Calderdale and Huddersfield NHS
NHS Foundation Trust

Meeting of the Board of Directors
To be held in public
Thursday 17 December 2015 from 1:30 pm

Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital, Halifax HX3 0PW

AGENDA

1	Welcome and introductions:	Chairman	
2	**Apologies for absence:** Jan Wilson, Non Executive Director Mandy Griffin, Director of THIS		
3	Declaration of interests	All	**VERBAL**
4	**Minutes of the previous meeting** held on 26 November 2015	Chairman	**APP A**
5	**Matters arising and review of the Action Log**	Chairman	**APP B**
6	**Patient/Staff Story:** **'Theatre Action Week'** Kathryn Aldous, General Manager, Operating Services, Pain Service and Critical Care	Executive Director of Nursing	**Presentation**
7	**Chairman's Report:** a. NHS Providers- Chair/CE Meeting – 8.12.15 b. Board to Board with SWYPFT – 9.12.15 c. Right Care Joint Stakeholder Event – 10.12.15	Chairman	**VERBAL**
8	**Chief Executive's Report:**	Chief Executive	**VERBAL**
Keeping the base safe			
9	Risk Register	Executive Director of Nursing	**APP C**
10	Nursing Revalidation	Executive Director of Nursing	**APP D**
11	**Governance Report** a. Attendance at Board of Director Meetings b. Board Appointments Update	Company Secretary	**APP E**

	c. Board Workplan d. Use of Trust Seal e. Q2 Submission Feedback from Monitor f. Calderdale Artefacts		
12	Care of the Acutely Ill Patient Report	Executive Medical Director	**APP F**
13	Medical Revalidation	Executive Medical Director	**APP G**
14	Agency Cap/Spend	Executive Medical Director	**VERBAL**
15	Integrated Board Report	Chief Operating Officer	**APP H**
Financial Sustainability			
16	Month 8 – November 2015 – Financial Narrative	Executive Director of Finance	**APP I**
Transforming and improving patient care – no items			
A workforce for the future – no items			
17	**Update from sub-committees and receipt of minutes** ▪ Quality Committee – minutes of 24.11.15 and verbal update from meeting 15.12.15 ▪ Finance and Performance Committee – minutes of 17.11.15 and verbal update from meeting 15.12.15		**APP J**

Date and time of next meeting

Thursday 28 January 2016 commencing at 1.30 pm

Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital, Halifax HX3 0PW

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 17th December 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTOR MEETING MINUTES - 26.11.15 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 26 November 2015.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 26 November 2015.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 26 November 2015.

Appendix

Attachment:

APP A - BOD MINS - PUBLIC - 26 11 15(2).pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 26 November 2015 in the Conference Suite, Todmorden Health Centre, Lower George Street, Todmorden OL14 5RN

PRESENT

Andrew Haigh	Chairman
Dr David Anderson	Non-Executive Director
Dr David Birkenhead	Executive Medical Director
Julie Dawes	Executive Director of Nursing and Operations/Deputy Chief Executive
Keith Griffiths	Executive Director of Finance
Philip Oldfield	Non-Executive Director
Dr Linda Patterson	Non Executive Director
Jeremy Pease	Non-Executive Director
Prof Peter Roberts	Non-Executive Director
Owen Williams	Chief Executive
Jan Wilson	Non-Executive Director

IN ATTENDANCE/OBSERVERS

Helen Barker	Associate Director of Community Services and Operations
Anna Basford	Director of Transformation and Partnerships
Kathy Bray	Board Secretary
Mandy Griffin	Director of the Health Informatics Service
David Himelfield	Huddersfield Examiner Reporter
Victoria Pickles	Company Secretary
Di Wharmby	Publicly Elected Membership Councillor

Item

170/15 APOLOGIES FOR ABSENCE AND INTRODUCTIONS

Apologies were received from:

Julie Hull	Executive Director of Workforce and Organisational Development
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities

The Chairman welcomed everyone to the meeting.

171/15 DECLARATION OF INTERESTS

There were no declarations of interest to note.

172/15 MINUTES OF THE MEETING HELD ON THURSDAY 29 OCTOBER 2015

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

173/15 MATTERS ARISING FROM THE MINUTES/ACTION LOG

a. NICE GUIDELINES – CANCER DRUGS - This had been raised with the Commissioners and a response was awaited. The Executive Director of Nursing and Executive Medical Director agreed to bring the response back to the Board.

ACTION: Executive Director of Nursing/Executive Medical Director
ACTION: BOD Action Log

128/15 – CAIP/MORTALITY REVIEWS – The Board members who were present at the Workshop held on the 18 November 2015 advised that this had been extremely useful. It was agreed that the Executive Medical Director would make contact with

Professor Mohammed on his return from leave in the New Year, with a view to him presenting his findings to the other Board members.

ACTION: Executive Director of Nursing/Executive Medical Director
ACTION: BOD Action Log

161/15 – CARE OF THE ACUTELY ILL PATIENT – GO AND SEE VISIT TO TYNE & WEAR – Due to annual leave the Executive Medical Director had not had the opportunity to liaise with Professor Roberts with a view to visiting Tyne and Wear to obtain shared learning around their whole economy-wide piece of work around reducing the number of people dying in hospital.

ACTION: Executive Medical Director
BOD Action Log

165/15 – INTEGRATED BOARD REPORT (IBR) CONTENT – The Chairman reported that a meeting had been arranged for Friday 4 December with himself, Associate Director of Community Services and Operations and Company Secretary to review the IBR content to ensure that the Board receives appropriate information and assurance on the Trust's performance.

There were no other items outstanding on the Action Log.

174/15 PATIENT/STAFF STORY

Unfortunately the presenter was not available for the meeting and it was agreed to re-schedule to a future date.

175/15 CHAIRMAN'S REPORT

There were no matters for the Chairman to report.

176/15 CHIEF EXECUTIVE'S REPORT

a. SPEECH TO NHS PROVIDERS ANNUAL CONFERENCE – 10.11.15 BY CHRIS HOPSON, CE, NHS PROVIDERS

The Chief Executive advised that he had included a copy of this speech to give the Board a flavour of the NHS Providers' perspective. It was noted that a number of themes which had emerged from the speech were already being moved forward by the Trust through the Strategic Plan.

Discussion took place regarding the Comprehensive Spending Review and the implications for the Trust, the wider NHS as well as Health Education, Public Health and Regulators and that the key messages from this are borne in mind for future discussions.

177/15 BOARD ASSURANCE FRAMEWORK (BAF)

The Board Assurance Framework was received and noted. It was agreed that Winter Resilience should be included in the BAF and the Company Secretary agreed work with the Interim Associate Director of Community to develop an overarching risk in the BAF around Winter Resilience.

ACTION: Company Secretary

The Chief Executive requested that following, the work by Professor the Executive Medical Director review the Mortality section of the BAF and reword this section before its next issue in 3 months' time.

ACTION: Executive Medical Director

The Executive Director of Nursing and Operations thanked the Company Secretary for the work done to develop the BAF alongside the Risk Register and reminded the

Committee Chairs to ensure that issues arising in these documents are included on appropriate sub-committee agendas. The Company Secretary reported that arrangements had been made for all sub-committees to include the BAF on future agendas.

178/15 RISK REGISTER

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

- Progression of service reconfiguration impact on quality and safety
- Dependence on middle grades in A&E
- Failure to meet cost improvement programmes
- Outlier on mortality levels
- Staffing risk, nursing and medical
- Ability to deliver service transformation

Risks with increased score:-

- No risks had increased score over the previous month.

Risks with reduced score:-

- No risks had reduced in score over the previous month.

New risk added:-

No new risks had been added to the register over the previous month.

Discussion took place regarding the Electronic Patient Record risk register particularly around benefits realisation and project delivery. It was noted that arrangements were in hand to append any risk(s) from this to the Trust Risk Register by escalation.

Reference was made to the transfer of services and discussion took place regarding the levels of risk for phase 2 of the process. The Executive Director of Finance reported that further discussions would be taking place with the Commissioners. The Associate Director of Community Services and Operations agreed that the financial and service risks would be clarified prior to the next issue of this document.

ACTION: Associate Director of Community Services & Operations.
RESOLVED: The Board received and approved the Risk Register report.

179/15 PROGRESS AGAINST WELL LED GOVERNANCE REVIEW ACTION PLAN

The Company Secretary presented the progress against the action plan and requested that any further inclusions from the Board be submitted to her before the document was forwarded to Monitor the following day.

It was agreed that milestones should be built in against each action.

ACTION: Company Secretary/Director of Nursing & Operations

180/15 PERFORMANCE MANAGEMENT FRAMEWORK

The Associate Director of Community Services and Operations presented the key points from the Performance Management Framework. It was noted that this document had been produced as one of the actions from the Well Led Governance Review and that it sat alongside the Divisional structures. It was supported by a clear Accountability Framework based on Monitor
principles but delivered in line with the Trust's own values and behaviours, the four pillars and the strategic objectives.

It was noted that, if approved by the Board, further work would be undertaken on the key performance indicators with the Divisions over the next three months prior to full

implementation in the new financial year. It was however agreed that an update should be brought back to the Board in February 2016.

ACTION: BOD Agenda Item – February 2016

Jeremy Pease requested that over 4 hour trolley waits should be included in the targets.

ACTION: Associate Director of Community Services & Operations

Discussion took place regarding Non-Executive Director oversight and challenge of this framework and it was agreed that Phil Oldfield would act as the Non-Executive Director lead.

RESOLVED: The Board approved the Performance Management Framework and requested an update on progress in February 2016.

181/15 DIRECTOR OF INFECTION PREVENTION AND CONTROL (DIPC) REPORT

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

- **C.Diff** – 4 cases had been reported in October. (The year to date position was 14 - 4 avoidable and 10 unavoidable). The ceiling is 21 cases for the year to March 2016. The Executive Medical Director stressed that the position should be monitored closely although comparative data showed the Trust to be performing well.

- **Isolation Breaches** – recorded by the Infection Control Team during October were 39, compared to 27 in September. Staff were being reminded of the importance to be vigilant in the recognition of isolation breaches. It was noted that this position would be improved with the introduction of the Electronic Patient Record.

- It was noted that from November onwards the DIPC report would be taken to the Board on a Quarterly basis as the main metrics are included in the Integrated Board Report.

ACTION: BOD Workplan – DIPC report to be received quarterly from November 2015 onwards

RESOLVED: The Board received the report.

182/15 SAFEGUARDING ADULTS AND CHILDREN UPDATE

The Executive Director of Nursing presented the update which was received and noted. The key issues within the report included:-

The last quarter saw a decrease in compliance for level 2 and level 3 safeguarding training. Training sessions have been consistently offered but there has been poor attendance. Level 3 training is better attended. Staff were being reminded of the need to ensure compliance with safeguarding training and their responsibilities.

The Chief Executive stressed that the Board could test this when undertaking leadership/staff walkabouts within the Trust.

Jan Wilson asked whether the Trust had any problems and concerns regarding female genital mutilation and the Executive Director of Nursing & Operations agreed to investigate this.

ACTION: Executive Director of Nursing & Operations.

RESOLVED: The Board received the report.

183/15 NURSING WORKFORCE MODEL REVIEW PANEL RECOMMENDATIONS

The Executive Director of Nursing reported that this paper followed on from the detailed Safe Staffing report provided to the Board in September 2015. The paper provided an overview of the Nursing Workforce Model Review Panels held in October and November, and resulting recommendations for the Board to consider which the Nursing Strategy Workforce Group have identified as critical to achieve nursing and midwifery safe staffing levels.

Philip Oldfield asked how this investment related to other work in the Trust, how this impacted on the financial position overall and the linkage between the proposals and actual recruitment. The content of the report was noted and it was agreed that the paper would be submitted to the Commercial Investment and Strategy Committee in order that a summary can be provided to the Board in two months' time regarding the size of investment and how it is structured.

Dr Linda Patterson commented that this was a good piece of work but was concerned that vanguard issues and gaps should not be overlooked.

Jan Wilson enquired about long shift working and how this was working on the wards. The Executive Director of Nursing & Operations advised that audit work had been undertaken and advantages and disadvantages had been identified.

ACTION: Executive Director of Finance/Executive Director of Nursing & Operations
ACTION: BOD Agenda item – January 2016

184/15 QUARTERLY QUALITY REPORT

The Executive Director of Nursing & Operations reported that the quarterly quality report covered contractual, quality account, national and local quality priority requirements to provide a comprehensive overview of quality performance during the second quarter of 2015-2016 within the Trust. It was noted that this document had been discussed in detail at the last Quality Committee and Jeremy Pease and Linda Patterson reported that issues were being monitored although it was noted that most of these were included in the Integrated Board Report. There were no issues of concern for the Board.

RESOLVED: The Board noted the content of the report and supported the actions contained within the report

185/15 INTEGRATED BOARD REPORT

It was noted that that further work had been undertaken to improve the content of the report and arrangements were being made for the glossary to be uploaded to Boardpad.

The Associate Director of Community Services and Operations introduced the Integrated Board Report as at 31 October 2015 and explained that key areas would be presented in detail by the appropriate Executive leads.

Key issues arising from the report were:

Responsiveness

- Emergency Care Standard was delivered again for the month
- Day 38 cancer referral performance continues to improve
- Delayed transfer of care better than target in October

- Cancelled operations performance was better than target in October despite periods of high non elective activity
- Referral to treatmentperformance externally is now only reported at incomplete level

Discussion took place regarding the daily discharges being below target and it was noted that further work was on going with 4 Eyes and a detailed report would be provided to the December Board of Directors Meeting.

ACTION: Associate Director of Community Services & Operations

Caring
- Complaints responded to within target improved further
- Friends and Family positive responses have dipped slightly
- A small number of mothers reported being concerned having been left alone during labour

Safety
- Falls and Pressure ulcer focus continues but impact not yet demonstrated
- C Section rate remains high
- Planned home birth rates remain low

Effectiveness
- C Difficile underlying trend a concern but numbers due to lapse in care remain low
- HSMR remain high
- Fractured Neck of Femur, access to theatre within 36 hours significantly improved
- Readmission rates are worse than target

Well led
- Sickness has improved in 4 of the 7 service areas reported and 5 out of 8 staff categories with overall % sickness at its lowest point in current service year with a downward trend
- Staff in post and FTE is static
- Over 91% of colleagues have now started their mandatory training programme.
- Appraisal activity plans are in place with divisions now RAG rated against these plans.
- The number of 'red' nursing shifts reduced in October.

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

186/15 MONTH 7 – OCTOBER 2015 FINANCIAL NARRATIVE

The Executive Director of Finance presented the finance month 7 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 20 October 2015:-

The key issues included:-

Summary Year to Date:
- The year-to-date deficit (excluding restructuring costs) is £12.94m versus a planned deficit of £11.48m
- The overall deficit is £13.25m against a planned £14.48m, due to restructuring costs not being incurred.
- Elective and day case activity have again fallen further behind planned levels in month with an adverse impact on income
- Pay expenditure remains high, including significant levels of agency staffing

expenditure

- Capital expenditure year to date is £10.92m against the planned £14.17m with due to timing differences mainly on IT spend
- Cash balance is £11.24m against a planned £1.96m, due predominantly to securing cash payments in advance for clinical activity
- CIP schemes delivered £8.67m in the year to date against a planned target of £6.93m
- 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 £22.13m against a planned £20.01m, an adverse variance of £2.12m. This position includes full release of remaining contingency reserves and delivery of £17.39m CIP against the original planned £14m
- This is a slight improvement on the forecast at Month 6. This adverse position from plan is driven by the on-going impact of the activity, income and pay expenditure pressures seen in the year to date and costs associated with additional bed capacity.
- The overall forecast deficit position shows an adverse variance of £0.22m from plan due to £3m of restructuring costs no longer being forecast to be incurred. This is not a reflection of the trading position but does bring the reliance on external cash support down from £18m to £15m.
- Year-end capital expenditure is forecast to be £20.93m against the planned £20.72m. The year-end FSRR is forecast to be at level 2.

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

187/15 UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES

The following information was received and noted:-

- **Joint MC/BOD Annual General Meeting Minutes - 17.9.15 -** The draft minutes were approved by the Board of Directors. These had previously been approved by the Membership Council at its meeting on the 4 November 2015.

- **Quality Committee** – The Board received a verbal update from Jeremy Pease from the meeting held on 24.11.15.

  Matters arising from the meeting not already discussed at the Board meeting included:-
  - **PSQB Quarterly Report** received and issues noted.
  - **Emergency Planning Preparedness Policy** received and agreed
  - **Cleaning Services** update on new management arrangements received
  - **QIA metrics**
  - **CQC Action plan** - progress on plans for the visit on 8 March were received.

- **Finance and Performance Committee** - The Board received the minutes of the 20.10.15 and a verbal update from Phil Oldfield on the meeting held 17.11.15.

  The main issues discussed at the Committee included concentration on the 2016/17 baseline and the work to date from Ernest and Young, assumptions between the models and an outline of the discussions held with Monitor on the 24 November 2015. Staff were working hard to triangulate the data.

- **Audit and Risk Committee** – Minutes from the meeting held on 20 October 2015 were received and noted. The contents of the meeting had previously been discussed at the October Board of Directors Meeting.

- **Audit and Risk Committee** – Terms of Reference – The Board received and approved the Audit and Risk Committee Terms of Reference.

- **Nomination and Remuneration Committee (Membership Council) Terms of Reference** – following discussion at the Membership Council amendments had been made and these were approved by the Board of Directors.

The Chairman thanked everyone for their attendance and contributions.

188/15 DATE AND TIME OF NEXT MEETING

Thursday 17 December 2015 at 1.30 pm in the Large Training Room, Learning Centre, Calderdale Royal Hospital HX3 0PW

The Chairman closed the meeting at 3.30 pm.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 17th December 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS - ACTION LOG - 1 DECEMBER 2015 - The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 December 2015	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 December 2015

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 December 2015

Appendix

Attachment:

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

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 December 2015 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
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 ?Jan 2016		
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		
29.10.15 (155/15)	**MATTERS ARISING – NICE GUIDELINES – CANCER DRUGS** Raise the issue with commissioners and feedback to the Board	Executive Medical Director / Executive Director of Nursing	Response awaited from Commissioners to be followed up by DB.	17.12.15		1.12.15 Email circulated to Board
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.	December 2015		
29.10.15 (165/15)	**INTEGRATED BOARD REPORT** Review to take place on how information is presented and summarised	Chair / Interim Associate Director of Operations / Company Secretary		December 2015		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 December 2015 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
26.11.15 (177.15)	**BOARD ASSURANCE FRAMEWORK – WINTER RESILIENCE** Reference to Winter Resilience in Risk Register to be recorded to create an overarching statement in BAF,	VP		25.2.16		
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.	DB		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	HB		17.12.15		
26.11.15 (179/15)	**WELL LED GOVERNANCE REVIEW** Milestones to be built in against each action	JD/VP		28.1.16		
26.11.15 (180/15)	**PERFORMANCE MANAGEMENT FRAMEWORK (PMF) – TROLLEY WAITS** Over 4 hour trolley waits to be included	HB		25.2.16		
26.11.15 (180/15)	**PERFORMANCE MANAGEMENT FRAMEWORK – UPDATE ON PMF PILOT** Update on pilot to be brought in February 2016.	HB		25.2.16		
26.11.15 (182/15)	**SAFEGUARDING REPORT** Agreed to investigate whether there were any concerns regarding Female Genital Mutilation.	JD		17.12.16		
26.11.15 (185/15)	**INTEGRATED BOARD REPORT – DAILY DISCHARGES** Below target – further work on going with 4 Eyes and a detailed report to be provided to December BOD Meeting	HB		17.12.15		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 December 2015 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
26.11.15 (185/15)	**INTEGRATED BOARD REPORT – GREEN CROSS PATIENTS** Further assurance about direction of discharges to be provided to December BOD Meeting	HB		17.12.15		

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Andrea McCourt, Head of Governance and Risk
Date: Thursday, 17th December 2015	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: Corporate Risk Register - This paper presents to the Board the Corporate Risk Register as at December 2015 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 December Corporate Risk Register has been reviewed at the Risk and Compliance Group on 1 December 2015.	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

This paper presents to the Board the Corporate Risk Register (CRR), which identifies the current significant risks facing the organisation as at December 2015, for the Board's consideration and oversight.

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 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 summarises the Trust risk profile as at December 2015 and identifies the highest scoring risks (with scores of 20 and 25), risks with increased scores, risks with reduced scores, any new risks and any closed risks.

It also includes the CRR which identifies 18 risks and the associated controls and actions to manage these.

At the meeting on 1 December 2015 the Risk and Compliance Group reviewed two new risks relating to Electronic Patient Record (EPR) and clinical administration.

It was agreed that both these risks should be added to the Corporate Risk Register and these are therefore included within the attached report as follows:

EPR – risk 6503 – risk score of 20. To note the previous EPR risk relating to not realising the financial benefits of EPR has now been closed.

Clinical administration – risk 6507 – risk score of 15.

The risk relating to staff, risk 6345, has been amended to include therapy staff.

Next Steps:

The CRR is a dynamic document and will continue to be presented to the Board on a monthly basis 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 - BOD - 17.12.15.pdf

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CORPORATE RISK REGISTER REPORT

Risks as at 8 December 2015

TOP RISKS
6131 (25): 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
No risks have reduced in score.
NEW RISKS
The following new risks have been added to the Corporate Risk Register in December 2015. 6503 – delivery of Electronic Patient Record (EPR) Programme, risk score of 20 6507 - clinical administration workforce, risk score of 15
CLOSED RISKS
Risk 6230 relating to the financial benefits of EPR has been closed – a new risk for EPR has been added as noted above.

CORPORATE RISK REGISTER –DECEMBER 2015 Summary of Risks by Risk Type

Risk Ref	Strategic Objective	Risk	Executive Lead (s)	Sept. 2015	October 2015	November 2015	Current Risk score and change
		Strategic Risks					
6346	Transforming & Improving Patient Care	Capacity and capability to deliver service reconfiguration	Director of Nursing (JD)	20	20	20	**20 =**
6503	Transforming & Improving Patient Care	Non delivery of Electronic Patient Record Programme	Chief Executive	-	-	-	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 =
4783	Transforming & Improving Patient Care	Outlier on mortality levels	Medical Director (DB)	20	20	20	20 =
2827	Developing Our workforce	Poor clinical decision-making in A&E	Medical Director (DB)	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 =
5806	Keeping the base safe	Urgent estate work not completed	Director of Estates and Performance (LH)	16	16	16	16 =
6300	Keeping the base safe	Clinical, operational and estates risks	Director of Nursing	16	16	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 =
6130	Financial sustainability	Loss of income / service due to commissioner procurement decisions	Director of Commissioning and Partnerships (AB)	16	16	16	16=
6150	Keeping the base safe	Cash flow risk	Director of Finance (KG)	-	15!	15	15 =
6027	Keeping the base safe	Suspension of capital programme risk	Director of Finance (KG)	-	15!	15	15 =
		Performance and Regulation Risks					
6499	Keeping the base safe	CQC Inspection Outcome	Director of Nursing (JD)	15	15	15	15 =
6078	Keeping the base safe	Insufficient Appointment Slots	Director of Nursing (JD)	16	16	16	16 =
2828	Keeping the base safe	Slow patient flow and breach of A&E targets	Director of Nursing (JD)	16	16	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 =
6507	Keeping the base safe	Clinical Administration workforce	Chief Operating Officer	-	-	-	15!
6094	Keeping The Base Safe	Potential loss of training grade posts	Medical Director (DB)	-	12!	12	12 =

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 December 2015

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 ! 6507 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 – AIS, 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	= 2827 –Over reliance on middle grade doctors in A&E = 4706 – Failure to meet CIP & adhere to financial governance = 6499 CQC inspection outcome
Highly Likely (5)				= 4783 – Outlier on morality levels = 6345 – Staffing risk, nursing and medical = 6346 – Ability to deliver service transformation	= 6131 – Progression of service reconfiguration impact on quality and safety

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

	Risk No	Div	Dir	Dep	Opened	Status	Goal	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Further Actions	Review	Target	RC	Exec Dir	Lead
Extreme	6131	Corporate	Commissioning & Partnerships	Commissioning & Partnerships	Oct-2014	Active	Transforming and improving patient care	There is a risk that the Trust will not be able to quickly progress service reconfiguration due to the requirements of a consultation process initiated by local CCG's resulting in delays to important clinical quality and safety issues e.g: Compliance with A&E National Guidance Compliance with Paediatric Standards Compliance with Critical Care Standards Speciality level review in Medicine Unable to meeting 7 day standards Difficulties in recruiting a medical workforce (increased reliance on Middle Grades and Locums) Increased gaps in Middle Grade Doctors Dual site working is one of the causes of the Trust;s underlying deficit. Delays in being able to reconfigure services will impact on the Trust's financial recovery plan. ***It should be noted that risks 2827 and 4783 should be read in conjunction with this risk.	The continued funding of medical staff on both sites Nurse led service managing Paediatrics Critical care still being managed on both sites High usage of locum doctors Frequent hospital to hospital transfers to ensure access to correct specialties The Trust has developed a contingency plan should it not be able to provide sufficient medical staffing to provide safe A&E services on two sites.	Financial plans of associated reconfiguration not yet completed or agreed with CCG's Estate limitations inhibit the present way of working Consultant rotas cannot always be filled to sustain services on both sites Interim actions to mitigate known clinical risks need to be progressed.	25 5 x 5	25 5 x 5	15 5 x 3	Joint working is in place with Commissioners (through the joint Hospital Board) to revisit the clinical model, activity, workforce and financial modelling of options for hospital reconfiguration. The Trust is required by Monitor to develop a 5 year strategic plan that will improve the Trust's financial and clinical sustainability. This plan will be completed by December 2015 and will include plans for reconfiguration of services across hospital sites. The Trust's five year plan will inform and enable CCG's to make a decision in early January to commence public consultation. The Trust has developed and is discussing with CCGs options for progressing interim actions to mitigate known clinical risks (cardiology and respiratory service configuration, Emergency Pregnancy Assessment configuration).	Dec-2015	Jan-2016	WEB	Anna Basford	Catherine Riley
Major	6346	Trustwide	All Divisions	All Departments/Wards	Jul-2015	Active	Transforming and improving patient care	Capacity and Capability of Delivering Service Transformation Risk of not achieving service transformation due to insufficient capacity and capability across the organisation to deliver the many transformation schemes underway (Electronic Patient Record (EPR), clinical administration review, financial turnaround and cost improvement schemes, CQC preparation, service reconfiguration, i.e. consultation and planning for Outline Business Case, Care Closer to Home Proposal) resulting in impact on delivery of safe clinical care for patients in the right setting and financial imbalance.	Programme Management Office established to managing schemes Strategic and Financial Turnaround Plan, 2015/166 financial plans and cost improvements Integrated Board report details Trust financial position monthly Well Led Governance Review identifies areas to strengthen governance across the Trust CQC Steering Group reviews progress with CQC action plan preparation to identify areas of risk of non-delivery EPR implementation programme	Assurance that the totality of transformation schemes can be delivered	16 4 x 4	20 4 x 5	9 3 x 3	To consider adding the risk to the Board Assurance Framework. July update: Workshop held with Executive team to consider this conflicting priorities. A number of proposals developed to be discussed at next Directors meeting.	Dec-2015	Mar-2016	WEB	Julie Dawes	Director of Nursing, Julie Dawes

Major	6345	Trustwide	All Divisions	All Departments/Wards	Jul-2015	Active	Keeping the base safe	Staffing Risk Risk of not being able to deliver safe and effective high quality care and experience for patients due to: - lack of nursing staffing as unable to recruit to substantive posts, i.e. not achieving recommended nurse staffing levels (as per Hard Truths workforce model) - lack of medical staffing as unable to recruit to Consultant / middle grade doctor / junior doctor vacancies across a number of specialties (A&E, Opthalmology, Anaesthetics, Paediatrics, Histopathology, Radiology, Gynaecology/Urology Oncology, Acute Oncology Service) - over-reliance on middle grade doctors meaning less specialist input - dual site working and impact on medical staffing rotas - lack of workforce planning / operational management process and information to manage medical staffing gaps - 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, 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). Risk that patients in extra capacity wards (6A, 5B, 4D & HRI11) cannot be safely cared for due to insufficient nursing staff across the whole acute medical directorate - no established workforce for these area, directorate averages 50WTE Band 5 vacancies, resulting in possible harm to patients, poor management of deteriorating patients, poor patient experience and negative feedback.	Nurse Staffing: To ensure safety across 24 hour period: electronic duty roster, approved by Matrons, risk assessment of nurse staffing levels per shift and escalation process to Director of Nursing to secure additional staffing, staff redeployment, staff skill mix, eg extend roles of nursing / AHePs, use of flexible labour for staffing shortfalls, review of interim resource costs as part of control workstream. 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. Medical Staffing: Medical Workforce Groupealing with recruitment and selection, international recruitment, non-contract spend, and controlling the deployment of staff by improved rota management. Exit interviews for Consultants. Therapy Staffing: posts as flexible as possible, review of skill mix across the workforce with development of Assistant Practitioner posts where appropriate. Increase availability of flexible work force by actively recruiting bank staff and staff to work additional hours. All staff: Contribute to Health Education England survey to inform future commissioning / provision of education / training	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 patients Therapy staffing Lack of: - workforce plan / strategy for therapy staff identifying level of workforce required - dedicated resource to develop workforce model for therapy staffing - system to identify changes in demand and activity, gaps in staffing and how this is reflected through block contract - flexibility within existing funding to over recruit into posts/ teams with high turnover	16 4 x 4	20 4 x 5	9 3 x 3	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) October update: Daily review of staffing and patients and re-deployment of staff by matrons Reallocation of Trust staff from within the medical division to support the ward - some wards still to identify named staff to release on an ongoing basis. Monthly job fairs to address vacancies plus overseas recruitment - some nurses already commenced and further due to commence in due course. Weekly "hotspots" escalation to flexible workforce priority for agency for this ward. **November update** Medical Staffing International recruitment is progressing through the procurement process, three potential suppliers are involved, two have been chosen to progress to reference stage and a decision will be made to use either a sole or dual suppliers. A paper will be taken to the Trust Board to approve improvements to the Consultant Recruitment process written by senior clinical and HR colleagues. Senior nursing colleagues have joined the Medical Workforce Group to help in developing a more flexible and responsive clinical workforce to include new roles, skill mixes and ways of working. 1-1 discussions will take place with Consultants planning to leave to aid understanding of the reasons why, to commence January 2016	Dec-2015	Mar-2016	WLG	David Birkenhead, Julie Dawes & Jackie Green	Lindsay Rudge, Jason Eddleston & Claire Wilson
Major	2827	Medical	Emergency Network	Accident & Emergency	Apr-2011	Active	Developing our workforce	There is a risk of poor clinical decision making in A/E due to a dependence on locum Middle Grade Doctors at weekends and on nights resulting in possible harm to patients, extended length of stay and increased complaints ***It should be noted that risks 4783 and 6131should be read in conjunction with this risk.	Associated Specialist and Regular locums for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Where necessary other medical staff re-located to ED Consultants act down into middle grade roles to fill gaps temporarily	Difficulty in recruiting Consultants, Middle Grade and longer term locums Relatively high sickness levels amongst locum staff	20 4 x 5	20 5 x 4	12 4 x 3	Expedite Outline Business case for reconfiguration of services across sites to afford better deployment of medical staff Explore use of ANP to fill vacant doctor posts 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	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/outsourcing if necessary) Formal Finance Our Future training Board to	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. November 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.	Jan-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	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.	Jan-2016	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	Owen Williams	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 in still insufficient at certain times The night period is particularly vulnerable. There is a reliance on locum middle grade doctors due to vacancies	20 4 x 5	16 4 x 4	12 4 x 3	Bed modeling review underway as part of the ED Action Plan. To be completed by mid-June 15 Capacity and demand modeling being undertaken (matching resources to peak activity periods). To be complete by mid-June 15 Urgent Care Board is accessible to consider new initiatives and act as an escalation decision making body in the case of very urgent situations. The Board has reserve resources October update: Daily review of staffing and patients and re-deployment of staff by matrons Reallocation of Trust staff from within the medical division to support the ward - some wards still to identify named staff to release on an ongoing basis. Monthly job fairs to address vacancies plus overseas recruitment - some nurses already commenced and further due to commence in due course. Weekly "hotspots" escalation to flexible workforce priority for agency for this ward.	Dec-2015	Dec-2015	CG	Julie Dawes	Sajid Azeb

Major	5806	Estates & Facilities	Estates, Planning & Contracting	Capital Team	May-2015	Active	Keeping the base safe	There is a risk that the following urgent Estates schemes cannot be undertaken due to insufficient resources, resulting in a poor patient experience, possible ward closures and harm caused by slips, trips and falls A) Failure to maintain privacy and dignity on the Chemotherapy Unit at HRI B) Poor/unsafe flooring in ICU at HRI C) Environmental/safety standards on Ward 18 at HRI D) Temperature control in winter on Ward 4 at HRI E) Poor environmental conditions on Ward 5 at HRI F) Uneven floor surface on Ward 19 G) Poor fitting windows on Ward 6 at HRI H) Damaged floor on CCU at CRH I) A&E Resus requires more space.	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	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	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) ED resus area at HRI. October Update: Chemo Unit transferred onto new facilities. Action complete November Update:- a) Discussions taking place with Estates, Clinicians / A&E to agree suitable location for Resus. b) Monthly meetings organised with Ward Staff / Nursing & Estates to agree a prioritised programme of maintenance work. Dec 15 Update Feasibility on A&E Resus Area taking place.	Mar-2016	Mar-2016	RC	Lesley Hill	Paul Gilling
Major	6078	Family & Specialist Services	Appointments & Records	Appointment Services	Aug-2014	Active	Keeping the base safe	Appointment Slot Issues – A failure to provide sufficient appointment slots to manage demand. Caused by an increase in referrals to services/reduced available capacity to manage demand. Resulting in: - poor patient experience - inability to access referral letter as e-referrals cannot be accessed until an appointment is allocated - increased administration (reliance on spreadsheets to track capacity requirements) - impact on Trust ability to attract income	Process: Daily spreadsheet to Clinical Divisions highlighting capacity requirements. Regular communications with Specialty capacity leads. Reallocation of cancelled slots to maximise capacity.	- Variations in capacity and demand plans. - Consultant vacancy factor. - Manual process in place to record ASIs extracting information from ERS and PAS. - THIS are working on a live document that clinical and administrative leads can access to eliminate the emailing and filtering of spreadsheets on a daily basis.	16 4 x 4	16 4 x 4	4 4 x 1	ASI action plan developed which includes trajectories at specialty level Between August 2015 and November 2015 the volume of ASIs has decreased from 2136 to 1387 which represents a decrease of 32% in ASIs. Further actions planned to improve the position include: - Weekly cross-divisional access Meetings established (at ADD level) to monitor performance. - Continued review of clinic templates providing increased capacity for new patient slots - Development of a capacity management team within appointment centre which will help improve the utilisation of clinics - Development of the Knowledge portal as a capacity planning tool to assist directorates.	Jan-2016	Jan-2016	PCB	Julie Dawes	Rob Aitchison / Katharine Fletch

Major	6300	Trustwide	All Divisions	All Departments/Wards	May-2015	Active	Keeping the base safe	Clinical, operational and estates risks in:Children and young people, maternity and family planning, out patients and diagnostic imaging, A&E, Medical care, end of life care, surgery causing increased risks to patients and possible non-regulatory compliance which may result in CHFT not achieving a CQC rating of good or outstanding (e.g. Estates risks; Paediatric Standard compliance; A&E National Standards compliance), which could cause the Trust to have breach of licence.	- System for regular assessment of Divisional and Corporate compliance - Routine policies and procedures - Quality Governance Assurance structure - CQC compliance reported in Quarterly Quality and Divisional Board reports - Weekly strategic CQC meetings	- Full Divisional and Corporate self-assessment still to be completed - Some out of date policies and procedures - Assessments show us to be be in the "requiring improvement" category	16 4 x 4	16 4 x 4	8 4 x 2	- CQC compliance Steering Group - Implementation CQC Compliance action plan - CQC Operational Group - Further embedding of CQC assurance into the Divisions and Corporate Governance structures 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	Feb-2016	Feb-2016	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 Greater Huddersfield CCG and Kirklees and Calderdale Councils undertaking competitive procurements. This could have negative impact by increasing the Trust's underlying deficit and on the clinical resilience and stability of retained services.	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. November 2016 Update: The Trust is awaiting update from Kirklees Council regarding their review of the procurement of sexual health services.	Jan-2016	Jan-2016	CISC	Anna Basford	Rob Aitchison & Lisa Williams
Major	6499	Community	Intermediate Care & Community	All Departments	Dec-2015	Proposed for Acceptance	Keeping the base safe	Failure to meet minimum standards for CQC registration. Caused by a material breach of one or more fundamental CQC standards. This may result in an unsatisfactory rating damaging the Division's, and possibly the Trust's, reputation	Compliance with Trust Policies, procedures and Guidelines. Adherence to Clinical Governance policies and practices. Staff are aware and understand the fundamental standards and what to do to meet them.	See CQC readiness assessment and action plan (Oct 2015)	15 5 x 3	15 5 x 3	12 4 x 3	All Division CQC 90-day plans have been refreshed. See 90-day plans for details. External scrutiny and challenge to plans provided by internal peers and Deborah Turner.	Feb-2016	Mar-2016	PSQB	Helen Barker	Jo Middleton - matron

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.	• 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.	Jan-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.	Jan-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. This arises from: Voice Recognition - releasing workforce through the voluntary redundancy and MARS schemes without the implementation of Voice Recognition. V.R solution is being tested in December 2015, full scale implementation date of July 2016. 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. This is resulting in time delays and failure demand within the current workflow from CHFT SLAs (e.g.): 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 resulting 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) · Implementation of the Voice Recognition software (Project) - 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 milestone) to the appropriate users. · 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. Voice recognition – temporary staff - transition period for an experienced medical typist to achieve	15	15	9	Voice recognition: December 18th 2015 end of the testing phase and future review C.A.T: Turnaround Executive to make investment decision E.P.R: System implementation August 2016	Jul-2011	Mar-2017	NA	Chief Operating Officer	Rob Aitchison, FSS
									5 x 3	5 x 3	3 x 3							

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 competed by end October 2015 by V. Wotherspoon 2/3. Medical devices database audit by V. Wotherspoon, completion August 2016 to ensure accurate picture of devices needing maintenance and location of devices.. 4. Review final report and actions of independent assessor (due September 2015) and amend plans accordingly. 5. Newly recruited Medical Engineer to start September 2015 6. Medical Engineering team to move to Estates from end of September 2016 to ensure systems and processes for medical devices are closely monitored.	Feb-2016	Aug-2016	DB	Lesley Hill	V Wotherspoon
Moderate	6094	Corporate	Medical & Nursing Directors Office	Medical Education - Post & Under Grad	Jun-2014	Active	Keeping the base safe	There is a potential loss of training grade posts due to national reductions in numbers or 'gap allocation' which may have an impact on direct service delivery and service stability. There is a risk of industrial action by junior doctors that will result on the ability of the Trust to deliver a full range of services.	Regular dialogue with the Deanery to maintain awareness of which posts may be under threat and as a consequence look at alternative ways of delivering the service. Monitoring closely the results of the GMC and Deanery placement surveys and acting upon any areas identified in need of improvement to minimise the risk of posts being removed.	This risk may now increase due to current issues with junior doctor contract negotiations. If junior doctors choose to work overseas then this will further exacerbate the problem.	12 4 x 3	12 4 x 3	8 4 x 2	Action planning following GMC/HEYH Surveys. November update-planning to take place within divisions to mitigate risk of potential industrial action	Feb-2016	Mar-2016	NA	David Birkenhead, Medical Director	Dr Andy Lockey

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Jackie Murphy, Deputy Director of Nursing
Date: Thursday, 17th December 2015	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: NURSE REVALIDATION - From April 2016 nurses and midwives in the UK will be legally expected to undertake a process of revalidation every 3 years in order to remain on the nursing register. This paper describes the purpose and the expectation that has been agreed by the Nursing and Midwifery Council (NMC). It describes the implications to the Trust including the significant risks for consideration by the Board.	
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:

• All nurses will have to revalidate every 3 years
• A performance management system for appraisal, mandatory and essential skills will be crucial
• Registered nurses will be expected to undertake and evidence 450 hours of nursing practice over 3 years which will have implications for colleagues who are registered but are not employed in a nursing role
• All nurses will be expected to undertake 35 hours of professional development over 3 years; 20 hours of which has to be interactive – this will have implications on the allocated absence assumption in ward/dept. budgets
• All nurses will be expected to participate in a professional conversation (with a confirmer) to discuss 5 pieces of reflection in relation the Nursing Code of Conduct and 5 pieces of feedback to facilitate learning. It is anticipated that the conversation will take 2 to 3 hours which is not currently factored into the establishment headroom.
• Nurses will be expected to utilise the documentation mandated by the NMC

Main Body

Purpose:

To update the Board of Directors with regards to the current position in relation to Nurse Revalidation.

