Calderdale and Huddersfield NHS
NHS Foundation Trust

Meeting of the Board of Directors
To be held in public
Thursday 26 November 2015 from 1:30 pm

Venue: Conference Suite, Todmorden Health Centre, Lower George Street, Todmorden, OL14 5RN

AGENDA

1	Welcome and introductions:	Chairman	
2	**Apologies for absence:** Julie Hull, Executive Director of Workforce & OD Lesley Hill, Executive Director of Planning, Performance, Estates & Facilities Welcome: Mrs Di Wharmby, Publicly Elected Membership Councillor		
3	Declaration of interests	All	**VERBAL**
4	**Minutes of the previous meeting** held on 29 October 2015	Chairman	**APP A**
5	**Matters arising and review of the Action Log** **128/15 – CAIP/Mortality Review** **161/15 – Shared Learning – reducing number of people who die in hospital**	Chairman Chairman Executive Medical Director	**APP B** VERBAL VERBAL
6	**Patient/Staff Story**	Executive Director of Nursing	
7	**Chairman's Report:**	Chairman	
8	**Chief Executive's Report:** a. Speech to NHS Providers Annual Conference & Exhibition – 10.11.15 by Chris Hopson, CE, NHS Providers	Chief Executive	**APP C**
Keeping the base safe			
9	Board Assurance Framework	Company Secretary	**APP D**
10	Risk Register	Executive Director of Nursing	**APP E**
11	Progress Against Well Led Governance Review Action Plan	Company Secretary	**APP F**
12	Performance Management Framework	Associate Director of Community/Operations	**APP G**

13	Director of Infection, Prevention and Control	Executive Medical Director	**APP H**
14	Safeguarding Adults and Children Update	Executive Director of Nursing	**APP I**
15	Nursing Workforce Model Review Panel Recommendations	Executive Director of Nursing	**APP J**
16	Quarterly Quality Report	Executive Director of Nursing	**APP K**
17	Integrated Board Report - Responsive - Caring - Safety - Effectiveness - Well Led - CQUINs - Monitor Indicators - Finance	Associate Director of Community/Operations “ Executive Director of Nursing Executive Director of Nursing Executive Medical Director Executive Director of Nursing Associate Director of Community/Operations Executive Director of Finance Executive Director of Finance	**APP L**
Financial Sustainability			
18	Month 7 – October 2015 – Financial Narrative	Executive Director of Finance	**APP M**
Transforming and improving patient care – no items			
A workforce for the future – no items			
19	**Update from sub-committees and receipt of minutes** ▪ Joint MC/BOD Annual General Meeting Minutes – 17.9.15 ▪ Quality Committee – Verbal update from meeting 24.11.15 ▪ Finance and Performance Committee – minutes of 20.10.15 and verbal update from meeting 17.11.15 ▪ Audit and Risk Committee – minutes from meeting held 20.10.15 ▪ Audit and Risk Committee – Terms of Reference ▪ Nomination and Remuneration Committee (Membership Council) Terms of Reference		**APP N**
Date and time of next meeting Thursday 17 December 2015 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, 26th November 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 29.10.15 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 29 October 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 29 October 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 29 October 2015.

Appendix

Attachment:

DRAFT BOD MINS - PUBLIC - 29 10 15(2).pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 29 October 2015 in the Large Training Room, Learning Centre, Calderdale Royal Hospital

PRESENT

Andrew Haigh	Chairman
Dr David Anderson	Non-Executive Director
Dr David Birkenhead	Executive Medical Director
Julie Dawes	Executive Director of Nursing and Operations/Deputy Chief Executive
Keith Griffiths	Executive Director of Finance
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities
Philip Oldfield	Non-Executive Director
Dr Linda Patterson	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
Caroline Wright	Communications Manager
Kathy Bray	Board Secretary
Nick Laviguer	Huddersfield Examiner Reporter
Victoria Pickles	Company Secretary

Item

152/15 APOLOGIES FOR ABSENCE AND INTRODUCTIONS

Apologies were received from:

Julie Hull	Executive Director of Workforce and Organisational Development
Jeremy Pease	Non-Executive Director
Anna Basford	Director of Transformation and Partnerships

The Chairman welcomed everyone to the meeting.

153/15 DECLARATION OF INTERESTS

There were no declarations of interest to note.

154/15 MINUTES OF THE MEETING HELD ON THURSDAY 24 SEPTEMBER 2015

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

155/15 MATTERS ARISING FROM THE MINUTES

a. NICE Guidelines – Cancer Drugs - The Executive Director of Nursing and Executive Medical Director would raise this issue with Commissioners and feedback to the Board.

ACTION: Executive Director of Nursing/Executive Medical Director

156/15 ACTION LOG

128/15 – CAIP/Mortality Reviews – It was noted that Professor Mohammed from Bradford University had been invited to present at the Board of Directors Workshop to be held on the afternoon of 18 November 2015.

There were no other items outstanding on the Action Log.

157/15 CHAIRMAN'S REPORT

a. Meeting with local Chairs regarding winter pressures - The Chairman reported that the recent meeting with neighbouring Chairs regarding winter pressures had been constructive and reinforced the desire to work together to face the forthcoming challenges.

b. Celebrating Success – This had been a very successful event held at the Town Hall on the previous evening. The Chairman and Chief Executive had received a number of emails from those who had attended.

158/15 CHIEF EXECUTIVE'S REPORT

a. CQC Report on the state of health care and adult social care in England 2014-15 - The Chief Executive reported that these documents had been brought to the attention of the Board in preparation for the CQC visit to the Trust which was due to commence on the 8 March 2016. It was noted that dialogue and overlap of collective messages would take place with South West Yorkshire Partnership FT, who were due to receive an inspection at the same time.

Discussion took place regarding the possible picture of future regulation and the Chief Executive stressed the need to ensure that all staff focus on the quality of care, irrespective of the other on-going factors in the Trust.

159/15 RISK REGISTER

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

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

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:-

Two new risks had been added over the month:-

- Cash Flow risk
- Suspension of capital programme

Discussion took place regarding the capital programme and Monitor's desire to reduce the year-end cash balances.

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

160/15 DIRECTOR OF INFECTION PREVENTION AND CONTROL REPORT

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

- **C.Diff** – 3 cases had been reported in September. (The year to date position was 10 - 3 avoidable and 7 unavoidable). The ceiling is 21 cases for the year to March 2016.
- **MRSA** – 1 case had been reported in September. The total year-to-date performance was a total of 3 cases.

The Board asked if there were any new challenges on the horizon facing hospitals in the near future. The Executive Medical Director advised that MS screening to eradicate staff infections was underway and the flu vaccine was now available. No information was yet available on the anticipated impact of the winter pandemic this year.

RESOLVED: The Board received the report.

161/15 CARE OF THE ACUTELY ILL PATIENT REPORT

The Executive Medical Director presented the updated report which showed that SHMI remained stabled at 109. Work to look at the factors affecting the Trust's HSMR position continued with the help of Professor Mohammed from Bradford University. There was an improvement in completion of mortality reviews during August. This had dropped again in September (though remains above average for the year). Regular reports of findings are now established. Mortality data is under constant scrutiny and focused reviews are commissioned where concerns are identified.

The Executive Medical Director explained that the care bundles work is now being managed by a PMO approach; all are being reviewed, with the related audit tool, for implementation in January 2016. This remains a challenge for the Trust. Nervecentre is now in place throughout the Trust, with the exception of paediatric areas as some amendments are required to the Nervecentre technology.

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

Work is progressing on the frailty work-stream to implement a rapid assessment screening tool.

Work continues within the coding team to recruit qualified coders, for which there is a national shortage, and to improve clinical documentation to facilitate coding.

Prof Roberts asked about shared learning around reducing the number of people dying in hospital. It was noted that Tyne and Wear have undertaken a whole economy-wide piece of work around this and Prof Roberts was happy to facilitate shared learning with the Board.

ACTION: PR/DB

162/15 REVIEW OF ONE YEAR PLAN

On behalf of the Director of Transformation and Partnerships, the Company Secretary presented the review of the one year plan. The Board noted the progress against all deliverables contained within the report. The Company Secretary stressed that the risks to delivery of the plan had been assessed and were included in the Board Assurance Framework.
The Board found this update very helpful and gave assurance that for the vast majority of deliverables were on track.

The Board **RECEIVED** the report and noted where else assurance on progress would be monitored.

163/15 EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) CORE STANDARDS ASSURANCE

The Executive Director of Planning, Performance, Estates and Facilities presented the EPRR report. It was noted that this document had been discussed at the Executive Board earlier that day. The contents of the report were noted together with the work being undertaken on the 92 standards assigned to the revised EPRR assurance process which were divided for into four main work areas applicable to Acute Hospitals.

- EPRR Core Standards
- Pandemic Influenza
- Hazardous Materials (and CBRN) Standards
- Hazardous Material (and CBRN) Equipment

It was noted that plans were in place to reinstate the multi-agency emergo table top exercise in the near future and seek external validation.

The Board **RECEIVED** the report and noted the Trust's position against the EPRR core standards.

164/15 HEALTH AND SAFETY ANNUAL REPORT UPDATE

The Executive Director of Planning, Performance, Estates and Facilities presented the update to the Health and Safety Annual Report. The key updated issues included:-

- Risk Assessment Methodology
- Reportable Injuries And Dangerous Occurrences Regulations (Riddor)
- Healthcare Specific Health & Safety Training
- Generic Health And Safety Awareness Training
- Health And Safety Monitoring Via Front Line Ownership (Flo)
- Promote The Use Of Datix
- Improve Attendance At Manual Handling Training
- Implement Coshh Framework as part of mandatory training
- Improve Divisonal Representation Attendance At H&S Committee
- Improve Staff Side Representive Attendance At H&S Committee

The Board **NOTED** the progress against the health and safety action plan.

165/15 INTEGRATED BOARD REPORT

The Associate Director of Community Services and Operations introduced the Integrated Board Report as at 30 September 2015 and explained that key areas would be presented in detail by the appropriate Executive leads.

Summary

The report on September performance remains good for the Monitor indicators and is showing more indicators improving on the previous month. The key areas to note were:

Responsiveness

- The Trust delivered the Emergency Care Standard for the month and quarter
- National cancer standards were met at Trust level and Day 38 performance is improving. Delayed transfers of care significantly improved in September.
- Diagnostics performance dipped with a fail for the month.
- Cancelled operations performance deteriorated with some high volume cancellations in Ophthalmology related to equipment failure.
- Elective activity continues to track below plan.

- Slight improvement of Appointment Slot Issues in month but sustainable improvement not yet in place.

Caring

- Complaints acknowledged within 3 days remains at 100%.
- The Friends and Family Test percentage was achieved in Maternity for September.

Safety

- Falls and pressure ulcers remain a concern and are the focus of specific in depth reviews involving a multi-disciplinary approach.
- Percentage of serious incident investigations completed within timescales has significantly improved.
- Maternity indicators show continued good performance.

Effectiveness

- A further MRSA reported in September.
- HSMR remains a key area of concern.
- Stillbirth rate was above tolerance for the month, all incidents related to known risk factors.
- Fractured neck of femur performance still not at required standard. Theatre capacity issues continue to be reviewed and improvements were being noted.

Well led

- Sickness has improved in 5 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 85% of colleagues have now started their mandatory training programme.
- Appraisal activity plans are in place with divisions now RAG rated against these plans.

Discussion took place regarding the cultural impact of reconfiguration of services on staff in the future together with the increasing number of agenda items being addressed by trust staff and how this affected staff morale. The Executive Director of Nursing reported that 'hard truths' work continued to ensure safe staffing. Some 40 hour contracts were being offered to staff and the potential to extend notice periods in line with neighbouring trusts was being considered. Pastoral nurses had been introduced to support newly qualified, overseas and junior nurses.

A Performance Management and Accountability Framework is currently in development that will further increase the scrutiny, structure and delivery of effective performance across the Trust.

Discussion took place around the size of the IBR and the Chair asked that a review be undertaken to ensure that the Board receives appropriate information and assurance on the Trust's performance.

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

ACTION: AH/HB/VP to review IBR content

166/15 MONTH 6 – SEPTEMBER 2015 FINANCIAL NARRATIVE

The Executive Director of Finance presented the finance month 6 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 £12.14m versus a planned deficit of £10.71m
- The overall deficit is £12.24m less than the planned £13.71m, due to restructuring costs not being incurred in the year to date
- Elective and day case activity have 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 £9.62m against the planned £12.66m with due to timing differences mainly on IT spend
- Cash balance is £8.61m against a planned £1.92m, due predominantly to securing cash payments in advance for clinical activity
- CIP schemes delivered £6.93m in the year to date against a planned target of £5.64m
- 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 £22.21m against a planned £20.01m, an adverse variance of £2.20m. This position includes full release of remaining contingency reserves and delivery of £17.46m CIP against the original planned £14m
- This is a slight worsening on the forecast at Month 5. This adverse position 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
- No further contingency reserves remain to cover other pressures and risks
- Efforts must continue to be focused on delivering planned activity by increasing productivity and containing pay spend, particularly agency costs
- The year-end cash balance relies on external cash support of £18m. This is higher than originally planned due to the forecast increased deficit
- Year-end capital expenditure is forecast to be £20.53m 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.

167/15 DISCLOSURE AND BARRING SERVICE (DBS) REPORT

The Executive Director of Nursing presented the report prepared by the Workforce and Organisational Development team following previous discussion at the Board following the Saville Enquiry. The recommendations in the report were discussed and agreed:-

- **Who to seek and obtain DBS disclosures for?**

It was agreed to continue to seek and obtain DBS disclosures for new employees and those moving between posts in the Trust in accordance with current practice (for those in eligible posts and/or in 'regulated activities').

- **DBS Update Service**

It was agreed to introduce mandatory subscription to the DBS Update Service as a condition of employment for new employees in eligible roles and/or involved in 'regulated activities'.

- **Periodic DBS checks**

It was agreed to continue to seek and obtain DBS disclosures for new employees and those moving between posts in the Trust in accordance with current practice (for those in eligible posts and/or in 'regulated activities') and await further direction from the Secretary of State.

RESOLVED: The Board received and approved the recommendations within the report.

168/15 UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES

The following information was received and noted:-

- **Quality Committee** – The Board received the minutes of the 22.9.15 and in the absence of Jeremy Pease a verbal update was received from Linda Patterson from the meeting held on 27.10.15.

  Matters arising from the meeting not already discussed at the Board meeting included:-
  - **Emergency Department** report received and agreed that Quality Committee should continue to monitor this.
  - **Education and Training** - A paper was being prepared to bring together Education and Training for all disciplines.
  - **Research & Development** – a report from R&D was received.

- **Finance and Performance Committee** - The Board received the minutes of the 15.9.15 and a verbal update from Phil Oldfield on the meeting held 20.10.15.

  The main issues discussed at the Committee included:-
  - **Year-end cash** performance issues.
  - **Clinical negligence claims** – renegotiation of contract being undertaken.
  - **Theatre productivity** – CIP targets and learning from work of 4 Eyes regarding theatre planning, delivery and staffing issues.
  - **CIP 2015/16 and 2016/17** updates to continue.
  - **Electronic Patient Record** remains on plan.

- **Audit and Risk Committee –** The Board received the draft summary notes from the meeting held on 20.10.15. Prof. Peter Roberts advised that the key issues were:-
  - **Follow-up on recommendations within Internal Audits –** concern by ARC that timely actions are undertaken following recommendations. Lead staff were being invited to attend and give an update where the ARC had concerns.
  - **Local Counter Fraud –** progress report received noted that exercise still underway regarding disclosure of interests.
  - **External Auditors –** The contract to KPMG had been extended for a further two years, subject to ratification by the Membership Council on the 4 November 2015.

The Chairman thanked everyone for their attendance and contributions.

169/15 DATE AND TIME OF NEXT MEETING

Thursday 26 November 2015 at 1.30 pm in the Conference Suite, Todmorden Health Centre, Lower George Street, Todmorden OL14 5RN

The Chairman closed the meeting at 3.30 pm.

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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, 26th November 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: ACTION LOG - PUBLIC BOARD OF DIRECTORS - NOVEMBER 2015 - The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 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 Action Log for the Public Board of Directors Meeting as at 1 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 Action Log for the Public Board of Directors Meeting as at 1 November 2015

Appendix

Attachment:

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

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 November 2015 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
30.10.14 140/14	**PATIENT/STAFF STORY** 30.10.14 - 'Carol's Story' extract video. 27.11.14 – 'Mr P' – Drug Error 18.12.14 – Dr Sarah Hoye 29.1.15 – Dr Mary Kiely – Care of the Dying 26.2.15 – Catherine Briggs, Matron – Green Cross Patient 26.3.15 – Diane Catlow – Families Senior Locality Manager 23.4.15 – Dr Mark Davies – Perfect Week 28.5.15 – Stroke Team - Patient Story/FAST Awareness 25.6.15 – No information received 30.7.15 – No information received 27.8.15 – Bethany's Story – Complex Needs Care 24.9.15 – Pharmacy Manufacturing Unit/Huddersfield Pharmacy Specials (HPS) 29.10.15 – No information received	Executive Director of Nursing	Regular item on BOD Agenda going forward.	Monthly Reports		Now included on BoD workplan
24.9.14	**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	29.10.15 – Professor Mohammed to be invited to present at the BOD Workshop on 18.11.15	18.11.15		18.11.15
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		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 November 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 (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		26.11.15		
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		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		

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th November 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: CHIEF EXECUTIVE'S REPORT - The Board is asked to receive and note the contents of the speech from Chris Hopson, Chief Executive, NHS Providers at the Annual Conference and Exhibition held 10.11.15	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive and note the contents of the speech from Chris Hopson, Chief Executive, NHS Providers at the Annual Conference and Exhibition held 10.11.15

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 and note the contents of the speech from Chris Hopson, Chief Executive, NHS Providers at the Annual Conference and Exhibition held 10.11.15

Appendix

Attachment:

2015 ACE CEO speech - Final.pdf

SPEECH TO NHS PROVIDERS ANNUAL CONFERENCE AND EXHIBITION
Tuesday November 10 2015
Chris Hopson, Chief Executive, NHS Providers

Introduction

First of all let me welcome you to Birmingham and our third annual conference and exhibition.

I'd particularly like to thank our overall event partners Hempsons and Johnson & Johnson, along with our other sponsors DAC Beachcroft, Healthcare at Home, RSM, Hunter Healthcare, EY, NHS Supply Chain and NHS Professionals who all play such an important role in enabling this event to happen.

In our recent membership survey you asked us to increase commercial revenue to keep membership subscriptions as low as possible. One way of doing that is to create an exhibition that also allows you, our members, to explore potential commercial partnerships to address your current challenges.

But, to be successful, that exhibition needs your support. So can I please encourage you to spend as much time as you can at the exhibition which you will find in Hall 3 to the left of registration.

Five uncomfortable truths

It's been some year since we last met. So, how are we doing?

Providing outstanding quality of care to patients 24 hours a day 365 days a year remains the mission. But there are five uncomfortable truths which now threaten the quality of that care that I believe we need to acknowledge openly and honestly. And that's where I want to concentrate today.

First, it is no longer possible to deliver both the NHS constitutional performance standards and a provider sector surplus on the current NHS financial envelope and tariff. Something has to give.

Second, as predicted, continuing to give providers an impossible task to deliver means we have now lost control of NHS provider side finances, triggering the biggest NHS financial problem in a generation.

Third, whilst running harder in the existing model is no longer an option, we are a long way from creating the conditions for the rapid and consistent transformation on the ground that the NHS needs.

Fourth, setting providers an impossible task, pressurising them to do better and then blaming them when they fall short, will never work as a strategy. That approach has now been tested to destruction. Something different is needed.

Fifth, our health and social care system cannot meet the much greater level of challenge it now faces with the degree of misalignment we currently have at both a national and a local level.

Some will interpret this as an attack on the present Government. It isn't. All the evidence suggests that any Government of any colour at this point would be struggling with these issues, as every other advanced Western health and care system is.

A values based approach

You might think that, given this rather bleak diagnosis, I am pessimistic about the future. I'm not. I can see a clear way forward.

But that way forward must be based on three key pairs of values:

- Honesty and realism
- Support and respect
- Collaboration and alignment

These values underpin the five solutions that we urgently need:

- Honesty in matching what the NHS is expected to deliver with the NHS budget;
- Realism in quickly returning the provider sector to surplus;
- Collaboration to support the transformation the NHS needs;
- Support for providers not ever tighter performance management and regulation; and
- Much greater alignment across health and care at both national and local levels.

Matching the NHS service offer to the NHS budget

Let me start with how we match the care that you are asked provide with the NHS budget.

NHS Providers will continue to argue that we have to spend more as a nation on health and care if we want to maintain, let alone improve, the quality of patient care that we currently provide.

Just last week the OECD reported that we spend less per head on healthcare than every other major advanced Western nation and that figure is now dropping. We do remarkably well to deliver what we deliver in the NHS for the money we receive. But in the end, in healthcare, you get what you pay for.

In our taxpayer funded system, it is the Government that sets the NHS's overall financial envelope.

All the signs are that this Government will ring fence NHS spending and increase it by £10 billion over this parliament. This will give the NHS real terms growth of around 1.3% a year, when other unprotected public services will be cut by an average of 4% a year.

But we need honesty and realism that this comparatively generous settlement, when compared to other public services, will fall a long way short of meeting the demands the NHS faces over the next five years:

- The inexorable annual 4% rise in demand and costs just to keep providing what we currently provide;
- Funding the transformation the NHS needs;
- Extending the ring fence in some form to social care because when social care is cut the NHS bleeds too; and
- Meeting the new demands the Government wants to place on the NHS such as the introduction of seven day services.

Of course, we can cover some of this gap, over time, through efficiency savings. But we need honesty and realism here too.

Honesty that the immediately realisable savings have now been largely exhausted and that any further savings can only come through more complex, transformational, change.

Realism about what extra investment, capacity and capability will be needed to deliver that complex change and how long that will take.

The sort of honesty and realism we saw in the Carter Review with its identification of up to £5 billion of potential savings by the end of 2019/20.

So there will be a gap, particularly over the next two to three years. And we need honesty and realism about how big that gap will be and how we, as a service, will close it.

Other public services, free from NICE guidelines, constitutional performance targets and intense public scrutiny, have reduced their service standards and access, their staffing numbers and their quality levels.

Twenty years ago that's what we used to do in the NHS. Lengthen the waiting lists, hoping no one would notice. Those days are gone. Rightly so.

So we face a choice. Pretend there isn't a gap and that we can muddle through. Which will result in the slow drip feed of missed target after missed target. Poor headline after poor headline. And an unacceptable and unfair burden on front line leaders and staff.

Or we can have honesty and realism about what can be delivered within the available financial envelope. An agreed plan that makes the difficult and painful choices required.

I have some sympathy for our political leaders as the plan I am asking for carries significant political risk. It will be all too easy, as soon as the conversation starts, for opposition parties to form a raucous chorus alleging mismanagement of the NHS.

We need a brave, mature, cross party, discourse which rises above party political point scoring and wrestles a big, hairy, problem to the ground.

But what we can't do is:
Carry on pretending that there isn't a gap and that an extra £10 billion will meet all the NHS's needs;

Carry on pretending that providers can deliver the impossible; and
Carry on pretending that difficult choices aren't now needed.

Returning the provider sector to surplus

Looking more immediately, we also need an honest and realistic plan to quickly return the vast majority of providers, and the provider sector as a whole, to financial surplus. This is now the single, biggest, immediate priority for the NHS and the whole service needs to act accordingly.

The outlines of such a plan are clear:

- A realistic 2016/17 tariff efficiency factor;
- A significant, but appropriately capped, shift of financial risk from providers to commissioners;
- Temporary capital to revenue transfers at both national and local levels; and
- Finding ways to restructure provider debt to reduce debt repayments
- And recognising that however helpful a 2% headline tariff efficiency factor is, it won't help much if it's swamped by the cost of new pension National Insurance arrangements; rises in CNST premiums; and provider penalising approaches to paying for specialised services.

It's good that we have a new Chief Executive and Chair at NHS Improvement and a new Director General Finance at the Department of Health who can help create the whole system alignment that will be needed to deliver this plan.

You tell us you recognise that provider leaders must play their part too. Stretching every sinew to get back to surplus and that just being in the middle of a large pack of providers in deficit is simply not sustainable.

But, be in no doubt, failing to return providers to surplus is the clearest and most present danger to the NHS and we need to act as such.

Creating the conditions for change

But getting the money right is not enough.

This is perhaps the greatest achievement of the Five Year Forward View. To create the consensus that running harder in the existing model is no longer sustainable and that we have to move to new models of care.

It's easy to be cynical that the vanguards and the move to devolution will be the latest in a long line of NHS change programmes that promised much but delivered little.

That would ignore the energy, the innovation and the new forms of collaboration they have already stimulated from Salford to Southern Healthcare; from Northumbria to Yeovil.

It would ignore the fact that vanguards now cover 25% of our population and that important changes are now beginning to happen on the ground at real speed.

Changes that dissolve the all too rigid boundaries between health and social care; between primary and secondary care; between physical and mental health.

Changes that allow patients to finally say "I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me." The National Voices definition of co-ordinated care, by the way.

Changes which pioneer a new relationship between national and local leaders. Where national leaders recognise that change can only be delivered locally. That it is their role to support, enable and facilitate that local delivery. And that delivery at scale will require a different approach to identifying and spreading best practice.

However, before we get carried away on a tide of excess optimism, the early experience from the vanguard programme also shows an equal need for honesty and realism.

About how long these changes will take.

How difficult they will be.

How large any savings will be and how quickly they will be delivered.

These are changes that will take 5 to 10 years to deliver, not 3 to 5 years.

It's interesting to see how much of the existing NHS strategic framework vanguards are seeking to tear up and re-engineer:

- The payment and contracting mechanisms;
- The performance management, regulation and inspection regimes;
- The single institution focussed organisational and governance structures;
- The fragmented approach to workforce;
- The data that's collected and how the IT works.

The list goes on. But its length and breadth suggest two things.

First, there is a huge amount of work to do. To design and implement, to name but a few:

- New capitated budgets and alliance or lead provider contracts;
- New, whole system, regulatory and inspection regimes and accountable care organisational structures; and
- New integrated workforce models

So let's have honesty and realism. Local health and social economies currently working within the existing framework will not, tomorrow morning, be able to throw off their current chains and bound, Promethean like, straight to new care models.

Indeed, the remarkable thing about those who are delivering integrated care at the moment is that they are delivering it despite the current NHS system framework. Not because of it.

Until we change that system framework - the payment mechanisms, the performance measurement, the workforce models - we will not get the rapid, consistent, move to new care models that we need.

We need a similar degree of honesty and realism about how and when savings from these new care models will be delivered.

All the international evidence suggests that savings, should they arrive, tend to be much later and smaller than predicted. So, unless we receive evidence to the contrary, we should plan on that basis.

And there is also a need for honesty and realism about the size and complexity of the local leadership challenge to deliver all this.

The challenge for providers to not just move to new care models…

…but to also keep delivering outstanding patient care all day every day….

...and to start realising significant new efficiency savings.

All at the same time.

Some challenge!

A challenge that takes a leadership and management capacity and capability that no longer exists after five years of Cost Improvement Programmes. A leadership and management capacity and capability that needs to be rebuilt.

None of this should be taken as an argument against the need to move to new care models.

To echo a phrase, there is no alternative.

But we require honesty and realism about what will be needed to deliver new care models in each and every health and social care economy and how long this will take.

Transforming provider regulation and performance management into provider support
Which brings me neatly to the fourth element of the solutions we need.

Underpinning the need to match the NHS service offering to the NHS budget….to get the provider sector back to surplus….and to create the conditions for a consistent move to new care models….is the need for a different relationship between providers and our national system leadership.

I've already talked about the pressure the NHS is under and how the response has been to load risk on to providers; to set an increasingly impossible task; to increase the pressure on providers; and to then blame them when they fall short, with more regulatory intervention.

Even worse, an implication that providers' failure has somehow been due to lack of will; lack of leadership competence; or lack of effort.

A first quarter financial deficit of £930 million compared to last year's whole year deficit of £822 million is the latest in a long line of examples to show that this approach of all stick and no support doesn't work; can't work and won't work.

We need to replace a system of provider performance management, with support as an afterthought, into a system where provider support is the first, instinctive, reflex, reaction and regulatory intervention is the exception, not the rule.

As NHS Improvement considers how it will work as a single unified organisation, this is surely one of its greatest challenges.

How to develop a culture of collaboration, support and respect.

Assuming that provider Boards want to do the right thing and are, in the vast majority of cases, well equipped to deliver an ambitious and stretching but reasonable task, if they are given the right support.

Recognising that the fundamental truth behind the Foundation Trust model is right: that providers are best run by autonomous Boards accountable to their local communities.

That for regulation and performance management to work, they have to be proportionate and risk based.

And that it's impossible to run an effective provider system when we have anything other than a small number of providers in some form of regulatory intervention.

There is a simple truth that should be universally acknowledged but isn't: it is far far better to set providers a realistic task and support them to deliver that task…..

….than it is to set them an impossible task and consistently intervene when they fall short.

Alignment

And this leads inexorably to the final element of where we need to go next. The need for alignment across the system.

We are where we are with the structure bequeathed us by the 2012 Health and Social Care Act. I note, with some sympathy, the Government's strong desire to avoid primary legislation.

But I can't see how our health and social care system can meet the challenges we face when we have this degree of misalignment at both a national and local level.

The lack of alignment at a national level on how we strike the difficult balance between staffing levels and finances;

The lack of alignment on how affordable and deliverable the Government's pledges on seven day services really are;

The lack of alignment on what constitutes a reasonable efficiency task for providers.

Again, I could go on.

At a national level we need much better alignment between our political leaders and the arms length bodies; and between the arms length bodies themselves.

The creation of NHS Improvement offers a good first step and we should acknowledge that it has been taken. But it must just be a first step.

And just in case we thought this was only a national problem, we need to acknowledge the need for greater alignment at local level.

As I said last year, one of the privileges of my job is the chance to visit you. Thank you for your welcome and the time you take to host me and the wider team.

I am excited by the rapidly growing collaboration I see across local systems. I am inspired by the examples of innovative patient care I see, twelve of which are featured in the Provider Showcase zone in our exhibition area.

But I also see how difficult many of you are finding it to bring your local health and social economy together.

I'm struck by how many places have tried and failed. By how many are struggling to get started.

It's usually not through want of trying.

In some places, it's sheer volume of traffic meets limited senior leadership capacity. Creating alignment takes time.

In other places, it's struggling to understand different perspectives and make a coherent whole. Creating alignment requires shared understanding and common purpose.

In other places, it's being unable to throw off the chains of the existing framework with its single institution focus. Creating alignment requires the prioritisation of the collective system at the expense of the individual institution.

But we have to overcome these barriers, however high they may be.

To find a local answer, for example, to the delayed discharges that are rapidly becoming the single biggest operational problem in our system.

To sit alongside the national answer on how we extend the NHS ring fence to support social care.

A concrete example

Let me give you just one concrete example of what needs to change which brings all these strands together.

I've talked about the financial pressure that providers are under and the need for providers to get back to surplus as quickly as possible. The need to support providers not punish them. The need for alignment across our service.

So, how can it make sense for CCGs to be forced to levy provider fines that drive providers into deficit? Driving two providers I spoke to last week from breakeven to a £10 million deficit in one case and from a £5 million deficit to a £15 million deficit in another?

How can it make sense for Monitor to tell providers to do all they can to get their local CCG to reinvest any fines…and for NHS England to then tell the CCGs that they must maximise the fines, not reinvest them, and return them to the centre?

How can it make sense to ensure providers are unable to manage their finances properly because they don't know whether the fines will be permanently withheld; will be reinvested locally; or will eventually reach them via distressed funding, particularly if the provider doesn't intend to apply for distressed funding?

How can it make sense to have some CCGs going through all kinds of contortions to avoid levying fines for failures that they know providers aren't responsible for. And then have those CCGs worrying they will fall foul of NHS England for doing what they know to be right?

How can it make sense to have markedly different approaches to this issue in different regions? Why is this such a big issue in the South West and the Midlands and East but not in the North East?

And how can we still be having this argument eleven months after the entire provider sector – providers, their representative body, their regulators – clearly stated that this whole approach simply doesn't make sense.

Our system leadership is entitled to expect provider leaders to do everything they can to deliver a stretching task.

But this is a two way street. Provider leaders are entitled to expect a logical, supportive and reasonable operating model and this is a great example of where that isn't happening. It has to change.

What we need

So, in summary.

The challenge may be significant. But so is the opportunity. There is a clear way forward.

But we need honesty and realism; support and respect; collaboration and alignment.

We need to honestly match what the NHS is expected to deliver with the NHS budget;

We need to quickly return individual providers and the provider sector to surplus;

We need to create the conditions for local transformation;

We need to build a provider support regime; and

We need to align more effectively at both national and local levels.

NHS Providers
Let me finish by talking a little about NHS Providers.

We are very proud of all that we have achieved over the last year on your behalf.

95% of you saying in the latest membership survey that you are satisfied or very satisfied with the service we provide, a 5% improvement since last year.

98% of you feeling that it is very or fairly important for your organisation to be a member.

Figures, by the way, which IPSOS Mori, the leading opinion poll company who oversaw the survey, say are unprecedented for an organisation of our type.

100% of our staff saying that they would recommend NHS Providers as a place to work.

Our stakeholders saying that they want us in the room for our thought leadership and our insight; but they respect how we represent our members with real power, strength and skill.

The way we have significantly increased the amount of material we send you and the network meetings we host; and judging, by the feedback, increased the quality too.

Highlighting how Boards can develop best practice on race equality and diversity issues where we simply have to do better.

And this week four more things to launch:

- An important practical, new, report on improving transfers of care produced by a commission led by Paul Burstow;
- An updated version of our popular Foundations of Good Governance document which we've produced with DAC Beechcroft that now reflects the needs of both Foundation Trusts and Trusts;
- Our new website; and
- Our Time to Change pledge where we are committing to a series of actions as an organisation to tackle the stigma and discrimination around mental health

But, and this is the key to NHS Providers, this is your organisation and it only exists to serve you. Our strength and our influence come from your engagement and your involvement.

So it's fitting that my last words should be two thank yous.

First, to our NHS Providers staff team, who have once again done a great job in organising this conference to its usual high standard, a standard we're proud to maintain across all that we do.

Second thanks to you for the support you have given us during this busy year. It's been instrumental in enabling us to succeed on your behalf.

Thank you, in particular, for coming to support this event and I hope you find it helpful, stimulating and interesting.

Cathy, back to you.

ENDS

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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, 26th November 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: BOARD ASSURANCE FRAMEWORK - The Board is asked to receive and approve on the Board Assurance Framework	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Board of Directors Meeting - 24.9.15	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board Assurance Framework (BAF) is a strategic document that the Board uses to obtain assurance on the achievement of the organisation's principal objectives. The Board is asked to receive and approved the Board Assurance Framework

Main Body

Purpose:

The Board Assurance Framework (BAF) is a strategic document that the Board uses to obtain assurance on the achievement of the organisation's principal objectives and was last presented to the Board in September 2015.

Background/Overview:

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

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

The Issue:

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

In particular the Board is asked to consider whether there should be any strategic risk in relation to winter resilience included on the BAF.

Next Steps:

The Board should expect to receive the BAF on a quarterly basis. A mapping exercise will be done against the work plans of the Board and its subcommittees to ensure that assurances are being appropriate received and that all areas covered by the BAF are included on a future Board agenda.

Recommendations:

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

Appendix

Attachment:

15.16 Board Assurance Framework November update.pdf

ACRONYM LIST

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

INITIALS LIST

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

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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, 26th November 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 November for consideration and oversight 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: The November Corporate Risk Register has been reviewed at the Risk and Compliance Group on 10 November 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 November 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 November 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 16 risks and the associated controls and actions to manage these.

At the meeting on 10 November 2015 the Risk and Compliance Group reviewed the management of three risks currently captured within risk 6346, the risk relating to the capacity and capability to deliver service reconfiguration. These were: Electronic Patient Record (EPR), Clinical Administration Systems and the CQC outcome (the CQC risk is also detailed separately as risk 6300).

It was agreed that the Clinical Administration Risk, which currently has its own risk register, should have one risk on the CRR and this will be presented to the Risk and Compliance Group at the December meting.

For EPR for which there is a specific risk register, it was also agreed that one EPR risk should be added to the CRR and this will be presented and reviewed at the Risk and Compliance Group meeting in December.

Risk 6300, relating to the CQC outcome was confirmed as being an accurate reflection of the current risk.

It was agreed that risk 6345 relating to staffing would be separated into separate risks for staff groups and these will be presented to the Board in the paper for the December meeting.

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 15+ - NOVEMBER 2015.pdf

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CORPORATE RISK REGISTER REPORT

Risks as at 18 November 2015

TOP RISKS
6131 (25): Progression of service reconfiguration impact on quality and safety 2827 (20): Dependence on middle grades 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
RISKS WITH INCREASED SCORE
No risks have increased in score.
RISKS WITH REDUCED SCORE
No risks have reduced in score.
NEW RISKS
There are no new risks added to the Corporate Risk Register in November 2015
CLOSED RISKS
No risks have been closed.

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

Risk Ref	Strategic Objective	Risk	Executive Lead (s)	Sept. 2015	October 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 =**
		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 =
4783	Transforming & Improving Patient Care	Outlier on mortality levels	Medical Director (DB)	20	20	20 =
2827	Developing Our workforce	Dependence on middle grades in A&E	Medical Director (DB)	20	20	20 =
6299	Keeping the base safe	Failure of high risk medical devices	Director of Estates and Performance (LH)	15	15	15 =
5806	Keeping the base safe	Urgent estate work not completed	Director of Estates and Performance (LH)	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 =
6230	Transforming & Improving Patient Care	Failure to deliver expected financial benefits of Electronic Patient Record	Director of Finance (KG)	15	15	15 =
6130	Financial sustainability	Loss of income / service due to commissioner procurement decisions	Director of Commissioning and Partnerships (AB)	16	16	16=
6150	Keeping the base safe	Cash flow risk	Director of Finance (KG)	-	15!	15 =
6027	Keeping the base safe	Suspension of capital programme risk	Director of Finance (KG)	-	15!	15 =
		Performance and Regulation Risks				
6300	Keeping the base safe	CQC Inspection Outcome	Director of Nursing (JD)	16	16	16 =
6078	Keeping the base safe	Insufficient Appointment Slots	Director of Nursing (JD)	16	16	16 =
2828	Keeping the base safe	Slow patient flow and breach of A&E targets	Director of Nursing (JD)	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 =
6094	Keeping The Base Safe	Potential loss of training grade posts	Medical Director (DB)	-	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 18 November 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	= 6230 – Failure to deliver expected benefits of EPR = 6299 – Medical Device failure levels = 6150 Cash flow risks = 6027 Suspension of capital risk programme
Likely (4)				= 2828 – Slow patient flow & breach of A&E targets due to bed blockages / transport = 5806 – Urgent estate work not completed = 6078 – AIS, insufficient appointment slots = 6130 = Loss of income/services due to commissioner procurement decisions = 6300 – CQC inspection outcome	= 2827 – Dependence on mddle grades in A&E = 4706 – Failure to meet CIP & adhere to financial governance
Highly Likely (5)				= 4783 – Outlier on morality levels = 6345 – Staffing risk, nursing and medical = 6346 – Ability to deliver service transformation	= 6131 – Progression of service reconfiguration impact on quality and safety

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

Corporate Risk Register risks 15+
November 2015

The Health Informatics Service
Informing Healthcare

	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. Nov. Update: EPR risk and Clinical Admin. Systems risk to be added as separate risks on risk register December 2015	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 resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on sickness and absence - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives	To ensure safety across 24 hour period: - use of electronic duty roster for nursing staffing, approved by Matrons - risk assessment of nurse staffing levels for each shift and escalation process to Director of Nursing to secure additional staffing - staff redeployment - staff skill mix, eg extend roles of nursing / Allied Health professionals - medical rotas (organised by division) - use of flexible labour where identified staffing shortfalls - bank/ additional hour payments (nursing), internal / agency locum cover - weekly report on usage of agency / bank staff and review of interim resource costs as part of control workstream by Director of HR Active recruitment activity, including international recruitment Retention strategy for nursing Integrated Board Report /Hard Truths report identifies nursing staffing levels below requirements Divisional management:specific staffing gaps identified on Risk Register and reviewed through governance structures, divisional business meetings identify staffing risks and plan to mitigate risk Contribute to Health Education England survey to inform future commissioning / provision of education / training	Lack of: - workforce plan / strategy for medical staff identifying level of workforce required - dedicated resource to develop workforce model for medical staffing - centralised medical staffing roster (currently divisional) / workforce planning for medical staff - system /process to identify, record and manage gaps in planned medical staffing, particularly for junior doctors - measure to quantify how staffing gaps increase clinical risk for patients International recruitment for medical staff yet to take place	16 4 x 4	20 4 x 5	9 3 x 3	Nursing recruitment - investigate the possibility of outsourcing flexible workforce department Continue to recruit to vacant posts / skill mix review, progress international recruitment of medical staff, consider incentive schemes. (Director of Nursing, Medical Director) Secure resource to develop medical staffing workforce planning (Medical Director) Improved operational management of medical staffing workforce (Medical Director) Set up a Task and Finish Group led by Assistant Director of Operations to agree the response to manage the medical workforce risk (September 2015). August update: Medical staffing paper to be presented to August Quality Committee to understand the full extent of the problem and further mitigations to be considered. 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	Mar-2016	WLG	David Birkenhead, Julie Dawes & Jackie Green	Jackie Murphy, Jason Eddleston & Juliette Cosgrove
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	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)	Feb-2016	Dec-2015	WEB	David Birkenhead	Dr Mark Davies/Mrs Bev

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 Budget Holders in place Budget reviews hold budget holders to account Accurate Income and Expenditure forecasting CIP target greater than actual savings required and contingency reserve established by the Director of Finance	The unpredictability of Commissioners tendering process and possible decommissioning of services. Impact of decisions in wider local health and social care system on capacity driven expenditure requirements in Trust.	15 5 x 3	20 4 x 5	10 5 x 2	Plans to be agreed to manage gains or losses following tendering process. October update: The year end forecast continues to be a worsened position from plan, currently forecast £22.2m deficit against planned £22.0m (excluding restructuring costs)	Dec-2015	Mar-2016	FPC	Keith Griffiths	Kirsty Archer
Major	4783	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Aug-2011	Active	Transforming and improving patient care	There is a risk that the Trust falls below national standards for mortality levels due to not delivering appropriate standards of care for acutely ill patients/frail elderly patients and possible incorrect clinical coding resulting in inaccurate reporting of preventable deaths, increased external scrutiny and a possible increase in complaints and claims. ***It should be noted that risks 2827 and 6131 should be read in conjunction with this risk.	Outlier areas are monitored (e.g. Stroke, Sepsis and COPD) Outliers are investigated in depth to identify the cause. Improvement work is implemented via an action plan Mortality dashboard analyses data to specific areas Monitoring key coding indicators and actions in place to track coding issues Written mortality review process agreed to clarify roles and to facilitate a greater number of reviews being completed, process for escalation, linking with other investigation processes e.g. SI panel review. August reviews of July deaths (using new process) compliance 70% - highest since Feb'15 Monthly report of findings to CEAM and COG from Sept 2015 (Aug reviews of July deaths) Revised investigation policy clarifies process for learning from all investigations, including mortality reviews, and monitoring of actions CAIP plan revised Aug 2015 and now focusing on 6 key themes: investigating mortality and learning from findings; reliability; early recognition and response to deterioration; end of life care; frailty; and coding. Care bundles in place	Mortality reviews to assess preventable deaths which is indicating there isn't a problem but not yet performed for long enough or to sufficient depth to determine causes Mortality case notes review may not pick up all factors relating to preventability Coding improvement work not yet complete Improvement to standardized clinical care not yet consistent. To be completed by Dec 15 Care bundles not reliably commenced and completed	20 4 x 5	20 4 x 5	16 4 x 4	- To complete the work in progress - CQUINS to be monitored by the Trust - External review of data and plan to take place - assistance from Prof Mohammed (Bradford) August update: Further information received with increased risks to mortality. Action plan reviewed and presented to WEB. PMO approach to be adopted for reliable implementation of care bundles Sept update: Compliance with mortality reviews for last month significantly increased. 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	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 September update: Beds paper and presentation delivered at BoD - recommendation approved. Operational plan in development and additional beds will be brought on line as per plan. Work underway with SRG to ensure a robust system level response to cope with peak season demand. ED nurse staffing paper in development and will be presented to Medical Division Business Meeting. Senior decision makers on site from 5-8pm 4 days per week due to commence from mid- September. Achieved compliance with . ED 4 hour standard in August. 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	6453	Surgery & Anaesthetics	Orthopaedics	All wards/departments Orthopaedic	Nov-2015	Active	Transforming and improving patient care	A failure to undertake surgical repair of #NOF within 36 hours of admission. Caused by decreased laminar operating time, inefficient clinical processes, availability of suitably trained surgeons. This may result in extended exposure to pain and suffering, poor patient experience, extended Length of Stay.	Use of 'fallow' lists - 3 per week to keep up with demand. Clinical priority Senior clinical review of patients waiting for surgery Optimise trauma at CRH where possible.	Capacity to use 3 'fallow' lists per week Availability of surgeons with appropriate skills to undertake. Volume of admissions overwhelming capacity to treat within 36 hours of admission.	16	4 x 4	16	4 x 4	8	4 x 2	Targeting 3 fallow lists per week. Enhanced monitoring and escalation.	Feb-2016	Jan-2016	DB	Helen Barker	Andrew Bottomley

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.	A) Chemo unit- currently still on ward 3 but will be moving to new facilities on ward 7 in September 15 B) ICU- temporary repairs carried out as & when required but decant necessary for full floor replacement. C) Ward 18- Discharge lounge re-located onto Ward 18 which has been decorated & patient entertainment fitted. Ongoing concerns with Ward 18 (Childrens Area). Estates working with AM Henshaw to provide action plan for intermediate repairs (ward upgrade necessary) - ACTION COMPLETE D) Ward 4- heaters were available for cold rooms. Ward 4 has now been connected to existing vent plant The heating system has been set up to enable the BMS system to control BMS valves within the ward to give better heating control within the area. ACTION COMPLETE E) Ward 5- now moved to ward 11 whilst the ward has works done and a minor upgrade. 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	A) The privacy & Dignity Issues are being managed by the ward until move onto new Ward. B) Situation monitored by Estates until opportunity to decant ward and fully replace,. E) Issues highlighted for inclusion in the minor upgrade will be addressed prior to the Ward returning to Ward 5. F) Situation monitored by Estates until opportunity to decant ward and fully repair. G) Superficial repair of Ward 6 windows (carried out Site Wide); windows will be monitored by Estates. H) Cofley aware of CCU Flooring at CRH, on lifecycle replacement however monitored prior to decant. I) A&E resus area requires expansion at HRI	16	4 x 4	16	4 x 4	8	4 x 2	A) Chemo Unit to transfer to upgraded area in Sept 15. B) ICU floor to be monitored until decant possible. F) Ward 19 flooring will be monitored until decant possible G) Windows on Ward 6 will be managed by Estates H) CCU Flooring at CRH will be monitored until decant possible. I) ED resus area at HRI. August update: Further work to improve estates on ward 18 has been completed and therefore risk in relation to this specific estates risk has been reduced. Sept Update:- Repairs carried out to Ward 4 Heating; action complete. October Update: Chemo Unit transferred onto new facilities. Action complete	Jan-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. October 2015 Update: Greater Huddersfield CCG has selected Locala Community Partnerships as the preferred provider of Care Closer to Home services in Kirklees. This represents a £5m loss of income to the Trust. The Trust is working with Locala and Commissioners to manage the transfer of services. A number of services transferred to Locala on 1st October. Further services will transfer during November. The Trust is awaiting update from Kirklees Council regarding their review of the procurement of sexual health services.	Jul-2015	Dec-2015	CISC	Anna Basford	Rob Aitchison & Lisa Williams

Major	6230	Corporate	Finance	Corporate Finance	Feb-2015	Active	Transforming and improving patient care	There is a risk that the Trust will not be able to deliver the expected financial benefits of the Electronic Patient Record (EPR) system due to the implementation being impeded by financial and operational constraints (eg additional costs incurred due to time delays or lack of appropriate resource being made available) resulting in a failure to demonstrate return on investment or value for money. There are two elements to this risk: Implementation of tactical solutions (e.g. e-rostering; nerve centre; maternity; voice recognition; EDMS); and Project management delays, changes to specification and lack of capacity; clinical engagement and complexities with working jointly with Bradford Teaching Hospitals.	• Agreed loan from Independent Trust Financing Facility (ITFF) received in April 15 to support capital programme, specifically Electronic Patient Record (EPR). • Financial appraisal and selection of preferred supplier that included full benefits realisation and implementation plan. • Modernisation Programme Management and Governance structure to manage the implementation and roll-out of the EPR system within the Trust-wide IT Modernisation Programme. • Transformation Board meets on a monthly basis chaired at CEO level. • Creation of an Assurance Board that includes Non-Executive directors. • A detailed project plan and timelines has been agreed with Cerner (EPR Provider) and Bradford for the roll-out of the EPR.	The full gap analysis of EPR processes against current working practices to be completed with the requirement to develop an associated change management programme.	15 5 x 3	15 5 x 3	10 5 x 2	Regular updates from EPR Benefits Realisation now regular agenda item at the Trust Finance and Performance Committee.	Feb-2016	Apr-2016	FC	Keith Griffiths	Kirsty Archer
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.	Dec-2015	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.	Nov-2015	Mar-2016	FPC	Keith Griffiths	Kirsty Archer
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	1 x 1	Action planning following GMC/HEYH Surveys. November update-planning to take place within divisions to mitigate risk of potential industrial action	Feb-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:** Kathy Bray, Board Secretary
Date: Thursday, 26th November 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PROGRESS AGAINST WELL LED GOVERNANCE REVIEW ACTION PLAN - The Board is asked to receive and approve the Action Plan on progress against the Well Led Governance Review.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Board of Directors (August meeting)	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The final version of the Well Led Governance Review action plan was approved by the Board at its meeting in August. It was agreed to receive quarterly updates on progress against the actions. This is the first of those progress reports which shows that all of the actions are underway with one complete and a number due to complete by the end of December.

Main Body

Purpose:

The report sets out the progress against the Well Led Governance Review action plan.

Background/Overview:

In May 2015, the Trust undertook a Well Led Governance Review led by an independent consultancy. The resulting action plan was approved by the Board at its meeting in August and it was agreed to receive a quarterly report on progress against the actions.

The Issue:

There has been some progress against all of the actions in the plan.
One action has been fully implemented. One action has been implemented to this point (it is given an 'ongoing' timescale).

A number of actions with a 1-3 month deadline (i.e. due for completion by the end of November) are almost complete:
- the Performance Management Framework is presented to the Board for approval at this meeting (action ref 2)
- increased capacity has been agreed and the Chief Operating Officer interviews are taking place on 25/11 with Non-Executive interviews in January (action ref 3)
- alongside this executive portfolios have been reviewed in preparation for the appointment of the Chief Operating Officer (action ref 10).
- executive and non-executive development programmes are in place and being delivered with a joint session planned for February(action ref 7,10 and 20).

There are some areas where the timescale has slipped slightly:
- following the development of the performance management framework, further work is required to develop the clinical leadership capacity across the Trust (action ref 6)
- there is significant work continuing on the embedding of risk management, incident reporting and lessons learned culture across the organisation (actions 5,12, 13 and14)
- the process the Trust is following on the development of the 5 Year Strategy has set the template for how some of the actions relating to development and communication of strategy will be delivered and therefore these should be complete by early January (action ref 11,21 and 22).
- the Integrated Board Report has been strengthened. There is further work to do to ensure that the information is clear and that the Board has assurance on the quality of the data contained in the report (action ref 9 and 16).

Next Steps:

Progress will continue against all of these actions. Monitor are also providing oversight of the Trust's implementation of its action plan through the monthly Progress Review Meetings. The next report will be brought to the Board in February 2016.

Recommendations:

The Board is asked to receive and approve the Action Plan on progress against the Well Led Governance Review.

Appendix

Attachment:

Progress report to Board November 2015.pdf

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PROGRESS AGAINST THE WELL LED GOVERNANCE REVIEW ACTION PLAN as at 13 November 2015

Ref	Action to be taken by the Trust	Owner	Timeframe	Progress	Rating
1	**Audit Committee** The private session of the Audit Committee should not include members of management, including the Director of Finance.	Chair of the ARC / Company Secretary	Immediate	COMPLETE The ARC has held a private meeting with the Auditors at its last two meetings.	
2	**Accountability framework** The Trust should consider the introduction of a more formal accountability framework as an enabler to performance management and operational delivery. This internal contractual agreement between the Trust Board, divisions and directorates should be used as a basis to define an appropriate level of devolution across the Trust.	Interim Associate Director of Operations	1-3 months	PARTIALLY COMPLETE A performance management framework has been developed, consulted upon and approved by the Weekly Executive Board (12/11). It will be presented to the Board 26/11. It will be fully implemented from April 2016 but will run in shadow form until that time.	
3	**Capacity** The Trust must assess and reflect on the capacity of the Board and staff at all levels to deliver operational improvement and future strategic priorities, and therefore the resilience of the organisation and individuals.	Chief Executive	1-3 months	PARTIALLY COMPLETE Approval was given at the Nominations & Remuneration Committee- BoD (24/9) to recruit a Chief Operating Officer. Interviews take place 25/11. ADD posts and Deputy Director of Nursing posts have been filled. Nominations & Remuneration Committee – MC taking place 7 December to review recruitment of Non-Executive posts.	
4	**Turnaround Executive** The Trust should seek to adopt and adapt the lessons learnt from the Turnaround Executive structure within divisions and consider how this process, developed during turnaround, could be adapted to strengthen performance management more generally (that is, not just to facilitate CIP delivery), allowing the Trust to meet the ongoing challenges that it will face.	Chief Executive	1-3 months	WORK UNDERWAY Divisions have put in place monitoring arrangements that follow turnaround process. This is being reviewed both through EY review of governance arrangements for the CIPs and through the implementation of the new Performance Management Framework.	
5	**Divisional risk management** The Trust should undertake an in depth review of risk management, incident reporting and escalation in the divisions to ensure that these processes are robust and aligned to the Trust's strategic priorities (see also actions 12 & 14).	Executive Director of Nursing	1-3 months	PARTIALLY COMPLETE Claims Policy revised, with accountability and processes to ensure clear routes for sharing learning; Revised Incident Policy including detailed guidance and supporting documents to ensure robust reports and action plans, with clear accountability for sign off of action plan; Training on undertaking investigations into serious incidents was delivered to staff earlier in the year and in October the first of the in-house training	

Key: Action fully complete; Action partially completed; Action underway but further work to do; Action not started

				programme sessions on Effective Investigation Skills was delivered to support staff in identifying root causes of serious incidents and identifying and delivering recommendations to prevent recurrence; New inquest Policy has been developed confirming the Trust policy on inquests and support processes / templates for staff. Reviewing the role of the Patient, Safety & Quality Boards at a divisional level and how these then cascade into directorates.	
6	**Clinical Leadership** The Trust should evaluate the current clinical leadership models as a means of strengthening leadership roles. The Trust should build on the leadership training provided to clinicians by clearly defining the job description and responsibilities of Divisional and Clinical Directors, and ensuring that there is sufficient ring-fenced time in their roles for this to be completed. There are several well established models of medical leadership that may provide further insight, for example, the Clinical Leadership Model developed at University Hospital of South Manchester NHS Foundation Trust.	Medical Director / Interim Associate Director of Operations	1-3 months	WORK UNDERWAY Review of clinical director role taking place in line with the development of the new Performance Management Framework which sets out the roles of the divisional leadership and their accountability. There is more to do to define the leadership training and development associated with these roles.	
7	**Board challenge** Board debate and challenge could be enhanced by ensuring that all aspects of issues are considered, and that the debate "closes the loop" by identifying the actions to be taken, their expected impact, how this will be measured and under what timeframe.	Chairman / Company Secretary	1-3 months	PARTIALLY COMPLETE Improvements made to the action log. Board challenge included in board development work currently underway with Greengage.	
8	**Board reporting** The Board needs to be assured that the Trust is delivering its strategic priorities. Information presented to the Board should be integrated and triangulated to enable to the Board to make efficient judgements as to whether strategic and operational objectives are being achieved as expected. The Board should receive intelligence distilled from a more detailed review at the sub-committees.	Chairman / Director of Planning, Performance, Estates and Facilities	1-3 months	PARTIALLY COMPLETE The Board receives a quarterly update setting out progress against the delivery of the Trust's objectives	
9	**Data and data quality** Further development of the data quality kite mark will allow Board members to gain assurance over the reliability of each measure and could provide greater assurance that there are no	Director of Planning, Performance, Estates and	1-3 months	WORK UNDERWAY A data quality indicator is included within the Integrated Board Report however there is more work to do to describe how this indicator is made up and where the	

Key: Action fully complete | Action partially completed | Action underway but further work to do | Action not started

	unknown data quality issues. The Board should consider how the skills within the Trust (in particular, within the Health Informatics Service) could be leveraged to take a more transformation approach to data and data quality, and should consider the development of an information strategy to achieve this.	Facilities		assurances come from. As part of the Performance Management Framework there are recommendations about how performance may be managed and reported in the future which would support this work.	
10	**Executive Portfolios** To address a perceived lack of clarity over responsibility for planning, and to more closely align structures and processes relating to planning, the Trust should ensure that the responsibility and oversight for planning is clearly defined in Executive portfolios.	Chief Executive	1-3 months	PARTIALLY COMPLETE A programme of development is in place for the executive director team which looks at portfolios and responsibilities including the opportunities for change presented by the introduction of the new Chief Operating Officer post. This will result in clear portfolios and board level responsibilities. Key work objectives have been agreed individual directors. This has been done in a way that will facilitate a smooth transition of key work objectives to the Chief Operating Officer on appointment	
11	**Development of the strategy** The Trust should formalise the process for refreshing the strategy annually, ensuring involvement with external stakeholders, staff, patients and the wider public.	Chief Executive	1-3 months	PARTIALLY COMPLETE The work to develop the 5 Year Strategic Plan has included a clear communication and engagement plan that includes all internal and external stakeholders. This has set the template for how this will be done as part of the annual strategy refresh from 16/17 onwards.	
12	**Risk and safety culture** The Trust should continue its focus on improving its risk management and safety culture. This could include applying the "go see" methodology by observing an organisation with a strong risk management and safety culture. For example, Mid Cheshire Hospitals NHS Foundation Trust was the highest acute trust nationally for "Fairness and effectiveness of incident reporting procedures" in the 2014 staff survey. Salford Royal NHS Foundation Trust achieved outstanding for the well-led domain in a recent CQC inspection; risk management culture and processes were praised in a number of	Director of Nursing	1-3 months	WORK UNDERWAY One of the aims of risk management within the Trust is to continually improve performance by pro-actively adapting and remaining resilient to changing circumstances or events and learning. The Trust has strengthened its capacity within the Governance and Risk Team to support the organisation in managing clinical and non-clinical risk by the appointment of a Head of Governance and Risk and a Quality and Patient Safety lead. The quarterly quality report, presented to the Quality Committee and Board of Directors, is the key	

	divisions by the CQC (link to actions 5 & 14)			report that identifies adverse events that have occurred by reviewing complaints, incidents, and claims. The increase in the number of non-pressure ulcer serious incidents reported and investigated indicates a small improvement in risk management awareness. As part of preparation for the CQC inspection, an action plan has been developed for the "Safe" domain which covers a key number of risk management systems including incident investigations, the Risk Register, and near miss/low risk incidents. Progress with actions within the plan is reported to the CQC Steering Group.	
13	**Lessons learnt** The Trust should review the processes in place for sharing issues, lessons learnt and good practice between teams and consider whether further mechanisms at ward and service level might be required.	Director of Nursing	1-3 months	PARTIALLY COMPLETE To improve the learning culture and to ensure that information is shared with staff on learning from adverse events a newsletter has been introduced, " So What Happened Next ?; Summaries of learning from serious incidents, complaints and claims is planned to be share via the intranet. Public facing boards introduced on wards set out 'you said, we did'; the review of divisional Patient safety and quality boards will ensure that lessons learned are regularly discussed and shared.	
14	**Divisional risk management** The Trust must strengthen risk management capability within the divisions as they are a foundation to manage and mitigate risk. The Trust should could consider using external support to engage with divisions to improve risk management culture, in the same way that this has been done at a Board level. (link to actions 5 & 12)	Director of Nursing	4-6 months	WORK UNDERWAY Whilst progress has been made in the management of risk, particularly at Board and corporate level, further work is needed to ensure that risk management is embedded from ward to Board. An internal audit review of the Risk Registers took place during the summer of 2015 to ensure that risks are captured, risk assessed and filtered through the risk system which resulted in significant assurance. Each division has a Patient Safety and Quality Board at which updates to risk registers and top divisional risks are presented. Staff training in risk registers by the Governance	

Key: Action fully complete | Action partially completed | Action underway but further work to do | Action not started

				and Risk has begun and further training is planned to support the effective identification and use of risk registers at divisional level.	
15	**Board sub-committees** The ongoing development of the Board sub-committees should be continued. This should focus on the strength of challenge from all members and the presentation and use of information, to ensure that appropriate scrutiny is applied and that assurance can be given to the Trust Board.	Company Secretary	4-6 months	WORK UNDERWAY A self-assessment process for sub-committees has been tested with the Audit and Risk Committee resulting in a number of actions. This process will be rolled out to the remaining board sub-committees prior to the end of the FY 16.	
16	**Board awareness of data quality** As the Board development programme is refreshed, the Trust should consider the inclusion of data quality and interpreting information to inform judgments as a subject for Board training, to ensure that the Board are equipped to identify potential indicators of poor data quality and challenge these. (link to action 9)	Chairman / Company Secretary	4-6 months	WORK UNDERWAY A data quality indicator has been included in the Integrated Board Report. As part of the development of the IBR a session will be arranged for board members to look at the how the indicator is made up and assurances received on the quality of the information presented.	
17	**Cultural barometer** The Board should seek assurance that the programme of work generated from the PwC review of quality of care in October 2014 is having the planned impact on the culture of care. The Trust should could consider the use of a cultural barometer or similar tool as a way of assessing this.	Director of Workforce & OD	4-6 months	WORK UNDERWAY As part of the preparation for CQC inspection, focus groups have been held to test the culture of the Trust and engagement of staff. In addition the Trust is participating in a full Investor in People assessment which looks at culture and which is due to report in January. Actions to address the findings and to update against previous work will be identified and report to the Well Led Workforce Group in January / February.	
18	**Multi-professional leadership** The Trust should consider how to ensure that all professions are included and represented in leadership across the Trust. This will be of particular importance as the service model of the Trust continues to develop.	Medical Director / Director of Nursing	4-6 months	WORK UNDERWAY The creation of the Community division and close working with partners in primary care has presented an opportunity to consider how all professions can be included and represented in leadership across the Trust. This work is still in early stages.	
19	**Community engagement** The Trust should consider the use of wider community	Chairman	4-6 months	WORK UNDERWAY The Membership Strategy is being reviewed and	

	networks to ensure that the diversity of the local population is reflected in its membership, Membership Council and Board.			will be considered by the Membership Council in January 2016. This will take into account the use of wider community networks and will more clearly link to the Trust's approach to PPI.	
20	**Board development** In recognition of recent Board changes, and the changing context the Trust operates in, the Trust should consider the Board and organisational development needs to ensure that leadership, the desired behaviour and delivery capacity is optimised. This should reflect lessons learnt from previous development programmes, and how leadership can be enhanced at all levels in the Trust.	Chairman / Company Secretary	6 -12 months	WORK UNDERWAY Board development sessions have been put in place for executive and non-executive directors supported by an external facilitator. A joint session is in the diary for 26 February. Further work is being undertaken by the Director of Nursing to look at the wider organisational development plan.	
21	**Development of the strategy** Strategic development must include alignment of structures, processes and KPIs to the Trust's strategic priorities. The more robust planning process from 2015/16 should be embedded to ensure plans reflect capacity and workforce constraints, as well as the financial position.	Chief Executive	Ongoing	The development of the 5 Year Strategic Plan means that the planning process is very detailed for both 2016/17 and the following five years. This takes account of a baseline for activity, bed numbers, workforce and the financial impacts of these. Further work will need to be done to develop the process for this in subsequent years.	
22	**Communication of the strategy** The Board and those in leadership and managerial positions must consistently communicate strategic priorities to ensure the development and delivery of the operational plan.	Chief Executive	Ongoing	Improvements have been made to the internal communications and engagement structures at both a corporate and divisional level. There is a clear communications and engagement plan for the 5 Year Strategic plan supported by EY.	

Key: Action fully complete | Action partially completed | Action underway but further work to do | Action not started

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th November 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PERFORMANCE MANAGEMENT FRAMEWORK - The Board is asked to receive and approve the Performance Management Framework.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Executive Board	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Well Led governance review recommended the introduction of a Performance Management Framework with associated accountability clear; this paper describes both frameworks and has been completed following consultation with corporate departments and Divisional teams.

Main Body

Purpose:

The paper sets out a Performance Management Framework which will provide clear accountability and responsibility from Board to ward. The framework has been developed in consultation with divisions and has been reviewed by the Executive Board.

Background/Overview:

Best practice shows that in order to ensure an organisation assesses its performance across all aspects of its business, it is vital that different perspectives are incorporated into a Performance Management Framework (PMF) and an integrated and comprehensive view of the organisational performance is embedded. This would enable the Trust to:

- Assess performance and finance against clear targets and goals.
- Undertake exception based performance, financial and CIP delivery tracking.
- Predict future performance and forecast outturn and identify key actions.
- Put in place effective Review Meeting structures including intervention as necessary and appropriate.
- Focus resources and improvement efforts in required areas.

It is essential that this sits within the context of the Trusts vision and values in the four pillars

To enable this to occur each Division needs to have the capability, capacity and processes to ensure that the care it provides meets required standards and the performance against the Trust's objectives is maintained or exceeded. To support this approach and develop the capacity and capability within the Divisions and Directorates, the Executive Team provided development for teams and individuals, mentorship where appropriate and support from the corporate teams and processes.

The Issue:

To support the development of decision making and accountability, a framework is required to inform the assessment of each Division's position and the level of accountability that can be passed to each Division with the following principles:-

- Link to the Trust's Vision "to deliver outstanding compassionate care to the communities we serve"
- Incorporate the CQC standards and Framework including the rating.
- Include Monitor's requirements.
- Be in line with the Trust's objectives and behaviours.
- Take into account any recent third party reviews of Trust e.g Well Led Governance, and internal reviews such as PSQB reports
- The level of Autonomy would be dependent on the rating.

Underpinning this is the principle of the Executive team devolving decision-making and accountability to the Divisions with delivery using the values within the four pillars. Each Division will have core KPIs supplemented with specific KPIs reflective of their services. The target level for each Division will be agreed through annual planning. The level of autonomy will be developed and agreed with the Board of Directors

The framework will ensure there is a robust connection 'Ward to Board' with rapid escalation along with a comprehensive oversight of key metrics, clarity on areas of concern and associated actions.

Next Steps:

It is proposed to implement the framework gradually through Quarter 3 and 4 with full delivery from April 2016 having been accompanied by any agreed Divisional structure changes and reflective of the agreed annual planning priorities

Recommendations:

The Board of Directors are asked to:
o Confirm the frameworks reflect the recommendations of the Well led Governance review
o Support the implementation of both frameworks
o Agree the phased implementation through Quarter 3 & 4
o Agree to receive a recommendation on the KPIs by Division and associated levels of autonomy for future consideration.

Appendix

Attachment:

Performance Management Framework BoD Nov 15.pdf

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Performance Management and Accountability Framework

1. Introduction

This paper describes the work carried out to date to review the Calderdale & Huddersfield Foundation Trust (CHFT) Performance Management arrangements and recommends a new Performance Management Framework (PMF) supported by a clear Accountabiilty Framework based on Monitor principles but delivered in line with the Trusts own values and behaviours as described in our mission, four pillars and Strategic objectives

2. Scope

The scope of this work included a review of performance reporting at the Board of Directors, performance management of Divisions and the operational management of performance with associated information processes.

This work aligns with the review of Clinical management arrangements and associated Divisional structures that describe a model that will secure the delivery of the Trust strategy and associated objectives

3. Background

The Trust has clarity on its strategic objectives, vision and values as described in the four pillars and has historically performed well against the majority of national standards and CQUINs type indicators although this is not always consistent across every area of the organisation. It previously worked within a block contract arrangement meaning contract penalties were not as visible to Divisional teams therefore individual indicators were not always managed proactively.

The performance reporting culture was based on reported performance with little visible evidence of routine and documented proactive monitoring or management leaving it susceptible to adhoc failure or recovery plans that were reactive and unsustainable

The overall process, from Ward to Board, was variable with no systematic process for reporting and delivery however the performance management arrangements do include Executive attendance at Divisional business meetings to provide scrutiny and challenge. In addition the Trust's process of improvement and engagement means there are regular Executive walkabouts and time spent on the 'shop floor' which provided a level of assurance.

A review of the Performance management arrangements was requested by the Executive Director of Nursing and Operations which highlighted the key issues as follows:

- There is no defined PMF
- Whilst there is a lot of data available this is does not highlight risks or triangulate easily. There is minimal forward looking data set and no clear timetable for when each data source is available
- There are concerns with the awareness of all teams on the full suite of performance indicators
- There is limited use of locally relevant indicators in assessing performance
- A low level of documentation to evidence effective escalation or management
- There is no defined process for poor performance or assurance process for KPIs reported as green
- A lack of clarity on accountability within Divisional structures
- There is low level of clinical involvement with the system

These points will be addressed within this paper

4. Performance Management & Accountability Frameworks

4.1 Key elements of a performance framework

Best practice shows that in order to ensure an organisation assesses its performance across all aspects of its business, it is vital that different perspectives are incorporated into a Performance Management Framework (PMF) and an integrated and comprehensive view of the organisational performance is embedded. This would enable the Trust to:

- Assess performance and finance against clear targets and goals.
- Undertake exception based performance, financial and CIP delivery tracking.
- Predict future performance and forecast outturn and identify key actions.
- Put in place effective Review Meeting structures including intervention as necessary and appropriate.
- Focus resources and improvement efforts in required areas.

However it is essential that this sits within the context of the Trusts vision and values in the four pillars

To complement these Monitor guidance on performance management highlights five important components:

- Consists of tools and processes for accountability and transparency
- Creates a rhythm of reporting and review
- Links strategy, income, budgets and access
- Allows Lead Clinicians to shape their service in the delivery of the required contract
- Requires clarity in the contract with the Executive; accountability and KPI measures

To enable this approach the integration of performance information is essential and should include but not be limited to the following:

- Performance information – patient activity and process efficiency information;
- Strategic Direction – key strategic objectives;
- Organisational capability - capacity plans for both activity and staffing, benchmarking and comparative data where relevant;
- Finance – annual cost and income budget plans, other divisional financial information and efficiency programmes;
- Quality information – patient safety, clinical effectiveness, mortality measures, patient experience and compliments and complaints;
- Human resources information – staff engagement, absence data, turnover and vacancies;

- Governance and risk information – clinical audit, NICE compliance, serious incidents/never events, FOI response times risk registers and the Board Assurance Framework (BAF);
- Compliance information – regulatory bodies and other bodies to whom the Trust must have due regard will inform a compliance framework and be used to provide assurance to the Board of Directors; and
- Commissioning information – compliance with commissioning policies and thresholds;
- Transformation information – progress with agreed transformation projects; and
- Integrated business plans (IBPs) – progress with the rollout of IBPs within each operational division.

There will be different levels of KPIs reflective of the corporate and service level differences. Some indicators will be core for all with the same level of compliance required, some will be core but with different targets reflective of volumes or risk levels and further cohort of KPIs will be specific only to certain services.

KPIs will be set through annual planning and agreed between the Executives and Divisional/corporate Management Teams.

4.2 Key elements of an Accountability Framework

The Trust is committed to a clinical leadership model with clear accountability through a single accountable officer principle. The Trust has four clinical Divisions each led and managed by Divisional Directors with Assistant Divisional Directors,Associate Directors of Nursing and Quality and Assistant Directors of Finance. The Divisions are further divided into Directorates who are led and managed by Clinical Directors, Directorate Managers and Matrons.

Underpinning this is the principle of the Executive team devolving decision-making and accountability to the Divisions with delivery using the values within the four pillars of:

- Putting the patient first
- Working together to get results
- We 'Go See'
- We do the Must Do's

To enable this to occur each Division needs to have the capability, capacity and processes to ensure that the care it provides meets required standards and the performance against the Trust's objectives is maintained or exceeded. To support this approach and develop the capacity and capability within the Divisions and Directorates, the Executive Team provided development for teams and individuals, mentorship where appropriate and support from the corporate teams and processes.

To support the development of decision making and accountability, a framework is required to inform the assessment of each Division's position and the level of accountability that can be passed to each Division with the following principles:-

- Link to the Trust's Vision "to deliver outstanding compassionate care to the communities we serve"
- Incorporate the CQC standards and Framework including the rating.
- Include Monitor's requirements.
- Be in line with the Trust's objectives and behaviours.
- Take into account any recent third party reviews of Trust e.g Well Led Governance, and internal reviews such as PSQB reports
- The level of Autonomy would be dependent on the rating.

4.3 The Process

It is essential that our core behaviours sit at the heart of the delivery of both our performance management

and accountability frameworks. These four pillars form the basis of the process

The following principles will be followed:-

- The process and rating system would be the same for all Divisions.
- The metric will reflect specific Divisional business i.e. KPIs will vary between Divisions
- The Division's level of readiness and the accountability level include an assessment of each of their Directorates.
- The rating the Divisions are given would not be solely reliant on the Directorate's performance but also on the Divisional awareness of the issues and the robustness of their action plans.
- Peer review of Divisions would be utilised.

4.4 Objective of the frameworks

The frameworks are the vehicles to ensure we consistently deliver our vision and values which are:

To deliver outstanding compassionate care to the communities we serve.

This means that:
• We provide safe care in a clean environment
• Care is designed to meet patient and carers needs, not ours, and are delivered as close to their home as possible.
• Our staff are competent and compassionate, friendly and welcoming
• We work together with patients, their family and carers to help them take responsibility for their health and wellbeing
• Our treatments are up to date and we embrace change, innovation and new technologies to make sure we remain at the leading edge of care
• We are part of the communities we serve working together to create and sustain health and wealth for the future

4.4.1 Performance Management Framework

The objective of this framework is to ensure that information is available which enables the Board of Directors and other key personnel to understand, monitor and assess the Trust's quality and performance, enabling appropriate action to be taken when performance against set targets deteriorates. Information must be timely, accurate and complete and follow the principles set out in the Trust's Information Governance and Data Quality Policies.

In its simplest form the PMF includes the performance management processes which collectively help deliver the strategic objectives and ultimately the vision of CHFT. Performance management within CHFT will continue to be based on the following principles:

- The Board of Directors have established clear KPIs and targets that are balanced across clinical, operational, financial and staff dimensions driving towards the level of performance expected of a first class organization
- KPIs and targets will be tracked and monitored regularly with performance reviews at all levels to drive performance improvement.
- Performance conversations should focus on identifying root causes rather than symptoms, and participants should be focused on how performance can be improved
- It is important to reinforce desirable behaviours with rewards and consequences for performance.
- Divisions operate within a devolved clinical structure remaining directly accountable for the quality of

services delivered to patients within an agreed financial envelope.

- The performance management of productivity and efficiency (P&E) targets will be included in the revised performance arrangements. However, the detailed process of ensuring delivery of individual P&E schemes should continue to be led by the CHFT Programme Management Office (PMO) under the defined governance structure which is in place.

At all times the four pillars will be the underpinning behaviours for all performance improvement work and will be conducted using the methodology of 'Work together to get results'

4.4.2 Accountability Framework

Within a single accountable officer structure it is essential that the role of Divisional Director/Clinical Director is clear and it is understood that this is accountability for the integrated clinical, operational, and financial performance of the Division/Directorate through this single leadership model. They will be supported in these roles by senior general managers, nurses and experts in core corporate functions.

Decision making/levels of autonomy measures will be established to assess the performance of Divisions/Directorates which will, in turn, determine the level of autonomy. The assessment will reflect, but will not be limited to:

Finance
- Income
- Expenditure
- Activity
- CIP delivery

Quality (including performance metrics)
- Patient safety
- Patient Harm
- Patient experience

Workforce
- Turnover rates
- Sickness
- Appraisal and mandatory training
- Productivity and Efficiency

Governance
- Responsiveness
- NICE compliance
- Equality and Diversity

Metrics will be agreed at the start of each financial year based on but not limited to:

- Monitor requirements
- Contractual standards
- Patient and staff satisfaction feedback
- Annual planning priorities

Metrics will be set according to Divisional size, configuration and priorities, on some metrics Divisions will be identified as lead providers and as such will need to work with other Divisions in the delivery of a successful metric, see Appendix 1. The lead Division will remain the accountable Division.

4.5 Roles and Responsibilities

4.5.1 Board of Directors

The Board should establish the framework and key performance indicators for the organisation aligned to those set out by Monitor, NHS England, Care Quality Commission and those identified locally within

Contracts.

4.5.2 Performance Indicators & Standards

The key elements for the Board include:

- The use of 'soft' performance measurement, such as board visits and patient stories, which are supported by formal mechanisms for capturing, reporting and reacting to this information
- A formalised strategic approach to data quality improvement aligned to quality governance. This should be supported by regular data quality metrics and a data quality assurance, process mapping and audit programme will allow the board to receive assurance that this is effective
- Actively benchmarking performance with comparable organisations based on risk assessing areas of greatest need; internal benchmarking and 'peer reviews'; and a robust analysis of historical data.
- The board uses a strategic integrated performance dashboard which includes:
  - quality, performance, activity and finance;
  - aligning performance scorecards to strategic goals;
  - expanding to ward- and service-level dashboards;
  - explanation for variances;
  - analyses and comments;
  - performance projection and trends;
  - risk analysis on achieving trajectory; and
  - overview summary of the impact on quality by division or service.

4.5.3 Board Reporting

To ensure good governance as described in Monitor's Board Governance Assurance Framework and Quality Governance Framework the Integrated Performance Report will be reviewed for the Board and consist of a front end dashboard, a Divisional level scorecard, exception reporting where adverse performance is observed and a regular programme of assurance reports where a deep dive is undertaken on an area reporting Green.

The report will be presented with variances, trends and where possible benchmarking information to illustrate areas of good and adverse performance. The Divisional scorecards set out, at a high level, the relative performance against the agreed performance indicators.

The Integrated Performance Report will be collated by a Head of Performance using the outputs of the Divisional Performance reviews and will be reported on a monthly basis at the Board of Directors; collectively delivered by the relevant Director.

Prior to the Board of Directors the Weekly Executive Board (WEB) should review the Integrated Performance Report and the Divisional scorecards.

4.5.4 Soft Performance Measurement

The Board of Directors will supplement the formal performance management arrangements with what is described in the Quality Governance Framework as the use of 'soft' performance measurement, such as visits to services and patient stories, which are supported by formal mechanisms for capturing, reporting and reacting to this information.

The Board currently visit services after each formal monthly meeting and Executive Directors spend time either visiting or working within a department or service. Non-Executive Director visits to services outside of the formal Board and other intelligence obtained from their work (such as appointments panels) for the Trust may add to this. The use of patient stories at Board meetings can be an effective mechanism to

draw the Board's attention to the experience of patients cared for by CHFT.

4.5.5 Divisional Responsibilities

The key responsibilities for performance management at a Divisional level are:

- The Divisional Director (DD) is accountable for the performance of the Division in all areas and an Assistant Divisional Director (ADD) and Assistant Nurse Director (AND) who have this responsibility delegated to them
- These leaders should exhibit competencies across quality, finance, people and collaborative service leadership
- There should be a single line of accountability for delivering tasks

Within newly developing Divisional structures there must be specific focus on performance reporting; there would be logic in this being joined with business management and governance.

Specific responsibilities by role can be found in Appendix 1

4.5.6 Divisional Performance Indicators & Measurement

Divisional key performance indicators will be aligned to those which are agreed by the Board and include other specific indicators which are determined by the leadership team to reflect the nature of their business. All agreed performance indicators should have a target and where performance is met then a Green rating is given for that indicator where it is not either Amber or Red is apportioned depending on the extent to which it is not met.

For some Divisions, particularly those which are non-admitting, there will be more locally agreed performance measures compared to those set out nationally. Where this is the case locally agreed measures should be benchmarked and upper quartile performance should be the target.

4.5.7 Divisional Performance Management Review Meetings

There will be a clear and consistent schedule of performance management review meetings. The Chief Operating Officer (COO) is responsible for organising and leading the review meetings and all Directors will attend. The frequency of meetings will be determined by the level of performance achieved as described in the accountability section of the framework.

Meetings with Divisions will have clear terms of reference. A standard pre populated performance pack will be issued to Divisions 10days before their meeting. Divisions will update the pack with a focus on red and amber indicators articulating the reason for the reported performance, actions to address any variance, responsible officer and timeline for recovery. These completed packs will be circulated to the Executive 3 – 5 days before the review meeting from which the COO will coordinate the agenda.
It is expected that the Divisional Board of DD, ADD, AND & DFM all attend the review meetings

The performance reviews are the core component of the accountability framework with the level of delegated autonomy and frequency of performance reviews determined by the position of the Division across the agreed metrics grouped to reflect the CQC domains, a draft high level matrix is set out in Appendix 2. The matrix is structured to facilitate variable levels of autonomy for each domain for example a Division may achieve a 'good' for value for money but 'requires improvement' in workforce therefore may have frequent performance meetings with the Director of Workforce & OD but a two monthly review of finance and turnaround

Rating	**Level of Autonomy**
Excellent	Quarterly performance review *Divisional level sign off for vacancies**
Good	Performance Reviews every other month

	*Divisional level sign off replacement posts**
Requires improvement	Monthly Performance Reviews *Vacancy control panel for all posts**
Inadequate	Weekly Performance. *Recruitment by exception with* *All vacancies and any other expenditure over £50k signed off by Executive**

**Example autonomy level, to be determined for each domain*

4.6 Escalation and De-Escalation

The CHFT performance management process will help to further develop the devolved Divisional structure. Leadership teams will continue to be held to account for delivering high quality, efficient and financially sustainable service lines. The Divisional Management Teams will be expected to ensure matrix working across the Division to help maintain an overall Green rating for the Division including, where possible, over-performing to meet the under-performance in some Directorates. Across CHFT, Divisions will be expected to work together to maximise opportunities for success.

A robust escalation process will be established to ensure swift action can be taken to support Divisions where possible changes in performance are identified or anticipated. Ongoing performance conversations should take place with the COO at every opportunity to share this intelligence. All Divisions will, on an agreed basis, be offered additional support should any the delivery of the required standards of performance be at risk. This may include Service Improvement support, additional short term capacity to maintain performance or specific resources to implement remedial measures.

Escalation can occur for individual metrics or overall performance concerns and can be initiated by the Executive or the Division. For individual metrics escalation meetings will be led by the relevant Executive, for overall risk escalation meetings will be led by the COO.

Where issues are escalated by the Division a Quality Summit approach will be adopted using the three R's as the structure on which to build understanding and solution.

Where Divisions fail to achieve the required improvements after support they will be subject to increased monitoring where they will be required to produce detailed recovery plans and discuss these with relevant Executives. Should Divisions fail to act appropriately to deliver the agreed recovery plans detailed assessment, to understand the root cause, will be undertaken with the team collectively and individually. From this review the COO, in conjunction with Executive colleagues, may consider instigating further enforcement action which could include removal of the team or individuals and implementation of the CHFT Capability Procedure.

Where individuals or teams have responsibility for cross cutting metrics the same escalation and de-escalation principles apply.

Where performance improves and is sustained the Division will be returned on an agreed basis to less frequent monitoring. Where performance continues to deteriorate the COO will escalate to the Chief Executive for agreement on further interventions.

Notes will be taken of all meetings and action logs will be implemented to monitor delivery

The process described above is expected to be replicated in each Division with Directorates and within all corporate departments including the development and delivery of performance documentation. This will include Directorate Performance documentation and the development of ward/department dashboards.

Appendix 3 describes the role of Key committees relevant to the PMF

4.7 Weekly Performance management Meetings

On a weekly basis an agreed set of KPIs will be reviewed focused on key areas of risk; the purpose of the meetings is to identify areas of concern for month or quarter performance and allocate responsibilities for corrective actions.
The meetings do not focus on reasons for failure or sustainable changes, these remain within the Divisional Performance Meetings.
Where possible the data will be produced in a format that will allow identification of wards, departments or specialties where themes are developing to support early intervention.

Data will be produced the day before the meeting by Informatics staff who will also attend the session chaired by the COO. High level notes will be taken supplemented by an action log.

All Divisions and relevant corporate departments will send a senior representative who will be responsible for further communications and actions as identified

The KPIs currently reviewed weekly are shown in Appendix 4

4.8 Information

CHFT has a well-developed data system, this effective and comprehensive knowledge portal provides Divisions and corporate departments with the ability to interrogate data and effectively plan but does not currently signpost areas of potential concern or provide any analysis of the data to allow operational teams to focus on recovery planning.

Information, performance and operational services will work together to produce dashboards to complement the knowledge portal and Divisional Information Leads will provide analytical support to Divisions to support timely and effective decision making.

The production of performance packs at Directorate and Divisional level as well as the Integrated Performance Report will be coordinated between the Informatics team and a performance function ensuring the timely flow of information, prompt escalation and a golden tread from Ward to Board

It is recognized that some changes to the informatics function will be required to support the PMF at all levels with particular emphasis on the development of a performance function either within Informatics or Operations.

Within Divisions there will be a connection between the Divisional Information Manager and the Divisional Business and Performance Manager[1] to ensure data, analysis and reporting are aligned and operational teams appropriately supported.

5. Conclusion

In order for the Trust to be assured that its performance management processes are effective and that it can demonstrate full and comprehensive implementation of its strategic and operational plans, a standard performance management framework is essential.

To continue on the journey of delegated leadership it is essential to have in place clearly articulated roles and responsibilities at all levels and a mechanism for recognizing success and supporting the most challenges departments.

The implementation of the frameworks articulated in this paper will provide a solid foundation to future sustained improvement.

[1] Newly developed roles, final name to be determined

Roles and Responsibilities

Whilst it is everyone's job to manage performance, the Board must drive a culture of performance by providing a clear vision and Trust priorities, goals and objectives and by holding the executive to account for the delivery of strategy.

Effective performance management requires defined roles and responsibilities and clear ownership of outcome measures. A summary of these roles and responsibilities is as follows:

Chief Executive

- Overall statutory responsibility for patient safety, governance and performance management.
- Accountable to the Trust Board

The Board has delegated responsibility for Performance Management to the Chief Operating Officer and to discharge this responsibility, they work with the Executive Directors to ensure effective performance management arrangements are in place across the Trust.

Medical Director, Chief Nurse

Lead responsibility for driving professional accountability in delivering key performance indicators and engendering clinical leadership across the trust in these agendas.

Chief Operating Officer

Leads the development and implementation of the performance management arrangements and has delegated responsibility for preparing, implementing and updating the Performance Framework;

- ensuring that robust systems are in place for the performance management of national, local and internal targets;
- preparing the Integrated Performance Report highlighting to the Board areas
- of "off plan" performance;
- ensuring that plans to address "off plan" performance are developed and implemented;
- ensuring that governance arrangements to support performance management are in place, robust and effective.

Director of Finance

Lead responsibility for delivery of Financial Plan.

Director of Estates, Facilities and Planning

Lead responsibility for the annual planning cycle ensuring connectivity across all portfolios and alignment with Trust strategy

Director of Transformation, Partnership and Strategy

Lead responsibility for the improvement plan, contracting and ongoing strategy development

Director of Workforce and OD

Leads the development and implementation of the Individual Performance Review Process that aligns the contribution made by individual staff to delivering performance.

Leads on workforce strategy and planning and organisational development including training and talent management.

Director of the The Health Informatics Service.
To ensure the provision of accurate and timely analysis and interpretation of performance data for performance review and follow up purposes.

Divisional Director
The Divisional Director (DD) will be the single accountable officer responsible for providing leadership and direction to ensure the successful delivery of the Division. This will ensure the provision of effective, high quality, safe patient care which meets the needs of patients and can be met within the allocated budget.

The DD will work through the Divisional Management Team and Clinical Directors with a devolved system within their Division in which responsibility for budgets, objectives and clinical governance are clearly held at a Directorate level. They will ensure wide participation in the development and implementation of service plans and secure the greatest possible 'buy in' from colleagues for key decisions and objectives.

The DD will be responsible for the strategic direction of the Division within the parameters defined by the Executive Director team.

Clinical Director
The Clinical Director (CD) will be the single accountable officer responsible for providing leadership and direction to ensure the successful delivery of the Directorate. This will ensure the provision of effective, high quality, safe patient care which meets the needs of patients and can be met within the allocated budget.

All Staff
All staff contribute towards performance improvement and management by being encouraged and supported to identify improvement opportunities and to take the required action. It is important that staff own the data on their activity, and understand how that translates to the corporate performance of the organisation.

Appendix 2

Sample Autonomy Matrix

Each Division will have an individual set of KPIs and autonomy matrix

Scoring system for well-led directorates- linked to CQC?

	Excellent	Good	Requires Improvement	Inadequate
Workforce Mandatory Training	Have maintained a standard meeting the level 'Good' for > 3/12	Have achieved above the 85% compliance target.	Between 80%-84% compliance	Less than 80% compliance
Value for money	• Achieved a surplus on operational budgets > 3% • On target with Capital Plan • Los below benchmark • 92%+ theatre productivity • 85% or > OPD session utilisation. • 95% or > slot utilisation • 6.5 or < OPD DNA • 1% with loss then 6 weeks cancellation	• Achieved balanced operational budget • On target with capital plan • Los ≥ 1 day benchmark • 85%+ theatre productivity • 85% OPD session utilisation • 95% OPD slot utilisation. • >6.5-8.5% OPD DNA • 3% loss then 6 weeks cancellation	• Achieved 80-84% of operational budget performance • Los ≥ 2 day benchmark • 80-85% theatre productivity • 80%-82% OPD session utilisation • 85-90% OPD slot utilisation • >8.5% OPD DNA. • 10% loss then 6weeks cancellation	10% no achievement of balanced budget and CIP. • Increase in Los. • < 80% theatre productivity • <80% session utilisation • < 85% OPD slot utilisation. • > 10% OPD utilisation • >10% DNA • >12% loss then 6 weeks cancellation
Governance *Well Led*	• 0 SUI Outstanding actions for 3/12. • No dissatisfied complainants for 3/12. • Up to date Risk Register. • Top 10% F&F staff engagement score.	• 2 outstanding SUI actions for 1 month. • No dis-satisfied complainants 1 month • Risk Register upto date. • Top 20% F&F staff engagement score.	• > 2 outstanding actions for SUI. • > 3 dis-satisfied complainants for 3 months • Risk Register out of date > 1 month • Top 50% F&F staff engagement score.	• > 3 outstanding actions for SUI's. • > 3 dis-satisfied complainants for 1 month. • Risk Register out of date > 3 months. • <50% F&F staff engagement score.

