter of all people who need it. There must be a doubling of access to Individual Placement and Support programmes to reach an extra 30,000 people living with severe mental illness (so that at least 9,000 are in employment), and the new Work and Health Programme should prioritise investment in health-led interventions that are proven to work for people with mental health problems.

Creating mentally healthy communities

We heard from many people about the importance of the role of Local Government in the promotion and prevention agenda. Building on the success of local Crisis Care concordat plans, we recommend the creation of local Mental Health Prevention Plans, based on high quality evidence.

Housing is critical to the prevention of mental health problems and the promotion of recovery. The Department of Health, Communities and Local Government, NHS England, HM-Treasury and other agencies should work with local authorities to build the evidence

base for specialist housing support for vulnerable people with mental health problems and explore the case for using NHS land to make more supported housing available for this group.

In relation to the proposed Housing Benefit cap to Local Housing Allowance levels, the Department of Work and Pensions should use evidence to ensure that the right levels of protection are in place for people with mental health problems who require specialist supported housing. The Ministry of Justice, Home Office, Department of Health, NHS England and Public Health England should work together to **support those in the criminal justice system experiencing mental health problems** by expanding- liaison and diversion schemes nationally, increasing support for Blue Light services, and for the 90 per cent of people in prison with mental health problems, drug or alcohol problems.

Ending the **stigma** around mental ill-health is vital. The Department of Health and Public Health England should continue to help local communities build a grass roots social movement to raise awareness of good physical and mental health and support people to seek help when they need it.

Building a better future

There should be even greater emphasis put on people's "experience" and how experts-by-experience can be seen as real assets to design and develop services.'

The next five years will build the foundations for the next generation.

The UK should be a world leader in the development and application of new **mental health research**. The Department of Health, working with relevant partners, should publish a ten year strategy for mental health research one year from now including a co-ordinated plan for strengthening the research pipeline on identified priorities, and promoting implementation of research evidence.

A **data and transparency revolution** is required to ensure greater consistency in the availability and quality of NHS-funded services across the country. The information gathered by the NHS should reflect social as well as clinical outcomes – e.g. education, employment and housing - that matter to people with mental health problems. This requires better data linkage across the NHS, public health, education and other sectors, with absolute transparency on spending in relation to prevalence, access, experience and outcomes. **By 2020/21, CCGs should be required to publish a range of benchmarking data to provide transparency about mental health spending and performance.**

DELIVERING THIS STRATEGY

"Being both a junior doctor training in psychiatry, and a patient with mental health problems, enables me to experience both sides of the NHS, and I feel this gives me a great advantage and insight. Whilst a lot of the work I experience on both sides is very positive, I am frequently amazed by the heavy workloads of my colleagues and those treating me. And I know that for me, this can in fact contribute to deterioration in my own mental health."

Mental health services have been chronically underfunded. We know that the presence of poor mental health can drive a 50 per cent increase in costs in physical care. The Taskforce considers it a point of basic parity between physical and mental health that types of care and therapies shown to lead to improved mental health outcomes and found to be cost-effective should be made available to people with mental health problems. Without upfront investment it will not be possible to implement this strategy and deliver much-needed improvements to people's lives, as well as savings to the public purse.

Over the next five years additional funding should allow NHS England to expand access to effective interventions. The priority areas we have identified would require an additional £1 billion investment in 2020/21, which will contribute to plugging critical gaps in care the NHS is currently unable to provide. Our expectation is that savings and efficiencies generated by improved mental health care e.g. through a strengthened approach to prevention and early intervention, and through new models of care, will be re-invested in mental health services.

To deliver these commitments and realise the associated savings NHS England must be able to target investment and ensure there is sufficient transparency and accountability for putting them into action. Both the current Mandate priorities and those set out in this report should specifically be reflected in local Sustainability and Transformation plans that areas will need to produce by June 2016, in how those plans are assessed and in processes for allocating and assuring funds.

We recommend eight principles to underpin reform:

- Decisions must be locally led
- Care must be based on the best available evidence
- Services must be designed in partnership with people who have mental health problems and with carers
- Inequalities must be reduced to ensure all needs are met, across all ages
- Care must be integrated – spanning people's physical, mental and social needs
- Prevention and early intervention must be prioritised
- Care must be safe, effective and personal, and delivered in the least restrictive setting
- The right data must be collected and used to drive and evaluate progress

We make specific recommendations on the need to develop and support the mental health workforce, making it a career option of choice across medicine, social care, the allied health professions and the voluntary sector. We encourage the further development of personalised care, giving people choice in their own care, and the expansion of peer support.

We make a series of fundamental recommendations to hardwire mental health into how care is commissioned, funded, and inspected, across the whole NHS. These should enable mental health to be fully embedded in NHS planning and operations for the duration of the Five Year Forward View.

Co-production with experts-by-experience should also be a standard approach to commissioning and service design, with Arm's Length Bodies (ALBs) leading by example and supporting this practice in local areas. We recommend the creation of a Mental Health

Advisory Board reporting to the Five Year Forward View Board, publicly updating on progress against our recommended outcomes. We also encourage the Cabinet Office and Department of Health to put in place cross-government oversight of the wider actions we are recommending the Government should take, in addition to those being led by the NHS.

Conclusion

A summary of our recommendations can be found in the second annex of this report. Delivery of these recommendations is everybody's business - for the NHS, for health and social care professionals, for providers, employers, across government and communities.

But the critical element of success will be to put the individual with their own lived experience of mental health at the heart of each and every decision which is made. We have much to be proud of in the progress that has been made in empowering people to make their own decisions, and for services to be co-designed. We now have to go a step further and truly produce services which are led by the needs of the individual, not the system.

CONFIDENTIAL

CHAPTER ONE: GETTING THE FOUNDATIONS RIGHT: COMMISSIONING FOR PREVENTION AND QUALITY CARE

Every person with a mental health problem should be able to say:

I am confident that the services I may use have been designed in partnership with people who have relevant lived experience.

People with lived experience of mental health problems, carers and health and social care professionals told the Taskforce that prevention was a top priority. Specific themes raised included support for new mothers and babies, mental health promotion within schools and workplaces, being able to self-manage mental health, ensuring good overall physical and mental health and wellbeing, and getting help early to stop mental health problems escalating. Many people discussed the importance of addressing the wider determinants of good mental health, such as good-quality housing, debt, poverty, employment, education, access to green space and tough life experiences such as abuse, bullying and bereavement. It was suggested that while it is particularly important to recognise loneliness in older people, these issues can affect people of any age.

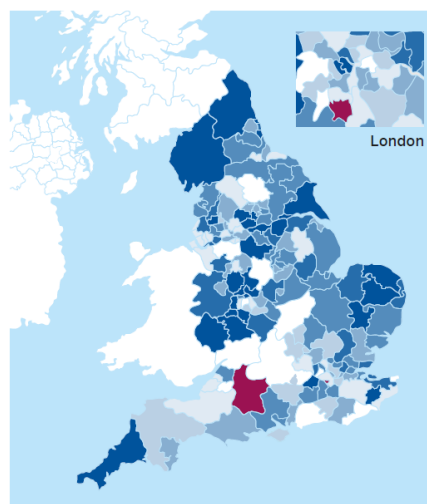
1.1 The system now

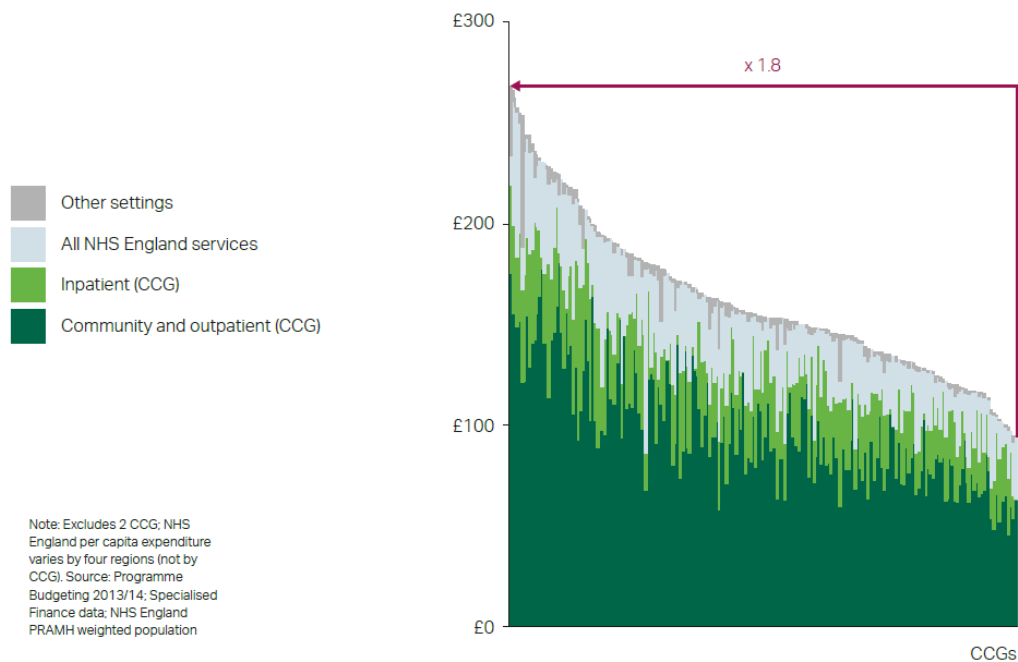
The quality of local mental health commissioning is variable. We found a twofold difference in apparent per-capita spend by CCGs, a more than threefold difference in excess premature mortality in people with mental health problems in England and a fourfold variation in mortality across local authorities. For children and young people there is wide variation in spend in both the NHS and local authorities. Detentions under the Mental Health Act continue to rise steadily year on year. Similarly, we know that many adults cannot get the right care locally, a clear demonstration of poor quality commissioning and a lack of investment to meet local need. Reductions in local authority budgets are also leading to rising pressures on important components of mental health care e.g. social care and residential housing.

Up to ~2x variation in per-capita spend, even when adjusted

Unadjusted spend shows 5x variation

Spend per PRAMH-weighted capita by CCGs and NHS England on mental health 2013/14
PRAMH model weights the population based on age, sex, prevalence of mental health conditions, markers of severity (e.g. MHA), accommodation and employment status, ethnicity and length of contact with mental health services





Commissioning of services is fragmented between CCGs, local authorities and the NHS. More needs to be done on prevention to reduce inequalities and there needs to be a greater focus on preventing suicide. There is increasing interest in “population-based” commissioning, either by pooling budgets or through joint decision-making with other commissioners, and a number of places are combining spending power across health and social care. The use of personal health budgets is increasing and other new models of care are being developed.

However, there is a long way to go to achieve integrated, population-based commissioning that is crucial for improving mental health outcomes, and incorporates specialised commissioning.

The Crisis Care Concordat action plans are promising as a model for integrated local commissioning. We also endorse the approach set out in Future in Mind as a model for wider system reform, which involves the NHS, public health, voluntary, local authority, education and youth justice services working together through Local Transformation Plans to build resilience, promote good mental health and make it easier for children and young people to access high quality care. This builds on a range of existing legislation that concerns children and young people and which requires agencies to take a coordinated approach. The Plans are also important because they address the full spectrum of need, including children and young people who have a particular vulnerability to mental health problems.

Challenges remain to breaking down barriers between how services are commissioned across the country. Within the NHS, primary, secondary and tertiary care services should deliver integrated physical and mental health outcomes. Currently needs are addressed in isolation, if at all, which is not effective or efficient. CCGs need to ensure people with multiple needs do not fall through service gaps. For example, the commissioning of alcohol and substance misuse services has been transferred from the NHS to local authorities, leading to the closure of specialist NHS addiction inpatient units. Referral pathways have

become more complex and many people with mental health and substance misuse problems no longer receive planned, holistic care.

On employment, the Department of Work and Pensions forecasts that it will spend £2.8 billion in total payments to contractors to help people into work under the Work Programme between June 2011 and March 2020. Yet fewer than one in 10 people with mental health problems have gained employment through the Work Programme. We know psychological therapies and Individual Placement and Support (IPS) services have proved highly effective – with around 30 per cent moving into jobs through IPS – but these are not being commissioned at scale. The Taskforce also welcomes the introduction of a Joint Unit for Work and Health, which is already piloting new approaches and recently secured significant new investment for an innovation fund.

Commissioners also need support to analyse data, moderate demand, channel individuals to appropriate care and test their use of resources against their priorities. Co-production with clinicians and experts-by-experience to ensure services are accessible and appropriate for people of all backgrounds is also essential. Commissioners also need to understand what works, be adept at the use of financial and other levers, and be fully accountable for improving the mental health of their communities.

1.2 The system in the future

Local communities will be supported to develop effective Mental Health Prevention plans, and use the best data available to commission the right mix of services to meet local needs. Plans should focus on public mental health, including promoting good mental health, addressing the wider social determinants of mental health problems, local approaches to challenging stigma, and targeting at risk groups with proven interventions. This approach should blend healthcare, social care and user-led support.

By 2020/21, NHS commissioning will be underpinned by a robust understanding of the mental health needs of the local population, bringing together local partners across health, social care, housing, education, criminal justice and other agencies, with a clear recognition of the mental health needs of people treated for physical ailments and vice versa, and with greater integration across agencies to build stronger, more resilient communities. Commissioners will have the knowledge and skills to embed what is proven to work, and to work in partnership with people using services, carers, and local communities to develop and evaluate innovative new models in a range of settings.

The quality of services and outcomes will be assessed on the basis of robust data. There will be clear plans in place to prevent mental ill-health and suicide. More areas will have the freedom to work jointly across whole health and social care systems, following the examples of Manchester and West Midlands. The Taskforce welcomes the invitation set out in NHSE Planning Guidance 2016/17 – 2020/21 for providers of secondary mental health services to manage budgets for tertiary (specialised) services, to reduce fragmented commissioning and improve care pathways. This is a significant change, which should be developed as a new vanguard programme, ensuring adequate inpatient resource is maintained while preparations are made to support people who are ready to transition into community based

services. NHS England should also have established new models of care to trial this new approach for perinatal and CAMHS inpatient services.

Commissioners will:

- work in partnership with local stakeholders and voluntary organisations
- co-produce with clinicians, experts-by-experience and carers
- consider mental and physical health needs
- plan for effective transitions between services
- enable integration
- draw on the best evidence, quality standards and NICE guidelines
- make use of financial incentives to improve quality
- emphasise early intervention, choice and personalisation and recovery
- ensure services are provided with humanity, dignity and respect

1.3 The Delivery Plan by 2020/21

Health and Wellbeing Boards should have plans in place to promote good mental health, prevent problems arising and improve mental health services, based on detailed local data for risk factors, protective factors and levels of unmet need. These should specifically identify which groups are affected by inequalities related to poor mental health and be co-produced with local communities to generate innovative approaches to care and improving quality. Each local council should have Mental Health Champions, building on the 60 that already exist. Nationally, the Department of Health should lead continued work to tackle stigma.

Co-production with clinicians and experts-by-experience should also be at the heart of commissioning and service design, and involve working in partnership with voluntary and community sector organisations. Applying the 4PI principles of Purpose, Presence, Presence, Process and Impact developed by the National Survivor and User Network will help ensure services or interventions are accessible and appropriate for people of all backgrounds, ages and experience.

We expect rapid progress in the transformation of services for children and young people following investment of £1.4 billion over five years announced by the Government in 2014/15 (including additional money for eating disorders in children and young people). Plans are ready and these will be the first major programmes set out in this strategy to be delivered.

More people with common mental health problems should be supported into work through expanding integrated access to psychological therapies and employment support in primary care. Thousands more people accessing secondary mental health services should also be supported to find or keep a job through evidence based Individual Placement and Support services.

The NHS, local authorities, housing providers and other agencies should be working together locally to increase access to supported housing for vulnerable people with mental health problems. They should also be acting to share joint plans and information between local

partners so that mainstream housing services play a more active role in preventing mental health problems arising.

While joint working between the CCG commissioners and other partners has been accepted for children and young people, further work is required across adult services. This offers a means of tackling the difficulties arising from the fracturing of commissioning pathways and escalating demand for inpatient services. Work is also required across secure services and the criminal justice system.

These are the opportunities – but there are also risks. There will be uncertainty about the role and function of commissioning as local geographies change, responsibilities shift, and budgets come under pressure. NHS England and the ALBs must be clear what they expect of commissioners and ensure they are supported.

The transformation we envisage will take a number of years and without clear information about what the best care pathways look like and good data on current levels of spending, access, quality and outcomes, it will be hard to assess the impact of organisational change and ensure mental health services are not disadvantaged. Priority should also be given to tackling inequalities and routine data must be made available so that there is transparency about how local areas are addressing age, gender, ethnicity, disability and sexuality in their plans.

We recognise that the new models of care will not be operating nationwide by 2020/21. Providers currently carry much of the risk and responsibility for improvements in quality and outcomes, with too little scrutiny of commissioning. In an increasingly devolved system, commissioners must remain responsible for meeting the needs of their local populations and must be properly held to account.

Recommendation 1: NHS England should continue to work with Health Education England (HEE), Public Health England (PHE), Government and other key partners to resource and implement Future in Mind, building on the 2015/16 Local Transformation Plans and going further to drive system-wide transformation of the local offer to children and young people so that we secure measurable improvements in their mental health within the next four years. This must include helping 70,000 more children and young people to access high-quality mental health care when they need it. The CYP Local Transformation Plans should be refreshed and integrated into the forthcoming Sustainability and Transformation Plans (STPs), which cover all health and care in the local geography, and should include evidence about how local areas are ensuring a joined up approach that is consistent with the existing statutory framework for children and young people.

Recommendation 2: PHE should develop a national Prevention Concordat programme that will support all Health and Wellbeing Boards (along with CCGs) to put in place updated JSNA and joint prevention plans that include mental health and co-morbid alcohol and drug misuse, parenting programmes, and housing, by no later than 2017.

Recommendation 3: The Department of Health, PHE and NHS England should support all local areas to have multi-agency suicide prevention plans in place by 2017, reviewed annually thereafter and supported by new investment.

Recommendation 4: The Cabinet Office should ensure that the new Life Chances Fund of up to £30 million for outcome-based interventions to tackle alcoholism and drug addiction through proven approaches requires local areas to demonstrate how they will integrate assessment, care and support for people with co-morbid substance misuse and mental health problems. It should also be clear about the funding contribution required from local commissioners to pay for the outcomes that are being sought.

Recommendation 5: By 2020/21, NHS England and the Joint Unit for Work and Health should ensure that up to 29,000 more people per year living with mental health problems should be supported to find or stay in work through increasing access to psychological therapies for common mental health problems (see Chapter Two) and doubling the reach of Individual Placement and Support (IPS). The Department for Work and Pensions should also invest to ensure that qualified employment advisers are fully integrated into expanded psychological therapies services.

Recommendation 6: The Department of Health and the Department for Work and Pensions, working with NHS England and PHE, should identify how the £40 million innovation fund announced at the Spending Review and other investment streams should be used to support devolved areas to jointly commission more services that have been proven to improve mental health and employment outcomes, and test how the principles of these services could be applied to other population groups and new funding mechanisms (e.g. social finance).

Recommendation 7: The Department for Work and Pensions should ensure that when it tenders the Health and Work Programme it directs funds currently used to support people on Employment Support Allowance to commission evidence-based health-led interventions that are proven to deliver improved employment outcomes – as well as improved health outcomes – at a greater rate than under current Work Programme contracts.

Recommendation 8: NHS England should work with NHS Improvement to run pilots to develop evidence based approaches to co-production in commissioning by April 2018.

Recommendation 9: NHS England should ensure that by April 2017 population-based budgets are in place which give CCGs or other local partners the opportunity to collaboratively commission the majority of specialised services across the life course. In 2016/17 NHS England should also trial new models through a vanguard programme that allow secondary providers of these services to manage care budgets for tertiary (specialised) mental health services to improve outcomes and reduce out of area placements.

Recommendation 10: The Department of Health, Communities and Local Government, NHS England, HM-Treasury and other agencies should work with local authorities to build the evidence base for specialist housing support for vulnerable people with mental health problems and explore the case for using NHS land to make more supported housing available for this group.

Recommendation 11: The Department of Work and Pensions should, based on the outcome of the “Supported Housing” review in relation to the proposed Housing Benefit cap to Local

Housing Allowance levels, use the evidence to ensure the right levels of protection are in place for people with mental health problems who require specialist supported housing.

Recommendation 12: The Department of Health should work with PHE to continue to support proven behaviour change interventions, such as Time to Change, and to establish Mental Health Champions in each community to contribute towards improving attitudes to mental health by at least a further 5 per cent by 2020/21.

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Every person with a mental health problem should be able to say:

I have rapid access, within a guaranteed time, to effective, personalised care. I have a choice of talking therapy so that I can find one appropriate to me. When I need urgent help to avoid a crisis I, and people close to me, know who to contact at any time. People take me seriously and trust my judgement when I say a crisis is approaching. I can get help in a crisis, fast. Where I raise my physical health concerns, in any setting, they are taken seriously and acted on. If I am in hospital, staff on the wards can help with my mental as well as physical health needs. Services understand the importance to me of having friends, opportunities and close relationships.

The Taskforce heard that timely access to effective, good-quality, evidence-based mental health pathways, with clear waiting times, is a primary concern. People also value having a choice of support, tailored to their specific needs, including access to a full range of psychological therapies. Access to treatment should be equal, and care should support people of all ages, regardless of the particular mental health problem they experience.

2.1 The system now

People who need physical health care – cancer care, for example – know what to expect and when to expect it. There are clear pathways of care, quality standards and maximum waiting times.

This is not always true of mental health care. Even though we know that the right care delivered in the right way at the right time improves and may save lives, mental health care has not benefited from the clear pathways and standards in place for secondary physical health care. Models of primary mental health care are also under-developed, and people with mental health problems are not always well supported in primary care with either their mental or physical health care needs.

The introduction of the first access and quality standards for mental health services therefore represents an important step forwards. Access to psychological therapies for common conditions such as anxiety and depression, as recommended by NICE, has increased. Work is in progress to improve services for people experiencing a first episode of psychosis, in perinatal care, crisis care and in children and young people's services, including for those with eating disorders.

What is lacking is a comprehensive set of standards – comparable to those for physical health care – and the supporting quality and outcomes data showing what works. Combined with under-investment, most people receive currently no effective care and too few benefit from the full range of NICE-recommended interventions.

Waiting times – for first appointments and for the right follow-on support – are unacceptably long. Basic interventions are in short supply, services are under pressure and thresholds for access are being raised. As a result, people's needs often escalate and they can become acutely unwell or experience a crisis, resulting in poorer outcomes and a reliance on higher cost care.

Crisis care is improving following the signing of the Crisis Care Concordat – but there is still a long way to go to match standards in urgent and emergency care for physical health needs. The Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists reported that the current reliance on acute beds means that it is often difficult for people to access care near home and that this is exacerbated by a lack of community services, particularly Crisis Response and Home Treatment Teams (CRHTTs). Only 14 per cent of adults experiencing a crisis feel they are provided with the right response and just over one third (36 per cent) feel respected by staff when they attend A&E. Less than half (48 per cent) of children and young people's services have a crisis intervention team. Too often people in crisis end up in a police cell rather than a suitable alternative place of safety.

Adult mental health services are under intense pressure. Less than half of crisis CRHTTs have sufficient staff to provide 24/7 intensive home treatment as an alternative to admission, putting extra pressure on hospital beds. Delayed discharge and transfers of care are as high as 38 per cent in some areas, often linked to a lack of suitable housing or social care. Bed occupancy routinely exceeds 95 per cent and the CQC 'Right Here, Right Now' report found that many people have to travel long distances to be admitted.

Comprehensive liaison mental health services are currently available in only one in six (16 per cent) of England's 179 acute hospitals. The situation is better for paediatric mental health liaison, with 79 per cent of hospitals reporting cover, but these frequently do not operate out of hours.

Long stays in high cost secure hospitals and delayed discharge are common, often owing to the lack of recovery-focused care and suitable "step-down" services. Nine out of ten people in prison have a mental health or substance abuse problem – often together – but most do not receive the right care.

Some groups are disproportionately represented in detentions to acute and secure inpatient services, and are affected by long stays. For example, men of African Caribbean ethnic origin are twice as likely to be detained in low secure services than men of white British origin and stay for twice as long in those services on average. This suggests a failure to ensure equal access to earlier intervention and crisis care services.

Older people's needs are also neglected, with many led to believe depression is a normal part of ageing.

People with mental health problems often also receive poorer physical health care. Those with severe mental illness die on average 15-20 years earlier than the general population. They are three times more likely to attend A&E with an urgent physical health need and almost five times more likely to be admitted as an emergency, suggesting deficiencies in the primary care they are receiving. The reverse is also true – people with long term physical health conditions do not routinely have mental health support included in their care package.

2.2 The future: Right care, right time, right quality, 7 days a week

People with mental health problems, regardless of their age, ethnicity, or any other characteristic will have swift access to holistic, integrated and evidence-based care for the biological, psychological and social issues related to their needs, in the least restrictive setting and as close to home as possible.

By 2020/21, there will be a comprehensive set of care pathways in place and we expect at least a million more people will be able to get the help they need, improving outcomes and reducing reliance on acute care services. Services will provide clear data about access and waiting times and payment will be linked to the interventions delivered and the outcomes achieved.

There will be a 7 day NHS providing urgent and emergency mental health crisis care 24 hours a day, as there is for physical health, delivering 24/7 intensive home treatment and not just crisis assessment. Police cells will be used only in exceptional circumstances for people detained under the Mental Health Act. Good quality liaison mental health services will be available more widely across the country.

Mental and physical health support will be integrated. People with severe mental illness at highest risk of dying prematurely will be supported to access tests and screening to monitor their physical health in primary care. Mental health services will be delivered by multi-disciplinary integrated teams, with named, accountable clinicians, across primary, secondary and social care. They will include provision of care for substance misuse issues.

People with acute mental health needs will be able to access the appropriate care, as inpatients or through community teams. Their housing, social care and other needs will be assessed on admission and the right support made available on discharge. Use of the Mental Health Act will be monitored, with a focus on Black and Minority Ethnic (BAME) groups.

People in the criminal justice system will also have their mental health needs assessed and the right care provided.

2.3 A Delivery plan for a 7 Day Mental Health Service

Clinical standards, including maximum waiting times for NICE-recommended care based on the ambitions set out in *Achieving Better Access to Mental Health Services by 2020/21* and the Five Year Forward View, should be rolled out nationwide. These must ensure that:

- Waiting times are informed by clinical evidence and should be for effective care in line with NICE recommendations
- All services should routinely collect and publish outcomes data

These are already in place for psychological therapies for common mental health problems, a waiting time standard for early intervention in psychosis will come into effect from April 2016 and one for children and young people with eating disorders the following year.

Urgent work is needed to establish comprehensive pathways and quality standards for the rest of the mental health system based on the timetable on page 36, which can then be

implemented as funding becomes available. This programme must be co-produced with clinical experts and experts by experience. Work is already in happening to secure input on what robust standards for children and young people, crisis care for people of all ages, and perinatal care should look like. There should also be a referral to treatment access standard for acute care, including quality standards and outcomes measures for home treatment and inpatient care for people with acute mental health needs.

Where evidence about the effectiveness of interventions is robust and pathways are in place or are being developed there is a strong case for NHS England to invest to expand access. NHS England, the Department of Health and the Ministry of Justice should also start joint work to develop pathways across the criminal justice system.

Improved access to high quality inpatient services for children, young people and adults is needed, as highlighted by the Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, which reported earlier this month.

Primary care (including Out of Hours services) should form a part of each of the relevant pathways within the new programme. There should also be a new focus in primary care on the physical health care of people with severe mental health problems, including psychosis, bipolar disorder and personality disorder.

Wherever it is provided care should be appropriate to people of all ages. Older people should be able to access services that meet their needs – bespoke older adult services should be the preferred model until general adult mental health services can be shown to provide age appropriate care.

Recommendation 13: By 2020/21, NHS England should complete work with ALB partners to develop and publish a clear and comprehensive set of care pathways, with accompanying quality standards and guidance, based on the timetable set out in this report. These standards should incorporate the relevant physical health care interventions and the principles of co-produced care planning.

Recommendation 14: NHS England should invest to increase access to integrated evidence-based psychological therapies for an additional 600,000 adults with anxiety and depression each year by 2020/21 (resulting in at least 350,000 completing treatment), with a focus on people living with long-term physical health conditions and supporting 20 000 people into employment. There must also be investment to increase access to psychological therapies for people with psychosis, bipolar disorder and personality disorder.

Recommendation 15: By 2020/21, NHS England should support at least 30,000 more women each year to access evidence-based specialist mental health care during the perinatal period. This should include access to psychological therapies and the right range of specialist community or inpatient care so that comprehensive, high-quality services are in place across England.

Recommendation 16: The NHS should ensure that from April 2016 50 per cent of people experiencing a first episode of psychosis has access to a NICE–approved care package within two weeks of referral, rising to at least 60 per cent by 2020/21.

Recommendation 17: By 2020/21, NHS England should ensure that a 24/7 community-based mental health crisis response is available in all areas across England and that services are adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission. For adults, NHS England should invest to expand Crisis Resolution and Home Treatment Teams (CRHTTs); for children and young people, an equivalent model of care should be developed within this expansion programme.

Recommendation 18: By 2020/21, NHS England should invest to ensure that no acute hospital is without all-age mental health liaison services in emergency departments and inpatient wards, and at least 50 per cent of acute hospitals are meeting the 'core 24' service standard as a minimum.

Recommendation 19: NHS England should undertake work to define a quantified national reduction in premature mortality among people with severe mental illness, and an operational plan to begin achieving it from 2017/18. NHS England should also lead work to ensure that by 2020/21, 280,000 more people living with severe mental illness have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention.

Recommendation 20: Public Health England should prioritise ensuring that people with mental health problems who are at greater risk of poor physical health get access to prevention and screening programmes. This includes primary and secondary prevention through screening and NHS Health Checks, as well as interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. As part of this, NHS England and PHE should support all mental health inpatient units and facilities (for adults, children and young people) to be smoke-free by 2018.

Recommendation 21: NHS England should ensure that people being supported in specialist older-age acute physical health services have access to liaison mental health teams – including expertise in the psychiatry of older adults – as part of their package of care, incentivised through the introduction of a new national Commissioning for Quality and Innovation (CQUIN) framework or alternative incentive payments, and embedded through the vanguard programmes.

Recommendation 22: In 2016, NHS England and relevant partners should set out how they will ensure that standards are introduced for acute mental health care, with the expectation that care is provided in the least restrictive way and as close to home as possible. These plans should include specific actions to substantially reduce Mental Health Act detentions and ensure that the practice of sending people out of area for acute inpatient care as a result of local acute bed pressures is eliminated entirely by no later than 2020/21. Plans should also include specific actions to substantially reduce Mental Health Act detentions and targeted work should be undertaken to reduce the current significant over-representation of BAME and any other disadvantaged groups within detention rates. Plans for introduction of standards should form part of a full response to the Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, by no later than end 2016/17.

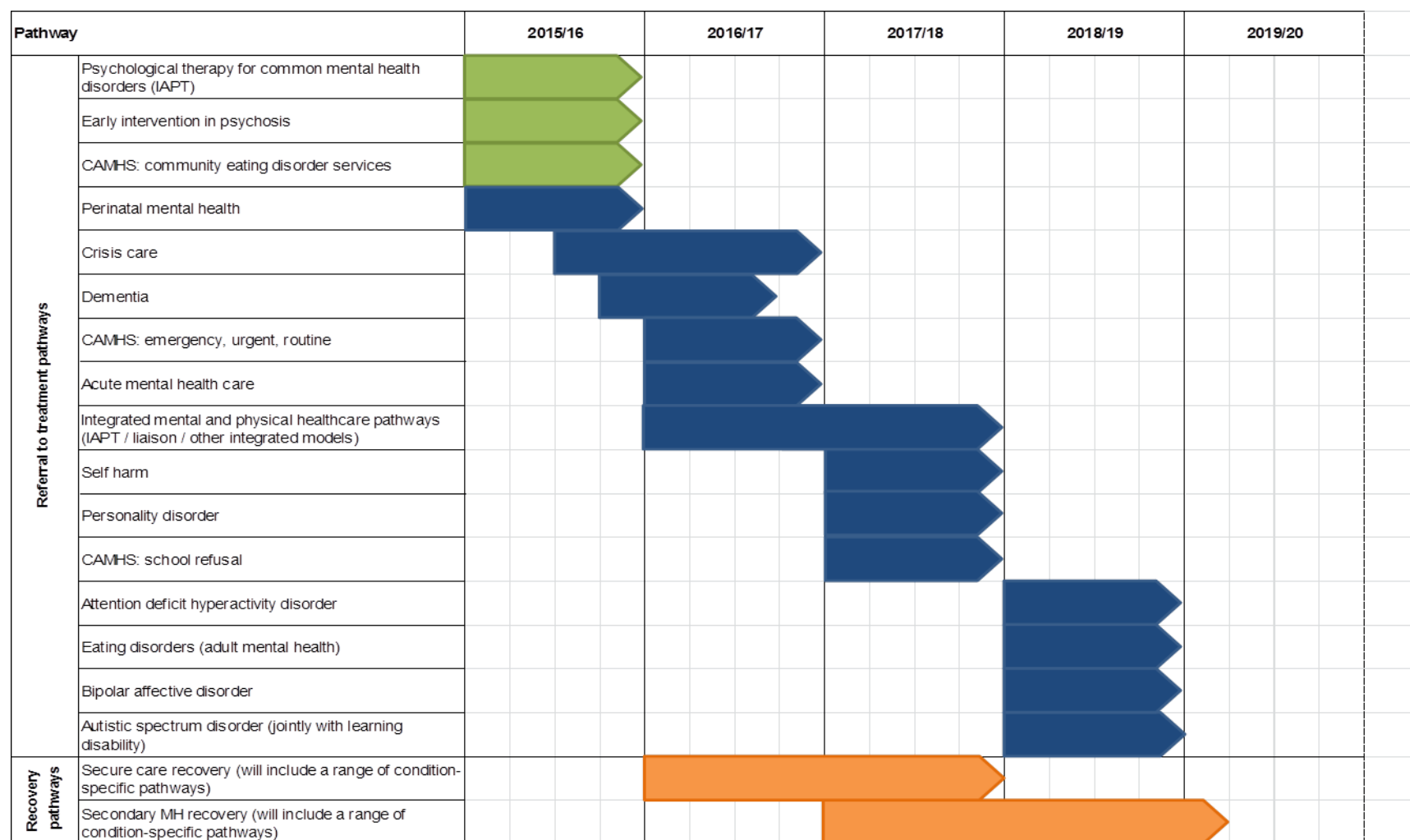
Recommendation 23: NHS England should lead a comprehensive programme of work to increase access to high quality care that prevents avoidable admissions and supports

recovery for people of all ages who have severe mental health problems and significant risk or safety issues in the least restrictive setting, as close to home as possible. This should seek to address existing fragmented pathways in secure care, increase provision of community based services such as residential rehabilitation, supported housing and forensic or assertive outreach teams and trial new co-commissioning, funding and service models.

Recommendation 24: The Ministry of Justice, Home Office, Department of Health, NHS England and PHE should work together to develop a complete health and justice pathway to deliver integrated health and justice interventions in the least restrictive setting, appropriate to the crime which has been committed.

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Proposed mental health pathway and infrastructure development programme*



There are a number of different mental health conditions, and the guidelines and quality standards produced by NICE are structured in line with broad diagnostic categories such as 'psychosis'. The aim of the existing mental health access and waiting time standards programme is to ensure that a greater number of people have timely access to the full range of interventions recommended by NICE and receive the 'right care, first time'. The proposed new standards have broadly been framed in line with NICE guidelines and quality standards, unless this makes little practical sense. For example, the crisis care standards will cut across multiple conditions because the focus must be responding rapidly to people's needs in the most appropriate setting. The proposed programme also includes work to ensure that people who are already receiving support get care that is fully NICE-concordant, including psychological therapy, as a core part of co-produced care plans that are recovery and outcome-focused.

CHAPTER THREE – INNOVATION AND RESEARCH TO DRIVE CHANGE NOW AND IN THE FUTURE

Every person with a mental health problem should be able to say:

I am confident that the services I may use have been designed in partnership with people who have relevant lived experience. I can access support services without waiting for a medical referral. I am able to access a personal budget for my support needs on an equal basis to people with physical health problems, for example, to help my recovery or to stay well. My mental and physical health needs are met together.

I am provided with peer support; contact with people with their own experience of mental health problems and of using mental health services. I can find peer support from people who understand my culture and identity. Peer support is available at any point in my fluctuating health – in a crisis, during recovery, and when I am managing being well. I have a place I can call a home, not just 'accommodation'. I have support to help me access benefits, housing and other services I might need.

There were also concerns from people from BAME communities, who told us they had lost trust with services and wanted more support within the community. More widely, we heard that community and voluntary sector providers play a critical role in supporting groups that are currently poorly served by services, such as BAME communities, children and young people, older people, lesbian, gay, bisexual and transgender people, and people with multiple needs.

The Taskforce heard that there is a strong appetite for mental health research to be equitably funded and to have parity with other areas of health research. There was also support for much more research involving experts-by-experience, looking at what matters most to people in relation to prevention and treatment or support. Understanding the causes of mental ill-health, including social and psychological factors, was considered a priority for research funding.

3.1 Building on innovation

Delivering better care to more people not only requires increased investment. It also requires the development of new ways to improve the quality and productivity of services. We heard of many examples of approaches which had promise, but where further research was required.

This is already being applied: successful innovations, such as the Crisis Care Concordat, have led to the transformation of services, highlighting the importance of multi-agency partnerships and strong local leadership in implementing change. NHS Improvement should seek to stimulate other local initiatives building a broad pipeline of improvements from which others can learn.

Alongside new standards we need to see further innovation in three areas:

- **New models of care** to stimulate effective collaboration between commissioners and providers to develop integrated, accessible services for all -for example Integrated Personal Commissioning.
- **Expanding access to digital services** to enable more people to receive effective care and provide greater accessibility and choice -for example the digital initiative in London that will be operational later this year
- **A system-wide focus on quality improvement** to support staff and patients to improve care through effective use of data, with support from professional networks.

Innovation must be robustly evaluated as part of a strengthened approach to mental health research. NHS England should trial new approaches at scale, first in the 50 vanguard sites which are working to integrate health and social care, and second by creating an equivalent cohort of vanguard areas to pilot new approaches to delivering integrated specialist mental health care.

All new models must be developed in partnership with experts-by-experience, carers, and community and voluntary organisations. Psychological and social interventions, such as peer support and short-stay alternatives to hospital, are particularly valued by people with mental health problems and it is essential to demonstrate whether they also provide value for money.

We see a pivotal role for digital technology in driving major changes to mental health services over the next five years. There are already good examples of its use by NHS Choices, and there are a number of apps with a mental health theme. There is a large mental health community on social media and voluntary organisations report heavy demand on their digital services.

Provision must be increased so that:

- People can access services conveniently, have greater choice, and can network with peers to provide mutual support and guidance
- Providers can deliver a more nuanced service, with contact through digital media backed up by face-to-face interventions
- Commissioners can improve outcomes through low-cost and easily scalable interventions
- Providers can work securely to share patient data on electronic health records, where appropriate, to benchmark their performance and to test new service models
- People who use services, carers and the wider public can hold the system to account by using data across the entire pathway (from prevention and access through to productivity and outcomes) to scrutinise performance.

Our engagement activity brought home the critical role that people with experience of mental health problems, carers and staff can play in improving services. Yet we heard countless stories of promising ideas not being heard or taken forward. A whole-system approach is needed among the health ALBs to encourage constructive challenge.

Mental health problems account for a quarter of all ill-health in the UK. Despite important new developments in mental health research it receives less than 5.5 per cent of all health research funding. Latest figures suggest that £115 million is spent on mental health research each year compared with £970 million on physical health research.

This disparity was highlighted by the Chief Medical Officer in her 2014 report. The biggest existing gaps include research into children's mental health, the promotion of good mental health and prevention of ill-health, and the links between mental and physical health. One pound spent on mental health research realises an additional return of 37p each year, the same rate of return as for research on cancer and heart disease.

3.2 Delivering on innovation and research

We aim to create a simple pathway for innovation and research:

- Identify areas of innovation and research promise
- Invest in research programmes which include testing approaches at scale
- Review research and embed it into care pathways and new models of care

In future, new models of care will support people's mental health alongside their other needs, including physical health, employment, housing and social care and will have a greater emphasis on prevention, self-management, choice, peer support, and partnership with other sectors.

Specifically, new models of enhanced primary care and collaborative specialist care that meets the physical and mental health needs of people with severe mental illness will have been fully trialled.

People will also have greater choice and control over the services provided for them. They will be able to access good information, help and advice online, via live chat, email, text message and phone. Organisations will have the technology to collect data to improve their services. Mental health will be integrated into national and local transformation programmes and NHS Commissioners supported to engage patients and staff in improving the quality and cost-effectiveness of care. There will be a more co-ordinated approach to research between government, private, public and philanthropic sectors over the long term and the involvement of people with lived experience of mental health problems as standard.

Mental health research should follow the roadmap set out in the ROAMER project, a collaboration of over 1,000 scientists, people using services, families, professional groups and industry representatives, published in September 2015, which identified the following priorities:

1. Preventing mental health problems arising, promoting mental health and focusing on young people
2. Focusing on the causal mechanisms of mental ill-health
3. Setting up international collaborations and networks for mental health research
4. Developing and implementing new and better interventions for mental health and wellbeing
5. Reducing stigma and empowering people with mental health problems and carers

6. Research into health and social systems.

3.3 New Models of Care

The new models of care being piloted by the vanguard sites offer opportunities to improve care for people with mental health problems by, for example:

- Working with Primary and Acute Care Systems (PACS) to incorporate mental health screening and support within maternity pathways, and considering new payment models for integrating mental health care within tariff prices.
- Working with Multispeciality Community Providers (MCP) to provide integrated psychological support within wider primary care and community services provision, and supporting mental health inpatients more effectively to manage their physical health
- Working with Urgent and Emergency Care (UEC) vanguards to ensure that sufficient liaison mental health and pathways to further care are available in acute hospitals to support those in mental health crisis.

NHS England should drive the development of new care models, starting with the implementation of NICE-recommended interventions. They should address current gaps in care and assess the work of relevant vanguards to benchmark how far mental health is reflected within their transformation plans to include:

- Working with Jobcentre Plus, to expand access to IPS to help more people into employment.
- Trialling dedicated inpatient services for 16-25 year olds, as they transition to adulthood, following the model adopted for young cancer patients.
- Delivering extra training for primary care staff in supporting people with severe mental illness.
- Building a robust invest to save model for integrating psychological therapies into primary care through GP collaboratives.
- Developing new partnerships with the community and voluntary sector.

NHS England should support these innovations by working with current programmes to integrate commissioning across agencies, ensure commissioners and providers are confident to work in partnership with their communities, including people who use services and carers, and make more use of digital technology, as laid out in the National Information Board's strategy. A co-ordinated approach across ALBs, backed by experts in clinical improvement and good quality data, is essential to give local leaders effective support to implement necessary change.

Recommendation 25: The MCP, PACS, UEC vanguards and the Integrated Personalised Commissioning programme should be supported to ensure that the inclusion of payment for routine integrated care adequately reflects the mental health needs of people with long-term physical health conditions. Vanguard sites should also provide greater access to personal budgets for people of all ages, including children and young people who have multiple and complex needs, to provide more choice and control over how and when they access different services.

Recommendation 26: The UK should aspire to be a world leader in the development and application of new mental health research. The Department of Health, working with all relevant parts of government, the NHS ALBs, research charities, independent experts, industry and experts-by-experience, should publish a report one year from now, setting out a 10-year strategy for mental health research. This should include a co-ordinated plan for strengthening and developing the research pipeline on identified priorities, and promoting implementation of research evidence.

Recommendation 27: The Higher Education Funding Council for England (HEFCE) should review funding requirements and criteria for decision-making to support parity through the Research Excellence Framework and take action to ensure that clinical academics in mental health (including in psychiatry and neuroscience) are not disadvantaged relative to other areas of health research, starting in 2016/17.

Recommendation 28: The Department of Health, through the National Information Board, should ensure there is sufficient investment in the necessary digital infrastructure to realise the priorities identified in this strategy. Each ALB should optimise the use of digital channels to communicate key messages and make services more readily available online, where appropriate, drawing on user insight. Building on trial findings, NHS England should expand work on NHS Choices to raise awareness and direct people to effective digital mental health products by integrating them into the website and promoting them through social marketing channels from 2016 onwards.

Recommendation 29: To drive and scale improvements in integration, the Department of Health and relevant partners should ensure that future updates to the Better Care Fund include mental health and social work services.

Recommendation 30: NHS England and NHS Improvement should encourage providers to ensure that ‘navigators’ are available to people who need specialist care from diagnosis onwards to guide them through options for their care and ensure they receive appropriate support. They should work with HEE to develop and evaluate this model.

Recommendation 31: NHS England should work with CCGs, local authorities and other partners to develop and trial a new model of acute inpatient care for young adults aged 16–25 in 2016, working with vanguard sites.

CHAPTER FOUR – STRENGTHENING THE WORKFORCE

Every person with a mental health problem should be able to say:

Services and professionals listen to me and do not make assumptions about me. Those who work with me bring optimism to my care and treatment, so that I in turn can be optimistic that care will be effective. The staff I meet are trained to understand mental health conditions and able to help me as a whole person. Staff support me to be involved in decisions at the right level. They respond flexibly and change the way they work as my needs change. Wherever possible, there are people with their own experience of using services who are employed or otherwise used in the services that support me. As far as possible, I see the same staff members during a crisis.

My culture and identity are understood and respected when I am in contact with services and professionals. I am not stigmatised by services and professionals as a result of my health symptoms or my cultural or ethnic background. The strengths of my culture and identity are recognised as part of my recovery. My behaviour is seen in the light of communication and expression, not just as a clinical problem.

The Taskforce heard a strong message that staff across the NHS need to have training that equips them to understand mental health problems and to treat people with mental health problems with dignity and respect: treating ‘the person, not the diagnosis’. This is critical in enabling people with mental health problems to play a more active role in making choices about all aspects of their care, based on a more equal and collaborative relationship between the person and professional(s). A number of people described encountering stigmatising attitudes from some staff within mental health services, as well as staff in the wider NHS (including GP surgeries and non-clinical staff). Developing a paid peer support workforce had considerable support. People also wanted clearer protocols for staff when they are working with carers.

Professionals and professional bodies wanted the NHS as an employer to pay greater regard to the health and wellbeing of NHS and social care staff, as an effective way to improve the quality of care at a time when staff are under increasing pressure.

4.1 The picture today - staff working hard in a tough environment

Building and maintaining a qualified workforce of committed staff is one of the greatest challenges facing the NHS - and it is most acute in mental health. Providing specialist care to people experiencing mental distress is difficult, demanding work and requires exceptionally dedicated, caring individuals. It calls for multi-disciplinary teams, including psychiatrists, mental health nurses, psychologists, occupational therapists and social workers. There are significant opportunities for increasing access to high quality, integrated care that rely upon an expanded workforce with the right skills, but recruitment is not easy in some areas.

Data from 2014 from Health Education England indicate a 6.3 per cent vacancy rate for NHS consultant psychiatrist posts, and over 18 per cent of core training posts in psychiatry are currently vacant. Psychiatry has the slowest rate of growth and the highest drop-out rate of any clinical specialty.

Between 2013/14 and 2014/15, referral rates increased five times faster than the Child and Adolescent Mental Health Services (CAMHS) workforce. Some areas report one in ten appointments cancelled because of staff shortages, specialist CAMHS run by junior staff who lack the requisite skills and too few therapists with the necessary training.

According to the King's Fund report 'Under Pressure', almost half of community mental health teams surveyed had staffing levels judged to be less than adequate in 2013/14 and many more were unable to provide a full multi-disciplinary team. Demand for temporary mental health nursing staff has risen by two thirds since the beginning of 2013/14. Staff shortages have contributed to deaths on inpatient wards, according to the 2015 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, and they have also been blamed for the rise in detentions.

Mind reported that in 2011/12, there were almost 1,000 incidents of physical injury following restraint in mental health services, with considerable variation between Trusts. According to NHS Benchmarking, use of restraint has increased this year.

Workforce planning for mental health across the entire care pathway has not been developed and as a result opportunities are being missed to identify how changes in skill mix could help improve delivery, retain staff and tackle the highest vacancy rates.

A chink of light has appeared in the past year: there have been small increases in staffing on adult and older people's inpatient wards, driven by the safer staffing initiative and new initiatives to increase social workers in mental health. However, bed occupancy rates have also risen.

In 2015, a five year plan began, led by NHS England and HEE, to set staffing levels to deliver high quality care under the existing standards programme. For example, to meet the access standard for Early Intervention in Psychosis, this has identified what staffing needs are required including psychologists, therapists, care co-ordinators, vocational workers and psychiatrists. Further work is needed by NHS England and HEE to expand this programme to put into action the full range of pathways and standards described in Chapter Two.

Staffing is not just a question of numbers. The resilience and wellbeing of staff is also critical. Morale varies widely across the system today, linked with pressure of work and level of training, according to the Commission on Acute Adult Psychiatric Care, established and supported the Royal College of Psychiatrists. Yet the Royal College of Physicians found fewer than half of NHS trusts had a plan in place to promote staff wellbeing.

It goes without saying that people seeking NHS care need to be treated with compassion. But what is sometimes forgotten is that staff do too. The care they receive impacts on the care they are able to deliver. Ten million working days are lost each year to sickness absence in the NHS. Some 43 per cent of mental health staff cite work related stress as the cause, second only to ambulance trusts at 51 per cent. Findings from the British Psychological Society and New Savoy staff wellbeing survey for 2015 show that around half of psychological professionals surveyed report depression 70 per cent say they are finding their

job stressful. Yet the quality of the NHS occupational health service is inconsistent and, in some cases, inadequate, according to the NHS Health and Wellbeing Review.

Despite the pressures, we heard many positive and inspiring stories about the quality of care provided by NHS staff for people with mental health problems. We also heard that some have poor attitudes to mental health. The CQC report 'Right here, Right now' found less than four in ten people (out of 316 surveyed) accessing A&E felt listened to, taken seriously and treated with warmth and compassion. Among those in touch with specialist mental health crisis services the response was only slightly more positive with half (of 748 surveyed) saying they were well treated. GPs, ambulance staff and the police were perceived as more caring and voluntary organisations as being the most caring of all.

Race discrimination is still perceived by some as a problem according to the CQC. The introduction of the NHS Workforce Race Equality Standard is welcome and must be monitored closely.

Primary care staff are not yet fully equipped to provide high quality mental health care. More than four out of five practice nurses have responsibilities for which they have not been trained, with 42 per cent having no training at all in mental health, according to the Royal College of GPs. The training of GPs could also be improved to ensure they are fully supported to lead the delivery of multi-disciplinary mental health support in primary care.

Drugs for mental health problems can have serious side effects, such as causing rapid weight gain, but standards in the prescribing of anti-psychotics and other medications are not consistently adhered to, according to the Prescribing Observatory for Mental Health.

Shared decision making between the person being supported and their practitioner is known to improve the quality of care by increasing active involvement, self-management and confidence. Yet less than half (42 per cent) of people using community mental health services "definitely" have a care plan and only just over half (56 per cent) said they were "definitely" involved as much as they wanted to be. New models are appearing. In secure care services, an approach to collaborative planning has been developed called My Shared Pathway which should be robustly evaluated.

Carers have a unique role to play for some people with mental health problems, and are often responsible for navigating complex health and social care systems and providing support to help the person manage. This includes the children of parents with mental health problems, who are likely to provide a caring role. Mental health practitioners should have the knowledge and skill to involve carers appropriately, including working with the person using the service and carers to determine what information can be shared between the three parties.

Peer support is highly valued, especially by young people and BAME adults, and should be developed as a core part of the multi-disciplinary team.

4.2 The workforce in the future-mental health as the profession of choice

As public interest and awareness of mental health increases and stigma diminishes, many more people are considering a career in mental health. The Think Ahead programme, a “Teach First” approach for social workers in mental health, has had in excess of 2,000 applicants for its first 100 places. There is the potential to put in place an approach that encourages more young people to choose a career in mental health, and more peer support.

The right workforce with the right skills is the single most important component of good care. All front-line staff, including those in the criminal justice system, should have basic skills to provide mental health care. Urgent work to jointly develop robust health and social care workforce planning for mental health must start now to:

- identify and fill workforce gaps
- provide the right training and support
- involve carers, as appropriate
- provide annual projections for staff numbers and costs

The ‘Public mental health leadership and workforce development framework’ has been published by Public Health England. It should be implemented in full. Staff should be trained to prevent ill health, working across traditional boundaries, in line with its recommendations. The need for access to effective social work as part of good quality mental health care should also be recognised through the routine inclusion of social workers in NHS commissioner and provider workforce planning.

Mental health staff should be trained to treat people with sensitivity, in the least restrictive way possible, prescribing in line with standards and using restraint only in exceptional circumstances. There should be a greater focus on mental health awareness for all front-line staff. This will involve cultural change and require strong leadership.

Staff should work in partnership with the people using services to develop plans based on the personal goals of the individual. Peer support should be offered from people who have had similar experiences and carers should be given help to play an appropriate role. Restraint will be used only as a last resort.

By 2020/21, measures to improve staff morale and wellbeing will be in place, backed by good data, and people with mental health problems will experience an improvement in staff attitudes. Training will have been strengthened and new models of care expanded. Most care should be provided in community and primary care settings.

Protecting the mental health of the workforce is also vital. NHS England has committed to helping staff make choices to improve their own health, and mental health is a key part of that. This should apply across the NHS-building on positive initiatives within Ambulance Trusts.

Every NHS Trust should become an ‘enabling’ environment, as recommended in the Francis Report, so people want to work there. Trusts should monitor the mental health of their staff and provide effective occupational health services.

Recommendation 32: HEE should work with NHS England, PHE, LGA and local authorities, professional bodies, charities, experts-by-experience and others to develop a costed, multi-disciplinary workforce strategy for the future shape and skill mix of the workforce required to deliver both this strategy and the workforce recommendations set out in Future in Mind. This must report by no later than 2016.

Recommendation 33: NHSE should ensure current health and wellbeing support to NHS organisations extends to include good practice in the management of mental health in the workplace, and provision of occupational mental health expertise and effective workplace interventions from 2016 onwards.

Recommendation 34: NHS England should introduce a CQUIN or alternative incentive payment relating to NHS staff health and wellbeing under the NHS Standard Contract by 2017.

Recommendation 35: NHS England should develop and introduce measures of staff awareness and confidence in dealing with mental health into annual NHS staff surveys across all settings.

Recommendation 36: The Department of Health and NHS England should work with the RCGP and HEE to ensure that by 2020 all GPs, including the 5,000 joining the workforce by 2020/21, receive core mental health training, and to develop a new role of GPs with an extended Scope of Practice (GPwER) in Mental Health, with at least 700 in practice within 5 years.

Recommendation 37: The Department of Health should continue to support the expansion of programmes that train people to qualify as social workers and contribute to ensuring the workforce is ready to provide high quality social work services in mental health. This should include expanding ‘Think Ahead’ to provide at least an additional 300 places.

Recommendation 38: By April 2017, HEE should work with the Academy of Medical Royal Colleges to develop standards for all prescribing health professionals that include discussion of the risks and benefits of medication, and take into account people’s personal preferences, including preventative physical health support and the provision of accessible information to support informed decision-making.

CHAPTER FIVE – A TRANSPARENCY AND DATA REVOLUTION

The Taskforce heard from a range of stakeholder organisations that data and transparency are critical aspects of a system that delivers good outcomes. Work needs to happen to link data from different public services and agencies (the NHS, social care, education, criminal justice and others) to help identify and meet the full needs of people with mental health problems. Similarly, there should be more national support with the analysis and presentation of raw data to support good commissioning and local planning.

Organisations representing different communities emphasised the importance of equalities monitoring by providers for greater transparency about access, quality and outcomes for various groups. This should help ensure that the provisions of the Human Rights Act and the Equalities Act 2010 are being met. Several organisations also stated that there needs to be greater transparency in how resources are allocated to mental health across NHS settings, the quality of services provided and to what extent they are improving outcomes.

5.1 A “black hole” of data

Understanding how quickly people are able to access services, what sort of care they are receiving and what outcomes they are experiencing is vital to good care. Consistent and reliable data in mental health, however, still lags behind other areas of health. There is good information available, but it is not co-ordinated or analysed usefully.

National data are collected through the Mental Health Services Data Set (MHSDS) by the Health and Social Care Information Centre (HSCIC) on behalf of the Department of Health. The MHSDS began operation on 1 February 2016 and its reporting capability is yet to be tested.

Prior to that point data reporting has been sporadic and the HSCIC has warned it will not be able to meet reporting needs quickly now the MHSDS is operational. Changes to the dataset can take more than 12 months which will limit the immediate usefulness of the MHSDS. For adults, data is also grouped together under ‘clusters’ which can inform how services are paid for but do not align with diagnosis or NICE guidelines so it not clear whether people are getting recommended interventions. The ‘cluster’ currency provides an indication of individual need and has demonstrated the ability of services to report high-quality data (the cluster currency has been mandatory for providers since 2012). However, this approach still does not provide the right kinds of incentives i.e. across pathways of care or to promote good outcomes. It may even encourage perverse incentives, such as paying more where people move into crisis or become acutely unwell.

Some datasets are better quality than others – for example the national data on access to psychological therapies for common mental health problems are robust. Collection of data on children and young people has been subject to delays and the data itself lacks clarity. We also do not have ready access to local and national equalities data, showing us breakdowns in access and outcomes across groups protected by the Equality Act 2010.

The National Mental Health Intelligence Network (NMHIN), run by PHE, with support from NHS England and the Department of Health, presents data to help improve commissioning and service provision. In some areas, it is well developed, providing details on levels of access, spending and social care. But it lacks the analytical capacity of other health data networks. PHE publishes additional resources for children and young people on the Chimat website although it also lacks analytic power.

Financial reporting is an important indicator for scrutinising commissioning and provision. Yet it is not consistently available in mental health. Provider level data is also linked to care 'clusters' and reference costs for the clusters vary hugely across the country, partly due to lack of consistency in their use and partly to variations in the services provided. Clusters describe the needs that people present with but do not clearly align with the care that NICE recommends, making it difficult to establish the true funding picture. While CCG programme budgets for physical health are broken down by disease, there is only one category for mental health. Local information on investment in care, by condition, is therefore essential.

An important barrier to good care is the lack of appropriate data sharing to enable organisations to identify co-morbidities, anticipate problems and plan care in a holistic fashion. People with poor mental health may require primary care, secondary physical care and social care, as well as mental health services, but the lack of linked datasets hinders effective provision.

The Summary Care Record is an attempt to address this by including key primary care information about an individual such as medication, allergies and adverse reactions. But it does not routinely include care plan information or allow access to mental health care records (or physical care records) which is a significant missed opportunity.

Good data are also necessary to allow people to make an informed choice of service. However, the information on mental health on myNHS is limited to CQC ratings and clinical audits. Waiting times for care and the range of interventions on offer would be more relevant to choosing a provider.

5.2 A transparency revolution

The inadequacy of good national mental health data and the failure to address this issue until recently has meant that decisions are taken and resources allocated without good information, perpetuating a lack of parity between physical and mental health care.

This lack of transparency has also had a negative impact on confidence in mental health services - we heard that many people felt that additional resources didn't reach the front line. Data about outcomes and acceptable levels of variation are unclear, but we are encouraged by the work of the NHS Benchmarking Network.

In the future, the quality of mental health services and how well they are meeting the needs of the local population will be demonstrated through the provision of accurate, relevant, timely data which will be collected routinely for each person with mental health problems receiving care.

National datasets will include information on diagnosis, interventions and outcomes and be appropriately linked with other datasets, such as for physical health and social care. The Department of Health, NHS England and PHE will lead the transformation in mental health information, with changes to HSCIC data collection backed by new funding.

The NMHIN and Chimat will provide comprehensive data resources to inform good quality commissioning and allow services to be benchmarked against each other, highlighting best practice and ensuring resources can be targeted where they have most impact. Commissioners will be able to assess prevalence, predict incidence and plan provision and identify individuals repeatedly admitted to inpatient care in order to target them for preventive interventions.

Budget reporting will be aligned to specific mental health conditions, increasing transparency. Everyone will be able to assess the responsiveness of services to local population needs, including the needs of marginalised groups covered by equalities legislation.

People using mental health services will be able to make informed choices about their care and how their data is used. Care will be increasingly personalised and measures will capture how well it is helping them achieve their goals. Individuals will be able to rate services, holding commissioners and providers to account.

5.3 Putting in place data plans

Providing high quality mental health care requires the collection of the right kind of mental health data, at the right time. The National Information Board has been charged with delivering this ambition. Their task now should be a national stock take of mental health data to ensure it includes the most meaningful measures, which align with national priorities, and that collecting it does not place undue pressures on clinicians and service managers. Clinical system suppliers, mental health commissioners, providers and experts-by-experience should be involved.

The transition to the MHSDS provides an opportunity to reconsider which data should be collected and reported. The HSCIC should develop a package of support to solve problems related to getting, using or sharing data.

More work is needed to ensure data can be linked across public agencies, to promote integration of care and generate insight into where people are accessing different parts of the system and, ultimately, what their needs, preferences and outcomes are.

PHE should work with other national agencies to develop the NMHIN as the trusted national repository of robust and publicly available mental health data and intelligence over the next 5 years.

A review of national clinical audits and how they supplement mandated datasets should be carried out, including the Prescribing Observatory for Mental Health UK, the National Audit of Schizophrenia and NHS Benchmarking club data. 'Future in Mind' also identified significant gaps in data on children and young people's mental health and these must be addressed.

Recommendation 39: The Department of Health, NHS England, PHE and the HSCIC should develop a 5-year plan to address the need for substantially improved data on prevalence and incidence, access, quality, outcomes, prevention and spend across mental health services. They should also publish a summary progress report by the end of 2016 setting out how the specific actions on data, information sharing and digital capability identified in this report and the National Information Board's Strategy are being implemented.

Recommendation 40: The Department of Health should develop national metrics to support improvements in children and young people's mental health outcomes, drawing on data sources from across the whole system, including NHS, public health, local authority children's services and education, to report with proposals by 2017.

Recommendation 41: The Department of Health, HSCIC and MyNHS, working with NHS England, should improve transparency in data to promote choice, efficiency, access and quality in mental health care, ensuring that all NHS-commissioned mental health data are transparent (including where data quality is poor) to drive improvements in services. The CCG Performance and Assessment Framework should include a robust basket of indicators to provide a clear picture of the quality of commissioning for mental health. To complement this, NHS England should lead work on producing a Mental Health FYFV Dashboard by the summer of 2016 that identifies metrics for monitoring key performance and outcomes data that will allow us to hold national and local bodies to account for implementing this strategy. The Dashboard should include employment and settled housing outcomes for people with mental health problems.

Recommendation 42: NHS England and the HSCIC should work to identify unnecessary data collection requirements, and then engage with NHS Improvement to prioritise persistent non-compliance in data collection and submission to the MHSDS, and take regulatory action where necessary.

Recommendation 43: During 2016 NHS England and Public Health England should set a clear plan to develop and support the Mental Health Intelligence Network over the next five years, so that it supports data linkage across public agencies, effective commissioning and the implementation of new clinical pathways and standards as they come online.

Recommendation 44: By 2020/21, NHS England and NHS Improvement should work with the HSCIC and with Government to ensure rapid using and sharing of data with other agencies. The Department of Health should hold the HSCIC to account for its performance, and consult to set minimum service expectations for turning around new data-sets or changes to existing data sets by no later than summer 2016.

Recommendation 45: The Department of Health and HSCIC should advocate the adoption of data-rich Summary Care Records that include vital mental health information, where individuals consent for information to be shared, by 2016/17.

Recommendation 46: The Department of Health should commission regular prevalence surveys for children, young people and adults of all ages that are updated not less than every seven years.

CHAPTER SIX – INCENTIVES, LEVERS AND PAYMENT

The Taskforce heard from a number of stakeholder organisations that the way services are contracted and paid for affects the quality of care people receive across settings. This includes a lack of transparency and accountability associated with the use of 'block contracts' which do not specify how many people will be supported by the service or the quality of care they should receive. The Taskforce also heard that the way services are currently paid for can prevent them from being integrated e.g. acute physical health services are not paid to include mental health support, even though this is good practice. Organisations said that the development of more effective payment models is heavily dependent on robust data about the quality of services.

6.1 The current approach to an uneven playing field

Mental health services have been plagued by years of under investment. More than half of mental health trusts are paid using block contracts providing a fixed amount unrelated to how local needs are being met or the quality of care provided. This rewards those that deliver low cost interventions, regardless of outcome, and penalises those that increase access or deliver more costly interventions, even though they may improve outcomes. This payment method also affects the development of personalisation in mental health care, since without more detailed information about individuals receiving care, the costs of that care, or clear care pathways, it is difficult for funding to be released through Personal Health Budgets or integrated with social care funding to support Integrated Personal Commissioning (combined personal budgets).

Some areas are moving away from block contracts but mental health is being left behind and thus lacks the financial levers to drive change. National guidelines to reward quality and outcomes are being poorly implemented at local level. There is also a risk that new models of care will make greater use of block contracts, which is not currently appropriate for payment of mental health interventions where there is little transparency around quality and outcomes.

However, new payment approaches are being developed. Care clusters, mandated since 2012, which aim to describe a group of people with similar mental health needs, are being used by a number of providers as the basis for payment. They have been criticised for not easily mapping to diagnoses, missing the complexity of some populations and failing to incentivise outcomes but they have provided an indication of need. Very few providers have moved to contracts that reward quality and outcomes.

Two new payment models are proposed for adult care in 2016/17 (for 2017/18). One is based on the 'year of care' or 'episode of care' appropriate to each of the mental health care clusters. The second is a capitation-based payment tied to care clusters or similar data. Both link payment in part to quality and outcome measures. NHS Improvement and NHS England are asking commissioners and providers to adopt one of the two approaches.

Several of the vanguard sites are adopting the capitation model but are using historical spending to set annual budgets. This risks reinforcing previous underinvestment. Some CCGs are developing local outcomes-based contracts. This is also encouraging but without a

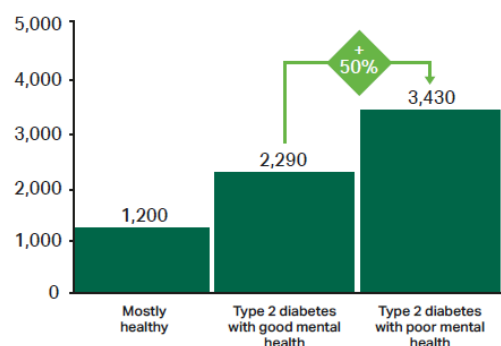
national approach, opportunities to share evidence about which models deliver the best outcomes may be lost.

Better integration with physical health is vital but payment models do not incentivise this. For example, payments for diabetes and cancer care do not routinely cover psychological interventions and payments for mental health care do not ensure physical health needs are met as standard.

Presence of poor mental health drives a further 50% increase in costs

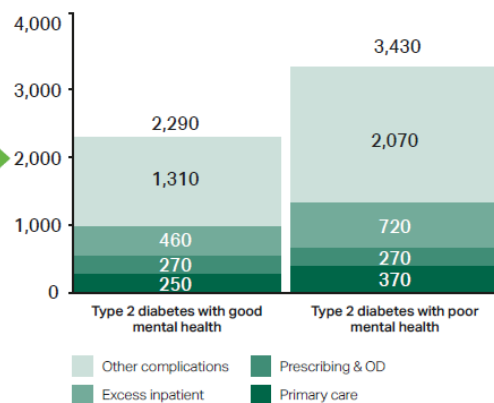
Physical healthcare costs 50% higher for type 2 diabetics with poor mental health

Annual physical healthcare costs per patient, 2014/15 (£)



Additional costs due to increased hospital admissions and complications

Annual physical healthcare costs per patient, 2014/15 (£)



Presence of poor mental health responsible for £1.8bn of spend on type 2 diabetes pathway

Note: Does not include spend on prescribing psychiatric drugs and other mental health services

Source: Hex et al, 2012; APHO Diabetes Prevalence Model for England 2012; Long-term conditions and mental health: The cost of co-morbidities, The King's Fund

There is one national CQUIN that rewards mental health providers for ensuring that the physical health needs of people with psychosis are met. This supports working relationships between specialist mental health providers and primary care which can avoid relapses and crises. Introduction of the CQUIN has seen physical care monitoring rise by a third, but performance is still well below target.

6.2 A future approach to a level playing field

In future, payments should incentivise swift access, high quality care and good outcomes, while deterring cherry picking of people who seem “easiest-to-treat”. Payment models should include a range of capitated or population-based approaches. Wider levers include the NHS standard contract, CQUINs, quality premiums, sanctions and regulation, which should be used to encourage good performance. A full set of principles underpinning what the new approach to payment in mental health should look like is annexed.

Payments should incentivise provision of integrated mental and physical healthcare and be adjusted to account for inequalities. Funding decisions should be transparent and public, including those of the independent Advisory Committee for Resource Allocation (ACRA) for the NHS.

NHS England and NHS Improvement will need to provide robust support to providers and commissioners to introduce new payment approaches for adult mental health based on either capitated or episodic/year-of-care payment models and which reward improved outcomes, quality and access. Where progress is not being made, regulation, assurance and enforcement may be necessary. Similar changes are needed for children and young peoples' services and psychological therapy services, and to incentivise the provision of mental health care to people with physical health problems.

Physical health providers will need to be reimbursed for meeting mental health needs which may require re-classification of patient care described by Healthcare Resource Groups (HRGs), Treatment Function Codes (TFCs) and Office of Population Censuses and Surveys Classification of Surgical Operations and Procedures (OPCS) codes.

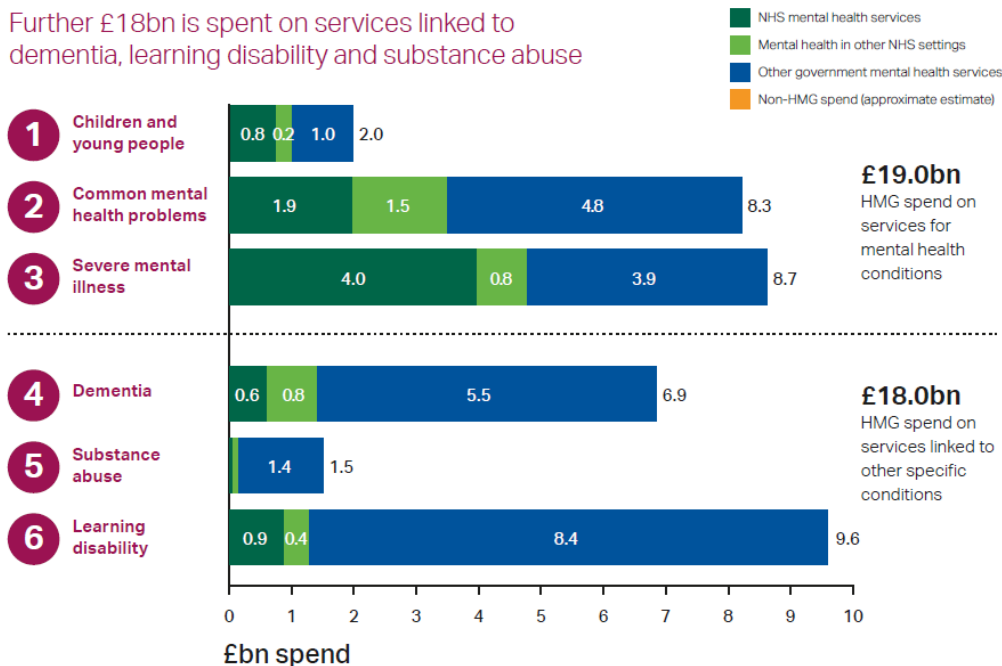
A new CQUIN to improve the recognition and treatment of depression in older people should be introduced, modelled on the dementia CQUIN. Since its introduction, the dementia CQUIN has raised the profile of the disease in general acute hospitals, and is now finding 90 per cent of people with possible dementia.

NHS funding formulae must be reviewed by ACRA to ensure they support parity between mental and physical health. They should also be reviewed to ensure they correctly estimate the prevalence and incidence of conditions across the mental health spectrum.

In respect of the annual inequalities adjustment given to CCGs for people with the poorest access and outcomes in health, CCGs should also report how their spending is related to need, access and outcomes for mental health. Mental health funding should be allocated to individual conditions in the same way as physical health funding to make it easier to track. Good quality data will be needed to determine whether care is cost-effective and whether new approaches are more appropriate than existing ones.

£19bn is spent on services for mental health conditions

Further £18bn is spent on services linked to dementia, learning disability and substance abuse



Note: Dementia healthcare expenditure only includes spend on mental health services for dementia, not on physical health co-morbidities (e.g. diabetes), which would increase spend by £3bn

Recommendation 47: NHS England and NHS Improvement should together lead on costing, developing and introducing a revised payment system by 2017/18 to drive the whole system to improve outcomes that are of value to people with mental health problems and encourage local health economies to take action in line with the aims of this strategy. This approach should be put in place for children and young people's services as soon as possible.

Recommendation 48: NHS England should disaggregate the inequalities adjustment from the baseline funding allocation for CCGs and Primary Care, making the value of this adjustment more visible and requiring areas to publicly report on how they are addressing unmet mental health need and inequalities in access and outcomes.

Recommendation 49: ACRA should review NHS funding allocation formulas, including the inequalities adjustment, to ensure it supports parity between physical and mental health in 2016/17. They should also be reviewed to ensure they correctly estimate the prevalence and incidence of conditions across the mental health spectrum. Membership of ACRA should be revisited with the specific goal of ensuring that mental health expertise is adequately represented across the disciplines involved, e.g. clinical, academic, policy and providers.

Recommendation 50: The Department of Health and NHS England should require CCGs to publish data on levels of mental health spend in their Annual Report and Accounts, by condition and per capita, including for Children and Adolescent Mental Health Services, from 2017/18 onwards. They should require CCGs to report on investment in mental health to demonstrate the commitment that commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall [allocation](#) increase.

CHAPTER SEVEN – FAIR REGULATION AND INSPECTION

Every person with a mental health problem should be able to say:

I feel safe. My strengths, skills and talents are recognised and valued. I am treated as a person, not just according to my behaviour. My personal goals are recognised by support services. I choose who to consider the people 'close to me', who can support me in achieving mental wellbeing. I am able to see or talk to friends, family, carers or other people who I say are 'close to me' at any time. I can determine different levels of information sharing about me. I am confident that if I need care or treatment, timely arrangements are made to look after any people or animals that depend on me. I feel confident that my human rights are respected, protected and progressively realised in all systems of regulation and inspection.

If I raise complaints or concerns about a service these are taken seriously and acted upon, and I am told what has happened in response. If I do not have capacity to make decisions about my care and treatment, any advance statements or decisions I have made will be respected. I am supported to develop a plan for how I wish to be treated if I experience a crisis in future. As far as possible, people who see me in a crisis follow my wishes and any plan I have previously agreed. When I need medicines, their potential effects – including how they may react with each other – are assessed and explained.

7.1 The system today: high levels of scrutiny painting a mixed picture of experience

Many stakeholders believe that the legislative and regulation framework underpinning mental health care can be improved.

The Mental Health Act 1983 provides a legal framework for the detention of individuals with mental health problems in order to be assessed and treated (including with medication) for mental illness without regard to their mental capacity or their ability to give or withhold consent. This applies if they have a mental illness which requires assessment or care in a hospital and they are detained because they are assessed as posing a risk to themselves or others.

The Mental Capacity Act 2005 makes no distinction between the mental and physical with regard to decisions about care. But the 2005 Act's provisions about having the mental capacity to consent to care can be over-ridden in the case of mental health by the 1983 Act. We heard that this can act as a barrier to making parity of esteem a reality because it enshrines differences in the treatment of people with mental and physical health problems and frames care as a method of social control rather than a therapeutic intervention. The 1983 Act should therefore be reviewed as part of the continuing drive for greater parity with physical healthcare.

Commissioners, providers and the CQC should ensure that the full range of people's human rights are protected at a time when their capacity, autonomy, choice and control may be compromised. This is reinforced by the Care Act 2014. However, the number of people detained and the number subject to restrictive Community Treatment Orders (CTOs) requiring them to adhere to particular interventions, including medication, continue to increase. The use of CTOs is much higher than anticipated when they were introduced in

2008, yet recent findings from a recent Oxford University study show they are not effective for the majority of people.

The Health and Social Care Act 2012, as reflected in the NHS Constitution, provides rights to specialist care, including access to consultant-led treatment within 18 weeks of referral and a choice of provider. However, there is not yet parity between an individual's rights to physical and mental health care. Although the right to choice of provider has been extended to mental health there is no legal right to recommended interventions or maximum waiting times, as there is for physical health care.

The CQC has a robust approach to regulating the quality of NHS service provision. However, inspection of mental health support in primary and acute physical health care settings should be strengthened. We must also ensure psychological therapies are properly regulated.

The only detailed measure of people's experience of mental health care is through the CQC survey of community mental health services. But this is inadequate, as revealed by the CQC's special inquiry into crisis care which showed that people's experiences of mental health care across other settings was very mixed and should be tracked on a regular basis. There is also no measurement of people's experience of inpatient mental health care, including secure care, despite the nature of compulsory treatment and the potential vulnerability of those who are detained, in some cases for months or years.

The Taskforce heard that the experience for people who are marginalised needs to be improved, with particularly strong messages coming through from BAME groups. The Workforce Race Equality Standard is a welcome development in the NHS for those providing services. But there is no equivalent for those accessing them. The 5-year Delivering Race Equality programme concluded in 2010 that there had been no improvement in the experience of people from minority ethnic communities receiving mental health care. Data since shows little change. These inequalities must be prioritised for action, and we support the recommendations of the Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists on this issue.

There were 198 deaths of people detained under the Mental Health Act in 2013/14, the majority of which were due to natural causes, including preventable physical ill health. Care providers must ensure that they take appropriate steps to prevent the avoidable deaths of people in inpatient care, including people of all ages who are deprived of liberty through detention under the Mental Health Act. However, unlike in prison or police detention, where every death is independently investigated, there is no independent pre-inquest process in place for investigating these deaths. Care organisations themselves carry out internal investigations. As highlighted by the recent findings within Southern Health NHS Foundation Trust, the quality of internal investigations can be poor and providers are not always able to demonstrate robustly how they have learned from them and made improvements.

There are no published death rates in individual units or by CCG area, no information on whether death has occurred in a public or privately run organisation, and no information on the number or nature of deaths that have occurred in specific settings. Patterns of deaths that merit closer examination may thus escape public scrutiny. In particular, there are

questions about the over-representation of black people in mental health settings and the use of force that features in some of their deaths. There is also very limited information available nationally on the number of children who have died in mental health settings.

Measurement of wider social outcomes – such as finding a job and accommodation – is also a marker of the quality of services and varies across organisations. Yet these outcomes can be more meaningful than strictly clinical outcomes such as being “symptom free”.

7.2 The system in the future

The full range of regulatory levers will be used to address inequalities and improve the quality and experience of people receiving mental health care. The right to equal treatment in the least restrictive setting will be clearly enshrined in legislation, and all providers will ensure they work in accordance with Human Rights legislation.

Strengthened inspection of mental health care by the CQC will be extended to all NHS-funded providers, including primary and acute physical health care. Measures of quality will show how services compare and specialist mental health services, including inpatient care, will include self-reported outcomes. Racial and other inequalities in rates of detention will be addressed and there will be greater transparency in the causes of deaths and how they can be prevented.

7.3 System reforms by 2020/21

It is essential that people’s human rights to receive care in the least restrictive setting, to give or withhold consent, to use advance decisions and to maintain family life are respected and that inspections assess the extent to which these rights are supported. Individuals deprived of their liberty under the Mental Health Act should be offered information, advocacy and support. In the light of rising rates of detention and the high and potentially inappropriate use of CTOs, there is a strong case for considering whether the current legislative framework strikes the right balance between risk and consent. This should include consideration of how mental capacity legislation should be applied in the use of the Mental Health Act to detain a person for compulsory treatment. This is a fundamental aspect of ensuring parity between mental and physical health.

The whole NHS plays a role in preventing mental health problems and caring for people who suffer them. The inspection system should be updated to ensure it covers all aspects of mental health provision in all settings, and all physical and mental health pathways of care.

For children and young people, we support the recommendation in ‘Future in Mind’ that the CQC should work with Ofsted should to develop a joint, cross-inspectorate view of how health, education and social care services are working together to improve their mental health.

In July 2015, the Secretary of State for Health announced the creation of a new Healthcare Safety Investigation Branch (HSIB). The Branch will be established from April 2016 and will provide support and guidance to NHS organisations on investigations, as well as carrying out certain investigations itself. It will also conduct national investigations into safety incidents, act as an exemplar. It will focus on incidents that signal systemic or apparently intractable

risks within the local health care system. The Department of Health should ensure that the scope of the HSIB includes deaths from all causes in inpatient mental health settings and that there is independent scrutiny of the quality of investigation, local and national trends, and evidence that learning is resulting in service improvement.

Recommendation 51: The Department of Health should work with a wide range of stakeholders to review whether the Mental Health Act (and relevant Code of Practice) in its current form should be revised in parts, to ensure stronger protection of people's autonomy, and greater scrutiny and protection where the views of individuals with mental capacity to make healthcare decisions may be overridden to enforce treatment against their will.

Recommendation 52: The Department of Health should carry out a review of existing regulations of the Health and Social Care Act to identify disparities and gaps between provisions relating to physical and mental health services. This should include considering how to ensure that existing regulations extend rights equally to people experiencing mental health problems (e.g. to types of intervention that are mandated, to access to care within maximum waiting times).

Recommendation 53: Within its strategy for 2016–2020, the CQC should set out how it will strengthen its approach to regulating and inspecting NHS-funded services to include mental health as part of its planned approach to assessing the quality of care along pathways and in population groups.

Recommendation 54: The Department of Health should consider how to introduce the regulation of psychological therapy services, which are not currently inspected unless they are provided within secondary mental health services.

Recommendation 55: The CQC should work with Ofsted, Her Majesty's Inspectorate of Constabulary and Her Majesty's Inspectorate of Probation to undertake a Joint Targeted Area Inspection to assess how the health, education and social care systems are working together to improve children and young people's mental health outcomes.

Recommendation 56: The Department of Health should ensure that the scope of the Healthcare Safety Investigation Branch includes deaths from all causes in inpatient mental health settings and that there is independent scrutiny of the quality of investigations, analysis of local and national trends, and evidence that learning is resulting in service improvement.

Recommendation 57: NHS Improvement and NHS England, with support from Public Health England, should identify what steps services should take to ensure that all deaths by suicide across NHS-funded mental health settings, including out-of-area placements, are learned from to prevent repeat events. This should build on insights through learning from never events, serious incident investigations and human factors approaches. The CQC should then embed this information into its inspection regime.

CHAPTER EIGHT: LEADERSHIP INSIDE THE NHS, ACROSS GOVERNMENT AND IN WIDER SOCIETY

We have recommended an ambitious but deliverable strategy for mental health to realise improvements in prevention, access, outcomes and experience, backed by a strong clinical and economic case for investment. Implementing it will require robust leadership.

We commissioned a review by the Centre for Mental Health which identified 12 key elements necessary for the successful implementation of our vision:

1. **Leadership:** Effective national and local leadership is vital
2. **Focus:** Strategies with a clear narrative and a set of widely supported, prioritised action points are more likely to succeed.
3. **Funding:** funding for change and the associated double running costs is particularly important.
4. **Incentives:** Effective mental health strategies have benefited from close alignment with the incentives used in mainstream health policy
5. **Workforce:** The most important changes are often the least amenable to policy-making and depend on the motivation of staff.
6. **Scrutiny:** Visible accountability for achieving a strategy's goals is essential to sustain implementation.
7. **Public opinion:** Strategies that enjoy support from the public and professionals are more likely to be implemented well.
8. **Partnerships:** Mental health policy relies on organisations working together
9. **Implementation:** Robust, stable and supportive implementation infrastructure is vital.
10. **Innovation:** Policy cannot stand still but needs to facilitate innovation
11. **Management:** Good-quality programme and project management is essential
12. **Time:** Changing practice takes longer than policymakers think. Policies need time to be implemented effectively

Building on this evidence, a robust governance framework should be put in place to implement a 5-year programme to transform mental health care in England. This strategy should be refreshed in 2019/20 in the light of new data that will emerge.

