Meeting of the Board of Directors
To be held in public

Thursday 29 January 2015 from 1:30pm

Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital.

AGENDA

1.	Welcome and introductions:- Joan Taylor, Publicly Elected Membership Councillor Mary Kiely, Staff Elected Membership Councillor	Chairman	
2.	Apologies for Absence: Prof. Peter Roberts, Non Executive Director	Chairman	
3.	Patient Story – Mary Kiely, Consultant in Palliative Medicine to attend re: Care of the Dying	Executive Director of Nursing	**APP AA PRESENTATION**
4.	Declaration of interests	All	**VERBAL**
5.	Minutes of the previous meeting ▪ Held on 18 December 2014	Chairman	**APP A**
6.	**Matters arising and review of the action log:** a. Feedback from Monitor's Investigation b. Voluntary Redundancy Scheme Update c. Health and Safety Policy d. Fire Risk Assessment e. Community Patient Equipment	Chairman Executive Director of Workforce & OD Director of Planning, Performance, Estates & Facilities "	**APP B** **VERBAL** **VERBAL**
7.	**Chairman's Report:-** a. Membership Council Meeting – 20.1.15	Chairman	**VERBAL**
8.	**Chief Executive's Report:-** a. A/E Throughput	Chief Executive	**VERBAL**
Keeping the base safe			
9.	**Integrated Board Report** - Responsive - Caring	Interim Director of Operations Executive Director of Nursing	**APP C**

	- Safety - Effectiveness - Well Led - Finance - CQUINs - Monitor Indicators - Community	Executive Director of Nursing Executive Medical Director Executive Director of Workforce and OD Executive Director of Finance Executive Director of Nursing Interim Director of Operations Executive Director of Nursing	
10.	Risk Register report	Executive Director of Nursing	**APP D**
11.	Director of Infection Prevention and Control Report	Executive Medical Director	**APP E**
12.	Care of the Acutely Ill Patient Update	Executive Medical Director	**APP F**
13.	Revalidation Report	Executive Medical Director	**APP G**
14.	Quality Report	Executive Director of Nursing	**APP H**
15.	Public Sector Equality Duty Annual Report	Ruth Mason, Associate Director of Engagement and Inclusion	**APP I**
Improvement and innovation through strategic alliance			
16.	NO ITEMS		
Transforming Care			
17.	NO ITEMS		
18.	**Update from sub-committees and receipt of minutes** ▪ Quality Committee (Minutes of 16.12.14 and verbal update from meeting held 27.1.15) ▪ Strategic Health & Safety Committee Minutes – 23.12.14 ▪ Audit & Risk Committee (Verbal update from meeting held 20.1.15)		**APP J** **APP K** **VERBAL**
Date and time of next meeting Thursday 26 February 2015 at 1.30pm Venue: Boardroom, Huddersfield Royal Infirmary.			

Resolution

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

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 29th January 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 18.12.14 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 18 December 2014.	
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 18 December 2014.

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 18 December 2014.

Appendix

Attachment:

APP A - public bod minutes - 18.12.14.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Public Board Meeting held on
Thursday 18 December 2014 in the Boardroom, Huddersfield Royal Infirmary

PRESENT

Andrew Haigh	Chairman
Dr David Anderson	Non-Executive Director
Dr David Birkenhead	Executive Medical Director
Julie Dawes	Executive Director of Nursing
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities
Julie Hull	Executive Director of Workforce and Organisational Development
Jeremy Pease	Non-Executive Director
Philip Oldfield	Non-Executive Director
Prof Peter Roberts	Non-Executive Director
Owen Williams	Chief Executive
Jan Wilson	Non-Executive Director

IN ATTENDANCE

Mags Barnaby	Interim Director of Operations
Kathy Bray	Board Secretary
George Richardson	Publicly Elected Membership Councillor
Dr Sarah Hoye	Consultant – Acute Medicine (for part of the meeting)
Mark Whitely	Allscripts Company (public observer)

Item

176/14 APOLOGIES FOR ABSENCE AND INTRODUCTIONS

Apologies were received from:-

Anna Basford	Director of Commissioning and Partnerships
Keith Griffiths	Executive Director of Finance
Dr Linda Patterson	Non-Executive Director
Victoria Pickles	Company Secretary

The Chairman welcomed everyone to the meeting.

177/14 PATIENT STORY

Dr Sarah Hoye, Consultant in Acute Medicine attended the meeting to share with the Board a verbal report, as seen through her eyes on the pressures brought about by the current workload for medical staff and the effects on patient care. The Board noted that the previous weekend had seen a national surge on NHS services. The Board recognised resultant pressures on staff and patients around A/E care, admissions and outliers, together with staff's physical ability and their desire to ensure that patient care and needs are central to everything they do.

Sarah explained that she had been a Consultant for the last 4 years and was lead for the Foundation Year 1 Doctors in the Trust. A typical working day was shared.

It was noted that the medical teams worked well together to help each other, but the stresses and pressures on them had increased. Discussion took place regarding winter pressures and some improvements had been noted for the acute medical team since the appointment of a 4th Consultant. The Board asked if there was anything further it could do to help ease the position. It was noted that approximately 30% of patients could possibly be treated closer to home and awareness of this was evident in local strategies being developed. Developments in the OBC and

reconfiguration may help to reduce pressures in the future. Work was underway to increase visibility of the senior team to support staff.

The Board thanked Sarah for her candid and honest feedback.