Scoring system for well-led directorates

	Excellent	Good	Requires Improvement	Inadequate
Patient safety & clinical outcomes *(Safe and effective)*	0 MRSA 0 Attributable C-Diff 0 03/4 PU 0 level 4/5 falls 95% MUST 95% HPC Safety Thermometer 100% SUI discussed at Ward meeting 95% HH audit Evidence of continual QI 100% Contemporaneous Records	0 MRSA ≤ 2 Attributable C-Diff ≤ 2 03/4 PU ≤ 2 Level 4 fall 0 level 5 fall 90-95% MUST 90-95% HPC Safety Thermometer 90% -100% SUI discussed at ward meeting 90% HH audit Evidence of current QI 100% Contemporaneous records	1 MRSA ≥ 2 Attributable C-Diff ≥ 2 03/4 PU ≥ 2 level 4 falls ≥ 0 level 5 falls ≤ 95% MUST ≤ 95% HPC Safety Thermometer 80-90% SUI discussed at ward meeting 80-90% HH audit Little evidence of QI Gaps in record keeping	>1 >5 >03/4 PU >5 Grade 2 Falls >5 Grade 3 Falls <80% MUST <80% HPC Safety Thermometer <80% SUI discussed <5% HH and little evidence of QI gaps in record keeping
Patient experience *(Caring and Responsive)*	Top 10% F&F 95% complaints response time RTT achieved for all specialties Cancer standards achieved for all specialties 6 week diagnostic achieved all specialties. All A&E relevant targets achieved.	Top 20% F&F 90% complaints response time RTT aggregate achieved. Cancer standards aggregate achieved. 6 week diagnostics aggregate achieved. A&E relevant targets achieved.	Top 50% F&F 80-90% complaints response time 5% below RTT achieved 5% below target cancer standards 5% below 6 week diagnosis. 5% below A&E targets.	<80% F&F <80% complaints response time > 5% below target RTT ➢ 5% below Cancer ➢ 5% below 6 weeks ➢ 5% below A&E targets
Workforce Sickness	Have maintained a standard of 'Good' for at least 2/12	4% or below	Above 4.5%	Above 5%

Role of Key committees relevant to the Performance Framework

Name	Role regarding Performance	Frequency
Trust Board	Chaired by Trust Chair; overall responsibility for setting Trust Strategy and assures risks to delivery of strategy are mitigated.	Monthly
Quality Committee (Board Sub-committee)	Chaired by non-executive director; Delegated responsibility from Trust Board for oversight of quality (clinical effectiveness, safety and patient experience) performance by assuring risks to quality are mitigated	Monthly
Finance and Performance Committee (Board Sub- committee)	Chaired by non-executive director; Delegated responsibility from Trust Board for oversight of financial performance, operational performance and planning.	Monthly
Workforce Committee	Chaired by a non-executive director, scrutinizes in detail the performance metrics of the well led element of performance within the IPR	Bi-Monthly
Weekly Executive Board (WEB)	Chaired by CEO; WEB is the Executive & Clinical management committee for the Trust and receives the Integrated Performance Report prior to Trust Board and Quality Committee. Key issues are discussed and agreed for communication/action	Monthly review of performance
Divisional Performance Reviews (DPR)	Division and agreed Corporate departments; chaired by the COO[2] and attended by all Directors. DPRs are the single performance meeting for the Division bringing all elements of performance across the Executive portfolio. They are formal meetings where Divisional Teams are held to account by the Executive. To be assured that action planning in response to adverse performance is adequate in content and responsiveness; monitoring performance and actions to improve performance, supporting Divisions with complex issues raised and confirmation on issues for escalation. The output of DPRs feed into the Trust Board Integrated Performance Report; approving target setting and detailed parameters for escalation.	Two-Monthly but may vary depending on level of risk

[2] For Operational Divisions, DCEO for corporate departments

Directorate Performance Reviews	Replicating the responsibilities in the Divisional Performance Reviews but held between the Division and Directorates	Monthly
Patient Safety & Quality Boards (PSQB)	Chaired by the Deputy Divisional Director[3] Responsible for the detailed review of governance within Divisions, ensuring compliance with standards, adherence to national directives, monitoring effectiveness of Directorate Governance arrangements and ensuring learning within and across Divisions	Monthly
Operational Performance Meeting	Chaired by COO a review and forward look at in month performance identifying risks and agreeing responsibilities for corrective action. Identifies any immediate requirement for escalation	Weekly

[3] Proposed new Clinical Leadership post to enhance governance

Appendix 4

Weekly Performance Indicators

- Emergency Care Standard
- Over 8 and over 10hr trolley waits
- Ambulance handovers 15, 30 and 60min
- Breach reasons
- All cancer standards including D7 and D38 by tumour site
- RTT Admitted, Non Admitted & Incompletes
- Total Over 26 & 40 week Incompletes
- Planned Waiting List
- Follow Up Wait Times & Partial Booking
- Incomplete Outcomes
- C Diff & MRSA
- Delayed Transfer of Care & long LOS patients
- Cancellation operations – reportable and non-reportable
- Diagnostics by modality
- VTE Risk Assessment Compliance
- FFT Response Rate & recommendation % - AED, inpatient, Outpatients & Maternity
- Appointment Slot Issues
- Clinical Cancellation & Patients Rescheduled
- E discharge
- Complaints, numbers and due date tracking
- Number of Open Incidents under Investigation
- Number of Open Incidents
- Mortality review % compliance
- CQUINs - all
- Ward Dashboards
- CRAS -Dashboard

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Carole Hallam, Assistant Director of Infection Prevention Control
Date: Thursday, 26th November 2015	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Monthly DIPC Report - Monthly DIPC report provides an overview on the postition of healthcare associated infections in the trust	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: WEB	
Governance Requirements: Improving patient experience - reducing healthcare associated infection	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

For information

Background/Overview:

As per summary

The Issue:

As per summary

Next Steps:

Actions to be delivered by the HCAI Operations Group

Recommendations:

For the Board to note the content

Appendix

Attachment:

Monthly DIPC Report November 2015.pdf

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

Performance targets

Indicator	Month agreed target	Current month (October)	YTD agreed target	YTD performance	Actions/Comments
MRSA bacteraemia (trust assigned)	0	**0**	0	**3**	
C.difficile (trust assigned)	3	**4**	21	**14**	4 avoidable 10 unavoidable
MSSA bacteraemia (post admission)	1	**1**	12	**6**	
E.coli bacteraemia (post admission)	3	**5**	29	**20**	
MRSA screening (electives)	95%	**96%**	95%	**95.23%**	September validated data
Central line associated blood stream infections (Rate per 1000 cvc days)	1*	**0.69**	1	**0.67**	* Target change agreed by Infection Control Performance Board
ANTT Competency assessments (doctors)	95%	**Not reported this month due to data cleanse**	95%	**Not reported this month due to data cleanse**	Work is on-going to validate the data
ANTT Competency assessments (nursing and AHP)	95%		95%		
Hand hygiene	95%	**99.35%**	95%	**99.64%**	

Quality Indicators

Indicator	Current month (October)	YTD performance	Comments
MRSA screening (emergency)	**91.52%**	**90.80%**	September validated data
Isolation breaches	**39**		
Cleanliness	**97.09**	**97.3**	

HCAIs/Areas of Concern/Outbreaks

- **Isolation breaches** recorded by the Infection Control Team during October were 39, compared to 27 in September.
    - 10 at HRI
    - 29 at CRH
- **Analysis of the isolation breaches** - The IPCN's identify the isolation breaches and follow up daily until the patient is isolated and also assist the ward staff by risk assessing the available side rooms and ensuring control measures are in place
    - Of the 29 breaches at CRH, 16 were patients with previous MRSA, 12 were other MDRO and 1 patient with diarrhoea. On 19 occasions the staff had not acknowledged the infection alert and were prompted by the IPCT to isolate the patient. On 14 occasions there was no side room available and

on 8 occasions the patient was risk assessed against other patients in the side rooms and deemed the lower risk. Isolation breaches ranged from 1 to 5 days.

- Of the 10 breaches at HRI, 7 were patients with previous history of MRSA, 2 were other MDRO and 1 patient had a rash ?chickenpox. On 5 occasions the staff had not acknowledged the infection alert and were prompted by the IPCT to isolate the patient. On 6 occasions there was no side room available and on 4 occasions the patients were risk assessed against other patients in the side rooms and deemed the lower risk. Isolation breaches range from 1 to 4 days.
- The IPCT will continue to monitor isolation breaches and actions to reduce breaches to be included in the HCAI annual action plan

- **Central line Infections –** there were two line infections identified on October. One case was in a neonate and currently being investigated. The second case was an oncology patient with a long term line. Investigation of this case has highlighted some concerns with the patient's care of the line at home. A training package for patients is being developed.

- **E. coli** - Unusually high number of bacteraemias this month with no obvious cause, these cases are not related**.** There is currently no capacity to fully RCA all post 48 hour E. coli bacteraemias. A task and finish group to be set up to examine how we can collect more meaningful data about these cases to identify actions. There is excellent work going on around intermittent catheterisation that with expansion should impact on the device related infection rate.

- **ANTT -** Data quality is to be validated and the data removed from the dashboard and will feed into the weekly meeting with Helen Barker. There are a number of training sessions for frontline key trainers. There is an expectation currently that nurses will do the Doctors' training but medical staff are to be encouraged to become key trainers. There is an expectation of at least one ANTT Assessor on each ward and the Divisions are requested to support this.

- **MRSA acquisition** – there were **6 cases** of hospital acquired MRSA identified in October; 2 in FSS and 4 in the medical division. There have been 16 cases in total since April

- **C.difficile** – there were **4** cases in September and are summarised in the below:-

Table 2

Case details	Summary of C.difficile case	Key issues identified from RCA
04.10.15 **H6** Datix 123894	Patient admitted generally unwell, had one episode of vomiting and 3-4 episodes of diarrhoea prior to admission.	• The RCA meeting concluded this was an unavoidable case • Documenting normal bowel action on admission • Prompt collection of stool specimens • All staff to be made aware of DoH guidelines of stool type 5-7
10.10.15 **8C CRH** Datix 124137	Patient admitted on the 4th October with a history of dizziness, and a 2 week history of nausea and loss of apetite. ?postural hypotension	• The RCA meeting concluded this was an unavoidable case • Ward Sr to ensure hand hygiene and FLO audits are complete • When permanent staff based established ensure all staff are compliant with mandatory training.
20.10.15 **5C CRH** Datix 124414	This 101 year old lady was admitted with a history of right anterior and lower rib pain on the 12th October, initial diagnosis	• The RCA meeting concluded this was an avoidable case • Delay in isolating patient • Poor levels of documentation in both

	suggestive of lung pathology either primary or secondary.	nursing and medical notes regarding stool specimen collection • Delay in collecting stool specimen
26.10.15 **H20** Datix 124655	Patient admitted on the 23rd October with a dislocated and left THR, has a history of CCF. 25th October patient began expectorating green sputum, commenced on Clarithromycin, began with loose stool on the 26th.	• The RCA meeting concluded this was an unavoidable case • Share RCA with ward team at the next meeting • Discuss at patient safety quality board.

Quality Improvement Audits

Four Quality Improvement Audits were performed in October

- Eye clinic, ENT and Audiology CRH – awaiting report
- Ward 17 HRI – Green 92%
  - Damage to doors and floors.
  - Ceiling tiles stained and wall protection required.
  - All vents required cleaning, some grit to floor edges.
- Ward 5AD CRH – Green 93%
  - Some environmental repairs required
  - Some low level dust
  - Some gaps in recording of fridge temperature
- Ward 15 HRI – Amber 84%
  - Overall the ward is looking tired and in need of refurbishment
  - Some Alcohol gel dispensers empty
  - Single use medicine pots are being reused
  - Cleaning throughout was sub standard

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Vicky Thersby, Safe Guarding Lead
Date: Thursday, 26th November 2015	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: SAFEGUARDING REPORT - ADULTS AND CHILDREN - The Board is asked to receive and note the Safeguarding update - November 2015	
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 purpose of this report is to provide a brief update to the Board of Directors about safeguarding activity within the Foundation Trust, and to provide accurate and current information about the effectiveness of internal systems and processes to demonstrate the status of the Foundation Trust's compliance with statutory safeguarding requirements.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

It is recommended that the Board note and accept this information. Can the Board please ask the Divisions to continue to encourage attendance at safeguarding meetings and completing mandatory training by performance managing colleagues to attend

Appendix

Attachment:

Safeguarding Update November 2015 (2).pdf

Report To:	**Calderdale and Huddersfield NHS Foundation Trust Board of Directors**

Title of Report:	**Safeguarding Children and Adults Update** **16th November 2015**

FOI Exemption Category:	**Private**

Responsible Director:	**Julie Dawes**

Report Author and Job Title:	**Victoria Thersby Head of Safeguarding**

Executive Summary:	The purpose of this report is to provide a brief update to the Board of Directors about safeguarding activity within the Foundation Trust, and to provide accurate and current information about the effectiveness of internal systems and processes to demonstrate the status of the Foundation Trust's compliance with statutory safeguarding requirements.
Risk Assessment:	CHFT is contributing to a high number of serious case reviews and domestic homicide reviews which may impact on capacity within the safeguarding team if further cases occur; the team are currently reduced in numbers. Training and supervision compliance remains a concern.
Health Benefits:	There is currently no Named Doctor in place and therefore not compliant with our statutory duty to provide a Named Doctor (Working Together to Safeguard Children 2015).
Recommendation (s):	It is recommended that the Board note and accept this information. Can the Board please ask the Divisions to continue to encourage attendance at safeguarding meetings and completing mandatory training by performance managing colleagues to attend

Calderdale and Huddersfield NHS Foundation Trust

Safeguarding Update:

November 2015

1. Purpose

This report provides Calderdale and Huddersfield NHS Foundation Trust (CHFT) Board of Directors with a quarterly update about safeguarding activity within the Foundation Trust, and accurate and current information about the effectiveness of our internal systems and processes, in order to demonstrate the status of compliance with our statutory safeguarding requirements.

The report highlights on-going work and developments across the Foundation Trust and outlines CHFT's engagement with the Local Safeguarding Boards and Commissioning Groups both in Calderdale and Kirklees.

Safeguarding Children is a statutory requirement under the Children Act 1989/2004, which imposes a legal duty on all professionals to safeguard and protect children. 'Working Together 2015' further emphasises the collective interagency arrangements of how agencies including NHS organisations must work together, and how this is implemented locally. The Intercolliage document further places responsibilities on organisations to ensure roles, responsibilities and competencies for key professionals who safeguard children are adhered to.

It is essential that the Board understand its role and responsibilities to ensure that it fulfils its obligations under these statutory responsibilities and receive assurance that safeguarding standards are maintained and continue to improve.

- Demonstrates an awareness and understanding of child maltreatment
- Demonstrates an understanding of appropriate referral mechanisms and information sharing
- Demonstrates clear lines of accountability and governance within and across organisations for the commissioning and provision of services designed to safeguard and promote the welfare of children
- Demonstrates an awareness and understanding of effective board level leadership for the organisations safeguarding arrangements
- Demonstrates an awareness and understanding of arrangements to share relevant information
- Demonstrates an awareness and understanding of effective arrangements in place for the recruitment and appointment of staff, as well as safe whistle blowing
- Demonstrates an awareness and understanding of the need for appropriate safeguarding supervision and support for staff including undertaking safeguarding training
- Demonstrates collaborative working with lead and nominated professionals across agencies

The introduction of the Care Act 2014 in April 2015 has now placed Adult Safeguarding on a statutory footing and imposes a legal duty on NHS organisations. This legislation replaces the 'No Secrets' guidance (2000). It not only addresses and recognises stopping abuse or neglect, preventing harm and reducing risk, but promotes an approach that improves the life for the adult concerned. The principles and values of adult safeguarding are built on empowerment, protection, prevention, partnerships, proportionality and accountability.

2. Introduction

Safeguarding Adults and Children must be an integral aspect of patient care, and requires services to work effectively together, and across boundaries to prevent harm and intervene when harm, neglect, or abuse is suspected. This update provides further plans and continued development for the forthcoming quarter.

It is vital that Safeguarding standards are maintained and continue to improve, and accountability remains clear.

Work continues across the Trust, both at an operational and strategic level to ensure that safeguarding Adults and Children is 'everybody's business' as opposed to it being seen as a separate entity that is the responsibility of a few specialist practitioners. It is essential that a safeguarding culture continues to be embedded across all departments and staff who work for CHFT, and that this key message is adopted across divisions.

CHFT is a partner organisation and works towards both the North and West Yorkshire Safeguarding Adults Policies and procedures and the Children's West Yorkshire Safeguarding Policy and Procedures. Both CHFT policies reflect these District wide policy and procedures to ensure all West Yorkshire partners are working together and are aligned in their working practices.

3. Progress to date

3.1 Safeguard children and adults at risk through further development of the partnership

CHFT is a Board member on the Adult's and Children's Safeguarding Board's for both Calderdale and Kirklees. The Foundation Trust ensures its commitment to District wide local safeguarding arrangements by actively engaging with their associated Boards and their subgroups across both Kirklees and Calderdale.

Reporting mechanisms continue to be in place for feedback from all Board meetings about safeguarding practice and developments via the Trust's Safeguarding Committee.

The Foundation Trust's Safeguarding Committee provides a forum to bring together key senior safeguarding professionals and other senior managers across CHFT to ensure the organisation's safeguarding responsibilities' are being discharged and disseminated effectively. It monitors CHFT's safeguarding activities and provides assurances, identifies gaps and provides regular updates to both commissioners and to the Safeguarding Boards with regard to our statutory safeguarding functions.

After a review of the Safeguarding Committee structure and Trust wide attendance at its committee and operational groups, this structure has been re-aligned and terms reference and membership are being revised to look at improving attendance and commitment and engagement with divisions. The Safeguarding Committee will now report directly to the Quality Committee with the Director of Nursing taking over as chair of this meeting. The committee will oversee and ensure the arrangements for safeguarding continue to develop throughout the organisation by commissioning task and finish groups to ensure children, midwifery and adult's safeguarding agendas continue to develop.

Key Challenges

- *Key challenges continue in relation to the growing agenda and the need to ensure the best and effective use of resources. Re-structure of the committee will address poor engagement and attendance at meetings.*

Ongoing work

- *On-going work will continue to ensure existing partnerships and collaborative working is maintained in order to improve quality outcomes for vulnerable groups, whilst ensuring these agendas and work streams continue to be developed through effective task and finish groups.*

3.2.1 To ensure effective communication and engagement with staff and the public in respect of the work of the Foundation Trust and the wider safeguarding agenda

There is currently no Named Doctor in place for safeguarding children and therefore CHFT is not compliant with its statutory duty to provide a Named Doctor (Working Together to Safeguard Children 2015). However CHFT has in place both Named Nurses and Designated Doctors who provide this support whilst a named Doctor is appointed, which enables this risk to be mitigated. Interviews are in December for this post, and Named Nurses and Designated Doctors will continue to support until the Named Doctor is in post.

Work continues to embed a safeguarding culture across all divisions and departments by ensuring that CHFT follows the principles into practice ethos of ensuring safe patient care and that the four behaviours of all employees are followed. The Safeguarding Team are currently reviewing their action plans and aligning them with Trust objectives and strategies to develop a Trust Safeguarding Strategy.

Work is ongoing to strengthen internal lines of accountability and internal structures within the Trust to ensure the organisation has a clear process in place for communicating with staff. The safeguarding team are working closely with the Risk department to strengthen these links and work is planned to link with the governance arrangements within each division.

Key Challenges

- *Key challenges continue in relation to the growing agenda in relation to children's and adults safeguarding and the need to ensure the best and effective use of resources.*

Ongoing work

- *On-going work will continue to ensure it continued engagement with partners and national and local legislation and guidance is implemented.*
- *Work continues to ensure different ways of working are explored in order to achieve an effective and efficient delivery of safe and quality services that meets patients' needs*

- *The development of a CHFT safeguarding strategy and divisional action plan that is aligned to the Trusts Nursing strategy and plan.*

3.2.2 To quality assure the work to the Board and partner agencies in safeguarding and promoting the welfare of adults at risk and children and challenge any areas of practice needing improvement

Children's Safeguarding have led:

Child protection information Sharing System (CP-IS)

This is a NHS England sponsored work programme dedicated to developing an information sharing solution that will deliver higher level of protection to children who visit NHS unscheduled care settings nationally. This system will share information about the children who are subject to child protection plan, looked after and pregnant women with a pre-birth protection plan. This went live in April 2015. CHFT is only one of very few NHS organisations that are live, and until this system is implemented throughout nationally in NHS organisations (2018) this will be limited in its effective's, however it has highlighted plans where other organisations are already signed up to this.

CHFT has a paediatric nurse liaison role in place that is effective to information sharing within the organisations to safeguard children. As part of this role information is collated and shared with other operation partner agencies and the Children's Safeguarding Board for Calderdale and Kirklees to provide assurance District wide.

Early Intervention

Where staff have concerns about a child at risk of immediate harm, these referrals are appropriately being referred to children's social care. Child protection concerns are referred into children's social care where 'early help' provides support as soon as the problem emerges. Early help is the starting point for the family to receive services in a multi-agency co-ordinated action. An audit has identified a knowledge gap in referring children into supportive pre-social care intervention.

The team have plans in place to address this and improve knowledge within their level 3 training; intranet based information and bespoke training beginning in December 2015.

Safeguarding Midwife has led:

Female Genital Mutilation

Female genital mutilation (FGM) or ''cutting'' refers to procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. The procedure is traditionally carried out by a woman with no medical training. In the United Kingdom all forms of FGM are illegal under the Female Genital Mutilation Act 2003 and the Prohibition of FGM (Scotland) Act 2005. FGM is child abuse.

From September 2014 the Department of Health have charged Acute Trusts with providing information on the prevalence of FGM on a monthly basis. CHFT have a mechanism in place to ensure reporting. A task and finish group is underway to develop a policy and pathway to support victims, children at risk of FGM, and

educate staff of how to refer concerns. This is near completion for dissemination with a training plan in December and additional information for wards and department areas. In addition there is a new professional duty to report cases of FGM in girls' under18 to the police which commenced on the 31 October 2015. This will be part of the pathway for to support staff reporting.

Adult Safeguarding have led:

Mental Capacity (2005) and Deprivation of Liberty Safeguards (2009)

A significant amount of time is devoted to supporting the application of the MCA principles into practice across all adult care areas which also includes making appropriate DoLS applications and ensuring associated administration matters are dealt with in a timely way. The aim is to involve senior ward nursing staff more directly in the DoLS application process, particularly on the complex care wards at CRH and HRI where significant numbers of patients are likely to meet the DoLS criteria at any one time.

There is a robust team action plan in place to continue to raise awareness of MCA and DoLS. The MCA DoLS secondment post is now in place until March 2016. This action plan should deliver the priorities of raising awareness and ward based training to key targeted areas, which will ultimately keep patients safe and protected.

Complex cases

Adult Safeguarding staff have been involved in several complex safeguarding cases over the last quarter in terms of supporting clinical colleagues and managers through the formal safeguarding process and in situations where care provision and planning, particularly relating to the assessment of capacity, has been challenged by colleagues from one of our local Social Services departments. On-going issues remain and are to be taken up by senior CHFT nursing management with senior Social Services management given the serious implications for greater integration and cross-agency team-working if these issues are not addressed.

Datix Incident Reporting

Work has been carried out to ensure that safeguarding concerns are captured on Datix, and data is correctly produced and analysed. Further work is planned with Tissue viability nurse to ensure pressure ulcers are correctly reported through safeguarding procedures where there is a concern of abuse or neglect

There is ongoing work to capture safeguarding data on a pivot chart to improve data collection, which will in turn lead to better analysis of any themes and trends.

Ongoing Work

- *The safeguarding team is currently updating its policies and procedures to reflect both national legislative and local policy changes in both children and adult safeguarding. There are ongoing plans to develop a separate MCA and DoLS policy and procedures.*

Key Challenge

- *Remains to continue to ensure that Divisions are represented at each strategic and operational meeting in a climate of competing priorities.*

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3.4.1 To raise the profile of the safeguarding agenda to ensure effective training is delivered.

The trajectory set for safeguarding training was agreed at the beginning of the year, in that 90% staff (in the relevant target groups) should have undertaken the relevant safeguarding training by the end of quarter 4 (March 2015) in order to demonstrate compliance with this important agenda. Whilst the safeguarding team have a comprehensive programme of training that is delivered on a monthly basis, often many of the sessions are not well attended. Divisions are asked to support safeguarding training and ensure their teams are compliant with safeguarding training.

The last quarter continues to see a decrease in compliance for level 2 and level 3 safeguarding training. Training sessions have been consistently offered but poor attendance at sessions is clearly reflected. Level 3 attendance remains better attended.

- Level 1 safeguarding has been historically recorded as being 100% compliant through the delivery of written updates, briefings, and the safeguarding newsletter twice yearly to the workforce. Since July 2015 safeguarding level 1 is now part of the core skill eLearning on ESR. This is currently at 68.3%, which is increasing in compliance since September when this was 20%.

- Level 2 safeguarding training (Adults and Children) has seen a slight decrease of 3.5% from 51.9 to 48.4 %. Training continues to be constantly reviewed and updated in order to maximise learning and meet the needs of the diverse workforce and overall evaluates well. This is delivered face to face. This will be offered as an eLearning package from January 2016 which will be easier for staff to access and increase training compliance.

- Level 3 safeguarding children training has decreased in the last quarter from 73.4% to 60.1% a decrease of 13.3%

- Level 3 safeguarding adults training is currently being reviewed.

- **Master classes** have been developed throughout 2015 in relation to the MCA and DoLS.

- **PREVENT** - Implementation of the PREVENT Strategy is underway across the organisation, with significant progress being made. The Trust has 7 accredited trainers and a clear training programme. Extra training sessions have been delivered and compliance is now at 37.5 %. NHS England and commissioners are happy with our Implementation of this strategy and training continues to evaluate well. All staff are identified on ESR who require this one off training. This compliance continues to increase.

- **Safeguarding Supervision** whilst safeguarding supervision is offered to staff there has been poor uptake on this. There are plans to address this through the Workforce Department to identify members of staff through ESR to ensure divisional managers are aware of members of staff who do not engage in regular mandatory supervision and that this is followed up. Community staff are better at attending supervision compared to acute sector staff.

Key Challenges

- *Ensuring that training compliance increases consistently*

Ongoing Work

- *The safeguarding team is currently working with workforce development in relation to how target groups are defined and how training is recorded since a number of anomalies have been identified. An achievement plan is being developed to address this which will involve the further identification of divisional non-compliance and individual staff identification.*

Other work has included;

- *Publication of the 7th edition the safeguarding newsletter in June 2015 provided further updates and information for staff, and a further edition is now due to be re-distributed.*

4. Monitoring and Assurance

Section 11 of the Children Act 2004

Places a statutory duty on organisations, and individuals, to ensure their functions are discharged with regard to the need to safeguard and promote the welfare of children. The Trust has a clear systems and processes in place to monitor safeguarding activity and provides regular updates to partners in Clinical Commissioning Groups, as well as the Local Safeguarding Boards.

Feedback from the section 11 events will be shared in the next Board report.

MCA and DoLS Audit June 2015 and October 2015

An audit carried out in June 2015 Foundation Trust wide has identified knowledge gaps on wards in relation to the assessments of patients capacity in relation to decision specific criterion; the lack of the identification of patients who are deprived of their liberty but without a legal safeguard on the wards, and a lack of comprehensive policy relating to the MCA and DoLS. A further audit in October 2015 is yet to be analysed.

The MCA secondment has now been extended until March 2016.

Supervision

Both **individual and group supervision** has been developed further and uptake is closely monitored. Target groups have been established identifying the type and

frequency of supervision. Progress continues to be made regarding the uptake for safeguarding supervision over the past quarter. A joint health and social care supervision meeting has been commenced to encourage joint working and shared learning.

Serious Case Reviews/Domestic Homicide Reviews

CHFT continues to work with the Local safeguarding boards and the Safer Stronger Partnerships to ensure lessons are learned following serious case reviews/domestic homicide reviews. CHFT is required to work with partners to identify learning from these cases in order to improve practice and services for the communities that we serve. The team is currently looking at how learning from serious case reviews, domestic homicide reviews and adult's reviews to ensure learning is disseminated Trust wide, and embedded into policy and practice.

The workload remains high with a significant number of reviews currently underway across Kirklees and Calderdale;

- Kirklees Safeguarding Children's Board – x2 Serious Case Reviews pending
- Kirklees Safeguarding Adults Board – x1 pending Safeguarding Adult Review/ x1 ongoing Domestic Homicide Review
- Calderdale Safeguarding Children's Board – x3 Serious Case Review's ongoing / x1 ongoing and x1 pending Domestic Homicide Review

4. Conclusion

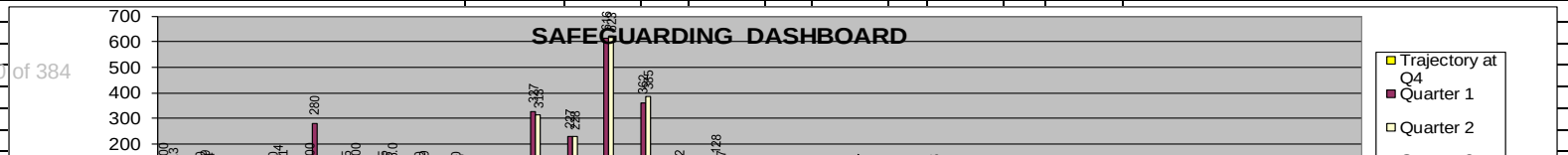
The key priorities and main focus for the safeguarding team over the next quarter continue to be training, supervision, SCR's/DHR's, and MCA and DoLS, FGM.

The Foundation Trust Safeguarding Team is committed to ensure that a Safeguarding culture is embedded into everyday practice for all staff who work for CHFT. Safeguarding is everyone's responsibility and should be part of everyone's practice, whatever their role. The safeguarding team is available Monday to Friday 9am – 5pm (but is not an emergency service). The roles are statutory, advisory and supportive, and it is important that the workforce take responsibility for safeguarding within their own area of work and know what to do if they are concerned that someone is at risk of harm. The safeguarding team continue to support staff who work with children, adults and families to ensure their needs are listened to and met.

The Foundation Trust has developed a committed team which over the coming months will endeavour to support Divisions in developing their practice and devolving their safeguarding responsibilities. The Foundation Trust aspires to achieve a safeguarding culture that safeguards and protects all of its patients and their families, by the principles laid down in primary legislation and local policy.

Victoria Thersby
Head of Safeguarding
16th November 2015

SAFEGUARDING ASSURANCES/DASHBOARD 2015/2016											
	Trajectory at	Quarter 1		Quarter 2		Quarter 3		Quarter 4		per year	Comments
JOB DESCRIPTION	ALL JD's	Included		Included		Included		Included			
TRAINING - LEVEL 1 %	100			68.3							100
TRAINING - LEVEL 2 (%) Joint Children and Adults	90	51.9		48.4							
Training - Level 3 (%) Adults		x		x							
TRAINING - LEVEL 3 (%) Children	90	73.4		60.1							
Numbers - Prevent Trained	100	280		37.5							100 per month . % recorded from Q2/ 7000 staff to train
% LAC IHA WITHIN TIMESCALES	95	60		100							Late notification to the LAC health team from CSC
% LAC RHA WITHIN TIMESCALES	95	85		86.0							The second column is the actual figure submitted after the deadline. Still awaiting completed RHA's from OOA health providers
% SUPERVISION for HV's and ScN	90	89									90% by Q4 Individual supervision where CP plan in place
% SUPERVISION for Specialist Midwives	90	75		75							90% by Q4 Individual supervision where ICP in place/Cause for Concern
% Supervision for others Children Services	50	40		10							50% by Q4 All supervision for all staff groups (individual and group)
Number of children currently Looked after (Calderdale)		327		313							
Number of children subject to CP Plan (Calderdale)		227		228							
Number of children currently Looked after (Kirklees)		616		623							
Number of children subject to CP Plan (Kirklees)		362		385							
NUMBER OF LAC HA		92		71							The second column is the actual figure submitted after the deadline.
Numbers - Supervision for Adult Services		128		97							All supervision for all staff groups (individual and group)
Referrals to FRT Acute Kirklees (Children)		17		16							
Referrals to FRT Acute Calderdale (Children)		13		12							
Referrals to FRT Calderdale Community (HV/SCN)		9		4							
Adult Concerns reported Acute -Calderdale Category 1		77		58							
Referals to Gateway Acute - Calderdale Category 2		17		30							
Adult Concerns reported Acute - Kirklees 1		75		54							
Referral to Gateway Acute - Kirklees 2		16		20							
Adult Concerns reported (communiuty)- Calderdale 1		58		20							
Referral to Gateway Community Calderdale 2		19		14							
Concerns raised against CHFT (in above numbers)				22							
Allegations against CHFT founded (in above numbers)				On-going							
Number of CP Medicals - Calderdale		39		42							
Number of CP Medicals - Kirklees		8		14							
Number of Dols Kirklees Authorised From quarter 2		5		17							
Number of Dols Kirklees- standard authorisation declined		3		0							
Number of Dols Calderdale authorised from quarter 2		11		22							
Number of Dols Calderdale -standard authorisation declined		3		1							
number of patients died under DoLS				3							
Number of children Kirklees attending A/E - Alcohol		6		6							
Number of children Calderdale attending A/E - Alcohol		8		6							
Number of children Kirklees attending A/E - Substances		7		5							
Number of children Calderdale attending A/E - Substances		6		11							
Number of children Kirklees attending A/E - self harm		10		29							
Number of children Calderdale attending A/E - self harm		13		26							
Number of Cause for Concern Forms in relation to - DV- Calderdale HV		7		0							The figures for q1 relate to the total number of forms for Calderdale and Kirklees in relation to DV. These will be split from q2
Number of Cause for Concern Forms in relation to - DV- Calderdale SCN				3							
Number of Cause for Concern Forms in relation to - DV- Kirklees HV		4		2							The figures from q1 relate to the total number of forms for Calderdale and Kirklees in relation to DV. These will be split from q2
Number of Cause for Concern Forms in relation to - DV- Kirklees SCN				6							
Number of FGM in Kirklees		1		2							
Number of FGM in Calderdale		0		0							
Number of LADO referrals Calderdale				0							
Number of LADO referrals Kirklees				3							
Number of DASM referrals Calderdale				1							
Number of DASM referrals Kirklees				2							
updated 29/9/15											



Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Vicki Drummond, Workforce Assurance Manager
Date: Thursday, 26th November 2015	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: Nursing Workforce Model Review Panel Recommendations - This paper follows on from the detailed Safe Staffing report provided to Board in September 2015. The paper will provide 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.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Nursing Workforce Strategy Group.	
Governance Requirements: NA	
Sustainability Implications: None	

Executive Summary

Summary:

This paper follows on from the detailed Safe Staffing Report received by the Board of Directors in September 2015.

The paper provides an overview of the Nursing Workforce Model Review Panels held in October and November 2015.

The Review Panel and process described within the paper will provide the Board with assurance that nursing workforce models have been reviewed, scrutinised and challenged.

Resulting recommended changes to nursing workforce models are presented for the Board to approve and note.

Main Body

Purpose:

Provide the Board with assurance that Nursing Workforce Models have been reviewed, scrutinised and challenged and recommendations for changes identified.

Background/Overview:

See report

The Issue:

See report

Next Steps:

This is one of a series of reports to provide monitoring and outline the completed reviews of nursing workforce models required to provide safe staffing.

Recommendations:

The Board is asked to approve the recommended changes to the nursing workforce models and the resulting investment and disinvestment for the nursing workforce.

Appendix

Attachment:

COMBINED HARD TRUTHS REPORT - NOVEMBER 2015.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

MEETING TITLE AND TYPE: Board of Directors	**REPORTING AUTHOR:** Julie Dawes Vicki Drummond
DATE OF MEETING: 26 November 2015	**SPONSORING DIRECTOR:** **Julie Dawes**
STRATEGIC DIRECTION – AREA: • Keeping the base safe • Transforming and improving patient care • A workforce for the future • Financial Sustainability	**ACTIONS REQUESTED:** • For comment • To approve • To note
PREVIOUS FORUMS: Nursing Workforce Strategy Group	

EXECUTIVE SUMMARY:
(inc. Purpose/Background/Overview/Issue/Next Steps)

This paper follows on from the detailed Safe Staffing Report received by the Board of Directors in September 2015.

The paper provides an overview of the Nursing Workforce Model Review Panels held in October and November 2015.

The Review Panel and process described within the paper will provide the Board with assurance that nursing workforce models have been reviewed, scrutinised and challenged.

Resulting recommended changes to nursing workforce models are presented for the Board to approve and note.

RECOMMENDATION:

The Board is asked to approve the recommended changes to the nursing workforce models and the resulting investment and disinvestment for the nursing workforce.

APPENDIX ATTACHED: YES

compassionate care

CONTENTS

1.0 INTRODUCTION

1.1 This paper follows on from the detailed Safe Staffing report provided to Board in September 2015.

The paper will provide 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.

2.0 NURSING WORKFORCE MODEL REVIEW PANEL

2.1 In October 2015 all nursing and midwifery workforce models were reviewed within a new format which consisted of each Associate Director of Nursing:

- Presenting their current workforce models
- Completing a documented review which included the rationale for any changes or no changes
- Identifying the risk if recommended changes were not supported
- Identifying the expected benefits if recommended changes were supported
- Providing a divisional summary of investment and disinvestment recommended for their nursing and midwifery workforce.

2.2 The review panel consisted of:

- Director of Nursing and Operations
- Deputy Director of Nursing – Modernisation
- Lead Nurse for workforce at Portsmouth Hospital
- Workforce Assurance Manager
- Assistant Director of Workforce and Organisational Development
- Finance Manager

The panel were tasked with reviewing the information provided (see 2.1) and providing scrutiny and challenge.

The panel benefited from an external expert on nursing workforce models, particularly as this colleague was able to provide benchmarking data within the panel setting.

2.3 Following the initial review panels held in October 2015 a summary of key areas of challenge from the panel was issued to each Associate Director of Nursing and a final review panel was then held on 6th November 2015.

3.0 OPERATING DEPARTMENT NURSING WORKFORCE MODEL REVIEW AND RECOMMENDATIONS

3.1 The operating department review has been complex due to the number of areas in scope, and the challenging exercise to accurately capture and align the current workforce models and budgeted workforce models. As the operating department workforce models have not been presented to Board in detail within the earlier paper more detailed information for each area has been provided.

This has been complicated due to the current absorption of 7 lists historically completed in theatre six into alternative areas within the review scope, and limited previous workforce model data available for this area.

The areas in scope for the Operating Department review are:

- Admissions Unit HRI
- Day Surgery HRI
- Day Procedure Unit and Admissions CRH
- HRI Theatres
- CRH Theatres
- Surgical Procedures Unit
- Pre Assessment

The complete review paper was presented in full to the Nursing Workforce Strategy Group in September 2015.

3.2 <u>Admissions Unit</u>

The current funded establishment does not allow for the workforce currently providing service in the Admissions Unit which is provided by transferring staff between Operating Department areas. There is also a significant pressure when annual leave or sickness occurs due to no absence assumption currently been included in the workforce model.

Investment is recommended to increased the workforce model and introduce 20% uplift and 20% supervisory status.

Current Model Admissions Unit			
Funded Establishment	Headroom	Supervisory Status	Skill Mix
1.19 wte Qualified / 0.77 wte Unqualified	0%	0%	72:28
Recommended Model			
Funded Establishment	Headroom	Supervisory Status	Skill Mix
2.60 wte Qualified/ 1.60 wte Unqualified	20%	20%	62:38

3.3 Day Surgery HRI

This area has a combined budget and workforce model which works across both the theatre areas and the ward area through a range of shifts to cover service demands.

Investment is recommended to meet the British Association Day Surgery Guidance which identified an additional recovery nurse is required to safely accommodate the quick turnaround of patients within recovery.
Investment is also required to ensure a minimum of 2 qualified nurses / practitioners rare on the unit in the evening to meet NICE safe staffing guidance.

Current Model Day Surgery Unit HRI			
Funded Establishment	Headroom	Supervisory Status	Skill Mix
26.44 wte Qualified / 7.33 wte Unqualified	18.9%	100%	74:26
Recommended Model			
Funded Establishment	Headroom	Supervisory Status	Skill Mix
30.61 wte Qualified/ 9.33 wte Unqualified	20%	100%	76:24

3.4 Surgical Procedures Unit

Investment is recommended to ensure the area has 20% uplift and prevent risk to safe staffing levels when annual leave / sickness / training occurs.

A skill mix review is also recommended which would increase the requirement for unqualified nurses by 0.52 wte enabling the service to provide one unqualified nurse per theatre for the whole duration of the theatre session.

Current Model Surgical Procedures Unit			
Funded Establishment	Headroom	Supervisory Status	Skill Mix
6.18 wte Qualified / 1.0 wte Unqualified	18.9%	0%	80:20
Recommended Model			
Funded Establishment	Headroom	Supervisory Status	Skill Mix
6.76 wte Qualified/ 1.52 wte Unqualified	20%	20%	82:18

3.5 Main Theatres HRI

The current establishment and recommended model is for 5 theatres. From the 6th theatre (currently been refurbished). From the 6th theatres 7 out of the 10 lists have been redeployed to other areas, therefore there is potential that further investment may be recommended if and when the additional 3 lists are re-introduced.

The recommended workforce model is significantly different to the current model as the budget has been held centrally in main theatres. Staff have been deployed to other areas whilst the budget and workforce model remained centralised to main theatres.

Current Model Main Theatres HRI			
Funded Establishement	Headroom	Supervisory Status	Skill Mix
58.59 wte Qualified / 12.13 wte Unqualified	18.9%	100%	79:21
Recommended Model			
Funded Establishement	Headroom	Supervisory Status	Skill Mix
51.69 wte Qualified/ 13.70 wte Unqualified	20%	100%	79:21

3.6 Surgical Admissions and Day Procedure Unit

Investment is recommended to support supervisory time and headroom in both areas.

Current Model Surgical Admissions			
Funded Establishment	Headroom	Supervisory Status	Skill Mix
2.26 wte Qualified / 0.6 wte Unqualified	0%	0%	79:21
Recommended Model			
Funded Establishment	Headroom	Supervisory Status	Skill Mix
3.4 wte Qualified/ 1.2 wte Unqualified	20%	20%	62:38

Current Model Day Procedure Unit			
Funded Establishment	Headroom	Supervisory Status	Skill Mix
10.51 wte Qualified / 1.06 wte Unqualified	18.9%	20%	91:9
Recommended Model			
Funded Establishment	Headroom	Supervisory Status	Skill Mix
10.51 wte Qualified/ 2.51 wte Unqualified	20%	20%	79:21

3.7 Theatres CRH

The review against AFPP guidance indicates that CHFT are recommended to have 3.0 qualified nurses, 0.5 qualified recover nurses per theatre and one HCA for each theatre session.

The current workforce model suggests CHFT skill mix does not meet this guidance and a reduction in qualified nurses and increase in unqualified staff is required.

The review panel recommend a reduction of 3.6 wte qualified practitioners.

Current Model Theatres CRH			
Funded Establishement	Headroom	Supervisory Status	Skill Mix
67.71 wte Qualified / 12.47 wte Unqualified	18.9%	100%	85:15

Recommended Model			
Funded Establishement	Headroom	Supervisory Status	Skill Mix
61.32 wte Qualified/ 16.68 wte Unqualified	20%	100%	76:24

3.8 Pre-Assessment

Recent approval through divisional business meetings for additional posts within pre-assessment has increased the workforce model to assist with a backlog of patients waiting for assessment.

This has been as a result of increased activity with the “magic numbers” for elective procedures.

Ongoing work within pre-assessment to define the long term model for the area is been led through a separate PMO scheme.

Investment recommended through the review panel is to accommodate 20% headroom.

Current Model Pre-Assessment			
Funded Establishement	Headroom	Supervisory Status	Skill Mix
8.7 wte Qualified / 5.75 wte Unqualified	18.9%	40%	60:40
Recommended Model			
Funded Establishement	Headroom	Supervisory Status	Skill Mix
9.88 wte Qualified/ 5.81 wte Unqualified	20%	40%	62:38

3.9 Summary of Investment and Disinvestment Recommended for the Operating Department

Overall this will be a £14K saving.

Table 1: Investment and Disinvestment Recommended Operating Department

Ward	Beds	Band 5 wte	Band 2 wte	Ward Clerk wte	House Keeper wte	Additional Roles wte	£ Band 5 FYE	£ Band 2 FYE	Ward Clerk FYE	House Keeper FYE	Additional Roles FYE
Admissions HRI		1.41	0.83				44,146	16,378			
Pre Assessment All			0.06					1,184			
Day Surgery HRI		4.17	2.00				130,559	39,466			
Main Theatre HRI		-6.90	1.57				-242,570	30,981			
Main Theatre CRH		-6.39	4.21				-224,640	83,076			
Surg Procedures HRI		0.58	0.52				18,159	10,261			
Day Procedures CRH		1.20	2.05				37,571	40,453			
		-5.93	**11.24**	**0**	**0**	**0**	**-236,775**	**221,799**	**0**	**0**	**0**
						5.31					**-14,976**

4.0 SURGICAL DIVISION REVIEW SUMMARY AND RECOMMENDATIONS

4.1 Orthopaedics

Ward 19 and Ward 20 workforce models have been reviewed and no recommended investment or disinvestment is required.

8AB (elective orthopaedics) workforce model was reviewed alongside bed occupancy trends as the current workforce model reduces at a weekend, and ward staff had highlighted this as a concern and requested their workforce model to be increased to staff 26 beds at all times.

Analysis of the bed occupancy data identified that whilst the workforce model reduces to a model for 16 beds at a weekend on average beds open numbered 17 / 18 at a weekend.

The Nursing Workforce Review Panel therefore recommended further work to be progressed on length of stay opportunities to enable the ward to remain within their bed base.

The review panel requested that the Associate Director of Nursing for Surgery monitors staffing requirements on 8AB.

Engagement support workers are in place across wards 19 and 20 and finance colleagues were tasked with reviewing and reporting the anticipated savings against HCA's utilised for 1-1 support.

4.2 8D – Head and Neck Surgery

A recommendation was made to panel to increase qualified nurses within the workforce model by 1.2 wte to accommodate a number of ward attenders.

The review panel requested additional data on the number of ward attenders and found this to be on average 3 per day.

There is no recommendation for investment at this time into any changes for the workforce model for 8D.

8D is currently trialling additional staff on long days which will not change the number of nurses both qualified and non-registered on each shift. If the trial is successful and does not impact upon quality metrics for the area it is anticipated that this will provide a saving within the nursing PMO scheme for 16/17.

4.3 Ward 10 – Surgery

Ward 10 requested investment for additional non registered nurses particularly to support patient care on the late shift.

The current Nurse to Bed ratio (1.25) is lower than the trust CHFT benchmarked against with (1.29).

Ward 10 has moved to a larger proportion of staff working long days and has vacancies at present which is impacting on the trained and experienced staff

available.

Ward 10 is currently over established by 1.6 wte Health Care Assistants (HCA). The review panel recommend that the over established HCA's remain on ward 10 whilst a level of qualified nurse vacancy remains, but did not support this request as a permanent change.

The review panel also recommend this area is monitored and training needs analysis is completed to ensure HCA's are able to be utilised as effectively as possible.

4.4 Ward 15 – Surgery

Ward 15 requested an additional 0.21 wte housekeeper per week.

The review panel noted that the ward had a low nurse to bed ratio (1.02) compared with other wards at CHFT and when benchmarked against another Trust (1.29).

Quality metrics including staff turnover and skill mix on the ward was reviewed. The ward currently has a relatively new team with a limited number of mentors and significant number of new starters. Ward 15 was noted to be placed under 'special measures' and received additional support.

Ward 15 are currently trialling additional staff on long days which will not change the number of nurses both qualified and non-registered on each shift. If the trial is successful and does not impact upon quality metrics for the area it is anticipated that this will provide a saving within the nursing PMO scheme for 16/17.

The panel therefore recommend:

- An additional HCA on the early and late shift each day (£60,852).
- Uplift current band 5 post into a second band 6 post.
- Requested increase in housekeeper not critical and not supported at this time.

Resulting nurses per shift following investment recommended will increase:

	Early	Late	Night
Current Model	4+2	4+2	3+1
Recommended Model	4+3	4+3	3+1

4.5 Ward 3 – Vascular Surgery

No recommended changes for this area were presented to the review panel and the panel do not recommend any changes to the workforce model at this time.

4.6 Ward 22 – Urology

The review panel acknowledged the ratio of Registered Nurses to patients at night is currently higher than the 1:10 ratio that the Nursing workforce aim to maintain. The area has 23 beds and 2 qualified nurses and 2 non registered nurses on at night.

The panel accepted the professional judgement from the Associate Director of Nursing Surgery and review of quality metrics to carry the risk of higher bed to qualified nurse ratio than usual.

4.7 Surgical Assessment Unit

SAU requested the panel to consider 1 additional HCA on both Early and Late shifts as professional judgement from the ward staff identified that the area felt busier and under pressure at times.

The panel reviewed the current workforce model against Portsmouth Hospitals:

	Beds	Early	Late	Night
CHFT SAU	25	5+2	5+2	4+1
Portsmouth SAU	28	6+2	5+2	4+1

On further review by the panel the workforce model for SAU is not working to full potential due to trying to accommodate the majority of HCA's preferring long days.

Following a review of the latest acuity results and quality indicators the review panel do not support a recommendation for an additional HCA at this time.

The Associate Director of Nursing for Surgery was requested to review the workforce model with finance and HR colleagues and take appropriate action.

4.8 Critical Care – ICU

NHS England's D16 (National ICU Guidelines) requirement for 24/7 supernumerary coordinator role will apply to units that have 6 or more beds, and it is anticipated this will become a contractual requirement at some point in the future. However, as the D16 standards remain draft at the time of Panel review, it was unclear if or how the guidance might change prior to publication. The panel agreed to wait for the definitive guidance before making a final decision on a 24/7 supernumerary coordinator role at the HRI ICU.

The role of the co-ordinator will be covered Monday to Friday 8am – 5pm through the supervisory sister role and supported by the Matron.

The review panel identified that the workforce model currently built to staff all 13 beds within critical care would have flexibility to accommodate further co-oridnator support if fully recruited to as within the last 365 days reviewed all 13 beds were only utilised at any one time on 52 days.

The turnover of nurses in critical care has been high in the last 12 months resulting in a larger proportion of inexperienced critical care nurses within both units.

As a level of vacancy remains the review panel recommended that the unit

considered supporting an additional clinical educator post on a temporary basis within existing funding to support the nursing team.

The workforce model in critical care has been realigned against working patterns the nursing team have and an increase in long days is currently been trialled. If successful this trial will provide a saving for the nursing workforce within the PMO scheme for 16/17.

4.9 Trauma Co-ordinators

Trauma co-ordinators on site at HRI were highlighted as a service with no headroom applied to their workforce model.

The review panel requested guidance on how the service was managed at a weekend and night when full cover is not available.

The division advised that at present this is covered by the medical staff.

No further investment in this service is currently recommended.

4.10 Deputy Associate Director of Nursing Surgery

Following the non ward based nursing review and review of the service the senior nursing team is recommending the uplift from an existing matron post to a Assistant Associate Director of Nursing for Surgery. This role will assist the Associate Director of Nursing for Surgery with ensuring the nursing workforce in surgery continues to be well-led and responsive, and provide succession planning.

Investment for this role is an approximate cost of £2,409.

4.11 Clinical Educators

As reported in 4.8 a further clinical educator to support and retain the nursing workforce in critical care settings has been supported by the panel.

A further clinical educator post to support the surgical division nursing workforce was requested by the division.

The panel approved a recommendation for a temporary clinical educator post for the division utilising to be funded from within existing surgical division budget to support the overall Recruitment and Retention Strategy.

Table 2: Summary of Investment and Disinvestment Recommended Surgical Division

Nursing and Midwifery Workforce Review — NOV-15
Divisional Summary of Investment and Disinvestment Recommended (Template B)

Table 1:- Acuity & Dependency

Ward	Beds	Band 6 wte	Band 5 wte	Band 2 wte	Ward Clerk wte	House Keeper wte	Additional Roles wte	£ Band 6 FYE	£ Band 5 FYE	£ Band 2 FYE	Ward Clerk FYE	House Keeper FYE	Additional Roles FYE
19	22												
20	30												
Engagement Support Workers													
Trauma Coordinator Team													
8d	**14**												
3	**15**												
10	**20**												
15	**27**	**1.00**	**-1.00**	**2.58**		**0.21**		**40,577**	**-33,813**	**60,852**			
22	23												
SAU	25												
Outreach / CVAD (cost neutral)													
Deputy ADN Post (Band 8a to 8b uplift)													**2,409**
Clinical Educators													
Total:	**176**	**1.00**	**-1.00**	**2.58**	**0**	**0.21**	**0**	**40,577**	**-33,813**	**60,852**	**0**	**0**	**2,409**
							2.79						**70,025**

Deputy ADN Post would be an excising substantive 8a , therefore the cost would be minimal. (uplift would be from £1,395 to £2,409 maximum investment in 2016/17)
Clinical Educators from the slippage / vacancies by Ward Manager being in the numbers rather than 100% supervisory, on a temporary basis.

Ward	Beds	Band 6 wte	Band 5 wte	Band 2 wte	Ward Clerk wte	House Keeper wte	Additional Roles wte	£ Band 6 FYE	£ Band 5 FYE	£ Band 2 FYE	Ward Clerk FYE	House Keeper FYE	Additional Roles FYE
8ab	**26**												
							0						**0**
ICU	13												
							0						**0**
Admissions HRI			1.41	0.83					44,146	16,378			
Pre Assessment All				0.06						1,184			
Day Surgery HRI			4.17	2.00					130,559	39,466			
Main Theatre HRI			-6.90	1.57					-242,570	30,981			
Main Theatre CRH			-6.39	4.21					-224,640	83,076			
Surg Procedures HRI			0.58	0.52					18,159	10,261			
Day Procedures CRH			1.20	2.05					37,571	40,453			
			-5.93	**11.24**	**0**	**0**	**0**		**-236,775**	**221,799**	**0**	**0**	**0**
							5.31						**-14,976**
Total:	**215**	**1.00**	**-6.93**	**13.82**	**0**	**0.21**	**0**	**40,577**	**-270,588**	**282,651**	**0**	**0**	**2,409**
							8.10						**55,049**
Long Shift Savings													
8d				-0.89						-21,057			
15			-0.56	-0.67					-19,492	-15,852			
8ab				-0.54						-12,776			
ICU			-2.36						-82,145				
			-2.92	**-2.10**					**-101,637**	**-49,685**			
							-5.02						**-151,322**

Tabel 2 only

Investment Recommended	£70,025
Disinvestment Recommended	**-£166,298**

5.0 COMMUNITY DIVISION SUMMARY OF REVIEW AND RECOMMENDATIONS

Community nursing has been included within the non ward based review, but was also included in detail within the Nursing Workforce Model Review Panel process to ensure any risks or recommendations could be included in the nursing workforce plan as a whole.

Through the review panel process it was acknowledged that the nursing workforce within community require increased support from both finance colleagues to establish their workforce models and from health informatics to develop further their acuity scoring tool.

5.1 Health Visiting

CHFT currently require no additional investment for qualified health visitors. A request was made for additional administrative support for the health visiting team, but as this was reviewed and identified as not critical at this time this request was not supported by the panel.

The health visiting team continue to meet their recruitment trajectory in line with NHS England mandated levels and working within CPHVA guidance for caseload sizes.

The review panel noted the risk that Health Visiting as a service will transfer to Local Authority commissioning and is expected to then go out to tender by April 2017. As the new service specification has not been released the content is not known, but the service lead anticipates there is likely to be a reduction in the financial envelope for services and this may lead to a reduction in qualified health visitor posts.

The panel recommended that as the service specification becomes clear if the reduction in health visitors is likely as posts become vacant the service reviews requirements and considers increasing administrative support.

5.2 Community Nursing (Adult)

No investment is currently recommended for this service area, but a request for support from finance to ensure workforce models can be established and a request for support from Workforce and Organisational Development is recommended to ensure the principles of agile working are embedded and to support staff in working within newly formed teams.

This team includes the following:

Service	Band 7 wte	Band 6wte	Band 5 wte	Band 4 wte	Band 3 wte	Band2 wte	Caseload size(average) per team
Lymphoedema service	1.00		0.60				654
Parkinson's Specialist nurse	2.00 Covers Calderdale and Huddersfield						83 Calderdale only Huddersfield nurse new in post and building

							caseload
Service	**Band 7 wte**	**Band 6wte**	**Band 5 wte**	**Band 4 wte**	**Band 3 wte**	**Band2 wte**	**Caseload size(average) per team**
Nutritional Nurse	1.00 Cross site inpatient						N/A
TB specialist team	1.00	Hours currently being calculated				0.61	204
Respiratory service	1.00	8.61		1.00	1.00		450 168 pulmonary rehab
Heart Failure specialist nurse	2.00						92
Cardiac rehab	1.00	3.52	0.86				CRH 242 HRI 129
End of Life OOH team	1.00	2.04			2.30		NO CASELOAD
Palliative care specialist nurse	1.00	3.00					60 per CNS
Quest for Quality	6.00						364
Primary care discharge coordinators		5.40					N/A
Virtual ward and Out patient anti-biotic therpay	1.00		3.00				PC/DC 215 VW 220 OPAT 7
Gateway to care		1.00	2.40				N/A
SIT(reablement)	1.00		0.50	1.60			720 Includes all patients in Intermediate care and long term conditions in Calderdale *NB fiqures do not include council employed staff*
Crisis intervention team	1.00	3.00			6.17		N/A
Intermediate care Beds	1.00	9.01 * awaiting confirmation of recurrent funding		4.07			48 beds across 4 sites

5.3 District Nursing

At this point the review panel was not requested to recommend any investment into district nursing.

The challenges the district nursing service are experiencing remain as described in the September 2015 Safe Staffing report for the Board of Directors.

Transformational work through the vanguard project including the creation of a more generic workforce who are able to respond to the changing needs of the local population are expected.

Support from finance colleagues, health informatics and workforce and organisational development colleagues to support the transformation of community services was recommended by the panel.

5.4 Immunisation Team

No change to the workforce model was requested through the panel review. The service continues to deliver as described in the September 2015 Report to the Board of Directors.

The team were noted to be part of an income generation scheme scoping additional immunisations which they could deliver to benefit both the population in terms of health protection and to benefit CHFT income generation.

5.5 Community Services Investment Requested and Investment Recommended Summary

Investment Recommended					**Investment Supported**
Service	**Role**	**WTE**	**Band**	**£**	
Health Visiting	Admin Support	2.0	2	£47,171	No
Immunisation Team	-	-	-	-	
District Nursing	-	-	-	-	
Community Nursing	-	-	-	-	

6.0 FAMILIES AND SPECIALIST SERVICES DIVISON SUMMARY OF REVIEW AND RECOMMENDATIONS

The Families and Specialist Services Division (FSS) was created in April 2015 following the merger of the Children's, Women's and Families and Diagnostic and Therapeutic Services Divisions.

FSS recommended disinvestment and investment into the nursing workforce across Directorates. The Panel noted that a significant amount of budgetary realignment has been completed within the division as the nursing workforce models have been developed and the financial ledger realigned.

6.1 Outpatients

The current outpatient nursing workforce model is based on workforce models developed when services were hosted by the Surgical and medicine Division. FSS are in the process of developing a new outpatient nursing structure and workforce model based on activity requirements of each clinic. It is envisaged that this work will be completed by the end of December 2015 with the new workforce model implemented from April 2016.

The current workforce model has a skill mix of 40% Registered Nurse to 60% non-registered nurses. A benchmarking exercise is underway to establish skill mix split in high performing OPDs and opportunities to realign workforce activities.

Early analysis suggests that it is feasible to convert 3 qualified nurse posts to non-registered nurse posts. Savings from this scheme will be picked up via the Nursing Workforce PMO scheme.

6.2 Paediatric Inpatient Wards

The review panel was requested to consider supporting investment into paediatrics to support a seasonal workforce model. The workforce model is currently being developed (completion due December 2015), however early analysis of data suggests that up to 10.0 wte posts could be released for up to 15 weeks a year (based on 2015-2016 activity) and savings invested in additional winter pressure nurses to better manage peaks of activity over this period.

For the financial year 2015-2016 an investment of £70K is recommended to support an additional 2.58 wte Band 5 paediatric Nurses from October 2015 – February 2016.

The Division recommend that this investment is realised from currently vacant advance neonatal nurse practitioner roles.

Achieving the seasonal workforce model is proposed to be managed through the division through seasonal contracts and turnover, but the review panel noted that there is a risk that this will not be achieved.

The Division recommended investment to uplift a band 6 to provide a second band 7 paediatric ward sister. The existing 1.0wte band 7 ward sister manages five ward ares (four wards at CRH and one ward at HRI and outpatient services). This investment would mean that the ward sister could fulfil the supervisory responsibilities of the role.

6.3 Neonatal Intensive Care Unit (NICU)

The NICU workforce plan is subject to an NHS England specialist commissioning derogation plan.

The Division recommended an increase in the proportion of staff working long days to 50%; an additional saving has been identified and released through the Nursing Workforce PMO scheme.

This is currently been trialled and if successful will be endorsed for the workforce model from April 2016.

The increase in long days will result in approximately 50% of the workforce working long days.

6.4 Gynaecology Services

The divisional review recommended an investment in band 2 administrative support and healthcare assistants across both the gynaecology inpatient ward and gynaecology assessment unit.

A review of the contact time studies in June 2015 identified the proportion of registered nurse time spent performing clerical and administrative tasks was high.

The HCA cover on night shift was historically low within the workforce model.

Investment of 2.69 wte Band 2 HCA was supported by the panel in addition to 1.01 wte Band 1 support funded by divisional housekeeping.

Additional funding was requested to support a trainee ACON Advanced Nurse Practitioners (ANP) to expand the service, but the panel recommended this was presented as part of an overall strategy for Advanced Nurse Practitioners (ANP).

6.5 Maternity Services

The Division recommended no changes to the midwifery workforce model for qualified midwives or unqualified maternity support workers or HCA's.

This will ensure that the service continues to deliver the 1:29 crude midwife to birth ratio at CHFT (currently commissioned to deliver a less than 1: 30 midwife to birth ratio.)

Benchmarking crude midwife to birth data against other trusts was reviewed by the panel and noted to be:

- CHFT 1:29
- Barnsley 1:25
- Leeds 1:27
- Mid Yorks 1:31
- Bradford 1:28

Clinical educators to support the workforce in midwifery was discussed at the review panel, but identified as not required this year. This was in part due to the award of NHSLA funding to support an intrapartum clinical educator and in part due to the 2015-2016 specialist midwife job planning exercise which identified training time within the working week.

Investment was recommended to provide a Deputy Head of Midwifery role which will provide clear midwifery development structure and support the Head of Midwifery who is also the Associate Director of Nursing for FSS. This was supported by the panel at a cost of £60K, which will be funded through divisional housekeeping.

6.6 Summary of Investment and Disinvestment Recommended in FSS

Area	Disinvestment £	Investment £
Vacant ANNP posts	106,442	
Uplift to additional Band 7 Paediatric Sister		9,922
Additional Paediatric Nurses 2.58 wte October – February inclusive (to be reviewed December 2015)		70,000
NICU 0.13 wte Band 3; 1.76 wte Band 2	47,423	
IVF / ACON 1.0 wte Band 6 (subject to business case)		32,555
GAU and Ward 2.69 Band 2; 0.71 Band 2 Admin and 1.01 Band 1 Admin		93,634
NICU long day savings 0.54 wte Band 6 and 2.03 wte Band 5	47,767	
Deputy Head of Midwifery		60,827
1.8 wte reduction in midwifery posts reinvested in Deputy Head of Midwifery post. (Maintains Midwife to birth ratio of 1:29)	65,306	
Total	266,938	266,939

7.0 MEDICAL DIVISION SUMMARY OF REVIEW AND RECOMMENDATIONS

7.1 NIV (Non Invasive Ventilation)

The division does not currently comply with the British Thoracic Society (BTS) guidance which suggests one registered nurse to two patient ratio for patients commencing on NIV for the first 24 hours.

The division made a recommendation to the review panel that as an interim solution whilst service reconfiguration of respiratory services is completed both MAUs, ward 5c and ward 11 all require an additional 1.0 WTE on shifts to provide this level of nursing care.

The investment recommended and supported by the panel is for:

MAU x 1 nurse on the Early and Late shift
Ward 5 c x1 nurse on the late and night shift
Ward 11 at HRI x1 nurse on the early , late and night shift

The panel noted that further work within the division is required regarding the medical workforce.

MAU (both sites)	Early	Late	Night
Current Model	5+2	5+2	5+2
Recommended Model	6+2	6+2	5+2
5C	**Early**	**Late**	**Night**
Current Model	3+2	2+2	2+1
Recommended Model	3+2	3+2	3+1
11	**Early**	**Late**	**Night**
Current Model	5+3	5+2	4+2
Recommended Model	6+3	6+2	5+2

7.2 6BC and CCU

6BC and CCU previously shared one workforce model, but this has recently been split into separate workforce models.

6BC currently has a higher skill mix currently 70:30, than benchmarked with Portsmouth, but this is accepted by the division and review panel and will be monitored.

The recommendation from the division to the panel was to increase the long days in this area from 45% to 65% providing a disinvestment of £22,534.

Due to the increase in long days and new leadership within a new workforce model no further changes to the area are recommended at this time.

7.3 CCU

The division requested one additional qualified nurse on a night shift to meet critical care standards of providing one nurse to two patients at level 2.

It was acknowledged that the Unit does not operate at full level 2 capacity although further developments in local cardiology service provision may change this in the future.

The panel therefore challenged the increase and this was not supported.

Benchmarking against Portsmouth Trust identified nurse to bed ratio was 1.50 against CHFT of 1.91.

7.4 MAU at HRI

An increase in long days for MAU at HRI was proposed by the division with an increase in long shifts from 42% to 50%.

The panel was asked to consider increased long days in ambulatory and considered how staff within ambulatory would receive their break if long days increased. Assurance was provided that cover from ward staff would allow for breaks to be taken. Concern regarding increasing long days to a higher level was raised and a decision made to maintain for the ward at 50%.

The panel recommended long days were increased to 50% with a saving of £22,534

7.5 Short Stay (2AB and Ward 6)

Both short stay area were reviewed and disparity between Ward 6 against 2AB was noted within the workforce models.

Nurse to bed on ward 6 is currently 1.43 and on 2AB it is 1.25

The panel challenged the 3.0 wte band 6 posts on ward 6, but agreed with the current challenges within nursing workforce and requirement to support newly recruited nurses additional experienced nurses is of value and approved accepting as a pressure.

Increased long days on 2AB were recommended from 45% to 68% providing a saving of £38,482

7.6 Ward 21

No changes to the workforce model for this areas have been recommended. Within the process each area has been reviewed and the rationale for no changes documented.

Wared 21 skill mix noted to be acceptable and comparable with benchmark in Portsmouth. The area meets the recommended guidance for Rehab care of 1:6 ratio.

7.7 Ward 5AD

Ward 5AD is currently subject to special measures and is being reviewed by the Director of Nursing. This may inform a revised workforce model subject to this review.

The Associate Director of Nursing for medicine has made a recommendation to increase qualified nursing on the Early shift, and to provide 2.0 wte Band 7 support for the ward area. The ward would also be separated into two smaller ward areas. This was not supported, but will be considered as part of the special measures support.

7.8 Ward 8

Division recommended increasing long days for nursing workforce in this area form 40% to 63% providing a saving of £22,203.

The panel accepted this recommendation.

7.9 Ward 17

Ward 17 has a nurse to bed ratio of 1.32 in comparison to 1.26 for a similar area at Portsmouth Hospital.

Consideration to increasing long days on ward 17 has been completed within the division but no further changes are recommended at this time.

Ward 17 Enhanced Care

A review of the current service provision for patients presenting with acute GI bleed has been undertaken by the medical and surgical divisions. A recommendation will be made to the weekly Executive Board for consideration.

7.10 Stroke Care (6D, 7BC and 7AD)

The panel acknowledged that this area have received investment to allow the workforce to achieve Hyper Acute Stroke Unit Guidance. The HASU workforce is supported at night by the thrombolysis nurse team.

The panel challenged the current workforce model for 7AD and 7BC which results in 4 qualified nurses on each area at night (both 26 bedded areas).

The complexity of the patients and environment provided the panel with justification to approve continuing with the existing workforce model.

Increase in long days on both 7AD and 7BC from 48% to 54% was approved by the panel. An increase in long days for 6D from 58% to 75% was also accepted providing an overall saving of £39,947.

7.11 Ward 5

This ward was previously ward 4 and following a move to ward 5 the bed base has increased temporarily with 10 additional step down beds.

The workforce model has been temporarily adjusted in line with the additional bed base.

No further changes to the workforce model or investment is required at this time.

Financial support for the increased workforce requirements due to the additional beds is provided through forecast for the medical division.

7.12 Engagement Support Workers

6.72 wte Engagement Support Workers are requested and recommended as invest to save process for the nursing workforce to reduce the use of 1-1 support, improve patient experience for patients on complex care ward areas through a dedicated and consistent workforce.

Finance colleagues have been tasked with providing evidence of the success of engagement support workers in reducing 1-1 requirements to support this recommendation.

7.13 Deputy Associate Director of Nursing Medical Division

As with the surgical division this post is recommended by the panel to support effective senior nurse leadership across the division and to support the development of nurse leaders with structured succession planning.

7.14 Clinical Educators

Following the non ward based review the nursing workforce identified that clinical educators and the support they provide for the nursing workforce benchmarks significantly below other organisations at CHFT.

In addition to the non ward based benchmarking clinical educators are also a recommendation as part of the retention strategy for nursing.

The medical division proposes to provide 4 Clinical Educator posts on a temporary basis to support patient care and the nursing workforce in the next 12 months.

Additional investment is not required to support this on a temporary basis.

7.15 Neurology and Upper GI Specialist nurses

The epilepsy service is vulnerable without a succession plan at present and therefore the division requested a new post within the service , 1.0 wte Band 6.

The Upper GI service is developing and a further post was requested to support growth within the team.

The review panel accepted the recommendations for both posts, but identified this was low priority at present and requested the division to identify how additional skills and training could be built without an additional post.

7.16 The Emergency Departments were both noted to not currently have 100% supervisory roles at present to support the nursing workforce.

The recommendations provided to the panel acknowledged that there remains a gap against full implementation of NICE guidance. The recommendations reflected the work completed using the BEST guidance tool which was available at the time of undertaking the review.

The matron has commenced work within the department to establish the development programme for aspirant Band 5 nurses into Band 6 posts to support retention and leadership development.

The difficulty in recruiting experienced Emergency Department nurses, Paediatric trained nurses for the department and retaining nurses was noted by the panel.

A change to the leadership on Ward 18 at HRI has released the Paediatric Advanced Practitioners managerial responsibility resulting in increased direct care working within the Emergency Department.

7.17 Emergency Department

The National Emergency Department Safe Staffing Guidance has been developed, but has not been approved by NICE. A review has been undertaken against the ED developed Guidance but only critical gaps considered for investment.

Summary of Recommendations for Investment

Recommendation	Priorities recommended	Priority / Risk level	WTE
No change to CDU staffing	X	n/a	0
Increased ENP cover 10.30am-2.00am	✓	High	4.0
Equity in staffing between sites – late shift	✓	High	1.7
Equity in staffing between sites – night shift	✓	High	2.3
Increased late shift – Ambulance Assessment	✓	High	4.6
Increased late shift – Walk in Assessment	X	Medium	3.4
Reduce variability of coordinator role – band 6's	✓	High	0
Increased headroom from 20% to 23%	X	Medium	2.9
Implement band 7 supervisory	X	Medium	1.6
Increase 1 HCA – night shift	X	Medium	4.6

7.18 The panel requested further information through the review process to identify:

- How the queue for patients requiring care, but returning to the waiting room is safely staffed
- Short term recommendation to staff any queue
- The impact of Advanced Clinical Practitioners within ED
- The staffing requirements if NICE guidance had been applied
- Priority requests and phased plan to implement

7.19 This has been submitted to the Workforce Committee and approved.

7.20 Hospital at Night

Fully implementing the Hospital at night programme is the preferred option and strategic direction set by the Nervecentre board.

Implementing the Hospital at Night programme is recommended to ensure that task management between 17.00 hrs – 08.00hrs and 24 hours at a weekend are safely and efficiently maintained.

Investment has been identified to support current clinical requirements through the out of hours system.

7.21 The panel explored how the current provision would be developed through Hospital at Night and requested further information as to how services such as CVAD would work within Hospital at Night.

Whilst the panel supported the outline of Hospital at Night the investment required to implement requires cross organisational change and therefore a separate business case to investment committee is recommended.

Table 4: Summary of Investment and Disinvestment Recommended Medical Division

Invest / Disinvest	Driver	Ward	Beds	Band 5 wte	Band 2 wte	Ward Clerk wte	House Keeper wte	Additional Roles wte	£ Band 5 FYE Substantive	£ Band 2 FYE Substantive	Ward Clerk FYE	House Keeper FYE	Additional Roles FYE
Invest	NIV Interim solution	MAU CRH - Additional Qualfied Long Shift - NIV interim solution	24	2.69					89,142	0			
Invest		MAU HRI - Additional Qualified Long Shift - NIV interim solution	24	2.69					89,142	0			
Invest		Ward 5c - create x2 NIV beds, increase late & night Qualified	16	3.47					114,990	0			
Invest		Ward 5 - Increase qualified night shift, interim NIV	27	5.16					170,994	0			
Invest	Wards	Engagement support workers - x 4/day			6.72				0	155,460			
Disinvest	Long Shift Savings	7AD increase long shifts 48% to 54%	26		-0.67				0	-15,500			
Disinvest		7BC increase long shifts 48% to 54%	26		-0.67				0	-15,500			
Disinvest		6D increase long shifts 58% to 75%	15	-0.27					-8,947	0			
Disinvest		Ward 8 - increase long shifts 40% to 63%	21	-0.67					-22,203	0			
Disinvest													
Disinvest		2AB - SSU - increase long days 45% to 68%	31	-0.68	-0.43				-22,534	-9,948			
Disinvest		Ward 6BC - increase long days 45% to 55%	32	-0.68					-22,534	0			
Disinvest		MAU HRI increase long shifts - 42% to 50%	24	-0.68					-22,534	0			
Invest		CCU & PCI - increase long days	13	-0.67					-22,203	0			
Disinvest	Supervisory	Band 7 supervisory reduced to 75% - all wards, 0.25WTE saving/ward - total 4.00 WTE saving. Replace with 4x band 6 clinical educators (non-recurrent, WFMs not amended).		0.00					0	0			
Invest	Neurology	Band 6 - succession Epilepsy Nurse (low priority)						1.00	35,944				
Invest	Upper GI	Band 6 - development, support growth (priority)						1.00	35,944				
Invest	GI Bleeds	GI Bleeds rota - enhanced care on 17, & endoscopy nurses. Separate Business Case											
Invest	ACPS	ACPs - x2 (fill junior doctor gaps)						2.00	0				
Invest		ACPS - x2 (faility) - utilisation of medical education funds						2.00	0				
Invest	Structure	Deputy ADN Post (Band 8a to 8b uplift)							10,516				
Total:		**Total:**		**10.36**	**4.95**	**0.00**	**0.00**	**6.00**	**425,717**	**114,513**	**0**	**0**	**0**
		Investment Recommended (@20% uplift)	679,929										
		Disinvestment Recommended *	-139,699										

8.0 NON-WARD BASED SUMMARY

8.1 All non-ward based nursing workforce areas have been reviewed through divisions as part of the Nursing Workforce PMO Scheme 2015 / 2016.

An agreed process was completed and job plans completed and retained within divisions.

8.2 The Director of Nursing and senior nursing team have a summary of all non-ward based nursing currently budgeted for at CHFT which has been benchmarked where possible against another NHS Trust.

8.3 Benchmarking non ward based areas has been a challenge due to the lack of professional guidance relating to staffing requirements in many of these areas.

8.4 The benchmarking exercise confirmed for the Nursing Workforce Strategy Group that the area of non-ward based nursing, which CHFT benchmarked lower against, was the provision of clinical educators to support the nursing workforce.

8.5 Lone practitioners with specialist knowledge and skills were identified through both the divisional workforce model reviews and the non ward based summary.

Divisional plans to support existing colleagues to develop specialist skills and knowledge has been encouraged through the review panel process.

8.6 The Nursing Workforce Strategy Group will review the template and process for annual job planning and non-ward based review early 2016.

9.0 SUMMARY OF INVESTMENT CONSIDERED

This paper outlines the recommendations supported by the panel for consideration by Board.

A number of requests following the review of each workforce model by the division have not been assessed as critical and therefore not currently supported for investment.

Table 5 Summary of all Investment requests made to the Nursing Workforce Review Panel.

AREA	REQUEST	SUPPORTED BY PANEL
8D	1.2 WTE Band 5	No
10	Additional HCA on Late Shift	No
15	Additional HCA on Early and Late	Yes
15	Additional HCA on Night Shift	No
15	Uplift from band 5 to second band 6	Yes
22	Increase RN Night to meet 1:10	No
SAU	Additional HCA on Early and Late	No
8AB	Increase staffing model to 26 beds	No
ICU	24 hr Co-ordinator role	No
Paediatrics	Uplift band 6 post to second Band 7	Yes
Paediatrics	2.58 wte Band 5 Winter posts	Yes
Maternity	Deputy Head of Midwifery	Yes
Gynaecology	3.4 Band 2 and 1.01 Admin Support	Yes
IVF / ACON	1.0 wte Band 6 post	NO
Health Visiting	Administrative Support 2.0 wte Band 2	No
5AD	Additional Band 7	No
5AD	Additional Band 5 0.33 wte and Band 2 4.48 wte	No
CCU	Additional qualified night shift	No
Engagement Support Workers	6.72 wte – investment to save to reduce 1-1 costs	Yes
MAU CRH and HRI	1 additional RN Early and Late shift	Yes
5C	1 additional RN on Late and Night shifts	Yes
11	1 additional RN Early, Late and Night shift	Yes
IBN	1.0 wte	No
Nutritional Nurse	1.0 wte	No

Hepatitis C Nurse	1.0 wte	No
Neurology Nurse	1.0 wte	Yes (low priority)
Rheumatology Nurse	1.0 wte	No
Upper GI Nurse	1.0 wte Band 6	Yes (low priority)
Deputy Associate Director of Nursing Medical and Surgical Division	Uplift from 8A to 8B	Yes

10.0 CONCLUSION

10.1 The Board can be assured that all nursing workforce models have been reviewed, scrutinised and challenged.

A record of the rationale for all recommendations (including where no change is indicated) has been maintained.

Investment and disinvestment opportunities have been identified and are summarised in Table 6.

The Board are asked to note and support the recommendations.

Table 6: Summary of Investment and Disinvestment Recommended

Division	Investment Recommended £	Disinvestment Recommended £
Surgery	70,025	166,298
Community	0	0
FSS	266,938	266,938
Medical	679,929	139,699
Total	**1,016,892**	**572,935**

Final decisions on investment will be considered by the Commercial and Investment Committee where they can be considered alongside other priorities.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Juliette Cosgrove, Assistant Director
Date: Thursday, 26th November 2015	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: Quarterly Quality Report Q2 2015/16 - Quarterly Quality Report - This quarterly quality report covers contractual, quality account, national and local quality priority requirements to provide a comprehensive overview of quality performance during the second quarter of 2015-2016 within Calderdale and Huddersfield NHS Foundation Trust (the Trust).	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Quality Committee 27th October 2015	
Governance Requirements: To approve the actions contained within the paper.	
Sustainability Implications: None	

Executive Summary

Summary:

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

During Quarter 2 2015/16, all CQUIN, Quality Account and Contract requirements were achieved, with the exceptions noted below:

Patient Safety Domain:
MRSA Bacteremia: (section 2.7)
The two cases in Q2 were assigned to the Trust.

July case - pre-admission case, it was attributed to CHFT following the post infection review (PIR). There were a number of missed opportunities for taking wound swabs in both the outpatient setting and community. It should be noted that the revised nationally set post infection review (PIR) process allows pre-admission cases to be assigned to CHFT when this was not the case in previous years.

September case – post-admission case. It was acknowledged at the PIR that there was variable practice of ANTT by ward medical staff which may have been a contributing factor. An action plan is in place to review ANTT practice training for medical staff. The IPCT will commence training for ANTT Assessors from October 2015 who will then cascade the training within their Ward/Department areas.

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

Harm Falls
Performance has now breached the internal target. Of 16 falls in Q1 and Q2 against a year end target of 14. Risk summit planned for November to review and address.

Partial Compliance

Areas showing partial compliance during Quarter 2 are:

Patient Safety
• Pressure Ulcer reduction: Quarter 2 trajectory not achieved (section 1.2)

Experience

• Friends and family test: low response rates

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

Well-Led
• Appraisal: 48% target for appraisal completion not met (section 5.3)

Main Body

Purpose:

Please see appendix

Background/Overview:

Please see appendix

The Issue:

Please see appendix

Next Steps:

The next report will cover quarter three

Recommendations:

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

Appendix

Attachment:

Q2 Quality Report 15-16 FINAL version BOD.pdf

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Calderdale & Huddersfield Foundation Trust
Quarter 2 Quality Report
2015-16

Subject:	Quarter 2 2015-2016 Quality Report
Prepared by:	Juliette Cosgrove – Assistant Director of Quality Andrea McCourt - Head of Governance and Risk Lisa Fox – Information Manager
Sponsored by:	Julie Dawes, Director of Nursing
Presented by:	Julie Dawes, Director of Nursing
Purpose of paper	Discussion requested by Trust Board Regular Reporting For Information / Awareness
Key points for Trust Board members	The report is structured into the five Care Quality Standards domains, with each section having a summary providing an overview of compliance with each indicator and highlights. During Quarter 2 2015/16, all CQUIN, Quality Account and Contract requirements were achieved, with the exceptions noted below: **Patient Safety Domain:** **MRSA Bacteremia:** (section 2.7) The two cases in Q2 were assigned to the Trust. July case - pre-admission case, it was attributed to CHFT following the post infection review (PIR). There were a number of missed opportunities for taking wound swabs in both the outpatient setting and community. It should be noted that the revised nationally set post infection review (PIR) process allows pre-admission cases to be assigned to CHFT when this was not the case in previous years. September case – post-admission case. It was acknowledged at the PIR that there was variable practice of ANTT by ward medical staff which may have been a contributing factor. An action plan is in place to review ANTT practice training for medical staff. The IPCT will commence training for ANTT

	Assessors from October 2015 who will then cascade the training within their Ward/Department areas. **Effective Domain:** **SHMI:** (section 2.1) The latest SHMI shows the Trust to have a SHMI of 109 which although classified 'as expected' is above the 100 target. *The HSCIC caution that it is inappropriate to conclude that a trust is performing better or worse than average based purely on whether or not there are more or less deaths than predicted. The trust has been placed in the 'as expected' range because any variation from the number of expected deaths is not statistically significant.* **Harm Falls** Performance has now breached the internal target. Of 16 falls in Q1 and Q2 against a year end target of 14. Risk summit planned for November to review and address. **Partial Compliance** Areas showing partial compliance during Quarter 2 are: Patient Safety • Pressure Ulcer reduction: Quarter 2 trajectory not achieved (section 1.2) Experience • Friends and family test: low response rates Effective • A&E performance: 2 of 5 quality indicators not achieved (section 4.1) Well-Led • Appraisal: 48% target for appraisal completion not met (section 5.3)

Contents

Domain Four – Responsive: Services are organised so that they meet people's needs

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

Appendices

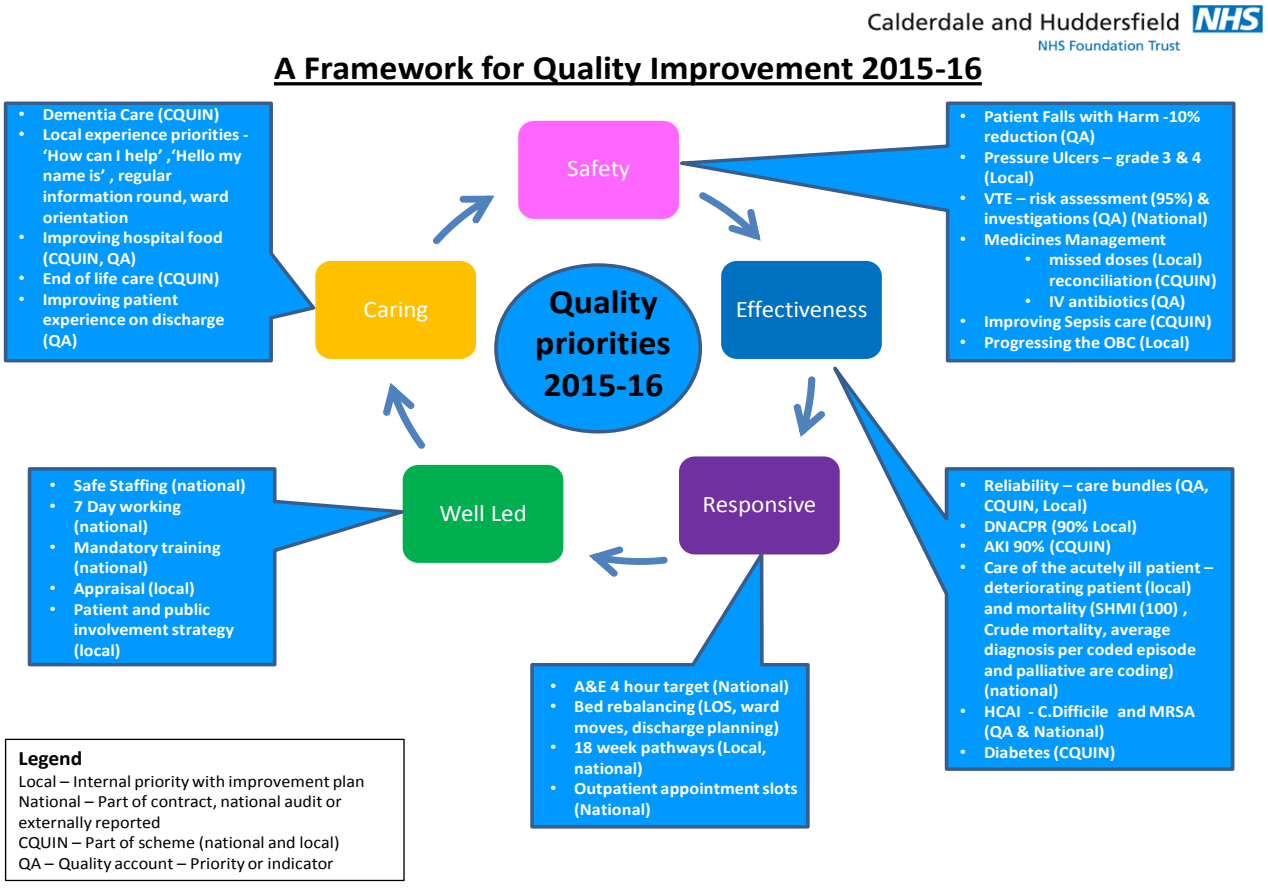
Introduction

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

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

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

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



Summary of Key Performance Frameworks:

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

Domain	Focus/Priority	More Details
Safety	Improving Sepsis Care (aligned with CQUIN measurement)	Pg.23
Effectiveness	To ensure Intravenous antibiotics are given correctly and on time (continued from last year)	Pg.18
Effectiveness	Improving the discharge process	Pg.113
Experience	Better Food & Improving Nutrition (aligned with CQUIN measurement)	Pg. 80

2015/16 CQUINS:
There are nine CQUIN areas for 2015/16. These are listed below and further detail regarding progress can be found on the page number indicated. The information contained in the Q2 performance box provides a quick overview of target attainment during the second quarter, where applicable.

	Indicator Name	Q2 Performance	Page
1	Acute Kidney Injury	32%	**Pg. 52**
2a	Sepsis Screening	40%	**Pg. 23**
2b	Sepsis Antibiotics	75%	**Pg. 23**
3	Urgent care	88%	**Pg. 94**
4a	Dementia - Find, Assess, Investigate and Refer	92%/100%/100%	**Pg. 59**
4b	Dementia - Clinical Leadership	Y	**Pg. 59**
4c	Supporting Carers of people with Dementia	Y	**Pg. 59**
5a	Asthma Care Bundle	80%	**Pg. 40**
5b	Pneumonia Care Bundle	78%	**Pg. 40**
6	Diabetes – Inpatient	64%	**Pg. 52**
7a	Medicines Reconciliation/E-Discharge	82%/88%	**Pg. 18**
7b	Medicines Discharge - Improvement	Y	**Pg. 18**
8	End of Life Care	44%	**Pg. 86**
9a	Nutrition patient satisfaction	76%	**Pg. 80**
9b	Nutrition reduce waste	5.48% HRI 3.34% CRH	**Pg. 80**
9c	Nutrition Vending	Y	**Pg. 80**

Domain One – Patient Safety

Patient Safety Compliance Summary

Indicator 2015-16	Compliance Q2
1.1 Falls Reduction	**Over Trajectory**
1.2 Pressure Ulcer Reduction	**OverTrajectory**
1.3 Reducing Hospital Acquired VTEs (Contract)	Achieved
1.4 Medicines Management (CQUIN)	Achieved
1.5 Sepsis (CQUIN)	Achieved
1.6 Safeguarding Patients	Reporting only
1.7 Incident Reporting	Reporting only
1.8 Effective Investigations	Reporting only
1.9 Central Alerts System (CAS) Alerts	Achieved

`

Highlights:

1.3 Reducing Hospital Acquired VTEs	Hospital Acquired Thrombosis (HAT) target achieved in Q1 and Q2.
1.4 Medicines Management	As at Q2, on track to achieve year end targets for: - % medicines reconciled for admission - % discharge accuracy checks
1.5 Sepsis	2015/16 sepsis baselines established for achievement by Q4 for sepsis screening and antibiotics within one hour
1.7 Incident Reporting	Q2 8% increase in incident reporting compared to Q2 in 2014/15 Year to date 17% increase in the number of incidents reported relating to the Trust showing an improvement in reporting following a reduction in 2014-15 No Never Events reported in Q2, to date no Never Events
1.8 Effective Investigations	Revised Incident and Investigation Policy developed

1.1 Reducing patient falls with harm

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

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

The Trust has detailed action plan to deliver the reduction in the number of harm falls. Performance surrounding the prevention of falls is overseen by the Patient Safety Group.