The key elements should be:

- **Establishing NHS England as the lead ALB** with responsibility for overall delivery of the strategy, led by the appointment of a new Senior Responsible Officer.
- **Embedding co-production** within the design and delivery of the programme, through the involvement of those with experience of mental health services and the organisations that represent them. This should include creating an independent external advisory board to provide independent scrutiny and challenge to the programme
- **Establishing a new cross-ALB programme board** as a single coherent governance structure for delivering the strategy at a senior operational level, including defining the best approaches for local delivery
- **Appointing an equalities champion**, with a specific remit to tackle mental health inequalities across the health system and through cross-government action.
- **Ensuring the necessary level of resource** within the national team overseeing day-to-day implementation.

The Department of Health, Cabinet Office and NHS England should put in place clear mechanisms for ensuring that the cross-government recommendations made in this report are implemented in full, and support continued action to combat stigma and discrimination in our society.

The Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, makes a recommendation that a Patients and Carers Race Equality Standard should be piloted in mental health. This should be given full consideration as quickly as possible as part of the remit of the new equalities champion.

Without additional investment it will not be possible to implement this strategy and deliver much-needed improvements to people's lives, as well as savings to the public purse. Funding is required in priority areas to help put the essential building blocks in place to improve the system over the long-term and to increase access to proven interventions that improve outcomes and deliver a return. We have identified that a minimum of £1 billion should be available in 2020/21. There should be a clear message that there is an expectation that more people are able to access NICE-evidenced services and that levels of investment in mental health should reflect this, across primary care, acute and mental health systems. Expenditure on mental health should be fully transparent.

Our proposals for investment are primarily targeted at expanding access to evidence-based care and scaling up effective programmes of work, supported by system reforms that are already happening and where the NHS can expand workforce capacity relatively quickly.

However, the Taskforce recognises the reality that reinvesting in services, planning for and recruiting into workforces that in many cases have been depleted in recent years, and initiating the essential system reforms required to support service expansion and transformation (e.g. relating to data and financial incentives) takes time.

Our proposals therefore focus on consolidating and expanding programmes for children and young people, for perinatal care and for Early Intervention in Psychosis in 2016/7, in parallel to laying the ground for wider investment across the full range of priorities for action from 2017/18 onwards.

Securing new investment and realising the associated savings will require commissioners and providers, nationally and locally, to demonstrate that they are delivering high-quality care and value for money within their budgets. This means implementing evidence-based standards, supporting quality improvement, improving data on outcomes and spend, a strong commitment to transparency, and integrating services at every level to meet the needs of their population. The transformation programme for Improving Access to Psychological Therapies for Children and Young People is a good example of how this can work. To make best use of new investment and ensure savings will materialise on the ground NHS England must also begin work now with ALB partners and local areas to trial new models of implementation.

We know that the scale of unmet mental health need is significant – hundreds of thousands of people go untreated each year at a cost of billions of pounds to our society and the economy. This investment would, however, make a start in plugging that gap, building on

£1.4 billion of new funding over five years for children and young people's and perinatal mental health last year, including additional funding for eating disorders.

Mental health must remain a priority in a challenging financial climate for the NHS in the next five years, which is why we have set out specific recommendations to ensure that there is proper transparency and accountability for how money is spent. At a minimum, from 2016/17 we expect CCGs to be able to demonstrate how they will increase investment in mental health services in line with their overall increase in allocation each year or in line with the growth in recurrent programme expenditure.

Recommendation 58: By no later than Summer 2016, NHS England, the Department of Health and the Cabinet Office should confirm what governance arrangements will be put in place to support the delivery of this strategy. This should include arrangements for reporting publicly on how progress is being made against recommendations for the rest of government and wider system partners, and the appointment of a new equalities champion for mental health to drive change.

Annex A: Principles underpinning payment approaches in mental health

1. There must be no more unaccountable block contracts for mental health.
2. Providers should never entirely be rewarded for providing a number of days of care within a particular setting, but instead be rewarded for delivering whole pathways of care with achievement of defined outcomes or meeting local population need, as appropriate.
3. Both national and local outcome measures should be used as part of the payment system, these should be co-produced and developed by all stakeholders with a leading role taken by people with lived experience of mental ill-health (and their families).
4. Where integrated care is needed, payment should similarly be integrated. For example, for urgent and emergency mental health care, the payment approach should be embedded within the wider urgent and emergency care payment approach, and payment for mental health care within physical care pathways should be similarly integrated.
5. Payment approaches should include access standards, where these are developed, to drive achievement of improved access to timely, evidence-based care with routine outcome measurement.
6. Payment approaches should be developed with experts-by-experience, reward engagement and delivery of access to excellent care for particular groups, where this is appropriate. This may include BAME populations and people with co-morbidities, such as substance misuse or diabetes.
7. Outcomes should be holistic and reward collaborative working across the system (e.g. stable housing, employment, social and physical health outcomes).
8. Payment systems must promote transparency and increased provision of high-quality, relevant data that can drive improvement
9. Payment systems should support improved productivity, value, efficiency and reduced costs, where possible.
10. Payment systems should support pathways through services, rewarding and incentivising step down to lower-intensity settings and a focus on care in the least restrictive setting. They should aim to reduce avoidable crises, admission and detentions, while protecting against any misalignment of incentives that might give rise to cherry-picking or other risks that might impact negatively upon those people with mental health problems who are 'hardest to reach'.
11. National guidance should support commissioners to commission effectively using appropriate payment approaches.
12. Additional support should be provided to commissioners to build leadership, capacity and capability in commissioning services, including for the use of new payment approaches that will necessarily require new skills and competencies.

Annex B: Full recommendations

Recommendations are listed by lead or joint lead agency

NHS England	Future in Mind	NHS England should continue to work with HEE, PHE, Government and other key partners to resource and implement Future in Mind, building on the 2015/16 Local Transformation Plans and going further to drive system-wide transformation of the local offer to children and young people so that we secure measurable improvements in their mental health within the next four years. This must include helping at least 70,000 more children and young people each year to access high-quality mental health care when they need it by 2020/21. The CYP Local Transformation Plans should be refreshed and integrated into the forthcoming Sustainability and Transformation Plans (STPs), which cover all health and care in the local geography, and should include evidence about how local areas are ensuring a joined up approach that is consistent with the existing statutory framework for children and young people.
	Access standards and care pathways	By 2020/21, NHS England should complete work with ALB partners to develop and publish a clear and comprehensive set of care pathways, with accompanying quality standards and guidance, for the full range of mental health conditions based on the timetable set out in this report. These standards should incorporate relevant physical health care interventions and the principles of coproduced care planning, balancing clinical and non-clinical outcomes (such as improved wellbeing and employment). Implementation should be supported by: · Use of available levers and incentives to enable the delivery of the new standards, including the development of aligned payment models (NHS England and NHS Improvement) · Alignment of approaches to mental health provider regulation (NHS Improvement and CQC) · Comprehensive workforce development programmes to ensure that the right staff with the right skills are available to deliver care in line with NICE recommendations as the norm (HEE) · Ensuring that the relevant public health expertise informs the development of the new standards and that they are aligned with the new co-existing mental health and alcohol and/or drug misuse services guidance being developed for commissioners and providers of alcohol and/or drug misuse services. (PHE)
	Perinatal mental healthcare	NHS England should invest to ensure that by 2020/21 at least 30,000 more women each year access evidence-based specialist mental health care during the perinatal period. This should include access to psychological therapies and the right range of specialist community or inpatient care so that comprehensive, high-quality services are in place across England.
	Psychological therapies for people with long term conditions	NHS England should invest to increase access to integrated evidence-based psychological therapies for an additional 600,000 adults with anxiety and depression each year by 2020/21 (resulting in at least 350,000 completing treatment), with a focus on people living with long-term physical health conditions and supporting people into employment. There must also be investment to increase access to psychological therapies for people with psychosis, bipolar disorder and personality disorder.
	Employment support	By 2020/21, NHS England and the Joint Unit for Work and Health should ensure that up to 29,000 more people per year living with mental health problems should be supported to find or stay in work through increasing access to psychological therapies for

		common mental health problems (see above) and doubling the reach of Individual Placement and Support (IPS). NHS England should seek to match this investment in IPS by exploring a Social Impact Bond or other social finance options.
	Early Intervention in Psychosis	NHS England should ensure that by April 2016 50 per cent of people experiencing a first episode of psychosis have access to a NICE-approved care package within two weeks of referral, rising to at least 60 per cent by 2020/21.
	Crisis services	By 2020/21, NHS England should expand Crisis Resolution and Home Treatment Teams (CRHTTs) across England to ensure that a 24/7 community-based mental health crisis response is available in all areas and that these teams are adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission. For children and young people, an equivalent model of care should be developed within this expansion programme.
	Acute liaison	By 2020/21 no acute hospital should be without all-age mental health liaison services in emergency departments and inpatient wards, and at least 50 per cent of acute hospitals should be meeting the 'core 24' service standard as a minimum.
	Least restrictive acute care	In 2016, NHS England and relevant partners should set out how they will ensure that standards – co-produced with experts by experience, clinicians, housing and social care leads – are introduced for acute care services over the next five years. Integral to the standards should be the expectation that acute mental health care is provided in the least restrictive manner and as close to home as possible, with the practice of sending people out of area for acute inpatient care due to local acute bed pressures eliminated entirely by no later than 2020/21. Plans for introduction of the standards should form part of a full response to the Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, by no later than end 2016/17. NHS England and NHS Improvement should also ensure that use of the Mental Health Act is closely monitored at both local and national level, and rates of detention are reduced by 2020/21 through the provision of earlier intervention. Plans should include specific actions to substantially reduce Mental Health Act detentions and targeted work should be undertaken to reduce the current significant over-representation of BAME and any other disadvantaged groups in acute care.
	Secure care pathway	NHS England should lead a comprehensive programme of work to increase access to high quality care that prevents avoidable admissions and supports recovery and 'step down' for people of all ages who have severe mental health problems and significant risk or safety issues in the least restrictive setting, as close to home as possible. This should seek to address existing fragmented pathways in secure care, increase provision of community based services such as residential rehabilitation, supported housing and forensic or assertive outreach teams and identify new co-commissioning, funding and service models. This work should also tackle inequalities for groups shown to be over-represented in detentions and lengthy stays, and seek to ensure that out of area placements are substantially reduced. The programme should identify where and how efficiencies could be realised within the system and reinvested, and include recommendations on the wider reforms required to make this happen, including changes to legal processes. NHS England should also roll out the proven model of teams delivering community forensic CAMHS and complex

		need services nationally from 2016.
	Using and sharing data	By 2020/21, NHS England and NHS Improvement should work with the HSCIC and with Government to ensure rapid using and sharing of data with other agencies. The Department of Health should hold the HSCIC to account for its performance, and consult to set minimum service expectations for turning around new datasets or changes to existing data-sets by no later than summer 2016.
	Vanguards	MCP, PACS, UEC vanguards and the Integrated Personalised Commissioning programme should be supported to ensure that the inclusion of payment for routine integrated care adequately reflects the mental health needs of people with long-term physical health conditions within new care model programmes. Vanguard sites should also provide greater access to personal budgets for people of all ages, including children and young people who have multiple and complex needs, to provide more choice and control over how and when they access different services.
	Physical health outcomes in people with mental illness	NHS England should undertake work to define a quantified national reduction in premature mortality among people with severe mental illness, and an operational plan to begin achieving it from 2017/18. NHS England should also lead work to ensure that by 2020/21, 280,000 more people living with severe mental illness have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention. This will involve developing, evaluating and implementing models of primary care whereby GPs and practice nurses take responsibility for delivering the full suite of physical care screenings, outreach, carer training and onward interventions or referrals, in line with NICE guidelines. This model should include outreach workers or carer training to support people to access primary care because many people with psychosis struggle to access services, and give GPs and practice nurses the training and time they need to deliver NICE-concordant screening and care.
	Older age specialist services	NHS England should ensure that people being supported in specialist older-age acute physical health services have access to liaison mental health teams – including expertise in psychiatry of older adults – as part of their package of care, incentivised through the introduction of a new national CQUIN or alternative incentive payments and embedded through the vanguard programmes.
	Trialling population based budgets	NHS England should ensure that by April 2017 population-based budgets are in place which give CCGs or other local partners the opportunity to collaboratively commission the majority of specialised services across the life course. In 2016/17 NHS England should also trial new models through a vanguard programme that allow secondary providers of these services to manage care budgets for tertiary (specialised) mental health services to improve outcomes and reduce out of area placements. We recommend testing this at scale, with a particular focus on secure care commissioning, perinatal and specialised CAMHS services.
	Co-production evaluation	NHS England should work with NHS Improvement to run pilots to develop evidence based approaches to co-production in commissioning by April 2018.
	CCG inequalities – funding	NHS England should disaggregate the inequalities adjustment from the baseline funding allocation for CCGs and Primary Care, making the value of this adjustment more visible and requiring areas to publicly report on how they are addressing unmet mental health need and mental health inequalities.

	NHS staff mental health	NHS England should ensure current health and wellbeing support to NHS organisations extends to include good practice in the management of mental health in the workplace, and provision of occupational mental health expertise and effective workplace interventions from 2016 onwards.
	Navigators	NHS England and NHS Improvement should encourage providers to ensure that ‘navigators’ are available to people who need specialist care from diagnosis onwards, to guide them through options for their care and ensure they receive appropriate information and support. In parallel, NHS England and HEE should work with voluntary and community sector organisations, experts-by-experience and carers to develop and evaluate the role of ‘navigators’ in enabling more people-centred care to be provided.
	Trialling acute care models or 16-25s	NHS England should work with CCGs, local authorities and other partners to develop and trial a new model of acute inpatient care for young adults aged 16–25 in 2016, working with vanguard sites. This should evaluate: developmentally and age-appropriate inpatient services for this group; supporting young people in an environment that maximises opportunities for rehabilitation and return to education, training or employment; viewing the young person within their social context; and enlisting the support of families or carers. This should build on the existing trials of new models of ‘transitional’ services for those aged 0–25.
	NHS staff awareness	NHS England should develop and introduce measures of staff awareness and confidence in dealing with mental health into annual NHS staff surveys across all settings.
	Staff health & wellbeing	NHS England should introduce a CQUIN or alternative incentive payment relating to NHS staff health and wellbeing under the NHS Standard Contract by 2017.
	Data stocktake	NHS England and the HSCIC should work to identify unnecessary data collection requirements, and then engage with NHS Improvement to prioritise persistent non-compliance in data collection and submission to the MHSDS, and take regulatory action where necessary. For the most important data items (including inequalities data), commissioners should use NHS standard contract sanctions (financial penalty) for a data breach where there is persistent non-return of data. Commissioners should be required to use national data flows where they exist and not place undue pressure on providers by asking for local data that duplicates national data.
	Payment system	NHS England and NHS Improvement should together lead on costing, developing and introducing a revised payment system by 2017/18 to drive the whole system to improve outcomes that are of value to people with mental health problems and encourage local health economies to take action in line with the aims of this strategy. This approach should be put in place for children and young people’s services as soon as possible.
	Governance	NHS England, the Department of Health and the Cabinet Office should confirm what governance arrangements will be put in place to support the delivery of this strategy. This should include arrangements for reporting publicly on how progress is being made against recommendations for the rest of government and wider system partners.

Public Health England	Mental Health Intelligence Network	During 2016 NHS England and Public Health England should set a clear plan to develop and support the Mental Health Intelligence Network over the next five years, so that it supports data linkage across public agencies, effective commissioning and the implementation of new clinical pathways and standards as they come online.
	Preventing poor physical health outcomes	Public Health England should prioritise ensuring that people with mental health problems who are at greater risk of poor physical health get access to prevention and screening programmes. This includes primary and secondary prevention through screening and NHS Health Checks, as well as interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. As part of this, NHS England and PHE should support all mental health inpatient units and facilities (for adults, children and young people) to be smoke-free by 2018.
	Preventing mental ill health	PHE should develop a national Prevention Concordat programme that will support all Health and Wellbeing Boards (along with CCGs) to put in place updated JSNA and joint prevention plans that include mental health and comorbid alcohol and drug misuse, parenting programmes, and housing, by no later than 2017.

Care Quality Commission	Integrated regulation of CYP services	The CQC should work with Ofsted, Her Majesty's Inspectorate of Constabulary and Her Majesty's Inspectorate of Probation to undertake a Joint Targeted Area Inspection to assess how the health, education and social care systems are working together to improve children and young people's mental health outcomes.
	Quality inspection across settings	The CQC should develop regulation and inspection of NHS-funded services to include mental health as part of its planned approach to assessing the quality of care along pathways and in population groups, beyond the inspection of providers. Within its strategy for 2016–2020, the CQC should also set out how it will strengthen its approach to: - How it inspects primary medical services, acute and adult social care services, so that it assesses whether these services are providing high-quality care for people with mental health problems - Inspect providers on the quality of co-production in individual care planning, carer involvement and in working in partnership with communities to develop and improve mental health services (drawing on good practice such as the 4PI principles) - Ensure that, from 2016, inspections of all specialist mental health services reflect the extent to which the provider ensures that people have an outcomes-focused recovery path that includes discharge and future planning and is integrated with other services, incorporating housing and other social needs - Ensure (with support from the Department of Health) that data captured about experience of inpatient mental health services is represented in a form which allows comparison and improvement monitoring at national level - Incorporates good practice in information sharing with other providers and with mental health carers, to address complex issues relating to how patient confidentiality rules apply in the care of people with mental health problems.

NHS Improvement	Learning from deaths by suicide	NHS Improvement and NHS England, with support from Public Health England, should identify what steps services should take to ensure that all deaths by suicide across NHS-funded mental health settings, including out-of-area placements are learned from to prevent repeat events. This should build on insights through learning from never events, serious incident investigations and human factors approaches. The CQC should then embed this information into its inspection regime.
Health Education England	Workforce planning and development across settings	HEE should work with NHS England, PHE, professional bodies, charities, experts-by-experience and others to develop a costed, multi-disciplinary workforce strategy for the future shape and skill mix of the workforce required to deliver both this strategy and the workforce recommendations set out in Future in Mind. This review should address training needs for both new and existing NHS-funded staff and should report by no later than the end of 2016. This workforce strategy should include: Clear projections for required staff numbers to 2020/21 and what action will be taken to plug any gaps · Core training in basic mental health awareness and knowledge, understanding of mental health law, public mental health, compassion and communication skills · For professions involved in the care and support of people with mental health problems, tailored curricula with competencies in dealing with the common physical health problems people may present with, shared decision-making, mental health prevention (including suicide), empowering people to understand their own strengths and self-manage, carer involvement and information sharing. Drawing on the best available evidence, this should also ensure that professionals are equipped to provide age-appropriate care and reduce inequalities. HEE and PHE should develop an action plan so that by 2020/21 validated courses are available in mental health promotion and prevention for the public health workforce (including primary care).
	Prescribing standards	HEE should work with the Academy of Medical Royal Colleges to develop standards for all prescribing health professionals that include discussion of the risks and benefits of medication, take into account people's personal preferences, include preventative physical health support and the provision of accessible information to support informed decision-making. This should be completed in collaboration with relevant stakeholders by April 2017 and subject to regular review.

Recommendations for Government

Cabinet Office	Co-morbid mental health and substance misuse problems	The Cabinet Office should ensure that the new Life Chances Fund of up to £30m for outcomes-based interventions to tackle alcoholism and drug addiction requires local areas to demonstrate how they will integrate assessment, care and support to people with co-morbid substance misuse and mental health problems, and make a funding contribution themselves. It should also be clear about the funding contribution required from local commissioners to pay for the outcomes that are being sought.
Department of Health	Research	The UK should aspire to be a world leader in the development and application of new mental health research. The Department of Health, working with all relevant parts of government, the NHS ALBs, research charities, independent experts, industry and experts-by-experience, should publish a report one year from now, setting out a 10-year strategy for mental health research. This should include a co-ordinated plan for strengthening and developing the research pipeline on identified priorities, and promoting implementation of research evidence.
	Equalities	The Department of Health should appoint a new equalities champion with a specific remit to tackle health inequalities amongst people with mental health problems and carers across the health and social care system and through cross-government action. This role should include responsibility for advising on operational activity within the NHS to reduce discrimination for people found to be at particular risk, including but not limited to those with characteristics protected by the Equalities Act. The Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, makes a recommendation that a Patients and Carers Race Equality Standard should be piloted in mental health and this should form part of the remit of the new role-holder.
	Suicide prevention	The Department of Health, PHE and NHS England should support all local areas to have multi-agency suicide prevention plans in place by 2017, contributing to a 10 per cent reduction in suicide nationally. These plans should set out targeted actions in line with the National Suicide Prevention Strategy and new evidence around suicide, and include a strong focus on primary care, alcohol and drug misuse. Each plan should demonstrate how areas will implement evidence-based preventative interventions that target high-risk locations and support high-risk groups (including young people who self-harm) within their population, drawing on localised real time data. Updates should be provided in the Department of Health's annual report on suicide.
	Mental Health Act	The Department of Health should work with a wide range of stakeholders to review whether the Mental Health Act (and relevant Code of Practice) in its current form should be revised in parts, to ensure stronger protection of people's autonomy, and greater scrutiny and protection where the views of individuals with mental capacity to make healthcare decisions may be overridden to enforce treatment against their will.
	Social work	The Department of Health should continue to support the expansion of programmes that train people to qualify as social

		workers and contribute to ensuring the workforce is ready to provide high quality social work services in mental health. This should include expanding 'Think Ahead' to provide at least an additional 300 places.
	Supported housing	The Department of Health, Communities and Local Government, NHS England, HM-Treasury and other agencies should work with local authorities to build the evidence base for specialist housing support for vulnerable people with mental health problems and explore the case for using NHS land to make more supported housing available for this group.
	Health and Justice care pathway	The Ministry of Justice, Home Office, Department of Health, NHS England and PHE should work together to develop a complete health and justice pathway to deliver integrated health and justice interventions in the least restrictive setting, appropriate to the crime which has been committed. This should build on the national roll out of Liaison and Diversion schemes (including for children and young people) across England by 2020/21 and the increased uptake of Mental Health Treatment Requirements (diversion through court order to access community based treatment) as part of community sentences for everyone who can benefit from them. It should also improve mental health services in prison and the interface with the secure care system, with continuity of care on release, to support offenders to return to the community.
	Data improvement	The Department of Health, NHS England, PHE and the HSCIC should develop a 5-year plan to address the need for substantially improved data on prevention, prevalence, access, quality, outcomes and spend across mental health services - set out responsibilities for each agency in providing the necessary legal, commissioning, and quality and safety information required. - design and develop new datasets, linking physical health, mental health, social care and employment datasets, while ensuring that information governance adequately protects people's rights - include mental health measures in all physical care datasets, including emergency care. The HSCIC should act as a data system leader and set new minimum service expectations for turning around new datasets or changes to existing datasets. The Department of Health, NHS England, HSCIC and NHS Improvement should publish a summary progress report by the end of 2016 setting out how the specific actions on data, information sharing and digital capability identified in this report and the National Information Board's Strategy are being implemented.
	Children and Young People metrics	The Department of Health should develop national metrics to support improvements in children and young people's mental health outcomes, drawing on data sources from across the whole system, including NHS, public health, local authority children's services and education, to report with proposals by 2017.
	Greater transparency	The Department of Health, HSCIC and MyNHS, working with NHS England, should improve transparency in data to promote choice, efficiency, access and quality in mental health care, ensuring that all NHS-commissioned mental health data are transparent (including where data quality is poor) to drive improvements in services. The CCG Performance and Assessment Framework should include a robust basket of indicators to provide a clear picture of the quality of commissioning for mental health. To complement this, NHS England should lead work on producing a Mental Health FYFV Dashboard by the summer of 2016 that identifies metrics for monitoring key performance and outcomes data that will allow us to hold national and local bodies to account for implementing this strategy. The Dashboard should include health and social outcomes including

		employment and settled housing outcomes for people with mental health problems.
	Prevalence surveys	The Department of Health should commission regular prevalence surveys for children, young people and adults of all ages that are updated not less than every 7 years.
	CCG transparency	The Department of Health and NHS England should require CCGs to publish data on levels of mental health spend in their Annual Report and Accounts, by condition and per capita, including for Children and Adolescent Mental Health Services, from 2017/18 onwards. They should require CCGs to report on investment in mental health to demonstrate the commitment that commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall allocation increase. For children and young people, this should be broken down initially into spend in the community, on emergency, urgent and routine treatment, and for inpatient care.
	Parity for mental health in Health & Social Care Act regulations	The Department of Health should carry out a review of existing regulations of the Health and Social Care Act to identify disparities and gaps between provisions relating to physical and mental health services. This should include considering how to ensure that existing regulations extend rights equally to people experiencing mental health problems (e.g. to types of intervention that are mandated, or to access to care within maximum waiting times).
	Deaths in inpatient settings	The Department of Health should ensure that the scope of the new Healthcare Safety Investigation Branch includes a clear focus on deaths from all causes in inpatient mental health settings, including independent scrutiny of the quality of investigation, analysis of local and national trends, and evidence that learning is resulting in service improvement. This should include the involvement of families and build on the models and experiences of the Independent Police Complaints Commission and the Prisons and Probation Ombudsman. The Department should also work with the CQC to establish a methodology for inspecting the quality of learning from all deaths in inpatient mental health services, including introducing greater transparency around the cause of deaths within each provider.
	Challenging stigma	The Department of Health should work with PHE to continue to support proven behaviour change interventions, such as Time to Change, and to establish Mental Health Champions in each community, to contribute to improving attitudes to mental health by at least a further 5 per cent by 2020/21.
	Innovation fund for devolved areas	The Department of Health and the Department for Work and Pensions, working with NHS England and PHE, should identify how the £40 million innovation fund announced at the Spending Review and other investment streams should be used to support devolved areas to jointly commission more services that have been proven to improve mental health and employment outcomes, and test how the principles of these services could be applied to other population groups and new funding mechanisms (e.g. social finance).

	Digital	The Department of Health, through the National Information Board, should ensure there is sufficient investment in the necessary digital infrastructure to realise the priorities identified in this strategy. Each ALB should optimise the use of digital channels to communicate key messages and make services more readily available online, where appropriate, drawing on user insight. Building on trial findings, NHS England should expand work on NHS Choices to raise awareness and direct people to effective digital mental health products by integrating them into the website and promoting them through social marketing channels from 2016 onwards.
	New GPs	The Department of Health and NHS England should work with the RCGP and HEE to ensure that by 2020/21 all GPs, including the 5,000 joining the workforce by 2020/21, receive core mental health training, and to develop a new role of GPs with an extended Scope of Practice (GPwER) in Mental Health, with at least 700 in practice within 5 years.
	Regulation of psychological therapies	The Department of Health should consider how to introduce the regulation of psychological therapy services, which are not currently inspected unless provided within secondary mental health services.
	Better Care Fund	To drive and scale improvements in integration, the Department of Health and relevant partners should ensure that future updates to the Better Care Fund include mental health. This might include making an element of payment for outcomes contingent on reducing acute admission through requiring all hospitals to comply with Crisis Care Concordat and NICE standards on liaison and crisis mental health care.
	Summary Care Records	The Department of Health and HSCIC should advocate adoption of data-rich Summary Care Records that include vital mental health information, where individuals consent for information to be shared, by 2016/17.
Department for Work & Pensions	Employment support	The Department for Work and Pensions should ensure that when it tenders the Health and Work Programme it directs funds currently used to support people on Employment Support Allowance to commission evidence-based health-led interventions that are proven to deliver improved employment outcomes – as well as improved health outcomes – at a greater rate than under current Work Programme contracts. The Department of Work and Pensions should also invest to ensure that qualified employment advisers are fully integrated into expanded psychological therapies services.
	Housing Benefit cap	The Department of Work and Pensions should, based on the outcome of the “Supported Housing” review in relation to the proposed Housing Benefit cap to Local Housing Allowance levels, use the evidence to ensure the right levels of protection are in place for people with mental health problems who require specialist supported housing
Department for Education / Department	Parenting programmes and support for children	The Departments of Education and Health should establish an expert group to examine the needs of children who are particularly vulnerable to developing mental health problems and how their needs should best be met, including through the provision of personalised budgets. The Government should also review the best way to ensure that the significant expansion of parenting programmes announced by the Prime Minister builds on the strong-evidence base that already exists and is integrated

of Health / Department for Work and Pensions	with complex needs	with local Transformation Plans for Children and Young People's mental health services.
HEFCE	Research	HEFCE should review funding requirements and criteria for decision-making to support parity through the Research Excellence Framework and take action to ensure that clinical academics in mental health (including in psychiatry and neuroscience) are not disadvantaged relative to other areas of health research, starting in 2016/17.
ACRA	Inequalities and funding allocation formula	ACRA should review NHS funding allocation formulas, including the inequalities adjustment, to ensure it supports parity between physical and mental health in 2016/17. They should also be reviewed to ensure they correctly estimate the prevalence and incidence of conditions across the mental health spectrum. Membership of ACRA should be revisited with the specific goal of ensuring that mental health expertise is adequately represented across the disciplines involved, e.g. clinical, academic, policy and providers.

Approved Minute

Cover Sheet

Meeting: Board of Directors	Report Author: Kathy Bray, Board Secretary
Date: Thursday, 25th February 2016	Sponsoring Director: Victoria Pickles, Company Secretary
Title and brief summary: BOARD ASSURANCE FRAMEWORK - The Board is asked to receive and approve 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: Board of Directors Meeting - November 2015	
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. The Board is asked to receive and approved the Board Assurance Framework

Background/Overview:

Following feedback, 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 BAF has been updated and confirmation given as whether actions described in the last version have been completed in line with the timescale.

BAF risks are now also being discussed routinely at each of the sub-committee meetings and are scrutinised in detail alongside the risk register at the Risk and Compliance Group.

It is proposed that the following risks have been amended:

Risk 1 HSMR - The wording of this risk has been slightly amended to make it more reflective of the current position.

Risk 3 Service reconfiguration - The risk has been reduced from 25 to 20. This is as a result of agreement on the way forward and the clinical model across the Trust and the CCG along with CCG accepting the Trust's Five Year Strategic Plan. There is still a significant level of risk to progressing service reconfiguration.

Risk 6 Patient and public involvement - The risk has been reduced from 12 to 9. A Patient and Public Involvement plan has been developed and is being implemented. In addition we now have a number of examples of detailed public engagement and consultation being carried out around different service areas including early pregnancy assessment and gynaecology; the Rainbow Unit; and the work to complete pre-engagement. This has resulted in more embedded systems and processes.

Risk 10 Local and national performance - There has been an increase in the risk score from 12 to 16 as a result of the significant pressures on the Trust and the impact that this may have on performance against some of the key targets including the 4 hour emergency care target.

Risk 14 Colleague engagement has a reduced score from 16 to 12. This is a reflection of the feedback received through the Investor in People accreditation. This score is being discussed at the Well Led Workforce Committee on 19 February and a verbal update will be given at the Board.

Risk 15 2015.16 cost improvement - This score has been reduced to reflect the Trust's position in delivery of the cost improvement schemes for FY16.

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 maybe needed.

Next Steps:

The Board should expect to receive the BAF on a quarterly basis.

Recommendations:

The Board is asked to receive and approve the Board Assurance Framework.

Appendix**Attachment:**

15.16 Board Assurance Framework Feb 16.pdf

BOARD ASSURANCE FRAMEWORK 2015/16

Contents:

- 1 Summary sheet
- 2 Heat map
- 3 Transforming and improving patient care
- 4 Keeping the base safe
- 5 A workforce fit for the future
- 6 Financial sustainability
- 7 Key



REF	RISK DESCRIPTION	Current score	Lead	Link to RR
Transforming and improving patient care				
001	Trust is perceived to provide poor standards of care for acutely ill patients/frail elderly patients as a result of a high HSMR and / or SHMI.	20 =	DB	4783 2827 6313
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) while keeping the base safe	20 =	OW	6346
003	Failure 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	
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	9 ↓	JD	
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	
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	16 ↑	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 colleagues.	20 =	JD / DB	6345
013	Failure to attract and develop appropriate clinical leadership across the Trust.	16 =	DB	
014	Failure to appropriately engage all colleagues and embed the culture of the organisation across all sites.	12 ↓	JE	
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	15 ↓	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	
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)
Highly likely (5)				1. Mortality 2. Large scale transformation	
Likely (4)			4. Seven day services	11. Estate fit for purpose 13. Clinical leadership 18. Income loss 10. National and local targets	15. Financial delivery 15/16 16. Financial plan 16/17 12. Staffing levels 9. Breach of monitor licence 3. Service reconfiguration
Possible (3)			6. PPI	8. Governance 14. Staff engagement	5. EPR 7. Compliance with quality standards 17. Five year turnaround plan
Unlikely (2)					
Rare (1)					

Assessment is Likelihood x Consequence

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE												
Ref	OWNER Board committee Exec Lead		RISK DESCRIPTION <i>(What is the risk?)</i>	KEY CONTROLS <i>(How are we managing the risk?)</i>	POSITIVE ASSURANCE & SOURCES <i>(How do we know it is working?)</i>	GAPS IN CONTROL <i>(Where are we failing to put controls / systems in place?)</i>	GAPS IN ASSURANCE <i>(Where are we failing to gain evidence about our system/ controls?)</i>	RATING				
1.1516	Quality Committee	Executive Medical Director	Risk Trust is perceived to provide poor standards of care for acutely ill patients/frail elderly patients as a result of a high HSMR and / or SHMI.	• Safety thermometer in use on wards • Safety huddles being implemented • Mortality review process redesigned and rolled out with clinical leads appointed to address the gaps in capacity / capability to undertake reviews - now achieving around 60% • 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 • Ongoing work to improve the care of frail patients • Implementation of care bundles	<u>First line</u> Mortality dashboard in divisions Mortality reviews provide themes to improve standards of care <u>Second line</u> Care of the Acutely Ill patient report to Board PSQB reports to Quality Committee <u>Third line</u> Independent review of cases by Professor Mohammed	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. Mortality reviews not yet undertaken consistently	• HSMR position has worsened • SHMI position has worsened • Regulation 28 reports from Coroner received	Initial	Current	Target		
				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					5x4 = 20	5x4 = 20	4x4 = 16	
Action					Timescales			Lead				
CQUINS to be monitored by the Trust Continue implementation Care of the Acutely Ill Patient plan Implement workforce Model around nervecentre (Hospital @ Night / Weekend) Continue to implement mortality review process					Ongoing April May March			JC DB MG AH				
Links to risk register: Risk 4783 - Outlier on Mortality Risk 2827 - Clinical decision making in A&E Risk 6313 - Inability to progress service transformation												

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE												
Ref	OWNER Board committee Exec Lead		RISK DESCRIPTION <i>(What is the risk?)</i>	KEY CONTROLS <i>(How are we managing the risk?)</i>	POSITIVE ASSURANCE & SOURCES <i>(How do we know it is working?)</i>	GAPS IN CONTROL <i>(Where are we failing to put controls / systems in place?)</i>	GAPS IN ASSURANCE <i>(Where are we failing to gain evidence about our system/ controls?)</i>	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)	• 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 / Board on progress with delivery of EPR	<u>First line</u> Modernisation WEB held every 6 weeks CIP plan on track for 15/16 EPR implementation programme Strategic turnaround plan development <u>Second line</u> Integrated Board Report EPR report to Finance and Performance Committee / Board Turnaround Executive scrutiny weekly Monthly report on turnaround to Finance and Performance Committee Board approval of 5 Year Strategic Plan <u>Third line</u> PRM meetings with Monitor demonstrate progress Well Led Governance Review showed some areas of good practice Gateway 1 assurance report	• Job plans to be reviewed to include time for clinical leadership responsibilities • Performance Management Framework to be implemented	• Gateway 2 assurance review for EPR programme to be undertaken Self assessed against CQC standards as requires improvement 16/17 CIP CCG Consultation process only just beginning	Initial	Current	Target		
			Impact - Delivery of safe clinical care - Financial sustainability - Low staff morale. - Viability and competitiveness of Trust is compromised	• Weekly CQC steering group • Risk reporting and review arrangements • Executive team undertaking review of capacity and responsibilities Hospital Programme Board Partnership Board with CCGs				4x4 = 16	4x5 = 20	3x3 = 9		
Action				Timescales				Lead				
Well Led Governance review action plan to be implemented Contribute to CCG consultation process				September - March May				JD / VP AB				
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 <i>(What is the risk?)</i>	KEY CONTROLS <i>(How are we managing the risk?)</i>	POSITIVE ASSURANCE & SOURCES <i>(How do we know it is working?)</i>	GAPS IN CONTROL <i>(Where are we failing to put controls / systems in place?)</i>	GAPS IN ASSURANCE <i>(Where are we failing to gain evidence about our system/ controls?)</i>	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 - Inability 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. 20/1/16 CCGs made the decision to commence public consultation on the future configuration of hospital services. • CCGs and NHS England representatives included in roundtable discussion with Monitor • There is an agreed consensus between the CCGs and the Trust on the preferred clinical model.This has been reviewed and endorsed by Yorkshire and Humber Clinical Senate. • Monitor support for development of 5 Year Strategic plan which was approved by the Trust Board on 29th December and then updated to take account of 16/17 planning guidance. Refreshed version approved by the Trust Board in January. • 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. 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 specialities	<u>First line</u> Vanguard work in Calderdale showing an impact <u>Second line</u> 5 Year plan progress report to Finance & Performance Committee and Board Urgent Care Board and System Resilience Group in place <u>Third line</u> Recent Trauma review shows positive position for CHFT PRM meeting with Monitor tracks progress	• 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 staff	Initial	Current	Target				
										5x5 = 25	4x5 = 20	3x5 = 15		
Action					Timescales					Lead				
Participate in Right Care, Right Time, Right Place consultation					May					ALL				
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 Exec Lead		RISK DESCRIPTION <i>(What is the risk?)</i>	KEY CONTROLS <i>(How are we managing the risk?)</i>	POSITIVE ASSURANCE & SOURCES <i>(How do we know it is working?)</i>	GAPS IN CONTROL <i>(Where are we failing to put controls / systems in place?)</i>	GAPS IN ASSURANCE <i>(Where are we failing to gain evidence about our system/ controls?)</i>	RATING					
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 - Part of the West Yorkshire early implementers - Capacity brought in to support programme	<u>First line</u> Improvement in performance against some key indicators including delayed discharges & green cross although still behind trajectory <u>Second line</u> Integrated Board report Benchmarked against four key Keogh standards Paper received at WEB <u>Third line</u> Independent review of mortality cases by Professor Mohammed	- 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 - Medicine action plan to be implemented - Approval to be sought on implementing hospital@night	Not yet meeting a number of indicators in the IBR including pre-11am daily discharges; outliers; bed movements;	Initial	Current	Target			
				4x3 = 12				4x3 = 12			2x3 = 6		
Action					Timescales			Lead					
7 day service action plan to be finalised Approval for hospital@night module and training to be sought					October / November- March March			SU SU					
Links to risk register: No corporate (>15) risks													

TRUST GOAL: 1. TRANSFORMING AND IMPROVING PATIENT CARE												
Ref	OWNER Board committee Exec Lead		RISK DESCRIPTION <i>(What is the risk?)</i>	KEY CONTROLS <i>(How are we managing the risk?)</i>	POSITIVE ASSURANCE & SOURCES <i>(How do we know it is working?)</i>	GAPS IN CONTROL <i>(Where are we failing to put controls / systems in place?)</i>	GAPS IN ASSURANCE <i>(Where are we failing to gain evidence about our system/ controls?)</i>	RATING				
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 report Monthly update to Monitor as part of PRM reporting arrangements	• Future state to be completed • Second gateway report to be signed off.	• EPR assurance process to be undertaken	Initial	Current	Target		
										3x5 = 15	3x5 = 15	1x5 = 5
Action				Timescales				Lead				
Engagement plan to be implemented System testing to be completed Integration testing to be completed				Ongoing starting in September February April				MG MG 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 <i>(What is the risk?)</i>	KEY CONTROLS <i>(How are we managing the risk?)</i>	POSITIVE ASSURANCE & SOURCES <i>(How do we know it is working?)</i>	GAPS IN CONTROL <i>(Where are we failing to put controls / systems in place?)</i>	GAPS IN ASSURANCE <i>(Where are we failing to gain evidence about our system/ controls?)</i>	RATING					
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 completed with CCG scrutiny and OSC oversight • Participation in communication and engagement strategic oversight group with CCGs. • Patient and Public involvement plan developed for the Trust and being implemented • Greater clarity on process for engagement and consultation sign off for service redesign with CCGs	<u>First line</u> Some PPI activity included in divisional patient experience reports to Patient Experience Group each quarter <u>Second line</u> Contribution to CCG Annual Statement of Involvement PPI included in Quarterly Quality Report to Board <u>Third line</u> OSC oversight and approval of Child Development Unit; EPAU / Emergency Gynae engagement plan; Cardio & Respiratory engagement plan.	• No identified capacity to deliver co-ordinated approach to PPI • Membership Strategy requires review and appropriate action plan putting in place	• PPI action plan to be delivered	Initial	Current	Target			
									3x4= 12	3x3 = 9	2x3 = 6		
Action					Timescales					Lead			
PPI action plan to be delivered Cardio / respiratory engagement work to be delivered Membership Strategy review to be completed					June March May					RM VP RM			
Links to risk register: No corporate (>15) risks													

TRUST GOAL: 2 KEEPING THE BASE SAFE											
Ref	OWNER Board committee Exec Lead		RISK DESCRIPTION <i>(What is the risk?)</i>	KEY CONTROLS <i>(How are we managing the risk?)</i>	POSITIVE ASSURANCE & SOURCES <i>(How do we know it is working?)</i>	GAPS IN CONTROL <i>(Where are we failing to put controls / systems in place?)</i>	GAPS IN ASSURANCE <i>(Where are we failing to gain evidence about our system/ controls?)</i>	RATING			
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 • Policies reviewed	<u>First line</u> Staffing levels reported to WEB CQC Steering Group reports Clinical audit plan reviewed Assessment of compliance with NICE guidance CQC self assessment including strengths and weaknesses <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 CQC Action plan progress reported to Quality Committee DIPC report to Board Care of the Acutely Ill Patient plan report to Board <u>Third line</u> 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 • 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 • Standard of serious incident investigations needs to be improved • Some infection control concerns identified • Estate issues identified	• 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 small number of areas • Staff FFT response to recommendation as a place to work and place to be cared for declining • Essentials skills monitoring • Medical and therapy staffing monitoring arrangements	Initial	Current	Target	
							3x5 = 15	3x5 = 15	2x5 = 10		
Action CQC preparation programme to be delivered					Timescales March			Lead JD			
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 <i>(What is the risk?)</i>	KEY CONTROLS <i>(How are we managing the risk?)</i>	POSITIVE ASSURANCE & SOURCES <i>(How do we know it is working?)</i>	GAPS IN CONTROL <i>(Where are we failing to put controls / systems in place?)</i>	GAPS IN ASSURANCE <i>(Where are we failing to gain evidence about our system/ controls?)</i>	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 • Improved board level risk management reporting arrangements • PMO in place and improved governance in relation to CIP planning • Performance Management Framework approved	<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 Work undertaken to strengthen PSQB governance arrangements <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 Partnership Board meeting with CCGs	• Risk management arrangements to be strengthened at divisional level and below • Performance management framework requires further work to embed	• Well Led Governance review actions to be implemented across a small number of remaining areas • Assessment of divisional governance to align to Well Led Governance review • Self assessed against CQC as requires improvement	Initial	Current	Target		
			3x4 = 12	3x4 = 12	2x4= 9							
Action					Timescales			Lead				
Well Led Governance review action plan to be implemented Performance Management framework to be implemented					September - March March			JD / VP HB				
Links to risk register: No corporate (>15) risks												

TRUST GOAL: 2. KEEPING THE BASE SAFE												
Ref	OWNER Board committee Exec Lead		RISK DESCRIPTION <i>(What is the risk?)</i>	KEY CONTROLS <i>(How are we managing the risk?)</i>	POSITIVE ASSURANCE & SOURCES <i>(How do we know it is working?)</i>	GAPS IN CONTROL <i>(Where are we failing to put controls / systems in place?)</i>	GAPS IN ASSURANCE <i>(Where are we failing to gain evidence about our system/ controls?)</i>	RATING				
9.1516	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 • 5 Year strategic plan completed and formally adopted by the CCGs as part of the pre-consultation business case • 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 5 Year Strategic 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 CCG acceptance of 5 Year Strategic Plan EY independent assessment of 5 Year Plan	• 16/17 CIP plan to be finalised	• Forecast deficit position has improved from £22M to £21M but remains above the £20M original plan	Initial	Current	Target		
									5x5 = 25	4x5 = 20	2x5 = 10	
Action					Timescales			Lead				
Well Led Governance Review action plan to be implemented Development of 16/17 CIP schemes to be completed					September 15 - March 16 March 16			JD / VP AB				
Links to risk register: Risk 4706 - Financial plans												

TRUST GOAL: 2. KEEPING THE BASE SAFE												
Ref	OWNER Board committee Exec Lead		RISK DESCRIPTION <i>(What is the risk?)</i>	KEY CONTROLS <i>(How are we managing the risk?)</i>	POSITIVE ASSURANCE & SOURCES <i>(How do we know it is working?)</i>	GAPS IN CONTROL <i>(Where are we failing to put controls / systems in place?)</i>	GAPS IN ASSURANCE <i>(Where are we failing to gain evidence about our system/ controls?)</i>	RATING				
10.1516	Finance and Performance Committee	Chief Operating Officer	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 • Theatre productivity work and Theatres perfect week • New patient flow programme • CQUINS compliance monitored by Quality directorate • Bronze, silver and gold command arrangements and escalation process • External expertise brought in to support the patient flow work • System-wide gold commanders meeting in place • Regular forum in place between Operations and THIS to strengthen information flows and reporting • Interim Head of Performance in place	<u>First line</u> 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 with wider representation from divisions 'Deep dive' discussions into areas of under performance Appointment slot issues action plan has resulted in reduced ASIs Work begun to develop more intuitive dashboard <u>Second line</u> Enhanced Integrated Board Report discussed at Quality Committee and Board Finance and Performance Committee monthly report on activity Report on compliance with best practice tariff <u>Third line</u> Urgent Care and Planned Care Boards and System Resilience group	• System responsiveness • Appointment slot issues backlog still to be addressed • 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. • Gap in external reporting sign off process.	• External Audit unable to give assurance around 18 week data • A number of indicators remain off track including A&E target in Q4; delayed discharges. • Lack of robust system surge plans.	Initial	Current	Target		
									4x4 = 16	4x4 = 16	2x3 = 6	
Action				Timescales				Lead				
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 <i>(What is the risk?)</i>	KEY CONTROLS <i>(How are we managing the risk?)</i>	POSITIVE ASSURANCE & SOURCES <i>(How do we know it is working?)</i>	GAPS IN CONTROL <i>(Where are we failing to put controls / systems in place?)</i>	GAPS IN ASSURANCE <i>(Where are we failing to gain evidence about our system/ controls?)</i>	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 maintenance 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 • Health Technical Memorandum (HTM) structure in place including external Authorising Engineers (AE's) who independantly audit Estates against statutory guidance.	<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 Assurance provided by AE's following audits against Estates statutory requirements <u>Third line</u> PLACE assessments CQC Compliance report Assurance received from Environment Agency regarding healthcare waste implementation plans Progress made on DoH Premises Assurance Model (PAMs) to illustrate to patients, commissioners & regulators that robust systems are in place in regarding the premises and associated services are safe.	• 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 of equipment 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	• 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'. • A number of areas for improvement identified on the PAMs model. Department making progress on the areas identified.	Initial	Current	Target			
									4x4 = 16	4x4 = 16	2x4 = 8		
Action					Timescales			Lead					
Work to improve compliance with mandatory training Implementation CQC Compliance action plan Implement actions from PAMS assessment					Ongoing ~~November-~~ March March			ALL DIVISIONS LH 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 <i>(What is the risk?)</i>	KEY CONTROLS <i>(How are we managing the risk?)</i>	POSITIVE ASSURANCE & SOURCES <i>(How do we know it is working?)</i>	GAPS IN CONTROL <i>(Where are we failing to put controls / systems in place?)</i>	GAPS IN ASSURANCE <i>(Where are we failing to gain evidence about our system/ controls?)</i>	RATING								
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 colleagues.	• 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; Escalation process in place • ED business continuity plan in place; • Vacancy review process in place; • Use of e-rostering. • Framework for identifying wards potentially unsafe (under-resourced or under performing) and placing in special measures • Risk assessments in place • Nursing recruitment and retention strategy	<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; ophthalmology; gastroenterology; respiratory;elderly medicine; dermatology; SALT; therapies; clinical administration Additional beds open meaning that although nursing recruitment has almost achieved full establishment, there is still significant use of bank and agency to support additional bed capacity. Clear workforce strategy / plan required Recruitment and retention strategy for medical and therapy staffing required Continued spend on locums and agency above the Monitor cap leading to financial pressures in year. Bed retraction plan in place but not yet delivering.	• Medical workforce paper to Quality Committee highlighted particularly difficult areas for recruitment. • Need clear workforce plan • Need recruitment and retention strategy for medical and therapy	Initial	Current	Target						
			4x4 = 15					4x5 = 20	3x3 = 9							
Action								Timescales				Lead				
Medical staff tool to be developed and rolled out Medical and therapy plan to be developed Improved reporting on planned and actual staff in post								May May May				DB JE JE				
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 <i>(What is the risk?)</i>	KEY CONTROLS <i>(How are we managing the risk?)</i>	POSITIVE ASSURANCE & SOURCES <i>(How do we know it is working?)</i>	GAPS IN CONTROL <i>(Where are we failing to put controls / systems in place?)</i>	GAPS IN ASSURANCE <i>(Where are we failing to gain evidence about our system/ controls?)</i>	RATING				
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 • Performance Management Framework agreed including job description for clinical leads.	<u>First line</u> Established escalation framework to prioritise action to address week areas Clinicians leading of transformation programmes e.g. cardio /respiratory Engaged leaders toolkit in place Clinical lead participation 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 Impact 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 responsibilities • Performance Management Framework to be implemented	• 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	Initial	Current	Target		
								4x4 = 16	4x4 = 16	3x3 = 9		
Action					Timescales			Lead				
Well Led Governance review action plan to be implemented Clinical leadership review to be completed					September - March March			JD / VP DB				
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 <i>(What is the risk?)</i>	KEY CONTROLS <i>(How are we managing the risk?)</i>	POSITIVE ASSURANCE & SOURCES <i>(How do we know it is working?)</i>	GAPS IN CONTROL <i>(Where are we failing to put controls / systems in place?)</i>	GAPS IN ASSURANCE <i>(Where are we failing to gain evidence about our system/ controls?)</i>	RATING			
14.1516	Well Led Workforce Committee	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 • Implemented star award • Leadership walkaround and feedback process in place	<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 accreditation - Bronze award	• Cultural barometer indicators to be developed • Continued difficulty in engaging clinical staff	• 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	Current	Target	
									3x4 = 12	3x4 = 12	1x4 = 4
Action					Timescales			Lead			
Full roll out of WTGR programme IIP and Staff FFT action plan to be delivered					March April			Greengage JE			
Links to risk register: No corporate (>15) risks											

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY													
Ref	OWNER Board committee Exec Lead		RISK DESCRIPTION <i>(What is the risk?)</i>	KEY CONTROLS <i>(How are we managing the risk?)</i>	POSITIVE ASSURANCE & SOURCES <i>(How do we know it is working?)</i>	GAPS IN CONTROL <i>(Where are we failing to put controls / systems in place?)</i>	GAPS IN ASSURANCE <i>(Where are we failing to gain evidence about our system/ controls?)</i>	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 regulatory 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 • Cash action plan delivered	<u>First line</u> Divisional Board reports <u>Second line</u> Turnaround Executive Reports Monthly scrutiny at Finance and Performance Committee and Board Integrated Board report including CQUIN delivery reporting <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 Well Led Governance Review Internal Audit Report on divisional performance management arrangements	• £0.5M 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	Initial	Current	Target			
									3x5 = 15	3x5 = 15	2x5 = 10		
Action					Timescales					Lead			
Continued close monitoring of financial position / contract challenges for 2015/16					March					KG			
Links to risk register: Risk 4706 - failure to achieve financial plans													

TRUST GOAL: 4. FINANCIAL SUSTAINABILITY												
Ref	OWNER Board committee Exec Lead		RISK DESCRIPTION <i>(What is the risk?)</i>	KEY CONTROLS <i>(How are we managing the risk?)</i>	POSITIVE ASSURANCE & SOURCES <i>(How do we know it is working?)</i>	GAPS IN CONTROL <i>(Where are we failing to put controls / systems in place?)</i>	GAPS IN ASSURANCE <i>(Where are we failing to gain evidence about our system/ controls?)</i>	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 • Participation in WYAAT and WY Urgent Care vanguard enabling discussions on collaboration 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 full gateway assurance process • Ongoing pressures in Trust may result in continued expenditure and therefore need to identify additional savings		Initial	Current	Target		
									4x5 = 20	4x5 = 20	2x5 = 10	
Action				Timescales				Lead				
Further work to be done to identify savings and test through gateway process				February				AB				
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 <i>(What is the risk?)</i>	KEY CONTROLS <i>(How are we managing the risk?)</i>	POSITIVE ASSURANCE & SOURCES <i>(How do we know it is working?)</i>	GAPS IN CONTROL <i>(Where are we failing to put controls / systems in place?)</i>	GAPS IN ASSURANCE <i>(Where are we failing to gain evidence about our system/ controls?)</i>	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 - EY appointed to develop 5 year plan. 5 Year Strategic Plan completed at end December 2015 and updated in January 2016 to take account of 16/17 planning guidance. Plan approved by Trust Board in January 2016.t	<u>First line</u> WEB assessment of direction of travel <u>Second line</u> Board scrutiny and approval of 5 Year Plan. Hospital Services Programme Board discussions to ensure plan aligned with local health economy plans - this has enabled CCGs in January to confirm decision to commence public consultation on future configuration of hospital services. <u>Third line</u> PRM meetings with Monitor and Roundtable discussions with CCGs, Monitor and NHSE. Monitor oversight of strategy development process. NHSE assurance of CCG processes and	The Five Year Strategic Plan has been agreed and submitted to Monitor. An application has been made to DH for the required external funding support. CCGs have taken the decision to commence public consultation. Therefore the aim of developing a 5 Year plan has been achieved. The ongoing areas of work / gaps in control relate to: CCG confirmation of the timescale and process for public consultation and the outcome of the application for funding support to DH to enable the proposed reconfiguration.	• Monitor yet to provide formal feedback on the 5 year plan and the application for DH funding support.	Initial	Current	Target		
Action					Timescales			Lead				
Continue to work with CCGs and JOHSC on the process of public consultation.					May			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 <i>(What is the risk?)</i>	KEY CONTROLS <i>(How are we managing the risk?)</i>	POSITIVE ASSURANCE & SOURCES <i>(How do we know it is working?)</i>	GAPS IN CONTROL <i>(Where are we failing to put controls / systems in place?)</i>	GAPS IN ASSURANCE <i>(Where are we failing to gain evidence about our system/ controls?)</i>	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 additional activity or to compete in competitive market Impact - financial sustainability - viability of certain services - inability to offset cost pressures	• Clearly articulated 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> NHS Calderdale CCG decision not to go out to tender on community services and collaborative work to progress Calderdale Vanguard New Models of Care. 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 • Depth of clinical coding to be improved to ensure trust is paid appropriately for activity	• Lost CC2H Kirklees tender	Initial	Current	Target			
						3x4 = 12			4x4 = 16	2x4 = 8			
Action					Timescales					Lead			
Continued work with WYAAT (West Yorkshire Association of Acute Trusts) and WYUEC (West Yorkshire Urgent and Emergency Care Network) to explore and develop shared opportunities for improving clinical and financial viability. This will include assesement of the opportunities identified in the Carter Review.					March					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 indicator
CSU	Commissioning 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 Case
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 Griffiths, Executive Director of Finance
MG	Mandy Griffin, Interim Director of the Health Informatics Service
AH	Alex Hamilton, Associate 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

Approved Minute

Cover Sheet

Meeting: Board of Directors	Report Author: Andrea McCourt, Head of Governance and Risk
Date: Thursday, 25th February 2016	Sponsoring Director: Julie Dawes, Director of Nursing
Title and brief summary: Risk Register - Corporate Risk Register - This paper presents to the Board the corporate risk register as at February 2016 for review	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: The Risk and Compliance Group reviewed the risk register at its meeting on 9 February 2016	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

The role of the Board is to assure itself that all risks are accurately identified and mitigated adequately by reviewing the risks identified on the CRR.

Background/Overview:

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

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

The Issue:

The attached paper includes:

- A summary of the Trust risk profile as at February 2016 which identifies the highest scoring risks (with scores of 25, 20, 16 and 15), risks with increased scores, risks with reduced scores, any new risks and any closed risks.
- The Corporate Risk Register which identifies 18 risks and the associated controls and actions to manage these.

Next Steps:

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

Recommendations:

Board members are requested to:

- consider, challenge and confirm that potential significant risks within the Corporate Risk Register are under control
- consider and approve the current risks on the risk register

- advise on any further risk treatment required.

Appendix

Attachment:

COMBINED RISK REGISTER - FEB 2016.pdf

Appendix E1

CORPORATE RISK REGISTER REPORT

Risks as at 12 February 2016

TOP RISKS
6131 (20): Progression of service reconfiguration impact on quality and safety 2827 (20): Over-reliance on middle grade doctors in A&E 4706 (20): Failure to meet cost improvement programmes 4783 (20): Outlier on mortality levels 6345 (20): Staffing risk, nursing and medical 6346 (20): Ability to deliver service transformation risk 6503(20): Delivery of Electronic Patient Record Programme
RISKS WITH INCREASED SCORE
No risks have increased in score.
RISKS WITH REDUCED SCORE
Risk 6131 has reduced in score from 25 to 20 due to the commencement of public consultation on service reconfiguration in February. Risk 6078 regarding appointment slots has been reduced from a score of 16 to a score of 12 and is being managed within the divisional risk register governance arrangements.
NEW RISKS
There are no new risks to be added to the Corporate Risk Register in February 2016. The following risks will be reviewed at the Risk and Compliance Group on 9 March for inclusion on the corporate risk register: • Inability to deliver the capital programme • Infection control cleaning risk at HRI (risk 6361) • Infection control curtain risk (risk 6558) • Monitor staffing expenditure cap • Divisional governance arrangements • Operational impact of the imposition of 2016/17 financial control totals, as notified by Monitor in January 2016
CLOSED RISKS
No risks have been closed.

CORPORATE RISK REGISTER –FEBRUARY 2016 Summary of Risks by Risk Type

Risk Ref	Strategic Objective	Risk	Executive Lead (s)	Sept. 2015	Oct. 2015	November 2015	December 2015	January 2016	February 2016
		Strategic Risks							
6346	Transforming & Improving Patient Care	Capacity and capability to deliver service reconfiguration	Director of Nursing (JD)	20	20	20	20	20 =	20 =
6503	Transforming & Improving Patient Care	Non delivery of Electronic Patient Record Programme	Chief Executive	-	-	-	20!	20=	20=
		Safety and Quality Risks							
6131	Transforming & Improving Patient Care	Progress of reconfiguration, impact on quality and safety	Director of Commissioning and Partnerships (AB)	25	25	25	25	25 =	20 ↓
4783	Transforming & Improving Patient Care	Outlier on mortality levels	Medical Director (DB)	20	20	20	20	20 =	20 =
2827	Developing Our workforce	Poor clinical decision-making in A&E	Medical Director (DB)	20	20	20	20	20 =	20 =
6299	Keeping the base safe	Failure of high risk medical devices	Director of Estates and Performance (LH)	15	15	15	15	15 =	15 =
5806	Keeping the base safe	Urgent estate work not completed	Director of Estates and Performance (LH)	16	16	16	16	16 =	16 =
6300	Keeping the base safe	Clinical, operational and estates risks	Director of Nursing	16	16	16	16	16=	16=
6594	Keeping the base safe	Radiology risk acting on diagnostic test findings	Medical Director (DB)	-	-	-	-	16!	16=
6598	Keeping the base safe	Essential skills training data	Interim Director of Workforce and OD	-	-	-	-	16!	16=
		Financial Risks							
4706	Financial sustainability	Failure to meet cost improvement plans and not adhere to financial governance	Director of Finance (KG)	20	20	20	20	20 =	20 =
6130	Financial sustainability	Loss of income / service due to commissioner procurement decisions	Director of Commissioning and Partnerships (AB)	16	16	16	16	16=	16=
6150	Keeping the base safe	Cash flow risk	Director of Finance (KG)	-	15	15	15	15 =	15 =
6027	Keeping the base safe	Suspension of capital programme risk	Director of Finance (KG)	-	15!	15	15	15 =	15 =

		Performance and Regulation Risks							
6499	Keeping the base safe	CQC Inspection Outcome	Director of Nursing (JD)	15	15	15	15	15 =	15 =
2828	Keeping the base safe	Slow patient flow and breach of A&E targets	Director of Nursing (JD)	16	16	16	16	16 =	16 =
6596	Keeping the base safe	Timeliness of serious incident investigations	Director of Nursing	-	-	-	-	16!	16=
		People Risks							
6345	Keeping the base safe	Ability to deliver service transformation	Medical Director (DB) , Director of Nursing (JD), HR Director	20	20	20	20	20 =	20 =
6057	Keeping the base safe	Clinical Administration workforce	Chief Operating Officer	-	-	-	15!	15=	15=

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

Trust Risk Profile as at 8 January 2016

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Rare (1)					
Unlikely (2)					
Possible (3)				= 6094 Potential loss of training grade posts	= 6299 – Medical Device failure levels = 6150 Cash flow risks = 6027 Suspension of capital risk programme = 6057 Clinical administration workforce
Likely (4)				= 2828 – Slow patient flow & breach of A&E targets due to bed blockages / transport = 5806 – Urgent estate work not completed = 6078 – Insufficient appointment slots = 6130 = Loss of income/services due to commissioner procurement decisions = 6300 – Clinical, operational and estates risks outcome = 6503 – Non delivery of EPR programme = 6594 – Radiology risk/ diagnostic tests = 6596 – Serious Incident investigations = 6598 – Essential Skills Training Data	= 2827 – Over reliance on middle grade doctors in A&E = 4706 – Failure to meet CIP & 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
! New risk since last period

↓ decreased score since last period
↑ increased score since last period

Risk No	Div	Dep	Dir	Opened	Status	Goal	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initial	Current	Target	Further Actions	Review	Target	RC	Exec Dir	Lead
6131	Corporate	Commissioning & Partnerships	Commissioning & Partnerships	Oct-2014	Active	Transforming and improving patient care	There is a risk that the Trust will not be able to quickly progress service reconfiguration due to the requirements of a consultation process initiated by local CCG's resulting in delays to important clinical quality and safety issues e.g: Compliance with A&E National Guidance Compliance with Paediatric Standards Compliance with Critical Care Standards Speciality level review in Medicine Unable to meeting 7 day standards Difficulties in recruiting and retaining a medical workforce (increased reliance on Middle Grades and Locums) Increased gaps in Middle Grade Doctors Dual site working is one of the causes of the Trust's underlying deficit. Delays in being able to reconfigure services will impact on the Trust's financial recovery plan. During the period of public consultation there is a risk of an impact on the Trust's reputation. ***It should be noted that risks 2827 and 4783 should be read in conjunction with this risk.	The continued funding of medical staff on both sites Nurse led service managing Paediatrics Critical care still being managed on both sites High usage of locum doctors Frequent hospital to hospital transfers to ensure access to correct specialties The Trust has developed a contingency plan should it not be able to provide sufficient medical staffing to provide safe A&E services on two sites. Consultant rotas cannot always be filled substantively to sustain services on both sites but locum arrangements used 5 year plan completed in December 2015 and agreed with CCGs. Emergency Pregnancy Assessment and Emergency gynae clinic both changed to be delivered from CRH following public engagement and engagement with Kirklees Overview and scrutiny Committee. Change implemented January 2016. Dual site working additional cost is factored into the trust's financial planning.	Interim actions to mitigate known clinical risks need to be progressed.	25 5 x 5	20 5 x 4	15 5 x 3	The Trust has developed and is discussing with CCGs options for progressing interim actions to mitigate known clinical risks. Public engagement has commenced on Cardiology and Respiratory inpatient change. A change in consultant recruitment process (that commenced during January 2016) will reduce time to appointment. February Update: Calderdale and Greater Huddersfield CCGs have decided to undertake public consultation on the proposed reconfiguration of hospital services. The period of public consultation will commence during February and extend over a 14 week period.	Monthly	Oct-2016	WEB	Anna Basford	Catherine Riley
6346	Trustwide	All Divisions	All Departments/Wards	Jul-2015	Active	Transforming and improving patient care	Capacity and Capability of Delivering Service Transformation Risk of not achieving service transformation due to insufficient capacity and capability across the organisation to deliver the many transformation schemes underway whilst keeping the base safe (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 whilst keeping the base safe.	16 4 x 4	20 4 x 5	15 3x 5	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. January Update: PMO Office mapping key deadlines and impact of transformation schemes to inform discussion of risk mitigation February Update: PMO continues to map key milestones to ensure critical milestones are managed. Held team development session with executive team to agree behaviours and mindset required to lead this change.	Monthly	Mar-2016	WEB	Julie Dawes	Assistant Director of Quality, 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, Ophthalmology, 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 - lack of therapy staffing as unable to recruit to Band 5 and Band 6 Physiotherapists, Occupational Therapists, Speech and Language Therapists and Dieticians in both the acute hospital and in the community across a number of different teams 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) There is a risk that patients in the extra capacity wards (6A, 5B, 4D and HRI11) cannot be safely cared for due to insufficient nursing staff across the whole acute medical directorate - there is no	Nurse Staffing To ensure safety across 24 hour period: - use of electronic duty roster for nursing staffing, approved by Matrons - risk assessment of nurse staffing levels for each shift and escalation process to Director of Nursing to secure additional staffing - staff redeployment - staff skill mix, eg extend roles of nursing / Allied Health professionals - 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 Ward based medical staff reviewing patients daily- escalation to responsible Consultant Consultant allocated to review daily as outliers Escalation of patients who become acutely unwell to return as priority to speciality bed base. Band 7 and matron reviewing ward daily Band 6 appointed. Staff released from other wards for 6 months. Gaps in controls - Inability to recruit qualified nurses to cover gaps.	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). January Update Additional support is being arranged through HR to build a better understanding of the gaps in the medical and therapy workforce February Update: Finalising report on vacancy position within therapy staffing	Mar-2016	Mar-2016	MLG	David Birkenhead, Julie Dawes & Jackie Green	Lindsay Rudge, Jason Eddleston & Claire Wilson

Major	6345	Trustwide	All Divisions	All Departments/Wards	Jul-2015	Active	Keeping the base safe	Staffing Risk 6345 continued	Staffing risk 6345 continued	Risk 6345 cont.	16 4 x 4	20 4 x 5	9 3 x 3	Nursing recruitment - investigate the possibility of outsourcing flexible workforce department	Mar-2016	MLG	David Birkenhead, Julie Dawes & Jackie Green	Lindsay Rudge, Jason Eddleston & Claire Wilson
								There is a risk that patients in the extra capacity wards (6A, 5B, 4D and HRI11) cannot be safely cared for due to insufficient nursing staff across the whole acute medical directorate - there is no established workforce for these areas and the directorate has on average 50WTE Band 5 vacancies at any one time ongoing, resulting in possible harm to patients, poor management of deteriorating patients, poor patient experience and negative feedback.	Medical Staffing Establishment of the Medical Workforce Group chaired by the Medical Director, dealing with recruitment and selection, international recruitment, non-contract spend, speed up the Consultant recruitment process and controlling the deployment of staff by improved rota management. Exit interviews for Consultants are being conducted.	Medical Staffing Lack of: - workforce plan / strategy for medical staff identifying level of workforce required - dedicated resource to develop workforce model for medical staffing - centralised medical staffing roster (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 patient Therapy staffing Lack of: - workforce plan / strategy for therapy staff identifying level of workforce required - dedicated resource to develop workforce model for therapy staffing - system to identify changes in demand and activity, gaps in staffing and how this is reflected through block contract - flexibility within existing funding to over recruit into posts/ teams with high turnover			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). January Update Additional support is being arranged through HR to build a better understanding of the gaps in the medical and therapy workforce February Update: Finalising report on vacancy position within therapy staffing					

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 6131 should 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 Business Continuity Plan awaiting approval of Urgent care Board covering ability to provide safe services for varying periods of time October 2015 4 Consultant posts advertised in June 15 still vacant as no applications and under consideration for international recruitment December 2015- Recruited to 1 consultant post. To advertise posts again. Locum consultant now in post.	Mar-2016	Aug-2016	WEB	David Birkenhead	Dr Mark Davies/Mrs Bev Walker
Major	4706	Corporate	Finance	Corporate Finance	Jun-2011	Active	Financial sustainability	The Trust is planning to deliver a £20m deficit (excluding restructuring costs) in 2015/16. There is a risk that the Trust fails to achieve it's financial plans for 2015/16 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/outourcing 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 4 x 5	10 5 x 2	Plans to be agreed to manage gains or losses following tendering process. February update: Re-forecast year end position submitted to Monitor in late November is to deliver a year end deficit of £20.94 against the originally planned £20.0m deficit (excluding restructuring costs). Inclusion of restructuring costs at £1.10m brings the overall re-forecast deficit to £22.04m. The Trust continues to aim to meet the £20.0m deficit (excluding restructuring costs), operational pressures in the final quarter bring further risk to achievement of this, the latest forecast is £20.7m (excluding restructuring costs and other exceptional items)	Feb-2016	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. October update: Improvements in coding noticed. Professor Mohammed, mortality expert, has made recommendations which are being progressed. plan To commission Royal College review into some key services. January update Depth of coding increasing, Palliative care coding actions being implemented, Reliability in sepsis care improving. February Update - Palliative care coding improving. Consultant coding leads developing improvement plans, mortality reviews continue at similar level of compliance, SHIMI position is now an outlier	Mar-16	Aug-2016	COB	David Birkenhead	Juliette Cosgrove
Major	6503	Corporate	THIS	THIS Modernisation	Dec-2015	Active	Transforming and improving patient care	RISK of: non - delivery of Electronic Patient Record Programme due to failure to deliver the transformation associated with not achieving the key deliverables around timescales, engagement and financial targets causing CRB to not be realised, significant cost overruns which ultimately could make the programme unsustainable. The Trust along with its partners BTHFT (Bradford Teaching Hospitals Foundation Trust) and Cerner are implementing an EPR system that will enable service transformation whilst improving patient safety and patient and clinician experience. This is a summary risk, EPR risks escalated at Transformation Group will be brought to R&C by exception. This will impact on patient care, safety and patient experience and mean the expected financial benefits of EPR programme will not be realised.	A Well-developed Governance Structure in place underpinned by a contract between CHFT and Cerner and a partnership agreement between CHFT and BTHFT. Management of EPR programme risks using Best Practice MSP (Managing Successful Programmes) methodology and EPR specific risk register Executive sponsorship of the programme with CEO's chairing the Transformation Board Separate assurance process in place Clinical engagement from divisions Clearly identified and protected funding as identified in the Full Business Case. All Risk and issues are recorded on the programme risk and issue register and managed by the EPR Risk Review Board.	- Further divisional engagement required - A more in depth understanding of the transformational change is required within the clinical divisions. The impact on activity during go live will be significant and the changes in processes post go live will be equally significant. An understanding, acceptance and support will be essential to success. - Completed future state review by all parties including Cerner - This is essential to understand what the fundamentals will look like post go live. - Financial offsetting for 16/17 to mitigate against the reduction in activity during go live and short term post go live.	20 5 x 4	20 5 x 4	5 5 x 1	- Continual monitoring of actual programme risk and issues log - Any risks escalated to the Transformation Board brought to this committee - Access to the full EPR Risk Log will be made available to R&C group via the Cerner Portal if required, any escalations from transformation group will be brought to R&C by the programme leads.	Mar-2016	Sep-2017	RC	Mandy Griffiths	Mandy Griffin

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. There is a risk that patients in the extra capacity wards (6A, 5B, 4D and HRI11) cannot be safely cared for due to insufficient nursing staff across the whole acute medical directorate - there is no established workforce for these areas and the directorate has on average 50WTE Band 5 vacancies at any one time ongoing, resulting in possible harm to patients, poor management of deteriorating patients, poor patient experience and negative feedback.	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). Ward based medical staff reviewing patients daily-escalation to responsible Consultant. Consultant allocated to review daily as outliers. Escalation of patients who become acutely unwell to return as priority to speciality bed base. Band 7 and matron reviewing ward daily. Band 6 appointed. Staff released from other wards for 6 months. Gaps in controls - Inability to recruit qualified nurses to cover gaps.	Despite the controls, the bed base is still insufficient at certain times. Occupancy levels remain high. The night period is particularly vulnerable. The number of patients who are a delayed transfer of care have increased and social care have limited capacity to transfer patients into the community with support.	20 4 x 5	20 4 x 5	16 4 x 4	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 or agency for this ward. December/January update: Further Winter capacity beds established to ensure timely patient flow on 8B and 4D at CRH and Ward 4 at HRI. Approval to high cost agency via flexible workforce. Each extra capacity area given dedicated Matron support . System wide Silver command meetings ongoing. Detailed bed modelling 2016/17 with Foureyes. Clear plans to provide Senior nurse leadership in all areas. However these areas are high risk and current bed reduction plan being implemented to close additional flex beds above plan. Feb update System wide gold meetings held w/c 25th Jan, some increased discharges but no sustainable improvement. Escalation to gold commanders, formal risk summit requested, meeting of gold commanders taking place. CCG Quality lead attended Trust for walkround , plan to attend again in February /March. Further system actions agreed, including the implementation of a daily MDT led by Urgent Care change lead and joined by acute Trust and LA staff, publication of transfer of care summary data, review of effectiveness of non-hospital resilience plans and capacity descriptor from across the system Further discussion at SRG 16th Feb 16. Issues escalated to Board of Directors w/c 8th February with Board conference call held to discuss options to retract beds; options currently having an risk assessment undertaken. Wd4 closed 12th February as an output of the MDT work, ward 4 to close by 22nd February followed by Ward 8b to facilitate elective work recommencement. Work on 16/17 resilience plans commenced with focus on actions other than bed increases, to be concluded before	Mar-2016	Apr-16	CG	Helen Barker	Sajid Azeh

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 I) A&E Resus requires more space. J) Poor fitting windows on MAU at HRI	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. F) Staff aware of issue; decant to be planned to enable re-skimming of floor G) Windows repaired (temporary) & heaters provided H) Cofley aware of CCU Flooring which is being monitored prior to decanting ward to refurb under lifecycle. I) Project to move switchboard to another location to enable expansion of Resus J) Windows are of an age and difficult to open / close without significant force.	B) ICU Floor - monitored by Estates until opportunity to decant ward and fully replace,. 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 life-cycle replacement however monitored prior to decant. I) A&E resus area requires expansion at HRI J) Understand size of problem with windows on Wards at HRI.	16 4 x 4	16 4 x 4	8 4 x 2	B) ICU floor to be monitored until decant possible. H) CCU Flooring at CRH will be monitored until decant possible. I) A&E Resus area to be identified at HRI. J) Review condition of windows Trust wide Dec 15 Update Feasibility on A&E Resus Area taking place. Review state of windows across HRI wards. Jan 16 Update Review of windows completed at HRI and temporary fixes made on wards (based on risk). Curtains hung at windows on a number of wards. Feb 16 Update Curtains hung at windows on a number of wards and temporary fix to close windows carried out by estates	May-2016	Mar-2017	RC	Lesley Hill	Paul Gilling / Chris Davies

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. Key areas of concern identified for CQC self assessment: Medical Care: safe, responsive and well-led domain Urgent and Emergency Services - safe domain Community Services for Adults -- safe domain	- 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 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 October Update: External support for assurance on key areas. Date of inspection confirmed. CQC handbook to all staff (October 2015) and focus groups being held with staff November update Assurance inspections commenced with actions for divisions identified Additional capacity to be brought into the corporate team to assist planning for the inspection Risks that are unlikely to be mitigated prior to inspection to be identified throughout November to inform overall position January Update CQC data submitted. Self assessments submitted identifying 5 areas requiring improvement. February Update: CQC self assessment completed identifying areas for improvement. Provider Information request submitted. Action plan ongoing to improve compliance, High level of visibility of clinical and managerial staff to support changes.	Month: y	May-16	WEB	Julie Dawes	Juliette Cosgrove
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 competitive procurements. This could have negative impact by increasing the Trust's underlying deficit and on the clinical resilience and stability of retained services.	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. February Update: Decision made by Kirklees local authority to award sexual health contract to Locala resulting in TUPE of CHFT staff and loss of contract and associated income from 1st April 2016. CHFT (working with the GP Federation) has been selected through an 'Any Qualified Provider' (AQP) process to provide Fertility services in Bradford.	Apr-2016	Apr-2016	CISC	Anna Basford	Rob Aitchison & Lisa Williams

Major	6594	Family & Specialist Services	Radiology	CT & MRI	Jan-2016	Active	Transforming and improving patient care	Acting upon radiological results This risk relates to how radiology clinical results are received and acted on by the referring clinician. It is the responsibility of the referring clinician to act upon any findings reported in a diagnostic tests. On occasions there may have been examples where important clinical results were followed up, with instances such as these posing a potentially significant risk to patients. This risk has been identified by a recently reported incident. Without appropriate action been taken there is a potential risk to patient safety.	Radiology reports are flagged to referring clinicians when important findings are recorded, a manual system utilising the **Alert Process is in place where Radiology seek to inform clinicians of these findings. The current process does not however guarantee that a clinician has read and acted upon these results.	- No current electronic system to record that Radiology reports have been received. - No failsafe system in place to ensure that referring clinicians have acted upon the results of a finding.	16 4 x 4	16 4 x 4	4 1 x 4	Initial paper submitted by Radiology describing a set of future actions that will required to minimise risks, copy of paper attached. Deputy Director of Nursing to lead an urgent, Trust-wide task and finish group to respond to this risk which will report in March 2016	Apr-2016	Apr-2016	Serious Incident Review Group	David Birkenhead	Lindsay Rudge
Major	6596	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Jan-2016	Active	Keeping the base safe	Risk of not conducting timely investigations into serious incidents (SIs). due to not responding quickly enough to the new national SI framework introduced in March 2015, resulting in delayed learning from incidents, concerns from commissioners and delays in sharing the findings with those affected.	- Revised Incident Reporting Policy aligns with national framework, with template reports, clarity on process for divisional sign off and Trust sign off of SIs. - Director led panels held weekly to ensure quality assurance of final reports. Meet commissioners monthly on SIs - Patient Safety Quality Boards review of serious incidents, progress and sharing of learning - Accurate weekly information for divisions identifying serious incidents and timescales for completion of reports - Investigator Training - 1 day course held monthly to update investigator skills and align investigations with report requirements. - Recent introduction of Serious Incident Review group chaired by Chief Executive to ensure senior Trust wide oversight and peer challenge of SIs - Interim resource in place in Risk Management to oversee management of Serious Incident Investigations	1. Lack of capacity to undertake investigations in a timely way and 2. Need to improve sharing learning from incidents within and across Divisions 3. Training of investigators to increase Trust capacity and capability for investigation	16 4 x 4	16 4 x 4	8 4 x 2	1. Capacity - recruitment taken place for dedicated investigation resource in Governance and risk team - final stages of recruitment process being completed 1. Ongoing delivery of Effective Investigation Training Course (1 day, monthly) 2. Greater identification and sharing of learning from each SI, sharing within PSQBs and across division through reporting and SI review group	Apr-2016	Apr-2016	QC	Director of Nursing, Julie Dawes	Juliette Cosgrove
Major	6598	Corporate	Workforce, OD & Training	Training	Jan-2016	Proposed for Acceptance	Keeping the base safe	There is a risk of being unable to provide essential skills training data for some subjects and where data is available this is not always set against a target audience. Therefore the organisation cannot be assured that all staff have the relevant essential skills to practice safely. This is due to the data being held in a devolved structure with no required target audience setting mechanism or central gathering/recording process. This will result in a failure to understand essential skills training compliance against set targets across the whole of the organisation.	There is an essential skills matrix which aims to identify all the essential skills training within the organisation. There is a training strategy proforma to capture the target audience for essential skills subjects. Clinical supervision/preceptorship structures are in place to monitor staff compliance with essential skills training. We have a learning management system, Oracle Learning Management (OLM) which can centrally record training attendance and compliance against a target where one is set within it's functionality limitations.	1/ Essential skills training data held is inconsistent and patchy. 2/ target audiences setting to allow compliance monitoring against a target is inconsistent and patchy 3/ Functionality of the OLM system is limited and cannot facilitate disaggregated target audience setting. A manual system to facilitate the actions above will be required.	16 4 x 4	16 4 x 4	12 4 x 3	1/ A data gathering exercise is currently ongoing to draw in all existing essential skills training data and will be completed by end January 2016 2/ Target audience setting for all essential skills subjects will be completed by end Feb 2016 3/ A manual system to accommodate recording and reporting to the level required must be designed and implemented to facilitate full reporting/monitoring by end March 2016. There are resource implications in completing this action.	Mar-2016	Mar-2016	NA	Interim Director of Workforce and	Bev France

Major	6027	Corporate	Finance	Corporate Finance	May-2014	Active	Financial sustainability	There is an operational risk that the Trust will have to suspend its capital programme for 2015/16 due to having insufficient cash to meet on-going commitments resulting in a failure to develop infrastructure in support of a sustainable future for the organisation. This also risks knock on reputational damage to the Trust	• Agreed loan from Independent Trust Financing Facility (ITFF) received in April 15 to support capital programme, specifically Electronic Patient Record (EPR). • Capital programme has been risk assessed and reduced based on this risk assessed process. • Capital programme managed by Capital Planning Group and overseen by the Commercial, Investment and Strategy Group, including forecasting and cash payment profiling. • Discussed and planned for distressed funding cash support from Monitor. • Agreed re-profiling of cash payments of clinical contract income with commissioners to support treasury management in the short term. • Cash Committee established	Distressed cash support through 'Revenue Support Loan' not yet approved by Monitor.	16 4 x 4	15 5 x 3	10 5 x 2	Working Capital Facility from the Independent Trust Financing Facility (ITFF) approved in September 2015 to secure cash in advance of approval for Revenue Support Loan being sponsored by Monitor to ITFF. February update: The Trust has reviewed its planned capital programme for 2015/16 and considers that there is scope to reduce the programme up to the value of £1.0m without having an adverse impact on patient safety. Discussions with Monitor have concluded that there is no option to transact a capital to revenue transfer. The latest forecast is an under spend of £0.7m due to additional CQC related expenditure.	Feb-2016	Mar-2016	WEB	Keith Griffiths	Kirsty Archer
Major	6150	Corporate	Finance	Trustwide	Nov-2014	Active	Financial sustainability	There is a risk that the Trust will not be able to pay suppliers, staff and PDC loans due to cash flow timing or an overall shortfall of cash resulting in external scrutiny, significant reputational damage and possible inability to function as a going concern	• Agreed capital loan from Independent Trust Financing Facility received in April 15 • Agreement with main Commissioners to maintain their matching cash flow payments prior to agreement of contracts for 2015/16 • Capital Programme restricted by risk assessing and prioritising schemes • Cash forecasting processes enhanced through 13 week rolling forecasts • Discussed and planned for Distress Funding cash support from Monitor • Trust's Standards Operating Procedures for Treasury Management and Accounts Payable give authority to withhold payments to suppliers • Agreed re-profiling of cash payments of clinical contract income with commissioners to support treasury management in the short term. • Cash management committee being initiated to review and implement actions to aid treasury management.	Distressed cash support through 'Revenue Support Loan' not yet formally approved by Monitor.	15 5 x 3	15 5 x 3	10 5 x 2	Working Capital Facility from the Independent Trust Financing Facility (ITFF) approved in September to secure cash in advance of approval for Revenue Support Loan being sponsored by Monitor to ITFF. February update: Pro-active cash management actions continue	Mar-2016	Mar-2016	FPC	Keith Griffiths	Kirsty Archer

Major	6507	Trustwide	All Divisions	All Departments/Wards	Dec-2015	Active	Keeping the base safe	There is a risk of patients coming to harm due to the current capacity and capability gap within the clerical and admin workforce. - Issues with Clinical Administration infrastructure Variation and ambiguity in the roles and responsibilities of 'Clinical Admin' staff, reliance upon temporary staff, decline in the provision of training, staff working in isolation, teams too small to provide support 52 weeks of the year, variation within in the processes and procedures of the administrative pathways which enable the clinical pathways, numerous handoffs, inconsistent ratio of case holding clinicians to the number of clinical admin team members supporting them. - Voice recognitionAs part of a wider recurrent opportunity savings scheme a number of medical secretaries/typists took voluntary redundancy and left CHFT between 2014 and May 2015. Implementation of VR has been delayed due failure to develop a product which is complete and stable. The VR solution is currently being tested and that testing phase is forecast to be completed by the end of February 2015. The current proposed timescale for the workable solution is between February to July 2016. This is resulting in time delays and failure demand within the current workflow including: - Clinical letter turnaround, outpatient, booking of follow-up pre-treatment outpatient appointments, response to inbound telephone call answering, booking of diagnostic & therapeutic appointments), result receipt, review & action, scheduling of inpatient treatment, consultant to consultant and provider to provider referral, turnaround of discharge letters, booking of FU appointments, response to inbound telephone call answering. This may result in a negative impact upon the patient pathway macro process measures, outcome measures associated with the workflow activities, e.g. increased cancellations	- Divisional performance framework (in part) - Transforming our clinical Admin programme board (Clinical Admin Team & Voice Recognition projects) - Voice Recognition – meeting capacity & capability gap through the use A&C temporary resource (agency)	Gaps In Controls - Interim operational capacity deficit reduction plan and multi divisional clinical administration performance framework – to be mitigated following a review and options exploration by the ADD's and Programme Lead (Transforming our Clinical Admin) - Comprehensive (multi divisional) and standardised clinical administration operating model and performance framework (Process and outcome measures). This gap will be mitigated by implementation of the 'Clinical Admin Team' (C.A.T) model (Project) proposed implementation date of C.A.T is October/November 2016. - Implementation of the Electronic Patient Record (Programme) - Digitalisation of aspect of the manual process, proposed implementation date of E.P.R is September 2016. - Implementation of the Voice Recognition software - gap to be mitigated once the Voice Recognition software has proved successful in the testing phase (18.12.2015 milestone) and successfully implemented (July 2016)	15	15	6	C.A.T: Turnaround Executive to make investment decision E.P.R: System implementation August 2016	Apr-2016	Mar-2017	NA	Chief Operating Officer	Helen Barker/Rob Alitchison
											5 x 3	5 x 3	3 x 2						

Major	6299	Trustwide	All Divisions	All Departments/Wards	May-2015	Active	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.	Maintenance prioritised based on categorisation / risk analysis of medical devices Tight control of management of service contracts to ensure planned preventative maintenance (PPM) activity performed. PPM programme being developed. Progress monitored by Health & Safety Committee ensuring recruitment issues, database, risk analysis of devices is progressing. Recruitment of administrator and 1 Medical Engineer	1. PPM Programme development ongoing. 2. Complete review Medical Device database to ensure accuracy 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 completed 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. January Update Work to improve the situation continues. January 2016 medical device backlog report confirms work in progress and will be presented to February Patient Safety Group. Feb Update PPM scheduling in progress using additional bank resource.BOC on HRI site to carry out inspection/maintenance activities of a number of devices. Overtime offered to give improved focus. Database audit continues using existing staff. Additional support brought in (Med Device Engineering & Admin for training database). Improvement shown in completed maintenance activities. Improvement shown on review of devices on database.	May-2016	Mar-2017	DB	Lesley Hill	V Wotherspoon

Approved Minute

Cover Sheet

Meeting: Board of Directors	Report Author: Andrea McCourt, Head of Governance and Risk
Date: Thursday, 25th February 2016	Sponsoring Director: Julie Dawes, Director of Nursing
Title and brief summary: Risk Management Policy - To present to the Board for approval the Risk Management Policy	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Risk and Compliance Group - 12 January 2016 Audit and Risk Committee - 20 January 2016 WEB	
Governance Requirements: This paper describes the Trust's risk management system that is a key part of the Trust's system of internal control	
Sustainability Implications: None	

Executive Summary

Summary:

The paper details how the Trust manages risks, duties and responsibilities, governance of risk and the risk management process,
Further operational guidance has been included to support staff articulating, scoring and closing risks on the risk register.