Background/Overview:

See report

The Issue:

See report

Next Steps:

The Board is asked to support the revalidation process to ensure there is a robust system for continuing professional development and a performance management system for appraisal, mandatory and essential training in order to be assured that nurses and midwives remain fit for practise.

The Board is also asked to be aware of the additional time commitment to give and receive third party feedback.

Recommendations:

The Board is asked to support the revalidation process to ensure there is a robust system for continuing professional development and a performance management system for appraisal, mandatory and essential training to be assured that nurses and midwives remain fit for practise.

The Board is also asked to be aware of the additional time commitment to give and receive third party feedback.

The Board is asked to note the retention risk associated with revalidation.

Appendix

Attachment:

Nurse Revalidation - DEC 2015.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Board of Directors: 17 December 2015 **Agenda Item Number:**

Report to:	Board of Directors – December 2015
Subject:	**NURSE REVALIDATION**
Sponsored by:	Julie Dawes, Director of Nursing
Prepared by:	Jackie Murphy, Deputy Director of Nursing
Purpose of the Report:	From April 2016 nurses and midwives in the UK will be legally expected to undertake a process of revalidation every 3 years in order to remain on the nursing register. This paper describes the purpose and the expectation that has been agreed by the Nursing and Midwifery Council (NMC). It describes the implications to the Trust including the significant risks for consideration by the Board.
Key Points for Trust Board Members:	• All nurses will have to revalidate every 3 years • A performance management system for appraisal, mandatory and essential skills will be crucial • Registered nurses will be expected to undertake and evidence 450 hours of nursing practice over 3 years which will have implications for colleagues who are registered but are not employed in a nursing role • All nurses will be expected to undertake 35 hours of professional development over 3 years; 20 hours of which has to be interactive – this will have implications on the allocated absence assumption in ward/dept. budgets • All nurses will be expected to participate in a professional conversation (with a confirmer) to discuss 5 pieces of reflection in relation the Nursing Code of Conduct and 5 pieces of feedback to facilitate learning. It is anticipated that the conversation will take 2 to 3 hours which is not currently factored into the establishment headroom. • Nurses will be expected to utilise the documentation mandated by the NMC
Next Steps Future action:	The Board is asked to support the revalidation process to ensure there is a robust system for continuing professional development and a performance management system for appraisal, mandatory and essential training in order to be assured that nurses and midwives remain fit for practise. The Board is also asked to be aware of the additional time commitment to give and receive third party feedback.
Strategic Aim	Keeping the Base Safe

NURSE REVALIDATION

1.0 INTRODUCTION

This paper describes the Nursing and Midwifery Council requirement for all registered nurses and midwives to undertake a process of revalidation every 3 years.

Nurses and Midwives will need to revalidate at the point of the renewal of their registration in order to remain on the NMC register.

This is a legal requirement for all nurses and midwives who work in the UK and is a key recommendation following the Francis Inquiry.

The new system of revalidation replaces the current process of post registration education and practice (PREP), and comes into effect April 2016. This means that by April 2019 all nurses and midwives on the register will have undergone revalidation.

2.0 PURPOSE

The purpose of revalidation is to improve public protection by making sure that nurses and midwives continue to be fit for practise throughout their career. Furthermore, it ensures that employers can be assured that the nurses and midwives are deemed fit to practise.

It aims to prevent scandals such as Mid Staffordshire by improving patient safety and ensuring all nurses and midwives are providing care that is an acceptable standard.

This means that nurses and midwives need to do more to remain on the Nursing and Midwifery Council Register.

Registrants need to stay up to date in their professional practice, develop new skills, keep up to date on standards and understand the changing needs of the public they serve and fellow healthcare professionals with whom they work.

It is not about addressing bad practice amongst a small number of nurses and midwives; it is about promoting good practice across the whole population of nurses and midwives.

3.0 PROCESS

Revalidation is a process that all nurses and midwives will need to comply with to demonstrate that they are fit to practise throughout their career.

All nurses and midwives will have ownership of, and will be held accountable for their own revalidation process.

All nurses and midwives are currently required to renew their registration every three years; however, revalidation will strengthen the renewal process by increasing professionalism and introducing new requirements. Nurses and midwives will be

required to;

- Declare they have practised for 450 hours during the three years.
- Demonstrate up-to-date practice and professional development; 35 hours over 3 years, 20 hours of which is interactive.
- Produce five reflective pieces on the professional standards of practice and behaviour as set out in the Code;- **http://www.nmc-uk.org/Publications/Standards/The-code/Introduction/**
- Ensure the reflection is discussed with another registrant.
- Demonstrate engagement in professional discussions with other registered nurses or midwives.
- Obtain five pieces of feedback based on practice (this can be formal or informal, written or verbal and for peers, professional's or patients.
- Registrants need to ensure they have indemnity insurance.

The revised system requires an additional level of monitoring as every nurse and midwife will need to be signed off by their manager or someone in a similar position.

The NMC requires confirmation is received from someone well placed to comment on a nurse or midwife practice. This will confirm that a nurse or midwife is performing to the standard set out in the Code and it will be based on information available at the time.

If a nurse or midwife fails revalidation, they will not be registered to work legally in the UK.

4.0 PROGRESS IN CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST (CHFT)

A Task and Finish approach led by the Deputy Director of Nursing has been adopted to ensure the Trust is ready to revalidate nurses and midwives.

The group have undertaken a go see and participated in sessions facilitated by NHS England in order to ensure the CHFT process is robust.

Colleagues due for revalidation in April, May and June have been identified and offered personal support to ensure they are ready.

Managers will receive an alert of colleagues due to revalidate to ensure they can be offered support if necessary.

Nurses and Midwives will be contacted by the NMC to inform them when they are due to revalidate.

The appraisal tool indicates the requirements of revalidation to act as a prompt to discuss the expectations.

Presentations have been undertaken to inform the nursing and midwifery workforce

of revalidation, including reflection and lifelong learning.

All nursing and midwifery staff due to revalidate have been written to by the Director of Nursing to inform them of revalidation.

5.0 NEXT STEPS

Further presentations are planned for December 2015.

Communicate and offer individual support to nurses and midwives who will revalidate in April, May and June 2016.

Continue to scope an electronic portfolio.

Develop the process to verify nurses and midwives have been revalidated when commencing employment at CHFT.

6.0 RISKS

Retaining nurses and midwives who are due to revalidate over the next 3 years who are close to retirement and may chose to leave the profession rather than revalidate.

Ensuring there are robust systems to alert of the nurses and midwives to revalidate every three years.

Currently not achieving 100% compliance with appraisal.

Many nurses and midwives in the Trust do not work in nursing and midwifery roles.

Additional time expected for CPD.

Additional time expected for reflection and supervision.

All nurses and midwives keeping an e portfolio.

Expectation of registered nurses and midwives working in non-nursing roles undertaking 450 hours of practice in order to remain on the register.

Dual registrants (e.g. nurse/midwife) will be expected undertake 450 hours of practice in both disciplines.

7.0 SUMMARY

The Board is asked to support the revalidation process to ensure there is a robust system for continuing professional development and a performance management system for appraisal, mandatory and essential training to be assured that nurses and midwives remain fit for practise.

The Board is also asked to be aware of the additional time commitment to give and receive third party feedback.

The Board is asked to note the retention risk associated with revalidation.

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 17th December 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: GOVERNANCE REPORT - DECEMBER 2015 - This report brings together a number of governance items for review and approval by the Board.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

This report brings together a number of governance items for review and approval by the Board:
1. Board of Directors attendance register
2. Q2 Feedback from Monitor
3. Update on Board appointments
4. Board work plan
5. Use of Trust seal
6. Calderdale artefacts

Main Body

Purpose:

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

Background/Overview:

The Issue:
1. Board of Directors attendance register
The Trust's Standing Orders state that 'the names of the Chair and directors present at the meeting shall be recorded in the minutes. The Secretary shall maintain a record of the number of meetings of the Board of Directors and the attendance of individual directors.'
The attendance register from April to October 2015 is attached at appendix 1.

The Board is asked to NOTE the attendance register.

2. Q2 2015-16 submission feedback from Monitor
The Trust received feedback from Monitor in relation to the Q2 15/16 submission on 15 September. A copy of the letter is attached at appendix 2. Clarification is being sought in the discrepancy between the Trust's agreed calculation of the FRR and that reported in this letter. An update will be provided to the Board once received.

3. Update on appointments to the Board.
At the September Nominations and Remuneration (Board of Directors) Committee it was agreed to recruit to the position of Chief Operating Officer. Helen Barker was the successful candidate and will take up post from 1 January 2016.

The Nominations and Remuneration (Membership Council) Committee met on 7 December 2015 and agreed the recruitment of two Non-Executive Directors and supported the recommendation that candidates be sought with experience of the commercial sector or HR / workforce. The advertisement for these posts was placed on 8 December with a closing date of Wednesday 13 January 2016. Interviews are scheduled for week commencing 25 January 2016.

The Board is asked to NOTE the progress in appointments to the Board of Directors.

4. Board work plan
The Board work plan has been updated and is presented to the Board for review at Appendix 3.

The Board is asked to CONSIDER whether the items allocated for the January meeting are correct and if there are any other items they would like to add.

5. Use of the Trust seal
Five documents have been sealed since the last report to the Board and a copy of the register of sealing is attached for information at Appendix 4. These were in relation to:
- The refurbishment of the Child Development Unit at Calderdale Royal into the new Rainbow Unit (2

documents)
- Building works in relation to key fob changes at Calderdale
- The deed for St Luke's Hospital between Pennine Property Partnerships, Kirklees Council and the Trust
- A licence for Dental Care Direct to occupy rooms at Huddersfield Royal Infirmary.

The Board is asked to RATIFY the sealings.

5. Calderdale Artefacts
The Board will be aware that the Trust holds a number of artefacts that were kept following the closure of the Halifax Royal infirmary. The Trust was approached a number of years ago by the Halifax Royal Infirmary Hospital Management Company and the Halifax Civic Trust to request that the artefacts be held and displayed within the old building (now apartments) given their historical significance to that property.

There has been significant work since this time to locate and itemise the artefacts which include paintings, plaques, trophies and a number of small trophies. A full itemised list of the items is available for the Board to review. Following several discussions and legal advice, it is recommended that, subject to a final valuation report, the items be transferred to the management company under an exhibition agreement. A copy of this agreement is available for review if required. While they remain the property of the Trust, this agreement will enable the management company to display and archive the artefacts. Further work will then be undertaken to look at the possibility of giving the artefacts to the management company.

There are three items which reference existing organisations in Halifax:
- The Queens Club cup
- The Halifax Infirmary Football Cup
- Lister Horsfall Cricket Trophy

It is proposed that these organisations be approached separately to see if they would like to receive these items under the same terms.

The items will be insured by the management company while in their possession. The Company Secretary has reviewed the proposed locations for display and storage of the items to ensure that these are secure.

The Board is asked to APPROVE the proposal in relation to the Calderdale artefacts.

The Issue:

As above

Next Steps:

As above

Recommendations:

-The Board is asked to receive the report and:
- Note the Board of Directors attendance register
- Receive the Q2 Feedback from Monitor
- Note the update on Board appointments
- Note and comment on the Board work plan
- Ratify the use of Trust seal
- Approve the plan for the Calderdale artefacts

Appendix

Attachment:

COMBINED GOVERNANCE REPORT - 17.12.15 BOD.pdf

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Attendance	✓	Apologies	×	Not co-opted	-

ATTENDANCE REGISTER – BOARD OF DIRECTORS
1 APRIL 2015 – 31 MARCH 2016

DIRECTOR	23.4.15	28.5.15	25.6.15	30.7.15	27.8.15	17.9.15 JOINT AGM	24.9.15	29.10.15	26.11.15	17.12.15	28.1.16	25.2.16	31.3.16	TOTAL
A Haigh (Chair)	√	√	√	√	x	√	√	√						/13
D Anderson	√	√	√	√	√	x	√	√						
P Oldfield	√	√	√	√	√	x	√	√						
L Patterson	√	√	√	x	x	√	√	√						
J Pease	√	√	√	√	√	√	√	x						
P Roberts	√	√	√	√	√	√	√	√						
J Wilson	√	√	√	√	√ (Acting Chair)	√	√	√						
O Williams	√	√	x	√	x	√	√	√						
D Birkenhead	√	√	√	√	√	√	√	√						
J Dawes	√	√	√	√	√	√	√	√						
K Griffiths	√	√	√	√	x	√	√	√						
L Hill	√	√	√	√	√	√	√	√						
J Hull	x	x	x	x	x	x	x	x	x					
Vicky Pickles	√	√	√	√	√	√	x	√						
J Green (Interim Dir W & OD from April 2015)	√	√	√	√	√	-	-	-						
A Basford	-	√	√	√	√	-	√	-						
H Barker	-	√	√	-	√	-	√	√						

1 December 2015

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

Monitor
Making the health sector work for patients

Wellington House
133-155 Waterloo Road
London SE1 8UG

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

Dear Owen

Q2 2015/16 monitoring of NHS foundation trusts

Our analysis of your Q2 submissions is now complete. Based on this work, the trust's current ratings are:

- Financial sustainability risk rating: 1
- Governance rating: Red

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

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

We have raised the concerns arising from our review of the trust's Q2 submissions as part of our regular Progress Review Meetings.

A report on the FT sector aggregate performance from Q2 2015/16 is now available on our website[1] which I hope you will find of interest.

We have also issued a press release[2] setting out a summary of the key findings across the FT sector from the Q2 monitoring cycle.

If you have any queries relating to the above, please contact me by telephone on 020 3747 0484 or by email (Kemi.Oluwole@monitor.gov.uk).

[1] https://www.gov.uk/government/publications/nhs-providers-quarterly-performance-report-quarter-2-201516
[2] https://www.gov.uk/government/news/challenging-environment-for-nhs-providers

Yours sincerely

Kemi Oluwole
Senior Regional Manager

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

BOARD WORK PLANWORKING DOCUMENT – NOVEMBER 2015 - LATEST update TO BOD 17.12.15 – NOT YET SUBMITTED

Date of meeting	23 April 2015	28 May	25 June	30 July	27 Aug	24 Sept	29 Oct	26 Nov	17 Dec	28 Jan 2016	25 Feb 2016	31 March 2016
Date of agenda setting/Paper Review of drafts						14.9.15	19.10.15	6.11.15	7.12.15	18.1.16	15.2.16	21.3.16
Date final reports required	15.4.15	10.5.15	17.6.15	22.7.15	19.8.15	16.9.15	21.10.15	18.11.15	9.12.15	20.1.16	17.2.16	23.3.16
STANDING PUBLIC AGENDA ITEMS												
Introduction and apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Patient Story	✓	✓	X	X	✓	✓	X	✓				
Chairman's report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chief Executive's report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Integrated Board report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
DIPC report	✓	✓	✓	✓	✓	✓	✓	✓			✓	
Minutes of sub-committees	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
REGULAR ITEMS												
Board Assurance Framework (Quarterly)				✓		✓	✓	✓			✓	
Risk Register	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Governance report: to include such items as: - Standing Orders / SFIs review - Non-Executive appointments - Board workplan - Board skills / competency - Code of Governance - Board meeting dates - Committee review and annual report - Annual review of NED roles - Use of Trust Seal - Quarterly Feedback from Monitor			✓			✓			✓			✓
Care of the acutely ill patient report	✓		✓		✓		✓		✓		✓	

BOARD WORK PLANWORKING DOCUMENT – NOVEMBER 2015 - LATEST update TO BOD 17.12.15 – NOT YET SUBMITTED

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

BOARD WORK PLANWORKING DOCUMENT – NOVEMBER 2015 - LATEST update TO BOD 17.12.15 – NOT YET SUBMITTED

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

BOARD WORK PLANWORKING DOCUMENT – NOVEMBER 2015 - LATEST update TO BOD 17.12.15 – NOT YET SUBMITTED

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

Register of Sealings or Executions

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

REGISTER OF SEALINGS OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED	PERSONS ATTESTING SEALING OR EXECUTION
236		4/11/15	PFI Hospital Project – Confirmed Variation Instruction No. 60 – CHFT & Calderdale Hospital SPC Ltd	V.L. Pickles. COMPANY SECRETARY
237		4/11/15.	Confirmed Works Variation relating to Ashdale Ward Key Fob System – CHFT & Calderdale Hospital SPC Ltd	V.L. Pickles. COMPANY SECRETARY

REGISTER OF SEALINGS OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED	PERSONS ATTESTING SEALING OR EXECUTION
238	9.11.15	9.11.15	Deed – under Section 106 of the Town & Country Planning Act 1990 relating to land former St Luke's Hospital, Huddersfield Deed between Kirklees Council/CHFT/Pennine Property Partnership	**Name:** V Hickey. **Title:** COMPANY SECRETARY. Julie Dowd. **Name:** **Title:** Director of Nursing + OPS.

REGISTER OF SEALINGS OR EXECUTIONS

CONSECUTIVE NUMBER	DATE OF SEALING OR EXECUTION	DATE OF AUTHORITY	DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED	PERSONS ATTESTING SEALING OR EXECUTION
239	3.12.15	3.12.15	License to occupy rooms within HRI by Dental Care Direct	Name: Julie Davis Title: DIRECTOR OF NURSING Name: V.L Pickles. Title: COMPANY SECRETARY.

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 17th December 2015	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: CARE OF THE ACUTELY ILL PATIENT UPDATE (CAIP) - This paper provides the Board with an update on the Care of the Acutely Ill Patient programme which is aiming to reduce avoidable mortality for our patients.	
Action required: 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 note:-
• HSMR and SHMI remain higher than target, with no reduction expected in the near future.
• Actions off the back of the HSMR deep dive in conjunction with the Improvement Academy.
• 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 consultant colleagues allocated time specifically for coding and mortality reviews.
• Clinical Coding support into the upper gastrointestinal team.
• A regular monthly report of findings is in place, scheduled for CEAM and COG. There will be a focus on learning from the review findings, and implementing targeted actions to make improvements
• New Bundle process to be tested in January 2016
• Clinical Leadership Fellow will commence her role in December to examine the e-handover and Hospital @ Night model locally
• DNACPR compliance continues to improve.

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 CAIP Update.

Appendix

Attachment:

CAIP programme summary for BoD_Dec 2015_v5.pdf

Care of the Acutely Ill Patient programme

Progress Report for Board of Directors; December 2015

1. Introduction

The Care of the Acutely Ill Patient (CAIP) programme commenced in September 2013, and was revised in August 2014 and again 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 divided into six themes:

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

This is a working document and is reviewed with updates monthly to the Clinical Outcomes Group (COG).

2. Current Mortality Position

2.1 HSMR – The most recent published rolling 12 months data for HSMR, Sept '14 to August'15, indicates a score of 116.44, showing no significant change since the previous release.

Indicator	Target	Oct-15	Nov-15	Performance Tre
Rolling 12 month SHMI (from HED Monthly – latest HSCIC publication date) April 2014– March 2015	100	108.9		↓
HSMR – comparing to same time period as latest SHMI	100	110.01		↑
HSMR – September 14– August 15	100	116.15	116.44	↑

2.2 SHMI – The most recent published SHMI was released in October, and shows a slight decrease from 109.3 to 108.9

2.3 Crude Mortality - Overall our latest current rolling 12 month mortality rate (Dec 14 – Nov15) is higher than the same time period last year, 1.37% vs 1.24%.

The table below show the month on month Crude Mortality rate, from April 15. Although November 15 is lower than the same month in the previous year, the YTD position shows that overall crude mortality is higher than it was YTD last year.

Indicator	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15		YTD	Performance Tre
Number of In Hospital Deaths	NA	159	140	120	118	120	120	122	131		1030	
% Crude Mortality - All Admissions	NA	1.62%	1.41%	1.19%	1.08%	1.17%	1.20%	1.22%	1.33%		1.28%	
% Crude Mortality - Previous year		1.28%	1.25%	1.12%	0.98%	1.21%	1.08%	1.09%	1.38%		1.17%	

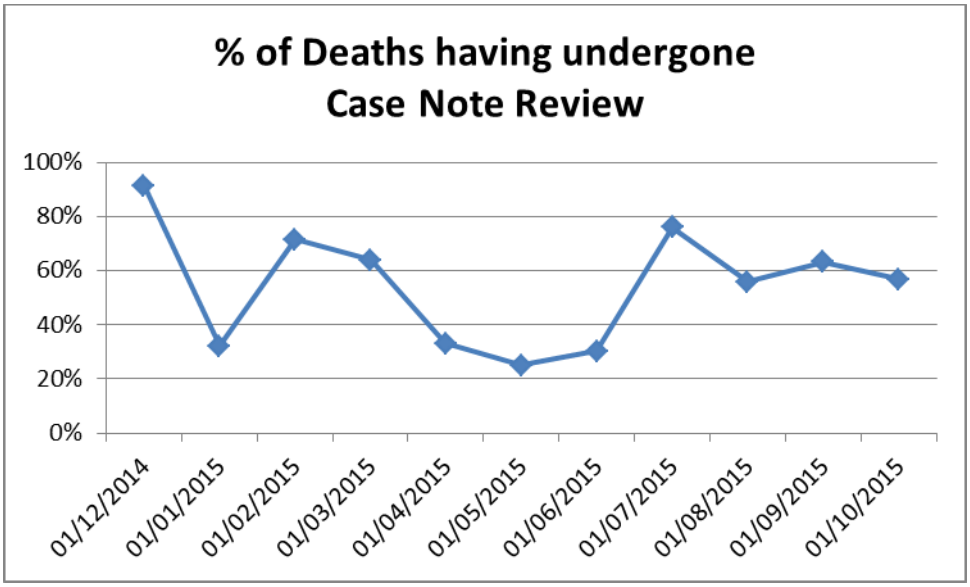
3. Investigating Causes of Mortality and Learning from Findings

3.1 Current position

3.1.1 Level one reviews

In order to identify key problem areas to focus improvements, the Trust remains committed to the aim of reviewing 100% of its mortality cases. At present, the trust is sustaining 50% of deaths being reviewed. The new process commenced in August (July's deaths) resulted in 75% of reviews being completed and performance was expected to improve from that point, however challenges remain in fully supporting the process and performance has remained at an average of 58% over the latest 3 months. Since December this has resulted in 1569 case notes having undergone reviews from which learning has been drawn.

The charts below show the current position.



3.1.2 Learning from Mortality

Since the start of the revised mortality review process, there is recognition of the need to share the learning, this is done at present through the Learning from Mortality report shared at CEAM and COG. In summary the latest report noted that in September:

74 of the 117 adult deaths were reviewed.
61 cases were assessed as Hogan score 1 (no evidence of preventability).
8 cases were a Hogan score 2 (Slight evidence of preventability, but unlikely to have affected outcome) the main issues identified by reviewers were:

- Waiting in CDU for Hospital Beds
- Delay to senior review at the weekend
- Limited evidence of responses to NEWs score

5/74 cases were judged requiring a second review (3 x Hogan 3, 1 x Hogan 4, 1x Hogan 5). These reviews are currently in progress and will be reported in the next monthly mortality review report. This is now scheduled to present monthly to Clinical Effectiveness, Audit and Mortality (CEAM) Group and COG with a summary of the review of compliance, findings, learning and actions.

3.1.2 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. 80% of these cases have been reviewed to date and the attention is now being given to have the provisional findings reported back at the December COG.

The Trust will continue to seek external peer review of our clinical services to confirm that they are of high quality and to identify areas for improvement.

Professor Mohamed A Mohammed of Bradford University presented findings back to the Board in relation to CHFTs HSMR over the last three years. Data patterns revealed that there appeared to be a systematic difference in the HSMRs of the two hospital sites; however it was felt that recent HSMR increases reflected the natural variation in HSMR scores as similar peaks and flows had been seen throughout the three years of data similar patterns noted in comparable trust's data. Professor Mohamed was keen to point out that there is at present no national academic evidence that high HSMRs directly relate to poor quality of care. Case note review is recognised as the only way to identify quality of care concerns.

3.2 Next steps

There are plans to develop an online data collection process to support the timeliness of Mortality Review feedback. The process has currently been paused as it has been decided to engage further with the Improvement Academy in relation to content of structure of the tool to ensure some consistency with the regional approach.

The job description for consultant additional PA mortality reviewers has received a number of applicants and it is expected that there will be people in post for these roles early 2016.

In respect to Professor Mohamed's findings, work is commencing to look at palliative care provision in each hospital, the documentation and coding of patient comorbidities and the % of patient who die in hospital as opposed to those within 30 days of discharge. All of these were felt to be factors that might influence site differences in HSMR.

4. 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.

4.1 Current Position

4.1.1 Care Bundles

The care bundles work has adopted the PMO approach, overseen by the newly-formed Clinical Standardisation Group, which first met on 1st September. 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.

It was agreed by the CEAM Group than there is a suitable amount of baseline data and that auditing will be paused whilst the new bundle paperwork (see appendix A) is incorporated into the relevant documents. A provisional go-live date for testing this approach has been scheduled for the 18th January. Audit will recommence at that time.

4.1.2 Conditions currently alerting

An investigation is requested when concerns are raised, either locally or by the benchmarking software alerting the Trust that a condition appears to be outlying with a higher rate than expected. However, there is a need to increase our capacity to review to ensure these are completed. The appointment of clinical mortality reviewers is expected to resolve this issue. A standard reporting template for findings of these reviews has been produced alongside the Mortality Review Process to try to facilitate and simplify the generation of the report of findings.

Previously, formal reviews had been previously requested by the Associate Medical Director for:

- Complication of device; implant or graft
- Cancer of colon
- Contusion
- Skin ulcers

- Urinary tract infections
- Chronic obstructive pulmonary disease and bronchiectasis
- Pneumonia (except that caused by tuberculosis or sepsis)

As some of these are no longer alerting there is challenge to ensure prioritisation takes place. The CEAM group now received an alert tracker, decisions are made as to the requirement of the condition-specific reviews, when the condition may only trigger transiently

A review into Diseases of mouth; excluding dental was reported in the previous report. Since then the Urinary Tract Infections (UTI) review has been completed by the Lead Infection Control Doctor and reported to CEAM in November. Of the 20 deaths reviewed, whilst death was not related to the UTI, there were issues identified relating to the early identification of deteriorating patients, work to improve this is already ongoing.

4.1 Next steps

The work stream looking into the Development of Care bundles will go live with the new care bundle processes of the second week in January 2016.

A session is taking place in December with the Palliative Care service to examine the drivers' behind the differences between the CRH and HRI hospital site.

5. Early Recognition and Treatment of Deteriorating Patients

5.1 Current Position

Implementation of 'Nervecentre,' the electronic observation and handover tool to improve accuracy of NEWS and standardisation of escalation is now complete across the Trust except for paediatric areas. Nervecentre needs to be adjusted to take account of the different early warning score that applies in paediatrics.

The outcome measures for this theme are reduction in cardiac arrests and ICU admissions. The chart below (Nov 2015) shows a reduction in cardiac arrests, both of which continue to show improvement.

	Indicator	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	YTD	Performance Tre
Theme 3: Early recognition and treatment of deteriorating	Number of Cardiac Arrests	NA	16	15	20	11	10	9	15	14	110	
	Number of Cardiac Arrests per 1000 bed days (Rate)	0.68	0.77	0.60	0.97	0.54	0.50	0.45	0.66	0.66	0.64	
	Unplanned Admission to ICU	43	37	55	51	45	40	49	49	39	326	

A business case for the implementation of the Hospital at Night (H@N) Task Management module in Nervecentre has now been approved.

The Resuscitation committee is still considering developing a Medical Emergency Team, rather than Cardiac Arrest Team, and team drills / response to simulated crash calls as a training tool to improve communication and teamwork have now commenced.

5.2 Next steps

The Deteriorating Patient work stream is now undergoing further refinement as much of the work planned for the collaborative has now been delivered and improvement in outcomes are being seen. This review will focus on areas for further improvement. Data available on the Nerve Centre system is being utilised to look into how reliably observations are being carried at and how escalation processes are working.

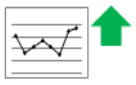
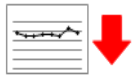
A Clinical Leadership Fellow will commence her role in December to examine the e-handover and H@N model locally and will work with the Nervecentre team on implementation of the H@N Task Management module. There is a plan for the night sisters to receive outreach escalations overnight through Nervecentre, these will be integrated into the H@N system when activated.

6. End of Life Care

6.1 Current Position

A new theme, end of life care, has been added to the revised CAIP plan incorporating DNACPR (appropriate ceiling of care decisions) and also aims to reduce unnecessary admissions for patients who are expected to die within 48 hours, who could have been managed in an alternative location.

The table below is from the November 2015 dashboard.

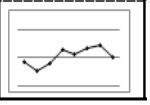
	Indicator	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	YTD	Performance Trends
Theme 4: End of Life Care	DNACPR % Discussion completion	95%	90.5%	83.1%	85.7%	88.4%	86.0%	82.8%	92.3%	93.7%	87.2%	
	DNACPR Review date completion %	95%	76.2%	68.2%	71.1%	74.4%	73.0%	68.1%	84.6%	77.2%	73.4%	

An improvement continues to be seen in compliance with DNACPR discussions, either with the patient or with their family. The % with a review date completed continues to be variable.

The Data is now displayed by individual consultant and ward; this is helping to identify areas in need of further improvement. DNACPR compliance features on the monthly audit as part of the improving clinical documentation work commissioned by the Clinic Records Management Board.

A second focus of work is the roll out of the Individualised Care of the Dying Document (ICODD) within the community. It is a care plan that guides clinical staff caring for patients who are in the last hours or days of their lives, and was implemented in the trust in November 2014. The 'Integrated Care of the Dying Document' (ICODD) is currently in place in the hospitals and hospices, and there is a plan for it to be implemented in the community.

The table below shows the percentages of patients who die in the trust and had an ICODD in place, since April 2015. The level of performance is considered to be reflective of good practice.

	Indicator	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	YTD	Performance Trends
Theme 4: End of Life Care	% of patients on the ICODD	N/A	38.0%	32.7%	37.2%	44.4%	41.7%	45.3%	46.6%	40.0%	40.4%	

4.2 Next Steps

DNACPR stickers to be rolled out Trustwide – These are currently on order with the printers. The stickers are used as a prompt to medical staff to complete a DNACPR form. The feedback received from the pilot wards has been very positive.

Duplicated DNACPR forms printed with a red border have been ordered. This will ensure that a copy remains on the patients' 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.

7. Frailty

7.1 Current Position

Currently the only measure of frailty on the CAIP dashboard is as shown below: % of deaths where the patient is aged 80+, with 3 or more com-morbidities and three or more previous admissions. A seasonal variation is noted.

	Indicator	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	YTD	Performance Trends
Theme 5: Frailty	% frailty Deaths (as a proportion of all deaths)	N/A	10.8%	12.8%	14.7%	6.8%	14.3%	9.2%	8.2%	4.6%	10.9%	

In recognition of the complexity involved with this group of patients, a business case is being worked up to assign an 'in reach' service which will enable a lead nurse to keep track of patients as they are admitted into the hospital. This will mirror a 'frail safe' model adopted by Bradford and entails a rapid assessment frailty screening tool.

At present, there is a task and finish group overseeing developments in this area.

7.2 Next Steps

The Business Case is expected to be completed early in the New Year.

8 Coding

In relation to the CAIP aim of reducing SHMI and HSMR at the Trust, clinical coding is a key theme as it plays a part in the calculation of expected deaths. Accurate coding of patients' co-morbidities and identification of patients receiving specialist palliative care are of particular importance as they affect a patients assessed "likelihood of dying" and therefore the Trust's ratio of actual to expected deaths.

8.1 Current Position

The metrics from the November 2015 dashboard are shown below and show a improvements in Average Diagnosis, Average Charlson Score, completion of Co-morbidity forms and Sign and Symptoms as a Primary Diagnosis.

	Indicator	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	YTD	Performance Tre
Theme 6: Coding	Average Diagnosis	5	4.0	3.9	4.0	4.0	4.1	4.4	4.4	4.5	4.2	
	Average Charlson Score	4	3.6	3.5	3.7	3.5	3.6	3.7	3.9	3.9	3.7	
	Co-morbidity capture	90%	28%	35%	12%	11%	26%	24%	30%	47%	27%	
	% Sign and Symptom	9.5%	9.5%	9.7%	9.6%	10.0%	9.4%	10.9%	10.1%	9.9%	9.9%	
	% Coded with Specialist Pall Care	NA	0.7%	0.6%	0.6%	0.6%	0.6%	0.7%	0.7%	0.7%	0.6%	

Staffing levels remain an issue with recruitment of qualified coders a problem despite rolling adverts. This has resulted in coders coding far in excess of both nationally recommended levels and the level of peer organisations and has also limited the amount of time required for clinical engagement. To address this clinical coder pay structure has been refined as part of a recruitment and retention strategy. Whilst there are still vacancies due to the unavailability of qualified coders in the market place, the decision taken has certainly strengthened our position in the market. In the past 4 weeks 2 fully Accredited Clinical Coders (ACC) and an approved Health and Social Care Information Centre (HSCIC) Clinical Coder Trainer have started in post. Appointment of the trainer will improve the pace at which trainee coders become clinical coders but it can still be a number of years before a trainee will become ACC and fully competent at coding across all specialties.

The team continues to engage as much as possible; the following processes are in place:

- Presentations have gone ahead throughout the year at doctors inductions and within paediatric with provision of bookmarks to act as an aide memoire as to what can and cannot be coded.

- The validation process for deceased patients still includes the Charlson Index scores to aid clinician awareness of co-morbidities that affect HSMR.

- The coding team have built excellent working rapport with surgical teams. Starting imminently Clinical Coders will be supporting ward rounds with Brian Dobbins, Will Ainslie and Arin Saha for a trial period to support the upper gastrointestinal team.

- Within Ophthalmology co-morbidities which affect HSMR/SHMI have been added to the relevant screens within Medisoft software package in conjunction.

- Within Orthopaedics, clinical leadership in utilising the BlueSpier theatre system functionality of electronic capture of operation notes and design of templates to assist capture of key information for coding is in place. All templates are being reviewed and signed off from a coding perspective.

Work has continued to include co-morbidity capture within existing documentation and systems including:

- Medical clerking in proforma
- Acute surgical clerking in proforma
- Paediatric specific proforma
- Endoscopy Pre-Assessment Care Checklist (Colonoscopies/Sigmoidoscopies)
- Pain management pro-forma's
- Pre-operative assessment co-morbidities form

8.2 Next Steps

Staffing: Continue will rolling advert for qualified coders and commence recruitment of 4 additional coding trainees in January 2016 to fill remaining vacancies.