Background

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

The prevention and management of inpatient falls is described in The National Institute for Clinical Excellence – Guideline 161 (2013)/ Implementing FallSafe.
The Trust action plan for falls focusses on the following 6 areas:

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

Current Performance

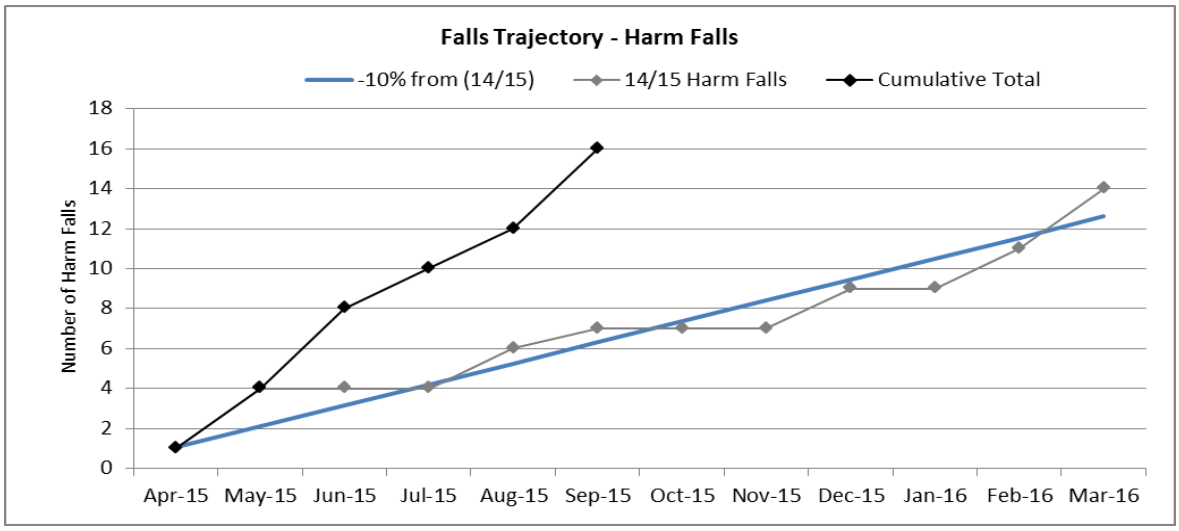
<u>Overall Summary of Q2 performance 2015/16 for falls prevention</u>

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

During the first six months of 2015/16 the Trust has had 16 falls with harm, which is 10 above the trajectory target of 6, and results in the Trust breaching its annual threshold of 14. There have been 10 falls with harm at the CRH site with 6 falls with harm at the HRI site. Of

these one has occurred on a Trauma Orthopaedic ward and one on a Gynaecology ward with the remaining majority occurring within the medical bed base.

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
SAS		1											1
MED	1	2	4	2	2	3							14
FSS						1							1
Total	**1**	**3**	**4**	**2**	**2**	**4**	**0**	**0**	**0**	**0**	**0**	**0**	**16**
OBDs	**21629**	**22306**	**21509**	**21120**	**20963**	**20806**	**0**	**0**	**0**	**0**	**0**	**0**	**128333**
Rate of Falls/ 1000 OBDs	0.05	0.13	0.19	0.09	0.10	0.19	0.00	0.00	0.00	0.00	0.00	0.00	0.12
Cumulative Total	**1**	**4**	**8**	**10**	**12**	**16**							**16**
-10% from (14/15)	1	2	3	4	5	6	7	8	9	11	12	13	13



Recommendations were made to the Patient Safety Group on 3 September 2015 in response to this poorer than anticipated performance and the following actions have been agreed:

Improvement Plans for Quarter 3

1. Director of Nursing to consider business case to support the roll out of a 'Fall Safe' Project with the key objective of reducing the number of in-patient falls by Improving the quality of assessments and interventions for falls prevention for patients at risk of falls; and improve multidisciplinary working with regard to the assessment and management of patients at risk of falls in particular to educate and empower ward staff to make small but effective innovation and change.

2. Introduce a Falls Investigation Prompt sheet to compliment the CHFT root cause analysis (RCA) investigation tool developed by Effective Investigation Group (to improve quality of RCA). This is currently out to consultation and expected to be in use by end Quarter 3.

3. Attend the CHFT first Harm Summit on 10 November 2015. This summit will focus on key patient harm areas, such as falls, pressure ulcers and medication safety.

Update re: Improvement Plans for Q2

1. Continue to maintain links with the Improvement Academy, with an aim to achieve 95% compliance in actions identified from the safety briefings. The Medical Division Falls Collaborative has now taken this work forward and rolling it out across the division.

2. The Vulnerable Adults Operational Group (VAOG) is the focus of future falls action planning. This will enable the agenda to link with other key areas impacting upon falls with a shared action plan – Dementia, Learning Disability, Mental Health, Safeguarding, Restrictive Practice and MCA/DoLs. The Trust Falls Collaborative is now part of this group. The VAOG will undertake person centred care walk rounds to support clinical areas in reducing risks for vulnerable patients across the organisation from October going forward.

3. The formal feedback from the first National Inpatient Falls audit in May / June 2015 is due in October. The lead clinician for falls, Dr Greenwood, presented the local findings to the Medical Division clinical audit meeting in September 2015.

4. Clear signage is now in place over all in-patient bed areas to enable the identification of individual risk factors and mobility requirement.

5. A Falls Alarm tool to enable assessment of mental capacity and potential restriction / DoLS has been developed and is to be trialled alongside the Falls Care plan. Trial commenced October on cardiology CRH. The tool is to give assurance of compliance with Mental Capacity Act and DOLs.

1.2 Reducing Pressure Ulcers

Aims and Objectives of Work

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

For 2015-16 a trajectory of 10% reduction for all hospital acquired category 2, 3 and 4 pressure ulcers has been agreed. This equates to no more than 11 category 2 pressure ulcers and 5 category 3 pressure ulcers per month and no more than 3 category 4 pressure ulcers per annum.

For 2015-16 a trajectory of 10% reduction for CHFT community acquired category 2, 3 and 4 pressure ulcers has also been agreed. This equates to no more than 9 pressure ulcers per month.

The pressure ulcer prevention and reduction programme is being overseen by the Patient Safety Group which received a progress report in September.

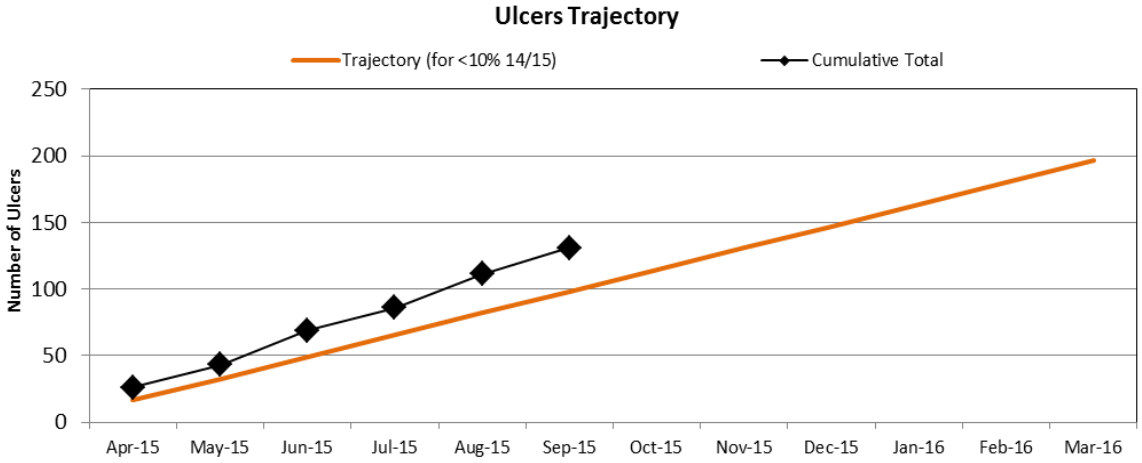
Overall Summary of Q2 and year to date performance 2015/16

CHFT hospital acquired pressure ulcer incidents are above the planned improvement trajectory for Quarter 2 with 62 incidents in Quarter 2 compared to a trajectory of 48. This means that in order to achieve 10% reduction for the year there should be no more than 65 incidents for Quarter 3 & 4. If performance continues at the present rate incidents will have increased by 20% compared to 2014/15.

Community pressure ulcers have exceeded the planned improvement trajectory for Quarter 2 with 203 incidents compared to a trajectory of 52. The target for the year is 104. Approximately three quarters of the pressure ulcers were category 2 (154 of 203).

The increase in incidents is related to ongoing issues highlighted in 2014/15, which includes increased awareness of reporting following training, the impact on continuity of care that has arisen through unplanned capacity (particularly at CRH) and subsequent use of agency staff. Root cause analyses of the most severe pressure ulcers demonstrated that the pressure ulcers were related to patient issues/ conditions, equipment issues, education and training, accuracy and timeliness of assessment and record keeping.

Hospital acquired pressure ulcer performance against planned trajectory

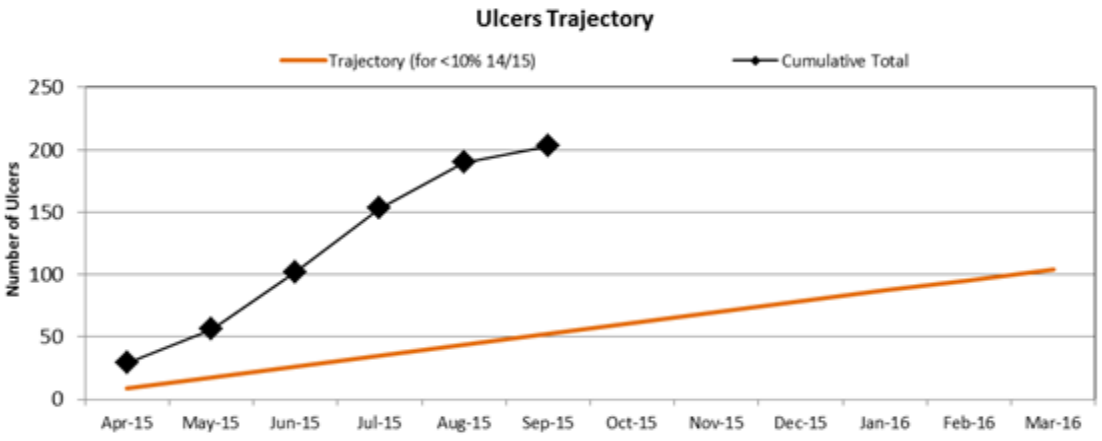


	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
SAS	9	3	6	5	11	6							40
MED	17	12	20	12	14	14							89
FSS		2											2
Total	**26**	**17**	**26**	**17**	**25**	**20**	**0**	**0**	**0**	**0**	**0**	**0**	**131**

OBDs	21629	22306	21509	21120	20963	20806	0	0	0	0	0	0	128333
Rate of Ulcers/ 1000 OBDs	1.20	0.76	1.21	0.80	1.19	0.96	0.00	0.00	0.00	0.00	0.00	0.00	1.02

Cumulative Total	26	43	69	86	111	131							131
Trajectory (for <10% 14/15)	16	33	49	65	82	98	114	131	147	164	180	196	196

Community services acquired pressure ulcers



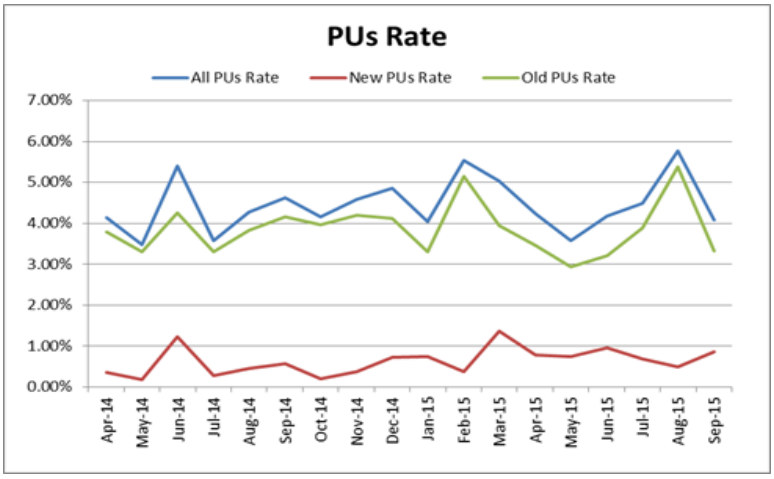
	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
Category 2	19	23	36	41	26	9							154
Category 3	7	4	10	8	11	3							43
Category 4	3			2		1							6
Total	**29**	**27**	**46**	**51**	**37**	**13**	**0**	**0**	**0**	**0**	**0**	**0**	**203**

Cumulative Total	**29**	**56**	**102**	**153**	**190**								**203**
Trajectory (for <10% 14/15)	9	17	26	35	44	52	61	70	78	87	96	104	104

Safety Thermometer

Pressure ulceration is one of the harms measured as part of the Safety Thermometer. The measure includes old pressure ulcers (pre-existing and occurring within 3 days of admission) and newly developed pressure ulcers.

For Quarter 2 the average rate for new pressure ulcers is 0.67% which is a decrease of 0.16 from quarter 1. The overall rate for Quarter 2 is 4.77% which is an increase of 0.78% from quarter 1. When benchmarked against national data (obtained from HSCIC) CHFT rate for all pressure ulcers is above the national average for Quarter 2 (4.27%) but below the rate for new pressure ulcers (0.93%).



Completed actions in Q2

- Specific targets have been set for the wards (in terms of numbers) in order to make improvement meaningful for staff.
- Ongoing clinical support and training is being provided to wards to ensure appropriate use of pressure relieving equipment, however, to date no wards have achieved required training and competency assessment for this equipment. The figure required is 95%.

- All severe (category 3 and 4s) CHFT acquired pressure ulcer investigations now have Senior Nursing approval at the completion stage.
- Introduction of a Pressure Ulcer Newsletter.
- Development of Pressure Ulcer audit tool.
- Tissue Viability team have commenced validation of severe pressure ulcers although the timeliness of this continues to present a challenge due to clinical demand.
- Implementation of action plans for 5 highest reporting wards to support improvement. Tissue Viability Nurses (TVNs) are offering/ providing support in terms of training and clinical advice.
    - For Quarter 2, 3 of the wards (11, 19 and 20) are within trajectory to achieve a 10% reduction of pressure ulcers. However, 5ad & 6bc have exceeded the trajectory for this quarter and 5ad have exceeded the trajectory for the year.
    - Ward 11 have been supported by the Improvement Academy to introduce Consultant-led Safety Huddles, which include a focus on patients who may be at risk of pressure damage. Ward staff have completed pressure ulcer prevention training and patient care is being monitored through audit.
    - Wards 19 and 20 have developed care plans regarding the use of medical devices such as braces. Staff have also completed pressure ulcer prevention training (including the use of equipment).

Improvement Plan:

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

- Introduction of a new pressure ulcer risk assessment tool. Work is ongoing to establish whether this tool can be successfully adopted in line with the introduction of the Electronic Patient Record (EPR).
- Competencies for the prevention and management of pressure ulcers will form part of the competency assessment for new nurses however, the competencies require approval from the Training group before they can be adopted across the organisation.
- Doncaster model of training: an expert nursing programme is being delivered across Doncaster & Bassetlaw Foundation Trust. This has realised a 30% drop in pressure ulcers. However, this was supported by the recruitment of 3 additional Tissue Viability Nurses. A review of this approach is to be completed, in terms of resources at CHFT, once the impact of the Care Closer to Home contract for the Tissue Viability Service is understood (November 2015). The Doncaster model of training has been supported at board level with an expectation that wards lead their improvement with support from the specialist team. This support includes independent audit and rigorous competency based training on pressure ulcer prevention and management. The specialist nurses support a number of ward areas for a period of 6 months. This includes a 2 day training programme for key members of staff (including ward sisters/ charge nurses). Competencies are assessed by the tissue viability nurses and in order to complete the training staff must achieve 90% to pass; this includes practical and cognitive skills.

- New equipment (Repose Wedge) has been evaluated. This device offloads pressure from the heel thereby reducing the risk of pressure ulcers. Feedback from the ward areas has been positive. The Tissue Viability team has commenced the procurement process.

Community plan

- Pressure area training should be delivered to all community teams.
    - Monthly training sessions are being delivered to community nursing staff. Non-nursing teams have also been invited to attend. Training includes pressure ulcer prevention and management.
- Information for care staff needs to be clear, specific and patient focused and highly visible.
    - A communication sheet is in development in order to improve communication between District Nurses & Home Care staff.
    - Development of a tool to raise awareness of levels of risk for patients in residential care homes is in development.
- Concerns with care agencies or care staff should be escalated in a consistent and timely way.
    - This aspect of care is included within staff training and communication will be delivered to raise awareness regarding reporting processes.
- Skin inspection should be integral to the role of all relevant professionals. Care between multiple professionals should be joined up with clearly defined responsibilities. Daily handover should include a discussion around every patient who has been seen who is at high risk of developing a pressure ulcer.
    - A community team is working with the Improvement Academy to introduce the Safety Huddle. A multi-disciplinary approach will be adopted.
    - Quality indicators will be shared with community teams.
    - Investigations into severe pressure ulcers are being shared at the divisional Patient Safety & Quality Board meetings. A monthly thematic report will be shared at team brief.
- Ensure that patients who are refusing pressure area care are fully aware of the risks involved.
    - A patient information leaflet is available, however a pictorial guide will also be produced to aid discussions with patients and their families.
    - Issues relating to patient choice, mental capacity and documentation is included in the training programme being delivered to all community staff.
- Patients should be given individualised self-management plans to manage their pressure area care.
    - Self-management plan is in development.
- Equipment checks should be carried out as part of pressure area care.
    - This will be added to the SystmOne care plan.

1.3 Reducing Hospital Acquired VTEs

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

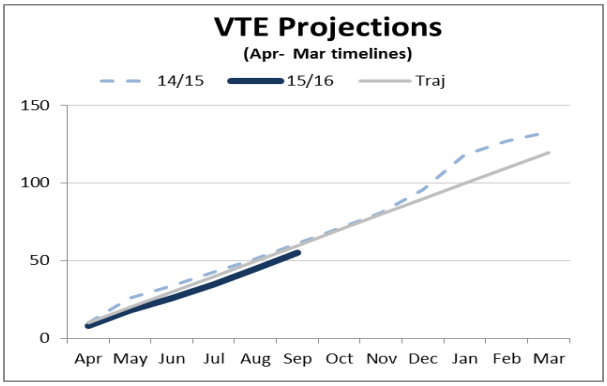
It has been estimated that the management of hospital associated VTE costs the NHS millions per year. This includes the costs of diagnostic testing, treatment, prolonged length of stay in hospital and long term care. Long term complications that reduce the quality of life add to the human cost and overall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

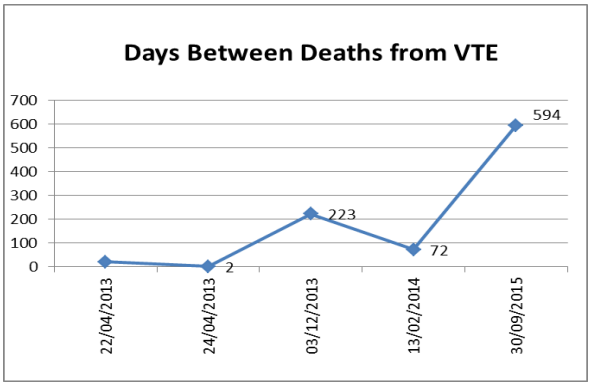
The VTE Committee agreed new trajectories for 2015/16 as follows:

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

Current Performance

The Trust achieved all its VTE targets for quarters one and two:





All HAT Cases are subject to a Root Cause Analysis. There were 30 cases throughout July 15 – September 15. Of these 30 cases, none were found to be avoidable. All had been correctly assessed for the risk of developing a VTE and had been prescribed the appropriate prophylaxis where indicated or had contraindications to receiving prophylaxis. These findings

are shared with the Divisional Patient Safety Quality Boards on a quarterly basis and the Patient Safety Group six monthly.

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

The table below shows how we are performing in comparison to other local trusts on VTE risk assessments in Q1. Data is not available for the most recent quarter.

	Quarter 1 2015-16		
Organisation Name	VTE Risk Assessed Admissions	Total Admissions	% of Admitted Patients Risk - Assessed for VTE
BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST	24663	24958	98.8%
YORK TEACHING HOSPITAL NHS FOUNDATION TRUST	31702	32649	97.1%
LEEDS TEACHING HOSPITALS NHS TRUST	43997	45861	95.9%
MID YORKSHIRE HOSPITALS NHS TRUST	33622	35165	95.6%
AIREDALE NHS FOUNDATION TRUST	13720	14359	95.5%
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	23430	24605	95.2%
	3371530	**3513583**	**96.0%**

Improvement plans for Q3 2015/16

In order to maximise any learning, a new process has been designed for reviewing all HAT cases. This process has been signed off by the Thrombosis Committee and will be in place from the 1st November. Feedback will be available in the Q3 report.

The VTE assessment is being developed onto the nerve centre. There is not yet a date for when this will be implemented, but once it is established it will be piloted and then rolled out trust wide. This will have the benefit of monitoring completion in real time, meaning where assessment are not done this will be picked up on whilst the patient is still in our care and rectified at the point of needs

1.4 Medicines management

Aims and Objectives of Work

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

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

- To reduce unintentional missed doses to a target of less than 10% by April 2016.
- To improve the percentage of patients who had their medicine reconciled on admission – with a 2015/16 CQUINS target of 80% by the end of the year
- To improve the percentage of patients who had pharmacist approval of discharge prescriptions – with a 2015/16 CQUINS target of 70% by the end of the year.
- To look in detail at improving discharge processes as part of a local CQUIN.

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

Q2 Performance:

Missed Doses:

The Trust wide missed doses audit monitors intentional and unintentional missed doses (see table below for overview of the differences) with a focus on blanks, ticks and crosses which are in breach of policy as outlined in section 12 of the Medicine Code (Preparation & Administration of Medicines).

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

The next Trust wide missed doses audit will take place week commencing October 12th. Data will be collected for one 24 hour period in order to establish the number of intentionally missed and unintentionally missed doses.

	Q1 15/16	Q2 15/16
For all missed doses	13.37%	Audit being undertaken week commencing October 12th
Intentional missed doses	5.57%	
Unintentional missed doses	7.80%	
Blanks	216	
Ticks/crosses etc	32	

In order to ensure that performance continues to improve, the results will be fed back to all Ward Managers/Matrons, the Nursing and Midwifery Practice Group and to the Nursing and Midwifery Committee.

There is an ongoing campaign to encourage patients to bring all their medicines and diabetes related equipment into hospital with them so they can manage their medicines if they are able and reduce the number of missed/delayed doses. The campaign has targeted both Primary and Secondary care. Focus in Primary Care has been GP Practices, Health Centres, Schools, Community Centres, places of worship, Social Services, Council offices amongst others. In Secondary Care admission areas continue to be targeted to encourage relatives/carers to bring medicines into hospital and encourage the transfer of medicines with patients when they move areas.

Wards are encouraged to check Prescription Chart & Administration Records on each shift change/handover to check documentation and ensure doses have not been missed. It also gives the opportunity to challenge practice. Identifying missed doses and raising any concerns with the nurse in charge is also part of the mock CQC medicines management audits. These audits are used to populate individual ward/departmental action plans for improvement.

In the future, EPR will allow CHFT to run missed/delayed dose reports at any point so missed/delayed doses, good practice and practice in need of improvement can be identified and acted upon quickly.

Medicine Reconciliation and Discharge Checking (CQUIN):

The target for medicines reconciliation was not met in August, which was partly due to pharmacy staff vacancies and additional demands of extra capacity wards remaining open. A significant improvement was seen in September due to additional resource (from within existing staff) targeting 2ab at Calderdale. This is a high turnover area and patients were being discharged before clinicians had resolved medicines discrepancies identified by pharmacy staff to ensure that medicines were reconciled. A prescribing pharmacist was able to resolve a number of issues to assist with medicines reconciliation.

6 - Improving Medicines Safety Support the effective transfer of information about medicines when patients are being transferred from one provider to another following an unplanned admission to hospital	Quarter 1			Q1	Quarter 2			Q2
	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15	Total
The number of patients on acute medical wards having a medicines reconciliation process by pharmacist or pharmacy technician during hospital stay	644	634	675	1953	605	590	702	1897
The total number of patients admitted to acute medical wards	797	788	862	2447	760	746	805	2311
% Medicines following the reconciliation process	81%	80%	78%	80%	80%	79%	87%	82%
Target	80.0%				80.0%			

Numerator Denominator

Targeted improvement work in September is expected to recover the quarter performance.

Part 6.2 - Discharge Accuracy Checks	Quarter 1			Q1	Quarter 2			Q2
	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15	Total
The number of patients (admitted for longer than 24 hours) on acute medical wards having their e-discharge prescription approved and reconciled against the inpatient prescription chart by a pharmacist	797	788	862	2447	760	746	805	2311
The number of patients (admitted for longer than 24 hours) on acute medical wards	1127	1064	1149	3340	881	844	898	2623
Discharge Medication - total	70.7%	74.1%	75.0%	73.3%	86.3%	88.4%	89.6%	88.1%
Target	70.0%				70.0%			

Pressure will remain to deliver 80% medicines reconciliation throughout Q3 & Q4. Staff have been recruited to fill vacant positions and there will be a period of training required. Extra capacity wards have remained open during the summer period and it is anticipated that further wards will open to accommodate medical patients during the winter period.

Improving Discharge Processes (CQUIN):

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

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

There are two elements to this CQUIN:

Part 1 – to improve the accuracy of information on the e-discharge about medication changes made during the admission. This builds on the discharge accuracy check which just focuses on transcription of the medicine chart.

Quality of information on discharge has already been identified as an issue and junior medical staff have made suggestion to change the Drug prescription and Administration to

include an simple tool for recalling what was required, as such the acronym 'PAN' was added to the prescription chart, standing for:

P =Pre-admission drug
A =Amended dose
N =New Drug

The following elements of the e-discharge will be audited against the patient's notes and the medicine chart before discharge:

- Medicines reconciled
    - If not reconciled – is the TTO a full list of all medicines
- Accurate transcription of discharge medication from the medicine chart
- Correct information about medication changes
    - Medication changed (i.e dose amended or started)
        - Includes reason
    - Medication stopped
        - Includes reason
    - Medication to be continued by GP
        - If no, course length specified

A bundle approach will be applied – i.e all elements need to be correct.

Measure – monthly audit discharges from identified wards

- 10 from 6b and 8
- 5 from 7d and 4

Improvement targets:

Time Period	Proposed Targets	Actual
Q1 – Baseline	n/a	40%
Q2	45%	63%
Q3	50%	
Q4	55%	

Part 2 – Ensure that patients leave the hospital with correct medication. There continue to be errors when patients are discharged from hospital as incorrect medication is given to patients e.g. incorrectly labelled, unlabelled ward stock, medication which has stopped during the admission.

Currently it is nursing staff responsibility to hand medication to patients at the point of discharge. In Q1 the process of giving medication to patients has changed from a two nurse check to a single nurse checking discharge medication. It is anticipated that a one nurse check will take more responsibility for ensuring correct medication is supplied and should reduce any errors on discharge.

On the test wards, the plan is to eventually have a Pharmacy Technician to go through the medicines with the patient on the day of discharge, but we are not likely to have this person

in post until mid-way through Q3. Therefore during Q2 we would record the number of locker checks undertaken on the day of discharge, which would make sure that the medicines in there were relevant to the discharge.

Targets for this would then become:

	Target	Actual
Q1	Nil	Nil
Q2 Measure baseline of number/percentage of locker checks being carried out (and recruit technician)	Baseline	22/25 (9 n/a – MDS)
Q3 Increase the number of locker checks and establish a baseline for the information giving/bag go through element by the technician		
Q4 Increase the information giving element, increase/maintain locker checks depending on level of compliance already seen, this task could be replaced by the technician so may no longer need to measure this.		

National Drug Safety Alerts

Safe and Secure Storage of Medicines - A tool has been developed for use by matrons and ward managers to assess compliance with national standards.

Nursing and pharmacy staffs are being more proactive in identifying areas of concern and risks addressed. Newsletters will be used to reinforce and remind staff about action required

Q3 planned improvement:

Learning and Development:
Four mandatory modules of the e-learning package SCRIPT have been introduced this year to help safer prescribing by FY1s.

Medication Safety:
The Diabetic Collaborative is still working on an aid memoire to improve understanding of the different types of insulins and duration of action.

Incidents involving Oxycodone are a reccurring theme. Information has been distributed to prescribers, nurses and pharmacy staff updating and reinforcing the standards for **S**torage, **P**rescribing, **R**ecording, **E**ndorsing, **A**dministering and **D**ispensing.

Clinical areas have been issued with a laminated poster which is to be applied to the medicines trolleys and displayed where intravenous medicines prepared.

Nursing leads have been undertaking work looking at the storage and management of medicines in their clinical areas with the aim of identification of any gaps and areas for improvement.

A task and finish group is meeting in Q3 to discuss Controlled Drug management in the Trust.

1.5 Improving Sepsis Care

Aims and Objectives of Work:

Sepsis is a complex disease process associated with multiple pathologies, and high mortality rates. Sepsis causes about 37,000 deaths per year in the United Kingdom alone, as such accounting for more deaths than lung cancer alone, or breast and bowel cancer combined (Survive Sepsis, 2010).

Early identification and intervention improves both morbidity and mortality from sepsis. The UK Sepsis Trust, working with Health Education England (HEE) have produced a number of clinical tools to support consistent recognition and response across primary and secondary care.

We have had a sepsis collaborative for 6 years that includes clinical staff from all admitting areas (emergency department, medical/surgical assessment units etc), intensive care, pharmacy, microbiology, informatics and governance. The work has been focussed on improving identification and early treatment of patients with sepsis across the organisation.

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

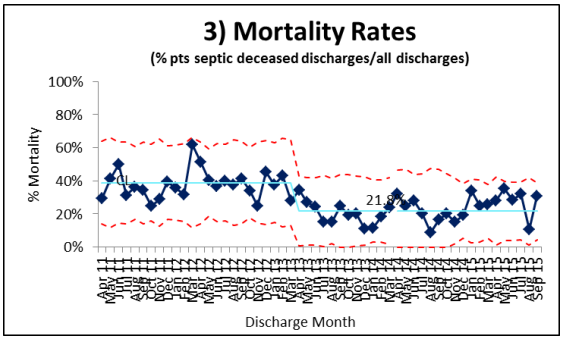
- 90% by Quarter 4 of emergency admissions being screen for sepsis where appropriate. ***Quarter 2 target was to continue to establish a baseline position.***

- 90% by Quarter 4 those patients who have been identified as Septic having received antibiotics within an hour of admission. ***Quarter 2 target was to continue to establish a baseline position.***

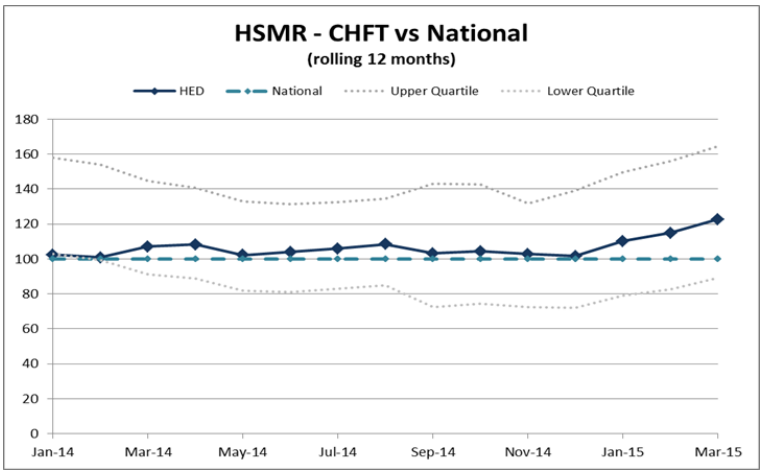
Q2 Performance:

Over the last two quarters the crude mortality rates for patients diagnosed with sepsis has been higher than the 14/15 average. Q2 average mortality rate was lower than that of Q2 due to a particular favorable August position. This is shown in the charts below:

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



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



The Sepsis Collaborative maintains a close eye on the key metrics each month, and there is no clear reason for the apparent rise in mortality. The Trust has recently begun a mortality case note review process (see section 2.1). During Q2, 14 out of the 36 sepsis deaths underwent review, 10 cases showed no evidence of preventability and scored a Hogan 1. 1 case scored a Hogan 2 - Slight evidence of preventability. A Hogan 2 is assigned when there are elements of the care which could have been improved but were extremely unlikely to affect the patient outcome, in this instance it was related to the non-delivery of antibiotics within the hour. 3 cases scored a Hogan 3 or above, all three are now ongoing second level review.

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

Screening for Sepsis:

Performance for Q2 was 40% of applicable patients being screened; this was considerably less than the first quarter. This dip in performance was expected as due to the nature of the sampling, a large proportion of A&E admissions were present in the Q1 sample which is an area the trust is known to perform better with sepsis screening compliance. It was agreed that Q2 would have a greater focus on emergency admissions went directly to the admission wards. The CQUIN aims were met as indicated by the green box below. It will be now to determine a sensible Q3 target.

	Quarter 1			Q1	Quarter 2			Q2
2.2a - Sepsis Screening	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15	Total
Number of emergency patients who had a NEWS score of 5 and above and were screened for sepsis	5	5	5	**15**	**4**	**4**	**2**	**10**
The total number of emergency patients who require screening for sepsis according to the agreed local protocol (NEWS of 5 and above on admission)	6	6	5	**17**	**9**	**8**	**8**	**25**
% Eligible patients screened for Sepsis	**83.3%**	**83.3%**	**100.0%**	**88.2%**	**44.4%**	**50.0%**	**25.0%**	**40.0%**
Target	**Baseline**				**Further Baseline Data**			

Antibiotics within an hour:

The CQUIN aims for Q1 and Q2 were to gather enough data to have a baseline to work from going forward – this was achieved and is indicated by the green box in the performance table below. This audit requires consultant resources and due to the time required to carry out the audit it has resulted in the September data being delayed. However this will be updated in the Q3 report.

	Quarter 1			Q1	Quarter 2			Q2
2.2b - Sepsis Antibiotic Administration	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15	Total
Number of patients (in sample) with severe red flag or septic shock who received IV antibiotics < 1 hour	3	5	5	**13**	9	6	12	**27**
Patients who had recorded evidence of severe, Red Flag or Septic Shock on emergency presentation who should have IV antibiotics < 1 hr	7	17	8	**32**	12	12	12	**36**
% Patients with severe red flag or septic shock that received Iv antibiotics < 1 hour.	**42.9%**	**29.4%**	**62.5%**	**41%**	**75.0%**	**50.0%**	**100.0%**	**75%**
Target	**Baseline**				**Further Baseline Data**			
					*Partial Dataset	*Partial Dataset		

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

What we have achieved in Q1/2

- The new sepsis protocol includes a new trigger to identify high risk/red flag sepsis at an early stage and initiate treatment. This was rolled out in September to coincide with World Sepsis Day. We expect to see an impact into Q3

- The GP referral criteria have now changed for admissions into MAU and SAU, to again capture early indicator of sepsis. GPs will now be asked to complete initial observations on referrals. This started in May and has been rolled out during Q2.

- Tested process for the collection of CQUIN data, recognition that support will be needed to ensure this process is as smoother and therefore more effective in both the collection of the information and the learning from any findings – further support has now been accessed with a plan to include a specific Quality Improvement lead for the project and management support to ensure consistent measurement.

Improvement plans for Q3:

- In Q3, ward and Emergency Department education on the new protocol will be rolled out to reinforce learning and ensure all staff, medical and nursing, are fully aware of changes and are confident to identify and respond to patients who have sepsis.

- Q3 – further tests using quality improvement methods will be agreed within the Sepsis Collaborative to refine screening at all admission points and reduce time to antibiotic. These will be undertaken in specific clinical areas prior to widespread roll-out.

- Introduce a lead practitioner for sepsis to support the collaborative in meeting the CQUIN over the next six months. They will lead the improvement work, including training/education.

1.6 Safeguarding Patients

Aims and Objectives of Work

Aims for the work are to:

(i) Safeguard children and adults at risk through further development of the partnership between health and social care in Calderdale and Kirklees.

(ii) To ensure effective communication and engagement with staff and the public in respect of the work of the Trust and the wider safeguarding agenda

It is vital that Safeguarding standards are maintained, continue to improve and accountability remains clear and unambiguous. With this is mind safeguarding remains a key priority within the Trust for 15/16 and that staff are fully supported in delivering safe and quality services.

(i) Quarter 2 Progress.

Safeguarding Adults and Children remains an integral aspect of patient care, and requires services to work effectively together and across boundaries to prevent harm and intervene when harm, neglect, or abuse is suspected.

There were 58 adult concerns reported in Quarter 2 in Calderdale compared to 77 in quarter 1; and respectively 75 concerns reported compared 54 in Kirklees. This data is captured from Datix and work is ongoing to ensure accuracy. Of these concerns 52% and 37 % respectively proceeded as adult safeguarding referrals. The remaining referrals were reported as quality of care concerns and did not proceed down the safeguarding procedures.

Data capturing continues to be reviewed and analysed, alongside other mechanisms for collecting data. Data now is captured by division which will provide information for divisional managers regarding numbers of concerns raised, ward or departments and type of concern. This data required further analysis in November and how this will be presented and shared Trust wide. Further work is planned to explore how more in-depth capturing and recording of pressure ulcers on Datix can illicit if pressure ulcers are preventable and potentially a result of abuse of neglect.

In order to address concerns on ward areas the Vulnerable Adults Operational Group has now formulated an action plan to support wards on a monthly basis. This will commencing in October 2015 and will focus on a number of areas such as nutrition, falls, pressure ulcers, dementia etc. As part of the action plan 'person centred walk-rounds' are aimed at supporting ward staff to ensure that the quality of care on the wards is discussed with ward staff and any concerns are addressed in a supportive mechanism with staff and actions required are followed up with Matrons. Concerns that do not meet the threshold for reporting into the safeguarding procedures can be addressed through the person centred walk rounds.

Originally work was planned to begin developing the safeguarding strategy; this is now planned for Quarter 3. This has been delayed to enable implementation of other priorities.

Internal lines of accountability and structures within the Trust are being reviewed to support both the safeguarding adult and children's agendas to enable a clearer process for the safeguarding committee to actively support and seek assurances from the Divisions and departments. Work has started to review the safeguarding structure and committee functions to promote inclusion of all divisions and departments. The safeguarding team continues to work closely with the risk department to provide advice and support in relation to complaints and incidents where safeguarding concerns have been identified. Further governance work is ongoing in engaging with Divisions ensuring safeguarding continues to be a priority, and attendance at Divisional Patient Safety and Quality Boards is ongoing.

Further plans in the forthcoming year follow acknowledgement of:

- The introduction of The Care Act 2014 in April 2015
- The continuation of The Children Act 1989/2004

April 2015 saw the introduction into primary legislation of the Care Act 2014, which now legislates Adult Safeguarding and imposes a legal duty on NHS organisations. This legislation replaces the 'No Secrets' guidance (Department of Health and Home Office, 2000). It not only addresses and recognises stopping abuse or neglect, preventing harm and reducing risk, but promotes an approach that improves the life for the adult concerned. The principles and values of adult safeguarding are built on empowerment, protection, prevention, partnerships, proportionality and accountability. This includes such duties for care providers as:

- Providers of care regulated by the CQC have a duty to report any allegations of abuse or neglect.

- Where there is an employee involved with a Section 42 formal enquiry, there will need to be an investigation by the provider and the sharing of information sufficient to include all facts in a Case Conference report.
- Employers must report all findings of abuse to the Disclosure and Barring Service and professional bodies.
- There is a Duty of Candour for Care Providers
- Local Authorities must cooperate with relevant partners, and those partners must cooperate with the Local Authority (The Care Act specifies NHS Trusts and hospitals, amongst others).
- There is in addition a greater emphasis on making safeguarding personal for patients in helping them achieve the outcomes that they want.
- The Trust should ensure that they have the mechanisms in place to enable early identification of risk and collaborate and work together, whilst considering the wishes of the adult on whose behalf they are working.

The legislation confirmed that:

- Safeguarding Adult Boards became statutory.
- There is a requirement to conduct Safeguarding Adult Reviews.
- Information sharing duties.
    - The statutory organisations for the Safeguarding Adults Board are the Local Authority, the Police and the Clinical Commissioning Groups.
    - All statutory agencies to have a Designated Adult Safeguarding Manager (DASM). A DASM would be involved where concerns are raised about an employee, volunteer or student, paid or unpaid. This role is recommended for members of Safeguarding Adults Boards

In addition to this the Trust is required to comply with The Children Act 1989/2004 which imposes a legal duty on all professionals to safeguard and protect children. The 'Working Together 2015' statutory guidance further emphasises the collective interagency arrangements of how agencies including NHS organisations must work together, and how this is implemented locally. Members of the Trust's Safeguarding Children's team attend both Calderdale and Kirklees Safeguarding children's Boards and their sub-groups.

They contribute to district wide strategies and work which is then disseminated within the Trust. An annual section 11 audit is carried out within Children's safeguarding services within the Trust which is sent to the Children's Safeguarding Boards. Section 11 of the Children Act 2004 places duties on a range of organisations and individuals to ensure their functions, and any services that they contract out to others, are discharged having regard to the need to safeguard and promote the welfare of children. It places a duty on NHS Foundation Trusts.

MCA and DoLS Audit June 2015 and October 2015

The increased number of Deprivation of Liberty Safeguards (DoLS) applications reflects increasing awareness of deprivation of liberty arising from the Mental Capacity Act (MCA).

There were 27 patients at HRI and 8 patients at CRH who met the acid test. A further audit is being carried out in October 2015.

The MCA/DoLS policy and procedures are currently being written.

A more comprehensive report has been prepared to action this. This report has identified a clear action plan which includes the development of a separate Mental Capacity Act and Deprivation of Liberty Safeguards Policy and Procedures which will be completed by the end of September, the production of a training plan, development of an action plan to increase knowledge and awareness in areas identified in the audit. A further audit has been carried out in October 2015.

ii) Training

The last quarter has again seen a decrease in compliance for level 2 and level 3 safeguarding training. Level 3 training remains better attended. There are plans to address this through the Workforce Department to identify members of staff using the Electronic Staff Record (ESR) system to ensure divisional managers are aware of members of staff who do not engage in regular mandatory supervision and that this is followed up. The safeguarding team is currently working with workforce development in relation to how target groups are defined and how training is recorded since a number of anomalies have been identified. An achievement plan is being developed to address this which will involve the further identification of divisional non-compliance and individual staff identification.

- Level 1 safeguarding continues to be delivered via written updates and briefings across the workforce in the form of the safeguarding newsletter which is circulated twice a year. It not only gives relevant information to meet the criteria for level 1 training, but it also supports levels 2 and 3 training and is currently at 100**%.** Level 1 training is now part of the induction training and as this is being captured through ESR the compliance is now 68.3%.

- Level 2 safeguarding training (Adults and Children) has seen a slight decrease again from 51.9 % to 48.4%. Training continues to be reviewed and in order to maximise learning and meet the needs of the diverse workforce and overall evaluates well. An eLearning package has been written and awaiting development and production to

improve compliance in this area. Unfortunately the eLearning package is not available for staff as yet.

- Level 3 safeguarding children training has decreased in the last quarter from 73.4% to 60.1%.

- Level 3 safeguarding adults training is not being recorded in %. Staff that require level 3 training have not been identified in a matrix and therefore further work is being carried out here.

- Master classes have been developed throughout 2015 in relation to the MCA and DoLS.

- **PREVENT** - Implementation of the PREVENT Strategy is now underway across the organisation, with significant progress being made. The Trust now had 9 accredited trainers and a clear training programme is currently underway**.** NHS England and commissioners are happy with our Implementation of this strategy and training continues to evaluate well. All staff are identified on ESR who require this one off training. PREVENT is now captured as a % and stands at 37.5%. 430 staff have been trained in the last quarter. There are 7,000 staff to train and there have been 25 sessions provided to improve Trust compliance.

Other work has included;

- Further update and development of the Trusts Intranet pages to facilitate easier access to safeguarding information. The safeguarding icon is now clearly visible on the intranet pages, and work continues to develop the content in order to make it easier for staff to access up to date safeguarding information.

- Publication of the 7th edition the Safeguarding Newsletter in June 2015 provided further updates and information for staff. The latest newsletter is currently being developed.

- Promotion of district wide events hosted by the local Safeguarding Boards

- Production of a safeguarding banner on the main intranet page which includes topical information evolving from serious case reviews, domestic homicide reviews and local and national guidance.

Improvement Plans for 2015/16 (Quarter 3)

CHFT continues to be represented at their planned regular meetings on both Children and Adult Safeguarding Boards and their subgroups in Calderdale and Kirklees, and work continues to ensure existing partnerships and collaborative work is maintained.

There is development of a safeguarding strategy and plan which has commenced and will be completed by November to ensure that CHFT policies and procedures seamlessly transfer information from admission to discharge and beyond whilst continuing to embed a safeguarding culture across all divisions. The children and adults policies have not yet been updated.

The content of the level 2 training has been updated and the safeguarding team are awaiting the compilation of an eLearning package for staff in an attempt to address poor compliance at level 2. There has been no progress on the provision of this to date.

Reporting of Female Genital Mutilation (FGM) is in place within the Trust and there is ongoing development of a pathway. This pathway is expected to be completed by November 2015. The Safeguarding team engage with both strategic and operational groups relating to Child Sexual Exploitation and both these are being referred to in the safeguarding policies. This work is ongoing.

Datix Incident Reporting: Further ongoing work is continued to ensure that systems are in place where safeguarding concerns are reported through the Trusts internal reporting mechanism. This work also includes ensuring the Trust is meeting its obligations in relation to the Care Act 2014 by involving the Local Authority partner organisation.

Lessons learned from Serious Case Reviews/ Domestic Homicide Reviews and Serious Adult Reviews are being currently being collated to ensure that actions and lessons are disseminated and actioned Trust wide. This task and finish group is planning its commencement in September. This work is to commence.

The safeguarding team have worked with the Risk Department to contribute to the Incident and Inquest policies and been involved with ensuring that safeguarding cases are highlighted with the risk department.

The Safeguarding team are contributing to the Allegations Management Policy and reviewing this to ensure clearer systems and processes are in place to ensure appropriate referrals are made to the statutory agencies.

Overview of Current Performance KPIs	Trajectory for Q4	Quarter 1	Quarter 2
JOB DESCRIPTION	ALL JD's	Included	Included
TRAINING - LEVEL 1 %	100		68.3
TRAINING - LEVEL 2 (%) Joint Children and Adults	90	51.9	48.4
Training - Level 3 (%) Adults		x	x
TRAINING - LEVEL 3 (%) Children	90	73.4	60.1
Numbers - Prevent Trained	100	280	37.5
% LAC IHA WITHIN TIMESCALES	95	60	100
% LAC RHA WITHIN TIMESCALES	95	85	86.0
% SUPERVISION for HV's and ScN	90	89	
% SUPERVISION for Specialist Midwives	90	75	75
% Supervision for others Children Services	50	40	10

1.7 Learning from Incidents

Key messages:

- 8% Increase in CHFT incidents recorded in Q2 compared to Q2 in 2014/15
- Year to date increase in incidents reported by 17% compared to first 6 months of 2014/15
- Suspected falls is the top reported incident in Q2
- Medical Division is the highest reporter of incidents in Q2 (47% all incidents)
- Labour Delivery Recovery Post Natal Unit is the highest reporting department (194 incidents)
- 30 pressure ulcer incident Serious Incidents (SIs) Q2, 5 other SIs
- No never events in Q2

Numbers of Incidents

For the period 1 July 2015 to 30 September 2015 a total of 3,053 incidents were reported by CHFT members of staff. Of these, a total of 2,467 were CHFT related incidents.

Incidents by Organisation and Quarter	14/15 Q1	15/16 Q1	Movement	14/15 Q2	15/16 Q2	Movement
Nursing Agency	0	1	↑	1	0	↓
Bradford Teaching Hospital Trust	0	1	↑	2	1	↓
Care UK - out of hours doctors in Halifax	0	0	=	0	2	↑
Castleford & Normanton District Hospital (Health Informatics)	0	1	↑	0	1	↑
Calderdale & Huddersfield NHS Trust	1938	2402	↑	2239	2476	↑
Coop Pharmacy	2	11	↑	5	2	↓
Calderdale CCG was Calderdale PCT	34	154	↑	122	131	↑
External Agencies	139	32	↓	55	36	↓
GP Surgeries Calderdale (Health Informatics)	0	1	↑	0	1	↑
Greater Huddersfield CCG was Kirklees PCT	131	135	↑	121	144	↑
Leeds Teaching Hospitals	5	6	↑	1	2	↑
Mid Yorkshire Hospitals NHS Trust	1	2	↑	0	0	=
NLA Embankment Leeds (Health Informatics)	0	1	↑	0	1	↑
Nursing/Care Home	110	169	↑	155	133	↓
Other PCT	3	0	↓	3	0	↓
Screening Programme	0	3	↑	0	1	↑
South West Yorkshire Mental Health Trust	1	5	↑	4	4	=
Yorkshire Ambulance Service	14	21	↑	27	34	↑
Totals:	2378	2945	↑	2735	2969*	↑

*This excludes 93 incidents still being coded and allocated to the appropriate organisation.

The above table shows that the number of incidents report has increased (increase of 225 incidents, 8%) in Q2 compared to the Q2 in 2014/15.

It is positive to note the number of CHFT incidents reported continues to increase into Quarter 2, indicating a continuous improvement in reporting culture. The year to date position is a 17% increase in incidents reported, with 885 more incidents reported in the first 6 months of 2015/16 compared to 201415.

CHFT Incidents

The top 20 reported incidents for Quarter 2 are given below with suspected fall accounting for 36.5% of these:

2015-16 Incidents : Top 20 reported incidents	Q2
Suspected fall	391
Lack of suitably trained /skilled staff	199
Pressure Sore Grade 2	69
Fall on level ground	65
Medicine not administered	57
Simple complication of treatment	51
Accident of some other type or cause	51
Hospital Acquired Pressure Sore Grade 2	43
Patient incorrectly identified	41
Physical abuse, assault or violence	41
Failure to note relevant information in patient's record	41
Delay	40
Discharge - planning failure	39
Fall from a height, bed or chair	34
Communication failure - outside of immediate team	34
Missing, inadequate or illegible healthcare record	33
Injury from dirty sharps	29
Breach of Isolation Policy	29
Dose or strength was wrong or unclear	27
Resulting in 3rd or 4th degree tear	27
Totals:	1341
Total falls incidents:	490

Incidents by Divisions:

The tables below show that the number of incidents reported in Quarter 2 per Division, with the Medical Division reporting 47% of total incidents

Incidents reported by Division 2015-16	Q2
Medical Division	1152
Families and Specialist Services	622
Surgical & Anaesthetics Services Division	457
Community Division	202
Estates and Facilities	29
Corporate Division	5
Totals:	2467

Incidents by Department:

The table below identifies the highest reporting ward/department (Top 20):

	Q2
Labour Delivery Recovery Post-natal Unit	194
Patient's Home	163
Accident and Emergency	137
Operating Theatre	82
CWD2C MAU CRH	75
HRI MAU	66
HWD19 Trauma	58
CWD5D	56
HWD6	54
HWD8	54
CWD6C Cardiology CRH	54
CWD2D MAU CRH	54
Outpatient Department	52
CWD7D	45
Intensive Care Unit/High Dependency Unit	44
CWD6B	44
C3 Paediatrics	44
CWD7B	44
CWD7A	42
Neo-Natal care unit	42
Totals:	1404

Incidents by Severity:

The numbers of incidents by severity are:

	Q2
Green	1773
Yellow	609
Orange	45
Red	40
Totals:	2467

Learning from Incidents:

Examples of learning from incidents:

Incident	Investigation Highlighted	Actions
Datix ID: 118248 Patient's sodium levels were significantly increased.	Areas for improvement: 1) There isn't readily available guidance for the making up of normal milk feeds irrespective of method of administration whilst babies and children are in hospital. There needs to be written information readily available to all parents such as 'Start to Life Guide to Bottle Feeding'. 2) Where babies have been admitted with feeding problems there is no care plan to directly observe parents competency in making feeds up appropriately. 3) Prescribed medicines are being added to feeds by the parent or guardian un-witnessed by the nursing staff. 4) Prescribed medicines are being added to feeds and are not signed for on the drug chart. 5) There was no consultant review within 24 hours of admission as per national guidance. There was no consultant review until day three of admission and only due to significant clinical deterioration. That said although there was no Consultant review there is documented evidence of discussion with the Consultant on the ward. Earlier Consultant review may have raised concerns earlier however this is unlikely to have impacted on the eventual outcome. 6) There are a number of concerns regarding	Recommendations: 1) The ward to provide parents ready access to verbal and written advice on the make-up of all infant formula feeds. 2) If a baby is admitted with feeding problems that there is an assessment of feed preparation and feeding by parents or carers with a completed care plan. 3) All medications given whilst in hospital are prescribed on a drug chart. Administration of all medications must be signed for on the drug chart and administration directly supervised by qualified nursing or medical staff. 4) Consultant review of all children within 24 hours of admission (in line with RCPCH standards).

	documentation that include: a. No documentation of clinical review b. Incomplete labeling of admission sheet and fluid balance charts c. Poor quality documentation of medical review	
Datix ID: 119837 Incorrect reporting of x-ray resulting in delayed diagnosis of cancer	Areas of concern: • Member of staff made an error in interpreting a plain chest x-ray which resulted in the patient, the family and the GP being reassured that it was normal. • It has been established that there is no standard operating procedure on maximum lengths of time for reviewing x-rays or scans; or how often breaks should be taken during these sessions. • There was a delay in reporting the error as an incident which was identified on 11 February 2015 and reported on 27 April 2015.	Recommendations: • The final report must be shared with the patient. • The Trust should develop guidance/SOP with regard to maximum lengths of time for reviewing x-rays or scans; or how often breaks should be taken during these sessions. • The member of staff reflects on the incident with the Clinical Director for Radiology with a view to improving standards and reducing the risk of errors in the future. • Incidents should be reported as soon as the incident/error is noted via the trust's Datix Incident Reporting System.

Incidents Classed as "Serious" Reportable to the CCG:

In Quarter 2, 35 incidents were identified as being "serious" and required reporting to the CCG/NHS England via STEIS. The types of incidents were:

Breach of patient confidentiality	1
Diagnosis – wrong	1
Pressure Sore Grade 3	27
Pressure Sore Grade 4	3
Discharge – inappropriate	1
Lack of clinical or risk assessment	1
Unexpected admission to Neo-Natal Unit	1
Totals:	35

All incidents were reported on STEIS within the 48hr timescale.

The Executive team were provided with a brief description of the non-pressure ulcer related incidents at the time the incidents were identified.

Never Events

As in Q1, there were no Never Events reported within Quarter 2.

Improvements:

An update against improvement areas for 2015/16 is given below:

Improvement	Progress
To improve and increase the number of incidents reported	Cumulative 17% increase in incidents reported for first 6 months 2015/16 compared to the same period in 2014/15, demonstrating a continued improvement in the number of incidents reported.
To increase the number of trained investigators	A number of RCA training sessions have now been provided. Investigation training is to commence in October 2015.
To improve quality of investigation reports (through the action above)	Introduction of the updated reviewed Incident Management Policy provides new reporting templates. This will therefore become more evident in future investigations.
To improve the timescale for booking 72hr incident panels	This continued to be a challenge in Quarter 2. However, a number of panel slots have been reserved within the Directors diaries to ease facilitation of these. The new Incident Management Policy has extended the timescale of 72 hours.
To develop mechanisms to report: Investigation themes/ Learning themes	In development; Identified within the new Incident Management Policy.
To develop linkages with Complaints/ Coroners cases to ensure appropriate incidents/investigations are highlighted and undertaken.	This is an ongoing development. However, all new cases as discussed and linked via Datix and our investigation process.
Work continues on reducing harm from falls and pressure ulcers	This work continues with the nominated leads.

In August 2015, the Patient Safety Group received a paper which provided the results of a review of the last 3 years (1 April 2012 to 31 March 2015) orange (moderate harm) investigation findings. This looked at:

- The number of incidents reported;
- Types of incidents;
- Time of incidents;
- Themes and trends from the investigations, which identified the following:
  - Human error
  - Not following Trust Policy/Protocols
  - Documentation (failure to complete/lack of)
  - Communication
  - The majority of incidents took place during normal working hours

1.8 Ensuring Effective Investigations

Aims and Objectives of Work

Whilst a high level of resources are utilised by the Trust to investigate complaints and incidents, (often from senior clinical staff), it is difficult to evidence positive change as a result. Improving the efficiency of the investigations process was the focus for establishing the Effective Investigations Group in January 2015.

The group aims to:

- Advise the corporate and clinical divisions of CHFT on their CDP (clinical delivery problem) investigations processes.
- Incorporate human factors and evidence based methodology to service delivery problems (SDP) and care delivery problems (CDP) investigations
- Streamline reporting of incidents and near-misses
- Design, pilot and make available SDP/CDP investigative tools across CHFT.
- Develop educational material (e.g. written, eLearning and workshop materials as appropriate) to train CHFT staff in incident investigations

Current Performance

The last three months have been focusing on establishing the group and engaging relevant stakeholders both within and outside CHFT. Initial discussion with key staff has highlighted the following points that need addressing:

- Variance in the quality and depth of investigations being completed
- There are different tools in use and little standardisation.
- Investigators have not been formally trained
- Often investigations do not reveal the root causes, contributory factors and latent conditions
- There is a mismatch between recommendations which tend to be far reaching rather than actions generated which tend to be easier to implement
- There is a lack of shared learning from investigations
- Reporters do not feel they receive any feedback and this adversely affects their willingness to report.
- It is difficult to evidence change as a result of investigations.

- Implementation of the duty of candour reliably will need a robust structure and guidance and support for staff.

Improvement Plans for 2015/16

- A detailed action plan has been written, progress against this will be reported as part of the CQC dashboard and actions plan on a monthly basis to Clinical Outcomes Group.

- The first of 10 per year in-house Effective Training days was held on 14 October 2015. The training day is proving to be popular, with a waiting list for the next courses already.

- Trust wide awareness and communication for the Effective Investigation Group has been developed for dissemination in October 2015 via the Trust newsletter.

- Current barriers to timely roll-out continue to be lack of availability of training rooms. This is proven to be a problem only at Calderdale site. The situation has been escalated to the Education Department.

- Liaising with Datix and site visits to neighbouring trusts is ongoing to improve the IT integration of Datix with PAS and to optimise CHFT use of Datix. Small capital investment may be required for IT upgrades, and authorisation for this will be sought but incurring any expense.

- The Trust Incident and Investigation Policy has been reviewed and reporting templates developed to incorporate the latest NHS England Serious Incident framework guidance, greater clarity on how learning from incidents is shared, more structured report templates and clarity on responsibility for completion of actions

1.9 Central Alerts System (CAS) Alerts

Aims and Objectives of Work

The Central Alerting System (CAS) is a web-based cascading system for issuing patient safety alerts, important public health messages and other safety critical information and guidance to the NHS and others, including independent providers of health and social care

Current Performance

There were 35 Alerts received in Q2 (between 1 July – 5 October 2015)

35 - TOTAL RECEIVED - 1.7.15 TO 5.10.15 (+1 outstanding alert from Q1)
31 – CLOSED ALERTS (8 - ACTION COMPLETED – AS BELOW AND 24 - ACTIONS NOT REQUIRED)
1 - ACTION COMPLETED FROM LAST QUARTER
4 – ONGOING (as below)

Reference	Alert Title	Originated By	Issue Date
MDA/2015/033	Sterile electrosurgical forceps and electrodes. Manufactured by Zethon Limited and Ross Electro Medi ...	MHRA Medical Device Alerts	26-Aug-15
MDA/2015/032	Charging base for surgical hair clippers. Manufactured by Medline Industries	MHRA Medical Device Alerts	25-Aug-15
MDA/2015/031	Home-use blood glucose monitoring system: Accu-Chek Mobile meter and Accu-Chek Mobile test cassette ...	MHRA Medical Device Alerts	18-Aug-15
NHS/PSA/Re/2015/007	Addressing antimicrobial resistance through implementation of an antimicrobial stewardship programme	NHS England	18-Aug-15
MDA/2015/030	Shiley neonatal and paediatric tracheostomy tubes, manufactured by Medtronic (previously Covidien): ...	MHRA Medical Device Alerts	05-Aug-15
MDA/2015/029	All Accu-Chek® Insight insulin pumps. Manufactured by Roche Diabetes Care	MHRA Medical Device Alerts	04-Aug-15
MDA/2015/025	1.TransWarmer infant transport mattress 2.NovaPlus TransWarmer infant heat therapy mattress with War ...	MHRA Medical Device Alerts	06-Jul-15
MDA/2015/012	INRatio® and INRatio®2 PT/INR coagulation monitor and test strips used at home and at poin ...	MHRA Medical Device Alerts	19-Mar-15

The 4 Alerts still open and on-going are:-

Reference	Alert Title	Originated By	Issue Date	Response	Deadline On-going
MDA/2015/035	Enteral syringe pumps P500, P700 and P900 - recall because CE marking is invalid. Nutritional nurse ...	MHRA Medical Device Alerts	29-Sep-15	Assessing Relevance	27-Oct-15
MDA/2015/034	Implantable medical devices manufactured by SILIMED - Industria de Implantes Ltda	MHRA Medical Device Alerts	25-Sep-15	Action Required: Ongoing	09-Oct-15
NHS/PSA/RE/2015/008	Supporting the Introduction of the National Safety Standards for Invasive Procedures	NHS England	14-Sep-15	Action Required: Ongoing	14-Sep-16
MDA/2015/027	Steel cannula infusion sets manufactured by Unomedical a/s	MHRA Medical Device Alerts	23-Jul-15	Action Required: Ongoing	23-Oct-15

Domain Two – Effective

Effectiveness compliance summary

Indicator	Compliance
2.1 Learning from Mortality	Partial Compliance
2.2 Improving Reliability – Implementing Care Bundles (CQUIN)	Reporting Only
2.3 Improving the Management of Acute Kidney Injury (CQUIN)	Achieved
2.4 Improving the Management of Stroke	Reporting Only
2.5 Improving the Management of Fracture Neck of Femur Patients	Reporting Only
2.6 Improving Diabetes Care (CQUIN)	Achieved
2.7 Reducing Hospital Acquired Infections (Contract)	Partial Compliance
2.8 Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR)	Reporting Only

Highlights:

2.2 Improving Reliability – Implementing Care Bundles	CQUIN target achieved for asthma, pneumonia, sepsis
2.3 Improving the Management of Acute Kidney Injury (CQUIN)	CQUIN target achieved and compliance improving.
2.6 Improving Diabetic Care	Self - care bundle rolled out on 12 wards

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2.1 Learning from Mortality

Through understanding our hospital mortality the Trust is able to both gain assurance and learning regarding current care processes and further identify any areas requiring improvements.

The main outcome measure is the Summary Hospital Mortality Index (SHMI) calculated by the Health and Social Care Information Centre (HSCIC). The SHMI is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

The Trust aims to:

- Reduce the SHMI to 100
- To review 100% of all in hospital deaths each month by the March 2016

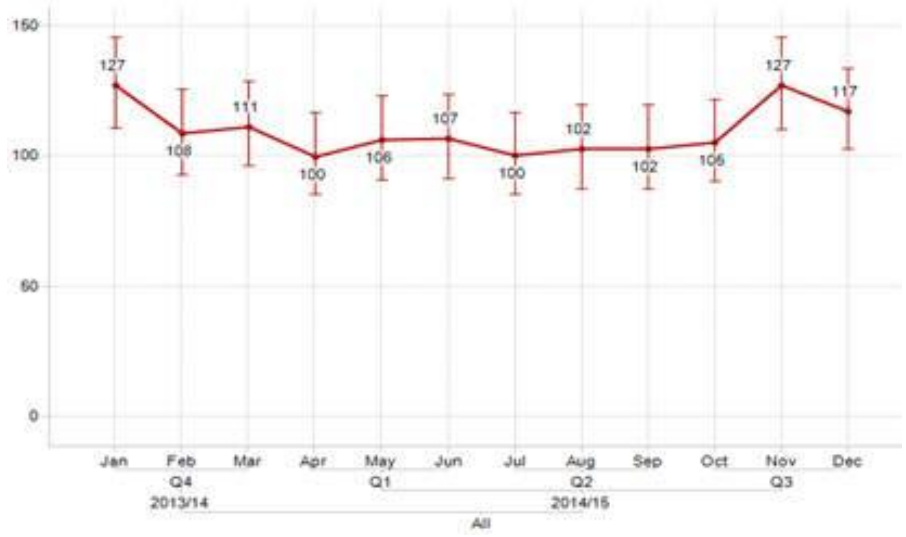
Current Performance

The Trust's SHMI for the latest period published (Jan 14 – Dec 2014) is 109.4; this is in the category of "as expected", however it is higher than the aim of having a SHMI closer to the national average of 100. The HSCIC caution that it is inappropriate to conclude that a Trust is performing better or worse than average based purely on whether or not there are more or fewer deaths than predicted. There is also evidence that standardised mortality ratios such as SHMI correlate poorly with other measures of care quality.

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

The official SHMI from HSCIC for April '14 to March '15 will be previewed to the Trust on 14th October. Analysis from HED, our commercial data provider suggests that the SHMI may have rose slightly to around 110 but will still in the in 'as expected' range.

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



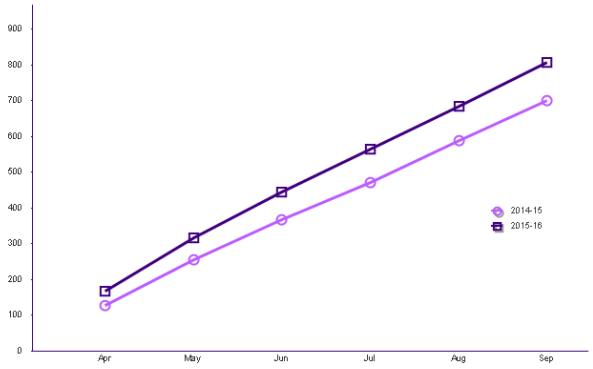
The SHMI data can be tracked to specific conditions where the actual number of deaths exceeds expected. Where this occurs cases are investigated and reports presented to Clinical Outcomes Group (and its subgroup Clinical Effectiveness and Mortality Group) with actions where necessary.

The latest SHMI was released during Quarter 1 and the following areas were noted to have higher than expected mortality rates:

Cancer of the Colon
Contusions
Skin Ulcer

These cases are undergoing case note review; initial findings indicate that there is no evidence to suggest a reason for concern.

The Trust has noted a higher crude mortality than in previous years, a phenomenon seen across England and Wales in 2015. It is not yet clear how this relates to the CHFT SHMI position.



As the Trust consistently performs at the “as expected” level, In order to identify key problem areas to focus improvements, the Trust is committed to reviewing 100% of its mortality cases and not just for those conditions which triggered an alert. However, the process does require expert resource, and as such the 100% target has been difficult to attain with significant monthly fluctuations and the average reviews to July being 46%.

A new process for mortality reviews was commenced in August (July’s deaths) which resulted in 75% of reviews being completed. A further improvement was expected in September (August’s deaths) as initial difficulties had been resolved, but unfortunately this was not the case and to date is only 51.66%. However, the final figure is still to be confirmed, and may rise slightly, though not approaching 75%. The reasons for this are being identified by the Governance team and Q3 is expected to see further improvement in compliance.

	Apr	May	Jun	Jul	Aug	**Total**
Adult deaths	167	149	129	119	120	439
Reviews	53	37	36	88	62	104
Compliance	**31.7%**	**24.8%**	**27.7%**	**75%**	**51.66% *** **updated 16/10/15**	**42.17%**

Following the completion of each months set of case note reviews, a “Learning from Mortality Report” (see Appendix A) is written up and disseminated through the patient safety and quality boards in order to ensure learning reaches a wide audience.

A “Deep Dive into Mortality” presentation was given to WEB in August by the Lead for Patient Safety and Risk, with the Associate Medical Director. The presentation focused on the current mortality position, the developments in and findings from investigations, and the revised CAIP plan. The presentation was well-received and generated some good discussion and positive reaction; it is hoped that this will translate into increased engagement with the review and learning process.

The new mortality review protocol that was approved in July and commenced in August changed the criteria for those cases requiring a second review: this would no longer be done if the initial Hogan score was 2 (slight evidence of preventability) unless there were any other concerns or the case was associated with a complaint, inquest or claim.

In August, 10/88 cases were assessed as Hogan score 2. The main issues identified by reviewers were:

delay in antibiotics (two cases of sepsis and one not stated) x 3 patients
delayed investigations (chest xay) - 1 patient
patient under the care of wrong speciality - 1 patient
delayed insertion of nasogastric tube - 1 patient
poor nutrition - 1 patient
delayed discharge and then developed pneumonia - 1 patient
lack of senior review - 1 patient

3/88 cases were judged as Hogan score 3 and therefore subject to a second review, together with a further case where no Hogan score was assigned. These reviews are currently in progress and will be reported in the next monthly report: this is now scheduled each month and is presented to CEAM and COG and will summarise the review compliance, findings, learning and actions

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. This review was to include, where possible, an audit of the coding accuracy. It was expected that this would be completed and reported by the end of September but this has been delayed due to capacity issues.

Approximately 75% of these cases have been reviewed to date, and the review has also looked at locum and agency usage during the period. This is still underway.

Improvement Work is being delivered primarily through the Care of the Acutely Ill Patient (CAIP) programme, The plan was therefore reviewed and refreshed in August 2015, when some of the original eight themes were merged and some removed (as the actions had been incorporated into other work-streams). The revised plan has the overarching aim “to contribute to the reduction of mortality rates within the Trust” in acknowledgement that reduction in the Trust’s mortality rates is dependent upon delivery of other actions and work-streams, e.g. leadership and operational improvements.

The revised plan is simplified into six themes:

1) Investigating mortality and learning from findings
2) Reliability
3) Early recognition and treatment of deteriorating patients.
4) End of life care
5) Frailty
6) Coding

Monthly updates are received by the Clinical Outcome Group COG**.**

Improvements in Q2

Establishment of Clinical Standardisation group

Theme 2 - Reliability was raised as needing some focused attention in order to realise the benefit of care bundles as timely as possible. See Section 2.2 for further details.

Design of Mortality Review tools

The level I and 2 mortality review tools have been redesigned, and the level 1 tool tested in its new form. The testing of the level 2 tool is in progress. Also new is the template for reporting the outcome of condition-specific reviews and work has gone into an improved process for delivery of case notes to reviewers. Increasingly mortality reviews are done using scanned notes on EDMS, which is bringing fewer problems than feared, although there are still some barriers to be overcome.

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Clinical Effectiveness, Audit and Mortality (CEAM) group

The role of the Clinical Effectiveness, Audit and Mortality (CEAM) group has been reviewed and refreshed; including a review of membership to ensure representation from all divisions, and this group now receives mortality review information, makes recommendations, and reports to COG as necessary.

Improvement plans for Q3

Professor Mohamed Mohammed of Bradford University is supporting the Trust with analysis. He is looking for patterns in the data that allow the formulation of hypotheses to be tested. Regular meetings are being established.

Five additional staff have been recruited to the mortality review team, and the new process is being tightly managed by the Governance team. If the increase in reviews that was seen in August is not sustained, then the process will be reviewed again. Additionally, a job description for consultant mortality reviewers has been completed by the Associate Medical Director, to recruit consultants for an additional PA. It is expected that these appointments will be made early in Q3. Additionally, a simple training programme for all reviewers, to facilitate consistency, is being developed.

A discussion has taken place to make the review tool / data collection process electronic, similar to the CRAS tool. This should be available from 1st December for November reviews. It is intended to develop the second-level reviews to include additional information, not just case notes e.g. duty rotas etc, which will facilitate a more in-depth review.

2.2 Improving Reliability – Implementing Care Bundles

Aims and Objectives of Work

Care bundles are being implemented in health care as a way of focusing improvement efforts on a defined set of factors and actions which contribute to achievement of a clearly specified aim. Care bundles are a simple way of focusing improvement efforts on a set of actions which contribute to achievement of a clearly specified aim. Improvement theory suggests that care bundles allow clinical teams to focus their efforts on a small number of measurable strategies aimed at improving specified outcomes (BTS/NHSI; 2012). Protocol-based care also enables staff to quickly see what action should be taken, when and by whom. They allow practice to be standardised and reduce variation in the treatment of patients. They are also an important tool in improving the quality of care, as variance from the agreed care pathway can be measured easily, allowing systemic factors that inhibit provision of best care to be identified

There is some evidence from single pilot sites in the UK that the implementation of in-patient care pathways or bundles can improve clinical outcomes such as mortality, hospital re-admission rates and hospital length of stay (Robb E; BMJ 2010).

1. Reliability

In the revised CAIP plan a new overall “reliability” work-stream was created comprising care bundle compliance, and investigation into SHMI alerting conditions and any concerns relating to site differences. .

Current Performance

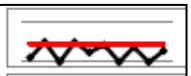
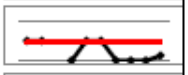
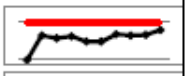
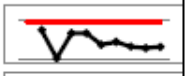
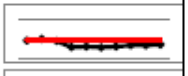
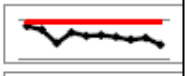
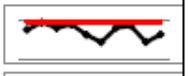
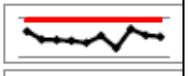
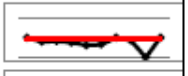
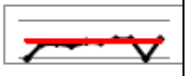
The care bundles work has adopted the PMO approach, overseen by the newly-formed Clinical Standardisation group. The first meeting took place on the 1st of September 2015. Clinical leads have been identified for each of the bundles and currently they are reviewing the bundles to standardise them to ensure they are simple, clear and do the right thing first time. The aim of this

work is initially to ensure the existing care bundles are being used reliably (95% and above) and are having the desired impact on clinical outcomes.

Compliance with appropriate commencement of bundles is currently audited by the presence of the “stickers” in the notes for

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

Where bundles have been commenced, completion is also assessed. Compliance is variable, as can be seen from the September 2015 CAIP dashboard shown below:

Indicator	Month Agreed Target	Current Month Performance	Target/YTD	YTD Performance	Performance Trends
Asthma - Bundle Started	95%	57%	95%	63%	
Asthma - Bundle Completed	95%	25%	95%	60%	
AKI - Bundle Started	95%	76%	95%	62%	
AKI - Bundle Completed	95%	32%	95%	39%	
Sepsis - Bundle Started	95%	70%	95%	61%	
Sepsis - Bundle Completed	95%	38%	95%	56%	
COPD - Bundle Started	95%	63%	95%	59%	
COPD - Bundle Completed	95%	53%	95%	54%	
Pneumonia - Bundle Started	95%	100%	95%	68%	
Pneumonia - Bundle Completed	95%	100%	95%	92%	
Heart Failure	Design Phase				

The trends are from Dec 2014.

Bundle	N° of patients	N° commenced	N° completed
Asthma	7	4	1
AKI	33	25	8
Sepsis	64	45	17
COPD	27	17	9
Pneumonia	1	1	1

Chart shows figures from

Sept 2015 audit

The heart failure "bundle" has proved difficult to develop and standardisation of care for this group of patients is still under consideration, to incorporate within the clinical documentation.

Plans for Q3

- One amended the four bundles will be added to the medical clerking in document in preparation for a go live date of the first week in January 2016
- A communication and clinical engagement plan is to be developed to embed the new process.
- A clinical champion has been identified to encourage compliance in completing the bundles.

In addition to this work there are three care bundles which form part of the Trusts 2015/16 CQUINS, sepsis and pneumonia will be supported by the work above. However Asthma is being led by clinical and managerial leads from within the A&E unit, further information regarding each of these for Q1 and Q2 is given below.

Asthma (CQUIN) – The aim of improving the management of patients presenting with Asthma in A&E, by achieving 75% of compliance with the bundle complete in the final quarter.

This CQUIN is applied to Emergency Department (ED) attenders with Asthma who are treated and who are subsequently discharged home. The data for compliance with CQUIN is taken from the ED EDIS system, looking at the relevant fields and measuring compliance with each CQUIN element and the care bundle as a whole for each patient.

The data collection for the CQUIN is 50 consecutive cases within the quarter.
Q1 performance was 66%.
Q2 performance was 80%

	Quarter 1			Q1	Quarter 2		
5.1 Respiratory Care Bundle - Improving management of patients presenting with Asthma in ED	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15
Number of patients (<18) attending ED/PAU and the Number of patients (over 18) attending ED/MAU with asthma discharged home/not admitted with completed care bundle		33				40	
Number of patients (<18) attending ED/PAU and the Number of patients (over 18) attending ED/MAU with asthma discharged home/not admitted with / without completed care bundle		50				50	
% patients receiving care bundle		66%				80%	
Target		65.0%				70.0%	

Q3: Performance Plan: The Q3 target is set at 72%. Weekly monitoring in the unit will ensure that this performance level maintained.

The Division is utilising the previous year's action plan in order to remain joined up with progress made last year. See below for current updates:

ACTION PLAN

Issue	Current State	Future Plan and action	Timeframe
Performance, failure to meet CQUIN target	The under-performance has been communicated to the senior A&E team on both sites to highlight the situation.	The message around performance will be re-iterated to staff via Directorate Management Team meetings, Sister and Staff meetings.	May 2015 Completed
Staff compliance of the Asthma Bundle	Staff compliance variable, though addressed as a department, no performance addressed with individuals.	Daily monitoring of the compliance to begin on all asthma presentations. Weekly performance will go to the Turnaround Meetings. Targeted training and performance management of staff who fail to comply. Main issues to be recorded to identify common barriers and themes. Issue resolution to be put in place. **Following each patient case review any gaps noted are addressed with individual nurses/doctors.**	27 April 2015, to review at weekly intervals **Update July 2015** **Actions continue- October 2015**
Staff understanding of the Asthma bundle detail	Training has been delivered to all staff; it is believed that there is a good understanding that staff are aware of the elements required.	Spot check of understanding to take place across both sites. **Staff awareness good for both medical and nursing.** **Spot checking monthly continues**	May 2015 **Update July 2015** **Actions continue** **Completed. All staff on spot checks aware.**
Administering medications within timeframe	The difficulty in getting medications administered in time has be explored in more detail by the A&E consultant nurse, to look for process barriers and changes that can be made to increase compliance.	Work is underway to make the process more nurse led getting senior nurses to sign off the bundles as completed before patients leave the department. This will help ensure actions particularly around the discharge elements are more robustly followed but in addition will allow real time challenge of non-compliance and better understanding of delivery issues. Monitor compliance and take action where performance is poor. **Performance much improved, monitoring continues.**	May 2015 **Update July 2015** **Actions continue**
Compliance with recording Peak Flow scores	Review of supplies and access to equipment was completed – all necessary equipment in place.	Continue to monitor monthly and check the number of peak flow meters and access to other essential equipment.	Ongoing
Asthma Bundle visible within EDIS	Reception staff not fully compliant with including 'finish bundle' alongside presenting complaint.	Message to be re-iterated to all reception staff. To inform them that this will now be monitored on a daily basis. Staff to be informed once and if non-compliant then performance management will commence. **Monitoring closely**	1 May 2015 **Update July 2015** **Actions continue**
Current and visible data available for all.	Data is pulled on a weekly basis as part of the A&E quality indicators' by the nursing team. Issues	Repeat audit required, to work in conjunction with the daily monitoring of staff compliance. Visible up to date displays in both departments. **New screens in each department providing up to date**	May 2015

	identified quickly and rectified.	**data on all quality indicators and CQUINs**	
Evaluation of current work		To consider the effectiveness of the new measures to be put in place. Process that Matron has put in place is sustainably delivering the required performance. The monitoring was daily and is now weekly.	June 2015 **Update July 2015** **Actions continue**

Pneumonia (CQUIN)

The Community Acquired Pneumonia Care bundle (CAP) was introduced in 2014/15 for patients admitted with a Community Acquired Pneumonia. As one of the Trusts key care bundles this work is designed to reduce harm and improve identification and response to deterioration. The work reports to Clinical Outcomes Group on a monthly basis and through this route to the Quality Committee and Board.

The CQUIN consists of 4 measures which should be achieved within 4 hours:

1) C-XRAY
2) CURB Score recorded
3) Antibiotics given
4) Oxygen given

CURB Scoring was the lowest performing element.
Q1 performance was 70%
Q2 performance was 78%

	Quarter 1			Q1	Quarter 2		
5.2 Respiratory Care Bundle - Improving management of patient attending A&E with pneumonia	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15
Number of patients attending A&E with pneumonia who receive the CAP care bundle within 4 hours of admission		35				39	
Number of patients attending A&E with pneumonia who are admitted.		50				50	
% patients receiving care bundle		70%				78%	
Target		60.0%				65.0%	

Q3 Performance Plan: Performance was above target for Q1 and Q2 and is expected to continue into Q3. There is an action plan in development which will address the difficulties with capturing CURB scores, and over the next 6 months compliance with this element is expected to improve.

Sepsis Screening (CQUIN) – See Improving Sepsis Care Section 1.5 which shows achievement of Quarter 2 target.

Acute Kidney Injury (CQUIN) – See Improving Management of Acute Kidney Injury Section 2.3 which shows achievement of Quarter 2 target.

2.3 Improving Management of Acute Kidney Injury

Aims and Objectives of Work

Acute kidney injury (AKI) is characterised by a rapid reduction in kidney function, potentially resulting in a failure to maintain fluid, electrolyte and acid-base homeostasis. Small rises in serum creatinine in a variety of clinical settings are associated with significant adverse outcomes, including increased mortality and prolonged length of stay. Recent reports have highlighted deficiencies in AKI management (Adding Insult to Injury, NCEPOD, June 2009, NICE clinical guideline August 2013). AKI was highlighted as a high mortality condition in the organisation based on HSMR and SHMI data.

The Trust has design a care bundle for the treatment of inpatients with AKI. This bundle has been in place now for 18 months, it has not yet been reliably implemented. More recently a CQUIN for delivery of AKI care has been agreed with the CCG.

The aim of the work is to reduce the number of deaths whereby Acute Kidney Injury was stipulated as the primary, secondary or other diagnosis, and to deliver the agreed CQUIN.

Targets for improvement:

1) Maintain HSMR below 100 – Target met.
2) Delivery of the national CQUIN, target of 90% compliance with specific elements on discharge to form part of the electronic discharge summary by Q4.

Q1 Performance: This CQUIN focuses on AKI diagnosis and treatment in hospital, and the plan of care to monitor kidney function after discharge. It is measured through the percentage of patients with AKI treated in an acute hospital whose discharge summary includes each of four key items of information listed below:

1. Stage of AKI (a key aspect of AKI diagnosis);
2. Evidence of medicines review having been undertaken (a key aspect of AKI treatment);
3. Type of blood tests required on discharge for monitoring (a key aspect of post discharge care);
4. Frequency of blood tests required on discharge for monitoring (a key aspect of post discharge care).

Each item counts separately towards the total i.e. review of four items in each of 25 discharge summaries creates a monthly numerator total of up to 100.
All stages of AKI (1, 2 or 3) are included in the denominator data.

Performance for Q1 was 21.3% of the required elements being captured on the discharge summary.

2.1 - Acute Kidney Injury	Quarter 1			Q1
	Apr-15	May-15	Jun-15	Total
The number of key items found in discharge summaries for patients in the sample of 25	25	21	18	**64**
4 key items in discharge summaries for 25 inpatients randomly selected from pathology system with AKI *	100	100	100	**300**
% key Items included	**25.0%**	**21.0%**	**18.0%**	**21.3%**
Target	**Baseline**			

Improvements for Q2 onwards:

In order to ensure that we consistency collect the elements listed above, a change is required to be made to the Electronic Discharge Summary (EDS). This work has been scheduled into the system enhancement diary and will is expected to be delivered at the beginning of Q3.

There are some additional actions taking place to address the current compliance, these include:

1. Ensuring that the CQUIN requirements are communicated to the junior doctors starting in August 2015 as part of junior doctor induction. This will complement the existing training provided around the importance of accurately completing the EDS
2. There will be ongoing monitoring of Q2 performance, which will enable feedback to clinical teams who are not compliant with CQUIN to challenge their practice and further improve reliability going into Q3.

Q2 Performance: CQUIN delivery has increased slightly during Q2

2.1 - Acute Kidney Injury	Quarter 1			Q1	Quarter 2			Q2
	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15	Total
The number of key items found in discharge summaries for patients in the sample of 25	25	21	18	**64**	30	30	37	**97**
4 key items in discharge summaries for 25 inpatients randomly selected from pathology system with AKI *	100	100	100	**300**	100	100	100	**300**
% key Items included	**25.0%**	**21.0%**	**18.0%**	**21.3%**	**30.0%**	**30.0%**	**37.0%**	**32%**
Target	**Baseline - Achieved**				**21.0%**			

1. CQUIN concept and components were introduced to new junior doctors through Trust induction in August 2015
2. Divisional directors have been contacted regarding the CQUIN elements and importance of delivery via e-mail in August 2015
3. EDS update has been delivered and “gone live” in September 2015
4. A procedure for informing non-complying clinical team for auctioning in Q3 has been agreed
5. Weekly monitoring of the CQUIN to commence in Q3 to allow a more proactive management of the CQUIN delivery programme

The expectation is that CQUIN compliance will improve in Q3, with a target of 50% compliance in Q3. Compliance will be monitored and reviewed in the AKI work stream meetings and the CQUINs Improvement Group.

HSMR

AKI performance for Q1 then the HSMR is just above the 100, with 18 deaths against a 17.77 expected.

2.4 Conditions of Interest – Stroke

Aims and Objectives of Work

Strokes affects between 174 and 216 people per 100,000 population in the UK each year (Mant et al 2004), and accounts for 11% of all deaths in England and Wales. It is accepted that 85% of strokes are due to cerebral infarction, 10% due to primary haemorrhage and 5% due to subarachnoid haemorrhage. The risk of recurrent stroke is 26% within 5 years of a first stroke and 39% by 10 years (Mohan et al 2011). By focusing in improvement in stroke care, patient outcomes can be vastly improved,

The Trust has the following aims to strengthen and improve stroke services

- Reduce stroke mortality to a SHMI of less than 100,
- Improve functional outcomes for patients
- Reduce the length of stay by 20%
- Improve overall SSNAP score to “A”

To do this we will:

- Ensure all stroke patients are admitted directly to a stroke bed
- Ensure all patients received 45 minutes of therapy 5 times a week
- Ensure all appropriate patients receive thrombolysis within 60minutes of arriving at hospital

Current Performance

The Directorate and Division monitor Stroke performance each month at Board and at the monthly stroke governance meeting. The Division were asked to work with Greengage, an external consultancy, to review the approach to action planning and develop new ways of working. This was to ensure delivery of agreed actions in time and in full. The Division introduced bimonthly meetings with the Stroke Team that are on-going. One of the first meetings was led by Greengage and focussed on Creating the Success Story, Engaging the Stroke multidisciplinary Team and development of the Must Do’s

The must do’s were:

1. All suspected stroke patients to have FAST test
2. Improve patient flow by ensuring 90% compliance with PFEP
3. Write SOP for patient flow
4. Undertake RCA on patients who breech the 90% time on the stroke unit
5. Agree SOP with radiology
6. Write joint rehabilitation pathway

7. Ensure 45 min of therapy at least 5 times a week across 7 days
8. Increase clinical time for therapists and consultants with data officer for SSNAP

Each was linked to a desired outcome and progress against the actions monitored:

Result - Overal Outcome Wanted	Reality as of Nov 14	Must Do (enabler)	Completion of Enablers RAGd and date
100% of all suspected stroke patients brought to ED at CRH	13% of stroke patients taken to HRI ED by YAS	1) All suspected stroke patients to have FAST test	19th January 2015
90% of stroke patients admitted directly to ASU within 4 hrs 80% of stroke patients spend >90% of their time of the stroke unit	55% of stroke patients admitted directly to ASU within 4 hrs 85% of stroke patients spend >90% of their time of the stroke unit	2) Improve patient flow by ensuring 90% compliance with PFEP	16th February 2015
		3) Write SOP for patient flow	Final version Feb 9th 2015
		4) Undertake RCA on patients who breech the 90% time on the stroke unit	Repeat RCA done by 1st March
100% of appropriate patients receive thrombolysis within 60min	15% of appropriate patients receive thrombolysis with 60 min	5)Agree SOP with radiology	February 1st 2015
Reduce LoS by 20%	Mean LoS for stroke and stroke rehab patients 28days	6)Write joint rehabilitation pathway	Final version: 1st April 2015
	Therapy once a week	7)Ensure 45 min of therapy at least 5 times a week across 7 days	Therapy x3 weekly by March 1st
Improve SSNAP Case ascertainment and data quality		8)Increase clinical time for therapists and consultants with data officer for SSNAP	February 1st 2015

Performance against outcomes:

Outcome 1 - 100% of all suspected stroke patients brought to ED at CRH

Currently YAS transport 85-90% of patients with a stroke directly to the ED at CRH

By undertaking the FAST test, checking for:

- Facial drooping: A section of the face, usually only on one side, that is drooping and hard to move
- Arm weakness: The inability to raise one's arm fully
- Speech difficulties: An inability or difficulty to understand or produce speech
- Time: Time is of the essence when having a stroke, and an immediate transfer to the hospital is recommended

The YAS staff are able to make a note more reliably as to which ED to present the patient to.

YAS recently re-audited patients diagnosed with a stroke who were admitted to HRI rather than directly to CRH. During a 7 month period, during mid-November 2014 – mid-May 2015, there have been 24 patients, later confirmed as stoke patients, who have been taken to HRI and not to

CRH. When looking into the incident details it shows that there were other reasons for the patients to go to HRI:

- 13 patients did not present as a stroke, FAST negative or treated for another acute condition from fitting to been unconscious.
- 2 Patients were referred to Calderdale but the CT scanner was not working.
- 1 patient was referred and declined.
- 6 patients were FAST negative but did have other stroke symptoms mainly lower limb weakness.
- 2 Patients that should have gone to Calderdale but went to Huddersfield and these clinicians have had a discussion with their Clinical Supervisor.

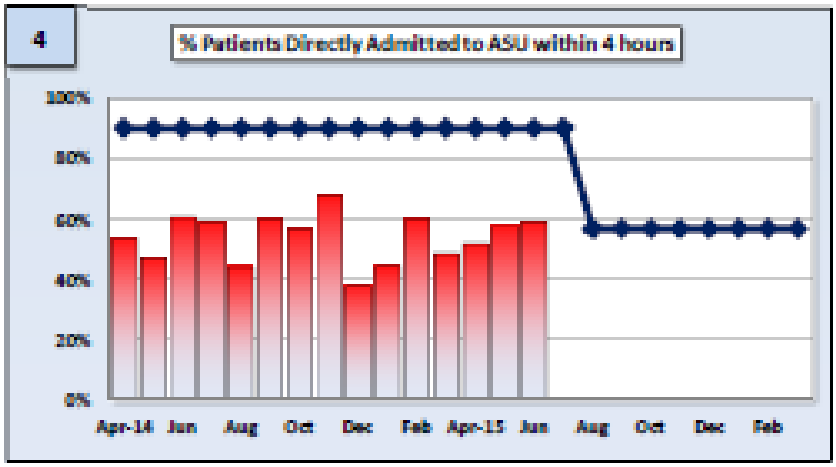
Regular operational review takes place between CHFT and YAS. YAS is also represented at the quarterly Stroke Strategic Group.

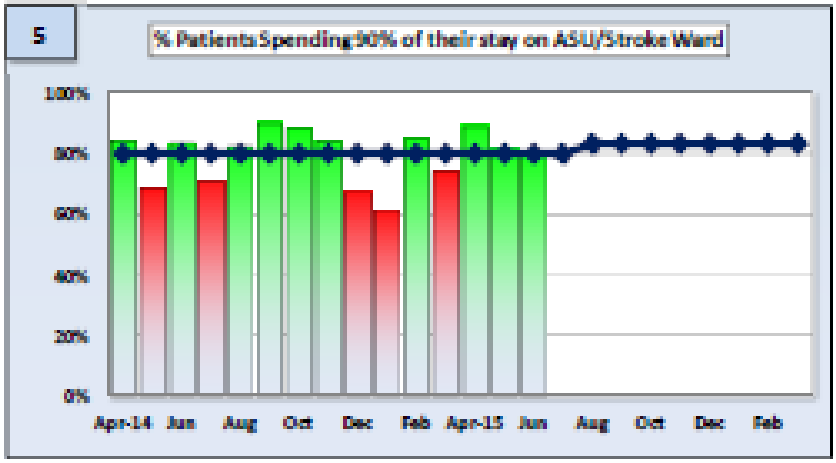
Outcome 2 - 90% of stroke patients admitted directly to ASU within 4 hrs and 80% of stroke patients spend >90% of their time of the stroke unit

Current 4hr and 90% stay performance.