178/14 DECLARATION OF INTERESTS

There were no declarations of interest to note.

179/14 MINUTES OF THE MEETING HELD ON THURSDAY 27 NOVEMBER 2014

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

180/14 MATTERS ARISING FROM THE MINUTES

a. 167/14 Hard Truths – The Executive Director of Nursing advised that the issue regarding recruitment bursaries would be covered later in the agenda under item 14.

b. 168/14 Board Assurance Framework – It was noted that further work would be undertaken on the Board Assurance Framework and brought back to the Board after circulation to the Audit and Risk Committee in January.

ACTION: Agenda Item ARC and BOD – FEBRUARY 2015 (JD/VP).

181/14 ACTION LOG

There were no actions outstanding on the Action Log.

182/14 CHAIRMAN'S REPORT

a. Monitor Meeting 5.12.14 – The Chairman gave a brief overview of the meeting held with Monitor on Friday 5 December 2014 when himself, the Chief Executive, Executive Director of Finance, Director of Operations and Phil Oldfield, Non Executive Director had attended. It was noted that a summary of the meeting had been circulated from the Chairman in an email to the Board. The agenda had focussed on the current financial position and 2015/16 forecast plan. It was noted that Monitor had embargoed release of any information until the issues had been through their governance processes. Formal feed back to the Trust was expected on the 22 January 2015.

b. Joint Board to Board with South West Yorkshire Partnership NHS Foundation Trust

- **RAID Initiative** - It was noted that a meeting had taken place between the two Boards on the 8 December. The progress made with the RAID initiative was discussed. Although there had not been a reduction in the number of patients admitted to hospital, there had been a marked difference for clinicians as well as the positive view of patients on their treatment with this joint pathway of care.

- **Equality and Diversity** – A meeting in January was to take place to discuss recruitment of Board and Membership Councillors. It was noted that Non Executive recruitment did not currently pose a problem for CHFT.

183/14 CHIEF EXECUTIVE'S REPORT

a. Voluntary Redundancy Scheme Update – The Executive Director of Workforce and Organisational Development advised that the Voluntary Redundancy Scheme had been launched on the 9 December and to date 119 applications had been received. It was noted that the panel was scheduled to meet every week until 31

January when the scheme was due to close. It was noted that a report would be brought back to the Board on how the scheme was progressing next month.

ACTION: BOD AGENDA ITEM – JANUARY 2015 – (JRH).

b. Market Testing for CC2H Tender – The Chief Executive advised that the following further work a decision had been made for a single tender for the whole of the Kirklees footprint. CHFT were working in partnership with the GP Federations and other organisations to explore models of care going forward.

184/14 INTEGRATED BOARD REPORT

The Interim Director of Operations introduced the performance report as at 30 November 2014 and explained that each area would be presented in detail by the appropriate director.

- **Responsive -** the Interim Director of Operations highlighted to the Board the key issues from the Executive Summary Commentary:-
  - During the month the Trust had seen a rise in the number and acuity of urgent and emergency patients. This has resulted in outliers in both Medicine and Surgery. All the flexible beds have been opened on both sites and to date (10.12.14) 8 beds are open on ward 11. These beds were not originally part of the winter capacity. During November there was a small rise in length of stay. This had reduced to October levels at the start of December. Acute and emergency activity, however, is below contracted levels for November.
  - The 4 hour A&E access target was not achieved in November. This was the second month this quarter where it had been missed. Elective activity was down against plan for both inpatients and day cases. Elective inpatient activity is -8.9% away from target to the end of November. Activity planning for 2015/16 is now underway. There is a risk that there will be a reduction in elective activity in next year's contract.
  - Wards are still having some issues meeting their registered nurse staffing levels on each shift. Some shifts are being filled by bank and agency staff, and recruitment is underway, but this still leaves some wards down on expected numbers of staff for some shifts.
  - Un-rebased HSMR is now 102.41 against a target of 80. Our SHMI is 111. This puts us in the bottom quartile of Trusts in the country.
  - The C.diff figure to the end of November is 19 against an annual target of 18. (unavoidable 13, avoidable 6).

- **Caring – the Executive Director of Nursing reported:-**
  - **Family and Friends Test** – A/E Survey response rates. Methodology changes now put in place and currently on target.
  - **Complaints** – The overall number of complaints open was currently off trajectory and had increased in the previous 3 months. There had been no changes in the themes of complaints arising. A risk relating to this would be added to the risk register.
- **Safety – the Executive Director of Nursing reported:-**
  - **Duty of Candor** – From 27 November, the statutory Duty of Candor came into effect. This duty requires that the Trust is open and honest to all patients/relatives/carers) when an incident takes place regarding their care. The duty requires that we inform them in writing within 10 days of the incident and the investigation process.

- **Effectiveness – The Executive Medical Director reported:-**
  - **C.Diff** – 19 cases reported against a ceiling of 18 (unavoidable 13, avoidable 6).

- **HSMR** – Dr Foster data suggested that some areas of the Trust were slightly better than the national average.
- **Fractured Neck of Femur** – Improvements had been made over the previous 3 months although progress against the targets would be challenged through December were expected due to the increased trauma activity.
- **CQC Alerts** – the Board asked that thanks be forwarded to colleagues who helped prepare the information and audit work for the CQC alerts.