Main Body

Purpose:

The Risk Management Policy has been reviewed in line with it's scheduled review date of February 2016.

Background/Overview:

A Risk Management Policy was agreed in February 2015, having previously formed part of a Governance Strategy.

The policy has been reviewed as it has now been in place for one year.

The Issue:

The Risk Management Policy covers both clinical and non clinical risk.

Next Steps:

Following the Audit Committee, comments have been received by the Chair of the Audit Committee. These will be discussed and reviewed, with agreed changes being made to the policy following this.

Recommendations:

The Board is asked to approve the Risk Management Policy.

Appendix

Attachment:

DRAFT Risk Management Policy feb 2016.pdf

Calderdale and Huddersfield

NHS Foundation Trust



Risk Management Policy

Version 2

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

Document Summary Table		
Unique Identifier Number	G/101/2015	
Status	Approved	
Version	1 (previously formed part of the Governance Strategy)	
Implementation Date	February 2015	
Current/Last Review Dates		
Next Formal Review	February 2016	
Sponsor	Director of Nursing	
Author	Risk Manager/Company Secretary	
Where available	Trust Intranet	
Target audience	All Staff	
Ratifying Committees		
Name of Ratifying committee		
Board of Directors		TBC
Consultation Committees		
Committee Name	Committee Chair	Date
Risk & Compliance Group	Director of Nursing/Assistant Director	12 January 2016
Audit and Risk Committee	Non-Executive Director	27 January 2016
Weekly Executive of Directors	Chief Executive/Chair	18 February 2016
Other Stakeholders Consulted		
Stakeholders who were consulted on this document		

Does this document map to other Regulatory requirements?	
Regulator details	Regulator standards/numbers etc

Document Version Control	
Version no	Details of review/alterations, rationale for document etc
1	The Risk Management Strategy used to form part of the Trusts Governance Strategy. The Risk process has been removed from this to form its own policy.
2	Risk Management Policy review in line with scheduled review date

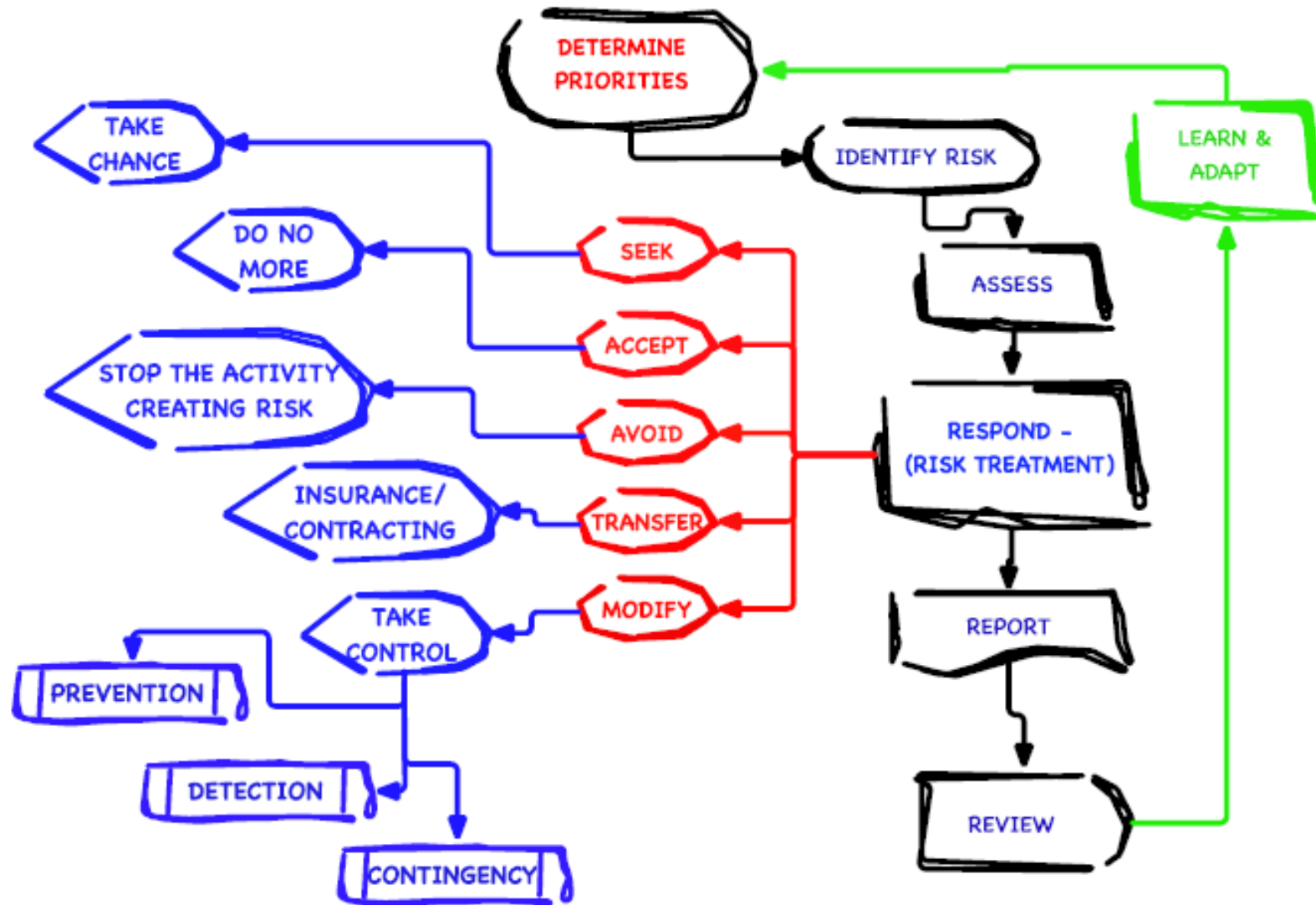
CONTENTS

Section	Page No.
Key Points for Staff	3
At A Glance: The Risk Management Process	4
1 Introduction	6
2 Objective	6
3 Scope of Policy	7
4 Roles and Responsibilities	8
5 The Risk Management Process:	11
Step 1: Determine Priorities	11
Step 2: Identify Risk	11
Step 3: Assess Risk	11
Step 4: Respond to the Risk	11
Step 5: Report Risk	12
Step 6: Review Risk	13
6 Training	14
7 Equality and Diversity	15
8 Monitoring and Audit	15
9 Associated documentation and references	16
 Appendices	
Appendix 1: Glossary of Terms used within Policy	20
Appendix 2 Risk Register Guidance - Risk Description	21
Appendix 3: Assessing Risk and Calculating Residual Risk	22
Appendix 4: Risk Grading	24

Key Points for Staff

- The primary purpose of risk management is to:
 - Reduce harm for patients, staff, visitors or contractors;
 - Continuously improve patient experience, safety and quality performance.
 - Promote the success of Calderdale & Huddersfield NHS Foundation Trust (“CHFT”) by ensuring it is an organisation which manages risk effectively and reduces risks that threaten the delivery of the Trust’s objectives, putting in place actions that reduce the likelihood and impact of each risk to reach an acceptable level;
 - Protect everything of value to the Trust (such as reputation, market share, exemplary clinical outcomes);
- When identifying risk we anticipate what could stop us from achieving our objectives or goals. To help identify areas of risk we look at our historical performance and trends, previous events, current challenges, and needs of people who use our services as well as thinking about future scenarios or potential outcomes that could help or hinder the delivery of our strategy. We are all required to be open, honest, think ahead and take an active part in identifying risk.
- Risk analysis involves estimating the severity (the impact the risk has on the Trust and people in our care) and likelihood (the probability of that impact happening). The scores are multiplied to give an overall risk rating. The risk rating is used to determine risk management priorities and monitor acceptable amounts of risk. Colleagues are required to challenge constructively any assumptions made regarding severity and likelihood, and to strive to ensure risk is kept within agreed tolerance.
- Risk is treated proactively using a combination of prevention, detection and contingency controls. **Prevention** controls ensure activities are performed in a certain way and typically involve policies, clinical or operational procedures, guidelines, training or computer systems. **Detection** controls alert management to any deficiencies preventing risk and typically involves performance monitoring, audits, alarms or tests. **Contingency** controls are designed to allow the Trust to recover from a failure to manage risk and allow the Trust to continue to function albeit in a modified way. Colleagues are required to understand and implement all controls designed to manage risk at the Trust.
- Organisational learning is reflected in the Trust’s ability to continuously reduce the frequency of the same adverse event (incident, complaint or claim), and continuously improve performance. Controls are monitored and continuously improved as part of an open and learning culture.
- Risk management is everyone’s responsibility. This policy applies to all Trust employees, contractors or volunteers working at the Trust.

At a Glance: The Risk Management Process



1. Introduction

This document is the policy for the management of all types of risk at CHFT, both clinical and non clinical. Risk management is an integral component of the Trust's Quality Governance Framework. By complying with the organisational arrangements described in this document, services will ensure the effective identification, assessment and control of risk thereby promoting and supporting the achievement of objectives.

The achievement of the Trust's strategic objectives is subject to uncertainty, which gives rise to both opportunities (desirable risk) and threats (undesirable risk). Risk management includes identifying and assessing risks and responding to them in an effective and resilient manner. This policy defines the framework and systems that the Trust uses to manage risk.

At all times the Trust will take all reasonably practicable steps to protect patients, staff, visitors and contractors from the risk of harm.

The Trust's governance framework will be supported by an effective risk management system that delivers continuous improvements in safety and quality, and maximises opportunity for growth and development. Risk management provides a solid foundation upon which to build a culture of high reliability wherein clinical and organisational excellence can flourish.

2. Aims/Objective

The overall purpose of risk management at the Trust is to:

1. **Reduce the level of exposure to harm for patients, colleagues or visitors** by proactively identifying and managing personal risk to a level as low as reasonably practicable
2. **Continuously improve performance** by proactively adapting, remaining resilient to changing circumstances or events, and learning.
3. **Promote success and protect everything of value** to the Trust, such as high standards of patient care, safe working environment, the Trust's safety record, reputation, community relations, equipment or sources of income

The Trust will establish an effective risk management system which ensures that:

- All risks that have a potential adverse effect on quality of care, safety and wellbeing of people, and on the business, performance and reputation of the Trust are proactively identified and managed well
- There is a structured and systematic approach to risk management across the Trust that supports the delivery of the Trust's strategic objectives
- Priorities are determined, continuously reviewed and expressed through objectives that are owned and understood by all staff

- Controls are put in place, effective in their design and application to manage risks, and risk treatment is understood by those expected to apply control
- All staff have a responsibility to comply with controls, whilst the operation of controls is monitored by management
- Gaps in control are rectified
- Management are held to account for the effective operation of controls
- Assurances are reviewed regularly and acted on
- Staff continuously learn and adapt to improve safety, quality and performance
- Risk management systems and processes promote the ethos that risk management is everyone's business and are embedded within the organisation and locally across divisional teams and in corporate services including business planning, service development, financial planning, project and programme management and education.

The Trust will achieve this by:

- Developing and driving a clear strategy to meet patient needs
- Actively engaging openly with patients and the public, colleagues and stakeholders
- Anticipation of opportunities or threats and responsive adaptation through an explicit risk management process
- Ensuring that regular, effective and sufficient assessments of risk are carried out in all areas of the Trust's operations
- Providing training to keep risk under prudent control
- Investigating thoroughly, learning and acting on defects in care
- Liaising with enforcing authorities, regulators and assessors
- Effective oversight of risk management through team and committee structures
- Formulation and implementation of policies and procedures for all significant hazards arising from the Trust's undertakings
- Effective reporting and arrangements to hold staff to account

3. Scope of this Policy

Risk management is everyone's responsibility. This Policy applies to all employees, contractors and volunteers. All employees will co-operate with the Trust in managing and keeping risk under prudent control. Specific responsibilities are placed on members of the management team for ensuring the requirements of this policy are met within their respective areas of control. Specific roles and responsibilities for risk management are summarised at Section 4 below.

Effective employee engagement is vital to our success and vision to provide care all of us would recommend to family and friends. Our values and

behaviours set out “*the way we do things around here*” and these guide our work.

Our vision is :

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

Our guiding behaviours are:

- We put the patient first
- We go see
- We work together to get results
- We do the must dos

By wholeheartedly embracing our values and behaviours in all risk management activity, this policy supports high performance and fosters a culture that is confident about resilience; respects diversity of opinion; involves staff, patients and partners in all that we do; and improves capacity to manage risk at all levels of the organisation.

4. Roles and Responsibilities

In order to achieve the aims of this policy the following roles, accountabilities and responsibilities apply:

Specific Duties & Responsibilities

The **Chief Executive** has overall accountability to the Board of Directors for effective risk management. The Chief Executive is responsible for ensuring priorities are determined and communicated, risk is identified and managed in accordance with the Board’s appetite for taking risk.

The **Director of Nursing**, on behalf of the Chief Executive, is the Board lead for risk management processes across the Trust. They shall, on behalf of the Board, implement and maintain an effective system of risk management. The Director of Nursing is responsible for:

- (i) risk management policy development;
- (ii) developing and communicating the Board’s appetite for taking risk;
- (iii) establishing mechanisms for scanning the horizon for emergent threats and keeping the Board sighted on these; and
- (iv) monitoring the management of risk across divisions. In the event of unsatisfactory compliance with the risk management process or unacceptable risk exposure, the Director of Nursing will escalate the matter to a relevant Executive Director for their immediate attention and action.

All Executive, Clinical, Divisional and other Directors have a specific responsibility for the identification and prudent control of risks within their

sphere of responsibility. They are responsible for ensuring effective systems for risk management within their division and directorates and ensuring that their staff are aware of the risk management policy and their individual responsibilities. They shall intervene robustly to ensure teams within their sphere of control follow the risk management process. In addition, Executive Directors, Clinical and all other Directors will also be responsible, where required, for the provision of specialist advice to the Board of Directors. This acknowledges that all Directors are subject matter experts and have specific responsibilities for interpreting and applying national policy, legislation and regulations in respect of their specific areas of expertise.

Ward Sisters/Charge Nurses/ Service Managers / Departmental Managers

- are responsible for ensuring effective systems for risk management and risk registers are in place at ward and departmental level.

Head of Risk & Governance - has day-to-day responsibility for risk management process, quality governance and safety management. They will report to the Director of Nursing for:

- (i) the development of risk management policy;
- (ii) administration of risk management systems;
- (iii) oversight of risk exposures facing the business;
- (iv) provision of risk management training and support to divisions; and
- (v) the maintenance of the corporate risk/safety management plan. They will be responsible for the maintenance and reporting of the Corporate Risk register and carry out sufficient checks within and across divisions to monitor the management of risk alongside the Board's appetite for taking risk. They will be responsible for the effectiveness of the Risk Register system, a governance system on which the Board depend, taking whatever action is necessary with colleagues, or the system Vendor, to ensure its effectiveness, validity, data quality and data completeness. The Head of Risk & Governance will take the lead in triangulating lessons for learning ensuring defective arrangements, alerts or changes in practice are conveyed to front line teams promptly and acted upon.

Company Secretary – is the lead officer for the Board Assurance Framework ("BAF") supported by the Executive Directors and is responsible for the co-ordination and the updating of the BAF, ensuring that the information is reported appropriately. They shall also be responsible for ensuring that the BAF and risk register are aligned.

Generic Duties and Responsibilities

See table below:

Main Duties	Board of Directors	Executive Director	Divisional & Clinical Director	Other Managers	All Employees
Strategy & Policy	- Determine the Trust's vision, mission and values - Set corporate strategy - Provide leadership	- Develop and oversee the implementation of strategic plans - Develop and communicate corporate objectives - Proactively anticipate risk - Provide leadership and guidance to employees, business partners and stakeholders	- Develop and Implement Clinical Strategy - Alignment of divisional objectives to Trust strategy	Alignment of team/personal objectives to Trust strategy	- Deliver personal objectives - Abide by Trust values and behaviours
Organise	- Establish an effective risk management system - Establish and keep under review the Board's appetite for taking risk - Focus on material risk and proactive anticipation of future risk	- Develop & apply Risk Management Process - Accept and allocate ownership for risk - Share ownership for cross-enterprise risk	- Apply Risk Management Process - Accept and allocate ownership for risk - Proactively anticipate risk - Provide leadership and guidance	- Apply Risk Management Process - Accept and allocate ownership for risk - Proactively anticipate risk - Provide leadership and guidance	- Follow Risk Management Process - Accept ownership for risk
Plan & Control	- Decide what opportunities, present or future, the Board wants to pursue and what risks it is willing to take in developing the opportunities selected - Routinely, robustly and regularly scan the horizon for emergent opportunities and threats by anticipating future risks - Decide whether or not a risk can be accepted - Simultaneously drive the business forward whilst making decisions which keep risk under prudent control	- Design, apply and monitor the operation of controls to ensure the achievement of objectives and promote organisational success - Ensure failure does not disable – contingencies are in place and tested for all reasonably foreseeable situations - Allocate, structure and prioritise resources within and across divisions or directorates so that risk is managed in accordance with the Board's risk appetite.	- Design and apply controls to manage risk in line with the Board's appetite for taking risk - Prepare risk management mitigation plans - Ensure adequate emergency preparedness and contingencies for foreseeable disruptive events - Manage resources to optimum effect - Develop policies, guidelines, procedures and standards to govern the management of risk locally	- Design and apply controls to manage risk in line with the Board's appetite for taking risk - Remain alert to risk - Manage resources to optimum effect - Develop and implement risk management plans	- Undertake and keep up to date with mandatory training and other relevant training - Follow policies, clinical standards and relevant procedures - Act on lessons for learning
Monitor	Keep under review material risk exposures that are not accepted by the Board at each formal meeting	Challenge, support, supervise and hold colleagues to account for performance and continuous improvement	Monitor the operation of controls and address identified gaps in control	Supervise the work of others to ensure controls are applied correctly	Report concerns, defects, adverse events or failures to contain risk adequately.
Audit	- Determine Audit priorities using a risk-based approach - Take account of reports from the Audit Committee	- Determine Audit Priorities using a risk-based approach - Assist Internal Audit where required and ensure recommendations are acted upon by relevant colleagues - Account for control of risk to the Audit Committee where required	- Assist Internal Audit where required and ensure recommendations are acted upon by relevant colleagues - Account for control of risk to the Audit Committee where required - Undertake appropriate inspection/checks of controls for safety critical procedures	- Cooperate fully and assist Internal Audit, - Challenge recommendations if they are not agreed - Develop and implement changes in practice within the timescales agreed - Report when concluded.	- Cooperate with Internal Audit and act on their findings - Carry out instructions based on agreed audit recommendations
Review	- Effectively hold those responsible for managing risk to account for performance and continuous improvement. - Take decisions	Report to the Board all material risks and significant gaps in control	- Report to the Board all material risks and significant gaps in control - Escalate risk in accordance with this Policy - Ensure all risks are reviewed correctly		

5. Risk Management Process

Step 1: Determine Priorities

Risk is defined as anything that is stopping or could prevent the Trust from providing safe and sustainable clinical services, and from being successful (for a summary of key terms used in this document see Appendix 1). The Board of Directors and Senior Management will be clear about objectives for each service and express these in specific, measurable, achievable ways with clear timescales for delivery.

Step 2: Identify Risk

Evaluating what is stopping, or anticipating what could prevent the Trust from achieving stated objectives/strategic priorities, annual plans, financial plans, delivering safe clinical services will identify risk. Risks should not be confused with issues, which are things that have happened, were not planned and require management action.

Risk identification concerns future events; it involves anticipation of failure and is based upon consideration of strengths, weaknesses, opportunities or threats.

Risks need to be clearly described to ensure there is a common understanding by stakeholders of the risk. The recommended way for describing a risk is **risk of.....due to resulting in**, as follows:

Steps to write a risk	
Identify the risk	Risk of
Identify the cause of the risk	Risk due to
Identify the impact of the risk	Risk results in

Appendix 2 includes guidance on how to write a risk.

The identification of risk is an ongoing process and is never static, but is particularly aligned to the annual planning process and compliance requirements.

Staff may draw on a systematic consideration of reasonably foreseeable failures alongside incident trends, complaints, claims, patient/staff surveys, observations, formal notices, audits, clinical benchmarks or national reports to identify risk. This list is not exhaustive. In order to do this the Board of Directors, senior leaders and divisional teams will identify what is uncertain, consider how it may be caused and what impact it may have on the objective and service.

Step 3: Assess Risk

All risks must be assessed in an objective and consistent manner. Risks are assessed on the probability, i.e. the likelihood of a risk happening and on what would happen (impact) should the risk occur.

The magnitude of a risk can be estimated by multiplying the severity of impact by the likelihood of the risk occurring using a standard 5x5 risk scoring matrix to score likelihood and impact of a risk.

The Trust procedure uses three risk scores:

- **Initial risk score** - this is the score when the risk is first identified and is assessed with existing controls in place. This score will not change for the lifetime of the risk and is used as a benchmark against which the effect of risk management will be measured
- **Current risk score** - this is the score at the time the risk was last reviewed in line with review dates. It is expected that the current risk score will reduce and move towards the target / residual risk score as action plans to mitigate risks are developed and implemented
- **Target / residual risk score** - this is the score that is expected after the action plan has been fully implemented

Staff should be realistic in the quantification of severity and likelihood and use, where appropriate, relative frequency to consider probability. A guide to calculating target / residual risk and risk scoring matrix guidance is provided in appendices 2 and 3.

Step 4: Respond to the Risk

There are a number of different options for responding to a risk¹. These options are referred to as risk treatment strategies. The main options most likely to be used include:

- **Seek** - this strategy is used when a risk is being pursued in order to achieve an objective or gain advantage. *Seeking risk must only be done in accordance with the Board's appetite for taking risk.*
- **Accept / Tolerate** - this strategy is used when no further mitigating action is planned and the risk exposure is considered tolerable and acceptable. Acceptance of a risk involves maintenance of the risk at its current level (any failure to maintain the risk may lead to increased risk exposure which is not agreed).
- **Avoid / Terminate** - this strategy usually requires the withdrawal from the activity that gives rise to the risk.
- **Transfer** - this strategy involves transferring the risk in part or in full to a third party. This may be achieved through insurance, contracting, service agreements or co-production models of care delivery. *Staff must take*

advice from the Executive Team before entering into any risk transfer arrangement.

- **Modify** - this strategy involves specific controls designed to change either the severity, likelihood or both. This is the most common strategy adopted for managing risk at the Trust. For this reason, we expand on the nature of control as follows:

The following three types of control are used to modify risk:

- (i) **Prevention/Treatment** - these controls are core controls and are designed to prevent a hazard or problem from occurring. They typically involve policies, procedures, standards, guidelines, training, protective equipment/clothing, pre-procedure checks etc.
- (ii) **Detection** - these controls provide an early warning of core control failure, such as a smoke alarm, incident reports, complaints, performance reports, audits
- (iii) **Contingency** - these controls provide effective reaction in response to a significant control failure or overwhelming event. Contingency controls are designed to maintain resilience.

A combination of all 3 types of control is usually required to keep risk under prudent control.

Step 5: Report Risk

All risks must be recorded on the Risk Register. It is the responsibility of each division to maintain and monitor their divisional risk registers and ensure they feed into the Corporate Risk Register which is an integral part of the Trust's system of internal control and defines the risks which may impact on the Trust's ability to deliver its objectives.

Risks which score 15 or higher must be brought to the attention of the Head of Risk and Governance for escalation to the appropriate committee for consideration and potential inclusion on the Corporate Risk Register. The Risk and Compliance Group will also consider for inclusion on the corporate risk register risks scored at 12 as highlighted by the divisions. The Corporate Risk Register prioritises risk, populated from risk assessments carried out both at a strategic and operational level.

The Risk and Compliance Group, on behalf of the Quality Committee and Board, oversees the Corporate Risk Register, with identified Board Committees or groups overseeing the management of risks on behalf of the Trust.

Key outputs from the risk management system will be reported to relevant staff/committees depending on the residual risk score as follows:

- ≥ 15 – each formal meeting of the Board of Directors
- ≥ 10 – [Relevant] Committee of the Board of Directors as part of the Committee's annual work plan
- ≥ 8 – Specialty/Divisional /Departmental Governance meeting at least

- quarterly
- ≥6 – Ward/Departmental Management at least annually

The BAF is the document that holds all risks which may prevent the achievement of the Trust's strategic objectives. All risks from the BAF are presented to the Board, via the Executive Board. All other Board committees may make recommendations for including or amending strategic or significant risks. Containing only high level risk, this document is brought to the attention of the Board at each of its public meetings

The **Board of Directors** will also receive summary reports at each formal meeting to inform them of all material risk, the nature of controls and action plans. The risk profile will be part of the Chief Executive's report and cover as a minimum the risk source, description of the risk, the residual risk, main controls, date of review and risk owner.

The **Risk & Compliance Group is a sub-committee of the Audit and Risk Committee**. It will receive reports to monitor the quality, completeness and utilisation of risk registers, and also to oversee of the distribution of risk across the Trust. Reports will cover the risk description, the residual risk (exposure after control), main controls, date of review and risk owner.

The Quality Committee, which has a specific role for clinical risks, received the risk register on a monthly basis.

Divisions have access to the Risk Register and produce system generated Divisional specific reports in order to review the identification of risks within their wards, departments and specialties, and check that adequate controls are in place and actions are being implemented.

Divisions need to ensure that local governance arrangements are in place that provide assurance about the effectiveness of risk management systems and processes within directorates within the Division.

Patient Safety Quality Boards within Divisions regularly review the divisional risk register to ensure that these capture all risks within the division and their Directorates and report on their risk registers on a quarterly basis to the Quality Committee.

The Executive Team will be informed by the Director of Nursing (or relevant Executive Director) of any new significant risk arising at the first meeting opportunity.

The Audit and Risk Committee will scrutinise assurances on the entire risk management system to ensure it remains fit for purpose and, at the Committee's discretion, will examine assurances on the operation of controls for all significant risk exposures or any other risk of interest to the Committee.

Urgent Escalation - in the event of a significant risk arising out with meetings of the above, the risk will be thoroughly assessed, reviewed by the relevant

Clinical Director, Associate Director of Nursing, Divisional Manager and Executive Director and reported to the Chief Executive (or their deputy) within 24 hours of becoming aware of the risk. The Chief Executive, with support from relevant members of the Executive Team and advisors, will determine the most appropriate course of action to manage the risk. The Chief Executive will assign responsibility to a relevant Executive Director for the management of the risk and the development of mitigation plans. The risk will be formally reviewed by the Executive Team at their next weekly meeting.

Step 6: Review Risk and Risk Closure

Risks will be reviewed at a frequency proportional to the residual risk. Discretion regarding the frequency of review is permitted. As a guideline it is suggested, as a minimum, risk is reviewed as follows:

- ≥ 15 – at least monthly
- ≥ 10 – at least quarterly
- ≥ 8 – at least bi-annually
- ≤ 6 – annually.

Risk Closure

A risk can be closed and moved to the closed section of the electronic risk register system for audit purposes when:

- i. There is a change in practice which removes the hazard;
- ii. Where the risk / event has passed
- iii. where it is clear that the action taken to treat a risk eliminates all reasonably foreseeable exposure to that risk.

Completion of actions does not necessarily mean that a risk can be eliminated and closed.

Each division should have governance arrangements which define a clear process for authorising the closure of risks by managers / through appropriate directorate / department or divisional meeting and ensure that all staff are aware of this.

Corporate Risk Register - for risks scoring 15 or above which are included within the Corporate Risk Register, risks that are proposed for closure should be reviewed for closure by the Risk and Compliance Group prior to closing the risk.

It is good practice to periodically audit closed risks to satisfy that the risk is no longer present.

The Committees of the Board

The totality of the Trust's risk governance infrastructure includes the oversight provided by Board committees in their risk-related roles. Committees of the Board of Directors play a vital role in effective risk management and will apply the following principles to enable the Board to keep risk under prudent control at all times:

- a) oversee and advise the Board on current risk exposures and future risks to the Trust's strategy;
- b) oversee risk appetite and tolerance for those areas under the Committees purview;
- c) address risk and strategy simultaneously taking into account assurance on the operation of control, the current and prospective macro-economic, public policy and financial environment;
- d) challenge the Trust's analysis and assessment of risk;
- e) advise the Board on risk treatment and strategy;
- f) oversee due diligence appraisal of any proposed strategic transactions involving acquisition, merger or disposal;
- g) evaluate risk management capability;
- h) examine risks associated with emerging regulatory, corporate governance and industry best practices; and
- i) consult experts to optimise risk treatment where necessary.

6. Training

Risks may be identified pro-actively by managerial review, analysis of incidents, complaints, claims or outcomes of safety inspection and/or audit. Root cause analysis may also be a source of risk identification. To ensure that all risks are identified, accurately described, appropriately controlled and consistently documented the following risk management tools are in place:

a) Risk Register

The Risk Register provides a mechanism for recording details of each risk within a database so that risk records can be analysed and facilitate effective oversight of risk management at all levels. When agreed all risk assessments must be entered onto the risk register.

b) Risk Management Training

Training is required to effectively manage risks in line with the process set out above. Bespoke risk management training will be available to teams, tailored to their specific needs. This could include sessions on :

- operational use of the electronic risk register system and guidance on how to articulate a risk, controls and actions (group or individual)
- advice and guidance on management of risk in their area
- peer review of risk registers
- support with the development of risk registers

- i) The Board of Directors and Senior Managers (which for the purpose of this policy are defined as Directors, Associate Directors, Clinical Directors and Assistant Directors) will receive training and/or briefings on the risk management process by staff from the Governance and Risk team. In addition, supplementary briefings will be provided as required following

publication of new guidance or relevant legislation.

- iv) Divisional, Ward and Departmental managers will have further more detailed risk management process training incorporating how to use the Risk Register database before access to the database is enabled.
- v) Staff designated to regularly undertake Root Cause Analysis will have the opportunity to undertake Root Cause Analysis training.

7. Equality Impact Statement

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

8. Monitoring and Audit

The following indicators will form the Key Performance Indicators by which the effectiveness of the Risk Management Process will be evaluated:-

- All verified significant risks are reported to the Board of Directors at each formal meeting of the Board
- All significant risks are reported to and reviewed as a standing agenda item at each formal meeting of a Committee of the Board
- Risks of ≥ 15 are reviewed by the Risk and Compliance **Group**, with risks of 12 also reviewed when requested by divisions.
- Local risk registers are in place, maintained and available for inspection at ward/departmental level
- Local risk registers show details of control, assurances, location, owner, action plan (where necessary) and $\geq 80\%$ of risks are within review date and none are overdue for review by 6 or more months.

Compliance with the above will be monitored by the Head of Risk & Governance, reviewed by the Director of Nursing and reported within an annual report submitted to the Quality Committee.

The following mechanisms will be used to monitor compliance with the requirements of this document:

- Evidence of reporting verified significant risk exposures to the Board of Directors at each formal meeting
- Evidence of review of significant risk exposure by the Risk & Compliance Group at each formal meeting of the Group
- Periodic internal audit of any or all aspects of the Risk Management process as determined by the Audit and Risk Committee (risk

identification, assessment, control, monitoring and reviews).

9. Associated Documents/Further Reading

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

- Incident Reporting, Investigation and Management policy
- Complaints policy
- Claims policy
- Inquest Policy
- Being Open / Duty of Candour Policy
- Major Incident policy
- Blood Transfusion policy
- Capability policy
- Consent Policy
- Falls Prevention and Management policy
- Fire Policy
- Freedom of speech/Whistleblowing policy
- Health and Safety policy
- Induction policy
- Infection Control policies
- Information Governance Strategy and associated policies
- Mandatory Training Policy
- Medicines Management policies
- Medical Devices policy
- Moving and Handling policy
- Patient Identification policy
- Personal Development Review
- Policy on the Appointment of Medical locums
- Policy for Developing Policies
- Policy on the implementation of NICE guidelines
- Promoting Good Health at Work Policy
- Race Equality Scheme

NHS England Risk Management Policy 2013

Moore P., A. (2013) *Countering the Biggest Risk Of All: attempting to govern uncertainty in healthcare management*. London. Good Governance Institute

Chapman R., J. (2012) *Simple tools and techniques for enterprise risk*

Audit Commission (2009) *Taking it on Trust: a review of how boards of NHS Trusts get their assurance*. London. Audit Commission

BSI (2008) *Risk Management - Code of Practice*. BS 31100:2008. London. British Standard International

NPSA (2004) *Seven Steps to Patient Safety*. London. NPSA

DH (2003) *Building the Assurance Framework: A Practical Guide for NHS Boards*. London. Department of Health

DH (2000) *An Organisation with a Memory*. London. HSMO

Glossary of Terms used within Policy

Risk management will operate under a common language. Adopting standard risk management terms and definitions set out in the Risk Management Code of Practice (BS 31100:2008) will improve consistency and avoid confusion. Common terms may include:

Board Assurance Framework	A document setting out material risk and assurances on the operation of controls to manage those risks	Risk	Effect of uncertainty on objectives
Control	An intervention used to manage risk	Risk acceptance	Informed decision to take a particular risk
Exposure	Extent to which the organisation is subject to an event	Risk aggregation	Process to combine individual risks to obtain more complete understanding of risk
Hazard	Anything that has potential for harm	Risk analysis	Process to comprehend the nature of risk and to determine the level of risk
Incident	Event in which a loss occurred or could have occurred regardless of severity	Risk appetite	Amount and type of desirable risk the organisation is prepared to seek, accept or tolerate
Inherent risk	Exposure arising from a specific risk <u>before</u> any intervention to manage it	Risk assessment	Overall process of risk identification, risk analysis and risk evaluation
Level of Risk	Overall magnitude of a risk. It can be significant, high, moderate, low or very low.	Risk avoidance	Decision not to be involved in, or to withdraw from, an activity based on the level of risk
Material Risk	Most significant risks or those on which the Board or equivalent focuses	Risk management	Coordinated activities to direct and control the organisation with regard to risk
Near Miss	Operational failure that did not result in a loss or give rise to an inadvertent gain	Risk owner	Person or entity with the specific accountability and authority for managing the risk and any associated risk treatments
Operational Risk	The risk of loss or gain, resulting from internal processes, people and systems or from external events	Risk Register	A record of information about identified risks.
Programme Risk	Risk associated with transforming strategy into solutions via a collection of projects	Target Risk	A level of risk being planned for
Residual risk	Current risk. The risk remaining <u>after</u> risk treatment		

Appendix 2

Risk Register Guidance - Risk Description

This section describes how to articulate a risk for the risk register.

Risk description should describe the risk, what is causing the risk (i.e. What the risk is due to) and the impact.

The risk should be articulated clearly and concisely with appropriate use of language, suitable for the public and with acronyms spelt out in the first instance.

Think of the risk in 3 parts and write it using the following phrases:

There is a risk of.....

This is due to / caused by.....

Will result in / have an impact on

The example below provides a useful guide to help staff define the risk accurately and precisely:

Objective: To travel from Huddersfield Royal Infirmary to Calderdale Royal Hospital for a meeting at a certain time.		
Risk Description		Comment
Failure to get from HRI to CRH for a meeting at a certain time	X	This is simply the converse of the objective
Being late and missing the meeting	X	This is a statement of the impact of the risk and not the risk itself
Eating on the shuttle bus is not allowed so I was hungry	X	This does not impact on the achievement of the objective
Missing the shuttle bus causes me to be late and miss the meeting	√	This is a risk that can be controlled by ensuring I allow enough time to get to the shuttle bus stop
Severe weather prevents the shuttle bus from running and me getting to the meeting	√	This is a risk that I cannot control but against which I can make a contingency plan

Be careful and sensitive about wording of risks as risk register are subject to Freedom of Information requests.

Appendix 3

Assessing Risk and Calculating Residual Risk

This section describes how to score risks by estimating severity of impact and likelihood of occurrence using a standard 5x5 matrix. Each risk can be measured by multiplying the severity of harm and the likelihood of that harm occurring, i.e. multiplying the consequence / severity score by the likelihood score.

The Trust procedure uses three risk scores:

- **Initial risk score** - this is the score when the risk is first identified and is assessed with existing controls in place. This score will not change for the lifetime of the risk and is used as a benchmark against which the effect of risk management will be measured
- **Current risk score** - this is the score at the time the risk was last reviewed in line with review dates. It is expected that the current risk score will reduce and move towards the target / residual risk score as action plans to mitigate risks are developed and implemented
- **Target / residual risk score** - this is the score that is expected after the action plan has been fully implemented and refers to **the amount of risk remaining after treatment**.

The Trust uses a standard 5 x 5 scoring matrix set out below:

5x5 Risk Scoring Matrix

SEVERITY INDEX		LIKELIHOOD INDEX*	
5	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure; Total loss of public confidence	5	Very Likely No effective control; or ≥1 in 5 chance within 12 months
4	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Divisions; Extended service closure	4	Somewhat Likely Weak control; or ≥1 in 10 chance within 12 months
3	Moderate harm – medical treatment required up to 1 year; £100k – £1m loss; Temporary disruption to one or more Divisions; Service closure	3	Possible Limited effective control; or ≥1 in 100 chance within 12 months
2	Minor harm – first aid treatment required up to 1 month; £50k - £100K loss; or Temporary service restriction	2	Unlikely Good control; or ≥1 in 1000 chance within 12 months
1	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Extremely Unlikely Very good control; or < 1 in 1000 chance (or less) within 12 months

*Use of relative frequency can be helpful in quantifying risk, but a judgment may be needed in circumstances where relative frequency measurement is not appropriate or limited by data.

Appendix 3 cont.

Severity

Severity is graded using a 5-point scale in which 1 represents the least amount of harm, whilst 5 represents catastrophic harm/loss. Each level of severity looks at either the extent of personal injury, total financial loss, damage to reputation or service provision that could result. Consistent assessment requires assessors to be objective and realistic and to use their experience in setting these levels. Select whichever description best fits.

Likelihood

Likelihood is graded using a 5-point scale in which 1 represents an extremely unlikely probability of occurrence, whilst 5 represents a very likely occurrence. **In most cases likelihood should be determined by reflecting on the extent and effectiveness of control in place at the time of assessment, and using relative frequency where this is appropriate.**

Differing Risk Scenarios

In most cases the highest degree of severity (i.e. the worst case scenario) will be used in the calculation to determine the residual risk. However, this can be misleading when the probability of the worst case is extremely rare and where a lower degree of harm is more likely to occur. For example, multiple deaths from medication error are an extremely rare occurrence, but minor or moderate harm is more frequently reported and may therefore have a higher residual risk. **Whichever way the residual risk score is determined it is the highest residual risk score that must be referred to on the risk register.**

Risk Grading

Risk grading makes it easier to understand the division / directorate / Trust risk profile. It provides a systematic framework to identify the level at which the risks must be managed and overseen in the organisation, prioritise actions and resources to address risk and direct which risks should be on the corporate risk register.

Having assessed and scored the risk using the 5x5 risk scoring matrix, use the table below to grade the risk as very low, low, moderate, high or significant.

SCORE	Incident / Risk Grade (NPSA Cat.)	Level of Risk	Communicated to and overseen by	Investigation Level
15 - 25	Catastrophic	SIGNIFICANT	Alert Chief Nurse Reported to Board of Directors	SI Procedures RCA – 45 days (Board notification)
10-14	Major	HIGH	Alert Clinical Director Reported to Risk Management Committee	Divisional RCA – 28 days
8 - 9	Moderate	MEDIUM	Inform Divisional Manager Overseen at Divisional Level	Directorate Analysis – 28 days
4-6	Minor	LOW	Inform Ward/Departmental Manager Oversee at Ward/Departmental Level	Ward/Department Analysis – 10 Days
1-3	None	VERY LOW	Ward/Departmental Management	Ward/Department Analysis – 10 Days

5X5 MATRIX

X	LIKELIHOOD				
		1	2	3	4
Y	1	1	2	3	4
	2	2	4	6	8
	3	3	6	9	12
	4	4	8	12	16
	5	5	10	15	20

Approved Minute

Cover Sheet

Meeting: Board of Directors	Report Author: Carole Hallam, Assistant Director of Infection Prevention Control
Date: Thursday, 25th February 2016	Sponsoring Director: David Birkenhead, Medical Director
Title and brief summary: Quarterly DIPC Report - The quarterly DIPC report provides an update on 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: Quality Committee and WEB	
Governance Requirements: Improving patient experience - reducing healthcare associated infections	
Sustainability Implications: None	

Executive Summary

Summary:

The attached quarterly DIPC report provides an update on healthcare-associated infections including surveillance and audit activity and what actions for improvement are being taken

Main Body

Purpose:

To provide a regular update for the Board of Directors for information

Background/Overview:

as per report

The Issue:

as per report

Next Steps:

Actions required are managed through the Preventing Infections and Improving Prescribing (PIIP) Group, formerly the HCAI Operational Group

Recommendations:

To note the content

Appendix

Attachment:

Quarterly DIPC Report Feb 2016.pdf

Report from the Director of Infection Prevention and Control to the Weekly Executive Board November 2015 to January 2016

Performance targets

Indicator	YTD agreed target	YTD performance	Actions/Comments
MRSA bacteraemia (trust assigned)	0	3	139 days since the last infection
C.difficile (trust assigned)	21	20	5 avoidable and 15 unavoidable cases
MSSA bacteraemia (post admission)	12	8	On track
E.coli bacteraemia (post admission)	29	24	At risk of breaching internal target
MRSA screening (electives)	95%	95.06%	On track
Central line associated blood stream infections (Rate per 1000 cvc days)	1	0.60	On track
Hand hygiene	95%	99.52%	

Quality Indicators

Indicator	YTD performance	Comments
MRSA screening (emergency)	90.80%	December validated data
Isolation breaches	270	
Cleanliness	97.3	

MRSA bacteraemia

To date, there have been 3 post admission cases MRSA bacteraemia: 1 unavoidable and 2 avoidable. 3 pre MRSA bacteraemia cases: 2 unavoidable, 1 avoidable and attributed to CHFT.

MSSA bacteraemias

There have been 8 post-admission MSSA bacteraemia cases to date.

MRSA - Hospital-Acquired Infections (HAIs)

There have been 17 acquisitions this year compared to 22 for the same time period last year. Wards are informed of any HAIs that occur within their area and are asked to carry out a ward-led investigation; these are presented to the PSQBs. If more than one case occurs in a short period of time, an outbreak meeting may be held to identify any issues / concerns and formulate an action plan in order to reduce the risk of further acquisitions.

Clostridium difficile

All post admission cases of C. difficile are investigated by RCA.

Key themes from the C-diff cases are:

- Delay in isolating the patient
- Delay in obtaining stool specimen
- Completion of the Bristol Stool Chart

Work is ongoing to improve compliance with the above issues with the development and roll out of the Nerve Centre.

Escherichia-coli (E-coli) bacteraemias

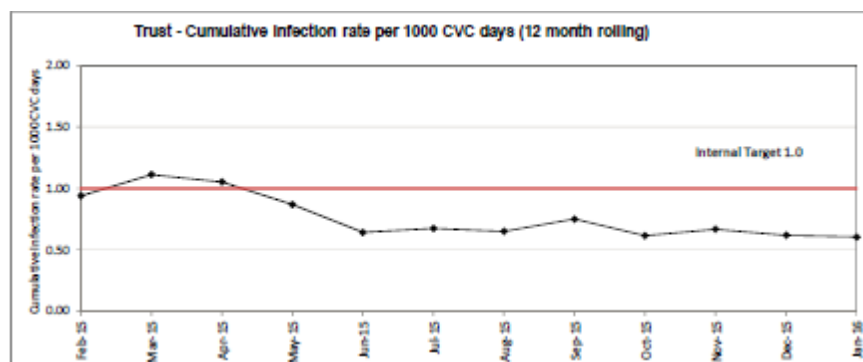
There have been 24 post-admission E-coli bacteraemia cases to date:

- 17 within the Medical Division
- 6 within the Surgical Division
- 1 within the FSS Division

There is currently no capacity to hold a RCA meeting for all post-admission E-coli bacteraemia cases but analysis is currently underway following which a Task & Finish Group will be established to address any areas of improvement identified.

Central Vascular Access Device related bacteraemias

The internally set target for CVAD related bacteraemias is 1 per 1000 CVAD line days. The current rate is 0.6 and below target.



CVAD infections are investigated using RCA. The current improvement work includes standardising all areas to use Chlorhexidine dressings, development of a training package for patients and to include a checklist of understanding and development of a 'CVAD passport' to improve communication when patients have received shared care between different hospitals and community.

Isolation Breaches

Isolation breaches are identified by the IPCNs and followed up daily until the patient has been isolated; assistance is also given to ward staff to risk assess available side-rooms and prompt infection control measures.

There have been 78 isolation breaches during the last three months bringing the total to date as 270. Of the breaches in the last quarter

- 54 were at CRH and 24 were at HRI
- 67 were on medical wards with 37 of these on the medical assessment units

The IPCT will continue to monitor isolation breaches and actions to reduce breaches will be included in the HCAI annual action plan, this includes ongoing work with the nerve centre.

Nasoendoscopes

There is currently an investigation into the decontamination of nasoendoscopes following notification of a failure in the reprocessing cycle. This involves a look back exercise which will involve the contacting of a number of patients. This is being coordinated with the support of Public Health England.

Environmental Quality Improvement Audits

43 Audits have been carried out to date.

- 21 of the areas achieved a green rating
- 21 of the areas achieved an amber rating
- 1 area achieved a red rating.

(Compliance scores: <75% = red rating; 76-90% = amber rating; 91%+ = green rating).

Action plans are produced by the Ward / Department following an audit in order to address any issues or concerns identified; a follow-up audit is completed for areas that only achieve a red rating.

Commode audits

These audits are carried out by the IPCT on a monthly basis. Commodes on all ward areas are inspected to ascertain whether they have been cleaned according to CHFT policy and are ready for use.

- The average score for CRH during 2015 is 80%: scores ranged between 76% and 96%.
- The average score for HRI during 2015 is 80%: scores ranged between 80% and 96%.

Compliance issues include urine splashes to the commodes, including some dried urine and faeces. Results are discussed with ward staff at the time that the audit is carried out and are included on the IPC monthly reports.

CJD audit

A CJD audit was carried out to ascertain whether the appropriate question was being asked of patients due to be admitted to CHFT for elective procedures, including Endoscopy. 30 sets of notes were audited and showed 100% compliance.

CPE (Carbapenemase-producing Enterobacteriaceae)

A CPE audit was carried out during November 2015. 6 wards who take direct admissions were audited to ascertain whether the CPE questions were being asked when a patient was admitted to CHFT.

HRI: MAU and SAU both demonstrated 100% compliance; Ward 3 achieved a compliance rate of 85%.

CRH: 8A and 4C both demonstrated 100% compliance; MAU demonstrated a compliance rate of 93%.

Hand hygiene

The weekly hand hygiene audits continue with staff being encouraged to report actual practice so that any problems may be identified and actions put in place.

Influenza

There has been a significant increase in suspected and confirmed cases of influenza during 2016. There is a lot of IPC information regarding mask usage on the intranet and the IPCT have held many fit testing sessions for staff. It has become apparent that there remains some confusion regarding mask usage and that not all wards / departments have purchased a supply of both surgical masks, disposable FFP3 masks and reusable FFP3 masks and filters, as recommended. Most wards / departments were issued with a 'fit testing' kit some years ago; a 'train the trainer' approach was used however, due to staff turnover, a lot of staff have not been fit tested to ascertain whether they are able to use the disposable masks or need to use the reusable masks. A number of areas e.g. A/E have now decided to buy some reusable masks and filters as this negates the need for fit testing. Staff need to know how to attach the filters to the mask correctly and be able to carry out a fit check in order to ensure that they are adequately protected. This information is available on the staff intranet and the IPCT can also provide support.

ANTT (Aseptic Non-Touch Technique) training for Assessors

The IPCT have now taken over the training for ANTT Assessors. CHFT employs a 'train the trainer' approach. All staff who are involved in patient care and carry out procedures such as removing peripheral venous cannulae (PVCs), emptying urinary catheters, venepuncture and cannulation, wound dressings etc., are required to be assessed as competent for ANTT. This is a once only assessment for most staff however ANTT Assessors need to be reassessed every 2 years.

A training package has now been purchased which will be used to update ANTT Assessors and will also be used to train medical staff. Declarations of competency are entered into a portal on the intranet and figures are produced by the Training Dept. on a monthly basis to indicate how many staff have completed this training.

HCAI Operational Group

The HCAI Operational Group and the Antibiotic Management Team merged to form the Preventing Infection and Improving Prescribing (PIIP) Group in December with new terms of reference. The group will continue to manage the HCAI Action Plan.

Link Infection Prevention & Control Practitioners (LIPCPs)

The IPCT continue to provide 4 workshops per year for the LIPCPs for each ward area and department, plus one aimed specifically at community staff, in order to address specific IPC issues and provide relevant information and support.

Training

The IPCT continue to deliver both planned and ad hoc sessions to all levels of CHFT staff. All clinically-based staff are required to attend 'Right from the Start' sessions at the commencement of employment and thereafter to attend the 'Beyond the Basics' sessions every 2 years. There is an IPC e-learning package that must be completed by all CHFT staff on an annual basis.

HCAI Clinical Champions 'Learning and Sharing' event

The 3rd HCAI Clinical Champions 'Learning and Sharing' event was held on 11th January with 24 senior doctors and nurse attending. There were a range of presentations provided including E. coli bacteraemia surveillance, the intermittent catheters, effective investigations and improvements in vascular access.

IPCNs

The number of IPCNs employed by CHFT has reduced during 2015 with one IPCN taking voluntary redundancy. Two IPCNs have recently retired/leaving during March therefore it is hoped to appoint 2 further IPCNs. This has an impact upon the whole team as training and orientation of newly-appointed staff takes place.

IPCNs continue to work both proactively and reactively, dealing with potential and actual outbreaks and situations as they arise; informing ward staff of results which require further action such as isolating the patient and maintaining enhanced precautions; carrying out planned training sessions and ad hoc sessions upon request; audit and surveillance; reviewing and updating IPC policies. New ways of working are also being adopted with IPCNs being able to enter information straight on to the Nerve Centre so that IPC information is highlighted for the individual patient. The emergency on-call advisory service continues.

Approved Minute

Cover Sheet

Meeting: Board of Directors	Report Author: Juliette Cosgrove, Assistant Director
Date: Thursday, 25th February 2016	Sponsoring Director: David Birkenhead, Medical Director
Title and brief summary: CAIP Report - The Board are asked to receive and approve the CAIP report.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Quality Committee - 26 January 2016	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

Summary of the main discussions in the COG (14th December 2015) an updated Care of the Acutely Ill Patient (CAIP) plan and updates on key areas of improvement work relating to reducing mortality.

Summary:

HSMR is continuing to rise, and SHMI remains broadly unchanged. The official SHMI from HSCIC for July '14 to June '15 will be published on 27th January. We believe it will have risen slightly to 111. It is not clear if that will represent an outlying position or not.

The table below outlines the number and percent of mortality cases reviewed and included the Hogan score of preventability year to date.

April May June July Aug Sept Oct Nov

Total deaths 163 147 129 117 120 117 118 131

Total 1st level reviewed 54 37 39 89 67 74 67 79

% reviewed 33.1 25.2 30.2 76.1 55.8 63.2 56.8 60.3

Hogan 1 48 32 33 75 52 61 56 62

Hogan 2 6 3 3 10 10 8 7 10

Hogan 3 0 0 2 2 2 3 3 4

Hogan 4 0 0 1 0 0 1 2 3

Hogan 5 0 0 0 0 0 1 0 0

Not rated 0 2 0 2 3 0 0 0

Total second level reviewed 1 n/a n/a 0 3 1 1 5 3

Care bundles work is now being managed by a PMO approach: all are being reviewed, with the related audit tool, for implementation in January 2016.

Nervecentre is now in place throughout the trust, except for paediatric areas for which some amendments are required.

An improvement in DNACPR compliance is noted, and positive feedback to a pilot of "DNACPR stickers" has led to a plan to use them Trust-wide.

Work continues within the coding team to recruit qualified coders, for which there is a national shortage, and to improve clinical documentation to facilitate coding. A clinical lead from the Orthopaedic team has been appointed with more expected over the coming months.

Please see updated action plan and Patient Treatment Bundles attached.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board are asked to receive and approve the CAIP report.

Appendix**Attachment:**

COMBINED CAIP REPORT - FEB 2016.pdf

PAPER TITLE: CAIP programme update	REPORTING AUTHOR: Juliette Cosgrove																																																																																																			
DATE OF MEETING: 25 February 2016	SPONSORING DIRECTOR: David Birkenhead																																																																																																			
STRATEGIC DIRECTION – AREA: Keeping the base safe	ACTIONS REQUESTED: - For comment - To note																																																																																																			
PREVIOUS FORUMS: Quality Committee 26.01.2016																																																																																																				
EXECUTIVE SUMMARY: Summary of the main discussions in the COG (14th December 2015) an updated Care of the Acutely Ill Patient (CAIP) plan and updates on key areas of improvement work relating to reducing mortality. Summary: HSMR is continuing to rise, and SHMI remains broadly unchanged. The official SHMI from HSCIC for July '14 to June '15 will be published on 27th January. We believe it will have risen slightly to 111. It is not clear if that will represent an outlying position or not. The table below outlines the number and percent of mortality cases reviewed and included the Hogan score of preventability year to date. <table><tr><td></td><td>April</td><td>May</td><td>June</td><td>July</td><td>Aug</td><td>Sept</td><td>Oct</td><td>Nov</td></tr><tr><td>Total deaths</td><td>163</td><td>147</td><td>129</td><td>117</td><td>120</td><td>117</td><td>118</td><td>131</td></tr><tr><td>Total 1st level reviewed</td><td>54</td><td>37</td><td>39</td><td>89</td><td>67</td><td>74</td><td>67</td><td>79</td></tr><tr><td>% reviewed</td><td>33.1</td><td>25.2</td><td>30.2</td><td>76.1</td><td>55.8</td><td>63.2</td><td>56.8</td><td>60.3</td></tr><tr><td>Hogan 1</td><td>48</td><td>32</td><td>33</td><td>75</td><td>52</td><td>61</td><td>56</td><td>62</td></tr><tr><td>Hogan 2</td><td>6</td><td>3</td><td>3</td><td>10</td><td>10</td><td>8</td><td>7</td><td>10</td></tr><tr><td>Hogan 3</td><td>0</td><td>0</td><td>2</td><td>2</td><td>2</td><td>3</td><td>3</td><td>4</td></tr><tr><td>Hogan 4</td><td>0</td><td>0</td><td>1</td><td>0</td><td>0</td><td>1</td><td>2</td><td>3</td></tr><tr><td>Hogan 5</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>1</td><td>0</td><td>0</td></tr><tr><td>Not rated</td><td>0</td><td>2</td><td>0</td><td>2</td><td>3</td><td>0</td><td>0</td><td>0</td></tr><tr><td>Total second level reviewed¹</td><td>n/a</td><td>n/a</td><td>0</td><td>3</td><td>1</td><td>1</td><td>5</td><td>3</td></tr></table> Care bundles work is now being managed by a PMO approach: all are being reviewed, with the related audit tool, for implementation in January 2016. Nervecentre is now in place throughout the trust, except for paediatric areas for which some amendments are required. An improvement in DNACPR compliance is noted, and positive feedback to a pilot of "DNACPR stickers" has led to a plan to use them Trust-wide. Work continues within the coding team to recruit qualified coders, for which there is a national shortage, and to improve clinical documentation to facilitate coding. A clinical lead from the Orthopaedic team has been appointed with more expected over the coming months.			April	May	June	July	Aug	Sept	Oct	Nov	Total deaths	163	147	129	117	120	117	118	131	Total 1 st level reviewed	54	37	39	89	67	74	67	79	% reviewed	33.1	25.2	30.2	76.1	55.8	63.2	56.8	60.3	Hogan 1	48	32	33	75	52	61	56	62	Hogan 2	6	3	3	10	10	8	7	10	Hogan 3	0	0	2	2	2	3	3	4	Hogan 4	0	0	1	0	0	1	2	3	Hogan 5	0	0	0	0	0	1	0	0	Not rated	0	2	0	2	3	0	0	0	Total second level reviewed ¹	n/a	n/a	0	3	1	1	5	3
	April	May	June	July	Aug	Sept	Oct	Nov																																																																																												
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Please see updated action plan and Patient Treatment Bundles attached.

Below are updates that are included in the Quarterly Quality Report.

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.

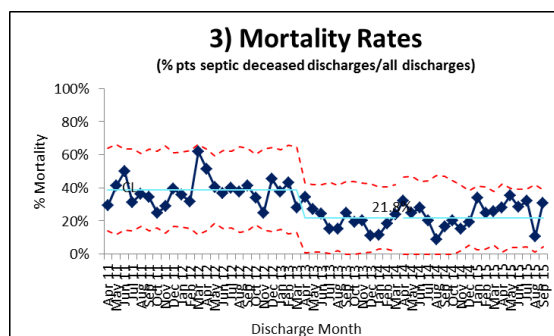
In 2015/16 a new national CQUIN has been introduced which aims to have:

- 90% by Quarter 4 of emergency admissions being screen for sepsis where appropriate. Quarter 3 target =60%.
- 90% by Quarter 4 those patients who have been identified as Septic having received antibiotics within an hour of admission. Quarter 3 target =60%.

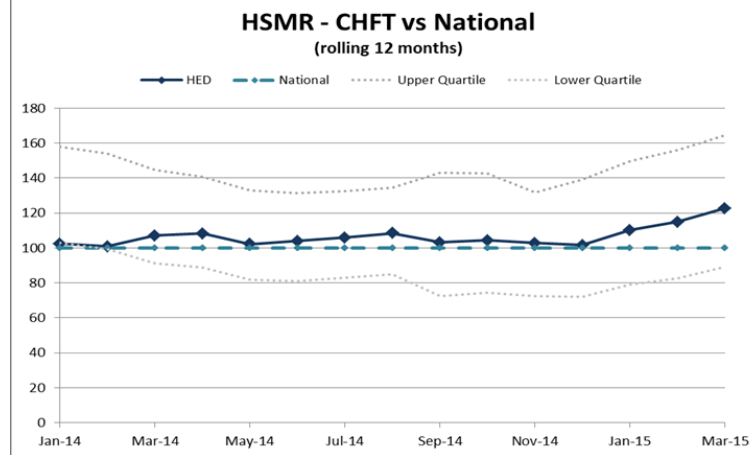
Q3 Performance:

Over the first three quarters the crude mortality rates for patients diagnosed with sepsis has been higher than the 14/15 average.

	Q1	Q2	Q3
Number of Discharged	133	139	TBC
Number of deaths	41	36	TBC
Mortality Rate %	30.8%	25.9%	TBC



A corresponding rise in the trust HSMR has also been seen for this condition. However the ration does still remains in the “as expected” range, with a HSMR of 120 (LCI 95, UCI 160).



The Sepsis Collaborative maintains a close eye on the key metrics each month, and there is no clear reason for the apparent rise in mortality. The Trust has recently begun a mortality case note review process (see section 2.1). During Q3, 7 out of the 12 sepsis deaths (assigned into the Dr Foster diagnosis group of septicemia) underwent review, 6 cases showed no evidence of preventability and scored a Hogan 1. 1 case scored a Hogan 2 - Slight evidence of preventability. A Hogan 2 is assigned when there are elements of the care which could have been improved but were extremely unlikely to affect the patient outcome, in this instance it was related to the non-delivery of antibiotics within the hour.

It is important to note that the Hogan score runs from 1 – 6, with 6 being definite evidence of preventability. The reviews for Q2 and Q3 are currently undergoing further analysis.

Screening for Sepsis:

Performance for Q3 was 60.7% of applicable patients being screened. The CQUIN aims were met as indicated by the green box below. Q4 Performance target is set at 90% and will be a considerable challenge. See Q4 improvement plans for details on work ongoing to improve compliance to this level.

	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3
2.2a - Sepsis Screening	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15	Total	Oct-15	Nov-15	Dec-15	Total
Number of emergency patients who had a NEWS score of 5 and above and were screened for sepsis	5	5	5	15	4	4	2	10	32	28	31	91
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	9	8	8	25	50	50	50	150
% Eligible patients screened for Sepsis	83.3%	83.3%	100.0%	88.2%	44.4%	50.0%	25.0%	40.0%	64.0%	56.0%	62.0%	60.7%
Target	Baseline				Further Baseline Data				60.0%			

Antibiotics within an hour:

The CQUIN aims for Q1 and Q2 were to gather enough data to have a baseline to work from going forward – this was achieved and is indicated by the green box in the performance table below. This audit requires consultant resources and due to the time required to carry out the audit it has resulted in the December data being delayed. However this will be updated in the Q4 report.

	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3
2.2b - Sepsis Antibiotic Administration	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15	Total	Oct-15	Nov-15	Dec-15	Total
Number of patients (in sample) with severe red flag or septic shock who received IV antibiotics < 1 hour	3	5	5	13	9	4	12	25	8	12		20
Patients who had recorded evidence of severe, Red Flag or Septic Shock on emergency presentation who should have IV antibiotics < 1 hr	7	17	8	32	13	9	12	34	14	16		30
% Patients with severe red flag or septic shock that received IV antibiotics < 1 hour.	42.9%	29.4%	62.5%	41%	69.2%	44.4%	100.0%	73.5%	57.1%	75.0%		66.7%
Target	Baseline				Further Baseline Data				60.0%			

**Some cases are still outstanding so the performance above is subject to update*

What we have achieved in the first three quarters

- The new sepsis protocol includes a new trigger to identify high risk/red flag sepsis at an early stage and initiate treatment. This was rolled out in September to coincide with World Sepsis Day, feedback has highlighted that the new chart requires some updates in order to be more beneficial, these changes will be address in the coming quarter.

- 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 has been rolled out during Q2. The new paperwork is prompting questions to be asked and having the desired result of increasing awareness of those patients which are presenting with possible sepsis.
- 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. The lead QI nurse was recruited in October 2015 and is working with the clinical teams to identify the barriers to compliance with the screening tool and antibiotic delivery with an hour.
- In Q3, ward and Emergency Department education was delivered d out to reinforce learning and ensure all staff, medical and nursing, are fully aware of changes and are confident to identify and respond to patients who have sepsis.

Improvement plans for Q4:

- Ongoing testing using quality improvement methods will be agreed by the Sepsis Collaborative to refine screening at all admission points and reduce time to antibiotic. These will be undertaken in specific clinical areas prior to widespread roll-out.

A sepsis engagement session will be run at the end of January with the clinical teams; this will follow a Work Together to Get Results model to address the barriers faced in delivering high quality care to septic patients.

2.1 Learning from Mortality

Through understanding our hospital mortality the Trust is able to both gain assurance and learning regarding 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

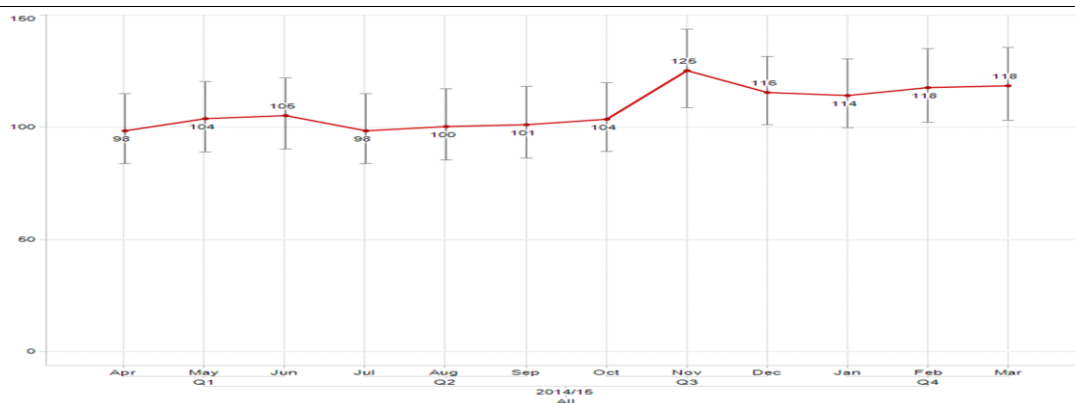
Current Performance

The Trust's SHMI for the latest period published (April 14 – March 2015) is 108.86; this is in the category of "as expected", however it is 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 fewer deaths than predicted. There is also evidence that standardised mortality ratios such as SHMI correlate poorly with other measures of care quality.

The Trust has hitherto been placed in the 'as expected' range because any variation from the number of expected deaths is not statistically significant.

The official SHMI from HSCIC for July '14 to June '15 will be published on 27th January. We believe it will have risen slightly to 111. It is not clear if that will represent an outlying position or not.

The trend data below shows how each month in the year has contributed to the overall performance.



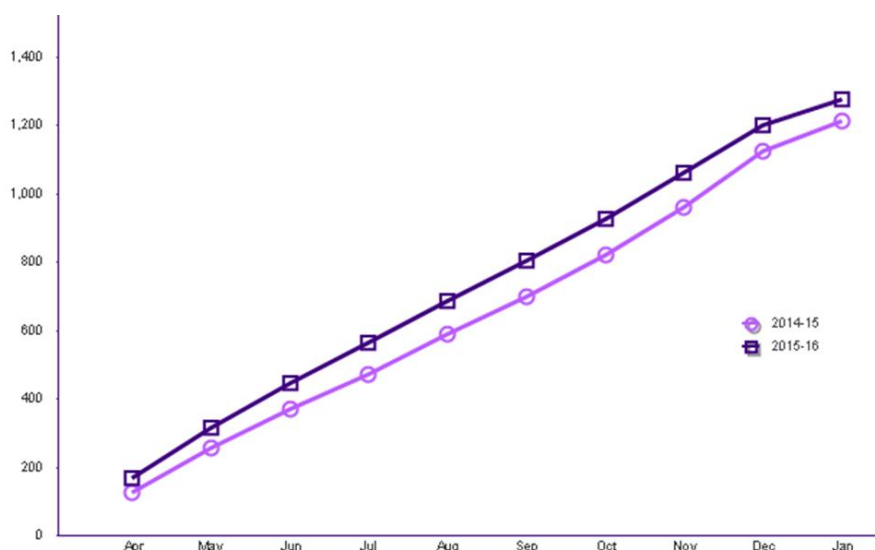
The SHMI data can be tracked to specific conditions where the actual number of deaths exceeds expected. Where this occurs cases are investigated and reports presented to Clinical Outcomes Group (and its subgroup Clinical Effectiveness and Mortality Group) with actions where necessary.

The SHMI position relating to the time period of (April 2014- March 2015) was release in Quarter 3 and the following areas were noted to have higher than expected mortality rates:

- Inflammatory diseases of female pelvic organs,
- Diseases of month: excluding dental,
- Urinary tract infections,
- Chronic obstructive pulmonary disease and bronchiectasis,
- Hypertension with complications and secondary hypertension,
- Nausea and vomiting,
- Cancer of breast,
- Abdominal pain.

These cases and those previously noted (Skin Ulcer, Contusions, Cancer of the Colon), are undergoing case note review; initial findings indicate that there is no evidence to suggest a reason for concern.

In the first part of 2015 the Trust noted a higher crude mortality than in previous years, a phenomenon seen across England and Wales. However the raw number of deaths in the final few months of 2015 were relatively low for the time of year. It is not yet clear how this will be reflected in the CHFT SHMI position in due course, given the time lag in the SHMI measure.



As the Trust consistently performs at the “as expected” level, In order to identify key problem areas to focus improvements, the Trust is committed to reviewing 100% of its mortality cases and not just for those conditions which triggered an alert.

The Mortality Review Process Protocol was approved at the Clinical Outcomes group in August 2015. This outlines the process for reviewing the mortality cases and improvements in process have been noted already. There are around 40 1st level reviewers with a steady increase. In order to increase the performance, each reviewer is allocated the cases they are required to review each month. This has provided a significant increase in

performance, increasing from an average of 29.5% in quarter 1 to 65% in quarter 2 with a slight decline to 60.9% in quarter 3, (December mortality reviews are still in progress).

First level review

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 and acts as a screening tool to prompt a second level review in cases scored 3-6. The scale ranges from 1 to 6 and the level of preventability described below.

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.

Second Level review

The purpose of the second level review is to provide a more in-depth review of the patients care and management to understand where the gaps have occurred. These are performed on mortality cases that have been scored Hogan 3-6. The process has been slow due to a number of factors such as delay in the 1st review being performed, locating a reviewer to perform the second review and getting the case notes to the right place.

This has improved over the last 4 months particularly with EDMS and focusing on Hogan 3 – 6 cases excluding Hogan 2 cases unless there was an incident, inquest or claim against the case. Further improvements are expected following the recruitment of new 2nd level reviewers.

Performance

The table below outlines the number and percent of mortality cases reviewed and included the Hogan score of preventability.

	April	May	June	July	Aug	Sept	Oct	Nov
Total deaths	163	147	129	117	120	117	118	131
Total 1 st level reviewed	54	37	39	89	67	74	67	79
% reviewed	33.1	25.2	30.2	76.1	55.8	63.2	56.8	60.3
Hogan 1	48	32	33	75	52	61	56	62
Hogan 2	6	3	3	10	10	8	7	10
Hogan 3	0	0	2	2	2	3	3	4
Hogan 4	0	0	1	0	0	1	2	3
Hogan 5	0	0	0	0	0	1	0	0
Not rated	0	2	0	2	3	0	0	0
Total second level reviewed ¹	n/a	n/a	0	3	1	1	5	3

Improvements to the review process

Both the level 1 and level 2 review forms have been revised to capture useful information and on preventability and provide a score of the care provided. Quality information on clinical and organisation factors is also requested from the reviewers.

Reporting the findings

Once the reviews have been performed, the data is added to the Knowledge Portal and can be viewed within 24 hours of it being added to the system. In addition, data is now being analysed on a monthly basis using the key learning themes from cases assessed as Hogan 2 and the more in-depth details gathered from the Hogan 3-5 cases. The ‘Learning from Mortality Reviews’ reports are shared with the reviewers, members of the Clinical Effectiveness and Mortality Group and the Clinical Outcomes Group.

The last report presented in December provided the key issues for preventability. The lack of senior medical review, particularly noted at weekends is commonest theme listed by the reviewers for preventability and concerns on fluid balance recording and bundles not completed are reoccurring themes listed under clinical care concerns. The full report is attached.

Special reviews

A review of all March 2015 deaths in HRI was commissioned in response to a sharp rise in HSMR that was identified at that time. Of the 92 deaths, 80.4% (74 cases) were available for review and were reviewed using the

standard level one review tool. The key learning themes were not dissimilar to other periods, therefore other factors were considered for the increased mortality including organisational issues. Whereas it was acknowledged that between January and March 2015 was particularly busy in the hospital due to the winter pressures and high levels of admissions to A&E departments there was no increase use in agency, bank or locum staff during March compared to January and February. There was no significant difference in unfilled shifts for medical or nursing staff in March.

March was a low month for Palliative Care coding; this coupled with a dip in comorbidity capture is likely to have played a part in generating a lower number of expected deaths. The full report provides the data that shows that comorbidity capture had been lower than the month of March, however it may have been being compensated by the higher Palliative Care coding in that particular month.

Improvement Work

Improvement Work is being delivered primarily through the Care of the Acutely Ill Patient (CAIP) programme. The plan was reviewed and refreshed in August 2015, when some of the original eight themes were merged and some removed (as the actions had been incorporated into other work-streams). The revised plan has the overarching aim “to contribute to the reduction of mortality rates within the Trust” in acknowledgement that reduction in the Trust’s mortality rates is dependent upon delivery of other actions and work-streams, e.g. leadership and operational improvements.

The revised plan is simplified into six themes:

- 1) Investigating mortality and learning from findings
- 2) Reliability
- 3) Early recognition and treatment of deteriorating patients.
- 4) End of life care
- 5) Frailty
- 6) Coding

Monthly updates are received by the Clinical Outcome Group COG.

Improvements in Q3

Three senior doctors have been recruited, with identified time in their job plans, to deliver second level reviews, condition specific reviews, and help develop the design of the process. These appointments will improve the response time to review both the SHMI alerts cases and the mortality cases requiring a second level review. Regular meetings will be established and a feedback process to enable effective actions, as appropriate to take place. Cases are being allocated to this team on a weekly basis.

A closer relationship has been developed between the outcomes of mortality reviews and the incident reporting system.

External data analysis.

Professor Mohamed Mohammed of Bradford University has supported the Trust with analysis of our HSMR position, looking for patterns in the data that allow the formulation of hypotheses to be tested. He has identified improvements in Palliative Care coding, in comorbidity capture, and effective mortality case review as being essential.

Improvement plans for Q4

Mortality Surveillance Group

It is proposed that, in accordance with national recommendations, CHFT establish a Mortality Surveillance Group (MSG), chaired by the Medical Director, and reporting directly to the Quality Committee, to strengthen the Governance system around mortality. This group will receive reports on mortality data, outcomes of reviews, and seek assurance on all aspects of hospital care as they relate to mortality.

Development of the existing process

Additional 1st level reviewers will be recruited by each of the Divisions to assist with achieving a 100% of mortality cases being reviewed. Performance of the 1st level reviews will be closely managed by the Governance Team. Nationally there is recognition of the need to standardise methodology and training. HQIP have been commissioned to roll out a standardised methodology and training programme. The contract is expected to be awarded in January, and the chosen model piloted in Spring '16. In the meantime, a short video training package

will be developed with support of the training department.

Preparation for the national process

It is expected that the national Retrospective Case Record Review (RCRR) process will mirror CHFT's two level review system, with an expectation of review of all inpatient adult deaths. It may be that the professional composition of the review team will evolve with more consultant involvement.

The national process is likely to require that second level reviews involve multidisciplinary team discussions in the relevant specialty. How this might work is yet to be designed, but it may be that the recently recruited specialist second level reviewers may initially review the case and lead the MDT discussion.

Electronic data capture

It is hoped to make the review tool / data collection process electronic, similar to the CRAS tool. There are still technical issues to overcome before we achieve the goal of real-time data capture

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).

1. Reliability

In the revised CAIP plan a new overall "reliability" work-stream was created comprising care bundle compliance, and investigation into SHMI alerting conditions and any concerns relating to site differences. .

Current Performance

The care bundles work has adopted the PMO approach, overseen by the newly-formed Clinical Standardisation group. The first meeting took place on the 1st of September 2015. Clinical leads have been identified for each of the bundles and currently they are reviewing the bundles to standardise them to ensure they are simple, clear and do the right thing first time. 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.

Compliance with appropriate commencement of bundles is currently audited by the presence of the "stickers" in the notes for

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

Where bundles have been commenced, completion is also assessed.

During Q3 plans were made on how to improve completion of care bundles, and therefore the reliability of the delivery of the key intervention. The discussion was made to include the key bundles into the clerking in the medical document. It was anticipated that there would be a go live date in early January. However this has been delayed and a go live date is expected towards the end of Q4.

- The communication and clinical engagement plan is under development to embed the new process.
- A clinical champion has been identified to encourage compliance in completing the bundles.

In addition to this work there are three care bundles which form part of the Trusts 2015/16 CQUINS, sepsis and pneumonia will be supported by the work above. However Asthma is being led by clinical and managerial leads from within the A&E unit, further information regarding each of these for Q1 and Q2 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. The trust is meeting its CQUINs targets at present.

	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3
	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15	Total	Oct-15	Nov-15	Dec-15	Total
Respiratory Care Bundle - Improving management of patients presenting with Asthma in ED												
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			33	40			40	38			38
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			50	50			50	50			50
% patients receiving care bundle	66%			66%	80%			80%	76%			76%
Target	65.0%				70.0%				72.0%			

Q4: Performance Plan: The Q3 target is set at 75%. Weekly monitoring in the unit will ensure that this performance level maintained. In haler Technique is the area most in need of improvement.

The Division is utilising the previous year's action plan in order to remain joined up with progress made last year.

Pneumonia (CQUIN)

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

The data collection for the CQUIN is 50 cases within the quarter. The trust is meeting its CQUINs targets at present.

	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3
	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15	Total	Oct-15	Nov-15	Dec-15	Total
Respiratory Care Bundle - Improving management of patient attending A&E with pneumonia												
Number of patients attending A&E with pneumonia who receive the CAP care bundle within 4 hours of admission	35			35	39			39	35			35
Number of patients attending A&E with pneumonia who are admitted.	50			50	50			50	50			50
% patients receiving care bundle	70%			70%	78%			78%	70%			70%
Target	60.0%				65.0%				70.0%			

Q4 Performance Plan: There is an action plan in development which will address the difficulties with capturing CURB scores, and over the final quarter compliance with this element is expected to improve.

Sepsis Screening (CQUIN) – See Improving Sepsis Care Section 1.5 which shows achievement of Quarter 3 target.

Acute Kidney Injury (CQUIN) – See Improving Management of Acute Kidney Injury Section 2.3 which shows achievement of Quarter 3 target.

2.3 Improving Management of Acute Kidney Injury

Aims and Objectives of Work

Acute kidney injury (AKI) is characterised by a rapid reduction in kidney function, potentially resulting in a failure to maintain fluid, electrolyte and acid-base homeostasis. 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. Recent reports have highlighted deficiencies in AKI management (Adding Insult to Injury, NCEPOD, June 2009, NICE clinical guideline August 2013). AKI was highlighted as a high mortality condition in the organisation based on HSMR and SHMI data.

The Trust has design a care bundle for the treatment of inpatients with AKI. This bundle has been in place now for 18 months, it has not yet been reliably implemented. More recently a CQUIN for delivery of AKI care has been agreed with the CCG.

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, and to deliver the agreed CQUIN.

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 Q4 was 66% of the required elements being captured on the discharge summary.

	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3
2.1 - Acute Kidney Injury	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15	Total	Oct-15	Nov-15	Dec-15	Total
The number of key items found in discharge summaries for patients in the sample of 25	25	21	18	64	30	30	39	99	57	66	74	197
4 key items in discharge summaries for 25 inpatients randomly selected from pathology system with AKI *	100	100	100	300	100	100	100	300	100	100	100	300
% key items included	25.0%	21.0%	18.0%	21.3%	30.0%	30.0%	39.0%	33%	57%	66%	74%	66%
Target	Baseline - Achieved				21.0%				50.0%			

Improvements during Q3 included:

There has been a significant and sustained improvement in performance through Q3 as junior doctors have become more familiar with the changes to the EDS. This has been supported by continued feedback on performance, particularly with regard to junior doctors who have not completed the EDS correctly.

A process for weekly monitoring of performance has been established which is allowing closer monitoring of the trajectory.

Conversations regarding targets for Q4 have been undertaken and a target of 90% compliance has been agreed. Based on the current trajectory we are in a reasonable position going into Q4 and should achieve this target.

Ongoing work into Q4:

1. Continue weekly monitoring of performance
2. Continue feedback to junior doctors who do not complete EDS correctly
3. Twice monthly e-mail to consultants and junior doctors regarding ongoing need to complete AKI CQUIN via EDS and highlighting areas of good practice

We will be further publicizing the work of the AKI work stream group as we prepare for World AKI Awareness Day in March 2016.

2.4 Conditions of Interest – 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 Division has recently reviewed the Stroke Dashboard and, with the clinical team agreed changes to the report. There are currently no nationally agreed targets for stroke however, as we aim to achieve a SSNAP (Sentinel Stroke National Audit Programme) score of “A”, we have updated to the targets for each measure to indicate the performance required to achieve a score of “A” in that particular measure.

The updated dashboard is included in the appendix.

Improvements:

- We have seen significant improvement in the percentage of patients with a joint care plan on discharge from 40% to 86.2%
- 100% of patients presenting with AF anticoagulated on discharge for 3 consecutive months (91.4% YTD)
- 87.5% of all patients scanned within 12 hours

Areas of focus:

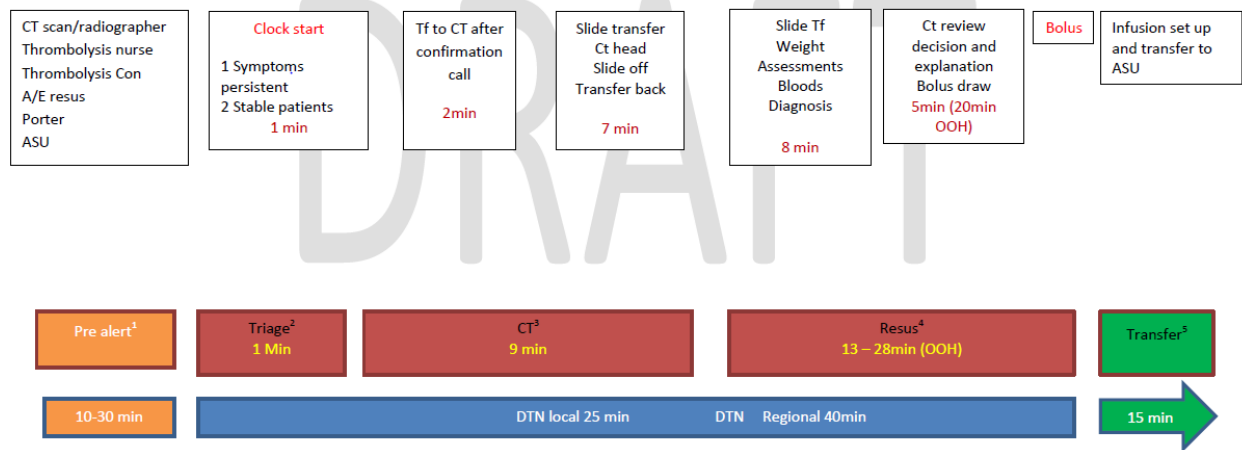
- Patients scanned within 1hr of hospital arrival (where appropriate) 66.7%, target 90%
- Direct admissions to ASU within 4hrs 60%, target 90%
- Patients spending 90% of their stay on the stroke unit 80%, target 90%

Scanning within 1hr of arrival:

Members of the stroke team have recently visited the Stroke Unit at North Lincolnshire and Goole NHS Foundation Trust. This Trust scored an “A” in the SSNAP score. The aim of the visit was to learn how to best

minimise time delays in the management of stroke patients, in particular those patients needing thrombolysis. Since the team has undertaken mock dummy runs and developed a new DTN (Door to Needle) process (see below). We are working with YAS, ED and radiology to implement this.