Recent performance for direct admissions and patients spending more than 90% of their stay on the stroke wards improved in Q1 of 2015/16, however Q2 has seen some deterioration against the 90% stay performance. Some of this was due to a reduction in the number of stroke beds whilst the rehab wards were decanted for essential estates and infection control work, resulting in patients outlying on MAU and other wards. The step-down ward 5B also has a negative impact on the 90% target as, whilst this is used where clinically appropriate, it is not a dedicated stroke ward.

The latest SSNAP national average performance is 56.8% for direct admissions within 4 hours. CHFT performance was 53.1% in July (improving picture). There is no national target for direct admissions within 4 hours and the dashboard has been changed to reflect the current national average (step change in blue line below).





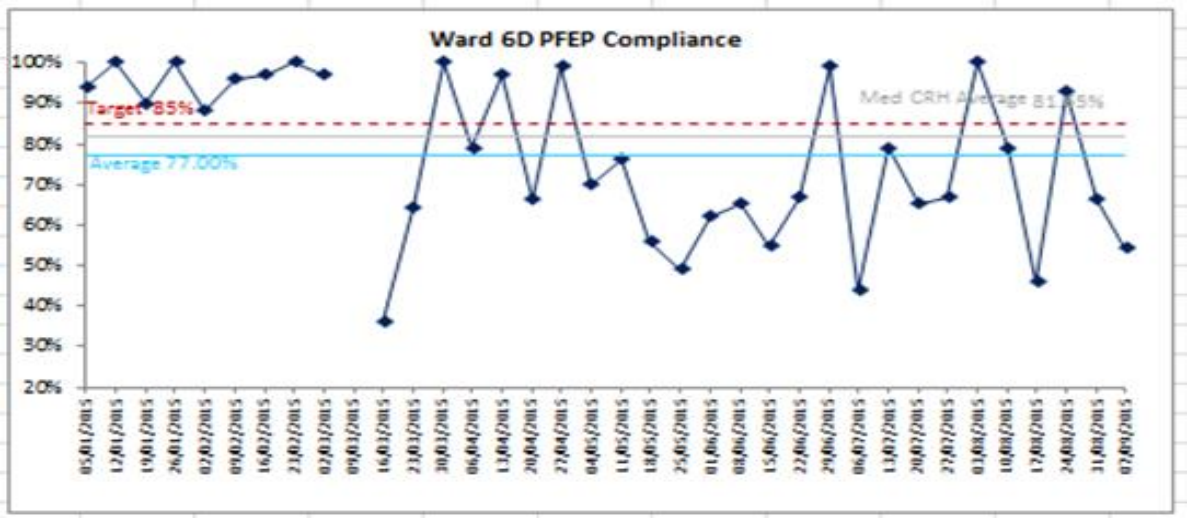
The actions undertaken to improve this were:

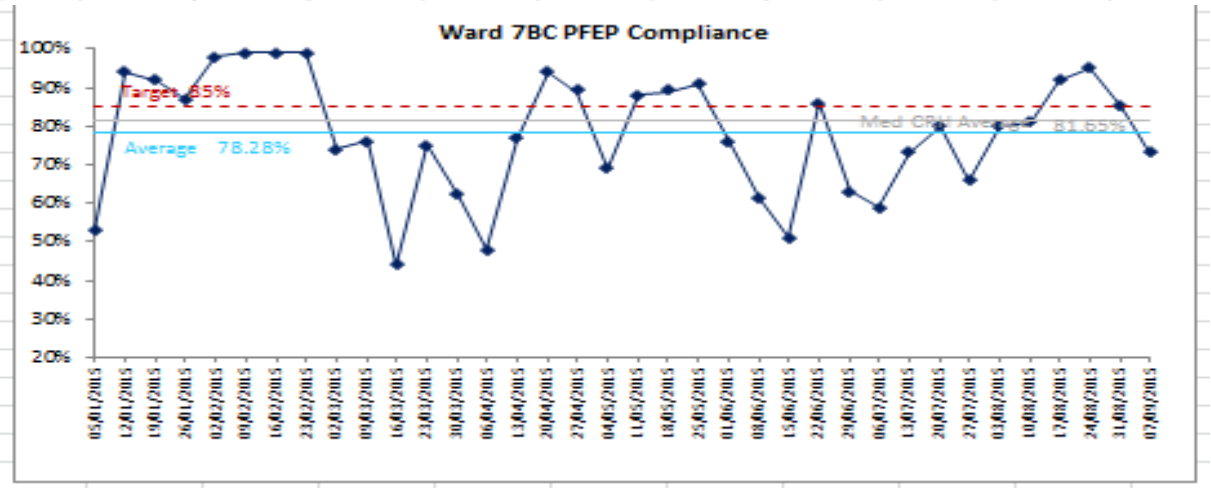
Improve patient flow by ensuring 90% compliance with PFEP:

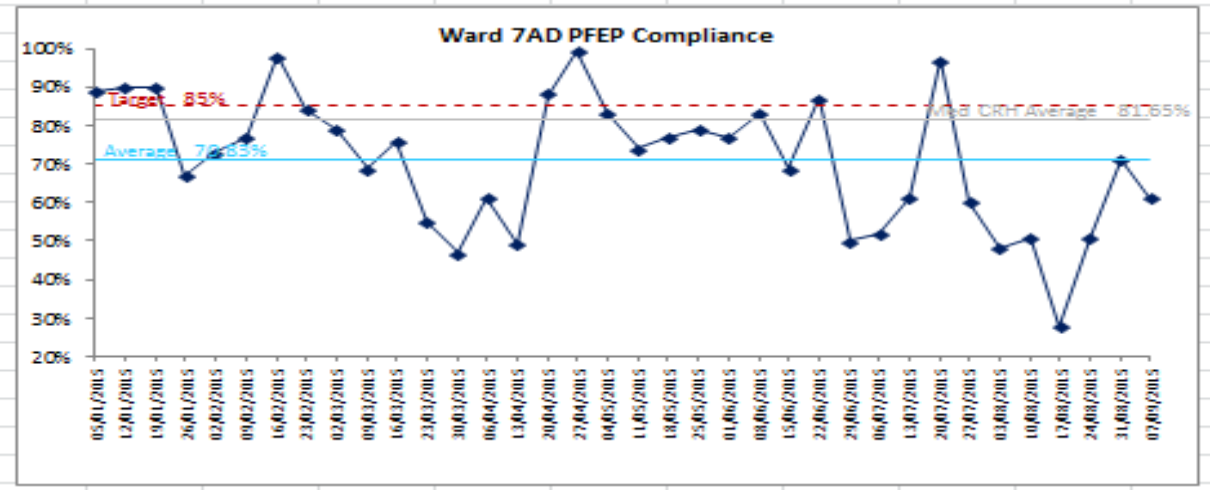
Plan for Every Patient (PFEP) is an integral component of CHFT's approach to goal setting and planning a patient's stay in hospital. It has consistently demonstrated a reduction in LOS by ensuing individual patient plans are adhered to or escalated if there is a delay.

The stroke team identified this as a "Must Do" to improve patient flow through the acute stroke ward and rehab areas to ensure acute beds were available for patients admitted acutely with a stroke.

Performance over time has improved although is not yet consistently above 90%. There has been a recent drop in performance which may reflect changes in nurse leadership on the stroke wards. We continue to review this weekly and support the wards and new ward managers whilst they establish themselves on the ward. The check and adjust meetings are not happening consistently and following a recent meeting these wards have been identified for further support with PFEP.

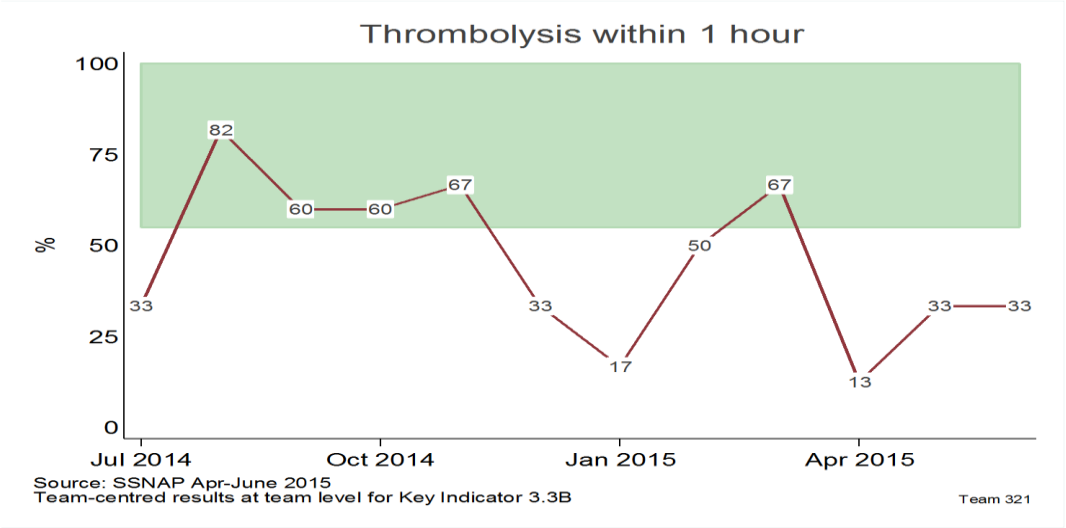






Outcome 3 - 100% of appropriate patients receive thrombolysis within 60min

The most recent thrombolysis data available from SSNAP demonstrates that this outcome remains a challenge for the service and is a key focus of the current stroke improvement work.



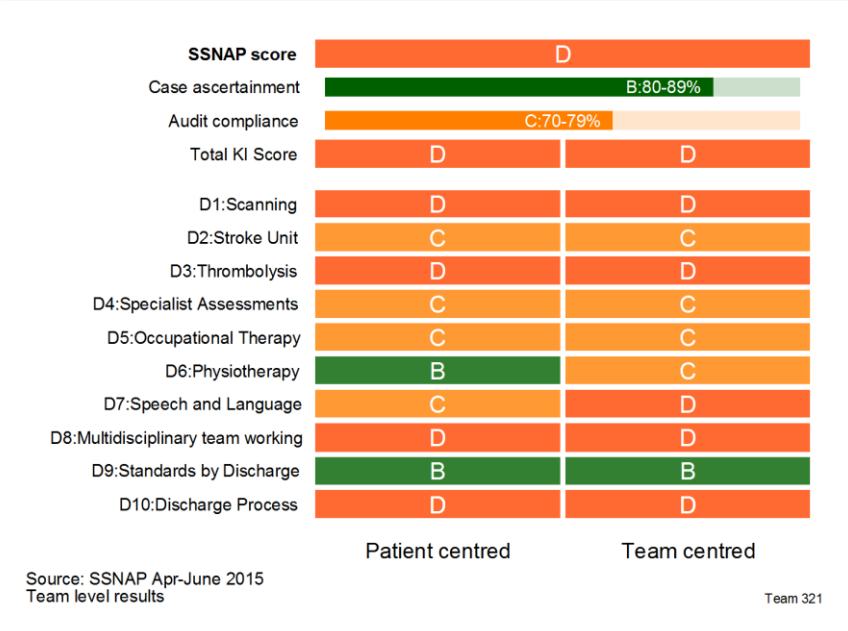
A task and finish group has been established for door to needle time for thrombolysis. The best in region for this outcome are Scunthorpe and the group are currently reviewing our pathway against theirs and a “go see” is being organised.

Outcome 4 - Reduce LOS by 20%
The average LoS for June is 20.4 days which is a considerable reduction from previous performance and the baseline which was 28 days. The must do was to reduce LOS by 20% from 28 days which would be 22.4 days. This target has been over-achieved in the latest month’s data (June).

Outcome 5 - Improve SSNAP Case ascertainment and data quality
The majority of organisations providing acute stroke services employ data entry officers to ensure full case ascertainment and audit compliance and to release clinical staff to deliver patient focused care. It is estimated it takes a total of 60min to complete SSNAP entry for 1 patient (approx. 10hrs per week). Following redeployments within the Division a data officer came into post.

The April-June 2015 SSNAP data has just been released and has shown an improvement in case ascertainment, moving the Trust’s rating for this domain from a C (70-79%) to a B (80-89%). Further improvement is expected to be shown in the next quarter’s data as this is when changes were made to the data collection and submission process.

SSNAP performance
The latest SSNAP performance data is below which has shown significant improvement. The overall score has improved from an E to a D and there have been several improvements, particularly around therapies and case ascertainment.



Improvement plans for 15/16

The Directorate and Division monitor Stroke performance each month at Board and at the monthly stroke governance meeting against the outcome above.

In addition, there are action plans in place following the SQuINs (National Stroke Peer Review programme) annual report and HASU resilience review.

The SQuINs self-assessment identified non-compliance against the following standards:

- S13-1D-T105 1 month follow-up offered routinely
- S13-1D-WF05 Minimum Physiotherapy staffing levels
- S13-1D-WF06 Minimum Psychology staffing levels
- S13-1D-WF07 Minimum Dietetic staffing levels
- S13-1D-WF08 Minimum Speech and Language Therapist (SALT) staffing levels
- S13-1D-WF09 Minimum Occupational Therapist (OT) staffing levels
- S13-1D-WF10 Social Worker Involvement

The areas for focus as identified by the CCGs following the HASU review were:

- Occupational Therapy – 1 WTE/5 beds, 7 days a week
- Physiotherapy – 1 WTE/5 beds, 7 days a week
- Speech and Language Therapy - 1 WTE/10 beds, 7 days a week
- All patients with non-urgent urgent indications scanned within 12 hours
- Median time between clock start and thrombolysis (minutes)
- Proportion of RCP guideline eligible patients given thrombolysis
- Direct admission to stroke unit within 4 hours
- Nurse assessment within 24hrs at least 1 therapist with 24h and all relevant therapists within 72h and rehab goals within 5 days
- Proportion of applicable patients receiving a joint H&SC plan on discharge

Progress update re HASU review and SQUIN action plans

- S13-1D-WF05 Minimum Physiotherapy staffing levels
- Physiotherapy – 1 WTE/5 beds, 7 days a week
- S13-1D-WF07 Minimum Dietetic staffing levels
- S13-1D-WF08 Minimum Speech and Language Therapist (SALT) staffing levels
- Speech and Language Therapy - 1 WTE/10 beds
- S13-1D-WF09 Minimum Occupational Therapist (OT) staffing levels
- Occupational Therapy – 1 WTE/5 beds, 7 days a week

The Trust has invested in the 4 therapies as above, in order to achieve the standard described. The inpatient therapies service is also now delivering a 7 day service for physiotherapy and occupational therapy. This is facilitating achievement of number 7 of the must dos (ensure all patients received 45 minutes of therapy 5 times a week).

- S13-1D-T105 1 month follow-up offered routinely

The above is a SAF standard, however is not supported by clinical evidence. The Trust's clinical team currently review patients at 6 weeks, not because of capacity issues, but because it gives them a better clinical picture. This is in-line with other centres and there are no plans to change current practice.

- S13-1D-WF06 Minimum Psychology staffing levels

There is currently no clinical psychology service in the Trust. A case was submitted for business planning purposes but was unsuccessful and the status quo remains, however, this is in line with other centres.

- S13-1D-WF10 Social Worker Involvement

The SAF standard requires a dedicated and named social worker to attend MDTs. There is ongoing frustration with a lack of allocated social worker attendance at MDT, frequent changes in social worker and/or non-attendance. This is being escalated.

- All patients with non-urgent urgent indications scanned within 12 hours

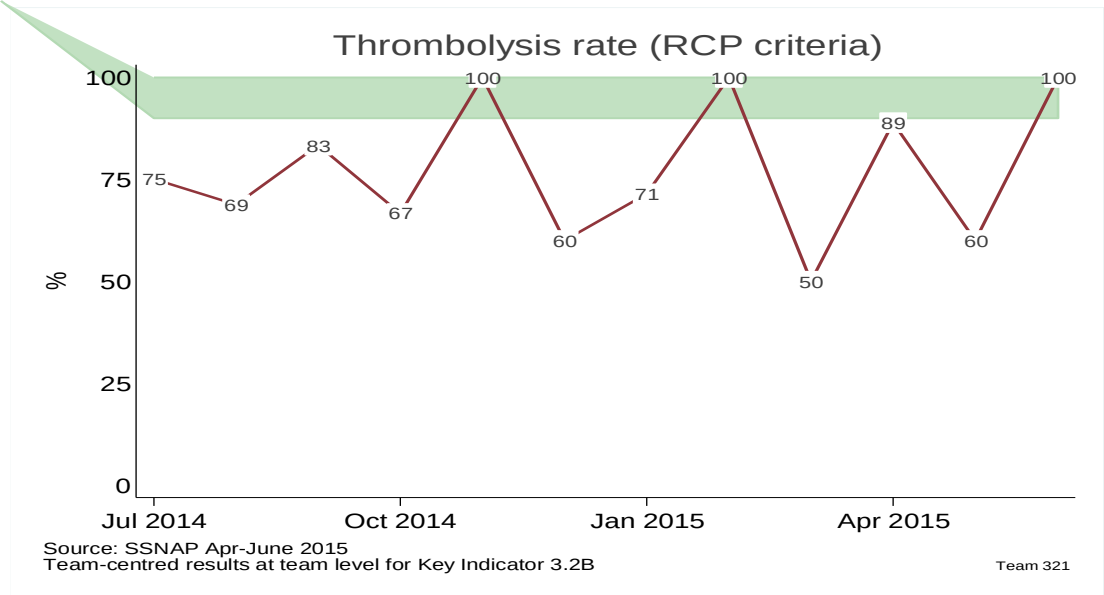
CHFT performance 89.1% in July - improving picture and above national average (88.2%) (based on 14/15 SSNAP annual report). Agreed SOP in place for 12 hour scans and breach analysis ongoing. All stroke nurses can now request non-urgent scans within 12 hours. The scanning department have agreed that before midnight, newly admitted stroke patients will be scanned prior to midnight. Past midnight admissions will be scanned before midday.

- Median time between clock start and thrombolysis (minutes)

- Direct admission to stroke unit within 4 hours

Both of these have been discussed earlier in this paper and work continues.

- Proportion of RCP guideline eligible patients given thrombolysis



This was identified by the HASU review for further work, however no further action is needed to improve position clinically, but changes to data submission process for SSNAP internally should see an improved position from Q2 data. The actual position is expected to be 90+% (national average 81.8%).

- Nurse assessment within 24hrs at least 1 therapist with 24h and all relevant therapists within 72h and rehab goals within 5 days

This was identified by the HASU review as requiring further work. Nurse assessment in 24 hr as of last quarter on SSNAP is 90.9% (national average 87.2%). The closest data we have for the HASU data pack figure, which includes therapy assessment is “nurse<24hr+ one therapy<24hr and all team <72hr” from SSNAP. The last quarter figure was 47.9% (national average 52.4 percent) but therapy services have improved since then. The Trust has above national average performance for nurse assessment and 24/7 stroke nurse rota - no further action at this time. The Trust has also increased in therapy staffing and changed ways of working, including 7 day physio and OT - no further action at this time.

- Proportion of applicable patients receiving a joint H&SC plan on discharge

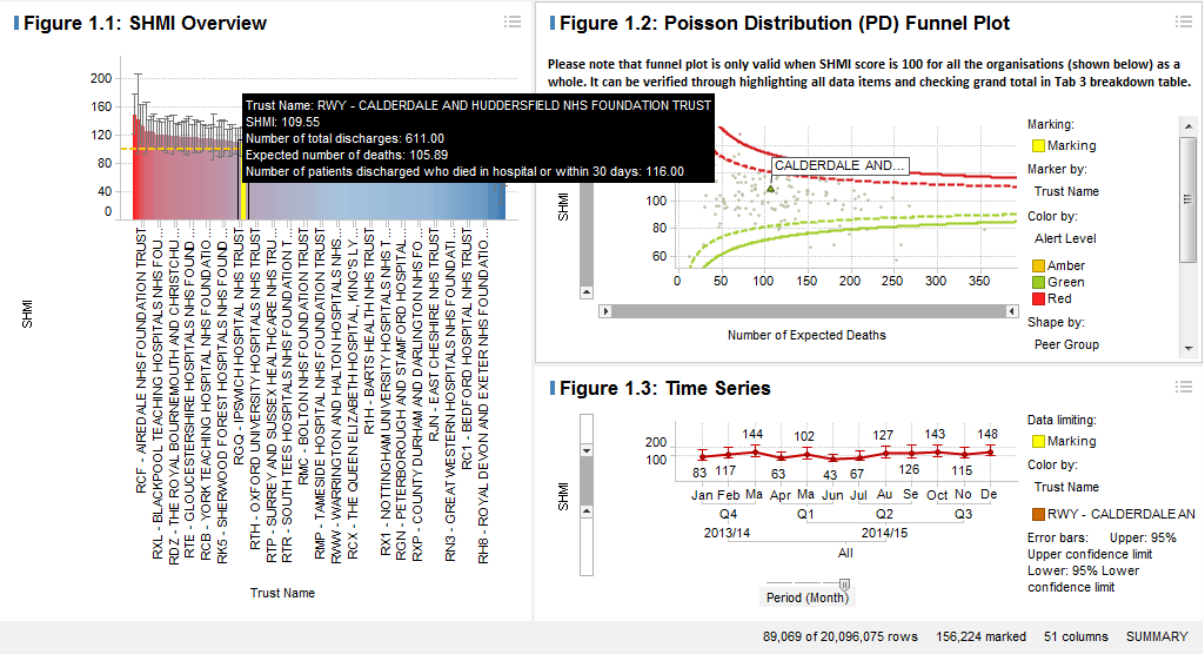
The joint health and social care plan has been refreshed and relaunched and is now given to patients at admission and used throughout their hospital stay until discharge. We expect performance figures from August to be much improved.

Mortality

The following is the latest mortality data as provided by HED. The latest published SHMI is 109.55. There were no stroke deaths subject to second stage mortality reviews for the period December 2014 and May 2015. Mortality reviews have been added to the monthly Stroke Clinical

Governance meetings to be reviewed by the multi-disciplinary team. Further analysis is required in order to agree further actions.

Latest published SHMI Jan 14 – Dec 14:



2.5 Improving Management of Fracture Neck of Femur

Introduction:

The Best Practice Tariff (BPT) was introduced in 2010. It aims to act as a financial incentive for hospitals to optimize management of patients with neck of femur (NOF) fractures.

Where all the factors associated with best practice have been delivered a supplement of just over £1300 is added to the tariff.

We expect to receive between 450 and 500 patients who have sustained a fractured NOF each year.

Aims and Objectives of Work:

Seven factors have been identified by NICE and require inputting into the National Hip Fracture Database (NHFD). Each of these seven factors relates to either patient experience or outcome.

The first of the factors relates to getting patients to theatre within 36 hours of admission, this target was set to ensure no patient ever spent more than one night in a hospital bed with a broken hip.

The Directorate will be delivering 85% of patients to theatre within 36 hours by October 2015.

In order to deliver this the division is prioritising specialty and long waiting trauma into the elective side of the Directorate. The impact on income and RTT pathways is being monitored.

Quarter 2:

The NHFD shows that 65.2 % (Q1 66%) of patients got to theatre in 36 hours, and 57.8% (Q1 51%) of patients got all components of BPT. (Patients from the very end of September may not yet be included in this data set)

The rest of the year:

In order to deliver 85% of BPT the Directorate has tried to deliver 3 extra theatre lists a week. This has not been achieved. The Directorate has not been able to align surgeons, anaesthetists, laminar theatres and teams on unscheduled basis.

The surgeons with flexible sessions have been invited to do work on evening lists, but the nature of the work is such that it is not proving appropriate for evening lists.

Ward staff are demonstrating continued success in chasing down the individual components and allocating them to named individuals where a medic is required.

The kit has now been ordered to be able to provide total hip replacements on the HRI site, and staff training is almost complete.

Improvement Plans for 2015/16

- Data collection for the PERFECTED research study (Peri-operative Enhanced Recovery hip Fracture Care of patients with Dementia) has started. This is a National Institute for Health Research (NIHR) funded Applied Research Programme aiming to improve hospital care for patients with Dementia who break their hip.

- Once the impact on elective activity and RTT for October has been seen the directorate will be able to articulate its requirements to deliver the 36 hour target.

2.6 Improving Diabetic Care

Aims and Objectives of Work

People with diabetes admitted to hospital benefit most when they are cared for by appropriately trained staff, provided with access to a specialist diabetes team, and given the choice of self-monitoring and managing their own insulin (NICE quality standard). In order to ensure high standards of care for diabetic patients the Trust aims to:

- Enable patients on insulin to self-manage – CQUIN target 50% of diabetic patients completing the self-care bundle on a number of ward in the Trust by Q4

- Reduce length of stay for people with Diabetes by 0.5% days or more

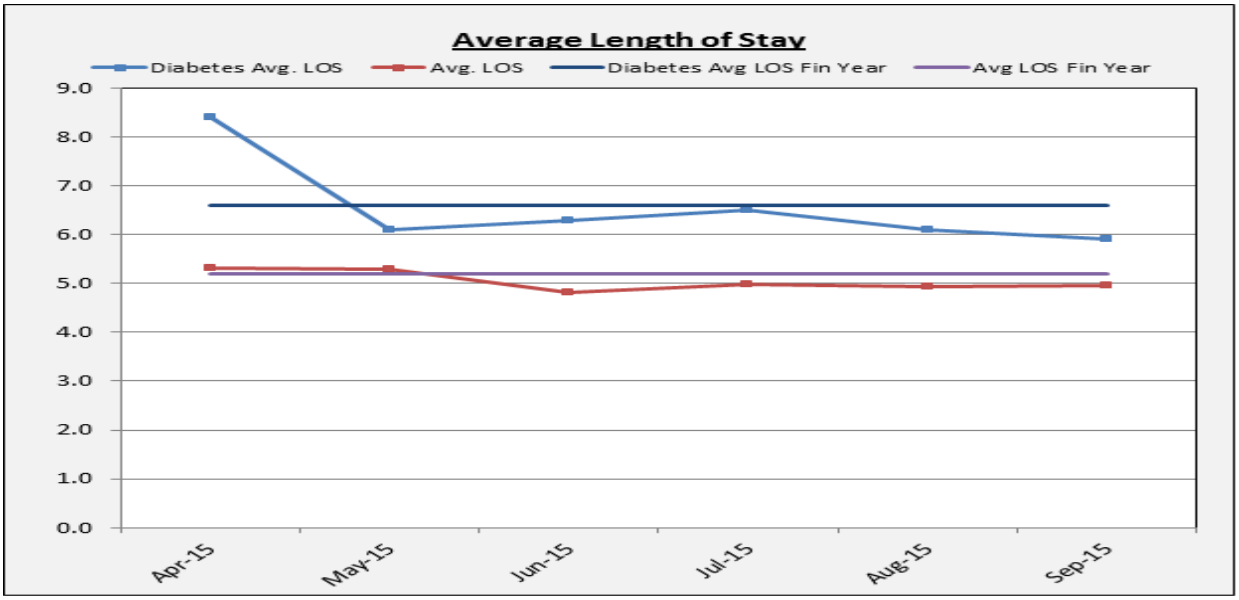
Current Performance

The diabetic CQUINS were achieved for Q2, with 62.7**%** of patients who are able to self-care doing so.

Quarter 2			Q2
Jul-15	**Aug-15**	**Sep-15**	**Total**
6	19	12	37
11	26	22	59
54.5%	**73.1%**	**54.5%**	**62.7%**
On 12 wards			

Reduce length of stay for people with Diabetes by 0.5% days:

We continue to see a reduced length of stay for diabetic patients.



Work continues to implement the self-care process for Insulin dependent patients on the nine collaborative wards from 2014/15, with the introduction of two further wards in Q1 and a further two in Q2.

There is now work ongoing in the following areas

HRI: Wards - 22, 17, 12, 10, 6, 3, 15

CRH: Wards =- 5C, 6BC, 9, 8AB, 8D, CCU

As the extra wards were included, nursing staff have undertaken a program of training in the elements of self-administration and self-management and the use of associated documentation. Training is continual in order to implement the process on each new ward area.

This work stream is clinically led by one of the Trust's senior Diabetologists/Clinical Director and supported by other clinical, nursing and pharmacy colleagues. Project support is provided by the Clinical Governance Support Unit and The Health Informatics Service.

The outcome aims for this work is to reduce harm and also the length of stay for diabetic patients.

Work continues with pre assessment ensuring letters are given to patients about bringing diabetes related equipment into hospital.

Improvement Plans for 2015/16

- We are currently training another 2 wards in the process, they will be brought on line in Q3 and a further 2 in quarter
- We will continue to monitor the data so we can increase compliance in all the ward areas and through the collaborative team.
- Camapign poster and launch of self management in June/July Liasion with Yorkshire Ambulance Service and Calderdale and Huddersfield CCG's has taken place.
- Working with the ambulance service for them to ensure patients bring all their medication and diabetic equipment into hospital.
- Work with pharmacy, A+E, MAU and SAU staff to ensure diabetes medication and equipment are brought in if the patient is staying in hospital
- Add onto e-dischage information about bringing diabetes related equipment into hospital if coming back in.
- Recent tender completed and due to be introduced over the next 3-4 months.
  Every capillary BG will be Wi-Fi linked to central system to allow DSN team to remotely monitor every patient with diabetes on the wards

2.7 Reducing Hospital Acquired Infections

Aims and Objectives of Work

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

In 2015/16 the Trust aims are to:

- Have 0 Trust assigned MRSA bacteraemias
- Have no more than 21 Clostridium difficile (Post 48-hour admission) infections
- Improve on the previous year's outturn of 12 MSSA Bacteraemias
- Improve on the previous year's outturn of 29 E.Coli infections
- Screen more than 95% of all elective in-patients for MRSA

Current Performance

Performance at the end of Q2:

Indicator	Quarter 1 End Target	Q1 Performance	Quarter 2 End Target	Q2 Performance	YTD
Meeting the MRSA bacteraemia (Trust assigned)	0	1	0	2	3
Meeting the C-diff target (Post 48 hours)	6	3	10	7	10
MSSA Bacteraemias	3	3	6	2	5
E-coli rates	9	9	14	7	16
Screening all elective in-patients for MRSA	95.0%	97.0%	95.0%	95.28%	

MRSA (Meticillin-resistant *Staphylococcus aureus*) bacteraemia:
There have been three cases of MRSA since April. Of these, one case (Q1) was assessed as unavoidable. The two cases in Q2 were assessed potentially preventable, as follows.

July case - was a pre-admission case, it was attributed to CHFT following the post infection review (PIR). There were a number of missed opportunities for taking wound swabs in both the outpatient setting and community. It should be noted that the revised nationally set post infection review (PIR) process allows pre-admission cases to be assigned to CHFT when this was not the case in previous years.

September case – this was a post-admission case. It was acknowledged at the PIR that there was variable practice of ANTT by ward medical staff which may have been a contributing factor. An action plan is in place to review ANTT practice training for medical staff. The IPCT will commence training for ANTT Assessors from October 2015 who will then cascade the training within their Ward/Department areas.

MSSA (Meticillin-sensitive *Staphylococcus aureus*) bacteraemias:
There have been 2 reported cases in Q2. These cases have not been linked.

E.coli bacteraemias:
There have been 7 post admission cases in Q2. These cases have not related but the common theme is urinary tract infections.

***Clostridium difficile* (*C. difficile*)** is one of the major causes of infective diarrhoea. There have been 7 post admission C-diff cases in Q2.
5 of the cases have been classed as unavoidable following the RCA meetings, 1 was classed as avoidable and 1 case is currently pending.

Improvement Plans for 2015/16

The Trust recognises the increase in the number of MRSA bacteraemia cases and has included the following actions into the comprehensive programme and action plan to reduce healthcare associated infections:

- A plan is in place for IPCT to deliver Aseptic Non-touch Technique (ANTT) training for allocated clinically-based staff who will then act as ANTT Assessors for their work areas.

ANTT is a one-time assessment but Assessors are required to receive an update every 2 years.

- A report was submitted to the Trust in March 2015 following an external review of cleaning services. The recommended changes now form part of the Cleaning Redesign Programme, details of which are due to be finalised by the end of October 2015.

- Work has been done to improve the timeliness of isolation of patients with infective diarrhoea, this has involved use of the new Nerve Centre technology and support from the Matrons. A number of RCAs indicated that patients were not isolated when infective diarrhoea was suspected and specimens sent whilst the timeliness of isolation does not appear to have been a contributory factor to date in the C-diff cases improvement in this area is required. .

- The catheter project continues with the main aim to reduce indwelling urinary catheters to prevent infections associated with these devices. This project has been shortlisted as a finalist in the Nursing Times Awards 2015

2.8 DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation)

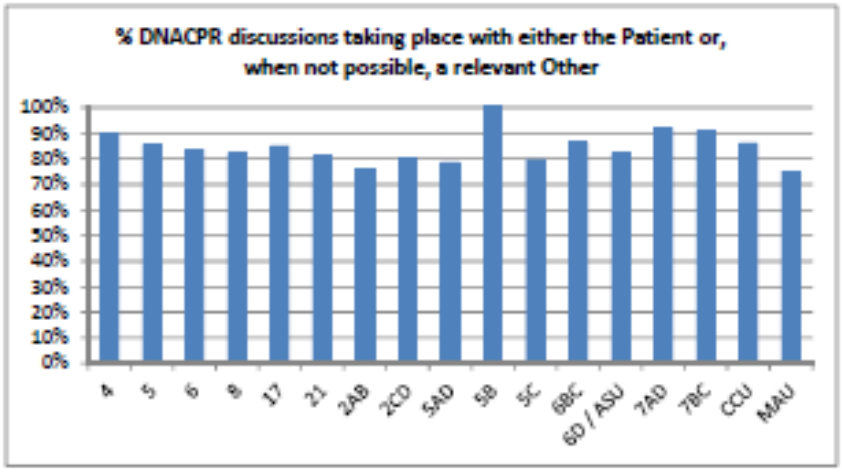
Aims and Objectives of Work

This work aims to ensure Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions are taken in an appropriate and timely manner, documented accurately and wherever possible communicated with the patient.

In June 2014 the Court of Appeal handed down a judgement regarding the duty of clinicians to consult patients when making a DNACPR decision. The Court of Appeal ruled that patients should be consulted in relation to advance DNACPR decisions save in exceptional circumstances.

Current Performance

The table below shows the Trust percentage of DNACPR decisions that have been discussed with the patient or where the patient is unavailable (i.e. dementia, unconscious) it was discussed with a relative/carer. This data is collected by the clinical audit team as a monthly point prevalence audit. The target is 90% to allow some leeway when decisions need to be taken in critical situations and there is no opportunity to communicate with the patient or carer.



A Trust wide point prevalence audit was carried out in January which provided baseline data of all patients with a DNACPR decision and provides detailed reasons for non-discussion, this led to further consultant engagement and ward level and consultant information. A second point prevalence audit was carried out in September. The full report will be distributed as soon as it is finalised.

Improvements since January 2015 have been noted. Data is reported monthly at the Trust Clinical Outcomes Group and ward level data is sent to Divisional Directors and reported at Divisional Patient Safety & Quality meetings.

Full point prevalence audit has been repeated in September 2015 the result will be analysed and shared with through the organisation.

Compliance audit documentation has been updated to capture if both the patient and the family have been spoken to by a clinician regarding DNACPR. This data is sent to divisions for discussion at their PSQBs.

A regional training DVD on DNACPR decisions was produced earlier this year and is now available on the intranet.

Improvement Plans for Q3 2015/16

- DNACPR status is included as part of the handover module of the new electronic 'Nerve Centre' platform. Roll out is now complete across the trust. During Q3 nerve centre data will be explored to see how will this information is being captured and utilised.
- Work with the intensivists regarding the decision making process in relation to patients not suitable for escalation to ICU. Intensive care consultants have been briefed about a process for flagging up the need for DNACPR and family discussions.
- DNACPR bundles have been trialled on 3 Medical and 1 Surgical ward. Feedback has been very positive so is being rolled out Trust wide. The stickers are currently on order at the printers. The stickers are used as a prompt to medical staff to complete a DNACPR form. The Resuscitation Officers will distribute these on the wards and include as part of the BLS training. This is to be completed in Q3.

- Monthly reports on compliance will begin to be reported at the Trust Clinical Outcomes Group and Divisional PSQBs.

- New Patient information leaflet to be published (what happens if my heart stops?). This will be distributed to all wards and available on the repository by the end on the year.

- Duplicated DNACPR forms printed with a red border are currently on order with the printers. This will ensure that a copy remains on the patient's records when the original copy is discharged with the patient. The new forms will be distributed by the Resuscitation officers and incorporated in the Basic Life Support training.

Domain Three – Experience (Caring)

Patient experience compliance summary

Indicator	Compliance
3.1 Dementia (CQUIN)	Achieved
3.2 Improving In Patient experience	Achieved
3.3 Friends and Family Test (contract)	Partial
3.4 Improving Hospital Nutrition (CQUIN, Quality Account)	Achieved
3.5 Improving care for end of life patients and their relatives	Partial
3.6 Claims	Reporting only
3.7 Inquests	Reporting only
3.8 Learning from Complaints	Reporting only
3.9 Mixed Sex Accommodation	Reporting only

Highlights:

3.1 Dementia	Dementia Find, Assess, Investigate, Refer CQUIN achieved. Journal Testing going well,
3.2 Improving the In Patient Experience	Progress with five projects in programme for wards to improve in patient experience
3.3 Improving Hospital Nutrition	Achievement of all CQUINs

3.1 Dementia

Aims and Objectives of Work:

Improving services for patients with dementia has the potential to enhance the quality of their care experience as well as shortening their length of stay and reducing unnecessary costs. Dementia is not generally the prime reason for admission to hospital and therefore it can become difficult to factor into a patient's care programme.

The dementia quality improvement work has 3 objectives:

1) To improve early diagnosis of dementia in order that people can live well with dementia and receive the care and treatment they need
2) To work in partnership with carers to ensure that we understand and meet the specific needs and preferences of people with dementia
3) To deliver training and clinical leadership to all staff to ensure that people with dementia receive person centred and appropriate care whilst in hospital

There are also 3 CQUIN requirements which support the aims above:

1) Dementia Assessment and Referral
2) Clinical Leadership & Training
3) Carers Support

Current Performance:

Improved Diagnosis:

The dementia assessment is completed by the doctors on the ward for patients age 65 and over. This is a 3 part process which each part must achieve 90%.

- Part 1: How many patients have been asked the following question “Has the person been more forgetful in the past 12 months, to the extent that it has significantly affected their daily life?” If the answer is yes, part 2 must then be completed.

- Part 2: For patients that were yes in part 1, abbreviated memory tests score (AMTS) must be completed.

- Part 3 For those patients that had an AMTS score of 8 or below they must now be referred to their GP

We consistently achieve 90% or above in each element.
The assessment is included in the clerking in document. The assessment is then included as a mandatory field on the electronic discharge system with the option to refer those appropriate back to their GP for further assessment.

Performance in this area also fulfils the first national CQUIN requirement.

Dementia and Delirium - Find, Assess, Investigate, Refer and Inform (FAIRI)	Apr-15	May-15	Jun-15	Q1 Total	Jul-15	Aug-15	Sep-15	Q2 Total
No. of patients > 75 years admitted/accepted for unplanned care, who have known diagnosis of dementia or clinical diagnosis of delirium, or been asked the case fining question.	452	430	452	1334	440	402	442	1284
No. of patients > 75 non elective admissions with a LOS > 72 hours (excl those for whom the case finding question is not applicable or answered positively on the dementia case finding question/underwent a diagnostic assessment for dementia in whom the outcome was either positive or inconclusive)	490	474	490	1454	484	435	481	1400
% asked the Question*	92.2%	90.7%	92.2%	91.7%	90.9%	92.4%	91.9%	91.7%
Target	90.0%				90.0%			

Dementia AMTS - Emergency Admission 75 Years & Above	Apr-15	May-15	Jun-15	Q1 Total	Jul-15	Aug-15	Sep-15	Q2 Total
No of Non Elec patients admitted aged 75 and above, who have scored positively on the Case finding questions reported as having had a dementia diagnostic assessment. (AMTS)	81	66	61	208	70	71	63	204
No of Non Elective patients > 75 admitted as inpatients, who have scored positively on the caser finding question	82	66	62	210	70	71	63	204
% of patients aged 75 and over admitted as inpatients who were appropriately risk assessed	98.8%	100.0%	98.4%	99.0%	100.0%	100.0%	100.0%	100.0%
Target	90.0%				90.0%			

Dementia Referral - Emergency Admission 75 Years & Above	Apr-15	May-15	Jun-15	Q1 Total	Jul-15	Aug-15	Sep-15	Q2 Total
No of Non Elec Patients admitted > 75 who have had a positive diagnostic assessment who are referred on for further diagnostic advice.	41	33	39	113	35	25	33	93
No of Non Elec patients > 75 and above admitted as inpatients, who underwent a diagnostic assessment (in whom the outcome is either "positive" or "inconclusive")	41	33	39	113	35	25	33	93
% appropriately referred on to GP	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Target	90.0%				90.0%			

Partnership Working:

The mental health liaison team employed by the mental health trust support assessment of people with dementia, and provide expert advice for patients and their families, and for staff. The principle aim of the service is to prevent unnecessary admission to hospital, often activating appropriate community services for support and care closer to, or at, home. The team also support timely discharge of people with dementia, activating appropriate community care as above.

5 Action plans to meet national requirements

- Assessment and diagnosis
- Training plan
- Carer support – designated projects to support carers and people with dementia
- Dementia friendly environments
- Person centred care – Butterfly scheme and POD (prevention of delirium) programme

Dementia friendly ward and department refurbishments and upgraded

Working in Partnership with Carers

A patient journal is being developed and tested on the trauma orthopaedic wards. Working in partnership with carers, the social engagement workers are supporting this initiative capturing the events of the day, requests for information or for items from home and generally communicating through a two way process with carers. The journal was introduced on one ward during quarter one, and feedback from the carers was very positive. In quarter two the journal has been used on both orthopaedic wards and continues to develop. The aim for quarter three is to refine the design of the journal and involve more members of staff in the communication process. In quarter four, formal evaluation will take place.

Training

A training strategy addresses 3 levels of training. These are dementia awareness, dementia competent and dementia expert.

Dementia awareness is currently delivered to wards and departments by request. An e-Learning dementia package has been developed this will be available from November 2015, and will be mandatory for all Trust staff from April 2016.

Dementia competent is currently delivered through education, ward/department based support, and care pathways:-

- Vulnerable adult leaders training
- Vulnerable adult champion training
- Person centred dementia training
- Butterfly scheme in place on all relevant adult wards, supported with training
- Memory care assessment tool to facilitate person centred care
- Prevention of delirium pathway (POD) included in clinical documentation
- Recruitment of volunteers – rolling programme whereby A level students receive training and induction each year to support people with dementia and delirium on the POD pathway (student enrichment scheme)
- Engagement and Care Support workers in post on wards 19 and 20.
- MYLIFE software to promote social engagement. 6 units now in use, 3 on each hospital site

Dementia is now included in the Vulnerable Adult Network – operational group where issues relating to dementia, delirium, LD, safeguarding adults, person centred care, dignity and mental health, nutrition, and falls are discussed. This operational group oversees the dementia action plan and reports to the Patient Experience Group and Safeguarding Committee.

Training performance supports the second element of the CQUINs requirement. Currently this measures the number of senior nurses at band 6, 7 and 8 who receive dementia awareness through the vulnerable adult leader's course. The training targets new starters and nurses who have been promoted into senior positions. It runs on a once a year basis and is planned for February 2016.

Improvement Plans for Q3 onwards

Delivery of person centred care training – 3 sessions delivered in Quarter 2 and 3 more planned for 2015.
Support to POD students on wards 4, 8, 19, 20 and 21 at HRI, and ward 5AD at CRH –
With designated support from key ward members and 3 Student leads

POD and supporting roles – social engagement and care support workers and intergenerational student enrichment scheme, enhances care and outcomes, staff experience, patient and carer experience, reduce incidents and need for 1:1. Resources including MYLIFE software and recruitment of more students in October 2015

Butterfly scheme promotes person centred care and ensures people receive care relevant to their needs and choices – uptake would improve care and outcomes, patient and carer satisfaction, staff satisfaction, reduce incidents and need for 1:1

Principles into Practice ward based support from the vulnerable adult strategic leads is providing direct education and support regarding the care of people with dementia and/or delirium on adult wards

3.2 Improving the Inpatient Experience

Aims and Objectives of Work

It is important that we measure patient experience, not only in terms of their satisfaction with the care they received but also giving them the opportunity to tell us how we can make it better. This may often be about the small things as well as any large system changes.

The primary method of measuring the patient experience in the trust is through the Friends and Family test (FFT) which is now well established across all inpatient areas and is becoming embedded as a performance measure and indicator for improvement at ward level.

FFT is no longer a CQUIN, however is now incorporated into the trust contract with an expectation to at least maintain the 14/15 position in relation to a response rate of 40% or more.

In addition to this the trust is aiming for a local target of 95% of respondents stating they would recommend the care they received.

Q2 Update

Feedback from the FFT comments has been used to influence the Inpatient Experience Improvement Programme, with 5 key projects being carried over from the end of 2014/15. These commenced during last year and are now being formalised as a programme for all wards to participate in.

A summary of each project is detailed below:

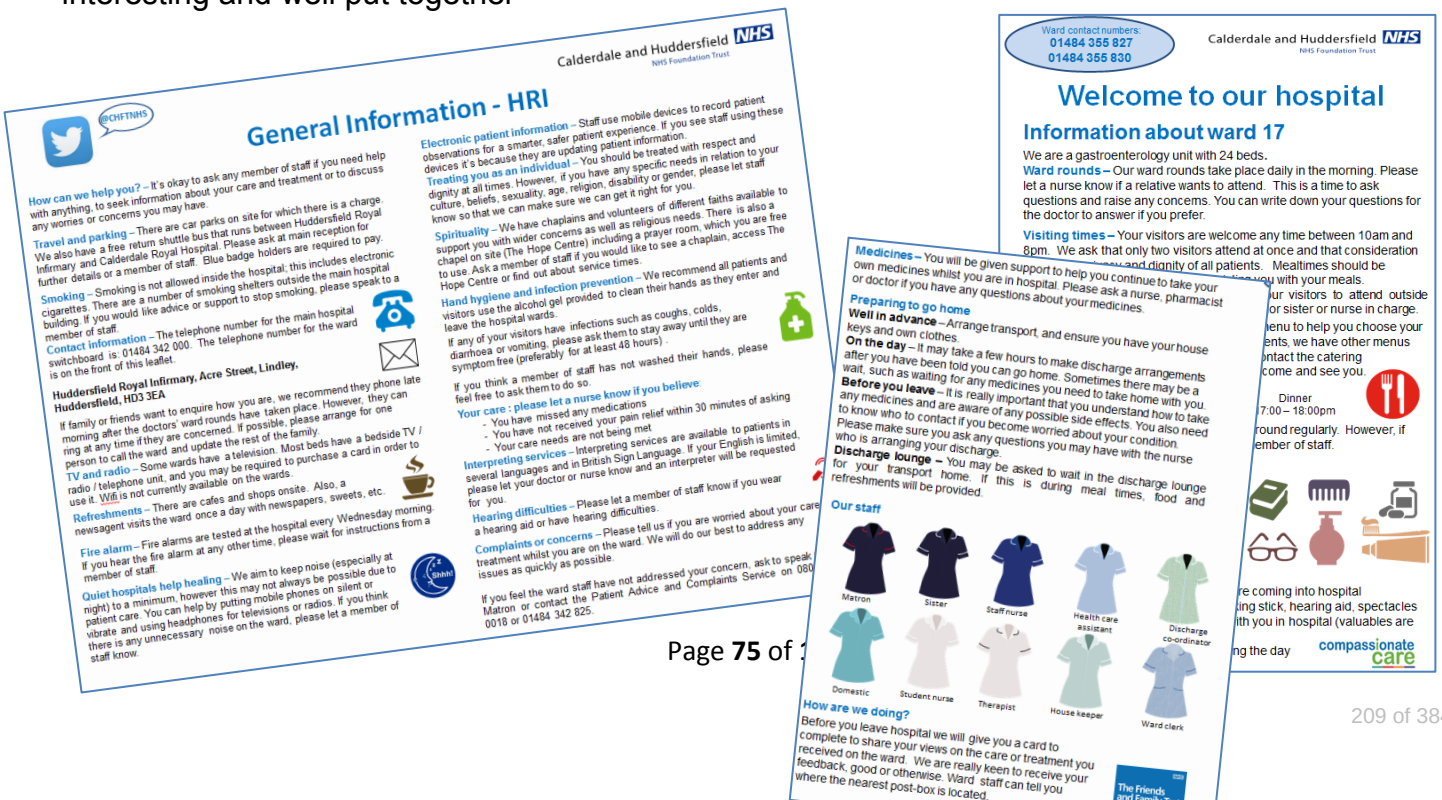
1) **Hello my name is** … This is aimed at reminding staff of the importance of introducing themselves to patients, carers and visitors and to always include their role in any proposed care or treatment with them. ….

   Further emphasis has been placed on embedding this campaign during Q2, with the Divisional Patient Experience and Caring Group leads liaising with all wards and departments to promote the importance across all professions. An article has also featured in CHFT weekly reminding staff of this simple intervention and the impact it can have on delivering compassionate care

2) **Ward orientation.** This project has three components:

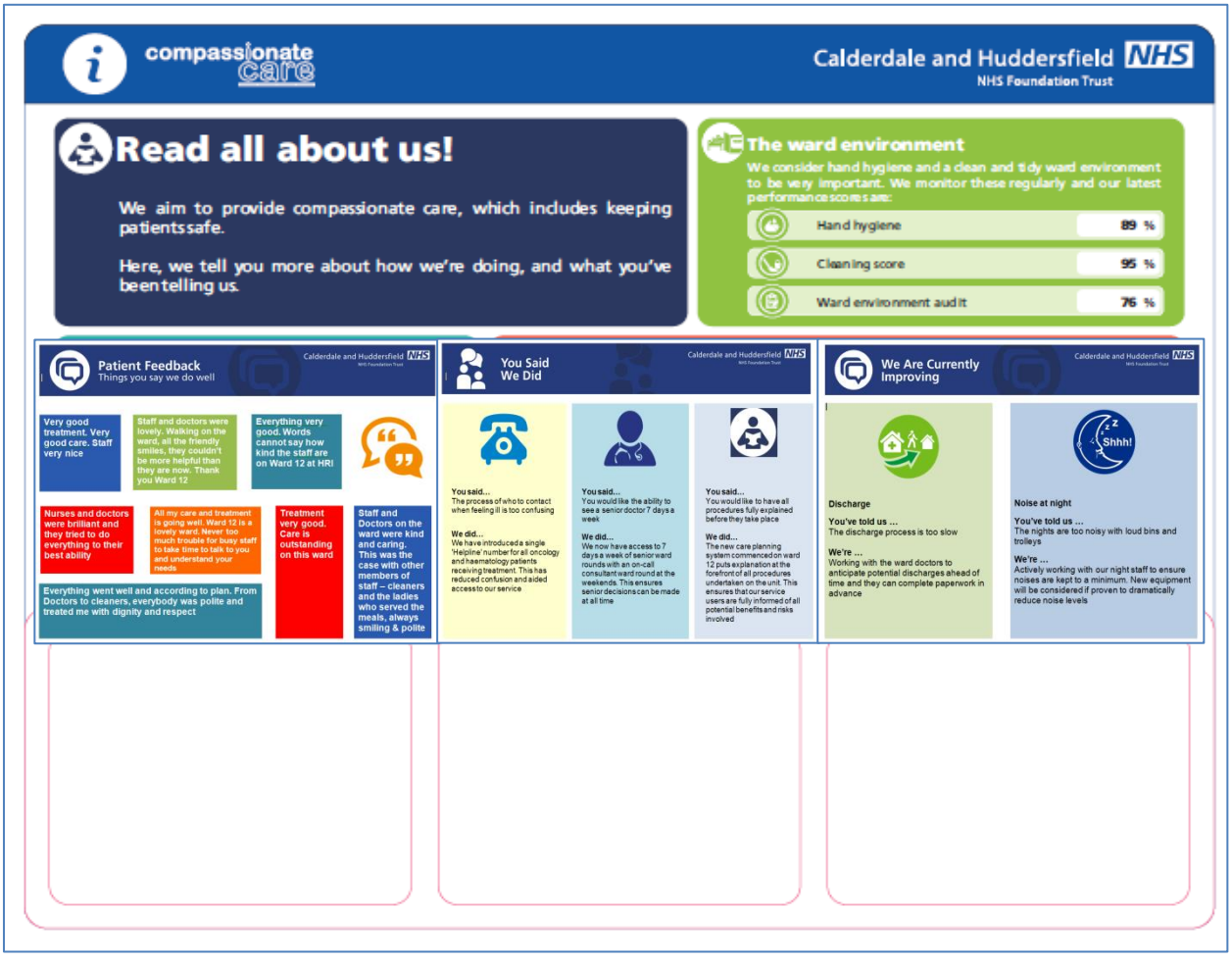
   - Orientation of patients to the ward supported by a welcome to the ward leaflet. Our patient feedback has told us that patients do not always feel welcomed onto the wards and that once they are there, they would like more information about the ward routines.
   - Availability of individual 'about me' information for all patients. These aim to provide an 'at a glance' source of information for staff about individual patient care needs and a personal 'what is important for me' statement
   - Provision of a public facing information board for patients / visitors about the ward. The public facing board will provide consistent information for patients and visitors across all wards.

Ward leaflets: Quarter 2 has focused on an evaluation of the leaflets on two of our inpatient wards. This was carried out independently by volunteers; as a result some slight amendments have been made, including changing the leaflet from an A3 double sided laminated document, to a folded A4 booklet. In general the leaflets evaluated well - "I found it all useful it is very interesting and well put together"



The **behind the bed boards** are now located across all permanent inpatient wards and assessment units. These have also been mounted on the 2 extra capacity medical wards at CRH. An alternative design is being developed for the Neonatal Unit.

During Q2 the **public facing boards** have been put up at the entrance to all inpatient areas, these provide information on some of the KPIs along with an opportunity to share changes introduced in response to feedback via a 'you said, we did' approach. These boards have been designed in line with the Trust corporate branding using simple icons to help create a visual impact.



3) Reducing Noise at night. Noise at night is something patients continue to raise with us through our patient feedback. Research tells us that quiet hospitals help healing – we have therefore made this our message in a campaign to reduce avoidable noise.

During Q2 there has been further progression, action planning and ongoing assurance across the inpatient wards. Core concerns identified relate mainly to noisy bins, noisy staff and noisy equipment.
Some ward have purchased soft closing bins and located these close to the nurses station (most frequently used), however this has not been done consistently across all wards. During Q3 there will be a review of the areas using the new bins to assess whether they are making a difference
Noise at night from staff is a common area of concern raised by patients via FFT comments. Leads have been identified on each ward to act as the champion, providing appropriate challenge to colleagues and escalating consistent difficulties e.g. domestic staff arriving on ward areas in a morning. All staff have been encouraged to promote the 3 step challenge:

- ***Step 1. Take a minute*** *to just listen – imagine you are trying to rest or sleep, what do you hear? Think how you can help to make changes to create a quieter ward or department.*
- **Step 2. Take five minutes** *to ask patients or families on your ward or department what disturbs their rest.*
- ***Step 3. Make it happen*** **–**We regularly challenge colleagues about being naked below the elbow when entering our clinical areas – so please make
  It normal practice to help reduce unnecessary noise too –Together we can – "Shhh" and create a calm healing environment

During Q3 support will be co-opted from staff working in the hospital at night, who will be better placed to observe and address issues as they arise.
Noisy equipment that has been identified during Q2 includes the bed pan machine washers and some issues with Nerve centre equipment, these will be looked into during Q3.
There has been joint working with Estates on this project, who have supported the wards by addressing squeaky trollies and placing sponges on door frames to prevent banging.
A reduction in noise related comments have been noted on some wards

4) How can I help? Patients have expressed a view that staff are not always empowered or enabled to respond to solve problems for them. Another view from patients is that they don't always want to bother staff with their issues as they can see how busy they are. This project recognises the following as being key to achieving a culture of 'How can I help you?' within a team:

- Sharing experiences of helping
- Troubleshooting on behalf of patients and colleagues
- Taking actions to solve problems, no matter how large or small

During Q2 the project has been linked to some improvement work for complaints, this includes achieving a change in staffs approach to complaints, via a co-ordinated campaign. Key actions in this project are to promote a culture where staff feel empowered to sort out concerns on the spot and to encourage staff to recognise that dealing with situations / capturing a complaint on behalf of a patient is their responsibility, not that of the corporate team. The result we are aiming to achieve is an improved handling of concerns by staff and that these do not therefore develop into a complaint. Having a 'How can I help?' attitude will be key to achieving the result.

5) Regular information round. Surveys of patients' views have revealed that doctor/patient communication is not always as good as it could be and in some cases it is judged by patients to be extremely poor. The areas where we seem to consistently fail relate to

communication between doctors and patients about a patient's clinical condition, the treatment plan, and expected outcomes. This project is being linked to a set of 'always events' and a learning package in the style of a short DVD based on some good practice examples of communication on the ward.

This project is still in the design phase and further details will be shared in the Q3 report

Plans for Improving the Inpatient Experience from Q3 onwards:

1) **Hello my name is** …
   Continued embedding
   Commence measurement via ward surveys

2) **Ward orientation.**

Printing and distribution of leaflets, translation into top 5 languages
Complete design of behind the bed board and public facing board for NICU
Commence patient feedback via ward surveys

3) **Regular information round.**

Agree content of learning package – short DVD based on some good practice examples of communication and look into the production

4) **Reducing Noise at night.**

Review success of quiet closing bins on the wards where these have been purchased
Co-opt support from staff working at night
Look in to the issues raised re equipment
Ensure the message is being acknowledged across all professional groups

5) **How can I help**

Progress the work being led through the complaints task and finish group – culture of staff feeling empowered to sort out concerns on the spot

3.3 Friends and Family Test

	Percentage response rate						Percentage would recommend					
	Apr 15	May 15	June 15	July 15	Aug 15	Sept 15	Apr 15	May 15	June 15	July 15	Aug 15	Sept 15
Inpatient	25.8%	21.4%	21.9%	26.5%	28.1%	24.4%	97.3%	96.4%	97.4%	96.6%	97.1%	96.5%
Maternity	18.2%	23.8%	26.3%	27.5%	29.6%	42.6%	94.0%	91.1%	94.8%	97.8%	95.2%	98.8%
A&E	6.8%	10.0%	8.6%	5.7%	2.7%	9.6%	90.7%	90.5%	91.1%	91.1%	84.8%	86.2%
Community	3.8%	3.3%	3.2%	3.1%	3.2%	3.0%	90.9%	89.1%	90.6%	92.4%	89.7%	91.6%
Outpatient	14.4%	13.9%	13.6%	13.8%	13.5%	13.3%	88.0%	87.9%	88.4%	89.5%	89.2%	89.2%

Inpatients: Quarter 1 reported on some changes that were introduced in April 2015 for the inpatient FFT that have resulted in a significant drop in response rate. The requirement is to include patients admitted into any inpatient area regardless of whether they have an overnight stay. Prior to April 2015 this was not the case.

Since the change was introduced not only has the response rate dropped, but also our ranked position. It is worth noting that nationally there are fewer trusts achieving the high levels of response rates which had been seen last year.

During Q2 the Divisional FFT leads have been liaising with teams to ensure they are progressing the FFT process for this patient group. The 'day case' category covers a number of areas where a patient does not have an overnight stay, e.g. admissions / decisions units as well as all areas where a procedure is carried out, 27 in total. A more formal arrangement has been established to monitor weekly progress at each individual area, this requires a named lead for each area who are responsible for ensuring that:

- colleagues are aware of the requirement
- they have a supply of the FFT postcards
- they have located the nearest FFT post box / ordered another if the nearest location isn't suitable.

Whilst there have been some slight improvements, there is still significant work to do to get back to the 40% target.

Whilst it is important to maintain a high response rate, an additional key measure for the trust is to have our patients stating that they would be happy to recommend the care they received.
During 2014/15, this averaged at 96.3%, which placed us in the top half of Trusts when compared nationally. It is reassuring to note that the Trust has continued to score well, remaining around 97% across all months.

Maternity: The response rate for maternity services has always fluctuated along the 4 touchpoints of the pathway. Up until recent months the responses have relied on text messaging (with the exception of antenatal). A number of approaches have been tried to promote the text with women and encourage them to respond to the text messaging, with limited success.
The introduction of the maternity EPR system (June 15) removed the link to envoy, our FFT text provider; therefore postcards or web based tools via electronic devices were introduced. This appears to be having a positive month on month effect with September 15 achieving the 40% target.

The percentage of women who would recommend the service has also seen an improvement with a score of 98.8% in September 15. A programme of improvement work is being led by the Maternity patient experience champions group, currently focusing on the Trust priorities of ward orientation / information, reducing noise and night and the Hello my name is campaign.

A&E: This response rate has been a significant challenge since the removal of the token system. The replacement system for collecting responses was by postcard and issuing the cards and promotion of the test was not always achieved during periods of high activity. SMS text messaging has been implemented in Sept 15 this has seen some initial improvement, but not to a level required. Further evaluation is required with the A&E team.

The A&E score for patients recommending the service remained around 91% for Q1 however this has taken a dip in Q2. A patient experience group has been set up which will include a focus on messages from complaints / concerns / FFT and leading on improvement work. An example of issues raised in the FFT comments is the waiting time in the department with further reference being made to the need to keep patients informed of the length of the wait. In response to this the departments now have electronic screens displaying real-time waiting times

Community: The response rate for community has always been low, never achieving higher than 4%. The current method of capturing the feedback is the use of SMS text messaging and recognising that this is not reaching all patients a decision has been made to move to a variety of data collection methods which will run alongside the text service. This will include a web based method which staff can ask patients to input directly onto a mobile device such as staff lap tops or mobile phones. The new data collection methods are expected to be embedded during September with improvements seen shortly after.

Further focus is being placed on the use of comments to better understand opportunity for improvement as the percentage of patients who would recommend the service is lower than we would expect it to be. Themes will be identified from the comments to progress this work

Outpatients: The response rate for outpatients remains fairly low, at just below 14% throughout Q2. However a national benchmarking report from June 15 shows the Trust rate to be in the top 25%. SMS text messaging is the current method of obtaining the feedback. In order to achieve an improvement staff working in the outpatient departments have been asked to ensure that postcards promoting FTT are in place in all waiting areas. Along with verbally informing patients to expect a SMS survey. There is also a plan to add FFT to the Electronic Communication Boards in the OPD areas.

The June 15 benchmark data for percentage would recommend places the Trust in the lowest quartile. Common themes from FFT comments have been used to inform a Patient experience focus group which took place in September 15. The outputs from this have been turned into a transformation project, with a plan for delivery during Q3

3.4 Improving Hospital Nutrition

Aims and Objectives of Work

The Trust has a responsibility to provide the highest level of care possible and this includes the quality of the food that is provided for patients, visitors and staff.

Nutrition designed to meet patients' individual needs is central to a good recovery. The Trust aims to provide patient choice which is both hot and appetising and nutritionally balanced. Nutrition is an agreed priority for the trust in the annual Quality Account and is supported by the 2015/16 CQUINs which aim to:

- Measure and Increase patient satisfaction with food
- Show a reduction in the amount of food which is wasted.
- Improve the Hospital vending facilities.

Current Performance

Patient Satisfaction: Patient satisfaction is being measure by the distribution of a questionnaire to inpatients. Volunteers on the HRI site and members of ISS on the CRH site sample 400 or more patients each quarter. The Q1 and Q2 performance is outlined below:

	Quarter 1			Q1	Quarter 2			Q2	
8.1 Nutrition and Hydration - Patient satisfaction	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15	Total	YTD
No. of patients reporting satisfaction with hospital food	137	146	165	**448**	113	99	114	**326**	**774**
Number of patients audited in quarter	185	177	210	**572**	139	141	149	**429**	**1001**
% patients reported satisfaction with Hospital Food	74%	82.49%	78.57%	78.32%	81.29%	70.21%	76.31%	75.92%	**77.3%**
Target	Patient feedback (400 survey's)				Patient feedback (400 surveys & report on 6mnths)				

As a result of this work, the catering team at CRH have raised the profile of supervisors and team leaders on the ward so they are available to speak to patients and staff around any concern related to food and feedback from the wards around this has been positive.

Concerns had also been raised around the lack of choice for patients who require a soft mashable type diet, as such a meeting took place in Q2 with staff from one of the CRH rehab wards and now a wider choice of category D and E meals are being tested with patients, staff and dietetic team to see how this is benefiting patients. Alongside this, Halal meals are also under review to improve both quality and choice.

Throughout Q2, ISS have been working with Burlodge, the heated trolley provided on the CRH site, and Anglican Crown who provides majority of the meals. The review looked at different ways the food could be plated and reheated in order to prevent some meals becoming overheated and drying out. It is noticeable that complaints from both patients and staff have reduced since this piece of work began.
Highlighted below are some of the other work that has taken place as a result of feedback during Q1 and Q2.

HRI site:

Negative Comments:	
Comment	**Action**
Temperature of Food re food not hot	• Porters assisting with swift delivery of meal trolleys to wards. • Smaller portions of less dense food products i.e. vegetables de creasing temperature loss. • Assistance at ward level to cut service time down.
Cooked breakfast option	• Ward staff able to order cooked breakfast option at patients request.
Meal plates too hot	• Plate warmers have been turned down to alleviate this issue.
Sandwiches more variety	• Will look into alternating sandwich options and look at other varieties.
Tea and coffee always cold	• Ward issues will contact wards
Over cooked vegetables	• We have reduced the timings for vegetables and haven't had issues since.
More green vegetables	• 27% of the current menu are green vegetables.
Cold Toast	• Toast is made on the wards will contact wards
Not enough salt and Pepper	• Salt and pepper sachets served with every meal if the patient required extra we would take advice from ward staff.
More choice at Breakfast	• Currently a continental breakfast 3 choices of cereals, Porridge,2 choices of bread rolls, preserves, toast from ward and hot breakfast on request from ward staff.

Positive Comments
Food better than I thought it would be.
Like salads & soups
Very satisfied with the meals that I have had.
Porridge and rice pudding are exceptional.
Meals are always tasty and hot
Very friendly catering staff
Very happy 1st class
Impressed with catering staff who frequently ask if you are happy with the food.
I was in hospital 5 years ago and the food is much improved.
My whole experience of this has been good so far, meals have been the icing on the cake.
The meals and staff have been excellent can you book me in over Xmas please.
Meals are an important part of a long day, something to look forward to, I haven't been disappointed.

CRH site:

Negative Comments	
Comment	**Action**
Temperature	
The food was sometimes cold , and I sometimes did not get what I had asked for	The comments are almost generic and relate to the plated meal system. Work is being undertaken presently within the Department looking at temperatures and checking for abnormally high temperatures occurring. Also a Patient Service Catering Supervisor is being developed to work around the ward areas to intercept problems and encourage meals to be given out as soon as is possible to avoid drying. Matron walkabouts with Catering Senior Team should also bring a better understanding of system.
Food left standing in trolley	
Meat dry and overcooked	
Food and gravy dry	
Left standing long time sauce had stuck to the plate	
Food	
Vegetables overcooked and could have done with more variety of vegetables	Looking into choices available and going to make alterations to menu shortly so will take this matter on board as part of this next piece of work.
Breakfast menu boring-Kippers would be nice	Additional items can be made available for patients with menu fatigue and we intend to communicate this better to ward areas with the introduction of the Patient Service Supervisor. Meeting has taken place with Dietician/SALT Team also to communicate this matter further
• Rice pudding never available. • There was no bread for breakfast	Both comments related to two items that are always in stock with contingencies. There appeared to be a communication issue with ward based staff
Soups powdery	Continuing to review soup product for lunch time as it is the fresh homemade soup for evening meal which is very popular, and there will appear a disparity in the two. Unfortunately the kitchen presently does not have the capacity to produce enough homemade soup for both meal times
Overall	

Portion size too big	Can accept comments re menu card as there is flexibility to request larger or smaller portion sizes, but perhaps layout of menu is complicated. Bulk breakfast is in the middle of being rolled out giving more flexibility at breakfast time.
Menu too complicated, too many boxes	
Patient missed meal times	When asked patient explained that the ward staff had not fed him, nothing had been sourced from Catering.
Not getting what had been ordered	Newly reprinted menus have now been received. Catering staff had tried to make sure wards are not in possession of old menu cards.

Positive Comments
So far very good- Happy
Quite good food, I was surprised I enjoyed it
Absolutely
Really satisfied, didn't think that it would taste as good as I imagined- Gammon very nice
Soups and Ham sandwiches very good
Enjoyed salad/Omelettes/
Overall happy with the service, no complaints
Always enjoyed meals, nice choices

Food Waste

We are continuing to work on reducing the amount of patient food waste; actions are currently focusing on improving communication at ward level which helps to feed back to patients the food choices available to them. This work is also helping to increase accurate ordering at ward level.

	Quarter 1			Q1	Quarter 2			Q2
Indicator 8.2 Nutrition & Hydration - Reducing Hospital Food Waste	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15	Total
HRI - % Returned	5.72%	5.35%	4.77%	5.70%	5.07%	3.95%	5.17%	5.48%
CRH - % Returned	4.60%	4.60%	3.70%	4.30%	5.51%	3.34%	3.35%	3.34%
Target	Baseline				Report on baseline			

During Q2, there has been work with our supplier for HRI which is looking at provide food in smaller foils, this will allow the meals to retain their heat and continue to remain appetizing for longer and as such reduce waste by reducing the amount of the meal that is returned untouched.

Vending Facilities

The following report was submitted in support of achieving the third CQUIN element which is looking at improving vending machine facilities on the HRI site

Remit: - Huddersfield Royal Infirmary (HRI) is reviewing their vending service offered to patients, visitors and staff across the HRI Site, working with Joe Harvey Health Education Trust Director and Food for Life Associate. The outcome is for CHFT to become a flagship in having a radical approach to vending in line with the Simon Stevens CEO for the NHS recommendations.

Current Services: - Traditionally the 9 available machines have provided snacking and beverages options within the HRI site in three dedicated locations, the current vending service provision is from two companies, LTT vending, who provide 4 cold beverage machines stocking a range of traditional cola and sugar based branded products, water, fruit juice, and energy drinks. Wilkes Group operate the 2 hot drinks machines offering tea, coffee, and 3 snack machines providing a range of traditional branded products.

The Trust has worked with service providers to ensure the machines are not just based on traditional sugary drinks, confectionary bars and unhealthy snacks, the cold drink offerings now include a range of juice drinks and water. Snack machines are marked with green circles these are linked to a "spot the dot" campaign highlighting hand-picked healthier snacks.

The two companies currently provide a fully managed vending service for the Trust this include loan of the equipment repair and breakdown cover, maintaining stock levels, cleaning and full cash handling for all machines.

Proposal: A full review of HRI's vending services is being undertaken to improve customer satisfaction and health and well-being of the population we serve as well as ensuring ongoing income generation.

This will be achieved the following next steps:-

1. **Engagement of Food For Life**

The review includes partnership working with Joe Harvey from FFL who will support CHFT on the back of his expertise in improving vending in schools.

2. **Complete Vending Users Survey**

The surveys have been completed and we are currently reviewing the results. A site visit has also been completed looking at where vending is currently located

3. **Networking**

Use learning from other NHS and public sector organisations (Royal Brompton/Liverpool ISS)

4. **Hot Food Provision**

Continue to explore the option of offering food that is nutritious healthy with the ability to re-heat offering a genuine alternative to current out of hours feeding arrangements.

Updates on these areas will be provided in Q3. There is a vast amount of work surrounding hospital nutrition, some of the complimentary work streams and projects are outlined below:

Partnership working with Food for Life:

Calderdale CCG have funded the Soil Association Food for Life (FFL) for the next 2 years. Part of their role will be using their expertise in supporting CHFT in improving the food experience for staff, visitors and patients. FFL for life also link into other NHS organisations and are keen to share other projects with CHFT

Part of this support has already been outlined above with the vending project.

Nutrition and Hydration Strategy:
In October 2015 FFL are supporting CHFT in an engagement event with staff, and users to help in the development of a Nutrition and Hydration strategy for the Trust.

Fruit and Veg stall HRI:
From the 7th October as a pilot for approximately 7 weeks a food and veg stall will be in place in the main entrance at HRI. It demonstrates excellent partnership working with the Council and local businesses selling local produce and if proves to be successful will be rolled out onto the CRH site too. This is to encourage health and Wellbeing of staff and public and also links into the NHS CEO Simon Stevens drive to improve health in the NHS

Calderdale Food Assembly:
On the 8th October 2015 an assembly was undertaken where the FFL hospital work at CHFT was shared with nursing homes. The event brought together caterers and procurement teams from all settings to enable networking and learning.

Packaging Test study:
CHFT are involved in a study to measure food packaging opening ability and ease of access for common NHS packaging items. It is in conjunction with the Hospital Caterers Association, NHS England led by Caroline Lecko and Sheffield Hallam University led by Alistair Yoxall. The test is in 3 stages looking at strength, dexterity and the pack open ability test. The request has been for mainly female over the age of 65. We have used our patient reps to assist with this study and has involved them basically being observed open the packaging. Updates will be given on the outcome of the study

Food for Life Catering Mark:
In December last year ISS achieved their Bronze Catering mark in retail. This relates to the coffee shop and the onsite restaurant. In December 2015 they will be going for silver award and to achieve this they are planning on buying products like fish, fruit, vegetables, meat from a local source.

Incredible Edible:
On the 17th June 2015 Incredible Aqua Garden (part of the Incredible Edible Todmorden Group) created edible landscapes in the grounds of Calderdale Royal Hospital. Incredible Aqua Garden, along with a group of volunteers from Lloyds Bank, Halifax, planted edibles in four sites, within the hospital grounds.

The two courtyards have 'sensory' planters, containing herbs and other plants, which are good to look at, to touch, to smell and to taste, and brings a new dimension to the spaces.
The area in front of the Learning & Development building has three raised 'kitchen garden' beds, containing summer vegetables, herbs and fruit.

There is a new planter in front of the Macmillan building which have a variety of herbs and edible flowers.

5 fruit trees will also be planted on the CRH site over the next month

MUST (Malnutrition Universal Screening Tool) Compliance:
In August 2015 an audit of MUST screening was undertaken across 4 wards totalling 90 patients
Feedback will be shared with the sisters in at October's sister meeting

Key findings

- 98% of patients had a MUST care plan
- 30% were completed in full
- 68% had accurate height and weight
- 68% had BMI recorded accurately
- 43% had a relevant care plan in place
- 23% fluid balance charts completed in full
- 32% had food diaries completed in full

Whilst it was a positive that almost all patients had a MUST care plan, Q3 will look to understand some of the barriers to fully completing the MUST tool and the Fluid Balance Charts.

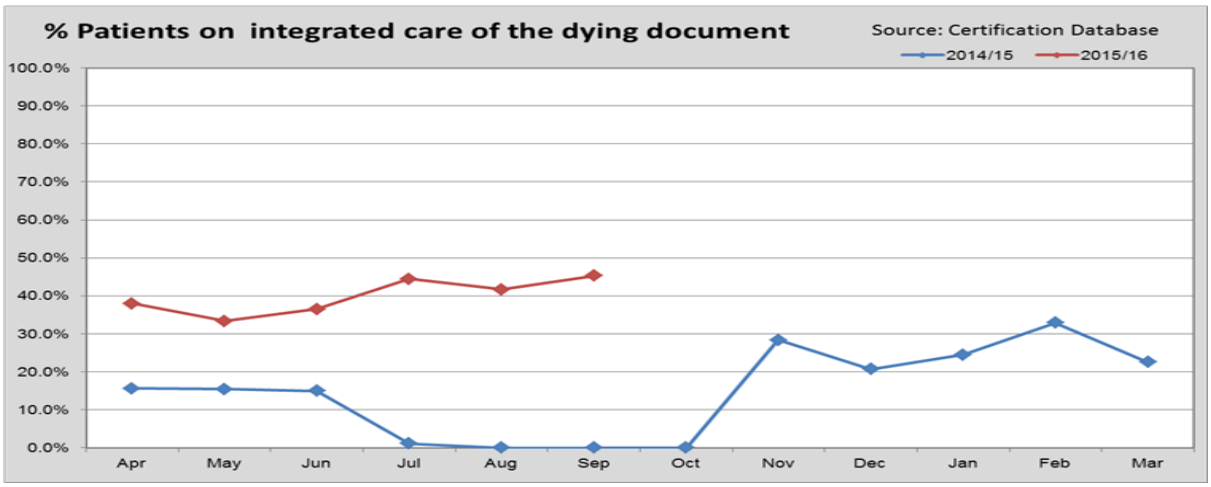
3.5 Improving End of Life Care

Aims and Objectives of Work

End of life care provides particular challenges, not only because of the special needs of many at the end of life but also because of the need to coordinate and integrate a wide range of services across different sectors. However the rewards for getting it right are huge. Personalised, integrated care at the end of life can transform that experience for the individual, their family, and the staff caring for them (source: NHSIQ)

Current Performance

The chart shows the percentage of patients who are supported by an end of life care plan who then go onto die, since the ICODD was implemented in November 2014 (currently 45.30%).



Progress against Improvement Plans for last 12 Months

- The introduction of comfort bags has received warm feedback from both families and clinicians. The bags contain little essentials, such as bed socks, tissues, a dental kit, and a notebook and pen, to ease time spent at a bedside if a relative needs to stay overnight.

- Education and training is being rolled out to Cardiology and Complex care wards. The one day sessions started in June and will continue to November 2016. Extra sessions have been planned for medical staff at the Clinical Governance half days in November and time out sessions arranged for ward staff.

- Funding received earlier this year from Health Education for Yorkshire & Humber for training. CHFT commissioned Kirkwood Hospice to deliver a series of free one day courses for doctors and registered nurses working in the Trust. This course is designed to improve knowledge, skills and confidence when communicating with palliative care patients. It will focus on the five priorities of care. There have been three sessions to date and one more session planned for October. Over the 3 study days we have had 56 attendees. .A further six sessions are planned in 2016. The course has evaluated very well by those who have attended.

- Continue to identify and review end of life related complaints using the criteria of death during admission or within 3 months of discharge. Identify any themes. This gives the trust insight in where to focus training/action which is specific to each area, and in particular whether there are nursing or medical actions required. Reports are being produced every 2 months and trends identified. Themes identified so far are - lack of or poor communication, poor care, poor symptom management, reference to the LCP and poor discharge planning. This is reported through the end of life meeting and will be shared with staff through training and education.

- Continue to monitor use of the ICODD. This is an individualised plan of care which helps to support and care for people who are dying. Compliance is increasing as staff attend the organised training sessions and awareness spreads.

- Participation in the National End of Life Care Audit. Data for CHFT has been submitted for 80 patients who died during May 2015. The closing date for submission of data was 30th September 2015.This audit will look at the progress acute hospitals have made in addressing the 'five priorities of care' for people in their last hours, days of life. Reports are expected to be published in March 2016.

- Local audit carried out of 20 patients who died in May 2015 whilst being cared for on the individualised care of the dying document. The data is currently being analysed – The report will be produced within the next few weeks and results presented at the next available slot at the Clinical Governance meetings.

Plans for improvement 2015/2016

- More training days on advanced communication skills and end of life care are organised for 2015/2016. Two more sessions are planned for 2015 and five in 2016.

- Purchase of more comfort bags for use with the ICODD– Comfort bags contain useful items for the relatives of patients dying on the ward; bed socks, lip gel, toothbrush/paste, etc.

- Further improvement in the use of the ICODD through training and education.

- Further improvement in review of decisions for DNACPR through training and education and the data received from monthly audits.

- Local survey to bereaved relatives will take place in October 2015. Questionnaires will be sent to relatives/carers of patients who died in January and February 2015. The questionnaire will be used to assess the quality of care and the level of support provided to individuals and their families in the last days and hours of life. One of the recommendations from the National Care of the dying audit was that all hospitals should undertake local audits of the care of the dying including the assessment of the views of bereaved relatives, at least annually

3.6 Claims

All formal claims received are handled on behalf of the Trust by the NHS Litigation Authority who effectively provides indemnity through our annual insurance premium. The annual premium is based upon our claims history. Learning from claims will improve the quality of the care we provide and help to reduce further increases in our premiums.

Activity relating to claims is captured throughout this section. A new process for capturing learning from claims has been introduced during the Q2 and this learning will be available in the Q3 report.

Clinical Claims	Q1	Q2	Comment
New Claims opened during quarter	44	36	Reduction on Q1/Q2 last year
Claims closed in quarter	17	19	3 cases were settled this quarter.
Services with highest level of clinical claims	61% relate to 3 service areas: - Emergency Network - Orthopaedics - Women's Services	64% relate 3 service areas: - General & Specialist Services -Women's Services -Emergency Network	There has been an increase this quarter, in cases relating to General & Specialist Services

Non Clinical Claims	Q1	Q2	Comment
New Claims during quarter	6	4	Reduction on Q1/Q2
Claims closed in quarter	3	10	1 case liability accepted

Inquests	Q1	Q2
Inquests opened during quarter	12	10
Inquests held during quarter	6	5

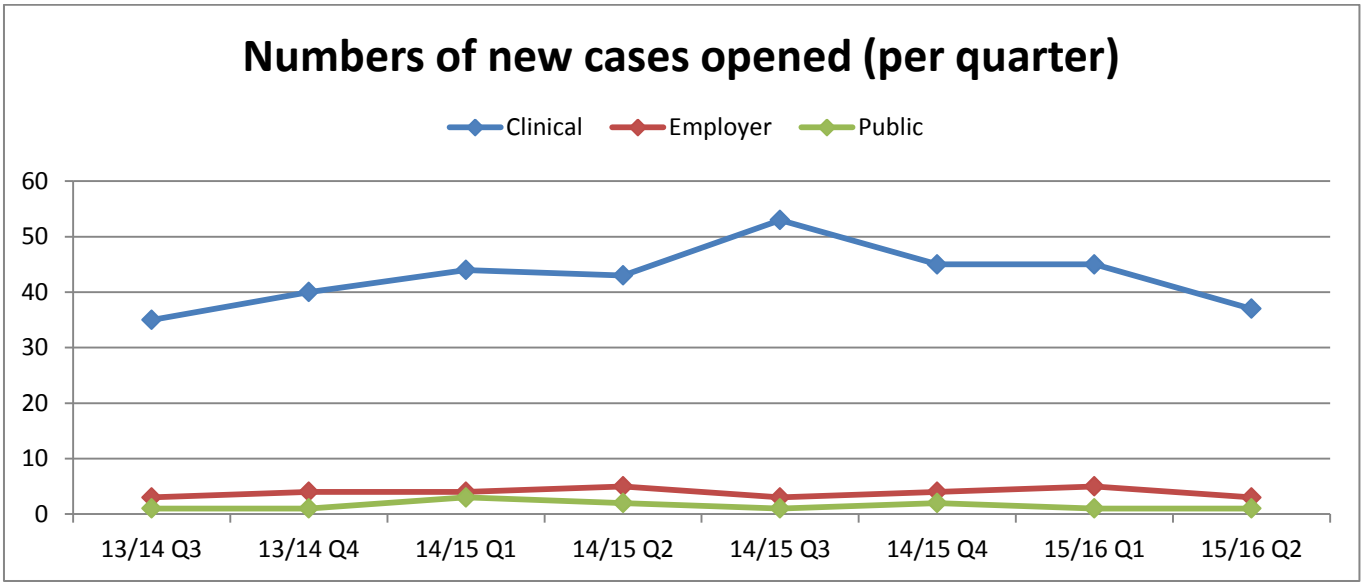
New claims:

40 new cases have been registered on the Datix system in Quarter 2, 2015/16.

- 36 clinical claims – of which **1** was a formal letter of claim; 35 were requests for records;
- 3 employer liability claims
- 1 public liability claims.

In addition, of the existing cases on the system, **11** requests for records have progressed to formal claims.

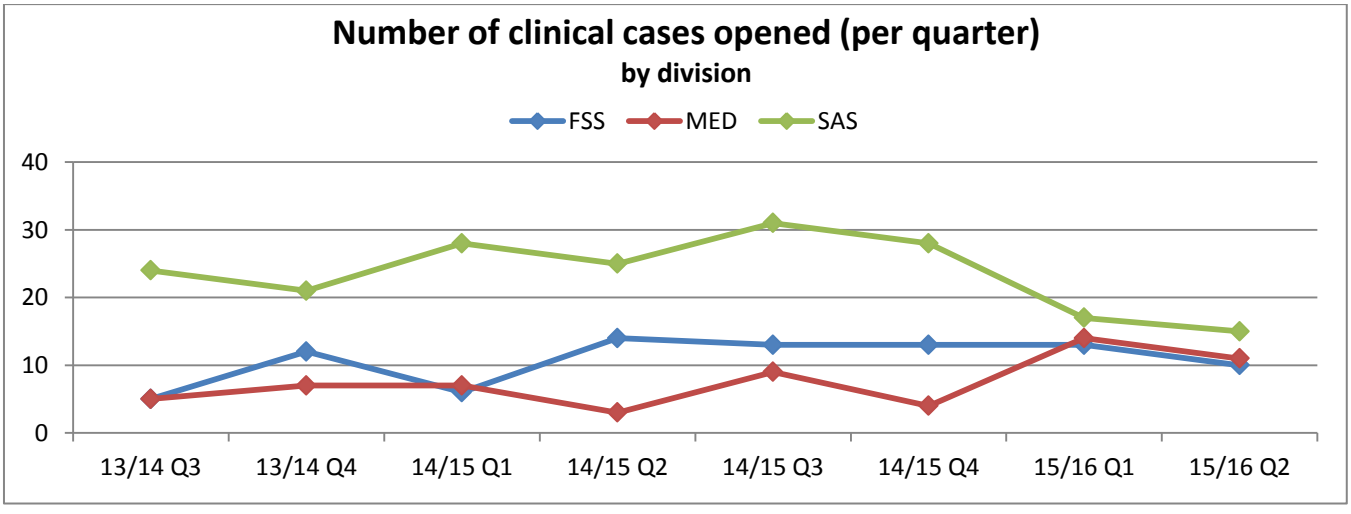
The numbers of new cases opened per quarter over the last two years are shown in the graphs below:



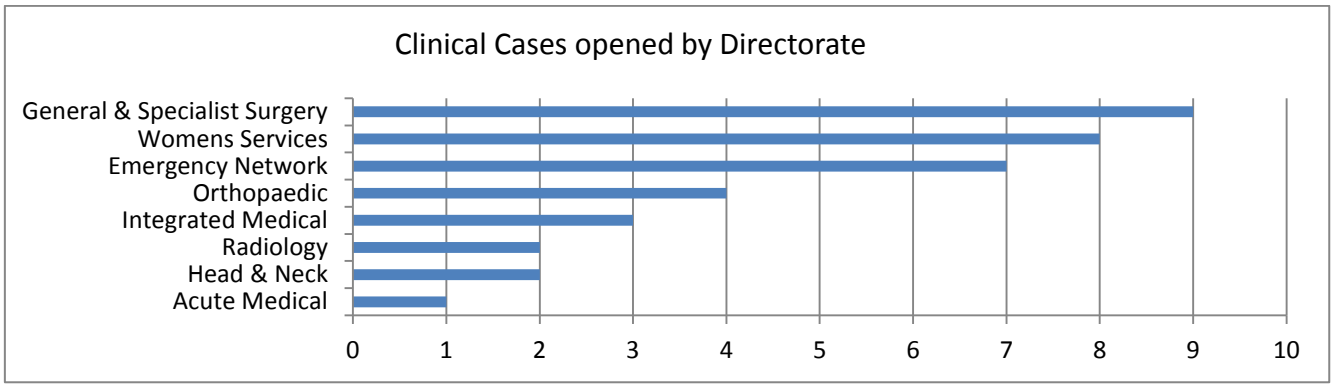
The number of clinical claims opened peaked in Quarter 3 14/15, with a reduction in the following quarters and a further fall in Quarter 2 15/16

Non clinical claims increased slightly in Quarter 115/16 but have fallen again in Quarter 2.

Clinical Cases Opened: Reviewing the number of clinical cases opened per quarter by Division, shows that the reduction is across all Divisions.



Drilling into the Q2 cases, the spread of the directorates is shown below:



Employer liability claims have reduced in Quarter 2

Clinical Negligence – New Letters of Claim / Letters before Action:

Directorate	Incident date	Summary	Previous Investigation
Children's	29/08/2014	On initial admission to A&E xray of lower arm identified no abnormality. On return visit to A&E lower arm re-x-rayed with no abnormality identified and referred to Fracture clinic. X-Ray of whole arm in Fracture Clinic revealed missed buckle fracture in upper arm. Claim alleges failure to correctly assess injury and to carry out appropriate investigations resulting in increased pain and suffering through lack of diagnosis. Also possibility of complications due to delayed diagnosis.	Complaint - upheld
Orthopaedic	18/12/2013	Alleged failure to provide adequate treatment when left thumb nail removed and post-surgery treatment to avoid infection.	Complaint - not upheld
Acute Medical		Alleged failure to identify broncho carcinoma developing on regular check chest xrays taken in December 2011; February 2013 and December 2013. Diagnosis delayed until March 2014.	No records
Emergency Network	08/12/2012	Alleged failure to recognise and treat an Abdominal Aortic Aneurism.	Inquest - Natural Causes
Acute Medical	23/04/2010	Claim being pursued against LTHT and CHFT. Alleged failure by LTHT to diagnose diffuse large B-cell lymphoma; treat with blind radiotherapy with a failure to remove plastic tubing from drain post operatively. Claim against nursing care at CHFT which it is alleged did not prevent falls, provide adequate catheter care or prevent pressure sores leading to considerable pain and discomfort.	Complaint - not upheld and Inquest – natural causes
Emergency Network	31/08/2014	When admitted with a history of falls, the level of monitoring failed to prevent an unwitnessed fall leading to a significant left sided subdural haematoma and death.	SI
Orthopaedic	04/03/2014	Attended Orthopaedic Clinic following ski-ing injury abroad and provided clinical report from doctor in Switzerland suggesting need for CT scan. This was not initially carried out leading to a delay in corrective surgery.	Complaint - upheld
Women's Services	14/01/2014	Alleged failure to adequately risk assess pregnancy and identify need for increased surveillance scans and potential for early delivery to prevent IUD.	NPSA perinatal Review
Emergency Network		Claim being jointly pursued against GP and CHFT for alleged failure to provide adequate treatment in Community for leg ulcers which deteriorated sufficiently to require below knee amputation.	No records

Emergency Network	30/06/2012	Alleged delay in diagnosing cauda equina syndrome during three attendances at A&E.	Complaint - partially upheld
Women's Services	27/11/2012	Difficulties with stiches following delivery of baby resulting in need to undergo division of vaginal adhesions.	No records
General & Specialist Surgery	17/07/2013	It is alleged that a piece of sponge was inappropriately left in wound causing infection.	Incident

Employer's Liability – New Letters of Claim:

Directorate	Incident date	Summary	Previous investigation
Operating Services	19/11/2014	Claimant reports sustaining an injury to his back when Huntleigh trolley was moving towards door frame he attempted to stop it.	Incident
Children's Services	26/05/2015	Needle stick injury when disposing of sharp in sharps bin	Incident
Pathology	28/04/2015	Injury sustained when moving a trolley of equipment weighing over 25kg into storage; the trolley was taken down a ramp to the storage area. The trolley picked up speed going down the ramp and trying to control it caused whiplash to neck, back and shoulders.	Incident

Public Liability – New Letters of Claim:

Directorate	Incident date	Summary	Previous investigation
Estates Maintenance	12/03/2015	Patient used handle on the toilet wall which came away from the wall causing him to fall and sustain soft tissue injury to right wrist and injury to right knee.	Incident/Complaint - upheld

<u>Settled Claims</u>

Clinical Negligence Claims:

19 clinical claims settled / closed during Quarter 2.
9 of these were unsuccessful with liability denied or the claim withdrawn. 7 were closed after being settled the previous quarter. The 3 claims settled in this quarter are summarised below. The damages and costs for clinical claims are covered by our CNST premium to the NHSLA.