- **Well Led – the Executive Director of Workforce and Organisational Development reported:-**
  - **Sickness rates** – Matrix included from last month "days lost to absence". It was hoped that by next month some granularity of data will be available.
  - **Staff Survey** – The Trust's response rate was 45%. National data would be available early in the new year. It was felt that the introduction of a the quarterly staff Family and Friends Survey could have impacted on the low response rate and intitial feedback from other Trusts showed a similar position.
  - **Staff Appraisals** – Rolling position of 70% of workforce having a current appraisal noted. It was expected that a move towards undertaking appraisals within the month of birthday would be implemented ov er the next year. Divisions had provided assurance that a 100% compliance rate would be achieved by the end of March 2015**.**
  - **Workforce Numbers** - The reduction in line with MARS scheme would be shown in January figures.
  - **Long Term Sickness/Absence** – It was suggested that this should be reported separately in the future.
  - **Flu Vaccination** – Current update 52.8%. The Board wished to thank all the vaccinators and encourage front line staff who had not been vaccinated to come forward.
  - **Fire Risk Assessment** – Although the report showed only 18% compliance, the Executive Director of Planning, Performance, Estates and Facilities advised that all areas had been fire risk assessed and that the report only showed those areas where all actions had been signed off. It was agreed that more work would be put in place with regard to outstanding actions, along with timelines and a report brought back to the next Board for assurance.

ACTION: BOD AGENDA ITEM – JANUARY 2015 (LH)

- **Finance – the Deputy Director of Finance reported:-**
  Summary Year to Date
  - Elective inpatient and day case activity has seen a level of recovery in-month but remained significantly below contract.
  - The year to date deficit is £2.50m against a planned surplus of £2.73m.
  - Capital expenditure of £13.34m against revised planned £13.41m, an underspend of £0.07m (£4.67m below original plan).
  - The cash balance was £17.53m, versus a planned £17.26m, an increase of £0.27m. This incorporates drawdown of £7m of loan funded borrowing.
  - The Continuity of Service Risk Rating (CoSSR) stands at 3, although underlying performance is at level 2.
  - The Regulator, Monitor, is investigating why the Trust's financial position had deteriorated from plan.

  Summary Forecast

- The deficit excluding 'exceptional' restructuring costs is forecast to be £2.50m, against a planned £3.0m surplus. Due to their exceptional one-off nature, restructuring costs are excluded from the calculation of the CoSRR but these payments will adversely affect the cash balance.
- The year end forecast including restructuring costs is a deficit of £5.72m. This will result in a CoSRR of 2 for the year.
- CIP schemes are forecast to deliver £8.92m against the planned £19.53m. This is a shortfall of £10.61m and will have an impact on 2015/16.
- £1.5m has been committed to extra substantive nurse staffing, and winter funds have been ring-fenced.
- Receipt of additional income to support quality investments is anticipated and included in the forecast.
- The revised capital forecast, is a £21.46m spend, a reduction of £2.85m from the revised plan, (£7.74m lower than original plan).
- The forecast year end cash balance is £11.94m, against the planned £22.71m.

The Board noted the contents of the report regarding:

- **CQINS**
- **Monitor Indicators**
- **Community –** The Executive Director of Planning, Performance, Estates & Facilities agreed to obtain further information regarding patient equipment indicators, revising the Community indicators and report back to the next meeting.

ACTION: BOD AGENDA ITEM – JANUARY 2015 (LH)

RESOLVED: The Board approved the Integrated Board Report

185/14 FEEDBACK FROM MONITOR RE: Q2 SUBMISSION

The contents of the letter received from Monitor were noted:-

Continuity of services risk rating	-	2
Governance risk rating	-	Investigation open

The Trust's governance risk rating is "Under Review – Monitor is investigating financial risks and sustainability concerns at the trust, triggered by deterioration in the Trust's financial position from a CoSRR3 to an unplanned CoSSR2".

The Chief Executive encouraged Board members to look at the national picture available on Monitor's website.

186/14 RISK REGISTER REPORT

The Executive Director of Nursing presented the Trusts risks scored at 15 or above. The Board noted the contents of the paper and the top risks within the organisation:-

- Progression of service reconfiguration impact on quality and safety
- Financial risk
- Monitor Investigation
- Risk of poor patient outcomes due to dependence on middle grades and locums
- Risk of poor patient outcomes and experience caused by blocks in patient flow
- HSMR and SHMI
- Overarching risk for Infection Control

It was noted that further work was being undertaken within the Trust to raise awareness and risk management skills via the risk Master classes currently taking place.

RESOLVED: The Board received the report and noted the high level risks.

187/14 DIRECTOR OF INFECTION, PREVENTION AND CONTROL REPORT

The Executive Medical Director presented the DIPC report and highlighted areas of concern:

- Breached C.Diff position – no further cases for December had been reported – Trust remains at 19 cases against a ceiling of 18.
- Summary of 3 root cause analysis investigations undertaken during November were noted.
- Isolation challenges – unlikely to improve with Winter Plans.
- CHFT Antimicrobial management team - update on antibiotic data noted.

RESOLVED: The Board received the report.