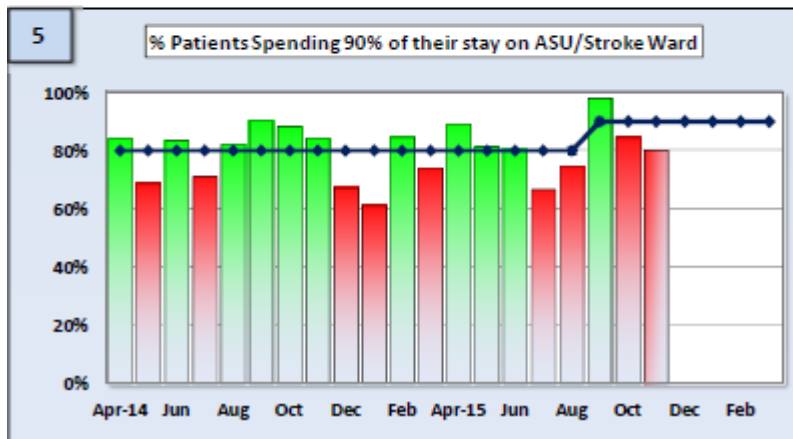
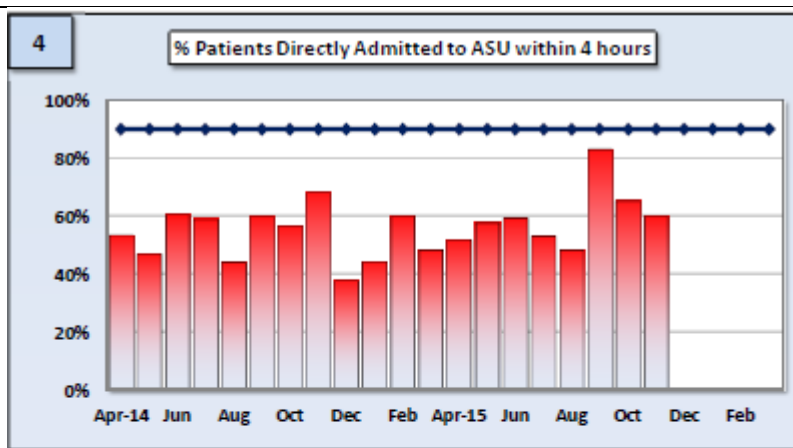
Thrombolysis process map



4hr and 90% LoS

The stroke team routinely review breeches in the 4hr and 90% LoS measures. Previously a number of breeches were due to availability of beds on the ASU. We have introduced a number of measures to improve this: there is a weekly ASU sitrep report indicating the number of empty beds, beds occupied by stroke patients and beds occupied by non-stroke patients (see appendix). Using this we have been able to actively intervene and reduce the number of non-stroke patients on the ASU and increased the availability of ASU beds. We have also increased the bed base for the stroke team with an additional 6 stroke rehab beds. At present the most significant factor now affecting both measures is the early recognition of stroke as the diagnosis. Patients presenting with atypical symptoms for example dizziness or a collapse may be admitted to the acute medical units and only after further investigation is a stroke identified. The stroke team is working with YAS, ED and acute medical teams to ensure a higher degree of suspicion for stroke in patients presenting with atypical features.

Data from previous years shows a reduced performance in December and January reflecting the wider bed pressures associated with winter. Full data for December is not yet available although early feedback indicates performance in both measures is under pressure.



Other Developments:

Consultant recruitment

- Approval has been given to recruit a 5th stroke consultant. This will improve the quality of care for stroke patients and ensure service resilience.

Health Watch Calderdale

- On 7 December 2015 the ASU was visited by Health Watch Calderdale. This visit was organised following feedback from members of the public. The report (see appendix B) highlights areas of good practice as well as areas for improvement. The ward has developed an action plan to address the issues raised. In addition the consultant input on the ward has changed; rather than each consultant doing a ward round on the ASU one day each week they have a consultant of the week. This is expected to improve continuity of care, communication and patient experience.

Divisional Structure

- Following a review of the Divisional and Directorate Structures Stroke services will move from the Medical Directorate to the Integrated Medical Specialities (IMS) Directorate.
- The Clinical Director for IMS is Dr Simon Grant; the General Manager is Maureen Overton.

Mortality

The following is the latest mortality data as provided by HED. The latest published SHMI is 109.55. There were no stroke deaths subject to second stage mortality reviews for the period December 2014 and May 2015. Mortality reviews have been added to the monthly Stroke Clinical Governance meetings to be reviewed by the multi-disciplinary team. Further analysis is required in order to agree further actions.

Latest published SHMI Jan 14 – Dec 14:

Figure 1.1: SHMI Overview

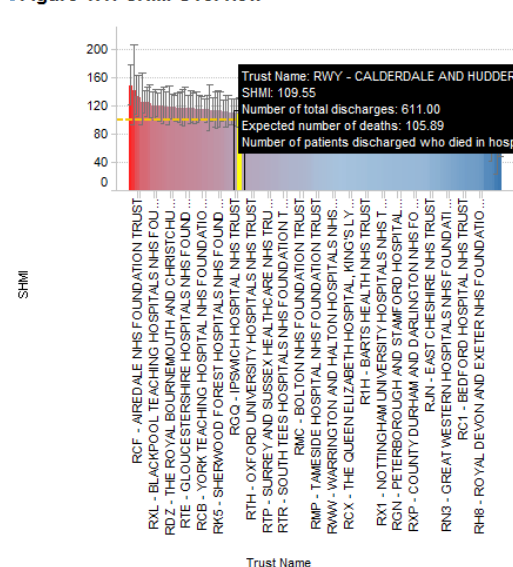


Figure 1.2: Poisson Distribution (PD) Funnel Plot

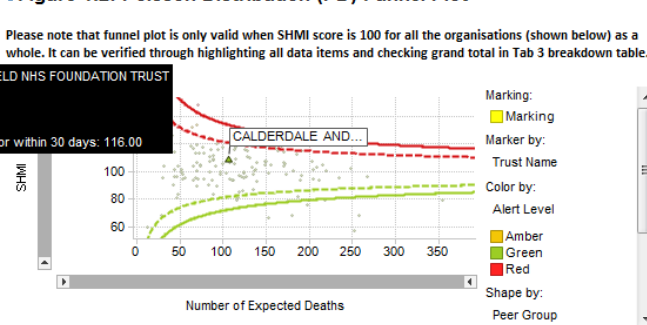
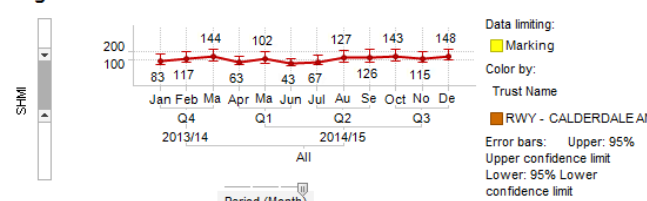


Figure 1.3: Time Series



89,069 of 20,096,075 rows 156,224 marked 51 columns SUMMARY

2.8 DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation)

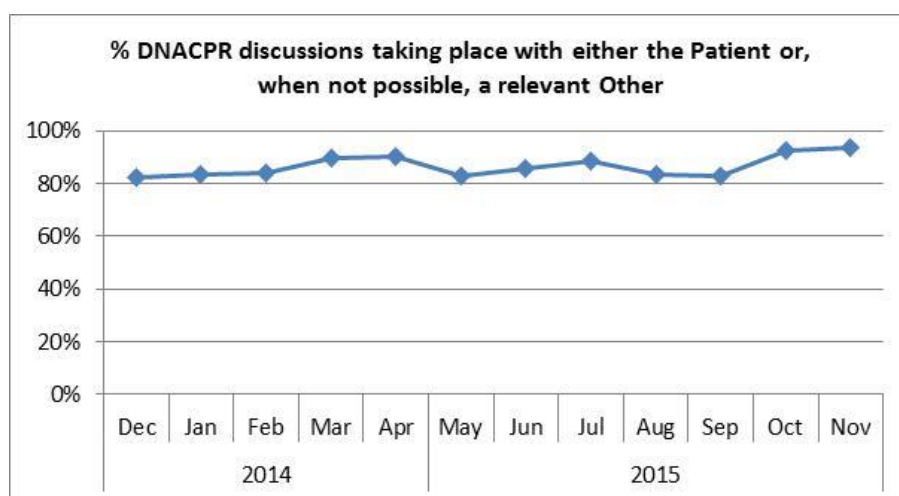
Aims and Objectives of Work

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.



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. A second point prevalence audit was carried out in September. The full report will be distributed as soon as it is finalised.

Improvements since January 2015 have been noted. Data is reported monthly at the Trust Clinical Outcomes Group and ward level data is sent to Divisional Directors and reported at Divisional Patient Safety & Quality meetings.

Full point prevalence audit has been repeated in September 2015 the result will be analysed and shared with

through the organisation.

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 is sent to divisions for discussion at their PSQBs.

A regional training DVD on DNACPR decisions was produced earlier this year and is now available on the intranet.

Improvement Plans for Q3 2015/16

- DNACPR status is included as part of the handover module of the new electronic 'Nerve Centre' platform. Roll out is now complete across the trust. During Q3 nerve centre data will be explored to see how well this information is being captured and utilised.
- 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.
- DNACPR bundles have been trialled on 3 Medical and 1 surgical ward. Feedback has been very positive so will be rolled out Trust wide. The stickers are still on order at the printers. The stickers are to be used to document a discussion with a patient and/or their family after a DNACPR decision has been made and a form completed. The Resuscitation Officers will distribute these on the wards and include as part of the BLS training. This is to be completed in Q4.
- Monthly reports on compliance are reported at the Trust Clinical Outcomes Group and Divisional PSQBs.
- New Patient information leaflet is at the printers (what happens if my heart stops?). This will be distributed to all wards and available on the repository once in the Trust.
- Duplicated DNACPR forms printed with a red border are currently on order with the printers. This will ensure that a copy remains on the patient's records when the original copy is discharged with the patient. The new forms will be distributed by the Resuscitation officers and incorporated in the Basic Life Support training.

Improvement plans for Q4 2015/16

- Once the bundles are in use on all wards, completion will be monitored
- Review of monthly compliance will continue and will be monitored thorough divisional PSQBs and the end of life collaborative.
- Review of impact of duplicate forms;

Patient information leaflets will be distributed to all wards once they are returned from the printers. Use of the leaflet will be monitored.

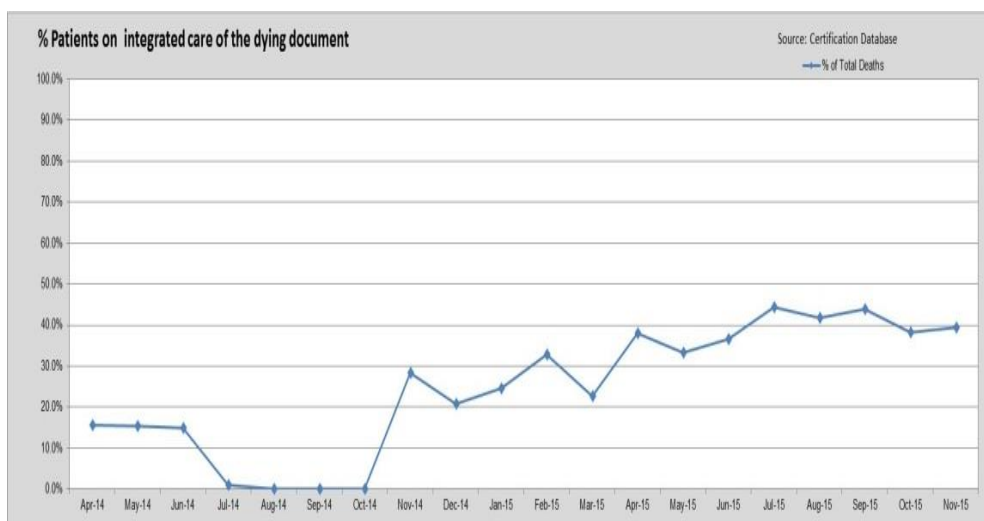
3.5 Improving End of Life Care

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 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 39.4%).



Progress against Improvement Plans for last 12 Months

- The introduction of comfort bags continues to receive 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.
- Education and training has been rolled out to Cardiology and Complex care wards. Training with the consultants from elderly care and cardiology was carried out in November, 16 out of 22 consultants have now been fully trained. Ward based training is also booked for relevant wards at HRI. It is expected that 50% of staff on the (4 out of 5) designated wards will have been trained by the end of January 2016. The remaining ward will be completed by the end of March 2016.
- Funding received earlier this year from Health Education for Yorkshire & Humber for training. CHFT commissioned Kirkwood Hospice to deliver a series of free one day courses for doctors and registered nurses working in the Trust. This course is designed to improve knowledge, skills and confidence when communicating with palliative care patients. It will focus on the five priorities of care. There have been four sessions to date and a further six sessions are planned in 2016. Feedback from 'The One Chance to get it Right' study day has been very positive, with 52 staff attending and expressing that their practice would change as a result of the training day.
- 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 gives the trust insight in where to focus training/action which is specific to each area, and in particular whether there are nursing or medical actions required. Reports are being produced every 3 months and trends identified. Themes identified so far are - lack of or poor communication, poor care, poor symptom management, reference to the LCP and poor discharge planning. This is reported through the end of life meeting and is shared with staff through training and education. It is recognised that there may be value in analysing clinical incidents through the DATIX system in a similar fashion.
- 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 is increasing as staff attend the organised training sessions and awareness spreads.
- The pilot of the ICODD has been completed in community. Feedback has been very positive. Training will commence in January for all district nursing teams and agencies. It is expected that the ICODD will be rolled out and used in all areas by May 2016.
- Participation in the National End of Life Care Audit. Data for CHFT has been submitted for 80 patients who died during May 2015. This audit will look at the progress acute hospitals have made in addressing the 'five priorities of care' for people in their last hours, days of life. Reports are expected to be published in March 2016.
- Local audit carried out of 20 patients who died in May 2015 whilst being supported with the individualised care of the dying document. The results indicate that the use of ICODD has generally improved. The report will be produced within the next few weeks and results presented at the next

available slot at the Clinical Governance meetings.

Plans for improvement for Q4 2015/2016

- More training days on advanced communication skills and end of life care are organised for 2015/2016. Five sessions are planned in 2016.
- Continue to support the roll out of the ICODD to community services
- Further improvement in review of decisions for ICODD through training and education.
- Local survey to bereaved relatives took place in October 2015. Questionnaires were sent to 140 relatives/carers of patients who died in January and February 2015. The response rate so far is 32%. The data will be analysed this month and the results of the questionnaire will be used to assess the quality of care and the level of support provided to individuals and their families in the last days and hours of life. One of the recommendations from the National Care of the dying audit was that all hospitals should undertake local audits of the care of the dying including the assessment of the views of bereaved relatives, at least annually
- A business case is being developed to support workforce enhancement within the hospital specialist palliative care team (SPCT) so that a 9-5 seven day face to face service can be delivered. Monies from a current maternity leave vacancy are being used to deliver some clinical nurse specialist (CNS) shifts, and several weekend and Bank Holiday shifts have been delivered, and an audit of activity undertaken.
- Timely availability of syringe drivers to deliver medication is crucial to good end of life care, and proposals are in place to develop a central equipment store to meet this need. This model would also address important governance issues such as regular servicing, calibration, etc, and will reduce inequity in access.
- Changes in how contacts with SPCS are recorded and coded will give a more accurate assessment of the input of this team into patient care in hospital.

The Quality Committee is asked to note the following:

- HSMR and SHMI remain higher than target, with an updated SHMI figure due this month.
- The mortality review process is resulting in a consistent number of reviews being done each month but this is not at yet sustainable at the 100% level that the trust is aspiring to.
- Recruitment of 5 PA specifically for coding and mortality reviews is continuing.
- Clinical Coding support into the upper gastrointestinal team.
- A new Mortality Group is to be set up and will report directly to the Quality Committee
- New Bundle process to be tested in January 2016
- Clinical Leadership Fellow has commenced her role to examine the e-handover and Hospital @ Night model locally

DNACPR compliance continues to improve.

FINANCIAL IMPLICATIONS OF THIS REPORT:

RECOMMENDATION:

APPENDIX ATTACHED: YES

Appendix 1: Patient Treatment Bundles

Appendix 2: Care of the Acutely Ill Patient Action Plan

Patient Treatment Bundles

Sepsis Care Bundle		Time Delivered	Signature
Does this patient have systemic sepsis at admission? Yes ☐ No ☐			
ALL ELEMENTS MUST BE COMPLETED WITHIN 1 HOUR			
Blood Cultures	Take Blood Cultures +/- wound swab, sputum and urine sample as appropriate		
Urine Output	Dip urine, monitor urine output hourly. Aim for 0.5ml/kg/hr. Consider urinary catheter. Commence fluids balance chart		
Fluids	Give 500ml bolus of Crystalloid stat. If systolic BP <90 give further 20mls per kg bolus. Monitor input hourly		
Antibiotics	To be given AFTER Cultures in compliance with local guidelines		
Lactate & Blood Tests	Lactate, ABG, FBC, U&E, Clotting, CRP, LFTs		
Oxygen	Give 15 litres via Reservoir Mask unless O2 restriction (COPD aim for saturations 88-92%)		

Community Acquired Pneumonia Care Bundle		Time to Intervention	Time Delivered	Signature
Does this patient have a Community Acquired Pneumonia at admission? Yes ☐ No ☐				
Sepsis	Assess for sepsis and USE SEPSIS BUNDLE	< 1 hour		
Assess Gas Exchange	Assess SpO2 & Perform ABG if SpO2 <94% on air or RR >30 Prescribe and administer oxygen therapy (if applicable)	< 1 hour		
Severity	Confusion? Yes +1 ☐	Score:	< 4 hour	
	Urea >7mmol/l? Yes +1 ☐		< 4 hour	
	Resp Rate >30? Yes +1 ☐		< 4 hour	
	Systolic BP <90 mmHg or Diastolic BP <60 mmHg? Yes +1 ☐		< 4 hour	
	Age 65 or above? Yes +1 ☐		< 4 hour	
Antibiotics	Prescribe antibiotics according to CURB-65 score and local guidance	< 4 hour		
	Ensure antibiotics given	< 4 hour		
Actions based on CURB-65 score 0-1 Low risk: <3% 30-day mortality. Consider outpatient treatment 2 Moderate risk: 6.8% 30-day mortality. Consider inpatient treatment or outpatient with close follow up 3-5 High risk: >15% 30-day mortality. Consider inpatient treatment with possible intensive care admission. Consider ICU Outreach Team and Respiratory Physiotherapy referral for CURB-65 Score of 3 or more Tests: 1. Consider measuring baseline CRP 2. Consider sputum culture, Bloods cultures, Urine for pneumococcal antigen for moderate and high risk group 3. High risk group – Consider additional tests – Legionella antigen, atypical serology and viral PCR 4. Consider HIV test in patients <65 years old				

Patient Treatment Bundles

Acute Kidney Injury Care Bundle			
Does this patient have Acute Kidney Injury at admission? Yes ☐ No ☐			
Recognition			
Stage	Serum Creatinine	Urine Output	
1	Rise >1.5x baseline or 26µmol/l in 48 hour	<0.5ml/kg/hr >6 hrs	
2	Rise >2x baseline SCr	<0.5 ml/kg/hr >12 hrs	
3	Rise >3x baseline or >354 26µmol/l or on RRT	<0.3ml/kg/hr >24 hrs/ anuria 12 hrs	
Immediate Intervention: To be completed at initial assessment			
Document Urinalysis Result	Target	Time Delivered	Signature
Document calcium and Bicarbonate (HCO3)	<4 hr		
Record Fluid Balance	<4 hr		
Prescribe IV fluids with target urine output of >0.5ml/kg/hr	<4 hr		
Stop nephrotoxic drugs and review anti-hypertensives	<4 hr		
Alter dose of medication based on eGFR	<4 hr		
Additional good practice points			
Examine bladder +/- bladder scan to exclude retention		Consider renal referral for stage 3 AKI, possible primary renal pathology or previous renal transplant	
Consider renal USS if possible pyelonephritis or obstruction			
AKI CQUIN: Information required at discharge (Mandatory field in Tab 2 of EDS)			
1/ Stage of AKI		3/ State if any further blood tests required	
2/ If medications stopped indicate if/when to restart		4/ State when further blood tests required and who will do	
Acute Exacerbation of COPD Care Bundle			
Does this patient have an Acute Exacerbation of COPD at admission? Yes ☐ No ☐			
Intervention	Target	Time Delivered	Signature
Prescribe and administer oxygen according to Trust guidelines. Document target saturations and starting device	<2 hr		
Prescribe bronchodilators via air-driven nebuliser	<2 hr		
Check arterial blood gases on prescribed oxygen	<2 hr		
Order CXR and document result	<4 hr		
Prescribe and administer steroids	<4 hr		
• 30mg prednisolone orally or 100mg Hydrocortisone IV Does the patient require NIV Yes ☐ No ☐ NIV is indicated if: • Respiratory acidosis after one hour of standard treatment or • Immediate ventilator support required Document if contraindicated, inappropriate or declined			
Give oral antibiotics if increased sputum volume or purulence	<4 hr		
REMEMBER to complete the ongoing care and Discharge Phase of the Bundle			
Acute Asthma Care Bundle			
Does this patient have an Acute Exacerbation of Asthma at admission? Yes ☐ No ☐			
Intervention	Target	Time Delivered	Signature
Document PEFR or documented as unrecordable	On arrival		
Pulse rate and respiratory rate documented	On arrival		
Oxygen saturations (SpO2) recorded and ABG performed if sats <92% (or other life-threatening features)	On arrival		
Nebulised salbutamol driven with oxygen	<20 mins		
Prescribe and administer steroids	<20 mins		
• 40mg prednisolone orally or 100mg Hydrocortisone IV Order and document CXR results			
REMEMBER to complete the ongoing care and Discharge Phase of the Bundle			

Care of the Acutely Ill Patient Action Plan: Revised August 2015 CAIP Lead: Alex Hamilton; Associate Medical Director						Last updated with progress 20/10/15		
						Completed / ongoing	minor delay / additional ac ⁿ	
						moderate delay	major delay	
Overarching aim ~ to contribute to the reduction of mortality rates within the Trust.		AHam: Alex Hamilton AHar: Andy Hardy CH: Carole Hallam DDs: Divisional Directors	DV: Dimple Vyas HMcC: Heather McClelland JA: Jeena Ackroyd JM: Jackie Murphy	KT: Kath Thorley LF: Lisa Fox MK: Mary Kiley MH: Mary Hytch	MS: Marie Sullivan SI: Sam Ingram SS: Sue Shaw TM: Terry Matthews			
Timescale ~ actions to be completed August 2016.								
The revised plan no longer includes the themes relating to Effective (focus on the Courage to Put Patient First programme, and Well Led Organisation which were part of the CAIP plan August 2014. The elements of the CPPF theme have been incorporated into the Length of Stay and Bed Efficiency work-stream, and CPPF was formally stood down in May 2015. The Well-Led organisation theme incorporated many different work-streams but oversight is now provided by the “Well-led” group which has been established to help the Trust prepare for the CQC inspection. However, the plan acknowledges that reduction in mortality within the trust is dependent upon the delivery of these work-streams in association with the CAIP plan.								
Theme1: Investigating Mortality and Learning from findings Lead: Alex Hamilton, Associate Medical Director								
Action Plan N ^o	Recommendations	Action Needed	Action Lead	Timescale	Verification of achievement	Evidence of impact	KPI	Oversight
1.1	Mortality reviews of all patient deaths to be undertaken and findings reported and actioned	Mortality review process to be written, ratified and implemented to ensure standardised approach to mortality reviews.	KT	Aug-15 completed	Process agreed and available to users	Clarity as to roles and responsibilities with relation to mortality reviews, with an increase in the number of reviews being conducted.	% of deaths having a Mortality Review.	COG
		Update Sep'15 – protocol has been written and approved by COG. On the intranet. To date (10.9.2015) 75% of reviews completed in August (July deaths) which is a big improvement on recent months, and the best since Feb 2015. Oct'15 – unfortunately a dip in performance to 51.66% of reviews in Sept (Aug deaths). Reasons being examined to identify process solutions. Nov'15 – Performance rising slightly in Oct (Nov deaths) to 63%. Conversations have taken place to address some of the issues with notes being delivered to the right places. Weekly CAIP/Reducing meeting weekly to address gaps and support reviewers where possible. Dec 15 - Despite ongoing work to resolve process difficulties around access to case records, the completion rate has begun to drift downwards in contrast to the incremental improvement that had been expected. Performance data has been escalated to Divisions. Further reviewer recruitment being considered.						
		Review of Mortality review proformas.	AHam	Aug-15 completed but now further	Forms agreed and available to users	Streamline and clarify mortality review process	% of deaths having a Mortality Review. .	COG

		to a bundle – process for dealing with poor compliance being considered. Nov’15 – New Bundle paperwork designed. Aim to test this as part of the clerking in document in January. Audit currently suspended until the testing phase is started again. Dec 15 – progress slowed, in order to understand the barriers, lead has been invited to present at the next COG.						
		Audits completed as plan to provide data on bundle uptake and completion.	AHar / TM	Oct-15 and ongoing	Monthly bundle compliance reporting to COG	Identification of difficulties in completion of certain elements of bundles, and reasons. Benchmarks for improvement identified / set	% of audits and sample completed as plan. Audit results available	COG
		Update Sep’15 – awaiting update Oct’15 – Audits under review as part of PMO work-stream Nov’15 – Audit currently suspended until the testing phase is started again. Dec 15 - Audit currently suspended, however due to the delay in having new paperwork, audits are to recommence using the previous methodology.						
		Audit data circulated to Divisional PSQBs and cascaded to clinical teams to drive improvement in compliance.	DDs	Nov-15 and ongoing	Report to PSQBs	Clinicians aware of their teams' compliance with relevant care bundles and to drive improvements	% bundle compliance. Improved outcomes, including shorter LoS and reduced mortality for those conditions relevant to care bundles	COG
		Update Sep’15 – no progress – awaiting audit data to sent to Div PSQBs Oct’15 – Audits under review as part of PMO workstream Nov’15 – Audit currently suspended until the testing phase is started again. Dec 15 - Audit currently suspended, however due to the delay in having new paperwork, audits are to recommence using the previous methodology.						
		Performance management of bundle compliance	HB	Dec-15 and ongoing	Divisional business cycle / monthly IBRs	Improvement in compliance with implementing and completing care bundles		Ops board

		Update Sep'15 – Care bundles work is under review by PMO, and the preliminary meeting was held on 1st September. A Clinical Standardisation Group will take over the work begun by the Care Bundles Group. The clinical conditions of focus will remain as before: COPD; AKI; Heart Failure; Sepsis; and Pneumonia, and a lead will be appointed for each of these. Key milestones were identified, and the detail of these and timescales will be agreed at a meeting to be held 22nd September. Oct'15 – Once audit restarts non-compliance can be monitored and addressed. Dec 15 - Audit currently suspended, however due to the delay in having new paperwork, audits are to recommence using the previous methodology.						
2.2	Development of new bundles to be overseen by clinical experts in the field to ensure they meet best practice standards and will deliver improved outcomes. These should be evidence-based from national sources and other Trusts.	To have a robust process in place in each speciality to oversee and prompt the development and implementation of new care bundles where there is evidence to suggest they will be of benefit.	DDs	Sep-15	Divisional PSQB minutes COG meeting minutes	Bundles will be available where relevant and will be developed and updated in line with best practice	All bundles evidence-based and in line with best practice. Implementation of new bundles is audited	Care bundle group
		Update Sep'15 – As above Oct'15 – As above Nov'15 - Bundles developed for 5 key areas. Heart Failure is next to be developed. Dec 15 – Waiting further discussions around the heart failure Bundle.						
2.3	Priority work streams, commissioned by Medical Director, identified from review of information (e.g. SHMI alerts, findings of SIs and clinical audit etc) and initiated to assure COG that issues are being resolved in a timely	Clinical lead to deliver priority work stream findings and reports to agreed ToR and within agreed timescales. Non-delivery of milestones and work streams to be escalated to the QC via the COG.	DDs	Aug 2015 to agree process Individual timeframe for each ongoing	Report of findings to COG as necessary	Areas for improvement will be identified and action plan to improve is agreed. Improved adherence to clinical pathways as demonstrated via clinical audit and other quality indicators e.g. mortality rates, best practice tariffs etc.	Outcome targets met for work streams, and action plans completed Reduction in SHMI alerts	COG COG
		Update Sep'15 – a number of priority work-streams have been identified, including review of all March deaths at HRI, and some relating to clinical						

	Where site differences are identified to investigate and identify the causes.	Sep'15 – awaiting update Oct'15 – Nov'15 – Dec 15 – Monthly summary reports now included HSMR , SHMI, and crude mortality by each site.						
		Where a concern is raised, to ensure any on-going work is addressing these or commission work if won't be addressed any other way	DDs	Aug 2015 to agree process	Report of findings to COG as necessary	Improvement actions identified and implemented	Reduction in site differences for key quality and mortality metrics	COG
				Individual timeframe for each				
		Update Sep'15 – The process for this has been agreed. A case of poor outcome in which site differences was a contributing factor was identified from a divisional investigation into the care of a patient with upper GI bleed who was admitted to Calderdale. A summary is to be taken to the COG meeting in September for discussion. Oct'15 – No major concerns relating to site differences						
Theme 3: Early recognition and treatment of deteriorating patients Lead: Heather McClelland, Consultant Nurse Emergency Care								
Action Plan N°	Recommendations	Action Needed	Action Lead	Timescale	Verification of achievement	Evidence of impact	KPI	Oversight
3.1	Accurate and timely monitoring and recognition of deteriorating patients leading to prompt and appropriate escalation	Implement 'Nerve Centre' electronic observations and handover module across all wards of the Trust	HMcC	Oct-15	Nerve centre in place on all wards	Full implementation of nerve centre and increased availability of patients' clinical status	Nerve centre electronic observations and handover module implemented as plan.	Modernisation Board
						Early recognition of, and response to, the deteriorating patient.	Reduction in the n° of cardiac arrests Reduction in n° of unplanned admissions to ICU	Patient Safety Group
						Update Sep'15 – nerve centre roll-out complete at Calderdale; on track in HRI completion of roll-out end of Sept in adult areas, moving into paediatrics by end of Oct. Outstanding areas will probably take us into Oct (ICU – not previously on plan, and extra capacity). Staff feel it is beneficial in general, some initial teething issues with using the technology but these quickly settle. Easier to monitor ward progress remotely for senior staff. Limited engagement by senior medical staff - KPIs will be identified in the Deteriorating Patient Performance report. Early indications are that		

APPENDIX 2

		there has been a reduction in cardiac arrests. . Oct'15 – Nervecentre roll-out across the Trust is now complete. Now awaiting work on paediatric model (some technical issues at NC end) and funding for Task Management co-ordination prior to implementation. Improving engagement from Divisional teams (esp. Medicine), and plan for cut-off points for full uptake of handover. Improvements seen in recent Cardiac Arrest data (small numbers) showing running lower than trajectory and falling. Nov'15 – COMPLETE						
	Improve handover communication and procedures, within professional groups, for the MDT and out of hours.	Implement 'Nerve Centre' electronic observations and handover module across all wards of the Trust	HMcC	Oct-15	nerve centre handover module operational on all wards	Improvement in handover of patient information	Reduction in the nº of incidents where miscommunication is a cause or contributory factor	COG
		Update Sep'15 – nerve centre roll-out complete at Calderdale; on track in HRI. Implementation of handover module is variable. A Board paper in next few weeks will raise issues re engagement with handover. Staff feel there is benefit in one communication process where this is working well. No data on incidents has been received for the Deteriorating Patient report. Oct'15 – Improving engagement from Divisional teams (esp. Medicine), and plan for cut-off points for full uptake of handover. Nov'15 –as above Dec 15 - Handover in use on all clinical areas using Nervecentre						
	Accurate and timely monitoring and recognition of deteriorating patients leading to prompt and appropriate escalation	Implement 'Nerve Centre' electronic observations and handover module into 'off plan' areas – Endoscopy, Radiology, CDU (A&E), Day case Unit. Paed.	HMcC	Feb - 16	Nerve centre in place in additional areas	Full implementation of nerve centre and increased availability of patients' clinical status	Nerve centre electronic observations and handover module implemented as plan.	Modernisation Board
						Early recognition of, and response to, the deteriorating patient.	Reduction in the nº of cardiac arrests Reduction in nº of unplanned admissions to ICU	Patient Safety Group
		Update Nov'15 – Model in build stage and in line to go-live first week Feb. Some barriers in access to CDU CRH for training.						
3.2	Fully implement recommendations from the Deteriorating Patient work	Outreach to extend hours to be available 8am-8pm on both sites, managing staffing issues.	MH	In place and ongoing	Outreach cover available 12 hours; 7 days	Improvement in early recognition of, and response to, the deteriorating patient.	Reduction in the nº of cardiac arrests Reduction in nº of unplanned admissions to ICU	Patient Safety Group

Action Plan N°	Recommendations	Action Needed	Action Lead	Timescale	Verification of achievement	Evidence of impact	KPI	Oversight

4.1	Appropriate ceiling of care, as indicated by timely DNACPR decisions, to be in place for patients where appropriate, and this to be communicated	Monthly audit data re DNACPR completion to include compliance with all indicators. To be reported by ward and consultant to EoL and COG for identification of appropriate action.	TM / LF	Sep-15 and ongoing	New-style reports available to identify areas for focused improvement	Better identification of patients needing end of life care.	Reduction in the n° of inappropriate cardiac arrest calls Improvement in % of appropriate DNACPR completed	End of Life Group
						Fewer complaints in relation to DNACPR	Reduction in n° of complaints relating to DNACPR	Patient Experience Group
	Update Sep'15 – Continued analysis of DNACPR decision-making/compliance. Review by EOLC leads of core criteria for analysis, to reflect clinical priorities. Oct'15 – Point prevalence audit carried out in September. Awaiting update re specific audit detail. Nov'15 – PP audit showed increased compliance. Continued monthly reporting. DNACPR part of the Medic audit commissioned by the Clinical Records Management board. Dec 15 – Audit data ongoing.							
	All cardiac arrests to be reported as clinical incidents	SS	Sep-15 and ongoing	Datix of all cardiac arrest calls	To identify areas for focused improvement in ceiling of care decisions.	Data from Datix compared with calls via switchboard	Resus group	
Update Sep 15 – analysis beginning Oct 15 – awaiting update Nov 15 – None reported through DATIX. Reasons for non-reporting need to be understood.								

		Dec 15 – As above						
4.2	Reduce unnecessary admissions for patients who are expected to die within 48 hours that could have been managed in an alternative location.	Analysis of 3/12 of cases (identified by mortality review) to identify numbers and causes.	AH / CH	Nov-15	Report of findings to COG	Report identifies causes and makes recommendations.	Relevant actions identified to progress	COG
Update Sep'15 – analysis on-going Oct'15 – awaiting update Nov'15 – Updated needed. Dec 15 – Updated needed								
Participation in national EoL care audit of deaths in 2015, in relation to last episode of care.		MK / TM	Mar-16	Report of findings to EoL group, governance ½ days and COG	Report identifies causes and makes recommendations.	Relevant actions identified to progress	COG	
Update Sep'15 - Analysis of May's deaths continues; target of 80 deaths to be analysed by end September. Short extension period may be required. Oct'15 - Data submitted on 80 patients without the need for an extension. Report due March 2016 Nov'15 – as above Dec '15 – not due until March 16								
Improvement plan to be devised once findings of audits are known		TBC	TBC	TBC	A reduction in unnecessary admissions for patients who are dying that could have been managed in an alternative location, more appropriate to their needs.	Reduction in the nº of patients readmitted following a fast track discharge. Reduction in the nº of patients admitted from a nursing care facility who die.	COG	
Updates – not to be updated until after March 16.								

4.3	Ensure the full implementation of the Integrated Care of the Dying Document (a care-plan that has been designed to work in hospital, hospice and in community). Currently in place in the hospitals and hospices: to be implemented in the community.	Local audit being conducted alongside national audit to identify completion of ICODD	MK / JA	Dec-15	Audit report completed	To identify areas for improvement and focused actions	N/A	EoL group
		Update Sep'15 - Data collection complete; analysis awaited. Analysis of 20 sets of patients' notes completed by members of the SPCT Oct'15 – Preliminary data available. To be presented at various forums Nov'15 – Findings to be shared. Dec 15 – Awaiting update						
		Complete programme of training within the community, to include care agencies, nursing homes etc	MS	Jul-16	Training completed	All staff will be trained and confident to use the ICODD. Patients will have care as ICODD appropriate for their needs	Training completed as plan	EoL group
		Update Sep'15 – awaiting update Oct'15 – awaiting update Nov'15 – awaiting update Dec 15 – A number of nursing homes are trailing the ICODD. It is evaluating well and will be rolled out further.						
		Three pilot teams to commence ICODD in September as pilot	MS	Dec-15	Pilot completed	To identify any areas of concern and focus for further action prior to full roll-out	Pilot completed as plan	EoL group
		Update Sep'15 – awaiting update Oct'15 – awaiting update Nov'15 – awaiting update Dec 15 – Pilot site undergoing trial						
		Roll-out of ICODD to all community areas, commencing Jan'16	MS	Jul-16	Full implementation across the Trust	Patients nearing the end of their life receive care and treatment appropriate for their needs, and in the right location.	Compliance measured (sample via certification database) re presence of care plan in records of patients expected to die. (CQUIN)	EoL group

APPENDIX 2

		Update Sep'15 – awaiting update Oct'15 – awaiting update Nov'15 – awaiting update Dec 15 – On going.						
Theme 5: Frailty Lead: Lindsey Rudge								
Action Plan N ^o	Recommendations	Action Needed	Action Lead	Timescale	Verification of achievement	Evidence of impact	KPI	Oversight
5.1	Work to take place on refining how we identify this group of patients and therefore focus planned improvement work	Detailed action plan being drafted following discussions with Sheffield Teaching Hospitals and the use of Frailsafe bundle.	DV	Oct-15	Action plan for the management of Frail patients in place and agreed			COG
		Update Sep'15 – awaiting update Oct'15 – now working towards implementation of an electronic screening as in place at Bradford. This section of CAIP to be reviewed as specific actions are identified. PMO scheme now established for Frailty. Nov'15 – Business case to be written. Dec '15 - Actions to be defined and summary bought back to COG in Feb						
5.2		Additional actions TBC according to initial findings	TBC	TBC	TBC	Improved outcomes for Frail Patients. Additional evidence TBC	TBC	TBC
		Update Sep'15 – awaiting update Nov'15 – Business case to be written. Dec 15 – Actions to be defined and summary bought back to COG in Feb						
Theme 6: Coding Lead:								
Action Plan N ^o	Recommendations	Action Needed	Action Lead	Timescale	Verification of achievement	Evidence of impact	KPI	Oversight
6.1	To improve the depth, extent and quality of clinical coding	Provision of information to new doctors so they know their responsibilities in relation to clinical record keeping for	LF	Aug-15	Scheduled slot on doctors' induction day.	Improvement in clinical records to facilitate accurate coding	Increase in co-morbidity coding Reduction in S/S as	COG
				In place and	Dedicated session			

		accurate coding		ongoing	on clinical coding as part of FY1s' education programme.		primary diagnosis	
		Update Sep'15 – training to new doctors in August, with follow-up training in September Oct'15 – training to registrars in October – resulted in additional reviewers for mortality review programme being recruited. No significant change noted to coding of co-morbidities or signs and symptoms to date. Nov'15 – ongoing Dec '15 – ongoing						
		To improve clinical engagement across all specialities and divisions	SI / AH	Nov-15	Clinical documentation is 'fit for purpose' for coding	Improvement in clinical records to facilitate accurate coding	Clinical Coding Steering group has clinical representation from all divisions Increase in co-morbidity coding Reduction in S/S as primary diagnosis	COG
		Update Sep'15 – no update Oct'15 – A 'coding and documentation' presentation was given to the new Registrars who started at CHFT in October. A pilot is to commence in the next 2 weeks with clinical coders attending ward rounds alongside 3 upper GI consultants. Aim is to improve the documentation required by clinical coders and hopefully improve the coding process. Work continues to improve existing clinical documentation to improve the quality and content of information used for clinical coding eg pre-operative assessment, medical and surgical clerking in proformas. Nov'15 – Coders to work with the GI team and join the ward round to see if capture of co-morbidities increasing and clarity of documentation improves. Dec '15 - Coding team continue to engage with clinical teams. 1 Coding PAS has been agreed and will help with this work.						
		Reports by directorate and speciality in relation to co-morbidity scores, diagnosis, signs & symptoms etc	LF	Jan-15 In place and ongoing	Monthly reports to PSQBs	To enable identification of specific areas for improvement within teams to improve coding	Improvements demonstrated	COG

		Care going to assist in improving case note documentation where they have provided Level 1 input.						
		TBC following info on clarity of new process from HSCIC	SI	TBC	TBC	All patients will have a specialist palliative care code applied where applicable	Increase in n° of patients with specialist palliative care code	COG
		Update Sep'15 – no update Oct'15 – awaiting data following implementation of new process Nov'15 – Process implemented.						
6.3	Support for clinical coding to build improvements and efficiency: Improve recruitment and retention of clinical coders	Re-band qualified clinical coders to retain existing team and attract staff from other areas	SI	Jul-15 In place and ongoing	Team structure and vacancies	Coding completed within timescales and within acceptable levels of accuracy	N° of FCEs per coder reduced to below 7000	COG
		Update Sep'15 – still remain short of clinical coders on the team and no response to adverts Oct'15 – The recruitment process continues and whilst a trainee and two ACC qualified coders will start work with the Trust in the next month there remains a gap of 5/6 WTEs. A coding contractor has been recruited to bridge the gap but the situation remains critical Nov'15 - . 2 fully Accredited Clinical Coders (ACC) and an approved Health and Social Care Information Centre (HSCIC) Clinical Coder Trainer have started in post. Still vacancies to be filled. Rolling advert back out in January. Dec 15 - Rolling advert for qualified coders continued and commenced recruitment process for additional trainee coders.						

Approved Minute

Cover Sheet

Meeting: Board of Directors	Report Author: Juliette Cosgrove, Assistant Director
Date: Thursday, 25th February 2016	Sponsoring Director: Julie Dawes, Director of Nursing
Title and brief summary: Quarterly Quality Report - The Board is asked to receive and note the Quarterly Quality Report.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Quality Committee - 26 January 2016	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

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 Q3 2015/16, all CQUIN, Quality Account and Contract requirements were achieved, with the exceptions noted below:

Patient Safety Domain:

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.

Harm Falls:

Performance is in breach of the internal target as noted in the previous report. As of the end of Q3, there were 21 falls against a year-end target of 14. A review of the Fall Strategy is due to take place ahead of creating the performance

Partial Compliance

Areas showing partial compliance during Q3 are:

Patient Safety

- Pressure Ulcer reduction: Q3 trajectory not achieved (section 1.2), looking unlikely to meet year end internal target.

Experience

- Friends and family test: low response rates. Targets have been aligned to the national performance. Some areas are doing better than comparison but A&E Response rates require improvement.

Effectiveness

- 3 out of the 4 main infections under surveillance remain above the end of Q3 trajectory:

MRSA bacteraemias 3 against a trajectory of 0,
C.diff = 17 against a trajectory of 15,
E.Coli = 27 against a trajectory of 22.

Well-Led

- Appraisal: Target for appraisal completion not met (section 5.3)

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 Quarterly Quality Report.

Appendix

Attachment:

Q3 Quality Report 15-16 FINAL for BOD.pdf

Calderdale & Huddersfield Foundation Trust

Q3 Quality Report

2015-16

Subject:	Q3 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 Q3 2015/16, all CQUIN, Quality Account and Contract requirements were achieved, with the exceptions noted below: Patient Safety Domain: 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. <i>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.</i> Harm Falls: Performance is in breach of the internal target as noted in the previous report. As of the end of Q3, there were 21 falls against a year-end target of 14. A review of the Fall Strategy is due to take place ahead of creating the performance

	Partial Compliance Areas showing partial compliance during Q3 are: Patient Safety - Pressure Ulcer reduction: Q3 trajectory not achieved (section 1.2), looking unlikely to meet year end internal target. Experience - Friends and family test: low response rates. Targets have been aligned to the national performance. Some areas are doing better than comparison but A&E Response rates require improvement. Effectiveness 3 out of the 4 main infections under surveillance remain above the end of Q3 trajectory: MRSA bacteraemias 3 against a trajectory of 0, C.diff = 17 against a trajectory of 15, E.Coli = 27 against a trajectory of 22. Well-Led - Appraisal: Target for appraisal completion not met (section 5.3)

Contents

Introduction:	pg. 5
Key Performance Frameworks	pg. 6

Domain One – Patient Safety: People are protected from abusive and avoidable harm.

1.1 Reducing patient falls with harm	pg.8
1.2 Reducing pressure ulcers	pg.10
1.3 Reducing Hospital Acquired VTEs	pg.15
1.4 Improving Medicine Management (CQUIN, Quality Account)	pg.17
1.5 Improving Sepsis Care (CQUIN, Quality Account)	pg.23
1.6 Safeguarding Patients	pg.30
1.7 Learning from Incidents	pg.41
1.8 Ensuring Effective Investigations	pg.43
1.9 Learning from CAS Alerts	pg.40
1.10 Who Checklist	pg.45

Domain Two – Effective: Peoples care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence

2.1 Reducing Mortality	pg.47
2.2 Improving Reliability – Implementing Care Bundles (CQUIN)	pg.52
2.3 Improving the Management of Acute Kidney Injury (CQUIN)	pg.55
2.4 Improving the Management of Stroke patients	pg.57
2.5 Improving the Management of Fracture Neck of Femur	pg.60
2.6 Improving Diabetic Care (CQUIN)	pg.62
2.7 Reducing Hospital Acquired Infections (Contract)	pg.65
2.8 DNACPR	pg.67

Domain Three – Experience (Caring): Staff involve and treat people with compassion, kindness, dignity and respect

3.1 Dementia (CQUIN)	pg.71
3.2 Improving the Inpatient Experience	pg.74
3.3 Friends and Family Test	pg.78
3.4 Improving Hospital Nutrition (CQUIN, Quality Account)	pg.81
3.5 Improving End of Life Care (CQUIN)	pg.87
3.6 Learning from Claims	pg.88
3.7 Learning from Complaints	pg.96
3.8 Ensuring Privacy and Dignity – Mixed Sex Accommodation	pg.110

Domain Four – Responsive: Services are organised so that they meet people’s needs

4.1 Improving Patient Flow	pg.112
4.2 18 Week Pathway (RTT)	pg.112
4.3 Outpatients	pg.114
4.4 Diagnostic Waits	pg.120
4.5 Cancer Waiting Times	pg.121

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.

5.1 Safe Staffing	pg.128
5.2 Mandatory Training	pg.133
5.3 Appraisal	pg.137
5.4 Patient and Public Involvement	pg.139
5.5 Sickness and Absence	pg.141
5.6 Staff Experience and Engagement	pg.143

Appendices

Appendix A: Learning from Mortality – Sept/Oct	pg. 146
Appendix B: Health Watch Visit to ASU (PDF)	pg. 150

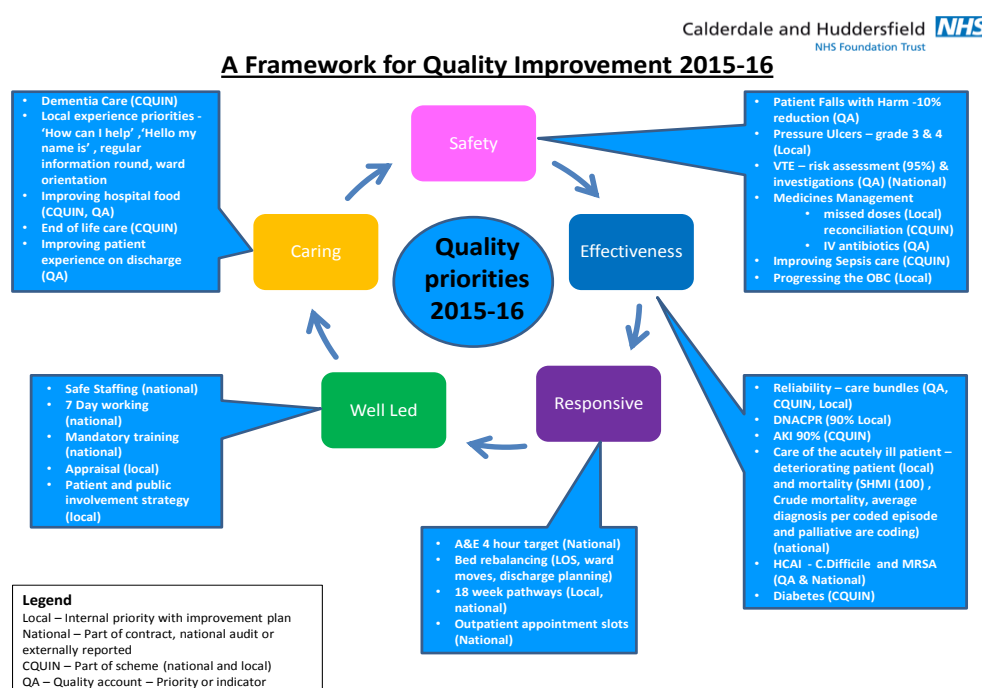
Introduction

This quarterly quality report covers contractual, quality account, national and local quality priority requirements to provide a comprehensive overview of quality performance during each 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 (aligned with CQUIN measurement)	Pg.23
Effectiveness	To ensure Intravenous antibiotics are given correctly and on time (continued from last year)	Pg.17
Effectiveness	Improving the discharge process	Pg.117
Experience	Better Food & Improving Nutrition (aligned with CQUIN measurement)	Pg. 81

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 Q2 performance box provides a quick overview of target attainment during the second quarter, where applicable.

	Indicator Name	Q3 Performance	Page
1	Acute Kidney Injury	66%	Pg. 55
2a	Sepsis Screening	61%	Pg. 23
2b	Sepsis Antibiotics	62%	Pg. 23
3	Urgent care	88%	Pg. 117
4a	Dementia - Find, Assess, Investigate and Refer	92%/100%/100%	Pg. 71
4b	Dementia - Clinical Leadership	Y	Pg. 71
4c	Supporting Carers of people with Dementia	Y	Pg. 71
5a	Asthma Care Bundle	76%	Pg. 52
5b	Pneumonia Care Bundle	70%	Pg. 52
6	Diabetes – Inpatient	80%	Pg. 62
7a	Medicines Reconciliation/E-Discharge	89%/83%	Pg. 17
7b	Medicines Discharge – Improvement	Y	Pg. 17
8	End of Life Care	47%	Pg. 87
9a	Nutrition patient satisfaction	73%	Pg. 81
9b	Nutrition reduce waste	4.84%	Pg. 81
9c	Nutrition Vending	Y	Pg. 81

Domain One – Patient Safety

Patient Safety Compliance Summary

Indicator 2015-16	Compliance Q2
1.1 Falls Reduction	Over Trajectory
1.2 Pressure Ulcer Reduction	Over Trajectory
1.3 Reducing Hospital Acquired VTEs (Contract)	Achieved
1.4 Medicines 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	VTE target continues to be achieved in Q3 2015/16
1.4 Medicines Management	Q3 target achieved for % medicines reconciled and discharge checking
1.5 Sepsis	Q3 target of 60% of applicable to patients being screened met
1.7 Incident Reporting	Incident Reporting Policy approved 31.12.15.
1.8 Effective Investigations	Two training courses delivered to develop investigation skills amongst staff

1.1 Reducing patient falls with harm

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.

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.

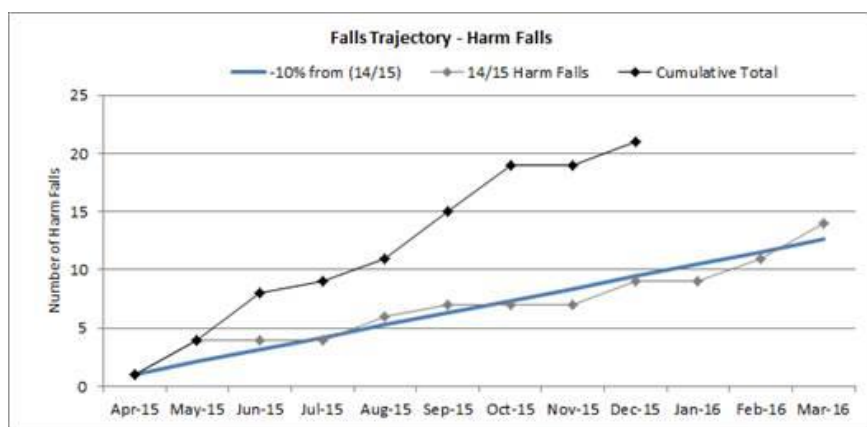
Performance surrounding the prevention of falls is overseen by the Patient Safety Group.

Current Performance

Overall Summary of Q3 performance 2015/16 for falls prevention

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. There has been a total of 21 falls with harm up to December.

Comment [MH1]: Unable to give detail of falls



Recommendations were made to the Patient Safety Group on 3 September 2015 in response to this poorer than anticipated performance the following actions have been agreed:

Update re: Improvement Plans for Q3

1. Director of Nursing to consider business case to support the roll out of a 'Fall Safe' Project with the key objective of reducing the number of in-patient falls by Improving the quality of assessments and interventions for falls prevention for patients at risk of falls; and improve multidisciplinary working with regard to the assessment and management of patients at risk of falls in particular to educate and empower ward staff to make small but effective innovation and change – this is currently on hold pending review of the internal falls strategy in Q4.
2. Introduce a Falls Investigation Prompt sheet to compliment the CHFT RCA investigation tool developed by Effective Investigation Group (to improve quality of RCA). The consultation has been delayed and the anticipated implementation is now the end of quarter 4.
3. The CHFT first Harm summit on the 10th November went ahead. Presentations were heard from the Improvement Academy and CHFT representatives from Falls, Pressure Ulcer and Medicines Management. All attendees have identified key areas for improvement such as falls mapping, improving safety huddles, a review of footwear that is available for patients at CHFT and embedding bedside handover to ensure these safety elements are of key focus in their specialities to improve patient safety. The Ward Sisters committed to these actions and it has been agreed that progress will be reviewed in February 2016.
4. Dr Greenwood has presented the feedback from the first National Inpatient Falls audit in May / June 2015 to clinical audit meetings with the exception of General Surgery.

5. 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 has now taken this work forward and is rolling it out across the division. This work has started on Ward 11 at Huddersfield Royal Infirmary. The % compliance from the latest data was 75%. The roll out is a long term and on-going strategy.
6. The Vulnerable Adults Operational Group (VAOG) has delegated the person centred ward round to the Senior Sisters and Matrons due to ensure delivery. This is to be undertaken as part of general audit (CRAS, Matrons documentation audit). The Matrons undertake 4 audits around documentation per month in their clinical areas. It has been recognised across the Trust that improvement work is needed.
7. A Falls Alarm tool to enable assessment of mental capacity and potential restriction / DoLS has completed the trial phase. The tool is to give assurance of compliance with Mental Capacity Act and DOLS. This now needs to go to the Medical and Allied Meeting on 13th January (consultant meeting) for approval prior to progressing for sign off from a documentation management perspective at the 'Nursing and Midwifery Practice Group'.

Improvement Plans for Quarter 4:

1. The Medicine Falls collaborative will be reviewing the Falls Prevention bundle following first National In-patient Falls Audit recommendations.
2. The areas with a high incidence of falls will be undertaking a falls mapping exercise, to further understand what additional measure can be put in place to aid prevention.
3. The falls prevention strategy will be reviewed, with recommendations to shape the improvement work plan for 16/17.

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. This equates to no more than 11 category 2 pressure ulcers & 5 category 3 pressure ulcers per month & no more than 3 category 4 pressure ulcers per annum.

For 2015-16 a trajectory of 10% reduction for **CHFT community** acquired category 2, 3 and 4 pressure ulcers has also been agreed. This equates to no more than 9 pressure ulcers per month.

The pressure ulcer prevention and reduction programme is being overseen by the Patient Safety Group which receives regular progress reports

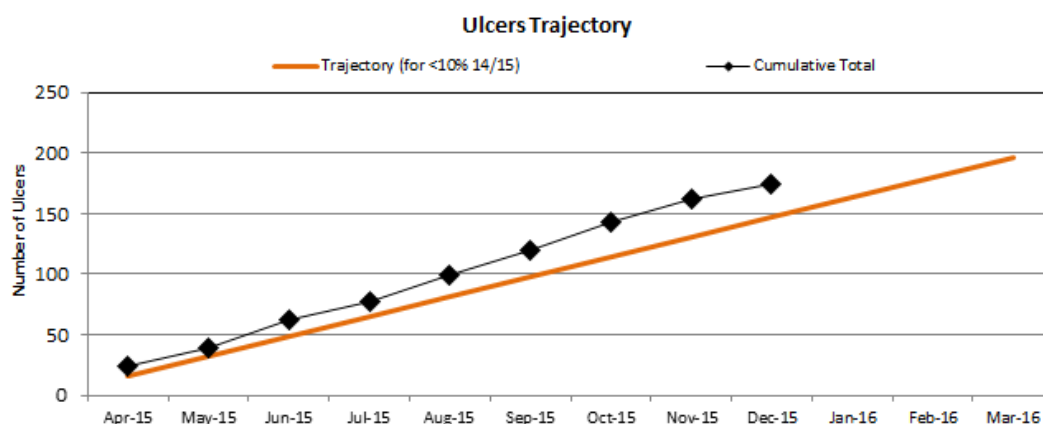
Overall Summary of Q3 & year to date performance 2015/16

CHFT hospital acquired pressure ulcer incidents are above the planned improvement trajectory for Q3 with a total of 186 incidents up to the end of Q3 compared to a trajectory of 147. It is looking very unlikely that the year-end target will be met.

Community pressure ulcers have exceeded the planned improvement trajectory for Q3 with 220 incidents compared to a trajectory of 78. The target for the year is 104.

The increase in incidents is related to ongoing issues highlighted in 2014/15, which includes increased awareness of reporting following training, the impact on continuity of care that has arisen through unplanned capacity (particularly at CRH) & subsequent use of agency staff. Root cause analyses of the most severe pressure ulcers demonstrated that the pressure ulcers were related to patient issues/conditions, equipment issues, education & training, accuracy and timeliness of assessment and record keeping.

Hospital acquired pressure ulcer trajectory

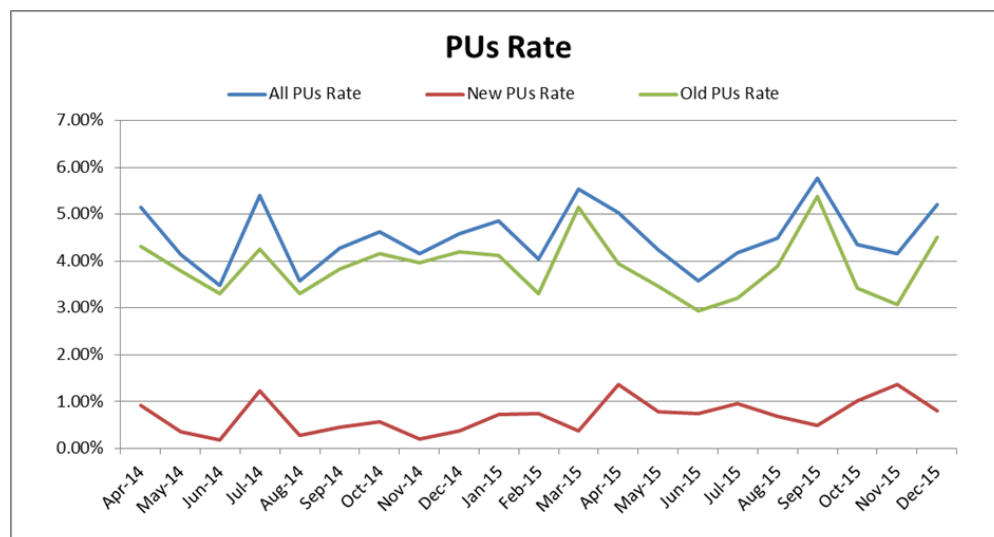


Safety Thermometer

Pressure ulceration is one of the harms measured as part of the Safety Thermometer. The measure includes old pressure ulcers (pre-existing & occurring within 3 days of admission) and newly developed pressure ulcers.

For Q3 the average rate for new pressure ulcers is 0.99% which is an increase of 0.32% from Q2. The overall rate for Q3 is 4.37% which is a decrease of 0.40% from Q2. When benchmarked against national data (obtained from HSCIC) CHFT rate for all pressure ulcers

is above the national average for Q3 (4.24%) but below the rate for new pressure ulcers (0.93%).



Completed actions in Q3

- Ongoing clinical support and training is being provided to wards to ensure appropriate use of pressure relieving equipment, however, to date no wards have achieved required training & competency assessment for this equipment.
- All severe (category 3 and 4s) CHFT acquired pressure ulcer investigations now have Senior Nursing approval at the completion stage, a new process is being introduced to undertake cluster investigations of pressure ulcers where themes are identified if serious harm has been caused. The new approach which will involve a panel review of pressure ulcers to ascertain if harm was avoidable and whether harm was caused.
- This will allow better identification of learning from incidents.
- A review of all pressure ulcers in quarters 1, 2 and 3 is being undertaken following identification of reporting of pressure ulcers that are not attributable to CHFT.
- 4 editions of the Pressure Ulcer Newsletter have been published and circulated across CHFT.
- Tissue Viability team have commenced validation of severe pressure ulcers although the timeliness of this continues to present a challenge due to clinical demand. –the expectation is that all category 3 and 4 pressure ulcers are reviewed by a Tissue Viability nurse within 24 hours. Going forward this will be measured as a key performance indicator for senior specialist clinical review
- The Tissue Viability team are providing training to new RGNs, HCAs and apprentices on pressure ulcer prevention as part of the trust induction plan and continue to support a commissioned programme of education in community.
- The team are reviewing e training and education modules to support wider access to training and education tools available.
- A poster competition was held to help raise awareness of heel ulcers. A winner has been selected.

Improvement Plan:

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

- There is to be an introduction of a new pressure ulcer risk assessment tool. Work is ongoing to establish whether this tool can be successfully adopted in line with the introduction of the Electronic Patient Record.
- Competencies for the prevention and management of pressure ulcers will form part of the competency assessment for new nurses. The competencies are due to be ratified in January at the Clinical and Vocational training operational group(CVTOG)
- HCA competencies *have also been developed*. They have been forwarded to the HCA apprentice lead for review, these will then be approved at the next CVTOG
- Doncaster model of training: an expert nursing programme is being delivered across Doncaster & Bassetlaw Foundation Trust. This has realised a 30% drop in pressure ulcers. This model for improvement was supported by the recruitment of 3 additional Tissue Viability Nurses. The programme has been supported at board level with an expectation that wards lead their improvement with support from the specialist team. This support includes independent audit and rigorous competency based training on pressure ulcer prevention and management. The specialist nurses support a number of ward areas for a period of 6 months. This includes a 2 day training programme for key members of staff (including ward sisters/ charge nurses). Competencies are assessed by the tissue viability nurses and in order to complete the training staff must achieve 90% to pass; this includes practical and cognitive skills. 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) & team vacancies have been filled. This would then amalgamate current training provision
- New equipment (Repose Wedge) has been positively evaluated by ward staff. This device offloads pressure from the heel thereby reducing the risk of pressure ulcers. The procurement process commenced this quarter, with 20 devices ordered for each hospital. These devices will be distributed the areas with the highest levels of dependency/ pressure ulcer incidence. Prior to distribution training will be delivered to ensure appropriate use.
- The MOP (moisture or pressure) tool will be tested on ward 19 This tool helps staff to accurately identify whether tissue damage is due to pressure, moisture or both and act accordingly
- The winning poster from the Heel Pressure Ulcer poster competition will be printed and distributed across the organisation in January.
- Risk management have reviewed the process for completing and submitting RCAs as well as external reports.

Community plan

- Pressure area training should be delivered to all community teams.
 - Monthly training sessions are being delivered to community nursing staff. Non-nursing teams have also been invited to attend. Training includes pressure ulcer prevention and management.
- Information for care staff needs to be clear, specific, patient focused and highly visible.

- A communication sheet has been developed in order to improve communication between District Nurses & Home Care staff.
- Development of a tool to raise awareness of levels of risk for patients in residential care homes is in development.
- Concerns with care agencies or care staff should be escalated in a consistent and timely way.
 - This aspect of care is included within staff training and communication will be delivered to raise awareness regarding reporting processes.
- Skin inspection should be integral to the role of all relevant professionals. Care between multiple professionals should be joined up with clearly defined responsibilities. Daily handover should include a discussion around every patient who has been seen who is at high risk of developing a pressure ulcer.
 - A community team is working with the Improvement Academy to introduce the Safety Huddle. A multi-disciplinary approach will be adopted.
 - Quality indicators will be shared with community teams.
 - Investigations into severe pressure ulcers are being shared at the divisional Patient Safety & Quality Board meetings. A monthly thematic report will be shared at team brief.
- Ensure that patients who are refusing pressure area care are fully aware of the risks involved.
 - A patient information leaflet is available however, a pictorial guide will also be produced to aid discussions with patients and their families.
 - Issues relating to patient choice, mental capacity and documentation are included in the training programme being delivered to all community staff.
- Patients should be given individualised self-management plans to manage their pressure area care.
 - Self-management plan is in development.
- Equipment checks should be carried out as part of pressure area care.
 - This will be added to the SystmOne care plan.

Tissue Viability Service

The Tissue Viability team is a nurse-led service that provides expert advice and support to patients and colleagues across the health economy. The team provides clinical advice, assessment & treatment as well as training on a range of topics, such as pressure ulcer prevention and equipment use and the monitoring of pressure relieving equipment within the hospitals.

The Tissue Viability team has continued to provide training on pressure ulcer prevention & management, wound care and leg ulcer management. However, due to resource issues, half of the planned sessions have not taken place. The team has supported training for apprentices and new nursing recruits and will review the delivery of training to allow wider access via e training modules and tools

The Tissue Viability service has seen a significant increase in referrals April-September 2015 in comparison with the same period for 2014. The total number of referrals for this period in 2014 was 763; this has risen to 990 (approx. 30% increase). There has been an increase in the number of patients referred with pressure ulcers and leg ulcers from Greater Huddersfield (including Locala & CRH & HRI). The impact of this increase in referrals and

changes to the pressure ulcer validation process has affected the team's ability to provide additional support to clinical areas in terms of training.

The team comprises of 1 WTE Lead Nurse, 2 WTE Tissue Viability Nurses, 1.6 WTE Equipment Co-ordinators & 0.21 WTE Admin Clerk. However, as a result of the Care Closer to Home contract, one of the Tissue Viability Nurses has transferred to Locala on 1st November 2015. The full extent of the impact of this change is not known but flexibility and efficiency may be affected as will ability to provide training and support regarding improvement. The change will create a risk to the organisation in relation to response times to referrals and pressure ulcer incident validation, capacity for clinical visits and provision of education and training as well as leading improvement. The service will become more reactive rather than proactive, which may have an added impact on pressure ulcer incidence. In addition to this change the Lead Tissue Viability Nurse Post will be vacant until a new post holder commences.

From 2012 Calderdale CCG has commissioned the service (on a year by year basis) to provide additional support to nursing homes within Calderdale. This support has included training & education and service improvement e.g. introduction of the SKIN bundle. This service is supported by 1.6 WTE Tissue Viability Nurses & 0.21 Admin Clerk (fixed term). The fixed term for these posts ends 31.3.2016. The team are still waiting for a response from the CCG regarding the future of this project.

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.

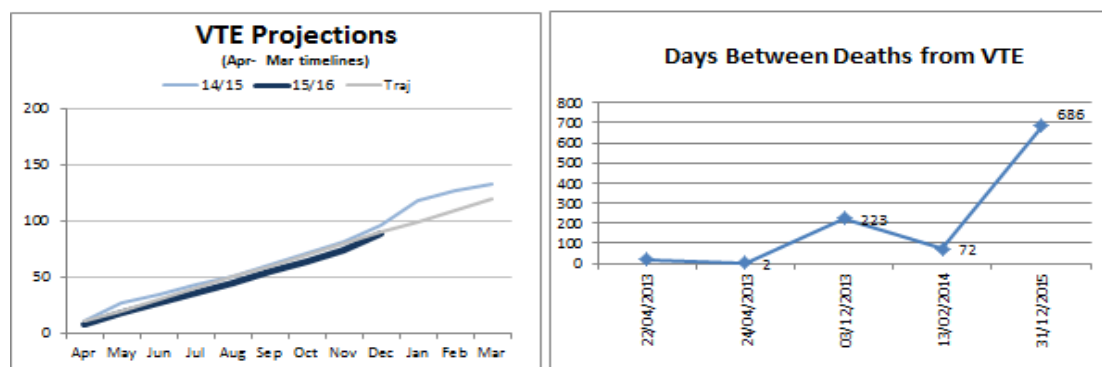
It has been estimated that the management of hospital associated VTE costs the NHS millions per year. This includes the costs of diagnostic testing, treatment, prolonged length of stay in hospital and long term care. Long term complications that reduce the quality of life add to the human cost and overall 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 VTE Committee agreed new trajectories for 2015/16 as follows:

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

Current Performance

The Trust has achieved all its VTE targets for Q1, Q2 and Q3



All HAT Cases are subject to a Root Cause Analysis (RCA). There were 33 cases throughout October 15 – December 15. Of these 33 cases, 29 had undergone RCA, all of which were found to not be preventable. NB - There are 4 RCA to be completed at the time of reporting. All 29 had been correctly assessed for the risk of developing a VTE and had been prescribed the appropriate prophylaxis where indicated or had contraindications to receiving prophylaxis. These findings are shared with the Divisional Patient Safety Quality Boards on a quarterly basis and the Patient Safety Group six monthly.

A new process has been designed for reviewing all HAT cases. This process was been signed off by the Thrombosis Committee, with the aim of being in place from november 1st.

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

The table below shows the latest data available regarding how we are performing in comparison to other local trusts on VTE risk assessments in Q1. Data is not yet available for the last two quarters.

Organisation Name	Quarter 1 2015-16		
	VTE Risk Assessed Admissions	Total Admissions	% of Admitted Patients Risk - Assessed for VTE
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	24663	24958	98.8%
YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	31702	32649	97.1%
LEEDS TEACHING HOSPITALS NHS TRUST	43997	45861	95.9%
MID YORKSHIRE HOSPITALS NHS TRUST	33622	35165	95.6%
AIREDALE NHS FOUNDATION TRUST	13720	14359	95.5%
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	23430	24605	95.2%
	3371530	3513583	96.0%

Improvement plans for Q3 2015/16

The VTE assessment is being developed onto the nerve centre. There is not yet a date for when this will be implemented, but once it is established it will be piloted and then rolled out trust wide. This will have the benefit of monitoring completion in real time, meaning where assessments are not done this will be picked up on whilst the patient is still in our care and rectified at the point of needs

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 prevents 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.

Q3 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 are in breach of policy as outlined in section 12 of the Medicine Code (Preparation & Administration of Medicines) and documentation on Prescription Chart & Administration Records.

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

The last missed doses audit was undertaken week commencing October 12th. This was one month later than usual for Q2 and was because the new pre-Registration Pharmacists who collect the data had only just come into post and had to receive training to enable them to collect the data.

	Q1 15/16	Q2 15/16	Q3 15/16
For all missed doses	13.37%	17.26%	Audit being undertaken week commencing January 11 th
Intentional missed doses	5.57%	8.50%	
Unintentional missed doses	7.80%	8.68%	
Blanks	216	268	
Ticks/crosses etc	32	45	

Performance did slip but unintentional missed doses remains below 9.0%. The next Trust wide missed doses audit will take place week commencing January 11th. Data will be collected for one 24 hour period in order to establish the number of intentionally missed and unintentionally missed doses.

Specific information/guidance has been drafted for Registered Nurses/Midwives and separately for Prescribers in order to them to work together to reduce unintentional missed doses from prescribing and administration perspectives.

In order to ensure that performance improves and remains below 9.0% results continue to be fed back to all Ward Managers/Matrons, the Nursing and Midwifery Practice Group and to the Nursing and Midwifery Committee.

There is an ongoing campaign to encourage patients to bring all their medicines and diabetes related equipment into hospital with them so they can manage their medicines if they are able and reduce the number of missed/delayed doses. Work has now spread to the Yorkshire Ambulance Service and other regional NHS Trusts. The plan is for a targeted approach to encouraging this practice. This would include the use of a 'sealable green medication bag' (that is currently being used for medicines when a patient is transferred or discharged) that would be used by ambulance staff when they bring patients from home to a Medical Assessment Unit, Surgical Assessment Unit, Accident and Emergency, Coronary Care. In addition, tests are to be carried out in January (to get a baseline) and then February to establish if more patients (presenting for surgery) than before bring their medicines and diabetes related equipment into hospital after being given a green bag in Pre Assessment.

Wards continue to be encouraged to check Prescription Chart & Administration Records on each shift change/handover to check documentation and ensure doses have not been missed. It also gives the opportunity to 'challenge' colleagues. Identifying missed doses and

raising any concerns with the nurse in charge is also part of the mock CQC medicines management audits. These audits are used to populate individual ward/departmental action plans for improvement.

In the future, EPR will allow CHFT to run missed/delayed dose reports at any point so missed/delayed doses, good practice and practice in need of improvement can be identified and acted upon quickly.

Medicine Reconciliation and Discharge Checking:

All targets achieved through Q1, Q2 and Q3.

	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3
	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15	Total	Oct-15	Nov-15	Dec-15	Total
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												
The number of patients on acute medical wards having a medicines reconciliation process by pharmacist or pharmacy technician during hospital stay	1998			1998	1974			1974	635	642	677	1954
The total number of patients admitted to acute medical wards	2375			2375	2391			2391	742	740	704	2186
% Medicines following the reconciliation process	84%			84%	83%			83%	86%	87%	96%	89.39%
Target	80.0%				80.0%				80.0%			
	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3
	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15	Total	Oct-15	Nov-15	Dec-15	Total
Discharge Accuracy Checks												
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	2375			2375	2391			2391	742	740	784	2266
The number of patients (admitted for longer than 24 hours) on acute medical wards	2956			2956	2814			2814	878	890	950	2718
Discharge Medication - total	80%			80.3%	85%			85.0%	84.5%	83.1%	82.5%	83.37%
Target	70.0%				70.0%				70.0%			

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 q1 was to scope out how intensive audit work could be carried out to examine this in detail. The wards which have been identified to undertake this improvement work are 4 (now ward 5) and 8 at HRI, 6b and 7d at CRH.

There are two elements to this CQUIN:

Part 1 – to improve the accuracy of information on the e-discharge about medication changes made during the admission. This builds on the discharge accuracy check which just focuses on transcription of the medicine chart.

Quality of information on discharge has already been identified as an issue and junior medical staff have made a 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
A =Amended dose
N =New Drug

The following elements of the e-discharge will be audited against the patient's notes and the medicine chart before discharge:

- Medicines reconciled
 - If not reconciled – is the TTO a full list of all medicines
- Accurate transcription of discharge medication from the medicine chart
- Correct information about medication changes
 - Medication changed (i.e dose amended or started)
 - Includes reason
 - Medication stopped
 - Includes reason
 - Medication to be continued by GP
 - If no, course length specified

A bundle approach will be applied – i.e all elements need to be correct.

Q1 – a snapshot audit showed that only 40% of e-discharge prescriptions were completed correctly according to this criteria. Improvement work will be undertaken in real time during working hours, in Q2 will be Mon-Friday discharges:

- pharmacist will check for accuracy against the audit tool

Measure – monthly audit discharges from identified wards

- 10 from 6b and 8
- 5 from 7d and 4

Improvement targets:

Proposed Targets	Aim	Actual
Q1 Baseline	40%	40%
Q2	45%	63%
Q3	50%	56%
Q4	55%	

Part 2 – to ensure that patients leave the hospital with correct medication. There continue to be errors when patients are discharged from hospital as incorrect medication is given to patients e.g. incorrectly labelled, unlabelled ward stock, medication which has stopped during the admission.

Currently it is nursing staff's responsibility to hand medication to patients at the point of discharge. During Q1 the process of giving medication to patients has changed from a two nurse check to a single nurse checking discharge medication. It is anticipated that one nurse check will take more responsibility for ensuring correct medication is supplied and should reduce any errors on discharge.

Q2 - recorded the number of locker checks evidenced as a percent of the total EDS checked by pharmacy.

Q3 – continue as for Q2, whilst planning for increased involvement during Q4 following appointment of a ward based technician.

Q4 – plan to identify patients for discharge from the target wards each day. The ward based technician will then visit the ward and check patient's locker and discuss medicines with the patient.

	Target	Actual
Q1	Nil	Nil
Q2 Measure baseline of number/percentage of locker checks being carried out (and recruit technician)	Baseline	25%
Q3 Increase the number of locker checks and establish a baseline for the information giving/bag go through element by the technician	Baseline +5% = 30%	36%
Q4 Increase the information giving element, increase/maintain locker checks depending on level of compliance already seen, this task could be replaced by the technician so may no longer need to measure this.	Q3 + 5% = 41%	

Medication Safety

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

Q3 planned improvement:

Incidents involving Oxycodone are a reoccurring theme. Information has been distributed to prescribers, nurses and pharmacy staff updating and reinforcing the standards for **Storage**, **Prescribing**, **Recording**, **Endorsing**, **Administering** and **Dispensing**. Any new incidents are

being followed up to see what impact the above guidance has in terms of reducing risk and implementation

Clinical areas have been issued with a laminated poster to support safe administration of antibiotics in patients with allergies which is to be applied to the medicines trolleys and displayed where intravenous medicines are prepared.

Nursing leads continue to undertake work looking at the storage and management of medicines in their clinical areas with the aim of identification of any gaps and areas for improvement.

A task and finish group is meeting to discuss Controlled Drug (CD) management in the Trust with a focus on patients own CDs, checks on CDs at ward level and improving the acquisition of signatures for ordering CDs.

Responding to the NHS England Alert: Support to minimise the risk of distress and death from inappropriate doses of Naloxone (Stage 2 Alert)

Medication Safety Group is looking at the medication incidents submitted in the previous month and identifying any themes or areas for follow-up.

Medication Safety Group is working on a checklist for incidents involving allergies to standardise what is reviewed in an investigation and help identify actions which will minimise the risk of an incident reoccurring.

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) has 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:

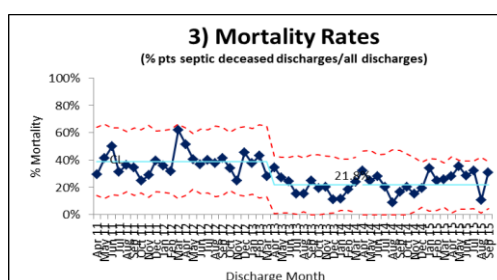
- 90% by Quarter 4 of emergency admissions being screen for sepsis where appropriate. Q3 target =60%.
- 90% by Quarter 4 those patients who have been identified as Septic having received antibiotics within an hour of admission. Q3 target =60%.

Q3 Performance:

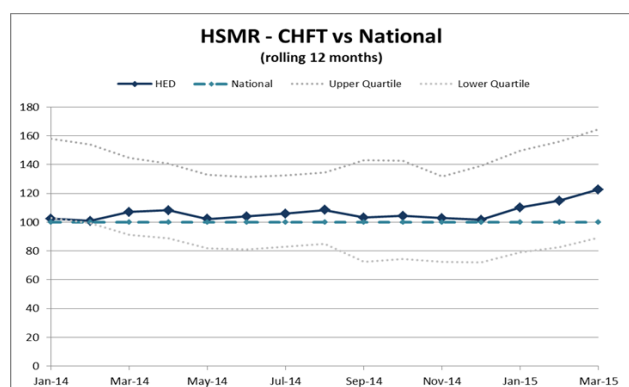
Over the first three quarters the crude mortality rates for patients diagnosed with sepsis has been higher than the 14/15 average.

	Q1	Q2	Q3
Number of Discharged	133	139	103
Number of deaths	41	36	23
Mortality Rate %	30.8%	25.9%	22.3

*Awaiting December Data



A corresponding rise in the trust HSMR has also been seen for this condition. However the ration does still remain in the “as expected” range, with a HSMR of 120 (LCI 95, UCI 160).



The Sepsis Collaborative maintains a close eye on the key metrics each month, and there is no clear reason for the apparent rise in mortality. The Trust has recently begun a mortality case note review process (see section 2.1). During Q3, 7 out of the 12 sepsis deaths

(assigned into the Dr Foster diagnosis group of septicemia) underwent review, 6 cases showed no evidence of preventability and scored a Hogan 1. 1 case scored a Hogan 2 - Slight evidence of preventability. A Hogan 2 is assigned when there are elements of the care which could have been improved but were extremely unlikely to affect the patient outcome, in this instance it was related to the non-delivery of antibiotics within the hour.

It is important to note that the Hogan score runs from 1 – 6, with 6 being definite evidence of preventability. The reviews for Q2 and Q3 are currently undergoing further analysis.

Screening for Sepsis:

Performance for Q3 was 60.7% of applicable patients being screened. The CQUIN aims were met as indicated by the green box below. Q4 Performance target is set at 90% and will be a considerable challenge. See Q4 improvement plans for details on work ongoing to improve compliance to this level.

	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3
2.2a - Sepsis Screening	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15	Total	Oct-15	Nov-15	Dec-15	Total
Number of emergency patients who had a NEWS score of 5 and above and were screened for sepsis	5	5	5	15	4	4	2	10	32	28	31	91
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	9	8	8	25	50	50	50	150
% Eligible patients screened for Sepsis	83.3%	83.3%	100.0%	88.2%	44.4%	50.0%	25.0%	40.0%	64.0%	56.0%	62.0%	60.7%
Target	Baseline				Further Baseline Data				60.0%			

Antibiotics within an hour:

The CQUIN aim for Q3 was to achieve 60% of Red Flag/Sever septic patient presenting as an emergency having antibiotics prescribed and delivered within an hour and was achieved.

	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3
2.2b - Sepsis Antibiotic Administration	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15	Total	Oct-15	Nov-15	Dec-15	Total
Number of patients (in sample) with severe red flag or septic shock who received IV antibiotics < 1 hour	3	5	5	13	9	4	12	25	8	12	5	25
Patients who had recorded evidence of severe, Red Flag or Septic Shock on emergency presentation who should have IV antibiotics < 1 hr	7	17	8	32	13	9	12	34	14	16	10	40
% Patients with severe red flag or septic shock that received IV antibiotics < 1 hour.	42.9%	29.4%	62.5%	41%	69.2%	44.4%	100.0%	73.5%	57.1%	75.0%	50.0%	62.5%
Target	Baseline				Further Baseline Data				60.0%			

What we have achieved in the first three quarters

- The new sepsis protocol includes a new trigger to identify high risk/red flag sepsis at an early stage and therefore initiate more timely treatment. The protocol was rolled

out in September to coincide with World Sepsis Day. Feedback during Q3 has highlighted that the new chart requires some updates. These changes will be address in the coming quarter.