Theatre Op notes: Clinical coders will be integral in the clinician launch event early 2016. Once operational this will enable clinical information to be both easily accessible and easily legible. It is envisaged that other specialties will also move to using this functionality from April 2016.

3M Encoder software deployment: There is a strong belief that the software can support the clinical coding process and increase quality of the coding. After much discussion with the Modernisation team (including Bradford and Cerner) it is now set to progress prior to EPR go-live.

Engagement: 5 doctors to have 1 PA dedicated to improving clinical coding and providing the link to clinical colleagues. This is anticipated to increase the speed of future coding improvement initiatives with known direct links always available to the coding team from a capacity perspective. Colleagues are expected to start this work in January.

To take learning from the recent York visit regarding how EPR assists in the capture of co-morbidities and complexities and implement short, medium and long term plans from this including re-visiting the development of an automated and validated capture of co-morbidities.

Exploration of the development of a training package on clinical coding for clinical team will take place in the coming months.

9. The Board of Directors is asked to note the following:

- HSMR and SHMI remain higher than target, with no reduction expected in the near future.
- Actions following on from the Work of Professor Mohammed in conjunction with the Improvement Academy.
- 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 consultant colleagues allocated time specifically for coding and mortality reviews.
- Clinical Coding support into the upper gastrointestinal team.
- A regular monthly report of findings is in place, scheduled for CEAM and COG. There will be a focus on learning from the review findings, and implementing targeted actions to make improvements
- New Bundle process to be tested in January 2016
- Clinical Leadership Fellow will commence her role in December to examine the e-handover and Hospital @ Night model locally
- DNACPR compliance continues to improve.

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			< 1 hour		
	Prescribe and administer oxygen therapy (if applicable)			< 1 hour		
Severity	Confusion?	Yes +1 ☐	Score:	< 4 hour		
	Urea >7mmol?	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		Target	Time Delivered	Signature
Document Urinalysis Result		<4 hr		
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 USS if possible pyelonephritis or obstruction	Consider renal referral for stage 3 AKI, possible primary renal pathology or previous renal transplant			
AKI CQUIN: Information required at discharge (Mandatory field in Tab 2 of EDS)				
1/ Stage of AKI 2/ If medications stopped indicate if/when to restart	3/ State if any further blood tests required 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 • 30mg prednisolone orally or 100mg Hydrocortisone IV	<4 hr		
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	<4 hr		
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 • 40mg prednisolone orally or 100mg Hydrocortisone IV	<20 mins		
Order and document CXR results	<4hrs		
REMEMBER to complete the ongoing care and Discharge Phase of the Bundle			

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Sue Burton, Medical Education Manager
Date: Thursday, 17th December 2015	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Update on the Revalidation and Appraisal of Non Training Grade Medical Staff - Update the Board on the progress of the Trust towards the management of medical appraisal and revalidation in 2015/16	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: None	
Governance Requirements: Keep the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

Update the Board on the progress of the Trust towards the management of medical appraisal and revalidation in 2015/16

Main Body

Purpose:

The purpose of the purpose is to make the Board aware on the current status of revalidation and medical appraisal completion in the current year (1st April 2015 - 31st March 2016)

Background/Overview:

Medical revalidation was introduced by the GMC in December 2012. It is the process by which licensed doctors will demonstrate to the GMC that they remain up to date and fit to practise (GMC 2010). This will need to be demonstrated to the GMC (normally every five years). One cornerstone of the revalidation process is that doctors will participate in annual medical appraisal

The Issue:

The Trust is required to comply with the GMC requirements regarding medical appraisal and revalidation of medical staff.

Next Steps:

The paper outlines the action plan to improve the current processes in place and the value of revalidation and appraisal

Recommendations:

To receive and note the contents of the paper

Appendix

Attachment:

Revalidation - BoD December 2015.pdf

BOARD OF DIRECTORS – THURSDAY 17 DECEMBER 2015

REVALIDATION AND APPRAISAL OF NON TRAINING GRADE MEDICAL STAFF

1. Introduction

The purpose of this report is to update the Board of the progress of the Trust towards the management of medical appraisal and revalidation this appraisal and revalidation year to date (1st April 2015 – 30th November 2015)

2. Background

2.1 On 19th October 2012, the Secretary of State for Health formally announced the introduction of medical revalidation with effect from 3rd December 2012.

2.2 Revalidation is the process by which licensed doctors are required to demonstrate on a regular basis that they are up to date and fit to practice.

3. Revalidation Cycles

3.1 The first revalidation cycle started in January 2013 and ends March 2018. During this period all doctors to whom the Trust is the designated body will have a recommendation made about their fitness to practise by the Trust's Responsible Officer (the Medical Director).

3.2 The current cycle is in Year 3. The Responsible Officer has made recommendations as follows:

Revalidation Cycle	Positive Recommendations	Recommendation Deferred	Comments on Recommendation Deferred
Year 3, Quarter 1 (April 2015 – June 2015)	17	3	1 positive recommendation subsequently. 1 deferred for 8 months 1 deferred for 1 year
Year 3, Quarter 2 (July 2015 – September 2015)	33	3	1 deferred for 4 months 2 deferred for 6 months
Year 3, Quarter 3 (October 2015 – December 2015)	19	1	1 deferred for 6 months
Year 3, Quarter 4 (January 2016 – March 2016)	Panel scheduled for 11th December 2015	Panel scheduled for 11th December 2015	Panel scheduled for 11th December 2015
Total:	**69**	**7**	**7**

4. Appraisal Compliance

4.1 Medical Appraisal underpins the revalidation process. Doctors are required to have completed an annual appraisal.

4.2 The appraisal year runs from 1st April – 31st March. The table below shows the compliance rate for the current appraisal year as at 30th November 2015.

4.3 Medical Appraisal compliance as at 30th November 2015

Staff Group	Compliance Rate %		
	Total Number of Staff to be appraised	Percentage of Staff currently appraised	
Consultants (including Locums)	215	98	**45.6%**
Staff Grade, Associate Specialists, Specialty Doctors, Trust Doctors, Locum Appointments for Service	95	37	**38.9%**
Trust Total	310	135	**43.5%**

(Staff Numbers sourced from GMC Connect list – 30th November 2015)

The compliance rate is lower than it should be at this stage in the year since a significant minority of doctors still do not undertake their appraisal, as requested, during their month of birth.

The number of appraisals completed at this stage is in line with previous years when we have achieved an overall compliance rate at the end of the year of above 85% (which is in line with the expectations of the NHS England revalidation team).

5. Trained Appraisers

5.1 There are currently 81 trained appraisers (Consultant and Specialty Grades). Of these 56 have attended one of the Appraisal and Revalidation Training days which have been held in the Trust. A further 25 have attended one of the three top up training sessions held.

Top up training sessions have been arranged for 2016.

6. Quality Assurance of the Process

The Trust invited the Regional Revalidation Team to undertake an Independent Verification visit. Whilst we did not fall into any of the categories which trigger a visit, we felt it important to invite them to the Trust to review our processes, particularly in terms of quality assurance. The visit report is attached (Appendix 1).

The visit was positive with no real concerns regarding the systems and processes in place for appraisal and revalidation. The following recommendations were made:

- Regular meetings should be made for appraisers (at least three per year).
- We audit the reasons for a revalidation deferral so we can assess whether it is a system or doctor failure.
- Review how we calculate the 'approved missed' or incomplete appraisal figures reported.
- Quality assure three documents per appraiser per year.

The above have been actioned.

7. Action Plan

a) Appraisal Completion Rate

To end the transition process from April 2016 (this had allowed non training grade doctors the opportunity to gradually move their appraisal date to their month of birth). From 1st April 2016 all non-training grade doctors will be required to complete their appraisal in their month of birth. The only exceptions will be short term contract holders and those doctors born in March since, in line with guidance from the NHS revalidation team, appraisals will no longer be undertaken in the final month of the appraisal year.

b) Medical Appraisal Policy

To revise the policy in line with recommendations made as part of the Independent Verification visit and the NHS England Medical Appraisal (April 2015).

c) Quality Improvement

To place greater emphasis on the individual quality improvement submissions doctors as part of the revalidation/appraisal process.

d) Quality Assurance

To review thoroughly a minimum of 10% of all appraisal forms submitted. This will include appraiser feedback.

e) Appraiser Training

To make it a mandatory requirement that all appraisers attend two half day sessions training sessions over a three year period.

8 Action Required of the Board

The Board is asked to receive this report.

Dr David Birkenhead
Medical Director/Responsible Officer
December 2015

Independent Verification Visit Notes

Organisation: **Calderdale and Huddersfield NHS Foundation Trust (C&H)**		**Date: 16th October 2015**
Attendees		**Meeting time:** 3pm-5:30pm **Location:** Meeting Room 3 Third Floor Acre Mills Outpatients Department Acre Street Lindley Huddersfield HD3 3EB
Dr David Birkenhead	Responsible Officer / Medical Director	
Mr Sudhi Ankarath	Clinical Lead for Revalidation and Appraisal / Consultant Orthopaedic Surgeon	
Ms Claire Wilson	Assistant Director of Human Resources	
Mr Omar Khatab	Revalidation and Appraisal Administrator / Medical Education Co-ordinator	
Dr Paul Twomey	Clinical Lead for Medical Appraisal & Revalidation. NHS England (North)	
Kerry Gardner	Revalidation Programme Manager. NHS England (North)	
Barry Fulton	Lay representative. NHS England (North)	
Janet Bell	Project Support Officer. NHS England (North)	

Notes

Explanation of the independent verification process and reason for the visit

In July, the regional revalidation team completed a desktop review of all designated bodies. There were a number of factors that were looked at which included an appraisal rate <85% and >10% unapproved missed appraisals, significant negative responses in the AOA and limited engagement in the networks.

C&H did not fall into any of these categories and therefore a visit was not necessary but as Dr David Birkenhead had requested a visit the team was happy to oblige. The purpose of the meeting was to enable benchmarking, share good practice and as appropriate provide some formative challenge from the anticipated interactive discussion.

Appraisal

318 doctors have a prescribed connection to C&H. The appraisal uptake is as illustrated in the table below.

	C&H	Same sector	All sectors

AOA 2014/15	87% 276 doctors	81%	86%
Measure 2 14/15 Approved incomplete or missed appraisal	12% 38 doctors	9%	8%
Consultants	9% 20 Doctors	6%	6%
Staff grade, associate specialist, specialty doctor	10% 6 doctors	9%	9%
Temporary or short-term contract holders	33% 12 doctors	20%	17%
Measure 3 14/15 Approved incomplete or missed appraisal	1% 4 doctors	10%	6%
Consultants	1% 3 doctors	8%	7%
Staff grade, associate specialist, specialty doctor	1% 1 doctor	8%	8%

- A discussion around the working definition of an approved missed or incomplete appraisal led to the following points:

    - NHS England advised that newly qualified consultants having completed their ARCP are considered to have been appraised in that medical appraisal year.
    - When completing the AOA, the appraisal status relates to the doctor not the organisation i.e. if a doctor is new to C&H and has had an appraisal in the year in question with another organisation that counts as a completed appraisal.

- **Short term contract doctors**
  On appointment early clarification is sought about the appraisal and revalidation status of all short term contract doctors. The HR department request this information and continuously chase if it is outstanding. The form they use asks for details of the previous RO and C&H are considering asking for a copy of the 360 feedback .

- **360 feedback**
  C&H have observed that the 360 is not a good tool for differentiating doctors. Generally the scores are compressed around a narrow section with most scores hovering around the 5s. Comments are more revealing and in future this survey may need to be more comments based. Paul Twomey agreed with this view which has also been expressed at the networks and will feed this into the national discussions.

- C&H use the MAG form to which the CEO has added an additional 4 questions.

- **Non-participation**
  C&H have an initial reminder letter that is triggered 6 weeks prior to the planned appraisal date. A non-engagement letter is sent 1 month after the appraisal date followed by a 3rd letter informing the doctor that the GMC would be informed and eventual escalation to the MD.

  This was contrasted with NHS England's policy (attached **Paper 1**). Two areas were explored, the early prompting to participate in appraisal for the NHS England framework. Also the potential benefit of a face to meeting within the non- participation process between the RO (or appropriate deputy) and the doctor was highlighted and agreed as a helpful step to focus the doctor's mind regarding their opportunities and responsibilities within the process and the subsequent consequences of non- participation.

- **Allocation of appraisals**
  C&H use the birth month for allocating appraisals. It would be worth considering re-structuring the appraisal year so that appraisals are not scheduled in March and the last two weeks of Feb to provide flexibility and enable uptake within the appraisal year. (NHS England's medical appraisal position statement attached **Paper 2)**

- **Job planning**
  Appraisal is currently separate from job planning but C&H would like this process to be more integrated. It is an opportunity for synergy and an area that many organisations are struggling with but could be very beneficial.

  "CEAMS" (clinical effectiveness mortality group) is going to help the PDP drive discussion led changes.

- **SPA**
  SPA time has not been specifically identified for appraisal and revalidation purposes and a meeting has been arranged with the doctors representative group to address this (Medical appraisal position statement relating to this attached **Paper 3**)

- **Cross speciality appraisal**
  C&H advised that cross-speciality appraisal should be encouraged. Appraisal is considered most effective when it builds on internal peer reviews, MDT meetings and clinical meetings which provide context and reflection for the doctor to feed into their appraisal.

Appraisers

- C&H have 81 trained appraisers which equates to 1appraiser - 4 doctors. They are planning to reduce the number of appraisers.
- The trust policy states that each appraiser should complete 5-10 appraisals a year.
- The NHS England appraisal policy states “Where the ratio of appraisers to doctors is lower than 1:20 or higher than 1:5, the justification for this will be recorded as part of the overall governance review of the appraisal process”.
- C&H have a few SAS appraisers which NHS England has observed helps with compliance and ownership of the programme in this group.
- Regular meetings should be arranged for appraisers amounting to at least 3 per year as detailed in the blueprint.

Monitoring Performance and responding to concerns

- Data is provided annually by the Trust to each appraisee to assist with the appraisal process. The DATIX incident reporting system provides basic information relating to serious incidents, complaints and claims where the doctor is named. The Health Informatics department also provide information relating to CHFT activity data, benchmarking data (Dr Foster) and attendance at audit.
- Concerns flagged up in the appraisal process are escalated to the clinical director if necessary and to the medical director for remediation actions. However, this has to be set in the context of the move towards doctors taking ownership for raising such issues at their appraisal. The aim is to discuss such matters in a formative context with the output being that the issue has been considered and reflected on.
- Every serious concern is reviewed after 72 hours by the MD or director of nursing taking into account the duty of candour.
- There was some discussion about the benefits and opportunities of a regional resource for case investigation as this would be more independent and facilitate the delivery of complex cases in a timely manner.
- C&H expressed an interest in a consultation/decision making panel for difficult decisions that could result in referral to the GMC. The regional team are aware of an organisation that has set one up and will facilitate some liaison around this.
- It is recommended that an organisation has a reciprocal arrangement with another RO for conflict of interest cases. C&H had such an arrangement with Prof. Clive Kay and will seek to establish this with his successor Dr Bryan Gill.

Recommendation process

- It is important that an organisation audits the reasons for deferral so that they can see if it is doctor or system failure.
- C&H asked about how their deferral rates compared with other organisations. Information can be found here: http://www.gmc-uk.org/doctors/revalidation/revalreports.asp
- It is worth assessing if the subsequent action plan for deferred doctors prevented a second deferral.
- The revalidation panel consists of the RO, Clinical Lead for appraisal & revalidation, Assistant director HR, Consultant rep. Non-executive director, doctor's rep, revalidation manager and support staff. This group meets mostly to discuss recommendations where there are issues.
- The doctor gets a formal letter 4 months prior to the panel meeting. This includes details of the revalidation date, date of the panel meeting and the requirements for submission.
- The panel reviews the submission in order to make a decision on the recommendation.

The Framework of Quality Assurance

- All appraisals submitted as part of the revalidation process are reviewed thoroughly by the Revalidation Panel quality assurance group (approximately 33% of all appraisals). This involves a comprehensive review of the appraisal form (appraisal inputs and supporting information).
- To cover scope of work a letter of support is requested from private hospitals where the doctor works and this is reviewed as evidence for revalidation.
- All appraises are asked to provide feedback.
- A peer review of the output forms is fed back to the appraisers
- NHS England advised there is no prescribed coverage of the quality assurance of documents per appraiser; however, in addition to an initial check that all relevant information is provided and the appraisal has been appropriately signed off, a commonly accepted approach is 3 documents per appraiser per year. With the option of additional reviews where indicated where there may be concerns, recommendations due or for new appraisers.
- Some discussion centred on making more use of the skill mix within the team and the use of a standardised quality assurance tool to aid consistency. (attached **Paper 4**)
- C&H will be introducing a more formal and systematic process for assuring the quality of the appraisals submitted. They will also be focussing attention on the quality improvement submissions as part of the appraisal process.

IT system used for revalidation

- C&H currently use one knowledgeable and competent member of staff, a network drive, the MAG form and an excel spreadsheet for recording and monitoring appraisals.

- C&H are exploring the possibility of the introduction of an electronic appraisal system. The systems have quality assurance checks incorporated and it would mean it is possible to physically integrate the Trust values into the appraisal documentation.
- The directory of IT platforms and relevant users in the North was highlighted as a resource to inform their decision making.**(attached Paper 5)**

Kirkwood and Overgate Hospice

- Both Overgate and Kirkwood Hospices share the same RO and as part of good practice, have met to share good practice and reviewed policies, CQC reports and appraisal outputs. These will continue formally on an annual basis, but with informal meetings in between.
- The 2 hospices are contracted through a service level agreement.
- A meeting has been proposed with the appraisal lead to streamline the process.

Summary of C&H planned actions in relation to appraisal and revalidation

- Produce a monthly report on new starters and leavers and update GMC connect
- Introduce the appraisal and revalidation team to new starters at induction
- Hold one to one engagement sessions with new starters
- Appraisal Lead to do RO training as part of succession policy
- Introduce electronic system to support appraisal & revalidation admin.
- Review non-participation process and prompts
- Consider re-structuring the appraisal year
- Address SPA time issue
- Reduce the number of appraisers
- Explore reciprocal RO arrangement with Dr Bryan Gill
- Develop a consultation/decision making panel.
- Quality assure 3 documents per appraiser per year using an approved tool

C&H views on the impact of revalidation

- It has increased reflection on practice
- It is a tool to encourage engagement in performance review
- It offers a level of assurance around the standard of practice
- It has offered a structured approach to ongoing medical education resulting in safer doctors.
- C&H would like to see a balance between the drive for quality and bureaucracy required to evidence this.

Papers		
1	NHS England Medical Appraisal Policy. Non-participation in appraisal	MAP Annex E Non participation in apprai
2	NHS England Medical Appraisal Position Statement L6: Scheduling medical appraisals	MAPS L6 Scheduling Appraisal.docx
3	NHS England Medical Appraisal Position Statement L11: Allocating SPA time within job plan for appraisers in secondary/mental/community health sectors	MAPS L11 Allocating SPA time.docx
4	Quality Assurance Tools	MAP Annex J Routine appraiser ass
5	IT platforms used throughout the region	IT Systems (updated 01.10.15).pdf

Board of Directors Integrated Performance Report

Calderdale and Huddersfield NHS
NHS Foundation Trust

compassionate care

Contents

Report For: November 2015

Board of Directors

Integrated Performance Report

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Executive Summary Commentary

November was a disappointing month for some key metrics but work continues to secure the required improvement:

Responsiveness

- Emergency Care Standard failed the month but quarter still green and plans in place to manage the peak pressure points between Xmas and mid-January
- Day 38 cancer performance and 62day screening performance deteriorated
- Delayed transfer of care continues to deliver better than 5%
- Stroke performance failed in 2 of the 3 metrics
- RTT performance remains green

Caring

- Complaints responded to within target deteriorated in month
- Friends and Family inpatients who would recommend continues at above 96%
- Several Maternity indicators deteriorated in November

Safety

- Pressure Ulcers remains a concern with numbers remaining high
- C-section rates improved slightly

Effectiveness

- C Difficile improvement noted
- HSMR remain high
- #NOF, access to theatre within 36hours continues to improve
- Readmission rates are better than target

Well led

- Sickness has increased in 5 of the 7 service areas reported and 7 out of 8 staff categories with overall % sickness at its highest point in current service year.
- Staff in post and FTE is static
- Over 91% of colleagues have now started their mandatory training programme.
- Appraisal activity plans are in place with divisions now RAG rated against these plans.

The Performance Management and Accountability Framework agreed at November Board with work commenced on implementation

The Glossary is now separately filed in the Boardpad reading room for reference

Calderdale and Huddersfield NHS
NHS Foundation Trust

Table Of Risk

compassionate care

	Improving						No Change						Deteriorating					
Monitor	Ccr 62 Dy Gp	Ccr 2 Wk Wt Brst	Cdiff Tst Assgnd				Ccr 31 Dy 2nd or sub Trt drg	Cmmnty - RTT info comp	Cmmnty - rfrrl info comp	Cmmnt - actvty info comp			A and E 4 hr	Ccr 62 Dy Scrn 2 Trt	Ccr 31 Dy Sub Sur Trt	Ccr 31 Dy Diag to Trt	Ccr 2 Wk Wt	Ccr 38 Dy Ref to Trtry
Contract	% Strk scan < 1 hr arrival	% Strk Thrmblysd < 1 hr	VTE Rsk Ass	DQ NHS no comp A&E	A&E Amb H/O 30-60 mn	DTOC	DQ NHS no comp IP	MRSA Trst Assgnd	Percentage of Non-Compliant Duty of Candour informed within 10 days of Incident	Total Duty of Candour shared within 10 days	Cncl Elctv Surg 28 Dy Std	Cncl Urgnt Ops 2nd time	% Strk 90% stay on unit	RTT Community	Cncl Elctv Surg	% Harm Free Care	N & H - Ptnt Stsfctn	18 wks >=26 wks
	RTT Non-admitted	RTT Incomplete	Ccr 62 Dy Agg Trt & Scrn	Home Births			Mixed Sex Breach	Never Events	A&E Trlly Wts	Diagn 6 Wks	18 wks >=40 wks	RTT Waits > 52 wks						
NHSE	FFT Mat recmmnd	FFT IP Response	Sepsis Screen	IPMR - Breastfeeding			FFT IP recmmnd	Stg 1 RCAs HAT					FFT A&E recmmnd	FFT Cmmty recmmnd	FFT A&E Response			
Quality	Avg Diag / FCE	Percentage Non-elective NoF Patients	A&E Intl Ass	Falls - Serious Harm	All Falls	SG Alerts by Trust	Local SHMI - Relative Risk (1yr Rolling Data	Hospital Standardised Mortality Rate (1 yr	Prntl Dths (0-7 days)	Nntl Dths (8-28 days)	Cdiff Unavoidable	Comp < 3 wking dys	Crude Mort Rate	Mortality Reviews – October Deaths	A&E Left not seen	A&E Time to Treat	A&E Unplnnd Re-Attend	Diabetic pats self-care
	SG Alerts agnst Trust	Stillbirths Rate	Lbr safety	Lbt alone	Emer Rdmssns <= 30 Dys	Emer Rdmssns <= 30 Dys CCG	SIs < 2 dys	Pat Incidents	PU CHFT acqrd Cat 4				Hand Hygiene	Complaints < time	Comp received	SIs	PU CHFT acqrd	PU CHFT acqrd Cat 2
	Emer Rdmssns <= 30 Dys GHCG	Cdiff Unavoidable	MRSA Screen	EColi	MSSA - Post 48 Hrs	Concerns												
	Harm Incidents	PU CHFT acqrd Cat 3	PU CHFT acqrd Cat 3&4	Women Harm Free	Women - safety	Women cmbnd Harm Free												
Other Internal	% Elective Var	% Day Case Var	% Out Var	T Util (TT) - CRH	T Util (TT) - HRI Main	T Util (TT) - HRI DSU	Green Cross	% Spells > 5 Moves	Elec C-Section				% Non-elec Var	% Daily Discharges - Pre 12pm	Outliers	Research Recruit	3rd / 4th Degree tear	% Non_Elec NoF Adm < 36 hrs
	T Util (TT) - HRI SPU	WHO	1st DNA Rate	Hosp Out Cncl	Spells	Spells > 2 Moves												
	% Spells > 2 Moves	Spells > 5 Moves	Total C-Section Rate	Over 37 wks APGAR5<7	Full Trm to SCBU (NNU)	Major PPH												
	Ccr 7 Dy Ref 1st Frst Sn																	

Improving Green	Improving Amber	Improving Red
32	2	17

No Change Green	No Change Amber	No Change Red
23	1	6

Deteriorating Green	Deteriorating Amber	Deteriorating Red
10	6	15

Green	Currently Achieving Target
Amber	Under/Over target but close to threshold/Not achieving future threshold
RED	Not currently achieving target
White	No target or performance cannot be determined as yet

Calderdale and Huddersfield NHS
NHS Foundation Trust

Monitor Risk Assessment Framework

compassionate care

Overall Rating: Red reflecting enforcement action in place.

CQC status – Formal announced inspection date confirmed as commencing on the 8th March 2016. Planning continues with updates presented to Quality Committee

		Threshold	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Access and Outcome Metrics	% Admitted Closed Pathways Under 18 Weeks	>=90%	91.65%	92.41%	92.67%	92.79%	92.03%	91.64%	90.20%	-					91.90%
	% Non-admitted closed Pathways under 18 weeks	>=95%	98.35%	98.89%	98.63%	98.23%	98.55%	98.67%	98.48%	98.62%					98.55%
	% Incomplete Pathways <18 Weeks	>=92%	95.02%	95.85%	95.44%	95.55%	95.44%	96.07%	95.80%	96.04%					96.04%
	A and E 4 hour target	>=95%	95.01%	94.80%	95.44%	95.44%	95.36%	95.37%	95.11%	94.87%					95.19%
	Total Number of Clostridium Difficile Cases - Trust assigned	21	2	0	1	1	3	3	4	2					16
	Total Number of Clostridium Difficile Cases - Lapses in Care	10.5	1	0	1	0	0	1	1	1					4
	62 Day Gp Referral to Treatment	>=86%	89.38%	92.31%	90.00%	88.95%	93.94%	88.24%	91.77%	95.00%					90.89%
	62 Day Referral From Screening to Treatment	>=90%	85.71%	100.00%	100.00%	100.00%	100.00%	100.00%	95.65%	88.24%					93.58%
	31 Day Subsequent Surgery Treatment	>=94%	95.45%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.77%					98.76%
	31 day wait for second or subsequent treatment drug treatments	>=98%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%					100.00%
	31 Days From Diagnosis to First Treatment	>=93%	100.00%	100.00%	99.24%	100.00%	100.00%	100.00%	100.00%	99.12%					99.80%
	Two Week Wait From Referral to Date First Seen	>=93%	96.45%	98.43%	96.55%	95.64%	93.78%	97.82%	98.73%	96.84%					96.75%
	Two Week Wait From Referral to Date First Seen: Breast Symptoms	>=93%	93.33%	93.75%	94.92%	94.87%	98.60%	98.47%	94.85%	95.89%					95.71%
	Community care - referral to treatment information completeness	>=50%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%					100.00%
	Community care - referral information completeness	>=50%	98.10%	98.12%	97.99%	97.58%	98.14%	97.70%	97.52%	97.44%					97.85%
	Community care - activity information completeness	>=50%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%					100.00%

Third Party Reports	
Quality Governance Indicators	**Patient Metrics -Narrative on Friends and Family included within Exception reports.**
	Staff Metrics : Reported quarterly – no further update from previous report

Finance	Financial Sustainability Risk Rating	2	2
	Operational Performance (Capital Service Cover)	1	1
	Cash & Balance Sheet Performance (Liquidity)	1	1
	Income & Expenditure Margin	1	1
	Income & Expenditure Margin - Variance from Plan	3	3
	Use of Capital	£15.60m	£12.62m
	Income and Expenditure (excluding Restructuring)	(£12.89m)	(£14.24m)

Calderdale and Huddersfield NHS
NHS Foundation Trust

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Responsive

Report For: November 2015

		Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Directon of travel (past 4 months)	Financial Penalities/Non Financial Impact	Data Quality
									Year To Date									
Activity	% Elective Variance against Plan	Local	0.00%	3.50%	1.60%	6.40%	10.50%	-	0.00%	-2.60%	-3.30%	-8.20%	0.63%	-		↓		
	% Day Case Variance against Plan	Local	0.00%	-3.40%	-5.40%	1.20%	0.30%	-	0.00%	-5.00%	-5.10%	-5.90%	-10.99%	-		↑		
	% Non-elective Variance against Plan	Local	0.00%	2.70%	-4.30%	4.20%	4.30%	-	0.00%	3.20%	-1.60%	4.30%	4.30%	-		↑		
	% Outpatient Variance against Plan	Local	0.00%	2.70%	2.80%	1.40%	4.70%	-	0.00%	-2.30%	-2.50%	-3.20%	0.10%	-		↑		
RESPONSIVE - Theatre Utilisation	Theatre Utilisation (TT) - Main Theatre - CRH	Local	92.50%	88.30%	86.78%	-	99.72%	-	92.50%	87.56%	86.04%	-	98.61%	-		↑		
	Theatre Utilisation (TT) - Main Theatre -HRI	Local	92.50%	99.25%	99.25%	-	-	-	92.50%	94.55%	94.55%	-	-	-		↑		
	Theatre Utilisation (TT) - HRI DSU	Local	92.50%	82.36%	80.69%	-	97.84%	-	92.50%	78.18%	76.83%	-	98.61%	-		↑		
	Theatre Utilisation (TT) - HRI SPU	Local	92.50%	81.94%	81.94%	-	-	-	92.50%	82.61%	82.61%	-	-	-		↓		
Exception Report - Patient Flow	% Daily Discharges - Pre 12pm	Local	40.00%	17.43%	25.84%	14.84%	14.17%	-	40.00%	20.05%	28.29%	15.94%	18.71%	-		↓		
	Delayed Transfers of Care	Local	5.00%	4.50%	-	-	-	-	5.00%	6.10%	-	-	-	-		↓		
	Green Cross Patients (Snapshot at month end)	Local	40	91	-	91	-	-	40	71	-	71	-	-		↑		
	Number of Outliers (Bed Days)	Local	441	730	41	689	0	-	2542	4973	456	4516	0	-		↑		
	No of Spells with > 2 Ward Movements	Local	M	126	20	82	24	-	-	1088	175	688	225	-		↓		
	% of Spells with > 2 ward movements (2% Target)	Local	2.00%	2.37%	1.29%	4.68%	1.20%	-	2.00%	2.33%	1.39%	4.88%	1.12%	-		↑		
	No of Spells with > 5 Ward Movements	Local	M	3	0	3	0	-	-	28	1	27	0	-		↑		
	% of spells with > 5 ward movements (No Target)	Local	M	0.06%	0.00%	0.17%	0.00%	-	-	0.06%	0.01%	0.19%	0.00%	-		→		
	Total Number of Spells	Local	M	5310	1552	1754	2004	-	-	46789	12547	14100	18134	-		↓		

Calderdale and Huddersfield NHS
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Responsive Executive Summary - Helen Barker Associate Director of Operations

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Report For: November 2015

		Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Year To Date Target	Year To Date Trust	Year To Date Surgical	Year To Date Medical	Year To Date Families and Specialist Services	Year To Date Community	Trend (Rolling 12 Month)	Direction of travel (past 4 months)	Financial Penalities /Non Financial	Data Quality
Exception Report - Patient Flow 2	A and E 4 hour target	National & Contract	95.00%	94.87%	-	94.87%	-	-	95.00%	95.19%	-	95.19%	-	-		↓		
	Time to Initial Assessment (95th Percentile)	National	00:15:00	00:18:00	-	00:18:00	-	-	00:15:00	00:19:00	-	00:19:00	-	-		↑		
	Time to Treatment (Median)	National	01:00:00	00:57:00	-	00:57:00	-	-	01:00:00	00:58:00	-	00:58:00	-	-		↑		
	Unplanned Re-Attendance	National	5.00%	5.27%	-	5.27%	-	-	5.00%	5.06%	-	5.06%	-	-		↓		
	Left without being seen	National	5.00%	2.83%	-	2.83%	-	-	5.00%	3.17%	-	3.17%	-	-		↓		
	A&E Ambulance Handovers 30-60 mins (Validated)	National	0	6	-	6	-	-	0	57	-	57	-	-		↑		
	A&E Ambulance 60+ mins		0	0	-	0	-	-	0	4	-	4	-	-				
	A&E Trolley Waits	National	0	0	-	0	-	-	0	0	-	0	-	-		→		
Exception Report - Elective Access	First DNA Rate	Local	7.00%	6.19%	6.32%	6.61%	5.41%	4.50%	7.00%	6.68%	6.76%	6.69%	6.34%	4.90%		↓		
	% Hospital Initiated Outpatient Cancellations	Local	12.0%	12.30%	11.80%	15.70%	8.40%	-	12.0%	13.90%	14.10%	15.30%	11.10%	-		↓		
	Appointment Slot Issues on Choose & Book	Local	-	-	-	-	-	-	5.00%	15.00%	12.25%	8.33%	7.38%	-				
Exception Report - Elective Access 2	% Non-admitted Closed Pathways under 18 weeks	National & Contract	95.00%	98.62%	98.51%	98.80%	98.73%	-	95.00%	98.55%	98.54%	98.49%	98.74%	-		↑		
	% Admitted Closed Pathways Under 18 Weeks	National & Contract	90.00%	-	-	-	-	-	90.00%	91.90%	91.16%	100.00%	94.98%	-		#N/A		
	% Incomplete Pathways <18 Weeks	National	92.00%	96.04%	95.29%	98.57%	96.27%	-	92.00%	96.04%	95.29%	98.57%	96.27%	-		↑		
	18 weeks Pathways >=26 weeks open	Local	0	94	78	11	5	-	0	94	78	11	5	-		↓		
	18 weeks Pathways >=40 weeks open	National	0	1	1	0	0	-	0	1	1	0	0	-		↓		
	RTT Waits over 52 weeks Threshold > zero	National & Contract	0	0	0	0	0	0	0	0	0	0	0	0				
	% Diagnostic Waiting List Within 6 Weeks	National & Contract	99.00%	99.94%	100.00%	100.00%	99.92%	-	99.00%	99.66%	99.92%	100.00%	99.55%	-		↑		
	Community - 18 Week RTT Activity	National	95.00%	80.30%	-	-	-	80.30%	95.00%	95.00%	-	-	-	95.00%		↓		
	% Last Minute Cancellations to Elective Surgery	National & Contract	0.60%	0.59%	0.84%	0.00%	1.42%	-	0.60%	0.62%	0.90%	0.02%	1.02%	-		↑		
	28 Day Standard for all Last Minute Cancellations	National & Contract	0	0	0	0	0	-	0	0	0	0	0	-		→		
	No of Urgent Operations cancelled for a second time	National & Contract	0	0	0	0	0	-	0	0	0	0	0	-		→		

Year To Date

Report For: November 2015		Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Direction of travel (past 4 months)	Financial Penalties/ Non Financial Impact	Data Quality
Exception Report - Access Stroke	% Stroke patients spending 90% of their stay on a stroke unit	National	90.00%	84.60%	-	84.60%	-	-	90.00%	81.90%	-	81.90%	-	-		↑		
	% Stroke patients Thrombolysed within 1 hour	National & Contract	55.00%	80.00%	-	80.00%	-	-	55.00%	80.00%	-	80.00%	-	-				
	% Stroke patients scanned within 1 hour of hospital arrival (where indicated)	National & Contract	90.00%	75.00%	-	75.00%	Data Source from SNAP. 2 months in arrears		90.00%	72.40%	-	72.40%	-	-				
Exception Report - Elective Access 3	62 Day Gp Referral to Treatment	National & Contract	85.00%	95.00%	93.33%	97.37%	100.00%	-	85.00%	90.89%	90.96%	90.68%	95.54%	-		↑		
	62 Day Referral From Screening to Treatment	National & Contract	90.00%	88.24%	87.50%	-	100.00%	-	90.00%	93.58%	92.22%	-	100.00%	-		↓		
	31 Day Subsequent Surgery Treatment	National & Contract	94.00%	96.77%	100.00%	88.89%	-	-	94.00%	98.76%	100.00%	95.45%	-	-		↓		
	31 day wait for second or subsequent treatment drug treatments	National & Contract	98.00%	100.00%	100.00%	100.00%	-	-	98.00%	100.00%	100.00%	100.00%	100.00%	-		→		
	62 Day Aggregated Gp Urgent Referral To Treatment And Screening Referral To Treatment	National & Contract	86.00%	93.67%	91.59%	97.37%	100.00%	-	86.00%	91.11%	90.99%	90.68%	96.48%	-		↓		
	31 Days From Diagnosis to First Treatment	National & Contract	96.00%	99.12%	100.00%	100.00%	87.50%	-	96.00%	99.80%	99.84%	100.00%	97.62%	-		↓		
	Two Week Wait From Referral to Date First Seen	National & Contract	93.00%	96.84%	98.96%	92.16%	95.10%	-	93.00%	96.75%	98.14%	92.97%	96.88%	-		↑		
	Two Week Wait From Referral to Date First Seen: Breast Symptoms	National & Contract	93.00%	95.89%	95.89%	-	-	-	93.00%	95.71%	95.71%	-	-	-		↓		
	7 Day Referral to First Seen	National & Contract	50.00%	32.38%	35.01%	23.88%	37.25%	-	50.00%	35.44%	37.29%	30.20%	36.20%	-		↑		
	38 Day Referral to Tertiary	National & Contract	85.00%	58.82%	83.33%	50.00%	33.33%	-	85.00%	52.44%	54.26%	52.83%	43.75%	-		↓		
	104 Referral to Treatment	National & Contract	100.00%	97.90%	97.73%	97.62%	100.00%	-	100.00%	98.26%	98.02%	98.40%	100.00%	-				
Exception Report - Maternity	Antenatal Assessments < 13 weeks		90.00%	92.10%	-	-	92.10%	-	90.00%	92.10%	-	-	92.10%	-		↑		
	Maternal smoking at delivery		11.90%	8.50%	-	-	8.50%	-	11.90%	10.30%	-	-	10.30%	-		↓		