Date of Claim	Directorate	Summary	Damages	COSTS	
				Claimant	Defence
16.07.2012	Orthopaedic	Incorrect treatment for fractured leg with use of single screw fixing. Delay in recovery led to early discharge from Armed Forces (Complaint investigation)	£60,000	(Estimated) £60,000	£6,048
24.12.2013	Emergency Network	Failure to diagnose tendon damage to right thumb and to carry out appropriate treatment which caused a delay in treatment. (Complaint investigation)	£6,000	£17,425	£2,969

07.02.2014	Women's Services	There was a failure to perform removal of the placenta after the birth in the manner identified in the care plan. Manual removal resulted in infection. (Incident reported)	£5,000	(Estimated) £10,000	(Estimated) £1000

Employer's Liability Claims:

10 employer liability claims settled / closed during Quarter 2.
6 of these were unsuccessful with liability denied or claim withdrawn. 3 were after being settled in a previous quarter. The employer liability claim settled in this quarter is summarised below. The Trust pays an excess of up to £10,000 for Employer Liability claims as a result of incidents occurring from 1st April 2010.

Directorate	Description (Policies)	Damages	COSTS	
			Claimant's	Defence
Operations & Facilities	Tripped over bollard on pavement sustaining fractured wrist and cuts and bruises to face and knee. Breach of duty admitted and the claimant has been put to proof on causation. Earnings details are being collated. (Incident reported)	£9,950	£17,625	£1,833

Public Liability Claims:

The Trust pays an excess of up to £3000 for PL claims as a result of incidents occurring from 1st April 2010.
No public liability claims have settled in this quarter.

Ongoing claims:

Claims open as at end September 2015:

- 435 clinical negligence claims – of which 316 are requests for records. The 119 "live" cases include:
  - 78 letters of claim / letters before action
  - 27 ongoing – proceedings issued / defence
  - 14 settled – awaiting final outcome and closure
- 23 employer's liability claims, 2 have settled, awaiting final closure the rest remain under investigation.
- 7 public liability claims, all currently under investigation.

Learning from Claims

A new process for evidencing learning from claims has been introduced. As a claim is settled a Summary and Learning Form is completed and sent to the Division to identify actions taken. As the feedback is received back it will be included in the next quarterly report. No feedback is available for this quarters report due to the recent introduction of the process.

3.7 Inquests

The Trust has a legal duty to report a death to the Coroner (Coroners and Justice Act 2009) if the cause of death is violent, unnatural (died as a result of a healthcare procedure), unknown or occurred whilst in custody or State detention (including Deprivation of Liberty) and other situations.

A new Inquest Policy has been developed explaining the process involved which are corporately handled through the Governance and Risk team. The policy includes guidance for staff when they are required to provide a statement for the Coroner and the support available in preparation for attending an inquest.

To ensure we are learning from all inquests, cases which are not investigated as a serious incident will be subject to a Divisional Case Review in line with the new investigation policy.

Inquests opened in quarter by Directorate

Acute Medical	3
Critical Care	1
Emergency Network	2
General & Specialist Surgery	2
Intermediate and Community	1
Orthopaedic	1
Totals:	10

There were 5 inquests held in quarter Q2, there was learning an actions off the back of one case.

1. Next of kin to be contacted immediately after a fall as per clinical records guidance and falls bundle guidance.
2. All staff to receive a copy of the in-patient falls chart and a copy to be displayed in the ward office
3. All staff to receive training in utilising the falls care bundle by the ward trainers

3.6 Complaints

COMPLAINTS
Complaints are a vital source of information for the Trust, helping to identify where the quality and safety of services and care require improvement for service users.

This section includes information on:

- Performance re: complaints management in Quarter 2 2015-16
- Learning from complaints
- Key publications in the quarter
- Areas for improvement

Formal complaints are investigated thoroughly following the Trust's Complaints Policy. Complaints data is reported across the organisation in a number of ways:

- via the quarterly quality report to the Quality Committee and Trust Board
- via the Patient Experience Group
- via Divisional Patient Quality and Safety Boards
- via key performance information in the monthly Board Integrated Performance Report.

1. Complaints Performance Quarter 2, 2015-16

The Trust received 156 complaints between 1 July 2015 and 30 September 2015, a decrease of

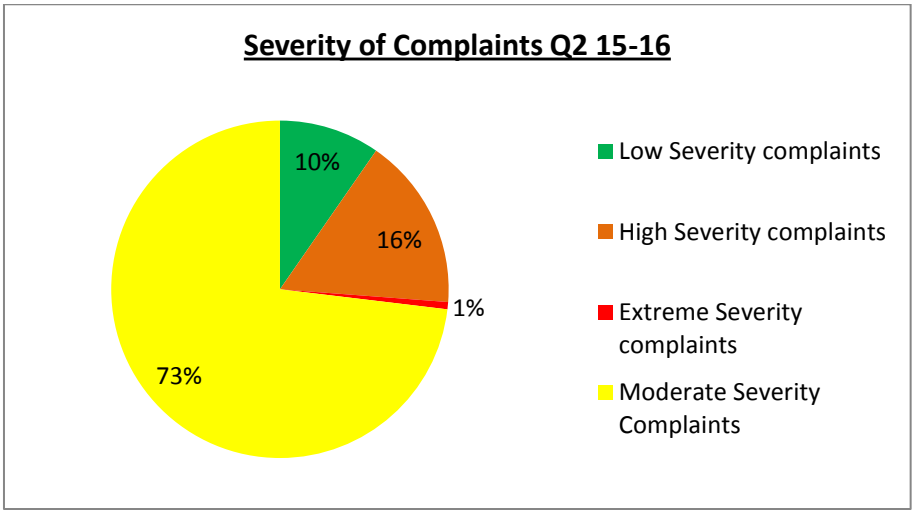
10% on the same quarter in 2014/15.

Key Performance Indicators

Complaints and Concerns 2015/16	Q1	Q2	Q3	Q4
Number of new complaints received Cumulative total	169 169	156 Tbc		
% increase / decrease on same period 2014/15	↑10%	↓10%		
Number of complaints acknowledged within 3 working days - target 100%	93%	94%		
Number of complaints closed within the quarter	206	136		
% complaints upheld	56%	48%		
% complaints partially upheld	31%	35%		
% complaints not upheld	13%	16%		
Number of complaints re-opened within the quarter following final response	24	27		
Number of complaints overdue at end of quarter.	33	50		
Number of complaints received from Ombudsman for investigation during quarter	3	4		
Number of complaints upheld by Ombudsman in quarter	0	2 partially upheld		
Number of complaints not upheld by Ombudsman in quarter	2	2		
Number of concerns in quarter Number of concerns cumulative	158 158	172 335		

New Complaints – Severity

The majority of complaints (70%) received in Quarter 2 are graded as yellow severity; no lasting harm.



Key:
Green – no / minimal impact on care
Yellow – no lasting harm
Amber – quality care issues/ harm
Red – long term harm, death, substandard care

Red Complaints data

A red complaint is a case where the patient or their family feel the action or inaction of the Trust have caused the death or significant and non-reversible harm to the patient. At the end of Q2

there are 5 red complaints are under investigation:

Division	Directorate	Description
Surgery & Anaesthetics	Orthopaedics	Poor treatment received on ward 19 at Huddersfield Royal Infirmary, patient admitted as a result of fractured neck of femur but subsequently dislocated replacement, concerns re nutrition, management of delirium and staff behaviours
Surgery & Anaesthetics	Head& Neck	Treatment received from hospital. Contracted meningitis following routine sinus surgery.
Surgery & Anaesthetics	Orthopaedic	Care and treatment following fall at home. Treatment of fractured femur inadequate. Patient died unexpectedly next day
Surgery & Anaesthetics	General & Specialist Surgery	Delay in identifying cancer metastases
Medical	Emergency	Family seeking explanation on cause of sudden death of patient
Medical	Emergency	Care and treatment extended to patient leading to their death. Patient was treated for kidney infection when in fact was having a heart attack.

Acknowledgement time
Complaints were acknowledged 100% of the time in two of the three months in the quarter, making the overall Quarter 2 acknowledgement figure 94%. 100% complaints in August and September were acknowledged within three working days, however in July this figure was 82%, a continuation of the drive to close overdue complaints and annual leave within the team. The steps taken to improve resilience to ensure all complaints are acknowledged within time have been effective in August and September.

Overdue Complaints
The drive continues by all divisions to reduce the number of overdue complaints in the quarter leading to a reduction in numbers overdue. The number of overdue complaints has increased from 33 in quarter 1 to 50 in Quarter 2 with the breakdown as follows:

0 – 1 month overdue: 33 complaints
1 – 2 months overdue: 9 complaints
2-3 months overdue: 6 complaints
3-4 months overdue: 2 complaints

Weekly monitoring reports continue to be provided to divisions to ensure that all cases overdue are clearly identified and timescales for completion of complaints that are due are clear, seeking to prevent further cases becoming overdue.

25 of the overdue complaints are within the Medical Division; however 18 of these are overdue by up to one month.

10 of the overdue complaints are within the Surgical and Anaesthetics Division

Outcome of Complaints
Information on the number of complaints which are upheld, partially upheld or not upheld is included in this report for the first time. Overall across the two quarters 53% of all complaints are

upheld and 32% partially upheld. (The HSCIC counts partially upheld complaints as upheld complaints so if looked at in this way the figure is 85%).

On average across Quarter 2, 14% of complaints were not upheld.

Ombudsman Complaints
During quarter 1 the Trust is aware of three complaints that have been raised with the Parliamentary and Health Service Ombudsman following final response.

During Quarter 2 there were 13 active complaints cases which the Ombudsman is investigating. Five relate to care in the emergency department and four relate to care by Acute Medicine. The breakdown of these is as follows (*Red lines indicate complaints that were graded and managed as red complaints, i.e. where Trust actions / inactions caused death or significant and non-reversible harm to the patient*):

Medical Division

Directorate	Complaint Date	Issue of Complaint
Acute Medicine	2012	Care prior to death
Acute Medicine	2013	Distress re: events prior to death
Acute Medicine	2013	Care prior to death
Emergency Dept.*	2013	Patient fall causing prolonged pain
Emergency Dept*	2013	Negligent care in A&E and Surgical Assessment Unit in 2010
Acute Medicine	2014	Stroke Care
Emergency Dept*	2014	A&E care prior to death in ICU following surgery
Emergency Dept	2015	Alleged misdiagnosis, patient death cancer
Emergency Dept	2015	A&E treatment June 2013

*To note Emergency Department was not in Medical Division until 2015

Surgical and Anaesthetics Division

Directorate	Complaint Date	Issue of Complaint
Head & Neck	2014	Care & treatment by Ophthalmologist

Family Specialist Services Division

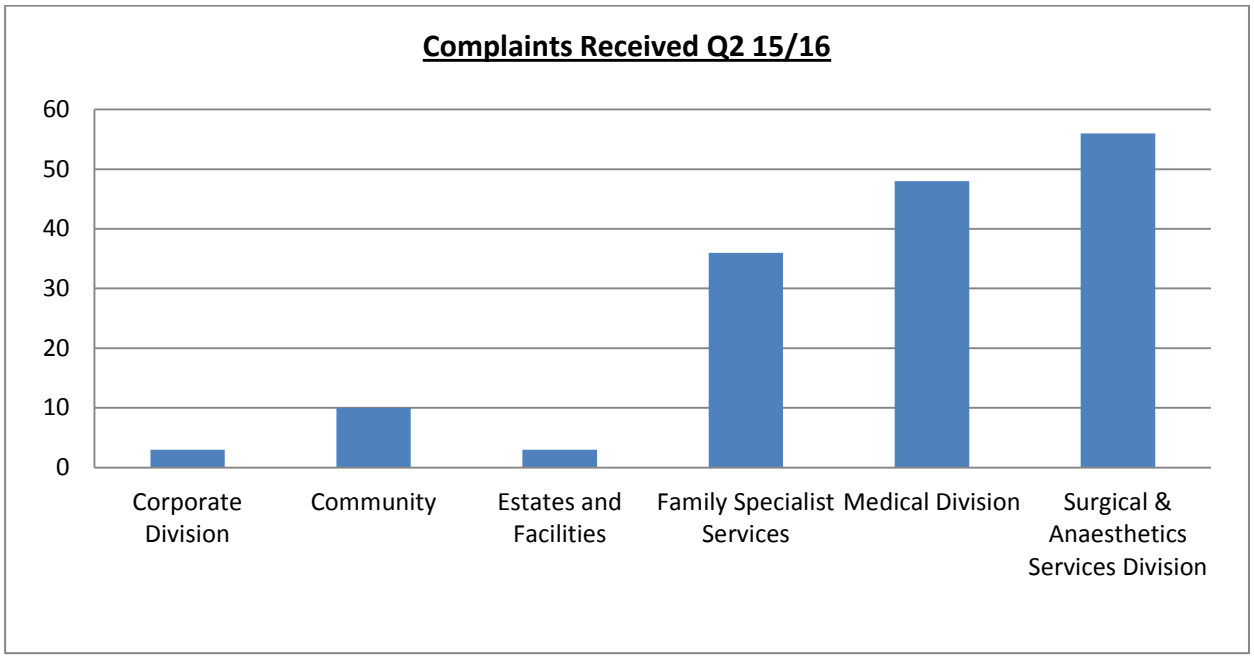
Directorate	Complaint Date	Issue of Complaint
Women's	2013	Care & treatment HRI
Children's	2013	Care during, labour, birth, discharge, baby death

During quarters 1 and 2 six Ombudsman complaints have been closed, of which two were partially upheld and four not upheld. Details of the two upheld complaints are given in the section below on learning from complaints.

National Quarterly Complaints Returns
The new quarterly national complaints information, KO41 return was submitted within time to the HSCIC. This monitors written hospital and community health services complaints in the NHS.

This return requires more analysis of themes of complaints and requires a considerable amount of work to re- align coding of complaints to provide this level of detail. It is expected that this information will be submitted retrospectively in Q3 and will be shared in the Q3 report. The main change is the move to report all aspects of a complaint rather than the main issue in a complaint, as previously.

Complaints Numbers by Division



The split of complaints by Division by month was as follows:

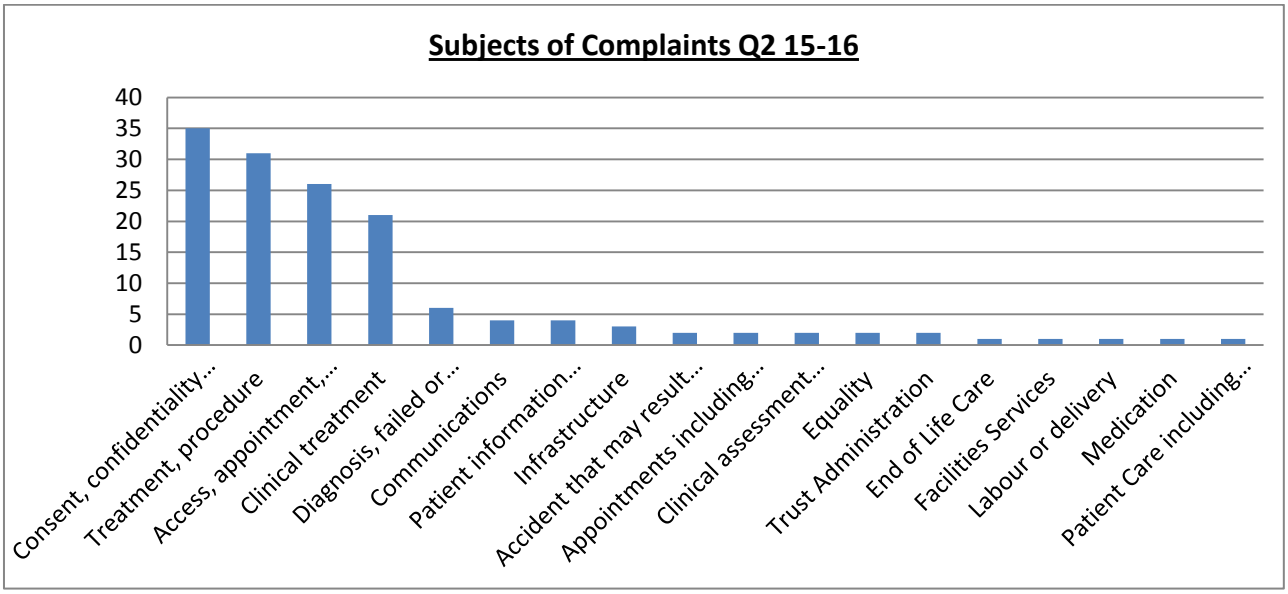
Division	2014/15	Total Q1 2015/16	July	August	September	Total Q2 2015/16
Corporate	3	2	1	1	1	3
Family & Specialist Services	146	34 (CWF 14) (DATS 20)	14	9	13	36
Estates and Facilities	12	16	1	0	2	3
Community	N/A	5	4	4	2	10
Medical	174	56	15	16	17	48
Surgical & Anaesthetic Services (SAS)	282	56	24	15	17	56
Total	**617**	**169**	**59**	**45**	**52**	**156**

Analysis of Complaints by Theme
Complaints are analysed in two ways below, by primary subject code.

Complaints by Primary Subject Code
The top three subjects of complaints remain clinical treatment, communication and appointments as shown below, consistent with 2014/15:

Subject	2014/15	2015-16 Q1	2015-16 Q2
Treatment, procedure (& clinical treatment)	30%	26%	36%
Consent, confidentiality, communication	25%	25%	24%

Access, appointment, admission, transfer, discharge	14%	15%	18%



Once further work on coding of reasons for complaints is completed data will be re-run for Q1 and Q2 2015/16.

2. Learning From Complaints

The feedback we receive from complaints gives the Trust a wealth of information that can be used to improve services as an individual complaint provides detailed insight into a patient's experience.

As an organisation we need to ensure that we learn from complaints so that we can:

- Share good practice
- Increase patient safety
- Improve the patient experience
- Reduce the number of complaints

It is therefore essential that information on learning from complaints is captured and shared across the organisation. Each service and division needs to be clear:

- How the services records learning from complaints
- How this learning is disseminated within the service / directorate / division
- How it can point to changes arising from learning from complaints

The complaints process includes a form to document learning from each individual complaint, known as learning from experience form.

There continues to be a low level of completion of the learning forms in the Surgical and Anaesthetics Division. This has been brought to the attention of the Associate Director of Nursing for action.

Further work is needed to ensure that staff, teams and services are learning from complaints. Issues identified are:

- Variable completion of learning from experience forms by division
- Identification of actual learning – the majority of learning forms completed talk about the need for better communication but do not identify learning. The focus needs to shift to identify changes made as a result of complaints upheld.

  Action being taken to improve this is:

- Re-design of learning from experience form
- Clearer communication to staff on what is expected in terms of learning
- Focus on ensuring the learning from experience forms are completed within divisions
- Quality assurance process within complaints team to ensure complaints are referred back to division to identify learning if this has not been included within the draft response / complaints file
- Development of patient stories framework - this was deemed to be the most powerful way of sharing learning by the members of the Complaints Task and Finish Group
- *So What Happened Next ?* newsletter to share with staff examples of learning identified and improve awareness of what learning is

This section includes details of learning in relation to:

- Complaints relating to Sign Language interpreters
- Learning from red / significant harm complaints
- Learning from Ombudsman cases in Quarter 2

Complaints relating to Sign Language Interpreters
As reported in the quarter 1 2015/16 report, an unexpected number of complaints were received during the period January to April 2015 relating to the services provided by the Big Word, with 8 complaints in total received and a petition from the Calderdale Deaf Community. The complaints relate to the skill level and availability of British Sign Language (BSL) Interpreters employed by the Big Word.

- As a result of the complaints an engagement event, attended by over 40 members of the deaf communities of Calderdale and Kirklees, was held on 21 August 2015 which included patients, carers, parents and local BSL interpreters, with BSL interpretation. Additionally the agreement to transfer services over to the preferred new provider, Pearl Linguistics, was paused to enable the Trust to consider the feedback from the engagement event and commission the most appropriate service for this client group.

- Key messages from the audience included the importance of local knowledge/accents; feeling assured that the BSL interpreter had been booked and for a long enough duration; having suitably qualified BSL interpreters.

- Notes and feedback from the event have been analysed and is being used to help draw up a list of requirements that the Trust will want to see from its BSL provider. Work with our deaf communities will continue during this process to help the Trust make the best decision about BSL interpretation services.

Learning from Red Complaints

The following red complaints are closed and formal action plans are being developed for each complaint.

Medical Division

Directorate	Complaint Date	Description	Upheld?	Issues and learning Identified
Acute Medicine	2013	Care and treatment on ward including fall leading to fracture of ankle. Patient developed pneumonia and died in hospital.	UPHELD	Call bells out of reach Failure to follow procedure on the administration of medication Incorrect completion of fluid balance chart Failure to provide assistance with drinking Failure to provide appropriate drinking vessel Failure to provide adequate information to family Significant delay in escalation of concern to medical staff Audit of intentional care rounding Improvement in communication between the multi-disciplinary team Improvement in Falls assessments and supporting documentation
Emergency Department	2013	Patient administered medicine to which they had a known allergy when wearing a red wristband.	UPHELD	Failure to follow procedure on the administration of medication
Acute Medicine	2014	Treatment whilst on ward	UPHELD	Failure to monitor and manage nutrition Failure to monitor and manage dementia Failure to monitor and manage wounds Communication regarding MDT, End of life care, discharge process Failure to be professional and compassionate at all times Failure to monitor and manage the impact of challenging behaviour (dementia) Failures or delays in intentional rounding Medication for patients who are approaching end of life, Medication reconciliation, medication review Failure to implement falls bundle Failure to monitor and manage pain Mobility and manual handling requirements not clearly communicated

Acute Medicine	2014	Poor treatment of patient from ward staff at HRI.		Support and supervision of newly qualified staff Escalation process Management of thickened fluids Engage with families who wish to take an active part in the care of relatives Weekly Patient Experience Ward Rounds Implement the safer staffing monitoring tool. Perform regular ward exemplar audits Participate in competency assessments. Ensure bedside handover takes place at every shift change and check bedside records Ensure the daily checks of the call bells are performed. Clearly define the role of the nurse in charge. Weekly record audits to be performed
Emergency	2015	Poor treatment received on MAU	Partially upheld	Communication
Acute Medicine	2015	Poor treatment on CCU	UPHELD	To be confirmed

Surgery and Anaesthetics Division

Directorate	Complaint Date	Description	Upheld?	Issues and learning Identified
General & Specialist Surgery	2015	Clinical decision making (including delay) may have meant a different outcome for the patient. Lack of compassion. Pain not managed. Lack of information.	UPHELD	No Stimuli in SAU side room Nursing documentation inadequate on SAU Failure to explain to family how extreme the patient's condition was Failure to provide time and privacy when explanations given by Doctor

Action Plans have been completed for the following 11 red complaints since April 2015

Received	Division / Directorate	Description	Upheld?
2014	MEDICAL - Acute	Care and treatment extended to patient leading up to death.	UPHELD

2014	MEDICAL - Acute	No record made of patient's fall during night. Delay to appropriate care, investigations and treatment due to lack of documentation and day staff unaware of incident. Patient fell prior to this whilst left unattended at toilet.	UPHELD
2014	MEDICAL - Acute	Family unhappy with end of life care provided to mother which caused family "deep anguish and distress".	UPHELD
2015	MEDICAL - Emergency	Letter received from family of deceased patient with concerns around the care he received whilst he was an in-patient at CRH prior to his death.	PARTIALLY UPHELD
2015	MEDICAL - Emergency	Concerns re care patient received prior to death. Pt passed away from a ruptured abdominal aortic aneurysm at BRI. Did delay to scan at HRI affect outcome? Why no scan undertaken in A&E, why no-one listened to either pt or wife. Wife felt had things being done sooner her husband have survived.	PARTIALLY UPHELD
2015	MEDICAL - Acute	Poor treatment before patient passed away.	UPHELD
2015	MEDICAL - Acute	Failed discharge complaint regarding patient with Alzheimer's.	UPHELD
2014	SURGERY & ANESTEHTICS Orthopaedics	Various issues relating to nursing care. Safeguarding issues raised.	UPHELD
2015	SURGERY & ANESTEHTICS Orthopaedics	Patient's wife wishes nurses to have more compassion.	PARTIALLY UPHELD
2014	SURGERY & ANESTEHTICS General and Specialist Surgery	Missed lung nodule in cancer patient in 2009, patient died 2014. Delay to patient receiving treatment in A&E in 2014.	UPHELD
2015	FAMILY SPECIALIST SERVICES - Women	Patient care following death of infant during birthing procedure and staff involved	NOTUPH

Learning from Ombudsman Cases

Two Complaints were partially upheld by the Parliamentary and Health Service Ombudsman (PHSO) in Q2.

PHSO Case: Partially Upheld

This complaint related to care provided to an adult in A&E at Huddersfield Royal Infirmary (HRI) in March 2012. The PHSO identified the following service failings:

- Medical Management – failure in the management of heart problem – delay in recognising and starting treatment for acute coronary syndrome
- Standards of record keeping – records not fully completed and not appropriate standard
- Delays in responding to complaint

Actions and learning identified from this complaint and shared with the complainant in July 2015 is summarised below:

Area of concern	Action taken
Improving patient experience and empathy	• Set up a patient experience forum at A&E at Huddersfield Royal Infirmary and Calderdale Royal Hospital involving staff and patients • Gain feedback via the Friends and Family survey and act on results • 'YOU SAID WE DID' board – display showing what has been implemented
Delay in assessment	• Introduction of the Emergency Department Intervention Team – led by senior staff for early recognition of illness and injury which operates 24 hours a day
Delay in complaint response	• Full review of complaints procedure • Increased focus on early contact with complainant • Dedicated senior nurse to co-ordinate and manage complaints within the Department • Feedback to the patient experience group
Lack of effective clinical record keeping	• Electronic recording on EDIS system, issues identified with retrospective documentation i.e. times needs to be considered when addressing complaints to ensure accurate picture is given • Monitoring is in place to audit the accuracy of the record i.e. the time the action happened rather than the time it was written • Awareness of the importance of effective clinical records highlighted at departmental staff meetings
Inaccuracy on the letter	• This was due to an administration error (explained in previous letter)
Appropriate monitoring equipment not accessible and used	• The reason that the monitoring equipment was not used was that the doctor did not recognise it as a rhythm that required monitoring. • The Early Warning Score (NEWS) system is now used within the Emergency Department as a standardised method of escalation to senior staff.
The care did not follow the Acute Coronary Syndrome (ACS) Pathway	• This was due to the doctor not recognising that this was required • Training issue now addressed with individual doctor • Access to ACS nurse embedded within the Department • ACS nurse delivering training as part of each doctor induction programme to ensure shared learning

PHSO Case: Partially Upheld

This complaint related to a fracture to a toe not manipulated correctly on initial presentation at A&E at HRI. The final report from the PHSO was received on 22 June 2015 and partly upheld the complaint.

It was confirmed the Trust had acknowledged within the complaint's response the failure to undertake a pain assessment and offer pain relief.

However the Trust had not acknowledged that the doctor's performance was below standard, i.e.:

- Initial treatment (manipulation of the toe) had been pointless
- Inadequate record of the episode
- No treatment plan following a second x-ray

The recommendation from the PHSO and action taken was for the Medical Director to discuss the incident with the doctor, who was employed on an ad hoc basis by the Trust.

Key Publications in Quarter 2 2015-16

Parliamentary and Health Service Ombudsman Complaints about Acute Trusts 2014 -15

The Parliamentary Health Service Ombudsman (PHSO) in September 2015 published their annual report for 2014-15 which details the information collected about complaints involving acute trusts in England in 2014-15. The report provides details of the number of complaints received for each Trust, the outcomes of these complaints and the reasons which led people to complain. In 2014-15 the PHSO upheld 44% of investigations into complaints about acute trusts.

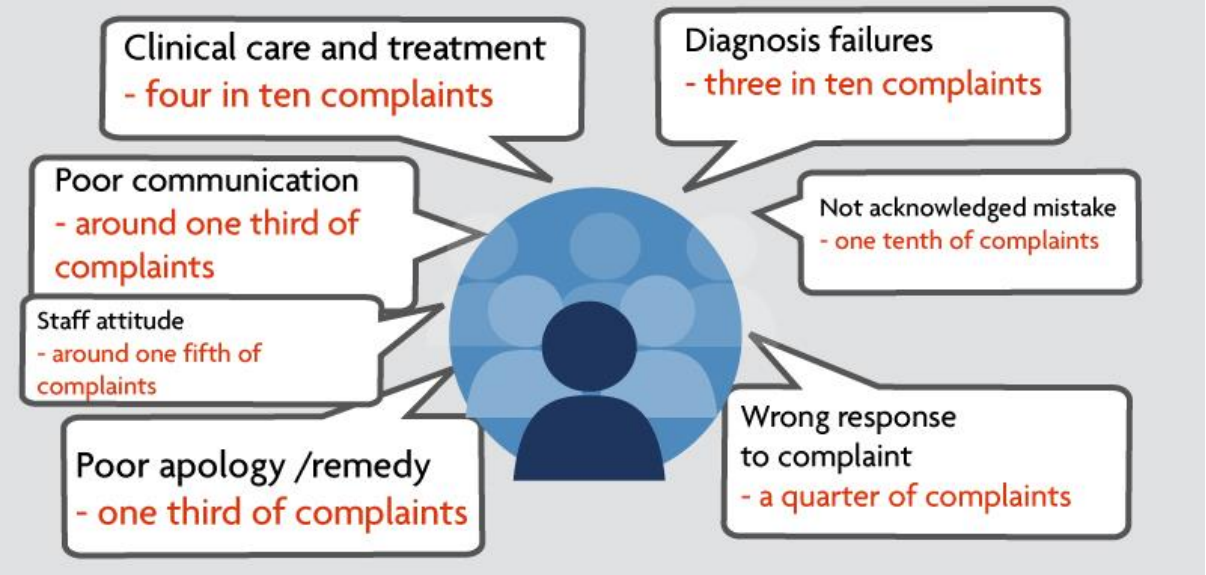
The report confirms that there continues to be an increase in complaints about acute Trusts. The report can be found at:

http://www.ombudsman.org.uk/reports-and-consultations/reports/health/complaints-about-acute-trusts-2014-15/5

Summarised below is the Ombudsman activity in 2014-15 relating to the Trust.
This shows 70 contacts to the PHSO were made regarding the Trust and of these 18 were taken forward, 9 were not upheld and 4 were partially or fully upheld. It is assumed the remaining 5 are still under investigation. Comparison with two neighbouring Trusts identifies similar levels of complaints referred to the PHSO.

Acute Hospital	Contacts made to PHSO	Investigations Accepted by PHSO	Complaints Not Upheld	Complaints Upheld / Partially Upheld
Calderdale and Huddersfield FT	70	18	9	4
Bradford Teaching Hospitals	58	11	3	9
Mid Yorkshire Hospitals	73	12	5	5

The main reasons nationally that complainants referred to the PHSO in 2014-15 are summarised below. These are consistent with two of our top themes of treatment and communication.



Areas for Improvement
An update against the key priorities for 2015-16 for the patient advice and complaints service are:

- to eradicate overdue complaints – work continues to reduce the numbers of overdue complaints
- work continues to improve the quality of complaints responses and reduce the number of re-opened complaints
- to respond to all complaints within agreed timescales – close monitoring via weekly reports highlighting complaints due dates and any overdue
- to complete coding changes for reasons for complaints for quarterly KO41 reports to submit retrospective completed data in Q3
- to continue to encourage meetings/discussions with complainants at the early stage of the complaints process
- to develop systems to improve the identification of and sharing of learning from complaints across the Trust
- to revise complaints literature and intranet site to ensure complaints process accessible, with focus on approaching staff in first instance with concerns
- continue to ensure an effective interface between divisions and the corporate complaints team
- to develop and plan delivery of training programme on complaints to support staff in managing complaints effectively

3.9 Ensuring Privacy and Dignity - Mixed Sex Accommodation

Aims and Objectives of Work

Being in mixed-sex hospital accommodation can be difficult for some patients for a variety of personal and cultural reasons. Therefore all providers of NHS-funded care are expected to eliminate mixed-sex accommodation, except where it is in the overall best interest of the patient or reflects their personal choice

A breach is said to occur when a member of the opposite sex shares sleeping accommodation. The breach takes into consideration how many patients were affected by that breach.

Current Performance

During quarter two there were no mixed sex breeches within the organisation. However, we continue to enact our improvement plan by revising trust policy and raising awareness particularly in critical care areas.

The Trust revised policy is now completed ratified and is available on the trust website.

The monitoring process is more robust, with the status regarding mixed sex issues being included in the SITREP.

Performance continues to be monitored and reporting within the Integrated Board Report which is review monthly by the Executive Team.

Our real time patient monitoring and patient survey demonstrate that some patients feel they are being cared for in mixed sex accommodation. We have commissioned further analysis into patient experience regarding this issue; the results should be available for the Quarter 3 report.

We monitor all mixed sex breaches and this demonstrates that we rarely breach this standard, over the entire of 2014/15 there were 2 instances of mix sexed accommodation breaches which affected 15 patients. These exceptions occurred due to patients being stepped down from critical or high dependency care.

We recognise that the process of step down and transfer to an appropriate bed needs to be enacted in a timely manner and we are focusing much of the awareness raising in these areas.

We measure compliance monthly and undertake root cause analysis to understand if the breach has occurred and share any learning. The main learning points have been around recognising a need to improve the planning and discharge of patients from high dependency areas.

Domain Four – Responsive

Responsive compliance summary

Indicator	Compliance
4.1 A&E Performance	Partial Compliance
4.2 18 week pathway RTT (referral to treatment)	Achieved
4.3 Bed Efficiency and Rebalancing	Reporting Only
4.4 Outpatients – Focus on DNAs	Reporting Only
4.5 Diagnostic Waits	Achieved
4.6 Cancer Waiting Times	Achieved
4.7 Theatre Utilisation	Reporting Only

Highlights:

4.1 A & E Performance	Achieved 3 of 5 quality indicators Achieved CQUIN target for improving recording of diagnosis in A&E of 80% in Q1
4.4 Out Patient DNA	Target of 7% for first appointment DNA's achieved Target of 8% is in place for Follow-Up DNA's achieved
4.6 Cancer Waiting Times	All 8 standards achieved in Quarter 2.

4.1 A&E Performance

Aims and Objectives of Work

All A&E units are monitored against 5 national performance indicators.

1. **Total Time in A&E:** This is measured on 95th percentile, stating that 95% of the patients should be discharged from A&E within 4 hours.

2. **Unplanned re attendances:** The target for this is that no more than 5% of A&E attendances should re-attend within 7 days of the original attendance.

3. **Left without being seen:** The target for this is no more than 5% of A&E attendances should leave the department without having been treated by a nurse or Doctor.

4. **Time to Initial Assessment:** This is an indicator only for patients brought in via Ambulance. The aim is that 95% of the patients attending via ambulance should have been assessed by a qualified member of staff within 15 minutes of arrival at A&E.

5. **Time to Treatment**: This indicator is measured by the median (middle) time. Aim is that all patients attending the A&E Department should wait no more than 60 minutes before commencing treatment by a doctor.

In addition to these mandatory targets, the Trust has a CQUIN scheme which aims to **Improve A&E diagnosis:** This indicator aims to improve diagnosis recording in the A&E HES data set so that the proportion of records with valid codes (either A&E 2 digit diagnosis codes or 3 digit ICD-10 codes) is at least 85%.

And also an improving patient experience programme which has specific focus on A&E patients – See Section 3.3 for further details on A&E Friends and Family Test.

The unit also supports the measurement surrounding compliance with the Asthma CQUIN – see section 2.2

Current Performance

Q2 saw 2 out of the 5 quality indicators not achieved: unplanned re-attendances and time to initial assessment, mirroring similar performance seen in Q1

A&E Quality Indicators for 2014/15

Indicator Name	Indicator Detail	Target	Site	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Qtr 1	Qtr 2
Unplanned Re-Attendances	*Unplanned re-attendances within 7 days of origional attendance*	5%	Trust	5.32%	4.82%	5.04%	4.99%	5.34%	4.73%	5.06%	5.02%
			CRH	5.75%	4.89%	5.57%	5.39%	5.75%	4.43%	5.40%	5.19%
			HRI	4.87%	4.75%	4.50%	4.58%	4.92%	5.04%	4.71%	4.84%
Left without being seen	*% of patients who leave the department without being seen*	5%	Trust	3.65%	3.09%	3.27%	3.16%	3.36%	3.21%	3.34%	3.24%
			CRH	4.72%	3.22%	3.18%	4.03%	3.51%	3.42%	3.71%	3.66%
			HRI	2.52%	2.96%	3.36%	2.27%	3.21%	2.98%	2.95%	2.82%
Time to initial assessment	*95th Percentile of time spent from arrival at A&E to initial assessment (999 Ambulance)*	15 mins	Trust	00:25:00	00:20:00	00:17:00	00:21:00	00:16:00	00:17:00	00:21:00	00:18:00
			CRH	00:55:00	00:41:00	00:43:00	00:44:00	00:38:00	00:51:00	00:24:00	00:14:00
			HRI	00:42:00	00:52:00	00:42:00	00:44:00	00:42:00	00:47:00	00:16:06	00:22:00
Time to Treatment	*Median time spent from arrival at A&E to Treatment*	60 mins	Trust	01:00:00	00:56:00	00:58:00	01:00:00	00:55:00	01:00:00	00:58	00:59
			CRH	01:12:00	00:54:00	00:59:00	01:05:00	00:57:00	00:58:00	01:01	01:00
			HRI	00:47:00	00:59:00	00:56:00	00:55:00	00:53:00	01:02:00	00:54	00:57
A and E 4 hour target	Numerator	95%	TRUST	11656	11935	11751	11823	11435	11545	35342	34803
	Denominator			12268	12590	12313	12388	11992	12106	37171	36486
	%			95.01%	94.80%	95.44%	95.44%	95.36%	95.37%	95.08%	95.39%

For 4.61% of patient who breached the four hour waiting time, the main reasons related to:

Breach Reason:	%
A&E Majors Delay	31.2%
Waiting for Medical Bed	17.5%
Continuing Care in dept	15.4%
Waiting for medical doctor	7.0%
Transport Delay	4.2%

In relation to the two underperforming areas, the reasons for being away from plan were:

Unplanned re attendances

The 5% target was missed this quarter; there was an increase in the number of attendances, as well as an increase in dependency and acuity of patients and long delays in moving patients from the Emergency Department to the wards. This may have an impact on other patients deciding to leave before being seen, this then can then result in the following situations:

- patients decide not to wait and come back later
- patients move between sites when one department is busy
- exit block causes patients to have lengthy waits

Each of the scenarios above can result in an attendance being recorded.
Through monthly validation, some performance issues are related to administration errors in how attendances are noted. These are being addressed with reception/admin staff.

Time to Initial Assessment

Both EDs have had difficulty in maintaining the time to initial assessment target this quarter due to the following:

Increase in attendances:

- Awareness of this issue to commissioners so that a review of capacity of services
- Out of area attendances appear to be increasing
- Appropriateness of ED presenting complaints
- Workforce model to reflect the demand

'Exit block':

- Patients waiting for speciality beds experiencing long waits in ED
- Lack of available cubicle space for assessment of incoming patients to ED

Staffing Issues

- Increased sickness levels at band 6 and above
- Ongoing vacancies
- Difficulties recruiting via generic job advert
- Further staff members leaving

Despite the pressure there were some significant improvements noted for Q2.

- The safety huddles continued to be delivered at the start of each shift, and works well in making staff aware of issues in a timely fashion and create opportunities to put any correctively action in place.

- There is now a daily review of patient's assessment times, so any issues can be rectified at the time. The daily review continues which allows the co-ordinator to change any issues at the time.

- A review of the assessment pathway work commenced in Q2, following a 90 day PMO plan methodology. This saw improvements in time to assessment in CRH and a similar piece of work will be rolled out to HRI in Q3

- The Standard Operating Procedure (SOP) for A&E clinical co-ordinators to aid decision making and standardisation was introduced. Further engagement work is now needed to embed this into working practices.

- The full introduction of Plan for Every Patient (PFEP)

- The Admission Avoidance work now has Medical Consultants/Medical Registrars are working in each A&E unit from 1pm - 8 pm at least 4 days a week. With systems in place to ensure additional support up to 7 days a week should it be required. This is having a positive impact on senior review with 12 hours and moving patients through the unit.

- The daily review of patients now includes noting those patients who are on a "green cross pathway" whereby they are waiting for a package of care to be arranged via social services and clinical teams. A lead person is then identified for each patient to expedite delays and the discharge process.

Improvement Plans for Q3 onwards

- Staff awareness of correct inputting of times on EDIS
- Daily review of assessment times
- Introduction of the discharge improvement meeting (all health economy partners involved)
- Clinical commanders in post to take control of site and improve flow
- Bed modelling to ensure correct capacity available
- Vacancies out to own ED advert rather than generic advert
- Management of sickness
- Band 6 posts recruited into to cover sickness giving senior presence on the shop floor to drive change

CQUIN performance:

Performance for Q2 was 88%, an improvement on Q2s performance.

Improving Recording of Diagnosis in A&E	Quarter 1			Q1	Quarter 2			Q2
	Apr-15	May-15	Jun-15	Total	Jul-15	Aug-15	Sep-15	Total
Number of records with a invalid diagnosis code	1828	1783	1570	**5181**	1570	1447	1376	**4393**
All records of A&E attendances within the last month	12268	12590	12313	**37171**	12388	11990	12106	**36484**
% with Valid Diagnosis Code	**85.1%**	**85.8%**	**87.2%**	**86.1%**	**87.3%**	**87.9%**	**88.6%**	**88.0%**
Target	**80% Coded**				**82.0%**			

CQUIN

Q3 Performance is expected to maintain above target for the rest of the year. The in-year targets were agreed with the commissioners and are outlined below

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)
Quarter 1	Baseline audit to ensure 80% of all A&E attendances are coded correctly
Quarter 2	82%
Quarter 3	83%
Quarter 4	85%

4.2 18 Week Pathway (RTT)

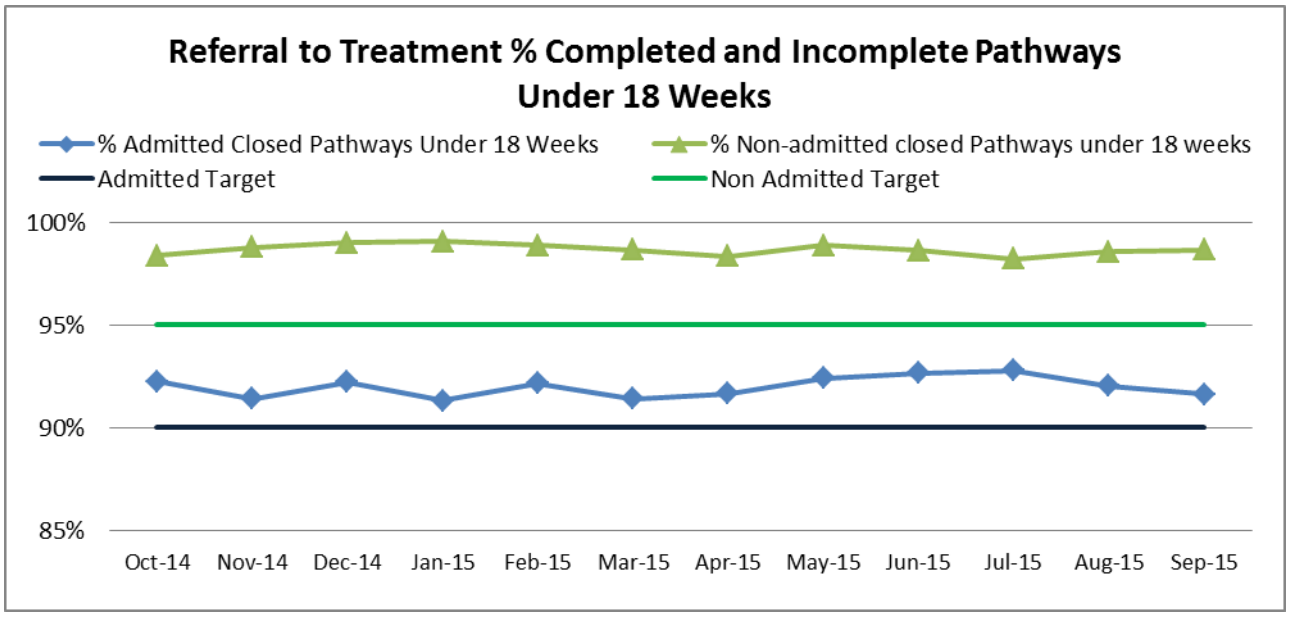
Aims and Objectives of Work

The NHS Constitution gives patients the right to access services within maximum waiting times, or for the NHS to take all reasonable steps to offer you a range of suitable alternative providers if this is not possible. This right is a legal entitlement protected by law, and applies to the NHS in England.

- 90% target for admitted treatment within 18 weeks
- 95% target for patients having outpatient treatment within 18 weeks

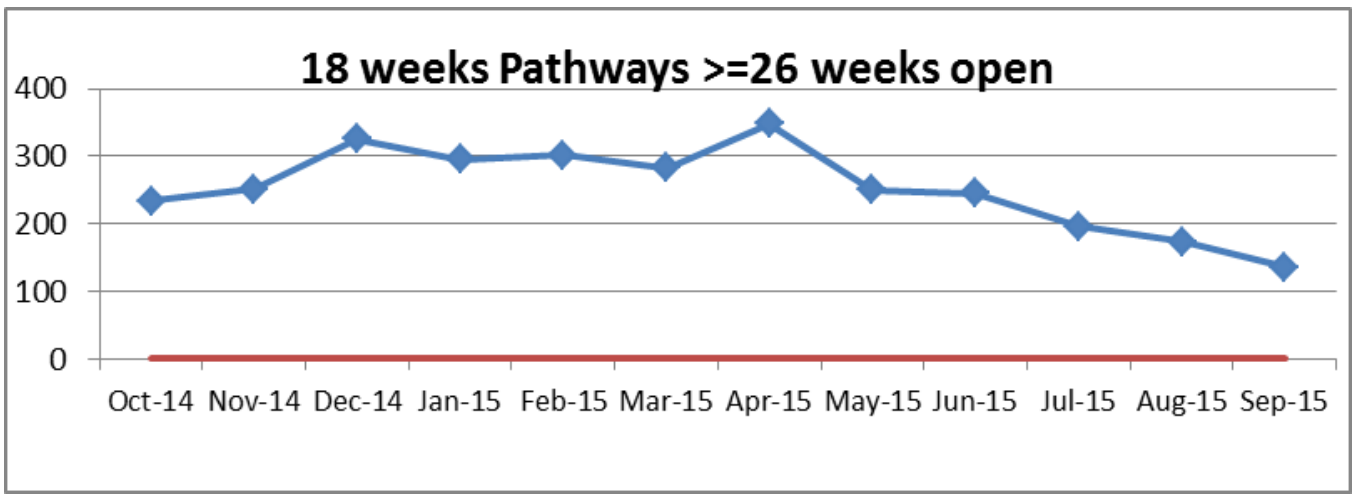
Current Performance:

Both of the key indictors continued to perform on target through Q2.



As a result of the report went to the Executive Board of the output of the Intensive Support Team (IST) engagement with the Trust in relation to the Referral to Treatment pathway elective access and other associated reports (see Q1 report). That report provided assurance that a comprehensive deep dive into delivery of the referral to treatment standards was undertaken and an action plan agreed. A full report into the delivery of the action plan will be available in the Q3 report.

Of note in Q2, and in specific relation to comment which noted that *"There is little movement on the reduction of over 18 week waiters with the 'clearance' and 'tip' being almost equal but the length of wait over 18 weeks appearing to grow and over 26 having significant peaks".* Work has begun Q2 to seek to improve this position, with consistent reductions being seen month on month throughout Q2.



Improvements in to Q3: The action plan derived from the IST review is being work on and a full report into progress is expected next quarter.

4.3 Bed Efficiency and Rebalancing

Aims and Objectives of Work

The programme commenced in 2014/15 with enabling work but continues into 2015-16. Further work will progress into 2016-17 .The need to ensure an appropriate bed base within CHFT is crucial. Work undertaken through existing trust schemes such as Care of the Acutely Ill Patient and the Courage to Put the Patient First programme have highlighted the link between patient safety, efficiency and the optimum bed occupancy level. This work stream will aim to further improve efficiency / LOS, standardise occupancy and seek to deliver improved care, reduced reliance on temporary nursing cost avoidance and delivery of the 2015/2016 financial plan. The project will aspire to a 90% occupancy level (16/17) across the adult bed base in this way ensuring patients can access the right bed at the right time. Significant improvement in LOS and Day case rates in order to ensure that we are best in class nationally and ultimately leading to improvements in quality, performance and financial performance.

Current Performance / Improvement Plans for 2015/16

The 2015/2016 Programme has six key work streams:

1. Bed Plan - A detailed bed model built upon contracted activity for elective work and based on trends from the last 3 years for non-elective activity. This work seeks to identify the required beds by week, by division at various occupancy levels. Having this bed model allows us to ensure early planning for flex bed capacity to deal with key pressure points. This will allow smoother patient flow ensuring our patients who need to be admitted have timely access to the right speciality bed as early as possible.
   Q2 update: Progress has been made in agreeing a revised medical bed base which will plan for winter pressures and reflect demand. The current challenge throughout Q3 is to link this with theatre productivity work in order to minimise variation in elective surgical demand to allow a consistently reduced occupancy.

2. Emergency Department / Admission Management-The aim of the ED work stream is to redesign the internal processes of the Emergency Department to facilitate pathways that deliver the assessment and initial treatment of patients on an 'On time, In Full' basis. The work stream will introduce standardised processes for treatment around assessment, treatment and handover in the ED. By this design the organisation can be more confident of its ability to meet the 4 hour target and dovetail ED to the larger hospital economy. In addition to the ED redesign, this work stream will look at the relationship between ED and hospital avoidance, both through redesign of Ambulatory Assessment and initiatives such as ESD and the introduction of the enhanced respiratory service.

   Q2 update: Work continues on this project, with standardised processes for ED coordinator now designed, and agreement regarding a standardised process of assessment which brings the crucial milestones of Majors ED pathways earlier in the attendance.

3. Ward Efficiency-This will maximise efficiency of inpatient ward areas by designing and embedding a range of processes. These will include;
   - A continued embedding of Plan For Every Patient (PFEP) and an extension of this to include real and measureable problem solving to minimise the common delays to patient journeys.

- PFEP will be extended to include the Consultant teams in the planning of care and the review of the plan. This will be done using a 'Board Round' model in conjunction with existing ward rounds.
- Although largely facilitated by the 'In Hospital Flow' work stream, discharging patient's at the most appropriate time of day will also form a part of the work stream, with ward areas taking responsibility for planning discharges throughout the day, avoiding batching of discharges for the later part of the afternoon.
- There will also be an OD element where process will be designed to help the staff on the wards (of all professions) to feedback success in efficiency, and also to voice any concerns or frustrations.
- Divisional projects such as Enhanced Recovery after surgery will also fall within this work stream.

Q2 update: Work on this project has been augmented by the engagement of Four Eyes Insight, who are now working on three inpatient wards to show the potential benefit in their methodology to achieve the above points. Measureable KPIs have been set with Four Eyes and the trail will be evaluated after 12 weeks.

4. In Hospital Flow- This work stream will design the role and practice of the Clinical Commanders (along with the wider patient flow team) as allow full operational management of patient flow, both internally within the hospital and when patients are being discharged. This will incorporate standardised procedures and processes for bed meetings, ensuring actions are planned and reviewed to completion. This work stream will also look at management of the patient flow by use of levelling discharges and escalation of any potential problems that cannot be solved operationally by the clinical commanders. To facilitate the flow, the discharge coordinators will have a standardised process for planning discharge and using a check/adjust model to ensure actions have been completed.
   Q2 update: Work has progressed defining standardised ways of working amongst the Patient Flow Team, although staff sickness has resulted in the delay in full implementation. New reporting processes of morning discharges have now also been established. A major project has begun to redefine the role of the Discharge Coordinators to more of a 'Case Management' role, rather than as a part of the ward teams.

5. Improvement of Reportable Delays in Transfers of Care- This work will focus on the ongoing projects in which CHFT is working with Local Authority's and CCGs to reduce the number of patients whose discharge/transfer of care is delayed due to sluggish process or lack of necessary social or ongoing health support. The work looks at both internal process and the interface between internal processes and the wider community.
   Q2 update: There are now three groups that interface CHFT with LA colleagues on this issue (Strategic, Governance, and Operational).

6. External System Capacity- This piece of work is again a collaborative initiative with Local Authority and CCG colleagues. The aim is to carry out an assessment of what community resource is needed to meet demand for services.
   Q2 update: This work had been commissioned and CHFT is in the process of establishing timescales with the CSU.

4.4 Outpatients

Aims and Objectives of Work

There are a number of areas of improvements which have targeted initiatives within outpatients to improve service efficiency and the patient experience, these include:

1. Reduction in Missed Appointments
2. Reduction in queues
3. Improved communications with patients
4. Improved data quality
5. Reduction in hospital initiated appointment cancellations
6. Development of dedicated Matron for Outpatient Services

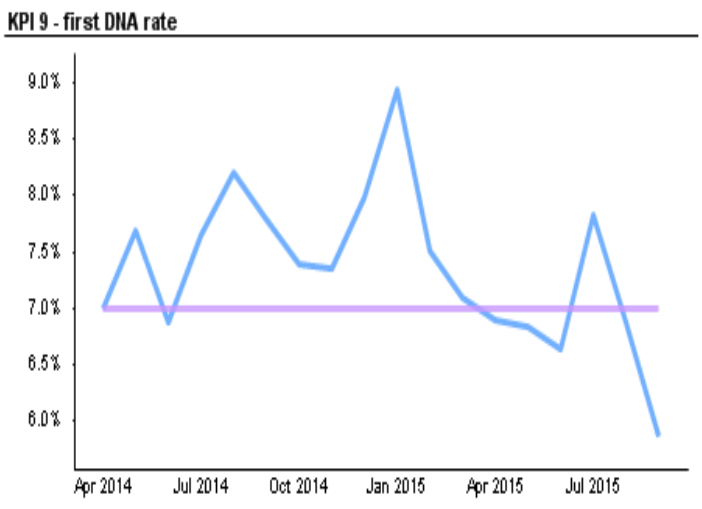
1) REDUCTION IN MISSED APPOINTMENTS

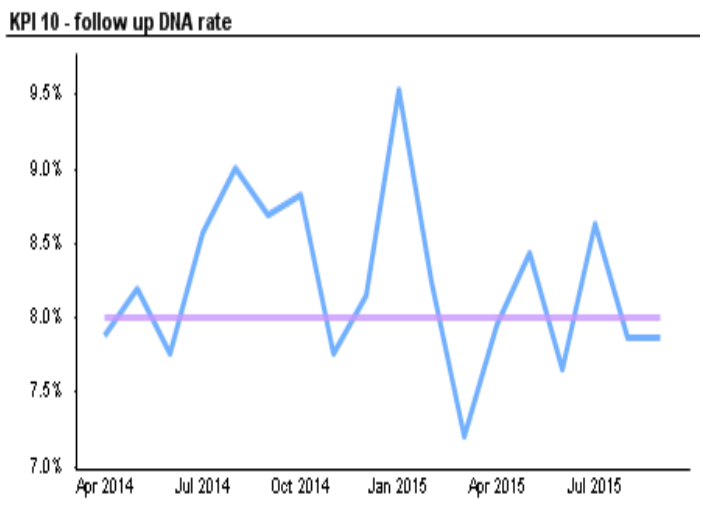
Last year (2014-15) in the Trust, 36,099 patients failed to attend their outpatient appointment; applying an average outpatient tariff of £127 this equates to £4.5m. This in itself was a reduction on the previous year when 40,880 appointments were missed.

As of the end of September 2015, 16,531 patients have missed their outpatient appointment at a cost of £2m. This represents a reduction of 1,687 missed appointments in comparison to the same period in 2014.

The Trust has set a target of 7% for first appointment DNA's (Did Not Attend).
Year to Date performance is 6.8%.

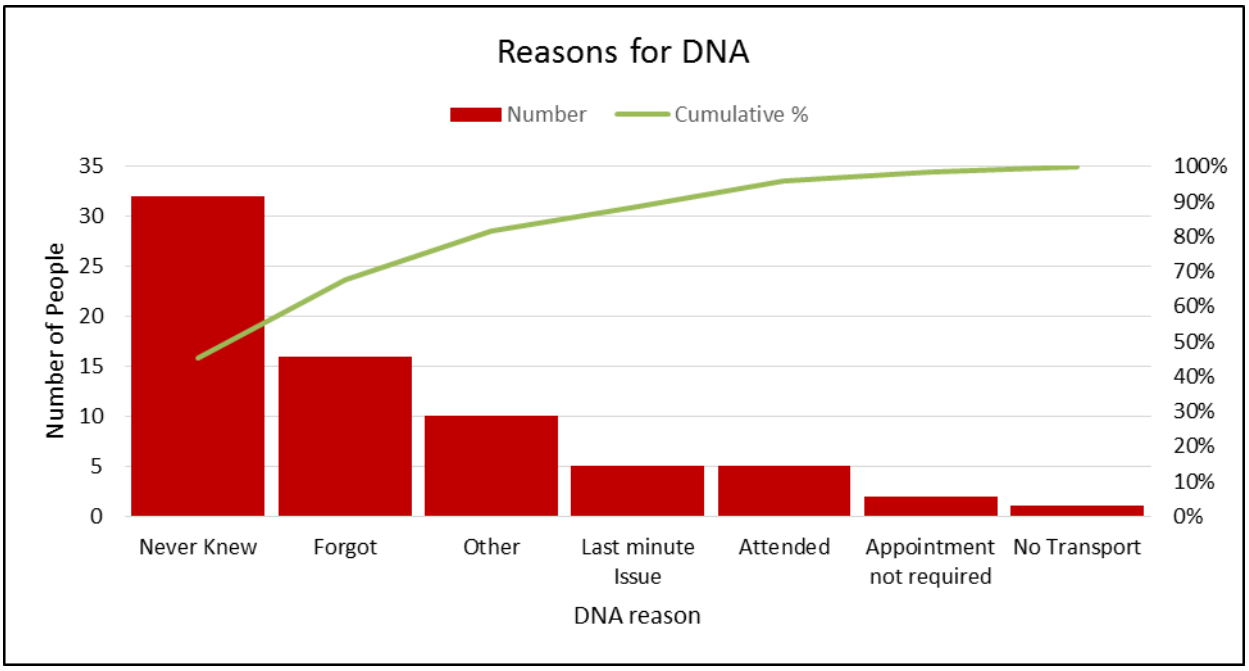
A target of 8% is in place for Follow-Up DNA's,
Year to Date performance is at 8%





Reasons for DNA

A recent survey of patients who had DNA'd appointments provided the following reasons for their DNA:



Reminder Service

The Trust operates a SMS and interactive voicemail reminder service. The service offers:

- Interactive Voice Messaging with human voice to landline
- 2-way SMS Text to mobile
- Partial Booking Contacts
- Email Reminder
- Ability to inform a group or individual patients of changes to clinic or appointment.
- Ability to identify available clinic slots and offer appointment to patient via SMS, Interactive or email and connecting to CHFT Appointment Centre on acceptance.
- Ability to cancel or change with the option of rebooking by auto connection to CHFT Appointment Centre
- Ability to target specific patient groups utilising Qlikview intelligence

Contact telephone numbers are updated via the National Spine, and/or updated by patients utilising the Self Check in Kiosks.

SMS Reminders

An SMS reminder is sent to the patient 7 days prior to the appointment with the following message:

You have an appt @ Huddersfield Royal on 21/09/13@15:30.To rebook call 01484 355370 to cancel reply "CANCEL 2473" Cancelling will result in discharge.

A second reminder is sent the day before the appointment.

Interactive Voice Message (IVM)

The software firstly checks for a mobile number, and if not found will use the landline number. The IVM includes a patient verification, asking the call receiver to confirm they are the person the reminder is intended for. Eight attempts are made to contact the patient via the landline number.

On confirmation, the IVM enables the patient to confirm attendance, or to be put directly through to the Appointment Centre at CHFT, to rebook.

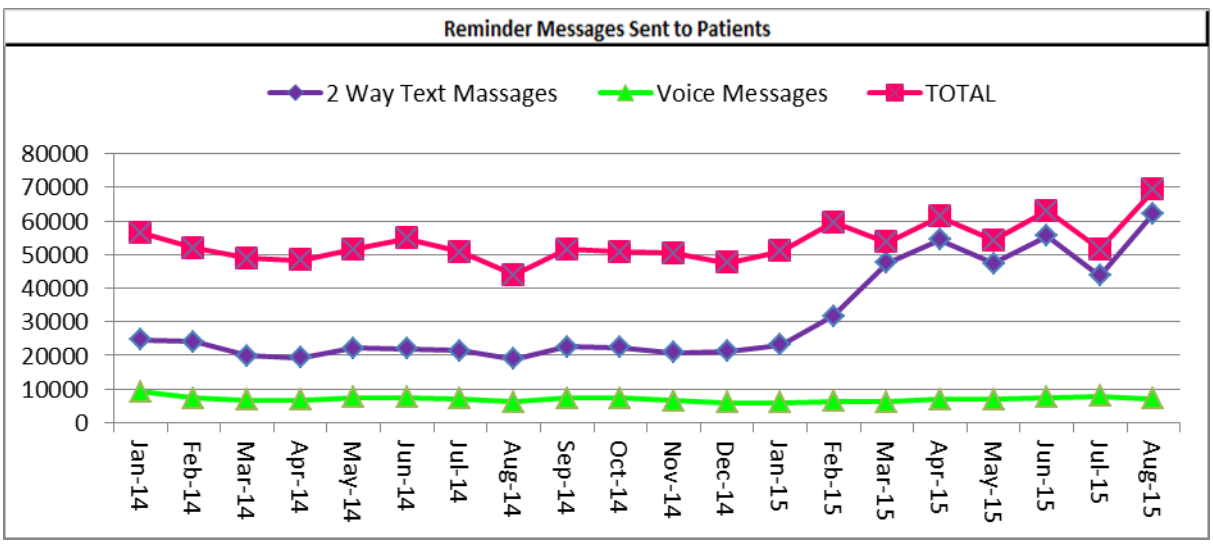
Reminder Performance Data

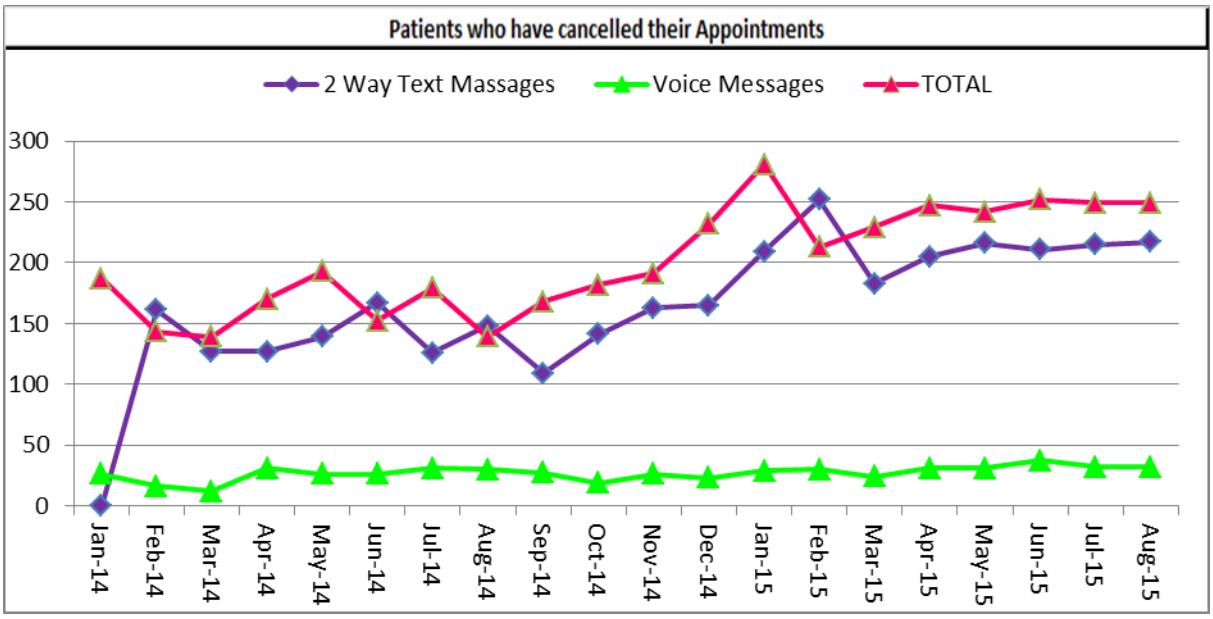
The software includes detailed reports of activity, including failed reminders. This will greatly assist with data quality improvements. The table and graphs below show performance to date.

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
In Transit	286	351	22710	1631	148	519	60	917
Delivered	19853	27612	21723	45922	41085	47953	37703	53579
Failed	3029	3740	3036	6844	6022	7145	5933	7660
Cancel	252	183	205	216	211	215	217	217
Total Sent	23168	31703	47469	54397	47255	55617	43696	62156

TOTAL – IVM

	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
In Transit	7	27	37	9	3	6	6	8
Delivered	5164	5162	4957	5705	5811	6161	6487	5869
Failed	833	1186	1194	1114	1188	1265	1369	1208
Cancel	29	30	24	31	31	37	32	32
Total Sent	6004	6375	6188	6828	7002	7432	7862	7085





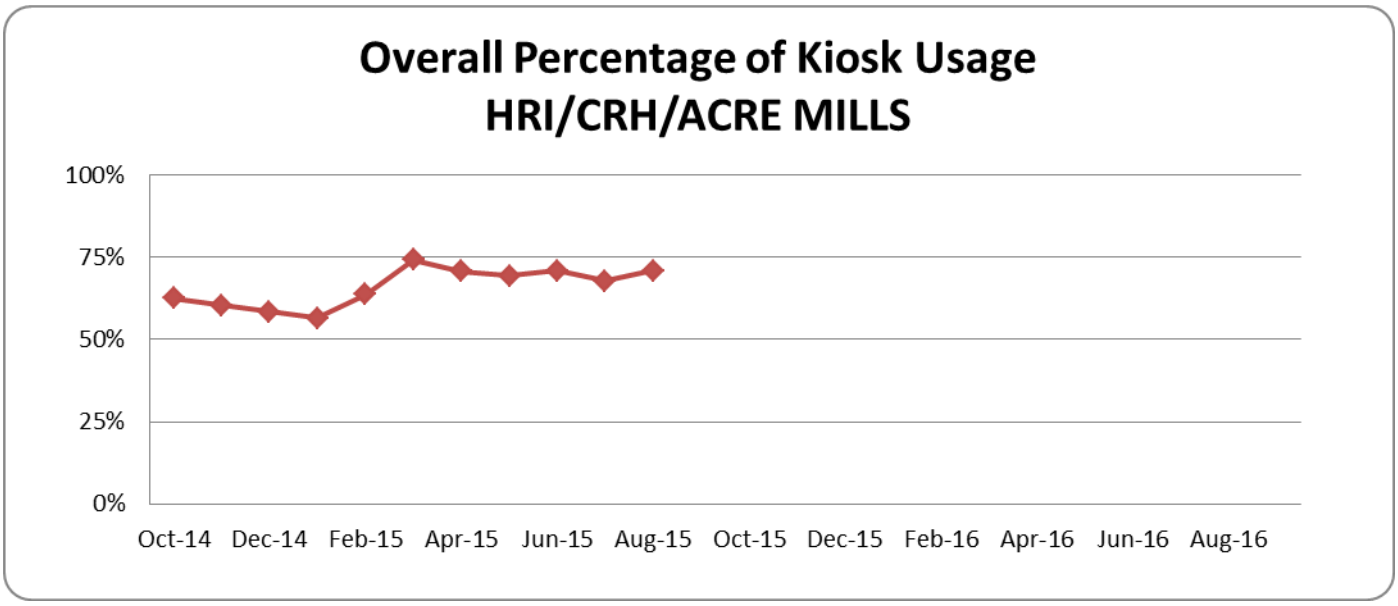
The SMS informs the patient that if they choose to cancel the appointment via SMS they will be discharged. In order to ensure that the clinical care is not compromised, monthly reports of cancellation messages are sent to each Clinical Manager, and the episode is not closed on PAS until the Manager is satisfied that the discharge outcome is appropriate.

Where a SMS or IVM message has failed to deliver, a list by Clinic Code is generated each day for the relevant Outpatient Clinic so that the details can be checked with the patient at the next visit. Our efforts are now being focussed on failed messages, and improving our data quality. All Check In Kiosks now include the option for patients to input any changes to demographic information.

Self-Check In Kiosks

Self-Check In Kiosks are now available in all outpatient areas and are being well utilised by our patients. The kiosks have enabled patients to complete the check in process quickly and update demographic changes e.g. address, telephone numbers and GP.

Over 70% of outpatient attenders now routinely use the kiosks, reducing queues at the desks and enabling the receptionists to efficiently book appointments, and support our more vulnerable patients.



The kiosks include functionality for patients to update contact information, improving demographic data quality.

PARTIAL BOOKING FOR >6 WEEK FOLLOW-UP APPOINTMENTS

Partial booking is now used in all outpatient specialties and is a system of managing all follow-up outpatient appointments. Partial Booking defers the actual booking of an appointment if the appointment date is more than 6 weeks in advance. Partial booking places the patient onto a pending list and invites booking approximately 5 weeks prior to the appointment due date.

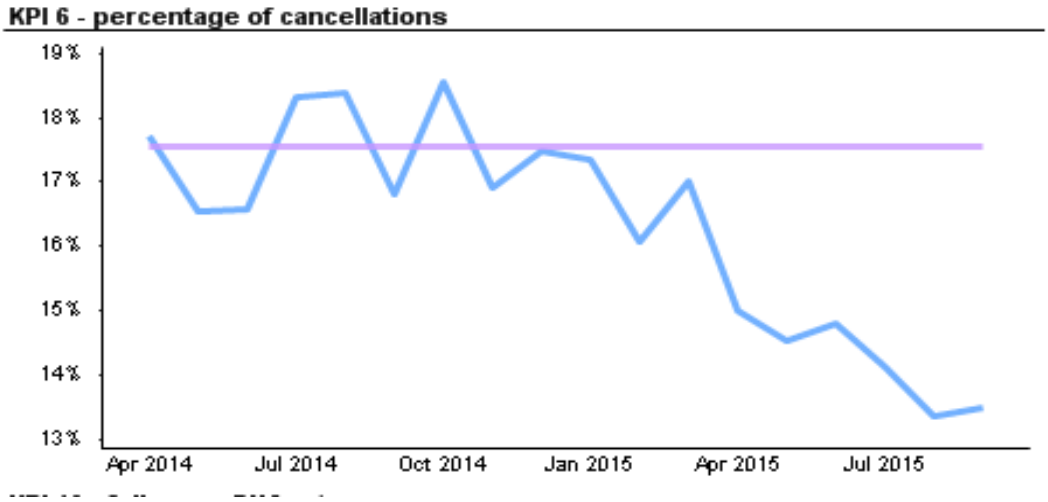
What are the benefits?

- Greater patient satisfaction
- Reduced DNA rates
- Reduced patient Cancellations
- Reduced hospital-initiated cancellations
- Reduce waiting times
- Better clinic utilisation
- Greater flexibility for changing rules to clinics as necessary
- Less administration
- Tracks non-responders minimising clinical risk

A number of enhancements have been added to PAS to provide robust reporting information to support partial booking. This ensures that each specialty is aware of the capacity and demand requirements.

One of the benefits on Partial Booking is the reduction in hospital initiated appointment cancellations, which can result frustration and confusion to patients and increased administration and cost to the service.

The graph below shows the month on month reduction in cancellations.



IMPROVED COMMUNICATION OUR PATIENTS

In order to advance communications with our patients a number of improvements have taken place:

- **Cancelling / Rebooking On Line**

Recognising that patients may wish to contact us to cancel or rebook their appointment, thus avoiding a DNA, the Trust public website includes an On-Line form for patients to complete and discussions are underway to develop email communication with patients. This service is well utilised.

- **Appointment Letters**

The style and content of appointment letters has been reviewed and a new clearer design and format has been introduced. The service provided by the downstream mail provider includes mail piece tracking so that the source of delayed/lost mail can be traced.

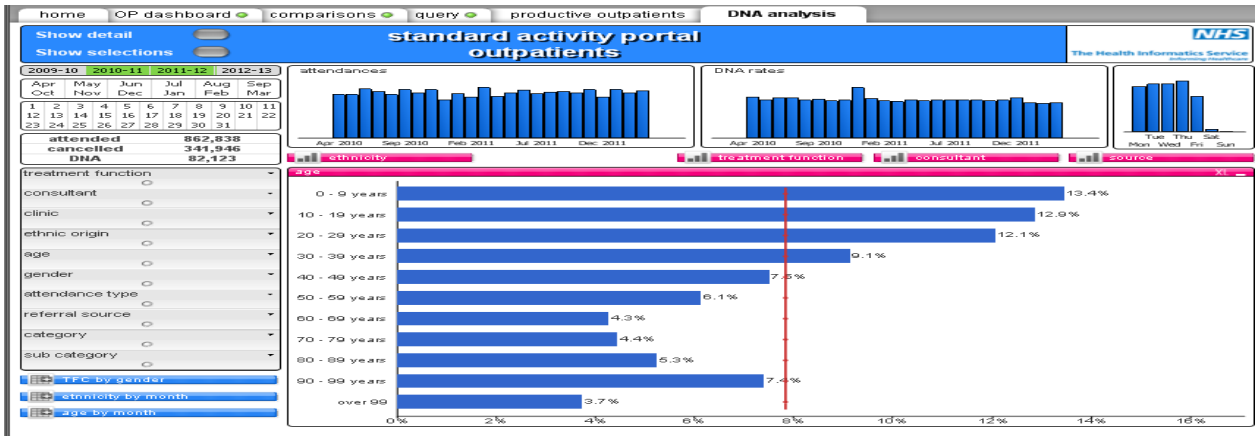
- **Friends and Family Test**

FFT communication is now in place via SMS and includes free-text comments. The data is routinely reviewed by the Outpatient Managers and data and comments shared with staff.

OUTPATIENT INTELLIGENCE REPORTING

- **Qlikview Intelligence**

By utilising collated DNA data from within the HIS Qlikview software, by age, ethnicity, treatment function, source, we can now identify those patients most likely to DNA (As per the screen shot below), and those less likely, therefore not requiring a reminder.



Additional staff have been recruited to contact patients in the high risk category (males aged 21-35) the evening before the appointment as an additional reminder to the automated reminder systems.

- **Compliance with DNA management procedures**

Continuing adherence to the DNA policy (Patient Access Policy 2014) will minimise repeat DNA offenders. Patients who do not attend their first outpatient appointment should be discharged back to the referrer and their 18 week clock will be stopped. In terms of Follow-Up Appointments no more than two consecutive DNAs should be permitted except in exceptional circumstances. Compliance with policy is being monitored at Divisional level.

IMPROVEMENT PLANS FOR 2015/16

Reminder Service

The SMS and Interactive Voice Messaging continue to deliver a reduction in missed appointments, the service is to be extended to include a message to partial booking patients to make contact in order to arrange the next appointment, and this will deliver a significant reduction costs associated with letter production.

Outpatient Restructure

The newly appointed Matron for outpatient services is already having a positive impact on patients and staff. The role focuses on visible, accessible and strong clinical leadership; alongside enhancing service quality and development; connected to the patient's experience of safe, timely and effective care in outpatients.

Patient Experience Workshop

A number of patients and staff recently attended an Outpatient Patient Experience Workshop to share experiences of our outpatient services and review comments received from the Friends and Family Test. A number of improvement ideas are to be taken forward and a follow-up workshop is to be arranged before the end of Q3.

4.5 Diagnostic Waits

Aims and Objectives of Work

There is a national target set for all diagnostics to ensure initial diagnostic tests are delivered within 6 weeks or less. The target was initially introduced to assist with the delivery of 18 week referral to treatment initiative as diagnostics are integral to the majority of pathways,

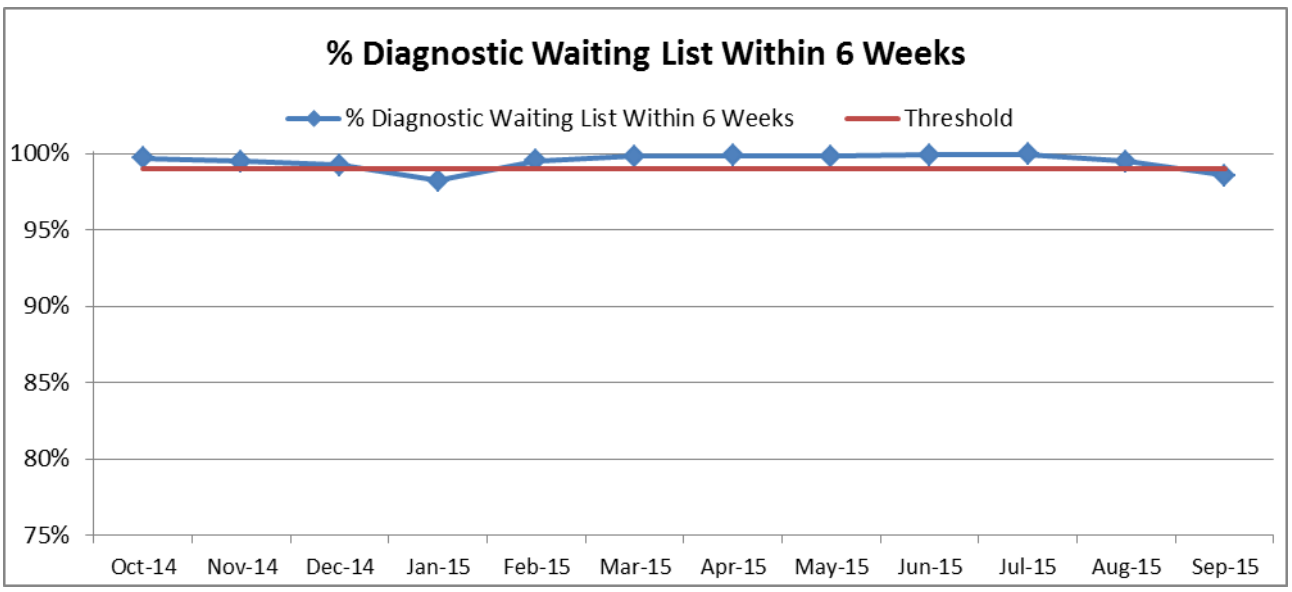
The threshold for performance is >99% in any month and is predominantly driven by MRI, Ultrasound and CT performance.

Current Performance

Q2 saw a dip in performance in the final month of the quarter. The Trust failed the 6 week diagnostic target in September. Amongst the drivers for this were increasing levels in demand via direct access in MRI and Ultrasound services.

A root cause analysis was carried out immediately and determined that the booking of patients outside of the 6 week window had not been sufficiently escalated to the service lead. As a result the need for additional capacity was not identified and acted upon. Corrective actions to reduce the risk of this occurring in future have now been put in place as a result.

All patients who breached the 6 week standard in September have now received their diagnostic and there are no known risks relating to October performance.



Improvement Plans for Q3

- A Root Cause Analysis has being undertaken; this will run in parallel to the immediate implementation of a revised booking protocol.
- Work will continue on the introduction of performance reports for radiology that look forward at booking pressures and referral trends. This work has being expedited with some manual reports and an automated solution is progressing. From the end of October 2015 this will be included in the weekly Performance review meeting.
- Monthly capacity and demand meetings are held within radiology to track performance across all modalities and ensure corrective actions are put in place to avoid any breach of the target.

Longer term plans

- The third MRI which will see additional capacity benefits is on target for installation towards the Q4 - further reducing patient waiting times and thereby improving the patient experience

4.6 Cancer Waiting Times

Aims and Objectives of Work

Delivery of the National Cancer Targets is a key part of cancer care and the Trust's performance around these key targets is a significant indicator of the quality of cancer services delivery.

High quality and accurate data is key to improving services and positive outcomes for patients, the Trust continues to be committed to supporting Cancer Outcomes and Services Dataset (COSD).

The Trust seeks to ensure all patients are treated with dignity, respect and in a timely manner ensuring that any delays are removed from the pathway where ever possible.

There are seven National Cancer Waiting Times Targets:

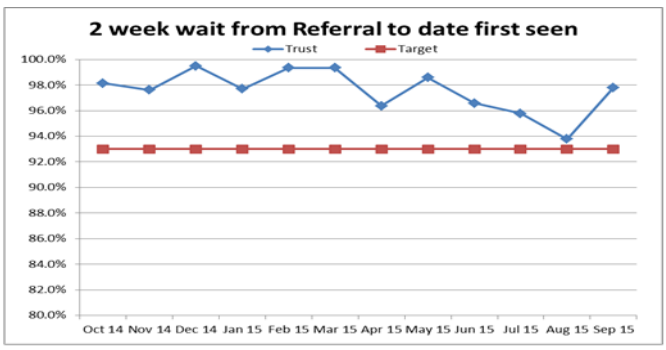
Target	Description
Two Week Wait Standard:	All patients urgently referred by their GP with a suspicion of cancer should wait no longer than 14 calendar days from the date the referral is received by the hospital to the date they are first seen in hospital.
31 Day Standard:	All patients who are newly diagnosed with a cancer should wait no longer than 31 calendar days from the date of decision to treat to receiving their first treatment.
62 Day Standard:	All patients who are urgently referred by their GP with a suspicion of cancer (Two Week Wait Standard) who are subsequently diagnosed with cancer should wait no longer than 62 calendar days from the date the referral is received by the hospital to the date of their first treatment.
Two Week Wait Symptomatic Breast Standard:	In addition to all patients with suspected cancer, all patients referred with any breast symptoms should have their first hospital appointment with 14 calendar days of the referral being received at the hospital even if cancer is not suspected.
31 Day Treatment Standard:	The 31 Day Standard applies to all cancers, irrespective of whether they are new or recurrent, relapsed or metastatic. In addition all surgical and drug therapy treatments (not just first treatment) are subject to a 31 Day Standard, e.g. a patient receiving surgery post radiotherapy must receive their surgery within 31 days of the decision to treat surgically being made.
62 Day National Screening Standard:	The 62 Day Standard now applies to referrals from National Screening Services (Bowel, Cervical and Breast screening). So patients diagnosed with a cancer that has been detected via the screening programme will need to start their treatment within 62 days of the screening referral.
31 Day Standard:	All subsequent treatments (not just surgery and drug therapy) will be subject to the 31 Day Standard, so every new and subsequent treatment is required to be delivered within 31 calendar days of a decision to treat date or an 'earliest clinically appropriate date'.

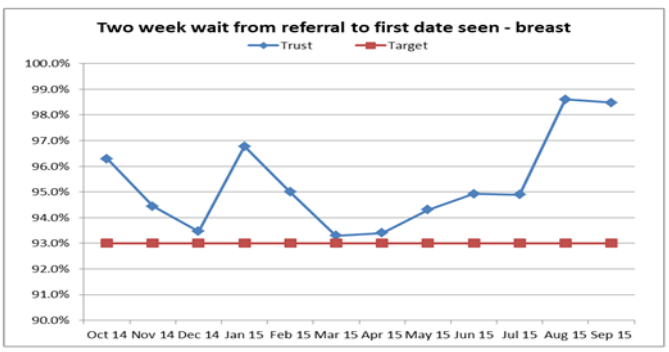
Current Performance

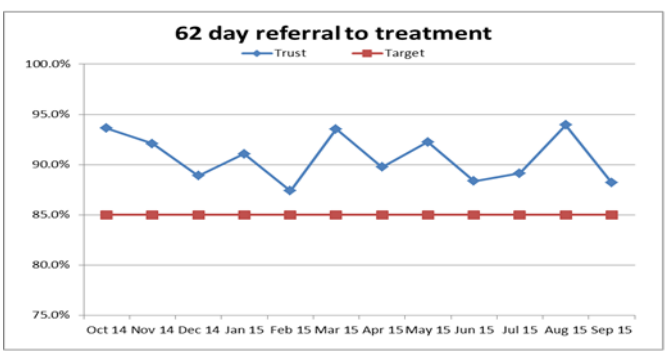
The Trust has achieved all 7 of the national standards for Quarter 2. An 8th measure which aggregates all the 62 day performance indicators are therefore also been met.

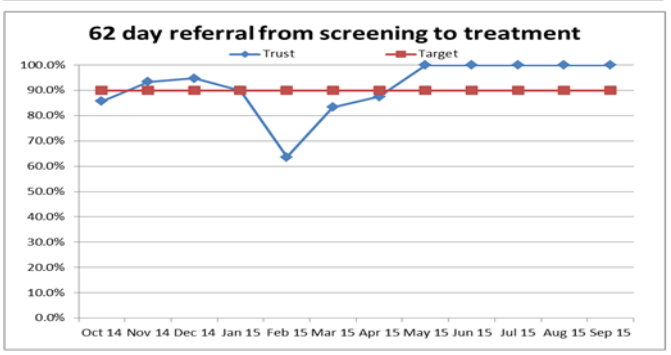
Significant progress has been made in delivering important aspects of cancer services leading to falling mortality rates and consistent achievement of the cancer waiting times.

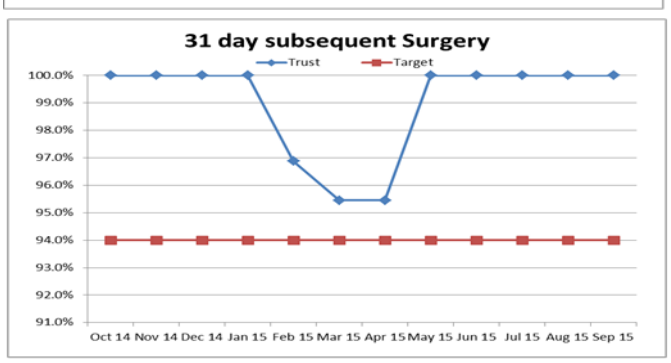
All issues have been regularly discussed at the Cancer Locality Board and Planned Care Board so that the GPs receive feedback along with ourselves and Public Health; so that we can education patients in the importance of being treated early.

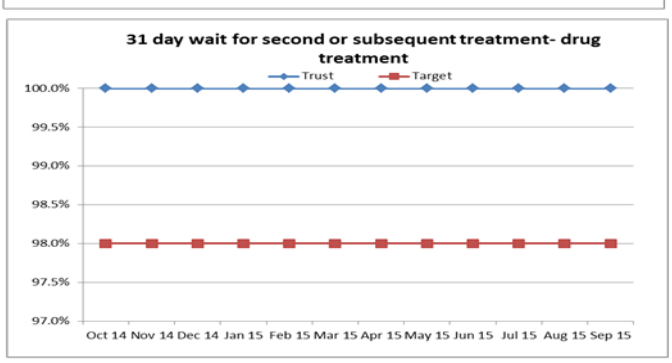


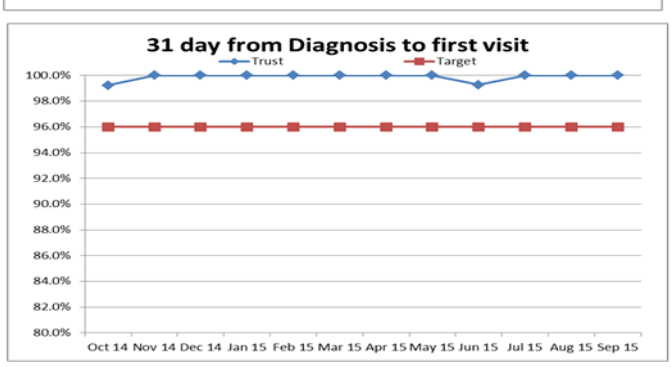


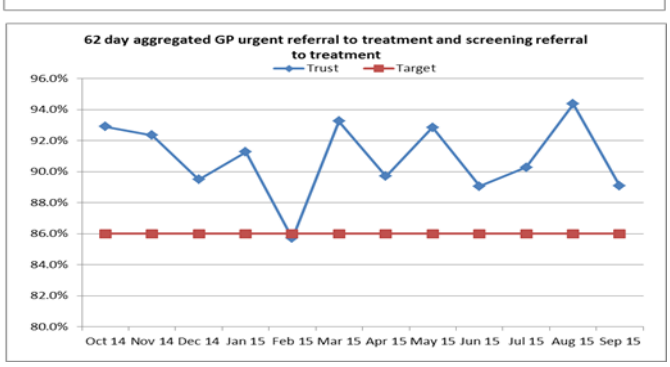












Alongside the national standards the trust is looking to report on regional targets to ensure patients are transferred to specialist hospitals in a timely fashion. This will aim to:

- See Fast Track patients within 7 days

  At present, 71% of patients are being seen within 7 days of referral which is excellent compared to the 30% we were achieving in April 2014.

- Provide diagnostics tests within 7 days

Unfortunately the 7 days to Diagnostics target which was an aspiration of WEB has not been successful and needs continued action to ensure this is achieved so that the measures become sustainable.

- Carry out any Inter Provider Transfers (IPT) by day 38

The Trust has issues meeting the target of referring 85% of patients to Tertiary centres by day 38 of their pathway. For August the Trust only managed to send 59.3% of patients by this target which is much lower than we would wish to have achieved at this point in the year.

Improvement Plans for Q2 forward

A further review of all tumour sites is to take place during July/August 2015 to address how the teams can operate differently to meet the 38 day referral to Tertiary centre. An action plan has been put in place by each division as to how they are going to rectify the poor performance and this will have to be closely monitored throughout the year.

From the Improvement plan set out by NHS England, NHS TDS and Monitor the Trust has completed their self-assessment and put together an action plan to achieve all the eight key priorities for the Cancer Waiting Time Standards within this financial year.

Cancer Site Specific and Specialist Palliative Care teams update:

The trust employs a number of specialist roles to support the delivery of cancer care, and end of life care in both cancer and non-cancer patients. The roles consist of Team Leaders/Lead Cancer Nurses of the specific cancer site (Band 7) to specialist sister (Band 6) development roles (band 5) and Cancer Care Co-ordinators (Band 4 - non RGN posts) and Health Care Assistants (Band 3)

Specialist Nurses roles have evolved due to the changing needs of patients, a much younger population, changes in treatment choices- more intensive and complex treatments and NHS service demand with an increase in newly diagnosed cancers every year as well as people ‘surviving’ their cancer and treatment , but living with the side effects of that treatment. Living with the consequences of successful cancer treatment is the great challenge of modern life.