- The GP referral criteria have now changed for admissions into MAU and SAU. This will again capture early indications of sepsis. GPs will be asked to complete the initial set of observations on the referrals. This process began in Q1 (May 2015) and saw a detailed roll out in Q2. Feedback gathering in Q3 is showing that the new paperwork has prompted questions and appears to be increasing awareness of those patients who are presenting with possible sepsis.
- During Q1 and Q2 testing of the process for the collection of CQUIN data commenced. This highlighted the need for additional support to ensure that this process is smoother and therefore more effective in both the collection of the information and implementation the learning from any findings. The lead QI nurse was recruited in October 2015 and is working with the clinical teams to identify the barriers to compliance with the screening tool and antibiotic delivery with an hour.
- During Q3 the QI nurse spent time mapping out the current processes and delivering ward and Emergency Department education to reinforce the benefits of accurate screening and timely antibiotics.

Improvement plans for Q4:

- Ongoing testing using quality improvement methods will be agreed by the Sepsis Collaborative to refine screening at all admission points and reduce time to antibiotic. These will be undertaken in specific clinical areas prior to widespread roll-out.
- A sepsis engagement session will be run at the end of January with the clinical teams; this will follow a Work Together to Get Results model to address the barriers faced in delivering high quality care to septic patients.

1.6 Safeguarding Patients

Aims and Objectives of Work

It is vital that Safeguarding standards are maintained, continue to improve and accountability remains clear and unambiguous. With this in mind safeguarding remains a key priority within the Trust for 15/16 and that staff are fully supported in delivering safe and quality services.

The specific 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

(i) Q3 Progress.

From January 2016 all contacts with the safeguarding office are now being captured centrally. Further work is planned to explore how more in-depth capturing and recording of pressure ulcers on Datix can illicit if pressure ulcers are preventable and potentially a result of abuse or neglect.

Data capturing continues to be reviewed and analysed, alongside other mechanisms for collecting data. Data now is being captured by the safeguarding team which will provide information for divisional managers regarding numbers of concerns raised, ward or departments and type of concern, including Mental Capacity Act activity and Deprivation of Liberty Safeguard authorisations.

In order to address concerns on ward areas the Vulnerable Adults Operational Group has now formulated an action plan to support wards. The Vulnerable Adult's Operational Group have teamed up with Matrons, senior sisters and charge nurses to support understanding and monitoring of vulnerable adult care. Further work regarding escalating concerns has been carried out and will be disseminated in January to form part of our commitment to joint working in line with the Care Act 2014.

Originally work was planned to begin developing the safeguarding strategy; this is now ongoing as part of the safeguarding action plans for 2016, in line with Trust and Safeguarding Team priorities.

The Safeguarding Team have worked with the Risk department to develop guidance for staff regarding completing legal statements, and to support staff when they are required to attend at Court and Coroners Court.

Internal lines of accountability and structures within the Trust have now been reviewed to support both the safeguarding adult and children's agendas to enable a clearer process for the safeguarding committee to actively support and seek assurances from the Divisions and Departments, and share safeguarding information.

The safeguarding structure within the Trust has been reviewed and the Safeguarding Committee Meeting now will report to the quality committee. This meeting will now be chaired by the Director of Nursing. The separate children and adult operational groups will now combine to form a Joint Children and Adult Operational group which will be chaired by the Head of Safeguarding, and report directly to the Safeguarding Committee. Both the Safeguarding Committee and the Operational Group will be able to initiate task and finish groups to complete pieces of work and report directly to the Safeguarding Committee.

The Allegations Management Policy is being reviewed and updated at present by both Human Resources and the Safeguarding Team. A database is now kept of any allegations that are made against members of staff and data is shared on a quarterly basis.

ii) Training

The last quarter has seen a decrease in compliance for level 1 adult and children from 68.3% to 66.1%.

Level 2 joint adult and children's training continues to be delivered face to face while the eLearning package is being developed; this is anticipated to be ready by the end of January. This training has increase from 48.4% to 53.2%.

The level 3 children safeguarding training compliance has increase from 60.1% to 64%, and PREVENT increased from 37.5% to 51.4%.

The level 3 safeguarding adults training is not being recorded in %. This will be captured once the groups of staff have been re-reviewed.

The Safeguarding Team have reviewed the groups of staff within the Trust who require different levels of safeguarding training. This work is being supported by the Divisions by then allocating the groups of staff to the correct levels of training. The Workforce Department will 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 mandatory training. This piece of work has arisen since a number of anomalies have been identified.

Other work has included;

- Further work update and development of the 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 8th edition the Safeguarding Newsletter in 2015 provided further updates and information for staff. This includes key messages regarding MCA, DoLS, Principles into Practice, and information regarding when a patient dies who is subject to a DoLS. There is information regarding Child Sexual Exploitation and the team have further plans in 2016 to ensure this is a key priority in its action plan. There is information on how to keep babies safe from suffocating or choking from nappy sacks. Dissemination of this information has arisen out of the Trust activity within the Child Death overview process, to ensure that national lessons are learned and shared locally.
- Information was shared at the Nursing and Midwifery committee regarding Private Fostering and how to identify when a child is being privately fostered following from promotion and raising awareness from the Calderdale Safeguarding Children Board.
- The Trust has contributed to Section 11 audits for both Kirklees and Calderdale Councils, alongside providing the Local Children Safeguarding Boards with assurances regarding its plans on how it the Trust safeguards children.
- The safeguarding team have worked with the Risk Department to contribute to the Incident and Inquest policies and have been involved with ensuring that safeguarding cases are highlighted with the risk department.

Improvement Plans for 2015/16 (Quarter 4)

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. There are further plans to meet weekly to discuss safeguarding concerns, complaints and Trust incidents.

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. Key updates and messages to these Boards are planned with up to date safeguarding information and data.

Work has commenced on reviewing historic Serious Case Reviews/ Domestic Homicide Reviews and Serious Adult Reviews to provide assurance that actions and lessons are recorded and audited. This piece of work will be ongoing.

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 is ongoing. With further planned collaborative working with Discharge Matron and continued attendance at the length of stay meeting.

Work is also ongoing to continue to embed a safeguarding culture and emphasise that safeguarding is everyone's business Trust wide.

Reporting of Female Genital Mutilation (FGM) is in place within the Trust. This has resulted in the production of a guideline which is currently awaiting further comments. The guideline is expected to be distributed before the end of January 2016, and briefing sessions are planned for staff. These sessions are also to be rolled out to maternity, gynaecology and sexual health forums, along with medical, surgical and community divisions.

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. Further work is planned for CSE briefings for 2016.

Datix Incident Reporting: Further ongoing work is continued to ensure that systems are in place where safeguarding concerns are reported through the Trusts internal reporting mechanism. This work also includes ensuring the Trust is meeting its obligations in relation to the Care Act 2014 by involving the Local Authority partner organisation.

Training: Further work with the Volunteers Service managers in capturing all volunteers safeguarding training is planned for 2016.

The Safeguarding Team are collaboratively working with Bradford Teaching Hospitals Safeguarding Teams to ensure there is a robust system when the Electronic Patient Record goes live this year.

Mental Capacity Act and Deprivation of Liberty (DoL) Safeguards: The Mental Capacity Act and DoLS policy is currently part of the Adult Safeguarding Policy. There are plans to separate this and include a clear training plan and strategy within the Trust.

1.7 Learning from Incidents

Key messages:

- A 1% increase in CHFT incidents recorded in Q3 2015/16 compared to Q2
- Slips, trips, falls and collision is the top reported incident type (569), as in Q2

- Medical Division is the highest reporter of incidents (1,138), as in Q2
- Operating Theatres is the highest reporting department (171 incidents), due to an increase in incidents reported regarding bed availability
- There were 22 serious incidents reported in Q3, of which 16 were pressure ulcer incidents
- 1 reported never event was reported in Q3 which was de-logged following further investigation

Numbers of Incidents in Q3 with Divisional breakdown

For the period 1 October 2015 to 31 December 2015 a total of 2,488 CHFT incidents were reported, an increase of 21 incidents (1%) compared with figures reported in Q2. The increase in reported incidents indicates an improved reporting culture throughout the Trust.

Table 1 below shows the number of incidents reported in Q3 per division. The Medical Division reported the highest proportionate (46%) of total incidents. This is similar to the distribution of incidents reported in Q2.

Table 1: Incidents reported by Division

Reported incidents 2015 /16	Q2	Q3
Medical Division	1152	1138
Families and Specialist Services	622	635
Surgical & Anaesthetics Services Division	579	579
Community Division	202	104
Estates and Facilities	29	26
Corporate Division	5	5
Huddersfield Pharmacy Services	0	1
Totals:	2467	2488

Note: 78 incidents are going through the coding process and require the appropriate organisation allocating. Of these, 13 (16%) were reported in January 2016 relating to incidents occurring in December 2015.

To note the above report now focusses on CHFT incidents only and excludes incidents reported within the Trust relating to incidents that Trust staff report about others, such as nursing homes, primary care, external agencies.

CHFT Incidents

The top 20 reported incidents for Q3 are shown in table 2, with slips, trips, falls and collisions accounting for 28% of these.

A breakdown of the reported falls is provided in table 3.

Table 2

Top 20 reported incidents	Q3 2015/16
Slips, trips, falls and collisions	569
Administration or supply of a medicine from a clinical area	183
Adverse events that affect staffing levels	162
Lack of/delayed availability of facilities/equipment/supplies	133

Connected with the management of operations / treatment	123
Patient's case notes or records	104
Pressure sore / decubitus ulcer	86
Discharge	83
Infection control	70
Accident caused by some other means	69
Communication between staff, teams or departments	66
Abuse etc of Staff by patients	57
Transfer	52
Administration of assessment	41
Medical device/equipment	39
Transfusion of Blood related problem	35
Electronic Patient Record	35
Medication error during the prescription process	34
Security incident related to Personal property	33
Post-partum haemorrhage > 1,000ml	31

TOTAL

2005

The figure in Table 2 of 2005 incidents is lower than the Q3 incident figure of 2488 as it includes information on only the top 20 incident categories. The remaining 483 were distributed amongst other less frequently seen categories.

Analysis of Slips, Trips and Falls Data in Q3

Table 3 below provides details of falls that were reported during Q3. Suspected falls were the highest (81%) reported type. Of these, 74% were graded green (no harm) and 25% yellow (low/minimal harm) incidents.

Table 3: Analysis of Slips, Trips and fall data for Q3 2015/16

Q3 Falls by Adverse Event and Severity	GREEN	YELLOW	ORANGE	Total
Unexpected collapse	4	2	0	6
Collision with an object	0	1	0	1
Faint during procedure or treatment	0	3	0	3
Fall from a height, bed or chair	9	8	0	17
Fall on level ground	50	21	1	72
Struck against furniture/object/fitting	0	2	0	2
Suspected fall	341	117	4	462
Tripped over an object	4	2	0	6
Totals:	408	156	5	569

The Trust has implemented a falls programme which aims to reduce the number of falls resulting in harm by 10% during the year 2015 – 2016 (see section 1.1). The action plan focuses on improving documentation which meet national and local standards; ensuring all patients being admitted undergo a falls risk assessment and a falls management care plan is implemented; undertaking thematic reviews of in-patient falls and identifying learning for

enhanced care; increased staff engagement regarding falls prevention work, sharing patient stories and provision of appropriate staff training.

Incidents by Department:

Table 5 shows the highest reporting ward/department (Top 20): The top 3 reporting ward/departments accounted for 35% of total incidents reported. These occurred within the operating theatres (14%), labour delivery/recovery post-natal unit (13%) and accident and emergency (7%).

Table 5

Operating Theatre	184
Labour Delivery Recovery Post-natal Unit	171
Accident and Emergency	131
HRI MAU	83
C3ABCD Paeds	78
Patient's Home	71
HWD19 Trauma	69
CWD5B	53
HWD8	51
HWD6	48
CWD7D	47
CWD6A	45
HWD20 Trauma	45
Intensive Care Unit/High Dependency Unit	45
Surgical Assessment Unit	43
CWD5D	42
Acute Stroke Unit CRH6D	40
HWD5	40
CWD2C MAU CRH	37
CWD2D MAU CRH	35

TOTAL 1358

Operating theatres was the area with the highest number of incidents with 184 incidents, 77 of these of 184 incidents related to lack of or delayed availability of beds. The figure in Q2 for Operating Theatres was 82.

Labour delivery recovery post-natal unit was the second highest area of incidents, with 171 incidents of which 48 of the 171 incidents involved a simple complication of treatment. This is a slight reduction on the number of incidents reported in Q2 which was 194 incidents.

Incidents by Severity: Table 6

The numbers of incidents by severity in Q3 were:

Table 6

2015-16	Q3
GREEN	1891
YELLOW	504
ORANGE	23
RED	13
Totals:	2431

77% of reported incidents were no harm (green), 21% were low/minimal harm (yellow), 1% were moderate/short term (orange) and 1% were severe/permanent or long term (red). These figures reflect a good reporting culture whereby the majority of incidents caused no harm to patients.

Learning from Incidents:

Examples of learning from incidents given in this section include:

- Learning from two serious incidents within the Family and Specialist Services Division
- Learning from incidents from the Medication Safety Group in Q3
- Learning from incidents in the Surgical and Anaesthetics Division
- The “*So What Happened Newsletter*” issued to staff in November 2015, which can be found on the Risk Management page of the intranet, included learning from the following incidents:
 - ❖ Trial of a pillow replacement following a grade 2 pressure ulcer as the mattress bed used was not pressure relieving
 - ❖ Advice on the correct fitting of a face mask following three pressure ulcer incidents
 - ❖ Introduction of red alert sheets identifying when a Deprivation of Liberty was in place, following an incident where a death of a patient with a DOLS in place was not reported to the Coroner
 - ❖ Medicines allergies and introduction of a red allergy band
 - ❖ Patient story following a discharge medication incident where a medication dose change that was not noticed on discharge, with advice to staff on checks needed

Learning from Serious Incidents

Serious Incident Datix ID: 118248	Division: FSS

Patient's sodium levels were significantly increased.	
Investigation Highlighted	Actions
Areas for improvement: 1) There isn't readily available guidance for the making up of normal milk feeds irrespective of method of administration whilst babies and children are in hospital. There needs to be written information readily available to all parents such as 'Start to Life Guide to Bottle Feeding'. 2) Where babies have been admitted with feeding problems there is no care plan to directly observe parents competency in making feeds up appropriately. 3) Prescribed medicines are being added to feeds by the parent or guardian un-witnessed by the nursing staff. 4) Prescribed medicines are being added to feeds and are not signed for on the drug chart. 5) There was no consultant review within 24 hours of admission as per national guidance. There was no consultant review until day three of admission and only due to significant clinical deterioration. That said although there was no Consultant review there is documented evidence of discussion with the Consultant on the ward. Earlier Consultant review may have raised concerns earlier however this is unlikely to have impacted on the eventual outcome. 6) There are a number of concerns regarding documentation that include: a. No documentation of clinical review b. Incomplete labeling of admission sheet and fluid balance charts c. Poor quality documentation of medical review	Recommendations: 1) The ward to provide parents ready access to verbal and written advice on the make-up of all infant formula feeds. 2) If a baby is admitted with feeding problems that there is an assessment of feed preparation and feeding by parents or carers with a completed care plan. 3) All medications given whilst in hospital are prescribed on a drug chart. Administration of all medications must be signed for on the drug chart and administration directly supervised by qualified nursing or medical staff. 4) Consultant review of all children within 24 hours of admission (in line with RCPCH standards).
Serious Incident: D/119837	
Incorrect reporting of x-ray resulting in delayed diagnosis of cancer	
Investigation Highlighted	Actions
Areas of concern: • Member of staff made an error in interpreting a plain chest x-ray which resulted in the patient, her family and the GP being reassured that it was normal. • It has been established that there is no standard operating procedure on maximum lengths of time for reviewing x-rays or scans; or how often breaks should be taken during these sessions.	Recommendations: • The final report must be shared with the patient. • The Trust should develop guidance/SOP with regard to maximum lengths of time for reviewing x-rays or scans; or how often breaks should be taken during these sessions.

• There was a delay in reporting the error as an incident which was identified on 11 February 2015 and reported on 27 April 2015.	• The member of staff reflects on the incident with the Clinical Director for Radiology with a view to improving standards and reducing the risk of errors in the future. • Incidents should be reported as soon as the incident/error is noted via the trust's Datix Incident Reporting System.

Medication Safety Group – Learning from Incidents

In Q3 the Medication Safety Group focused on anticoagulation and issued the following advice to staff following a cluster of incidents involving Dalteparin.

Are your patients getting the correct anticoagulation with dalteparin?

The Medication Safety Group in November 2015 focused on reports on Datix coded DALTEPARIN/FRAGMIN.

WHY?

- Anticoagulants are critical medicines.
- In 2015 we changed the prescription, to include a dedicated section for prescribing VTE, to improve the management and particular the prescribing of VTE for inpatients.

In October 2015 there were 15 incidents reported involving DALTEPARIN.

- In 8 patients doses were missed over one or more days
- There were 3 patients who received the wrong dose
- There was 1 patient was given a dose twice a day instead of daily
- There was 1 patient who received a dose which was not intended for them
- There were 2 patients who received a dose against an unsigned prescriptions

What can you do?

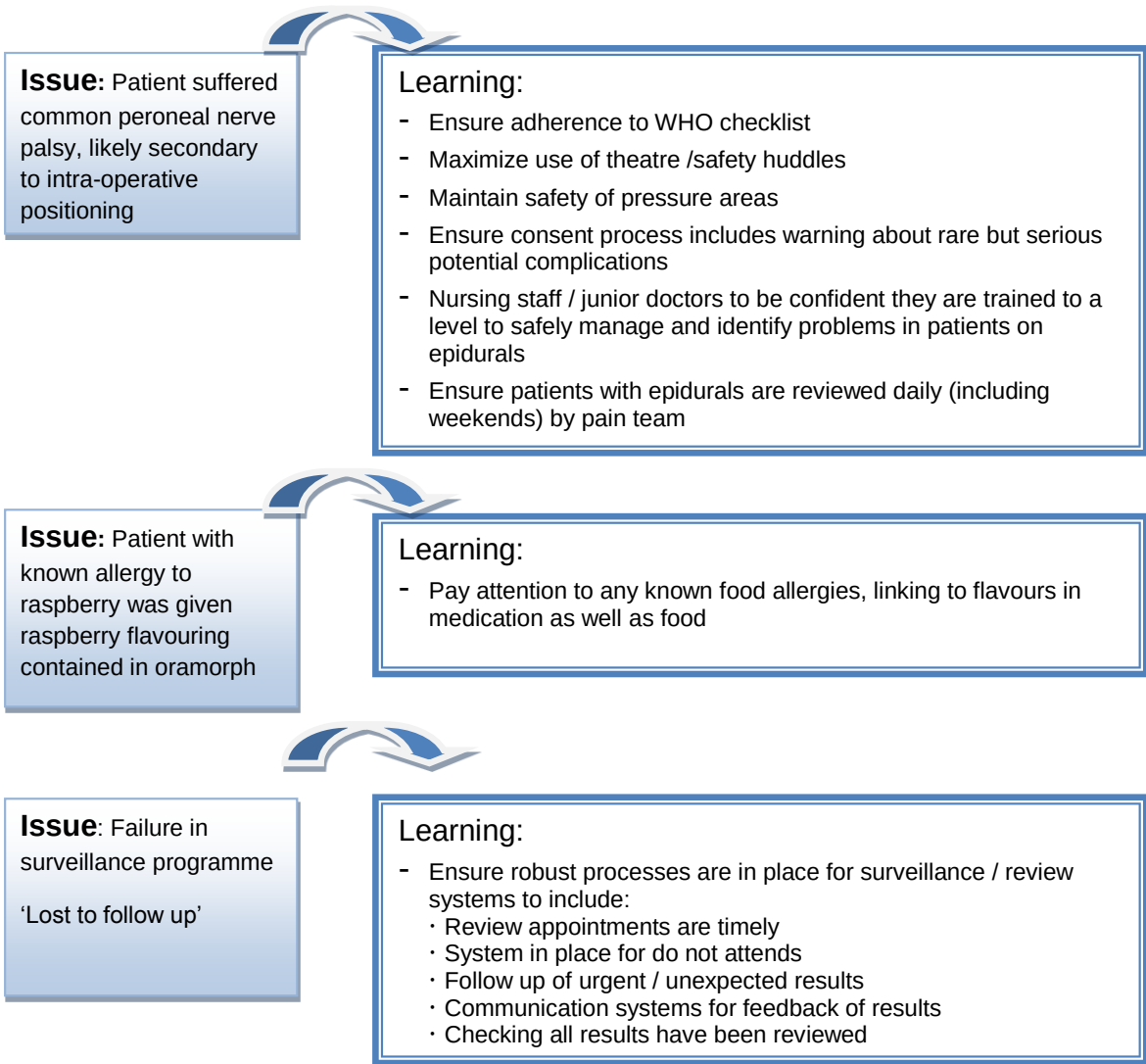
- **Check** you have the right patient before prescribing and administering medicines.

- **Ensure** that each patient has a completed VTE risk assessment. For medical, surgical and orthopaedic patients this is part of the Prescription Chart and Administration Record
- **When reviewing a patient be vigilant and check**
when indicated that a prophylactic dose is prescribed, usually in the designated pink section of the prescription or a therapeutic doses is prescribed in the regular section of the prescription or
entry states no prophylaxis required or contraindicated
- At **patient reviews**, check medicines are being administered no blanks, codes of '6' used if clinically to withhold and that appropriate reviews of '6' are undertaken.
- **At tea time administration rounds be vigilant.** Doses are most commonly prescribed to be given at tea time.
- At **hand over** discuss medicines. This will help minimise missed doses.
- **Be proactive speak** to the Medical Team about prescriptions which are unclear, incomplete and where the VTE risk assessment does not fit the actual prescription.

Learning the Lessons

Incidents closed in Q3 2015/16 Surgical Division

Learning from incidents that occur within the Trust is a vital process which aims to improve patient safety and overall quality of care. Please take the opportunity to read about the learning taken from the serious incident investigations that were closed in the surgical division during Q3 2015/16. When incidents happen, it is important that lessons are learned to prevent the same incident occurring elsewhere, therefore when looking at these it is important that you think about your own clinical practice, or ward / department processes to see whether a similar incident could occur and whether any of the learning could be applied to prevent this.



Issue: Patient suffered common peroneal nerve palsy, likely secondary to intra-operative positioning

Learning:

- Ensure adherence to WHO checklist
- Maximize use of theatre /safety huddles
- Maintain safety of pressure areas
- Ensure consent process includes warning about rare but serious potential complications
- Nursing staff / junior doctors to be confident they are trained to a level to safely manage and identify problems in patients on epidurals
- Ensure patients with epidurals are reviewed daily (including weekends) by pain team

Issue: Patient with known allergy to raspberry was given raspberry flavouring contained in oramorph

Learning:

- Pay attention to any known food allergies, linking to flavours in medication as well as food

Issue: Failure in surveillance programme
'Lost to follow up'

Learning:

- Ensure robust processes are in place for surveillance / review systems to include:
 - Review appointments are timely
 - System in place for do not attends
 - Follow up of urgent / unexpected results
 - Communication systems for feedback of results
 - Checking all results have been reviewed

Learning the Lessons : Medical Division

Incidents closed in Q3 2015/16

Learning from incidents that occur within the Trust is a vital process which aims to improve patient safety and overall quality of care. Please take the opportunity to read about the learning taken from the serious incident investigations that were closed in the surgical division during Q3 2015/16. When incidents happen, it is important that lessons are learned to prevent the same incident occurring elsewhere, therefore when looking at these it is important that you think about your own clinical practice, or ward / department processes to see whether a similar incident could occur and whether any of the learning could be applied to prevent this.

Issue:

- Patient was given IV chlorphemamine despite having a documented allergy to this medication.
- Staff Nurse had asked Consultant to prescribe the medication on corridor.

Learning: Staff involved to complete online medicine management training.

- Ensure medications are prescribed on the ward round by the Doctor who knows the patient in order to maintain safety. If unable to do this, ensure medics have access to medical notes when prescribing medications.
- Medics to document why medications are required / prescribed in medical notes.
- Nurses to document in communication notes if patients are refusing to wear wrist bands and document these conversations of the risks of not wearing these bands with the patient.

Issue:

- NG Feed was not commenced and a delay in administering insulin resulting in patient becoming acidotic and developing diabetic ketoacidosis.

Learning:

- Education and training from Nutritional Specialist Nurse and Diabetic Specialist Nurse regarding insulin and feeds.
- All staff to complete the insulin training.
- Clear and accurate documentation of the conversations and information provided to the Doctors and the agreed management plan.

Issue:

- Non-escalation of raised NEWS

Learning:

- Improved knowledge skills of patients with acute and chronic respiratory conditions.
- Escalating patients with elevated NEWS scores appropriately and understanding of resources available when escalating.
- Use of case studies to support how to care for unexpected events.

**Issue:**

Harm fall resulting in fractured neck of femur.

Learning:

- Ensure Intentional Rounding is completed for all patients at risk.
- To ensure patients at risk are assessed for 1:1 care and supervision and for staff to use vulnerable adult assessment care plan to support decision making.
- To ensure safety rails assessments are completed for patients at risk.
- To ensure appropriate preventative interventions are in place post fall, i.e. Falls alarms.
- FRASE to be recorded accurately.

**Issue:**

Concerns regarding complete heart block patient not receiving external pacing.

Learning:

- Hospital at night team to be trained in external pacing to link with ACS nurses for competency based assessment to support clinical teams out of hours.
- Nursing staff to carry out on the ward training for external pacing.
- Ward staff to be aware of the contents of the pacing box and where to find it.
- Visual checklist of the contents to be located on the lid of the box to assist in the checking process.
- Pacing to be carried out at CRH due to no pacing room on the ward at HRI. Emergency pacing only will be carried out at HRI in x-ray between 8am – 5pm. Theatres will be used out of hours and weekends.

Incidents Classed as “Serious” Reportable to the CCG:

In Q3, 22 incidents were identified as being “serious” and required reporting to the CCG/NHS England via STEIS. This is lower than the number of serious incidents reported in Q2 (35). The types of incidents were:

Q3	2015-16
Abuse to patient from staff	1
Diagnostic delay	1
Pressure Ulcers	16
Still Birth	2
Falls	1
Treatment delay	1
Totals:	22

73% of serious incidents were pressure ulcers, a decrease by 5% reported in Q2.

All incidents were 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

One incident involving a possible misplaced naso-gastric tube was reported as a never event. Following further investigation, the CCG accepted the Trust's request to de-log the incident which has now been graded as no harm (green) incident.

Improvements:

An update against improvement areas for 2015/16 is given below:

Improvement	Progress
To improve and increase the number of incidents reported	Figures in Q3 show a 1% increase – demonstrating a continued improvement in the number of incidents reported.
To increase the number of trained investigators	Two full day effective investigation training sessions were delivered to staff in Q3, 1 in October and 1 in November.
To improve quality of investigation reports (through the action above)	Incident Reporting Policy finalised and approved in December 2015, with reporting templates to improve quality of reporting.
To improve the timescale for booking 48hr incident panels	Revised process introduced towards the end of Q3 to hold dedicated weekly panels on set day improving organisation and planning of panel

	attendance
To develop mechanisms to report: Investigation themes/ Learning themes	In development; Identified within the new Incident Reporting Policy.
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. Plan to revise reporting and review process for pressure ulcer orange and red incidents in Q4.

Serious Incident Review Group

In December 2015 a Serious Incident Review Group, chaired by the Chief Executive met for the first time. The group's membership includes senior clinical division colleagues and aims to provide assurance that the Trust is learning from Serious Incidents. The terms of reference for the group were approved by the Quality Committee in December 2015. The group will meet again in late January 2016

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 (clinical delivery problem) 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

Challenges

Discussions with key staff have highlighted the following points:

- 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.

Current Performance

- The first two of the in-house Effective Investigations Training Days have taken place at Acre Mill (14/10/15) and CRH (02/11/15). Feedback has been extremely positive, including from an attender who had only recently had investigation training earlier in the year in CHFT (sourced externally). A total of 46 staff have been trained to date, including 7 senior doctors.
- Previous barriers to scheduling training days included lack of availability of training rooms. This has been successfully addressed with the Education Department.
- As the trust progresses towards implementing an electronic patient record (EPR) system, liaising with Datix has been paused until new the Patient Administration System (PAS) has been fully scoped and possibly even implemented. A small capital investment may be required for IT upgrades, and to avoid spending twice, this is currently on hold.
- The Trust "Incident Reporting, Management, and Investigation Policy" G-104-2015, which incorporates investigation tools and report templates on which the Effective Investigation Group provided feedback, was approved at the last weekly executive board meeting of December 2015.

Improvement Plans for Q4 2016

- The following dates have been agreed for training in 2016 on various days of the week to enhance attendance: 19 Jan, 8 Feb, 10 Mar, 12 Apr, 13 May, 13 Jun, 6 Jul & 14 Sep. In order to free up clinical capacity and respond to demand, dates might be changed to alternative months.
- Highlight work of "Effective Investigation Group" at trust-wide "Clinical Champions" event to give taster advertise full training day.
- Develop eLearning package for all staff. This will be under the Workforce Development section of the Intranet.
- Liaise with mortality reviewers to spread good practice in contributory factors and human factors integration across CHFT.

- Now that the new Incident Policy is approved, and once training resources have been finalised, the Effective Investigation Group will cease in its advisory function and no longer meet. Its members will only meet as the in-house incident investigation training continues.

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 34 Alerts received in Q3 (between 1 October – 31 December 2015)

34 - TOTAL RECEIVED - 1.10.15 TO 31.12.15 (+ 3 outstanding alert from Q2)

22 – CLOSED ALERTS

9 – ONGOING (as below)

3 - ACKNOWLEDGED AND ASSESSING RELEVANCE

Reference	Alert Title	Originated By	Issue Date	Response	Deadline On-going
NHS/PSA/RE/2015/008	Supporting the Introduction of the National Safety Standards for Invasive Procedures	NHS England	14-Sep-15	Action Required: Ongoing	14-Sep-16
MDA/2015/039	Home use blood glucose monitoring system: GlucoMen LX Sensor test strips – risk of over-estimation o ...	MHRA Medical Device Alerts	21-Dec-15	Assessing Relevance	28-Jan-16
EFN/2015/45	High Voltage Hazard Alert - SUSPENSION OF OPERATIONAL PRACTICE (SOP) - UPDATE - Long & Crawford ...	DH Estates and Facilities	21-Dec-15	Action Required: Ongoing	18-Jan-16
EFN/2015/49	High Voltage Hazard Alert - NATIONAL EQUIPMENT DEFECT REPORT (NEDER) - FKI - Eclipse - Circuit Breaker	DH Estates and Facilities	23-Dec-15	Action Required: Ongoing	20-Jan-16
EFN/2015/48	High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - Merlin Gerin - YSF6 - Circuit Br ...	DH Estates and Facilities	23-Dec-15	Action Required: Ongoing	20-Jan-16

EFN/2015/17 (U)	High Voltage Hazard Alert - DANGEROUS INCIDENT NOTIFICATION (DIN) - UPDATE - Merlin Gerin - Genie Ev ...	DH Estates and Facilities	22-Dec-15	Action Required: Ongoing	19-Jan-16
NHS/PSA/W/2 015/011	The importance of vital signs during and after restrictive interventions/manual restraint	NHS England	03-Dec-15	Action Required: Ongoing	21-Jan-16
EFA/2015/006	Self-closing fire doors	DH Estates and Facilities	03-Dec-15	Action Required: Ongoing	31-Mar-16
NHS/PSA/Re/2 015/009	Support to minimise the risk of distress and death from inappropriate doses of naloxone	NHS England	26-Oct-15	Action Required: Ongoing	26-Apr-16
NHS/PSA/W/2 015/012	Risk of using different airway humidification devices simultaneously	NHS England	15-Dec-15	Assessing Relevance	02-Feb-16
NHS/PSA/W/20 15/012	Risk of using different airway humidification devices simultaneously	NHS England	15-Dec-15	Assessing Relevance	02-Feb-16
MDA/2015/038	Cardiac Resynchronization Therapy Pacing (CRT-P) – Risk of loss of pacing therapy. Medtronic InSync III	MHRA Medical Device Alerts	09-Dec-15	Assessing Relevance	09-Jun-16

1.10 WHO Checklist

Aims and Objectives

In May 2004 the WHO approved the creation of an international alliance to improve patient safety globally. World Health Organisation (WHO) patient safety was launched the following October. The problem area selected for the second Global patient safety challenge in 2007-2008 was the safety of surgical care. Preparation of guidelines for safe surgery followed the steps recommended by WHO. The goal of the WHO is to improve the safety standard of surgical care around the world by defining a core set of safety standards that can be applied in all countries and settings.

The checklist approach has several advantages (1). Checklists help memory recall especially for mundane matters that are easily overlooked in all patients. Checklists clarify the minimum expected steps in a complex process. By helping a team work together, checklists establish a higher standard of baseline performance and are particularly applicable to the operating room setting where checklists continue to be used successfully around the world.

The 5 Steps to Safer Surgery are; *Briefing / Sign In / Time Out / Sign Out / Post Op Brief*.

The WHO checklist at CHFT is completed on the new Electronic Theatre System Bluespier. This ensures that a full audit trail can be kept regarding compliance with daily reporting from Bluespier which is then acted upon.

Q3 Current Performance

The Target Compliance for WHO is 100%.

December's WHO Compliance was 98.24%. This was a slight reduction from the previous month's performance of 99.27%.

As a matter of course, all non-compliance of the WHO is validated. The reasons for the drop in performance in December were identified as being as a result of the Bluespier System upgrade which resulted in a number of patient checklists having to be completed on the old paper-based process. These should have been identified on the system.

Improvement Plans

The introduction of whiteboards into Obstetric Theatres to capture the data on during times when Surgeon and Anaesthetist / team have to focus on getting distressed baby delivered. Accepted practice is to document the important details and input these later which is the new process in this theatre.

Ensuring ownership of the WHO is taken by the entire team. Regular briefings to ensure WHO is completed via Team Huddle events and Audit Days.

Process to ensure the 'sign out' is completed in full. An Operational Policy including WHO developed for Theatres. Lessons learned and shared where non-compliant example being Obstetrics where improvement via the whiteboard has been introduced.

Domain Two – Effective

Effectiveness compliance summary

Indicator	Compliance
2.1 Learning from Mortality	Partial Compliance
2.2 Improving Reliability – Implementing Care Bundles (CQUIN)	Achieved
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)	Achieved
2.8 Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR)	Reporting Only

Highlights:

2.3 Improving the Management of Acute Kidney Injury (CQUIN)	Continued improvement with compliance against the bundle. Q3 CQUIN achieved.
2.6 Improving Diabetic Care	Further spread of the self-management work into two additional ward area. Development of a patient feedback questionnaire
2.7 Reducing Hospital Acquired Infections (Contract)	No further MRSA Bacteremia in Q3, December 2015 saw all measure perform well against targets.

2.1 Learning from Mortality

Through understanding our hospital mortality the Trust is able to both gain assurance and learning regarding 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 March 2016

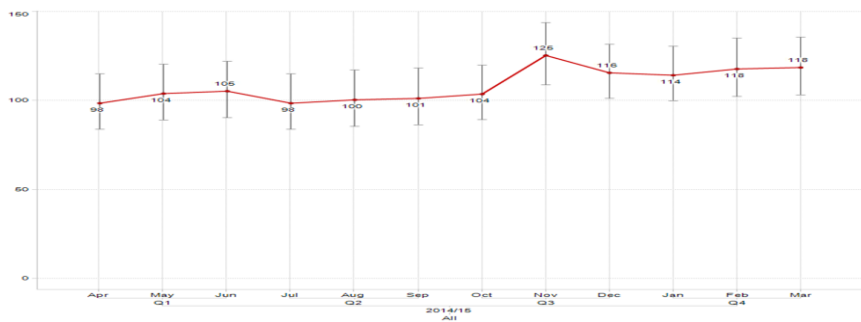
Current Performance

The Trust's SHMI for the latest period published (April 14 – March 2015) is 108.86; this is in the category of “as expected”, however it is 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 fewer deaths than predicted. There is also evidence that standardised mortality ratios such as SHMI correlate poorly with other measures of care quality.

The Trust has hitherto been placed in the ‘as expected’ range because any variation from the number of expected deaths is not statistically significant.

The official SHMI from HSCIC for July '14 to June '15 will be published on 27th January. We believe it will have risen slightly to 111. It is not clear if that will represent an outlying position or not.

The trend data below shows how each month in the year has contributed to the overall performance.



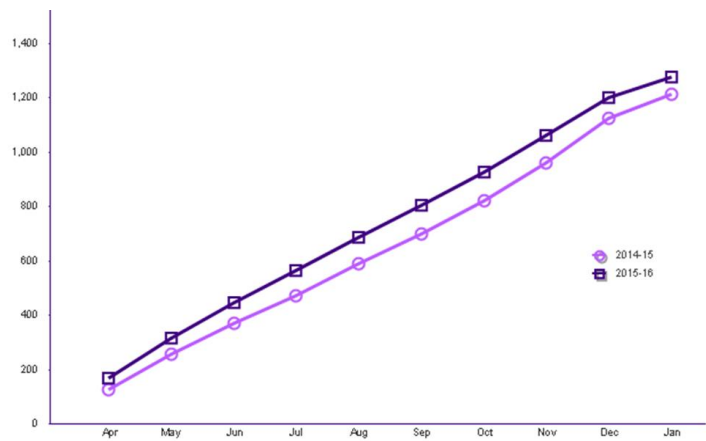
The SHMI data can be tracked to specific conditions where the actual number of deaths exceeds expected. Where this occurs cases are investigated and reports presented to Clinical Outcomes Group (and its subgroup Clinical Effectiveness and Mortality Group) with actions where necessary.

The SHMI position relating to the time period of (April 2014- March 2015) was release in Q3 and the following areas were noted to have higher than expected mortality rates:

- Inflammatory diseases of female pelvic organs,
- Diseases of month: excluding dental,
- Urinary tract infections,
- Chronic obstructive pulmonary disease and bronchiectasis,
- Hypertension with complications and secondary hypertension,
- Nausea and vomiting,
- Cancer of breast,
- Abdominal pain.

These cases and those previously noted (Skin Ulcer, Contusions, Cancer of the Colon), are undergoing case note review; initial findings indicate that there is no evidence to suggest a reason for concern.

In the first part of 2015 the Trust noted a higher crude mortality than in previous years, a phenomenon seen across England and Wales. However the raw numbers of deaths in the final few months of 2015 were relatively low for the time of year. It is not yet clear how this will be reflected in the CHFT SHMI position in due course, given the time lag in the SHMI measure.



As the Trust consistently performs at the “as expected” level, In order to identify key problem areas to focus improvements, the Trust is committed to reviewing 100% of its mortality cases and not just for those conditions which triggered an alert.

The Mortality Review Process Protocol was approved at the Clinical Outcomes group in August 2015. This outlines the process for reviewing the mortality cases and improvements in process which have been noted already. There are around 40 1st level reviewers with a steady increase. In order to increase the performance, each reviewer is allocated the cases they are required to review each month. This has provided a significant increase in performance, increasing from an average of 29.5% in quarter 1 to 65% in Q2 with a slight decline to 60.9% in Q3, (December mortality reviews are still in progress).

First level review

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 and acts as a screening tool to prompt a second level review in cases scored 3-6. The scale ranges from 1 to 6 and the level of preventability described below.

- 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.

Second Level review

The purpose of the second level review is to provide a more in-depth review of the patients care and management to understand where the gaps have occurred. These are performed on mortality cases that have been scored Hogan 3-6. The process has been slow due to a number of factors such as delay in the 1st review being performed, locating a reviewer to perform the second review and getting the case notes to the right place.

This has improved over the last 4 months particularly with EDMS and focusing on Hogan 3 – 6 cases excluding Hogan 2 cases unless there was an incident, inquest or claim against the case. Further improvements are expected following the recruitment of new 2nd level reviewers.

Performance

The table below outlines the number and percent of mortality cases reviewed and included the Hogan score of preventability.

	April	May	June	July	Aug	Sept	Oct	Nov
Total deaths	163	147	129	117	120	117	118	131
Total 1 st level reviewed	54	37	39	89	67	74	67	79
% reviewed	33.1	25.2	30.2	76.1	55.8	63.2	56.8	60.3
Hogan 1	48	32	33	75	52	61	56	62
Hogan 2	6	3	3	10	10	8	7	10
Hogan 3	0	0	2	2	2	3	3	4
Hogan 4	0	0	1	0	0	1	2	3
Hogan 5	0	0	0	0	0	1	0	0
Not rated	0	2	0	2	3	0	0	0
Total second level reviewed [†]	n/a	n/a	0	3	1	1	5	3

Improvements to the review process

Both the level 1 and level 2 review forms have been revised to capture useful information on preventability and provide a score of the care provided. Quality information on clinical and organisation factors is also requested from the reviewers.

Reporting the findings

Once the reviews have been performed, the data is added to the Knowledge Portal and can be viewed within 24 hours of it being added to the system. In addition, data is now being analysed on a monthly basis using the key learning themes from cases assessed as Hogan 2 and the more in-depth details gathered from the Hogan 3-5 cases. The 'Learning from Mortality Reviews' reports are shared with the reviewers, members of the Clinical Effectiveness and Mortality Group and the Clinical Outcomes Group.

The last report presented in December provided the key issues for preventability. The lack of senior medical review, particularly noted at weekends is most common theme listed by the reviewers for preventability and concerns on fluid balance recording and bundles not completed are reoccurring themes listed under clinical care concerns. The full report is attached.

Special reviews

A review of all March 2015 deaths in HRI was commissioned in response to a sharp rise in HSMR that was identified at that time. Of the 92 deaths, 80.4% (74 cases) were available for review and were reviewed using the standard level one review tool. The key learning themes were not dissimilar to other periods, therefore other factors were considered for the increased mortality including organisational issues. Whereas it was acknowledged that between January and March 2015 was particularly busy in the hospital due to the winter pressures and high levels of admissions to A&E departments there was no increase use in agency, bank or locum staff during March compared to January and February. There was no significant difference in unfilled shifts for medical or nursing staff in March.

March was a low month for Palliative Care coding; this coupled with a dip in comorbidity capture is likely to have played a part in generating a lower number of expected deaths. The full report provides the data that shows that comorbidity capture had been lower than the month of March, however it may have been being compensated by the higher Palliative Care coding in that particular month.

Improvement Work

Improvement Work is being delivered primarily through the Care of the Acutely Ill Patient (CAIP) programme. The plan was reviewed and refreshed in August 2015, when some of the original eight themes were merged and some removed (as the actions had been incorporated into other work-streams). The revised plan has the overarching aim "to contribute to the reduction of mortality rates within the Trust" in acknowledgement that reduction in the Trust's mortality rates is

dependent upon delivery of other actions and work-streams, e.g. leadership and operational improvements.

The revised plan is simplified into six themes:

- 1) Investigating mortality and learning from findings
- 2) Reliability
- 3) Early recognition and treatment of deteriorating patients.
- 4) End of life care
- 5) Frailty
- 6) Coding

Monthly updates are received by the Clinical Outcome Group COG.

Improvements in Q3

Three senior doctors have been recruited, with identified time in their job plans, to deliver second level reviews, condition specific reviews, and help develop the design of the process. These appointments will improve the response time to review both the SHMI alerts cases and the mortality cases requiring a second level review. Regular meetings will be established and a feedback process to enable effective actions, as appropriate to take place. Cases are being allocated to this team on a weekly basis.

A closer relationship has been developed between the outcomes of mortality reviews and the incident reporting system.

External data analysis.

Professor Mohamed Mohammed of Bradford University has supported the Trust with analysis of our HSMR position, looking for patterns in the data that allow the formulation of hypotheses to be tested. He has identified improvements in Palliative Care coding, in comorbidity capture, and effective mortality case review as being essential.

Improvement plans for Q4

Mortality Surveillance Group

It is proposed that, in accordance with national recommendations, CHFT establish a Mortality Surveillance Group (MSG), chaired by the Medical Director, and reporting directly to the Quality Committee, to strengthen the Governance system around mortality. This group will receive reports on mortality data, outcomes of reviews, and seek assurance on all aspects of hospital care as they relate to mortality.

Development of the existing process

Additional 1st level reviewers will be recruited by each of the Divisions to assist with achieving a 100% of mortality cases being reviewed. Performance of the 1st level reviews will be closely managed by the Governance Team.

Nationally there is recognition of the need to standardise methodology and training. HQIP have been commissioned to roll out a standardised methodology and training programme. The contract is expected to be awarded in January, and the chosen model piloted in Spring '16. In the meantime, a short video training package will be developed with support of the training department.

Preparation for the national process

It is expected that the national Retrospective Case Record Review (RCRR) process will mirror CHFT's two level review system, with an expectation of review of all inpatient adult deaths. It may be that the professional composition of the review team will evolve with more consultant involvement.

The national process is likely to require that second level reviews involve multidisciplinary team discussions in the relevant specialty. How this might work is yet to be designed, but it may be that the recently recruited specialist second level reviewers may initially review the case and lead the MDT discussion.

Electronic data capture

It is hoped to make the review tool / data collection process electronic, similar to the CRAS tool. There are still technical issues to overcome before we achieve the goal of real-time data capture

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).

1. Reliability

In the revised CAIP plan a new overall “reliability” work-stream was created comprising care bundle compliance, and investigation into SHMI alerting conditions and any concerns relating to site differences. .

Current Performance

The care bundles work has adopted the PMO approach, overseen by the newly-formed Clinical Standardisation group. The first meeting took place on the 1st of September 2015. Clinical leads have been identified for each of the bundles and currently they are reviewing the bundles to standardise them to ensure they are simple, clear and do the right thing first time. 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.

Compliance with appropriate commencement of bundles is currently audited by the presence of the “stickers” in the notes for

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

Where bundles have been commenced, completion is also assessed.

During Q3 plans were made on how to improve completion of care bundles, and therefore the reliability of the delivery of the key intervention. The discussion was made to include the key bundles into the clerking in the medical document. It was anticipated that there would be a go live date in early January. However this has been delayed and a go live date is expected towards the end of Q4.

- The communication and clinical engagement plan is under development to embed the new process.
- A clinical champion has been identified to encourage compliance in completing the bundles.

In addition to this work there are three care bundles which form part of the Trusts 2015/16 CQUINS, sepsis and pneumonia will be supported by the work above. However Asthma is being led by clinical and managerial leads from within the A&E unit, further information regarding each of these for Q1 and Q2 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. The trust is meeting its CQUINs targets at present.

	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3
Respiratory Care Bundle - Improving management of patients presenting with Asthma in ED	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15	Total	Oct-15	Nov-15	Dec-15	Total
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			33	40			40	38			38
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			50	50			50	50			50
% patients receiving care bundle	66%			66%	80%			80%	76%			76%
Target	65.0%				70.0%				72.0%			

Q4: Performance Plan: The Q3 target is set at 75%. Weekly monitoring in the unit will ensure that this performance level maintained. Inhaler Technique is the area most in need of improvement.

The Division is utilising the previous year’s action plan in order to remain joined up with progress made last year.

Pneumonia (CQUIN)

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

The data collection for the CQUIN is 50 cases within the quarter. The trust is meeting its CQUINs targets at present.

Respiratory Care Bundle - Improving management of patient attending A&E with pneumonia	Quarter 1			Q1	Quarter 2			Q2	Quarter 3		
	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15	Total	Oct-15	Nov-15	Dec-15
Number of patients attending A&E with pneumonia who receive the CAP care bundle within 4 hours of admission	35			35	39			39	35		
Number of patients attending A&E with pneumonia who are admitted.	50			50	50			50	50		
% patients receiving care bundle	70%			70%	78%			78%	70%		
Target	60.0%				65.0%				70.0%		

Q4 Performance Plan: There is an action plan in development which will address the difficulties with capturing CURB scores, and over the final quarter compliance with this element is expected to improve.

Sepsis Screening (CQUIN) – See Improving Sepsis Care Section 1.5 which shows achievement of Q3 target.

Acute Kidney Injury (CQUIN) – See Improving Management of Acute Kidney Injury Section 2.3 which shows achievement of Q3 target.

2.3 Improving Management of Acute Kidney Injury

Aims and Objectives of Work

Acute kidney injury (AKI) is characterised by a rapid reduction in kidney function, potentially resulting in a failure to maintain fluid, electrolyte and acid-base homeostasis. 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. Recent reports have highlighted deficiencies in AKI management (Adding Insult to Injury, NCEPOD, June 2009, NICE clinical guideline August 2013). AKI was highlighted as a high mortality condition in the organisation based on HSMR and SHMI data.

The Trust has design a care bundle for the treatment of inpatients with AKI. This bundle has been in place now for 18 months, it has not yet been reliably implemented. More recently a CQUIN for delivery of AKI care has been agreed with the CCG.

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, and to deliver the agreed CQUIN.

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 Q4 was 66% of the required elements being captured on the discharge summary.

	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3
	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15	Total	Oct-15	Nov-15	Dec-15	Total
2.1 - Acute Kidney Injury												
The number of key items found in discharge summaries for patients in the sample of 25	25	21	18	64	30	30	39	99	57	66	74	197
4 key items in discharge summaries for 25 inpatients randomly selected from pathology system with AKI *	100	100	100	300	100	100	100	300	100	100	100	300
% key items included	25.0%	21.0%	18.0%	21.3%	30.0%	30.0%	39.0%	33%	57%	66%	74%	66%
Target	Baseline - Achieved				21.0%				50.0%			

Improvements during Q3 included:

There has been a significant and sustained improvement in performance through Q3 as junior doctors have become more familiar with the changes to the EDS. This has been supported by continued feedback on performance, particularly with regard to junior doctors who have not completed the EDS correctly.

A process for weekly monitoring of performance has been established which is allowing closer monitoring of the trajectory.

Conversations regarding targets for Q4 have been undertaken and a target of 90% compliance has been agreed. Based on the current trajectory we are in a reasonable position going into Q4 and should achieve this target.

Ongoing work into Q4:

- 1. Continue weekly monitoring of performance
- 2. Continue feedback to junior doctors who do not complete EDS correctly
- 3. Twice monthly e-mail to consultants and junior doctors regarding ongoing need to complete AKI CQUIN via EDS and highlighting areas of good practice
- 4. We will be further publicizing the work of the AKI work stream group as we prepare for World AKI Awareness Day in March 2016.

1.3 Conditions of Interest – 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 60 minutes of arriving at hospital

Current Performance

The Division has recently reviewed the Stroke Dashboard and, with the clinical team agreed changes to the report. There are currently no nationally agreed targets for stroke however, as we aim to achieve a SSNAP (Sentinel Stroke National Audit Programme) score of “A”, we have updated to the targets for each measure to indicate the performance required to achieve a score of “A” in that particular measure.

The updated dashboard is included in the appendix.

Improvements:

- We have seen significant improvement in the percentage of patients with a joint care plan on discharge from 40% to 86.2%
- 100% of patients presenting with AF anticoagulated on discharge for 3 consecutive months (91.4% YTD)
- 87.5% of all patients scanned within 12 hours

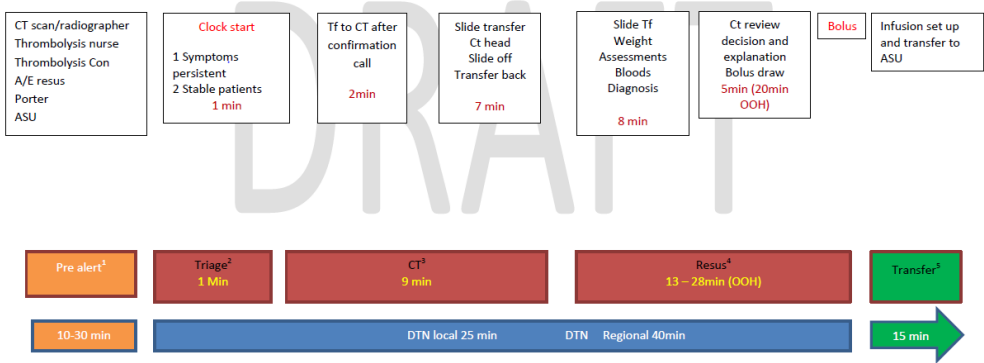
Areas of focus:

- Patients scanned within 1hr of hospital arrival (where appropriate) 66.7%, target 90%
- Direct admissions to ASU within 4hrs 60%, target 90%
- Patients spending 90% of their stay on the stroke unit 80%, target 90%

Scanning within 1hr of arrival:

Members of the stroke team have recently visited the Stroke Unit at North Lincolnshire and Goole NHS Foundation Trust. This Trust scored an “A” in the SSNAP score. The aim of the visit was to learn how to best minimise time delays in the management of stroke patients, in particular those patients needing thrombolysis. Since the team has undertaken mock dummy runs and developed a new DTN (Door to Needle) process (see below). We are working with YAS, ED and radiology to implement this.

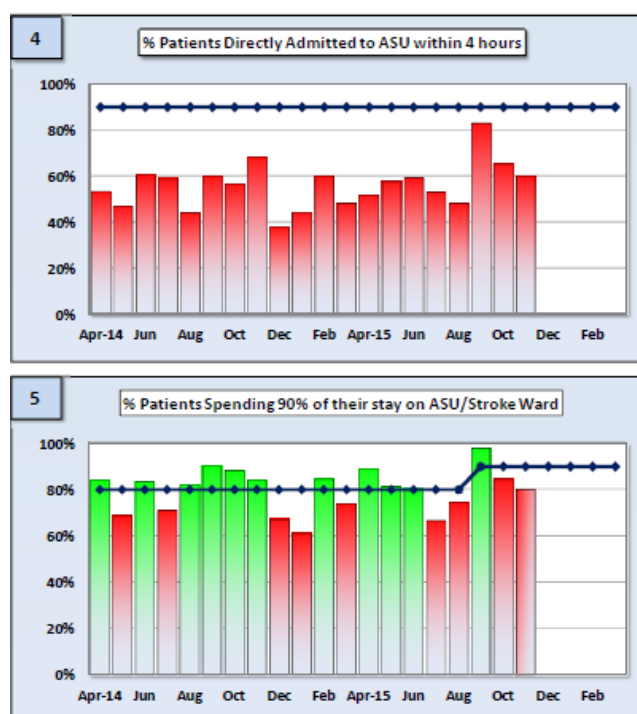
Thrombolysis process map



4hr and 90% LoS

The stroke team routinely review breeches in the 4hr and 90% LoS measures. Previously a number of breeches were due to availability of beds on the ASU. We have introduced a number of measures to improve this: there is a weekly ASU sitrep report indicating the number of empty beds, beds occupied by stroke patients and beds occupied by non-stroke patients (see appendix). Using this we have been able to actively intervene and reduce the number of non-stroke patients on the ASU and increased the availability of ASU beds. We have also increased the bed base for the stroke team with an additional 6 stroke rehab beds. At present the most significant factor now affecting both measures is the early recognition of stroke as the diagnosis. Patients presenting with atypical symptoms for example dizziness or a collapse may be admitted to the acute medical units and only after further investigation is a stroke identified. The stroke team is working with YAS, ED and acute medical teams to ensure a higher degree of suspicion for stroke in patients presenting with atypical features.

Data from previous years shows a reduced performance in December and January reflecting the wider bed pressures associated with winter. Full data for December is not yet available although early feedback indicates performance in both measures is under pressure.



Other Developments:

Consultant recruitment

- Approval has been given to recruit a 5th stroke consultant. This will improve the quality of care for stroke patients and ensure service resilience.

Health Watch Calderdale

- On 7 December 2015 the ASU was visited by Health Watch Calderdale. This visit was organised following feedback from members of the public. The report (see appendix B) highlights areas of good practice as well as areas for improvement. The ward has developed an action plan to address the issues raised. In addition the consultant input on the ward has changed; rather than each consultant doing a ward round on the ASU one day each week they have a consultant of the week. This is expected to improve continuity of care, communication and patient experience.

Divisional Structure

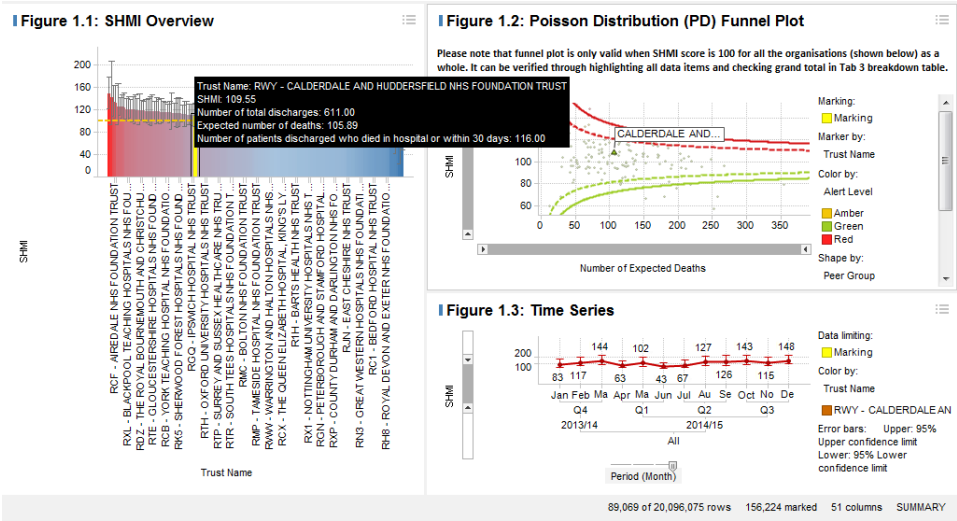
- Following a review of the Divisional and Directorate Structures Stroke services will move from the Medical Directorate to the Integrated Medical Specialities (IMS) Directorate.
- The Clinical Director for IMS is Dr Simon Grant; the General Manager is Maureen Overton.

Mortality

The following is the latest mortality data as provided by HED. The latest published SHMI is 109.55. There were no stroke deaths subject to second stage mortality reviews for the period December 2014 and May 2015. Mortality reviews have been added to the monthly Stroke Clinical

Governance meetings to be reviewed by the multi-disciplinary team. Further analysis is required in order to agree further actions.

Latest published SHMI Jan 14 – Dec 14:



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 were identified by NICE and require inputting into the National Hip Fracture Database (NHFD). Each of these factors relates to either patient experience or outcome.

An additional 2 factors have been added as part of the BPT from January 2016. They require all patients to have a nutritional assessment and a delirium assessment.

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 aspired to deliver 85% of patients to theatre within 36 hours by October 2015

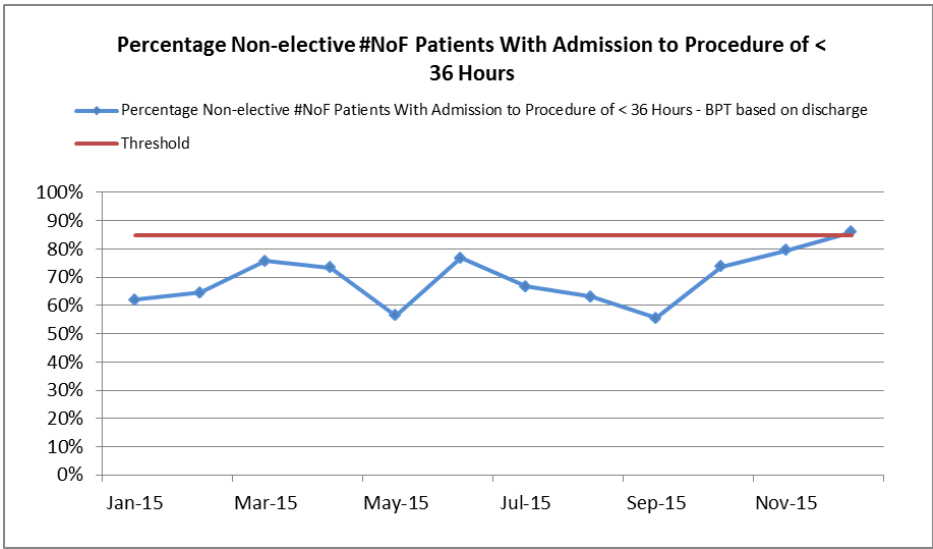
Q3:

Overall for Q3 83% of patients got to theatre in 36 hours and 78% of admitted patients got all components of BPT, with improvement being seen each month. The 36 hour target was reached for patients admitted in December 2015.

This has been achieved in part due to the team utilising Calderdale elective theatres for trauma lists when clinically able to be carried out at that location. This did however have a knock on affect in reduced our elective activity over the quarter by approximately 25 patients.

Once patients have had their operations, all members of the orthopaedic team are aware of and understand the components of best practice guidance and their benefit to a patient's recovery. They therefore make a point of completing each of them for every patient.

There are always periods of time where elements of cover cannot be provided, such as Ortho-geriatric cover over weekends and bank holidays. On Sundays there are no planned elective lists, as such cases cannot be moved across site to utilise that potential capacity. These challenges remain.



The rest of the year:

The team is designing processes to assure all patients receive the 2 new components for BPT from January

The kit has now been ordered to be able to provide total hip replacements on the HRI site.

Appointment of Dr Kumar Bhamidimarri, who will be supporting Dr Seebass in delivering the Ortho-geriatrician input until summer 2016

Ongoing participation in the PERFECTED research study (Peri-operative Enhanced Recovery hip Fracture Care of patients with Dementia). This 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. Baseline assessments are complete and now recommendations are being made and the impacts measured.

Hip fracture programme strategy to standardise levels of care includes things such as:

- HCA/Engagement SW re-enablement training to get NOF back to preadmission levels.
- Physio skills partially complete, OT plan in place.
- Delirium assessment 4AT (part of BPT from January)
- Dementia pack, all docs for nursing staff-ICP
- Communications between theatres and ward re patients with challenging behaviour in an effort to decrease delirium and its impact on patients
- Increased post care discharge support for care home patients.

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:

- 1) 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
- 2) Reduction in Length of Stay for Diabetic patients.

Self Management:

It is important that patients who successfully manage their diabetes in community are also supported to manage their diabetes whilst in hospital. This reduces the risk of issues such as missed doses (nationally 40% of in-patients with diabetes experience an insulin prescribing or management error) and can reduce the length of stay for insulin-dependent diabetic patients alongside encouraging their independence.

Q3 Performance was 77.1% of patients who are able to self-care doing so, and the self-management training had been delivered to 14 wards.

	Q1	Q2	Quarter 3			Q3	
Diabetes Self Care - Number of wards included in the audit	Total	Total	Oct-15	Nov-15	Dec-15	Total	YTD
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	26	37	8	12	7	27	90
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	35	59	10	16	9	35	129
% eligible patients receiving care bundle	74%	63%	80%	75%	78%	77%	69.8%
Target	On 14 wards						

There is now work ongoing in the following areas

HRI: Wards - 22, 17, 12, 10, 6, 3, 15
CRH: Wards - 5C, 6BC, 9, 8AB, 8D, CCU

The Diabetes Improvement work stream was clinically led by one of the Trust's senior Diabetologists/Clinical Lead Rob Moisey. This role has now been taken by Julie Kyaw-Tun who continues to be supported by other clinical, nursing and pharmacy colleagues. Project support is provided by the Clinical Governance Support Unit and The Health Informatics Service.

Training ward staff

As each new ward become involved in the collaborative, nursing staff undertake a program of training in the elements of self-administration and self-management and the use of associated documentation. Training sessions are arranged on all the wards for Nursing/Midwifery staff and the sessions are delivered in the main by the Specialist Nurse Medicines Management, remaining staff are trained by the Ward Manager. The Specialist Nurse Medicines Management maintains contact with wards after self-care has been launched and ward staff are made aware to contact her should any problems arise or if any clarification is required.

It has been acknowledged by the Collaborative and the Nursing and Midwifery Committee that the training of ward staff in self-management of diabetes and self-administration of medicines can no longer be sustained using this approach due to the workload of the Specialist Nurse, Medicines Management and capacity to release ward staff for training. Due to the latter training has been delayed on 4C CRH and Ward 11 HRI. 4C CRH will offer and encourage the self-management of diabetes and self-administration of medicines from December 30th in line with meeting the end of Q3 deadline but Ward 11 HRI will miss this slightly offering the self-management of diabetes and self-administration of medicines from January 18th.

In view of this, from Q3 onwards Ward Managers will be asked to put forward 4 RNs/RMs to be trained to train their colleagues in the self-management of diabetes and the self-administration of medicines with the support of the Specialist Nurse Medicines Management who will then have capacity to support wards already part of the Collaborative.

Initial discussions took place late in Q3 with Occupational Health to support RNs/RMs who have been off work sick, but can return to work but not in the capacity of a ward based RN/RM. These staff would be able to support the work on the Collaborative wards.

Reduce length of stay for people with Diabetes by 0.5% days or more

Length of stay in December 2015 was 6.8 days, which is appearing in line with the average. A reduction was seen in 2014/15 when this work first commenced, however during 15/16 no further reductions are being seen

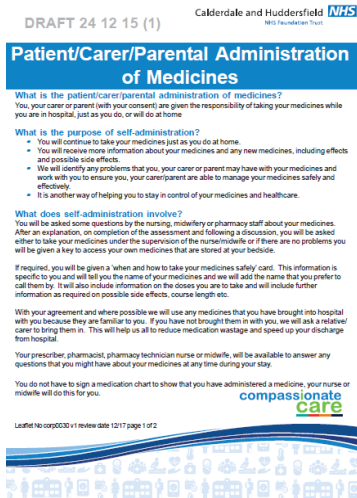
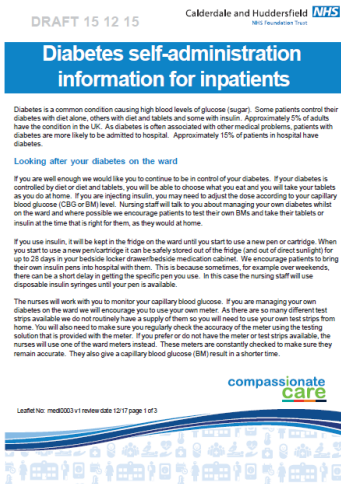
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD	14/15 YTD
Average Length of Stay of Diabetes Patients	8.4	6.1	6.3	6.5	6.2	7.5	6.1	6.9	6.8				6.8	6.7
Average Length of Stay of All Patients	6.0	5.2	5.4	5.4	5.5	5.6	5.0	5.4	5.7				5.5	5.5

Campaign

There is an ongoing campaign to encourage patients to bring all their medicines and diabetes related equipment into hospital with them so they can manage their medicines if they are able and reduce the number of missed/delayed doses. Work has now spread to the Yorkshire Ambulance Service and other regional NHS Trusts. The plan is for a targeted approach to encouraging this practice. This would include the use of a 'sealable green medication bag' (that is currently being used for medicines when a patient is transferred or discharged) that would be used by ambulance staff when they bring patients from home to a Medical Assessment Unit, Surgical Assessment Unit, Accident and Emergency, Coronary Care.

Patient information

During Q1 a diabetes and self-management leaflet has been developed with the help of our patients and was introduced to the wards in June 2014. This leaflet has now been reviewed and reformatted (see below). To complement the above leaflet a new leaflet about the self administration of medicines has been developed and is awaiting approval (see below).



Pre Assessment

Q2 saw work in the Pre Assessment and the Admissions Units to encourage patients to bring their medicines and diabetes related equipment into hospital with them. This information is given verbally and in written format and tests were carried out in Q3 to establish if more patients (when presenting for surgery) than before bring their medicines and diabetes related equipment into hospital after being given a green bag in Pre Assessment. The findings of this work will be presented back in Q4.

Patient questionnaire

A questionnaire has been developed and has been in place since late Q3 in order to obtain feedback from patients about their experiences managing their diabetes and/or self-administering their medicines (see below).

**The Self-administration of medicines and the
Self-management of diabetes questionnaire**

1. Please add which ward and indicate which site are you on
Ward Huddersfield / Calderdale (please delete)
2. Please indicate below with a tick which you have been self managing

I have been self-administering my medicines	☐
I have been self-managing my diabetes (monitoring my own blood sugars, adjusting my dose, self-administering my insulin)	☐
I have been self-managing my medicines and self managing my diabetes	☐
3. Have you liked being able to continue to self administer your medicines / self manage your diabetes like you do at home?
Yes ☐

Q4 Improvement Plan:

- Two more wards have been identified as the next to be brought into the collaborative in late January/February and a training programme is now in place for these wards
- Continue working with the Yorkshire Ambulance Service (YAS) to ensure patients bring all their medicines and diabetic equipment into hospital.
- Continue working with Pre Assessment encouraging patients to bring their medicines and diabetes related equipment into hospital with them on the day of their surgery. It is anticipated that this will be completed by the end of Q4.
- Continue to distribute the questionnaire to patients managing their diabetes and/or self-administering their medicines. It is anticipated that this initial feedback will be available by the end of Q4.
- Every capillary Blood Glucose Monitor will be Wi-Fi linked to central system to allow Diabetic Nurse Specialist team to remotely monitor every patient with diabetes on the wards
- Discussions will continue with Occupational Health to support RNs/RMs who have been off work sick, but can return to work but not in the capacity of a ward based RN/RM. These staff would be able to support the work on the Collaborative wards
- Examine and risk-manage the European Directive about insulin safety needles/ syringes and the safe prescribing and safe administration of high dose insulin. Ian Harrison (Pharmacist) will Lead this subgroup of the Diabetes Collaborative
- Continue to share progress at the Joint Sisters meeting, nursing and midwifery practice group and Nursing and Midwifery Committee

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-hour 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 Q3:

Indicator	Q1 Performance	Q2 Performance	Q3 Performance	YTD	Q3 End Traj.	On Track?
Meeting the MRSA bacteraemia (Trust assigned)	1	2	0	3	0	Over Trajectory
Meeting the C-diff target (Post 48 hours)	3	7	7	17	15	Over Trajectory
MSSA Bacteraemias	3	2	2	7	9	On Track
E-coli rates	9	7	10	27	22	Over Trajectory

MRSA (Meticillin-resistant *Staphylococcus aureus*) bacteraemia:

There have been no further cases of MRSA bacteraemia since Q2. The main action identified from the last case was improvement work with ANTT (aseptic non-touch technique). The Infection Prevention and Control Team have provided training sessions for key trainers and junior doctors.

MSSA (Meticillin-sensitive *Staphylococcus aureus*) bacteraemias:

There have been 2 reported cases in Q3. These cases have not been linked. MSSA screening has commenced for patients with central venous access devices and for patient undergoing selected high risk elective surgery.

E.coli bacteraemias:

There have been 10 post admission cases in Q3. Whereas there is no national reduction target set for E. coli bacteraemia the trust recognises the need to set the internal target and this was set at not exceeding the out-turn of cases (29) in the previous year. These cases are not related with any obvious cause; however, many are associated with urinary tract infections.

***Clostridium difficile* (C. difficile):**

There have been 7 post admission C. difficile cases in Q3. Two of the 7 cases have been agreed as avoidable following the RCA meetings, bringing the total cases agreed as avoidable to 5 cases, 11 cases agreed as unavoidable and one case still under investigation. Of the two cases agreed as avoidable the following key learning opportunities were

identified; appropriate timeliness of stool specimens, clear documentation on normal bowel habits and when specimens have been taken and prompt isolation of patients with loose stools.

Improvement Plans for 2015/16

The Trust recognises the challenge to meet the target for *C.difficile* cases (external target) and *E. coli* bacteraemia cases (internal target) and also the increase in MRSA bacteraemia cases in Q1 and Q2. There is a comprehensive programme and action plan to reduce healthcare associated infections, the following actions are included within the action plan:

- The HCAI Operational Group has been merged with the Antimicrobial Management Group with revised terms of reference and due to meet in January, this group will report to the Infection Control Committee (ICC). In addition, the Divisions will be requested to provide information on their performance on reducing HCAI, particularly on the progress of their action plans with quarterly reporting to the ICC.
- The IPCT are leading an audit of Aseptic Non-touch Technique (ANTT) practice across the trust. This is an observational audit which will provide information of where there are gaps in practice and where there is good practice which can be shared.
- A report was submitted to the Trust in March 2015 following an external review of cleaning services. The recommended changes now form part of the Cleaning Redesign Programme, details of which are due to be finalised by the end of October 2015
- 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. A number of RCAs indicated that patients were not isolated when infective diarrhoea was suspected and specimens sent. Whilst the timeliness of isolation does not appear to have been a contributory factor to date in the C-diff cases improvement in this area is required
- A task and finish group is currently being set up to agree a set of actions to reduce *E. coli* bacteraemia. The catheter project continues with the main aim to reduce indwelling urinary catheters to prevent infections associated with these devices.

2.8 DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation)

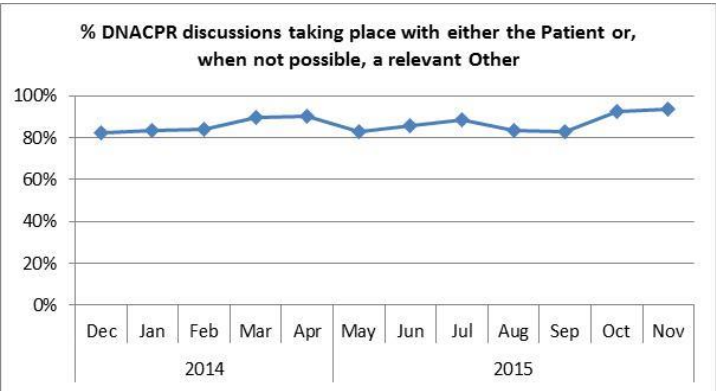
Aims and Objectives of Work

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.



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. A second point prevalence audit was carried out in September. The full report will be distributed as soon as it is finalised.

Improvements since January 2015 have been noted. Data is reported monthly at the Trust Clinical Outcomes Group and ward level data is sent to Divisional Directors and reported at Divisional Patient Safety & Quality meetings.

Full point prevalence audit has been repeated in September 2015 the result will be analysed and shared with through the organisation.

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 is sent to divisions for discussion at their PSQBs.

A regional training DVD on DNACPR decisions was produced earlier this year and is now available on the intranet.

Improvement Plans for Q3 2015/16

- DNACPR status is included as part of the handover module of the new electronic 'Nerve Centre' platform. Roll out is now complete across the trust. During Q3 nerve centre data will be explored to see how well this information is being captured and utilised.
- 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.
- DNACPR bundles have been trialled on 3 Medical and 1 surgical ward. Feedback has been very positive so will be rolled out Trust wide. The stickers are still on order at the printers. The stickers are to be used to document a discussion with a patient and/or their family after a DNACPR decision has been made and a form completed. The Resuscitation Officers will distribute these on the wards and include as part of the BLS training. This is to be completed in Q4.
- Monthly reports on compliance are reported at the Trust Clinical Outcomes Group and Divisional PSQBs.
- New Patient information leaflet is at the printers (what happens if my heart stops?). This will be distributed to all wards and available on the repository once in the Trust.
- Duplicated DNACPR forms printed with a red border are currently on order with the printers. This will ensure that a copy remains on the patient's records when the original copy is discharged with the patient. The new forms will be distributed by the Resuscitation officers and incorporated in the Basic Life Support training.

Improvement plans for Q4 2015/16

- Once the bundles are in use on all wards, completion will be monitored
- Review of monthly compliance will continue and will be monitored thorough divisional PSQBs and the end of life collaborative.
- Review of impact of duplicate forms;
- Patient information leaflets will be distributed to all wards once they are returned from the printers. Use of the leaflet will be monitored.

Domain Three – Experience (Caring)

Patient experience compliance summary

Indicator	Compliance
3.1 Dementia (CQUIN)	Achieved
3.2 Improving In Patient experience	Achieved
3.3 Friends and Family Test (contract)	Partial
3.4 Improving Hospital Nutrition (CQUIN, Quality Account)	Achieved
3.5 Improving care for end of life patients and their relatives	Achieved
3.6 Claims	Reporting only
3.7 Learning from Complaints	Reporting only
3.8 Mixed Sex Accommodation	Reporting only

Highlights:

3.1 Dementia	Dementia Find, Assess, Investigate, Refer CQUIN achieved. Journal Testing going well,
3.2 Improving the In Patient Experience	Progress with five projects in programme for wards to improve in patient experience
3.3 Improving Hospital Nutrition	Achievement of all CQUINs

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, abbreviated memory tests 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.

	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3
	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15	Total	Oct-15	Nov-15	Dec-15	Total
Dementia and Delirium - Find, Assess, Investigate, Refer and Inform (FAIR)												
No. of patients > 75 years admitted/accepted for unplanned care, who have known diagnosis of dementia or clinical diagnosis of delirium, or been asked the case finding question.	452	430	452	1334	440	402	442	1284	426	410		836
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	484	435	481	1400	464	444		908
% asked the Question*	92.2%	90.7%	92.2%	91.7%	90.9%	92.4%	91.9%	91.7%	91.8%	92.3%		92.1%
Target	90.0%				90.0%				90.0%			

	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3
	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15	Total	Oct-15	Nov-15	Dec-15	Total
Dementia AMTS - Emergency Admission 75 Years & Above												
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	70	71	63	204	72	82		154
No of Non Elective patients > 75 admitted as inpatients, who have scored positively on the caser finding question	82	66	62	210	70	71	63	204	72	82		154
% of patients aged 75 and over admitted as inpatients who were appropriately risk assessed	98.8%	100.0%	98.4%	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%
Target	90.0%				90.0%				90.0%			

	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3
	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15	Total	Oct-15	Nov-15	Dec-15	Total
Dementia Referral - Emergency Admission 75 Years & Above												
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	35	25	33	93	40	55		95
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	35	25	33	93	40	55		95
% appropriately referred on to GP	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%
Target	90.0%				90.0%				90.0%			

** December data to be updated.

Partnership Working:

The 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

Working in Partnership with Carers

A patient journal is being developed and tested on the trauma orthopaedic wards. Working in partnership with carers, the social engagement workers are supporting this initiative capturing the events of the day, requests for information or for items from home and generally communicating through a two way process with carers. The journal was introduced on one ward during quarter one, and feedback from the carers was very positive. In quarter two the journal has been used on both orthopaedic wards and continues to develop. During quarter three the design of the journal was refined and in the next quarter formal evaluation will take place.

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. An e-Learning dementia package has been developed this will be available from November 2015, and will be mandatory for all Trust staff from April 2016.

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 is now included in the Vulnerable Adult Network – operational group where issues relating to dementia, delirium, LD, safeguarding adults, person centred care, dignity and mental health, nutrition, and falls are discussed. 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. Currently this measures the number of senior nurses at band 6, 7 and 8 who receive dementia awareness through the vulnerable adult leader's course. The training targets new starters and nurses who have been promoted into senior positions. It runs on a once a year basis and is planned for February 2016.

Improvement Plans for Q3 onwards

Delivery of person centred care training – 3 sessions delivered in Q2 and 3 more planned for 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. 6 key trainers for CA, Dols, and dementia

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.

FFT 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.

Q3 Update

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.



Progress during Q3:

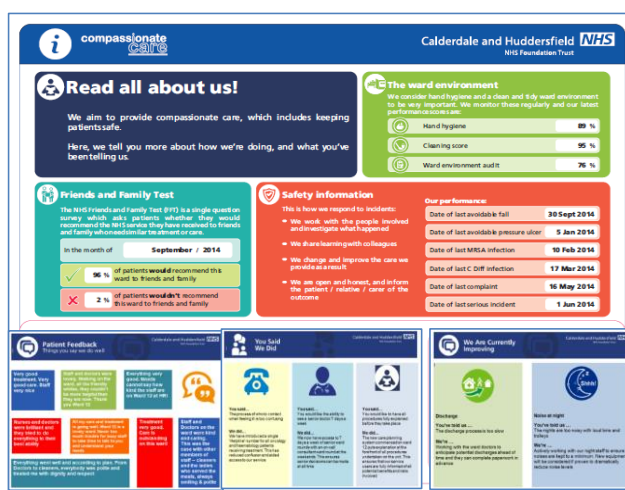
- Measurement has commenced on 4 surgical wards through a revised real time patient monitoring survey (RTPM). 91% of patients reported that all staff introduced themselves and a further 7% said some of the staff.

Behind the bed boards:

- Behind the bed boards are now located on the majority of inpatient wards, final orders are being placed for the extra capacity wards, so that all wards are working to the same standards. A decision has been made that they are not appropriate for the neonatal unit
- A walk around across all wards has been carried out to confirm all boards are in place, check for any additional boards required, remind staff that they can order additional magnets if required

Public facing boards

- The NICU board has now been designed and ordered
- Final orders have also been made for extra capacity wards and additional areas identified, e.g. medical day case ward, A&E wards



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.



Progress during Q3:

- A bag to bed system is being trialled on 4 wards and due to be evaluated during January 16. This reduces the need for bins on the wards, therefore supporting the reduction in noise
- A night matron is supporting the project group, creating awareness amongst the night staff and influencing practice. An issue picked up this quarter was the use high wattage light bulbs on 2 of the wards. This has been resolved and whilst this wasn't a noise issue, it was impacting on ability to sleep.

- Nervecentre alerts have been highlighted as disturbing patient sleep. Feedback has been provided to staff on how to adjust the volume whilst still being able to hear the alerts.
- A learning event is scheduled for January 16, with an invite to all wards, to come together and share good practice and remaining concerns. This will include a review of any patient feedback regarding noise at night, to understand current issues being raised
- RTPM measurement on 4 surgical wards identified 6% of patient stating they were definitely bothered by noise at night, supporting comments will be used as part of the January 16 learning event
- In order to maintain the profile of the campaign with all professional groups, a communications briefing has been prepared and will be disseminated following the January 16 event

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. Another view from patients is that they don't always want to bother staff with their issues as they can see how busy they are. This project recognises 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



Progress during Q3:

- During this quarter the priority for the complaints group has been to improve the management process for complaints. The focus has been on timeliness and quality of responses and good communication with the complainant
- The work described in the Q2 report regarding a shift in culture (staff to be empowered to sort out concerns on the spot and to encourage staff to recognise that dealing with situations / capturing a complaint on behalf of a patient is their responsibility, not that of the corporate team), has been on hold awaiting a new complaints manager to take up post in January 16.

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.

Progress during Q3:

This project has been on hold during Q3 and will be reviewed to focus on the issues arising from the real time patient monitoring results

Plans for Improving the Inpatient Experience from Q4 onwards:

1) Hello my name is ...

Continued embedding

Continue measurement via ward surveys

2) Ward orientation.

Distribution of leaflets

Translation of leaflet into top 5 languages and make available via repository

Commence updates of you said, we did posters

Continue measurement via ward surveys

3) Reducing Noise at night.

Obtain results from bag to bed trial

Strengthen links with staff working at night

Share good practice via learning event

Ensure the message is being acknowledged across all professional groups

Continue measurement via ward surveys

4) How can I help

Progress the work being led through the complaints task and finish group – culture of staff feeling empowered to sort out concerns on the spot

5) Regular information round.

Continue measurement via ward surveys

Link project to information being identified from the ward based RTPM surveys

Agree content of learning package – short DVD based on some good practice examples of communication and look into the production

3.3 Friends and Family Test (FFT)

		Percentage response rate								
	Target (green)	Apr 15	May 15	June 15	July 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15
Inpatient	28.0%	25.8%	21.4%	21.9%	26.5%	28.1%	24.4%	31.1%	32.9%	34.3%
Maternity	22.0%	18.2%	23.8%	26.3%	27.5%	29.6%	42.6%	30.9%	40.8%	33.6%
A&E	14.0%	6.8%	10.0%	8.6%	5.7%	2.7%	9.6%	12.1%	9.2%	9.1%
Community	3.4%	3.8%	3.3%	3.2%	3.1%	3.2%	3.0%	3.6%	15.6%	10.0%
Outpatient	5.0%	14.4%	13.9%	13.6%	13.8%	13.5%	13.3%	13.2%	13.1%	12.9%

		Percentage would recommend								
	Target (green)	Apr 15	May 15	June 15	July 15	Aug 15	Sept 15	Oct 15	Nov 15	Dec 15
Inpatient	96.0%	97.3%	96.4%	97.4%	96.6%	97.1%	96.5%	96.7%	96.7%	96.4%
Maternity	96.9%	94.0%	91.1%	94.8%	97.8%	95.2%	98.8%	95.0%	97.0%	96.5%
A&E	90.0%	90.7%	90.5%	91.1%	91.1%	84.8%	86.2%	86.8%	81.6%	85.4%
Community	96.2%	90.9%	89.1%	90.6%	92.4%	89.7%	91.6%	91.3%	84.4%	86.0%
Outpatient	95.0%	88.0%	87.9%	88.4%	89.5%	89.2%	89.2%	90.2%	90.5%	91.6%

Please note the above targets are based on the revised targets see rationale below

FFT revised Trust targets (agreement finalised December 15)

After consultation with the Director of Nursing and CCG colleagues it has been agreed to revise the current FFT targets so they are more in line with current national performance. This will impact on the red, amber green (RAG) thresholds used in the integrated performance report and any internal reporting.