188/14 NURSING AND MIDWIFERY SAFE STAFFING

The Executive Director of Nursing gave a power point presentation in support of the paper previously circulated. The purpose of the paper was to provide the Board with an update on the previous 'Hard Truths' investment in nursing and midwifery and a current overview of the nursing and midwifery workforce situation and challenges being addressed. The key issues within the presentation and next steps were noted:-

- Investment to date by Division – of £421,720 total part year effect 2014/15.
- Nursing and Midwifery spend with year to date variations – of £50,491,092.
- Agency reductions on nursing, midwifery and HCA pay expenditure
- Issues in relation to rota differences with the implementation of the e-rostering– discussions were on going with a flexible, mixed pattern of shifts being recommended.
- Offering Bursary – difficulties noted – agreed to continue with current Recruitment and Retention Strategy.
- Currently undertaking staffing review

In summary the Board noted that this 6 monthly review provided assurance to the Board that the Trust has a growing nursing and midwifery workforce. There remains significant risk to the workforce due to the national shortage of qualified nurses and recent level of vacancies, therefore sustained recruitment and retention of the nursing workforce is a priority.

RESOLVED: The Board received the report and agreed that a further report would be presented in February 2015.

189/14 PATIENT LED ASSESSMENT OF THE CARE ENVIRONMENT UPDATE (PLACE REPORT)

The Executive Director of Planning, Performance, Estates and Facilities presented the updated report on the progress made following the assessment in 2014. The contents of the report highlighting the performance on both sites was received and noted. The assessment had shown a significant improvement and thanks were given to the team for achieving this.

190/14 FIT AND PROPER PERSON REQUIREMENTS

The Executive Director of Workforce and Organisational Development presented the Fit and Proper Person Requirements paper. The report sets out the work being undertaken to ensure that the Trust meet the new regulations around the "fit and proper persons" standard. The contents of the paper were noted and the next steps approved.

The Deputy Finance Director reminded the Board that this also applied to Board Members with regard to their role within the Trust as Charitable Trustees.

RESOLVED: The Board received and approved the next steps.

200/14 GOVERNANCE REPORT

On behalf of the Company Secretary the Executive Director of Nursing presented the Governance Report. The report included the following issues:-

- Register of Interests for Board of Directors – any amendments to be notified to the Company Secretary.
- Amendments to Constitution – Model Election Rules to allow for electronic voting if identified.
- Workplan Update – amendments noted and approved.

RESOLVED: The Board received and approved the report.

201/14 HEALTH AND SAFETY POLICY

The Executive Director of Planning, Performance, Estates and Facilities presented the revised Health and Safety Policy. The Executive Director of Nursing requested clarification on the training days for Ward Sisters and it was agreed that this would be agreed outside the meeting.

The Chief Executive expressed concern that the Board were being asked to sign off this policy with reference to the Workplace Stress Policy but that the Board had not had sight of this. The Executive Director of Workforce and Organisational Development advised that this policy had been developed by the Well-led Group, following HSE guidance.

The Board agreed the Health and Safety Policy going forward subject to:-

- A link being sent to the Board of Directors containing the Workplace Stress Policy and that any comments are returned.
- The Board approved a sub group to agree the Health and Safety Policy and gave delegated approval to the Executive Director of Planning, Performance, Estates and Facilities, Executive Director of Workforce and Organisational Development and the Chief Executive to undertake this role.
- The Health and Safety Committee would review this policy and ensure that if necessary an action plan is drawn up.

RESOLVED: The Board received and approved the policy subject to the above undertakings.

ACTION: LH/JRH/OW

202/14 UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES

The following information was received and noted:-

Quality Committee – The Board received the minutes of the 25.11.14 and a verbal update from the meeting on 16.12.14 which included:

- An update on the implementation of the practice Perfect Week and the learning which would be carried forward to the 2nd week in January;
- Approval of the CQC Action Plan – which is being monitored monthly;
- A review of the quality aspects of the Integrated Board Report;
- Consideration of issues with A/E Staffing particularly in relation to middle grade rota's and locum staff.

Finance & Performance Committee – the Board received a verbal update from 16.12.14 which included:

- Focus on short-term CIP 2014/15 and developing 2015/16;
- Moving to more regular meetings;

- Discussion on volume of work to be undertaken during the next 8 weeks to demonstrate robust arrangements in place for 2015/16.

- **Membership Council Minutes** – 6.11.14 minutes received and contents noted.

203/14 DATE AND TIME OF NEXT MEETING

Thursday 29 January 2015 at 1.30 pm in the Large Training Room, Learning Centre, Calderdale Royal Hospital.

The Chairman thanked everyone for their attendance and contributions and closed the meeting at approximately 4.00 pm.

…….. ……

Mr Andrew Haigh, Chairman Date

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Stephanie Jones, PA to Director of Nursing
Date: Thursday, 29th January 2015	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: Individualised Care of the Dying Document - The Board is asked to receive the report and note the work done to develop the arrangements within the Trust around the care of the dying. The Board is also asked to nominate a Board member with the specific responsibility for the care of the dying.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: NA	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

Please see attached report.

Main Body

Purpose:

Please see attached report.

Background/Overview:

Please see attached report.

The Issue:

Please see attached report.

Next Steps:

Please see attached report.

Recommendations:

The Board is asked to receive the report and note the work done to develop the arrangements within the Trust around the care of the dying. The Board is also asked to nominate a Board member with the specific responsibility for the care of the dying.