To meet the changing landscape of cancer treatment and patient’s needs, specialist nurses (working closely with the designated named cancer site specific consultant) have and are developing nurse led clinics: assessing appropriate new cancer fast track patients, undertaking biopsies and ordering investigations, breaking the news of a new cancer to patients as well relevant cancer follow up (appropriate to the training level and competencies of the Specialist Nurse.). A crucial part of Specialist Nurses role is also in the assessment and interventions/care

of patients during the patient's treatment, recovery and living with the consequences of the treatment.

The advanced roles that Specialist Nurses are undertaking in the patient's pathway means that there is a changing landscape in professional roles and service provision for patients. Not only in piloting Nurse Consultant posts in cancer teams and how they help improve the patients experience and pathway to treatment but also new roles. One such are the 'Cancer Care Co-ordinators'.

These are non-registered roles, but provide low level support to patients and co-ordinate all the other referrals services. They include traditional non specialist parts of Cancer Nurse Specialist (CNS) roles. Cancer Care Co-ordinator posts are a valuable resource in the patient's management for low level specialist intervention once training and experience has been gained. They are a first port of call for patient's questions and queries, emails and phone calls. Baseline assessments and continuity for patients having access to the service can be through these posts.

In support of these roles, a number of Macmillan funded Projects are ongoing in CHFT currently:

Macmillan Head and Neck Specialist Nurses and Allied Health Professionals (Part of a Regional Head and Neck redesign project to inform national services for Macmillan)

- Continued Macmillan funding - to be trained in cancer follow up. (Extend a project that has been successful at Mid-Yorkshire Hospital) Sept 2015 -March 2018
- The team have just completed successful Specialist nurse and Allied Health professional management post treatment assessment and follow up , with funding for posts from Macmillan (up to march 2016). This replaces traditional consultant only follow up, with amazing outcomes for increased rehabilitation and recovery with intense intervention in first 6 weeks from head and neck team

Macmillan Pilot Breast Cancer August/September 2015- January/February 2018

- Nurse consultant project to audit the effectiveness of Nurse Consultant posts in diagnostics - biopsy and interpretation of results and cancer follow up (working closely with patients medical consultants) 30 month project with very clear objectives for measuring effectiveness and outcomes as well as Patient Related Outcome Measures (PROMS).

Macmillan pilot, Breast and Lung cancer care co-ordinators August/September 2015- January/February 2018

- Band 4 cancer care co-ordinators. The Breast and Lung posts will be mirrored in their audits. Do these posts have the same outcomes in different cancer specific sites. Are these post a possible future vision for all cancer sites. This 30 month pilot will show this. Lung is a completely new specialist nurse team, breast cancer is an established team and comparisons will be made and reported.

Macmillan Project - Acute Oncology nursing - Nov 2016 project completes

- Macmillan Funded 2 specialist Nurses, Lead Acute oncology nurse band 7 and Specialist Nurse band 6 (Nov 2013-nov 2015 extension funding agreed: Nov 2016) to develop in line with NICE guidance and Peer Review, a specialist acute oncology team. This service and outcomes are currently being audited.
- Macmillan have funded 0.2 WTE (12 months) Audit facilitator to measure outcomes for this service and future business cases.

PROMS Funded Macmillan 12 month project August 2015-July 2016

- In light of the results from the National Cancer Patient Experience Survey and showcasing what Specialist Nurse teams add to the patients experience, we have 12 months Macmillan funding (0.2 WTE) to audit the Specialist Nurses interventions and outcomes with each patient, in clinic, telephone consultation, ward visits/assessments and home visits. After each consultation patient are invited to complete a small questionnaire on their experience of the consultation as well as measuring the impact of Specialist Nurses intervention- PROMS
- This data will be reported in the Teams annual reports for outcomes clinically and patients experience as well as improvements in patients pathway due to specialist nurse assessment, interventions and management. Looking at keeping patients at home, prevented admission, consultant outpatient slots saved in follow up and safe early discharge.

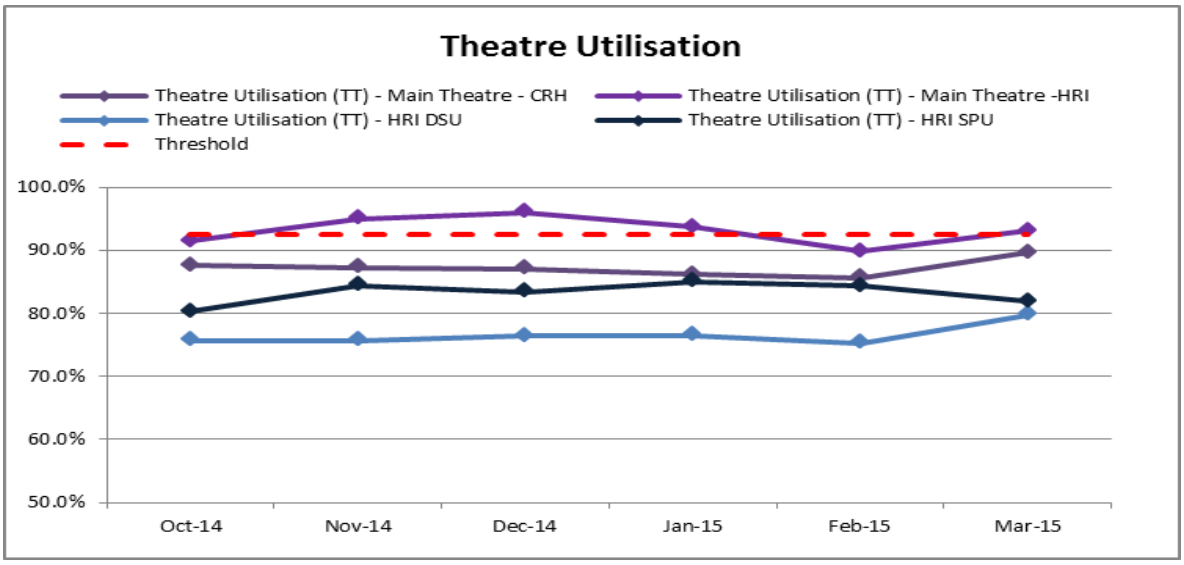
4.7 Theatre Utilisation

Aims and Objectives of Work

The trust has a target that all theatres will be at least 92.5% utilised each month. This is Touch time utilisation – Anaesthetic and Surgical procedure..

Q2 Current Performance

Over Q2 main theatre saw a drop below target performance, all other theatres also continue to performance below the designated threshold. There was however noticeable improvement in both the HRI main theatre and the Day Surgery Unit (DSU).



The Trust recognises that achieving optimal theatre utilisation more patients can flow through the system improving efficiency of service delivery and improvements in patient experience.

There are a number of factors as to Touch Time Utilisation can show figures below target.

- On the day cancellations.
- We have identified an issue with the way timings are being recorded in Bluespier System which we need to investigate.
- The scheduling process in place did not allow sufficient time for escalation.
- There is a challenge to delivery of 92% for day case lists due to high volume turnover of patients.
- Flow issues within the theatre process.

Throughout the first 6 months of 15/16 it has been identified that there are opportunities to optimise theatre space further, during Q2 work continued on the PMO scheme, which initially involved 10 surgeons spread over orthopaedics, ENT and general surgery looking at scheduling, patient flow to and from theatre, staff and skill mix, start and finish times of theatre lists. The actions in these schemes have all been agreed with the CD's and the surgeons concerned. The "better week" carried out in Q1 did show some improvements in orthopaedics and ENT and this has been examined further during the most recent quarter to see how this could be rolled out to all specialities and all surgeons.

Q2 also saw the beginning of the work with an external agency Four Eyes who have identified further 'in theatre' opportunity for our surgical specialties, further detail about Four Eyes and their specific remit will be available next quarter.

The theatre refurbishment at HRI is progressing well and is planned to be completed in December 2016.

Improvement Plans for Q3

Theatre Action week is due to take place during 5th – 9th October 2015. This will be akin to the perfect week, enabling interested staff members from across the organisation to get involved as an additional resource to assess and feedback what constraints they note in the theatre process.

It is hoped they will be able to either help alleviate them in real time or feedback their observations to aid the development of appropriate action plans going forward.

There will be the ongoing redesign our Surgical Pre-Operative Assessment Service Model to provide a more seamless service without the need for patients to travel all over the hospital; included in this will be early morning or evening sessions for patients to attend.

There are plan to re-locate both our Admissions Unit at HRI and Pre Assessment to a more patient-friendly area and plan to make this a place where patients can be relaxed and looked after prior to their surgery. Whilst this will not have direct impact on Theatre utilisation it will be of substantial benefit to the overall patient experience.

Domain Five – Well Led

Well Led Compliance summary:

Indicator	Compliance
5.1 Safe Staffing	Reporting Only
5.2 Mandatory Training	Partial Compliance
5.3 Appraisal	Partial Compliance
5.4 Patient and Public Involvement (6 month review)	Reporting Only
5.5 Sickness/Absence	Reporting Only
5.6 Staff Experience and Engagement	Reporting Only

Highlights:

5.1 Safe Staffing	Improvement in staffing fill rates for Day shifts

5.1 Safe staffing

Aim and Objectives of Work

The Nursing and Midwifery workforce group implement and lead the Nursing and Midwifery Workforce Strategy, providing monitoring and assurance of the Nursing and Midwifery Workforce across the Trust.

Objectives include:

- To set direction of the Nursing and Midwifery Workforce including defining, monitoring and continually updating the Trusts policies and procedures to ensure that the workforce is safe, effective and able to deliver high quality compassionate care consistently;
- To monitor and manage the Hard Truths requirements ensuring data is accurate, utilised to provide assurance and incorporated into workforce planning;
- To define standards for the workforce;
- To oversee nursing establishments which are linked to acuity and dependency studies, activity follows and NICE guidance on Safe Staffing

1.0 Safe Staffing Levels

Table 2 demonstrates the rag rating of the average fill rates reported for July - September 2015.

Table 2: Rag rating of average fill rates July – Sept 2015 Qualified + Unqualified

	Red (less than 75% fill rate) Q + Unqualified	**Amber** (75 – 89 % fill rate) Q + Unqualified	**Green** (90 – 100% fill rate) Q + Unqualified	**Blue** (greater than 100%) Q + Unqualified
July	7 + 4 = 11 shifts	23+ 9 = 32 shifts	35 + 19 = 54 shifts	7 + 36 = 43 shifts
August	9 + 6 = 15 shifts	31 + 11 = 42 shifts	27 + 21 = 48 shifts	3 + 28 = 30 shifts
Sept	7 + 10 = 17 shifts	24 + 7 = 31 shifts	35 + 15 = 50 shifts	4 + 34 = 38 shifts
Total	23+20 = 43 shifts	78+27 = 105 shifts	97+55 = 152 shifts	14+98 = 112 shifts

Average fill rates greater than 100%

Areas achieving greater than 100% for qualified staff can be attributed to supervisory status for ward managers being achieved, or newly recruited nurses being on the ward during their induction period.

Average fill rates of 100% and above for unqualified staff are mainly due to supporting one to one care for specific patients when required and supporting areas with reduced fill rates for qualified staff.

The overfill of Unqualified shifts is of concern and is being reviewed on a weekly basis by the Associate Directors of Nursing for each division. A task and finish group has been requested to review additional roles which will in part review the roles required which may reduce additional requirements for one to one support.

Average "fill rate" comparison September 2014 vs September 2015

	September 2014	September 2015
Average Fill Rate Day – Qualified Nurses / Midwives	79.4%	88.06%
Average Fill Rate Day – Unqualified Nurses / Midwives	93.6%	94.02%
Average Fill Rate Night – Qualified Nurses / Midwives	82.1%	89.77%
Average Fill Rate Night – Unqualified Nurses / Midwives	118.2%	109.43%

Increasing fill rates are as a result of a number of factors including focused recruitment and temporary workforce use; increased accuracy in reporting via the web based daily staffing tool and the implementation of long days into workforce models in April 2015.

Implementing a proportion of long days into planned hours has reduced some of the inaccuracies previously experienced where the right number of nurses were on duty but the actual hours against planned reduced due to nurses working long days completing 11.5 hours as opposed to 2 nurses working 15 hours to cover the same shifts. In some areas where vacancies remain nurses continue to work additional long days to ensure safe staffing levels are maintained which are not evident against their planned hours.

In May 2015 ward quality focused dashboards were commissioned from the Health Informatics team by the Nursing Workforce Strategy Group to monitor the impact of changes made to workforce models in April 2015 including the implementation of long days, and clearly present month on month data for key performance indicators.

Quality dashboards for each area are monitored by the Associate Director of Nursing for each division with reporting by exception through the Nursing Workforce Strategy Group.

Further development of the dashboards has been requested within the last quarter to ensure the data within is verified with the Matron for each area, and to ensure the dashboards are developed to provide a month on month view allowing trends to be easily identified.

2.0 Recruitment and Retention

Focused recruitment has continued for the nursing and midwifery workforce. Key developments within this quarter have included "keep in touch" events for soon to be qualified nurses offered posts commencing in September and October. This strategy was initiated to ensure engagement continued with nurses recruited to assist with maximising the number of potential nurses recruited for the Trust as the national shortage of nurses continues.

A welcome event was held in June 2015 to which over 50 nurses due to start in September attended to meet the Director of Nursing and learn about the support and opportunities available at Calderdale and Huddersfield NHS Foundation Trust.

International recruitment campaigns continue to form part of the recruitment strategy

All new recruits to the nursing and midwifery workforce are being offered an induction programme (one week) followed by a preceptorship programme spanning 6 months from September 2015 to increase support and development which we anticipate will increase retention rates.

A standardise local induction package has been developed within the last quarter to also support and provide consistency in the information provided to new recruits.

Following feedback from leavers surveys increased support for newly qualified or newly appointed nurses to the Trust is being trialled for 6 months through the creation of a new post. An experienced nurse will be providing support, supervision and reflection opportunities for nurses who will be able to self-refer with the aim of increasing their confidence and development particularly through the transition from student nurse to qualified nurse.

3.0 The Nursing and Midwifery Strategy Group

The Nursing and Midwifery Strategy group implement and lead the Nursing and Midwifery Workforce strategy and provide monitoring and assurance of the Nursing and Midwifery Workforce across Calderdale and Huddersfield NHS Foundation Trust.

Key objectives within the last quarter for the group have included:

- Increased focus on recruitment to the nursing and midwifery workforce particularly around securing and engaging nurses due to qualify in September 2015.
- To review and monitor the retention strategy.
- To lead, implement and review the “Contact time” audit which defined direct and indirect patient contact time on each inpatient ward area.
- To develop and monitor quality dashboards for inpatient ward areas.
- To set direction of the Nursing and Midwifery Workforce including defining, monitoring and continually updating the Trust’s policies and procedures to ensure that the workforce is safe, effective and able to deliver high quality compassionate care consistently.
- To monitor and manage the Hard Truths requirements ensuring data is accurate, utilised to provide assurance and incorporated into workforce planning.
- To oversee nursing establishments which are linked to acuity and dependency studies, activity follows and NICE guidance on Safe Staffing

4.0 Financial update

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

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

As vacancy levels and additional capacity demand have reduced the use of the highest cost agency stopped on 30.6.15. A further Tier 3 (highest cost) agency stopped in August 2015 in all but the most exceptional cases. In August 2015 the length of time provided to Tier 2 agencies to fill shifts was also reduced with the intention of filling unfilled shifts with Tier 3 agencies to the maximum prior to engaging Tier 2 agencies. An increased number of Tier 1 agencies have been recruited in August 2015 with the aim of increasing fill rates through Tier 1 agencies.

In September 2015 CHFT received new agency rules from Monitor and the TDA which impose a ceiling on the financial spend the Trust is permitted to spend on qualified nurses, midwives and health visitors from 1.10.15.

The agency rules also aim to prevent Trusts from utilising agencies which are not on an approved framework.

The Nursing Workforce Strategy Group are responding to the agency rules and monitoring compliance and identifying appropriate actions through weekly meetings.

The Nursing Workforce Strategy Group is currently reviewing the 20% headroom included within nursing establishments. Early indications suggest 20% may not be sufficient to achieve planned staffing levels with annual leave entitlement; current sickness and absence levels; mandatory training requirements and other leave such as maternity leave and study leave requiring greater than 20% uplift.

5.0 National Quality Board Expectations

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

Table 1: CHFT compliance against National Quality Board Expectations

Focus	Expectation	Status	Evidence of Compliance	Next Steps
Accountability & Responsibility	1. Boards take full responsibility for the quality of care provided to patients, and as a key determinant of quality, take full and collective	Achieved	• Board actively involved in agreeing staffing establishments (March 2015 and September 2015) • Board regularly updated on recruitment, training and key quality outcome measures	• Site view of daily staffing levels providing both current and prospective for next 24hours due to launch electronically

	responsibility for nursing, midwifery and care staffing capacity and capability		• Integrated Board report provides monthly update on safe staffing levels achieved, current areas of concern and action taken to address (accessible to patients and staff).	September 2015. • This will increase the information currently shared to include additional safe staffing indicators including red flag events and proportion of substantive to temporary workforce in any one area.
	2. Processes are in place to enable staffing establishments to be met on a shift-to-shift basis	Achieved	• Process in place to alert Flexible Workforce when additional staff required due to shortfall. • All areas reviewed with real-time monitoring to address absence, unplanned activities and change in skill mix as a result of temporary workforce use. • Matron of the day role commenced August 2015 to ensure senior nurse monitoring shift to shift staffing at all times • Promotion of escalating staffing concerns to Site Co-ordinator and Matron completed April 2015 through red flag event initiatives.	• Safe Staffing incorporated into nursing and midwifery induction from September 2015 to ensure all staff aware of how to raise concerns
Evidence-Based Decision Making	3. Evidence-based tools are used to inform nursing, midwifery and care staffing capacity and capability	Achieved	• Acuity and Dependency studies completed utilising NICE approved tool SNCT • Professional Judgement recorded daily on the web based safe staffing tool • Additional staffing indicators utilised (see section 8.0)	• Update / training session on classification of patients utilising SNCT scheduled for November 2015 • Review of electronic systems (SNCT APP and Nervecentre) underway to review possible use to complete SNCT.
Supporting and Fostering A Professional Environment	4. Clinical and managerial leaders foster a culture of professionalism and responsiveness, where staff fell able to raise concerns.	Achieved	• All areas have supervisory status built into their workforce models to provide structured and support within teams • All staff encouraged to raise concerns (guidance on how to do this included on nursing workforce induction)	• Additional support for newly qualified nurses due to commence October 2015 in response to concerns that nurses did not all receive preceptorship and level of support they required. • Preceptorship register to commence September 2015 • Nurses joining CHFT to be informed of their preceptor prior to arrival September 2015
	5. A multi-professional approach is taken when setting nursing, midwifery and care staffing establishments	Achieved	• Reviews are completed with ward managers, matrons and members of the multidisciplinary team. • The Nursing and Midwifery Strategy Group receive and endorse any recommendations to Board. • Membership of the Nursing and Midwifery Strategy Group include Workforce and Finance colleagues.	•
	6. Nurses, midwives and care staff have sufficient time to fulfil responsibilities that are additional to their direct caring duties.	Partially achieved	• Establishments incorporate supervisory time, but this is not always currently achieved due to vacancy levels and additional capacity demand. • Headroom has been set at 20%	• Review of headroom to be completed (see section 4.5)
Openness and Transpare	7. Boards receive monthly updates on workforce information,	Achieved	• Monthly report provided (Integrated Board Report) comparing the planned staffing level, reason for any gap and action taken.	• Quality dashboards have been developed within the last 6 months

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

6.0 Next steps

- Review the quality dashboards and agree parameters for exception reporting.
- Complete Clinical Supervision policy and implement across the nursing workforce
- Review of recruitment processes with Workforce and Development colleagues to ensure quality and efficiency of processes maximised.
- Increase visibility across sites of real time staffing position and 24 hour forecast for the nursing and midwifery workforce through the daily Site Staffing View which will also provide a record of any risks; action taken and the number of temporary staff utilised in each area per shift.

5.2 Mandatory Training

Aims and Objectives of Work

The new approach to mandatory training, the Core Skills Training Framework (CSTF) was introduced on 1 June 2015 for all colleagues in the Trust.

This approach brings numerous benefits including:

Clarity on what constitutes mandatory training

A move to an e-learning approach that provides an opportunity to access learning at any time, at work or at home, rather than being constrained by workplace classroom sessions

Access for the Trust to free, established and tested e-learning packages through a framework

The ability to 'passport' learning between organisations using the framework leading to the elimination of duplication in learning activity and time

'Stretched' refresher periods that reduce learning time each year

The table below details the suite of mandatory subjects and their source:-

Subject	Source
Equality, diversity and human rights	North West region e-learning package
Fire safety	In-house designed workbook
Health, safety and well being	North West region e-learning package
Infection prevention and control	North West region e-learning package
Information governance	Skills for Health e-learning package
Moving and handling	North West region e-learning package
Prevent	Central Government classroom session
Safeguarding (adults and children)	Skills for Health e-learning package
Conflict resolution	In-house e-learning package will be available in October 2015
Dementia awareness	In-house e-learning package will be available in December 2015

Current Performance

Mandatory training compliance at the end of Q2 is as follows:-

Division	Prevent	Equality & Diversity	Information Governance	Infection Control	Health & Safety	Manual Handling	Safeguarding	Fire Safety	Overall Compliance*
Surgery	22.50%	61.30%	64.30%	35.70%	35.10%	35.60%	24.0%	27.90%	18.11%
Medical	31.70%	70.30%	69.20%	37.80%	36.90%	37.70%	24.7%	28.00%	18.91%
FSS	39.40%	78.00%	77.30%	47.00%	46.80%	46.80%	27.9%	41.30%	7.72%
Community	78.50%	73.40%	75.00%	36.80%	36.20%	38.70%	22.6%	34.20%	9.82%
Estates	16.80%	81.00%	82.60%	19.30%	18.20%	18.50%	15.5%	47.90%	8.29%
Corporate	47.20%	78.20%	79.80%	30.30%	30.70%	31.00%	24.7%	40.30%	9.69%
THIS	28.40%	83.40%	81.50%	62.80%	56.30%	62.80%	28.8%	26.20%	6.99%
Trust	**37.5%**	**72.10%**	**70.90%**	**39.20%**	**38.50%**	**39.30%**	**25.2%**	**34.40%**	**10.33%**

Completion of each element of the 8 mandatory subjects at the end of Q2 is set out below: - The numbers at the top of the box indicated how many elements people have completed. I.e 10.33% have done all 8.

Division	0	1	2	3	4	5	6	7	8
372 Community L3	5.78%	10.21%	18.69%	20.42%	7.32%	4.43%	6.9%	8.09%	18.11%
372 Corporate L3	9.94%	17.95%	17.95%	8.33%	4.17%	3.53%	5.5%	13.78%	18.91%
372 Estates & Facilities L3	9.50%	30.27%	31.75%	8.90%	0.89%	1.78%	3.3%	5.93%	7.72%
372 Families & Specialist Services L3	6.46%	12.17%	16.98%	13.18%	5.26%	5.64%	12.6%	17.93%	9.82%
372 Health Informatics L3	9.33%	6.22%	10.36%	12.95%	5.18%	11.92%	9.3%	26.42%	8.29%
372 Medical L3	14.65%	18.84%	19.83%	6.71%	3.74%	5.26%	8.8%	12.51%	9.69%
372 Surgery & Anaesthetics L3	21.15%	20.98%	15.65%	5.94%	3.23%	4.02%	9.0%	13.02%	6.99%
Trust	**12.0%**	**16.72%**	**18.30%**	**10.22%**	**4.32%**	**4.95%**	**9.2%**	**13.94%**	**10.33%**

Improvement Plans for 2015/16

Elements of the improvement plan already achieved in Quarter 2 include:-

Challenges	Actions to date
Ensuring all colleagues are aware of the new approach	• A communication plan has been running since January 2015. Communication into the organisation commenced immediately after the Executive Board papers approved the new approach at its meeting on 8 January 2015 and has comprised the following:- • Payslip messages • CHFT Weekly • Workforce and Organisational Development Line Manager Bulletin • Posters • Information flyers in all general delegate packs for training courses and in-house conferences • Web-page messages and videos • Information flyers delivered through divisional business meeting via divisional HR manager briefings • Briefings at set-piece divisional and corporate service area meetings
Ensuring all colleagues are aware of how to access their mandatory learning	• Comprehensive intranet based webpages have been developed to support the implementation of the new framework. It has a number of videos and other tools to support learners, all of which are down-loadable as PDF documents. The resources include:- • An introductory video and text section explaining the new approach and highlighting how to get started • A video providing a step by step guide on how to access ESR • Help with obtaining a Trust e-mail address • Information about essential skills training • A support structures area detailing the desk-top support sessions available to all colleagues and the

	remote-on help service operated by workforce development. This service allows workforce development to remote onto and therefore see a colleague's computer screen when they are having difficulties with their mandatory training. It facilitates swift diagnosis and resolution of the problem. • Frequently asked questions • A trouble-shooting guide • A section for managers explaining their responsibilities and linking them to the IT access forms and relevant policies • • A glossary of tools
Ensuring colleagues can feedback their thoughts and recommendations to strengthen the approach	• Feedback opportunities have been provided as follows:- • Workforce Development team member attendance at divisional, set-piece meetings and corporate forums • A contact group comprising colleagues from staff groups that do not traditionally access IT to understand and focus their needs • An on-line feedback tool linked to all workforce development intranet and paper communications • An 'ask a question' facility • The remote access service operated by workforce development available for all service users. This service allows workforce development to remote onto and therefore see a colleague's computer screen when they are having difficulties with their mandatory training. It facilitates swift diagnosis and resolution of the problem.

Remaining Operational Challenges

An analysis of the continuing challenges/ risks to the successful implementation of the programme and the actions to mitigate them are detailed below:-

Challenge/issue	Detail	Next steps
Low compliance with safeguarding (adults and children)	There are two safeguarding training elements adults and children each requiring approximately 40 minutes to complete.	Test with colleagues who have completed other subjects to understand why they have yet to complete the safeguarding element
Low compliance with Prevent training	The Prevent learning is a classroom based session delivered locally by a small number of colleagues. The availability of trainers to lead sessions is an issue.	The need for an increase in available training sessions has been highlighted by the Trust's safeguarding lead. Existing trainers are prioritising time to facilitate more training places and sessions are being over-booked to ensure they run at maximum numbers. The possibility of having an e-learning

		package instead of the classroom session is being tested nationally.
Individual colleague time to complete the training	Feedback obtained has highlighted that some colleagues are struggling to prioritise time to complete their learning. The current eight mandatory subjects take an 'average' learner 5.5 hours to complete if they do the entire learning content and assessment for each subject. There is however the option to do the assessment associated with each subject only. This takes only a matter of minutes and providing the learner passes 100% of the questions they attain their competence.	Continue to promote the assessment option for all colleagues. This will be prioritised in planned communication sessions and a poster will be designed to further promote this option. Consideration is being given to an explicit statement regarding protected time for this activity.
Requirement to complete mandatory training elements where a higher level qualification in the same subject has been obtained	As the new mandatory approach was adopted it was agreed that an absolute approach to mandatory compliance would be adopted 2015/16. Feedback has highlighted that some colleagues have attained higher level qualifications in some of the mandatory subjects and their recommendation is that mandatory competence be automatically granted in such situations	Within ESR it is difficult to create a workaround that facilitates this process. A manual process of cross-referencing qualifications is in design. An automated work-around is being investigated with the regional ESR team
Training requirements associated with the EPR implementation	The mandatory training programme has a 5.5 hour requirement. In the near future colleagues will also need to do end-user the EPR learning which is estimated as 3.5 to 7 hours per user. There is a potential conflict of priority which could compromise compliance.	The Head of Workforce Development and the EPR training lead are liaising to mitigate this risk.
Access from home	To maximise the availability of the e-learning so colleagues can complete training from any NHS/own device at any time they require permission their line manager to access from home	An addition to the web-page is in design clarifying this process for colleagues and linking them to the permissions forms on line. A solution to the problem of smartcard users accessing from their personal device is in discussion with THIS colleagues. Options around creating a bank of loan devices are

		being explored.
The 'user-friendliness' of ESR	ESR screens are difficult to navigate. This has been mitigated by video and text tools on the mandatory training web page taking colleagues through the screens on a step by step basis.	The national ESR system has a planned new functionality release (planned June 2016) that may address this issue.
Difficulty in finding the on-line mandatory pages on intranet	Colleagues have fed back that finding their way to the mandatory tools is difficult.	An icon for mandatory training has been added to the intranet homepage In the near future (planned for late October), an icon will be placed on all desktops.
The continued visibility and understanding of the mandatory training programme	Extensive communication has been put in place. A communication plan is required.	The Head of Workforce Development and the communication team are producing a refreshed publicity campaign. Colleague surveys are in design to gather feedback on concerns that exist and recommendations for improvement. These will be issued to:- - Colleagues who have completed all 8 elements of the framework - Colleagues who have stopped part way through completion - Colleagues who have yet to start the programme - Line managers A paper information booklet re-iterating colleagues' responsibilities and offering tools to help them achieve compliance is being created to be issued to all colleagues by 31 March 2016 A proposal which links mandatory training (and appraisal) compliance with incremental pay progression and access to promotional opportunities will be considered by the Executive Board in October

5.3 Appraisal

Aims and Objectives of Work

A formal annual appraisal process provides employees with information around how they may be perceived within their team and organisation and offers constructive feedback about their performance at work. A good appraisal also helps colleagues understand the strengths they should capitalise on and the weaknesses where improvement may be required. This helps to ensure that each individual in the team understands how their input contributes to the whole and how achieving their goals will ensure the organisations vision of compassionate care is delivered.

The aims of appraisal are

- To ensure all colleagues have access to a simple and effective appraisal structure
- To maximise progress using that simplified structure towards the 100% annual target
- To facilitate effective and timely reporting for the organisation to ensure compliance

Current Performance

21.68% of appraisals were completed by the end of Q2. Performance in each division is now being measured against its planned appraisal activity. No division met its target for completed appraisals at the end of Q2. However, progress has been made in ensuring every service area has an activity plan in place. Community, Estates and Facilities and THIS are rated amber.

The breakdown position is set out below

Appraisal- Completeted Since April 2015			
Division	**Compliance**	**Planned Activity as of 30.09.2015**	YTD Target (48%)
Surgery	6.60%	30.00%	🔴
Medical	24.00%	-	🔴
FSS	28.00%	33.00%	🔴
Community	26.00%	27.00%	🟠
Estates	20.80%	22.00%	🟠
Corporate	20.10%	32.00%	🔴
THIS	37.30%	38.00%	🟠
Trust	**21.68%**	-	

Key	
Compliance	RAG
Equal or Above Plan	🟢
less than 2% off plan	🟠
More than 2% off plan	🔴

Improvement Plans for 2015/16

Elements of the improvement plan already achieved in Q2 include: -

Work with divisions has focused on making more robust plans to spread appraisal activity over the 12 month period as the bulk of appraisal activity has historically been delivered in the last quarter of the performance year. To assist with this an appraisal planning tool has been developed by THIS and Workforce Information colleagues. After initial testing in Workforce and OD the tool was rolled out for use by divisional colleagues. The tool enables an assessment to be made of planned activity against actual activity each month facilitating a forecast position to be determined month by month. From

August a ‘comply or explain’ approach has be adopted requiring divisional colleagues to identify the barriers to improve planned performance as well as actual delivery.

Line manager resources and information available through dedicated appraisal web pages have been further enhanced. In Q2 the appraisal template has been redesigned to incorporate the Trust’s refreshed service vision and to include the elements of the new mandatory training approach.

Remaining Operational Challenges

Further work is required to consolidate the use of the appraisal profiler facilitating a wider spread across the full business year for the appraisal workload.

A new animated film showing further aspects of appraisal for the web page on the intranet will be introduced in December 2015

Quality assurance of the appraisal process and experience will be completed by the end of the calendar year.

5.4 Patient and Public Involvement

Aims and Objectives of Work

Involving patients and the public in planning, monitoring and developing health services enables the Trust to ensure that services are responsive to individual needs, are focused on the needs of our patients and the local community local community and support us in improving the quality of care that we provide. On a one to one basis patients feel involved in their care when they are treated as equal partners, listened to and properly informed, making them feel valued and appreciated

Due to being a foundation trust, we have a legal required to involve our patients in:

- How we plan and provide our services
- How we develop and consider proposals to change the way we provide our services
- Decisions that affect how we operate our services.

During Quarters 1 & 2 our main areas of focus for patient and public involvement have been:

- Follow up on the engagement and consultation to centralise Child Development services at Calderdale Royal Hospital
- Seeking views on our plans to centralise Emergency Gynaecology and Early Pregnancy Assessment on to one site at Calderdale Royal Hospital
- Working with our commissioners on completing the outstanding engagement work on the provision of hospital services and care closer to home to inform the commissioner’s decision on readiness for consultation.

Child Development Service
In line with the decision to close Princess Royal Hospital in Huddersfield, public engagement and consultation on the centralising of the child development service was undertaken during 2014. Building work on the existing centre at Calderdale has begun and the Division have been undertaken ongoing conversations with the service users and their families on the development of the new facilities as well as the community based service that will be delivered

alongside. This has included sharing the plans for the new development and a Saturday open day and drop in to discuss the service. This engagement work is ongoing.

Emergency gynaecology and early pregnancy assessment services
The views and experiences of services users, members of the public, NHS staff and stakeholders were invited on proposals to centralise Emergency Gynaecology and Early Pregnancy Assessment services, currently provided from the Cedarwood Unit, Huddersfield Royal Infirmary, with services provided at Calderdale Royal Hospital.
A purpose built Gynaecology Assessment Unit was opened at the Calderdale Royal Hospital in November 2011. The purpose of the opening of the Gynaecology Assessment Unit was to facilitate rapid assessment of gynaecology conditions that require assessment, investigation and treatment in a timely fashion. Patients are referred to the Gynaecology Assessment Unit from a number of health professions, such as GP's, A&E & Community Midwives.

Prior to the opening of the Gynaecology Assessment Unit all Early Pregnancy Assessment Unit clinics at Calderdale Royal Hospital had to run from various venues on site on different days of the week. Emergency gynaecology appointments at Calderdale Royal Hospital were delivered on the Gynaecology inpatient ward with no waiting area or dedicated clinical rooms.

At the Cedarwood Unit at Huddersfield Royal Infirmary the Early Pregnancy Assessment Unit clinic runs alongside the general Gynaecology Clinics and the Antenatal Clinics and Antenatal Day Unit. This is non-compliant with NICE standards of care as the women are sat in a waiting room alongside ladies attending antenatal clinic appointments. The Emergency Gynaecology Clinics at Huddersfield Roya Infirmary are run by staff in and amongst general outpatient clinics and do not have dedicated medical support

A detailed engagement plan was developed by the Trust, quality assured by NHS Greater Huddersfield Clinical Commissioning Group and presented to the Kirklees Overview and Scrutiny Committee for review.

The plan set out the objectives of the Trust to:

- Communicate the messages on how CHFT deliver the current service.
- Present the ideas for change.
- Listen to the public and understand what the impact of change would be to current service users and ensure people have an opportunity to have their say.
- Ensure the views of service users and members of the public have been considered.

During September we have been engaging with women's groups across Kirklees in line with the engagement plan. This has been done through on-line and paper questionnaires as well as facilitated groups. The results of the engagement, along with an equality impact analysis, are currently being finalised for presentation to the CCG for assurance prior to being presented to the OSC on 10 November. As this is considered a minor service, if the OSC are sufficiently ensured with both the depth of engagement and the Trust's consideration of the feedback in its plans, it is hoped that we will not be required to go out to full consultation on the proposed service change.

Engagement on service reconfiguration to support readiness for consultation
Following the significant work to involve and engage the public in the development of the outline business case for service reconfiguration in spring 2014, the Clinical Commissioning Groups have been doing some further engagement focussed on those areas which were under-represented in an assessment of the feedback.

The Trust has been supporting the CCGs in this work which has concentrated engagement around planned and unplanned care across Calderdale and Greater Huddersfield with a focus on the harder to reach groups and further geographies of Greater Huddersfield. More recently, engagement work regarding maternity and paediatric services has been planned and will be delivered during November and early December. Comprehensive reports on the engagement work have been written by HealthWatch Kirklees on behalf of the two CCGs. Along with the maternity and paediatrics work, these reports will form the basis of a final deliberation event towards the end of the year prior to a decision on readiness for consultation being made in January 2016.

Activity for the next quarter
In addition to the work described above, plans are being developed for engagement with patients and potential patients of our respiratory and cardiac services to look at what would be the benefits and barriers of centralising these services.

5.5 Sickness and Absence

Aims and Objectives of Work

The Trust has a strong emphasis on the wellbeing of colleagues to allow them to fulfil their roles effectively in an environment conducive to their welfare. The Trust's Attendance Management Policy supports the regular attendance of staff at work and enables managers to manage attendance fairly with the focus on rehabilitation and return to work wherever possible.

The aim is to manage the % of full time equivalents (fte) on sick leave in any one period below 4%.

The table below shows the Trust's performance against the 4% threshold for Q3 and Q4 in 2014/2015 and Q1 and Q2 for 2015/2016:-

Quarter	CHFT (%)	Trust Threshold	RAG
2014/2015 Q3	4.58%	4.00%	🔴
2014/2015 Q4	4.63%	4.00%	🔴
2015/2016 Q1	4.55%	4.00%	🔴
2015/2016 Q2 To date	4.33%	4.00%	🔴

Current Performance

The sickness absence rates for the Q2 2015/2016 are broken down by division in the table below.

The highest sickness absence rates occur in the Medical Division with 5.34%. The lowest rates occur in Corporate Division with 2.29%.

Division	Q2 (TO DATE)	RAG
Surgery	4.36%	
Medical	5.34%	
Community	3.95%	
FSS	4.37%	
Estates	3.31%	
Corporate	2.29%	
THIS	2.74%	
Trust	**4.33%**	

Improvement Plans for 2015/2016

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

- Establishment of a dedicated Attendance Management team is progressing. A team leader has been appointed and a recruitment plan is in place and being actioned for the remaining posts in the team.

- 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. The policy has been approved by staff side representatives of the Staff Management Partnership Forum and Local Negotiating Committee and will now progress to Executive Board for ratification.

- 'Go see' activity planned with Leeds Teaching Hospitals NHS Trust in October 2015.

- A comprehensive colleague health and wellbeing strategy is in development and will be available at the end of November 2015.

5.6 Staff Experience and Engagement

Staff Friends and Family Test

The Staff Friends and Family test aims to provide a simple, headline metric which can be used to drive cultural change and continuous improvements in the quality of the care received by NHS patients and the working conditions of its staff. The survey questions are:

A – Would you recommend your Trust as a place to receive treatment?
B – Would you recommend your Trust as a place to work?

The survey runs on a quarterly basis with the exception of Q3 (October to December) when the National Staff Survey takes place.

From Q2 2015/2016 the Staff FFT comprises a sample survey with a third of the workforce being invited each quarter to participate through a mix of electronic and postcard based questionnaires with the facility for additional questions to be included. In Q2 the survey was focused on colleagues in two divisions – Families and Specialist Services and Medical.

The 2015/16 Q2 survey was focused on two clinical divisions – Family and Specialist Services and Medical. The results are as follows:-

Staff would recommend the Trust as a place to receive treatment
FSS – 78%, Medical – 79%
Staff would recommend the Trust as a place to work
FSS – 46%, Medical – 55%

Further analysis of the qualitative feedback received through the survey is to be completed with the respective divisions in order to identify themes and the necessary responses to improve colleague experience in the Trust.

NHS Staff Survey 2015

The Trust is participating in the 12th national annual NHS Staff Survey. A total of 850 colleagues have been randomly selected in our sample by Picker Institute Europe, our survey administrator. Our response rate for 2014 was 45%. The national target for the 2015 survey is 55%. The survey closes on 30 November 2015. Initial results will be available in late December 2015. The formal benchmarking results will be released by NHS England in February/March 2016. The Trust has incorporated local questions in the survey in the same way as it did in 2014 focusing on patient experience, raising concerns, Trust values and its financial position.

Developments in Q2 include:-

- Sign-off of a Trust colleague engagement and communication plan supported by divisional specific plans
- Reinforcement of back to the floor/leadership walk round activity
- The 'Big Brief' events led by Directors gaining traction
- Introduction of the 'Ask Owen' facility on the intranet
- Work Together Get Results (WTGR) workshops with senior teams to support the sustainability of the consistent approach to change management that has colleague engagement at its core.

Improvement Plans for Q3 onwards 2015/16

Staff feedback opportunities, including leaver survey, new staff starter survey, staff suggestion scheme, staff FFT and staff survey, require a co-ordinated response and monitoring.
The creation of a Board of Directors Workforce Committee with a sub group structure that includes colleague feedback will support the design of a more effective feedback capture model and robust response to feedback to ensure continuous improvement. This will assist in the delivery of a 'you said, we did' approach.

The design and introduction of a staff recognition scheme.

Introduce a colleague health and wellbeing strategy built with the involvement of key stakeholders.

APPENDIX A - Learning from Mortality - July

Mortality Reviews

Analysis of reviews - July 2015

Background

The method for performing mortality case note reviews was revised in August. Each of the reviewers were allocated three sets of notes to review during the month and the case notes were either available on EDMS or the case notes delivered to the reviewer. This provided a significant increase in the number of cases reviewed compared to previous months.

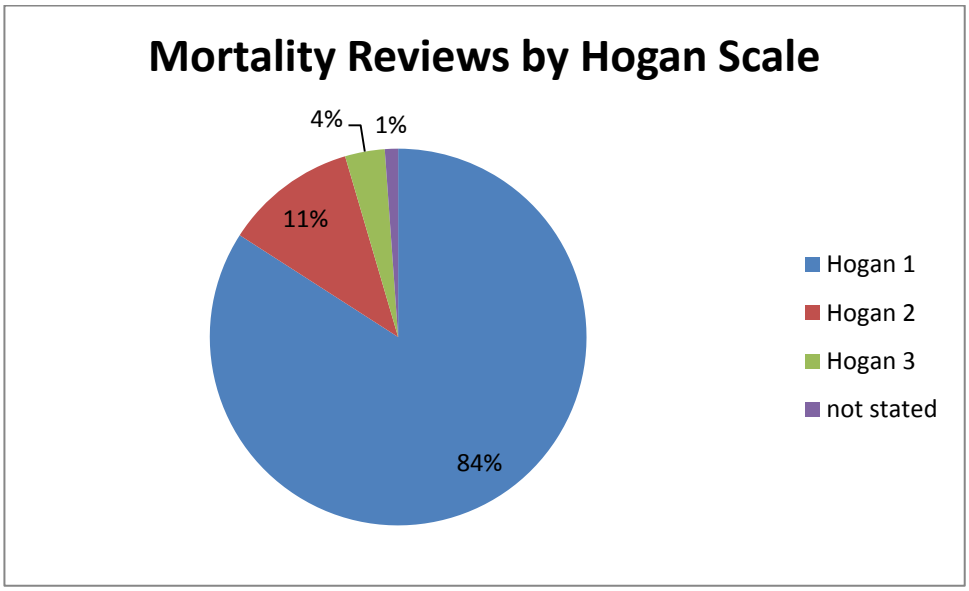
There were 119 deaths during July with a total of 74% (88) of cases reviewed.

Stage one review

Analysis of reviews performed for deaths in July 2015 found 84% (74) were assessed as 'definitely not preventable' using the Hogan scoring. 12% (10) were assessed as 'slight evidence for preventability' Hogan 2 and 4% (3) were assessed 'possibly preventable but not very likely, less than 50–50 but close call' Hogan 3. There was one case where the Hogan scale was not stated.

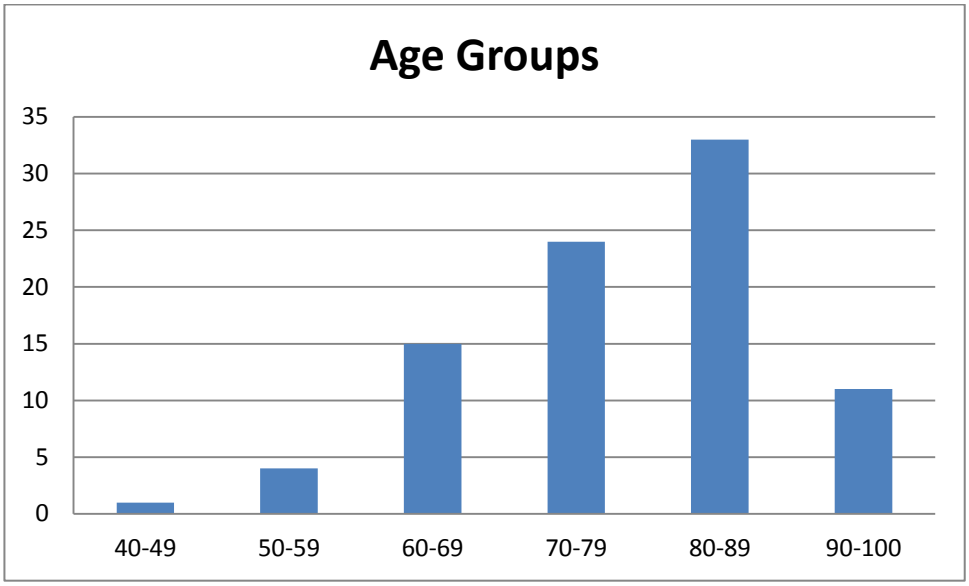
Chart one shows the percentage of preventability using the Hogan scale.

Chart 1



The ages of the patients ranged from 48 – 98 years old. Chart two shows the age distribution of the patients

Chart 2



Analysis of the 88 first stage case reviews showed the following information

- 4.5% (4) were patients in surgical wards
- Of the 4 of patients in surgical wards 1 was stated to be ‘medical outlier’ and one was stated as under inappropriate speciality
- 95.5% (83) of patients were on medical wards
- Of the 83 cases on medical wards, 8 were assessed as an ‘outlier’ and 2 were assessed as not in the appropriate speciality
- Length of stay ranged from 0 to 85 days
- 19% (17) of cases were assessed with ‘patient expected to die within 24 hours
- 14% (12) patients ‘death was not expected when it occurred’
- 16% (14) were assessed as ‘death not in the appropriate place’, reasons provided in the chart 3 below

Chart 3

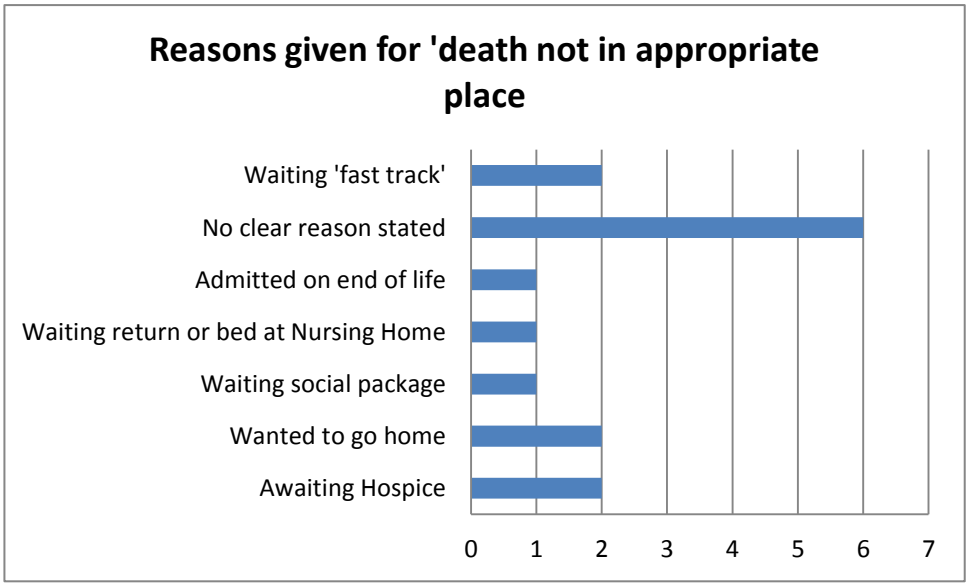
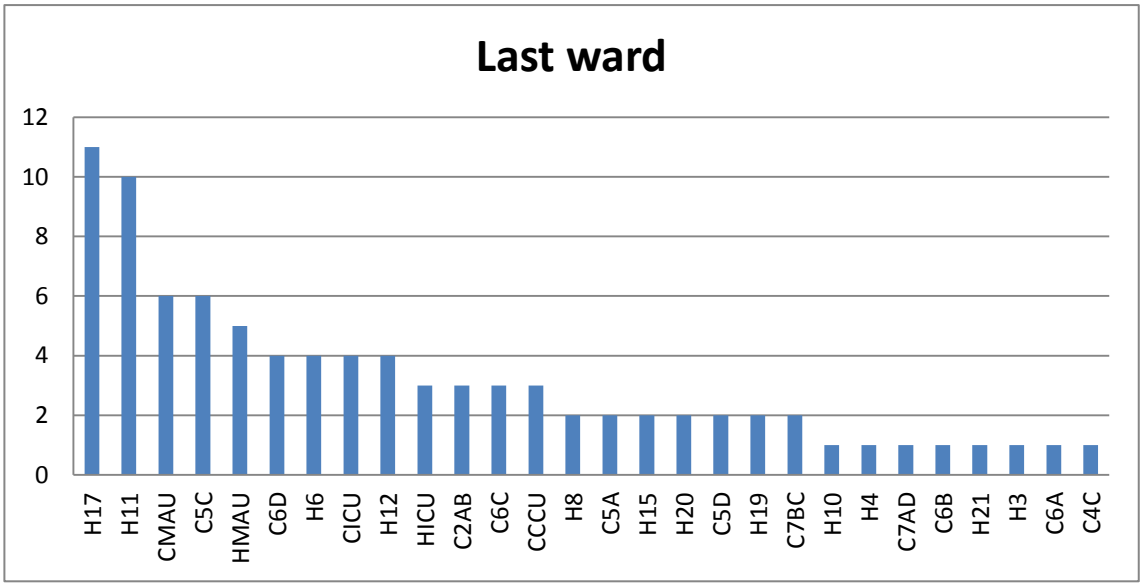


Chart four shows the last ward.

Chart 4



Summary of cases assessed as Hogan 2

A total of 10 cases were assessed as slight evidence for preventability. The table below includes the comments regarding preventability as stated by the reviewers.

Age	Length of stay	Primary diagnosis	Cause of death	Preventability Comments from the Reviewers
84	57	Cerebral infarction due to unspecified occlusion or stenosis of cerebral arteries	Ischaemic Bowel	Was palliative and was on ward 2a for long period. CT revealed stroke. 19/06/2015 - for care of elderly ward still long was on ward 2a. 23/06/2015 - physio felt deconditioned due to length of confusion and left sided weakness
98	4	Acute post haemorrhagic anaemia	Community Acquired Pneumonia	Complex presentation with multiple problems so unlikely to survive but slight delay in treatment for Sepsis. No record of antibiotics/cxr for 24 hours. Initially treated for SOB due to anaemia/PR bleed - transfused 2 units. Was also very agitated/confused
60	11	Lobar pneumonia, unspecified	Pneumonia	Transferred from BRI for rehab but remained under the care of the surgical team. ? Should have been referred to medical team for management as no acute surgical issues on transfer
61	3	Pneumonia, unspecified	hypoxic encephalopathy	Nothing documented by the reviewer
79	27	Lobar pneumonia, unspecified	Hospital Acquired Pneumonia	Poor nutrition, delays with naso-gastric tube. Unable to see referral to dieticians
83	27	Abnormal results of	Pneumonia	This patient with pancreatic cancer,

		liver function studies		though he could have gone home if right support was available socially. While waiting for this he acquired HAP (chest infection) and was unresponsive to antibiotics and was referred to palliative care.
86	2	Lobar pneumonia, unspecified	Pneumonia	Introduction of ivabx earlier in patient journey + use of cf niv may have altered pain but patient unwell with lots of co-morbidities
79	9	Acute subendocardial myocardial infarction	Septicaemia	Sepsis bundle antibiotics not given within bundle timeframe - started 28/07/2015
96	9	Urinary tract infection, site not specified	sepsis	I have concerns with regards to the DNACPR issue. Documentation and discussion with family. Even when the patient didn't want IV cannule, no senior discussion with patent /family or even recognising death and understanding that perhaps patient is dying
67	1	Acute renal failure, unspecified	Acute Kidney Injury	Patient died within 24 hours of admission

Main Key themes for requesting a second review

- Delay in antibiotics (2 cases of sepsis and one not stated) x 3 patients
- Delayed investigations – chest xay - 1 patient
- Patient under the care of wrong speciality - 1 patient
- Delayed insertion of nasogastric tube - 1 patient
- Poor nutrition - 1 patient
- Delayed discharge and then developed pneumonia - 1 patient
- Lack of senior review - 1 patient

Summary of cases assessed as Hogan 3 or above

Three cases were assessed as 'possibly preventable but not very likely, less than 50–50 but close call'. No cases were assessed above Hogan 3 but two cases didn't state the preventability score. The two cases are summarised below and will be subjected to a second level review.

Age	Length of stay	Primary diagnosis	Cause of death	Preventability Comments from the Reviewers
48	2	Cardiac arrest, unspecified	PEA Cardiac Arrest	Though possibly septic but no sepsis bundle or screening, Consultant review > 24 hours after admissions, On 18/7 planned for qds observations - but none then done until just before arrest on 19/7, planned for frusemide on 18/7 but

				never given.
77	6	Sepsis, unspecified	Not stated	Patient was admitted from Rehab having deteriorated to point that he hadn't passed urine for 24 hours and had stopped eating and drinking. Earlier intervention possibly by GP review may have instigated care and/or admission before patient became so unwell
89	9	Acute subendocardial myocardial infarction	Myocardial infarction	Nothing stated by reviewer. Reviewed again and noted 2 cardiac crash calls. Following first arrest medical staff stated ? cardiac event secondary to dehydration

There was one case where no Hogan scale was stated and will be subjected to a second review. The case is summarised below.

Age	Length of stay	Primary diagnosis	Cause of death	Preventability Comments from the Reviewers
80	3	Anaemia, unspecified	Renal failure	Needs 2nd review, post mortem for cause of death, 3 incident forms submitted; for radiology regarding delays chest xray, staff behaviour and no batteries in laryngoscope

Conclusions

The total number of case note reviews for mortality cases in July significantly increased with the introduction of the new review process from 48% to 74%. The key themes from the Hogan 2 cases have highlighted delays in administration of antibiotics; two of these cases had sepsis. It has been noted that there were no cases where the reviewers had documented concerns regarding NEWS observations and escalation which had been a notable theme in the previous reviews suggesting that NERVE centre is having a positive impact on appropriate observation and escalation.

There were only four cases referred for second level review and are currently being analysed.

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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, 26th November 2015	**Sponsoring Director:** Helen Barker, Associate Director of Community Services and Operations
Title and brief summary: INTEGRATED BOARD REPORT - The Board is asked to receive and approve the Integrated Board Report	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Executive Board - 19.11.15 Quality Committee - 24.11.15	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive and note the Integrated Board Report - October 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 receive and approve the Integrated Board Report - October 2015.

Appendix

Attachment:

IPR Report Oct 15.pdf

Board of Directors Integrated Performance Report

Calderdale and Huddersfield NHS
NHS Foundation Trust

compassionate care

Contents

Report For: October 2015

Board of Directors

Integrated Performance Report

Executive Summary Commentary

Another month of solid performance with increasing understanding of the risks and early corrective actions. The key areas to note for October are:

Responsiveness

- Emergency Care Standard was delivered again for the month
- Day 38 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
- RTT performance externally is now only reported at incomplete level

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
- #NOF, access to theatre within 36hours 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

The Performance Management and Accountability Framework has been agreed by WEB and will be presented to Board of Directors for approval

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	Ccr 38 Dy Ref to Trtry				Ccr 31 Dy Sub Sur Trt	Ccr 31 Dy 2nd or sub Trt drg	Ccr 31 Dy Diag to Trt	Cmmnty - RTT info comp	Cmmnty - rfrrl info comp	Cmmnt - actvty info comp	A and E 4 hr	Ccr 62 Dy Scrn 2 Trt	Ccr 2 Wk Wt Brst	Cdiff Tst Assgnd		
Contract	% Strk 90% stay on unit	MRSA Trst Assgnd	DTOC	RTT Community	Cncl Elctv Surg	Ccr 62 Dy Agg Trt & Scrn	VTE Rsk Ass	DQ NHS no comp IP	DofC non comp Informed 10 dy	RTT Waits > 52 wks	Cncl Elctv Surg 28 Dy Std	Cncl Urgnt Ops 2nd time	DQ NHS no comp A&E	A&E Amb H/O 30-60 mn	RTT Non-admitted	RTT Admitted	RTT Incomplete	% Harm Free Care
	SI's inv rep sub < tmscl						Mixed Sex Breach	Never Events	A&E Trlly Wts	18 wks >=40 wks			Med Sfty – Recncltn	Med Sfty – Dschge Acc	Diagn 6 Wks	18 wks >=26 wks	Home Births	
NHSE	FFT IP recmmnd	FFT A&E recmmnd	FFT IP Response	FFT A&E Response			Stg 1 RCAs HAT	IPMR - Breastfeeding					FFT Mat recmmnd	FFT Cmmty recmmnd	75+ dementia screen			
Quality	Crude Mort Rate	Mortality Reviews	Avg Diag / FCE	#NoF < 36 Hrs BPT	A&E Left not seen	A&E Time to Treat	A&E Intl Ass	Prntl Dths (0-7 days)	Nntl Dths (8-28 days)	Cdiff Unavoidable	Comp < 3 wking dys	SI's < 2 dys	Local SHMI - RR	HSMR	A&E Unplnnd Re-Attend	All Falls	SG Alerts by Trust	SG Alerts agnst Trust
	Falls - Serious Harm	Diabetic pats self-care	Lbr safety	Lbt alone	Complaints < time	Harm Incidents	Pat Incidents						Stillbirths Rate	Emer Rdmssns <= 30 Dys	Emer Rdmssns <= 30 Dys CCG	Emer Rdmssns <= 30 Dys GHCG	Cdiff Unavoidable	E.Coli
	PU CHFT acqrd Cat 2	PU CHFT acqrd Cat 4	Women Harm Free	Women - safety	Women cmbnd Harm Free								Hand Hygiene	MSSA - Post 48 Hrs	Comp received	Concerns	Number of SI's	PU CHFT acqrd
													PU CHFT acqrd Cat 3	PU CHFT acqrd Cat 3&4				
Other Internal	% Elective Var	% Day Case Var	T Util (TT) - HRI Main	T Util (TT) - HRI DSU	WHO	Pre 11am disc	Elec C-Section						% Non-elec Var	% Out Var	T Util (TT) - CRH	T Util (TT) - HRI SPU	1st DNA Rate	Research Recruit
	Green Cross	Outliers	Hosp Out Cncl	Spells	% Spells > 5 Moves	3rd / 4th Degree tear							Spells > 2 Moves	% Spells > 2 Moves	Spells > 5 Moves	Total C-Section Rate	Over 37 wks APGAR5<7	Full Trm to SCBU (NNU)
	#NoF < 36 Hrs Adm												Major PPH	Ccr 7 Dy Ref 1st Frst Sn				

Improving Green	Improving Amber	Improving Red
20	3	18

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

Deteriorating Green	Deteriorating Amber	Deteriorating Red
17	4	23

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

Monitor Risk Assessment Framework

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%						98.54%
	% Incomplete Pathways <18 Weeks	>=92%	95.02%	95.85%	95.44%	95.55%	95.44%	96.07%	95.80%						95.80%
	A and E 4 hour target	>=95%	95.01%	94.80%	95.44%	95.44%	95.36%	95.37%	95.11%						95.21%
	Total Number of Clostridium Difficile Cases - Trust assigned	21	2	0	1	1	3	3	4						14
	Total Number of Clostridium Difficile Cases - Lapses in Care	10.5	1	0	1	0	0	1	1						4
	62 Day Gp Referral to Treatment	>=86%	89.38%	92.31%	90.00%	88.95%	93.94%	88.24%	91.77%						89.94%
	62 Day Referral From Screening to Treatment	>=90%	85.71%	100.00%	100.00%	100.00%	100.00%	100.00%	95.65%						94.57%
	31 Day Subsequent Surgery Treatment	>=94%	95.45%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%						99.23%
	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%
	31 Days From Diagnosis to First Treatment	>=93%	100.00%	100.00%	99.24%	100.00%	100.00%	100.00%	100.00%						99.89%
	Two Week Wait From Referral to Date First Seen	>=93%	96.45%	98.43%	96.55%	95.64%	93.78%	97.82%	98.73%						96.75%
	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%						95.68%
	Community care - referral to treatment information completeness	>=50%	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%	97.95%	97.57%	98.13%	97.68%	97.33%						97.85%
	Community care - activity information completeness	>=50%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%						100.00%

Third Party Reports	QA Visit Antenatal and Newborn screening completed with very positive verbal feedback. 1 immediate concern relating to the Faxing of a very small cohort of referrals and actions to address ongoing. Formal report expected January 2016
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	£14.17m	£10.92m
	Income and Expenditure (excluding Restructuring)	(£11.48m)	(£12.94m)
	Cost Improvement Programme (CIP)	£6.93m	£8.67m

Calderdale and Huddersfield NHS
NHS Foundation Trust

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Responsive

Report For: October 2015

Year To Date

		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
Activity	% Elective Variance against Plan	Local	0.00%	-2.16%	1.08%	-21.58%	-2.60%	-	0.00%	-3.39%	-4.00%	-9.97%	4.98%	-		↑		
	% Day Case Variance against Plan	Local	0.00%	-7.66%	-6.12%	-11.37%	-9.76%	-	0.00%	-5.20%	-5.02%	-6.91%	0.69%	-		↓		
	% Non-elective Variance against Plan	Local	0.00%	4.54%	6.76%	3.92%	4.25%	-	0.00%	3.24%	-1.20%	4.31%	4.21%	-		↓		
	% Outpatient Variance against Plan	Local	0.00%	-5.60%	-5.60%	-5.85%	-5.12%	-	0.00%	-3.12%	-3.23%	-3.98%	-1.09%	-		↑		
RESPONSIVE - Theatre Utilisation	Theatre Utilisation (TT) - Main Theatre - CRH	Local	92.50%	88.07%	86.36%	-	101.55%	-	92.50%	87.45%	85.93%	-	98.46%	-		↑		
	Theatre Utilisation (TT) - Main Theatre -HRI	Local	92.50%	96.00%	96.00%	-	-	-	92.50%	93.81%	93.81%	-	-	-		↑		
	Theatre Utilisation (TT) - HRI DSU	Local	92.50%	81.42%	80.15%	-	97.08%	-	92.50%	77.52%	76.22%	-	88.39%	-		↑		
	Theatre Utilisation (TT) - HRI SPU	Local	92.50%	80.01%	80.01%	-	-	-	92.50%	82.72%	82.72%	-	-	-		↓		
Exception Report - Patient Flow	% Daily Discharges - Pre 11am	Local	28.00%	9.94%	14.98%	8.26%	7.67%	-	28.00%	10.36%	13.67%	8.46%	9.93%	-		↓		
	Delayed Transfers of Care	Local	5.00%	4.60%	-	-	-	-	5.00%	6.31%	-	-	-	-		↓		
	Green Cross Patients (Snapshot at month end)	Local	40	91	-	91	-	-	40	71	-	71	-	-		↓		
	Number of Outliers (Bed Days)	Local	319	508	53	455	0	-	2101	4243	415	3827	0	-		↓		
	No of Spells with > 2 Ward Movements	Local	M	138	24	83	31	-	-	962	155	606	201	-		↓		
	% of Spells with > 2 ward movements (2% Target)	Local	2.00%	2.54%	1.43%	4.60%	1.60%	-	2.00%	2.32%	1.41%	4.91%	1.11%	-		↑		
	No of Spells with > 5 Ward Movements	Local	M	3	0	3	0	-	-	25	1	24	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	5430	1684	1806	1940	-	-	41474	10994	12346	18134	-		↓		

Responsive Executive Summary - Helen Barker Associate Director of Operations

	Report For: October 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%	95.11%	-	95.11%	-	-	95.00%	95.21%	-	95.21%	-	-		↓		
	Time to Initial Assessment (95th Percentile)	National	01:15:00	00:19:00	-	00:19:00	-	-	00:15:00	00:19:00	-	00:19:00	-	-		↑		
	Time to Treatment (Median)	National	01:00:00	00:56:00	-	00:56:00	-	-	01:00:00	00:58:00	-	00:58:00	-	-		↓		
	Unplanned Re-Attendance	National	5.00%	4.95%	-	4.95%	-	-	5.00%	5.03%	-	5.03%	-	-		↓		
	Left without being seen	National	5.00%	2.79%	-	2.79%	-	-	5.00%	3.22%	-	3.22%	-	-		↓		
	A&E Ambulance Handovers 30-60 mins (Validated)	National	0	7	-	7	-	-	0	51	-	51	-	-		↑		
	A&E Trolley Waits	National	0	0	-	0	-	-	0	0	-	0	-	-		→		
Exception Report - Elective Access	First DNA Rate	Local	7.00%	6.20%	6.69%	6.35%	4.60%	-	7.00%	6.69%	6.77%	6.64%	6.51%	3.80%		↓		
	% Hospital Initiated Outpatient Cancellations	Local	17.6%	13.30%	13.10%	16.00%	9.50%	-	17.6%	14.10%	14.40%	15.20%	11.50%	-		↓		
	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%	98.48%	98.52%	98.58%	98.10%	-	95.00%	98.54%	98.55%	98.44%	98.75%	-		↑		
	% Admitted Closed Pathways Under 18 Weeks	National & Contract	90.00%	90.20%	89.22%	100.00%	95.33%	-	90.00%	91.90%	91.16%	100.00%	94.98%	-		↓		
	% Incomplete Pathways <18 Weeks	National	92.00%	95.80%	94.67%	98.95%	97.53%	-	92.00%	95.80%	94.67%	98.95%	97.53%	-		↑		
	18 weeks Pathways >=26 weeks open	Local	0	98	90	7	1	-	0	98	90	7	1	-		↓		
	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%	99.82%	99.70%	100.00%	99.82%	-	99.00%	99.60%	99.86%	100.00%	99.48%	-		↓		
	Community - 18 Week RTT Activity	National	95.00%	94.70%	-	-	-	94.70%	95.00%	94.70%	-	-	-	94.70%		↓		
	% Last Minute Cancellations to Elective Surgery	National & Contract	0.60%	0.43%	0.59%	0.06%	0.76%	-	0.60%	0.62%	0.90%	0.03%	0.96%	-		↓		
	28 Day Standard for all Last Minute Cancellations	National & Contract	0	0	0	0	0	-	0	0	0	0	0	-		→		
	No of Urgent Operations cancelled for a second time	National & Contract	0	0	0	0	0	-	0	0	0	0	0	-		→		

Responsive Executive Summary - Helen Barker Associate Director of Operations

Year To Date

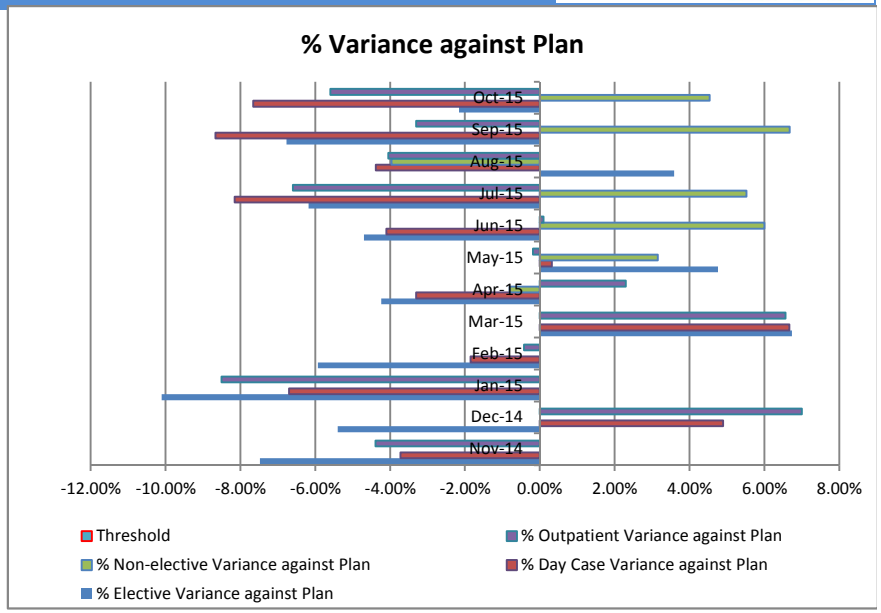
Report For: October 2015		Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Direction of travel (past 4 months)	Financial Penalities/ Non Financial Impact	Data Quality
Exception Report - Access Stroke	% Stroke patients spending 90% of their stay on a stroke unit	National	90.00%	97.80%	-	97.80%	-	-	90.00%	78.60%	-	78.60%	-	-		↑		
	% Stroke patients Thrombolysed within 1 hour	National & Contract	55.00%	50.00%	-	50.00%	-	-	55.00%	50.00%	-	50.00%	-	-				
	% Stroke patients scanned within 1 hour of hospital arrival (where indicated)	National & Contract	90.00%	-	Data Source from SNAP. 2 months in arrears				90.00%	-	-	-	-	-				
Exception Report - Elective Access 3	62 Day Gp Referral to Treatment	National & Contract	85.00%	91.77%	89.22%	95.92%	100.00%	-	85.00%	89.94%	90.04%	89.87%	94.79%	-		↑		
	62 Day Referral From Screening to Treatment	National & Contract	90.00%	95.65%	95.65%	-	-	-	90.00%	94.57%	94.44%	-	100.00%	-		↓		
	31 Day Subsequent Surgery Treatment	National & Contract	94.00%	100.00%	100.00%	100.00%	-	-	94.00%	99.23%	100.00%	97.14%	-	-		→		
	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%	92.35%	90.40%	95.92%	100.00%	-	86.00%	90.39%	90.58%	89.87%	95.41%	-		↑		
	31 Days From Diagnosis to First Treatment	National & Contract	96.00%	100.00%	100.00%	100.00%	100.00%	-	96.00%	99.89%	99.82%	100.00%	100.00%	-		→		
	Two Week Wait From Referral to Date First Seen	National & Contract	93.00%	98.73%	98.60%	99.27%	98.78%	-	93.00%	96.75%	98.02%	93.11%	97.20%	-		↑		
	Two Week Wait From Referral to Date First Seen: Breast Symptoms	National & Contract	93.00%	94.85%	94.85%	-	-	-	93.00%	95.68%	95.68%	-	-	-		↓		
	7 Day Referral to First Seen	National & Contract	50.00%	31.17%	27.17%	51.09%	29.27%	-	50.00%	35.94%	37.60%	31.39%	36.01%	-		↓		
	38 Day Referral to Tertiary	National & Contract	85.00%	77.78%	80.00%	100.00%	33.33%	-	85.00%	52.03%	52.27%	54.35%	41.67%	-		↑		
Exception Report - Maternity	Antenatal Assessments < 13 weeks		90.00%	92.40%	-	-	92.40%	-	90.00%	92.10%	-	-	92.10%	-		↑		
	Maternal smoking at delivery		11.90%	9.30%	-	-	9.30%	-	11.90%	10.60%	-	-	10.60%	-		↓		

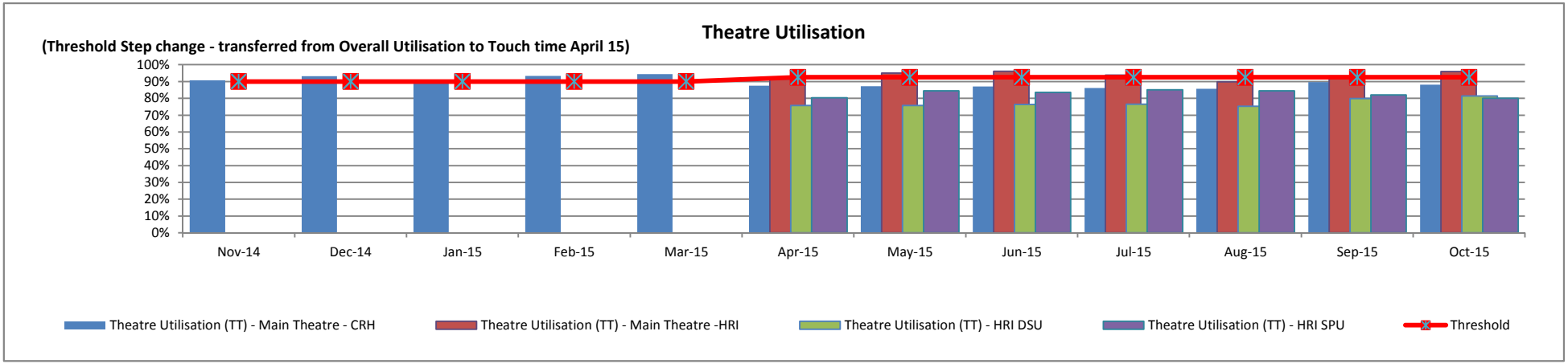
Calderdale and Huddersfield NHS
NHS Foundation Trust

Exception Report - Planned Activity - Associate Director of Operations

compassionate care

Report For: October 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Elective Variance against Plan	0.00%	-2.16%	1.08%	-21.58%	-2.60%	-
% Day Case Variance against Plan	0.00%	-7.66%	-6.12%	-11.37%	-9.76%	-
% Outpatient Variance against Plan	0.00%	-5.60%	-5.60%	-5.85%	-5.12%	-
Theatre Utilisation (TT) - Main Theatre - CRH	92.50%	88.07%	86.36%	-	101.55%	-
Theatre Utilisation (TT) - HRI DSU	92.50%	81.42%	80.15%	-	97.08%	-
Theatre Utilisation (TT) - HRI SPU	92.50%	80.01%	80.01%	-	-	-



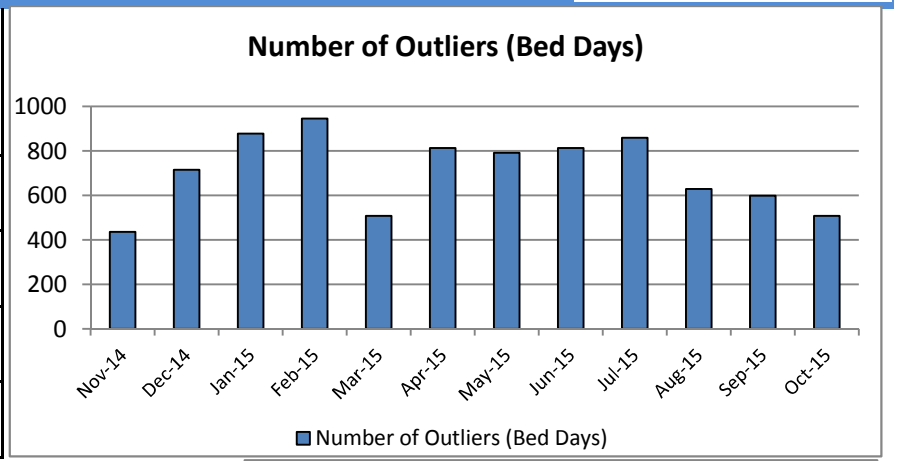


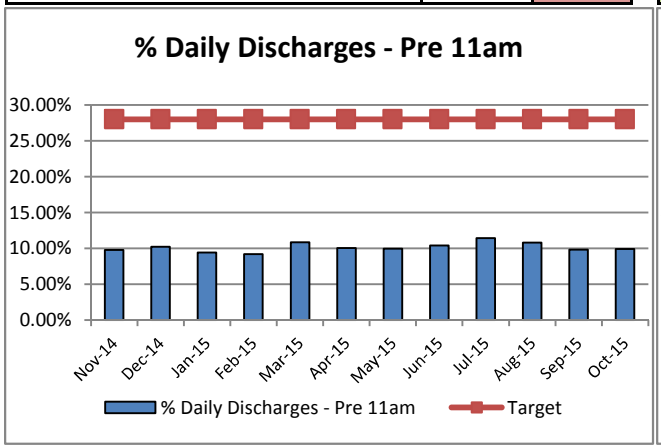
Details of position and delivery of recovery plans presented to Finance and Performance Committee

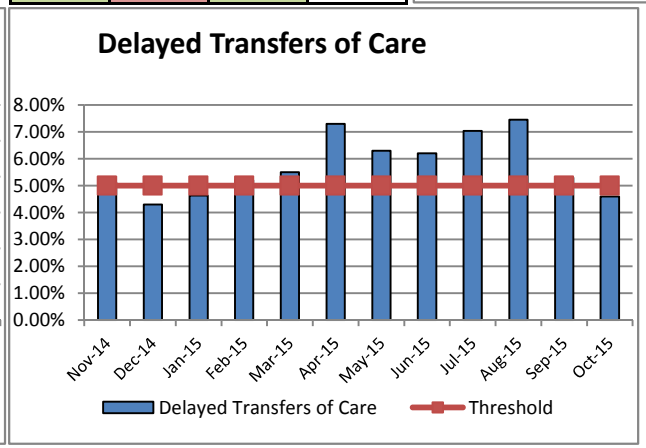
Theatre Utilisation:
Update on Previous actions

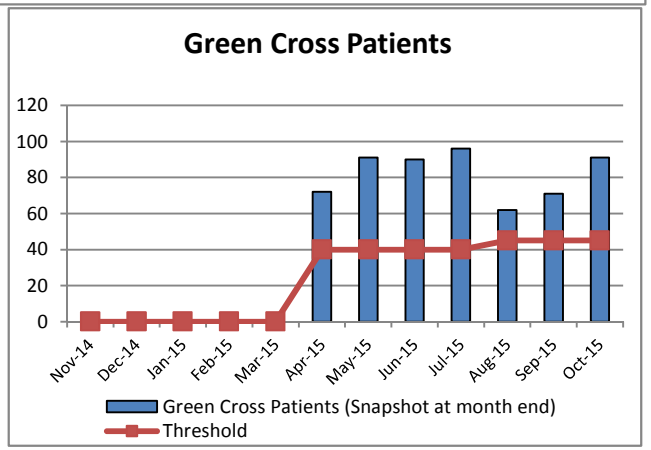
Showing an improvement at HRI & CRH main Theatres reflecting the work undertaken on focussed scheduling meetings where all planned lists are scrutinised to ensure they have optimal planned utilisation and identify any equipment or staffing issues.
Patients are contacted prior to admission to ensure they are planning to attend, this has had an impact on patient initatived cancellations and DNAs impacting positively on utilisation.
Further work required to understand issues and opportunities for HRI SPU & HRI DSU

Report For: October 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Daily Discharges - Pre 11am	28.00%	9.94%	14.98%	8.26%	7.67%	-
Green Cross Patients (Snapshot at month end)	45	91	-	91	-	-
Number of Outliers (Bed Days)	319	508	53	455	0	-
% of Spells with > 2 ward movements (2% Target)	2.00%	2.54%	1.43%	4.60%	1.60%	-









Update on previous actions:

Pre 11 am discharges & Green X - Three wards have now implemented the PFEP MDT morning board round and the wrap round board meeting in the afternoon and a Standard Operating Procedure is now in place that will be rolled out to other wards. The board rounds will improve communication and team working on each ward which will mean that, due to the rigour of the board rounds, everyone will know what the next step is for the patient and who is responsible for completing it. This will positively impact on both Green X and discharge before 12 O'clock (the IPR indicator will be updated in next report). There remains an issue with inpatient therapy input which is being addressed with senior leadership support and involvement is now confirmed.

Outliers: An audit of wards who have medical outliers has been undertaken to identify any clinical or experience risks which was very positively received by the staff on these wards. The key message from this review is that the medical cover has improved over the last year and staff are much more confident in caring for the patients. It is pleasing to report that medical review is taking place on a morning on these wards, there is an electronic report generated so there is clarity on where patients are and the Patient Flow team reported no problems with this process.

There was a couple of surgical wards where concerns regarding the complexity of some patients was raised, in response the checklist to identify patients as suitable to outlie has been amended and re-launched. In addition there remains a language in use that suggests some outlier patients are not seen as part of the ward; ADNs have the details and will be working with all wards on this issue to ensure the optimal patient experience. Of the patients interviewed as part of this audit they were all happy with their care.
This will be re-audited in three months to evidence the improvement

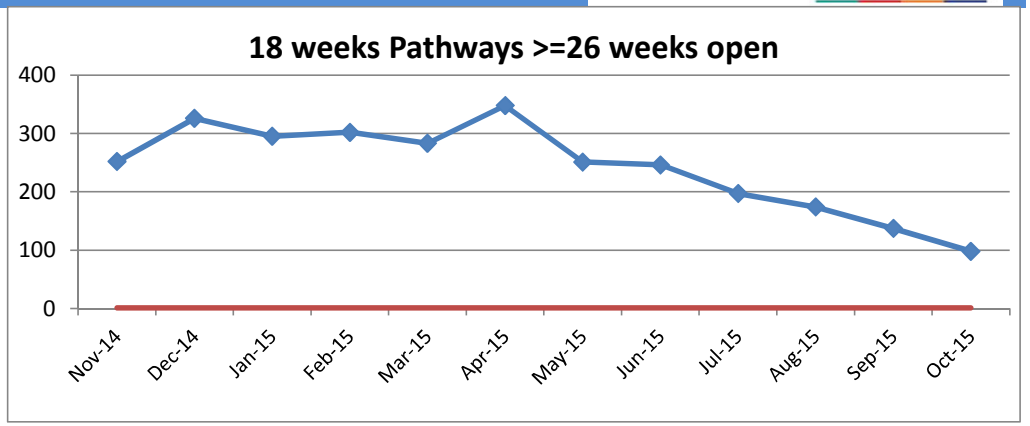
Calderdale and Huddersfield NHS
NHS Foundation Trust

Exception Report - Elective Access - Associate Director of Operations

compassionate care

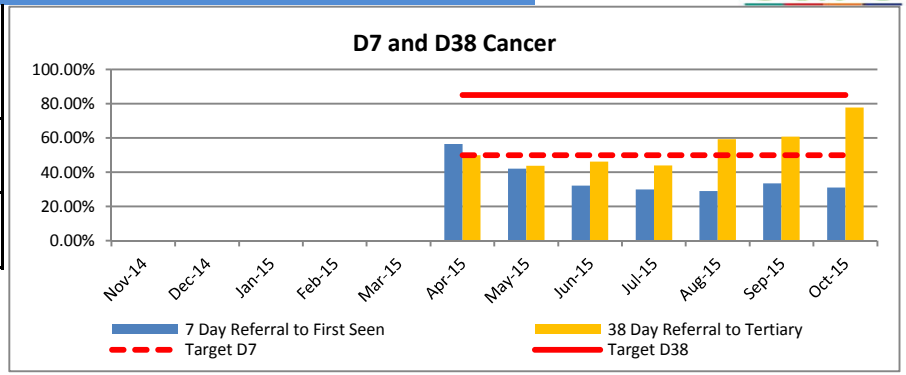
Report For: October 2015

	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
18 weeks Pathways >=26 weeks open	0	98	90	7	1	-
18 weeks Pathways >=40 weeks open	0	1	1	0	0	-
Community - 18 Week RTT Activity	95.00%	94.70%	-	-	-	94.70%



Community
Why off plan:
Podiatry – due to staff not stopping clocks
LTCM – Pod, OT and Physio – unsure as Allocator reviews RTT clocks on weekly basis.
Actions to get back to plan:
Podiatry – Repeat training with Pod staff on how to stop clocks. Arrange to check weekly active RTTs and stop as required
LTCM – Pod, OT, Physio – Allocator to check Long term Management Unit to see if some patients still on this unit and not been transferred to Intermediate Care Unit
When will we be back on track?
Podiatry – Aim to be back on track by End Dec – Admin support identified to stop old clocks
LTCM – Once located patients on the system will be RTT to be stopped with 3 days.
Accountable: Locality manager - Podiatry
NOTE: The Community - 18 Week RTT Activity currently includes the Services transferred to Locala on the 1st October 2015, as SystmOne is still being used by staff transferred to Locala and this cannot be separately accurately.

Report For: October 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
7 Day Referral to First Seen	50.00%	31.17%	27.17%	51.09%	29.27%	-
38 Day Referral to Tertiary	85.00%	77.78%	80.00%	100.00%	33.33%	-



Cancer D7

Most tumour sites struggling with D7 compliance, requirement (based on impact) to be incorporated into Capacity and Demand analysis and targets by tumour site will then be agreed.

D38 is showing further improvement with greater impact on pathways into Leeds Teaching Hospitals; Urology referrals have a pathway into Bradford which is less timely. The Division have identified this as a risk with a number of issues in terms of capacity in the pathway. For prostate cancer they need to find a solution to the MRI/TRUSS (Trans Rectal Ultrasound biopsy) pathway as requires an element of 'carve out' of capacity, GMs are meeting to agree a solution. For bladder tumours, the team are pursuing a straight to test pathway but this requires changes within Endoscopy that are not yet concluded.

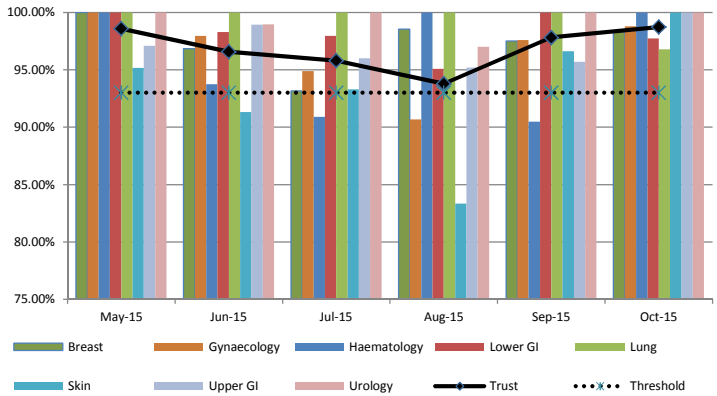
A review of the referrals before and after D38 and their ultimate treatment day has been undertaken which shows:

Of the 22 patients referred to Bradford 50% of those referred by D38 received definitive treatment by D62 and 53% of those referred after D38 also received definitive treatment by D62

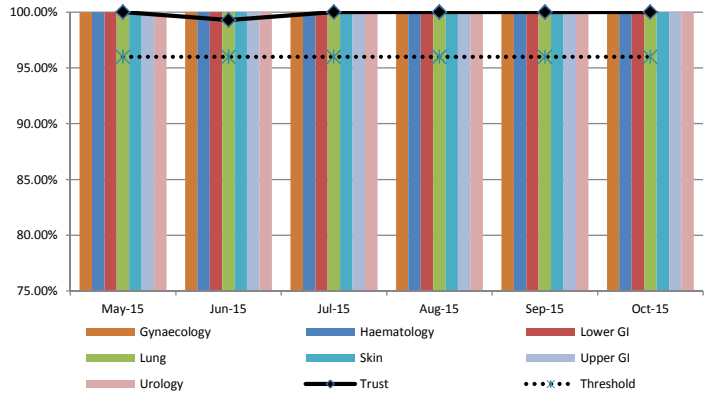
42 patients were referred to Leeds in the same period with 80% of those referred by D38 receiving definitive treatment by D62 and 60% of those referred after D38 receiving definitive treatment within the target 62days.

For both Trusts access to surgery was the main contributing factor.

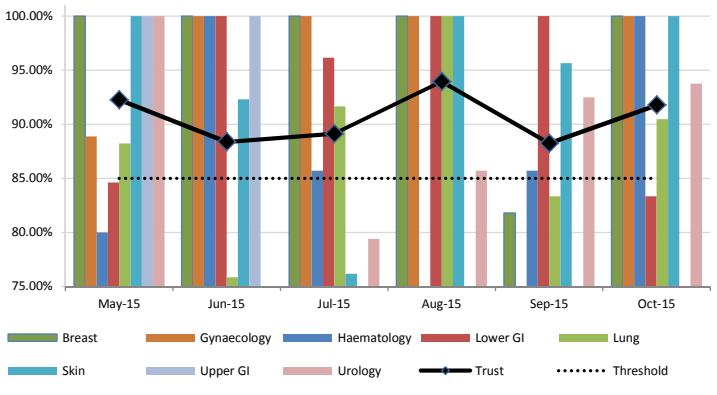
14 Day Referral to Date First Seen



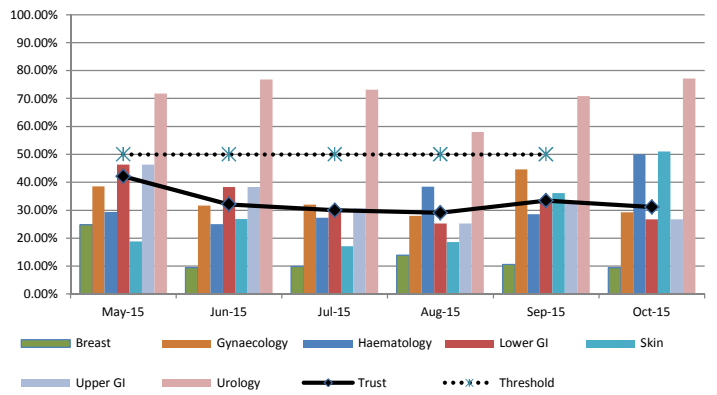
31 Day Diagnosis to First Treatment



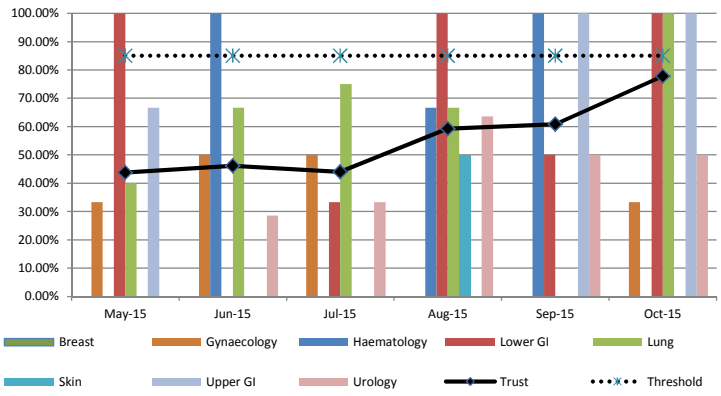
62 Day Referral to Treatment



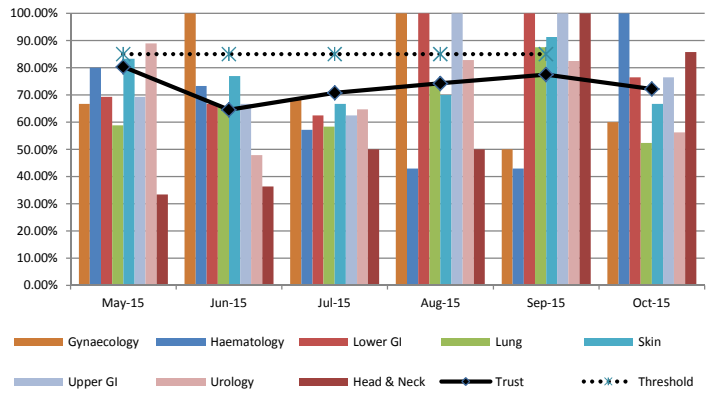
7 Day Referral to First Seen



38 Day Gp Referral to Referral to Tertiary



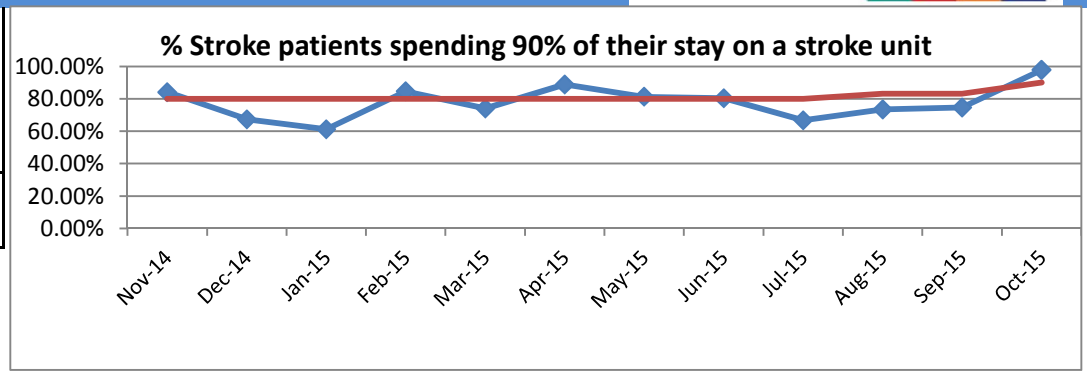
54 Day Referral to Treatment



Exception Report - Stroke - Associate Director of Operations

Report For: October 2015

	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Stroke patients Thrombolysed within 1 hour	55.00%	50.00%	-	50.00%	-	-



% Stroke patients Thrombolysed within 1 hour – Before September the Thrombolysis indicator was based on patients who were discharged with a confirmed stroke each month, therefore any data in relation to thrombolysis within 1 hour was based on the same cohort of patients. From September onwards all thrombolysis indicators are now based on SSNAP data, which calculates thrombolysis performance based on stroke patients who were admitted each month rather than basing it on discharge date.