Rationale:

- The introduction in April 2015, of the requirement to incorporate all day case scores with inpatient reporting has led to a drop nationally in the response rates.

- A local comparison / benchmarking exercise across all FFT areas, has demonstrated that some of our targets are set particularly high when compared to other Trusts.
- Nationally reports discussing FFT results, describe a positive performance as being above the national / England average

Therefore our revised RAG rating (based on ranked scores) will be:

Green= top 50% (i.e. above the England ranked average)
Amber = performance above the bottom 20% and up to 50%
Red = bottom 20%

Based on 3 month period June – Aug 15

Inpatient / day case:

Response rate: Target 28.0%

31.1%	32.9%	34.3%

The Trust is aware that the reduction in response rate was associated with the spread to all 'day case' areas in April 2015.

Work over the last few months has begun to have an impact and there has been a continued improvement over this quarter from 24.4% at the end of Q2 to 34.3% at the end of Q3. This places the Trust in a position which is above the England average of 28.0% (based on June- Aug 15)

In particular an impact has been made on the day case areas, increasing from 15.8% in Sept 15, to over 35% in November and December 15.

Attention is now being focused on the individual day cases areas with the lowest response rates, to ensure they are complying with the required processes and addressing any barriers they have encountered.

Feedback of actions being taken by teams in order to make an improvement includes:

- increasing the availability post boxes
- giving overall responsibility to specific members of staff

%age would recommend: Target 96.0%

96.7%	96.7%	96.4%

The Trust has continued to score well, remaining around 97% across the Q3 months to date.

Maternity:

Response rate: Target 22.0%

30.9%	40.8%	33.6%

The trust has performed above the revised target in the Q3 months, with the November results being in the top 20% of trusts nationally.

%age would recommend: Target 96.9%

95.0%	97.0%	96.5%

The percentage of women recommending the service has shown an improvement over the quarter so far, with the November score being 97.0% (above target) and December being slightly below the target.

A&E:

Response rate: Target 14.0%

12.1%	9.2%	9.1%

A steady Improvement has been seen since the introduction of the text system in September 2015, from a low of 2.7% in Aug, to 9.1% in Dec 15, which gives an amber rating. A position of 14% would place the department above the England average (revised target). Actions continue to support the increase in rates that are still required:

- Reception staff are collecting mobile phone numbers to enable use of the texting system.
- The poster campaign has been relaunched to inform patients of the FFT process.
- There are daily reminders for staff during the morning safety briefings
- All staff, inclusive of the medical team, are given postcards to hand out to patients throughout the day.
- There has been increased sharing of the patient comments to attract further engagement with staff in relation to the improvement work

It was acknowledged that Q3 would remain a challenge due to increases in work pressures, recognising it as the toughest quarter for A&E. The team aimed to be above the England average of 14.0% by the end of December 2015; however this has not been achieved and will now be the trajectory for the end of the financial year.

%age would recommend: Target 90.0%



In order to understand the reason why patients have given a response of unlikely / extremely unlikely to recommend care specific attention has been given to reviewing any supporting comments.

For October: Two (8%) of the comments were positive, suggesting that the wrong response had been selected and 18 (72%) related to long waits and the impact that had on their care. Other comments related to the uncomfortable chairs, lack of information, parking and care / treatment. An improved position was achieved at the end of the quarter, with an amber score of 85.4%. A review of the comments for this month show fewer references to waiting times and none about not being kept up to date, this follows the improved use of the electronic board advising patients of current waits.

Focus of the next few months will be on communication with patients; this will be the provision of waiting time information on arrival in the department, with ongoing updates. Other opportunities to address reduced waits will be discussed within the team and some of the wider services e.g. radiology.

The team aimed to be above the England average of 90.0% by the end of January 2016; however given the high number of comments relating times and the current pressures in A&E, this will now be the trajectory for the end of the financial year.

Community:

Response rate: Target 3.4%



The introduction of interactive voice mail has made a significant impact on the community response rate with a 10% increase in the responses received.

information has been sent to staff as a script to be used to increase engagement

%age would recommend: Target 96.2%



Analysis of negative comments from SMS texts show the majority to relate to out-patient Physio. These comments are about waiting times and service delivery. It is important to note that are a limited number of comments available for analysis.

Actions In the short term: 2 locums have been recruited, one started in October and the second is due to start in December 15.

There are longer term plans working closely with Calderdale CCG, specifically on a task and finish group for Physio which met for the first time early November 15. These meeting will be monthly with actions looking into referral criteria and clinical pathways.

In order to get more robust data, new data collection methods went live in December such as Interactive voice mail and web forms. All comments continue to be monitored and shared with the relevant staff groups – a recent example is how information is communicated regarding self-management, as this is an area that attracts some negative feedback. Whilst a number of the improvements identified are already in progress, the impact on improving the overall community score will take some time, therefore the aim is to work towards an amber rating by the end of quarter 4 (threshold range: 93.0 – 96.1%).

Outpatients:

Response rate: Target 5.0%

13.2%	13.1%	12.9%

Outpatients have continued to achieve a comparably high response rates during Q3 to date, placing it in the top 20% of response rates nationally.

%age would recommend: Target 95.0%

90.2%	90.5%	91.6%

Outpatients remains below the revised target of 95%required to be in the top 50% of trusts, however there has been an improved score at the end of Q3 - 91.6%, which gives an amber rating (no longer ranked in the bottom 20%).

2. Actions to get back on plan: An OPD improvement plan is in place based on core themes picked up from the patient comments across all specialties; this is being led by Matron Rachel Roberts. Individual specialty results indicate variation in practice with some achieving a 100% rating. A greater focus is being directed to the underperforming areas in order to understand and address the reasons for variation across the outpatient services. It is anticipated that a continued increase will take place over the next few months, achieving an improved amber rating by the end of quarter 4 (threshold range: 91.0 – 94.9%).

3.4 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, visitors and staff.

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. Nutrition is an agreed priority for the trust in the annual Quality Account and is supported by the 2015/16 CQUINs which 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: Patient satisfaction is being measure by the distribution of a questionnaire to inpatients. Volunteers on the HRI site and members of ISS on the CRH site sample 400 or more patients each quarter. The YTD performance is below:

Nutrition and Hydration - Patient satisfaction	Quarter 1				Quarter 2				Quarter 3			
	Apr-15	Mag-15	Jun-15	Q1 Total	Jul-15	Aug-15	Sep-15	Q2 Total	Oct-15	Nov-15	Dec-15	Q3 Total
No. of patients reporting satisfaction with hospital food	137	146	165	448	113	99	113	325	102	89	128	319
Number of patients audited in quarter	185	177	210	572	139	141	149	429	139	115	168	422
% patients reported satisfaction with Hospital Food	74%	82.49%	78.57%	78.32%	81.29%	70.21%	75.84%	75.76%	73.38%	77.39%	77.39%	75.59%
Target	Patient feedback (400 survey's)				Patient feedback (400 surveys & report on 6months)				Patient feedback (400 survey's)			

As a result of this work, the catering team at CRH have raised the profile of supervisors and team leaders on the ward so they are available to speak to patients and staff around any concern related to food and feedback from the wards around this has been positive.

Concerns had also been raised around the lack of choice for patients who require a soft mashable type diet, as such a meeting took place in Q2 with staff from one of the CRH rehab wards and now a wider choice of category D and E meals are being tested with patients, staff and dietetic team to see how this is benefiting patients. Alongside this, Halal meals are also under review to improve both quality and choice.

Throughout Q2 and Q3, ISS have been working with Burlodge, the heated trolley provided on the CRH site, and Anglican Crown who provides majority of the meals. The review looked at different ways the food could be plated and reheated in order to prevent some meals becoming overheated and drying out. It is noticeable that complaints from both patients and staff have reduced since this piece of work began.

The actions highlighted in Q2 are still ongoing and a refresh of these will be available in the Q4 report.

HRI site:

Negative Comments:	
Comment	Action
Temperature of Food re food not hot	- Porters assisting with swift delivery of meal trolleys to wards. - Smaller portions of less dense food products i.e. vegetables decreasing temperature loss. - Assistance at ward level to cut service time down.
Cooked breakfast option	Ward staff able to order cooked breakfast option at patients request.
Meal plates too hot	Plate warmers have been turned down to alleviate this issue.
Sandwiches more variety	Will look into alternating sandwich options and look at other varieties.
Tea and coffee always cold	Ward issues will contact wards
Over cooked vegetables	We have reduced the timings for vegetables and haven't had issues since.
More green vegetables	27% of the current menu are green vegetables.
Cold Toast	Toast is made on the wards will contact wards
Not enough salt and Pepper	Salt and pepper sachets served with every meal if the patient required extra we would take advice from ward staff.

More choice at Breakfast	Currently a continental breakfast 3 choices of cereals, Porridge, 2 choices of bread rolls, preserves, toast from ward and hot breakfast on request from ward staff.

Positive Comments
Food better than I thought it would be.
Like salads & soups
Very satisfied with the meals that I have had.
Porridge and rice pudding are exceptional.
Meals are always tasty and hot
Very friendly catering staff
Very happy 1 st class
Impressed with catering staff who frequently ask if you are happy with the food.
I was in hospital 5 years ago and the food is much improved.
My whole experience of this has been good so far, meals have been the icing on the cake.
The meals and staff have been excellent can you book me in over Xmas please.
Meals are an important part of a long day, something to look forward to, I haven't been disappointed.

CRH site:

Negative Comments	
Comment	Action
Temperature	
The food was sometimes cold , and I sometimes did not get what I had asked for	The comments are almost generic and relate to the plated meal system. Work is being undertaken presently within the Department looking at temperatures and checking for abnormally high temperatures occurring. Also a Patient Service Catering Supervisor is being developed to work around the ward areas to intercept problems and encourage meals to be given out as soon as is possible to avoid drying. Matron walkabouts with Catering Senior Team should also bring a better understanding of system.
Food left standing in trolley	
Meat dry and overcooked	
Food and gravy dry	
Left standing long time sauce had stuck to the plate	
Food	
Vegetables overcooked and could have done with more variety of vegetables	Looking into choices available and going to make alterations to menu shortly so will take this matter on board as part of this next piece of work.
Breakfast menu boring-Kippers would be nice	Additional items can be made available for patients with menu fatigue and we intend to communicate this better to ward areas with the introduction of the Patient Service Supervisor. Meeting has taken place with Dietician/SALT Team also to communicate this matter further
- Rice pudding never available. - There was no bread for breakfast	Both comments related to two items that are always in stock with contingencies. There appeared to be a communication issue with ward based staff
Soups powdery	Continuing to review soup product for lunch time as it is the fresh homemade soup for evening meal which is very popular, and there will appear a

	disparity in the two. Unfortunately the kitchen presently does not have the capacity to produce enough homemade soup for both meal times
Overall	
Portion size too big	Can accept comments re menu card as there is flexibility to request larger or smaller portion sizes, but perhaps layout of menu is complicated. Bulk breakfast is in the middle of being rolled out giving more flexibility at breakfast time.
Menu too complicated, too many boxes	
Patient missed meal times	When asked patient explained that the ward staff had not fed him, nothing had been sourced from Catering.
Not getting what had been ordered	Newly reprinted menus have now been received. Catering staff had tried to make sure wards are not in possession of old menu cards.

Positive Comments
So far very good- Happy
Quite good food, I was surprised I enjoyed it
Absolutely
Really satisfied, didn't think that it would taste as good as I imagined- Gammon very nice
Soups and Ham sandwiches very good
Enjoyed salad/Omelettes/
Overall happy with the service, no complaints
Always enjoyed meals, nice choices

Food Waste

We are continuing to work on reducing the amount of patient food waste; actions are currently focusing on improving communication at ward level which helps to feed back to patients the food choices available to them. This work is also helping to increase accurate ordering at ward level.

	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3
Nutrition & Hydration - Reducing Hospital Food Waste	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15	Total	Oct-15	Nov-15	Dec-15	Total
HRI - % Returned	5.72%	5.35%	6.13%	5.70%	6.59%	4.94%	5.17%	5.48%	5.28%	4.65%	4.61%	4.84%
CRH - % Returned	4.64%	4.55%	3.70%	4.30%	3.32%	3.34%	3.35%	3.34%	2.48%	2.64%	3.03%	2.72%
Target	Baseline				Report on baseline				0.5 Reduction on Q1 (5.2, 3.8)			

At the end of Q3 an initiative was in place to offer out any ward left overs to relatives who may be visiting patients for a long period of times due to the nature of the patient condition, thus ensuring that less food was wasted and returned to the kitchen. Formal feedback is awaited as the success of this approach in reducing waste and improving experience,

Vending Facilities

The proposal has been updated in line with feedback from board members to ensure there is still a choice for all users. Tendering exercise to be progressed.

Other Work:

Partnership working with Food for Life:

Calderdale CCG have funded the Soil Association Food for Life (FFL) for the next 2 years. Part of their role will be using their expertise in supporting CHFT in improving the food experience for staff, visitors and patients. FFL for life also link into other NHS organisations and are keen to share other projects with CHFT

Part of this support has already been outlined above with the vending project.

Nutrition and Hydration Strategy:

In October 2015 FFL supported CHFT in an engagement event with staff, and users to help in the development of a Nutrition and Hydration strategy for the Trust. The workshop has drawn together a strong multi-disciplinary team and in evaluation all participants reported that as a result of the workshop they feel more confident to be part of the team developing a food and drink strategy.

Fruit and Veg stall HRI:

From the 7th October as a pilot for approximately 7 weeks a food and veg stall will be in place in the main entrance at HRI. It demonstrates excellent partnership working with the Council and local businesses selling local produce and if proves to be successful will be rolled out onto the CRH site too. This is to encourage health and Wellbeing of staff and public and also links into the NHS CEO Simon Stevens drive to improve health in the NHS

The fruit and veg stall at HRI has proved to be a great success and is now in place 2 days a week. In partnership with Calderdale public Health and the Local authority the plan is to introduce a fruit and veg stall on the CRH site.

Calderdale Food Assembly:

On the 8th October 2015 an assembly was undertaken where the FFL hospital work at CHFT was shared with nursing homes. The event brought together caterers and procurement teams from all settings to enable networking and learning.

Packaging Test study:

CHFT are involved in a study to measure food packaging opening ability and ease of access for common NHS packaging items. It is in conjunction with the Hospital Caterers Association, NHS England led by Caroline Lecko and Sheffield Hallam University led by Alistair Yoxall. The test is in 3 stages looking at strength, dexterity and the pack open ability test. The request has been for mainly female over the age of 65. We have used our patient reps to assist with this study and has involved them basically being observed open the packaging. Updates will be given on the outcome of the study in Q4.

Food for Life Catering Mark:

In December last year ISS achieved their Bronze Catering mark in retail. This relates to the coffee shop and the onsite restaurant. In December 2015 they will be going for silver award and to achieve this they are planning on buying products like fish, fruit, vegetables, meat from a local source. The progress towards the Silver catering mark has been delayed. Food for Life is re auditing ISS retail in February 2016 to ensure they have managed to retain the Bronze standard. If the report is positive ISS will progress to achieve the silver standard

Incredible Edible:

On the 17th June 2015 Incredible Aqua Garden (part of the Incredible Edible Todmorden Group) created edible landscapes in the grounds of Calderdale Royal Hospital. Incredible Aqua Garden, along with a group of volunteers from Lloyds Bank, Halifax, planted edibles in four sites, within the hospital grounds.

The two courtyards have 'sensory' planters, containing herbs and other plants, which are good to look at, to touch, to smell and to taste, and brings a new dimension to the spaces.

The area in front of the Learning & Development building has three raised 'kitchen garden' beds, containing summer vegetables, herbs and fruit.

There is a new planter in front of the Macmillan building which have a variety of herbs and edible flowers. 5 fruit trees were planned to be planted October 2015. This has now been delayed until April 2016 in order to plant at the optimal time.

MUST (Malnutrition Universal Screening Tool) Compliance:

In August 2015 an audit of MUST screening was undertaken across 4 wards totalling 90 patients. Feedback was shared with the sisters October's sister meeting

Key findings

- 98% of patients had a MUST care plan
- 30% were completed in full
- 68% had accurate height and weight
- 68% had BMI recorded accurately
- 43% had a relevant care plan in place
- 23% fluid balance charts completed in full
- 32% had food diaries completed in full

Whilst it was a positive that almost all patients had a MUST care plan, work in Q3 looked to understand some of the barriers to fully completing the MUST tool and the Fluid Balance Charts and feedback and the corresponding action plans are due in Q4.

From April 2016 the trust will be taking part in the BAPEN (British Association Of Parenteral and Enteral Nutrition) national audit on a quarterly basis which includes the monitoring of the MUST tool

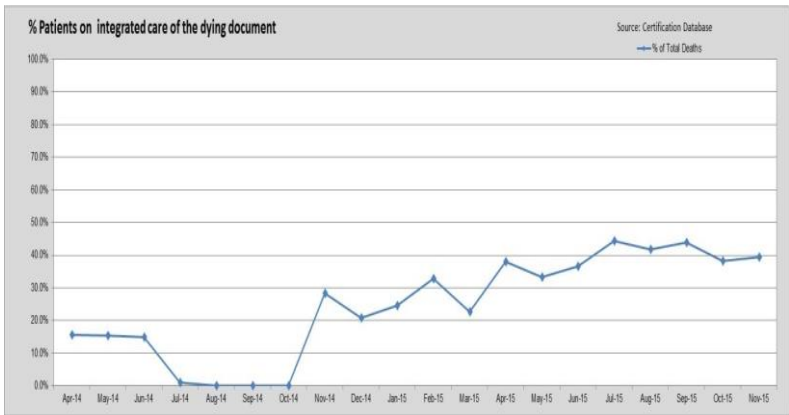
3.5 Improving End of Life Care

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 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 39.4%).



Progress against Improvement Plans for last 12 Months

- The introduction of comfort bags continues to receive 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.
- Education and training has been rolled out to Cardiology and Complex care wards. Training with the consultants from elderly care and cardiology was carried out in November, 16 out of 22 consultants have now been fully trained. Ward based training is also booked for relevant wards at HRI. It is expected that 50% of staff on the (4 out of 5) designated wards will have been trained by the end of January 2016. The remaining ward will be completed by the end of March 2016.
- Funding received earlier this year from Health Education for Yorkshire & Humber for training. CHFT commissioned Kirkwood Hospice to deliver a series of free one day courses for doctors and registered nurses working in the Trust. This course is designed to improve knowledge, skills and confidence when communicating with palliative care patients. It will focus on the five priorities of care. There have been four sessions to date and a further six sessions are planned in 2016. Feedback from 'The One Chance to get it Right' study day has been very positive, with 52 staff attending and expressing that their practice would change as a result of the training day.

- 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 gives the trust insight in where to focus training/action which is specific to each area, and in particular whether there are nursing or medical actions required. Reports are being produced every 3 months and trends identified. Themes identified so far are - lack of or poor communication, poor care, poor symptom management, reference to the LCP and poor discharge planning. This is reported through the end of life meeting and is shared with staff through training and education. It is recognised that there may be value in analysing clinical incidents through the DATIX system in a similar fashion.
- 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 is increasing as staff attend the organised training sessions and awareness spreads.
- The pilot of the ICODD has been completed in community. Feedback has been very positive. Training will commence in January for all district nursing teams and agencies. It is expected that the ICODD will be rolled out and used in all areas by May 2016.
- Participation in the National End of Life Care Audit. Data for CHFT has been submitted for 80 patients who died during May 2015. This audit will look at the progress acute hospitals have made in addressing the 'five priorities of care' for people in their last hours, days of life. Reports are expected to be published in March 2016.
- Local audit carried out of 20 patients who died in May 2015 whilst being supported with the individualised care of the dying document. The results indicate that the use of ICODD has generally improved. The report will be produced within the next few weeks and results presented at the next available slot at the Clinical Governance meetings.

Plans for improvement for Q4 2015/2016

- More training days on advanced communication skills and end of life care are organised for 2015/2016. Five sessions are planned in 2016.
- Continue to support the roll out of the ICODD to community services
- Further improvement in review of decisions for ICODD through training and education.
- Local survey to bereaved relatives took place in October 2015. Questionnaires were sent to 140 relatives/carers of patients who died in January and February 2015. The response rate so far is 32%. The data will be analysed this month and the results of the questionnaire will be used to assess the quality of care and the level of support provided to individuals and their families in the last days and hours of life. One of the recommendations from the National Care of the dying audit was that all hospitals should undertake local audits of the care of the dying including the assessment of the views of bereaved relatives, at least annually
- A business case is being developed to support workforce enhancement within the hospital specialist palliative care team (SPCT) so that a 9-5 seven day face to face service can be delivered. Monies from a current maternity leave vacancy are being used to deliver some

clinical nurse specialist (CNS) shifts, and several weekend and Bank Holiday shifts have been delivered, and an audit of activity undertaken.

- Timely availability of syringe drivers to deliver medication is crucial to good end of life care, and proposals are in place to develop a central equipment store to meet this need. This model would also address important governance issues such as regular servicing, calibration, etc, and will reduce inequity in access.
- Changes in how contacts with SPCS are recorded and coded will give a more accurate assessment of the input of this team into patient care in hospital.

3.6 Claims

All formal claims received are handled on behalf of the Trust by the NHS Litigation Authority which effectively provides indemnity through our annual insurance premium, which is based upon our claims history. Learning from claims will improve the quality of the care we provide and help to reduce further increases in our premiums.

Activity relating to claims is captured throughout this section. Learning from claims is identified for individual cases. Key messages are:

Clinical Negligence Claims

- Trend of reduction in clinical claims from the peak of Q3 2014/15 continues
- 72% claims related to following four service areas:
 - Emergency Network
 - Women's Services
 - Orthopaedic Services
 - General and Specialist Surgical Services
- In Q3 General and Specialist Surgical Services had the highest number of claims, at 9 claims, continuing the increase noted in Q2
- At end of Q3 there were 425 ongoing clinical negligence claims, 301 of which are records requests, with 151 live clinical claims

Non Clinical Claims

- In Q3 6 new non clinical claims received
- 13 clinical claims closed, 10 unsuccessful
- In Q3 1 employer liability claim settled, 1 public liability claim closed with liability denied

Clinical Claims	Q1	Q2	Q3	Comment
New Claims opened during quarter	44	36	37	The reduction in Q2 has been sustained in Q3
Claims closed in quarter	17	19	13	1 case was settled this quarter.
Services with highest level of clinical claims	61% relate to 3 service areas:	64% relate 3 service areas:	60% relate to 3 service areas:	The increase in the previous quarter relating to General & Specialist

	- Emergency Network - Orthopaedics - Women's Services	- General & Specialist Services - Women's Services - Emergency Network	Emergency Network Women's General & Specialist Surgery	Services cases has continued this quarter.

Non Clinical Claims	Q1	Q2	Q3	Comment
New Claims during quarter	6	4	6	The reduction in Q2 has been sustained in Q3
Claims closed in quarter	3	10	1	1 case liability accepted

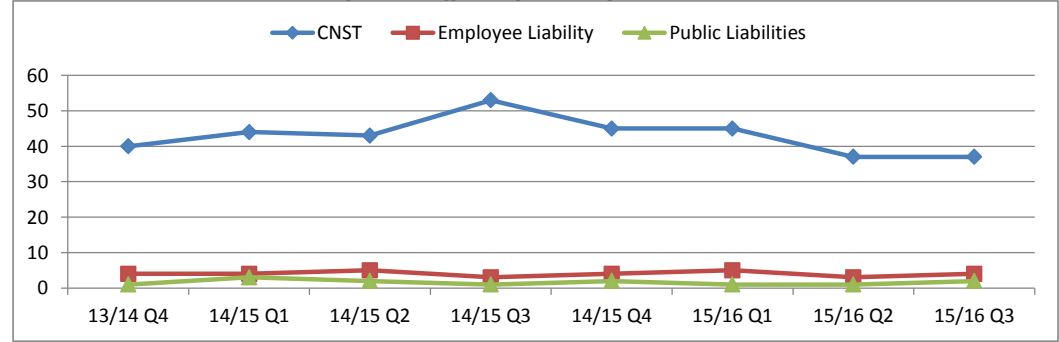
New cases in Q3:

- 59 new cases** have been registered on the Datix system in Q3, 2015/16.
- 37 clinical claims – of which **4** were formal letters of claim; **1** letter before action; 32 were requests for records;
 - 4 employer liability claims
 - 2 public liability claims.
 - 16 lost property claims

In addition, of the existing cases on the system, **17** requests for records have progressed to formal claims.

The numbers of new cases opened per quarter over the last two years are shown in the graphs below:

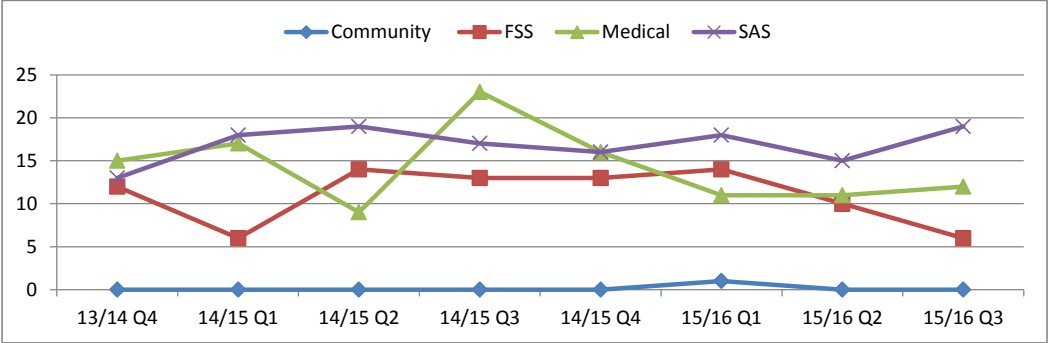
Number of new cases opened (per quarter)



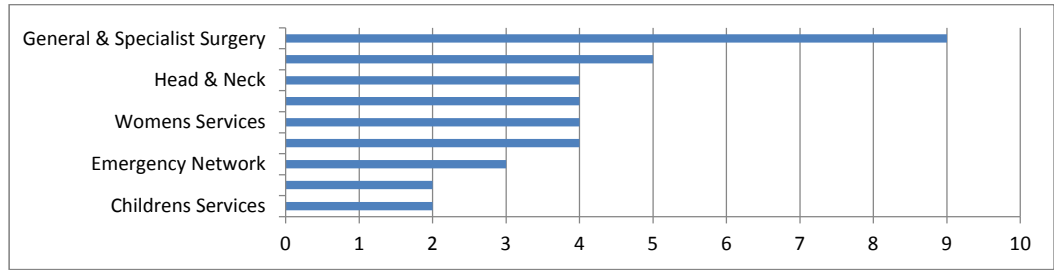
Following the peak in the number of cases received in Q3 14/15, there has been reductions in the following quarters, which has continued in Q3 15/16 for both clinical and non clinical claims.

Clinical Cases Opened: Reviewing the number of clinical cases opened per quarter by Division, shows that the reduction is across all Divisions.

Number of clinical cases received per division by quarter



Drilling into the Q3 cases, the spread of the directorates is shown below:

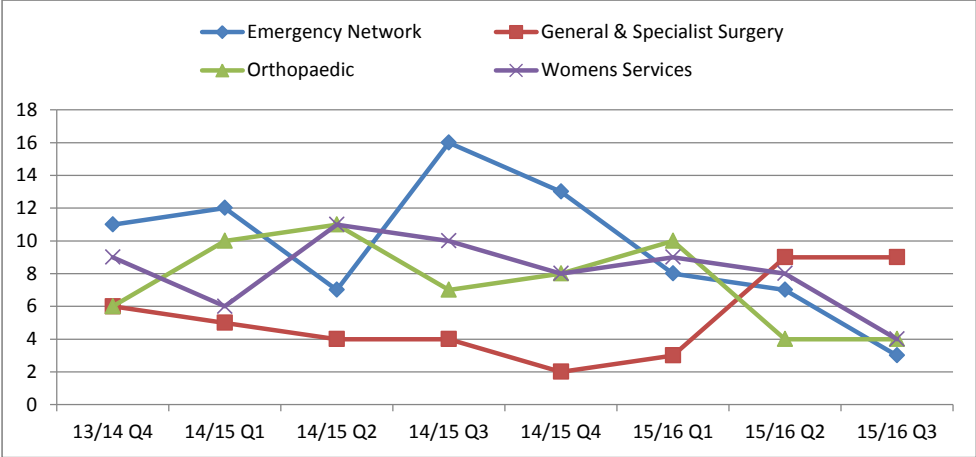


Reviewing the number of clinical cases opened by Directorate illustrates that almost three quarters (72%) relate to four key areas: Emergency Network; Womens' Services; Orthopaedic Services and General and Specialist Surgical Services.

	13/14 Q4	14/15 Q1	14/15 Q2	14/15 Q3	14/15 Q4	15/16 Q1	15/16 Q2	15/16 Q3	Total
Acute Medical	2	3	1	5	1	2	1	5	20
Childrens Services	2	0	2	1	3	3	0	2	13
Critical Care	0	0	0	0	1	1	0	0	2
Emergency Network	11	12	7	16	13	8	7	3	77
General & Specialist Surgery	6	5	4	4	2	3	9	9	42
Head & Neck	0	2	3	4	2	3	2	4	20
Intermediate and Community	0	0	0	1	1	1	0	0	3
Integrated Medical	3	3	2	2	1	1	3	4	19
Outpatient and Records	0	0	0	0	0	1	0	0	1
Operating Services	0	0	0	1	3	1	0	2	7
Orthopaedic	6	10	11	7	8	10	4	4	60
Pathology	0	0	0	1	0	0	0	0	1
Radiology	1	0	1	1	1	1	2	0	7
Womens Services	9	6	11	10	8	9	8	4	65
Totals:	40	41	42	53	44	44	36	37	337

The graph below illustrates there has been a reduction in three out of the four of these main areas in the last quarter, with the exception of General and Specialist Surgical Services where

The increase in the previous quarter has continued.



Clinical Negligence – New Letters of Claim / Letters before Action:

Division	Directorate	Specialty	Incident date	Summary	Previous Investigation
FSS	Radiology	MRI	March 2015	Alleged injury to face and neck caused during MRI scan	Complaint
FSS	Radiology	X-Ray	Dec 2011	Alleged delay in diagnosis of lung cancer ; did not identify broncho carcinoma developing on regular check x-rays	Nil
FSS	Women's	Maternity	Nov 2014	Baby died following alleged delays in delivery	Incident
FSS	Women's	Maternity	Dec 2012	Treatment following vaginal stiches allegedly caused labial adhesions	Nil
FSS	Women's	Maternity	Sept 2014	Treatment during and following childbirth allegedly culminated in cardiac arrest and significant psychological distress	Incident
SAS	Head & Neck	ENT	Sept 2011	Treatment received in respect of diagnosis and management of Wegener's Granulomatosis.	Concern
SAS	Head & Neck	Ophthalmology	March 2013	CHFT are Fifth Defendant in claim relating to treatment for 'white dot syndrome' with secondary CMV.	Nil

SAS	Orthopaedic	Ortho	Aug 2011	Alleged under treatment of fracture led to poor outcome	Nil
SAS	Orthopaedics	Spinal	Sept 2012	Alleged failure to fully remove synovial cyst at first operation	Nil
SAS	Orthopaedic	Ortho	March 2014	Fall whilst skiing. Advice of Doctor abroad to perform CT scan on return home was not followed.	Complaint
SAS	Orthopaedic	Ortho	2003/4	Alleged under treatment of fracture initially and then when surgery performed it was not adequate.	Nil
SAS	Gen Surg	Colorectal	July 2013	Foreign body allegedly found in wound following surgery and dressing of wound.	Incident
Medicine	Acute Medicine	Cardiology	March 2011	Primary claim against GP care, secondary claim from GP's alleges that cardiology treatment contributed to renal deterioration	Nil
Medicine	Acute Medical	Respiratory	Nov 2012	Alleged failure to give anticoagulation treatment	Nil
Medicine	Emergency Network	A&E	Dec 2012	Alleged failure to recognise and treat an Abdominal Aortic Aneurism.	Inquest
Medicine	Emergency Network	A&E	Feb 2013	Alleged failure to diagnose intestinal obstruction which led to patient's death.	Inquest
Medicine	Emergency Network	A&E	Feb 2013	It is alleged that Level of investigation did not identify tendon injury on initial assessment	Complaint
Medicine	Emergency Network	A&E	Nov 2013	Alleged failure to diagnose fracture of scaphoid.	Complaint
Medicine	Emergency Network	A&E	July 2014	It is alleged that the examination of a child's throat did not identify battery which was found 6 weeks later at a different hospital.	Nil

Medicine	Emergency Network	MAU	August 2014	Alleged inappropriate performance of lumbar puncture attempts causing back pain.	Nil
Medicine	Emergency Network	MAU	August 2014	Fell on ward causing subdural haematoma and subsequent death	Incident
Medicine	Emergency Network	A&E	Nov 2013	Alleged failure to diagnose fracture of scaphoid.	Complaint
Medicine	Emergency Network	Short Stay	July 2014	Alleged failure to prevent pressure damage	Incident and Complaint

Employer liability claims have remained static in Q3 compared to the previous quarter.

Employer’s Liability – New Letters of Claim:

Directorate	Incident date	Summary	Previous investigation
Women’s/ Staff Bank	6/10/2015	Claim for back injury caused by assisting patients alone.	Nil
Acute Medicine/ Staff Bank	13/11/15	Slipped and fell in a pool of water on floor in reception area	Nil
Acute Medicine	21/12/15	Handle came off door when pulling it to open, causing fall	Incident
Emergency Network	22/12/15	Injury caused when manoeuvring trolley in cubicle, due to shortage of space.	Incident

Public Liability – New Letters of Claim:

Directorate	Incident date	Summary	Previous investigation
Estates and Facilities	6/10/15	Visitor claiming fall down stairs due to spillage on stairs.	Incident
Children’s	30/10/15	Breach of confidentiality by member of staff	Complaint and Incident

Settled Claims

Clinical Negligence Claims:

13 clinical claims settled / closed during Q3.
 10 of these were unsuccessful with liability denied or the claim withdrawn. 2 were closed after being settled in a previous quarter. The 1 claims settled in this quarter is summarised below. The damages and costs for clinical claims are covered by our CNST premium to the NHSLA.

Date of Claim	Directorate	Summary	Damages	COSTS	
				Claimant	Defence
5/8/2013	Orthopaedics	Failure to diagnose and treat infection in right knee	£15,000	TBC	TBC

Employer's Liability Claims:

1 employer liability claims settled / closed during Q3.
The employer liability claim settled in this quarter is summarised below. The Trust pays an excess of up to £10,000 for Employer Liability claims as a result of incidents occurring from 1st April 2010.

Directorate	Description (Policies)	Damages	COSTS	
			Claimant's	Defence
Wd 4 HRI (Elderly Medicine at time)	Tripped over bin colliding with wall and fractured humerus. Unable to return to nursing. (Incident reported)	£108,500	£90,000	£22,500

Public Liability Claims:

The Trust pays an excess of up to £3000 for PL claims as a result of incidents occurring from 1st April 2010.
No public liability claims have settled in this quarter. 1 claim has been closed after liability was successfully denied.

Ongoing claims:

- Claims open as at end September 2015:
- 452 clinical negligence claims – of which 301 are requests for records. The 151 “live” cases include:
 - 59 letters of claim / letters before action
 - 78 ongoing – proceedings issued / defence - 57 Admissions made
- 21 No admissions made
 - 2 Listed for Trial
 - 11 settled – awaiting final outcome and closure
 - 25 employer's liability claims of which
 - 1 has settled, awaiting final closure
 - 13 ongoing – 9 Admissions made
- 2 No admissions made
 - 12 under investigation.
 - 8 public liability claims, all currently under investigation.

Learning from Claims

Claims settled in quarter 1

Datix ID	DETAILS	LEARNING	IMPROVEMENT
2009	Member of staff walking on road towards A&E car park. Ambulance approached so stepped onto the pavement. As ambulance passed unable to see bollard and fell over it. Facial injury and fractured arm	The area is insufficiently well lit for access at night.	Courtesy lights mounted alongside of the road and the bollards jet washed with reflectors fitted. Direction sign for the smoke shelter removed as not serving any purpose Door to be locked off at the same time as the main entrance doors to reduce access.
2434	When alighting from	Ground uneven and	Area resurfaced.

	vehicle went over on her ankles due to uneven ground	potentially hazardous.	
2287	Failure to identify tendon damage.	Identified in complaint investigation - Error by individual Practitioner	Correct investigation of tendon damage confirmed to staff.
1775	Discharged with low white cell count instead of receiving clinical review and septic screen		Since 2011, the process for recognising and treating sepsis (sepsis bundle), and discharge process have both changed significantly.

3.7 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 Q3 2015-16
- Information on concerns, patient feedback and compliments
- Learning from complaints
- Key publications in the quarter
- Areas for improvement

1. Complaints Performance Q3, 2015-16

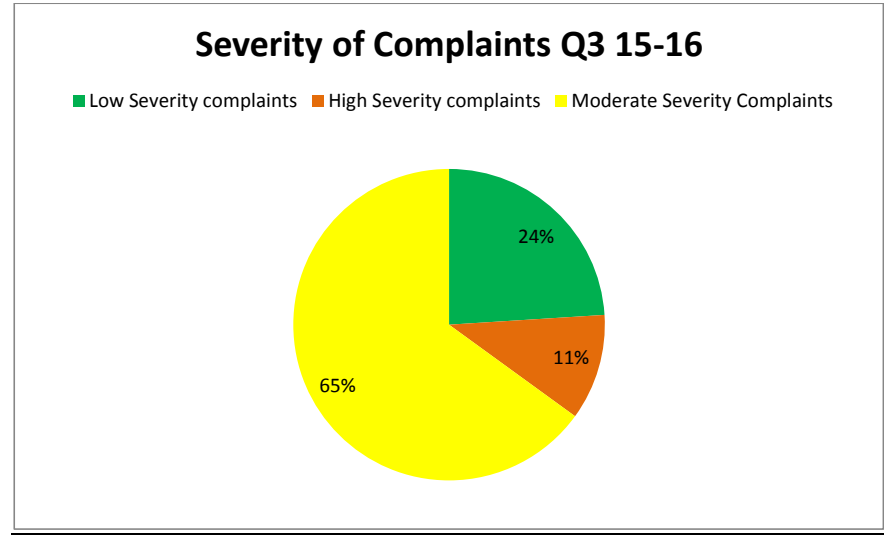
The Trust received 156 complaints between 1 October 2015 and 31 December 2015, an increase of 17% on the same quarter in 2014/15.

Key Performance Indicators

Complaints and Concerns 2015/16	Q1	Q2	Q3
Number of new complaints received	169	156	164
Cumulative total	169	325	489
% increase / decrease on same period 2014/15	↑10%	↓10%	↑20%
Number of complaints acknowledged within 3 working days - target 100%	93%	94%	99%
Number of complaints closed within the quarter	206	136	190
% complaints upheld	56%	48%	47%
% complaints partially upheld	31%	35%	33%
% complaints not upheld	13%	16%	20%
Number of complaints re-opened within the quarter following final response	24	27	20
Number of complaints overdue at end of quarter.	33	50	38
Number of complaints received from Ombudsman for investigation during quarter	3	4	0

Number of complaints upheld by Ombudsman in quarter	0	2 partially upheld	0
Number of complaints not upheld by Ombudsman in quarter	2	2	5
Number of concerns in quarter	158	172	159
Number of concerns cumulative	158	335	494

New Complaints – Severity
The majority of complaints (65%) received in Q3 are graded as yellow severity; no lasting harm.



Key:
Green – no / minimal impact on care
Yellow – no lasting harm
Amber – quality care issues/ harm
Red – long term harm, death, substandard care

Red Complaints data

A red complaint is a case where the patient or their family feel the action or inaction of the Trust have caused the death or significant and non-reversible harm to the patient.

Five red complaints were closed during Q3. Of these two were upheld and learning from these is given later on in this section. Three were partially upheld and two were not upheld.

At the end of Q3 the Trust had no red complaints under investigation.

Acknowledgement time

Complaints were acknowledged 100% of the time in the first two months of the quarter; unfortunately, in December only 1 complaint was not acknowledged within time making the overall

Q2 acknowledgement figure 99%. This was due to an administration error. The importance of keeping timescales has been discussed and reiterated with the team to ensure all complaints are acknowledged within time

Overdue Complaints

The drive continues by all divisions to reduce the number of overdue complaints in the quarter leading to a reduction in numbers overdue. The number of overdue complaints has decreased from 50 in Q2 to 38 in Q3 with the breakdown as follows:

0 – 1 month overdue: 17 complaints
1 – 2 months overdue: 10 complaints
2-3 months overdue: 7 complaint
3-4 months overdue: 4 complaint

Weekly monitoring reports continue to be provided to divisions 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

During quarter three 47% of all complaints were upheld and 33% partially upheld (The HSCIC counts partially upheld complaints as upheld complaints so if looked at in this way the figure is 85%). 20% of all complaints were not upheld.

Ombudsman Complaints

During Q 3 there were 8 active cases which the Ombudsman is investigating. The breakdown is as follows:

Division	Directorate	Received	Description
FSS	CHILD	11/11/2013	care received during labour, birth and discharge, baby death
FSS	WOMEN	21/10/2013	Care and treatment at HRI
MED	EMERGE	03/12/2013	Patient fall causing prolonged pain
MED	EMERGE	22/10/2013	Negligent care in A&E and Surgical Assessment Unit in 2010
MED	ACUTE	24/01/2014	care prior to death
MED	EMERGE	15/01/2015	Alleged misdiagnosis, patient death, cancer
MED	EMERGE	24/06/2015	A&E treatment June 2013
SAS	GENSPE	30/01/2013	Patient care, delay to receiving rehabilitation in appropriate area.

The red line indicates a complaint graded and managed as a red complaint, i.e. where Trust actions / inactions caused death or significant and non-reversible harm.

During Q3 five Ombudsman complaints were closed, none of which were upheld.

There were no new Ombudsman cases received in Q3.

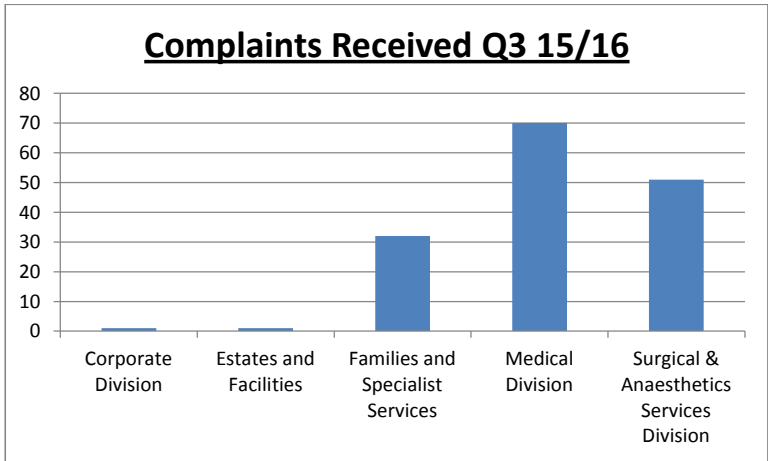
Five Ombudsman cases were closed during Q3 and none of these were upheld by the Ombudsman.

National Quarterly Complaints Returns

The Q2 quarterly national complaints information, KO41 return was submitted within time to the HSCIC during October. This monitors written hospital and community health services complaints in the NHS.

This return requires more analysis of themes of complaints and requires a considerable amount of work to re- align coding of complaints to provide this level of detail. It was hoped that this information will be submitted retrospectively in Q3 but it will now be in Q4 and will be shared in the Q4 report. The main change is the move to report all aspects of a complaint rather than the main issue in a complaint, as previously.

Complaints Numbers by Division



The split of complaints by Division by month was as follows:

Division	October	November	December	Total Q3 2015/16
Community Division	2	6	1	9
Corporate	0	1	0	1
Estates and Facilities	0	1	0	1
Families and Specialist Services	15	8	9	32
Medical Division	20	30	20	70
Surgical & Anaesthetics Services Division	18	14	19	51
Families and Specialist Services	15	8	9	32
Totals:	55	60	49	164

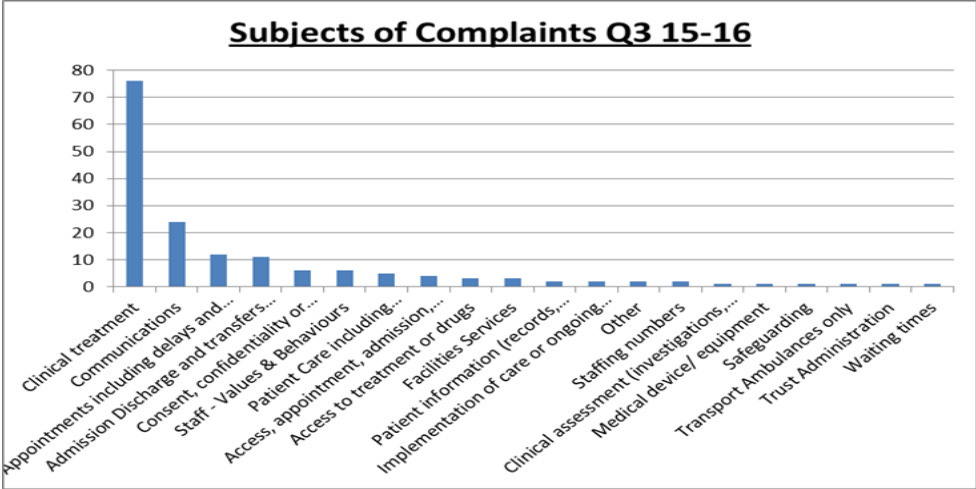
Analysis of Complaints by Theme

Complaints are analysed in two ways below, by primary subject code.

Complaints By Primary Subject Code

The top three subjects of complaints remain clinical treatment, communication and appointments as shown below, consistent with Quarter one and two, and 2014/15:

Subject	2014/15	15-16 Q1	15-16 Q2	15-16 Q3
Treatment, procedure (& clinical treatment)	30%	26%	36%	46%
Consent, confidentiality, communication	25%	25%	24%	14%
Access, appointment, admission, transfer, discharge	14%	15%	18%	7%



Once further work on coding of reasons for complaints is completed data will be re-run for Q1 and Q2 2015/16.

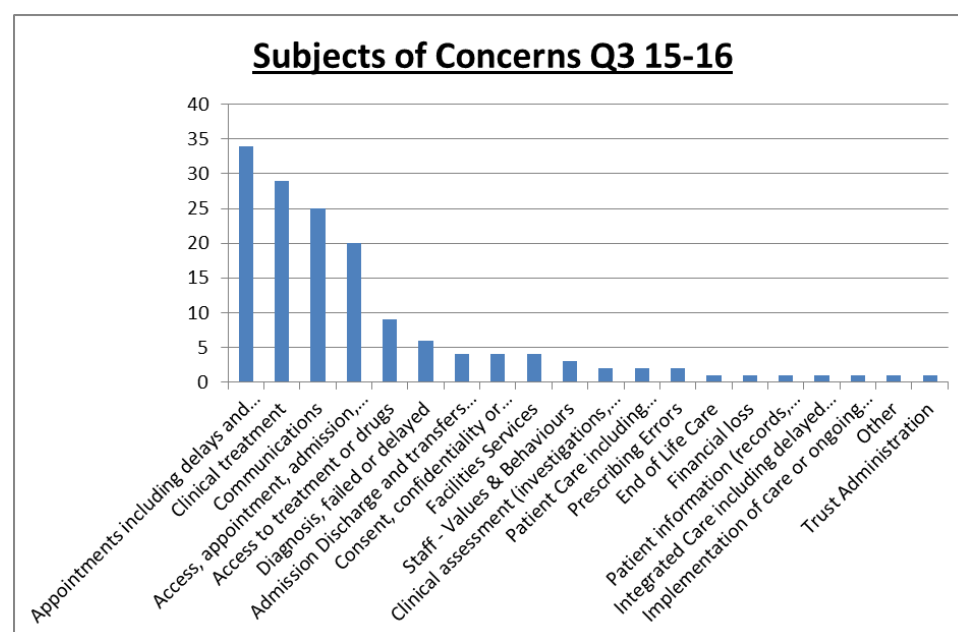
Patient Feedback from Other Sources: Concerns, Patient Opinion and Compliments

Concerns

Concerns are issues raised by patients or relatives via the Patient Advice and Complaints team which respond to them.

Information on the number of concern subjects is included in this report for the first time. The top three subjects of shown in the graph below were:

- Appointments
- Clinical Treatment
- Communication



Trends and Learning from top three Complaints and Concerns Subject.

The same three subjects have come out as the top three for both complaints and concerns in quarter three, although ranked differently; as can be seen from the table below.

Subject	Complaints percentage	Concerns Percentage
Treatment, procedure (& clinical treatment)	46%	19%
Consent, confidentiality, communication	14%	16%
Access, appointment, admission, transfer, discharge	7%	22%

Patient Opinion Feedback Q3 2015/16

Patient Opinion is an independent website about patient's experiences of health services, good and bad. Feedback received during Q3 is given below.

Feedback

The PALS team review comments receive and advise people leaving negative feedback to contact the service if they wish to take their concerns further.

The table below shows both negative and positive feedback received in Q3 from the Patient Opinion. Comments do not always identify site, ward or service.

Division	Huddersfield Royal Infirmary, HRI Poor Patient Experience	Calderdale Royal Hospital, CRH Poor Patient Experience	Compliments Positive patient experience
Medical Division: A&E	Not examined, no x-ray done or diagnosis given Lack of information about how patient's friend can help with eating Poor environment in A&E, patients ignored, not seen as an emergency Advice re: knee injury – advised to rest, GP confirmed torn ligament, expected crutches / physiotherapy referral X-ray when attending A&E – long wait	Disappointing experience – long wait, no after care, advice or follow-up, dismissive attitude of staff Treated appalling, told not to come back, admitted 12 hours later	A refreshingly positive experience (HRI) Staff friendly and professional, dealt with quickly (CRH) Excellent Service (CRH)
Medical Division: Gastroenterology	Doctor unable to explain reason for outpatient appointment to patient		
SAS: Day Surgery Orthopaedics	Ward 20 – nursing care at night – not allowed to get out of bed to use toilet, bottle given, in wet bed for 90 minutes, told not to make a noise	Long wait for surgery on day of procedure	Ward 9, Surgical Vascular surgery and ward 3 Admission Unit Orthopaedic appointment ENT appointment ENT “excellent care” Hip replacement surgery Fast track bowel cancer Endoscopy (2) Day Surgery – Maxillo-Facial Breast care
Out Patients	Called to cancel an appointment and was discharged		
FSS: Midwife		Insensitive midwife – comments made to new mum about not breastfeeding properly Tongue tie – noted tongue on baby but nothing done, later referred by lactation specialist	Labour Delivery, LRDP 2 positive comments Radiology
Car Parking	Acre Mill Car Park – poor signage re: payment machines, no information about not incurring further parking charges when		

	delayed in clinic		
Other	Poor discharge planning (ward not identified)		Big thank you to all HRI staff

Compliments Q3 2015/16

The following number of compliments were recorded on the Datix risk management system by staff. The numbers below under estimate the number of compliments received by staff, as many compliments are made direct to teams and wards and are not captured in a central system.

Division	Number of Compliments recorded on Datix Q3 2015/16 by directorate
Medical	20 of which: Acute: 5 Emergency Network 12 Intermediate Medicine 3
Surgical and Anaesthetics	19 of which: General & Specialist Services 10 Orthopaedics 4 Operating Services 2 Critical care 1
Family and Specialist Services	11 of which: Radiology 4 Children's Services 4 Out Patients & Records 2 Women's 1
Community	Community 1

2. Learning From Complaints

Learning from Red Complaints

Formal action plans are being developed for orange and red severity complaints upheld.

Three of the red complaints closed during Q3 were partially upheld and the learning from these is given below.

Red Complaint: Surgical and Anaesthetics: Head and Neck Directorate
Learning the Lessons

Complaint relating to patient contracting meningitis following routine sinus surgery at HRI.



Issue: Post-operative complication following nasal surgery at HRI

Finding:

No evidence of CSF leak during procedure, doctor not aware until contacted by patient.

Action:

Ward staff to be trained to recognize importance of symptoms of CSF leak.



Issue: Incident not reported

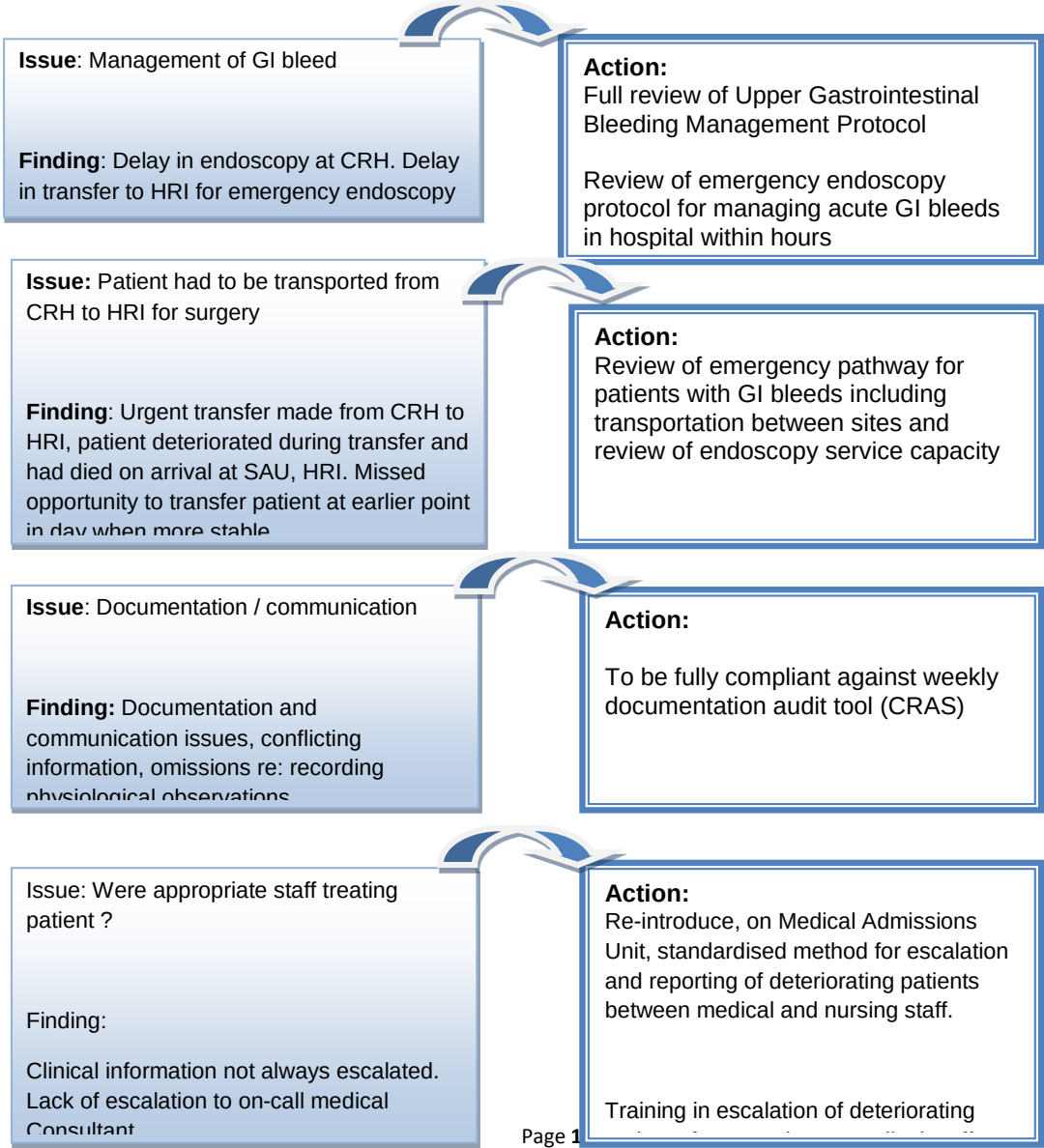
Finding: Clinical incident not reported at the time as unaware of incident. Not reported when team were made aware of incident.

Action:

Discussion within ENT department and reminder of need to report all clinical incidents on incident reporting system

Red Complaint and Serious Incident: Medical
Division: Emergency Directorate
Learning the Lessons

Complaint and serious incident relating to care at CRH following admission from ED due to upper gastrointestinal (GI) bleed, delay in endoscopy, patient transferred from CRH to HRI, deteriorated and died



Red Complaint: Surgical and Anaesthetics

Division: Orthopaedics

Learning the Lessons

Complaint relating to care of patient at Ward 19, HRI in 2015 at CRH following admission from A&E following fall

Issue: Failings in nursing care

Finding: Delay in referral to dietitian and Speech & Language Therapy, poor management of

Action:

Safety huddle on ward 19 and other wards at handover to discuss high risk patients and nursing care needs.

Issue: Confusion re: rehabilitation plan for patient

Finding: Confirmed physiotherapy staff and ward multi-disciplinary team (MDT) staff had different rehabilitation plans, one to hospital rehab ward, one for referral to community hospital. MDT decision not stored in medical notes.

Action:

Change in MDT process with record now stored in medical notes.

Issue: Communication failures

Finding: Communication failures between staff, staff and carers, medical staff, confusion for relatives about whether patient was approaching end of life

Action:

2 dedicated Consultants now responsible for liaising with relatives on ward 19 to ensure effective communication.

Issue: Poor standard of care

Finding: 2 of 10 NICE guidance on delirium risk factors not met: management of bowels, and poor nutrition.

Action:

Safety huddles – see above .

Issue: Poor complaints management

Finding: No meeting with complainant before investigation meaning not all concerns investigated, delay in sending report which had inaccuracies.

Action:

Reflection by complaints investigator and discussion re: importance of liaison with complainants at outset of complaint to identify all issues.

Learning from Divisions: Examples of learning are given below.

Medical Division

Acute Directorate Complaint re: multiple ward moves	Patient ward moves were not all clinically appropriate. Action / Learning: Introduced process where number of previous ward moves of a patient are reviewed
Acute Directorate Complaint re: discharge lounge environment.	Discharge lounge below expected standards. Action / Learning: Improvements to discharge lounge, TV wall mounted, reading material, refreshment facilities
Acute Directorate Complaint re: description of lesion.	Use of "sizeable to describe lesion found during an endoscopy. Action / Learning: Endoscopy advised to use estimated sizing to describe lesion.
Emergency Network Complaint management and lack of care on short stay ward, HRI	No designated time slots for patients in Ambulatory Assessment Unit for patients requiring on the day echo scan without been admitted to an in-patient bed. Extra slots of echocardiograms to be undertaken on the day if needed.
Emergency Network Complaint: poor communication re: discharge with family	Poor standard of communication with family on discharge confirmed. Discharge care plan to be implemented Trust-wide to aid communication re: discharge.

Learning from Divisions: Examples of learning are given below.

Family and Specialist Services Division

Radiology Complaint re: burn from MRI scan (also claim)	Skin to skin contact burn from the MRI scanner. The coils were sent to manufacturer and replacements provided –a waiting test results of jackets to see if any flaws. Second patient suffered burns –take as best precautions as possible to avoid this by providing padding to avoid skin to skin contact and skin to machine contact where appropriate.
Women's Services Complaint re: delays with induction at labour, communication	Delays Induction of labour (IOL) audit to look at reason for induction, delays and why and outcome and delays to be minimised. Unattended baby Staff will be reminded that baby should be in a cot at the nurses station or with staff and not

	left alone. Safety - staff to continue to closely monitor women who have the IOL delayed Communication with patient and families - not to make assumption that patients understand care. To ask if there are any concerns .
Women's Services Treatment at Sau at HRI following abdominal pain, delays, poor communication, confidentiality - hearing details of other patient's issues	SAU Sister to speak to SAU clinic staff regarding delays and excessive waits. Confidentiality issues with SAU staff and Gynecology staff. .

Learning from Ombudsman Cases

In Q3 there was no learning to be shared from Ombudsman complaints as no cases were upheld in this quarter.

Key Publications in Q3 2015-16

The Ombudsman issued a report on 8 December 2015 “**A Review of Quality if NHS Complaints Investigations where serious or avoidable harm has occurred**” which can be found at:

<http://www.ombudsman.org.uk/reports-and-consultations/reports/health/>

This includes their research of 150 complaints investigations with avoidable harm or death and recommendations made which are given below with a comment relating to how the Trust addresses these.

Issue Identified in Report	CHFT Position
The process of investigating is not consistent, reliable or good enough	Investigations are supported by the Risk and Governance team to ensure thorough investigation training. Investigation training offered to staff. Quality assurance process of complaints response at division, corporate and Director level
Staff do not feel adequately supported in their investigation roles	Panels held for red complaints at start of investigation where serious harm or death has occurred and investigation leads identified. Staff supported by Governance and Risk team and Division when investigation complaints.

Missed opportunities for learning	Process of action planning in place for all orange and red complaints Complaints process includes routine identification of learning and sharing within reports and divisional meetings

Areas for Improvement

An update against the key priorities for 2015-16 for the patient advice and complaints service are:

- Datix system recording to be changed from January 2016 to record and monitor number of concerns escalated to a complaint
- Complaints literature to be produced and disseminated
- Complaints training programme to be developed
- Completion of retrospective coding work for national quarterly return
- Review completion of complaints action plans

3.8 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 or passes through an area of the opposite sex for toilet/bathing facilities (Pass through breach). The breach takes into consideration how many patients were affected by that breach.

Current Performance (Amended)

This report highlights an amendment to the quarter two position. There were mixed sexed breaches within the Coronary Care Unit (CCU) on the Calderdale site and within the Hyper Acute Stroke Unit (HASU) on the Calderdale site. Seven patients in total were affected in these two areas. Four, within CCU and three within HASU.

These exceptions occurred due to patients requiring to step down from these critical/high dependency area. Transfers were not enacted timely and there was a failure to escalate when the transfers did not take place.

However, we continue to enact our improvement plan by:

- Amending the revising trust policy.
- Raising awareness particularly in critical care areas.
- A robust daily monitoring process is now in place in both the CCU and HASU.
- A monitoring process has been added to the daily Duty Matron and Night Matron report.
- Medical Matron Lead for EMSA meets ward managers for CCU & HASU weekly
- Medical teams review and document in patients notes the clinical need for patients to be in CCU & HASU and the date and time when clinically stable to step down.
- The monitoring process is more robust, with the status regarding mixed sex issues being included in the SITREP.

The Trusts revised policy includes escalation to the on-call Executive Director when any patient requiring to be stepped down from the critical care environment creates a gender breach or threat of a gender breach these must be escalated to the Executive director on- call between the hours of 07.00 and 22.00hrs. This amendment to the revised ratified policy was agreed at WEB on the 14 January 2016.

Domain Four – Responsive

Responsive compliance summary

Indicator	Compliance
4.1 Patient Flow (contained In separate report – to be reported at QC)	Partial
4.2 18 week pathway RTT (referral to treatment)	Achieved
4.3 Outpatients	Reporting Only
4.4 Diagnostic Waits	Achieved
4.5 Cancer Waiting Times	Achieved

4.1 Patient Flow

A full report into Patient Flow, inclusive of A&E quality performance will be received as a separate paper to QC in January.

4.2 18 Week Pathway (RTT)

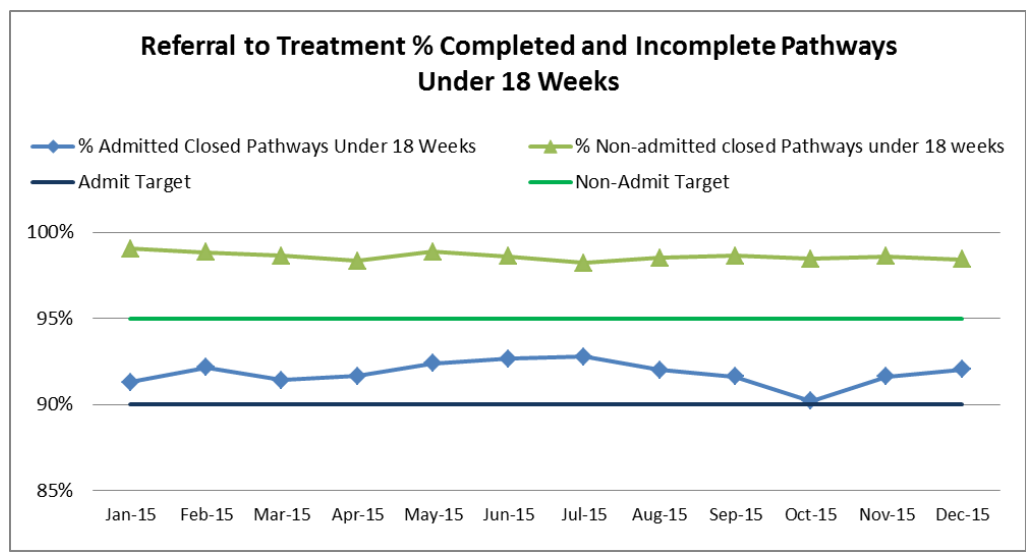
Aims and Objectives of Work

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 week

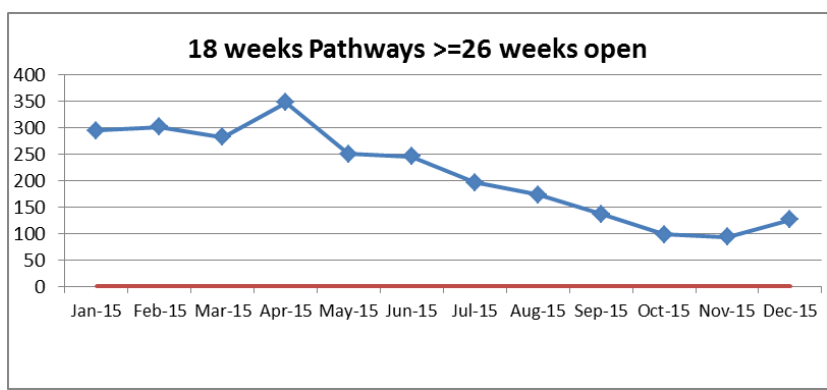
Current Performance:

Both of the key indicators continued to perform on target through Q3.



As a result of the report went 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 (see Q1 report). That report provided assurance that a comprehensive deep dive into delivery of the referral to treatment standards was undertaken and an action plan agreed.

Of note in Q2, and in specific relation to comment which noted that “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”. Work has begun Q2 to seek to improve this position, with consistent reductions being seen throughout Q2 and Q3.



Improvements in to Q4: A full report into RTT is in development will be received at a later date.

4.3 Outpatients

Aims and Objectives of Work

There are a number of areas of improvements which have targeted initiatives within outpatients to improve service efficiency and the patient experience, these include:

- 1. Reduction in Missed Appointments
- 2. Reduction in queues
- 3. Reduction in hospital initiated appointment cancellations
- 4. Increased slot utilisation
- 5. Improved communications with patients
- 6. Improved data quality
- 7. Improvement plans for 2016

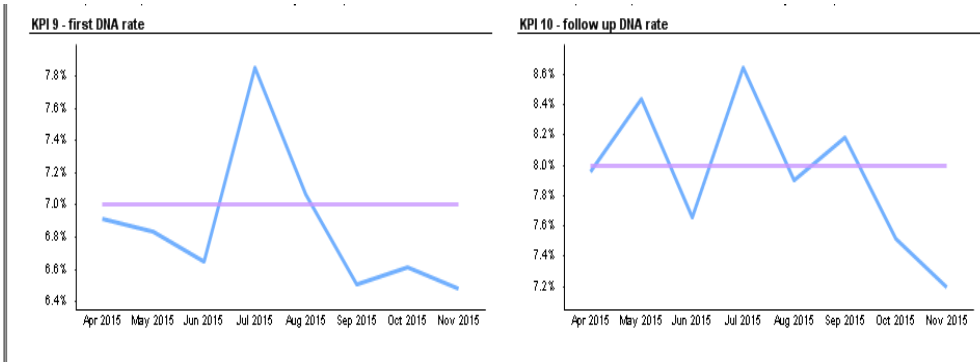
1) REDUCTION IN MISSED APPOINTMENTS

Last year (2014-15) in the Trust, 36,099 patients failed to attend their outpatient appointment; applying an average outpatient tariff of £127 this equates to £4.5m. This in itself was a reduction on the previous year when 40,880 appointments were missed.

As of the end of November 2015, 22,567 patients have missed their outpatient appointment. This represents a reduction of 1,760 missed appointments in comparison to the same period in 2014.

The Trust has set a target of 7% for first appointment DNA's (Did Not Attend).
Year to Date performance is 6.8%.

A target of 8% is in place for Follow-Up DNA's,
Year to Date performance is at 7.9%



Reminder Service

The Trust operates a SMS and interactive voicemail reminder service. The service offers:

- Interactive Voice Messaging with human voice to landline
- 2-way SMS Text to mobile
- Partial Booking Contacts
- Agent Calling
- 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

Contact telephone numbers are updated via the National Spine, and/or updated by patients utilising the Self Check in Kiosks.

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.

Agent Calling

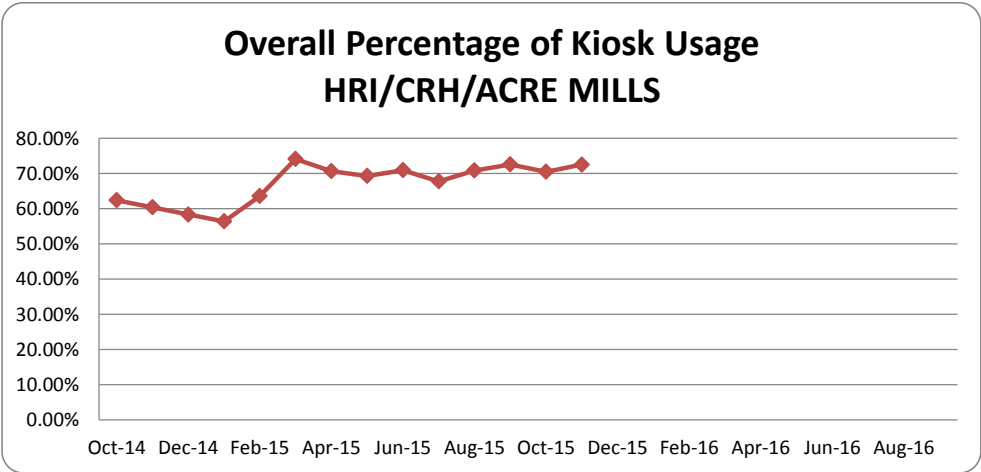
Following feedback from service users, Agent Calling has just been added to the reminder service for patients aged over 65, who have not registered a mobile contact number. This patient group now receive a telephone call to remind the patient of the pending appointment.

2. QUEUE REDUCTION

Self-Check In Kiosks

Self-Check In Kiosks are now available in all outpatient areas and are being well utilised by our patients. The kiosks have enabled patients to complete the check in process quickly and update demographic changes e.g. address, telephone numbers and GP.

Over 70% of outpatient attenders now routinely use the kiosks, reducing queues at the desks and enabling the receptionists to efficiently book appointments, and support our more vulnerable patients.



3. REDUCTION IN HOSPITAL INITIATED APPOINTMENT CANCELLATIONS

Partial Booking For >6 Week Follow-Up Appointments

In order to minimise appointments cancelled by the hospital, partial booking is now used in all outpatient specialties and is a system of managing all follow-up outpatient appointments. Partial Booking defers the actual booking of an appointment if the appointment date is more than 6 weeks in advance. Partial booking places the patient onto a pending list and invites booking approximately 5 weeks prior to the appointment due date.

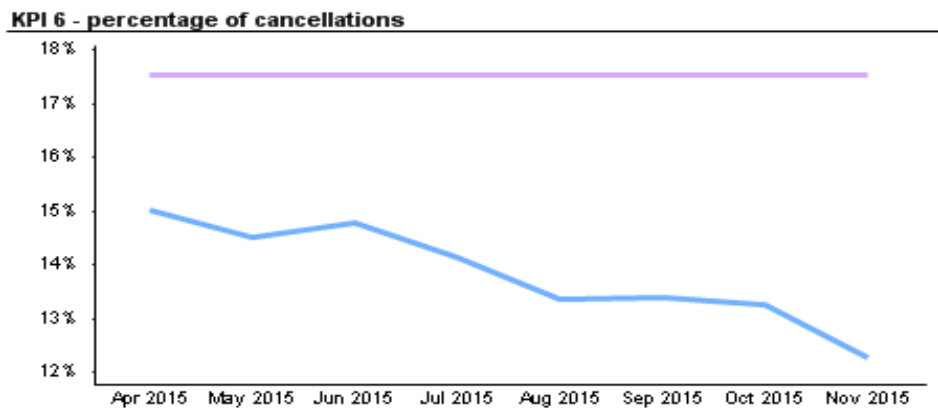
What are the benefits?

- Greater patient satisfaction
- Reduced DNA rates
- Reduced patient Cancellations
- Reduced hospital-initiated cancellations
- Reduce waiting times
- Better clinic utilisation
- Greater flexibility for changing rules to clinics as necessary
- Less administration
- Tracks non-responders minimising clinical risk

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.

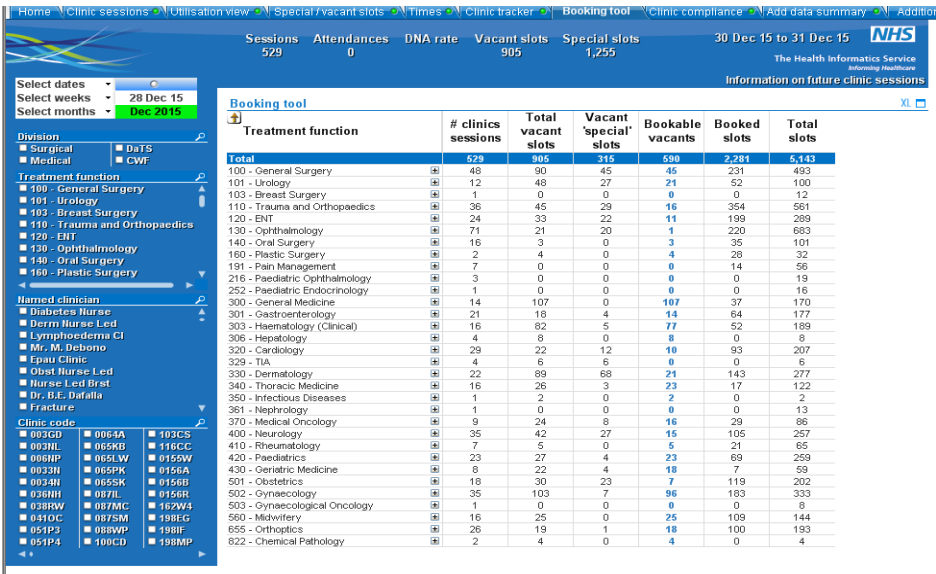
One of the benefits on Partial Booking is the reduction in hospital initiated appointment cancellations, which can result frustration and confusion to patients and increased administration and cost to the service.

The graph below shows the month on month reduction in cancellations.



4. SLOT UTILISATION

In order to ensure that maximum capacity is utilised, appointment slot utilisation is being monitored. Included in the suite of functions available on the Knowledge Portal, is a Booking Tool. The tool has been developed to support the Appointment Centre team and highlights slots as they book available.



Two additional posts have funded, dedicated to ensuring that slot utilisation is optimised. Performance is monitored via the Outpatient Productivity CIP team. Utilisation improvement of

1% per month has been set, with a target of 90% utilisation by March 2016. Current utilisation is above target of 86% at 87.5%.

	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Actual	84.40%	85%	84.90%	84.80 %	84.20 %	84.70%	85.10%	87.50%				
Expected	80%	80%	81%	82%	83%	84%	85%	86%	87%	88%	89%	90%

5. IMPROVED COMMUNICATION OUR PATIENTS

In order to advance communications with our patients a number of improvements have taken place:

- **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.
- **Friends and Family Test**

FFT communication is now in place via SMS and includes free-text comments. The data is routinely reviewed by the Outpatient Managers and data and comments shared with staff. Interactive Voice Messaging is currently being tested in the Community, and will available for outpatient feedback from 2016. December response rates are:

	% Recommend		
	% Response Rate	% Who Would Recommend	% Who Wouldn't Recommend
SURGICAL DIVISION TOTAL	13.9%	90.4%	5.2%
MEDICAL & ELDERLY TOTAL	12.7%	93.2%	3.8%
FSS TOTAL	10.9%	91.6%	4.3%
Grand Total	13.1%	91.3%	4.7%

Partial Booking contact letters

Partial booking contact letters are to be converted to SMS for those patients already using the SMS reminder service. This will significantly reduce the volume of letters produced each week.

6. IMPROVED DATA QUALITY

Outpatient Productivity

In order to measure outpatient efficiency, the Productive Outpatients Module has been developed on the Knowledge Portal. The module captures data at Divisional, Specialty, Clinician and Clinic level for:

- New to follow-up ratio's
- 1st and follow-up DNA
- Hospital Cancellations
- Slot Utilisation
- Start/Finish Times
- Booking Tool

Access and training has been provided for all General and Outpatient Managers. The module will assist in service planning and efficiency programmes of work.

7. IMPROVEMENT PLANS FOR 2016

Outpatient Restructure

Following the merger of general outpatient services (ENT, Medicine, Orthopaedics and General Surgery), a new management structure has been developed which includes, Matron, Outpatient Manager and Outpatient Sisters. All posts have now been recruited to and the post holders are already having a positive impact on patients and staff. The roles focus on visible, accessible and strong clinical leadership; alongside enhancing service quality and development; connected to the patient's experience of safe, timely and effective care in outpatients. Business Objectives for 2016 include:

- CQC preparedness
- Patient Workshops
- Workforce development and review
- You said, we did – response to FFT feedback

Electronic Communication

Discussion with service users has highlighted that some would prefer electronic communication for appointments. In order to support this, we are exploring opportunities for email and enhanced SMS communications, and enhancing demographic information in preparation for the EPR Patient Portal.

Call Volumes

The Appointment Centre monitors call volumes to ensure that the waiting time to speak to a call handler is minimal. Recent increase in appointment demand has impacted on call waiting times. A review of the service is to be undertaken in the first quarter of 2016, to ensure that response times are reduced in line with other similar services.

4.4 Diagnostic Waits

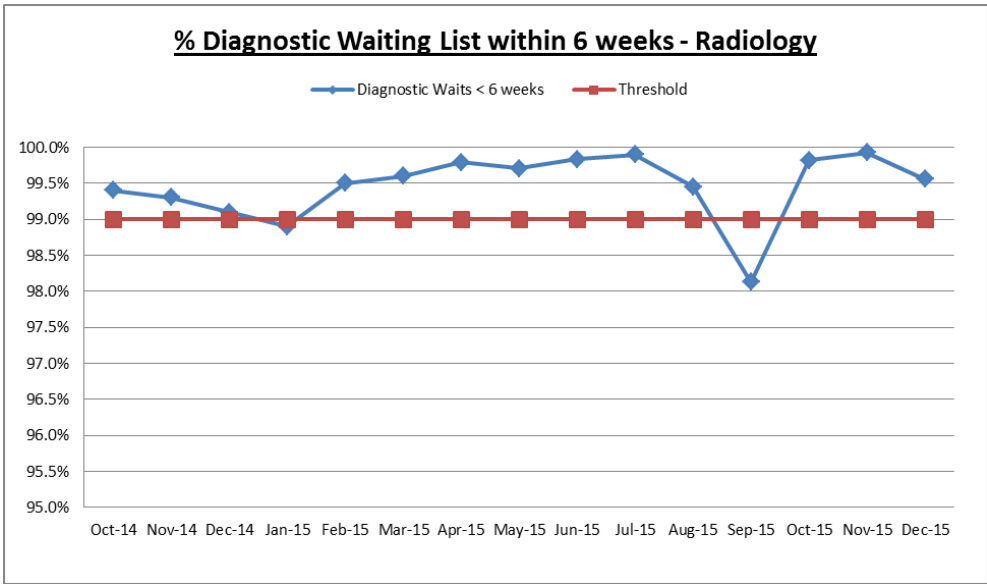
Aims and Objectives of Work

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 and is predominantly driven by MRI, Ultrasound and CT performance.

Current Performance

The Trust achieved the overall target of >99% of referrals being seen with 6 weeks for October, November and December 2015 in the context of increasing levels in demand via direct access in CT, MRI and Ultrasound services.



A small number of patients unfortunately have to wait > 6 weeks, often due to the complexity of the specific investigation required. There is currently additional demand for Radiology, particularly in relation to waiting times for 'fastrack' cancer referrals, urgent GP referrals and for urgent inpatients and when added to the overall 6 week waiting time target for routine referrals there is significant pressure on available capacity. The Department is currently achieving its internal targets and is in discussion with Divisional colleagues on plans for providing additional capacity across all modalities.

The Business Case for a 3rd MRI Scanner was approved in the summer and following a detailed procurement and tender exercise the order for the new scanner and associated modular build was placed in December 2015 and the new scanner should be on site and operational by the summer of 2016. .

Improvement Plans for Q4

In light of the ever increasing demand for Radiology further work is ongoing to assess how additional capacity is brought on line to support and deliver against the multiple targets for access to diagnostics. A detailed analysis of demand v capacity is underway and discussions are ongoing with Divisional colleagues to seek to fund additional capacity both over the winter period and beyond.

Longer term plans

The replacement of the 10+ year old MRI Scanner at CRH now requires active consideration, a capital bid is being developed as part of the work programme for 2016/17.

4.5 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	The 62 Day Standard now applies to referrals from National Screening Services

Screening Standard:	(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'.

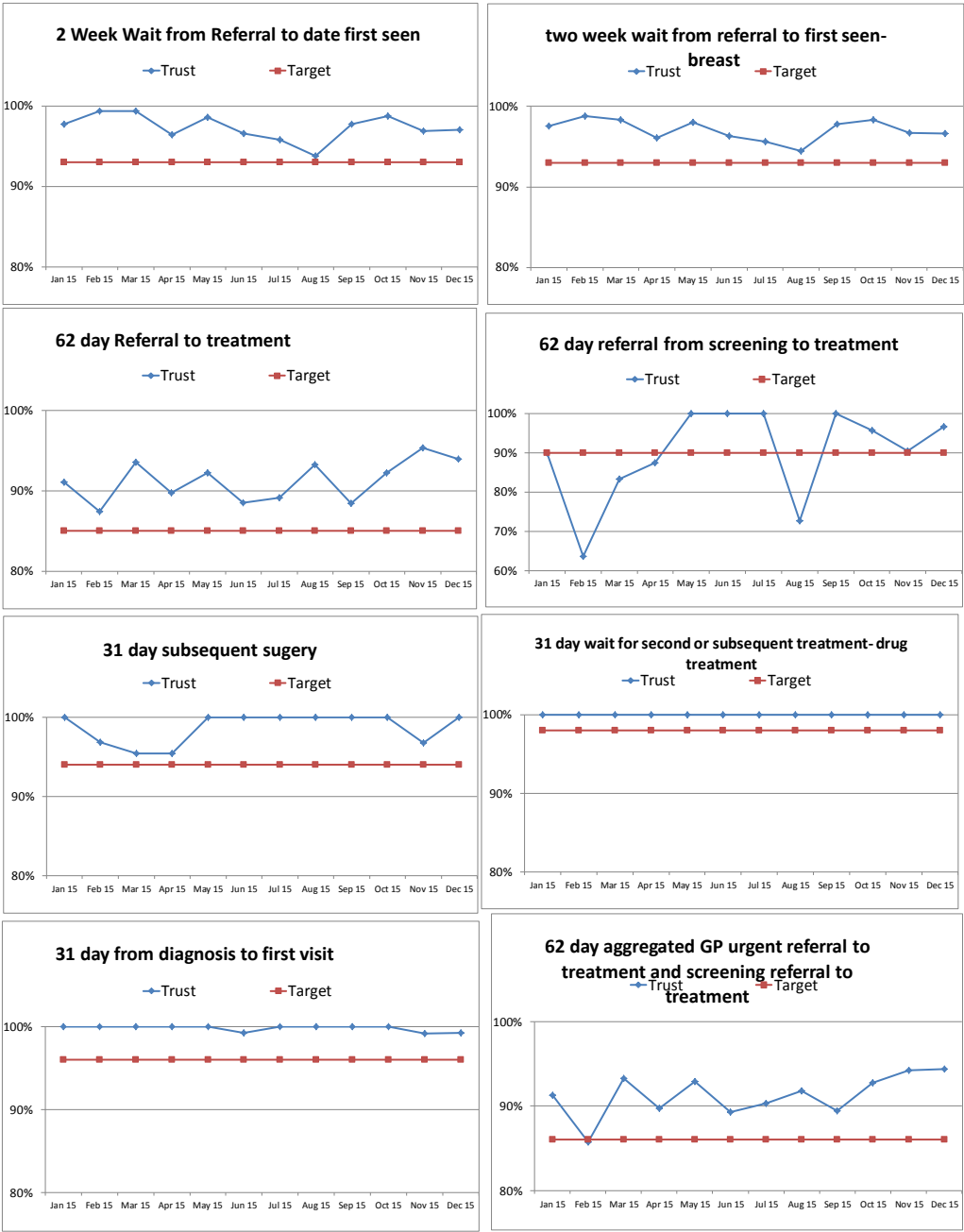
Current Performance

The Trust has achieved all 7 of the national standards for Q3.