Appendix

Attachment:

Individualised Care of the Dying Document (ICODD) - BOARD OF DIRECTORS - January 2015.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Thursday 29 January 2015

Individualised Care of the Dying Document (ICODD)

Background

The NICE recommended that the Liverpool Care Pathway (LCP) for supporting patients in the last days of life was reviewed by the Neuberger panel which reported in July 2013. The review produced evidence that in some parts of the country the LCP had not been used appropriately and therefore it recommended that it be withdrawn from use by July 2014. There are no plans for a national replacement document. The Leadership Alliance for the Care of the Dying Person has identified 5 key priorities for the care of dying patients:

- The possibility that a person may die within the next few days or hours is recognised and communicated clearly.
- Sensitive communication takes place between staff and the dying patient and those important to them.
- The dying patient and those identified as important to them are involved in decisions about treatment and care.
- The needs of families and others important to the dying patient are explored, respected and met as far as possible.
- An individual plan of care including food and drink, symptom control and psychological and spiritual support is agreed, co-ordinated and delivered with compassion.

Progress within Calderdale & Huddersfield NHS Foundation Trust

With the support and trust of the Chief Executive and Medical Director of the Trust, the LCP continued to be used appropriately within our organisation until the end of June 2014. The Specialist Palliative Care Team (SPCT) continued to support clinical teams caring for patients. In March 2014 a multiprofessional group was set up where it was identified that an alternative document was required following the withdrawal of the LCP. Staff recognised that generalists benefitted from documentary guidance to support dying patients and their families. A group of specialist palliative care professionals, generalist nursing and medical staff, chaplaincy, and staff from both hospices and from the community were involved. Using elements which worked well within the LCP and incorporating existing nursing documentation, a new document has been created. Evidence-based guidance relating to the role of artificial hydration and nutrition has been added. During the process the results of the National Care of the Dying Audit for Hospitals (NCDAH) were published which confirmed the need for better attention to the emotional and spiritual needs of patients and their families, and for better ways of recording these assessments. A detailed resume of the NCDAH is included as **Appendix A.** Patient representatives were approached during the creation of the document and very positive feedback was received from them.

The work of the multi-professional group has developed a new Individualised Care of the Dying Document (ICODD) for use on wards within the Trust, in both hospices and within the community. It is a multidisciplinary document for which all members of the clinical team have a responsibility to contribute. It covers assessment of physical symptoms, communication and understanding of needs, an assessment relating to hydration and nutrition and an assessment of the spiritual needs and value systems of the patient and their family. There is also guidance on appropriate medication for controlling common symptoms at the end of life and daily recording charts of a patient's and their family's needs.

An information leaflet for families has been created, with information about the dying process and the care that patients and their families should expect to receive within the Trust.

Following a successful pilot in June 2014 in both hospices and on 3 hospital wards, the document has been found to provide valuable information and guidance for clinical teams, is more intuitive in layout, and demonstrates a way of better recording the narrative of the patient journey. The information leaflets for families were particularly commended and overall the document has been described as "very ward friendly". The Clinical Records Group approved the document in September and an education programme implemented and delivered by the SPCT.

Charitable funding has allowed for the provision of 250 Comfort Bags, containing useful items for relatives who stay at their loved one's bedside (toothbrush/paste, tissues, comb, etc): these act as a helpful and kind conduit to communication with families. Arrangements have allowed for more bags to be purchased more cost-effectively, thereby almost doubling the number of bags that can be obtained following another very kind donation from a local church group (grateful thanks are due to Dr John Naylor).

Further actions consequent to NCDAH

The SPCT has developed dedicated Band 7 educational posts within its Clinical Nurse Specialist workforce, in both hospital and community. In conjunction with CHFT's Training Lead for End of Life Care, and agreement for an enhanced mandatory training programme for nursing staff, many more members of our organisation's workforce have received education on this important issue. There are also designated education sessions for medical staff.

A questionnaire has been devised to assess the views of bereaved people whose relatives died in our care, and in June 2015, this will be sent to the relatives of patients who died in December 2014. This will become an annual audit, allowing us to assess the quality of the care we deliver.
It is recommended that all Trusts have a designated Board member and a lay member with specific responsibility for the care of the dying, and this action remains outstanding.

The issue of 7 day availability of face-to-face specialist palliative care services within CHFT has been discussed by the 4 Consultants in Palliative Medicine. Within the current financial situation, it is unlikely that monies will be identified to fund such a service in the immediate future and with the existing workforce, but the whole team is open to considering this topic in the future.

Recommendation

The Board is asked to receive the report and note the work done to develop the arrangements within the Trust around the care of the dying. The Board is also asked to nominate a Board member with the specific responsibility for the care of the dying.

DR M T KIELY MB BCh MRCGP
Lead Clinician for Palliative Care/Consultant in Palliative Medicine
GMC Ref: 3270950
MTK/MB/Dec 2014

APPENDIX A

Résumé of the National Care of the Dying Audit for Hospitals – CHFT results

Sample

131 Trusts submitted data to the audit. A total of 6,580 patient datasets were analysed and 858 relative questionnaires returned.

Trust demographic data

	National	CHFT
Median number of adult deaths within Trusts in financial year April 12 to March 13	1311	1656
Median number of adult deaths within Trusts in the study period	104	149
Median number of eligible adult deaths	98	116

Organisational Key Performance Indicators (KPIs)

There were 7 main standards against which Trusts were scored. Several of the KPIs were themselves made up of several requirements and cut-off scores were created. The following table shows the percentage of Trusts nationally which achieved the cut-off score and we can see that our Trust achieved only 2 of these KPIs. (A=achieved; DNA=did not achieve)

	National %	CHFT
Access to information on death and dying	41	DNA
Access to Specialist Palliative Care Services face-to-face 7 days a week	21	DNA
Training, education and audit relating to care of the dying	40	A
Trust Board representation and planning for care of the dying	28	DNA
Clinical protocols for the drug management of the 5 common symptoms	98	A
Protocols for privacy, dignity and respect up to and including after the death of the patient	34	DNA
A formal feedback process to capture bereaved relatives' views	34	DNA

With respect to the above KPIs we failed the 'access to information' on one of the 5 sub-criteria because we lack the provision of a leaflet which explains facilities available to relatives whose loved one is dying.