Therefore, any current data we have for the 1 hour thrombolysis target April – August does not directly correlate to the September data and combining the two would mean some patients are recorded twice in the figures, making the YTD performance inaccurate.

Due to the small numbers of patients thrombolysed YTD it would be possible to retrospectively collate the data from April-Aug for the 1 hour target based on admissions rather than discharges, however, it is manual data collection and cannot be easily pulled off in a report. Unfortunately I was unaware that this would be required for the IBR report but Hannah will be able to provide it next month.

% Stroke patients scanned within 1 hour of hospital arrival (where indicated) – Before October this 1 hour imaging indicator was based on patients who were discharged with a confirmed stroke each month. From 1st October onwards this indicator started to be collected on SSNAP, however, it calculates performance based on stroke patients who were admitted each month rather than basing it on discharge date.

Like the thrombolysis target above, any current data we have for the 1 hour imaging target April – Sept will not directly correlate to the data October onwards, producing inaccurate YTD performance. Unfortunately this indicator is based on 50-60 patients per month and would be a massive undertaking to retrospectively collect the data before October based on admissions.

As previously confirmed performance for this indicator will not be available for the IBR report until next month, based on the fact that data was only collected in SSNAP from 1st October and needs to fall in line with the other stroke indicators being reported a month behind.

Calderdale and Huddersfield NHS
NHS Foundation Trust

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Caring

Caring Executive Summary - Julie Dawes Director of Nursing

Year To Date

	Report For: October 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
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%	61.11%	57.14%	62.50%	88.89%	66.67%	100.00%	52.58%	47.26%	48.95%	72.84%	35.71%		→		
	Total Complaints received in the month	Monitor	M	52	17	19	14	2	-	363	122	119	85	17		↑		
	Complaints acknowledged within 3 working days	Local	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	89.61%	87.14%	92.70%	95.96%	87.10%		↑		
	Total Concerns in the month	Monitor	M	62	20	35	6	0	-	397	124	151	76	17		↓		
Friends & Family Test	Friends & Family Test (IP Survey) - Response Rate	Contract	40.00%	31.10%	34.10%	26.30%	33.20%	-	40.00%	25.60%	28.10%	24.70%	26.10%	-		↓		
	Friends & Family Test (IP Survey) - % would recommend the Service	Contract	95.00%	96.70%	97.30%	95.40%	97.00%	-	95.00%	96.90%	97.30%	95.70%	97.90%	-		↑		
	Friends and Family Test A & E Survey - Response Rate	Contract	30.00%	12.10%	-	12.10%	-	-	30.00%	7.90%	-	7.90%	-	-		↑		
	Friends and Family Test A & E Survey - % would recommend the Service	Contract	95.00%	86.80%	-	86.80%	-	-	95.00%	88.80%	-	88.80%	-	-		↓		
	Friends & Family Test (Maternity) - % would recommend the Service	Contract	95.00%	95.00%	-	-	95.00%	-	95.00%	95.60%	-	-	95.60%	-		↓		
	Friends and Family Test Community Survey - % would recommend the Service	Local	95.00%	91.00%	-	-	-	91.00%	95.00%	90.82%	-	-	-	90.82%		↓		
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%	1.41%	-	-	1.41%	-		→		
	Proportion of women who were left alone at a time that worried them during labour	Local	4.50%	5.13%	-	-	5.13%	-	4.50%	3.76%	-	-	3.76%	-		↑		
	Proportion of Women who received Physical 'Harm Free' Care	Local	70.00%	82.05%	-	-	82.05%	-	70.00%	74.18%	-	-	74.18%	-		↑		
	Proportion of Women with a perception of safety	Local	90.40%	94.87%	-	-	94.87%	-	90.40%	95.31%	-	-	95.31%	-		↓		
	Proportion of Women who received Combined 'Harm Free' Care	Local	70.90%	76.92%	-	-	76.92%	-	70.90%	70.42%	-	-	70.42%	-		↑		

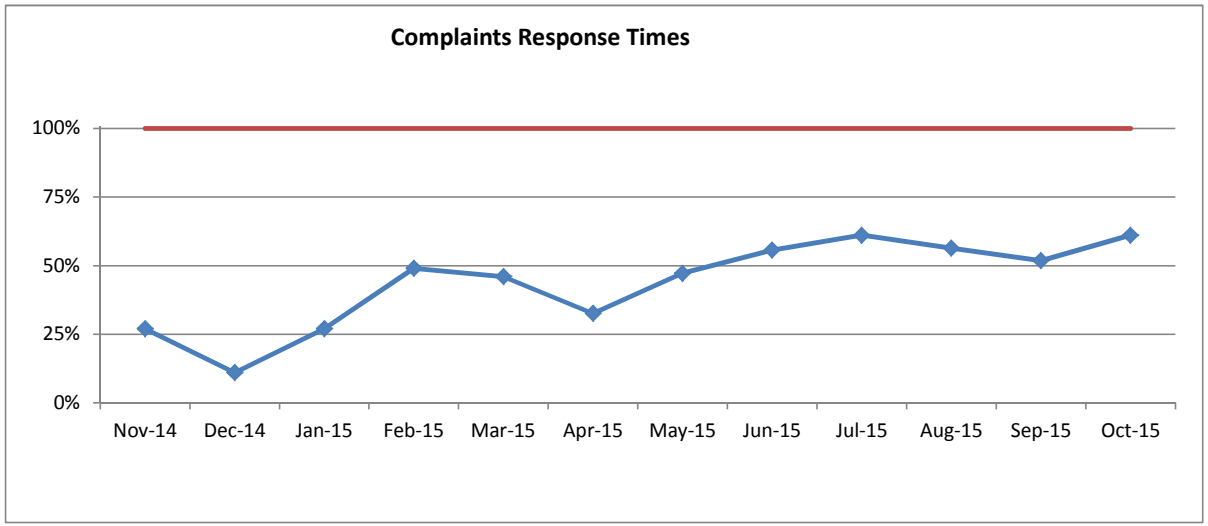
Report For: October 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Complaints closed within target timeframe	100.00%	61.11%	57.14%	62.50%	88.89%	66.67%

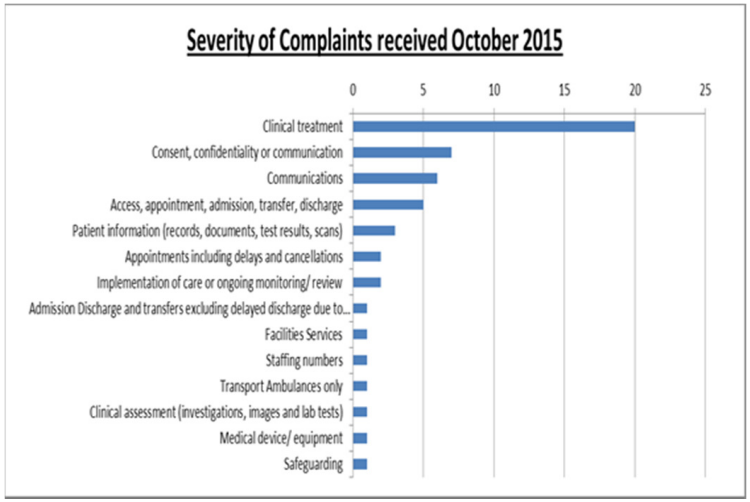
% Complaints closed within target timeframe

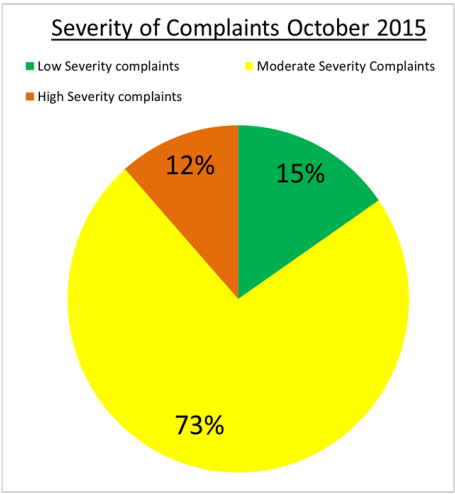
Why off Plan: We are seeing an improvement in the number of complaints closed in time frame, 61% this month, compared to 52% previously. As off the end of October there were 55 cases overdue (32 x 1 month, 12 x 2 months, 8 x 3 months, 3 x 4 months).
Actions to get back on plan: The focus remains on closing overdue cases and managing new cases within timescales. The weekly performance reports are proving to be of benefit to the divisions in highlighting all overdue complaints and keeping track of new complaints as they arise. There has also been the recruitment of support to the complaints department to support the closure of new investigations.
When will we be back on track: All ongoing cases over target are being completed by divisions as a matter of urgency, all new cases are being managed in target.
Accountable: Head of Governance and Risk

Complaints Overview:

As shown on the chart to the right, during October, the top 3 complaint subjects, were consistent with previous months. These were:
1) Clinical Treatment/Treatment Procedure , 2) Consent, confidentiality, communication – majority relate to communication issues with patients , 3) Access, Appointment, Admission, Transfer and discharge.
Severity: The majority of complaints were of moderate severity with no red complaints (i.e. none of extreme severity).
Ombudsman (PHSO)
There were no new cases referred to the Trust for investigation by the Ombudsman (PHSO) in

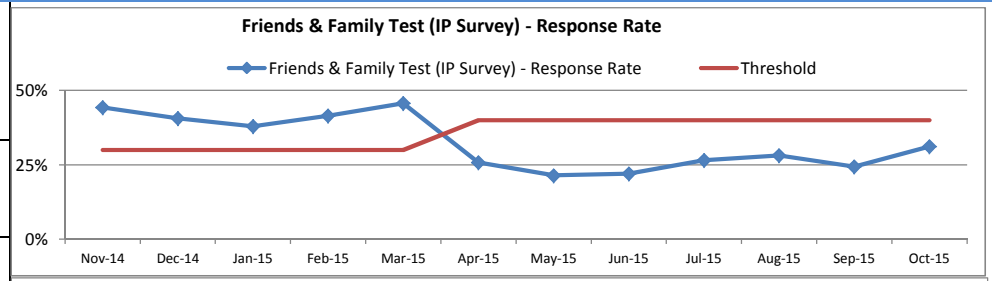


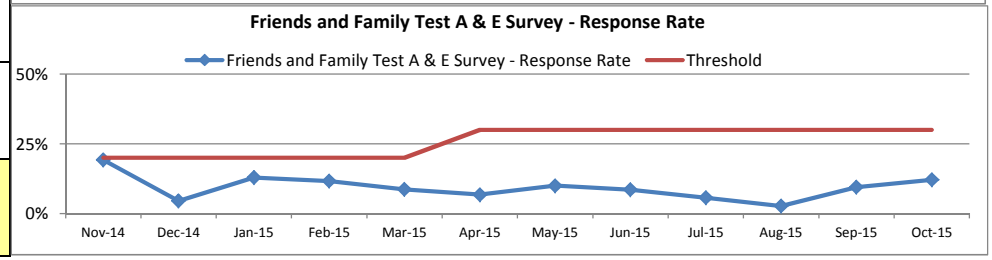




Exception Report - Friends & Family Test Director of Nursing

Report For: October 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Friends & Family Test (IP Survey) - Response Rate	40.00%	31.10%	34.10%	26.30%	33.20%	-
Friends and Family Test A & E Survey - Response Rate	30.00%	12.10%	-	12.10%	-	-
Friends and Family Test A & E Survey - % would recommend the Service	95.00%	86.80%	-	86.80%	-	-
Friends and Family Test Community Survey - % would recommend the Service	95.00%	91.00%	-	-	-	91.00%





Community FFT - Would Recommend:

1. Why off plan?
Analysis of negative comments from SMS texts shows 15 comments in total, 9 of which relate to out-patient Physio. These comments are about waiting times and service delivery. Of the 15 comments, 3 are not related to community teams and 1 is a positive comment. It is important to note that there is a low response rate for this indicator as such a limited number of comments available for analysis.

Actions to get back on plan: In the short term 2 locums have been recruited, one started in October and the second is due to start in December 15. There are longer term plans working closely with Calderdale CCG, specifically on a task and finish group for Physio which met for the first time early November 15. These meeting will be monthly with actions looking into referral criteria and clinical pathways.
In order to get more robust data, there will also be new data collection methods going live in December such as Interactive voice mail and web forms

3. Achieved by date:
Aim to reduce Physio waiting list by end of December 2015, therefore should start to impact by January 2016

A&E FFT – Response Rate:

1.Why off plan: A steady Improvement has been seen since the introduction of the text system in September 2015, from a low of 2.7% in Aug, to 9.5% last month and now 11.6%. A position of 15% would place the department above the England average (based on Jun – Aug).
2. Actions to get back on plan: Reception staff continue 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 will be 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 day. 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 is to focus on being above the England average of 14.9% by the end of December 2015.

A&E FFT - Would recommend:

1. Why off plan: There were 25 patients who said they wouldn't recommend the service who left comments. Two (8%) of which were positive comments, suggesting that the wrong response had been selected and 18 (72%) relating long waits and the impact that had on their care. Other comments related to the uncomfortable chairs, lack of information, parking and care / treatment
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

Inpatient FFT Response Rate:

1. Why off plan: The Trust is aware that the reduction response rate was associated with the spread to all 'day case' areas in April 2015. Work over the last few month has begun to have an impact and there is an improved position this month from 24% to 31%. This places the Trust in a position which is above the England average of 26.8% (based on June- Aug 15)

2. Actions to get back on plan: Attention is now being focused on the individual day cases areas with the lowest response rates, to ensure they are complying with the required processes and addressing any barriers they have encountered. Feedback of actions being taken by teams in order to make an improvement includes: increasing the availability post boxes and giving overall responsibility to members of staff, e.g. including on the nurse in charge jobs list on SAU, giving responsibility to the HCA and housekeeper on the A&E clinical decisions units.

3. Achieved by date: The plan is to achieve the target by the end of Quarter 4 . *(Please note, in light of the changes to the inclusion criteria from April onwards the targets are currently under review and are likely to be adjusted to be in line with national performance = 26.8%)*
Accountable: Deputy Director of Nursing

Exception Report - Caring Maternity - Director of Nursing

Report For: October 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Proportion of women who were left alone at a time that worried them during labour	4.50%	5.13%	-	-	5.13%	-

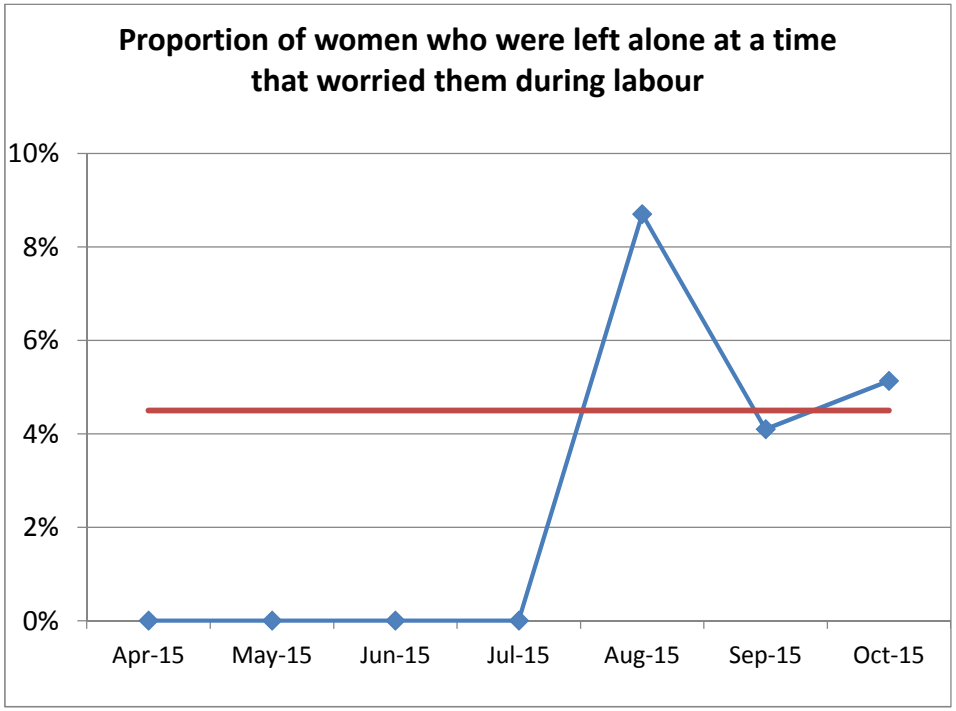
Proportion of Women who received Physical 'Harm Free' Care

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

Calderdale and Huddersfield NHS Foundation Trust

Safety Executive Summary - Julie Dawes Director of Nursing

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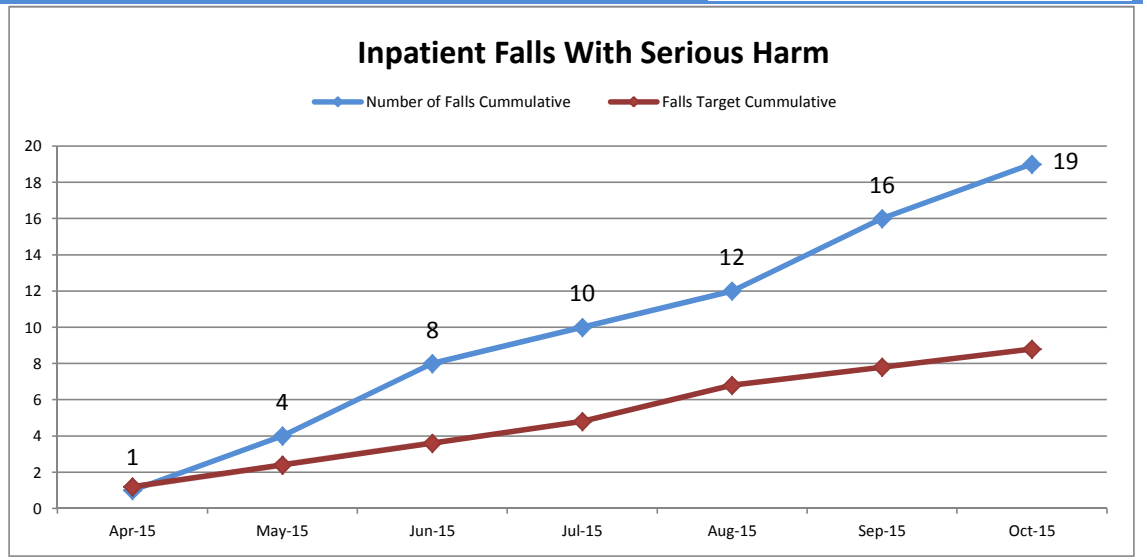
Report For: October 2015

		Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Months)	Direction of travel (past 4 months)	Financial Penalties/Non Financial Impact	Data Quality
									Year To Date									
Safety	Inpatient Falls with Serious Harm (10% reduction on 14/15)	Local	1	3	2	1	0	0	7	16	3	12	1	0		→		
	All Falls	Local	M	185	34	144	5	2	-	1193	198	938	28	29		↑		
	Number of Trust Pressure Ulcers Acquired at CHFT	Local	25	36	6	17	0	13	175	376	47	105	2	222		↓		
	Number of Category 2 Pressure Ulcers Acquired at CHFT	Local	17	23	4	11	0	8	119	278	33	76	2	167		↓		
	Number of Category 3 Pressure Ulcers Acquired at CHFT	Local	7	13	2	6	0	5	49	89	13	27	0	49		↑		
	Number of Category 4 Pressure Ulcers Acquired at CHFT	Local	1	0	0	0	0	0	7	9	1	2	0	6		↓		
	Number of Category 3 & 4 Pressure Ulcers Acquired at CHFT	Local	8	13	2	6	0	5	56	98	14	29	0	55		↑		
Safety 2	Percentage of Completed VTE Risk Assessments	National & Contract	95.00%	95.20%	95.90%	94.70%	92.80%	-	95.00%	95.40%	95.10%	95.10%	96.40%	-		↓		
	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%	93.30%	90.80%	90.24%	100.00%	96.51%	95.00%	93.69%	94.20%	91.15%	99.81%	94.55%		↓		
	Safeguarding Alerts made by the Trust	Local	M	16	-	-	-	-	-	113	-	-	-	-		↓		
	Safeguarding Alerts made against the Trust	Local	M	9	-	-	-	-	-	53	-	-	-	-		↓		
	World Health Organisation Check List	National	100.00%	98.27%	-	-	-	-	100.00%	98.07%	-	-	-	-		↓		
	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	733	175	362	170	25	-	4914	953	2306	1255	389		↑		
	Number of SI's	Monitor	M	13	1	6	2	4	-	58	8	27	4	17		↑		
	Number of Incidents with Harm	Monitor	M	159	28	92	33	6	-	1330	178	620	291	240		↑		
	Never Events	National	0	0	0	0	0	0	0	0	0	0	0	0		→		
	Percentage of SI's reported externally within timescale (2 days)	Local	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	-	-	-	-	-	-		→		
	Percentage of SI's investigations where reports submitted within timescale (45 days unless extension agreed)	Local	100.00%	0.00%	0.00%	0.00%	0.00%	0.00%	-	-	-	-	-	-		↓		
	Percentage of Non-Compliant Duty of Candour informed within 10 days of Incident	National & Contract	100.00%	89.00%	100.00%	84.00%	66.00%	80.00%	-	-	-	-	-	-		↓		
	Total Duty of Candour shared within 10 days	National & Contract	New Indicator - Data to be available for BOD						-	-	-	-	-	-		→		
Safety - Maternity	Elective C-Section Rate		10.00%	9.60%	-	-	9.60%	-	10.00%	8.70%	-	-	8.70%	-		→		
	Total C-Section Rate		22.50%	28.30%	-	-	28.30%	-	22.50%	24.10%	-	-	24.10%	-		↑		
	No. of Babies over 37 weeks with APGAR5<7		8.00%	1.20%	-	-	1.20%	-	8.00%	0.70%	-	-	0.70%	-		↑		
	Full Term to SCBU (NNU)		4.00%	2.90%	-	-	2.90%	-	4.00%	2.70%	-	-	2.70%	-		↑		
	Major PPH - Greater than 1000mls		8.00%	11.60%	-	-	11.60%	-	8.00%	10.00%	-	-	10.00%	-		↑		
	3rd or 4th Degree tear from ANY delivery		3.00%	2.10%	-	-	2.10%	-	3.00%	2.50%	-	-	2.50%	-		↓		
	Planned Home Births	National	2.30%	0.40%	-	-	0.40%	-	2.30%	1.50%	-	-	1.50%	-		↓		

Exception Report Safety - Director of Nursing

Report For: October 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Inpatient Falls with Serious Harm (10% reduction on 14/15)	1	3	2	1	0	0
Number of Trust Pressure Ulcers Acquired at CHFT	25	36	6	17	0	13
Number of Category 2 Pressure Ulcers Acquired at CHFT	17	23	4	11	0	8
Number of Category 3 Pressure Ulcers Acquired at CHFT	7	13	2	6	0	5
Number of Category 3 & 4 Pressure Ulcers Acquired at CHFT	8	13	2	6	0	5



Falls with Serious Harm

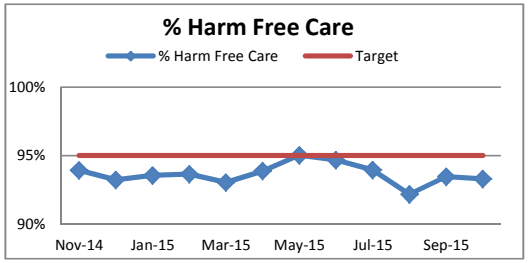
Why off Plan: The Trust has now had 19 falls with harm, which is above the annual threshold of 14. The recurring outcome of the RCA's is that falls prevention bundles have not been completed.

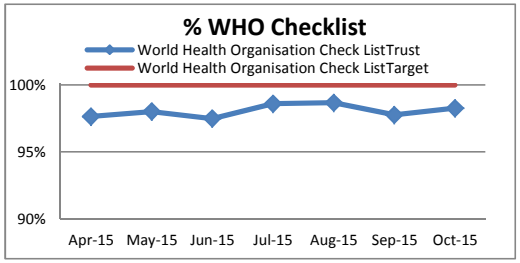
Actions to get back on plan: An internal harm summit took place on the 10th November. This included a focus on falls amongst other harm topics. The ward Sisters have committed to introducing safety huddles in their clinical areas. The safety huddles will ensure compliance is improved by delegating the completion of the bundle to a specific individual. A demonstration huddles was delivered and the tools used have been circulated to clinical areas. Other areas of focus are around footwear and ensuring availability of non-slip slipper socks. Stroke and elderly care wards are focussing on some falls mapping and the data will be reviewed to determine any themes. Wards on CRH site are already progressing with the implementation of drop down tables in the individual bays. This will ensure nursing colleagues can provide close observations to our patients whilst completing nursing care plans

When will we be back on track: As the 10% reduction target has already been passed future work focuses on reversing the current trends. This reversal will be expected as a result of outcomes of the safety summit. A realistic timescale of 3 months was given but Ward Sisters will continue to update on progress. As such the impact of this is not likely to be seen until Q4.
Accountable: Deputy Director of Nursing

Pressure Ulcers:
Why off Plan: The trust continues to see more ulcers each month than target - 36 in October against a monthly target of 25. An increased awareness of pressure ulcer incident reporting, unplanned capacity/ use of agency staff and increased demand on TV team (in relation to referrals) continue to impact on performance.
Actions to get back on plan: An internal harm summit took place on the 10th November which included a focus on pressure ulcers. The ward sisters from the wards which were off trajectory agreed a number of ward-specific actions to improve safety e.g. bedside handover, safety huddles. A demonstration huddles was delivered and the tools used have been circulated to clinical areas. The community directorate is due to hold a multi-professional forum on 13th November to launch initiatives to improve communication between community agencies & share learning from RCAs. The safety huddle approach within the community nursing team will commence in the New Year.
When we will be back on track: The impact of any actions is not likely to be seen until Q4.
Accountable: Deputy Director of Nursing

Report For: October 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Harm Free Care	95.00%	93.30%	90.80%	90.24%	100.00%	96.51%
World Health Organisation Check List	100.00%	98.27%	-	-	-	-





World Health Organisation Check List

1. Why off plan? In addition to the known system issues, further examination of the 2% not completed has identified pressures around the incomplete WHO checklists post Emergency C-Section and a small amount of cases whereby the sign-out process is not being adhered to.

2. Actions to get it back on plan: Discussions during a Safe Operating Theatre Network meeting, noted that other Trusts sought to resolve the C-Section concern by installing Whiteboards to capture urgent information, this can then be transferred onto the formal WHO checklist immediately after baby is delivered. Implementation of the Whiteboard process is to begin in November 15. In relation to the sign out process, a revised process using the Theatre Band 6 Leaders and the Theatre Co-Ordinator has been devised and will be commenced in November 15.

3. Achieved by date: Nov/Dec 15

4. Accountable: GM for Theatres

Harm Free Care:

1. Why off plan? Harm free care for the trust is at 93.30%. The harm events contributing to this are primarily old pressure ulcers, of which there were 34, this is a slight decrease from the 35 in September. These are ulcers which are present on admission or developed within the first 72 hours of admission. Alongside this there were also 15 new Pressure Ulcers, 7 harm falls, 14 UTIs in patients with a catheter and 4 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 p22) In relation to the UTIs, phase two of the indwelling improvement work continues and an associated drop in infection rates is anticipated when the work is more wide spread at the end of the year.

3. Achieved by date: See individual subject areas for Ulcers and Falls (page 22)

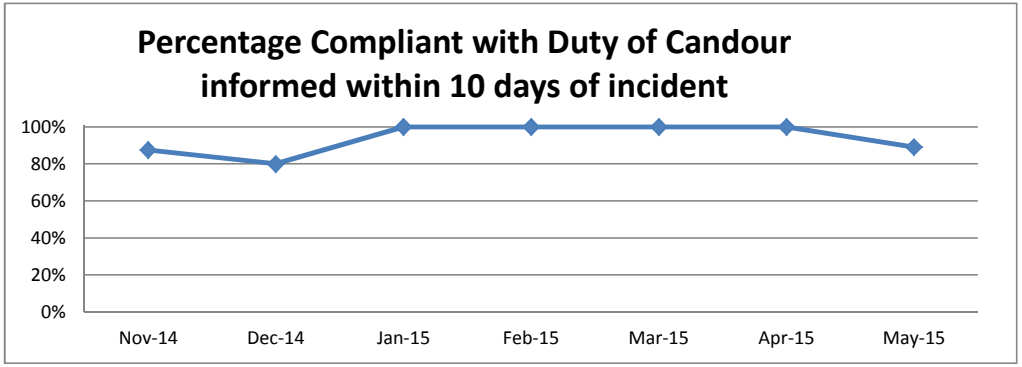
4. Accountable: Deputy Director of Nursing

Wards in special measures

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

Exception Report - Safety - Director of Nursing

Report For: October 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Percentage of SI's investigations where reports submitted within timescale (45 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%	89.00%	100.00%	84.00%	66.00%	80.00%



Percentage of SI's investigations where reports submitted within timescale (45 days unless extension agreed)

Why off Plan: There were 7 SI reports due for submission in October, due to unexpected staff sickness there was a failure to identify the required cases in time. and none were subitted in thre required time frame.
Actions to get back on plan: Revised system for collecting SI information in a more robust way being developed and monitoring of deadlines
When will we be back on track: December 2015 due to revised systems being developed in November
Accountable : Head of Risk and Governance

Percentage Compliant with Duty of Candour informed within 10 days of incident

Why off Plan: 29 Duty of Candour required in month, 26 DOC completed within 10 days, 3 DOC not completed within 10 days. This was an effect of unexpected staff sickness
Actions to get back on plan: Revised system for collecting information in a more robust way being developed.
When will we be back on track: December 2015 due to revised systems being developed in November

Calderdale and Huddersfield NHS
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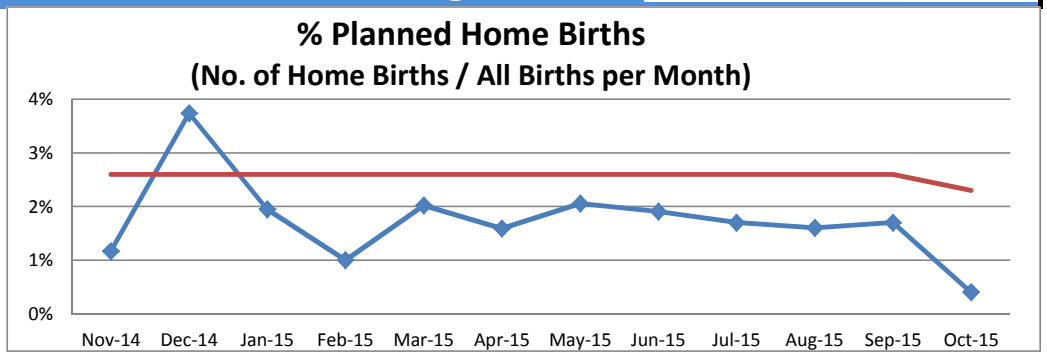
Exception Report - Safety - Director of Nursing

compassionate care

Report For: October 2015

	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Total C-Section Rate	22.50%	28.30%	-	-	28.30%	-
Major PPH - Greater than 1000mls	8.00%	11.60%	-	-	11.60%	-
Planned Home Births	2.30%	0.40%	-	-	0.40%	-



Planned Home Births:

Why off plan: Of the 482 births in October, 11 had originally planned to have a home birth. Due to changes in risk status during pregnancy and/or labour there were only 4 woman who were suitable for home delivery. 2 Went on to birth at home, 1 birthed before the arrival of the midwife and not recognised in our figures, and 1 woman agreed to come into the Birth centre as there was not a midwife available to attend her at home as the unit was at red escalation and was supporting critical activity.
Actions to get back on plan: The Home Birth Team continue to work to actively promote homebirth to women and amongst colleagues
When will we be back to target: By April 2016
Accountable: Midwifery Senior Clinical Manager - Community

Total C-Section Rate
Why off plan: There was a high rate of emergency caesarean sections during labour this month. Initial analysis of data does not suggest any individual performance issues and rates are within normal variation.
Actions to get back on plan: There is a divisional programme to unpick the reason for the variation seen month in month. The programme will look specifically at clinical decision making in relation to caesarean section. This programme will look to standardise clinical decision making and as such reduce the rate of emergency C-sections. The Maternity EPR is playing a part in enabling the teams to drill into the reasons behind the need for emergency C-Sections
When will we be back to target: End Q4 2015-2016

Major PPH
Why off plan: There is an association between increased C-section rate and rate of major PPH. 55 women out of the 482 births in October had blood loss of more than 1000mls. 33 of these women had a C-section.
Actions to get back on plan: The work described above to reduce the C-section will have an impact in the reduction of PPHs.
When will we be back to target: End Q4 2015-2016 as per C-Section work.

Calderdale and Huddersfield NHS
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Effectiveness

Calderdale and Huddersfield NHS
NHS Foundation Trust

Effectiveness Executive Summary

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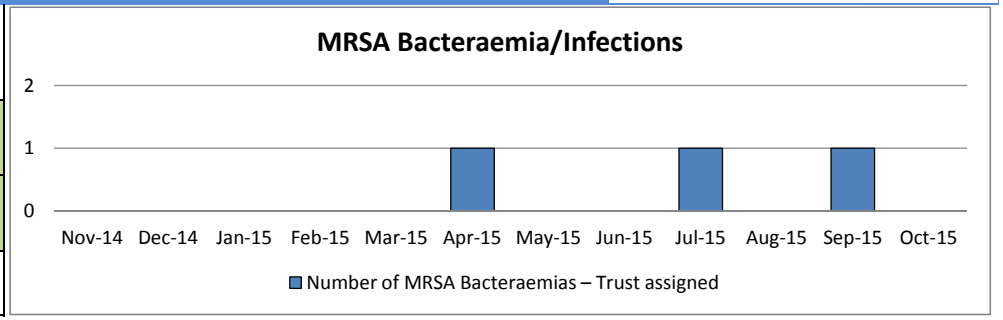
Year To Date

	Report For: October 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
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	4	1	3	0	0	15	14	3	11	0	-		↑		
	Avoidable number of Clostridium Difficile Cases	National & Contract	0	1	0	1	0	0	0	4	1	3	0	0		↑		
	Unavoidable Number of Clostridium Difficile Cases	National & Contract	3	3	0	3	0	0	16	10	0	10	0	0		↑		
	Number of MSSA Bacteraemias - Post 48 Hours	National	1	1	0	1	0	-	7	6	1	5	0	-		↑		
	% Hand Hygiene Compliance	Local	95.00%	99.35%	97.78%	99.91%	100.00%	100.00%	95.00%	99.66%	99.08%	99.82%	99.94%	100.00%		↓		
	MRSA Screening - Percentage of Inpatients Matched	Local	-	-	-	-	-	n/a	95.00%	95.06%	92.00%	99.00%	95.00%	-				
	Number of E.Coli - Post 48 Hours	Local	3	5	2	3	0	-	29	20	6	14	0	-		↑		
	Central Line Infection rate per 1000 Central Venous Catheter days	Local	1.00	0.69	-	-	-	-	1.00	0.67	-	-	-	-				
Effectiveness 2	Stillbirths Rate (including intrapartum & Other)	National	0.50%	0.80%	-	-	0.80%	-	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 August 14 - July 15)	National	100.00	116.00	-	-	-	-	100.00	113.00	-	-	-	-		↑		
	Mortality Reviews – September Deaths	local	100.00%	60.70%	42.90%	63.10%	n/a	n/a	100.00%	47.30%	52.30%	46.70%	n/a	n/a		↑		
	Crude Mortality Rate	National	1.09%	1.21%	0.35%	2.68%	0.19%	n/a	1.14%	1.27%	0.39%	3.02%	0.08%	-		↑		
	Completion of NHS numbers within acute commissioning datasets submitted via SUS	Contract	99.00%	99.90%	99.90%	99.90%	100.00%	n/a	99.00%	99.90%	99.90%	99.90%	99.90%	-		→		
	Completion of NHS numbers within A&E commissioning datasets submitted via SUS	Contract	95.00%	98.80%	-	98.80%	-	n/a	95.00%	99.10%	-	99.10%	-	-		↓		
	Average Diagnosis per Coded Episode	National	4.90	4.39	3.61	5.84	2.63	n/a	4.90	4.11	3.48	5.68	2.34	-		↑		
Effectiveness3	Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge	National	85.00%	73.81%	73.81%	-	-	-	85.00%	66.56%	66.56%	-	-	-		↑		
	Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - based on admission	National	85.00%	89.47%	89.47%	-	-	-	85.00%	71.43%	71.43%	-	-	-				
	IPMR - Breastfeeding Initiated rates		70.00%	80.20%	-	-	80.20%	-	70.00%	79.50%	-	-	79.50%	-		↑		
	Emergency Readmissions Within 30 Days (With PbR Exclusions)		6.95%	7.71%	4.84%	11.02%	7.78%	-	7.45%	8.22%	4.66%	12.58%	6.47%	-		↓		
	Emergency Readmissions Within 30 Days (With PbR Exclusions) - Calderdale CCG		7.43%	8.73%	-	-	-	-	8.05%	8.57%	-	-	-	-		↑		
	Emergency Readmissions Within 30 Days (With PbR Exclusions) - Greater Huddersfield CCG		6.80%	7.35%	-	-	-	-	7.07%	8.48%	-	-	-	-		↓		
	CHFT Research Recruitment Target		92	85	-	-	-	-	644	400	-	-	-	-		↑		

Exception Report - Effectiveness

Report For: October 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Total Number of Clostridium Difficile Cases - Trust assigned	2	4	1	3	0	0
Avoidable number of Clostridium Difficile Cases	0	1	0	1	0	0
Number of E.Coli - Post 48 Hours	3	5	2	3	0	-



Total Number of Clostridium Difficile Cases - Trust assigned

Why off Plan: Region wide there has been a sharp rise in the number of cases. All continue to be subject to RCA. Only one case was deemed avoidable and related to a failure of prompt isolation and broad spectrum antibiotic use in the community
Actions to get back on plan: Read and sign documents have been implemented in response to this case in order to help communication. There has been a letter sent to GP regarding antibiotics.
When will we be back on track: It will be challenging to get back on track, as the projected year end is for 24 cases in total against a threshold of 21. Only 4 of 14 completed cases have been classed as avoidable.
Accountable: Lead Consultant for Infection Control

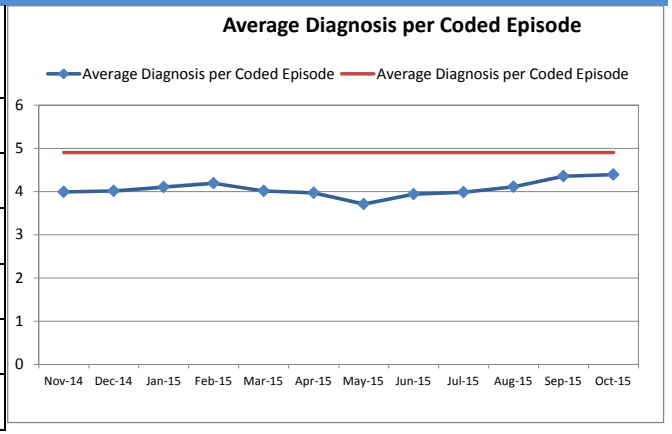
Total Number of E.Coli
Why off Plan: Unusually high number of Bacteraemias this month. No obvious cause from reviews undertaken as and all appear unrelated.
Actions to get back on plan: A Task and finish group will be set up in to examine how we can collect more meaningful data about these cases and identify any learning and actions. The work in the trust around intermittent catheterisation should impact on the device related infection rate.
When will we be back on track: E.coli infections appear to be sporadic infections subject to fluctuation.
Accountable: Lead Consultant for Infection Control

Calderdale and Huddersfield NHS NHS Foundation Trust

Exception Report - Effectiveness

compassionate care

Report For: October 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Stillbirths Rate (including intrapartum & Other)	0.50%	0.80%	-	-	0.80%	-
Local SHMI - Relative Risk (1yr Rolling Data April 14 - March 15)	100	108.9	-	-	-	-
Hospital Standardised Mortality Rate (1 yr Rolling Data August 14 - July 15)	100	116	-	-	-	-
Crude Mortality Rate	1.09%	1.21%	0.35%	2.68%	0.19%	n/a
Mortality Reviews – September Deaths	100.00%	60.70%	42.90%	63.10%	n/a	n/a
Average Diagnosis per Coded Episode	4.90	4.39	3.61	5.84	2.63	n/a



Average Diagnosis per Coded Episode

1. Why off plan? CHFT depth of coding is less than plan due to missed or undocumented relevant secondary diagnoses/complexities/comorbidities within the coding source documentation. This may also be due to incomplete coding documentation at the time of coding. Clinical Coding depth fell initially at the start of 2015-16 due to changes to coding rules. Since May coding depth has gradually improved although not to national average levels there remains variable improvement across specialties.

2. Action to get it back on plan: Clinical engagement continues around importance of complete and accurate documentation particularly within General Surgery, Ophthalmology and Pain Specialties. There is work planned to look at co-morbidity capture in Endoscopy. Work continues to develop existing documentation to assist coding process e.g. inclusion of co-morbidities into Medisoft (Ophthalmology) and Gastroscopy (Elective Outpatient Clinical Care Checklist). Co-morbidity form compliance continues to be monitored on a fortnightly basis. Recruitment process is ongoing and a clinical coding trainer started with the team in October and has commenced training the 4 coding trainees. 2 ACC qualified coders start with the team in November but the team are still 6wte below establishment. A pilot is to commence in December of 3 coders attending the ward round with 3 Upper GI clinicians in order to gain better mutual understanding. A number of PA sessions have been agreed to assist with clinical engagement and a workshop by the HSCIC to be delivered in December.

3.Achieved By: Expect to see continued improvement month on month, with a trajectory to hit target by March 2016

4.Accountable: Head of Clinical Coding

SHMI/HSMR/Crude Mortality

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 an increase from previous release and continues to be an outlying position. The October 2015 crude mortality is also higher than the same point in the previous year, although this reflects a national trend.

2.Action to get back on plan: The Care of the Acutely ill Patient (CAIP) plan continues with a focuses on six areas: mortality reviews and learning; reliability; deteriorating patients; end of life care; frailty; and coding. The latest figure of the number of mortality reviews carried out in October (September deaths) is 60.7%. This is an improvement against last month's performance but still some way off 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. Findings are fed back into the sub groups of the CAIP plan to ensure learning is disseminated. External support in further understanding our HSMR position has been useful and a presentation to the board will take place on the 18th November. Work around the reliability of care, in the form of a PMO work stream is planning to roll out a new integrated care bundle document early in the new year to increase reliability. The Nervecentre rollout is progressing well. The project work around Frailty will be carried out as part of a monthly task and finished group

3.Achieved By: Progressive improvement in mortality review completion is expected month on month. As HSMR and SHMI are delayed indictors 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

Still Birth Rates:

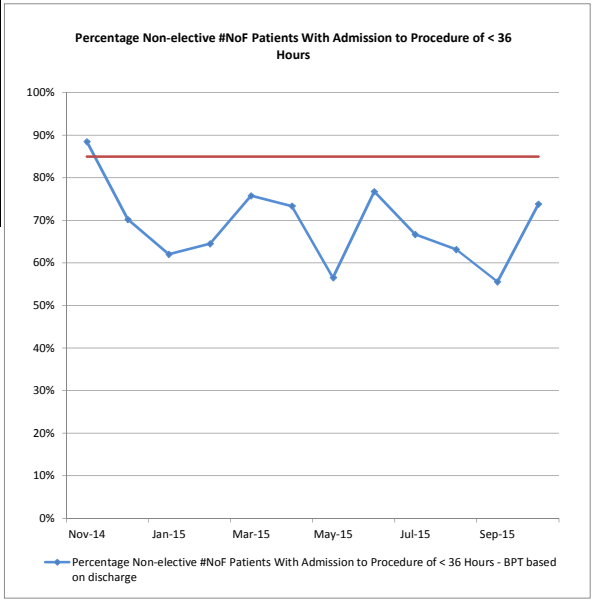
Why off plan: In the last 12 months the stillbirth rate has fallen significantly as a result of the work done as part of a North of England project. However during October there were 4 stillbirths (highest proportion of cases in month this year). 1 stillbirth was an intrapartum case and is undergoing investigation via the Serious Incident Reporting Framework. Of the remaining 3 stillbirths, all women had multiple risk factors for stillbirth (smokers, high BMI, history of IVF). Three of the four babies are having post-mortem examination.

Action to get back on plan: Continue with focused stillbirth reduction work (including participation in NHS England SABiNE project and roll out of NHSLA funded patient safety improvement work around intrapartum fetal surveillance.

Achieved by: Year-end threshold expected to be met as overall reduction in still birth cases this year vs last year (18 cases YTD 2015-2016 vs 28 cases YTD 2014-2015)

Accountability: Head of Midwifery Clinical Senior Manager

Report For: October 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%	73.81%	73.81%	-	-	-
Emergency Readmissions Within 30 Days (With PbR Exclusions)	6.95%	7.71%	4.84%	11.02%	7.78%	-
Emergency Readmissions Within 30 Days (With PbR Exclusions) - Calderdale CCG	7.43%	8.73%	-	-	-	-
Emergency Readmissions Within 30 Days (With PbR Exclusions) - Greater Huddersfield CCG	6.80%	7.35%	-	-	-	-
CHFT Research Recruitment Target	92	85	-	-	-	-



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

Why off plan? October performance reflects all patients who were discharged in October; some of the patients requiring treatment were September admission. During September the additional theatre capacity was not sufficient to meet the demands of all the trauma operating.
Actions to get back on plan: At the end of September the Directorate utilised elective capacity to clear the backlog of trauma operating. This was successful and performance for patients admitted in October was 90% to theatre in 36 hours and 85% of patients received all components of BPT.
When we be on track: Performance will be on track for all patients admitted in October onwards.

CHFT Research Recruitment Target
Why off plan: The Trust has entered a partnership agreement with the Y&H Clinical Research Network (CRN) to accept research funding in return for contribution to deliver research. The target of 1,100 for 2015-16 was set by the CRN. As funding is performance related, the current position of achieving less than 50% of its recruitment target at month 7 is of concern. This has resulted from a number of factors including having studies which are of a small recruiting nature –specialised studies which wouldn't expect a large number of applicable participants. There is a lack of large recruiting studies to balance this out. Alongside this the service pressures are resulting in clinical teams being unable to commit to opening new studies. Should the Trust not achieve target then research support funding for 2016-17 will decrease, adding further pressure for 2016-17.
Actions to get back on plan: A new research nurse structure has been implemented from the 1st of October in order to generate more capacity by enabling more flexible working across a range of studies. A review of non recruiting studies has also taken place and closure of studies where appropriate. A number of high recruiting studies are being set up, this will increase the number of participants however it is not yet known the full impact these will have.
When will we be back on plan? The actions above will enable us to bring together a recovery plan with divisional engagement to encourage greater participation to meet our target and put trajectories in place for modelling predicted performance at year end.
Accountable: Head of R&D

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						**298**
% achieving Best Practice Tariff	53.33%	45.65%	69.77%	66.67%	57.89%	55.56%	59.52%						**58.28%**
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%						**66.56%**
(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%						**98.00%**
(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%						**99.30%**
(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%						**92.10%**
(e) postoperative geriatrician-directed multi-professional rehabilitation team	82.22%	91.30%	93.02%	97.44%	92.11%	94.74%	95.20%						**92.40%**
(f i) fracture prevention assessments (Falls)	82.22%	80.43%	88.37%	92.31%	84.21%	92.11%	92.90%						**87.70%**
(f ii) fracture prevention assessments (Bone health)	100.00%	93.48%	100.00%	94.87%	94.74%	94.74%	97.60%						**96.00%**
(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%						**96.70%**
(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%						**93.00%**

COMMUNITY DIVISIONAL PERFORMANCE REPORT & DASHBOARD

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

OCTOBER 2015

Actions

- 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 - November

(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 13th 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 - December

(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 2016

	1 Enhancing quality of life for people with a Long Term condition (LTC)	Target	Current Month		YTD		YTD 14/15
a	Home equipment delivery < 7 days	95%	100.0%		99.4%		96.1%
b	% Patient died in preferred place of death	95%	100.0%		100.0%		94.1%
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%		94.6%
e	% of patients with a LTC with a Calderdale Care Plan	90%	100.0%		89.4%		60.0%
f	% of patients under the care of the community specialist matron who have been readmitted to hospital with the same LTC in less than 30 days	<10%	2.6%		3.7%		1.4%

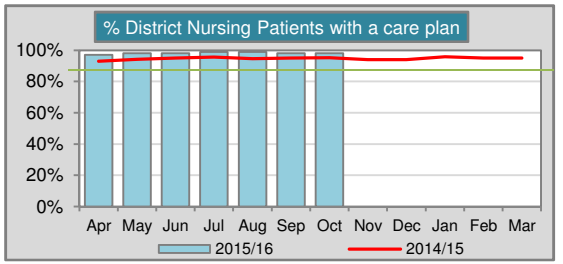
	2 Helping people to recover from episodes of ill health or following injury	Target	Current Month		YTD		YTD 14/15
a	% of leg ulcers healed within 12 weeks from diagnosis	75%	97.0%		93.4%		97.0%

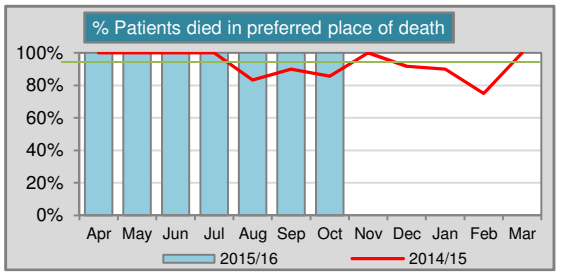
	3 Ensuring people have positive experience of care	Target	Current Month		YTD		YTD 14/15
a	Number of complaints	n/a	2		17		14
b	Number of complaints about staff attitude	n/a	0		0		0
c	Community AHP - 18 week RTT Snapshot at month end	95%	TBC		96.7%		89.9%
d	Community Friends and Family Test	n/a	91.0%		90.9%		N/A

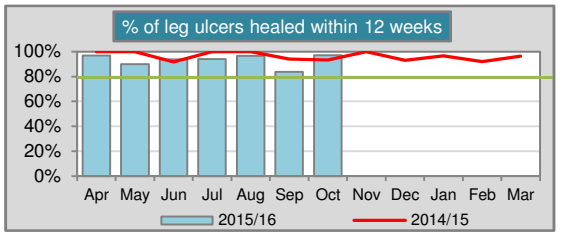
	4 Treating and caring for people in a safe environment; and protecting them from avoidable harm	Target	Current Month		YTD		YTD 14/15
a	% of patients in receipt of community nursing services that have had a pressure ulcer screening and this is documented in their care plan	90%	84.0%		84.7%		89.4%
b	Number of community acquired grade 3 or 4 pressure ulcers	<1.8	4		23		12
c	Number of falls that caused harm whilst patient was in receipt of Comm Services	<1.1	1		13		9
d	Patient safety thermometer - coverage - Harm free	>95%	96.5%		95.1%		94.2%
e	Patient safety thermometer - No of Harms Reported	<22.1	14		134		170
f	% of staff that have undertaken safeguarding / mental capacity act training	95%	TBC		64.1%		68.6%

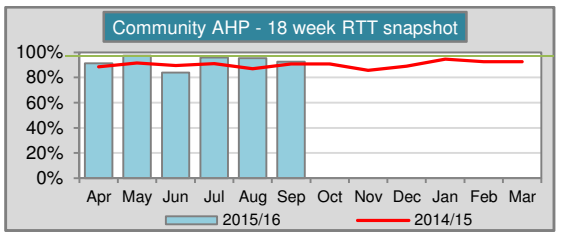
	5 Activity & Resource efficiency	Baseline	Current Month		YTD		YTD 14/15
a	Community DNA Rates	<1%	1.3%		1.2%		1.1%
b	Sickness Absence rate	<4%	TBC		3.6%		5%

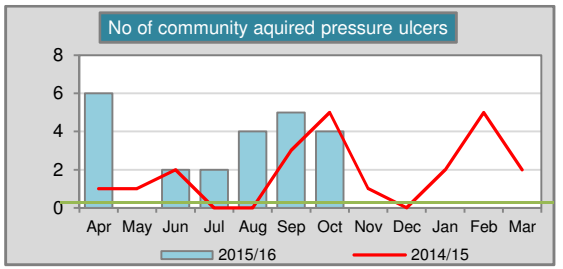
Target











Calderdale and Huddersfield NHS
NHS Foundation Trust

compassionate care

Workforce

Workforce indicators

The first table looks at the year to date performance of CHFT and the divisions against the 4% target. The second looks at performance by staff group against the 4% threshold.
The Second row of tables below show sickness absence rates for CHFT during August and September 2015, broken down by division, identifying movement from the previous month, performance against the 4% threshold, the average length of a sickness episode, identifying movement from the previous month.
The final tables looks at staff in post by headcount and full time equivalent (FTE).

FTE Days Lost is calculated by taking the FTE of the employee and multiplying by the length of sickness (in days). For example an employee on 0.5 FTE who is sick for 4 days would equate to an FTE Days Lost of 2.0
FTE Days Available is calculated by taking the FTE of the employee and multiplying by the number of days in the reporting period. For example during May an employee on 0.5 FTE would have 15.5 FTE Days Available.

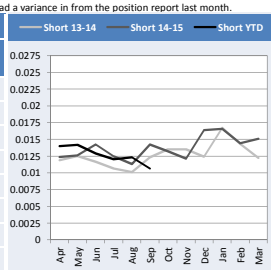
NB: Each month the month end sickness absence figures are adjusted to take account of all sickness absence returns. This could lead a variance in from the position report last month.

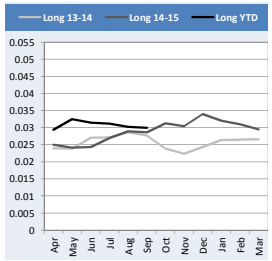
Sickness Absence full time equivalent (FTE) breakdown Year to Date

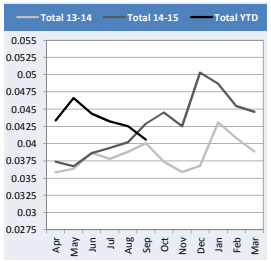
Division	Available FTE	FTE Days Lost	YTD Sickness %	RAG
Surgery	197719.86	8496.89	4.30%	
Medical	230085.26	12400.00	5.39%	
Community	111203.43	3586.65	3.23%	
FSS	237114.16	9995.04	4.22%	
Estates	49740.85	2345.60	4.72%	
Corporate	51666.83	1054.08	2.04%	
THIS	33466.10	1146.71	3.43%	
Trust	**910996.49**	**39024.96**	**4.28%**	

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

Staff Group	Available FTE	FTE Days Lost	YTD Sickness %	RAG
Add Sci & Tech	27861.99	669.33	2.40%	
ACS	192537.27	12550.12	6.52%	
Admin & Clerical	180565.46	6381.27	3.53%	
AHP	69935.19	1656.22	2.37%	
Estates & Ancil.	26093.67	1446.69	5.54%	
Healthcare Scientists	20947.41	442.13	2.11%	
Medical and Dental	92741.87	907.93	0.98%	
Nursing & Midwifery	300322.63	14971.28	4.99%	







In month Sickness Absence rate (%) (1 Month Behind)

Division	Short Term	Long Term	Overall %	RAG
Surgery	0.84%	2.99%	3.83%	
Medical	1.05%	4.11%	5.16%	
Community	1.25%	3.02%	4.27%	
FSS	1.35%	2.31%	3.66%	
Estates	1.10%	3.41%	4.50%	
Corporate	0.41%	1.39%	1.80%	
THIS	0.85%	1.41%	2.27%	
Trust	**1.06%**	**2.97%**	**4.04%**	

In month Sickness Absence rate (%) (1 Month Behind)

Division	Aug-15	Sep-15	Movement
Surgery	4.55%	3.83%	↓
Medical	5.67%	5.16%	↓
Community	3.61%	4.27%	↑
FSS	3.86%	3.66%	↓
Estates	3.16%	4.50%	↑
Corporate	2.42%	1.80%	↓
THIS	2.06%	2.27%	↑
Trust	**4.25%**	**4.04%**	↓

In month Sickness Average FTE Lost per Episode

Division	Aug-15	Sep-15	Movement
Surgery	10.37	10.52	↑
Medical	9.48	9.60	↑
Community	10.07	7.67	↓
FSS	9.58	7.82	↓
Estates	12.37	8.70	↓
Corporate	11.68	7.42	↓
THIS	10.85	6.42	↓
Trust	**9.94**	**8.79**	↓

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

Division	Available FTE	Short Term FTE	Long Term FTE	FTE Days Lost
Surgery	32400.93	273.02	968.85	1241.87
Medical	37958.15	396.94	1561.05	1957.99
Community	18323.19	229.58	553.19	782.77
FSS	38272.08	516.19	883.83	1400.02
Estates	7914.07	86.72	269.80	356.52
Corporate	8652.75	35.77	120.00	155.77
THIS	5663.68	48.40	80.00	128.40
Trust	**149184.85**	**1586.62**	**4436.72**	**6023.34**

In month Sickness Absence rate (%) (1 Month Behind)

Staff Group	Aug-15	Sep-15	Movement
Add Sci & Tech	2.35%	2.76%	↑
ACS	6.56%	5.45%	↓
Admin & Clerical	3.11%	3.23%	↑
AHP	2.39%	2.20%	↓
Estates & Ancil.	4.14%	6.04%	↑
Healthcare Scientists	2.06%	0.87%	↓
Medical and Dental	1.10%	0.73%	↓
Nursing & Midwifery	5.20%	4.22%	↓

Staff in Post (FTE)

Division	Sep-15	Oct-15	Movement
Surgery	1087.99	1093.14	↑
Medical	1273.00	1274.23	↑
Community	608.11	542.89	↓
FSS	1280.96	1301.94	↑
Estates	263.48	262.48	↓
Corporate	297.45	302.67	↑
THIS	189.96	190.76	↑
Trust	**5000.95**	**4968.12**	↓

Staff in Post (Headcount)

Division	Sep-15	Oct-15	Movement
Surgery	1215	1219	↑
Medical	1416	1416	→
Community	747	659	↓
FSS	1499	1522	↑
Estates	346	345	↓
Corporate	340	345	↑
THIS	197	198	↑
Trust	**5760**	**5704**	↓

Staff in Post (FTE)

Staff Group	Sep-15	Oct-15	Movement
Add Sci & Tech	157.97	159.85	↑
ACS	1041.93	1012.65	↓
Admin & Clerical	982.90	976.91	↓
AHP	384.26	344.97	↓
Estates & Ancil.	140.49	155.09	↑
Healthcare Scientists	111.88	111.08	↓
Medical and Dental	516.86	516.24	↓
Nursing & Midwifery	**1663.46**	**1689.32**	↑

Staff in Post (Headcount)

Staff Group	Sep-15	Oct-15	Movement
Add Sci & Tech	177	179	↑
ACS	1288	1255	↓
Admin & Clerical	1114	1107	↓
AHP	462	407	↓
Estates & Ancil.	158	174	↑
Healthcare Scientists	123	122	↓
Medical and Dental	538	536	↓
Nursing & Midwifery	**1898**	**1922**	↑

Sickness Absence/Attendance Management at work
Why are we away from plan -
The 2015-16 year to date sickness rate of 4.28% 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 1.06% long term absence at 2.99%. Surgery & Anaesthetics, Families & Specialist Services, THIS and Corporate have a % below the 4% threshold identified for September 2015. The September 2015 figure compares to a September 2014 figure of 1.42% short term absence and long term absence of 2.87%.

Action to get on plan?
There are a number of key interventions planned to address the current rate of sickness absence:-
dedicated absence management resource to support divisional activity/line managers (Establishment of a dedicated Attendance Management team is progressing. A team leader has been appointed and a recruitment plan is in place and being actioned for the remaining posts in the team.)
increasing awareness of health and lifestyle choices(a comprehensive colleague health and wellbeing strategy is in development and will be available at the end of November 2015)
Evidence based data driven – target action (BI)
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. The policy has been approved by staff side representatives of the Staff Management Partnership Forum and Local Negotiating Committee and has been ratified by Executive Board
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 organised for November 2015.

Training indicators

Mandatory Training Indicators compliance from April 2015												
Division	Prevent	Equality & Diversity	Information Governance	Infection Control	Health & Safety	Manual Handling	Safeguarding	Fire Safety	Overall Compliance 8 (Elements)	Dementia	Conflict Resolution	Overall Compliance 10 elements
Surgery	24.20%	50.78%	62.65%	44.54%	43.93%	55.98%	55.6%	48.79%	8.93%	7.40%	5.60%	0.76%
Medical	32.50%	51.28%	70.66%	46.68%	46.00%	59.65%	53.2%	54.90%	12.67%	7.90%	7.40%	1.15%
FSS	48.50%	64.86%	80.40%	58.55%	58.36%	62.73%	69.3%	69.16%	21.16%	11.70%	9.60%	1.22%
Community	75.30%	53.81%	73.77%	46.86%	45.52%	71.97%	76.5%	67.04%	26.91%	6.50%	7.00%	2.17%
Estates	25.60%	35.24%	58.13%	23.49%	23.80%	25.60%	20.2%	71.69%	12.65%	6.10%	4.40%	1.16%
Corporate	50.00%	64.65%	77.07%	51.27%	50.64%	53.50%	51.3%	62.10%	25.16%	8.90%	9.20%	3.47%
THIS	41.00%	72.31%	84.10%	65.64%	60.51%	65.64%	43.1%	68.21%	18.46%	3.00%	4.50%	0.00%
Trust	**39.9%**	**55.98%**	**72.18%**	**49.29%**	**48.62%**	**58.55%**	**57.9%**	**60.78%**	**16.52%**	**8.40%**	**7.40%**	**1.26%**

Medical Devices Training		
Division	Compliance	100% Target
Surgery	69.00%	
Medical	62.00%	
FSS	76.00%	
Community	78.00%	
Estates	98.00%	
Corporate	79.00%	
THIS	-	-
Trust	**77.00%**	

Number of Mandatory Training Elements Completed									
Division	0	1	2	3	4	5	6	7	8
Surgery	14.99%	13.08%	13.00%	8.67%	5.46%	5.20%	12.65%	18.02%	8.93%
Medical	11.39%	11.24%	13.20%	10.71%	5.43%	6.49%	12.75%	16.14%	12.67%
FSS	4.99%	6.37%	9.86%	10.11%	7.37%	6.12%	12.05%	21.97%	21.16%
Community	4.04%	5.38%	8.07%	11.66%	12.78%	11.21%	7.85%	12.11%	26.91%
Estates	10.54%	31.63%	25.00%	4.82%	3.61%	3.31%	3.61%	4.82%	12.65%
Corporate	7.64%	12.74%	13.38%	8.28%	5.73%	2.87%	11.78%	12.42%	25.16%
THIS	6.15%	5.13%	10.77%	11.28%	5.13%	9.23%	11.28%	22.56%	18.46%
Trust	9.20%	10.82%	12.38%	9.68%	6.52%	6.18%	11.43%	17.26%	16.52%

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.

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

Appraisal Activity

The first table shows the number of non medical and medical appraisal activity has been RAG rated against divisional activity plans. The second table shows the number of appraisals completed in the last 12 months against the 100% target.

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

Appraisal Completed Since April 2015			
Division	**Completed activity as at 31.10.2015**	**Planned activity as at 31.10.2015**	RAG
Surgery	7.80%	36.00%	🔴
Medical	35.80%	31.50%	🟢
FSS	44.50%	44.00%	🟢
Community	42.90%	44.90%	🟠
Estates	47.00%	57.00%	🔴
Corporate	28.20%	32.00%	🔴
THIS	42.80%	46.00%	🔴
Trust	**33.42%**	-	

Key	
Compliance	RAG
Equal or Above Plan	🟢
less than 2% off plan	🟠
More than 2% off plan	🔴

Appraisal Completed in last 12 Months		
Division	**Compliance**	100% Target
Surgery	52.40%	🔴
Medical	67.60%	🔴
FSS	83.70%	🔴
Community	71.90%	🔴
Estates	87.70%	🔴
Corporate	75.30%	🔴
THIS	79.50%	🔴
Trust	**71.80%**	🔴

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 Medical compliance is beyond planned activity as at 31 October 2015.
Compliance in Community is within the 2% tolerance level when measured against plan, Corporate and THIS is within 4% of planned activity.
Estates and Facilities is 10% behind plan and Surgery and Anaesthetics 28% 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 31 October 2015 as planned appraisal profilers will be refreshed to identify new appraisal dates.

Well Led indicators

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

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

FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly)			
Division	Quarter 1	Quarter 2	Movement
Surgery	79.00%	-	
Medical	76.00%	79.40%	↑
FSS	76.00%	78.40%	↑
Community	77.00%	-	
Estates	83.00%	-	
Corporate	82.00%	-	
THIS	72.00%	-	
Trust	77.00%	78.70%	↑

FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly)			
Division	Quarter 1	Quarter 2	Movement
Surgery	55.00%	-	
Medical	49.00%	55.30%	↑
FSS	51.50%	46.00%	↓
Community	49.10%	-	
Estates	45.00%	-	
Corporate	52.00%	-	
THIS	72.00%	-	
Trust	51.00%	49.10%	↓

The Q2 staff fft survey was conducted in FFS and medical only. Actions are being are being developed in response to the survey

Hard Truths Summary Day - Nurses/Midwives		
Division	Sep-15	95% Target
Surgery	94.84%	
Medical	82.69%	
FSS	92.02%	
Trust	87.82%	

Hard Truths Summary - Day Care Staff		
Division	Sep-15	95% Target
Surgery	107.49%	
Medical	98.10%	
FSS	89.64%	
Trust	99.69%	

Hard Truths Summary - Night Nurses/Midwives		
Division	Sep-15	95% Target
Surgery	97.43%	
Medical	90.41%	
FSS	84.46%	
Trust	90.67%	

Hard Truths Summary - Night Care Staff		
Division	Sep-15	95% Target
Surgery	116.09%	
Medical	119.14%	
FSS	83.19%	
Trust	113.43%	

Hard Truths Staffing Levels

Why we are away from plan

The average fill rate for qualified nurses (day and night) taken across both sites has decreased this month in comparison to September. The data includes the additional capacity areas which have been open this month (5B; 6A and 8C). As substantive staff have been transferred to additional capacity areas average fill rates across the organisation have been affected.

Average Fill Rate Qualified Nurses (Day and Night)	CRH	HRI
Aug-15	83.30%	88.85%
Sep-15	85.49%	92%
Oct-15	85.99%	90.22%

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)	5	2	1	1	9
Amber (75 – 89% fill rate)	17	7	12	2	38
Green (90-100% fill rate)	11	13	18	8	50
Blue (greater than 100%)	2	13	4	20	39

The number of areas rag rated red in October decreased from 17 in September to 9.

The number of areas rag rated green and blue this month remain largely static in comparison to September, with an increase in amber areas due to the decrease in red areas.

At present the nursing workforce continues to have a number of vacancies and level of sickness absence which exceeds the threshold built into the workforce model.

Two international recruitment trips were cancelled in September and October by the supplier which have impacted upon the nursing pipeline and subsequent fill rates.

Table 2: Analysis of reduced fill rate for Qualified Nurses

Area	Day	Night	Reason
MAU CRH	73.1%		Vacancies; supporting additional capacity
5AD	66.8%		Vacancies; Increased number of long shifts worked against planned resulting in decreased fill rates
6D	69.3%		Vacancies; Sickness; Increased number of long shifts worked against planned
21	66%		Vacancies; Sickness; Supporting additional capacity
4C	70.7%		Vacancies
NICU		70.5%	Vacancies; Sickness

Analysis of average fill rates for non registered nurses has been completed. As with the previous two months the main reasons for over fill are:

- Supporting reduced fill rate for qualified nurses
- Supporting 1-1 care

Ward 11 (previously ward 5) has a average fill rate of 235% due to a trial of increased HCA on nights which the Associate Director of Nursing is monitoring.

Table 3: Analysis of areas with unqualified average fill rates above 105%

Area	Day	Night	Reason
MAU HRI		121%	• Supporting reduced fill rate of 88.6% for qualified nurses • Additional 8 shifts provided for 1-1 care
2AB		112%	• Supporting reduced fill rate of 91.8% for qualified nurses • Additional 10 shifts provided for 1-1 care
5 (previously ward 4)	126.4%		• Supporting reduced fill rate of 85.9% for qualified nurses • Additional 4 shifts provided for 1-1 care
11 (previously ward 5)		235.5%	• Supporting reduced fill rate of 85.2% for qualified nurses • Trialling additional HCA on nights • Additional 6 shifts provided for 1-1 care
5AD	133.3%	128.0%	• Supporting reduced fill rate of 66.8% (days) and 90.3% (nights) for qualified nurses • Additional 28 shifts provided for 1-1 care
5B	184.4%	169.7%	• This area has a new workforce model which is under review. • Additional 62 shifts provided for 1-1 care
6	114%		• Supporting reduced fill rate of 88.7% for qualified nurses • Additional 14 shifts provided for 1-1 care
6A	138.3%	122.6%	• This area also has a new workforce model which is under review. • Average fill rates for qualified staff were reduced (89.4% day and 98.4% night).
6BC		115.7%	• Supporting reduced fill rate of 92.1% for qualified nurses • Additional 18 shifts provided for 1-1 care
7AD		122.6%	• Supporting reduced fill rate of 88.7% for qualified nurses
7BC		107%	• Supporting reduced fill rate of 93.5% for qualified nurses • Additional 1shift provided for 1-1 care
8		122.4%	• Supporting reduced fill rate of 79.5% for qualified nurses • Additional 31 shifts provided for 1-1 care
12		164.5%	• Supporting reduced fill rate of 78.5% for qualified nurses
17		112.9%	• Supporting reduced fill rate of 96.3% for qualified nurses
8AB		124.9%	• Supporting reduced fill rate of 88.3% for qualified nurses • Additional 4 shifts provided for 1-1 care
10	128.3%		• Supporting reduced fill rate of 86.1% for qualified nurses • Additional 2 shifts provided for 1-1 care
15	108.4%		• Supporting reduced fill rate of 92.3% for qualified nurses • Additional 15 shifts provided for 1-1 care
19		110.7%	• Supporting reduced fill rate of 91.0% for qualified nurses • Additional 4 shifts provided for 1-1 care

Action Plan

International recruitment of nurses has commenced this month with an alternative supplier. The first interviews were held on 9.11.15 and CHFT offered to 7 nurses.
Overseas recruitment (outside of the EEA) to support the nursing workforce is currently being explored.
UK based recruitment events continue including events at universities and a campaign through a recruitment campaign.
Web based site view for staffing has been developed and trialled this month. This allows a record of the current staffing position for the next 24 hours to be available and provides a clear record of safe staffing risks and mitigating action.
Reports from the site staffing tool are currently been developed.
Winter planning is been led by the Acting Deputy Director of Nursing. Recruitment to all HCA positions has been currently achieved. Further recruitment events for HCA positions are planned to avoid the use of agency for non registered requirements.
Listening events have been held in each division within the focus of retention to the nursing workforce.
An evaluation of E Roster is currently been undertaken by the E Rostering team following feedback from the nursing workforce regarding shifts and hours worked.
The recruitment and retention strategy for the nursing workforce has been updated and is currently been reviewed by the Nursing Workforce Strategy Group.
Roster scrutiny sessions are planned to be held weekly and led by a senior nurse. The process and tool are currently been developed. The aim of these sessions will be to ensure shifts are filled as safely and efficiently as possible for both the organisation and the nursing workforce.
Achieved by Date
The recruitment and retention strategy will be completed in November 2015.
The roster scrutiny sessions will commence by December 2015.
Winter planning for the nursing workforce will be completed and monitored through the Nursing Workforce Strategy Group.

Calderdale and Huddersfield NHS
NHS Foundation Trust

compassionate care

Financial Chapter

Calderdale and Huddersfield NHS
NHS Foundation Trust

Trust Financial Overview as at 31st Oct 2015 - Month 7

compassionate care

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

YEAR TO DATE POSITION: M07

CLINICAL ACTIVITY

	M07 Plan	M07 Actual	Var
Elective	5,292	4,919	(373)
Non Elective	28,415	29,352	937
Daycase	25,441	23,471	(1,970)
Outpatients	193,702	188,586	(5,116)
A & E	87,437	86,147	(1,290)

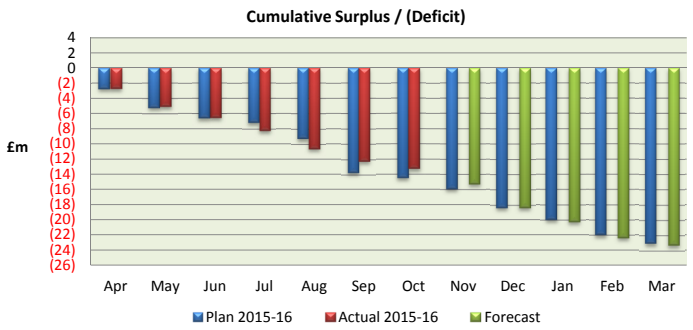
TRUST: INCOME AND EXPENDITURE

	M07 Plan	M07 Actual	Var
	£m	£m	£m
Elective	£13.53	£12.53	(£1.00)
Non Elective	£46.36	£48.16	£1.80
Daycase	£17.52	£15.18	(£2.35)
Outpatients	£23.32	£23.14	(£0.18)
A & E	£9.21	£9.35	£0.14
Other-NHS Clinical	£68.24	£68.28	£0.03
CQUIN	£3.93	£3.94	£0.01
Other Income	£21.93	£21.19	(£0.73)
Total Income	**£204.04**	**£201.75**	**(£2.28)**
Pay	(£130.29)	(£130.72)	(£0.43)
Drug Costs	(£18.48)	(£18.09)	£0.40
Clinical Support	(£18.24)	(£17.59)	£0.65
Other Costs	(£26.70)	(£26.77)	(£0.07)
PFI Costs	(£6.95)	(£6.89)	£0.06
Total Expenditure	**(£200.66)**	**(£200.06)**	**£0.60**
EBITDA	**£3.38**	**£1.70**	**(£1.68)**
Non Operating Expenditure	(£14.85)	(£14.63)	£0.22
Deficit excl. Restructuring	**(£11.48)**	**(£12.94)**	**(£1.46)**
Restructuring Costs	(£3.00)	(£0.32)	£2.68
Surplus / (Deficit)	**(£14.48)**	**(£13.25)**	**£1.22**

DIVISIONS: INCOME AND EXPENDITURE

	M07 Plan	M07 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	£12.50	£11.20	(£1.30)
Medical	£15.87	£13.78	(£2.09)
Families & Specialist Services	(£1.11)	(£1.27)	(£0.16)
Community	£3.43	£3.63	£0.20
Estates & Facilities	(£16.56)	(£15.19)	£1.37
Corporate	(£11.89)	(£12.72)	(£0.83)
THIS	£0.25	£0.16	(£0.09)
PMU	£1.67	£1.08	(£0.58)
Central Inc/Technical Accounts	(£17.20)	(£13.46)	£3.74
Reserves	(£1.44)	(£0.47)	£0.97
Surplus / (Deficit)	**(£14.48)**	**(£13.25)**	**£1.22**

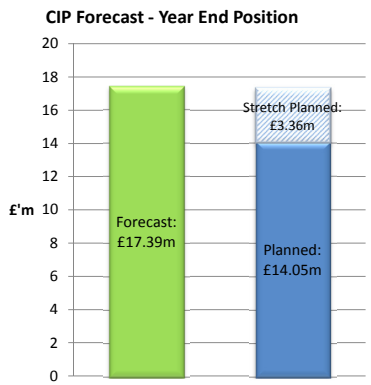
TRUST SURPLUS / (DEFICIT)



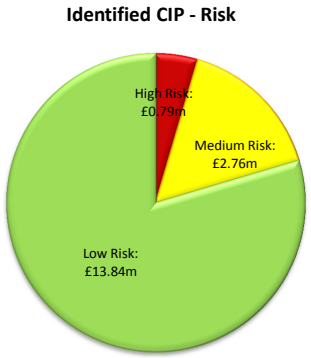
KEY METRICS

	Year To Date M07 Plan	Year To Date M07 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)	(£14.48)	(£13.25)	£1.22	(£23.01)	(£23.23)	(£0.22)
Capital (forecast Plan)	£14.17	£10.92	£3.25	£20.72	£20.93	(£0.21)
Cash	£1.96	£11.24	£9.28	£1.92	£1.85	(£0.07)
CIP	£6.93	£8.67	£1.74	£14.05	£17.39	£3.34
	Plan	Actual		Plan	Forecast	
Financial Sustainability Risk Rating	2	2		2	2	

COST IMPROVEMENT PROGRAMME (CIP)



Total Planned: £14.05m



Total Forecast £17.39m

YEAR END 2015/16

CLINICAL ACTIVITY

	Plan	Forecast	Var
Elective	9,185	8,392	(793)
Non Elective	49,263	51,024	1,761
Daycase	43,731	40,277	(3,454)
Outpatients	327,200	319,290	(7,910)
A & E	146,774	144,609	(2,166)

TRUST: INCOME AND EXPENDITURE

	Plan	Forecast	Var
	£m	£m	£m
Elective	£23.39	£21.53	(£1.86)
Non Elective	£79.89	£83.40	£3.51
Daycase	£30.25	£26.20	(£4.05)
Outpatients	£39.45	£39.78	£0.33
A & E	£15.49	£15.69	£0.20
Other-NHS Clinical	£117.49	£115.54	(£1.95)
CQUIN	£6.69	£6.76	£0.07
Other Income	£38.90	£38.45	(£0.45)
Total Income	**£351.55**	**£347.34**	**(£4.21)**
Pay	(£224.98)	(£226.71)	(£1.73)
Drug Costs	(£32.05)	(£30.66)	£1.38
Clinical Support	(£31.15)	(£29.66)	£1.49
Other Costs	(£45.94)	(£45.48)	£0.46
PFI Costs	(£11.92)	(£11.90)	£0.02
Total Expenditure	**(£346.04)**	**(£344.41)**	**£1.63**
EBITDA	**£5.51**	**£2.93**	**(£2.58)**
Non Operating Expenditure	(£25.52)	(£25.07)	£0.45
Deficit excl. Restructuring	**(£20.01)**	**(£22.13)**	**(£2.12)**
Restructuring Costs	(£3.00)	(£1.10)	£1.90
Surplus / (Deficit)	**(£23.01)**	**(£23.23)**	**(£0.22)**

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	(£28.64)	(£27.16)	£1.48
Corporate	(£20.22)	(£22.24)	(£2.01)
THIS	£0.53	£0.42	(£0.11)
PMU	£3.15	£2.95	(£0.20)
Central Inc/Technical Accounts	(£25.20)	(£22.34)	£2.87
Reserves	(£4.38)	£0.00	£4.38
Surplus / (Deficit)	**(£23.01)**	**(£23.23)**	**(£0.22)**

Trust Financial Overview as at 31st Oct 2015 - Month 7

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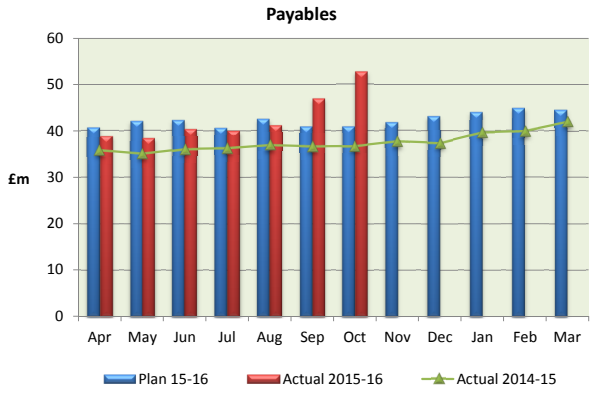
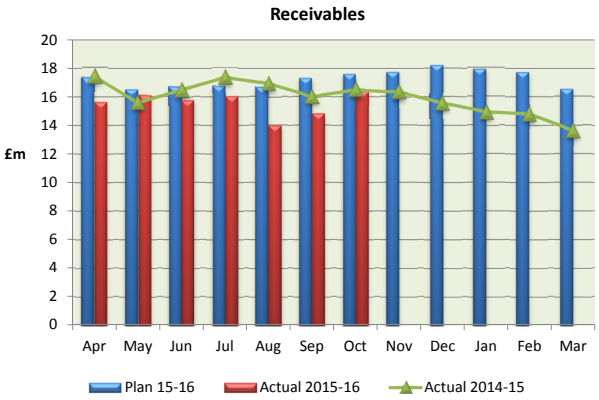
CAPITAL AND CASH COMPARED TO PLAN SUBMITTED TO MONITOR IN MAY 2015

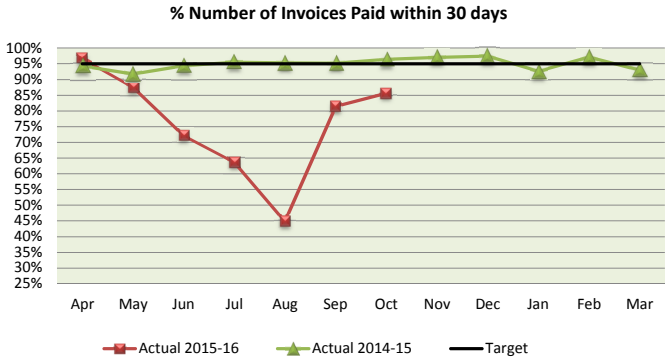
WORKING CAPITAL

	M07 Plan £m	M07 Actual £m	Var £m	M07
Payables * See note below	(£40.96)	(£52.79)	£11.83	
Receivables	£17.60	£16.46	£1.14	



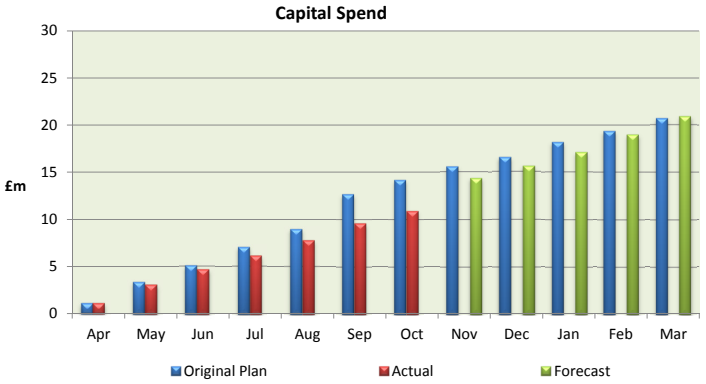


BETTER PAYMENT PRACTICE CODE



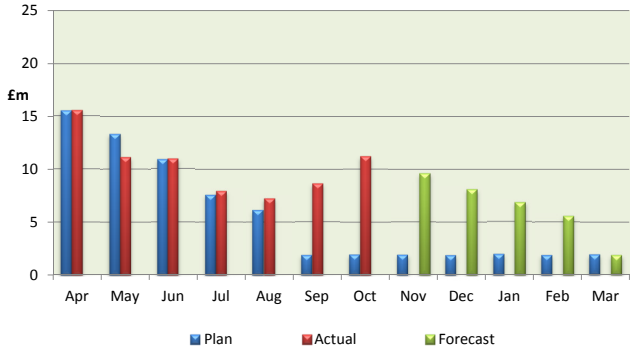
CAPITAL

	M07 Plan £m	M07 Actual £m	Var £m	M07
Capital	£14.17	£10.92	£3.25	

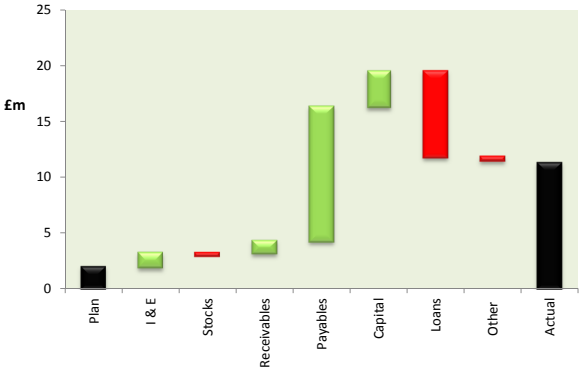


CASH

	M07 Plan £m	M07 Actual £m	Var £m	M07
Cash	£1.96	£11.24	£9.28	



CASH FLOW VARIANCE



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 the planned £14.48m, due to restructuring costs not being incurred.
- Elective and daycase 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 planed £1.96m, due predominantly to securing cash payments in advance for clinical activit
- 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 ongoing 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 planned £20.72m. The year end FSRR is forecast to be at level 2.

(* Payables note: The trade payables figure is inflated by £12.77m 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)

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%	47%		90%	Improvement Work Required
2a	Sepsis	Baseline	88%	40%	83%		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%	5.30%		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.

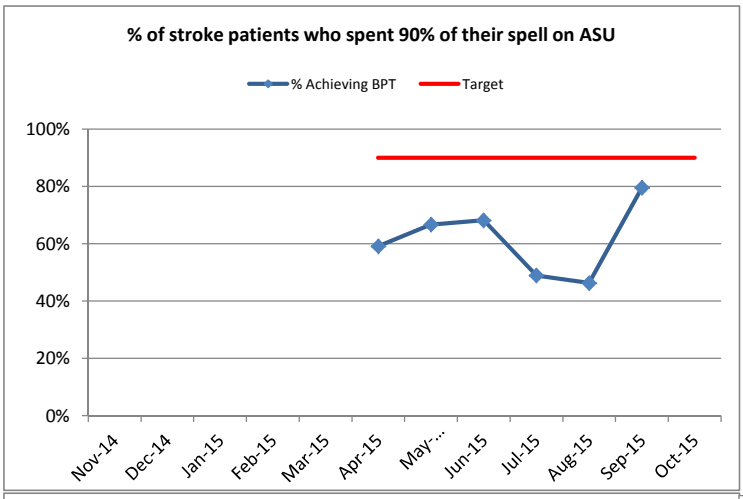
There has been additional education rolled out to junior ED and medical teams on induction.

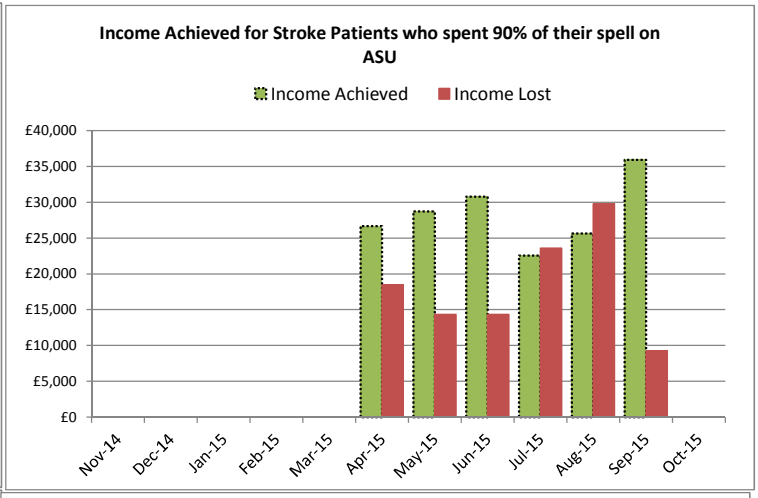
Improvement is expected gradually over the next 6 months and a trajectory will be in place to ensure we are on track. Weekly monitoring programme agreed with the audit team and results will be fed back to the clinical teams.