Calderdale and Huddersfield NHS
NHS Foundation Trust

Exception Report - Planned Activity - Associate Director of Operations

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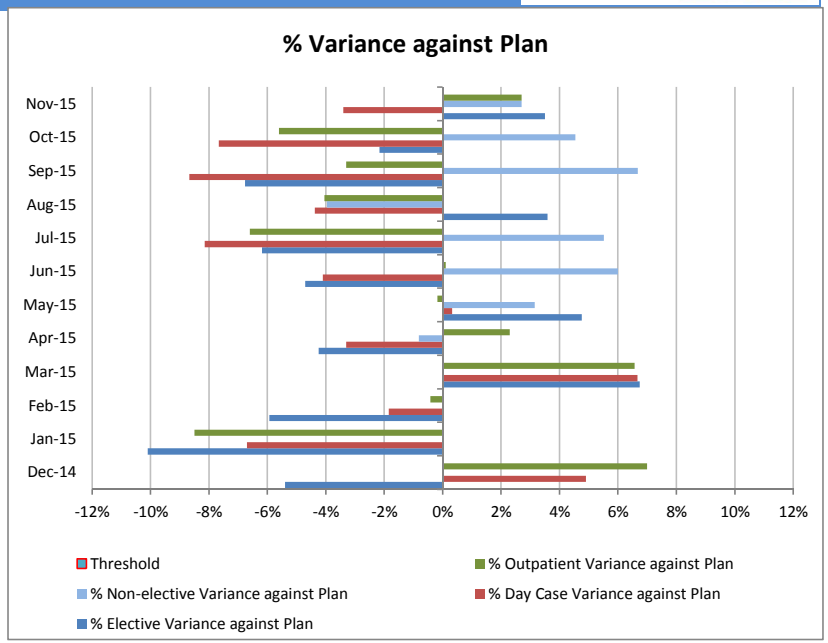
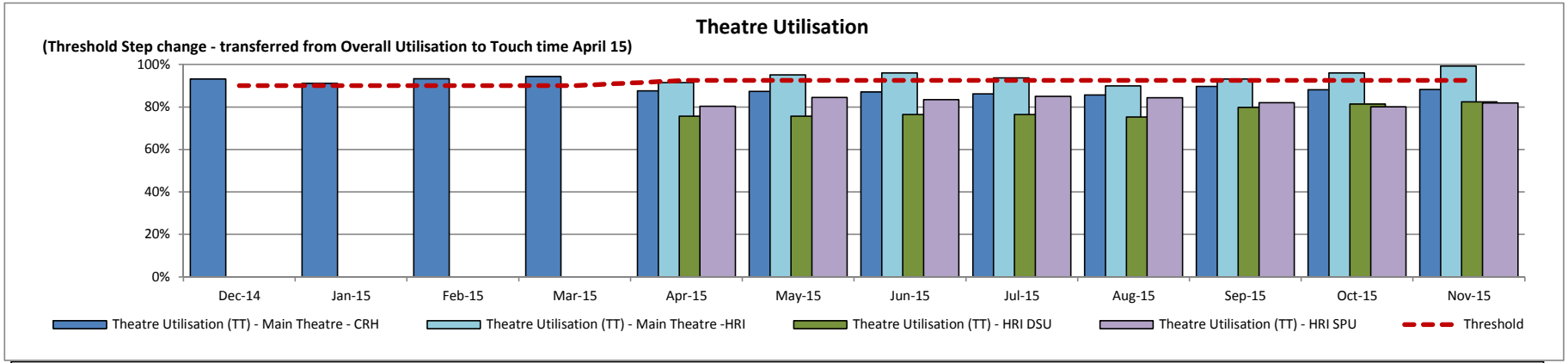
Report For: November 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Elective Variance against Plan	0.00%	3.50%	1.60%	6.40%	10.50%	-
% Day Case Variance against Plan	0.00%	-3.40%	-5.40%	1.20%	0.30%	-
% Non-elective Variance against Plan	0.00%	2.70%	-4.30%	4.20%	4.30%	-
% Outpatient Variance against Plan	0.00%	2.70%	2.80%	1.40%	4.70%	-
Theatre Utilisation (TT) - Main Theatre - CRH	92.50%	88.30%	86.78%	-	99.72%	-
Theatre Utilisation (TT) - HRI DSU	92.50%	82.36%	80.69%	-	97.84%	-
Theatre Utilisation (TT) - HRI SPU	92.50%	81.94%	81.94%	-	-	-





Details of position and delivery of recovery plans presented to Finance and Performance Committee

Theatre Utilisation:

Actions and timelines as previously reported

Key areas of progress

Work on Theatre utilisation continues with an update from Star Chamber provided to Turnaround Executive in early December

Key improvements seen in Urology, T&O, General Surgery and Gynaecology

Number of fallow lists reduced from 15per week to vey small volume

Scheduling management processes continue to improve

Key action in next 4 weeks is to improve session volumes in Urology, ENT and Ophthalmology

Calderdale and Huddersfield NHS Foundation Trust

Exception Report - Patient Flow - Associate Director of Operations

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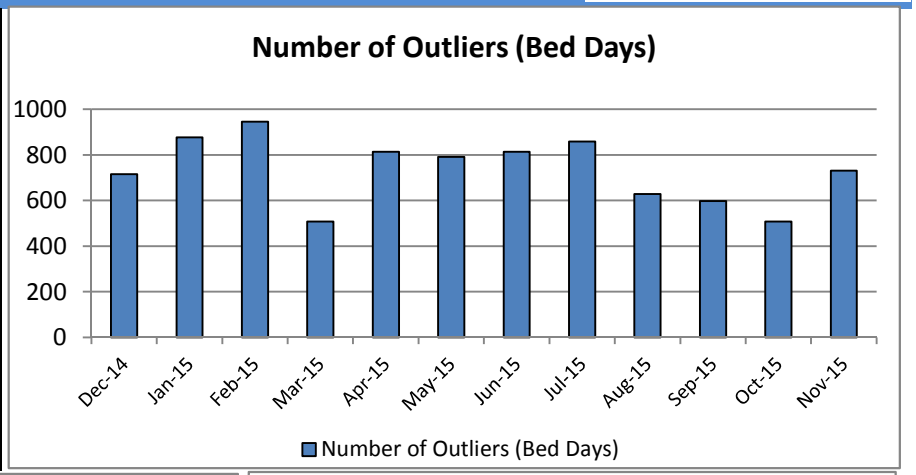
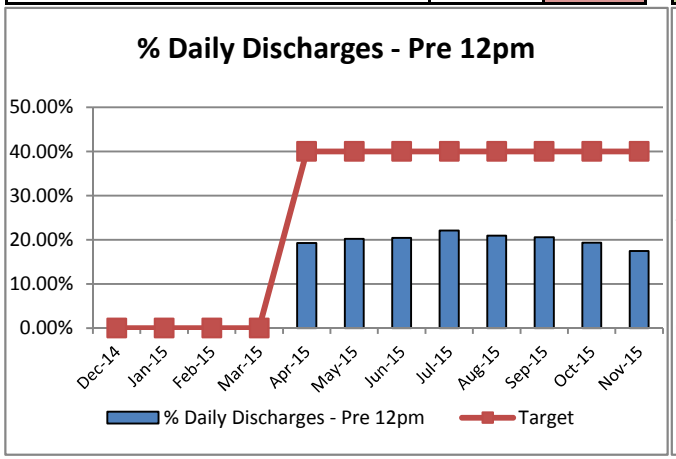
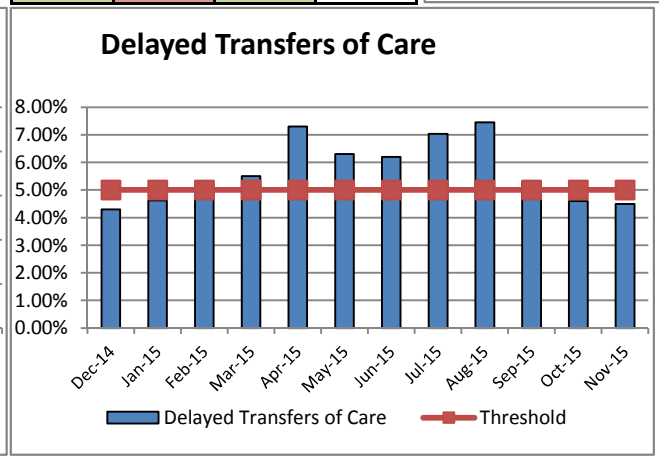
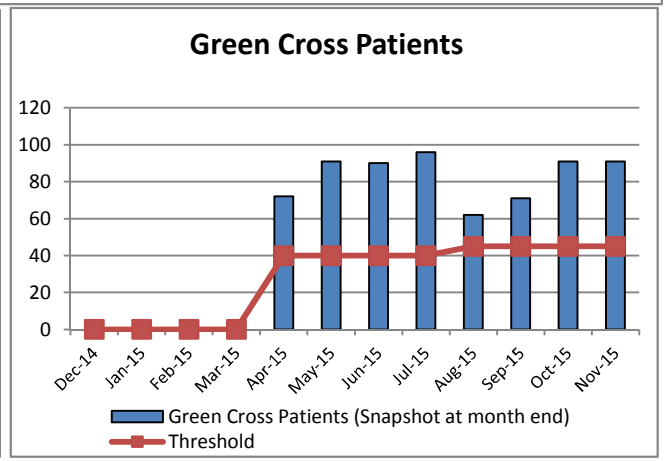
Report For: November 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Daily Discharges - Pre 12pm	40.00%	17.43%	25.84%	14.84%	14.17%	-
Green Cross Patients (Snapshot at month end)	45	91	-	91	-	-
Number of Outliers (Bed Days)	441	730	41	689	0	-
% of Spells with > 2 ward movements (2% Target)	2.00%	2.37%	1.29%	4.68%	1.20%	-





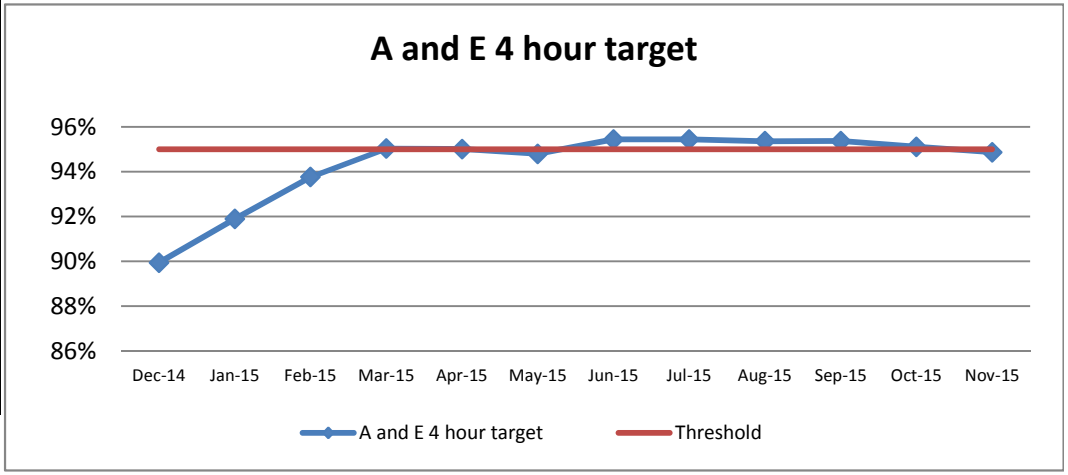




Following presentation provided at November Board of Directors a deep dive is currently being undertaken, supported with expertise from the ECIP team (Emergency Care Improvement Programme - previously ECIST). This will be presented as a formal exception report with the January report.
Specific activities are currently underway to ensure patients are safely managed over the 2 bank holiday periods with performance sustained at the level required to deliver the month and quarter performance standards. This activity includes ensuring the additional winter plans are in place, staffing cover is robust for the 2 long bank holiday weekends and management oversight is in place with Bronze Command daily from 26th December.
National guidance from Monitor has been received which suggests elective inpatient activity should be curtailed from 24th December until 11th January, this had been enacted proactively by the Surgical Division for w/c 4th January and has been extended to cover the period between Xmas and New Year with the exception of patients requiring admission for cancer or other urgent surgery. Day case activity has been increased to manage the income and RTT impact of this.
A new initiative called MADE (Multi-disciplinary Accelerated Discharge Event) is also recommended by ECIP and this is being discussed with SRG partners with the aim to run either w/c 11th or 18th January 16.

Exception Report - Patient Flow - Associate Director of Operations

Report For: November 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
A and E 4 hour target	95.00%	94.87%	-	94.87%	-	-
Time to Initial Assessment (95th Percentile)	00:15:00	00:18:00	-	00:18:00	-	-
Unplanned Re-Attendance	5.00%	5.27%	-	5.27%	-	-
A&E Ambulance Handovers 30-60 mins (Validated)	0	6	-	6	-	-



November was a disappointing month for performance which was as a result of specific pressures early in the month with several days of very poor performance and high breach numbers. Significant management action was undertaken to improve performance but this was not sufficient to recover fully to 95%. Performance in December has been solid with the month and quarter both anticipated to be green.

The pressures of exit block impacted on both AEDs with time to assessment and ambulance turnaround under pressure

Why off Plan:

Specific issues relate to high admission numbers at the beginning of the month combined with the closing of some of the additional beds; recovery was secured when the beds were re-opened. Staffing remains a challenge for these specific beds however activity through these has been limited to low acuity surgical cases releasing other beds to support Medicine which has managed some of the risk; this continues to be monitored daily

Actions to get back on plan:

Actions implemented included the opening of additional beds, development work with Clinical Commanders and their teams to ensure clarity of role and purpose which has seen a renewed focus on effective planning and early escalation

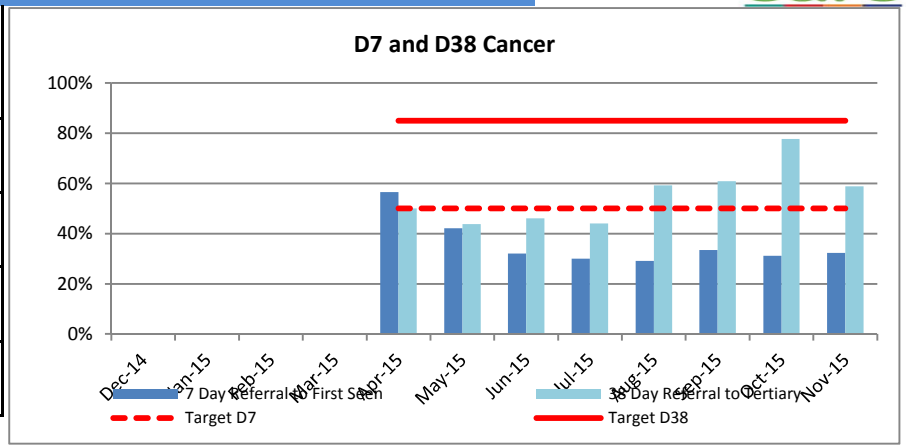
Actions previously identified through the additional winter schemes are also key to sustaining the improvement already seen

When will we be back on track:

December currently running in excess of 95% and quarter performance remains on track

Accountable : ADD Medicine

Report For: November 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
62 Day Referral From Screening to Treatment	90.00%	88.24%	87.50%	-	100.00%	-
7 Day Referral to First Seen	50.00%	32.38%	35.01%	23.88%	37.25%	-
38 Day Referral to Tertiary	85.00%	58.82%	83.33%	50.00%	33.33%	-
104 Referral to Treatment	100.00%	97.90%	97.73%	97.62%	100.00%	-



Why off plan

A disappointing picture on some elements of cancer performance in November indicating that the recently implemented Escalation Protocol is not embedded; some specific challenges around metrics with very small volumes e.g. screening where a single breach can lead to a fail. In November the screening breach related to patient choice with capacity in place for the patient who decided to take a holiday before progressing through her pathway.

D38 performance reported as treated rather than referred this month (referred is at 72%), a review of metric within the report is being undertaken in conjunction with tertiary providers to ensure consistency of reporting.

Issues with turnaround time in diagnostics is causing several pathway issues across various specialties, the ADDs and cancer team are currently reviewing the recurrent bottlenecks to develop corrective action plans which may include the need to increase capacity.

Actions to support improvement

ADDs have been reminded that their direct tracking is required until performance is sustained at the required level and timely escalation, as per the protocol, must be responded to.

Meetings are being arranged with each Division to discuss an appropriate percentage for 7day performance which will be variable by tumour site.

National guidance has been received requiring Board reporting of patients with a pathway over 104 days which is now included; currently discussing the management and reporting of pathways which have already been referred to the tertiary centre.

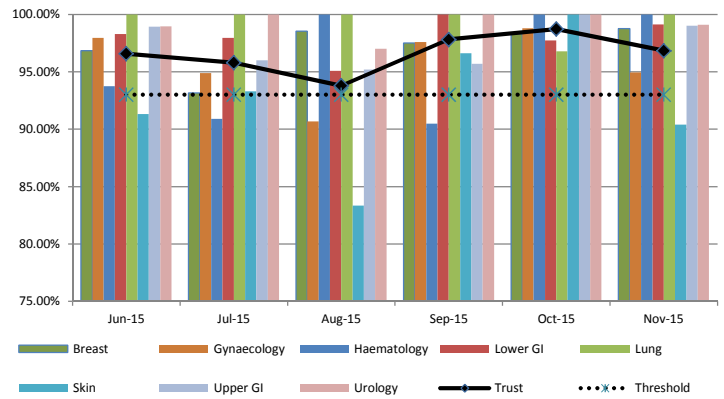
Improvement expected

Would expect screening performance to be green in December and D38 to have improved in the same period

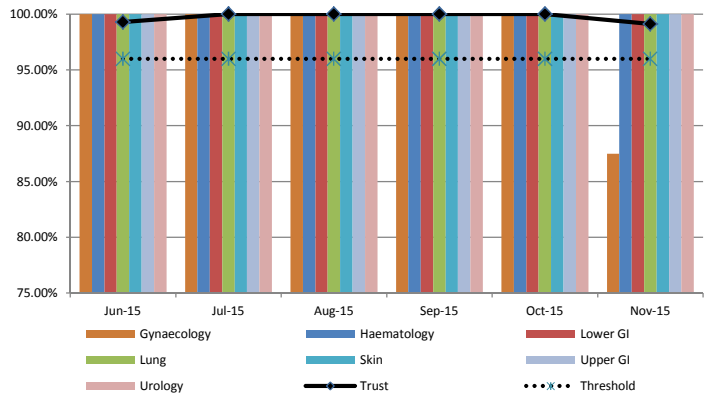
Accountable Officers - ADDs

Exception Report - Cancer by Tumour Site

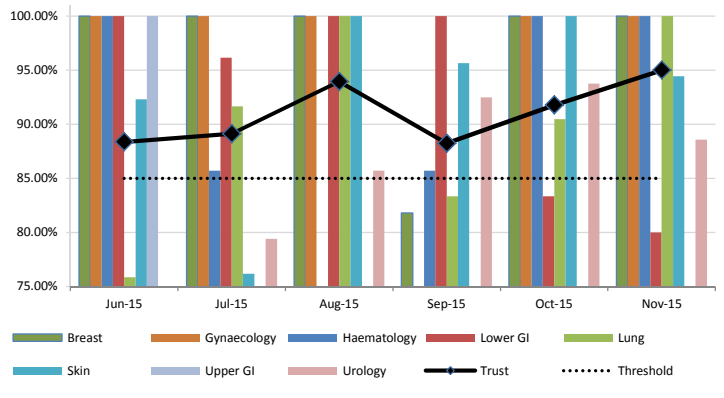
14 Day Referral to Date First Seen



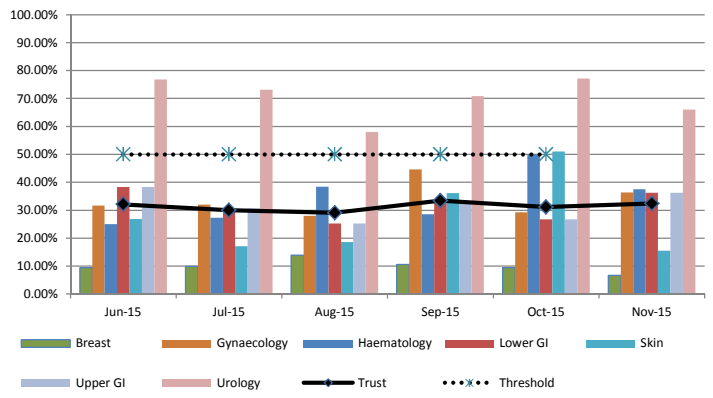
31 Day Diagnosis to First Treatment



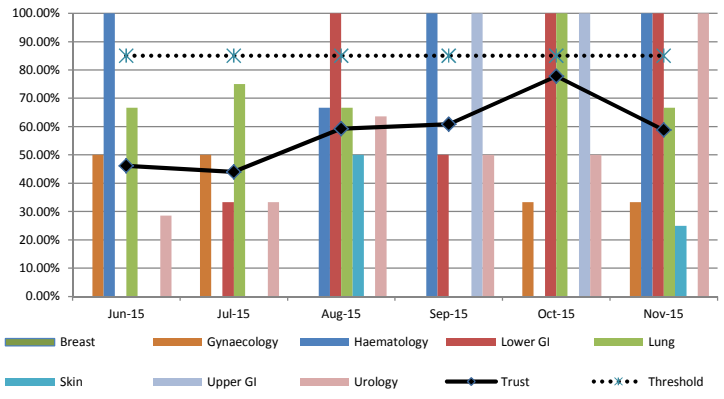
62 Day Referral to Treatment



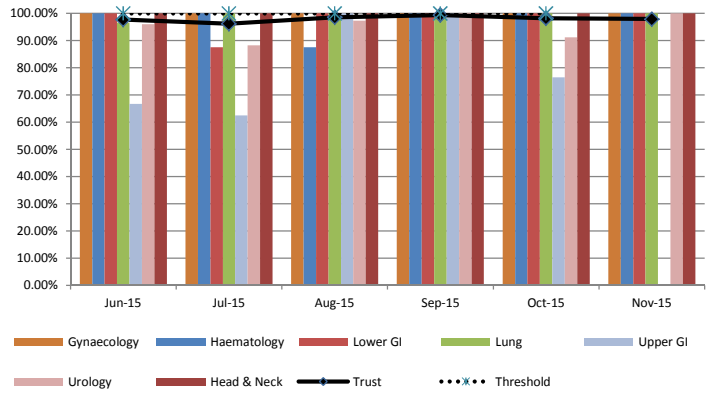
7 Day Referral to First Seen



38 Day Gp Referral to Referral to Tertiary



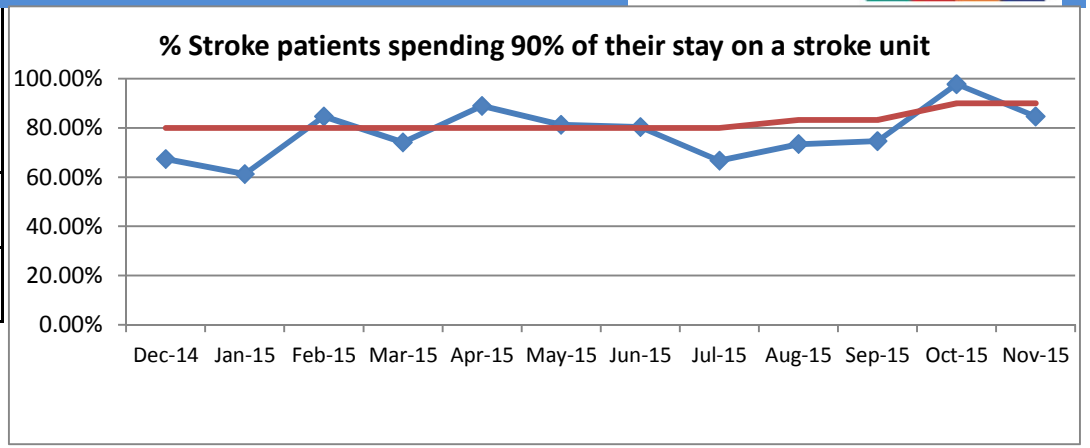
104 Day Referral to Treatment



Exception Report - Stroke - Associate Director of Operations

Report For: November 2015

	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Stroke patients spending 90% of their stay on a stroke unit	90.00%	84.60%	-	84.60%	-	-
% Stroke patients scanned within 1 hour of hospital arrival (where indicated)	90.00%	75.00%	-	75.00%	-	-



Stroke

% Stroke patients spending 90% of their stay on a stroke unit

% Stroke patients scanned within 1 hour of hospital arrival (where indicated)

Why off plan:

All stroke targets have been rebased in-line with the SSNAP (Stroke Sentinel National Audit Programme) "A" rating as an aspirational target (as there is no agreed national target). As a result, it is anticipated that the stroke performance will appear in red on the IPR reports whilst this improvement takes place.

The Trust is currently performing at a "C" SSNAP level for both scan within 1 hour of hospital arrival and patients spending 90% of their stay on a stroke unit. Please note there are SSNAP levels for scans within 1 hour but not for the "where indicated" performance, which is the KPI that both the stroke team and radiology find more useful as a benchmark of performance, therefore this has been set as an aspirational target of 90% as there is no nationally agreed target.

The target for 90% stay was previously 80% and the Trust is achieving this both in month (84.6%) and YTD (81.9%) but the target has been reset to 90% as per the SSNAP "A" level.

Actions to get back to plan:

As stated above, it is expected that the stroke KPIs will flag as red on the IPR due to the targets being rebased as aspirational targets to achieve the SSNAP "A" level rating.

It should be noted that in month, the following KPIs are now meeting the SSNAP "A" level:

- % of stroke patients thrombolysed within 1 hour
- % of patients supported by a stroke skilled Early Supported Discharge team
- % of stroke patients presenting with AF anti-coagulated on discharge

Further improvement work is ongoing, with a view to making all stroke KPIs compliant with the SSNAP "A" level.

Specifically, a revised SOP for stroke admissions is now in place alongside a revised bed base to support the 90% stay and radiology are part of the multidisciplinary stroke improvement team and we have already seen an increase in the percentage of 12 hour scans completed and anticipate further improvement to follow in the 1 hour scans.

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Caring

Year To Date

	Report For: November 2015	Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Directon of travel (past 4 months)	Financial Penalities/Non Financial Impact	Data Quality
Complaints	Number of Mixed Sex Accommodation Breaches	National & Contract	0	0	0	0	0	n/a	0	0	0	0	0	n/a		→		
	% Complaints closed within target timeframe	Local	100.00%	39.68%	33.33%	42.86%	57.14%	12.50%	100.00%	50.85%	45.73%	48.17%	70.53%	27.27%		↓		
	Total Complaints received in the month	Monitor	M	58	12	29	9	6	-	421	134	148	94	23		↑		
	Complaints acknowledged within 3 working days	Local	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	90.89%	88.16%	93.98%	96.30%	89.19%		→		
	Total Concerns in the month	Monitor	M	38	14	13	8	1	-	435	138	164	84	18		↓		
Friends & Family Test	Friends & Family Test (IP Survey) - Response Rate	Contract	28.00%	32.90%	39.80%	25.10%	29.10%	-	28.00%	26.50%	29.55%	24.78%	26.44%	-		↑		
	Friends & Family Test (IP Survey) - % would recommend the Service	Contract	96.00%	96.70%	97.50%	95.40%	95.50%	-	96.00%	96.90%	97.30%	95.66%	97.55%	-		↓		
	Friends and Family Test Outpatient - Response Rate	Contract	5.00%	13.10%	-	-	13.10%	-	-	13.60%	-	-	13.60%	-				
	Friends and Family Test Outpatients Survey - % would recommend the Service	Contract	95.00%	90.50%	-	-	-	-		89.11%	-	-	-	-				
	Friends and Family Test A & E Survey - Response Rate	Contract	14.00%	9.20%	-	9.20%	-	-	14.00%	8.10%	-	8.10%	-	-		↑		
	Friends and Family Test A & E Survey - % would recommend the Service	Contract	90.00%	81.60%	-	81.60%	-	-	90.00%	87.80%	-	87.80%	-	-		↓		
	Friends & Family Test (Maternity Survey) - Response Rate	Contract	22.00%	40.80%	-	-	40.80%	-	-	30.00%	-	-	30.00%	-				
	Friends & Family Test (Maternity) - % would recommend the Service	Contract	96.90%	97.00%	-	-	97.00%	-	96.90%	95.90%	-	-	95.90%	-		↑		
	Friends and Family Test Community - Response Rate	Local	3.40%	14.00%	-	-	-	-	3.40%	14.00%	-	-	-	14.00%				
	Friends and Family Test Community Survey - % would recommend the Service	Local	96.20%	85.00%	-	-	-	85.00%	96.20%	90.09%	-	-	-	90.09%		↓		
Caring Maternity	Proportion of Women with a concern about safety during labour and birth not taken seriously	Local	6.50%	0.00%	-	-	0.00%	-	6.50%	2.69%	-	-	2.69%	-		↓		
	Proportion of women who were left alone at a time that worried them during labour	Local	4.50%	5.13%	-	-	5.13%	-	4.50%	4.23%	-	-	4.23%	-		↓		
	Proportion of Women who received Physical 'Harm Free' Care	Local	70.00%	82.05%	-	-	82.05%	-	70.00%	72.69%	-	-	72.69%	-		↑		
	Proportion of Women with a perception of safety	Local	90.40%	94.87%	-	-	94.87%	-	90.40%	93.46%	-	-	93.46%	-		↑		
	Proportion of Women who received Combined 'Harm Free' Care	Local	70.90%	76.92%	-	-	76.92%	-	70.90%	68.46%	-	-	68.46%	-		↑		

Report For: November 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Complaints closed within target timeframe	100.00%	39.68%	33.33%	42.86%	57.14%	12.50%

% Complaints closed within target timeframe

Why off Plan: 63 responses were closed in November, the highest monthly number since June 2015, however only 24 of these were within timescale (40%) . This is a reduction of 21% compared to October 2015 with a drop in performance across all divisions. There has been a reduction in the number of overdue complaints with 46 at month end compared to 55 at the end of the previous month

Action to get back on plan: Introduction of weekly meetings with divisions and complaints team during December to improve responsiveness of complaints, supported by weekly performance report. Introduction of case management system within medical division to ensure more even distribution of complaints and improved responsiveness.

When back on track: There are a number of overdue complaints still to close. These will impact on the ability to attain the 100% target for a number of months.

Complaints Overview:

There were 58 new complaints were received in November, a slight reduction compared to 62 in October.

Responses overdue from the divisions at the end of November were: 26 overdue by 1 month, 8 by up to 2 months, 6 up to 3 months, 1 up to 4 months and 1 up to 5 months .

The top 3 complaints subjects, consistent with previous months were:

Clinical treatment / procedure

Consent, confidentiality, communication

Access, Appointments, Admission, transfer and discharge

There is a difference with complaints subject codes from previous reports due to changes in coding required for the national complaints return. This has not impacted on the recording of the top 3 complaints subjects.

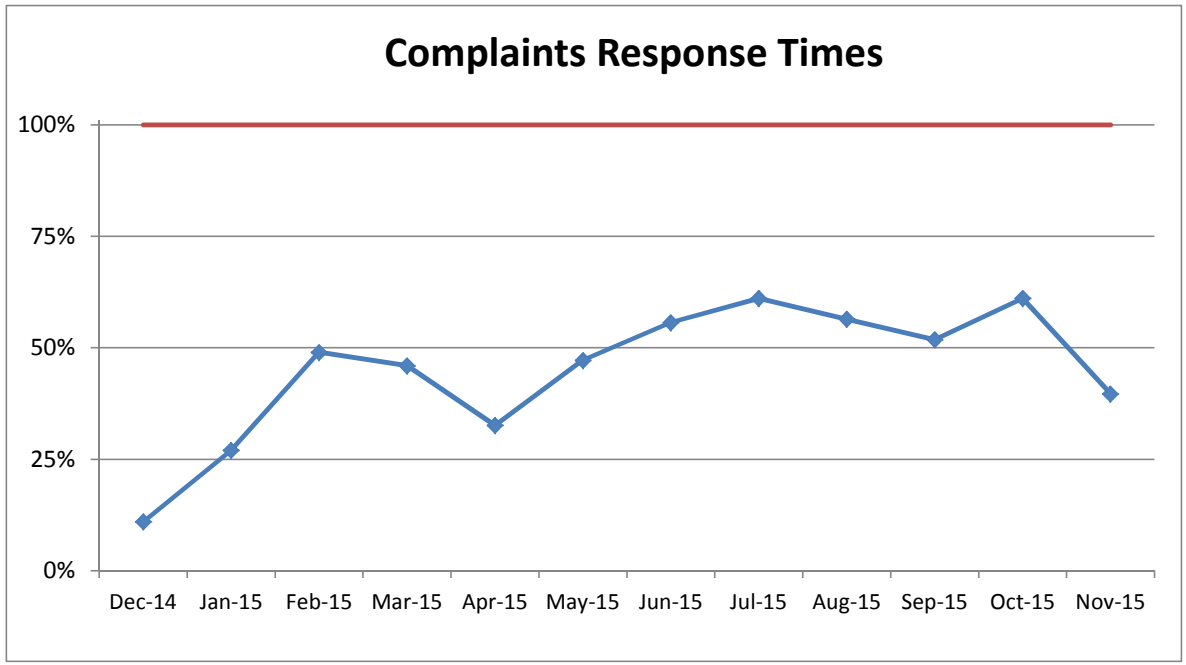
Severity: 54% of complaints received in November were of moderate severity with no red complaints received during November 2015.

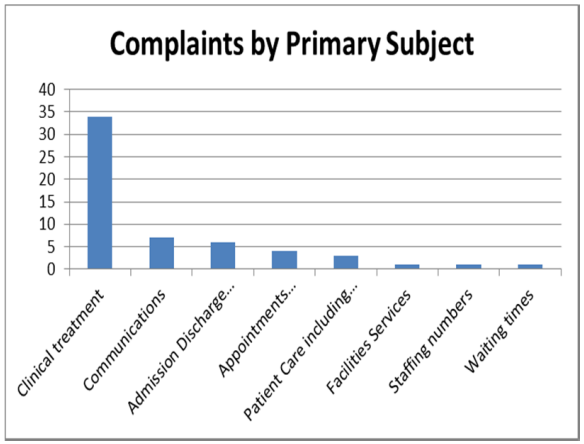
Ombudsman (PHSO)

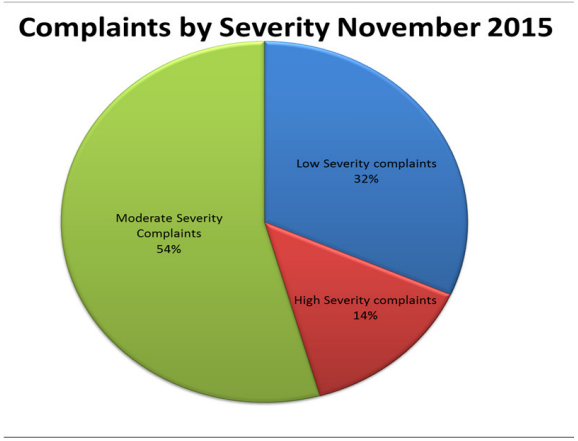
There were no new cases referred to the Trust for the investigation by the Ombudsman in November 2015.

Two cases were closed by the Ombudsman and were not upheld.

There are 11 active Ombudsman cases.

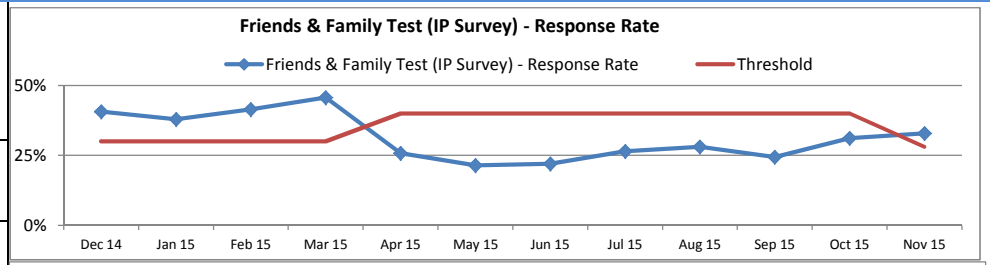


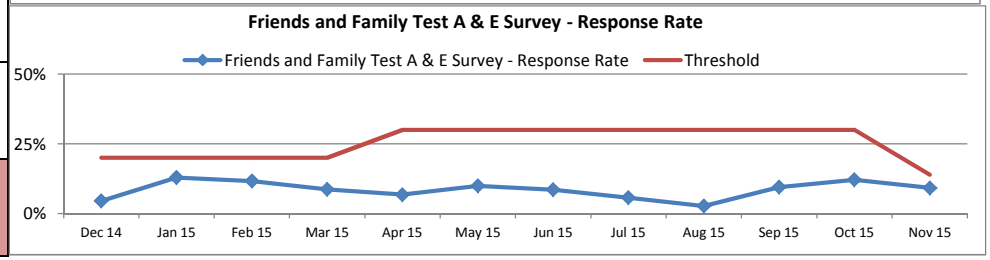




Exception Report - Friends & Family Test Director of Nursing

Report For: November 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Friends and Family Test Outpatients Survey - % would recommend the Service	95.00%	90.50%	-	-	-	-
Friends and Family Test A & E Survey - Response Rate	14.00%	9.20%	-	9.20%	-	-
Friends and Family Test A & E Survey - % would recommend the Service	90.00%	81.60%	-	81.60%	-	-
Friends and Family Test Community Survey - % would recommend the Service	96.20%	85.00%	-	-	-	85.00%





Indicator Update: *the Target threshold for all FFT indicators have undergone a review against national performance levels. Targets have now been aligned with achieving a performance level which will see the trust in the top 50% of trusts for each element.*

A&E FFT – Response Rate:

1. Why off plan: An improvement has been seen since the introduction of the text system in September 2015, from a low of 2.7% in Aug, to 9.2% this month. However this is a reduction of the previous high of 11% seen in October. As anticipated Q3 would be a challenge to sustain month on month improvements due to the demands on the service.