This Trust does not provide specialist palliative care face-to-face 7 days a week. There are huge funding implications for this and our existing workforce makes such an arrangement impossible.

There is no designated Board member or lay member with a specific remit to scrutinise the care of the dying in CHFT.

With respect to privacy and dignity protocols, we lack formal guidelines for the assessment and delivery of mouth care; we lack guidelines for referral to pastoral care/chaplaincy team; and we lack a policy for viewing the body in the immediate period after the death of a patient. We lack a formal feedback process by way of a bereaved relatives' questionnaire to assess care delivery.

Case note review

The notes of all 116 patients whose deaths met the entry criteria were analysed by Dr Mary Kiely and Dr Jeena Ackroyd. The areas covered related to demographics, the process whereby dying was recognised by the multidisciplinary team, details relating to discussions with the patient and/or their family, review of medication prescriptions, presence or absence of DNACPR decisions, assessment and discussion relating to nutrition and hydration, the frequency of regular patient assessments in the last 24 hours of their lives and care after death.
The following information relates to key areas which have been identified within the recommendations of the audit and where relevant they have been categorised according to whether we in CHFT fared better than the national average, worse than the national average, or at the national average.

Hospital department where death occurred:	**National %**	**CHFT**
Medical	75	76
Surgical	8	9
Median length of episode of care in days	9	12
Percentage of patients supported by Care of the Dying Pathway or LCP	48	**54**
Percentage of patients whose preferences for Preferred Place of Death documented within the last episode of care	24	**12**
Multidisciplinary recognition of dying	59	**64**
Percentage where at least one consultant was involved in the decision-making	75	**77**
Median number of hours between recognition of dying and patient's death	35	**46**
Documentary evidence of discussion about approaching death with patient or family	74	**73**
Median number of hours between this discussion and the patient's death	31	**43**
Documentary evidence of discussion about the patient's spiritual needs with the patient	21	**7**
Documentary evidence of discussion about the patient's spiritual needs with their relative	23	**15**
Documentary evidence of discussion about the plan of care with the relatives	73	**65**
Medication prescribed for the 5 common symptoms (prescription ranges varied between the different drugs; for example analgesics were more likely to be prescribed than drugs for the relief of noisy breathing)	50	**51**
Drugs were administered less often than they were prescribed: between 16% administered for dyspnoea and 36% administered for pain relief		
Syringe driver used	28	**23**
Median dose of diamorphine 10mg/24 hours Median dose of midazolam 10mg/24 hours		
Documentary evidence of a DNACPR decision in the notes	96	**94**
Documentary evidence of assessment regarding the patient's ability to eat	59	**49**
Documentary evidence of discussion about feeding with the relative	29	**18**
Artificial nutrition in place at the time of death	7	**10**

Documentary evidence of assessment regarding the patient's ability to drink	64	51
Documentary evidence of discussion about hydration with the relative	36	22
Artificial hydration in place at the time of death	29	25
Number of regular patient assessments in the last 24 hours: <4 5-10 11-15	 18 57 15	 14 68 13
Documentation that care of the body after death was undertaken	46	60
Written information given to nominated relative	45	26

Local survey of bereaved relatives' views

The response rate to our local questionnaire was 62% which compares favourably with the national response rate of 37%. As indicative of the nature of patients being cared for on medical wards, 83% of the patients were over 70 years old and 56% were over 80 years old. Patients' relatives were asked a variety of questions relating to their perception about the adequacy of personal care and nursing care; whether or not they felt they could trust the nurses and doctors and whether or not the nurses and doctors had time to listen to their concerns. Questions were also asked about involvement in decisions, the nature of explanations and preparation for the dying phase, along with some questions relating to symptom control. The table below shows these results in comparison with national figures. The percentage relates to the number of relatives who agreed or strongly agreed with the statements, and the last 5 results were affirmative answers (relative answered 'yes').

	National	CHFT
There was enough help with personal care	83	79
There was enough help with nursing care	81	83
Relatives expressed confidence or trust in all or some of the nurses	97	94
Relatives expressed confidence or trust in all or some of the doctors	93	88
The nurses had time to listen to my concerns	74	67
The doctors had time to listen to my concerns	73	63
Relatives feeling appropriately involved in decisions	76	77
The role of artificial fluids was discussed with relatives	39	38
Relatives who would have liked this discussion	35	43
Explanations from the healthcare team were easy to understand	82	79
Percentage of relatives who were told their loved one was likely to die soon	74	68
Healthcare team explained the likely symptoms that would arise during the dying process	46	50
Percentage of relatives who would have liked these explanations	44	44
Did your loved one die in the right place	72	71
Were you dealt with in a sensitive manner	83	82
There was sufficient help for control of pain	75	72
There was sufficient help for control of restlessness	65	72
There was sufficient help for control of chest secretions	44	33

Emotional support was rated as poor by 16% and fair or good as 66% which was in line with national figures but only 18% rated it as excellent (30% in the national figures rated emotional support as excellent).