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 e.g. the updated cancer fast track forms which incorporates the NICE guidelines. Planned Care Board is another forum to discuss issues affecting the whole health economy to provide seamless care for patients. The Trust works closely with Public Health; so that we can education patients in the importance of screening and being treated early.

An Operational Policy has been produced which is in Draft and will be Ratified by Board in March. Also a Trust Cancer Strategy will be completed in the New Year incorporating the Governments Achieving World Class Cancer Outcomes which sets out the next 5 years recommendations.



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 August the Trust only managed to send 59.3% of patients by this target which is much lower than we would wish to have achieved at this point in the year.

Discussions are on-going within the Divisions and with the cancer teams. Also discussions are being held with our Tertiary centres to agree some fundamental issues around transfer dates as at present there is no agreed criteria. This should be completed by March 2016.

Improvement Plans for Q4 forward.

A further review of all tumour sites has taken place 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. This has improved performance in certain areas, however due to demand and capacity areas such as diagnostics are struggling to improve their performance.

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. This will be achieved by 1st April 2016.

Cancer Site Specific and Specialist Palliative Care teams update:

The trust employs a number of specialist roles to support the delivery of cancer care, and end of life care in both cancer and non-cancer patients. The roles consist of Team Leaders/Lead Cancer Nurses of the specific cancer site (Band 7) to specialist sister (Band 6) development roles (band 5) and Cancer Care Co-ordinators (Band 4 - non RGN posts) and Health Care Assistants (Band 3)

Specialist Nurses roles have evolved due to the changing needs of patients, a much younger population, changes in treatment choices- more intensive and complex treatments and NHS service demand with an increase in newly diagnosed cancers every year as well as people 'surviving' their cancer and treatment, but living with the side effects of that treatment. Living with the consequences of successful cancer treatment is the great challenge of modern life.

To meet the changing landscape of cancer treatment and patient's needs, specialist nurses (working closely with the designated named cancer site specific consultant) have and are developing nurse led clinics: assessing appropriate new cancer fast track patients, undertaking biopsies and ordering investigations, breaking the news of a new cancer to patients as well

relevant cancer follow up (appropriate to the training level and competencies of the Specialist Nurse.). A crucial part of Specialist Nurses role is also in the assessment and interventions/care of patients during the patient's treatment, recovery and living with the consequences of the treatment.

The advanced roles that Specialist Nurses are undertaking in the patient's pathway means that there is a changing landscape in professional roles and service provision for patients. Not only in piloting Nurse Consultant posts in cancer teams and how they help improve the patients experience and pathway to treatment but also new roles. One such are the 'Cancer Care Co-ordinators'.

These are non-registered roles, but provide low level support to patients and co-ordinate all the other referrals services. They include traditional non specialist parts of Cancer Nurse Specialist (CNS) roles. Cancer Care Co-ordinator posts are a valuable resource in the patient's management for low level specialist intervention once training and experience has been gained. They are a first port of call for patient's questions and queries, emails and phone calls. Baseline assessments and continuity for patients having access to the service can be through these posts.

In support of these roles, a number of Macmillan funded Projects are ongoing in CHFT currently:

Macmillan Head and Neck Specialist Nurses and Allied Health Professionals (Part of a Regional Head and Neck redesign project to inform national services for Macmillan)

- Continued Macmillan funding - to be trained in cancer follow up. (Extend a project that has been successful at Mid-Yorkshire Hospital) Sept 2015 -March 2018
- The team have just completed successful Specialist nurse and Allied Health professional management post treatment assessment and follow up , with funding for posts from Macmillan (up to march 2016). This replaces traditional consultant only follow up, with amazing outcomes for increased rehabilitation and recovery with intense intervention in first 6 weeks from head and neck team

Macmillan Pilot Breast Cancer August/September 2015- January/February 2018

- Nurse consultant project to audit the effectiveness of Nurse Consultant posts in diagnostics - biopsy and interpretation of results and cancer follow up (working closely with patients medical consultants) 30 month project with very clear objectives for measuring effectiveness and outcomes as well as Patient Related Outcome Measures (PROMS).

Macmillan pilot, Breast and Lung cancer care co-ordinators August/September 2015- January/February 2018

- Band 4 cancer care co-ordinators. The Breast and Lung posts will be mirrored in their audits. Do these posts have the same outcomes in different cancer specific sites. Are these post a possible future vision for all cancer sites. This 30 month pilot will show this. Lung is a completely new specialist nurse team, breast cancer is an established team and comparisons will be made and reported.

Macmillan Project - Acute Oncology nursing - Nov 2016 project completes

- Macmillan Funded 2 specialist Nurses, Lead Acute oncology nurse band 7 and Specialist Nurse band 6 (Nov 2013-nov 2015 extension funding agreed: Nov 2016) to develop in line with NICE guidance and Peer Review, a specialist acute oncology team. This service and outcomes are currently being audited.
- Macmillan have funded 0.2 WTE (12 months) Audit facilitator to measure outcomes for this service and future business cases.

PROMS Funded Macmillan 12 month project August 2015-July 2016

- In light of the results from the National Cancer Patient Experience Survey and showcasing what Specialist Nurse teams add to the patients experience, we have 12 months Macmillan funding (0.2 WTE) to audit the Specialist Nurses interventions and outcomes with each patient, in clinic, telephone consultation, ward visits/assessments and home visits. After each consultation patient are invited to complete a small questionnaire on their experience of the consultation as well as measuring the impact of Specialist Nurses intervention-PROMS
- This data will be reported in the Teams annual reports for outcomes clinically and patients experience as well as improvements in patients pathway due to specialist nurse assessment, interventions and management. Looking at keeping patients at home, prevented admission, consultant outpatient slots saved in follow up and safe early discharge.

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	Reporting Only
5.5 Sickness/Absence	Reporting Only
5.6 Staff Experience and Engagement	Reporting Only

Highlights:

5.1 Safe Staffing	Improvement in staffing fill rates for Day shifts

5.1 Safe staffing

Safe Staffing

Aim and Objectives of Work

The Nursing Workforce Strategy Group lead and implement 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 contributing to 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.

1.0 Safe Staffing Levels

Average fill rates are monitored and reported to Board each month. Table 1 and 2 demonstrate the rag rated average fill rates for Qualified and Non Registered Nurses / Midwives for October – December 2016.

Table1: Average fill rates Qualified Nurses October – December 2016

	Red (Less than 75% Fill rate)	Amber (75 – 89% fill Rate)	Green (90 – 100% fill rate)	Blue (greater than 100% fill rate)
Oct	6	29	29	6
Nov	4	23	41	4
Dec	6	18	41	10
Total	16	70	111	20

Table 2: Average fill rates Non Registered Nurses October – December 2016

	Red (Less than 75% Fill rate)	Amber (75 – 89% fill Rate)	Green (90 – 100% fill rate)	Blue (greater than 100% fill rate)
Oct	3	9	21	33
Nov	6	8	20	33
Dec	6	12	17	35
Total	15	29	58	101

Within the last quarter areas achieving average fill rates of over 100% for Qualified nurses reflect areas achieving supervisory status; new nurses to the trust within their supernumerary period and additional staffing in flexible capacity areas.

Average fill rates of over 100% for non-registered nurses reflect the additional shifts required to support 1-1 care; increased non registered hours to support reduced fill rates for qualified nurses.

Average fill rates of less than 75% have been attributed to: Sickness; Vacancies; Increased long days (resulting in the right number of nurses on shift, but reduced total nursing hours per day); Supporting additional capacity.

Table 3: Average fill rates Qualified Nurses by Site October – December 2015

Average Fill Rate Qualified Nurses (Day and Night)	CRH	HRI
October 2015	85.99%	90.22%
November 2015	90.2%	91.9%
December 2015	93.73%	90.31%

Table 4: Average Fill Rate Non Registered Nurses by Site October – December 2015

Average Fill Rate Non Registered Nurses (Day and Night)	CRH	HRI
October 2015	100.2%	107.0%
November 2015	100.1%	107.8%
December 2015	102.4%	109.2%

Increasing fill rates are as a result of a number of factors including focused recruitment and a level of temporary workforce use.

2.0 Quality Focused Dashboards

Following the implementation of ward quality dashboards commissioned from the Health Informatics Team by the Nursing Strategy Group in May 2015 to monitor the impact of changes made to workforce models in April 2015, a focused group has been set up to identify parameters within the dashboards to report by exception any changes of concern to the Nursing Strategy Group.

The focused group will also provide further steer on validating the data within the dashboards and increasing the reporting of red flag incidents within the dashboards.

Further development to ensure each division receives the quality dashboards with a month on month view of data to identify trends is expected imminently from the Health Informatics team.

3.0 Recruitment and Retention

Focused recruitment has continued within this quarter for the nursing workforce.

New starter numbers joining the workforce peaked in September and October following the recruitment of newly qualified nurses and midwives and successful keep in touch events.

Additional recruitment events for non-registered nurses were undertaken in September and December as part of the nursing workforce plan to ensure capacity for additional beds over the next quarter.

International recruitment has continued but with reduced success in terms of candidate numbers. An additional agency has been utilised to support CHFT in international recruitment, and CHFT increased the “offer” to international nurses from 4 weeks accommodation to 6 weeks, with an additional online English course to assist.

The availability of International nurses from the EEA remains limited and therefore the Nursing Workforce Strategy Group has recommended a programme of overseas nurse recruitment from outside of the EEA.

Colleagues have reviewed Strengths Based Recruitment this quarter with a view to implementing this approach for recruitment to the nursing workforce. Strength Based Recruitment could offer further assurance that the right nurses are recruited for the right roles at CHFT.

A paper outlining the principles, benefits and potential next steps to implement Strengths Based Recruitment is scheduled to be discussed at the Nursing Workforce Strategy Group Feb 16.

The Nursing Workforce Strategy Group has implemented a number of initiatives with the aim of increasing retention rates of nurses within the last quarter:

- CHFT rose lapel pin to identify nurses within their first 6 months at CHFT
- Mandatory supernumerary period
- Focused 5 day Induction programme
- Monthly preceptorship programme workshops
- Development Support Sister has provided support, supervision and reflection opportunities to newly qualified nurses to increased their confidence and development.
- Face to face leavers interviews offered with the findings shared with Nursing Workforce Strategy Group
- Increased scrutiny of rosters to identify and eliminate unreasonable working patterns.

4.0 Agency Rules

The Trust initially applied to Monitor to have the ceiling of qualified nursing agency spend increased to 6% for the remainder of the financial year (6 months). This was not approved by monitor and a ceiling of 5% was given. To try to ensure the Trust did not breach this spend a further 5 Tier 1 agencies were recruited to supply qualified staff with the aim that this would reduce the number of shifts going to premium rate agencies. These agencies began to supply the Trust on 7th September 2015. With the current level of qualified nursing vacancies and additional capacity opened to support the winter period the number of shifts going to premium rate agencies has not reduced as anticipated, and for that reason a further 4 agencies have been approached to supply qualified nurses to the Trust.

Monitor introduced set price caps for the hourly rate payable to agency staff which came into place on 1st November 2015 with a further two reductions in the price rates set to come into force on 1st February 2016 and 1st April 2016. CHFT have negotiated with the agencies resulting in 10 out of 13 agencies providing registered nurses on or below the November price caps. Work is on-going with the agencies regarding the price caps for February and April.

Agencies which have not fallen in line with the price cap or are non-framework agencies are not asked to supply registered nurses unless the shortfall has been risk assessed, deemed critical and approved at Director level. This will be the same process moving forward should any agency not meet the February price caps.

A tier cascade system is in place for the supply of Qualified Nurses as follows:
Tier 1 – 10 agencies (all supply under monitor price caps), this figure will increase to 11/12 if the work regarding contracts/SLA comes to fruition with a further two agencies

Tier 2 – 2 agencies (framework agencies but do not comply with monitor price caps) Director level approval required before shift requests sent to these agencies.

Tier 3 – 2 agencies (non-framework), this may increase as we are negotiating with two additional agencies. Director level approval required before shift requests sent to these agencies.

5.0 National Quality Board Expectations

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 5 demonstrates CHFT progress within the last quarter against the next steps identified in September 2015.

Table 1: CHFT compliance against National Quality Board Expectations

Foc us	Expectation	Status	Next Steps – Sept 2015	Jan 2016 Update
Accou ntabilit y & Respo nsibilit y	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	- 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.	Launched. Further development in progress to provide automatic update reports 3 times a day by senior nurse and embed process.
	2. Processes are in place to enable staffing establishments to be met on a shift-to-shift basis	Achieved	Safe Staffing incorporated into nursing and midwifery induction from September 2015 to ensure all staff aware of how to raise concerns	Completed for both qualified and non-registered nursing workforce new starters.
Evide nce-Base	3. Evidence-based tools are used to inform nursing,	Achieved	Update / training session on classification of patients utilising SNCT scheduled for	- Completed 21.10.15 and 3.11.15 - Trial of utilising nerve centre completed – for further development

Decision Making	midwifery and care staffing capacity and capability		- November 2015 - Review of electronic systems (SNCT APP and Nervecentre) underway to review possible use to complete SNCT.	with Health Informatics team Feb 2016.
Supporting and Fostering A Professional Environment	4. Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff feel able to raise concerns.	Achieved	- 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	- Completed - Preceptorship register commenced Sept 2015 – complete - Audit to identify compliance with this standard to be completed.
	5. A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments	Achieved	Process clearly defined within Safe Staffing Reports	Completed
	6. Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties.	Partially achieved	Review of headroom to be completed (see section 4.5)	Completed through Nov 15 Safe Staffing Review
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	- 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	Month on Month view to be completed for FSS and Surgical divisions
	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	<u>Complete</u>	
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	- Operational recruitment and retention strategy updated Dec 15 - Review of development of band 1-4 roles commenced – paper considered at Nursing Workforce Group Jan 16 - Recruitment steering group commenced October 15. - Plan for Clinical Supervision for nursing workforce to be reviewed - Review of Recruitment processes through resourcing completed – awaiting outcome Jan 16
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	- Health Informatics team share staffing data from Unify report with CCG monthly - CCG quarterly quality report provided through CHFT quality account reporting. - Changes to workforce models / planned staffing published through public Board Report

Next Steps

6.0

- Focus group to review the quality dashboards; verify data and agree parameters for exception reporting
- Review recruitment processes to ensure quality and efficiency of processes maximised following outcome of recruitment processes within Workforce and Organisational Development team Jan 16.
- Consider Strength Based Recruitment
- Embed use of site staffing tool and reports

5.2 Mandatory Training

Aims and Objectives of Work

The new approach to mandatory training, the Core Skills Training Framework (CSTF) was introduced on 1st June 2015 for all colleagues in the Trust.

This approach brings numerous benefits including:

Clarity on what constitutes mandatory training

A move to an e-learning approach that provides an opportunity to access learning at any time, at work or at home, rather than being constrained by workplace classroom sessions

Access for the Trust to free established and tested e-learning packages through a framework

The ability to 'passport' learning between organisations using the Framework leading to the elimination of duplication in learning activity and time

'Stretched' refresher periods that reduce learning time each year

The following table shows the 10 mandatory subjects and the source learning.

Subject	Source
Equality, diversity and human rights	North West region e-learning package
Fire safety	In-house designed workbook
Health, safety and well being	North West region e-learning package
Infection prevention and control	North West region e-learning package
Information governance	Skills for Health e-learning package
Moving and handling	North West region e-learning package
Prevent	Central Government classroom session
Safeguarding (adults and children)	Skills for Health e-learning package
Conflict resolution	In-house e-learning package
Dementia awareness	In-house e-learning package

Current Performance

Table one shows mandatory training compliance up to the end of Q3

Workforce Metric		Trust	Surgery	Medical	Community	FSS	Estates	Corporate	THIS
Mandatory Training	Prevent	51.42%	46.05%	41.90%	74.92%	53.88%	38.84%	59.75%	65.63%
	Equality & Diversity	70.37%	68.37%	63.97%	71.57%	80.96%	43.12%	72.45%	86.98%
	Information Governance	76.48%	72.06%	71.69%	80.60%	85.66%	54.74%	77.71%	89.58%
	Infection Control	66.73%	64.76%	61.44%	68.06%	78.12%	37.92%	63.16%	81.25%
	Health & Safety	66.47%	64.85%	60.25%	67.56%	78.60%	36.09%	65.94%	78.13%
	Manual Handling	71.99%	72.06%	68.72%	79.60%	80.12%	36.39%	63.47%	84.90%
	Safeguarding	66.05%	68.28%	58.10%	81.10%	77.08%	31.50%	55.42%	55.73%
	Fire Safety	63.49%	63.09%	61.89%	65.38%	63.85%	66.97%	62.85%	64.06%
	Dementia	54.05%	57.12%	46.29%	58.70%	62.33%	35.78%	53.87%	45.31%
	Conflict Resolution	47.68%	47.72%	39.67%	50.17%	58.52%	30.28%	49.85%	40.63%

Improvement Plans for 2015/16

Elements of the improvement plan already achieved in Q3. These include;

Challenges	Actions to date
Ensuring all colleagues are aware of the new approach	A communication plan has been running since January 2015. Communication into the organisation commenced immediately after the Executive Board papers approved the new approach at its meeting on 8th January 2015 and has comprised the following:- Payslip messages CHFT Weekly Workforce and Organisational Development Line Manager Bulletin Posters Information flyers in all general delegate packs for training courses and in-house conferences Web-page messages and videos Information flyers delivered through divisional business meeting via divisional HR manager briefings Briefings at set-piece divisional and corporate service area meetings
Ensuring all colleagues are aware of how to access their mandatory learning	Comprehensive intranet based webpages have been developed to support the implementation of the new framework. It has a number of videos and other tools to support learners, all of which are downloadable as PDF documents. The resources include:- An introductory video and text section explaining the new approach and

	highlighting how to get started A video providing a step by step guide on how to access ESR Help with obtaining a Trust e-mail address Information about essential skills training A support structures area detailing the desk-top support sessions available to all colleagues and the remote-on help service operated by workforce development. This service allows workforce development to remote onto and therefore see a colleague's computer screen when they are having difficulties with their mandatory training. It facilitates swift diagnosis and resolution of the problem. Frequently asked questions A trouble-shooting guide A section for managers explaining their responsibilities and linking them to the IT access forms and relevant policies An glossary of tools
Ensuring colleagues can feedback their thoughts and recommendations to strengthen the approach	Feedback opportunities have been provided as follows:- Workforce Development team member attendance at divisional, set-piece meetings and corporate forums A contact group comprising colleagues from staff groups that do not traditionally access IT to understand and focus their needs An on-line feedback tool linked to all workforce development intranet and paper communications An 'ask a question' facility The remote access service operated by workforce development available for all service users. This service allows workforce development to remote onto and therefore see a colleague's computer screen when they are having difficulties with their mandatory training. It facilitates swift diagnosis and resolution of the problem. Creation and roll out of a number of on-line surveys testing colleague views on the mandatory approach
Low compliance with safeguarding e-learning packages	In this quarter those colleagues holding approved higher level competences in safeguarding have been awarded their mandatory compliance. This has improved the mandatory compliance rate. This work has also been completed for dementia awareness, health, safety and well-being and moving and handling, similarly improving compliance figures in these subjects.

Accessing mandatory training from home	The issues preventing colleagues from accessing their mandatory training from a range of devices and locations have now been overcome. A bank of loanable devices has now been sited with the Workforce Development team for colleagues to borrow as required. Information directing colleagues to this resource is available on line. http://nwww.cht.nhs.uk/divisions/corporate/workforce-and-organisational-development/mandatory-training/accessing-esr-from-home/
Difficulty in finding the mandatory training on the Trust intranet	 An icon has been added to all colleagues desktops to facilitate easy access to the mandatory web pages
Continued visibility of the mandatory training message	In December colleagues all received information about the final two e-learning subjects, conflict resolution and dementia awareness via a wage slip letter. They were also provided a card to log their appraisal and mandatory training dates 

Remaining operational challenges

An analysis of the continuing challenges/ risks to the successful implementation of the programme and the actions to mitigate them are detailed below.

Challenge/issue	Detail	Next steps
Low compliance with Prevent training	The Prevent learning is a classroom based session delivered locally by a small number of colleagues. The availability of trainers to lead sessions is an issue.	A National e-learning package for Prevent is anticipated in Spring of 2016. This will be available as an alternate to the existing classroom sessions.
Individual colleague time to complete the training	Feedback obtained has highlighted that some colleagues are struggling to prioritise time to complete their learning. The	Consideration is being given to an explicit statement regarding

	current eight mandatory subjects take an 'average' learner 5.5 hours to complete if they do the entire learning content and assessment for each subject. There is however the option to do the assessment associated with each subject only. This takes only a matter of minutes and providing the learner passes 100% of the questions they attain their competence.	protected time for this activity.
The continued visibility and understanding of the mandatory training programme	Extensive communication has been put in place. A communication plan is required.	A new Mandatory Training Booklet is in design and once complete will be distributed to all colleagues to reinforce the mandatory approach. It has been produced following colleague feedback suggesting a paper version of some of the web based information would be welcomed. A proposal which links mandatory training (and appraisal) compliance with incremental pay progression and access to promotional opportunities will be considered by the Executive Board in January 2016

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

21.68% of appraisals were completed in the first two quarters against a target of 75%. No division met their target for completed appraisals.

Appraisal- Completed Since April 2015			
Division	Compliance	Planned Activity as of 30.09.2015	YTD Target (48%)
Surgery	6.60%	30.00%	●
Medical	24.00%	-	●
FSS	28.00%	33.00%	●
Community	26.00%	27.00%	●
Estates	20.80%	22.00%	●
Corporate	20.10%	32.00%	●
THIS	37.30%	38.00%	●
Trust	21.68%	-	

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.

The combined completed appraisal and planned appraisal activity is as below.

		Trust	Surgery	Medical	Community	FSS	Estates	Corporate	THIS
Appraisal	Planned activity as at 31.12.2015	-	47.90%	47.90%	81.20%	80.00%	87.00%	76.96%	67.40%
	Percentage of Appraisal completed since April	56.5%	30.0%	43.3%	68.6%	83.2%	75.5%	45.8%	53.6%

The divisions have all completed Appraisal profilers to show planned activity from April 2014 showing how division's will achieve 100% compliance by 31st March 2016. The table above has been RAG rated based on the planned activity.

Line manager resources and information available through dedicated appraisal web pages have been further enhanced. In Q2 the appraisal paperwork was redesigned to emphasise the new vision and to include the elements of the new mandatory training approach. This has been further amended in Q3 to reflect the final 2 mandatory subject launch (conflict resolution and dementia awareness) in December 2015.

In December all staff were issued with a small business card on which to note their appraisal and mandatory training dates.



In Q3 an on line web-page based survey was launched to elicit qualitative views from colleagues regarding their appraisal. It is too early to have meaningful data from this survey but once that is achieved action planning to put in place recommendations from the data will occur.

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
- Appraisal comply or explain approach adopted in August 2015
- Qualitative survey data analysis in January 2016
- Qualitative survey data analysis action planning in February 2016
- 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 requirement 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.

During Quarters 3 our main areas of focus for patient and public involvement have been:

- Development of an overarching PPI strategy for the Trust
- Completion of the ongoing work to centralise Child Development services at Calderdale Royal Hospital
- Final reporting on the engagement work relating to centralising Emergency Gynaecology and Early Pregnancy Assessment on to one site at Calderdale Royal Hospital
- Working with our commissioners on completing the outstanding engagement work on the provision of hospital services and care closer to home to inform the commissioner's decision on readiness for consultation.
- Development of an engagement plan relating to cardiology and respiratory services

PPI Strategy

During December an overarching PPI Strategy and Plan has been developed setting out the Trust's approach; its statutory duties; why it's important; the fit with equality and diversity; existing good practice and mechanisms; and an implementation plan. This will be circulated for review and approval and implemented during Q4.

Child Development Service

In line with the decision to close Princess Royal Hospital in Huddersfield, public engagement and consultation on the centralising of the child development service was undertaken during 2014. Dialogue continued with service users and their families and other key stakeholders on the development of the new facilities as well as the community based service that will be delivered alongside. This culminated in the official opening of the new Rainbow Development Service on Monday 14 December 2015 by families who use the service. Time has been taken to listen to what families wanted and the service design is based around this. The unit uses the colours of the rainbow to ensure a bright, stimulating and child friendly environment was created.

Emergency gynaecology and early pregnancy assessment services

Following initial approval by the Calderdale and Greater Huddersfield Clinical Commissioning Groups, a comprehensive engagement report, including a detailed equality impact assessment was presented to the Kirklees Overview and Scrutiny Committee (OSC) in November. The report set out the findings from seeking the views and experiences of services users, members of the public, NHS staff and stakeholders on proposals to centralise Emergency Gynaecology and Early Pregnancy Assessment services onto one site at Calderdale Royal Hospital.

The report showed that service users and potential service users were willing to go to Calderdale for care and treatment for these emergency services. The OSC agreed that sufficient engagement had been undertaken and supported the findings of the report subject to:

- Information being well communicated to the public and to all referrers about the new arrangements
- Information on travel and transport being readily available and in particular clearly communicated to all referrers
- The car parking improvements at Calderdale being completed

Service colleagues are developing an action plan to respond to these points in preparation for making the changes to the service towards the end of Q4. There will be arrangements for checking patient experience of the service ongoing once the moves are implemented.

Engagement on service reconfiguration to support readiness for consultation

The Trust has been supporting the CCGs in its engagement work around the future configuration of hospital services. This work culminated in a final event with stakeholders on 10th December 2015 with presentations from the CCG on the findings of the engagement and from the Trust on progress with the 5 Year Strategic Plan. The event was facilitated by both CCG and Trust staff.

We are now supporting the CCGs in preparation for public consultation, dependent on the outcome of their Governing Body meeting on 20th January 2016 where they will decide on their readiness for consultation.

Cardiology and respiratory services

Both of our hospital sites provide inpatient cardiology and respiratory services. Our staff did some initial work to identify changes that can be made to cardiology and respiratory inpatient services that will:

- Reduce the morbidity and mortality of cardiology and respiratory patients
- Meet the Future Hospitals Commission and Academy of Royal Colleges recommendation of 7 day consultant delivered services
- Reduce differences in length of stay, improve quality of care and patient experience
- Reduce the number of patient transfers between sites
- Enable us to provide more services in the community

We have also listened to our patients, talked to specialist doctors, talked to GPs and looked at the evidence provided by the Royal Colleges. In order to identify the future of inpatient hospital services we need to continue the conversation with local people.

In December, we presented an engagement plan to OSC that set out why the change was required and how we would engage with service users, public and stakeholders. The OSC approved the commencement of engagement but asked that consideration be made as to how this was communicated to the public should formal consultation on the reconfiguration of hospital services also be underway.

Activity for the next quarter

The decision by the CCGs on their readiness for consultation will dictate much of the focus for the next quarter. If public consultation is launched, all available capacity will be focussed on supporting the CCGs in this. This will also impact on any engagement work around cardiology and respiratory services. Focus will also be on the implementation of the PPI Strategy and Plan.

5.5 Sickness and Absence

The Trust aims to ensure that employees are able to make the most effective contribution, individually and collectively, to improving the services that the Trust provides. The Trust, strives to improve the quality of working life for staff. Managing sickness absence and improving sickness absence rates is an indicator of creating both a healthier and more efficient workplace.

The aim is to manage the percentage of fulltime equivalents (FTE) on sick leave in any one period below 4%.

The table below shows the Trust's performance against the 4% threshold for Q4 in 2014/2015 and Q1, Q2 and Q3 for 2015/6.

Quarter	CHFT (%)	Trust Threshold	RAG
2014/15 Q4	4.65%	4.00%	□
2015/16 Q1	4.53%	4.00%	□
2015/16 Q2	4.25%	4.00%	□
2015/16 Q3 (to date)	4.95%	4.00%	□

Current Performance

The sickness rates for Q3 2015/2016 are broken down by Division in the table below.

Division	2015/16 Q3 (to date)	RAG
Community	4.02%	□
Corporate	2.14%	□
Estate & Facilities	5.86%	□
Families & Specialist Services	4.09%	□
THIS	2.53%	□
Medical	6.19%	□
Surgery & Anaesthetics	5.95%	□

Q3 includes the figures for October 2015 and November 2015.

Improvement plans for 2016/2017

There are a number of key interventions planned to address the current rate of sickness absence:-

- A dedicated attendance management team became operational in October 2015. The team is now fully resourced and members are currently developing specific case strategies with line managers for the management of individual long term and short term sickness absence cases.
- The Attendance Management policy was ratified by the Executive Board on 22 October 2015 following agreement on the content with staff side colleagues.

- Briefing sessions will be delivered for line managers to raise awareness of the new policy and the expectation and obligations placed on managers by it.
- Communication to all colleagues will be actioned to ensure there is a general awareness of the new policy so that they are compliant with their responsibilities in accordance with the policy.
- An Attendance Management intranet portal has been designed and will be developed to provide line managers with a range of support tools including frequently asked questions, key policy points, 'how to' do videos and a 'one stop' shop for template forms and letters and more generally information guides.

An increase in the return rate of monthly absence information to 100% by the end of March 2016.

- The development of clear and simple key performance indicators to monitor progress including :
 - Reducing the overall sickness absence rate by 0.5% by December 2016.
 - Produce a management plan for all long term absence cases by the end of March 2016.
 - Increase the number of return to work interviews carried out to 100% by December 2016.

5.6 Staff Experience and Engagement

Staff Friends and Family Test

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 survey runs on a quarterly basis with the exception of Q3 (October to December) when the National Staff Survey takes place.

From Q2 2015/2016 the Staff FFT comprises a sample survey with a third of the workforce being invited each quarter to participate through a mix of electronic and postcard based questionnaires.

The 2015/16 Q2 survey was focused on two clinical divisions – Family and Specialist Services and Medical. The results are as follows:

Staff would recommend the Trust as a place to receive treatment
 FSS – 78%, Medical – 79%
 Staff would recommend the Trust as a place to work
 FSS – 46%, Medical – 55%

The 2015/16 Q4 survey will focus on Community, Corporate and Surgery & Anaesthetics and results will be available at the end of March 2016.

Analysis of the qualitative feedback received through the surveys and actions plans are to be co-produced with the respective divisions in order to identify themes and the necessary responses to improve colleague experience in the Trust. These actions will be monitored by the Colleague Engagement, Health and Wellbeing Group.

2015 NHS Staff Survey

The Trust participated in the 12th national annual NHS Staff Survey. A total of 850 colleagues were randomly selected in our sample by Picker Institute Europe, our survey administrator. The formal benchmarking results will be released by NHS England on 23 February 2016. The Trust has incorporated local questions in the survey in the same way as it did in 2014 focusing on patient experience, raising concerns, Trust values and its financial position.

The following initiatives have been introduced in 2015/16:

- Colleague engagement and communication plan supported by divisional specific plans
- “Star Award” – we made our first nomination in January
- Appraisal planning tool
- New approach to mandatory training – online access (compliance to be monitored by the Colleague Engagement, Health and Wellbeing Group)
- Back to the floor/leadership walk round activity
- Monthly ‘Big Brief’ events led by Executive Directors
- ‘Ask Owen’ facility on the intranet
- Work Together Get Results (WTGR) workshops with senior teams to support the sustainability of the consistent approach to change management that has colleague engagement at its core
- Enhanced resources for line managers to assist in the management of colleague health and well being
- Board of Directors Workforce Committee with a sub group structure that includes colleague feedback, which will support the design of a more effective feedback capture model and robust response to feedback to ensure continuous improvement
- Attendance Management Team with dedicated resource into divisions
- Focus group activity as part of the CQC Inspection preparations and Investors in People assessment*

* The Trust had a successful outcome to a recent Investors in People (IIP) assessment against the national IIP Standard. The Trust achieved a Bronze Award – one step up from the core standard recognition in previous years.

Further Improvements Planned for 2015/16

- The re-launch of the staff recognition scheme
- Redesign of the Trust’s website
- A colleague health and wellbeing strategy, developed through involvement of key stakeholders
- A recruitment and retention strategy, developed through involvement of key stakeholders

- Extend the Trust's values-based recruitment approach to all staff groups (already operational for therapies and diagnostic staff)
- Focus groups for BME staff to improve opportunities for career progression, training and development (due to commence in February 2016 – led by the Chief Executive)
- Colleague panels to co-produce action plans in response to the staff survey and the IIP assessment
- Email account to be developed for colleagues to contribute to the survey and IIP action plan
- A social media engagement plan
- Create a network of "raising concerns" champions to signpost colleagues to appropriate resources and processes
- Design a communication strategy to support the "raising concerns" process

Learning from Mortality Reviews – September and October 2015

Background

A new process for mortality reviews commenced in August with the aim to achieve 100% of cases being reviewed. Although 100% has not been achieved, improvements in performance have been noted in the table below.

Table 1 – Number and % of mortality cases reviewed

	April	May	June	July	Aug	Sept	Oct
Total deaths	163	147	129	117	120	117	118
Total reviewed	54	37	39	89	67	74	67
% reviewed	33.1	25.2	30.2	76.1	55.8	63.2	56.8

Stage one review

Analysis of reviews performed found 82.4% (61) of deaths in September and 83.5% (56) of deaths in October were assessed as 'definitely not preventable' using the Hogan scoring. This compares to the average over the last 6 months of preventability score of 83.5% of cases assessed as 'definitely not preventable'.

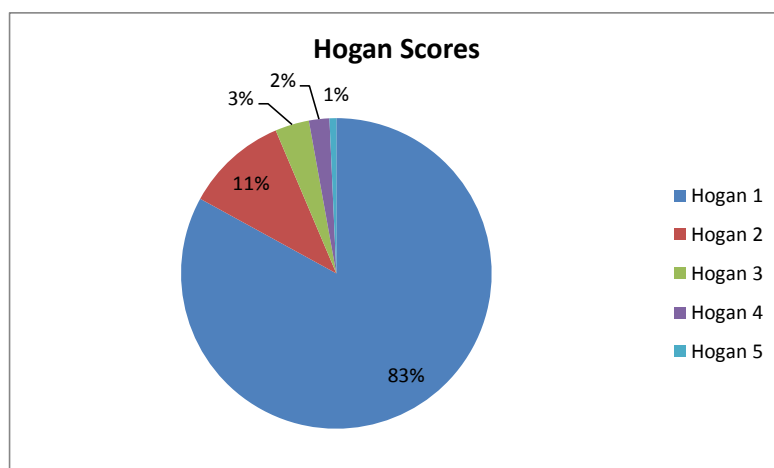
Of the cases assessed with some preventability, 11% (8) cases in September and 12.5% (7) cases in October were assessed as Hogan 2 'slight evidence for preventability'. Five cases (3 in September and 2 in October) were assessed as Hogan 3 'possibly preventable but not very likely, less than 50-50 but close call'. Three cases (1 in September and 2 in October) were assessed as Hogan 4 'probably preventable, more than 50-50 but close call' and one case in September was assessed as Hogan 5 'strong evidence for preventability, however, 3 cases the Hogan scale was not stated.

The table below shows the preventability scores over the last 6 months and

	April	May	June	July	Aug	Sept	Oct
Hogan 1	48 (88.8%)	32 (86.4%)	33 (84.6%)	75 (84.2%)	52 (77.6%)	61 (82.4%)	56 (83.5%)
Hogan 2	6	3	3	10	10	8	7
Hogan 3	0	0	2	2	2	3	2
Hogan 4	0	0	1	0	0	1	2
Hogan 5	0	0	0	0	0	1	0
Not rated	0	2	0	2	3	0	0

Chart one shows the percentage of preventability using the Hogan scale.

Chart 1



Analysis of the first stage case reviews showed the following information

- 98.5% (131) of patients were unplanned admissions. The remaining 2 patients were planned admissions, both were oncology patients admitted to ward 12
- 8.5% (12) were patients in surgical wards
- 91.5% (129) of patients were on medical wards
- 17.7% (25) of patients died within 24 hours
- 12.1% (12) patients 'death was not expected when it occurred'
- 22.6% (32) had a primary diagnosis of pneumonia
- 10% (14) had a primary diagnosis of acute cerebral vascular disease

Key themes for learning from cases

The first level review tool was reviewed in August and now includes sections for the reviewers to provide details of what were the clinical care concerns and what were the concerns that prompted their decision to score the case as having some level of preventability. This has enabled more information on the quality of care as well as the preventability issues. The following the themes have been taken from the 1st level reviewers' reasons for providing a Hogan score of 2 or above

Hogan 2

Age	Clinical Care concerns	Preventability
78	IV antibiotics stopped and changed to oral less than 24 hours Red Flag sepsis. No DNACPR/outreach team form or discussion, crash call and late anaesthetic involvement	Returned after discharge previous day complications initially following EBUS procedure in September. Readmitted with red flag sepsis
74	Not reviewed by the consultant until 48 hours after admission Some gaps between high NEWS and outreach team Given diamorphine used in pat with low EGFR Fluid balance not completed clearly	Perhaps earlier rehydration may have assisted – likely that underlying condition would have caused death anyway
72	Long 6 hour delay from admission to clerking 2 gaps in ward 6 >12 hour NEWS Fall on the ward MRSA Bacteraemia 8 days post admission Confusion at end of life – on and off ICOD, died 48 hours after ICOD stopped Inappropriate long stay admission on SSU No pneumonia bundle	Same as care column
89	None listed	Had a fall Developed pneumonia
78	Prolonged stay due to feeding issues (refused oral feed) Diagnosed as having a chest infection / aspirate pneumonia	Prolonged stay At least one if not two episodes of LRTI
66	Did not get daily consultant review on AMU – had only 3 on 5 days	Not preventable but care not optimal on–PEG fed till death, seemed expected but no actions taken.
62	Patient admitted to ICU following 'operative' drainage of cardiac tamponade. May have benefited from earlier echo given documented pericardial effusion in admission notes. This may have allowed drainage prior to peri-arrest situation	Early echo may have permitted drainage of the 2 litre pericardial effusion prior to decompensation The cause of ultimate deterioration was major GI bleed
55	Transfer from MAU to SAU ? why Notes a mess!	Coroner involved
80	Lack of medical review at weekend	No senior review at weekend. Delays in arranging discharge
74	Escalation to outreach via nerve centre – sister not aware Fluid balance intermittent – no totals Gaps in observation > 12 hours	Severe sepsis – no discussion with ITU Potential to be more aggressive with treatment though difficult to gauge frailty
90	Admitted to ward early hours of 7/9 first recorded consultant review was 15/9. Fell several times on the ward - superficial injury to arm	No initial consultant input although plan reasonable. Certified CoD 'AKI' but in fact end stage renal failure secondary to heart failure. Decision to transfer from CRH ED to SAU HRI proved wrong after clerking. Better initial assessment would have avoided this
76	Lack of medical review at the weekend	No medical review on weekend

		before dying on Tuesday
69	Patient admitted to CDU on 22/9/15 and not clerked in by surgeons until the following day by a 5 th year medical student	Lack of documented senior review on day of admission and again two days later although documented in nursing notes

Hogan 3

Age	Clinical Care concerns	Preventability
83	Patient refused medication food and drink Grade 4 pressure sore Cause of death as pneumonia but no chest xray taken	It can be argued that had she been discharged sooner the psychologically she would have been far less likely to 'give up' and subsequently die
91	NEWS on MAU not responded to and not repeated Next of kin didn't seem to have been contacted when admitted or prior to death	Not reviewed between clerking at 22.00 to death at 6am the following day
	Gaps in observation Poor filing of notes for last episode	Diagnosed with community acquired pneumonia and ?urinary sepsis but sepsis screening tool not completed although treatment appeared appropriate
82	Delay in setting up IC antibiotics as no pump available No sepsis bundle sticker Falls bundle not completed Gaps in documentation of dietary intake	
87	Initial care confused as referred to the wrong speciality. Management of the respiratory problem on the surgical ward was not well coordinated for the first few days with no consultant planning	Confused early management – no clear initial plan Not reviewed medically for 2 days prior to day of death

Hogan 4

Age	Clinical Care concerns	Preventability
79	Not seen by doctor for 2 days prior to death Gaps in nursing documentation	not reviewed by medical staff from 4/9 until found dead on 6/9, worsening renal failure on 5/9
69	Limited nursing documentation Strict fluid balance not done	Gaps in observations from 23.30 to time of death at 02.15 DNACPR completed after death Coroner's inquest
69	Missed doses of medication including antibiotics Fluid balance not completed	Mention in nursing and medical notes of incident involving patient (Datix 123875) not sure if relates to preventability. Patient non-compliant/aggressive/lack capacity – may have contributed to preventability ¹

¹Second level review stated this was a distressing incident which is a separate investigation - no impact on death and reassessed the case as Hogan 1

Second Level Review

The process for the second level reviews is being reviewed so ensure these are performed in a timely manner by a core group of reviewers. The process currently relies on one or two individuals but new level two reviewers will be in place by the New Year.

Conclusions

There has been significant increase in performance of 1st level reviews but further work is required to reach 100% of deaths being reviewed. The reviews are now providing better information to focus improvement work and these themes need to be aligned within the appropriate action plans. Second level reviewers are being recruited which will speed up the process and provide assurance of a thorough review where cases are assessed with preventability of Hogan 3 or above.

The lack of senior medical review, particularly noted at weekends is commonest theme listed by the reviewers for preventability and concerns on fluid balance recording and bundles not completed are reoccurring themes listed under clinical care concerns.

Recommendations

1. Recruitment of more 1st level reviewers to support achieving 100% mortality reviews
2. Provide a training package for new reviewers to assure standardisation
3. Analyse the key themes over the months to see where improvements are being made and where the focus for further work is required
4. Refine the process for 2nd level reviews to assure these are performed in a timely manner
5. Ensure the learning themes are aligned with the Care of the Acutely Ill Patient Action Plan or addressed within other work streams
6. Where there are cases assessed with preventability of Hogan 4 or above, these must be reported formally to Risk and Governance through the Datix reporting process

APPENDIX B: Health Watch Visit to ASU



Ward 6D CRH.pdf

Approved Minute

Cover Sheet

Meeting: Board of Directors	Report Author: Stephanie Jones, PA to Director of Nursing
Date: Thursday, 25th February 2016	Sponsoring Director: Julie Dawes, Director of Nursing
Title and brief summary: End of Life - Specific Update on the Individualised Care of the Dying Document - The report gives an update on the progress made since the launch of the Individualised Care of the Dying Document in November 2014.	
Action required: Note	
Strategic Direction area supported by this paper: Transforming and Improving Patient Care	
Forums where this paper has previously been considered: None	
Governance Requirements: None	
Sustainability Implications: None	

Executive Summary

Summary:

As reported to the Board of Directors last year, the Individualised Care of the Dying Document (ICODD) was launched in November 2014. The following paper outlines progress that has been made regarding the use of this care plan, associated training and education which has been delivered, and evidence of both user feedback and audit of its use.

Main Body

Purpose:

See report

Background/Overview:

See report

The Issue:

See report

Next Steps:

See report

Recommendations:

The Board are asked to note the report and the positive progress made.

Appendix

Attachment:

Individualised Care of the Dying Document - FEB 2016.pdf

MEETING TITLE AND TYPE: Board of Directors End of Life – Specific Update on the Individualised Care of the Dying Document	REPORTING AUTHOR: Mary Kiely Consultant in Palliative Medicine
DATE OF MEETING: 25 February 2016	SPONSORING DIRECTOR: Julie Dawes/Lindsay Rudge
STRATEGIC DIRECTION – AREA: • Keeping the base safe • Transforming and improving patient care • A workforce for the future • Financial Sustainability	ACTIONS REQUESTED: • For comment • To approve • To note
PREVIOUS FORUMS: None	
EXECUTIVE SUMMARY: (inc. Purpose/Background/Overview/Issue/Next Steps) As reported to the Board of Directors last year, the Individualised Care of the Dying Document (ICODD) was launched in November 2014. The following paper outlines progress that has been made regarding the use of this care plan, associated training and education which has been delivered, and evidence of both user feedback and audit of its use.	
RECOMMENDATION: The Board is asked to note the report and positive progress made.	
APPENDIX ATTACHED: YES	

BOARD OF DIRECTORS

End of Life – Specific Update on the Individualised Care of the Dying Document

Introduction

As reported to the Board of Directors last year, the Individualised Care of the Dying Document (ICODD) was launched in November 2014. The following paper outlines progress that has been made regarding the use of this care plan, associated training and education which has been delivered, and evidence of both user feedback and audit of its use.

Prior to the launch of the ICODD in November 2014, the Specialist Palliative Care Team delivered a comprehensive programme of training and education to all relevant wards within CHFT. This education and support has continued in the months since then, in conjunction with a CQuIN target delivering education on end of life care to staff working within cardiology and older people and complex care services. There has been a steady increase in the number of patients whose care is supported by the use of the ICODD and these figures along with other aspects of end of life care delivery are reported on a monthly quality dashboard.

The figures for November 2015 show that 40% of all patients who died in CHFT had their care supported by the ICODD. Further analysis of deaths has confirmed that 61% of patients whose deaths were anticipated during their hospital admission (as evidenced by goals of care decisions including ward-based care or DNACPR decisions) were supported by the ICODD. Our aim is that all anticipated deaths be supported by the ICODD.

Obtaining feedback from carers is essential if we are to continue to improve the quality of end of life care. A bereaved relatives' questionnaire was circulated in the second half of 2015 and the results are being analysed and expected soon. These will be reported when they are available. The views of families whose loved ones have been supported by the ICODD have been accessed by way of a short questionnaire which is contained within the comfort bags which they receive as part of the end of life care plan. Not all family members choose to complete the questionnaire, but those that do have clearly benefited from the provision of the items in the bag, but more importantly, from the communication and compassionate care which they receive from clinical staff (see the attached comments).

As agreed, audit of the use of the ICODD has taken place and this will become a regular occurrence. 20 deaths of patients who were supported by the ICODD were audited and below are the following important findings:

- 16 of the patients were over the age of 80 and 6 were aged over 90 and just under half were under the care of older people and complex care services.
- The mean duration of care supported by the ICODD was 50 hours and this is an important figure since it indicates that patients' families have been given time to prepare for the imminent death of their relative. Unfortunately 6 patients died within 24 hours of their care being supported by the ICODD.
- There was evidence that the decision to support the patient with the ICODD was discussed with a senior doctor in 16 out of 20 patients. Unfortunately most patients were either unconscious, too unwell or suffering from dementia so discussions did not take place with 19 out of the 20 patients. However, there was documentary evidence that in 18 out of 20 cases families had been given the opportunity to discuss the fact that their loved one was dying.
- The information leaflet on the Care of the Dying patient was documented as being given to only 7 out of 20 patients, and this is an area for improvement.

A major criticism about the use of the Liverpool Care Pathway related to the role of hydration and nutrition at the end of life and the new document has a designated section on this, with guidance for staff and space to document discussion regarding these issues with patients or their families. The audit revealed that these issues were discussed in 13 out of 20 cases. Timely prescription and availability of drugs to relieve common symptoms is a core aspect of good quality end of life care and the 4 commonly prescribed anticipatory medications for the relief of common symptoms were prescribed for 19 out of 20 patients. There was evidence of full completion of daily reviews and 4 hourly assessments by nursing and medical staff in 16 out of 20 cases.

Conclusion

There has been anecdotal evidence from teams caring for patients at the end of their lives that the ICODD has helped them in delivering this care. Generally, families are given time to prepare for the death of their loved one and in the majority of cases there is evidence of sensitive communication on important issues. However, it is clear that the provision of written information to families could improve and it is also essential that anticipatory medication be prescribed and available for all patients should they need these.

Further amendments will be made to the clinical guidance on medications at the end of life and a working group will meet soon to make these changes to the document. It is recognised that a continuing education programme is required to maintain awareness of the ICODD and compliance with its requirements for documentation. Following separate feedback from a bereaved relative, plans are in place to create an educational video to illustrate the importance of sensitive communication when supporting patients at the end of their lives.

Recommendation

The Board is asked to note the report and positive progress made.

Approved Minute

Cover Sheet

Meeting: Board of Directors	Report Author: Kathy Bray, Board Secretary
Date: Thursday, 25th February 2016	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 approve 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 - 18.2.16	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The January IPR report shows a mixed picture with deterioration in particular across several flow related metrics. The areas of specific note are as follows:

Responsiveness

Elective activity has deteriorated reflecting the impact of bed pressures across both sites, actions underway to try and recover the position but unlikely to impact before March

Emergency Care Standard failed January with Quarter 4 unlikely to be recovered

6week diagnostics failed in January relating in particular to Ultrasound

Elective access - All 18 week RTT targets

Outpatient backlog clearance continues at pace including ASI activity

All regulatory cancer targets were achieved but the deadline for submission was missed

Stroke performance improving

Caring

There has been a rise in mixed sex reported breaches

Complaints performance has deteriorated and is the focus of actions for Divisional teams following meetings with Chief Nurse

Maternity indicators have improved

Effectiveness

Hand Hygiene compliance remains a concern with specific focus on improvement

Mortality remains a concern and is the focus of significant work

#NoF performance in relation to Theatre within 36hours has deteriorated slightly

Safety

There remains a high proportion of Serious Incident reports out of time

Incident investigation clearance has been discussed with all Divisions with specific activity currently underway

Falls with harm numbers have stabilised

Well led

- Sickness has decreased in 4 of the 7 service areas reported and 4 out of 8 staff categories with overall % sickness at its highest point in current service year.
- Staff in post and FTE is static
- Over 95% of colleagues have now started their mandatory training programme.
- Appraisal activity plans are in place with divisions now RAG rated against these plans

CQUINs

Sepsis and Acute Kidney Injury CQUINs remain a challenge to deliver, Trusts with good performance identified and currently looking at their plans to replicate the good practice

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

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

Appendix

Attachment:

There is no PDF document attached to the paper.

Board of Directors Integrated Performance Report

Calderdale and Huddersfield
NHS Foundation Trust



compassionate
care

Contents

Report For: January 2016

Board of Directors

Integrated Performance Report

Approved Minute

Cover Sheet

Meeting: Board of Directors	Report Author: Kathy Bray, Board Secretary
Date: Thursday, 25th February 2016	Sponsoring Director: Keith Griffiths, Director of Finance
Title and brief summary: FINANCIAL NARRATIVE - MONTH 10 - The Board is asked to approve the Month 10 Financial Narrative - January 2016.	
Action required: Approve	
Strategic Direction area supported by this paper: Financial Sustainability	
Forums where this paper has previously been considered: Finance and Performance Committee - 23.2.16	
Governance Requirements: Financial Sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the Month 10 Financial Narrative - January 2016.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve the Month 10 Financial Narrative - January 2016.

Appendix

Attachment:

Month 10 15_16 financial commentary for BOD.pdf

MONTH 10 JANUARY 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 as follows:

- Key messages;
- Detailed commentary for the period with variance analysis against the original plan submitted to Monitor in May 2015;
- Financial Sustainability Risk Rating (FSRR) and forecast.

This paper has previously been discussed at the Finance & Performance Committee held on 23 February 2015.

1. Key Messages

The year to date financial position represents an adverse variance from plan of £1.12m from the original plan. A level of improvement in performance had been seen in the previous two months. This improvement has not continued from last month as a result of considerable operational pressure being borne in the month of January.

These operational pressures are continuing in February and are expected to remain through to year end adversely impacting the forecast. The year end forecast position now stands at £21.88m (including restructuring costs, but excluding joint venture profits and revaluation gains), this compares with the equivalent value last month of £21.64m, i.e. the forecast has deteriorated by £0.24m.

Month 10, January Position (Year to Date)

Income and Expenditure Summary	Original Plan £m	Reforecast Plan £m	Actual £m	Var (vs. Original) £m
EBITDA	4.28	2.08	2.83	(1.45)
Deficit excluding restructuring	(16.97)	(18.79)	(18.10)	(1.12)
Restructuring costs	(3.00)	(1.10)	(1.10)	1.90
Deficit including restructuring	(19.97)	(19.89)	(19.20)	0.78

- An EBITDA of £2.83m, an adverse variance from original plan of £1.45m, a favourable variance at £0.76m against reforecast plan.
- A deficit (excluding restructuring costs) of £18.10m, an adverse variance of £1.12m from plan.
- Delivery of CIP of £14.34m against the original planned level of £11.01m.
- Contingency reserves released of £2.31m.
- Capital expenditure of £14.53m, this is below the original planned level of £18.17m.
- A cash balance of £7.55m, this is above the planned level of £1.99m.
- A Financial Sustainability Risk Rating (FSRR) of level 2, in line with the plan.

2. Detailed Commentary for the Reporting Period

Statement of Comprehensive Income (SOCl)

The month 10 position shows a halt in the improvement seen in the last two months. In November and December the number of extra beds open was contained at a slightly lower level than anticipated benefitting staffing costs. As was raised early as a concern when reporting the month 9 position, this situation has reversed in January with a peak in A&E attendances coupled with increased non elective length of stay in month meaning that extra capacity was stretched to maximum levels with consequential financial pressure.

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

Operating income	(£2.02m) adverse variance
Operating expenditure	£0.57m favourable variance
EBITDA	(£1.45m) adverse variance
Non-Operating items	£0.33m favourable variance
Restructuring costs	£1.90m favourable variance
Total	£0.78m favourable variance

Operating Income

There is a cumulative £2.02m adverse variance from the original plan within operating income.

NHS Clinical Income

Of the £2.02m adverse income variance, £0.55m is driven by NHS clinical income. In summary this comprises an over performance versus original plan in outpatient and non elective activity offset by an underperformance in planned elective and daycase.

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

- Planned elective activity has seen a worsening in performance in month as a result of a level of cancellations to accommodate non elective patients and is 141 spells under planned levels for January. In order to compensate some of the loss, additional daycase activity has been carried out. Daycases are 191 spells above planned levels for the month.
- Non-elective admissions are above plan in month and the year to date 4,310 actual spells were seen against a projected 4,182 in month. However, average length of stay has increased by half a day from December to January.
- A&E attendances are considerably above planned levels particularly in January (908 attendances in month) which has impacted on the Trust's ability to maintain the four hour wait target.
- Outpatient attendances are again slightly above plan in-month. This follows an improved performance in recent months as compared to the early part of the year. The increase in activity levels is across both first and follow-up attendances across a wide range of specialties.
- Pass through high cost drugs costs are below planned levels whilst clinical devices are above plan.

The action described above in cancelling elective procedures to accommodate non elective patients has had a small financial impact in the year to date but is anticipated to have a considerably greater impact in the next two months as a surgical elective ward has been given over to non elective

medical patients. All actions to mitigate against the financial impact this operational decision are being pursued, including increasing day case work, re-organising elective lists and potential to utilise theatre capacity within the independent sector, although the latter would obviously come at a cost. The income impact of this operational decision over the final quarter is costed at £1.3m with a resultant loss of contribution of £0.8m.

In previous months it has been explained that the Trust was making financial provision in the anticipation of contract sanctions; any shortfall on CQUIN performance; contract challenges and commissioner affordability in the round. In light of the impact of the reduction of elective income, the level of provision held has been reassessed and reduced reflecting the lower risk against affordability that this brings, therefore meaning that the impact to the Trust financial bottom line is lessened.

Other income

Overall other income is £1.47m below the planned level. This includes a slight shortfall against income generated from private patients. Lower than planned income within the Trust's Health Informatics Service does not adversely affect the bottom line as it is offset by reduced costs. Whilst the Trust's Pharmacy Manufacturing Unit has seen a reduction in sales and contribution compared to the plan, remedial action is being put in place to contain this shortfall.

Operating expenditure

There was a cumulative £0.57m favourable variance from plan within operating expenditure across the following areas:

Pay costs	(£0.53m) adverse variance
Drugs costs	£0.19m favourable variance
Clinical supply and other costs	£0.91m favourable variance

Employee benefits expenses (Pay costs)

Pay costs are £0.53m above the planned level and the pay run rate has increased considerably in-month. The true pay overspend is even greater as this figure is offset by the release of more than £1.5m pay reserves.

The largest single driver of the additional costs which have been incurred in the year to date is the need for additional bed capacity. Whilst this pressure had eased somewhat in recent months, in January the Trust has seen bed capacity requirements increase considerably. The level of additional nursing and medical staffing costs have followed suit.

This pressure is exacerbated by recruitment difficulties which continue to be an issue in certain specialties for medical staff. This is driving additional costs through the requirement to engage agency locum staff in key specialties. Focussed activity is underway to manage attendance of clinical staff through the creation of an attendance management team in late 2015/16. Escalation protocols are in place for the authorisation of agency cover for junior medical posts and nursing shifts. The Trust has seen some success in driving down agency rates using the Monitor price cap as a lever particularly with nursing agencies.

With regard to non-clinical agency usage, the Executive Board is supporting work to ensure we comply with Monitor agency cap rules. Formal exception reporting is already in place and recognising the increased pay expenditure run rate, this is being reinforced through Divisional face to face challenge sessions in early February with the drive to bring ALL our arrangements within the cap rules and reduce overall agency usage across all staff groups as soon as possible.

Drug costs

Year to date expenditure on drugs was £0.19m below the plan. The underspend on 'pass through' high cost drugs is below plan matched by a corresponding income increase. However within this, there has been significant expenditure since September on a new Hepatitis C drug for which the Trust receives funding outside of the main clinical contracts directly from NHS England, bringing for £0.5m of additional spend.

Clinical supply and other costs

Clinical supply and other costs, including PFI costs, are £0.91m below the original plan.

This underspend reflects the reduced level of costs associated with the lower than planned elective and day case activity as well as reduced utilities spend linked to the relatively mild weather and a benefit on PFI charges due to RPI being at a lower rate than plan.

Non-operating Items and Restructuring Costs

Non-operating items and restructuring costs are £2.23m below the original plan.

Restructuring costs in the year to date are £1.10m versus a plan of £3.0m. Of the costs incurred £0.10m relates to redundancy payments to enable CIP, whilst the balance is the E&Y consultancy support to strategic turnaround which is now complete with outputs handed over to the Trust.

Cost Improvement Programme (CIP) delivery

The CIP and revenue generation schemes continue to perform in excess of plan in the year to date with £14.34m achieved against a planned £11.01m. 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. The former is partially offset in the overall financial position by the provision made against contract challenges by commissioners.

The latest risk assessment against all of the work streams indicates that the vast majority are now low risk which is congruent with the fact that these schemes are already well underway. There has however been a setback to the forecast delivery against the theatres productivity scheme due to the cancellations of elective activity to accommodate non elective patients. This brings a reduction to this scheme of £0.5m in the remainder of the year. The total forecast CIP delivery is now £17.53m.

Statement of Financial Position and Cash Flow

At the end of January 2016 the Trust had a cash balance of £7.55m against a planned position of £1.99m, a favourable variance of £5.56m, the key movements are summarised below.

		Variance £m
Operating activities	Deficit excluding restructuring	(1.12)
	Restructuring costs - redundancy	1.90
	Restructuring costs – consultancy support	0.00
	Deficit including restructuring	0.78
	Non cash flows in operating deficit	(0.15)
	Re-profiling of commissioner contract income	16.72
	Other working capital movements	(1.45)
Sub Total		15.90
Investing activities	Capital expenditure	3.64
	Movement in capital creditors	(1.15)
Sub Total		2.49
Financing activities	Drawdown of external DoH cash support	(13.10)
	Other financing activities	0.28
Sub Total		(12.82)
Grand Total		5.56

Operating activities

Operating activities show a favourable £15.90m variance against plan. This is driven by the favourable cash impact of the I&E position of £0.63m (£0.78m favourable I&E variance less £0.15m non-cash flows in operating deficit) offset by an adverse working capital variances from plan. As described in previous reports, agreement has been reached with our main commissioners to re-phase the contract income payments over eleven months rather than the standard twelve. This has enhanced the cash position by £16.72m in the year to date and pushed back the requirement for DH cash support.

The adverse variance on working capital movements is predominantly due to timing differences on receivables. The level of invoices overdue from other NHS organisations totals £1.10m, this remains at the same level as last month in spite of success in collecting payment against specific debts. The most material of those remaining are due from Greater Huddersfield CCH and Calderdale CCG for services that sit outside of the main clinical contract; NHS England in relation to Quarter 2 over performance and Hepatitis C Drugs pass through charges. All of these are being actively pursued by the Trust.

Payments to suppliers continue to be categorised prioritised for payment accordingly whilst seeking to maintain a healthy performance against the Better Payment Practice Code. In month 77% of invoices have been paid within 30 days and the Trust remains mindful of the need to maintain good creditor terms, particularly given that external cash support will not be available to restore the balance sheet position on payables.

Investing activities (Capital)

Capital expenditure in the year to date is £14.53m, £3.64m below the original planned level of £18.17m.

The decision has been taken by the Trust to re-prioritise capital expenditure where this can be done without detriment to safety in order to reduce reliance on external cash support. The year to date underspend is in part due to this re-prioritisation as well as issues of timing.

Against the Estates element of the capital expenditure the year to date expenditure is £5.78m against a planned £6.78m. The main area of spend in month was on backlog maintenance with planned spend on the theatre refurbishment of £0.36m in month being delayed due to asbestos being found. Another material contributor to the year to date underspend is £0.42m against the decommissioning of oil tanks which has been able to be delivered in a more cost effective way.

IM&T investments total £6.97m against a year to date plan of £9.14m. The main individual area of spend in month is again on the continuation of the Electronic Patient Record (EPR). This is also the key area of underspend against the plan although this is purely a timing difference which will rectify over forthcoming months. Alongside this, other areas of underspend have been as a result of re-prioritisation, including switchboard investment which had been planned at £0.4m in the year to date.

Expenditure on replacement equipment is also lower than plan and contingencies have not been required to be spent in the year to date although will be called upon in forecast against additional CQC requirements.

The favourable cash impact of this £3.64m under spend is offset by a £1.15m adverse variance against capital creditors as invoices have been forthcoming and paid in a timely way, explaining the overall £2.49m positive cash variance against investing activities.

Financing activities

Financing activities show a £12.82m adverse variance from plan but, as in previous months, in this instance this is positive news. The key driver for this variance is the fact that the Trust has not needed to draw upon external DoH loans, the reliance on which was originally expected to have reached £13.10m by January.

External cash support has not been called upon in the year to date and this continues to be anticipated to be required in March 2016. The Trust has recently been notified that the application for an Interim Revenue Loan of £12.9m has been progressed, subject to the final stages of processing this will be in place in March at an interest rate of 1.5%.

The separate £10m loan to support the EPR deployment was drawn down from the Independent Trusts Financing Facility (ITFF) in April as planned.

3. Financial Sustainability Risk Rating (FSRR) and forecast

FSRR

Against the new FSRR the Trust stands at level 2 in both the year to date and forecast position. This is in line with planned position (restated from the original CoSRR of 1).

Forecast – Income and Expenditure

As highlighted as a risk last month, in January the Trust has been experiencing extraordinary non elective pressures. This is forcing a level of elective cancellations over the remaining months of the financial year to free up bed capacity for non elective activity bringing consequent financial pressure.

At the time the reforecast plan was submitted to Monitor in November, the option of a capital to revenue transfer could have brought a further benefit of £1.0m to I&E was unconfirmed. The Trust now understands that this route is not available but we seek to generate the equivalent improvement back to the originally planned £20m trading deficit through other means, even in the face of the challenging operational situation.

It should be noted that the latest forecast is an I&E deficit of £21.88m (excluding joint venture investment gains of £0.4m). In trading terms, this a worsening from the Month 9 year end forecast of £0.24m.

The year end position at bottom line has been improved upon by the recognition of £0.40m anticipated share of profits and revaluation gain on investment property from the Trust's Joint Venture (JV) Pennine Property Partnerships. Notification of this non cash gain has been received from our JV partners but the final value will not be confirmed until closure of our accounts in March.

(This is correctly reportable within the I&E statement but to ensure we remain focussed on trading and comparable performance against previous forecasts, it has been highlighted separately.)

All further opportunities are being pursued to improve the financial position ranging from; internal challenge to the increased pay run rate in January which is currently forecast to continue; through to technical options such as the alternate asset valuation method has been discussed with the District Valuer. The Trust awaits advice on whether this offers a potential financial benefit.

Set against these opportunities, even at this advanced stage of the financial year risks remain. Notably contract settlement risks with commissioners, whilst provision has been made against this and open dialogue continues, the outcome is still uncertain.

The forecast year end position is summarised at headline level below:

Year-end Forecast Position

Income and Expenditure Summary	Original Plan £m	Reforecast Plan £m	Month 10 Forecast £m	Var (vs. Original) £m
EBITDA	5.51	4.14	4.33	(1.18)
Deficit excluding restructuring and JV profit/investment	(20.01)	(20.94)	(20.78)	(0.77)
Restructuring costs - redundancy	(3.00)	(0.10)	(0.10)	2.90
Restructuring costs – consultancy support	0.00	(1.00)	(1.00)	(1.00)
Deficit	(23.01)	(22.04)	(21.88)	1.13

Forecast – Capital

The Trust has reviewed its planned capital programme for 2015/16 and the latest forecast is a slight increase in spend versus last month, now representing a £0.7m reduction against the planned £20.7m investment, with CQC requirements driving some of this additional spend. The reduction against plan has been limited to those areas where there is scope to reduce the programme without having an adverse impact on patient safety. Whilst the Trust now understands that the option will not be available to transact a capital to revenue transfer to bring equivalent benefit to I&E, the forecast continues to be contained to reduce reliance on external cash support.

Forecast – Cash

The total cash support requirement currently remains at £12.9m and the Trust has been now been notified that this value has been supported to be progressed as an Interim Revenue Loan and the required Board resolution to support this will be made at the February Trust Board meeting. This level includes the additional cash requirement to support the restructuring costs relation to consultancy support £1.0m which has now been agreed with Monitor to stand as an agreed discretionary extension to the cash support requirements.

The pro-active measures that have been put in place to secure and preserve cash mean that the timing of this need is pushed back from September 2015 as originally planned to March 2016.

Conclusion

The Trust must continue to strive to improve upon the year end forecast I&E position. All avenues to achieve this will need to be pursued to contain the cash support required and to play our part in improving the overall national financial performance.

Approved Minute

Cover Sheet

Meeting: Board of Directors	Report Author: Linda Cordingley, Executive Assistant to Chief Executive
Date: Thursday, 25th February 2016	Sponsoring Director: Owen Williams, Chief Executive
Title and brief summary: Colleague Engagement - The purpose of this report is to appraise the Board of Directors of the outcome of the most recent assessments of the Trust's position in relation to the core colleague engagement measures which are listed as follows: • National Investors in People (IIP) Standard • 2015 Staff Survey (nationally embargoed 23rd February) • Staff Friends and Family Test	
Action required: Approve	
Strategic Direction area supported by this paper: A Workforce for the Future	
Forums where this paper has previously been considered: None	
Governance Requirements: A workforce for the future	
Sustainability Implications: None	

Executive Summary

Summary:

1.1. The purpose of this report is to advise the Board of Directors of the outcome of the most recent assessments of the Trust's position in relation to the core colleague engagement measures which are listed as follows:

- National Investors in People (IIP) Standard
- 2015 Staff Survey (nationally embargoed 23rd February)
- Staff Friends and Family Test

1.2. A colleague engagement action plan is being co-produced and compiled from common themes which have emerged from these three key information sources and other work such as our Health & Wellbeing Strategy. The key emerging actions from this piece of work seek to ensure that we have a co-ordinated approach and focus on actions which will impact the underlying causes in addition to addressing the specific issues.

Main Body

Purpose:

See attached report

Background/Overview:

See attached report

The Issue:

See attached report

Next Steps:

See attached report

Recommendations:

The Board is asked to:

(i) Support the suggested action planning themes and to identify any gaps or areas that they feel need further focus of attention.

(ii) Agree to the use of the IIP framework via the staged assessment process described in this paper.

(iii) Agree to receive quarterly updates from the Chair of the Workforce (Well-Led) Committee as to progress against the developed action plan.

Appendix

Attachment:

COMBINED COLLEAGUE ENGAGEMENT.pdf

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

BOARD OF DIRECTORS – 25 FEBRUARY 2016

COLLEAGUE ENGAGEMENT

1. Introduction

1.1. The purpose of this report is to advise the Board of Directors of the outcome of the most recent assessments of the Trust's position in relation to the core colleague engagement measures which are listed as follows:

- National Investors in People (IIP) Standard
- 2015 Staff Survey (nationally embargoed 23rd February)
- Staff Friends and Family Test

1.2. A colleague engagement action plan is being co-produced and compiled from common themes which have emerged from these three key information sources and other work such as our Health & Wellbeing Strategy. The key emerging actions from this piece of work are discussed at a later stage in this report and seek to ensure that we have a co-ordinated approach and focus on actions which will impact the underlying causes in addition to addressing the specific issues.

2. Investors In People

2.1. The Trust has been a recognised IIP organisation since 2001. The Trust was last successfully recognised in 2012 against the Core Standard and was seeking to secure this as minimum target following this latest assessment. It is a requirement that assessments take place every three years. The latest assessment took place between October and December 2015 against the full IIP framework (Appendix 1).

2.2. The IIP Specialist assessor carrying out the assessment, qualitatively interviewed c150 members of Trust staff, across a range of banding and service areas, to gather their opinions of working for the Trust. Based on evidence gathered against the IIP framework the Trust has met the necessary evidence requirements to achieve the IIP Bronze Award, which is a progression from the Core Standard maintained since 2001. The Trust therefore retains its recognition against the IIP Standard for a period of three years to December 2018.

2.3. The Assessor's report (Appendix 2) details strengths and areas of good practice which were viewed positively by staff and these are briefly summarised as follows:

- opportunities for staff to be involved in business planning;
- results from the practical application of the "Work Together Get Results" programme;
- on-line learning to keep up to date with mandatory training;
- examples of good line management;
- recognition of team and individual achievements;
- overall employee commitment to the aims of the Trust;
- support for new members of staff.

2.4. In addition to the standard IIP indicators, the Trust requested feedback on two specific areas, namely health & wellbeing - where staff welcomed the support they had received through the Global Corporate Challenge and quality & safety - where staff felt that the Trust had a strong focus.

2.5. The report also details potential areas for improvement which the assessor considers would transform performance and lead to sustainable organisational improvement. These are as follows:

- recruitment (to become an employer of choice)
- appraisal (more focus on the quality of appraisal conversations)
- individual responsibility and commitment (for team communications, appraisal and recognition)
- strategy development (organisational development and education and training)
- evaluation (developing metrics to demonstrate return on investment in people)

2.6. As part of the assessment, the Trust also requested feedback to assess staff views on how we could improve our approach to change management, and the level of engagement with our vision to provide 'Compassionate Care', staff recognition and examples of our 'Four Pillars' being demonstrated. These are identified in the Assessor's report.

2.7. In terms of next steps, the IIP Standard has been revised and moving forward the Trust will be assessed against Version 6 of the Standard (Appendix 3). To support and align approaches to meeting our key priorities, we will use the IIP Standard as a blueprint to inform our OD strategy which will assist us in maintaining IIP accreditation. This approach is very much in line with the requirements of the external Well Led Governance Review undertaken last year.

2.8. The IIP Specialist has advised that this can be done by a 'staged assessment' process spanning a three-year period. This would comprise an on-line assessment commencing in May 2016 and on-site interviews later in the year. These will generate a summary report at the end of the year. This approach will be replicated in years 2017 and 2018 in preparation for the Trust's formal IIP Assessment in December 2018. This approach will allow for any intermediate actions to be taken where needed.

2.9. The cost of the staged assessment approach will total £30,600 over the next 3 years. This will include all preparation, planning, online assessment, on site visits, report writing and feedback meetings over the three year period.

3. Staff Friends and Family Test (FFT)

3.1. The Staff FFT has been running each quarter since 1 April 2014 (with the exception of Q3 when the staff survey is running). Staff had positive views around:

- good quality care from caring healthcare professionals;
- staff work hard and are committed to their patients;
- friendly staff.

3.2. The FFT survey also highlighted staff priorities for improvement as:

- poor staffing levels;
- low staff morale;
- management support.

4. 2015 National Staff Survey

4.1. The Trust participated in the 2015 national staff survey during October - December 2015. The national results are embargoed until 23 February 2016, but early positive indications for the Trust are:

- low numbers of staff witnessing potentially harmful errors, near misses or incidents in last month;
- high level of reporting errors, near misses or incidents witnessed in last month;
- staff confidence and security in reporting unsafe clinical practice;
- staff satisfaction with the quality of work and patient care they are able to deliver

4.2. Early indications of where the Trust should focus its attention are:

- staff satisfaction with resourcing and support;
- quality of appraisals;
- recognition and value of staff by managers and the organisation.

5. Colleague Engagement Action Planning

5.1. The Board will note that there is consistency in results from these three sources and clear themes are emerging in terms of areas where the Trust should focus its resource and attention. The Colleague Engagement Action Plan is being designed to address underlying root causes and to respond to specific issues across the short, medium and long term.

5.2. The action plan is being co-produced with Divisions, and will be underpinned by specific Divisional plans and progress will be monitored through the Workforce (Well-Led) Committee. The action plan will also dovetail with actions from our focus on health & wellbeing and Board members are encouraged to comment on whether the following action planning themes are sufficient or whether there are any areas that they feel need further focus of attention.

Action Planning Theme(s)	Who
To gain a shared understanding of the current status of the Trust – a clear narrative on ‘where we’ve been, where we are, and where we are going’.	Chief Executive
To promote a 3 point focus on quality, people and money, locating the current and ongoing financial challenges and cost improvements as ‘part of the bigger transformation picture’.	Chief Executive
To implement the Year of Wellbeing Events 2016.	Director of Workforce & Organisational Development
To strengthen the approach to workforce and organisational development.	Director of Workforce & Organisational Development
To demonstrate that the Trust is listening and responding to concerns, issues and successes.	Chair of the Workforce (Well-Led) Committee
To improve the visibility of leaders who show through their behaviours and actions that ‘working together to get results’ is ‘the way to do things around here’.	Chief Executive

5.3. The detailed actions flowing from these action planning themes and their associated milestones will also be monitored by the Colleague Engagement, Health & Wellbeing Group, ensuring a broader, cohesive and coherent Trust-wide perspective and view on progress in these key areas.

6. Recommendations

The Board is asked to:

- 6.1. Support the suggested action planning themes and to identify any gaps or areas that they feel need further focus of attention.
- 6.2. Agree to the use of the IIP framework via the staged assessment process described in this paper.

6.3. Agree to receive quarterly updates from the Chair of the Workforce (Well-Led) Committee as to progress against the developed action plan.

Sponsor: Owen Williams, Chief Executive
Author: Linda Cordingley, IIP Lead

February 2016

Encs

THE INVESTORS IN PEOPLE FRAMEWORK: A SUMMARY OF ITS CONTENTS

PLAN				DO				REVIEW	
01: BUSINESS STRATEGY	02: LEARNING & DEVELOPMENT STRATEGY	03: PEOPLE MANAGEMENT STRATEGY	04: LEADERSHIP & MANAGEMENT STRATEGY	05: MANAGEMENT EFFECTIVENESS	06: RECOGNITION & REWARD	07: INVOLVEMENT & EMPOWERMENT	08: LEARNING & DEVELOPMENT	09: PERFORMANCE MEASUREMENT	10: CONTINUOUS IMPROVEMENT

THE STANDARD TOP MANAGERS SHOULD MAKE SURE (AND THEIR PEOPLE SHOULD CONFIRM) THAT:

The organisation has a vision/purpose, strategy and plan	Learning priorities are clear and linked to the plan	People are encouraged to contribute ideas	Managers are clear about the capabilities they need to lead, manage and develop people	Managers are effective and can describe how they lead, manage and develop their people	People believe they make a difference	Ownership and responsibility are encouraged	People's learning and development needs are met	Investment in learning can be quantified	Evaluation results in improvements to people strategies and management
People are involved in planning	Resources for learning and development are made available	There is equality of opportunity for development and support	People know what effective managers should be doing		People believe their contribution is valued	People are involved in decision-making		Impact can be demonstrated	
Representative groups (where appropriate) are consulted when developing the plan	The impact will be evaluated								

YOUR CHOICE TOP MANAGERS SHOULD MAKE SURE (AND THEIR PEOPLE SHOULD CONFIRM) THAT:

Clear core values relate to vision and strategy	The learning and development strategy builds capability	The recruitment process is fair, efficient and effective	Leadership and management capabilities for now and the future are defined	Managers are role models of leadership, teamwork and knowledge sharing	Reward and recognition strategies link to business strategy and are externally benchmarked	Effective consultation and involvement is part of the culture	Learning and development resources are used effectively	The contribution of people strategies is measured and evaluated	Self review and information from external review are used
Key performance indicators are used to improve performance	Plans take account of learning styles	A diverse, talented workforce is created	Managers are helped to acquire these capabilities	Coaching is part of the culture	Representative groups are consulted (where appropriate)	People are supported and trusted to make decisions	Learning is an everyday activity	Impact on key performance indicators can be described	Effective feedback methods are used to understand people's views on how they are managed
Social responsibility is taken into account in the strategy	People help make decisions about their own learning	A work-life balance strategy meets the needs of its people	Leadership and management strategy link to business strategy, taking account of external good practice	People are helped to develop their careers	Knowledge and information are shared	Knowledge and information are shared	Innovative and flexible approaches to learning and development are used	Performance improves as a result	Internal and external benchmarking are used
People and stakeholders are involved in strategy development	Learning and development is innovative and flexible	Constructive feedback is valued	Everyone is encouraged to develop leadership capabilities	There is a culture of openness and trust	What motivates people is understood	People are committed to success	People are given the opportunity to achieve their full potential	Career prospects improve	People's views on how they are managed improves
	There is a culture of continuous learning	The structure makes the most of people's talents			Success is celebrated	There is a culture of continuous improvement	All learning is valued and celebrated and is an everyday activity	Flexible and effective approaches to measuring return on investment are used	People believe it's a great place to work
					Benefits strategy goes beyond legal requirements	People can challenge the way things work	Mentoring is used	Return on investment in people is reported to stakeholders	
					Colleagues' achievements are recognised	There is a sense of ownership and pride in working for the organisation	Personal development is supported		



Review Report

Investors in People Version 5 assessment report for Calderdale and Huddersfield NHS Foundation Trust

Undertaken by

Mark Wem and assisted by Julia Stokes

On behalf of Investors in People North of England

Accreditation Date	18-month interaction due	Accreditation Expiry Date
10 th December 2015	June 2017	10 th December 2018

	Staged Assessment proposed	
	From January 2016 to December 2018	

Project Number: 15/0677

Date: December 2015

Commercial in Confidence

CONTENTS

	Page Number
Background	3
Business Context - Priorities/Objectives & Scope	3
Overview of Findings	5
Conclusion	8
Acknowledgement	9
Strengths and areas of good practice	10
Potential areas for development using the framework	14
Appendix 1 – Evidence Matrix	24
Appendix 2 – Continuous Improvement Plan	25

Background

In 2014/15 Calderdale and Huddersfield NHS Foundation Trust cared for more than 123,300 men, women and children as inpatients (stayed at least one night) or day cases and more than 438,300 people attended our outpatient clinics. Our A&E departments at both hospitals saw and treated more than 142,000 people. There were some 223,887 adult services and 64,108 children's service contacts by our community teams.

Our 6000 colleagues provide compassionate care from our two main hospitals, the Calderdale Royal Hospital, and the Huddersfield Royal Infirmary, as well as in our community sites, health centres and in patients' homes.

During 2014/15 our clinical services were divided into four divisions each headed up by a clinical Divisional Director, supported by an Assistant Director of Nursing, an Assistant Divisional Director and an Assistant Director of Finance.

Business Context – Priorities/Objectives & Scope

The organisation agreed a number of priorities and objectives focusing on its ability to improve business performance. These were set within the context of its organisational ambition whilst recognising current issues and challenges facing the organisation and where appropriate help facilitate change. These were discussed in detail and agreed at an initial meeting which took place on the 8th September 2015. These were defined in the Review Plan and included a focus around -

Business Topic:

Managing Change and using the Investors in People Review activity this year as a Benchmark against the whole of the Investors in People Framework. The findings would be seen to provide a more strategic organisational development plan which would inform progress set against the new Investors in People Generation 6 Framework which is based on a model of high performance working.

Business Impact to meet/support the above:

Reduction in financial deficit 2015-2016.

Improvement in staff survey results for 2015.

Scope:

As it was planned to focus on the above, the scope (those to be included in the interview process and ensuring a representative sample of the organisation) took into account certain factors whilst conforming to guidelines set nationally and included covering and interviewing over 150 full time and part time employees (colleagues) and others who contribute towards meeting the organisation's objectives e.g. volunteers. This included various roles and grades across all Directorates. It also involved the Investors in People Specialist attending a Big Brief Meeting, a Long Service Award Ceremony, a 'Working Together Get Results' training workshop, two hospital site tours and visiting a local health centre.

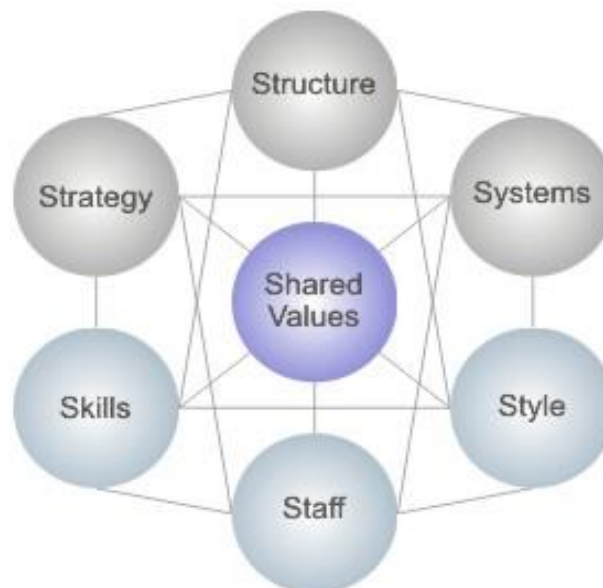
Overview of Findings

In agreement with you we used the Investors in People Framework to set objectives for this review and diagnose the organisation's current key business issues and challenges. The following sections of this report highlights strengths (those areas where there appears to be sufficient evidence of actions which work well) as well as areas for development (those areas which require consideration and action) and need to be addressed to improve business performance overall.

As discussed, to help with understanding the relevance of the areas included for improvement and how they interact and need to be aligned with each other, this section has been put together using the McKinsey 7S Framework. The basic premise of the model is that there are seven internal aspects of an organisation that need to be aligned if it is to be successful.

The seven S's that make up the framework are:

Figure 1: The McKinsey 7S Model



How the model is presented in Figure 1 shows the interdependency of the elements and indicates how a change in one affects all the others.

Reviewing your organisation using this approach has enabled me tremendous insight into your organisation and working environment and as a result having had experience of this and other sectors using the McKinsey 7S Framework can summarise my findings as follows:

Shared Values: these are the core areas of the organisation and are stated under 4 pillars of behaviours expected of all employees namely; *we put the patient first, we go see, we work together to get results and we do the must do's*. Each behaviour seeks to support its vision namely; *together we will deliver outstanding compassionate care to the communities we serve*. Documented as well as verbal evidence demonstrated that the majority of employees within the assessment scope were aware of and understood its vision and behaviours within the context of their role. However, at a time of unprecedented change facing this and many other NHS Trusts the extent to which employees believed in the vision and behaviours varied. Examples included constant internal and external changes e.g. contract changes in terms of medical practice towards patient care, staffing issues (as indicated/reported on by employees following its Staff Survey Results December 2015) which were seen to contribute to high levels of stress and absence leading to an inability to 'go see' due to time pressures and focus on cost targets. However, many employees remain totally committed to the work of the Trust and the NHS in general and many employees offer high levels of good will in the belief that this directly impacts on good patient 'compassionate' care. There has been a marked focus to work alongside both Monitor and the CQC in terms of addressing organisational issues and a real focus of attention is being placed to prepare and support all employees in terms of its CQC visit March 2016.