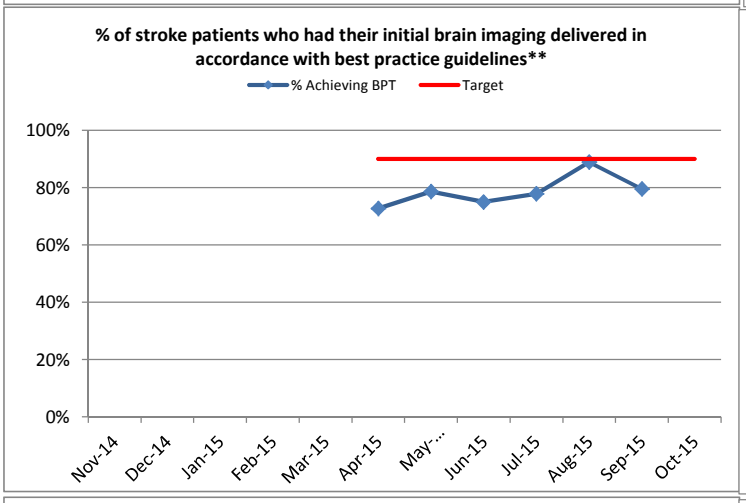
NHS England

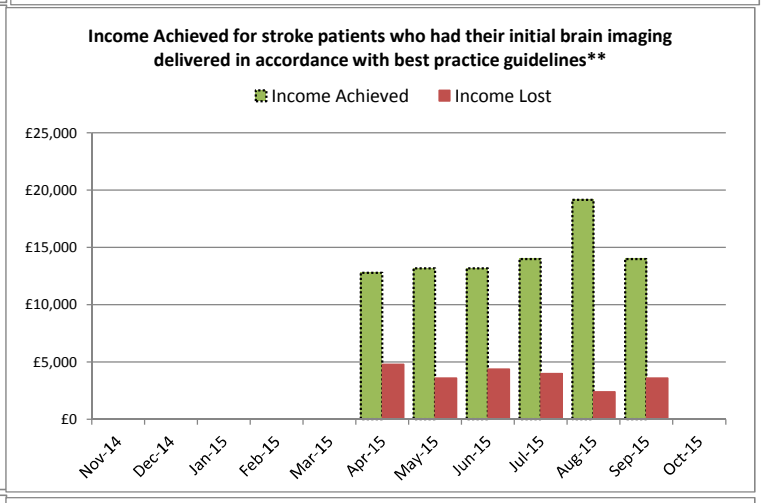
Goal Name	Value of CQUIN (£)	Q1	Q2	Q3	Q4
NICU	38,051	9,513	9,513	9,513	9,513
Oncotype DX	38,051	9,513	9,513	9,513	9,513
QIPP	126,836	31,709	31,709	31,709	31,709
Vac and Immunisations	90,860	22,715	22,715	22,715	22,715
National CQUIN	22,715	5,679	5,679	5,679	5,679
HV Building Community Capacity	104,680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

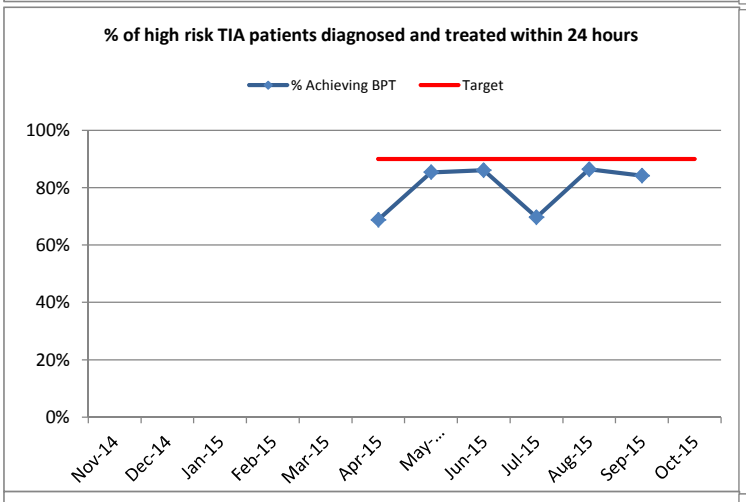
GRAND TOTAL	**6,691,905**	**904,814**	**1,958,294**	**1,444,095**	**2,384,702**

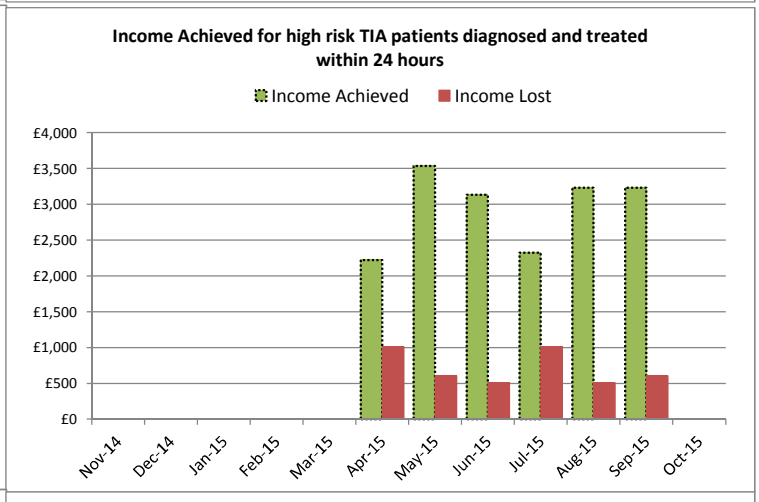

% of stroke patients who spent 90% of their spell on ASU
% Achieving BPT
Target
100%
80%
60%
40%
20%
0%
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-...
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15

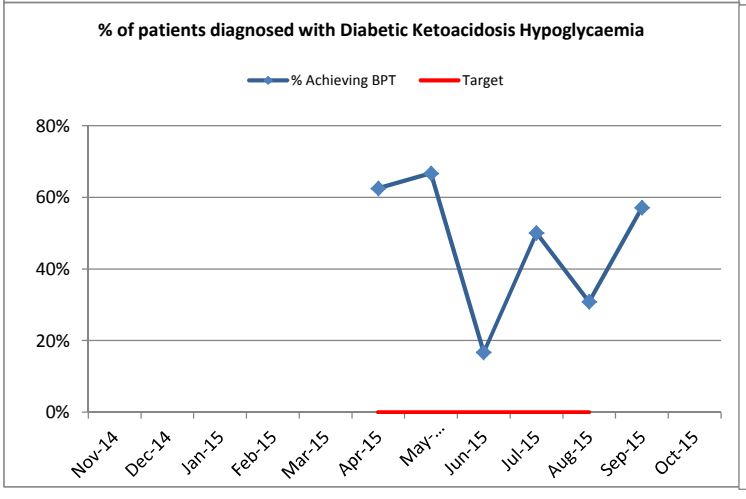

Income Achieved for Stroke Patients who spent 90% of their spell on ASU
Income Achieved
Income Lost
£40,000
£35,000
£30,000
£25,000
£20,000
£15,000
£10,000
£5,000
£0
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15

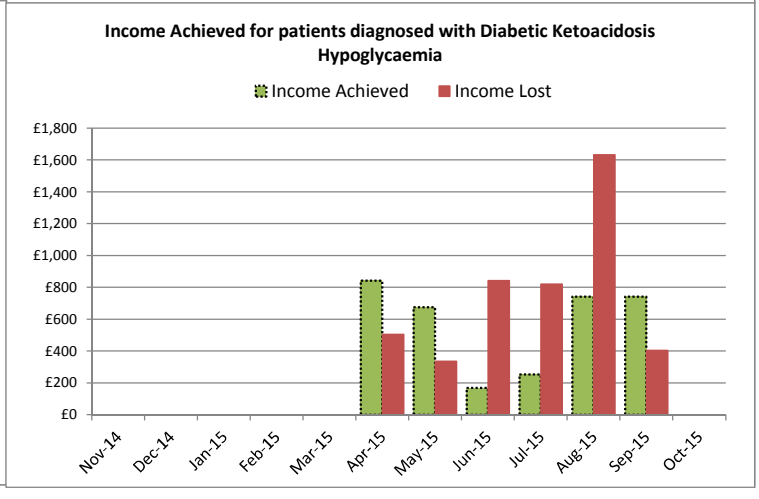

% of stroke patients who had their initial brain imaging delivered in accordance with best practice guidelines**
% Achieving BPT
Target
100%
80%
60%
40%
20%
0%
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-...
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15

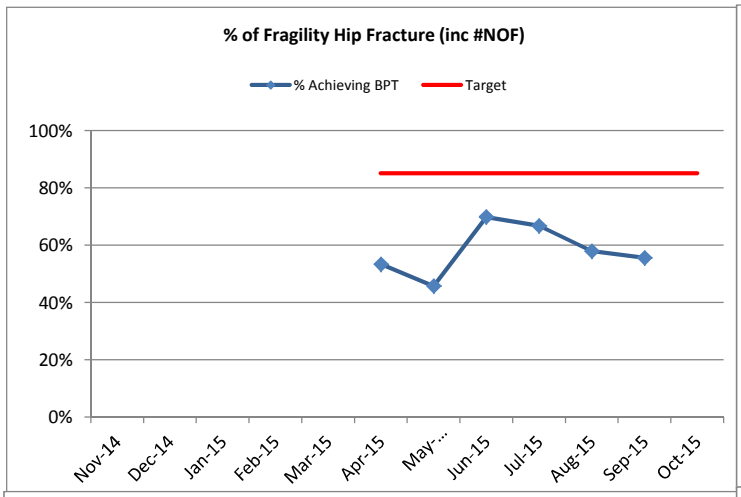

Income Achieved for stroke patients who had their initial brain imaging delivered in accordance with best practice guidelines**
Income Achieved
Income Lost
£25,000
£20,000
£15,000
£10,000
£5,000
£0
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15

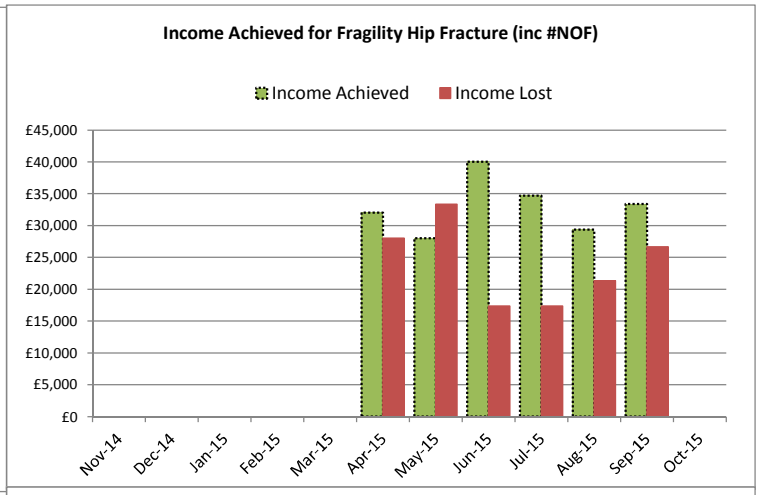

% of high risk TIA patients diagnosed and treated within 24 hours
% Achieving BPT
Target
100%
80%
60%
40%
20%
0%
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-...
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15

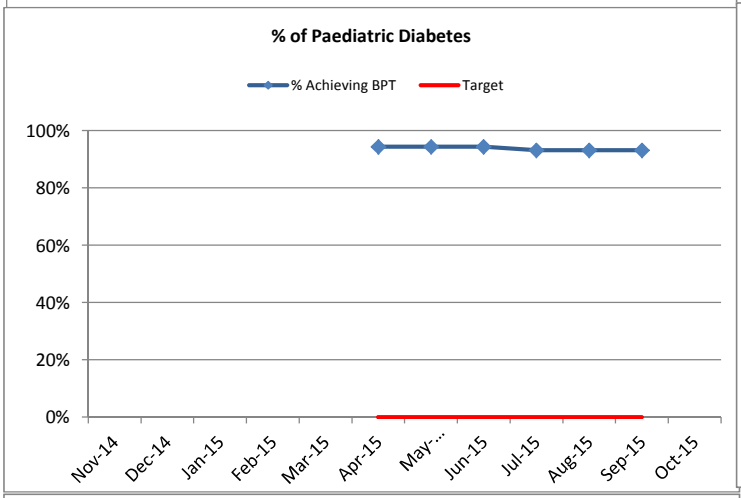

Income Achieved for high risk TIA patients diagnosed and treated within 24 hours
Income Achieved
Income Lost
£4,000
£3,500
£3,000
£2,500
£2,000
£1,500
£1,000
£500
£0
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15

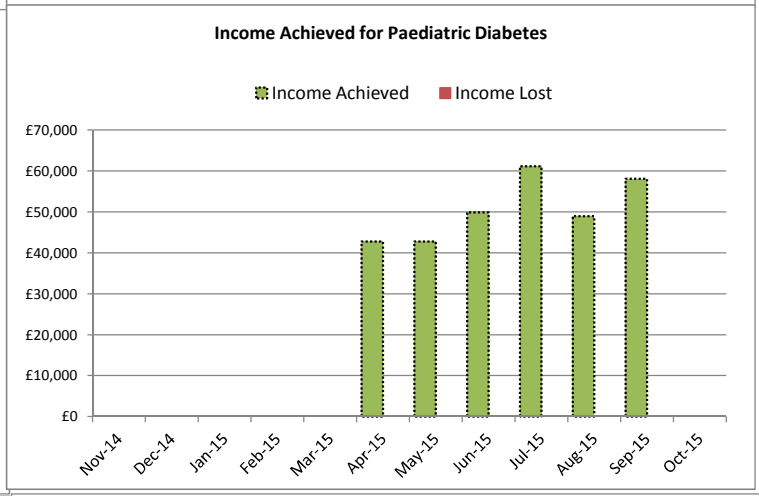

% of patients diagnosed with Diabetic Ketoacidosis Hypoglycaemia
% Achieving BPT
Target
80%
60%
40%
20%
0%
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-...
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15

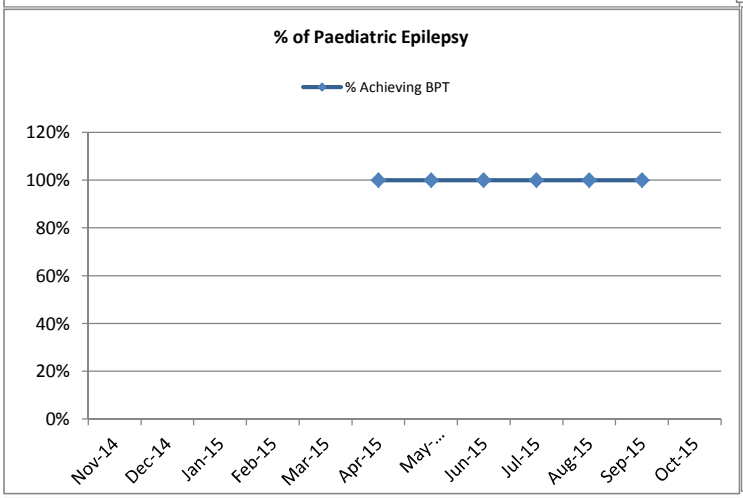

Income Achieved for patients diagnosed with Diabetic Ketoacidosis Hypoglycaemia
Income Achieved
Income Lost
£1,800
£1,600
£1,400
£1,200
£1,000
£800
£600
£400
£200
£0
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15

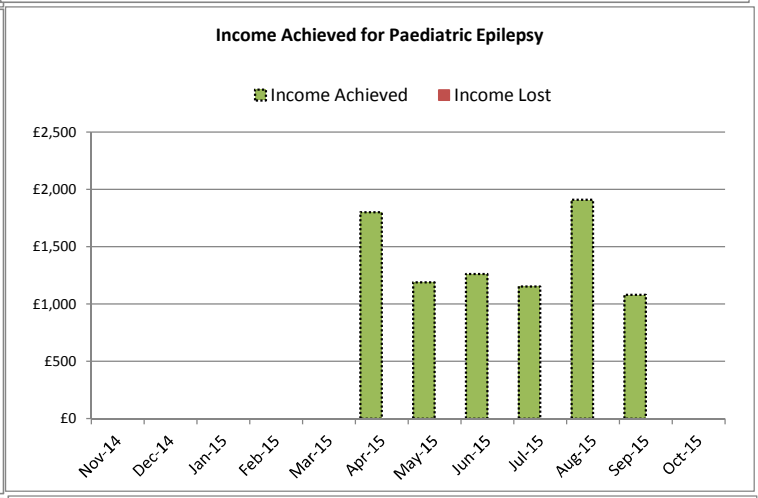

% of Fragility Hip Fracture (inc #NOF)
% Achieving BPT
Target
100%
80%
60%
40%
20%
0%
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-...
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15

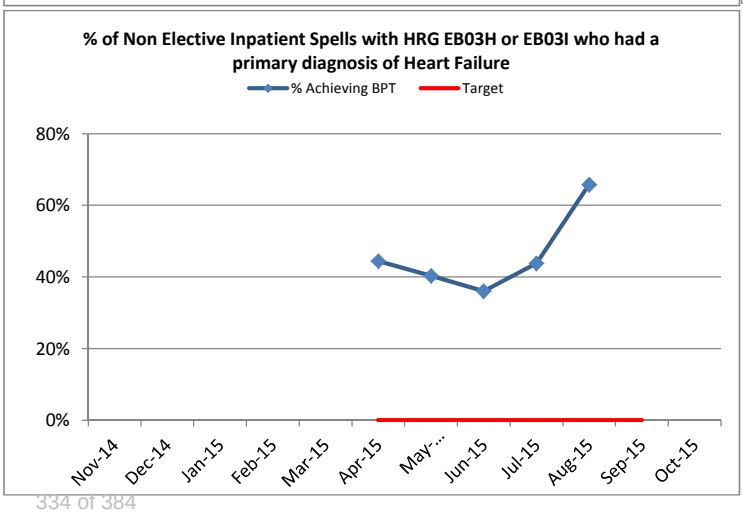

Income Achieved for Fragility Hip Fracture (inc #NOF)
Income Achieved
Income Lost
£45,000
£40,000
£35,000
£30,000
£25,000
£20,000
£15,000
£10,000
£5,000
£0
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15

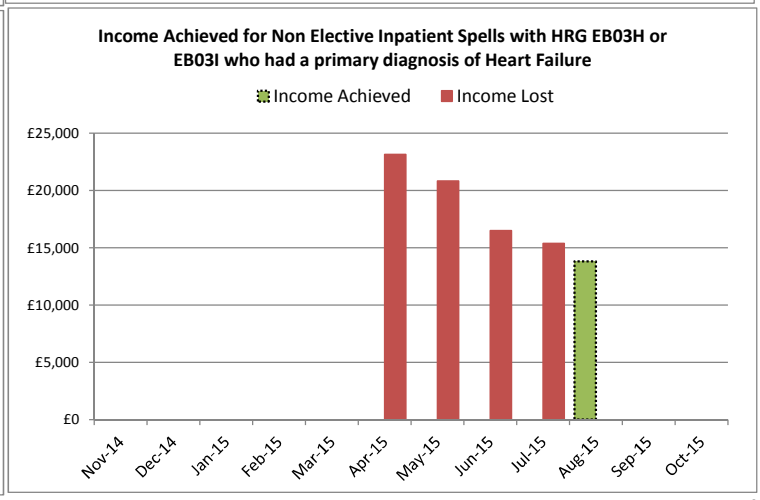

% of Paediatric Diabetes
% Achieving BPT
Target
100%
80%
60%
40%
20%
0%
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-...
Jun-15
Jul-15
Aug-15
Sep-15
Oct-15


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


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


Income Achieved for Paediatric Epilepsy
Income Achieved
Income Lost
£2,500
£2,000
£1,500
£1,000
£500
£0
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-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%
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-...
Jun-15
Jul-15
Aug-15
Sep-15
Oct-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
Nov-14
Dec-14
Jan-15
Feb-15
Mar-15
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Oct-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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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th November 2015	**Sponsoring Director:** Keith Griffiths, Director of Finance
Title and brief summary: MONTH 7 - FINANCIAL NARRATIVE - The Board is asked to approve the Month 7 Financial Narrative.	
Action required: Approve	
Strategic Direction area supported by this paper: Financial Sustainability	
Forums where this paper has previously been considered: Finance and Performance Committee - 17.11.15	
Governance Requirements: Financial Sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the Month 7 Financial Narrative.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve the Month 7 Financial Narrative.

Appendix

Attachment:

Financial Narrative Month 7 15_16 for BOD.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

MONTH 7 OCTOBER 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 17 November 2015.

1. Key Messages

The year to date financial position represents an improvement of £0.1m from last month's forecast trajectory with a £1.46m year to date adverse variance from plan (excluding restructuring costs). The forecast year end position has also seen some improvement on the level forecast last month with a £22.13m deficit against a planned deficit of £20.01m (excluding restructuring costs).

As reported previously, the downturn in the elective trading position, coupled with the Board's decision to increase bed capacity to accommodate increasing non elective activity, has impacted on the year-end forecast.

Month 7, October Position (Year to Date)

Income and Expenditure Summary	Plan £m	Actual £m	Variance £m
EBITDA	**3.38**	**1.70**	**(1.68)**
Deficit excluding restructuring	**(11.48)**	**(12.94)**	**(1.46)**
Restructuring costs	**(3.00)**	**(0.32)**	**2.68**
Deficit including restructuring	**(14.48)**	**(13.25)**	**1.22**

- An EBITDA of £1.70m, an adverse variance from plan of 1.68m.
- A deficit of £13.25m, an adverse variance of £1.22m from the planned position.
- Delivery of CIP of £8.67m against the planned level of £6.93m.
- Contingency reserves released of £1.30m against year to date pressures.
- Capital expenditure of £10.92m, below the planned level of £14.17m.
- A cash balance of £11.24m, above the planned level of £1.96m.
- 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 7 position has shown an improvement from forecast projections made last month. The number of extra beds open remains above planned levels as it has all year but in-month has been held below the forecast projection bringing some relief to the pay position.

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

Operating income	(£2.28m) adverse variance
Operating expenditure	£0.60m favourable variance
EBITDA for calculation of FSRR	**(£1.68m) adverse variance**
Non-Operating items	£0.22m favourable variance
Restructuring costs	£2.68m favourable variance
Total	**£1.22m favourable variance**

Operating Income

There is a cumulative £2.28m adverse variance from plan within operating income.

NHS Clinical Income

Of the £2.28m adverse income variance, £1.55m 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

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

- Planned day case and elective activity has continued to perform below plan. Cumulatively activity is now 9% below plan (2,640 spells). There was however a slight improvement in-month from the position seen against plan in month 6.

- Non-elective admissions overall are above the month 7 plan by 4.7% (197 spells) which is a continuation of the over-performance seen in month 6 but at a slightly reduced level. Cumulatively activity is now 3.3% above plan (937 spells).

- A&E attendances are 1.9% (231 attendances) above the month 7 plan. This is a shift from the previous months where activity has been below plan. Cumulatively activity is now below plan by 1.5% (1,290 attendances).

- Outpatient attendances are 2.6% below plan (5,116 attendances) in the year to date.

- Pass through high cost drugs costs are below plan by £0.68m in the year to date

In line with plan and in recognition of the outstanding income risks, allowance to the value of £1.11m 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. Very recent discussions have progressed positively with commissioners with regard to the challenges raised to date. This has brought confidence that the level of provision made will be sufficient and that the commissioners 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 may differ though across the two main commissioners.

Other income

Overall other income is £0.73m 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 £0.60m favourable variance within operating expenditure across the following areas:

Pay costs	(£0.43m) adverse variance
Drugs costs	£0.40m favourable variance
Clinical supply and other costs	£0.64m favourable variance

Employee benefits expenses (Pay costs)

Pay costs are £0.43m above the planned level. However, within the pay position there is a benefit of £1.17m 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 £1.60m. The breakdown of pay cost is outlined in detail at Appendix 1.

As previously reported, the largest single driver of the additional costs which have been incurred in the year to date is as a result of the Board recognising the need for additional bed capacity over and above the 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 staffing cost has been contained beneath the level forecast in recent months due to a lower level of beds being open than the high levels anticipated.

In order to balance the anticipated additional bed capacity requirement over the winter period with the availability in the market of nursing and medical staff, the Trust is considering a wide range of creative 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. This may switch the need for resource to different staff groups but is being viewed within the same funding level. This pro-active management is alongside the previously described positive measures to reduce reliance on non-contracted nursing staff and drive through reductions in rates with suppliers.

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 and has contributed to the shortfall in elective and day case activity in-month due to difficulty in securing NHS locums. Focussed activity is underway to manage attendance of clinical staff and ensure escalation of authorisation for agency cover for junior medical posts.

Drug costs

Year to date expenditure on drugs was £0.40m 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 £0.64m below plan in the year to date position.

As per last month, 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 combined at £0.60m overspend driven by the additional non-elective activity. Whilst the Surgery division shows a £0.88m underspend against planned expenditure on clinical supply costs aligned to the shortfall in elective and day case activity. Further

benefits have been realised by the successful delivery of CIP over and above the planned level, and a reassessment of utilities expenditure based on latest volumes and tariffs.

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 £0.22m 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 £0.32m. 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 £0.22m 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. The impact of this is expanded upon in the cash flow section below.

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.

Statement of Financial Position and Cash Flow

At the end of October 2015 the Trust had a cash balance of £11.24m against a planned position of £1.96m, a favourable variance of £9.28m, the key movements are summarised below.

		Variance £m
Operating activities	Deficit excluding restructuring	(1.46)
	Restructuring costs - redundancy	2.90
	Restructuring costs – consultancy support	(0.22)
	Deficit including restructuring	**1.22**
	Non cash flows in operating deficit	(0.14)
	Re-profiling of commissioner contract income	12.77
	Other working capital movements	(0.25)
	Sub Total	**13.59**
Investing activities	Capital expenditure	3.25
	Movement in capital creditors	0.31
	Sub Total	**3.56**
Financing activities	Drawdown of external DoH cash support	(7.70)
	Other financing activities	(0.17)
	Sub Total	**(7.87)**
	Grand Total	**9.28**

Operating activities

Operating activities show a favourable £13.59m variance against plan. This is driven by the favourable cash impact of the I&E position of £1.08m (£1.22m favourable I&E variance offset by £0.14m adverse variance against non-cash flows in operating deficit) coupled with positive working capital variances from plan. The I&E benefit to cash is driven by the fact that the plan assumed payment of one-off restructuring costs in respect of redundancy in September at £3.0m. There have only been minimal redundancy costs in the year to date at £0.10m and the balance of the planned costs will now not be required in this financial year. This has brought a cash benefit of £2.90m which will flow through to the year end cash position. 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 enhanced the cash position by £12.77m in the year to date.

Judicious treasury management of working capital is ongoing. 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 76% of invoices have been paid within 30 days, a slight improvement upon last month.

Investing activities (Capital)

Capital expenditure in the year to date is £10.92m, £3.25m below the planned level of £14.17m.

Against the Estates element of the capital expenditure plan the year to date expenditure is £4.66m against a planned £5.55m. The main areas of spend in month were the continuation of the Ward 7 upgrade at £0.12m, bringing year to date investment against this scheme to £2.14m; continuation of the Theatre refurbishment at £0.20m contributing to a year to date £1.09m; and £0.19m in-month across a range of other smaller schemes. The main single contributor to the underspend is a profiling difference from plan on the Theatres scheme which sits alongside timing differences across the smaller schemes.

IM&T investments total £5.13m against a year to date plan of £7.31m. The main individual area of spend in month is on the continuation of the Electronic Patient Record (EPR) at £0.27m bringing the year to date commitment on this to £1.56m. The key area of underspend in the year to date continues to be the EPR driving £2.02m of the shortfall. As previously reported, the scale of the underspend is not reflective of operational slippage on the scheme but rather positive action that the Trust has taken to schedule the commitments to payments based on staged deliverables from the supplier. This has also brought a timing benefit to cash.

The favourable cash impact of this £3.25m under spend is coupled with a £0.31m favourable variance against capital creditors, explaining the overall £3.56m positive cash variance against investing activities.

Financing activities

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. The original plan anticipated the need for this external cash in support of the trading position from September but the factors described above mean that this facility, which will bring interest charges at 3.5%, is not immediately required but is available as a ‘safety net’ in the short term.

Financing activities show a £7.87m adverse variance from plan but 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 £7.70m by October. This is clear evidence that the actions being taken by the Trust to pro-actively manage cash are having a real impact. There has been no let up on the implementation of these measures; the Trust continues to report daily on any variance from the cash forecast, the Cash Committee is

gaining impetus and this is marking a cultural shift in the wider organisation to place cash at the forefront of financial thinking.

Finally and again as previously reported, the £10m loan to support the EPR deployment was drawn down from the Independent Trusts Financing Facility (ITFF) in April in line with the plan.

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 position has been revised to a year end deficit of £22.13m against the planned £20.01m deficit (excluding restructuring costs). This is a slight improvement from the forecast at month 6, driven by the in-month benefit due to lower than projected bed capacity and the reduction in utilities costs, the latter of which continues through future months. A reduction in non-contracted pay against junior medical staff is also forecast when compared to previous projections as a result of escalation protocols and attendance management. These benefits are offset in part by the increased requirement for locum cover for consultant posts.

The main driver for the adverse variance to plan continues to be the reduction in intermediate / nursing home capacity in the health economy. Alongside this sits the financial pressure caused by the CCG's decision on the Care Closer to Home tender.

System wide pressures in intermediate / residential care provision across Calderdale and Kirklees drive the need for a greater level of bed capacity within the Trust. The Trust Board accepted the need to spend an additional £1.6m ensure the basic standards on patient safety could be maintained. As described above, in the pay costs section, consideration is being given to the best way to actively manage this operationally but this is anticipated to remain within the same forecast value.

The revised forecast deficit has already called upon the additional 'stretch' CIP which had been conceived to guard against such risks. The forecast year end position includes delivery of £17.39m CIP against the original plan of £14m. The full £3m of contingency reserves is also forecast to be released.

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). £3.0m restructuring costs were originally planned for redundancy payments. This will now not be incurred in this financial year, with the exception of £0.10m that has been paid out in the year to date. As such the overall commitment against restructuring costs has been revised downwards from £4.0m anticipated last month to £1.10m.

Thus when viewed at bottom line, the forecast I&E position is forecast to deliver close to the planned level. The make-up of this position is however significantly different from the plan and the changes described above are summarised at headline level below for clarity:

Year-end Forecast Position

Income and Expenditure Summary	Plan £m	Actual £m	Var £m
EBITDA	**5.51**	**2.93**	**(2.58)**
Deficit excluding restructuring	**(20.01)**	**(22.13)**	**(2.12)**
Restructuring costs - redundancy	(3.00)	(0.10)	2.90
Restructuring costs – consultancy support	0.00	(1.00)	(1.00)
Deficit including restructuring	**(23.01)**	**(23.23)**	**(0.22)**

Forecast – Capital

In aggregate across all capital schemes the current forecast year end position is in line with planned levels. The Trust has reviewed its planned capital programme for 2015/16 and considered where there is a possibility to reduce the programme without having an adverse impact on patient safety. Discussions with Monitor are ongoing at the time of writing which will determine whether the Trust will opt to curtail up to £0.8m of capital expenditure in order to reduce the dependency upon external cash support.

Forecast – Cash

The total cash support now anticipated to be required is £15.0m against the planned £14.9m. This is consistent with the bottom line I&E and capital forecast positions being in line with plan. A direct cash benefit is seen from the removal of the planned £3.0m redundancy costs from forecast. This is offset by the additional cash requirement to support the restructuring costs relation to consultancy support and the operational I&E pressures.

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.

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.

There continue to be a range of risks and opportunities to the year end forecast.

Month 7 - Detailed Pay Analysis

Year to Date

Pay Expenditure including Agency

Forecast

Pay Expenditure including Agency

	M7 YTD Budget	M7 YTD Actual					M7 YTD Variance	15/16 Budget	15/16 Year End Forecast					Year End Forecast Variance
	Total Budget	**Total Actual**	Substantive Pay	Agency / Locum	Bank	Overtime / WLI		**Total Budget**	**Total Forecast**	Substantive Pay	Agency / Locum	Bank	Overtime / WLI	
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Medical Staffing:	35.04	36.37	27.88	7.75		0.75	1.33	60.53	64.28	48.38	14.31		1.58	3.75
Nursing, Midwives and HCAs:	51.90	52.40	46.70	2.95	1.42	1.33	0.50	90.20	91.08	81.64	5.39	2.36	1.68	0.89
Other Clinical Staff:	18.64	18.65	18.07	0.19	0.10	0.29	0.01	32.10	31.06	30.64	0.16	0.10	0.15	-1.04
Non- Clinical Staff:	23.23	23.31	21.16	1.17	0.43	0.55	0.08	39.62	40.29	37.66	1.83	0.34	0.46	0.67
Pay Reserves	1.48						-1.48	2.54	0.00					-2.54
TRUST TOTAL	**130.287**	**130.720**	**113.804**	**12.060**	**1.945**	**2.910**	**0.433**	**224.983**	**226.707**	**198.316**	**21.704**	**2.808**	**3.880**	**1.724**

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th November 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. Joint MC/BOD Annual General Meeting Minutes - 17.9.15
b. Quality Committtee - verbal update from meeting 24.11.15
c. Finance and Performance Committee - minutes of 20.10.15 and verbal update from meeting 17.11.15
d. Audit and Risk Committee - minutes from meeting held 20.10.15
e. Audit and Risk Committee - Terms of Reference
f. Nomination and Remuneration Committee (Memebership Council) - Terms of Reference

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. Joint MC/BOD Annual General Meeting Minutes - 17.9.15
b. Quality Committee - verbal update from meeting 24.11.15
c. Finance and Performance Committee - minutes of 20.10.15 and verbal update from meeting 17.11.15
d. Audit and Risk Committee - minutes from meeting held 20.10.15
e. Audit and Risk Committee - Terms of Reference
f. Nomination and Remuneration Committee (Memebership Council) - Terms of Reference

Appendix

Attachment:

COMBINED - UPDATES AND MINS.pdf

Calderdale and Huddersfield NHS

NHS Foundation Trust

Minutes of the Calderdale & Huddersfield NHS Trust Board of Directors and Membership Council Members Annual General Meeting held on Thursday 17 September 2015 at 6.00 pm in Acre Mills Outpatient Building, 3rd Floor HD3 3EB

PRESENT:-

Speakers present on the stage were:-
Mr Andrew Haigh, Chairman
Mr Owen Williams, Chief Executive
Mr Keith Griffiths, Director of Finance
Mr Trevor Rees, Partner – KPMG External Auditors
Mr Wayne Clarke, Publicly Elected Member-Deputy Chair/Lead MC

Others present were:-
Board of Directors
Dr David Birkenhead, Executive Medical Director
Mrs Julie Dawes, Executive Director of Nursing & Operations
Mrs Lesley Hill, Executive Director of Planning, Performance, Estates & Facilities
Mr Jeremy Pease, Non Executive Director
Prof. Peter Roberts, Non Executive Director
Dr Linda Patterson, Non Executive Director
Mrs Jan Wilson, Non Executive Director

Membership Council

Mrs Rosemary Hedges	Miss Liz Farnell	Mr Bob Metcalfe
Mrs Dianne Hughes	Mrs Eileen Hamer	
Mr Ken Batton	Ms Julie Hoole	
Mrs Annette Bell		
Mr Grenville Horsfall		
Mr Brian Moore		
Mrs Liz Schofield		
Mr Andrew Sykes		
Mrs Jennifer Beaumont		
Mr Brian Richardson		
Mr George Richardson		
Mrs Lynn Moore		

1. CHAIR'S OPENING STATEMENT AND INTRODUCTIONS

The Chairman opened the meeting by thanking everyone for attending and introduced the speakers. It was noted that other members of the Board of Directors and Membership Councillors were also present in the audience. The Chairman reported that it gave him great pleasure to welcome everyone to the new Acre Mills Outpatients Building which was a mixture of old and new and a real investment for patient care for the future. Just that week the Trust had learned that it had been

shortlisted in the Building Better Healthcare national awards and the outcome was awaited.

The Chairman reported that 2015-16 will see the Trust continue to focus on delivering care with compassion for our patients and their families. He explained that the Trust is here to deliver the best patient care and that we want patients to leave us and spread the word about the quality of care at CHFT. He pointed out that a large number of Trusts, like CHFT, are struggling financially. To this end the Trust was constantly working to improve efficiency and reorganise the care we deliver at both hospitals. If we wish to retain services locally, collaboration across the system and providers is going to be key. Locally this would involve more work with partners including local commissioners and the Health and Wellbeing Board to discuss the changes we have to make.

The Chairman highlighted that safeguarding has also been a focus this year in the wake of the Jimmy Savile Inquire. CHFT had reviewed all appropriate policies and guidelines to ensure our patients and staff are protected.

He reported that for the first time, the Trust ended 2014/15 with a financial deficit and that a deficit position was also forecast for the end of March 2016. The Trust is working hard to rectify the position and has the full support of Monitor, our regulator. It was emphasised that we will not achieve this through compromising on care.

Thanks were given to the staff for their dedicated pursuit of delivering healthcare excellence, innovation and above all being caring. Two examples of this included a colleague in Costa winning the national Customer Service award and a colleague who delivers support to patients with deteriorating eye sight achieving the Mascular Society's Health Professional of the Year. Thanks were also given to the Membership Council for their support as well as the Board of Directors, Executive Team and League of Friends.

The Chairman reported that this was the eighth year when the Board of Directors and Membership Council had come together at a joint Annual General Meeting, alternating sites between Huddersfield and Halifax each year. It was noted that the Health Fair held from 5.00 to 6.00 pm that evening had been very successful and thanks were given to all staff involved.

It was noted that the packs which had been circulated contained:-

- Agenda
- Membership Council Register of Members at 17 September 2014
- Summary Annual Report and Accounts
- Evaluation Form
- Annual Audit Letter from the external auditors
- Membership Forms

Paper copies of the full Annual Reports and Accounts were available at the meeting and electronically on the Trust website.

2 APOLOGIES

Apologies were received from:-

Board of Directors
Dr David Anderson, Non Executive Director
Miss Julie Hull, Executive Director of Workforce and Organisational Development
Mr Philip Oldfield, Non Executive Director

Membership Council Members
Mrs Linda Wild
Mr Martin Urmston
Mrs Di Wharmby
Mr Peter Middleton
Mrs Marlene Chambers
Mrs Johanna Turner
Mrs Linda Wild
Mrs Kate Wileman
Dr Mary Kiely
Miss Avril Henson
Mrs Chris Bentley
Prof John Playle
Cllr Naheed Mather
Mr David Longstaff
Mrs Dawn Stephenson

3 TRUST ANNUAL ACCOUNTS – APRIL 2014 TO MARCH 2015
Keith Griffiths presented the Annual Accounts, full details of which were available in the Annual Report. It was noted that the details of these had been discussed at the Board of Directors Meeting and these were approved as a correct record.

The key areas were noted:-

Financial Context
- Turnover £354m
- Patients
- *49,000 inpatients – elective and day cases*
- *50,000 inpatients – non elective*
- *385,000 outpatients*
- *142,000 A&E attendances*
- 5,479 colleagues
- Property and equipment over two hospital sites with a combined value of £222m
- 4% Efficiency challenge for the 5th year running
- Challenging financial landscape

The Trust's Performance in 2014/15
- Income was £354m in 2014/15
- Total expenditure was £360m

2014/15 Financial Performance

	Plan	Actual
Income and Expenditure	£3m	(£6m)
Income and Expenditure (excl. exceptional items)	£3m	(£4m)
Capital Expenditure	£24m	£23m
Cash Balance	£23m	£14m
Monitor Continuity of Service Risk Rating	3	2

Unqualified Audit Opinion	√	√

Key Financial Pressures

- Investment in nurse staffing ratios £1.5m
- Medical and Nursing agency spend £3.0m

Efficiency Savings Achieved

Procurement	£1m
Administrative and other staffing	£4m
Budgetary Control	£1m
Service Reconfiguration	£2m
Other schemes	£2m
Total savings achieved	£10m

External Assurance/Impact

PWC - Forecasting accurate
- No financial mismanagement

Monitor - Breach of Licence
- Monthly monitoring regime

Overview and Scrutiny Committee (Greater Huddersfield and Calderdale Local Authorities)

KPMG - Unqualified audit opinion

The Future

- Unprecedented financial challenges – locally and nationally
- Higher quality standards to be achieved – CQC compliance
- Even better levels of patient access – patient expectations
- Modernisation – technology and estate
- No short term solutions to CHFT's financial deficit.

4 ANNUAL REPORT 2014/15 and FORWARD PLAN

Owen Williams welcomed everyone and thanked staff and Membership Councillors for their work and commitment in caring for patients.

He made reference to the Summary Annual Report which contained the Trust's achievements and challenges for 2014/15. Looking ahead he outlined the Trust's engagement work using the four pillars and goals of the Trust:-

Four Pillars of Behaviour

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

Trust Goals

- Transforming and improving patient care
- Keeping the base safe
- A Workforce for the Future

- Financial Sustainability

He emphasised the need to work together both as a Trust and with commissioners in the challenging times ahead and the changing face of healthcare. He made reference to his personal reflection of his own experience of healthcare and the need to get to a place where the clinical commissioners are able to 'work together to get results' being a fundamental part of this. Advances in technology with the implementation of the electronic patient record would help this joint working as well as the financial position. He ended his presentation with a question "How can we help each other to work together to put patients first and provide quality clinical care?"

5 EXTERNAL AUDIT OPINION ON ANNUAL REPORT/QUALITY ACCOUNTS

Trevor Rees, Head of External Audit from KPMG gave a presentation outlining the scope and the work undertaken of the external auditors and assurances given. The three areas focussed on within the Audit included:-

- Finance Statements Audit
- Use of Resources
- Quality Report

He explained that as part of the finance statements audit, KPMG had given a clean, unqualified audit opinion with one unadjusted audit difference and a number of presentational changes. The Annual Report and Annual Governance Statement were consistent with financial statements and complied with Monitor's requirements. Four recommendations had been made in relation to payroll and the accounts production, together with recommendations on improving the accounts production in the future.

Trevor Rees then went on to explain that the Use of Resources work:-

- A modified (qualified) opinion was issued in relation to Use of Resources issued.
- As a result of the matters highlighted in the enforcement undertakings issued by Monitor on 29 January 2015, KPMG were not satisfied that the Trust made proper arrangements for security economy, efficiency and effectiveness in its use of resources.

The content of the Quality Report complied with the requirements of Monitor. Three indicators were tested:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period (mandated by Monitor)
- Emergency readmissions within 28 days of discharge from hospital (mandated by Monitor)
- Average length of stay (selected by the Membership Council)

The work resulted in achieving a 'clean opinion' for the Emergency Readmissions and Average Length of Stay with one recommendation and two recommendations being made respectively. Unfortunately, as consistent with the majority of Trusts nationally, KPMG were unable to provide an opinion on the 18 week wait due to issues with data.

Overall a recommendation was made in relation to locating patient records relevant to all indicators.

Trevor Rees announced that he would be retiring at the end of the year and a new Engagement Lead, Clare Partridge would be taking on the role. He wished the Trust all the best for the future.

6 ELECTION RESULTS AND APPOINTMENTS

The Chair reported that the second half of the meeting would be concentrating on the Membership Council AGM. There were a number of elections and appointments over the last 12 months which required formal ratification at the meeting.

a. Council Members

As members were aware, over the period 9 June to 21 August 2015, on behalf of the Trust, the Electoral Reform Services had held elections. This had resulted in 5 public and 3 staff seats being filled by Mrs Rosemary Hedges, Mrs Di Wharmby, Mr Kenneth Batten, Mrs Annette Bell, Mr Brian Moore, Mrs Avril Henson, Mrs Eileen Hamer and Ms Julie Hoole. Rev Wayne Clarke had been appointed as Deputy Chair/Lead Governor to take over from Martin Urmston. The Chair thanked Martin for his support as Membership Councillor for the past 3 years and latterly as Deputy Chair/Lead Governor for the Membership Council since 2014.

All these appointments could be seen on the Register of Members which was available within the packs. The ballot turnout rates this year was around 12.3% which was comparable to other trusts.

The Chairman wished to thank the retiring members who included:- Mrs Marlene Chambers, Johanna Turner, Andrew Sykes, Liz Farnell, Chris Bentley and Martin Urmston, together with Linda Wild and Liz Schofield who had been on the Reserve List. Two Stakeholder representatives had also ended their tenures – Cllr Hilary Richards and Mrs Janet Boucher.

b. Board of Directors – Non Executive Directors

The Chair reported that the Nominations Sub Committee had not had cause to meet in the past year due to there being no Non Executive Director tenures to consider on the Board of Directors.

Those present formally ratified the aforesaid appointments and the Chairman introduced and welcomed the new members of the Membership Council.

7 MEMBERSHIP COUNCIL UPDATE – OVERVIEW OF THE MEMBERSHIP COUNCIL CONTRIBUTION DURING 2013/14

Rev Wayne Clarke, Deputy Chair gave an overview of the Membership Council Contribution during 2014/15. This included:-

- The role of the Membership Council and involvement via the Divisional Reference Groups with Service Users to develop the plans for the Trust.
- Training and Development opportunities including Induction, individual training and development days.
- Governance issues:-
    - Chairman's One to One Meetings

    - Attendance at full Membership Council meetings and AGM
    - Attendance at Board of Directors Meetings.
    - Attendance of Council members on a wide range of sub committees such as Nominations, Remuneration, Organ Donation, Quality, Finance and Audit and Charitable Funds.
    - Joint workshops with the Membership Council and Board of Directors
    - Council Members continue to be actively involved in Patient and User Interview Panels, Real Time Monitoring and Awards panels for the Trust's Celebrating Success.
    - Annual Report and Quality Accounts involvement in their compilation
    - Governance Task and Finish Group re member engagement
- Engagement and Involvement Opportunities including walkabouts, Real Time Patient Monitoring, Patient/User Interview Panels, Awards Panels, Staff Suggestion Scheme and Ad hoc involvement opportunities in partnership with the Patients Association.
- Opinion Seeking via surveys, strategic projects and Membership Email in-box

In conclusion Rev Wayne Clarke wished to thank the Membership Office for their help and support throughout the year.

8 QUESTIONS AND ANSWERS

The Chairman gave opportunity for those present to raise any general questions of the Board or Membership Council. The questions raised were:-

Q – Whether the capital and financial charges included the PFI and whether it would be possible to see the PFI Contract?

A – The Executive Director of Finance explained that the PFI is like a rent and therefore the charges did not apply. It was noted that the PFI Contract had some elements that would be commercially confidential and therefore it would need to be checked what could and couldn't be released.

Q – The Trust has described its development of robust plans for sustainability, could the Chief Executive provide a taster of what this might include?

A – The Chief Executive responded that over the next three months the Trust will be developing a 5 Year Strategic Plan. Some of the plan would be based on the work done to develop the outline business case but that the world had moved on since with new initiatives such as the West Yorkshire Vanguard and the changing relationship between health and local authorities into the future. He explained that the plan would be developed with partners in mind and would consider the best location of services. He pointed out that Calderdale Clinical Commissioning Group had made a decision to retain the Trust as the provider of community services until March 2017. The Chief Executive said that this work was in its early stages and so there was no more to share at this point but it would address the challenge faced by the Trust of providing care across two sites and would consider opportunities for delivery of care away from just the physical hospital locations. The Chair added that staying still was not an option for either delivery of high quality care or from a financial perspective.

Q – Why do you refer to Greater Huddersfield as most residents wouldn't recognise this?

A – The Chief Executive explained that it reflects how commissioning responsibilities are allocated whereby Kirklees is split into North Kirklees and then Greater Huddersfield which covers the area of Huddersfield and its valleys.

Q – What can be done to increase the staff friends and family test figures?

A – The Chief Executive responded that the way in which we currently provide care is a tremendous ask for people and impacts on their daily lives. We need to provide a better environment for staff and give them a platform to be able to make changes.

Q – What are the views about making the best use of technology and using innovative partnerships to do this?

A – The Chief Executive explained that he is passionate about using technology to get the best results for patients and that he feels aghast that in 2015 patients are unable to routinely be able to see their own clinical record. He gave hypertension as an example of a condition where technology could be used by patients in their own home to self-manage successfully. He commented that partners in the commercial and voluntary sectors are key to making a change and that the notion of competition was beginning to change as it was in the interests of patients to collaborate. The use of technology would be a way forward.

Q – Is there an opportunity to do more with the training suites and include an observation suite with a camera system?

A - The Chair commented that he recognised that the Trust did not have these facilities as it wasn't a teaching hospital. He added that the Trust did train a lot of students and that technology had been put in place such as the use of sophisticated manikins that responded like real patients to different care and treatment.

9 DATE AND TIME OF NEXT MEETING

It was noted that details of the next Annual General Meeting had yet to be confirmed but it was intended to be held on Thursday 15 September 2016. The time and venue would be confirmed nearer the date.

The Chairman closed the formal meeting at approximately 7.30 pm.

/KB/AGM2015-MINS

Minutes of the Finance & Performance Committee held on Tuesday 20 October 2015
Meeting Room 4, 3rd Floor, Acre Mill, Huddersfield Royal Infirmary commencing at 8.30am

PRESENT

Anna Basford	Director of Transformation & Partnerships
David Birkenhead	Executive Medical Director
Julie Dawes	Executive Director of Nursing
Keith Griffiths	Executive Director of Finance
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities
Phil Oldfield	Non-Executive Director - Chair
Peter Roberts	Non-Executive Director
Owen Williams	Chief Executive
Jan Wilson	Non Executive Director

IN ATTENDANCE

Kirsty Archer	Assistant Director of Finance
Mandy Griffin	Acting Director of the Health Informatics Service
Andrew Haigh	Chair
Peter Middleton	Membership Councillor
Victoria Pickles	Company Secretary
Betty Sewell	PA (minutes)

OBSERVING

Catherine Riley	Assistant Director of Strategic Planning

ITEM

225/10/15 WELCOME AND INTRODUCTIONS

The Chair of the Committee welcomed attendees including Catherine Riley who was observing the meeting.

226/10/15 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Jeremy Pease, Non-Executive Director
Linda Patterson, Non-Executive Director

227/10/15 DECLARATIONS OF INTEREST

There were no declarations of interest.

228/10/15 MINUTES OF THE MEETINGS HELD 15 SEPTEMBER 2015

The minutes were approved as a correct record, however it was noted that Linda Patterson's role should be noted as Non-Executive Director not Membership Councillor.

229/10/15 MATTERS ARISING AND ACTION LOG

Action Log

192/08/15 – Star Chamber - The Director of Transformation and Partnerships confirmed that an electronic star chamber repository had been created and that details would be circulated by the PMO team – action complete.

193/08/15
LLP – The Director of PPE&F confirmed that there are clearly identified separate lists and duplicate payments are not an issue – action complete.

Job Planning – A meeting will be taking place following Finance & Performance in include EY, Four Eyes and internal leads to ensure there is a connection with job planning, capacity and demand planning – action complete.

Matters Arising
72/02/15 – NHS Litigation Authority Report
The Director of Finance took the Committee through the background for the paper, it was noted that the Trust currently pays into the Clinical Negligence Scheme for Trusts (CNST), a scheme administered by NHS Litigation Authority. The Committee were advised that we would be looking to apply formal notice with CNST to enter into dialogue to re-negotiate. Keith Griffiths stressed that this was not just a finance issue and one of the main opportunities to drive out savings would be through reduction in incidents.

Discussions took place with regard to our claims history and the possible use of commercial insurance. The Committee also discussed our current claims procedure and how we focus internally managing/investigating complaints to prevent them progressing to claims.

The Committee recognised the risk in terms of our ongoing performance, however, it was acknowledged that there is an opportunity to try to renegotiate the premiums and if capacity was available within finance to pursue this issue it was agreed that the Trust should progress. The Committee requested an updated position in December.

ACTION : To progress discussions with the NHSLA to re-negotiate premiums with an update at the December meeting - **KG**

193/08/15 – Theatre Productivity
The Director of Transformation & Commissioning circulated a briefing paper requested at the last meeting. The paper provided the Committee with information of the work that has been undertaken, supported by Four Eyes Insight, to identify the potential opportunity to achieve enhanced theatre productivity and efficiency in 2015/16 and how we are performing against that productivity target at Month 6.

It was noted that the project had given visibility and a number of factors can delay theatre lists from IT issues to people not turning up on time. Part of the learning has identified the need for detailed activity planning on a weekly basis. It was agreed that planning for next year's holiday periods needs to be proactively managed.

The project has also highlighted the requirement of a cultural change. Particular reference was made to the description of clinical engagement by the Chief Executive and he would like to see the benchmark for engagement and how this is measured it should also be the ongoing feature of this piece of work.
Discussions took place as to whether we had the correct workforce model in place and

whether we had enough staff, it was acknowledged that we definitely had a workforce issue in theatres and David Birkenhead had had discussions with Kristina Rutherford with regard to over-establishing in some areas to enable continuity, Four Eyes have been asked to do some workforce modelling.

Peter Middleton stated that he and several other Membership Councillors had taken part in theatre week, he found it insightful and when he interviewed several patients at the end of it, the feedback was extremely positive. Peter echoed what had already been said regarding technology making it possible, people make it happen.

The Chair of the Committee summarised discussions by saying that productivity is improving with regard to the lists we are running, however, there is an issue relating to fallow lists and also issues relating to planning and engagement.

ACTION : The update in December to include a forward look a review of engagement and external influences that impact on theatre productivity, all to be brought together in one report – **AB/LH**

FINANCE AND PERFORMANCE

230/10/15 MONTH 6 PERFORMANCE SUMMARY REPORT

The Chair of the Committee agreed to go straight to questions. The Director of Finance highlighted the key messages.

The Chief Executive asked if there was an emerging positive trend with regard to GP referrals, the Director of Transformation and Partnerships confirmed that we had seen an increase in September and a YTD increase of 2.7% in referrals but that it is too early to say that it is a trend. Anna Basford confirmed that she would be attending a Partnership Steering Group meeting later that day and would raise the question based on Month 6.

The Executive Director of Nursing commented that the majority of activity is below plan and questioned whether we had the right plan. Julie Dawes also commented that within A&E we have had an increase in activity but are below plan, it was acknowledged that within A&E there is definitely learnings with regard to the modelling.

It was noted that with regard to CIP schemes for 16/17 the Trust have been working with EY and would like to see more schemes which are much less income related with more cost reduction schemes. Anna Basford confirmed that directly following Finance & Performance she had a meeting with EY, Four Eyes and internal leads for demand planning, to route map our approach for next year. The Acting Director of the Health Informatics Service asked for EPR to be considered for 16/17 as this will have a massive impact on activity.

The question was asked as to how we might approach the demand, workforce and budget setting process with more direct frontline input and also to ensure we allocate sufficient time at Board and Directors' meetings. The Director of Finance commented that we would keep the Board updated, however, activity levels need to be visible first as this drives headcount, I&E and cash. It was noted that on the governance schedule which was

developed with EY there is a planned workshop to present the activity based modelling on the 18 November and that, internally, the assumptions and procedure to drive the process can be shared ahead of this.

The Chair commented that moving forward, activity is going to be crucial over the next 2-3 years and getting an early sight of activity and the main assumptions will be important for Board understanding. The Director of Finance advised that the 16/17 forecast will be provided at the next Finance & Performance meeting following EY and Trust work programme.

231/10/15 MONTH 6 CONTRACT ACTIVITY AND INCOME PERFORMANCE

The Committee noted the contents of this paper.

232/10/15 MONTH 6 FINANCIAL NARRATIVE AND MONTHLY DASHBOARD

The Executive Director of Finance circulated a slightly amended Dashboard which had a revised year to date cash figure of £8.61m. The key messages were noted as follows:

The forecast year end I&E position is still £22.2m deficit against a planned deficit of £20m excluding restructuring costs. Looking at the Month 6 position, planned day case and elective income is beneath the forecasted level. The Division are, however, looking at compensatory schemes to generate that income, but this has a greater element of risk for the forecast. Pressures are emerging within PMU which are being tested. The finance and nursing teams are working together to have a closer look at nursing forecast. It was acknowledged that there will be pressure over winter rather than any further financial opportunity. It was felt that there was still an opportunity relating to medical agency spend and a paper will be going to WEB this week.

It was noted that there is potential for small amounts of income from the Commissioners relating to systems resilience and non-elective care. With regard to the provision for income risks for the year end, the first meeting will be taking place this week with the Commissioners to look at contract penalties for the first quarter of this year.

A further look at restructuring costs incurred to date is required with regard to the accounting procedure and discussions will take place with Monitor with regard to the financial treatment of these costs.

With regard to the Vanguard bid, if we are successful, the Trust may be in line for a retrospective payment with regard to costs already incurred which will affect the I&E position.

Cash is predictably quite low in March 2016 and two things are driving the £18m cash support £3m over the £15m originally planned, namely the trading position as forecasted at £22m not £20m and further restructuring costs (EY) of £1m which are built into the forecast. 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.

Discussions took place with regard to EBITDA, cash and the interface required between medicine and surgical divisions. It was noted that detailed bed modelling in medicine has been carried out and we need to do the same for surgery. The division know what is required but it is not a quick win.

The Chair summarised discussions and the issue comes back to capacity, it is also recognised that at this point in time there are still risks around the year end forecast. There is no short-term solution, but it is worth trying to get behind what is happening with the medicine bed base. The Executive Director of Nursing stated that if we experience more demand over winter than is anticipated we may physically be at the point where we have no more beds so there is a pressure on the whole system to work to find a solution.

ACTION – To provide a report re bed base and interface between surgery and medicine **- JD**

The Director of Transformation & Partnership commented that with the issues raised our preparation going into the next PRM with Monitor is critical.

The Assistant Director of Finance, Kirsty Archer, informed the Committee of a change in the Monitor Risk Rating matrix and how this is measured, the new 'Financial Sustainability Risk' matrix has been used for the first time at this meeting. The Chief Executive asked Kirsty to talk him through the new matrix outside this forum. It was agreed that a one-page summary be circulated to the Committee.

ACTION - To circulate a one-page summary of the changes to Monitor's Risk Rating matrix. **- KA**

The Committee approved the paper.

233/10/15 MONTH 6 COMMENTARY ON MONITOR FINANCIAL RETURN

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

The Committee noted the paper.

234/10/15 CONTRACTUAL MEDIATION UPDATE

The Director of Transformation & Partnerships reported that there are no additional issues for the Committee, but highlighted the issue with regard to the contract and the transfer of services to Locala for community care which is being managed. It was noted that residual costs are built into the I&E forecast, but not the income risk. It was agreed thatCHFT must get paid by CCGs for the work it is undertaking.

STRATEGIC ITEMS

235/10/15 TURNAROUND PROGRAMME UPDATE

The Chief Executive reported that the main conversation at the last TE meeting was how to get back to the £20m deficit in 15/16. Next year we have identified £13m against a plan of £16m, it was noted that this is a positive position and it was acknowledged that lots of

people are doing a lot of hard work to try to make a shift from income dependant schemes to more cost based reduction schemes, which are much harder to visualise. £10m of the £13m is at the gateway 1 stage with £1m at gateway 2 and another £1m waiting to go to gateway 2 and together with the EY work we hope to push that further. The communication message to go into the organisation is to thank everyone for their efforts so far, but a further push is required to get to where we need to be. It was noted that the EPR go live in August may be pushed back due to annual leave but this is still under review.

236/10/15 CIP 15/16 £14m/£18m PROGRESS AND PLANNING

It was noted that depth of coding has been impressive so far, however, there is a challenge process with the CCGs and we need to be cautionary as this supports HSMR.

ACTION : To provide an update with regard to the latest position of the 16/17 CIP schemes - **AB**

237/10/15 EPR UPDATE

The Acting Director of Health Informatics Service confirmed that the September milestones had been achieved and we are about to move to the 'Engaged' phase of the project which will mean it will become more visible. It was noted that the first gateway review around governance has been agreed and this will happen at the end of October with a report going to the November Board Meeting.

It was noted that the financial positon is still showing an underspend based on the same reasons as discussed in previous meetings, predominantly, trigger points for contract payments have been negotiated to later in the year. Discussions are taking place within the organisation with regard to when it would be best to 'go live' and the re-forecast is based on a November implementation date.

TREASURY MANAGEMENT

238/10/15 CASH FLOW 13 WEEK FORECAST

The Director of Finance highlighted the actions being taken to protect cash as well as the Trust-wide systems improvements that have been mobilised to strengthen the cash management and reporting arrangements. The specifics on this will be shared at the next meeting.

GOVERNANCE

239/10/15 WORKPLAN

There were no items added to the Workplan.

240/10/15 MATTERS FOR THE BOARD AND OTHER COMMITTEES

- Activity
- Medicine/Surgery
- EPR – November Board

241/10/15 ANY OTHER BUSINESS

The Chair requested the provisional dates for 2016 are circulated to committee members.

DATE AND TIME OF NEXT MEETINGS

Tuesday 17 November, 9.00am – 12.00noon, Meeting Room 4, 3rd Floor, Acre Mill Outpatients.

Apologies received : Lesley Hill

APPENDIX A

Minutes of the Audit and Risk Committee Meeting held on Tuesday 20 October 2015 in Acre Mill, 3rd Floor commencing at 10:45pm

PRESENT

Prof Peter Roberts	Chair, Non-Executive
Mr Phil Oldfield	Non-Executive Director

IN ATTENDANCE

Mr Stuart Baron	Assistant Director of Finance
Mr Chris Boyne	Internal Audit Manager
Mrs Jillian Burrows	Senior Manager, KPMG
Mrs Andrea McCourt	Head of Governance and Risk
Mrs Victoria Pickles	Company Secretary
Mrs Clare Partridge	External Audit
Mr Peter Middleton	Membership Councillor
Mr Iain Wallace	Interim Director of Finance
Miss Kathy Bray	Board Secretary (minutes)
Mr Victor Wotherspoon	Chief Medical Engineer (for part of meeting)

Item

67/15 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Mr Jeremy Pease, Non-Executive Director
Mrs Julie Dawes, Executive Director of Nursing and Operations
Mr Keith Griffiths, Executive Director of Finance
Mrs Adele Jowett, Local Counter Fraud Specialist

68/15 MINUTES OF THE MEETING HELD ON 21 JULY 2015

The minutes of the meeting were approved subject to the following amendments:-

- 53/15 Claims Policy – The Head of Governance and Risk clarified that part 36 financial settlements were used but this was not specific to financial claims.

69/15 DECLARATIONS OF INTEREST

There were no conflicts of interest declared at the meeting.

70/15 MATTERS ARISING AND ACTION LOG – No issues outstanding from the Action Log

- **Payroll Report** – update report was not available from Workforce and OD. It was agreed that the Company Secretary would ensure that an update is available from them by the next meeting.

ACTION: Company Secretary

- **Review of Standing Financial Instructions/Scheme of Delegation** – Following liaison with Procurement the Company Secretary reported that an updated version of these two documents would be brought to the January ARC Meeting. This would reflect the Monitor directive re financial limits.

ACTION: Company Secretary

- **Review of Outstanding Internal Audit Recommendations**.
  - **Medical Devices** – Victor Wotherspoon, Chief Medical Engineer attended the meeting to give an update on the current position around the Internal Audit recommendations regarding inventory/maintenance checks and

medical devices training. It was acknowledged that a great amount of work was on-going to address this.

It was agreed:-

- that a policy on writing off devices was required. It was appreciated that with the size of the organisation and community service being led by Locala it was difficult to maintain a full current inventory and this was compounded by the limited number of workforce available in Medical Devices.
- that a review of CQC reports from other Trusts with failings on medical devices would be undertaken for lessons to be learnt
- that the manufacturers' guidance on maintenance be reviewed and where appropriate maintenance from the default period of 3 years is amended as appropriate.
- the Chief Medical Engineer agreed to obtain an opinion from the external auditor who had undertaken a mini audit on medical engineering to give a view on the Trust's compliance with other Trusts.
- that an updated Internal Audit (IA) report be brought back to ARC in January via the IA report.
- support from Ward/Departmental staff had been asked for to enable staff to be released to undertake training.

It was agreed that all IA reports would be reviewed to reword any areas which could not be signed up to and the updated report be brought back to ARC in January 2016. **ACTION: VP/CB**

- **Governance Structures –** Agreed that Internal Audit would review the PWC recommendations.

- **Clinical Audit & IA reports –** Peter Middleton updated on his attendance at a seminar and agreed to circulate the paperwork. Discussion took place regarding Clinical Audit work and it was agreed that a review of Clinical Audit and Internal Audit plans be undertaken with scrutiny of Quality Committee and Clinical Audit Plans.
  Action: VP

71/15 COMPANY SECRETARY'S BUSINESS:

a. **Review of Terms of Reference** – approved subject to one small amendment to include Quality Directorate representation in attendance.

b. Review of Board Assurance Framework – The contents of the document were received and noted. It was acknowledged that this was a live document.

c. Standards of Business Conduct Policy – The tracked changes approved.

d. Review ARC Committee Self-assessment – The collated responses were received and noted. An Action Plan had been drawn up and this was agreed.

e. Declaration of Interests Registers - updated registers were received. It was suggested by External Audit that a column be inserted to indicate the date when the relevance of the declaration was confirmed.
ACTION: Board Secretary

f. Regulatory Compliance Issues – An updated template was received and noted. There were no issues to note.

g. ARC Annual Workplan – The updated workplan was received and approved. It was

noted that 'review of Internal Audit and Clinical Audit Plans' would be included on the next issue of the workplan.

ACTION: Board Secretary

The Committee **RECEIVED** and **APPROVED** the report.

72/15 REVIEW OF RISK MANAGEMENT SYSTEM

The Head of Governance and Risk updated the Committee on the development of risk management systems within the organisation, particularly progress in the development of the Board Assurance Framework and Corporate Risk Register. For assurance, a copy of the staff monthly newsletter had been circulated which demonstrated the significant work being done to improve systems for learning within the organisation.

It was noted that an internal audit of the risk register and board assurance framework had received significant assurance.

The Chair referred to discussions which had taken place at the Finance and Performance Meeting held earlier that morning and the work which was being undertaken to understand the rise in Clinical Negligence costs. This was both a corporate risk and reputational risk for the Trust. It was noted that Internal Audit would investigate this further.

ACTION: Internal Audit

73/15 EXECUTIVE DIRECTOR OF FINANCE'S BUSINESS

a. Reference Costs 2013/14 Audit and Costing Submissions 2014/15 – The Assistant Director of Finance reported on the outcome of the audit of 2013/14 costing and clinical coding were received together with a response to the issues raised during the audit and progress against the resulting action plan. It was noted that this report also included was an overview of the 2014/15 submissions for reference costs and the Patient Level Costing (PLICS) & Materiality and Quality Score (MAQS) voluntary submissions.

b. Review of Waiving of Standing Orders

The Interim Director of Finance presented a report detailing the waving of Standing Orders for the period 1 July to 30 September 2015. During the quarter there had been 9 orders placed as a result of standing orders being waived at a total cost of £243,804.35.

There were 6 tenders over the second quarter, the value of spend was £8,404,075.68. There were no areas of concern to escalate to the Board.

The Committee **RECEIVED** and **APPROVED** the report.

c. Review of Losses and Special Payments

In accordance with the Standing Financial Instructions, the Assistant Director of Finance presented the losses and special payments for the period 1 July to 30 September 2015. There were no areas of concern to escalate to the Board.

The Committee **RECEIVED** the report.

74/15 INTERNAL AUDIT

a. Outstanding Internal Audit Recommendations – The Committee agreed the need for it to be proactive and hold managers to account in the future when agreed actions in response to recommendations are not delivered. At the present time the areas of concern included Staff Bank and Agency, E-Rostering, E-Expenses and Estates Property and Income. It was agreed that the Internal Audit Manager and Company Secretary would work together to prioritise and invite appropriate personnel to attend

future Audit and Risk Committee Meetings.
ACTION: CB/VP

The Committee **RECEIVED** the report.

b. Progress Report – The Internal Audit Manager reported that since the last reported to the Audit & Risk Committee in July 2015 the following reports had been issued to and discussed with management.

Report No	Report	Opinion
CH01/2016	Availability of Critical Medicines	Limited
CH02/2016	Compliance with ISO Standard-27001	Significant
CH03/2016	Budget Setting and CIP	Significant
CH04/2016	Medicines - Community Midwives	Limited
CH05/2016	Authorisation Level Approvals (Authorised Signatory List)	Limited
CH07/2016	Overseas Visitors	Significant
CH08/2016	Absence Management Guidance	Not Applicable as best practice guidance is being provided to the Trust for consideration.
CH09/2016	Pennine Property Partnership	Significant
CH10/2016	Safe Management of Contractors	Significant
CH11/2016	Post Project Evaluation – Acre Mills	Significant
CH12/2016	Board Assurance Framework & Risk Management (Risk Registers)	Significant

The reports with limited assurance were discussed in detail:-

a. CH01/2016 - Availability of Critical Medicines
The objective of the review was to gain assurance that the Trust has controls in place to ensure that critical medicines are available when required. Further work is needed to ensure all staff are aware of the Medicines Finder Pathway and know how to obtain medicines as outlined in the Medicines Code.

The Specialist Nurse, Medicines Management is meeting with all Ward Managers individually to discuss previous audits and strategies to help to reduce missed doses by sharing "Top Tips" to cascade to their Nursing Teams. The implementation and monitoring of "Top Tips" should significantly reduce the number of missed doses.

It was agreed to cascade the Internal Audit recommendations re critical medicines to Quality Committee. **Action: VP**

b. CH04/2016 - Medicines - Community Midwives
The audit aimed to gain assurance that the Foundation Trust had adequate systems in
place so that registered Community Midwives may supply and administer, on their own

initiative, any of the substances that are specified in medicine legislation under midwives exemptions, provided it is in the course of their professional midwifery practice.

The review concluded with a limited opinion as a number of issues were noted during the course of the review that require management attention, these have been briefly outlined as follows:

- Evidence of conducting audits that monitor compliance with the Medicines Code
- (Section 31) needs to be maintained.
- Ensuring all Patient Group Directions' are up to date and that all Community Midwives
- (CMW's) signatures have been countersigned a by Manager.
- Ensuring drugs administered are correctly recorded on the patient's Prescription Chart and patient's notes.
- All drugs to be stored in a locked receptacle.
- Ensuring all CMW's conduct regular checks on drugs and equipment and that this is checked by a Manager.

c. CH05/2016 – Authorisation Level Approvals (Authorised Signatory List)
The audit aimed to establish what rules and procedures are in place over sign off of payroll changes.

The review concluded that robust systems need to be in place to provide assurance that those officers authorising pay and non-pay expenditure are approved to do so and that one of the main control systems in place, the Authorised Signatory List, was found to be out of date and not fit for purpose.

As a result there is an increased risk of loss and the report recommends immediate actions to be undertaken to address the weaknesses in both non-pay and pay systems.

In addition, the report included a number of suggestions regarding how systems can be further enhanced to take full benefit of electronic working developments, to provide better information and control for managers and to automate a number of the processes involved in maintaining authorisation approval controls.

The Committee **RECEIVED and APPROVED** the report.

75/15 **LOCAL COUNTER FRAUD SERVICES**
On behalf of the Local Counter Fraud Officer, the Internal Audit Manager presented the updated progress report, the contents of which were received and noted.

Progress with the joint random exercise being undertaken by the Trust and Counter Fraud to raise awareness of declarations of interests was on-going. 20 members of staff had yet to respond. It was agreed that a final reminder to be sent on behalf of the Committee.
Action: VP

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

76/15 **EXTERNAL AUDIT**
The External Auditors presented the Technical Update and its contents were received and noted. There were no specific issues to draw to the Board's attention.
The Committee **RECEIVED and NOTED** the report.

EXPRESSIONS OF CONCERN AND WHISTLEBLOWING

77/15 No information had been received.

78/15 **INFORMATION TO RECEIVE**

The following information was received and noted:-

a. Quality Committee Minutes – 28.7.15, 25.8.15
b. Risk & Compliance Group Minutes – 14.7.15, 11.8.15, 8.9.15
c. THIS Management Board – 29.7.15, 2.9.15
d. Audit and Risk Meeting Dates 2016 – Amendments required:-
   19.4.16 to move to 20.4.16. 19.7.16 meeting to be moved to another date.
   26.5.16 possible to move 1 hour to accommodate External Audit – TBC

79/15 **RE-TENDERING OF EXTERNAL AUDITORS**

It was noted that in July 2012, the Trust undertook a tendering exercise for the provision of external audit services commencing October 2012. As a result the Membership Council formally appointed KPMG as the Trust's external auditors for a period of 3 years with the option to extend to 5 years if required.
The 3 year term of contract was due to finish. Given the current position in relation to the Trust's breach of licence and the development of the five year strategic plan, there was significant benefit of maintaining the current arrangement with KPMG as the external auditor and extending the contract for the next two annual accounts processes. A detailed process for re-tendering the contract would be brought to the Audit and Risk Committee and Membership Council in April 2017, to enable contract award in July 2017 for commencement October 2017.

Discussion took place regarding the service satisfactory provided and it was agreed that the contract should be extended to a further 2 years. It was agreed that fee negotiations should be pursued by the Executive Director of Finance and the Non-Executive Directors.
ACTION: KG/PR/PO
WORKPLAN: April 2017

80/15 **ANY OTHER BUSINESS**

There were no matters to report

81/15 **MATTERS TO CASCADE TO BOARD OF DIRECTORS:-**

- **Board Assurance Framework**
- **Audit and Risk Committee Terms of Reference**
- **Internal Audit Follow-up Recommendations**
- **Internal Audit Progress Report – 3 Limited Opinion Audits**
- **Local Counter Fraud Services Progress Report**
- **Clinical Audit Plans**
- **Audit and Risk Committee Work Plan**
- **Clinical Negligence costs – discussion from F&P Committee – to be reviewed by IA**
- **External Audit Re-tender**

82/15 **DATE AND TIME OF NEXT MEETING**

Wednesday 20 January 2015 at 10.45 am - 3rd Floor Acre Mills Outpatient Building.
Other meeting dates in 2016 to be confirmed.
ACTION: Board Secretary

SUMMARY ON A PAGE

MEETING OF: AUDIT AND RISK COMMITTEE

DATE OF MEETING: 20 October 2015

FREQUENCY OF MEETINGS: 5 PER ANNUM

CHAIR OF MEETING: Prof. Peter Roberts

WAS MEETING QUORATE? Yes

SUMMARY OF KEY BUSINESS/ACTIONS AT THE MEETING:

1. **MATTERS ARISING AND ACTION LOG – No issues outstanding**
   - **Payroll Report** – update not available from Workforce and OD. Agreed that update be available from them by the next meeting. **ACTION: VP**
   - **Review of SFI/SoD** – Updated version of documents to be received at January 2016 ARC Meeting. **ACTION: VP**
   - **Review of Outstanding Internal Audit Recommendations**.
     - **Medical Devices** – Vic Wotherspoon attended and gave an update on the current position around the Internal Audit recommendations. A number of actions agreed including a clear understanding of equipment review dates to take into account manufacturers guidance and consideration of CQC inspection reports in relation to medical devices. An updated report to be brought back to ARC in January via the Internal Audit progress report.

     Agreed that all IA recommendation be reviewed to ensure that they were reasonable and achievable. Updated report be brought back to ARC in January – **ACTION: VP/CB**
   - **Governance Structures –** Agreed that Internal Audit would review the PWC recommendations.
   - **Clinical Audit & IA reports –** Peter Middleton updated on his attendance at a seminar on audit committee responsibilities in relation to clinical audit. It was agreed that the ARC should receive the clinical audit plan alongside the internal audit plan. It was agreed that this would be discussed further with Quality Committee.

2. COMPANY SECRETARY'S BUSINESS:

a. Review of TOR – one small amendment to include Quality Directorate representation in attendance – approved.
b. Review of Board Assurance Framework – agreed – live document.
c. Standards of Business Conduct Policy – tracked changes approved.
d. Review ARC Committee Self-assessment – collated responses received. Action plan drawn up and agreed.
e. Declaration of Interests Registers - updated registers received.
f. Regulatory Compliance Issues – updated template received and noted. No issues to note.
g. ARC Annual Workplan – updated workplan received and approved.

3. REVIEW OF RISK MANAGEMENT SYSTEM

Update received on the development of risk management systems within the organisation, particularly progress in the development of the Board Assurance Framework and Corporate Risk Register. It was noted that an internal audit of the risk register and board assurance framework had received significant assurance.

4. EXECUTIVE DIRECTOR OF FINANCE'S BUSINESS

a. Reference Costs 2013/14 Audit and Costing Submissions 2014/15 – The outcome of the audit of 2013/14 costing and clinical coding were received together

with a response to the issues raised during the audit and progress against the resulting action plan. Also included was an overview of the 2014/15 submissions for reference costs and the Patient Level Costing (PLICS) & Materiality and Quality Score (MAQS) voluntary submissions.

b. Review of Waiving of Standing Orders – Received and approved.

c. Review of Losses and Special Payments – Received and noted.

5. INTERNAL AUDIT

a. Outstanding Internal Audit Recommendations – The Committee agreed the need for it to be proactive and hold managers to account in the future when agreed actions in response to recommendations are not delivered. Agreed that the Internal Audit Manager and Company Secretary would work together to prioritise and invite appropriate personnel to attend future Audit and Risk Committee Meetings.

ACTION: CB/VP

b. Progress Report – Total of 11 Reports received. 3 Limited Assurance Reports:- Availability of critical medicines (missed doses), Medicines – community midwives (compliance with updated PGDs), Authorisation Level Approvals (weaknesses in the authorised signatory list control type systems for both pay or non-pay systems)

Agreed to cascade IA recommendations re critical medicines to Quality Committee.

Action: VP

6. LOCAL COUNTER FRAUD SPECIALIST REPORT

Updated progress report received and noted. Progress with joint exercise noted. 20 members of staff yet to respond. Agreed final reminder to be sent on behalf of the Committee. **Action: VP**

7. EXTERNAL AUDIT – Technical Update received and noted. No specific issues to bring to the Board's attention.

8. INFORMATION TO RECEIVE

a. Quality Committee Minutes – 28.7.15, 25.8.15
b. Risk & Compliance Group Minutes – 14.7.15, 11.8.15, 8.9.15
c. THIS Management Board – 29.7.15, 2.9.15
d. Audit and Risk Meeting Dates 2016 – Amendments required:-
19.4.16 to move to 20.4.16. 19.7.16 meeting to be moved to another date.
26.5.16 possible to move 1 hour to accommodate External Audit - TBC

9. RE-TENDERING OF EXTERNAL AUDITORS

Contract to be extended to a further 2 years. Fee negotiations to be pursued.

ACTION: KG/PR/PO

10. ANY OTHER BUSINESS – No matters to report

11. MATTERS TO CASCADE TO BOARD OF DIRECTORS:-

- Board Assurance Framework
- Audit and Risk Committee Terms of Reference
- Internal Audit Follow-up Recommendations
- Internal Audit Progress Report – 3 Limited Opinion Audits
- Local Counter Fraud Services Progress Report
- Clinical Audit Plans
- Audit and Risk Committee Work Plan
- Clinical Negligence costs – discussion from F&P Committee – to be reviewed by IA
- External Audit Re-tender

15. DATE AND TIME OF THE NEXT MEETING:
Wednesday 20 January 2016 at 10.45 am

AUTHOR OF THIS REPORT
NAME: Kathy Bray
POSITION: Board Secretary

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

AUDIT & RISK COMMITTEE

TERMS OF REFERENCE

Version:	1.1 (first draft circulated for review to Chair / DoF / DDof)
Approved by:	Board of Directors
Date approved:	30.10.15
Date issued:	20.10.15
Review date:	October 2016

AUDIT & RISK COMMITTEE TERMS OF REFERENCE

1. Authority

1.1 The Audit and Risk Committee is constituted as a standing sub committee of the Foundation Trust's Board of Directors. Its constitution and terms of reference shall be as set out below, subject to amendment at future board of directors meetings. The Audit & Risk Committee shall not have executive powers in addition to those delegated in these terms of reference.

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

1.3 The Audit & Risk Committee is authorised by the Board of Directors to obtain outside legal or other specialist ad-hoc advice at the expense of the organisation, subject to budgets agreed by the Board. The Committee is authorised by the Board of Directors to request the attendance of individuals and authorities from outside the foundation trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.

2. Purpose

2.1 The Audit & Risk Committee will have primary responsibility for monitoring and reviewing financial and other risks and associated controls corporate governance and assurance frameworks.

2.2 The Audit and Risk Committee will have close working relationships with Quality Committee which has responsibility for oversight and monitoring of clinical risks.

2.3 The Board of Directors is responsible for ensuring effective internal control including:

- Management of the foundation trust's activities in accordance with statute and regulations;
- The establishment and maintenance of a system of internal control to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided and reliable financial information produced, and that value for money is continuously sought.

2.4 The Audit & Risk Committee shall provide the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Foundation Trust's activities both generally and in support of the statement of internal control. In addition the Audit & Risk Committee shall:

- Ensure independence of External and Internal audit;
- Ensure that appropriate standards are set and compliance with them is monitored, in all areas that fall within the remit of the Audit & Risk Committee; and
- Monitor corporate governance (e.g. Compliance with terms of licence, constitution, codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests).

3. Membership

3.1 The Committee shall be composed of not less than three Non-Executive Directors, at least one of whom should have recent and relevant financial experience. The Trust Chair will not be a member of the Audit & Risk Committee.

3.2 A quorum shall be two members.

4. Attendance

4.1 Only members of the Committee have the right to attend. The Director of Finance, Deputy Finance Director, Company Secretary and Head of Internal Audit of the Foundation Trust shall generally be invited to routinely attend meetings of the Audit & Risk Committee.

4.2 A representative of the External Auditors may normally also be invited to attend meetings of the Audit & Risk Committee.

4.3 The Chief Executive should be invited to attend at least annually to discuss the assurance supporting the Annual Governance Statement and when considering the Internal Audit plan. Other Directors are expected to attend as required by the Audit and Risk Committee and where items relating to their areas of risk or responsibility are being considered.

4.4 The Foundation Trust Chair may be invited to attend meetings of the Audit & Risk Committee as required.

4.5 A representative of the Local Counter Fraud Service is invited to attend all meetings of the Audit & Risk Committee.

4.6 The Chair of the Board of Directors will appoint a Membership Councillor to attend the public meetings of the Audit and Risk Committee. The appointment will be reviewed each year.

4.7 Attendance is required by members at 75% of meetings. Members unable to attend should inform the Board secretary at least 7 days in advance of the meeting except in extenuating circumstances.

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

5. Administration

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

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

6. Frequency of meetings

6.1 Meetings shall be held at least three times per year, with additional meetings where necessary. The Committee must consider the frequency and timing of meetings required to discharge all of its responsibilities on a regular basis.

6.2 The External Auditor shall be afforded the opportunity at least once per year to meet with the Audit & Risk Committee without Executive Directors present.

7. Duties

7.1 Governance, internal control and risk management

7.1.1 To ensure the provision and maintenance of an effective system of integrated governance, risk identification and associated controls, reporting and governance.

7.1.2 To maintain an oversight of the Foundation Trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control-related disclosure statements.

7.1.3 To review processes to ensure appropriate information flows to the Audit and Risk Committee from executive management and other board committees in relation to the Trust's overall internal control and risk management position (in liaison with the Quality Committee).

7.1.4 To review the adequacy of the policies and procedures in respect of all counter-fraud work.

7.1.5 To review the adequacy of the Foundation Trust's arrangements by which foundation trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern.

7.1.6 To review the adequacy of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks.

7.1.7 The adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements.

7.2 Internal audit

7.2.1 To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation.

7.2.2 To oversee on an ongoing basis the effective operation of Internal Audit including:

- Adequate resourcing;
- Its co-ordination with External Audit;

Complying with the public sector Internal Audit Standards

- Providing adequate independence assurances;
- Having appropriate standing within the Foundation Trust; and

- Meeting the internal audit needs of the Foundation Trust.

7.2.3 To consider the major findings of Internal Audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

7.2.4 To consider the provision of the Internal Audit Service, the cost of the audit and any questions of resignation and dismissal. The appointment/dismissal of Internal Audit remains the responsibility of the Director of Finance.

7.2.5 To conduct an annual review of the Internal Audit function.

7.3 External audit

7.3.1 To make a recommendation to the Membership Council in respect of the appointment, re-appointment and removal of an External Auditor. To the extent that that recommendation is not adopted by the Membership Council, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

7.3.2 To discuss with the External Auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy. This should include discussion regarding the local evaluation of audit risks and assessment of the foundation trust associated impact on the audit fee.

7.3.3 To assess the External Auditor's work and fees on an annual basis and, based on this assessment, make a recommendation to the Membership Council with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the External Auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

7.3.4 To oversee the conduct of a market testing exercise for the appointment of an Auditor at least once every five years and, based on the outcome, make a recommendation to the Membership Council with respect to the appointment of the Auditor.

7.3.5 To review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

7.3.6 To develop and implement a policy on the engagement of the External Auditor to supply non-audit services.

7.3.7 To consider the provision of the External Audit Service, the cost of the audit and any questions of resignation and dismissal.

7.4 Annual accounts review

7.4.1 To review the annual statutory accounts, before they are presented to the Board of Directors, to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- The meaning and significance of the figures, notes and significant changes;
- Areas where judgment has been exercised;

- Adherence to accounting policies and practices;
- Explanation of estimates or provisions having material effect;
- The schedule of losses and special payments;
- Any unadjusted statements; and
- Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

7.4.2 To review the annual report and annual governance statement before they are submitted to the Board of Directors to determine completeness, objectivity, integrity and accuracy.

7.4.3 To seek assurance from the Quality Committee that the Trust's Quality Account and opinions of External Audit have been scrutinised in detail.

7.4.4 To review all accounting and reporting policies and systems for reporting to the Board of Directors.

7.5 Standing orders, standing financial instructions and standards of business conduct

7.5.1 To review on behalf of the Board of Directors the operation of, and proposed changes to, the Standing Orders and Standing Financial Instructions, the Constitution, Codes of Conduct and Standards of Business Conduct; including maintenance of Registers.

7.5.2 To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

7.5.3 To review the Scheme of Delegation.

7.6 Other

7.6.1 To review performance indicators relevant to the remit of the Audit & Risk Committee.

7.6.2 To examine any other matter referred to the Audit & Risk Committee by the Board of Directors and to initiate investigation as determined by the Audit & Risk Committee.

7.6.3 To ensure that the Quality Committee performs at least an Annual Review of the clinical audit plan and considers the findings and recommendations of in-year reports, ensuring the plan and extras are consistent with the strategic direction of the Trust.

7.6.4 To develop and use an effective assurance framework to guide the Audit & Risk Committee's work. This will include utilising and reviewing the work of the Internal Audit, External Audit and other assurance functions as well as reports and assurances sought from Directors and Managers and other investigatory outcomes so as fulfil its functions in connection with these terms of reference.

7.6.5 To consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health and social care sector and professional bodies with responsibilities that relate to staff performance and functions.

7.6.6 To review the work of all other Board sub-committees as part of the Audit and Risk Committee assurance role. The Audit and Risk Committee will receive a self assessment and annual report from each of the committees for approval.

8. Reporting

8.1 The minutes of all meetings of the Audit & Risk Committee shall be formally recorded and submitted, together with recommendations where appropriate, to the Board of Directors. The submission to the Board of Directors shall include details of any matters in respect of which actions or improvements are needed. This will include details of any evidence of potentially *ultra vires*, otherwise unlawful or improper transactions, acts, omissions or practices or any other important matters. To the extent that such matters arise, the Chair of the Audit & Risk Committee shall present details to a meeting of the Board of Directors in addition to submission of the minutes.

8.2 The Audit & Risk Committee will report annually to the Board of Directors in respect of the fulfilment of its functions in connection with these terms of reference. Such report shall include but not be limited to functions undertaken in connection with the governance statement; the assurance framework; the effectiveness of risk management within the foundation trust; the integration of and adherence to governance arrangements; its view as to whether the self-assessment against standards for better health is appropriate; and any pertinent matters in respect of which the Audit & Risk Committee has been engaged.

8.3 The Foundation Trust's Annual Report shall include a section describing the work of the Audit & Risk Committee in discharging its responsibilities.

9. Review

9.1 The Terms of Reference of the Audit & Risk Committee shall be reviewed by the Board of Directors at least annually.

NOMINATION AND REMUNERATION COMMITTEE (MEMBERSHIP COUNCIL)

TERMS OF REFERENCE

Version:	1.1 First draft circulated for review to Chair – 13.10.15 1.2 Draft submitted to Membership Council for approval – 4.11.15 1.3 Draft submitted to Board for approval – 26.11.15
Approved by:	Board of Directors & Membership Council
Date approved:	4.11.15 and 26.11.15
Date issued:	
Review date:	October 2016

NOMINATION AND REMUNERATION COMMITTEE TERMS OF REFERENCE (MEMBERSHIP COUNCIL)

1. Constitution

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

1.2 Please note that all references in these terms of reference to Non-Executive Directors are to be taken to include the Chair, unless specifically indicated otherwise.

2. Authority

2.1 The Membership Council Nomination and Remuneration Committee (the Committee) is constituted as a standing committee of the Membership Council. Its constitution and terms of reference shall be as set out below, subject to amendment at future Membership Council meetings.

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

2.3 The Nomination and Remuneration Committee is authorised by the Membership Council, subject to funding approval by the Board of Directors, to request professional advice and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

2.4 The Nomination and Remuneration Committee is also authorised to request such internal information as is necessary and expedient to the fulfilment of its functions.

3. Conflicts of Interest

3.1 The Chair of the Trust, or any Non-Executive director present at committee meetings, will withdraw from discussions concerning their own re-appointment, remuneration or terms of services.

3.2 In order to sit as a member of the committee participants must sign a declaration that they have no intention to apply for a Non-Executive Director appointment in the 12 months following attendance at the meeting of the Nomination and Remuneration Committee.

4. Nominations role

The Committee will:

4.1 Periodically review the balance of skills, knowledge, experience and diversity of the Non-Executive Directors and, having regard to the view of the Board of Directors and relevant guidance on board composition, make recommendations to the Membership Council with regard to the outcome of the review.

4.2 Review the results of the Board of Directors' performance evaluation process that relates to the composition of the Board of Directors.

4.3 Review annually the time commitment requirement for Non-Executive Directors.

4.4 Give consideration to and succession planning for Non-Executive Directors, taking into account the challenges and opportunities facing the Trust and the skills and

expertise needed on the Board of Directors in the future.

4.5 Make recommendations to the Membership Council concerning plans for succession, particularly for the key role of Chair.

4.6 Keep the leadership needs of the Trust under review at Non-Executive level to ensure the continued ability of the trust to operate effectively in the health economy.

4.7 Keep up-to-date and fully informed about strategic issues and commercial changes affecting the Trust and the environment in which it operates.

4.8 Agree with the Membership Council a clear process for the nomination of a Non-Executive Director.

4.9 Take into account the views of the Board of Directors on the qualifications, skills and experience required for each position.

4.10 For each appointment of a Non-Executive Director, prepare a description of the role and capabilities and expected time commitment required.

4.11 Identify and nominate suitable candidates to fill vacant posts within the Committee's remit, for appointment by the Membership Council.

4.12 Ensure that a proposed Non-Executive Director's other significant commitments are disclosed to the Membership Council before appointment and that any changes to their commitments are reported to the Membership Council as they arise.

4.13 Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest as well as with compliance with 'Fit and Proper Person' requirements are reported.

4.14 Ensure that on appointment Non-Executive Directors receive a formal letter of appointment setting out clearly what is expected of them in terms of time commitment, committee service and involvement outside Board of Directors Meetings.

4.15 Advise the Membership Council in respect of the re-appointment of any Non-Executive Director. Any term beyond six years must be subject to a particularly rigorous review.

4.16 Advise the Membership Council in regard to any matters relating to the removal of office of a Non-Executive Director.

5. Remuneration role

The Committee will:

5.1 Recommend to the Membership Council a remuneration and terms of service policy for Non-Executive Directors, taking into account the views of the Chair (except in respect of his own remuneration and terms of service) and the Chief Executive and any external advisers.

5.2 In accordance with all relevant laws and regulations, recommend to the

Membership Council the remuneration and allowances, and the other terms and conditions of office, of the Non-Executive Directors.

5.3 Receive and evaluate reports about the performance of individual Non-Executive Directors and consider this evaluation output when reviewing remuneration levels.

5.4 In adhering to all relevant laws and regulations establish levels of remuneration which:

5.4.1 are sufficient to attract, retain and motivate Non-Executive Directors of the quality and with the skills and experience required to lead the Trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable to the Trust;

5.4.2 reflect the time commitment and responsibilities of the roles;

5.4.3 take into account appropriate benchmarking and market-testing, while ensuring that increases are not made where Trust or individual performance do not justify them; and

5.4.4 are sensitive to pay and employment conditions elsewhere in the Trust.

5.5 Oversee other related arrangements for Non-Executive Directors.

6. Membership and attendance

6.1 The membership of the committee shall consist of Membership Councillors appointed by the Membership Council.

6.2 The Committee will normally be chaired by the Trust Chair. Where the Trust Chair has a conflict of interest, for example when the Committee is considering the Chair's re-appointment or remuneration, the Committee will be chaired by the Deputy Chair/Lead Membership Councillor.

6.3 A quorum shall be three members, two of whom must be public Membership Councillors.

7. Secretary

7.1 The Board Secretary shall be the secretary to the Committee

8. Attendance

8.1 Only members of the Committee have the right to attend Committee Meetings.

8.2 At the invitation of the Committee, meetings shall normally be attended by the Chief Executive and Director of Workforce.

8.3 Other persons may be invited by the Committee to attend a meeting so as to assist in deliberations.

9. Frequency of Meetings

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

10. Minutes and Reporting

10.1 Formal minutes shall be taken of all Committee meetings and once approved by the Committee, circulated to all members of the Membership Council unless a conflict of interest, or matter of confidentiality exists.

10.2 The Committee will report to the Membership Council after each meeting.

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

11. Performance Evaluation

11.1 The Committee shall review annually its collective performance.

12. Review

12.1 The Terms of Reference of the Committee shall be reviewed by the Membership Council at least annually.

/KB/MC-NOMREM-TOR
NOVEMBER 2015