The spiritual needs of the patient or their family were felt to have been met in just over a third of patients and approximately 15% of relatives felt that theirs or their loved ones spiritual needs were not met at all.

Discussion

It is clear from these results that there are some areas that we are doing rather well in CHFT but there is considerable area for improvement, particularly relating to the frequency and quality of discussions which staff undertake with patients and their families. It is likely that one of the most effective ways to improve the quality of communication is to improve the uptake of education relating to the care of the dying by nurses and doctors working in our organisation.

Key recommendations of the National Report

- Education and training in care of the dying should be mandatory for all staff caring for dying patients. This should include communication skills training and skills for supporting families and those close to dying patients.
- All hospitals should undertake local audits of the care of the dying including the assessment of the views of bereaved relatives, at least annually.
- All Trusts should have a designated Board member and a lay member with specific responsibility for the care of the dying.
- Hospitals should have an adequately staffed and accessible pastoral care team.
- Hospitals should provide face to face specialist palliative care services 9-5, 7 days a week to support patients, their families and staff

DR M T KIELY MB BCh MRCGP
Consultant in Palliative Medicine
GMC Ref: 3270950
MTK/MB/1st July 2014

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 29th January 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: ACTION LOG - PUBLIC BOARD OF DIRECTORS - JANUARY 2015 - The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 January 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 January 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 January 2015.

Appendix

Attachment:

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

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 January 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	Executive Director of Nursing	Regular item on BOD Agenda going forward.	Monthly Reports		
97/14	**NURSING AND MIDWIFERY STAFFING REVIEW 2013-14 – HARD TRUTHS REQUIREMENT** Agreed that Board would receive monthly updates via the Integrated Board Report .	Executive Director of Nursing		29.1.15		
18.12.14	**VOLUNTARY REDUNDANCY SCHEME – WORKFORCE PLAN** 27.11.14 – Draft proposal discussed in Private Board Meeting. Discussions to take place with Staff Representatives	Executive Director of Workforce & OD	18.12.14 – Verbal update	29.1.15		
25.7.13 113/13	**HSMR/MORTALITY/CARE OF THE ACUTELY ILL PATIENT** Presentation received from BC & HT. Action Plan discussed. Update on actions to be brought to BOD Meetings on a bi-monthly basis.	Executive Medical Director	Regular Updates to be brought back to BoD as plan progresses (bi- monthly). 26.9.13 – Update on worsened position received. Key themes and actions identified. Agreed that an updated plan would be brought back to the October 2013 BoD Meeting. 24.10.13 – Update and Action Plan received and note. Board endorsed plan and supported its implementation. Regular Updates to be brought back to BoD as plan progresses (bi- monthly). 19.12.13 – Update on progress received. Agreed that updated Action Plan would be brought to the Board in February 2014. 27.2.14 – Further work being undertaken by Divisions – roll out of mortality review process from March 2014	29.1.15		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 January 2015 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
			24.4.14 – Update received. 26.6.14 – Update received 25.9.14 – Update received 27.11.14 – Update received			
25.9.14	**PROGRESS AGAINST STRATEGY** Update to be brought to the Public Board of Directors Meeting on a quarterly basis	Director of Commissioning & Partnerships		26.2.15		
24.11.11 134/11b.	**APPOINTMENT OF VICE CHAIR & SINED** Role of Vice Chair and SINED split into two. Alison Fisher – Vice Chair and Jane Hanson – SINED. Effective from 1.12.11. To be reviewed October 2012.	Chairman/ Director of Workforce & OD	18.10.12 – Agreed that current arrangements continue for a further 12 months 26.9.13 – Appointments made:- Jan Wilson and Vice Chair, David Anderson, SINED. To be reviewed 25.9.14 25.9.14 – Appointments extended for 12 months for Vice Chair, SINED and Audit & Risk Committee Chair – to be reviewed in September 2015	24.9.15		
95/14 b.	**INTELLIGENT MONITORING REPORT** The Quality Committee had asked the CQC to explain how the indicators would be applied. Agreed that this would be brought back to the BOD at a future meeting.	Executive Director of Nursing		TBC		

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 29th January 2015	**Sponsoring Director:** Lesley Hill, Director of Planning, Performance, Estates and Facilities
Title and brief summary: INTEGRATED BOARD REPORT - PERFORMANCE AND QUALITY REPORT - The Board is asked to note and approve the contents of the Integrated Board Report.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Weekly Executive Board Quality Committee	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to note and approve the contents of the Integrated Board Report.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to note and approve the contents of the Integrated Board Report.

Appendix

Attachment:

Integrated Board performance report Dec 14.pdf

Board Of Directors Integrated Performance Report

Report For: December 2014

THIS

Calderdale and Huddersfield NHS
NHS Foundation Trust

Contents

Executive Summary Commentary

There has been a further increase in urgent and emergency activity in line with the rest of the country. We now have all our beds open. This additional activity put pressure on the A&E departments which led to a reduction in performance against the 4 hour target. For December we delivered 89.4%. Unfortunately this meant we didn't deliver the quarter 3 target.

The additional beds have put further pressure on nurse staffing levels. We have used bank and agency staff to bring these staffing levels up. There has however, been some occasions where levels have been below the agreed level.

We are starting to catch up with the access to diagnostics within 6 weeks target. This should be delivered for the year by the year end.

We are behind target on some of the quality indicators. This includes the number of falls, although those with serious injury have reduced. This will have been affected by staffing levels and the pressure we've had on beds.