2. Actions to get back on plan: Actions remain in place in relation to the reception staff continuing to collect mobile phone numbers to enable use of the texting system. The poster campaign will be 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, will be given postcards to hand out to patients throughout the data. there will be increased sharing of the patient comments to attract further engagement with staff in relation to the improvement work.

3. When will we be on track: Q3 will remain a challenge due to increases in work pressures, recognising Q3 as the toughest quarter for A&E. The initial aim was to focus on being above the England average of 14.9% by the end of December 2015, however Novembers performance would indicate that the trajectory needs to be realigned with a plan in place to reach national average by the end of Q4.

A&E FFT - Would recommend:

1. Why off plan: Comments for November are in the process of being analysed, initial review indicates that the common themes remain unchanged, relating to long waits and the impact that had on their care.

2. Actions to get back on plan: 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.

3. When will we be on track: As with the response rate the initial target will be to achieve a position of being above the England average (88.3%). It is expected that this will be achieved by the end of January 16.

Accountable: Deputy Director of Nursing

Community FFT - Would Recommend:

1. Why off plan? The introduction of interactive voice mail has made a significant impact on the community response rate with a 10% increase in the responses received. However the percentage of patients reporting that they would recommend the community services remains below target.

2. Actions to get back on plan: Themes identified from negative comments to date have related to waiting times and service delivery for out-patient Physio and action discussed in the previous report are in place to address. However given there is now an increase in responses this month, it is likely that comments will relate to other areas and a detailed analysis will be undertaken to determine whether any new themes are emerging.

3. Achieved by date: Aim to reduce Physio waiting list by Christmas, therefore should start to impact by January 2016.

Accountable: Deputy Director of Nursing

Outpatient FFT Response Rate:

1. Why off plan: Outpatients have continued with a slight month in month improvement increasing from 89.2% in September to 90.2% in October, and 90.5% in November. This remains below the revised target of 95% to be in the top 50% of trusts.

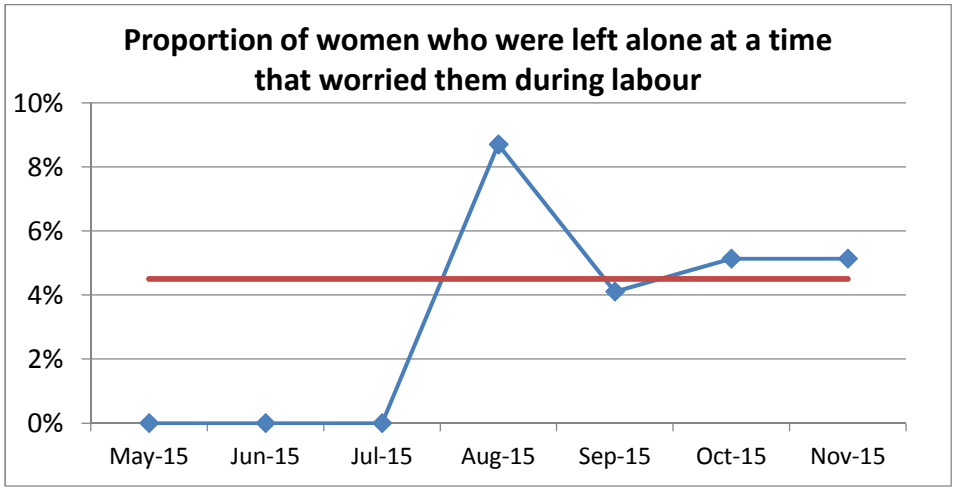
2. Actions to get back on plan: An OPD improvement plan is in place based on core themes picked up from the patient comments across all specialties; this is being led by Matron Rachel Roberts.

Individual specialty results indicate variation in practice with just over 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

3. Achieved by date: It is anticipated that a continued increase will take place over the next few months and a shift into the amber rating be achieved by the end of quarter 4

Accountable: Deputy Director of Nursing

Report For: November 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Proportion of Women with a concern about safety during labour and birth not taken seriously	6.50%	0.00%	-	-	0.00%	-
Proportion of women who were left alone at a time that worried them during labour	4.50%	5.13%	-	-	5.13%	-
Proportion of Women who received Physical 'Harm Free' Care	70.00%	82.05%	-	-	82.05%	-
Proportion of Women with a perception of safety	90.40%	94.87%	-	-	94.87%	-
Proportion of Women who received Combined 'Harm Free' Care	70.90%	76.92%	-	-	76.92%	-



Proportion of women who were left alone at a time that worried them during labour
Indicator update: *Please note this month is reported a month behind due to a review of data quality in the latest release*

Why off plan: The Maternity Safety Thermometer takes place at the same point in time every month, over 1 day. There were 2 women in October who reported that they had been left alone in labour at a point which concerned them
Actions to get back on plan: A number of new midwives (20+) have been recruited with the intention of achieving 100% 1:1 care in labour (maternity dashboard shows we are currently at 98%)
When will we be back to target: End of Q3.
Accountable: Clinical Director K Bhabra

Calderdale and Huddersfield NHS
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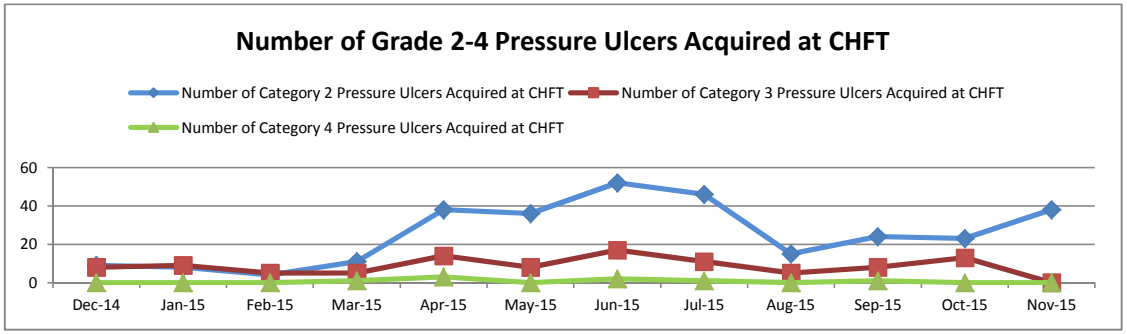
Safety

Report For: November 2015		Indicator Source	Target	Trust	Year To Date: Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Direction of travel (past 4 months)	Financial Penalties/Non Financial Impact	Data Quality
Safety	Inpatient Falls with Serious Harm (10% reduction on 14/15)	Local	1	0	0	0	0	-	8	19	3	15	1	0		→		
	All Falls	Local	M	168	31	136	1	-	-	1329	225	1075	29	29		↑		
	Number of Trust Pressure Ulcers Acquired at CHFT	Local	25	38	6	14	0	18	200	405	52	128	2	223		↑		
	Number of Category 2 Pressure Ulcers Acquired at CHFT	Local	17	38	6	14	0	18	136	316	40	100	2	174		↑		
	Number of Category 3 Pressure Ulcers Acquired at CHFT	Local	7	0	0	0	0	0	56	81	11	26	0	44		↓		
	Number of Category 4 Pressure Ulcers Acquired at CHFT	Local	1	0	0	0	0	0	8	8	12	28	0	5		→		
	Number of Category 3 & 4 Pressure Ulcers Acquired at CHFT	Local	8	0	0	0	0	0	64	89	12	28	0	49		↓		
Safety 2	Percentage of Completed VTE Risk Assessments	National & Contract	95.00%	95.30%	95.50%	96.60%	90.00%	-	95.00%	95.40%	95.20%	95.30%	96.00%	-		↓		
	Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	Local	100.00%	100.00%	100.00%	100.00%	n/a	-	100.00%	100.00%	100.00%	100.00%	100.00%	-		→		
	% Harm Free Care	CQUIN	95.00%	93.29%	91.51%	90.03%	100.00%	95.63%	95.00%	93.63%	93.90%	91.01%	99.84%	94.70%		↑		
	Safeguarding Alerts made by the Trust	Local	M	6	-	-	-	-	-	119	-	-	-	-		↓		
	Safeguarding Alerts made against the Trust	Local	M	6	-	-	-	-	-	59	-	-	-	-		→		
	World Health Organisation Check List	National	100.00%	99.28%	-	-	-	-	100.00%	98.23%	-	-	-	-		↑		
	Missed Doses (Reported quarterly)	National	10.00%	8.68%	7.30%	8.49%	18.36%	-	10.00%	8.24%	8.47%	7.80%	12.46%	-				
Safety 3	Number of Patient Incidents	Monitor	M	10	161	297	200	42	-	68	1114	2603	1455	431		↓		
	Number of SI's	Monitor	M	203	1	3	3	3	-	1533	9	30	7	20		↑		
	Number of Incidents with Harm	Monitor	M	0	34	100	43	19	-	0	212	720	334	259		↓		
	Never Events	National	0	0	0	0	0	0	0	0	0	0	0	0		→		
	Percentage of SI's reported externally within timescale (2 days)	Local	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	-	-	-	-	-	-		→		
	Percentage of SI's investigations where reports submitted within timescale (60 days unless extension agreed)	Local	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-	-	-	-	-	-		#N/A		
	Percentage of Non-Compliant Duty of Candour informed within 10 days of Incident	National & Contract	100.00%	70.50%	100.00%	80.00%	33.00%	80.00%	-	-	-	-	-	-		↓		
	Total Duty of Candour shared within 10 days	National & Contract	100.00%	100.00%		100.00%	100.00%		-	-	-	-	-	-		→		
Safety - Maternity	Elective C-Section Rate		10.00%	9.60%	-	-	9.60%	-	10.00%	8.70%	-	-	8.70%	-		→		
	Total C-Section Rate		22.50%	22.60%	-	-	22.60%	-	22.50%	23.90%	-	-	23.90%	-		↓		
	No. of Babies over 37 weeks with APGAR5<7		8.00%	0.80%	-	-	0.80%	-	8.00%	0.70%	-	-	0.70%	-		↓		
	Full Term to SCBU (NNU)		4.00%	1.60%	-	-	1.60%	-	4.00%	2.60%	-	-	2.60%	-		↓		
	Major PPH - Greater than 1000mls		8.00%	11.00%	-	-	11.00%	-	8.00%	10.20%	-	-	10.20%	-		↓		
	3rd or 4th Degree tear from ANY delivery		3.00%	3.20%	-	-	3.20%	-	3.00%	2.70%	-	-	2.70%	-		↑		
	Planned Home Births	National	2.30%	1.60%	-	-	1.60%	-	2.30%	1.50%	-	-	1.50%	-		↑		

Exception Report Safety - Director of Nursing

Report For: November 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Number of Trust Pressure Ulcers Acquired at CHFT	25	38	6	14	0	18
Number of Category 2 Pressure Ulcers Acquired at CHFT	17	38	6	14	0	18



Pressure Ulcers:

Why off Plan: The Trust continues to have more ulcers each month than the planned target, although recent months have begun to see a reduction in the monthly numbers from the peak. The root cause of the pressure ulcers are largely unchanged and relate to underlying medical/ nursing complexity, care delivery problems around the Assessment – level of risk, skin, reposition and the provision of the necessary equipment or Incorrect or unavoidable use of medical

Actions to get back on plan: As reported last month, actions to address these issues were considered as part of an internal risk summit.

There is the ongoing development of training pack with competencies – this is being tested on Ward 11. There is an aim to assess 3 link nurses competencies (2 = RGNs & 1 HCA) who will then assess their colleagues. A knowledge check and pressure ulcer guide has been developed which provides staff with written guidance that supports their knowledge development. The TVNs are developing HCA competencies – these will be a simplified version of the NVQ assessment, which is very detailed. Target date for completion to be agreed with ward staff/ manager and TVN.

Launch poster campaign in January 16 to raise awareness of heel ulcer prevention.

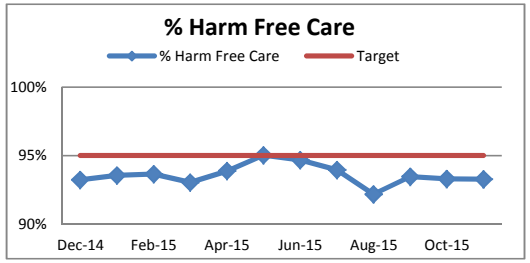
Community Clinical Manager is liaising throughout December with DN team regarding progress of a communication record based on SKIN bundle to improve communication about care needs/ delivery between various community agencies.

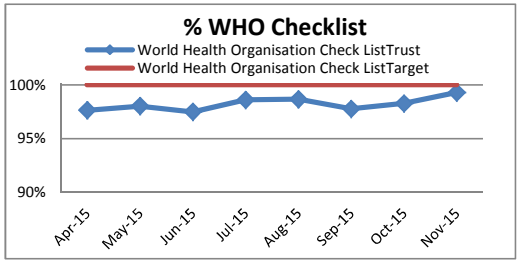
Ongoing actions from internal harm summit. Ward specific actions included introduction of bedside handover, safety huddles, equipment training.

When we will be back on track: As noted in the previous month, actions likely to become embedded during Q4.

Accountable: Deputy Director of Nursing

Report For: November 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Harm Free Care	95.00%	93.29%	91.51%	90.03%	100.00%	95.63%
World Health Organisation Check List	100.00%	99.28%	-	-	-	-





World Health Organisation Check List

1. Why off plan. Since the last report, the figure is improving and is at 99.28%. The sign out of the check sheet is the part where there has been a need to push the teams to ensure it is completed in full. The Obstetric white boards to capture acute data when dealing with distressed baby need to be implemented.

2. Actions to get it back on plan: The white boards have been implemented into Theatres. The Clinical Directors are working with the Surgeons who are still not doing the sign out. A Task and Finish Group has been arranged. The message is being passed out continually across all teams.

3. Achieved by date: January 2016

4. Accountable: GM for Theatres

Harm Free Care:

1. Why off plan? Harm free care for the trust is at 93.29%. The harm events contributing to this are primarily old pressure ulcers, of which there were 51, this is an increase from the 34 in October. These are ulcers which are present on admission or developed within the first 72 hours of admission. Alongside this there were also 9 new pressure ulcers, 2 falls, 7 UTI's in patients with a catheter and 2 VTEs.

2. Actions to get back to plan: Work is ongoing to improve the trust position in relation to the number of ulcers and Falls occurring in the trust (please see detail p??).

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

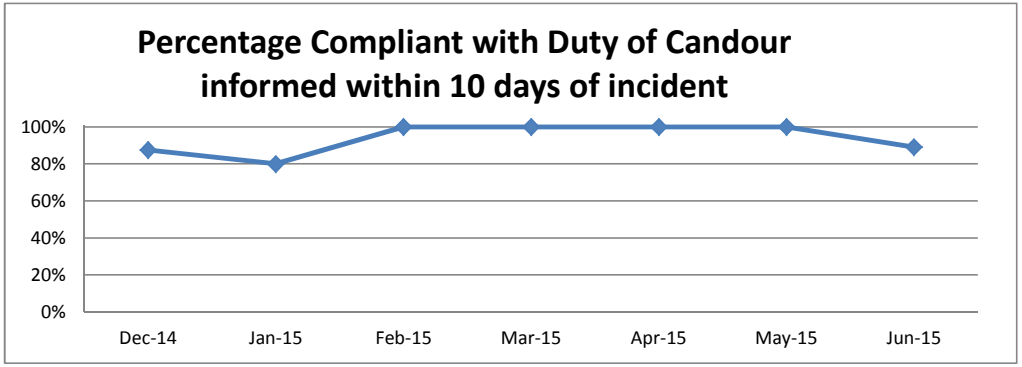
4. Accountable: Deputy Director of Nursing

Wards in special measures

At present there are 2 wards in special measures.
These wards have be identified as requiring additional support to enable them to achieve the required standards.

Exception Report - Safety - Director of Nursing

Report For: November 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Percentage of SI's investigations where reports submitted within timescale (60 days unless extension agreed)	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Percentage of Non-Compliant Duty of Candour informed within 10 days of Incident	100%	70.50%	100.00%	80.00%	33.00%	80.00%



Percentage of SI's investigations where reports submitted within timescale (60 days unless extension agreed)
Indicator update: *From 1st April 2015, the timescale for submission of the investigation report changed from 45 days to 60 days. According to the new framework reports are submitted to the relevant commissioner within 60 days unless an independent investigation is required. Within the framework, there is provision for providers to request extensions to the report submission deadline if there are compelling reasons e.g. new information coming to light requiring further investigation..*

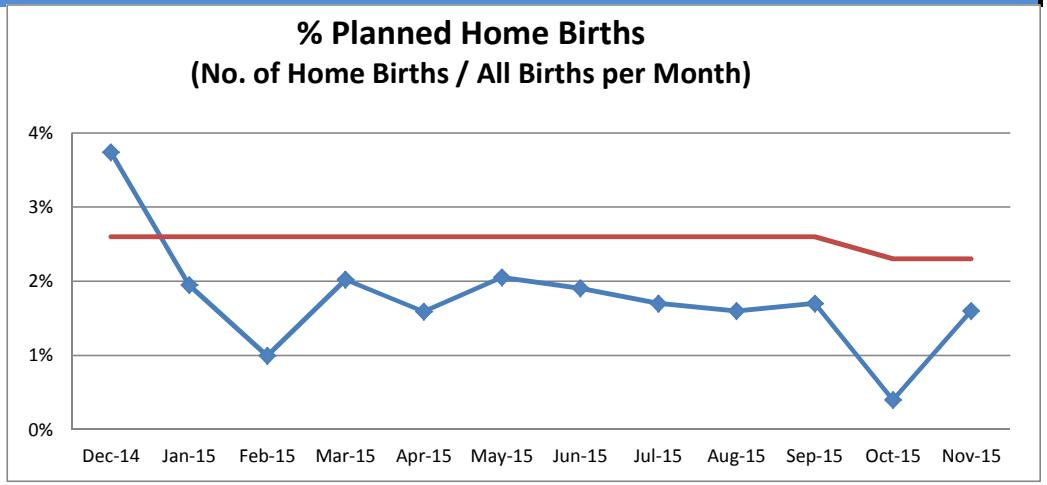
Why off Plan: There were 11 SI reports due for submission in November, none of which were submitted on time. As recognised last month a new process is being put in place to introduce more resilience in the system, making it less susceptible to factors such as unexpected staff sickness.
Actions to get back on plan: Full implementation of the revised system for collecting SI information,
When will we be back on track: there are still some overdue SIs in the system, which will not be completed until January 2016. Not expected to be back on track until the end of Q4.
Accountable: Head of Risk and Governance

Percentage Compliant with Duty of Candour informed within 10 days of incident
Why off Plan: 17 duty of Candour required in month, 12 DOC completed in timeframe.
Actions to get back on plan: Full implementation of the revised system for collecting SI information,
When will we be back on track: December 2015 due to revised systems now being in place
Accountable: Head of Risk and Governance

Exception Report - Safety - Director of Nursing

Report For: November 2015

	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Total C-Section Rate	22.50%	22.60%	-	-	22.60%	-
Major PPH - Greater than 1000mls	8.00%	11.00%	-	-	11.00%	-
3rd or 4th Degree tear from ANY delivery	3.00%	3.20%	-	-	3.20%	-
Planned Home Births	2.30%	1.60%	-	-	1.60%	-



Planned Home Births
Why off plan: Performance remains below target, but has substantially increased on the previous month and is back in line with the previous average.
Actions to get back on plan: The home Birth Team continue to work to activity promote homebirth amongst women and colleagues, alongside the directorate work which should lead to increased homebirth rates
When will we be back to target: April 2016
Accountable: Midwifery Senior Clinical Manager - Community

Total C-Section Rate
Why off plan: The C-Section rate has reduced since last month and is now marginally over the target rate.
Actions to get back on plan: The divisional programme has been in place for a number of months looking at the variation seen month in month. The programme looks specifically at clinical decision making in relation to caesarean section. The program looks to increase standardisation in terms of decision making and as such reduce the rate of emergency C-sections.
When will we be back to target: End Q4 2015-2016

Major PPH
Why off plan: PPH rates remain broadly in line with last month's performance and this month relates to a high number of instrumental and operative births compared to previous months
Actions to get back on plan: Division have changed management plan for all operative births to administer prophylactic oxytocic agents, as part of the work to address quality in the division, there is a specific piece of work to review PPHs and what proportion relate to instrumental or operative births as opposed to normal vaginal birth. The C- Section work above will also impact here.
When will we be back to target: January 2016

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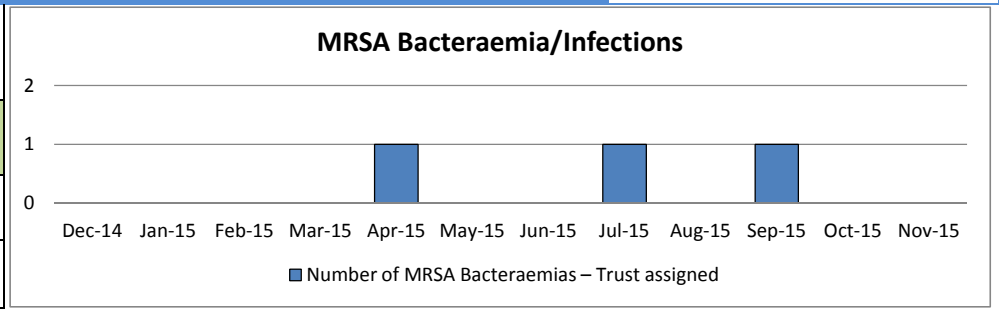
Effectiveness

Report For: November 2015

		Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Year To Date Target	Year To Date Trust	Year To Date Surgical	Year To Date Medical	Year To Date Families and Specialist Services	Year To Date Community	Trend (Rolling 12 Month)	Direction of travel (past 4 months)	Financial Penalities/Non Financial Impact	Data Quality
Effectiveness	Number of MRSA Bacteraemias – Trust assigned	National & Contract	0	0	0	0	0	0	0	3	0	2	0	1		→		
	Total Number of Clostridium Difficile Cases - Trust assigned	National & Contract	2	2	0	2	0	0	17	16	3	13	0	0		↓		
	Avoidable number of Clostridium Difficile Cases	National & Contract	0	1	0	1	0	0	0	5	1	4	0	0		↑		
	Unavoidable Number of Clostridium Difficile Cases	National & Contract	2	1	0	1	0	0	17	11	1	10	0	0		↓		
	Number of MSSA Bacteraemias - Post 48 Hours	National	1	0	0	0	0	0	8	6	1	5	0	-		↓		
	% Hand Hygiene Compliance	Local	95.00%	99.10%	97.93%	99.44%	99.58%	99.00%	95.00%	99.66%	99.08%	99.82%	99.94%	100.00%		↓		
	MRSA Screening - Percentage of Inpatients Matched	Local	95.00%	95.55%	95.30%	96.83%	90.57%	n/a	95.00%	95.06%	92.00%	99.00%	95.00%	-		↑		
	Number of E.Coli - Post 48 Hours	Local	2	4	1	2	1	-	29	24	7	16	1	-		↑		
	Central Line Infection rate per 1000 Central Venous Catheter days	Local	1.00	1.28	-	-	-	-	1.00	0.67	-	-	-	-				
Effectiveness 2	Stillbirths Rate (including intrapartum & Other)	National	0.50%	0.20%	-	-	0.20%	-	0.50%	0.40%	-	-	0.40%	-		↑		
	Perinatal Deaths (0-7 days)	Local	0.10%	0.00%	-	-	0.00%	-	0.10%	0.10%	-	-	0.10%	-		↑		
	Neonatal Deaths (8-28 days)	Local	0.10%	0.00%	-	-	0.00%	-	0.10%	0.00%	-	-	0.00%	-		↓		
	Local SHMI - Relative Risk (1yr Rolling Data April 14 - March 15)	National	100	108.9	-	-	-	-	100	109.1	-	-	-	-		↓		
	Hospital Standardised Mortality Rate (1 yr Rolling Data Sept 14 - Aug 15)	National	100.00	116.00	-	-	-	-	100.00	113.00	-	-	-	-		↑		
	Mortality Reviews – October Deaths	local	100.00%	56.90%	28.57%	60.58%	n/a	n/a	100.00%	49.40%	53.72%	48.84%	n/a	n/a		↓		
	Crude Mortality Rate	National	1.38%	1.33%	0.37%	2.99%	0.04%	n/a	1.17%	1.28%	0.39%	3.01%	0.08%	n/a		↑		
	Completion of NHS numbers within acute commissioning datasets submitted via SUS	Contract	99.00%	99.90%	99.90%	99.80%	99.90%	n/a	99.00%	99.90%	99.90%	99.90%	99.90%	-		→		
	Completion of NHS numbers within A&E commissioning datasets submitted via SUS	Contract	95.00%	99.00%	-	99.00%	-	n/a	95.00%	99.10%	-	99.10%	-	-		↑		
	% Sign and Symptom as a Primary Diagnosis	National	9.50%	9.9%	-	-	-	n/a	9.50%	9.90%	-	-	-	-				
	Average co-morbidity score	National	4.0	3.91	-	-	-	n/a	4.0	3.66	3.48	5.68	2.34	-				
	Average Diagnosis per Coded Episode	National	4.90	4.53	3.69	6.11	2.59	n/a	4.90	4.17	3.51	5.75	2.37	-		↑		
	Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge	National	85.00%	79.49%	75.00%	-	-	-	85.00%	68.04%	66.56%	-	-	-		↑		

Exception Report - Effectiveness

Report For: November 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Avoidable number of Clostridium Difficile Cases	0	1	0	1	0	0
Number of E.Coli - Post 48 Hours	2	4	1	2	1	-
Central Line Infection rate per 1000 Central Venous Catheter days	1.00	1.28	-	-	-	-



Total Number of Clostridium Difficile Cases - Trust assigned
Why off plan: there was one avoidable case of Clostridium difficile in November on ward 5D at CRH
Actions to get back on plan: The RCA investigation identified a number of issues that contributed to this case which included delay in isolation and delay in obtaining a stool specimen resulting in delayed diagnosis and treatment. The nursing and medical documentation was also poor with regard to obtaining the stool specimen. The matron has developed an action plan and all action are completed. As part of the shared learning with the clinical team, the matron has provided a 'we contributed towards a patient contracting Clostridium difficile' summary of the case which provides a powerful learning message to the staff
When will be back on plan: The trust remains below trajectory for the number of avoidable cases in year

Total Number of E.coli:
Why off Plan: This month have seen a reduction in infection on the previous month, however remoras above average. No obvious cause four concern noted and again all appear to be untreated
Actions to get back on plan: The task and finish group is due to be set up in the new year, which will address learning from any infections and any actions will form part of the HCAI action plan for 16/17.
When will we be back on track: E.coli infections appear trod be sporadic and subject to fluctuation..

Central Line Infection: There were 4 central line infections in November. Each case is being investigated individually, these cases are not related by ward or organism. Two cases have been in outpatients admitted with line infections, a third case was a patient that had a line inserted in Leeds and the fourth case was in a patient who has a long term feeding line. The cumulative Infection rate per 1000 CVC days (12 month rolling) remains below target at 0.71.
Why off Plan: Although 2 out of the 3 patients had been admitted with line infections there needs to be a standardised training package for patients managing central lines at home. This has been developed for patients and will be provided for patients caring for lines at home. The third patient is being investigated to understand if the care given at CHFT had contributed to the line infection or whether it was incubating prior to admission. The patient with the long term feeding line has had a number of infections over the last couples of years and has a large open wound in close proximity to the line connectors. A plan was put in place following the last infection and included alcohol impregnated connector protectors, line locks and chlorhexidine dressings to prevent further line infections but these did not prevent this infection. This patient has been scheduled for insertion of an implantable port which will minimise further risk.
When will we be back on track: The learning from these cases will be shared with the CVAD steering group and changes to policy and practice will be made as required in January. The standardised training package will be available for patients and will be carefully monitored.

Calderdale and Huddersfield NHS Foundation Trust

Exception Report - Effectiveness

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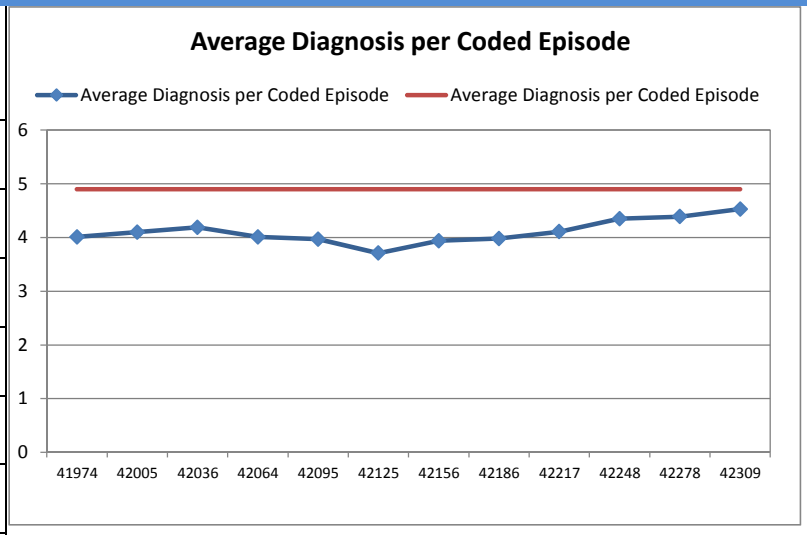
Report For: November 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Local SHMI - Relative Risk (1yr Rolling Data April 14 - March 15)	100	108.9	-	-	-	-
Hospital Standardised Mortality Rate (1 yr Rolling Data Sept 14 - Aug 15)	100	116	-	-	-	-
Mortality Reviews – October Deaths	100.00%	56.90%	28.57%	60.58%	n/a	n/a
% Sign and Symptom as a Primary Diagnosis	9.50%	9.90%	-	-	-	n/a
Average co-morbidity score	4.0	3.9	-	-	-	n/a
Average Diagnosis per Coded Episode	4.90	4.53	3.69	6.11	2.59	n/a



% Sign and Symptom as a Primary Diagnosis/Average co-morbidity score/Average Diagnosis per Coded Episode

New indicators have been added, as the three measures are used as good KPI's for coding quality . The average co-morbidity score is used for calculating a patient's relative risk of death and a lower sign and symptom coding is better as it means more patients coded with a definitive diagnosis e.g. coded as asthma rather than shortness of breath.

1. Why off plan? CHFT depth of coding and average co-morbidity score are less than plan due to missed or undocumented relevant secondary diagnoses/complexities/comorbidities within the coding source documentation. This may also be due to incomplete coding documentation at the time of coding. Since May coding depth has gradually improved although not to national average levels. Since July average co-morbidity score has continued to improve each month. CHFT Sign and Symptom coding compares favorably with the National average but has not achieved the local target. This may be as a result of the terminology, content and quality of what is written within the case notes. There is variable improvement across specialties for each KPI.
2. Action to get it back on plan: Clinical engagement continues around importance of complete and accurate documentation and developing existing documentation to assist coding process e.g. inclusion of co-morbidities and improved structure. A pilot commenced at the start of December of 3 coders attending the ward round with 3 Upper GI clinicians in order to gain better mutual understanding. This will be reviewed early in the New Year. Work has commenced with Graham Walsh on developing theatre templates which will assist the coding process. The recruitment process is ongoing and 4 additional trainees will be recruited early in the New Year to start to address the vacancy issue within the team. Procurement has started for replacing the Encoder the clinical coders use for coding it is anticipated that the 3M software will assist the coding process and improve quality of coding particularly for less experienced coders. To improve clinical coding and the link to clinical colleagues 5 doctors are to have 1 PA. This is anticipated to increase the speed of future coding improvement initiatives with known direct links always available to the coding team from a capacity perspective.
3.Achieved By: Expect to see continued improvement month on month across each coding KPI, with a trajectory to hit target by March 2016
4.Accountable: Head of Clinical Coding

SHMI/HSMR

1. Why it is off plan? The most recent release indicated a SHMI which had a slight reduction to 108.9 for the 12 months of Apr 14 to Mar 15. It remains in the "as expected" category, indicating that there are not significantly more deaths than would be expected for the trust's patient population. The most recent 12 months data for HSMR indicates a score of 116, which is a maintained position from previous release but continues to be an outlying position. The November2015 crude mortality is lower that the same point in the previous year,.
2. Action to get it back on plan: Tie Care of the Acutely Ill Patient (CAIP) plan continues with a focuses on six areas: mortality reviews and leaning; reliability; deteriorating patients; end of life care; frailty; and coding. The latest figure of the number of the mortality reviews carried out in October (Octobers death's) is 57%. A slight reduction since last month and performance is still short of the target. There has been joint planning with medical records to improve the availability of notes for review, particularly in those who have died close to the end of the month.
Intelligence is being received in the form of thematic learning reports received at the CEAM group. External support in further understanding our HSMR position has been useful and a presentation to the board took place in November. and led to a number of pieces of work to examine palliative care provision and the capture of patient comorbidities . Work around the reliability of care, is planning to roll out a new integrated care bundle document in January 2016 to increase reliability. The Nerve Centre rollout is progressing well. The Frailty work stream is currently in the process of compiling a business case to address how best to support frail patients following an emergency admission.
3.Achieved By: Progressive improvement in morality review completion is expected month on month. As HSMR and SHMI are delayed indicators then the impact of changes as a result of learning from mortality will not be seen in these figures for a number of months.
4. Accountability: Medical Director

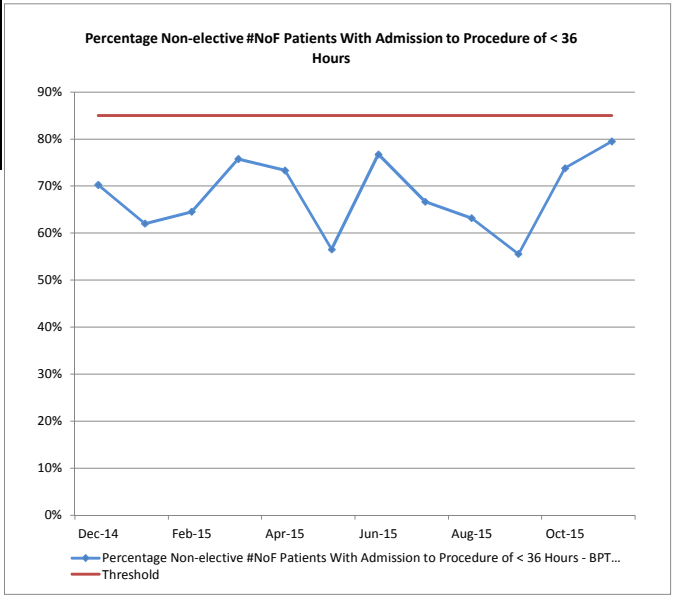
Report For: November 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge	85.00%	79.49%	75.00%	-	-	-
Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - based on admission	85.00%	78.05%	78.05%	-	-	-
Emergency Readmissions Within 30 Days (With PbR Exclusions) - Greater Huddersfield CCG	6.66%	6.95%	-	-	-	-

Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours (based on date of admission)

1.Why off plan: Overall there has been a much improved position , however still falling short of the 85% target. There was a larger than expected number of patients who needed theatre, some of which required cross site moves. One patient had a advanced directive which delayed time to operation

2.Actions to get back on plan: Continue with current action plan.