Strategy: the plans devised to maintain and build competitive advantage over the competition are detailed with a high level of engagement and inclusion such as stakeholder engagement plan though not always recognised by employees due to a lack of awareness of its business planning model, programme or milestones or the way in which their contribution is made and valued e.g. staff surveys. Documented evidence however, included its Annual Report and Accounts 2014-2015 and current draft plans around developing its 5 year strategy which included milestones in terms of reference for divisions and workteams, commissioning, clinical modelling, equality, technology and finance. January 2016 will see the final part of the planning process resulting in a CCG Joint Governing Body Meeting and decision on readiness to progress to public consultation. All Employees are kept informed of all business planning developments with the potential impact on service areas through the 'Big Brief' monthly meetings. Employees unable to attend should receive information via a cascade process and may access copies of the slides presentation on its Intranet site.

Structure: the way the organisation is structured and who reports to who is under constant review and change. Often this is down to external changes on employee contracts e.g. support staff and junior doctors. The Trust's major focus is on reducing its overall financial deficit which has also meant that all departments have had to review and re-structure to make cost savings as detailed in Cost Improvement Programmes (CIPs).

Systems: the daily activities and procedures that the organisation uses to get things done also remain a key driver for change and attempts to balance the need to maintain and improve patient care whilst at the same time contribute to cost savings. There has been a significant investment in terms of implementing electronic patient records due to go live September/October 2016. Many medical and non-medical staff are hugely excited by the potential benefits to patient care and the Trust is seen as extremely forward thinking in terms of being one of a handful of Trusts implementing what is a mandatory NHS initiative.

Style: the style of leadership adopted in the organisation and how leaders interact with their people is an area which has come under the most scrutiny in recent years. Its new CEO (in place now for 3 years) is seen as engaging, motivating and highly committed and this is reflected in the organisation's focus on developing leadership styles which promote and deal with change in the most productive way. Its 'Work Together Get Results' development programme has received excellent feedback from candidates and being rolled out across the organisation. Examples of good practice as a result are being captured through post programme feedback mechanisms including case studies.

Staff: the people in the organisation and their collective capabilities are highly recognised and valued by leaders and managers as well as peer groups e.g. through the CEO's Blog, Annual Reports, Newsletters, Team/Departments Briefs/Meetings and direct emails. However, again due to high levels of stress as reported on in many areas brought about by staff reductions/shortages, changes in working conditions and contracts many employees are not feeling supported, valued or recognised for the work they do. Currently regular team meetings, 1:1s which should take place or the annual appraisal process seeking to address this area does not meet many employee expectations. The organisation has worked hard in recent years to ensure that annual appraisals are at least taking place (as evidenced in information data) however; disappointingly many appraisers and appraisees see the process as a 'tick box exercise' pointing to a lack of follow up or genuine responsibility on the part of their line manager to support them on issues raised and documented.

Skills: the distinctive capabilities and competencies of people working for the organisation come under constant review, scrutiny and change due to either external factors e.g. NHS reforms or internal factors e.g. contract changes resulting in the need for many existing staff to take on new roles and responsibilities. The impact and acceptance of staff to these changes e.g. e-rostering are aligned to the speed at which they are implemented and this varies from role to role and grade to grade but all link directly back to two driving forces currently in place; the need to maintain and improve patient care and the need to implement cost savings.

Conclusion

Based on my findings and recommendations highlighted in Appendix 2 of this report under Continuous Improvement and supported by the latest Staff Survey Results 2015 there is clearly still much work to be done by way of organisational development though plans are in the process of being discussed and developed to achieve the organisation's vision and objectives best expressed to me by its CEO "*as a journey*". However, taking all areas into account recognising a high degree of commitment and dedication of its workforce I am satisfied that Calderdale and Huddersfield NHS Foundation Trust continue to meet the requirements of the Investors in People Standard. I also confirm based on evidence gathered against the whole of the Investors in People Framework that the organisation has met the necessary additional 'evidence requirements' (ERs) to meet the Investors in People Bronze Award. Bronze Award organisations have advanced in terms of using the framework to meet their goals, progressing beyond The Core Standard requirements. Confirmation of this achievement should be positioned as a positive 'good news' step towards meeting many strategic and operational challenges whilst recognising the need for the organisation to prioritise and address weaknesses in certain areas of people development in particular performance 'appraisal' management. Investors in People support organisations through change and further development in terms of applying the whole of the Investors in People Standard version 6 (launched September 2015) will assist the organisation progressing through higher performance levels over time e.g. Silver Award which will show it as a forward thinking and expansive approach to cascading best practice through every level of the organisation. It will demonstrate a progressive approach to organisational improvement through people. The Gold Award will represent achievement of world class best practice. It will show show a truly cutting-edge organisation operating at the very highest levels of people management practice using Investors in People to drive its ambition forward.

Acknowledgement

I would like to thank everyone involved in the planning and interview process especially Jason Eddleston – Deputy Director - Workforce and Organisational Development and Linda Cordingley – Executive Assistant to the Chief Executive in organising the review activity and the courtesy and hospitality offered throughout this review. I look forward to maintaining and developing our business relationship on an ongoing basis as agreed and assisting in supporting, facilitating, creating and maintaining a high commitment, high performance organisation.

A handwritten signature in black ink, appearing to read 'M. Wem', with a horizontal line underneath the name.

Mark Wem - Investors in People Specialist & idg Senior Associate

Strengths and Areas of Good Practice using the Framework

The following areas (listed for reference under the 10 Investors in People Indicators) were seen to work particularly well and viewed positively by those employees interviewed and /or supported by observed and/or documentary evidence. Where there is a direct correlation to your business objectives and Investors in People Indicators and/or Evidence Requirements this has been cross referenced and identified.

01 – Business Strategy –

The organisation has many business planning processes ensuring a high level of stakeholder involvement and engagement. *“There are many opportunities for us (Nurses) to contribute to established business planning processes such as through completing the NHS survey”.*

The Big Brief Meetings make direct reference to activities which support any one of its core values. *“I have noticed that wherever possible certain slides used in the Big Brief Presentations are directly linked to and align to our values”.*

02 – Learning & Development Strategy –

Various learning and development activities exist to support employee development linked to organisational priorities e.g. dealing with change through its Work Together Get Results Programme. *“I know that xx attended the workshop and they have used the tools they suggested to inform a more constructive and supportive team meeting. Our team have really noticed the improvement I that they are more constructive now”.*

03 – People Management Strategy –

Good use is made on online learning which ensure that all mandatory training is carried out which means employees feel a sense of being up to date and conforming to legislative and compliant approaches. *“The fact that we know it has to be done helps focus our minds in terms of we simply have to find the time to do them. It does mean though that all employees are aware of what we should be doing in term of meeting legislation and compliance”.*

04 – Leadership & Management Strategy –

Existing capabilities are defined within existing contracts, job descriptions and specifications and subject to review especially when there is a change in role requirements. *“Once my role changed we ensured that my job description mirrored what I would be doing in the future”.*

05 – Management Effectiveness –

Although this remains an area highlighted for development there were isolated but great examples of line managers/appraisers giving excellent balanced feedback to their direct reports via 1:1, team or appraisal meetings e.g. recognition of objectives achieved, going the extra mile, linking performance to organisational behaviours, career planning and secondment opportunities. *“My manager really values the opportunity to spend time in a structured way and I see that they have put a lot of time and effort in terms of preparation. As a result I think I put in as much effort as well”.*

06 – Recognition & Reward –

There were many examples cited by interviewees in terms of where the organisation recognises both team and individual achievements e.g. messages from the CE, approachability of directors, newsletters and emails and annual reporting.

The annual Celebrating Success Awards /Star Awards continue to be seen as effective ways to recognise and celebrate individual and team successes within the organisation. Long Service Award Ceremonies are also highly prized among those achieving 25 and 40 year service records. *“I think that with all the talk around cost cutting it was great that the CEO and other Directors saw the need in recognising individuals as well as teams”.*

07 – Involvement & Empowerment –

Overall employees appear truly committed to the organisation terms of what it is seeking to do. This is realised through results from its 2014 and 2015 NHS Survey Results.

08 – Learning & Development –

There were many examples where new members of staff were assigned a buddy or 'go to person' to assist in supporting them in their new role. It was felt that this enabled staff members to settle in more quickly, be reassured about what they were doing and individuals felt they were making a contribution far more quickly as a result. *"I (junior member of support staff) was buddied up with a team member who supported me directly through the first through weeks and remains a contact now should I need them. They were very encouraging and was someone I could turn to without feeling stupid in any way"*

09 – Performance Measurement –

Many of those interviewed who had attended the Work Together Get Results Programme cited examples where they saw changes in the approach of others who had attended e.g. Directors and Team Leaders and how they were applying the tools learnt. *"I have seen a real desire to remind us of how our vision and behaviours shape what we do and act as a constant reminder to what we should be doing"*.

10 – Continuous Improvement –

Results of previous NHS Surveys are looked at by a number of top level executives and also within departments to firstly understand then address areas for development. *"Following any feedback we sit down as a team and see what there can be done to address areas for improvement and come up with agreed actions. These are reviewed on an ongoing basis through team meetings"*.

Additional areas covered:

Health and Wellbeing -

Several approaches are now being recognised as to where the organisation is making attempts to promote, present and implement good practices in the area of health and wellbeing e.g. healthy food and living awareness events. Of particular note was the organisation's innovative approach to the Global Corporate Challenge (GCC) which produces impact data in terms of improvements to candidates' health and wellbeing. *"The GCC really gives us the quantifiable data to support positive approaches to the way we exercise, eat and drink"*.

Quality and Safety –

Overall employees interviewed felt that the health and safety of its employees was taken seriously and regular training takes place at both the induction stage and on an annual basis via mandatory online training. Most employees felt that the online training did remind them of the basics of good health and safety practice. *“Getting caught up with daily operational stuff having an annual refresher as to health and safety good practices act as a general reminder of what we all should be doing to make our sites safer”.*

Potential Areas for Development using the Framework

Although the organisation demonstrated that it continues to meet the National Standard the following areas were seen as worthy of consideration for improvement. These recommendations seek to challenge the organisation further so that real organisational benefits may be realised. These have been taken in context with aligning to your own business objectives and should help to inform decisions around finalising your Continuous Improvement Plan found at the end of this report.

01 – Business Strategy –

The opportunity to promote and present the organisation's business planning model and supporting processes to aid employee understanding, trust and openness is to be encouraged. *"I think many employees struggle to know how they can and do contribute to business planning process. A simple flow chart with timelines as to who does what and when would assist in terms of simplifying for them the start and end points of planning processes".*

02 – Learning & Development Strategy –

With such positive feedback obtained following the organisation's Work Together Get Results Programme the opportunity to 'scale up' ability to reach a wider audience is to be encouraged. *"I (Team Leader) wasn't even aware that the workshop existed. It sounds like a great idea and something that would really benefit our team".*

03 – People Management Strategy –

More work needs to be done in the area of ensuring that teams have the necessary resources to train and develop their staff. Expectations need to be managed through a more effective 1:1 and annual appraisal process with a greater focus on learning opportunities rather than training attendance. *"I constantly raise the desire to access more training and development but recognise that in reality I simply won't be released due to staffing shortages and delays in recruiting".*

More creative and innovative use of on line learning could be extended to leaders and managers e.g. annual subscription to the Investors in People Academy. *"I think I and my team knowing the work pressures should be*

able to access training, development and learning online. We simply don't make full use of the technology out there in this area".

04 – Leadership & Management Strategy –

More work needs to be evidenced to ensure that managers are reviewed against capabilities and that they are involved in defining the current and future capabilities required of leading and managing people in a high performance organisation. *"My review tends to focus on what I have done and not done without any reference to the way that I am supporting my team"*

Existing capabilities defined within existing contracts, job descriptions and specifications do not currently cover managers/ leaders responsibilities in relation to employee health and wellbeing. *"I really don't think as a manager (Team Leader) I have any responsibility in terms of promoting health and wellbeing to my team. That's an individual choice".*

05 – Management Effectiveness –

The quality of providing constructive feedback as part of organisational performance review processes (though mainly targeted at the annual appraisal process) should be seen as a key development priority. Currently there appears to be a high percentage of employees who under value this key support mechanism and as much effort should be placed on the quality of the appraisals undertaken as the volume of appraisals undertaken. Work should focus on appraiser as well as appraisee understanding to the role and responsibilities of both parties to gain the maximum benefit of what is fundamentally a key area of what contributes to be a high performance organisation. *"One main criticism of the appraisal process is that anything agreed is simply not followed up and seen simply as a tick box exercise". "In our team one of our colleagues (who has had no training and cannot authorise anything that has been agreed) took them on as our line manager said they were too busy and we haven't seen them since we moved into a new building. We use to have regular team meetings but we just muddle through as a team now and do the best we can".*

06 – Recognition & Reward –

Managers should be encouraged to understand and recognise what motivates their team members and teams and apply this understanding at every opportunity of employee engagement e.g. team and 1:1 meetings and appraisal reviews. *“It would make such a difference if just occasionally senior managers and/or directors would come and see what we are doing and take a genuine interest in our concerns”.*

07 – Involvement & Empowerment –

The opportunity wherever possible to free up employee time to ‘go see’ and get involved in other focus/working groups is to be encouraged and is by far the greatest way in terms of improving employee engagement. *“I suggested that I go and spend an hour or two in another team to understand why it was that aspects of the recruitment process were so slow to see if jointly we could speed up the process. I was told in no uncertain terms that I could not be spared so that was that”.*

08 – Learning & Development –

On the basis of the positive feedback obtained around the support that many new recruits receive from being assigned a buddy or ‘go to person’ any policy or process which ensures that this approach is carried out in every case and every grade is to be encouraged.

09 – Performance Measurement –

The opportunity to be more focused on determining the desired increase in performance expected e.g. quantitatively as a result of training approaches is to be encouraged. This will also ensure addressing those areas of the new Investors in People Standard Generation 6 Framework launched September 2015. *“At my appraisal we had a useful chat and agreed some objectives but nothing around when they should be achieved or how they would be measured. I knew that realistically the only time they would be talked about again is in a years’ time and the person new that they would be leaving”.*

10 – Continuous Improvement –

A number of teams/departments felt that although discussions take place post NHS Survey Results that any agreed resulting actions 'lost steam' over the time and prior to the next NHS Survey taking place. The opportunity to ensure that the 'foot is kept on the pedal' and resulting actions reviewed and implemented as agreed will strengthen this area. *"We agreed a number of actions some were implemented and some were not. Those that were quickly evaporated and reverted to how things were before".*

Additional areas covered:

Health and Wellbeing -

The opportunity to use a framework/standard on which to benchmark its approach to health and wellbeing would assist in improving this area. The Investors in People Health and Wellbeing provides such a framework and could be used effectively to raise the profile as well as impact on health and wellbeing initiatives. *"I think having a model on which to base what good practice looks like would be step in the right direction. I sense we are doing a lot but not sure what the full impact or return it is having on the organisation".*

Quality and Safety –

In only a few cases did employees not feel that health and safety issues were followed up. However, there were several cases where the outcomes of where Occupational Health was called in to carry out an audit employees were not aware of any resulting actions e.g. pre move of electronic patient records staff move into Acre House. A process needs to exist to ensure 'closing the loop' so employees are made aware of the outcomes of any Occupational Health interaction.

Additional Potential Areas for Development using specific areas of the whole Framework

01 – Business Strategy –

Any link made between the setting of individual objectives as part of any performance review (appraisal) process, team/group department objectives and organisational objectives will ensure greater alignment and therefore a focus (refer to Michael Beer's Alignment Model) to ensure that organisational objectives are achieved. (I1 – ER – 1)

Greater staff involvement/engagement would be gained through increased promotion of proven motivating approaches by employees being involved around the promotion and awareness of environmental, education or community approaches. This will support the organisation's approach to social responsibility. (I1 – ER – 10, 12, 16, 18, 22 & 25)

02 – Learning & Development Strategy –

Ensuring that all training, development and learning is planned and prioritised will strengthen this area. Making sure that all organisational, team and individual learning and development objectives are set and have a measure of evaluation and the expected impact defined will ensure a powerful tool in making sure that learning objectives are met. This will aid the evaluation and reporting of outcomes. (I2 – ER – 1 - 4)

03 – People Management Strategy –

Reviewing the way in which the organisation encourages ideas e.g. evaluating the approach it takes and measuring the impact of ideas generated will strengthen this area.

Due to the changes which have taken place consider the wider impact on the workforce and the 'resilience' needed at every level of the organisation to meet the long term aims of the organisation. Developing a structured 'health and wellbeing programme' would assist in ensuring that all employees are working both effectively and efficiently to ensure that these aims are met. The 'business case' for such an approach is well documented e.g. return on investment (ROI) and due to the organisational benefits worthy of such strategic

consideration. One easy way to improve wellbeing is to ensure that all employees are given the opportunity to work flexibly. The opportunity to review the extent to which this is possible for all work groups is to be recommended. (I3 – ER – 8, 13,16 & 24 linked with I1 – ER – 12,16 & 22)

04 – Leadership & Management Strategy –

A clear programme of leadership and management at each stage of a manager's development e.g. developing skills around coaching and mentoring will ensure that capability and capacity is built into the management of the organisation but integrated into the wider capability of the whole organisation thus contributing towards any succession planning. (I4 – ER – 1 - 3)

05 – Management Effectiveness –

Ensuring that employees and/or managers are developed in line with working towards coaching qualifications e.g. ILM's certification in Coaching and Mentoring in management would raise the profile as well as ensure that this approach is effective. Priority should be given as to how the organisation identifies and mentors future leaders. This should also consider and predict 'top talent' at risk of leaving the organisation. (I5 – ER – 8, 12 & 25 linked to I8 – ER – 7 & 20)

06 – Recognition & Reward –

Developing a more explicit Recognition and Reward Strategy designed to motivate all employees would develop the informal and formal processes currently in place. This should be linked to the organisations overall business strategy and plan and feedback gathered as to its effectiveness e.g. through staff surveys. It is strongly recommended that managers and employees be involved through consultation in development of such as strategy. (I6 – ER – 4 - 19)

07 – Involvement & Empowerment –

Encouraging all employees to be involved in some capacity e.g. contributing to focus or working groups will ensure that employees feel valued and appreciated on an ongoing basis.

More organisations are now looking at Social Media communications in a structured way as an opportunity to share and communicate knowledge and information. (I7 – ER – 5)

08 – Learning & Development –

Ensuring that all Induction and Re-induction processes are reviewed regularly e.g. by asking recent recruits about the effectiveness of the approach taken will ensure that all new recruits and/or those new to a role or following a period of absence contribute quickly and efficiently to the operations of the business.

Ensuring that all managers are provided with the skills to carry out mentoring effectively and promote this internally (ensuring that mentoring opportunities are available) within the organisation will seek to address this area. All too often some managers and employees are confused about the difference between managing, coaching and mentoring. Coaching is primarily about performance and the development of specific skills whilst mentoring is normally more broadly based and intuitive. It should focus on developing capabilities (defined by the organisation) and typically may involve the agreement of career planning either within or outside of the organisation. (I8 – ER – 7 & 20)

Encouraging the use of individual Continuing Professional Development (CPD) plans for all employees could support the approach that all employees take more responsibility for their own training, development and learning. This would help support create a 'culture of learning' within the organisation but also a part of an employee's career. (I8 – ER – 4-20)

09 – Performance Measurement –

Providing all employees with a constant update on training, development and learning activities will assist in raising the profile of learning on an ongoing basis.

Evaluation methods currently in use appear fairly basic providing only limited feedback in terms of any return on investment (ROI). Wider consideration of evaluation measures could include references to maintaining compliance, increase on workforce core skills, impact on competitive advantage, L & D effectiveness to reduce costs of internal/external training, comparisons ROI through using different training and development programmes. Applying Kirkpatrick's Learning and Training Evaluation Model would provide a wider structure in which to ensure that learning and training outcomes are captured at the individual, team and organisational level covering aspects and/or changes in knowledge, capability, behaviour and business performance overall.

Any evaluation should take a balanced view in terms 'learning what contributed to success is far more important than learning from failure'. (I9 – ER – 6-14)

10 – Continuous Improvement –

Ensure that outcomes and successes in terms of training, development and learning are communicated to all employees. This will assist and strengthen the organisation's resolve in terms of evidencing the impact of its investment in people to business performance.

The organisation may also wish to promote the 'Investors in People App' to employees to promote their understanding of the principles of Investors In People which you as an organisation are meeting.

Consider an annual license to access the Investors in People Academy as an online resource/learning platform that provides leaders, managers and those showing high potential with an extensive collection of videos, tools, events, books and on the job resources targeting essential leadership and management skills.

Questions and Responses

As part of the review process the organisation in discussion with the Investors in People Practitioner agreed to undertake asking a number of specific questions to interviews when and where appropriate. Those questions and a summary (collation/conclusion of responses received from those interviewed) are provided below which should also seek to inform aspects as to how the organisation takes the recommendations forward as part of its Continuous Improvement Plan. These will be discussed in more detail as part of the Investors in People Feedback Meeting.

What would make for a more effective approach to change management?

Greater inclusion and engagement activity of employees prior to key decisions taking place.

All employees gaining and insight into the behaviours associated with change management.

A rationale given to all employees behind major changes.

Employees being involved in the change rather than a feeling of 'having it done to them'.

Team Meetings take place as planned to aid regular organisational updates.

What do you understand as the Trust's vision for the future?

Patient care. Patient focus, putting yourself in the place of the patient.

Is it a vision or mission statement?

What would lead you to believe that you were part of that vision?

All employees living and demonstrating the values/behaviours which are defined.

That we are making progress and are delivering against that vision.

What examples do you have of providing compassionate care in your workplace?

Employees doing things outside of what they would normally be associated with in terms of doing their job.

What opportunities have you had to change things in your workplace?

Examples included changes to processes, procedures (within their remit), and input (in some cases) into recruitment decisions.

How could the Trust support you when changes are needed in your work area?

More time and opportunity to provide input.

Have employees come up with the solutions to make changes work.

How are you recognised for the contribution you make to your job?

Note from Investors in People Practitioner – this varied tremendously dependent on the skill and expertise of their line manager, the culture of the team/department and the ‘visibility’ of their Director. People felt a far higher level of contribution and recognition was needed as part of carrying out appraisals and team meetings effectively.

What evidence have you seen at work of staff demonstrating our behaviours – “putting the patient first”, “doing the must-do’s”, “working together”, “going to see what others are doing”?

For discussion with the Investors in People Specialist.

Appendix - 1

Investors in People Visual Guide of Evidence Requirements (ERs) Met

Appendix 1 - Investors in People Indicators										
ER	1	2	3	4	5	6	7	8	9	10
1										
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29										
Sub total	20	4	7	3	4	8	11	3	5	7
TOTAL										72

Appendix 2 – Investors in People Continuous Improvement (CI) Plan

Based on my recommendations on Areas for Development at the beginning of this report which support 'high commitment high performance' working practices this plan provides an outline of those areas which may form the focus as 'a map' for 'transforming performance leading to sustainable business improvement'. It is therefore recommended that development of this plan form the basis of further discussion and agreement as to who will take responsibility for the actions and when they are to be completed. This will ensure that the changes we have agreed need to take place can become realised over time. This will be discussed in detail as part of the Feedback Meeting planned to take place 16th December 2015 @ 10.30-12.00pm and finalised at the Continuous Improvement Meeting planned to take place April 2016 (date and time tbc).

Key Information

Organisation	Calderdale and Huddersfield NHS Foundation Trust	Date of last assessment/review	2013

Key Contacts as from January 2016

Client Key Contact	Linda Cordingley	E	Linda.cordingley@cht.nhs.uk	T	01484 355999
Investors in People Assessor & idg Senior Associate	Mark Wem	E	mark.wem@wemconsulting.co.uk	T	01904 471008
Investors in People Adviser	Julia Stokes	E	julia.stokes@btinternet.com	T	01484 544006
Investors in People North of England Client Services Adviser	Sara Barrie	E	SBarrie@iipnorth.co.uk	T	01423 229669
Investors in People North of England Centre Contact Details	idg 01423 – 229669 (T)				

C. Future Activity (to be agreed/ agreed)

Business Challenge <u>What</u> are the issues?	Required Change <u>How</u> do we address them?	Organisation <u>Why</u> do we need to address them and what measurement or impact will this have?	Suggested <u>When</u> do we need to have actioned this?	Support Required <u>Who</u> will be responsible for ensuring the action has been taken and is effective?
Strategically - The areas noted for discussion at the feedback meeting will include the need to RAiSE the game in the following areas: R – Recruitment (effectiveness/becoming an employer of choice) A – Appraisal (quality of meeting and follow up) i– Individual (Responsibility, Authority, Commitment in relation to team communications, appraisal and recognition) S – Strategy (Organisational development, learning & development and training & development) E –Evaluation (High Level Organisational reporting on ROI and impact/HR Metrics due to training, development and learning opportunities)	For discussion at the Feedback Meeting: Plan/Prioritise Timescales Ongoing support – Investors in People Adviser Employee Involvement	For discussion at the Feedback Meeting: Agree HR Metrics Staged assessment to marinating Investors in People accreditation. Aspire to achieve Investors in People Silver/Gold Award as a Benchmark of High Performance working by 2018.	High, Medium, Low High - by date	Person/Persons/Team

Operationally - The areas noted for discussion at the feedback meeting will include:	To transform and improve performance the organisation will need to consider the following:	People will support what they help to create and therefore will need to consider the following:		
Not all employees have an understanding of the business planning process.	Sharing aspects of the business planning model and supporting processes and timelines. This could be addressed by being presented on its Intranet and/or Newsletters will aid employee understanding as to how they may and do contribute to its formation.	Addressing this area will assist appraisers and appraises in terms of linking individual, team and organisational objectives. It will also seek to help employees understand how they do contribute towards the business planning process.	High, Medium, Low	Person/Persons/Team
Not all employees are aware of the Big Brief Meetings.	Ensure that all employees are invited to attend and that teams delegate staff to attend on a rolling basis and asked to provide feedback following each of the meetings through team meeting processes.	More staff would gain a more strategic understanding of organisational developments, leading to greater awareness, understanding and inclusion. This would also lead to a perception of higher staff inclusion and engagement in team/department developments.	High, Medium, Low	Person/Persons/Team

Not all employees can articulate or provide examples as to how they are living and breathing the organisation's core values.	By encouraging individual and team discussions e.g. through team meetings will help to articulate how employees are contributing to the values on a daily and weekly basis.	Such an approach will again raise the profile of all team members' contribution to the organisation by reflecting on their associated behaviours.	High, Medium, Low	Person/Persons/Team
For too long employees have not seen any value in terms of the appraisal process in place.	There needs to be a greater focus in terms of appraisals not just being done but done well! Areas needing to be addressed to address this area include: • Ensuring that those responsible for completing them have the relevant authority to progress matters raised. • Appraisers have training in performance management. • All appraisals are followed up within an agreed period of time but within 12 months of any future appraisal. • Development needs are identified and collated leading to appropriate action taking place by way of training, development and/or learning. • The opportunity to reflect on values and behaviours associated	Such an approach will ensure that performance management is seen as a cultural value rather than simply an operational process.	High, Medium, Low	Person/Persons/Team

	- with their role/job task. - For leaders and managers their ability to lead teams of people effectively which would highlight their ability in being good role models, communicate effectively and ensuring that performance review processes are carried out effectively.			

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The Standard for People Management

An introduction



The Investors in People Standard

Based on 25 years of leading practice, the Investors in People framework sets out the criteria to achieve the Investors in People Standard.

The standard for people management has evolved to keep pace with modern practices. The current sixth generation was launched internationally in 2015.

The framework reflects the latest workplace trends, leading practices and employee conditions required to create outperforming teams. The framework is constantly updated and reviewed by world leading academics, practitioners and industry experts to equip you with the ingredients of success.

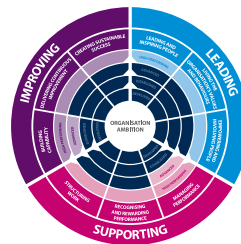


Achieving award levels



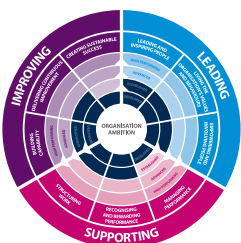
Investors in People Accredited

All nine indicators at 'Developed' level.



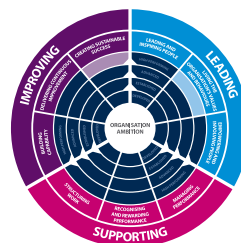
Investors in People Gold

All nine indicators at 'Developed' and 'Established' and seven of the nine indicators at 'Advanced' level.



Investors in People Silver

All nine indicators at 'Developed' and seven of the nine indicators at 'Established' level.



Investors in People Platinum

All nine indicators at 'Developed', 'Established' and 'Advanced' and seven of the nine indicators at 'High Performing' level.

NB The assessment criteria selected in the images above are for illustrative purposes only. They are not the specific indicators required for the performance level criteria.

It's the ingredients for higher performance

You won't find processes, policies or paperwork. You will find easily understandable principles for outperformance.

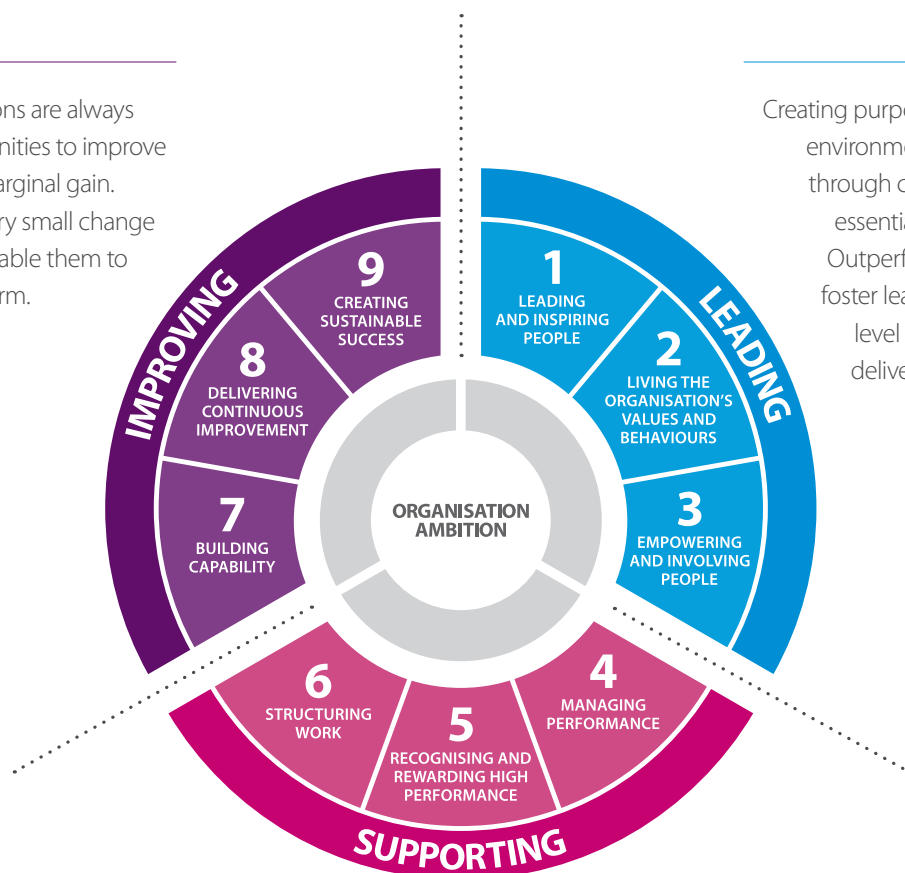
It's a simple roadmap for excellence in any industry. The framework is structured around 9 indicators which are organised under 3 clear headings. It's simple to understand and easy to follow.

Improving

The best organisations are always looking for opportunities to improve by seeking every marginal gain. They know that every small change adds together to enable them to constantly outperform.

Leading

Creating purpose in a fast changing environment, whilst motivating through change, have become essential skills for many roles. Outperforming organisations foster leadership skills at every level of the organisation to deliver outstanding results.



Supporting

Successful organisations are moving towards flatter structures to enable faster decision-making, customer focus and agility. Reduced overheads, better service for customers and more successful organisations are the benefits of this approach.

Your performance roadmap

Organisations that outperform others understand that high performance is a journey not an event. It requires a commitment to improvement and excellence. Constantly measuring. Constantly improving.

Underpinning each of the nine indicators is the Investors in People performance model. Each level from '**Developed**' to '**High Performing**' describes the practices and outcomes required for higher performance and higher accreditation.

Based on extensive research into the features of organisations that consistently outperform their peers, the Investors in People performance model creates a roadmap for continuous improvement, and a benchmark to strive for.

Each of the nine indicators build through four levels of performance.
Example: Indicator 1

1 Leading and inspiring people

Leaders make the organisation's objectives clear. They inspire and motivate people to deliver against these objectives and are trusted by people in the organisation.



Themes	<i>Developed</i> <i>In place and understood</i>	<i>Established</i> <i>Engaging and activating</i>	<i>Advanced</i> <i>Creating positive outcomes</i>	<i>High Performing</i> <i>Embedded and always Improving</i>
Creating transparency and trust	Leaders provide clarity around the organisation's purpose, vision and objectives	There is clear and regular two way communication between leaders and people at all levels	Leaders ensure that there is a consistent level of trust at all levels of the organisation	Leaders are active role models, leading by example and trusted by people in the organisation
Motivating people to deliver the organisation's objectives	People understand the organisation's objectives	Line managers support people to deliver the organisation's objectives	Leaders are passionate about delivering the organisation's objectives and motivating people to deliver against them	Leaders motivate and inspire people to achieve results above and beyond what is expected of them
Developing leadership capability	Line managers know what is expected of them to lead, manage and develop their people effectively	People know what to expect from their line manager and provide feedback on how they are managed and developed	People have confidence in the leadership and management capabilities within the organisation	Future leadership capabilities are defined in line with the organisation's values and leaders meet these challenges

Approved Minute

Cover Sheet

Meeting: Board of Directors	Report Author: Kathy Bray, Board Secretary
Date: Thursday, 25th February 2016	Sponsoring Director: Victoria Pickles, Company Secretary
Title and brief summary: UPDATE FROM SUB-COMMITTEES AND RECEIPT OF MINUTES - The Board is asked to receive and note the updates from Sub Committees and Receipt of Minutes.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Sub Committees as appropriate	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive, note and approve the following:-

- a. Quality Committee - verbal update from meeting 23.2.16 and minutes from 26.1.16
- b. Finance and Performance Committee - verbal update from meeting 23.2.16 and minutes of 26.1.16
- c. Audit and Risk Committee - minutes from meeting - 20.1.16

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive, note and approve the following:-

- a. Quality Committee - verbal update from meeting 23.2.16 and minutes from 26.1.16
- b. Finance and Performance Committee - verbal update from meeting 23.2.16 and minutes of 26.1.16
- c. Audit and Risk Committee - minutes from meeting - 20.1.16

Appendix

Attachment:

COMBINED SUB CTTEE MINS.pdf

**Minutes of the Quality Committee held on
Tuesday 26 January 2016 in Discussion Room 2, Learning and Development Centre,
Huddersfield Royal Infirmary**

PRESENT

David Birkenhead	Medical Director
Julie Dawes	Executive Director of Nursing
Lesley Hill	Executive Director of Planning, Performance, Estates and Facilities
Juliette Cosgrove	Assistant Director of Quality
Lynn Moore	membership Council Representative
Martin DeBono	Divisional Director, FSS Division
Sal Uka	Divisional Director, 7 Day Service/Hospital at Night

ALSO PRESENT

Stephanie Jones	Committee Secretary/PA to Director of Nursing
Saj Azeb	Assistant Divisional Director, Medical Division
Nicola Vallance	Clinical Governance Support Manager
Victor Wotherspoon	Chief Medical Engineer
Jayne Blakey	Medical Devices Training Co-ordinator

ITEM																													
001/16	<u>WELCOME AND INTRODUCTIONS</u> The Medical Director took position of the Chair in the absence of the Chair. It was noted that the meeting was not quorate as there was no chair or vice-chair present.																												
002/16	<u>APOLOGIES</u> <table> <tr> <td>Anne-Marie Henshaw</td><td>Associate Nurse Director/Head of Midwifery, FSS Division</td></tr> <tr> <td>Diane Catlow</td><td>Interim Associate Nurse Director, Community Services</td></tr> <tr> <td>Helen Barker</td><td>Chief Operating Officer</td></tr> <tr> <td>Jackie Murphy</td><td>Deputy Director of Nursing, Modernisation</td></tr> <tr> <td>Jason Eddleston</td><td>Deputy Director of Workforce and Organisational Development</td></tr> <tr> <td>Jeremy Pease</td><td>Non-Executive Director / Committee Chair</td></tr> <tr> <td>Joanne Middleton</td><td>Associate Nurse Director, Surgery and Anaesthetic Services</td></tr> <tr> <td>Julie O'Riordan</td><td>Divisional Director, Surgery and Anaesthetic Services</td></tr> <tr> <td>Keith Griffiths</td><td>Executive Director of Finance</td></tr> <tr> <td>Kirsty Archer</td><td>Deputy Director of Finance</td></tr> <tr> <td>Lindsay Rudge</td><td>Deputy Director of Nursing</td></tr> <tr> <td>Stuart Baron</td><td>Deputy Director of Finance</td></tr> <tr> <td>Tracy Fennell</td><td>Associate Nurse Director, Medical Division</td></tr> <tr> <td>Victoria Pickles</td><td>Company Secretary</td></tr> </table>	Anne-Marie Henshaw	Associate Nurse Director/Head of Midwifery, FSS Division	Diane Catlow	Interim Associate Nurse Director, Community Services	Helen Barker	Chief Operating Officer	Jackie Murphy	Deputy Director of Nursing, Modernisation	Jason Eddleston	Deputy Director of Workforce and Organisational Development	Jeremy Pease	Non-Executive Director / Committee Chair	Joanne Middleton	Associate Nurse Director, Surgery and Anaesthetic Services	Julie O'Riordan	Divisional Director, Surgery and Anaesthetic Services	Keith Griffiths	Executive Director of Finance	Kirsty Archer	Deputy Director of Finance	Lindsay Rudge	Deputy Director of Nursing	Stuart Baron	Deputy Director of Finance	Tracy Fennell	Associate Nurse Director, Medical Division	Victoria Pickles	Company Secretary
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003/16	<u>DECLARATIONS OF INTEREST</u> There were no declarations of interest.																												

004/16	<u>MINUTES OF THE LAST MEETING</u> The minutes of the last meeting, held on 15 December 2015, were approved as a correct record.
005/16	<u>ACTION LOG</u> All items on the action log due this month were agenda items under Matters Arising.
MATTERS ARISING / MAIN AGENDA ITEMS	
006/16	<u>REPORT ON MEDICAL DEVICES DEPARTMENT</u> Following a request by the Patient Safety Group, the Chief Medical Engineer, Victor Wotherspoon was in attendance to update the Committee on the workings of the Medical Devices Department further to concerns raised in relation to a number of areas. The following highlights were noted from the report: <u>Medical Device Training:</u> Performance in relation to medical device training continues to be a concern with staff being unable to be released from clinical areas due to capacity. Despite this an improvement in performance was noted for December 2015 from 76% to 77% compliance. Ward sisters and team leaders receive medical device data and have access to the medical devices database that details the training their staff have undertaken and also allows them to amend the data in order to reflect the most up to date position. The Medical Director asked that immediate action be taken to ensure staff are undertaking their training ACTION: • Medical Devices department to provide Assistant Divisional Directors (ADDs) with a list of those nurses, midwives and therapists who need to undertake their training. • Medical Devices department to provide Divisional Directors (DDs) with a list of medical staff that need to undertake their training. • The Director of Planning, Performance, Estate and Facilities to have oversight of the above. <u>Medical Equipment Replacement Programme:</u> The capital asset verification process takes place annually and is used by the Divisions to identify which equipment they still have in use and which equipment, based on age potential, requires replacement. The main area of equipment replacement is clinical equipment. In 2015-16 £1M was ring-fenced. The plan for 2016-17 is currently under discussion. The monitoring of equipment is carried out via various methods ranging from proactive audits, planned preventative maintenance (PPM) and inspections reactive to incidents. The key performance indicators for the planned preventative maintenance showed that 35.47% of PPMs on hi risk medical devices were non-compliant, which was noted to be a concern. The Medical Director queried whether we are in a position of knowing exactly what equipment needs to be replaced and a plan of how much it will cost. The Director for Planning, Performance, Estate and Facilities confirmed they are working towards this but it will take some time before it is fully complete. OUTCOME: The Committee RECEIVED and NOTED the content of the report and agreed to escalate the concerns to the Board of Directors meeting in January 2016.

007/16	<u>EMERGENCY PREPAREDNESS, RESILIENCE AND REPOSE (EPRR) POLICY</u> The Director for Planning, Performance, Estates and Facilities reported that the questions raised at the last Committee meeting had been addressed and approved at the Weekly Executive Board (WEB) at its meeting in December 2015 and no further action was required by the Committee. OUTCOME: The Policy was approved at the Weekly Executive Board (WEB) in December 2015.
008/16	<u>NICE COMPLIANCE</u> The Assistant Director of Quality presented a report to update the Committee on the current position in relation to the Trust's compliance with NICE guidelines. Further work is being undertaken to ensure that NICE guidelines working towards full compliance are regularly reviewed and that non-compliance guidelines are validated. A snapshot audit for two NICE guidelines were also reviewed and the results were detailed within the report, which gave assurance that compliance is being sustained. Progress with reviewing the guidelines is ongoing and currently stands at two thirds of the way through. The Divisional Director for FSS Division feels confident that for those guidelines that have been reviewed there is evidence to support how compliance has moved from non-compliant to compliant or for cases still non-compliant what action has been taken and documented to mitigate the risk. Routine audits have been put in place to review compliant guidelines to ensure compliance is sustained. The Chair commented that all 14 non-compliant should be reviewed and added to Divisional risk registers where required. OUTCOME: The Committee RECEIVED and NOTED the report and the progress made to date.
009/16	<u>REGULATION 28 LETTER FROM HMC (SURGICAL DIVISION)</u> An action plan was presented in response to a new Regulation 28 letter from H M Coroner received in December 2015. The case related to a surgical patient in our care who had a sudden deterioration in their condition which required acute intervention and insertion of a central venous line. The patient continued to decline and despite further medical intervention sadly died. The action plan was reviewed by the Committee and it was agreed that further work should be done to ensure it reflects the concerns raised by H M Coroner. ACTION: Action Plan to be reviewed and re-written to reflect the concerns raised in the letter. Assistant Director of Quality to liaise with Associate Director of Nursing for Surgery and Anaesthetics. OUTCOME: The Committee RECEIVED and NOTED the report.

010/16	<u>REGULATION 28 LETTER FROM HMC (MEDICAL DIVISION)</u> The Committee received an update on the Regulation 28 letter which the Trust had received following the death of a patient who had suffered a fall on a medical ward. The action plan highlighted in red the progress made since the last report. ACTION: The Committee requested the original letter from H M Coroner be reviewed to ensure all the concerns raised are addressed within the action plan. It was requested that when the action plan is re-submitted to the Committee for final approval it should include the original letter from H M Coroner so the two can be reviewed together.
011/16	<u>SAFEGUARDING COMMITTEE TERMS OF REFERENCE</u> The Director of Nursing informed the Committee that the responsibilities of the Safeguarding Group have transferred to the Quality Committee from the Patient Safety Group. Quarterly reports would be provided to the Committee with the first being received in March 2016. Two meetings of the newly formed group had been held to date. OUTCOME: The Committee RECEIVED the terms of reference for the Safeguarding Group, but as the meeting was not quorate, it was agreed that they should be emailed out to all members for approval. ACTION: 1. Committee Secretary to email out to members for approval. 2. Safeguarding Group lead (Vicky Thersby) to submit quarterly reports to the Committee with the first to be received in March 2016. <u>INFECTION CONTROL COMMITTEE</u> The Director of Nursing reported that responsibility of the Infection Control Committee will also transfer over from the Patient Safety Group to the Quality Committee. Reports will be submitted quarterly with the first due February 2016. ACTION: Committee Secretary to request quarterly Infection Control reports from the Senior Infection Control Nurse.
012/16	<u>RESEARCH AND DEVELOPMENT SIX MONTHLY REPORT</u> The Medical Director presented the six-monthly report on Research and Development. Since 1st April 2014 Sheffield Teaching Hospitals NHS Trust has been the host for the Yorkshire and Humber Clinical Research Network of which CHFT is a Partner Organisation and is contractually bound to undertake and deliver research adopted by the National Institute for Health Research. In April 2015 the Trust was allocated research support funding for 2015/16 at £753,730 from the Y&HCRN. This is a reduction in income of 11% from 2014/15. The Trust's recruitment target for 2015/16, set by Y&HCRN, is 1,100. At the end of December 2015 the Trust research portfolio had achieved 58% of its 1,100. A further 42% is required by the end of March 2016. Should the Trust fail to achieve the target this will result in a reduction of research funding up to 11% for 2016/17. It was reported there had been a change in the nursing staffing infrastructure within the

	Research and Development Department and a lead nurse had been appointed. It was expected the December figure for recruitment would improve and it is hoped some new studies currently under review will provide some high recruiting numbers over the coming months. The Director of Nursing suggested that the next report to the Committee incorporates the work of Felicity Astin, Professor of Nursing and Applied Health Research, as she has made good progress in a number of areas. The Terms of Reference for the Research and Innovation Committee were presented as an Appendix, which the Committee were asked to approve. As the Committee was not quorate the Terms of Reference would be emailed to all members for final approval. ACTION: 1. Committee Secretary to email out the Research and Innovation Committee Terms of Reference to the Committee for formal approval. 2. Next Research and Development report to include the work of Felicity Astin. OUTCOME: The Committee RECEIVED and NOTED the content of the report.
013/16	<u>VISIBLE LEADERSHIP: PROCESS AND OUTCOME OF FIRST VISITS</u> The Committee received a report on The Visible Leadership Programme that was introduced in October 2015 to strengthen the programme of the Executive and Non-Executive clinical governance visits that had previously been in place. The Visible Leadership programme is built around the four pillars of behaviour that we mandate across the Trust. The report describes the three methodologies that the visits are based upon. Since the commencement of the Visible Leadership Programme, seven Leadership Programme/Clinical Assurance visits have taken place involving 20 members of Executive and Non-Executive Staff and on occasions have involved appropriate external experts. Following the visits a summary report is provided and shared for learning and action. ACTION: Visible Leadership reports to be received quarterly going forward with the next report due in April 2016. OUTCOME: The Committee RECEIVED and NOTED the content of the report.
014/16	<u>REPORT ON WARD PLACED IN SPECIAL MEASURES</u> A report was presented to update on the two wards placed in Special Measures. The report, which includes ward metrics, gives the Committee an overview of the supportive measures being implemented within the two wards, which had been highlighted as requiring additional support to improve the quality of care. The report identifies key areas for each of the wards and the supportive actions that have been put in place to support the improvement required. The complex care ward is being closely monitored by the senior team on a weekly basis. The second ward has now stepped down from weekly support following improvements made, but will continue to remain on monthly reporting to ensure the improvements are sustained.

	<u>Questions raised by the Committee:</u> Q1 (Martin DeBono): Has the junior medical support improved on ward 5AD? A1 (Saj Azeb): Consultant support has improved, but would need to check with Rob Moisey in relation to junior medical support and will respond accordingly. OUTCOME: The Committee RECEIVED and NOTED the report and the working ongoing to improve care.
015/16	<u>EMERGENCY SERVICES DEPARTMENT QUARTER REPORT 2015/16</u> The Assistant Divisional Director for Medicine presented an update against the Emergency Department key quality performance indicators for Q3 2015/16 In Q3 the Trust has seen an overall increase in attendances of 410 patients in comparison to the same period in 2014/15. The A&E 4 hour target was a challenge for the Trust but was delivered at 95.08% against a target of 95%. The time to initial assessment performance is currently off track at 19mins against a target of 15 minutes. This is closely being monitored by the Emergency Department matron. This target is reliant upon having empty cubicles to receive patients into. Patients spending longer than 6 hours in the Emergency Department: since the last report to the Committee the Clinical Director for Emergency Medicine has undertaken a snap shot audit of six weeks of attendances. During this time a combined total of 15,434 attendances were received of which 305 patients (1.98%) spent longer than six hours in the Emergency Department. The main contributors to the delay are patients awaiting medical beds and major delays in the Emergency Department. The Length of Stay (LoS) group will focus on creating sufficient bed capacity, early morning discharges and utilisation rates of the discharge lounge to try and address the common causes. Matrons visit all patients who have experience a six hour wait to apologise for the poor patient experience and ensure no harm has come to the patient. CQUIN: The two CQUINS applicable to the Emergency Department for the financial year 2015/16 were both achieved for Q3 2015/16. Patient Experience: The department currently has 18 open complaints which has seen an improvement from the last report to the Committee which showed 23 open complaints. Work is ongoing to ensure the longest waiting complaints are investigated, tracked on a weekly basis and closed down. Friends and Family Test (FFT): performance for December 2015 shows a response rate of 9% against a target of 14%. 84% would recommend to a family or friend. The response rate has improved following the introduction of text messaging system, but still remains below the target. A Patient Experience Group has been established and work will be focussed on identifying further areas of improvement in order to increase the response rate. Patient Flow: The Length of Stay programme has undertaken detailed work to ensure timely patient flow through the hospital; this has included working with Four Eyes to ensure wider multi-disciplinary (medical) involvement in board rounds. The planning for 2016/17 programme is also complete, which reflects a change in structure to support larger transformation projects. The key areas of focus for patient flow will be against the following metrics: - % daily discharge pre 12noon (current performance at 20% against a target of 40%) - Green cross patients (snapshot in month show 79 against target of 40) - Number of ward moves (% of patients with >2 moves – 2.34% against target of 2%)

	Further action will be required to ensure these targets are reached and a number of new approaches are being tested to help improve performance. A discharge matron has been appointed and came into post in November 2015 who will work closely with the wards and partner organisations to aid the discharge process. A transfer of care list has been developed which captures all the reasons why a patient's discharge has been delayed. This is then discussed at the System Resilience Group to ensure there is system wide ownership of the pressures currently being faced. <u>Questions raised by the Committee:</u> Q1 (Sal Uka): Do our staffing models reflect the pattern of activity in the Emergency Departments? A1 (Saj Azeb): Not on a particular day of the week, however staffing does reflect by hour as shifts start at different times to support the busier periods. From Monday to Thursday 5pm - 8pm there is consultant presence on ambulatory. Q2 (Juliette Cosgrove): It is good to see that Matrons are visiting patients that have experience longer than six hours in A&E, but how confident are we that this is being followed through? A2 (Saj Azeb): Quite confident that this is being actioned, however not sure whether this visit is formally being documented. Q3 (Juliette Cosgrove): Sepsis CQUIN is not included and can this be included in the next report due in April 2016 OUTCOME: The Committee RECEIVED and NOTED the content of the report. The chair acknowledged the good work undertaken since the last report. ACTION: Next Emergency Services Department report due April 2016 to include update on sepsis CQUIN.
016/16	<u>QUALITY REPORT FOR Q3 2015/16</u> The Assistant Director for Quality presented the Quality Report for Q3 2015/16. The report is structured into the five Care Quality Standard domains, which each section having a summary providing an overview of compliance with each indicator and highlights. The highlights from the report were noted to be: <u>Effective:</u> • SHMI remains the same at 109 and it anticipated this figure will rise • Harm falls performance is in breach of the internal target. At the end of Q3 there were 21 falls against a year end target of 14. <u>Patient Safety</u> • The Q3 trajectory for pressure ulcers was not achieved and it is unlikely to meet the year end internal target. <u>Experience</u> • Friends and Family Test (FFT): some areas are performing better than others, but A&E response rates require improvement <u>Effectiveness</u> • 3 out of the 4 main infections remain above the end of Q3 trajectory

	<u>Well Led</u> Completion for appraisal target was not met for Q3 OUTCOME: The Committee RECEIVED and NOTED the report.

CQC PREPARATION AND ACTION PLAN	
017/16	<u>CQC REPORT</u> The Assistant Director of Quality presented the action plan for the CHFT Care Quality Committee Inspection, which is moving into the final phase of preparation ahead of the inspection on 8th to 15th March 2016. Although much work and progress has been made in preparation for the inspection there still remains a number of concerns: - Number of KLE were not visible to the Trust - Medical, nursing and therapy staff will be KLE; planned and actual and what action we are taking. Some work has been done in relation to nursing, but work required to be done in relation to therapy and medical - Training and education; cannot articulate and demonstrate a central system for recording mandatory training – safeguarding a particular issue. - Safeguarding; some staff unable to clearly articulate DoLs and MCA - Incident reporting and responsiveness; large backlog of incidents to investigate. Weekly walk-rounds to wards, clinical areas and departments have been in place since the beginning of January. Issues highlighted from these walk-rounds are addressed and dealt with promptly. Despite the concerns, feedback from the walk-rounds show that patients are happy with the care they are experiencing and many positive comments have been received. The main areas of focus were discussed going forward and the Divisions were asked to ensure staff are completing their mandatory training. For those areas that the Trust will not be complete on we need to ensure we can clearly articulate that we have a plan in place supported with a timeline. OUTCOME: The Committee RECEIVED the report and NOTED the concerns raised.
RESPONSIVE	
018/16	<u>INTEGRATED QUALITY AND PERFORMANCE REPORT</u> OUTCOME: The Integrated Quality and Performance Report was RECEIVED by the Committee and it was agreed that it will be discussed in detail at the Board of Directors meeting on 28 January 2016.
SAFETY	
019/16	<u>SERIOUS INCIDENT REGISTER</u> The Director of Nursing presented the Serious Incident report which summarised the position regarding serious incidents as at 31 December 2016.

	As at 31 December there were 17 serious incidents (non-pressure ulcers); 5 of these were not completed within the timescale. Additional support for the team has been put in place with an interim Risk Management Lead that will support the Divisions and a further member of staff will commence in March who will also focus on investigations. It is hoped the additional support and the actions outlined within the report would lead to an improved position. Shared learning continues to take place across the Trust and an example of a serious incident in the FSS Division was shared. OUTCOME: The Committee NOTED the report and RECEIVED ASSURANCE that the necessary action had been put in place to deal with serious incidents more timely.
020/16	<u>REPORT FROM THE PATIENT SAFETY GROUP</u> The Director of Nursing presented an update from the Patient Safety Group following the last meeting held on 7 January 2016. The group continues to monitor safety across the Trust and the following was highlighted from the meeting which required escalation to the Committee; Medical Devices: The group received a report at its meeting in January 2016 from the lead for Medical Devices. Concern was raised in a number of areas, particularly around medical device training and Planned Preventative Maintenance (PPM) and the risks to the Trust. The concerns were asked to be escalated to the Committee and a detail report was commissioned which the Committee received earlier in the meeting. The minutes from the meeting on 7 January 2016 were attached for information. OUTCOME: The Committee RECEIVED and NOTED the update report.
COMPLIANCE	
021/16	<u>RISK REGISTER (CORPORATE)</u> The Director of Nursing presented the Risk Register. The Risk and Compliance Group had considered the Corporate Risk Register at its meeting on 12 January 2016. The Register identified 19 risks which were detailed within the report. Since the last report 3 new risks had been added: 6594 – Radiology risk re: not acting on findings from diagnostic tests, score of 16 6596 – Essential skills data training risk, score 16 6598 - Timeliness of serious incident investigations, risk score of 16 It was noted since the last report that no risks had been closed, no risks have an increase in score and two risks had reduced in score. The Director of Nursing questioned whether infection control should be added as a risk and how it should be described. The following was suggested to be included within the risk: - Cleaning in non-clinical areas - Curtains - Waste management

	• Areas not covered under the cleaning contract • Linen storage ACTION: It was AGREED that this risk be added to the Register for 1 month whilst the issues are addressed. ACTION: It was noted that medical equipment is already on the risk register but an addendum should be added in relation to the back of Planned Preventative Maintenance (PPM). OUTCOME: The Committee RECEIVED and NOTED the content of the Risk Register.
EFFECTIVENESS	
022/16	<u>REPORT FROM THE CLINICAL OUTCOMES GROUP</u> The Medical Director presented an update report from the Clinical Outcomes Group. It was noted HSMR continues to rise and SHMI remains broadly unchanged. However going forward it is anticipated there will be a slight rise from 109 to 111. More recent data suggests it may reduce again but will take 6 to 9 months before this shows. Mortality reviews continue to progress but are not identifying any theme that we are not already aware of. Concern was noted around care bundles and the lack of progress being made with only 60% compliance at best. Capacity is an issue in relation to data collection as it is done by hand and requires clinical governance staff to visit the wards to manually collect the data. Emphasis was made on the need to continue to drive this forward, particularly with the consultant workforce whose responsibility it is to complete the bundle. The Medical Director agreed to meet with the clinical lead for care bundles, Paul Jarvis, to discuss the concern. OUTCOME: The Committee RECEIVED and NOTED the content of the report.
CARING	
023/16	<u>REPORT FROM THE PATIENT EXPERIENCE GROUP</u> The Assistant Director of Quality presented an update report from the Patient Experience and Caring Group following its last meeting held on 17 December 2015. From this meeting the following was noted to be escalated to the Committee: 1. PPI / Patient engagement framework: The group supported the model described by Ruth Mason that will bring together PPI and Equality & Diversity. A strategy is being developed to deliver this that supports the Trust's key priority of delivering personalised compassionate care and recognises involvement and equality as integral to all aspects of service planning and delivery. 2. Patient experience disability report: Amanda McKie reported on the annual audit data, with a focus on FFT results and a patient questionnaire. Feedback was mainly positive for this client group, particularly in relation to medical and nursing staff. Priorities for the next 12 months were provided. 3. Chaplaincy annual report: George Spencer shared the annual report which evidence how the chaplaincy service supports both staff and patients. The report covered compassionate care, patient understanding and involvement and emotional support.

	4. National patient survey updates: The group received updates on the various reports and progress against the associated action plans. This covered: inpatients, children & young people, Maternity and Cancer. Each action plan is monitored through the appropriate divisional forum and reported in the quarterly divisional patient experience reports, with the exception of the inpatient survey which is monitored directly by this group. It was noted that the maternity report was published this month (Dec 15), the Trust scored 'better' for 5 of the 49 questions, with no 'worse' scores. Local benchmarking analysis places the trust in the top 50% for each of the 8 section scores and in the top 20% for half of these. OUTCOME: The Committee RECEIVED and NOTED the content of the report.
WELL LED	
024/16	<u>UPDATE FROM THE WORKFORCE AND WELL BEING GROUP</u> It was reported that the newly reformed Workforce and Well Being Group had held its first meeting.
HEALTH AND SAFETY ISSUES RELATING TO QUALITY OF CARE	
025/16	<u>UPDATE FROM THE HEALTH AND SAFETY GROUP</u> The Director for Planning, Performance, Estates and Facilities reported that Manual Handling training remains a concern. ACTION: It was agreed a meeting would take place outside the Committee to address the concerns between the Director for Planning, Performance, Estate and Facilities, Director of Nursing and the Assistant Director of Quality.
ITEMS TO NOTE	
026/16	<u>MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS</u> The following items will be reported to the Board of Directors at its meeting on 28 January 2016: • Medical Devices • CQC Prep (Serious Incident Register) • Research and Development six monthly report • Regulation 28 Letter (RHS) • Emergency Services Report • SHMI Update
027/16	<u>QUALITY COMMITTEE WORKPLAN 2016</u> OUTCOME: The Committee RECEIVED the Work Plan and NOTED the reports going forward.
028/16	<u>ANY OTHER BUSINESS</u> There were no further items of business.

DATE AND TIME OF NEXT MEETING	
Tuesday 23 February 2016 2pm – 5pm Boardroom, HRI	

DRAFT

**Minutes of the Finance & Performance Committee held on
Tuesday 26 January 2016 at 9.00am
in Meeting Room 4, Acre Mill, Huddersfield Royal Infirmary**

PRESENT

Anna Basford	Director of Transformation & Partnerships (In part)
Keith Griffiths	Executive Director of Finance
Lesley Hill	Executive Director of Planning, Performance and Estates & Facilities
Phil Oldfield	Non-Executive Director - Chair
Owen Williams	Chief Executive

IN ATTENDANCE

Kirsty Archer	Assistant Director of Finance
Mandy Griffin	Acting Director of Health Informatics Services
Betty Sewell	PA (Minutes)

ITEM

001/16 WELCOME AND INTRODUCTIONS

The Chair of the Committee welcomed attendees.

002/16 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Helen Barker, Chief Operating Officer
David Birkenhead, Executive Medical Director
Julie Dawes, Executive Director of Nursing
Andrew Haigh, Chair
Brian Moore, Membership Councillor
Linda Patterson, Non-Executive Director
Jeremy Pease, Non-Executive Director
Victoria Pickles, Company Secretary
Peter Roberts, Non-Executive Director

003/16 DECLARATIONS OF INTEREST

There were no declarations of interest.

004/16 MINUTES OF THE MEETINGS HELD 15 December 2015

The Chair confirmed that the last meeting had been quorate and officially closed the meeting.

The minutes of the last meeting were approved as an accurate record.

005/16 ACTION LOG AND MATTERS ARISING

Action Log

193/08/15 – Theatre Productivity – Choose & Book system - The Director of PP&EF informed the forum that a meeting had taken place with Orthopaedics looking at the waiting times. It was found that Elland and Spire outpatient waiting lists were shorter than ours. Arrangements are being made for Lesley Hill and managers from the Surgical Division to meet with GPs to get their view with regard to patient choice.

As part of a marketing exercise, the Director of Transformation & Partnerships was

asked to research what is driving patient choice.

ACTION: To update the next meeting with regard to the Choose & Book looking at what is driving patient choice - **AB**

264-267/12/15 – To review the admission criteria at both sites – action carried forward.

271/12/15 – Lord Carter Efficiency Savings – the Director of Finance confirmed that discussions would be taking place next week at the Turnaround Executive and a further update would be available for the next Finance & Performance Committee.

276/12/15 – Alternative plans for OBC – Discussions took place and in summary it was noted that we are continuing with the option which is out to consultation. It was also noted that consultation could start either week commencing the 1st or 8th February, but this was still to be confirmed and the consultation period would last 12 weeks.

72/02/15 – CNST/NHS LA – The Director of Finance reported that conversations have taken place at Divisional Business Meetings to get front line engagement. The Assistant Director of Finance, Kirsty Archer, also reported that a meeting had taken place with the Risk Team which included attendance from the NHS LA to review and breakdown the detail of the claims. Director of Nursing to report back at next meeting.

193/08 – Theatre Productivity – In addition to the update above, The Director of PP&EF announced that the 16/17 CIP scheme had been agreed and that there has been a change in the governance arrangements with regard to the pathway. The Director of Transformation & Partnership wanted to flag the impact that capacity is now having on the elective activity and a plan would be going to Board.

Discussions then turned to the current situation with regard to the number of beds opened as of last night and The Chief Executive announced that formal escalation to the Commissioners had taken place and Gold Command had been triggered this morning.

The Director of Finance reported that the financial implications are not in the forecast and a £1.6m income loss has been identified which is a significant risk to the year-end forecast.

The Committee were reassured that everything that can be done is being done to help our own patient flow and we are working closely with our partners.

The Chair of the Committee requested that we move to the Strategic Item on the agenda.

STRATEGIC ITEMS

013/16

2016/17 PLANNING TIMELINE AND BUDGET SETTING PRINCIPLES

The Director of Finance referenced a letter which had been received from Stephen Hay of Monitor and the access to Sustainability and Transformation funding. To

enable access to this funding there are certain conditions which include delivery of a control total of £16m. The Director of Finance also referenced a session in Manchester which will be held tomorrow for the Finance Directors of the North of England where the detail will be discussed in more depth and further information will be available for the Board meeting on Thursday. Sign up to this arrangement is required by 8 February.

A slide detailing the implications of the Sustainability and Transformation funding to the 16/17 Plans showed that the sign up would leave the Trust with a gap of £6m, this was discussed in detail.

The Chair of the Committee reflected on conversations and summarised the discussions with regard to the Sustainability and Transformation Funding as follows:-

- Discussions to take place at the Private Board Session on the 28 January
- The Finance Team to work up options by 7 February articulating the following points:
 - To sign up to the £22m baseline on the work that has been done so far
 - To explore the support from CCGs and the re-negotiation of the control total
 - To look at CIP and how we manage/mitigate risks for EPR
 - To look at depreciation and accounting changes
 - To buy into £22m or £16, the resilience of the £34m needs to be described
 - CQC Inspection and the unknown impact
- In the background, the Director of PP & EF was asked to provide the figures for the “Roberts” plan and what, if anything, that might mean

It was agreed that a recommendation would go to the Board to set up a sub-committee to formulate an official response to Monitor, which would include:

Chairman, Andrew Haigh

The Chief Executive, Owen Williams

The Chair of Finance & Performance Committee, Phil Oldfield

The Director of Finance, Keith Griffiths, and

Another NED

In terms of the additional information with regard to the 16/17 Planning and Budget setting, the Director of Finance confirmed the timeline as follows:-

- Indicative draft by 8 February 2016
- 16/17 Plans to the next Finance & Performance Committee (23 February 2016)
- Final submission, 11 April 2016
- Contract discussions may continue beyond 8 February with an expectation that contracts will be signed by 31 March 2016

011/16 TURNAROUND PROGRAMME UPDATE

The Chief Executive reported that in terms of the 2016/17 CIP planning, the total stands at £12.8m CIP, of which, £3.3m is through Gateway 2, £6.7m is at Gateway 1 with detailed plans and £2.8m is at the ideas stage. The target is to get to £14m at Gateway 2 before 13 February 2016.

014/16 EPR UPDATE

The Acting Director of Health Informatics Services noted the following milestones:-

- Go live date agreed as 8 October 2016 for CHFT / Bradford will go live 3 September 2016.
- Gateway Review was approved by the EPR Assurance Board and will be presented to the Board.
- Future State checkpoint completed and agendas have gone out for the Future State Validation (Build & Design sign-off) which is planned for w/c 29 February, this will be a key week.

The operational plan from now until post-go live is still being worked up with regard to activity, workforce etc. An operational group will be set up within the Divisions and Helen Barker, Chief Operating Officer will lead.

It was noted that if the Bradford go live didn't go smoothly it would have a negative impact on our go live date which would be delayed. There are 5 weeks between each go live dates and more inter-migration tests are being introduced to try to mitigate risks prior to go live.

The second Gateway Review has been undertaken and there are still several areas which need to be addressed. The overall build/design sign-off should have a governance route from the Transformation Board back to the Trust's Board.

It was agreed that the Acting Director of Health Informatics Services should look at the timeline and arrange a session outside the normal Board meeting to look at the advanced state prior to asking Board members to make a decision within the normal Board Meeting.

ACTION : To schedule a session outside the normal Board meeting to enable Board members to have assurance that the project has clinical sign-off – **MG**

012/16 2016/17 CIP SCHEME POSITION

The Director of Transformation & Partnerships reiterated that we are below the £14m and work is in progress to get schemes to Gateway 2 by the end of January.

The Chair of the Committee asked about additional CIP schemes suggested by EY and it was noted that following their review, the only scheme prompted by EY was VAT. It was also noted that this was further confirmation that schemes are becoming harder to identify.

It was agreed that this should be formalised by EY and the Director of Transformation & Partnerships agreed to contact Gill Cooksley from EY to arrange for her to forward a confirmation with regard to their view of the limited CIP opportunities within the Trust.

It was acknowledged that there was still an appetite within the Trust to identify possible schemes but that capacity and resource may be an issue, and this was discussed.

One area which was also discussed was variation in care and standardising pathways which could also link into the Carter review. It was agreed that this will be looked at but it is unlikely that this would have an effect on 16/17. It was also agreed that the Trust should work with other Trusts in the area and this would be picked up at Turnaround Executive going forward.

ACTION : To update Finance & Performance Committee with progress regarding Clinical Variations in 6 months' time – **AB**

FINANCE AND PERFORMANCE
MONTH 9

**006 –
010/16**

The Director of Finance headlined that Month 9 had been a good month with outpatients and day case activity but that this has not translated through to the year-end forecast. However, it was noted that recruitment difficulties continue to be an issue in certain specialties for medical staff and this is driving additional costs to the pay bill.

The Director of Finance updated the Committee with regard to initial contract discussions with the CCG, these discussions will progress with another meeting taking place after Month 10.

The overall message was that it was still possible to achieve the £21m deficit notwithstanding the elective income issue and the recent bed capacity pressures encountered by the organisation.

It was also noted that with regard to capital and cash, the Trust would need to reduce capital spend by £1m. From a governance point of view, information from Monitor confirms that we will hit a Financial Sustainability Risk Rating of 2.

TREASURY MANAGEMENT
CASH FLOW 13 WEEK FORECAST

015/16

In addition to conversation with regard to cash, the Chair of the Committee raised a suggestion which had been made by the Auditors at the Audit & Risk Committee meeting, suggesting splitting out the capital from the revenue cash position. This was acknowledged and will be progressed.

GOVERNANCE
PERFORMANCE REPORTING/KPIs

016/16

Item to be carried forward to the next meeting.

WORKPLAN

017/16

The Workplan was noted by the Committee.

MATTERS FOR THE BOARD AND OTHER COMMITTEES

018/16

- Sustainability and Transformation funding to be discussed at the Board.

ANY OTHER BUSINESS

019/16

No items raised, the meeting was closed.

DATE AND TIME OF NEXT MEETING

Tuesday 23 February 2016, 9.00am – 12.00noon, Meeting Room 4, Acre Mill Outpatients building.

DRAFT

**Minutes of the Audit and Risk Committee Meeting held on
Tuesday 20 January 2016 in Acre Mill, 3rd Floor commencing at 10:45pm**

Prof Peter Roberts
Mr Phil Oldfield

Chair, Non-Executive
Non-Executive Director

IN ATTENDANCE

Mr Chris Boyne
Mrs Jillian Burrows
Mr Keith Griffiths
Mr Michael George
Mrs Adele Jowett
Mrs Helen Kemp-Taylor
Mrs Andrea McCourt
Miss Tiffany Nock
Mrs Clare Partridge
Mrs Victoria Pickles
Mrs Claire Wilson

Internal Audit Manager
Senior Manager, KPMG
Executive Director of Finance
Internal Audit Manager
Local Counter Fraud Specialist
Head of Internal Audit
Head of Governance and Risk
NHS Graduate Trainee
External Audit
Company Secretary (for part of meeting)
Assistant Director of Human Resources (for part of meeting)

Miss Kathy Bray

Board Secretary (minutes)

**Item
01/16**

APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Mr Jeremy Pease, Non-Executive Director
Mrs Julie Dawes, Executive Director of Nursing and Operations
Mr Peter Middleton, Membership Councillor
Mr Brian Richardson, Membership Councillor

02/16

DECLARATIONS OF INTEREST

Clare Partridge, External Auditor declared an interest in that her husband is part of the Clinical Senate who were involved in the current transactions within the local NHS.

There were no other conflicts of interest declared at the meeting.

03/16

MINUTES OF THE MEETING HELD ON 20 OCTOBER 2015

The minutes of the meeting were approved as a correct record.

04/16

ACTION LOG

40/15g Payroll Report – Report to be presented by Claire Wilson later in the meeting.
External Audit reported that work continued on the ISA260 Audit Highlights Memorandum.
STATUS: Closed

54/15 Review of Standing Financial Instructions/Scheme of Delegation – It was noted that the additional amendments required following the government directive re financial limits would be completed and circulated to the Committee before the next meeting on the 20 April and would include the Carter Review amendments.

ACTIONS: VP/KG

OUTCOME: To be circulated to ARC before next meeting

STATUS: Ongoing

58/15a Review of Outstanding Internal Audit Recommendations - It was noted that this item would be dealt with later in the meeting.

STATUS: Ongoing

70/15 Review of Outstanding IA Recommendations – Medical Devices – Michael George confirmed that as contained within the Internal Audit Report, further work had been undertaken and improvements noted.

STATUS: Closed

72/15 Review of Risk Management System – It was noted that this matter had been included within the Internal Audit paper to be discussed later in the meeting.

75/15 Local Counter Fraud Services – It was noted that this would be covered later in the meeting.

STATUS: Closed

79/15 Re-tendering of External Auditors – It was noted that this was now completed and had been transferred to the Work Plan for April 2017.

STATUS: Closed

MATTERS ARISING

05/16

40/15g Payroll Report – Claire Wilson attended the meeting, following her attendance at Audit and Risk Committee on 21 April 2015, to give the Committee an update on the work undertaken on the Payroll internal audit recommendations. The updated report covered all the action points and update on the recent internal audits undertaken with an analysis of the overpayments during the year broken down by Division. It was noted that a great amount of work had been undertaken within the Payroll and Divisions to improve the position. A proactive approach was now being undertaken with root cause analysis work for each incident and where necessary involving the Counter Fraud team. Phil Oldfield stated that bearing in mind the number of payroll transactions undertaken within the Trust this equated to a relatively small number of incidents. Jillian Burrows reported that she had just received a salary benchmarking report and this would be circulated to the Audit and Risk Committee for information.

ACTION: JB

OUTCOME: The Committee RECEIVED and NOTED the updated information and were assured that actions were being undertaken to mitigate risks.

STATUS: Closed

COMPANY SECRETARY'S BUSINESS

06/16

a. AUDIT AND RISK COMMITTEE ATTENDANCE REGISTER – App E1

The Company Secretary reported that as part of the on-going good governance arrangements we are required to monitor the attendance of members at Audit and Risk Committee meetings. The terms of reference state that Attendance is required by members at 75% of meetings. In the last 12 month period all Audit and Risk Committee members have met this requirement. It was noted that at the present time only two Non Executives were available to attend Audit and Risk Committee Meetings. It was reported that appointments were being progressed and interviews for the two vacancies would take place on Friday 19 February 2016.

OUTCOME: The Audit and Risk Committee received and noted the attendance register.

b. REPORT ON CURRENT REGULATORY COMPLIANCE ISSUES – App E2

The Audit and Risk Committee were asked to receive the updated Regulatory Compliance Register and note that no breaches have arisen in meeting the deadlines.

OUTCOME: The Audit and Risk Committee received and noted the contents of the Regulatory Compliance Register.

c. AUDIT AND RISK COMMITTEE ANNUAL WORKPLAN 2016 – App E3

The Committee were asked to receive and approve the Annual Workplan updated to October 2016. Committee members were asked to consider whether any other items of business require adding to the plan to reflect the strategic priorities and work of the Trust over the next 12 months.

OUTCOME: The Audit and Risk Committee received and agreed return comments on amendments required to the annual workplan.

d. SELF-ASSESSMENT OF AUDIT AND RISK COMMITTEE EFFECTIVENESS

The Company Secretary presented an updated Action Plan to address the actions of the ARC Effectiveness Self-Assessment undertaken in the summer. Since that time a revised template had been developed by the HFMA and the Audit and Risk Committee members were asked to complete and return APP E5. It was requested that the Committee also identify any areas where changes might be made before this form is cascaded to the other sub committees of the Board for completion.

ACTION: ALL

e. AUDIT AND RISK COMMITTEE INDUCTION PROGRAMME – App E6

The Company Secretary reported that one of the actions arising from the self-assessment was to develop a formal induction programme for members of the Audit and Risk Committee. A proposed programme was attached for comment. It was reported that Internal Audit were also developing an induction pack and when this was available in draft it would be shared with the Chair/Company Secretary and Philip Oldfield in order that it could be reviewed and the two documents could be aligned.

ACTION: Internal Auditors

EXECUTIVE DIRECTOR OF FINANCE'S BUSINESS

a. Review Waiving of Standing Orders

07/16

The Executive Director of Finance presented a report detailing the waving of Standing Orders for the period 1 October to 31 December 2015. During this quarter, 7 were placed as a result of standing orders being waived, at a total cost of £251,693.11. Additionally 0 amendments to earlier single sources were made this quarter. There were no areas of concern to escalate to the Board.

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

b. Review of Losses and Special Payments

In accordance with the Standing Financial Instructions, the Assistant Director of Finance presented the losses and special payments for the period 1 October to 31 December 2015. There were no areas of concern to escalate to the Board.

The Committee **RECEIVED** the report.

c. Final Accounts Process and Plans

The Executive Director of Finance presented the draft final accounts process and plans for 2016/17. It was noted that plans were in place to begin to draft the Annual Report, specifically the section related to Remuneration and it was aimed that this would be section would completed by February 2016.

The Committee **RECEIVED AND APPROVED** the proposed timeline.

08/16

INTERNAL AUDIT

The Committee were updated regarding the recent appointments made within Internal Audit and the formal alliance being made between the West Yorkshire and York Consortiums which would help provide a pro-active approach by Internal Audit in the future. Formal introductions were made to Helen Kemp-Taylor, Acting Head of

Internal Audit and Michael George, Internal Audit Manager who would be taking on the Trust's work from Chris Boyne in the future. On behalf of the Trust the Chairman wished to take the opportunity to thank Chris for his work with the Trust and particularly the challenges over the last few months.

a. Outstanding Internal Audit Recommendations – As discussed earlier in the meeting the Committee were satisfied that further work was being undertaken to complete the outstanding recommendations with regard to the Medical Devices Audit.

The Committee agreed that it needed to maintain a focus on the high and medium priority reports together with those which were due in the next three months. It was agreed that the Company Secretary and Internal Audit Manager would agree in March the areas which the Audit and Risk Committee should focus on and invite the persons responsible for the management of the activities to the next meeting in April. It was agreed that the areas of concern were:-
Theatre Stores, Capital Assets, Bank and Agency Staff, Infection Control.

ACTION: **Company Secretary and Internal Audit Manager to agree staff to invite to the next meeting on 20 April 2016.**

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

b. Review Internal Audit Progress Report

Michael George, Internal Audit Manager reported that since the last reported to the Audit & Risk Committee in October 2015 the following reports had been issued to and discussed with management:-

Report No	Report	Opinion
CH13/2016	Learning to Improve – Follow Up	Significant
CH14/2016	Emergency Preparedness, Resilience and Response	Limited
CH15/2016	Compliance with ISO Standard-20000	Significant
CH17/2016	Information Governance Toolkit	Limited
CH18/2016	Electronic Patient Record	Significant

The reports with limited assurance were discussed in detail:-

a. CH14/2016 – Emergency Preparedness, Resilience and Response

The Civil Contingencies Act, imposes a requirement on first responders to put in place business continuity plans of their own to ensure that they are able to continue to respond to the needs of emergencies should a threat to service delivery occur to them.

Whilst the necessary lead is provided by the Trust Board, the areas the Trust classes as critical are not yet covered by business continuity plans. The lack of coverage means that we can only provide limited assurance that the risks in this area are being adequately managed. The reason for the lack of coverage is principally based on the time necessary to produce reliable business continuity plans and not any lack of commitment to address this area.

The Chairman suggested that the Trust should produce an interim plan to give initial cover and it was necessary for this to be reference within the Risk Management Policy.

b. CH17/2016 - Information Governance Toolkit

The Department of Health had developed an Information Governance Assurance Framework, the framework is supported by the Information Governance Toolkit (IGT) which organisations must follow and achieve a level 2 score against each of the requirements. This audit was undertaken as a gap analysis prior to IGT submission in March 2016. The Trust self-certified as meeting level 2 or above for all IGT requirements. Testing on a sample of 8 requirements found that sufficient evidence was in place to support a level 2 for one of the 8 requirements whilst there was insufficient information readily available to support the remaining 7 requirements. Internal Audit considered that the remaining supporting evidence can be readily assembled and if this is undertaken should support a higher score by 31st March 2016.

The Committee were assured that further work was being undertaken and it was agreed that an update would be brought back to the next meeting.

ACTION: Update in Internal Audit Progress Report – 20 April 2016

c. CH18/2016 – Electronic Patient Record

Although this audit had been given an opinion of significant, this had been based on the progress made towards implementing the recommendations made in the 1st Gateway Review. The Executive Director of Finance expressed concern that before we go live on the 8 October 2016 it was necessary to have operational plans in place, particularly around staff training and governance. The Internal Audit Manager advised the Committee that the Project Assurance Board which had been established would steer some of the work being undertaken by Internal Audit with regard to this but the Committee questioned whether this would provide sufficient assurance for the Audit and Risk Committee. Helen Kemp-Taylor agreed to undertake a review and bring assurances to the next Audit and Risk Committee, but if any concerns arose before these would be brought back to the Audit and Risk Committee members outside the meeting.

**ACTION: Helen Kemp-Taylor
Internal Audit Progress Report – April 2016**

d. Review of Effectiveness of Internal Audit

Helen Kemp-Taylor presented the Review of Effectiveness of Internal Audit report which had been prepared for another organisation and if the Audit and Risk Committee wished the Audit team would be more than happy to complete this for the CHFT.

Discussion took place regarding the CIPFA guidance that Internal Audit should go through a peer review process and independent review every 5 years. It was noted that Internal Audit had commissioned the independent review some three years ago from Deloitte.

The Committee **RECEIVED and APPROVED** the Internal Audit reports and **AGREED** that Internal Audit should be subject to independent peer review.

09/2016 LOCAL COUNTER FRAUD SERVICES

The Local Counter Fraud Officer presented the updated progress report, the contents of which were received and noted.

Details regarding two on-going cases were discussed; one involving staff screening/IT security access for a member of agency staff; and the second regarding a corruption case investigation involving an external contractor.

At this point in the meeting the Chairman asked for clarification on the reporting

mechanisms in place for Prevent Training and that this should be reflected in the Risk Management Policy.

ACTION: Head of Governance and Risk

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

10/2016 EXTERNAL AUDIT

a. Technical Update

Gillian Burrows, External Auditor presented the Technical Update and its contents were received and noted. The specific issues to draw to the Board's attention included:-

- Waiting time legislation - Right to start consultant-led treatment within 18 weeks
- Transforming how the NHS deals with temporary workers
- Manchester Health and Social Care Devolution.

b. External Audit Plan

Clare Partridge, Engagement Lead presented the External Audit Plan for 2015/16. She emphasised that the responsibilities of the External Auditors were around providing opinions on the accounts, use of resources and the assurance opinions on the quality report. The key areas from the Audit Plan were noted:-

- Change in scope
 - work with NAO's code of Audit Practice
 - final scope for work on quality accounts awaited
- Change in materiality
- Change in timeline and approach – accounts to be available by 22.4.16
- Changes in significant risks and other areas of audit focus
 - Valuation of fixed assets
- Change in accounting or reporting standards
 - Minor changes to ARM (IFRS 13 – surplus assets and PFI disclosures)
 - New format for performance report and accountability within annual report and additional disclosures within remuneration report
- Change in deliverables
 - No significant change in reporting deliverables.

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

11/2016 RISK MANAGEMENT POLICY

The draft Risk Management Policy was received and discussed. It was noted that further work was required on this document and this would be undertaken by the Head of Governance and Risk and the Company Secretary and taken to the Board of Directors in February. This policy had been discussed at the Risk and Compliance Group and discussion was on going about expanding the policy to reference other policies, resilience issues, differentiate between strategic and operational issues together with activity with stakeholders.

It was requested that if any Committee members had other comments these should be returned to Andrea McCourt before the end of the first week in February

**ACTION: ALL
Board of Directors – February 2016**

12/2016 INFORMATION TO RECEIVE

The following information was received and noted:-

- a. Quality Committee Minutes – 25.8.15, 22.9.15, 24.11.15
- b. Risk & Compliance Group Minutes – 10.11.15, 1.12.15
- c. THIS Management Board – 25.11.15
- d. Nomination and Remuneration Committee (Membership Council) Minutes 7.12.15

e. Audit & Risk Committee Meeting Dates Jan-June 2017

13/2016 WHISTLEBLOWING AND EXPRESSIONS OF CONCERN

The Chairman reported that following a national consultation exercise undertaken regarding the national code, a copy of the revised response from the Trust was circulated for information.

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

14/2016 ANY OTHER BUSINESS

a. Effective Audit Committee – Contributing to a Well Led Organisation – Members were reminded about the Internal Audit event planned for 7 March 2016 at the National Railway Museum, York to which Prof. Peter Roberts had been asked to present.

15/2016 MATTERS TO CASCADE TO BOARD

- Audit Effectiveness Self-Assessment Template to be completed by attendees
- Note evolving internal audit arrangements
- Internal Audit Follow-up Recommendations – Review areas to focus on at April Meeting
- Internal Audit Progress Report – 2 Limited Opinion Reports - Emergency Preparedness, Resilience and Response, Information Governance Toolkit - plus discussion on EPR Assurance
- Noted review of effectiveness of internal audit and agreed this should be subject to peer review
- Local Counter Fraud Services Progress Report
- Technical Update
- External Audit Plan
- Risk Management Policy – more work required especially on non-clinical risk
- Whistleblowing response – noted changes to draft response and agreed final version.

16/2016 DATE AND TIME OF NEXT MEETING

Wednesday 20 April 2016 at 10.45 am - 3rd Floor Acre Mills Outpatient Building.