3.When will we back on track: December 2015



Fracture Neck of Femur	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
Number of fragility hip fracture discharges recorded on the National Hip Fracture Database	45	46	43	39	38	45	42	39					**337**
% achieving Best Practice Tariff	53.33%	45.65%	69.77%	66.67%	57.89%	55.56%	59.52%	71.79%					**59.82%**
a) time to surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an admitted patient, to the start of anaesthesia.	73.33%	56.52%	76.74%	66.67%	63.16%	55.56%	73.81%	79.49%					**68.04%**
(b) admitted under the joint care of a consultant geriatrician and a consultant orthopaedic surgeon.	97.78%	91.30%	100.00%	100.00%	100.00%	97.78%	100.00%	97.44%					**97.95%**
(c) admitted using an assessment protocol agreed by geriatric medicine, orthopaedic surgery and anaesthesia.	100.00%	100.00%	97.67%	100.00%	100.00%	100.00%	97.60%	100.00%					**99.41%**
(d) assessed by a geriatrician in the perioperative period (within 72 hours of admission).	93.33%	82.61%	95.35%	100.00%	97.37%	86.67%	90.50%	92.31%					**92.08%**
(e) postoperative geriatrician-directed multi-professional rehabilitation team	82.22%	91.30%	93.02%	97.44%	92.11%	94.74%	95.20%	89.74%					**92.08%**
(f i) fracture prevention assessments (Falls)	82.22%	80.43%	88.37%	92.31%	84.21%	92.11%	92.90%	79.49%					**87.10%**
(f ii) fracture prevention assessments (Bone health)	100.00%	93.48%	100.00%	94.87%	94.74%	94.74%	97.60%	94.87%					**95.89%**
(g i) two Abbreviated Mental Tests (AMT) performed and all the scores recorded in NHFD with the first test carried out prior to surgery and the second post-surgery but within the same spell - Pre-Op	93.33%	91.30%	97.67%	100.00%	94.74%	100.00%	100.00%	100.00%					**97.07%**
(g ii) two Abbreviated Mental Tests (AMT) performed and all the scores recorded in NHFD with the first test carried out prior to surgery and the second post-surgery but within the same spell - Post-Op	91.11%	84.78%	90.70%	97.44%	94.74%	97.37%	97.60%	92.31%					**92.96%**

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Workforce

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Well Led November 2015

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Workforce Metric		Trust Threshold	Trust	Surgery	Medical	Community	FSS	Estates	Corporate	THIS	Trust Trend	Division Comparison
Sickness YTD	Sickness Absence rate (%) (Year to date)	4.00%	4.48%	4.57%	5.60%	3.69%	4.31%	4.79%	2.11%	3.18%		
	Long Term Sickness Absence rate (%) (Year to date)		3.12%	3.17%	4.09%	2.42%	2.82%	3.63%	1.44%	2.38%		
	Short Term Sickness Absence rate (%) (Year to date)		1.36%	1.40%	1.51%	1.27%	1.49%	1.16%	0.67%	0.81%		
Sickness in month	Sickness Absence rate (%) (1 Month Behind)	4.00%	4.81%	5.50%	6.02%	4.18%	4.24%	5.46%	2.16%	1.80%		
	Long Term Sickness Absence rate (%) (1 Month Behind)		3.21%	3.70%	4.17%	2.64%	2.70%	3.64%	1.56%	1.09%		
	Short Term Sickness Absence rate (%) (1 Month Behind)		1.60%	1.80%	1.85%	1.53%	1.54%	1.82%	0.61%	0.72%		
Staff in post	Staff in Post Headcount		5730	1224	1433	650	1534	346	344	199		
	Staff in Post (FTE)		4998.21	1098.45	1294.13	536.16	1313.65	263.60	301.15	191.07		
Turnover	Turnover rate (%)		1.05%	0.41%	0.78%	1.91%	1.18%	1.04%	1.81%	1.57%		
	Turnover rate (%) (Rolling 12m)		16.23%	12.77%	15.48%	28.82%	14.48%	13.34%	18.65%	13.06%		

Workforce Metric		Trust Threshold	Add Sci & Tech	ACS	Admin & Clerical	AHP	Estates & Ancil.	Healthcare Scientists	Medical and Dental	Nursing & Midwifery	Staff Group Comparison
Sickness YTD	Sickness Absence rate (%) (Year to date)	4.00%	2.68%	6.74%	3.60%	2.53%	5.96%	2.47%	1.00%	5.26%	
	Long Term Sickness Absence rate (%) (Year to date)		1.43%	4.82%	2.51%	1.70%	4.50%	1.34%	0.71%	3.63%	
	Short Term Sickness Absence rate (%) (Year to date)		1.25%	1.92%	1.09%	0.83%	1.46%	1.14%	0.29%	1.63%	
Sickness in month	Sickness Absence rate (%) (1 Month Behind)	4.00%	4.00%	7.44%	3.50%	2.81%	6.93%	3.65%	1.00%	5.53%	
	Long Term Sickness Absence rate (%) (1 Month Behind)		2.70%	5.44%	2.28%	1.45%	4.51%	1.76%	0.71%	3.55%	
	Short Term Sickness Absence rate (%) (1 Month Behind)		1.30%	2.00%	1.21%	1.36%	2.42%	1.89%	0.29%	1.98%	
Staff in post	Staff in Post Headcount		180	1282	1103	402	178	121	541	1918	
	Staff in Post (FTE)		160.98	1041.66	974.64	340.24	158.67	109.87	520.83	1686.31	
Turnover	Turnover rate (%)		0.62%	1.06%	1.34%	1.56%	-	3.31%	-	0.93%	
	Turnover rate (%) (Rolling 12m)		14.23%	14.14%	16.28%	26.92%	11.50%	18.71%	16.06%	15.50%	

Sickness Absence/Attendance Management at work

Why are we away from plan -

The 2015-16 year to date sickness rate of 4.48% compares to a 2014-15 outturn sickness rate of 4.26%. Community ,THIS and Corporate have a YTD % below the 4% threshold identified .Short term sickness absence for the Trust is at 1.36% long term absence at 3.12%. The October 2015 figures compare to October year to date2014 figures of 1.29% short term absence and long term absence of 3.13 %.

In Month THIS and Corporate have a % below the 4% threshold identified for October 2015. Short term sickness absence in month for the Trust is 1.60% long term absence at 3.21%. The October 2015 figures compare to October 2014 figures of 1.32% short term absence and long term absence of 3.13 %.

Action to get on plan?

There are a number of key interventions planned to address the current rate of sickness absence:-

A dedicated Attendance Management team is now in place

Increasing awareness of health and lifestyle choices (a comprehensive colleague health and wellbeing strategy is in development with design workshops held in November 2015)

Evidence based data driven target action (through the use of the BI tool)

Clear and simple attendance management policy (the Attendance Management policy has been updated to include a case management approach, early intervention, fast access to Occupational Health and Physiotherapy, robust return to work process, meetings and action plans, revised triggers for short term episodes and active management)

Joined up approach – line manager/HR/Occupational Health/Staff Side

Fast access to Occupational Health and Physiotherapy

Robust return to work process – meetings and plans

Training for managers – " how to ….."

Realistic improvement targets

Case management approach

Early intervention

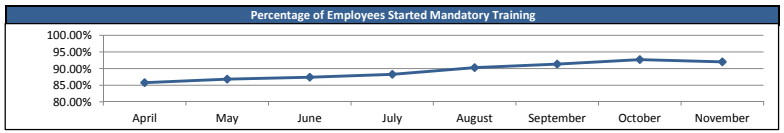
Active management

Eliminate barriers to comprehensive sickness absence reporting breakthrough event held in November 2015 with actions being progressed

Clear and simple KPIs being designed to monitor progress

Workforce Metric		Trust	Surgery	Medical	Community	FSS	Estates	Corporate	THIS	Trust Trend	Division Comparison
Mandatory Training	Prevent	43.37%	28.95%	34.14%	79.33%	48.37%	26.28%	57.53%	47.96%		
	Equality & Diversity	63.28%	57.72%	57.19%	64.83%	74.57%	39.27%	67.77%	82.14%		
	Information Governance	73.07%	63.64%	69.43%	80.17%	83.58%	50.15%	76.20%	87.24%		
	Infection Control	58.43%	52.31%	54.90%	60.00%	70.96%	27.79%	56.93%	75.51%		
	Health & Safety	58.36%	52.57%	53.84%	60.50%	71.17%	29.31%	58.43%	70.92%		
	Manual Handling	65.46%	62.86%	64.71%	74.33%	73.18%	29.00%	57.53%	77.04%		
	Safeguarding	60.97%	59.63%	55.13%	79.33%	71.66%	24.47%	53.61%	47.45%		
	Fire Safety	62.33%	46.29%	55.06%	70.17%	73.25%	78.85%	63.55%	70.92%		
	Dementia	32.92%	28.07%	29.66%	33.50%	42.48%	22.36%	33.13%	28.57%		
	Conflict Resolution	27.77%	21.97%	24.18%	25.67%	38.88%	19.34%	28.01%	24.49%		

Number of Mandatory Training Elements Completed		0	1	2	3	4	5	6	7	8	9	10
	Trust	7.98%	9.62%	9.41%	6.82%	5.18%	5.03%	8.44%	11.91%	13.94%	10.72%	10.94%



		Trust	Surgery	Medical	Community	FSS	Estates	Corporate	THIS
Appraisal	Planned activity as at 31.11.2015	-	41.70%	40.80%	70.40%	58.00%	82.60%	38.50%	58.70%
	Percentage of Appraisal completed since April	45.7%	22.6%	39.6%	53.2%	60.5%	72.7%	42.4%	48.5%
Medical Devices	Percentage of Medical Devices Training Completed (Target 100%)	76.00%	65.00%	61.00%	81.00%	75.00%	100.00%	76.00%	

Mandatory Training

Why are we away from plan?

The new mandatory training approach (The Core Skills Training Framework or CSTF) has been in operation since 1 June 2015. Colleagues are becoming more familiar with the approach and this is factoring positively into the compliance figures. 91% of colleagues have commenced completion of the new programme of mandatory training since 1 June 2015, this is an increase of 4% from last month. However, full completion across all of the 10 available programme elements is below desired levels. The final two subjects to complete the 10 mandatory subjects , Conflict Resolution and Dementia Awareness, were made live on 1 November 2015 and as they have just been launched they will clearly affect the overall compliance rate.

Action to get on plan including timescales:-

An intranet portal has been established giving access into the Electronic Staff Record (ESR) to complete the mandatory training elements. The web pages contain comprehensive support materials including videos and scripts which are to be used by colleagues enabling them to access the training and complete it satisfactory. A help facility has been established as well as an FAQ which sets out issues colleagues have raised in using the system and the solutions to them. Extra PREVENT classroom sessions have now been scheduled to increase availability for colleagues. Information about home access for colleagues who wish to complete training outside of the workplace has been strengthened on the mandatory training web page and a small bank of loanable Trust devices will be available from 1 December 2015 to increase Smartcard enabled users access the mandatory training. Work to ascertain which of the mandatory subjects might have alternate, higher level qualifications which satisfy the learning outcomes for the mandatory subjects and therefore avoid the need for colleagues to complete the awareness level mandatory packages is almost complete. A reconciliation report from McKesson will facilitate the completion by 1 December 2015. Mandatory training awareness sessions over October and November are now concluded but have been poorly attended.

Appraisal

Why are we away from Plan?

Significant progress has been made in planning appraisals for the period 1 April 2015 to 31 March 2016. All divisions report a comprehensive plan for ensuring 100% compliance by 31 March 2016.

FSS and Corporate compliance is beyond planned activity as at 30 November 2015.

Compliance in Medical is within the 2% tolerance level when measured against plan, Community 17% behind planned activity, THIS is 10% below planned activity. Estates and Facilities is 10% behind plan and Surgery and Anaesthetics 19% behind plan.

Action to get on plan:-

Continued focus within divisions to deliver planned activity and to ensure that completed appraisals are confirmed in ESR. Where appraisals have not been undertaken up to change date as planned appraisal profilers will be refreshed to identify new appraisal dates. A 'deep dive' appraisal and mandatory training review is on the agenda for WEB on 14th Jan 2016. It is anticipated that enhanced reporting and subsequent divisional action planning to attain compliance by 31st March 2015 will result from the review.

Medical Devices

Medical Devices Training is currently at 77% compliance across the Trust.

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

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

Workforce Metric		Trust	Surgery	Medical	Community	FSS	Estates	Corporate	THIS
Staffing Levels	Hard Truths Summary Day - Nurses/Midwives	88.66%	91.34%	84.27%	-	96.40%	-	-	-
	Hard Truths Summary - Day Care Staff	97.29%	93.38%	100.24%	-	92.42%	-	-	-
	Hard Truths Summary - Night Nurses/Midwives	92.54%	93.12%	92.07%	-	92.77%	-	-	-
	Hard Truths Summary - Night Care Staff	111.27%	113.53%	119.17%	-	71.27%	-	-	-
Staff Friendsand Family Test	FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q1	77.00%	79.00%	76.00%	77.00%	76.00%	83.00%	82.00%	72.00%
	FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q2	78.70%	-	79.40%	-	78.40%	-	-	-
	FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly) Q1	51.00%	55.00%	49.00%	49.10%	51.50%	45.00%	52.00%	72.00%
	FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly) Q2	49.10%	-	55.30%	-	46.00%	-	-	-

Hard Truths Staffing Levels

Why we are away from plan

Average fill rates for qualified nurses have increased in November. Additional capacity areas have been open across the Trust and to obtain the fill rates reported a level of temporary workforce has been required.

Average Fill Rate Qualified Nurses (Day and Night)	CRH	HRI
Sep-15	85.49%	92.00%
Oct-15	85.99%	90.22%
Nov-15	90.20%	91.90%

Average Fill Rate Un Qualified Nurses (Day and	CRH	HRI
Sep-15	100.50%	104.60%
Oct-15	100.20%	107.00%
Nov-15	100.10%	107.80%

Average fill rate for non registered nurses (day and night) has increased on both sites in October to 102% at CRH and 107% at HRI.

	Day		Night		
	Qualified	Unqualified	Qualified	Unqualified	Combined
Red (less than 75% fill rate)	3	4	1	2	10
Amber (75 – 89% fill rate)	17	8	6	0	31
Green (90-100% fill rate)	14	10	27	10	61
Blue (greater than 100%)	2	14	2	19	37

The proportion of areas rag rated Green and Blue have increased this month in comparison to September and October. This is in part due to the successful recruitment of newly qualified nurses and midwives.

Table 4: Analysis of Areas with Qualified Nurse Average fill rates less than 75%

Area	Day	Night	Reason
5AD	66.9%		Vacancies; Increased number of long shifts worked against planned resulting in decreased fill rates. Supported by additional HCA fill rate (122%)
21	71.9%		Vacancies; Sickness and supporting additional capacity areas. Supported by additional HCA fill rate (114%)
CCU		73.3%	Vacancies;
4C	70.1%		Vacancies

Successful recruitment to HCA posts has been completed with a resulting decrease in requests for HCA's to the Flexible Workforce Department. As all the recruited HCA's complete the resourcing process we anticipate that there will be minimal areas experiencing reduced fill rates for HCA's.
In November some areas have had average fill rates above 100% for non registered nurses predominantly to support reduced fill rate for qualified nurses and to support 1-1

Table 5: Analysis of Areas with Non Registered Average Fill Rates Above 105%

Area	Day	Night	Key Indicators for Fill Rate
MAU HRI		123%	6 additional 1-1 support shifts required
2AB		117%	Supporting reduced fill rate qualified nurses 4 additional 1-1 support shifts required
11 (previously Ward 5)		196.7%	Ward trialling changed workforce model with 1 non registered nurse additional on night shift transferred from late shift. Planned hours not changed until trial reviewed. Matron monitoring.
5AD	122.7%	118.9%	Supporting reduced fill rate qualified nurses 42 additional 1-1 support shifts required
5B	180.1%	131.2%	22 additional 1-1 support shifts required
6	109.9%	112.3%	Supporting Reduced fill rate qualified nurses 14 additional 1-1 support shifts required
6A	158.6%	113.3%	Additional Capacity Area – new team of staff and workforce model under review
7AD		145%	64 additional 1-1 support shifts required
7BC		114%	4 additional 1-1 support shifts required
8	113%	141.1%	Supporting reduced fill rate qualified nurses
12		186.7%	Supporting reduced fill rate qualified nurses
17		119.7%	Supporting reduced fill rate qualified nurses
21	114.6%		Supporting reduced fill rate qualified nurses
3		143.3%	20 additional 1-1 support shifts required
8AB		111.8%	4 additional 1-1 support shifts required
10	124.1%		Supporting reduced fill rate qualified nurses
15	106.4%		Supporting reduced fill rate qualified nurses
SAU		112.5%	Supporting reduced fill rate qualified nurses
NICU	122.1%		Supporting reduced fill rate qualified nurses (day)
Paediatrics	110.1%		Supporting reduced fill rate qualified nurses

Action Plan and Achieved by Date
Focused recruitment for both HCA and Qualified nurses
International recruitment for Qualified nurses to continue
Recruitment of nurses due to qualify in September 2016 commenced with additional keep in touch events and support from nursing workforce planned.
Roster scrutiny tool being trialled in December in one area with the intention of rolling out a programme of roster scrutiny sessions across the nursing workforce by February 2016
Site staffing reports developed and trialled. Due to commence December 2015 to identify daily staffing situation including number of outstanding shifts required and number of temporary workforce utilised on each site.

Calderdale and Huddersfield NHS
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Finance

Trust Financial Overview as at 30th Nov 2015 - Month 8

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

YEAR TO DATE POSITION: M08

CLINICAL ACTIVITY

	M08 Plan	M08 Actual	Var
Elective	6,017	5,668	(349)
Non Elective	32,586	33,669	1,083
Daycase	28,958	26,863	(2,095)
Outpatients	221,420	217,511	(3,909)
A & E	99,509	98,098	(1,411)

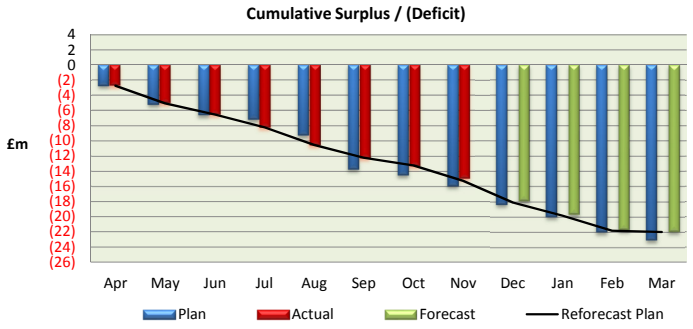
TRUST: INCOME AND EXPENDITURE

	M08 Plan	M08 Actual	Var
	£m	£m	£m
Elective	£15.56	£14.54	(£1.02)
Non Elective	£52.99	£55.10	£2.10
Daycase	£20.16	£17.43	(£2.73)
Outpatients	£26.67	£26.80	£0.14
A & E	£10.48	£10.65	£0.16
Other-NHS Clinical	£78.03	£78.02	(£0.01)
CQUIN	£4.49	£4.51	£0.02
Other Income	£25.18	£24.31	(£0.87)
Total Income	**£233.56**	**£231.35**	**(£2.20)**
Pay	(£149.06)	(£149.77)	(£0.71)
Drug Costs	(£21.05)	(£20.75)	£0.30
Clinical Support	(£20.87)	(£20.25)	£0.62
Other Costs	(£30.53)	(£30.22)	£0.31
PFI Costs	(£7.95)	(£7.88)	£0.07
Total Expenditure	**(£229.46)**	**(£228.87)**	**£0.59**
EBITDA	**£4.10**	**£2.48**	**(£1.61)**
Non Operating Expenditure	(£16.99)	(£16.72)	£0.26
Deficit excl. Restructuring	**(£12.89)**	**(£14.24)**	**(£1.35)**
Restructuring Costs	(£3.00)	(£0.65)	£2.35
Surplus / (Deficit)	**(£15.89)**	**(£14.89)**	**£1.00**

DIVISIONS: INCOME AND EXPENDITURE

	M08 Plan	M08 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	£14.41	£13.06	(£1.35)
Medical	£18.05	£15.78	(£2.28)
Families & Specialist Services	(£1.10)	(£1.25)	(£0.15)
Community	£3.90	£4.18	£0.27
Estates & Facilities	(£18.87)	(£17.22)	£1.65
Corporate	(£13.63)	(£14.80)	(£1.16)
THIS	£0.30	£0.20	(£0.11)
PMU	£1.93	£1.36	(£0.57)
Central Inc/Technical Accounts	(£18.17)	(£15.82)	£2.35
Reserves	(£2.71)	(£0.37)	£2.34
Surplus / (Deficit)	**(£15.89)**	**(£14.89)**	**£1.00**

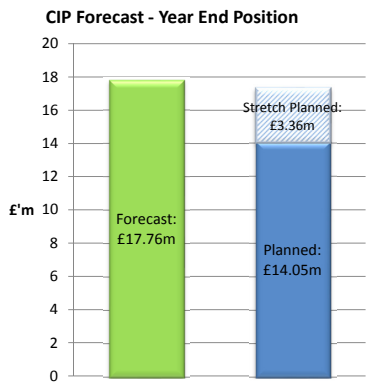
TRUST SURPLUS / (DEFICIT)



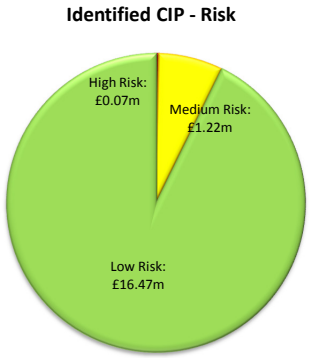
KEY METRICS

	Year To Date M08 Plan	Year To Date M08 Actual	Year To Date Var	Year End: Forecast Plan	Year End: Forecast Forecast	Year End: Forecast Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	(£15.89)	(£14.89)	£1.00	(£23.01)	(£21.92)	£1.09
Capital (forecast Plan)	£15.60	£12.62	£2.98	£20.72	£20.72	£0.00
Cash	£1.94	£10.38	£8.44	£1.92	£2.03	£0.11
CIP	£8.24	£10.90	£2.66	£14.05	£17.76	£3.71
	Plan	Actual		Plan	Forecast	
Financial Sustainability Risk Rating	2	2		2	2	

COST IMPROVEMENT PROGRAMME (CIP)



Total Planned: £14.05m



Total Forecast £17.76m

YEAR END 2015/16

CLINICAL ACTIVITY

	Plan	Forecast	Var
Elective	9,185	8,424	(761)
Non Elective	49,263	50,964	1,701
Daycase	43,731	40,078	(3,653)
Outpatients	327,200	321,467	(5,733)
A & E	146,774	144,693	(2,082)

TRUST: INCOME AND EXPENDITURE

	Plan	Forecast	Var
	£m	£m	£m
Elective	£23.39	£21.66	(£1.73)
Non Elective	£79.89	£83.35	£3.46
Daycase	£30.25	£26.23	(£4.02)
Outpatients	£39.45	£39.97	£0.52
A & E	£15.49	£15.70	£0.21
Other-NHS Clinical	£117.49	£117.02	(£0.47)
CQUIN	£6.69	£6.76	£0.07
Other Income	£38.90	£38.27	(£0.63)
Total Income	**£351.55**	**£348.96**	**(£2.59)**
Pay	(£224.98)	(£226.96)	(£1.98)
Drug Costs	(£32.05)	(£30.93)	£1.11
Clinical Support	(£31.15)	(£29.83)	£1.32
Other Costs	(£45.94)	(£45.09)	£0.85
PFI Costs	(£11.92)	(£11.90)	£0.02
Total Expenditure	**(£346.04)**	**(£344.70)**	**£1.34**
EBITDA	**£5.51**	**£4.26**	**(£1.26)**
Non Operating Expenditure	(£25.52)	(£25.08)	£0.44
Deficit excl. Restructuring	**(£20.01)**	**(£20.82)**	**(£0.81)**
Restructuring Costs	(£3.00)	(£1.10)	£1.90
Surplus / (Deficit)	**(£23.01)**	**(£21.92)**	**£1.09**

DIVISIONS: INCOME AND EXPENDITURE

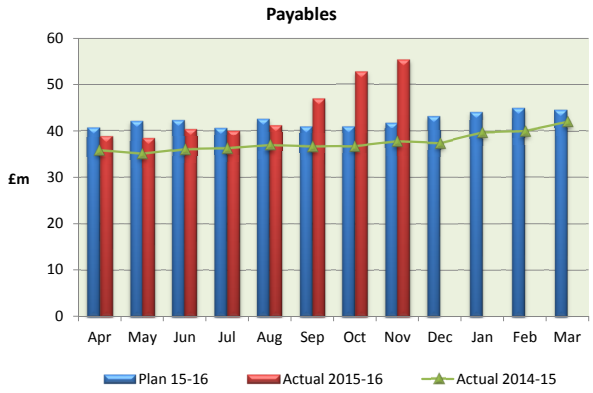
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	£21.11	£18.98	(£2.13)
Medical	£26.23	£21.76	(£4.47)
Families & Specialist Services	(£1.36)	(£1.39)	(£0.03)
Community	£5.77	£5.78	£0.01
Estates & Facilities	(£28.51)	(£27.16)	£1.35
Corporate	(£20.35)	(£22.24)	(£1.89)
THIS	£0.53	£0.42	(£0.11)
PMU	£3.15	£2.95	(£0.20)
Central Inc/Technical Accounts	(£25.20)	(£21.03)	£4.18
Reserves	(£4.38)	£0.00	£4.38
Surplus / (Deficit)	**(£23.01)**	**(£21.92)**	**£1.09**

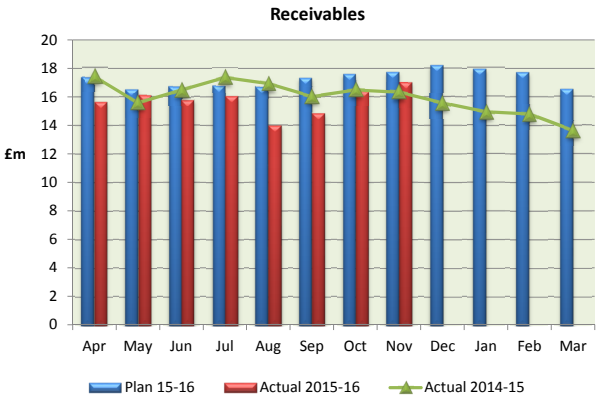
Trust Financial Overview as at 30th Nov 2015 - Month 8

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

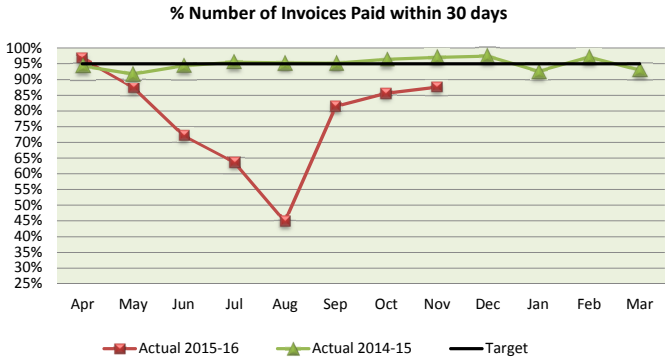
WORKING CAPITAL

	M08 Plan £m	M08 Actual £m	Var £m	M08
Payables * See note below	(£41.81)	(£55.43)	£13.62	
Receivables	£17.72	£17.00	£0.72	



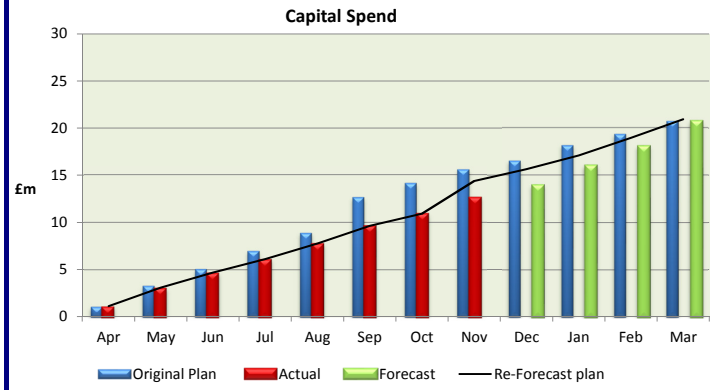


BETTER PAYMENT PRACTICE CODE



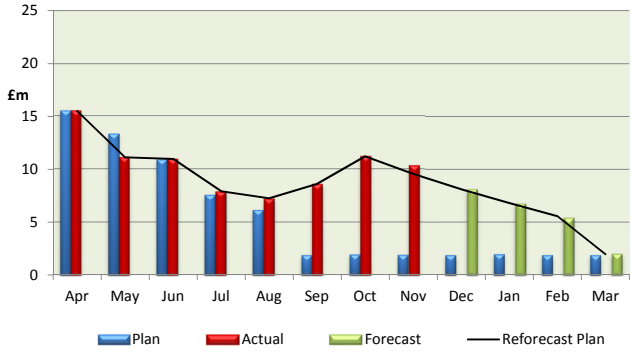
CAPITAL

	M08 Plan £m	M08 Actual £m	Var £m	M08
Capital	£15.60	£12.62	£2.98	

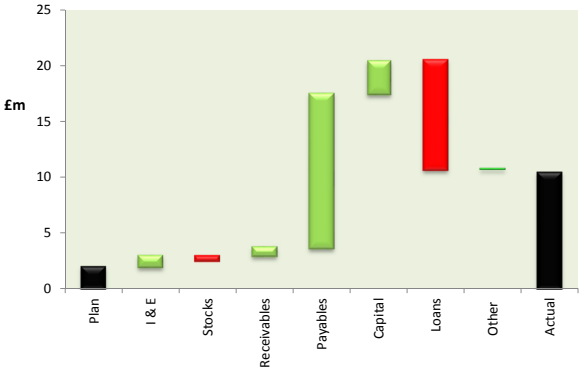


CASH

	M08 Plan £m	M08 Actual £m	Var £m	M08
Cash	£1.94	£10.38	£8.44	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The year to date deficit (excluding restructuring costs) is £14.24m versus a planned deficit of £12.89m.
- The overall deficit is £14.89m against the planned £15.89m, due to restructuring costs not being incurred.
- Daycase activity continued to fall behind planned levels but this was offset in month by improved levels of outpatient 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 £12.62m against the planned £15.60m due to timing differences mainly on IT spend.
- Cash balance is £10.38m against a planed £1.94m, due predominantly to securing cash payments in advance for clinical activit
- CIP schemes delivered £10.90m in the year to date against a planned target of £8.24m.
- 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 £20.82m against a planned £20.01m, an adverse variance of £0.81m.
This position includes full release of remaining contingency reserves and delivery of £17.76m 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.
- The overall forecast deficit position shows an favourable variance of £1.09m from plan due to a reduction in forecast restructing costs of £1.9m.
This is not a reflection of the trading position but does bring the reliance on external cash support down from a planned £14.90m to £13.90m.
- Year end capital expenditure is forecast to be £20.92m as per plan. The year end FSRR is forecast to be at level 2.

(* Payables note: The trade payables figure is inflated by £13.93m due to the receipt of cash payments in advance for clinical activity)

RAG KEY: (Excl: Cash)

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

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

RAG KEY - Cash:

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

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Community

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COMMUNITY DIVISIONAL PERFORMANCE REPORT & DASHBOARD

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

NOVEMBER 2015

compassionate care

Actions

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

(1c) Advance care plan
Individualised Care of the Dying (ICOD) training being rolled out across teams. First trial has been evaluated and changes are being made to the document

(1e) % with Calderdale Care Plan
Improvement seen in this area as all care plans completed in full within 2 weeks of arrival onto caseload as expected

(3c) 18 week RTT snapshot
Having looked at the teams RTT there are no patients waiting longer than 18 weeks. The reason for the target not being reached is that patients have not been discharged off the system or the clock stopped according to the rules. A report has been written as there is no national mandate for AHPs to adhere to the 18 week RRT.

(4a) Pressure ulcer screening
A - Work to do around how we report this as the screening is reflected in the holistic assessment in all cases and in the care plans where there is an issue.
B - Developed outcome measures for completion when a pressure ulcer care plan has been performed and there is targeted work ongoing to improve data capture
C - March

(4b) Community acquired pressure ulcers
A - Thematic review of RCAs has been performed and used to develop community wide action plan. Need to have a more joined up approach across all professionals and agencies to pressure ulcer prevention
B - Multi professional forum planned for November with plans to launch 2 trials aimed at working with care staff and care agencies
C- Unlikely to meet 10% reduction target as planned need to set revised target to monitor improvement work month on month

(4f) Safeguarding training
A - Recording is over a 36 month period therefore the target for the year is not in line with the current calculation methodology. Clarification has been requested around whether this training has to be repeated to allow data capture on ESR - informed that this is currently not shown for staff who have completed within a 3 year period prior to launch of ESR
B - Investigations around how best to represent this indicator with information available is ongoing
C - March

(5a) Community DNA rates
A - Number of patients have multiple DNAs and therefore inflate the percentage
B - The housebound policy second draft has gone to CCG and primary care for comments. Need to scope estates in terms of clinic space and understand the percentage of DV that can be converted to clinic setting. Managed through PMO as part of efficiency stream
C - March

	1 Enhancing quality of life for people with a Long Term condition (LTC)	Target	Current Month	YTD
a	Home equipment delivery < 7 days	95%	100.0%	99.5%
b	% Patient died in preferred place of death	95%	100.0%	100.0%
c	% of people that died who were expected to die and had an advance care plan	Indicator suspended pending new 'ICOD' pathway		
d	% District Nursing Patients with a care plan	90%	98.0%	98.1%
e	% of patients with a LTC with a Calderdale Care Plan	90%	92.0%	89.8%
f	% of patients under the care of the community specialist matron who have been readmitted to hospital with the same LTC in less than 30 days	<10%	6.3%	4.1%

	2 Helping people to recover from episodes of ill health or following injury	Target	Current Month	YTD
a	% of leg ulcers healed within 12 weeks from diagnosis	75%	94.3%	93.5%

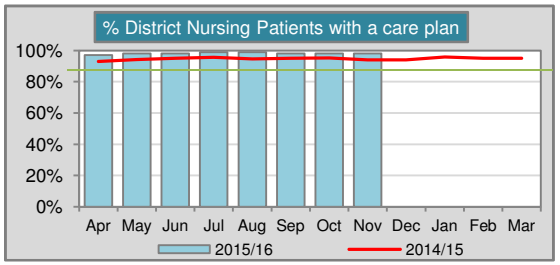
	3 Ensuring people have positive experience of care	Target	Current Month	YTD
a	Number of complaints	n/a	3	20
b	Number of complaints about staff attitude	n/a	0	0
c	Community AHP - 18 week RTT Snapshot at month end *	95%	80.3%	91.5%
d	Community Friends and Family Test	n/a	85.0%	90.1%

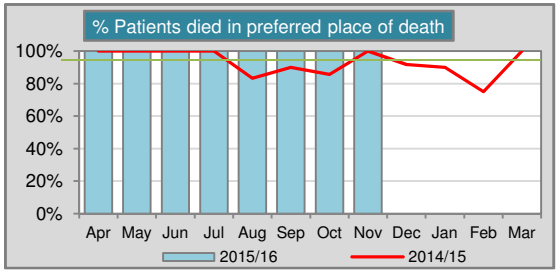
	4 Treating and caring for people in a safe environment; and protecting them from avoidable harm	Target	Current Month	YTD
a	% of patients in receipt of community nursing services that have had a pressure ulcer screening and this is documented in their care plan	90%	84.0%	84.6%
b	Number of community acquired grade 3 or 4 pressure ulcers	<1.8	0	23
c	Number of falls that caused harm whilst patient was in receipt of Comm Services	<1.1	0	13
d	Patient safety thermometer - coverage - Harm free	>95%	95.6%	95.2%
e	Patient safety thermometer - No of Harms Reported	<22.1	19	153
f	% of staff that have undertaken safeguarding / mental capacity act training	95%	46.6%	59.4%

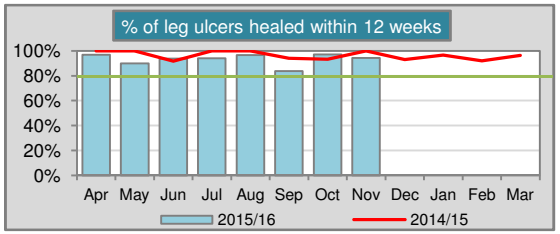
	5 Activity & Resource efficiency	Baseline	Current Month	YTD
a	Community DNA Rates	<1%	1.4%	1.2%
b	Sickness Absence rate	<4%	TBC	3.9%

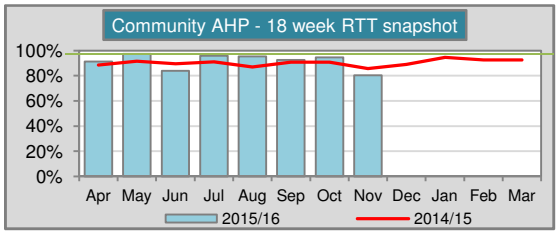
Target

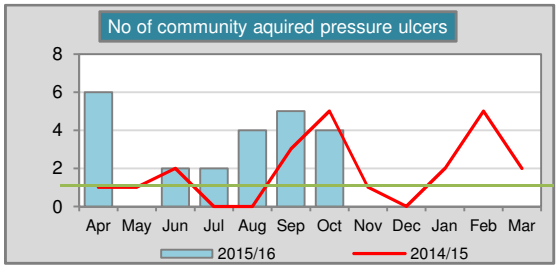
*NOTE: The Community - 18 Week RTT Activity currently includes the Services transferred to Locala on the 1st











Calderdale and Huddersfield NHS
NHS Foundation Trust

CQUINS Performance Report 2015-16

compassionate care

Goal Number	Goal Name	Current Target	Q1	Q2	Q3 to Date	Q4	Q4 Target	Commentary
1	Acute Kidney Injury	45%	22%	32%	57%		90%	Improvement Work Required
2a	Sepsis	Baseline	88%	40%	64%		90%	Improvement Work Required
2b	Sepsis	Baseline	41%	63%	Available Qtr End		90%	Improvement Work Required
3	Urgent care	85%	86%	88%	88%		85%	On Plan
4.1	Dementia	90%/90%/90%	91%/99%/100%	91%/100%/100%	92%/100%/100%		90%/90%/90%	On Plan
4.2	Dementia	Written Report	n/a	Y	n/a		Report	On Plan
4.3	Dementia	Written Report	n/a	Y	n/a		Report	On Plan
5.1	Respiratory - Asthma	Q3 = 72%	66%	80%	Available Qtr End		75%	On Plan
5.2	Respiratory - Pneumonia	Q3 = 70%	70%	78%	Available Qtr End		75%	On Plan
6	Diabetes	50%	74%	64%	80%		50%	On Plan
7.1	Improving Medicines Safety	80%/70%	80%/73%	82%/88%	Available Qtr End		80%/70%	On Plan
7.2	Improving Medicines Safety	Development	Y	Y	Available Qtr End		TBC	Target to be set after Q2
8	End of Life Care	Monitoring	36%	44%	47%		Monitoring	On Plan
9.1	Hospital Food	70%	78%	76%	73%		70%	On Plan
9.2	Hospital Food	Baselining	5.70%	5.48%	5.28%		TBC	Target to be set after Q2
9.3	Hospital Food	Written Report	Y	Y	Y		Report	On Plan
Total								

Goals - CCG CQUINs

Value of CQUIN (£)	Q1	Q2	Q3	Q4
627,071	62,707	125,414	125,414	313,536
313,536	78,384	78,384	78,384	78,384
313,536		62,707	125,414	125,414
1,254,142	125,414	376,243	376,243	376,243
250,828	62,707	62,707	62,707	62,707
125,414		62,707		62,707
250,828		125,414		125,414
250,828	62,707	62,707	62,707	62,707
376,243	94,061	94,061	94,061	94,061
627,071	156,768	156,768	156,768	156,768
125,414	31,354	31,354	31,354	31,354
501,657	125,414	125,414	125,414	125,414
627,071		313,536		313,536
250,828		125,414		125,414
250,828		50,166	100,331	100,331
125,414				125,414
6,270,712	**799,516**	**1,852,995**	**1,338,797**	**2,279,404**

Acute Kidney Injury - Q4 Achievement Plan

A step change in performance is expected once the changes to the Electronic Discharge summary take effect. This was implemented at the end of September2015 and early results are promising.
In addition to the changes in technology, the CQUIN concept and components were introduced to new junior doctors through Trust induction in August 2015

Divisional directors have been contacted regarding the CQUIN elements and importance of delivery via e-mail in August 2015

A procedure for informing non-complying clinical team for auctioning in Q3 has been agreed
Weekly monitoring of the CQUIN to commence in Q3 to allow a more proactive management of the CQUIN delivery programme

Weekly Monitoring of performance since October 2015

Sepsis - Q4 Achievement Plan

Intensive improvement work is needed throughout the trust to ensure robust processes for screening applicable patients on admission, and ensuring that when indicated those patient get antibiotics within an 1hour.

There is some way to go to achieve the Q4 position, as such a safety and improvement nurse has been deployed to work with the ward and Sepsis Nurse Consultant to implement sustainable and high quality processes.

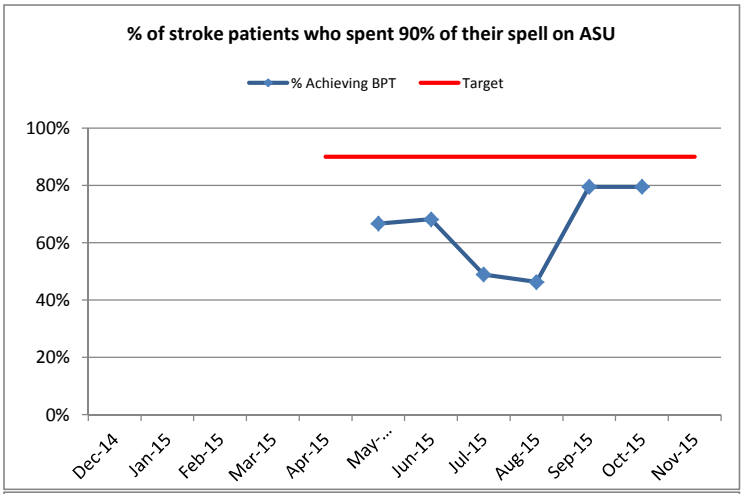
There has been additional education rolled out to junior ED and medical teams on induction.

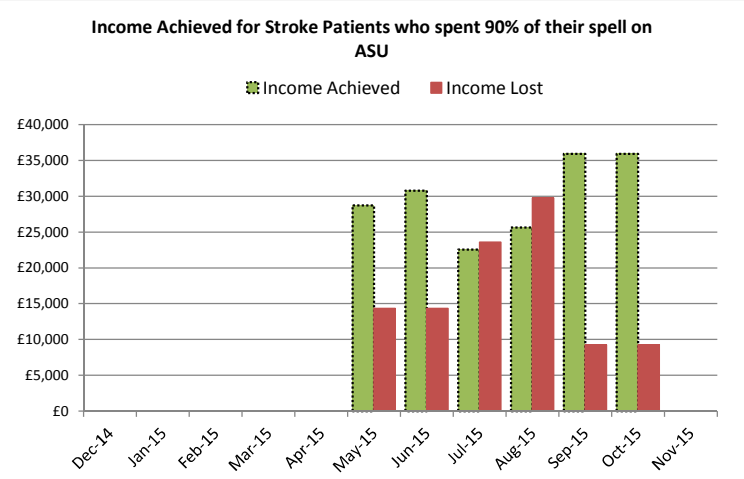
Improvement is expected gradually over the next 6 months and a trajectory will be in place to ensure we are on track. Weekly monitoring programme agreed with the audit team and results will be fed back to the clinical teams.

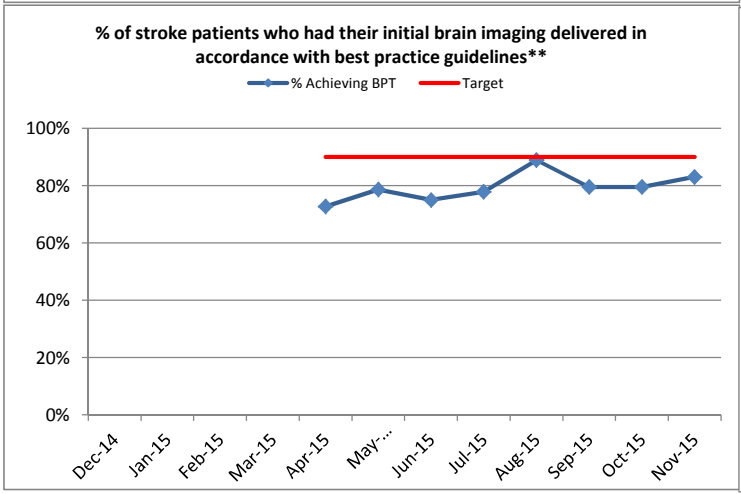
NHS England

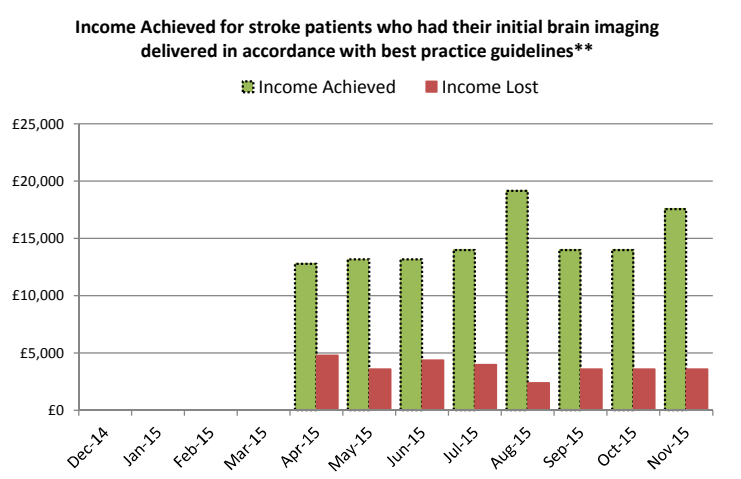
Goal Name	Value of CQUIN (£)	Q1	Q2	Q3	Q4
NICU	38,051	9,513	9,513	9,513	9,513
Oncotype DX	38,051	9,513	9,513	9,513	9,513
QIPP	126,836	31,709	31,709	31,709	31,709
Vac and Immunisations	90,860	22,715	22,715	22,715	22,715
National CQUIN	22,715	5,679	5,679	5,679	5,679
HV Building Community Capacity	104,680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

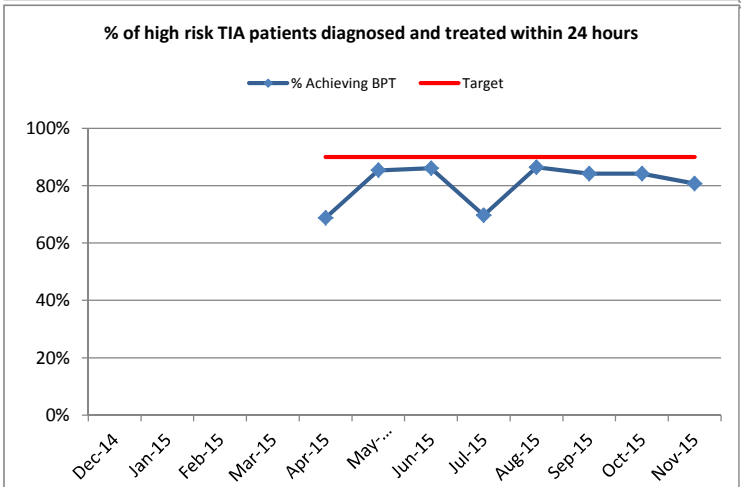
GRAND TOTAL	**6,691,905**	**904,814**	**1,958,294**	**1,444,095**	**2,384,702**

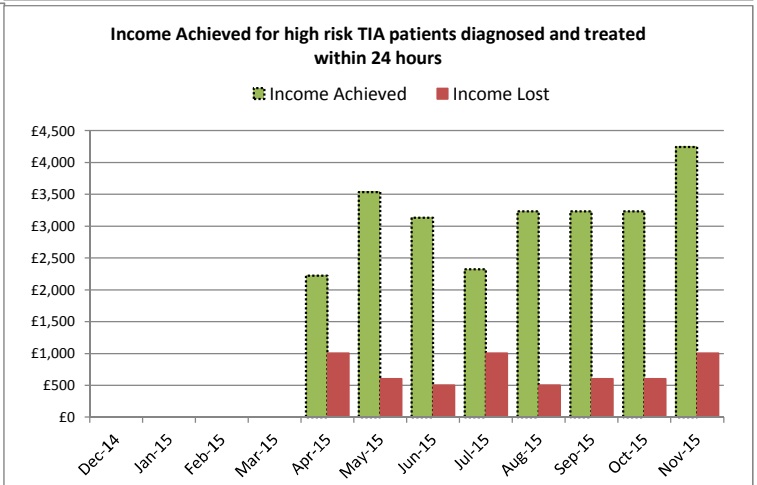

% of stroke patients who spent 90% of their spell on ASU
% Achieving BPT
Target
100%
80%
60%
40%
20%
0%
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-...
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15

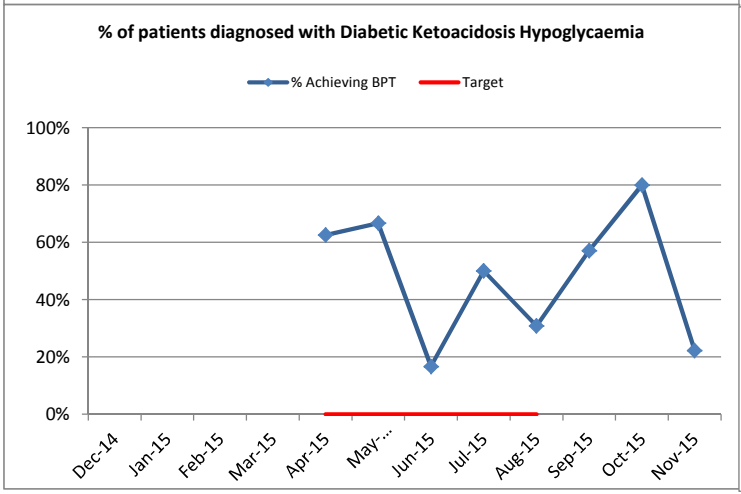

Income Achieved for Stroke Patients who spent 90% of their spell on ASU
Income Achieved
Income Lost
£40,000
£35,000
£30,000
£25,000
£20,000
£15,000
£10,000
£5,000
£0
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15

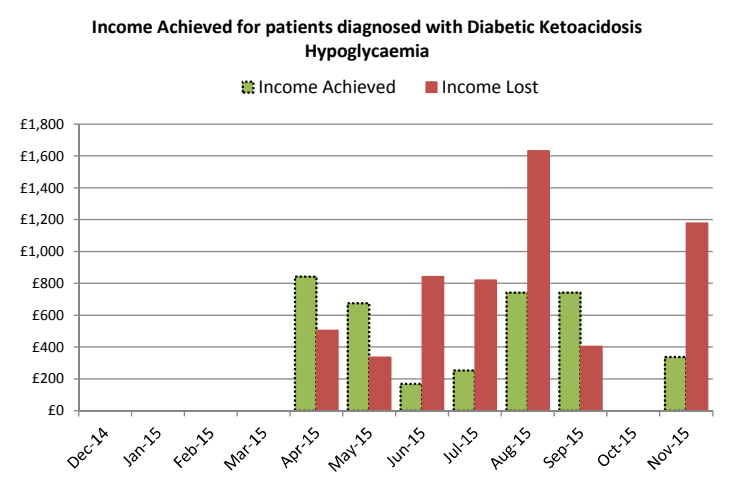

% of stroke patients who had their initial brain imaging delivered in accordance with best practice guidelines**
% Achieving BPT
Target
100%
80%
60%
40%
20%
0%
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-...
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15

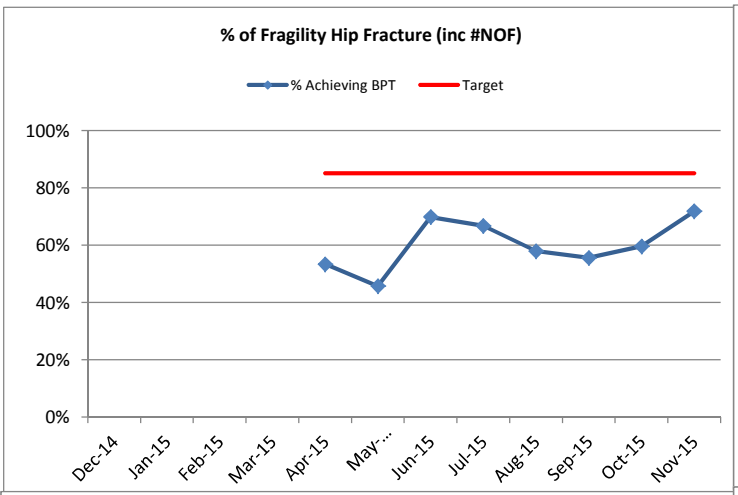

Income Achieved for stroke patients who had their initial brain imaging delivered in accordance with best practice guidelines**
Income Achieved
Income Lost
£25,000
£20,000
£15,000
£10,000
£5,000
£0
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15

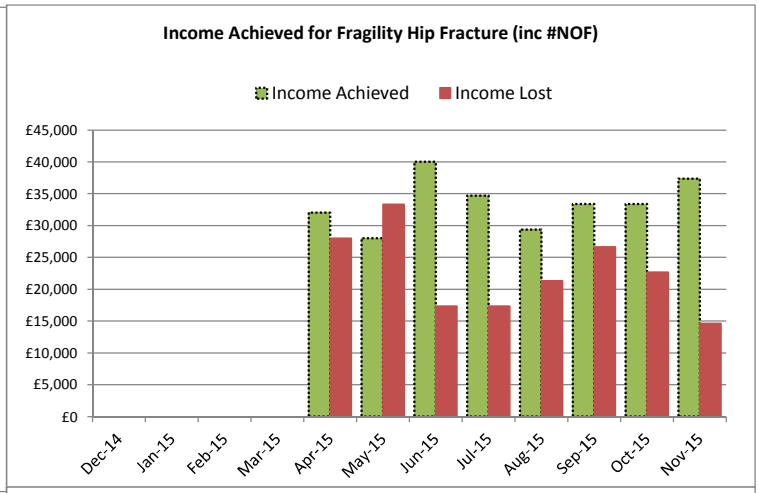

% of high risk TIA patients diagnosed and treated within 24 hours
% Achieving BPT
Target
100%
80%
60%
40%
20%
0%
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-...
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15

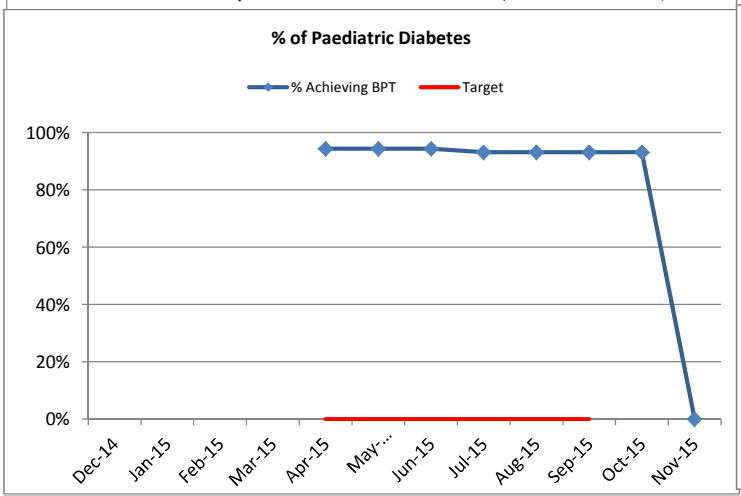

Income Achieved for high risk TIA patients diagnosed and treated within 24 hours
Income Achieved
Income Lost
£4,500
£4,000
£3,500
£3,000
£2,500
£2,000
£1,500
£1,000
£500
£0
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15

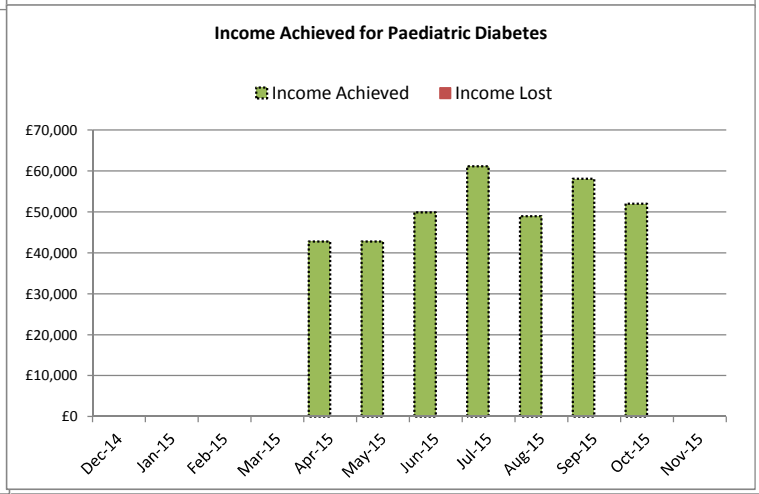

% of patients diagnosed with Diabetic Ketoacidosis Hypoglycaemia
% Achieving BPT
Target
100%
80%
60%
40%
20%
0%
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-...
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15


Income Achieved for patients diagnosed with Diabetic Ketoacidosis Hypoglycaemia
Income Achieved
Income Lost
£1,800
£1,600
£1,400
£1,200
£1,000
£800
£600
£400
£200
£0
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15


% of Fragility Hip Fracture (inc #NOF)
% Achieving BPT
Target
100%
80%
60%
40%
20%
0%
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-...
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15


Income Achieved for Fragility Hip Fracture (inc #NOF)
Income Achieved
Income Lost
£45,000
£40,000
£35,000
£30,000
£25,000
£20,000
£15,000
£10,000
£5,000
£0
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15


% of Paediatric Diabetes
% Achieving BPT
Target
100%
80%
60%
40%
20%
0%
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-...
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15


Income Achieved for Paediatric Diabetes
Income Achieved
Income Lost
£70,000
£60,000
£50,000
£40,000
£30,000
£20,000
£10,000
£0
Dec-14
Jan-15
Feb-15
Mar-15
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May-15
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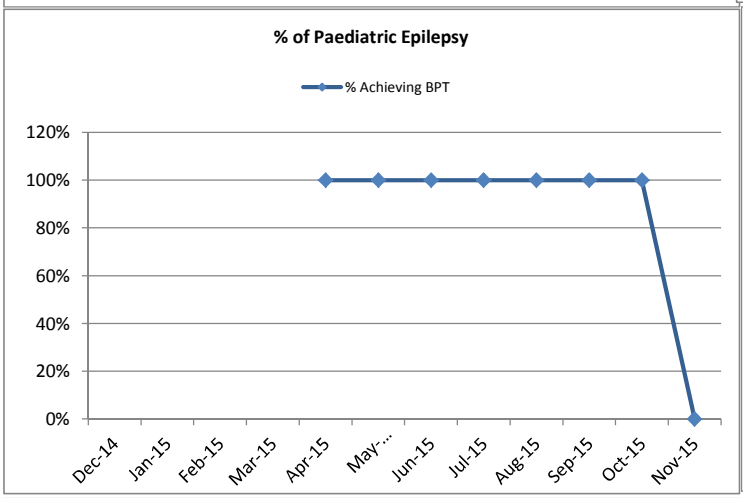
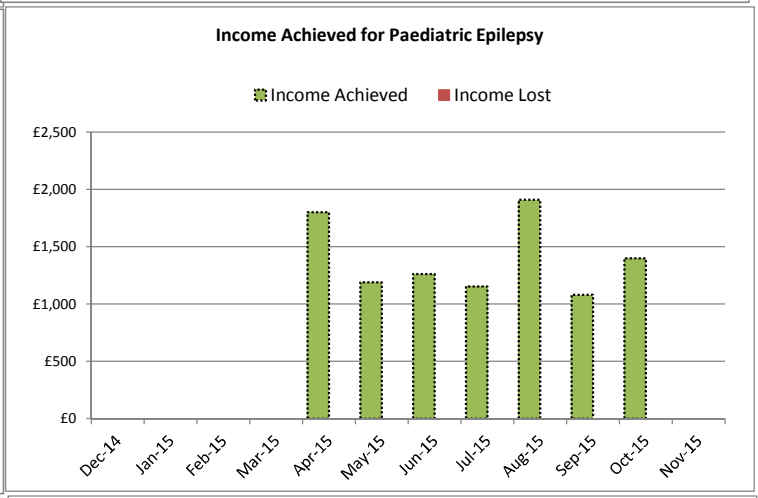
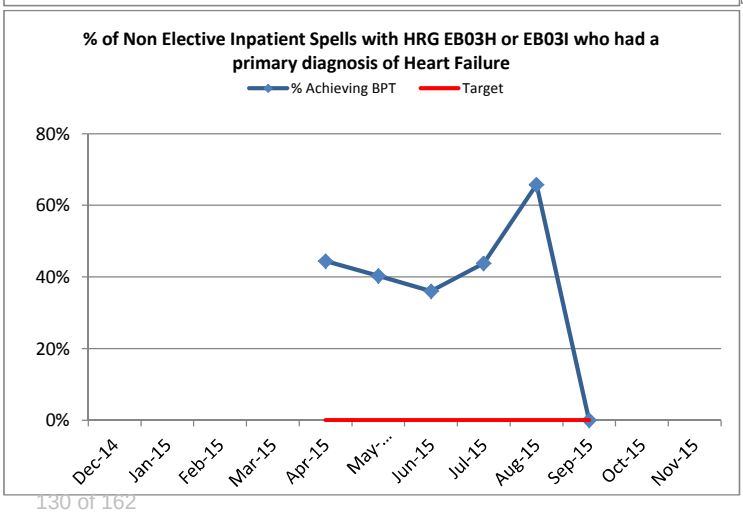
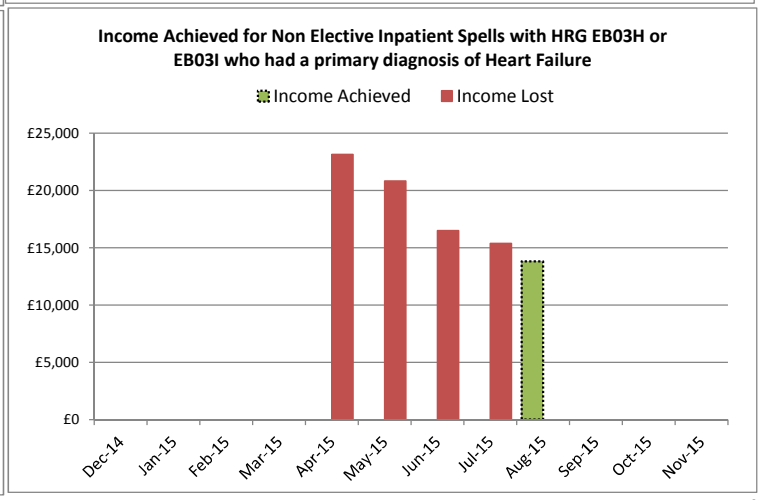
Sep-15
Oct-15
Nov-15


% of Paediatric Epilepsy
% Achieving BPT
120%
100%
80%
60%
40%
20%
0%
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-...
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15


Income Achieved for Paediatric Epilepsy
Income Achieved
Income Lost
£2,500
£2,000
£1,500
£1,000
£500
£0
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15


% of Non Elective Inpatient Spells with HRG EB03H or EB03I who had a primary diagnosis of Heart Failure
% Achieving BPT
Target
80%
60%
40%
20%
0%
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-...
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15


Income Achieved for Non Elective Inpatient Spells with HRG EB03H or EB03I who had a primary diagnosis of Heart Failure
Income Achieved
Income Lost
£25,000
£20,000
£15,000
£10,000
£5,000
£0
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15

Board of Directors Integrated Performance Report

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

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

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

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

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

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

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APPENDIX I

Calderdale and Huddersfield NHS
NHS Foundation Trust

MONTH 8 NOVEMBER 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 annual plan as submitted to Monitor in May;
- Financial Sustainability Risk Rating (FSRR) and forecast.

This paper has previously been discussed at the Finance & Performance Committee held on 15 December 2015.

1. Key Messages

The year to date position is an adverse variance to the original plan of £1.35m (excluding restructuring costs). Last month the Trust was required to submit a reforecast plan to Monitor. The year to date financial position represents an improvement of £0.37m from the trajectory in the reforecast plan.

The year end forecast position shows an improvement of £0.14m against the reforecast planned deficit of £22.04 (including restructuring costs of £1.10m). There is potential to improve this by a further £1m through a capital to revenue transfer, subject to confirmation from Monitor. Equally, the cash and I&E implications of the EY consultancy restructuring costs are currently under consideration by Monitor, which if approved would authorise the Trust to deliver a deficit of £21.0m.

The improved in-month position has a small impact on the year end forecast position whilst the Trust seeks to mitigate against the uncertainties of further winter pressures and contract settlement risks.

Month 8, November Position (Year to Date)

Income and Expenditure Summary	Original Plan £m	Reforecast Plan £m	Actual £m	Var (vs. Original Plan) £m
EBITDA	**4.10**	**2.11**	**2.48**	**(1.62)**
Deficit excluding restructuring	**(12.89)**	**(14.60)**	**(14.24)**	**(1.35)**
Restructuring costs	**(3.00)**	**(0.65)**	**(0.65)**	**2.35**
Deficit including restructuring	**(15.89)**	**(15.25)**	**(14.89)**	**1.00**

- An EBITDA of £2.48m, an adverse variance from original plan of 1.62m.
- A deficit (excluding restructuring) of £14.24m, an adverse variance of £1.35m from the original planned position.
- Delivery of CIP of £10.90m against the planned level of £8.24m.
- Contingency reserves released of £1.63m against year to date pressures.
- Capital expenditure of £12.62m, this is below the original planned level of £15.60m.
- A cash balance of £10.38m, this is above the original planned level of £1.94m.
- A Financial Sustainability Risk Rating (FSRR) of level 2, in line with plan (restated from Continuity of Service Risk Rating of level 1).

2. Detailed Commentary for the Reporting Period

Statement of Comprehensive Income (SOCI)

The month 8 position has shown an improvement from forecast projections made last month. The number of extra beds open has been contained at a slightly lower level than anticipated, slowing spend somewhat. The relatively mild weather in November has helped in this regard and also brought a benefit to utilities costs. Outpatient performance has also improved from the recent trend and forecast level, bringing additional income benefit.

In summary the main cumulative variances between the year to date position and the original plan are:

Operating income	(£2.20m) adverse variance
Operating expenditure	£0.59m favourable variance
EBITDA	**(£1.61m) adverse variance**
Non-Operating items	£0.26m favourable variance
Restructuring costs	£2.35m favourable variance
Total	**£1.00m favourable variance**

Operating Income

There is a cumulative £2.20m adverse variance from plan within operating income.

NHS Clinical Income

Of the £2.20m adverse income variance, £1.33m is driven by NHS clinical income. In summary this comprises a year to date over performance in non-elective activity outweighed by the underperformance against elective and day case activity. There has, however, been an improvement this month in the level of outpatient activity compared with the recent trend.

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

- Planned day case and elective activity has continued to perform below plan and is 9.1% below plan in month 8 (386 spells). This is however an improvement from the position seen against plan in month 7 when activity was 12% (589 spells) below plan. Cumulatively activity is now 8.9% (3,038 spells) below plan.

- Non-elective admissions overall are above the month 8 plan by 3.6% (149 spells) which is a continuation of the over-performance seen in month 7 of 4.7% (197 spells). Cumulatively activity is now 3.3% above plan (1,083 spells).

- A&E activity in the year to date is below plan by 1.4% (-1,411 attendances). Activity is, however, in line with the 2014-15 levels for November and cumulatively 1.2% (1,202 attendances) higher than that delivered in 2014-15.

- Outpatient attendances are 4% (1,132 attendances) above plan in month 8 which is significant shift from the level of under-performance seen in the previous 4 months. The increase in activity levels is across both first and follow-up attendances. Cumulatively outpatient activity is now 1.8% below plan (3,909 attendances).

- Pass through high cost drugs and devices costs are below plan by £0.60m in the year to date.

In line with the reforecast plan, in recognition of the outstanding income risks, allowance to the value of £1.30m has been made in the year to date in the anticipation of contract sanctions; any

shortfall on CQUIN performance; and contract challenges under a full PbR contract. The Trust has assurance from commissioners that they will endeavour to take a pragmatic view of the contractual position as a whole, recognising the operational pressures that are at play as a result of system wide resilience issues. The response is likely to differ across the two main commissioners.

Other income

Overall other income is £0.87m below the planned level. The Trust's Pharmacy Manufacturing Unit which generates commercial income had planned to exceed their prior year surplus delivery. As previously reported, there is a shortfall against this plan which is the main driver of the adverse variance. This is now not expected to be fully recovered back to plan by year end although the unit does still make a significant net contribution of £3.0m on a full year basis and plans for 16/17 are more resilient as sales and marketing efforts are paying dividends. The Health Informatics Service which is also hosted by the Trust and operates commercially continues to generate revenue in excess of plan in the year to date.

Operating expenditure

There was a cumulative £0.59m favourable variance within operating expenditure across the following areas:

Pay costs	(£0.71m) adverse variance
Drugs costs	£0.30m favourable variance
Clinical supply and other costs	£1.00m favourable variance

Employee benefits expenses (Pay costs)

Pay costs are £0.71m above the planned level. However, within the pay position there is a benefit of £1.40m versus plan against contingency reserves as this has been released to mitigate against the pay pressures experienced in the clinical divisions. The value of the overall pay pressure seen operationally in the year to date is therefore £2.11m.

The largest single driver of the additional costs which have been incurred in the year to date and built into the forecast projections, is the need for additional bed capacity over and above the original planned level. This is directly linked to dealing with the wider system resilience issues and has to be covered being by high cost non-contracted medical and nursing staff. In-month the level of additional nurse staffing cost has been held beneath the forecast trajectory due to a lower level of beds being open than anticipated.

As previously reported, in order to balance the availability in the market of nursing and medical staff required to safely serve the additional planned winter capacity, the Trust is developing a range of alternative mitigating actions. These include investment in other support staff groups to facilitate discharge, revisions to service models and enhancement of senior decision making presence to aid admission avoidance. A level of financial risk is inherent given the flexibility that will be required in these operational decisions and this is taken into account in the year end forecast.

Recruitment difficulties 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, offsetting the benefit against nursing spend in-month. Focussed activity is required to manage attendance of clinical staff; ensure escalation of authorisation for agency cover for junior medical posts; drive down agency rates using the Monitor price cap as a lever where possible; and efficiently record and monitor these bookings.

Drug costs

Year to date expenditure on drugs was £0.30m below plan. The underspend on 'pass through' high cost drugs is below plan matched by a corresponding income reduction.

Clinical supply and other costs

Clinical supply and other costs, including PFI costs, are £1.0m below plan in the year to date position.

As in previous months, activity driven non-pay costs vary significantly by division, reflecting the shape of the clinical activity delivery. Pressures on clinical supply costs are seen across the Medical and Families & Specialist Services divisions driven by the additional non-elective activity. Whilst the Surgery division shows a greater level of underspend on clinical supply costs aligned to the shortfall in elective and day case activity.

The benefit seen last month as a result of reassessment of utilities expenditure based on latest volumes and tariffs has increased further this month due in part to the mild weather conditions.

The recognition of a bad debt provision against invoices raised to Calderdale CCG in the early part of the year for system resilience pressures at £0.42m brings a pressure to non-pay, as previously reported.

Non-operating Items and Restructuring Costs

Non-operating items show a favourable £0.26m variance from plan. In the year to date this continues to be predominantly due to lower than planned inflationary charges on the PFI contract with actual RPI being lower than the projected level. There is also some benefit on interest payable as loans have not been required in the year to date as planned.

Restructuring costs in the year to date are £0.65m. Of the costs incurred £0.10m relates to redundancy payments to enable CIP, originally planned to be £3.0m in the year to date, whilst £0.55m relates to the year to date element of the E&Y consultancy support to strategic turnaround which comes in addition to the planned spend as previously discussed with Monitor.

Cost Improvement Programme (CIP) delivery

The CIP and revenue generation schemes continue to perform in excess of plan in the year to date with £8.67m achieved against a planned £6.93m. 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 by the provision made against contract challenges by commissioners.

The risk assessment against all of the work streams has been reviewed in month and is fully reflective of the increasing surety of delivery of schemes that are already well underway.

Statement of Financial Position and Cash Flow

At the end of November 2015 the Trust had a cash balance of £10.38m against a planned position of £1.94m, a favourable variance of £8.44m, the key movements are summarised below.

		Variance £m
Operating activities	Deficit excluding restructuring	(1.35)
	Restructuring costs - redundancy	2.90
	Restructuring costs – consultancy support	(0.55)
	Deficit including restructuring	**1.00**
	Non cash flows in operating deficit	(0.16)
	Re-profiling of commissioner contract income	13.93
	Other working capital movements	0.73
	Sub Total	**15.50**
Investing activities	Capital expenditure	2.99
	Movement in capital creditors	(0.53)
	Sub Total	**2.46**
Financing activities	Drawdown of external DoH cash support	(9.70)
	Other financing activities	0.18
	Sub Total	**(9.52)**
	Grand Total	**8.44**

Operating activities

Operating activities show a favourable £15.50m variance against plan. This is driven by the favourable cash impact of the I&E position of £0.84m (£1.00m favourable I&E variance offset by £0.16m adverse variance against non-cash flows in operating deficit) coupled with positive working capital variances from plan. In addition, 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. As expected, this has boosted the cash position by £13.93m in the year to date.

The Trust's pro-active treasury management work was discussed with Monitor on their recent site visit and this is ongoing with ever more developments being implemented. Debtors are being actively pursued and outgoing payments are being carefully scheduled to ensure that suppliers are paid in-time rather than ahead of time to preserve cash. In the year to date 77% of invoices have been paid within 30 days (88% in-month), as the Trust is mindful of the need to maintain healthy 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 £12.61m, £2.99m below the planned level of £15.60m.

Against the Estates element of the capital expenditure plan the year to date expenditure is £4.97m against a planned £5.91m. The main area of spend in month was the continuation the Theatre refurbishment at £0.26m.

IM&T investments total £6.29m against a year to date plan of £8.07m. The main individual area of spend in month is on the continuation of the Electronic Patient Record (EPR) at £1.05m, this being a partial catch-up against plan as this commitment had previously been planned earlier in the year

but the Trust took action to ensure that the payments were based on staged deliverables from the supplier. 'Single sign on' was planned in November at £0.40m but is now forecast to be implemented in February.

The favourable cash impact of this £2.99m under spend is offset in part by a £0.53m adverse variance against capital creditors, explaining the overall £2.46m positive cash variance against investing activities.

Financing activities

Financing activities show a £9.52m 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 requirement for which was originally expected to have reached £9.70m by November. This is further evidence that the actions being taken by the Trust to pro-actively manage cash are having a real impact.

As reported in previous months, the Trust has an approved working capital loan facility in place with the Independent Trust Financing Facility which is available to draw against up to a total value of £13.1m at an interest rate of 3.5%. This is a 'safety net' to the Trust as the requirement for external cash funding is not projected to arise until March 2016. The application process has commenced with the support of Monitor to progress to having a revenue support loan secured by March at the lower 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

The latest forecast is a £21.92m deficit, this is a slight improvement of £0.12m against the reforecast plan submitted to Monitor in November. At bottom line this is an improvement to the original plan although this is predominantly due to the lower than planned restructuring costs. In trading terms, as represented at EBITDA level there continues to be an adverse variance from the original plan of £1.24m.

The reforecast plan was to deliver a year end deficit of £22.04 (including restructuring costs of £1.10m). This incorporates £1.2m additional resource to compensate the Trust for its winter resilience plans which Calderdale CCG have recently confirmed, the costs of which had already predominantly been included within the forecast.

A £1.0m benefit to the forecasted I&E position would be delivered through a capital to revenue transfer. As advised by Monitor this was not built into the reforecast plan pending confirmation of agreement to proceed.

As previously reported and discussed with Monitor as a specific addition to the planned spend; the forecast includes £1m restructuring costs in respect of the appointment of Ernst & Young (to provide capacity and specialist capability to the development of the transformational five year strategic plan).

Overall, with the confirmation of the capital to revenue transfer and agreement from Monitor that the EY costs are an allowable extension to the deficit the Trust will deliver the out turn agreed with Monitor at £21.04m.

Financial risk remains against the operational management of winter pressures. This is exacerbated by the challenge in recruiting nurse staffing to additional capacity. In order that the bed capacity across the Trust is staffed appropriately at safe levels, alternative strategies to cope with non-elective demands with fewer beds are on-standby. This brings the risk of additional costs which will need to be mitigated alongside the ongoing contract settlement risks where provision has been made but the outcome is still uncertain.

The forecast year end position is summarised here against the original and reforecast plan for clarity:

Year-end Forecast Position

Income and Expenditure Summary	Original Plan £m	Reforecast Plan £m	Month 8 Forecast £m	Var (vs. Original Plan £m
EBITDA	**5.51**	**4.14**	**4.26**	**(1.26)**
Deficit excluding restructuring	**(20.01)**	**(20.94)**	**(20.82)**	**(0.81)**
Restructuring costs - redundancy	(3.00)	(0.10)	(0.10)	2.90
Restructuring costs – consultancy support	0.00	(1.00)	(1.00)	(1.00)
Deficit including restructuring	**(23.01)**	**(22.04)**	**(21.92)**	**1.09**

Forecast – Capital

In aggregate across all capital schemes the reforecast year end position is in line with planned levels. 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 are ongoing to determine whether the Trust option is available to transact a capital to revenue transfer of £1.0m to reduce the dependency upon external cash support and bring equivalent benefit to I&E. Pending conclusion of these discussions, the full capital expenditure is currently forecast.

Forecast – Cash

The total cash support requirement currently stands at £13.9m. This includes the additional cash requirement to support the restructuring costs relation to consultancy support and the operational I&E pressures at £1.0m, as previously discussed with Monitor, the Trust awaits confirmation that this will stand as an agreed discretionary extension to the cash support requirements.

A further cash benefit of £1.0m would be driven out by the potential to reprioritise capital expenditure. This would reduce the cash support requirement to £12.9m.

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 the original plan and is now not forecast to be required until March 2016 as per the reforecast plan.

Conclusion

The Trust continues to make every effort to improve upon the year end forecast I&E position and minimise the cash support required. All avenues to achieve this are being pursued, through internal challenge to deliver the operational pressures at best value; consideration of capital prioritisation where this can be done without detriment to safety; and open dialogue with commissioners.

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 17th December 2015	**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: 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 receive, note and approve the following:-

a. Quality Committtee - Minutes of 24.11.15 and verbal update from meeting 15.12.15
c. Finance and Performance Committee - Verbal update from meeting 15.12.15

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive, note and approve the following:-

a. Quality Committtee - Minutes of 24.11.15 and verbal update from meeting 15.12.15
c. Finance and Performance Committee - Verbal update from meeting 15.12.15

Appendix

Attachment:

QC Minutes 24 11 15 - draft 2.pdf

Minutes of the QUALITY COMMITTEE held on Tuesday 24 November 2015, 2pm – 5pm in Discussion Room 1, L&D Centre, HRI

PRESENT:
Anne-Marie Henshaw, Associate Director of Nursing, Family and Specialist Services Division
David Birkenhead, Medical Director (left at 3.50pm)
Jeremy Pease, Non-Executive Director (Chair)
Julie Dawes, Executive Director of Nursing & Operations (left at 3.50pm)
Juliette Cosgrove, Assistant Director for Quality
Joanne Middleton, Matron, Community Service Division
Julie O'Riordan, Divisional Director, Surgery & Anaesthetic Services Division
Linda Patterson, Non-Executive Director
Lindsay Rudge, Deputy Director of Nursing
Martin DeBono, Divisional Director, Family and Specialist Services Division
Paul Moore, Associate Nurse Director, Surgery & Anaesthetics Division

IN ATTENDANCE:
Stephanie Jones, Personal Assistant (Minutes)
Alison Wilson, Head of Estates, Operations and Compliance (on behalf of Lesley Hill)
Jason Busby, Facilities Manager, Operation & Facilities (Item 5.2)
Mike Culshaw, Pharmacy Director (Item 6.4)

01/11/15	**1. WELCOME AND INTRODUCTIONS** The Chair welcomed members to the meeting. The meeting was confirmed as quorate. There were no declarations of interest.
02/09/15	**2. APOLOGIES FOR ABSENCE AND ATTENDANCE REGISTER** **Apologies for absence were received from:** Andrea McCourt, Head of Governance & Risk Helen Barker, Assistant Director of Operations and Community Services Jackie Murphy, Deputy Director of Nursing - Modernisation Jan Wilson, Non-Executive Director Jason Eddleston, Deputy Director and Workforce and OD Keith Griffiths, Finance Director Lesley Hill, Executive Director of Planning, Performance, Estates and Facilities Lynne Moore, Membership Council Representative Sal Uka, Divisional Director, 7-day Services & Hospital at Night Victoria Pickles, Company Secretary
03/11/15	**3. MINUTES OF THE MEETING HELD ON 27 OCTOBER 2015** The minutes of the meeting held on 27 October 2015 were approved as a true record.

04/11/15	**4. ACTION LOG & MATTERS ARISING** (Items due this month) All items on the action log due this month were items on the agenda. It was noted an update on the lessons learnt from the Stepping Hill Hospital: Victorino Chua incident would be brought to the Committee in December.
05/11/15	**5. MAIN AGENDA ITEMS** **5.1 Emergency Preparedness, Resilience and Response Policy (EPRR)** Alison Wilson, Head of Estates, Operations and Compliance, presented the Emergency Preparedness, Resilience and Response Policy. The policy is an overarching policy that combines a number of policies together and is supported by a number of plans and guidance documents. It details the legislative and statutory requirements of the Trust and how the Trust plans meet these requirements. Specific duties for the Chief Executive, Executive Director of Planning, Performance, Estate and Facilities, Emergency Planning Officer and Divisional Director were outlined within the policy. The policy has been cited by the Trust's Health and Safety Committee and will be submitted to the Executive Board in December. The following questions were raised by the Committee: **1.** The Executive Director of Nursing queried whether the report had been linked to other organisations (i.e. Local Authority, Emergency Services, Environment Agency) as a response to a major incident would require a whole system approach? **2.** The Chair queried whether and how the policy references with the Trust's Majax Policy and other escalation policies? **3.** The Assistant Director of Quality queried what the process would be from learning and whether it should go to another Committee/Group that holds operational management responsibility. **ACTION:** • Alison Wilson will put forward the questions raised to the Emergency Planning Officer and will feedback to the next Committee meeting in December. • The Committee agreed the policy would need to go through the Executive Board and the Board of Directors for final sign off. **5.2 Cleaning Service Report: Update on the Introduction of a Management Framework and Accredited Cleaning Standards** Jason Bushby (Facilities Manager, Operation & Facilities) was in attendance to give an update on progress on the recommendations from the Independent Cleaning Services Report that was received by the Committee in June 2015.

The improvements made to Cleaning Services will be made by the delivery of the BICS training modules which will produce a standardised approach to service delivery ensuring a consistent cleaning method is applied achieving the required standards.

The Director of Nursing queried whether the cleaning frequencies have been approved by the Infection Control Team. Jason Bushby confirmed they are not currently adequate to national standards, but the department are working closely with the Infection Control Department on this. In light of this the Director of Nursing queried the risk for the Trust as they are not currently detailed on the Risk Register. Jason Bushby confirmed the risk would be a reduction in quality and service.

ACTION: Director of Nursing and Medical Director to meet with Alison Wilson and Jason Bushby outside the meeting to look in more detail at the risks and cleaning frequencies in order to ensure operational assurance.

Non-Executive Director, Linda Patterson queried how well the Trust had done in relation to cleanliness in the National Patient Survey and that it would be useful to evaluate these results to measure our progress.

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

5.3 Quality Impact Assessment (QIA) Matrix

The Director of Nursing presented an update report on the potential risks that individual Cost Improvement Programmes (CIP) might have on the quality of care provided to patients by the Trust.

The Quality Impact Assessment (QIA) process was developed to ensure that all risks to quality and performance are considered at the planning stage of any CIP project. Risks are assessed using a risk scoring matrix to reach a total risk score. The matrix was presented to the Committee which detailed those risks with a score of 12 or above.

An exercise with the CIP Leads to review the unintended consequences or benefits is currently ongoing. Some of the metrics used are not a good measure and a conversation with the lead may be more valuable.

Any impacts that are a concern are escalated to the weekly Executive Turnaround meeting.

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

06/11/15	**6. PATIENT SAFETY AND QUALITY BOARD REPORT (PSQB) FOR Q2** **6.1 Estates & Facilities Division** The Head of Estates, Operations and Compliance presented the report on behalf of the Division. The following highlights were taken from the report: • Fire Safety: West Yorkshire Fire Service will recommence inspection of hospital sites and will expect that fire risk assessments/action plans are managed and monitored. • CQUIN 2015/16 – Hospital food: The Trust is working in partnership with Calderdale CCG, Public Health at Kirklees and Calderdale Food for Life, focussing on patient satisfaction, reduced patient food waste and improving vending facilities. A paper regarding vending facilities will be submitted to WEB on 26 November 2015. • Half day workshop completed on CQC regulation 14 Meeting Nutrition and Hydration needs. Work planned to develop CHFTs Food and Drink Strategy, which will be submitted to the WEB. • Environment Agency visit has taken place and actions from the visit are being looked at. • Patient catering: The HRI catering team are showcasing patient food at HRI main entrance on a weekly basis, alongside a fruit and veg stall. • Car parking: ANP tender being considered for the Trust with learning from Acre Mill project being taken into consideration. Automatic number plate recognition being considered. • Patient equipment: proposed piece of work with ICU (HRI) providing CHFT owned nimbus mattresses and return current on hire mattresses back to supplier. This will be closely monitored with the Ward Manager to ensure a sufficient service and efficiencies for CHFT. • Issues noted with medical device equipment with the need for tracking system to be developed. Currently no robust system in place. The plan for 2016 will be to have an inventory in place for equipment. It is currently unclear where the Medical Devices department currently sits, but it was understood the department will transfer to Estate and Facilities Division from the 1st April 2016. Alison Wilson to advise what arrangements are in place in the meantime. • RIDDOR: Working with HR and Risk Management to ensure right reporting mechanisms are in place. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.

6.2 Surgery & Anaesthetics Division

The Divisional Director for Surgery and Anaesthetic Services presented the report on behalf of the Division.

The following highlights from the report were brought to the attention of the Committee:

- **NCEPOD Reports:** An Old Age Problem and Lower limb amputation currently partially compliant. Business case being discussed in order to ascertain the benefits of employing a full-time Geriatrician. A lower limb pathway is being developed.
- **NICE Guidance**: IV fluid therapy in adults in hospital (January 2014). Training programme across the Trust is being developed to improve performance.
- Acute upper GI bleed: this is a joint guideline between the Surgical and Medical Divisions. Awaiting confirmation on compliance from the Medical Division.
- **Incidents & Complaints:** There is a big drive to close down long standing incidents in Q1 and Q2. 55 Complaints were closed in Q2. There is an improved response on new complaints that have been received.
  Extensive work on the Risk Register has been carried out to ensure it is up to date. Every risk has been scrutinised and assigned a strategic objective and target date.
- **Duty of Candour:** 100% compliance against performance. There were 14 red/orange incidents reported in Q2 all of which required a DoC letter to the patient. All letters were sent out within the 10 day time period.
- **Walkrounds**: The Assistant Divisional Director and Associate Nurse Director have been undertaking daily walkrounds to the wards departments within their Division which have been well received by staff.
- **Infection Control:** There was one case of MRSA and one case of c.difficile both of which were unavoidable.
- **Staffing Levels:** It was noted there has been good recruitment in the last couple of months. The total vacancy rate for September stood at 7.4% which was an improvement on the previous month.
- **Harm Free Care:** Performance has recently deteriorated and is below the target of 95% at 92.7% this represents all care including Community. Teams are aware of the reduction in performance and are actively improving practice as a result. The predominant issues lie with pressure ulcers and catheters.
- **Friends and Family Test:** The year to date response rate stood at 26.9%. 97.3% would recommend and 0.9% would not recommend. Since October 2014 the response rate has continued to dip. The most positive comments relate to care and the most negative comments relate to Hospital and Environment.
- **HSMR:** stands at 113.57% which is a rolling 12 month score September

2014 to August 2015. This has been discussed in detail by speciality at the Divisional Board meeting in November. Urology/vascular and general surgery are the main areas of concern.

- **Audit:** There are 92 projects in the Division for 2015/16. 4 of these are at the completion stage. The Division continue to comply with the national audits, although some are only partially compliant.
- # **Neck of Femur - Q2 Best Practice Tariff:** Time to theatre in 36 hours has performed poorly for Q2. Significant work input is now seeing improvement, particularly in the last 6-8 weeks.
  15% of #Neck of Femur patients require a total hip replacement and for this patients are required to be transferred to Calderdale Royal Hospital which then impacts on the 36 hour timeframe. Training is ongoing for this procedure to be performend at Huddersfield Royal Infirmary, which should commence from December 2015.
  Well Led – appraisals: Compliance currently stands at 7.2%. The Division have a plan in place to ensure every member of staff has an appraisal date. Completed appraisals are currently being populated on ESR, although there is a backlog which is why the figure remains low.
  Mandatory Training: There were issues with staff not being released to carry out their mandatory training, however this is being driven forward within the Division.

Questions raised by The Committee:

Q1 (The Chair): Will elective surgery be cancelled around the Christmas period?
A1 (Divisional Director): The Division are looking at scaling back electives in the first week in January which will help release beds. Urgent cases will still be dealt with.

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

6.3 Medical Division

The Deputy Director of Nursing presented the PSQB report for the Medical Division. The following highlights were noted from the report:

- **Stroke:** performance in relation to non-urgent scans within 12 hours had seen improvement in September and stands at 91.7%

- **Emergency Department:** The Trust achieved the 4 hour Emergency Care Standard performance for Q2. However it was noted this will be a challenge to achieve at the end of November which may affect Q3 performance.
- **Bed Modelling:** Not as many beds had been opened due to staffing, which remains a high risk. The Division are experiencing a high number of Band 5 nursing vacancies, despite a strong recruitment process.
- **MRSA:** One bacteraemia case was noted within the Medical Division which was noted as avoidable. To share learning a patient story will be

done in relation to this case which involved a vulnerable adult who had had a fall.

- **C.difficile:** There were 6 cases of c.diff within the Division for Q2. 5 of these cases were unavoidable.
- **Pressure Ulcers:** There had been a decrease in category 3 and 4 pressure ulcers from a total of 15 in Q1 to a total of 7 in Q2.
- **Nursing Summit** had taken place in October and was well attended by staff in the Medical Division. The Summit focussed on pressure ulcers, falls and medication errors. Staff took away learning on how they can improve in these areas to share with their teams.
- **Provision of Acute GI Service:** A paper will be presented to the Weekly Executive Board (WEB) for consideration on 26 November 2015, which has been jointly developed by the Surgical and Medical Divisions. The paper will detail what action is required to mitigate risks to the service and gives recommendations.
- **Rheumatology:** delayed transfer of care – problems still being experienced but some improvements have been seen.
- **Divisional Bed Plan:** has been implemented with additional realignment of specialty beds across wards. The Division continues to outlie patients in surgical specialities in addition to the additional capacity beds open.
- **Special Measure Wards:** Wards 5a/d and 7b/c at CRH have been placed in Special Measures to address concerns raised.
- **Duty of Candour:** 35 red and orange incidents were reported in Q2 that required a Duty of Candour letter. Of these 4 were not completed within the 10 day timescale. A weekly meeting to ensure performance standards are met is taking place.
- **Fill rates:** the registered Nurse fill rates continue to fluctuate. Rates for September stand at:

  Average fill rate Registered Nurses

  Day: 83.3%

  Night: 88.7%

  Average fill rate Care Staff

  Day: 98.7%

  Night: 120.3%

  Reliance on agency and flexible workforce department continues whilst the gap exists in substantive posts. The Associate Nurse Director (ADN) continues to implement actions in line with the corporate strategy to mitigate risk with low fill rates.
- **Complaints:** 65% of complaints were closed within the time scale which was noted to be a great improvement for the Division. The top themes from complaints were noted to be communication, overall patient care and access to appointments.
- **Mixed Sex Accommodation Breaches:** 2 breaches were reported for Q2. It was noted that these were not detailed in the Integrated Performance Report and it was agreed the Deputy Director of Nursing would look into this further. **ACTION**
- **Clinical Effectiveness:** The figures for the compliance with NICE

Guidelines were presented. Reviews of partial and non-compliance with guidelines are taking place with the chair of Clinical Effectiveness, Audit and Mortality Group (CEAM) and the clinical lead for each area.
ACTION: Process will be reported back to The Committee (approx. February 2016) and will be submitted to the Commissioners.

- **Well Led:** Mandatory training is monitored weekly and improvements are being seen and the Division should be on track to be fully compliant by the end of Q4.
- **Risk and Compliance:** The Division have 3 risk scoring 15+ currently on their Risk Register. These relate to 1) poor clinical decision making in A&E due to dependence on locum middle grade doctors at weekends and nights; 2) slow patient flow and breaches against ED national standards; 3) patients in extra capacity wards cannot be safely cared for due to insufficient nursing staff across the whole acute Medical Division.
- **Learning:**
  - Patients stories presented at the Division's PSQB meeting.
  - All wards encourage using Nerve Centre at handover.
  - You said we did examples highlighted.
  - Safety Huddles been introduced across all medical wards

Questions raised by The Committee:

Q1 (The Chair): What plans do the Division have in place to deal with capacity in January 2016.
A1 (Deputy Director of Nursing): Bed modelling on-going. Extra wards that are currently open are only 50% staffed by CHFT staff. It may be necessary to step-down activity in January. Paper will be going to Board.

ACTION:
1. The Committee asked that a one off report be produced for its meeting in December regarding the two wards in Special Measures.
2. The Director of Nursing requested the CIP section of the PSQB report should highlight any impact the CIP is having in future PSQB reports.

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

6.4 Family & Specialist Services Division

The Associate Director of Nursing/Head of Midwifery presented the PSQB report for the Family & Specialist Services Division. The following key exceptions were highlights from the report.

Specialist Services:

- Failure to provide sufficient appointment slots to manage demand remains a red risk. The Division confirmed actions are in place to address this and it is hope improvements will be seen going forward.
- STEIS: currently one open STEIS reportable incident. The report will be submitted to the CCG by the 31 December 2015.
- Anti-coagulation Service: work ongoing in conjunction with the Commissioners to improve Key Performance Indicators (KPIs). The

Division concluded the service still remains safe.

- Histopathology consultants; still two consultants below the establishment.
- Radiology consultants; four posts currently vacant, but two of these are being covered by locums. Significant risk to breast and GI radiology, but the Division gave assurance that this is being managed within the department and any risks are being managed by outsourcing work to a private company.
- External audit of HRI Aseptic Dispensing Unit has identified four major deviations with significant risk. An action plan will be developed from the recommendations within the report. An update on these actions will be presented in the Q3 Patient Safety and Quality Board (PSQB) report to the Committee.

Family

- Performance and experience at Divisional Assessment Centre (Paediatrics and Maternity). You said, we did posters are now on display as part of the ward public facing information boards.
- Significant problems experienced in shift-fill in Children's and Maternity. Another process is used alongside UNIFY which provides a data set that can alert and transfer the workforce from one area to another.
- The annual Audit of the Statutory Supervision and Practice of Midwives has been received. Recommendations from the report would be developed into an action plan.
- Friends and Family Test response rate in most areas are showing improvement albeit some more quickly than others. An action plan for improvement has been developed and a review of patient experience is undertaken for those who wouldn't recommend our services to understand why.
- Well Led: issues experienced by staff in relation to accessing training. A number of staff have spent time with HR to look at Electronic Staff Record (ESR). Their experience is being rolled out across FSS Division.

Questions/comments raised by The Committee:

Juliette Cosgrove acknowledged the successes detailed within the report.

OUTCOME: The Committee **RECEIVED** and **NOTED** the report.

6.6 Community Services Division

The Matron for Community Services presented the report for the Community Division. Some omissions were noted in comparison to the other Divisional Reports as the Division continue to bed themselves in. However, the now the Division have Governance support in place a more robust report will be delivered for Q3.

The following highlights were discussed from the report:

- FSS: response rate is failing to make a significant or sustained

	improvement, but an action plan has been put in place to address this. • Pressure ulcers: category 3 and 4 pressure ulcers incidents in Community have not been reduced by the 10% target. Revised action plan in place which will hopefully see improvement in performance. Taking a multi-professional approach to be more proactive in how pressure ulcers are dealt with. • An Estates audit has taken place, the results from which will be issued shortly. • 1 safeguarding alert and 1 formal complaint reported with issues flagged around management of sepsis in Community. • Infection Control: A Community dashboard is under development to report metrics. There have been no community acquired c.difficile or MRSA bacteraemia in Q2. • Sepsis: support being received from the CCG to develop a sepsis bundle across the Community. Some safety huddles are being trialled in Brighouse. • District Nursing: Currently 1 WTE Band 6 District Nurse vacancy and 5 WTE Band 5 vacancies. Recruitment into the Band 5 posts has been successful. • Complaints: 8 informal complaints and 12 concerns have been received for Q2. The 12 concerns have been resolved informally. **OUTCOME:** The Committee **RECEIVED** and **NOTED** the report.
07/11/15	**CQC PREPARATION AND ACTION PLAN** <u>7.1 CQC Action Plan in preparation for the CHFT Care Quality Commission (CQC) Inspection</u> The Assistant Director for Quality presented an update on the action plan that has been developed pending the upcoming CQC inspection. The CQC Senior Steering Group continues to meet weekly and a programme of presentations has been received by the group based on the 90 day plan for core services, Divisions and CQC domains. These presentations have focussed on what has improved, what actions are outstanding and a forecast of when each domain will come green. Since the last report, presentations have been received from: **FSS Division (Radiology, Pathology and Outpatients**): Number of areas now green with Safe and Effective domains showing green across all three areas. Key risks and barriers that remain a challenge have plans in place to mitigate the risks. **Medical care:** Safe, Responsive, Effective and Well Led all require improvement. A significant amount of improvement across the medical clinical service pathway continues.

	Outpatient & diagnostic imaging core service: Well Led requires improvement across the three areas. The Caring domain for Outpatients has achieved Outstanding rating. Weekly progress meeting are taking place to improve the plan, offering support and encouraging peer challenge review. **Estate and Facilities Division:** The Premises Assurance Model (PAM) has been used to conduct the self-assessments for estate and facilities; this is aligned with the CQC Inspection approach. All five domains across the Division are Good or Requires minimal improvement/Good. **Communication:** All staff have received a copy of the CQC Handbook via the October payslip. A visit was undertaken to Bradford Royal Hospital to meet with some key people involved in their inspection. A series of conference calls have commenced at the weekly CQC Senior Steering Group involving staff from other Trusts who were involved in the preparation for their CQC Inspection. Capsticks will commence work with the Trust during December and January. Mock interviews will be carried out and they will also offer support with factual checking once the final inspection report is received. A CQC comms member of staff has been recruited to work one day per week. The Inspection Team will come in 1 week the planned date to look at governance. The CQC dashboard, which was shared with the Committee, is partly from self-assessment and what has been presented to the weekly CQC Senior Steering Group. The Committee **RECEIVED** and **NOTED** the report.
08/11/15	**MATTERS TO BE ESCALATED TO THE BOARD OF DIRECTORS** The Committee agreed the following items would be highlighted to the Board of Directors meeting on 26 November 2015: • Emergency Preparedness, Resilience and Response Policy • QIA update • CQC Action plan • PSQB Divisional reports
09/11/15	**ITEMS TO NOTE** **9.1 Quality Committee Work Plan for 2015/16** The Committee received the Quality Committee Work Plan for 2015/16 for information. The Committee **RECEIVED** and **NOTED** the updated work plan.

10/11/15	**ANY OTHER BUSINESS** • **Linda Patterson:** Non-Executive Director Linda Patterson wanted to formally acknowledge the fantastic work done by the teams and individuals involved in the Celebrating Success evening.
11/1/15	**DATE AND TIME OF NEXT MEETING** Tuesday 15 December2015 2pm – 5pm Boardroom, HRI **DATE MINUTES APPROVED:**

Minutes of the Finance & Performance Committee held on Tuesday 17 November 2015
Meeting Room 4, 3rd Floor, Acre Mill, Huddersfield Royal Infirmary commencing at 9.00am

PRESENT

Anna Basford	Director of Transformation & Partnerships
Helen Barker	Interim Associate Director of Operations
Julie Dawes	Executive Director of Nursing
Keith Griffiths	Executive Director of Finance
Phil Oldfield	Non-Executive Director - Chair
Peter Roberts	Non-Executive Director (In part)
Jan Wilson	Non Executive Director

IN ATTENDANCE

Kirsty Archer	Assistant Director of Finance
Mandy Griffin	Acting Director of the Health Informatics Service
Brian Moore	Membership Councillor
Victoria Pickles	Company Secretary (Minutes/In part)
Betty Sewell	PA (Minutes/In part)

OBSERVING

Alan Hudson	Engagement Partner, EY

ITEM

242/11/15 WELCOME AND INTRODUCTIONS

The Chair of the Committee welcomed attendees and introductions were made to both Brian Moore, Membership Councillor and Alan Hudson, Engagement Partner – EY.

243/11/15 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
David Birkenhead, Executive Medical Director
Andrew Haigh, Chair
Lesley Hill, Executive Director of Planning, Performance & Estates and Facilities
Linda Patterson, Non-Executive Director
Jeremy Pease, Non-Executive Director
Owen Williams, Chief Executive

244/11/15 DECLARATIONS OF INTEREST

There were no declarations of interest.

245/11/15 MINUTES OF THE MEETINGS HELD 20 OCTOBER 2015

The minutes were approved as a correct record.

246/11/15 MATTERS ARISING AND ACTION LOG

Action Log

02/15 - Recruitment and Retention Strategy – The Executive Director of Nursing explained that this had been completed and would be submitted to the newly established Well Led Workforce Committee.

193/08/15 - Patient Story – The Executive Director of Nursing reported that this would be brought to the next Board of Directors meeting.

All other items were included on the agenda.

FINANCE AND PERFORMANCE

247/11/15 to 250/11/15 **MONTH 7 PERFORMANCE SUMMARY REPORT**

The Executive Director of Finance provided a summary month 7 financial performance report. He explained that the Trust had been experiencing pressure and that capacity remains an issue. The Trust has occasionally had to use top end agency where required to keep services safe. Despite this the Trust has been able to contain its position in line with plan. It was noted that there may be further pressures over the winter period which may impact on elective activity and the workforce capacity. Forecast slightly reduced to £22.1M. Monitor have not yet confirmed whether able to do capital to revenue transfer. The Clinical Commissioning Groups (CCGs) had indicated that there would be some additional funding in relation to winter resilience however this will not be included in the forecast until confirmed. Confirmation was also awaited around a decision on Vanguard funding in Calderdale. It was recognised that the Trust must close the £2M gap from £22M back to £20M and it was likely that this will come from external funding rather than any savings within the Trust.

The Director of Transformation and Partnerships reported that she had sought further information regarding the reduction in referrals from the Doctor Lane practice. The Practice had reported that it had not taken a decision to reduce referrals and therefore this may be due to a change in staffing.

The Director of Transformation and Partnerships reported that activity is up overall on the previous year although elective and day case activity is below last year and overall activity is below plan. It was noted that this would need to be taken into consideration when planning for 16/17. CCGs were reporting concerns around the levels of non-elective activity and were likely to put in place referral management schemes.

The Executive Director of Finance explained that a re-forecast plan had to be submitted to Monitor in November and it was likely that this would include a £20M deficit and cash requirement of £12M. It was noted that confirmation was awaited from Monitor on whether cash support would be provided in relation to the support for the 5 Year Strategic Plan and capital to revenue transfer.

STRATEGIC ITEMS

251/11/15 **2016/17 OPERATIONAL & FINANCIAL BASELINE PRESENTATION**

The Director of Transformation and Partnerships explained that there was a need to set the baseline now to enable the work to progress on the 5 Year Strategic Plan. This would be shared with and scrutinised by Monitor as part of their visit to the Trust later in the month. The baseline had been drawn up with the Divisions and covered 16/17. It did not include the strategic overlays that would be included in the 5 Year Strategic Plan to support getting the Trust back to a sustainable position. It was noted that the Four Eyes work had not been included as this would not be completed until towards the end of the

year.

Activity
The Director of Transformation and Partnerships presented the assumptions included in the baseline:

- Outturn at month 6.
- Included what was known relating to changes in coding;
- The impact of the transfer of services under Care Closer to Home Kirklees;
- Other changes taking place to reduce non-elective demand.
- Assumed existing levels of new to follow-up ratios
- Technical adjustments around tariff deflation and contingency for contract challenges.

The impact of phase 2 of the Care Closer to Home Kirklees contract had not been included due to insufficient detail available at this point.

She explained that a moderate increase in activity had been assumed across the board and a reduction in non-elective activity related to the schemes described in the paper. It was recognised that the Trust was not achieving the elective activity this year due to sickness and vacancies but that there was a need to restore the volume of lists.

The Executive Director of Nursing asked what the Trust's history of delivering non-elective activity was. The Director of Transformation and Partnerships explained that there was a difference in non-elective activity between Calderdale and Huddersfield which may be due to the difference in investment in schemes to prevent hospital admission. The Interim Associate Director of Operations highlighted the need to carefully monitor the impact of the Care Closer to Home Kirklees contract and the risks with the local nursing home market.

Peter Roberts commented that there was a need to clearly identify the items that are out with the Trust's control which could have a detrimental or positive impact on the Trust's business and that these are explicit to commissioners and partners. Phil Oldfield also pointed out the need to be explicit about the assumptions being made that underpin the activity.

The Executive Director of Finance commented that the assumptions were important as they would drive the bed numbers and the associate workforce and estate configurations.

The Director of Transformation and Partnerships highlighted that if the Trust planned for an increase in non-elective, this would be challenged by the CCGs. Phil Oldfield added that consideration would need to be given to the length of stay as this had been increasing and had a consequence on nursing capacity. He asked that Directors to bear in mind that it is easier to put growth in rather than take costs out and there would be challenge around planning for no growth.

Discussion took place in relation to the workforce numbers and whether this included planned retirements of consultants and how activity related to the whole time equivalent of the workforce. It was also clarified that the potential impact of implementing the electronic patient record had been taken into account in the numbers.
Peter Roberts asked that consideration be given to being proactive about the nursing home market and it was agreed that this would be one of the things built in to one of the strategic overlays.

The Committee discussed the impact of the Care Closer to Home Kirklees contract and that there would be an impact on non-elective activity based on how quickly the community provider can support admission avoidance and discharge. Dialogue was being sought with the CCGs to ensure that they hold the whole system to account.

The importance of elective activity on the Trust's position was noted and it was highlighted that there needed to be movement on the elective activity to give confidence to the CCGs recognising that there were different views between the two CCGs. The Interim Associate Director of Operations added that the outpatient challenge was also significant as it had not been delivered in 15/16 to date.

Phil Oldfield highlighted the need to ensure that the plans were based on realistic assumptions of what activity would be deliverable. The Executive Director of Nursing added that there needed to be clear consideration of what reductions could realistically be achieved in non-electives that were not just offsetting any increases in demand. The Interim Associate Director of Operations added that a piece of demand modelling had been commissioned however it was not clear whether this would be ready in time for the completion of the 5 Year Strategic Plan.

The Executive Director of Finance reported that Monitor had explained that if the Treasury refused capital support, the only other option is a local tariff adjustment which also requires Treasury support and the CCGs would have to make decisions about what they want to commission.

Beds
The Interim Associate Director of Operations took the Committee through the assumptions, in depth discussions took place with regard to the bed modelling process with the following conclusion:

- Further correlation is required with regard to the alignment with activity and the day case/elective mix.
- With regard to the physical estate, to establish what are in-patient beds and what are day-case beds.

Workforce
It was acknowledged that the Workforce information was not as advanced as other areas. The Interim Associate Director of Operations took the Committee through the assumptions and it was noted that a sense check was required with regard to the full year effect of the consultant posts against the full year effect of the activity profile. It was also noted that the additional work which is taking place at the moment with regard to 'hard

truths' had not been assumed for the funded establishment.

With regard to EPR, the Interim Director of the Health Informatics Service highlighted that with regard to activity for the 60 days prior to 'go live' and 30 days after implementation it could not be assumed that there would not be cost implications. It was acknowledged that there would be a need to overlay the EPR impact onto the workforce, activity and bed assumptions.

It was noted that the following factors, which relate to workforce, need to be taken into account:

- Activity levels
- Sickness and absence rates – historical levels
- Staff retention and recruitment
- Consultant availability
- Management of holidays
- Assumptions regarding vacancies and use of locums – no assumption has been made around 7 day services and locums

Further work is required to provide assurance as to the overall numbers and what in reality is the base assumption.

Income & Expenditure

The Executive Director of Finance took the Committee through the assumptions for I&E with regard to the normalised 15/16 position and the bridge to 2016/17. Discussions took place around CIP for 16/17 and whether the £13.6m would be achievable. The Director of Transformation & Partnerships confirmed that it would be challenging, the EY work correlates with our assessment and there is an element of risk with those schemes, the best assessment is that we could achieve £8m of the £13.6m. There are approximately 100 workbooks which sit behind the £13.6m with a high volume of low value schemes. The following two areas will be looked at further:

- Drive through the £13.6m with the highest level of granularity – to look at higher impacted value schemes e.g. ambulatory care.
- Re-visit more strategic schemes

Discussions then focussed on EPR and the treatment of the scheme, it was agreed that we need to be clear on our assumptions and being open and honest will be key with regard to the discussions which take place with Monitor.

Capital Expenditure

The Executive Director of Finance referenced the two columns on the slide stating that £15.7m had been included within the baseline, however, the total capital requests received for 16/17 totalled £35.8m with the largest increase being estates maintenance. It was explained that some of the work may not be required and that a judgement call would be required to establish what work would be essential to keep the base safe, the task would be to manage expectations and to keep capital spend contained to around £16m.

Discussions took place with regard to the feasibility of spending within the timescales with regard to reconfiguration and the OBC. It was agreed that an Estates view was required.

The Interim Associate Director of Operations commented that we also need to establish if the service is being driven by the estate configuration or is the estate being driven by the service configuration and to make sure we get the balance right for the long term.

Cash

The Executive Director of Finance commented that £37m would be needed and this will be the challenge, however, it was important that we understand what has been discussed in the meeting today; what is driving the I&E position and to keep capital contained, discussions will take place with Monitor with regard to capital receipts.

Phil Oldfield noted that capital had already been scaled back to £15.7m within the assumptions.

The Executive Director of Finance commented that workforce is the area where there is still anxiety with regard to whether the correct assumptions have been made, we need to make sure that workforce links to activity and ensure extra costs have not been built in to support posts which do not need supporting.

The Executive Director of Nursing commented that financially she felt that all the correct items had been included but a catch up with regard to workforce was still required. She also commented that within workforce there were areas which are not activity related for example, nerve centre and A&E staffing.

Phil Oldfield agreed that workforce and EPR would be key in terms of safe staffing and this was something that has been flagged with Monitor. The Executive Director of Nursing commented that Monitor have a methodology to determine what staffing levels should be and we would need to have discussions with Monitor to try to articulate our position and demonstrate that we have challenged ourselves.

It was agreed that more work was required before the Monitor visit on the 24th November and that diaries should be prioritised. It was also agreed that WEB should start at 8am to ensure time was allowed to brief Andrew Haigh and Owen Williams. The Interim Associate Director of Operations suggested that ADDs and ADFs should be brought back into discussions for their input within the next 24 hours.

It was agreed that the overall next steps would be:-

- EY to commence modelling work
- Further triangulation of data required to prepare for Monitor meeting
- Further discussions will take place at WEB on Thursday pre-submission to Monitor
- Revised view plus feedback from Monitor Review Day should be included in the Private session of the November Board.

252/11/15 & 253/11/15 **TURNAROUND PROGRAMME UPDATE & CIP 15/16 PROGRESS AND PLANNING**

The Committee agreed that Turnaround and CIP had been discussed during the meeting, it was noted that papers had been read and accepted by the Committee.

254/11/15 **EPR UPDATE**

The Acting Director of Health Informatics Service presented the paper and the Committee noted the financial position for October 2015, the position to date and the forecast in addition to the progress made in appointing to planned posts and the planned key milestones for the project.

TREASURY MANAGEMENT

255/11/15 **CASH FLOW 13 WEEK FORECAST**

The 13 week Cash Flow Forecast report was noted by the Committee, in addition the Director of Finance reported that the team are working hard to ensure we are prepared for Monitor's visit on the 24 November 2015.

The Executive Director of Nursing announced that cost implications with regard to the Doctor's strike would be worked up by Helen Barker and this will be fed back to the Committee.

GOVERNANCE

256/11/15 **WORKPLAN**

There were no items added to the Workplan.

257/11/15 **MATTERS FOR THE BOARD AND OTHER COMMITTEES**

- All matters relating to the 15/16 Baseline to be discussed at WEB and Board

258/11/15 **ANY OTHER BUSINESS**

EPR External Review – Mandy Griffin confirmed that the EPR External Review had been completed and the final report had been submitted to Owen Williams. It was also confirmed that the report would go to Board. Anna Basford requested a copy of the report to be submitted to Monitor prior to their visit next Tuesday.

DATE AND TIME OF NEXT MEETING

Tuesday 15 December, 9.00am – 12.00noon, Meeting Room 4, 3rd Floor, Acre Mill Outpatients.

Apologies received : Jan Wilson

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