Our SHMI is still 111, with the unrebased HSMR at 102.41. The average diagnoses per coded episode is 4.05 against a target of 4.9. This may be affecting our SHMI and HSMR.

Calderdale and Huddersfield NHS Foundation Trust

Responsive Executive Summary - Mags Barnaby Director of Operations

THIS

Report For: December 2014		Indicator Source	Report For: December 2014 Target	Report For: December 2014 Trust	Report For: December 2014 Surgical	Report For: December 2014 Medical	Report For: December 2014 CWF	Report For: December 2014 DATS	Year To Date Target	Year To Date Trust	Year To Date Surgical	Year To Date Medical	Year To Date CWF	Year To Date DATS	Year End Forecast
Activity	% Elective Variance	Local	0.00%	-5.40%	-12.30%	-6.30%	12.00%	125.00%	0.00%	-8.20%	-8.60%	8.00%	-19.70%	6.10%	
	% Day Case Variance	Local	0.00%	4.90%	11.60%	0.90%	-24.90%	-45.70%	0.00%	2.10%	7.90%	-5.30%	-6.70%	-19.50%	
	% Non-elective Variance	Local	0.00%	5.00%	-5.80%	3.70%	10.80%	-	0.00%	0.00%	-6.00%	-0.90%	3.50%	-50.00%	
	% Outpatient Variance	Local	0.00%	7.00%	5.20%	8.50%	12.30%	-0.20%	0.00%	0.90%	-1.00%	1.40%	6.80%	1.60%	
RESPONSIVE - Operational Targets	Trust Theatre Utilisation	Local	90.00%	93.20%	93.20%	-	98:93%	-	90.00%	91.90%	91.91%	-	95.37%	-	
	% Daily Discharges - Pre 11am	Local	28.00%	10.23%	10.75%	10.03%	10.09%	13.64%	28.00%	9.25%	11.34%	8.62%	8.52%	3.86%	
	Number of Outliers (Bed Days)	Local	0	715	18	697	0	0	0	3259	205	3054	0	0	
	First DNA Rate	Local	7.00%	7.90%	8.20%	7.60%	7.90%	5.60%	7.00%	8.00%	8.30%	7.80%	7.80%	6.30%	
RESPONSIVE:18 Weeks and Other Access Indicators	% Non-admitted Closed Pathways under 18 weeks	National	95.00%	99.00%	98.84%	99.25%	99.24%	96.30%	95.00%	98.66%	98.72%	98.34%	99.15%	93.89%	
	% Admitted Closed Pathways Under 18 Weeks	National	90.00%	92.21%	91.44%	100.00%	97.33%	72.00%	90.00%	91.87%	90.98%	99.89%	96.35%	75.69%	
	% Incomplete Pathways <18 Weeks	National	92.00%	94.65%	92.75%	99.68%	99.00%	92.00%	92.00%	95.32%	93.66%	99.50%	99.04%	93.41%	
	18 weeks Pathways >=26 weeks open	Local	0	326	320	1	2	3	0	252	238	4	8	2	
	% Diagnostic Waiting List Within 6 Weeks	National	99.00%	99.24%	98.93%	100.00%	-	99.19%	99.00%	98.91%	99.60%	99.92%	-	98.66%	
RESPONSIVE: Cancer	62 Day Gp Referral to Treatment	National	85.00%	87.42%	91.11%	82.14%	100.00%	-	85.00%	90.73%	93.08%	86.22%	91.38%	-	
	62 Day Referral From Screening to Treatment	National	90.00%	94.74%	94.74%	-	-	-	90.00%	94.12%	93.84%	-	100.00%	-	
	31 Day Subsequent Surgery Treatment	National	94.00%	100.00%	100.00%	100.00%	-	-	94.00%	98.84%	100.00%	98.84%	-	-	
	62 Day Aggregated Gp Urgent Referral To Treatment And Screening Referral To Treatment	National	86.00%	98.47%	91.74%	82.14%	100.00%	-	86.00%	90.75%	93.25%	86.22%	92.94%	-	
	31 Days From Diagnosis to First Treatment	National	96.00%	100.00%	100.00%	100.00%	100.00%	-	96.00%	99.49%	99.48%	99.71%	97.22%	-	
	Two Week Wait From Referral to Date First Seen	National	93.00%	99.47%	99.45%	100.00%	98.36%	-	93.00%	98.00%	98.77%	95.10%	98.96%	-	
	Two Week Wait From Referral to Date First Seen: Breast Symptoms	National	93.00%	93.46%	93.46%	-	-	-	93.00%	95.86%	95.86%	-	-	-	
RESPONSIVE: Accident & Emergency	A and E 4 hour target	National	95.00%	89.94%	89.94%	-	-	-	95.00%	94.83%	94.83%	-	-	-	
	Time to Initial Assessment (95th Percentile)	National	00:15	00:25	00:25	-	-	-	00:15	00:20	00:20	-	-	-	
	Time to Treatment (Median)	National	01:00	00:18	00:18	-	-	-	01:00	00:20	00:20	-	-	-	
	Unplanned Re-Attendance	National	5.00%	5.38%	5.38%	-	-	-	5.00%	5.01%	5.01%	-	-	-	
	Left without being seen	National	5.00%	3.72%	3.72%	-	-	-	5.00%	2.81%	2.81%	-	-	-	

Calderdale and Huddersfield NHS
NHS Foundation Trust

Responsive/Operational Targets - Director of Operations

THIS

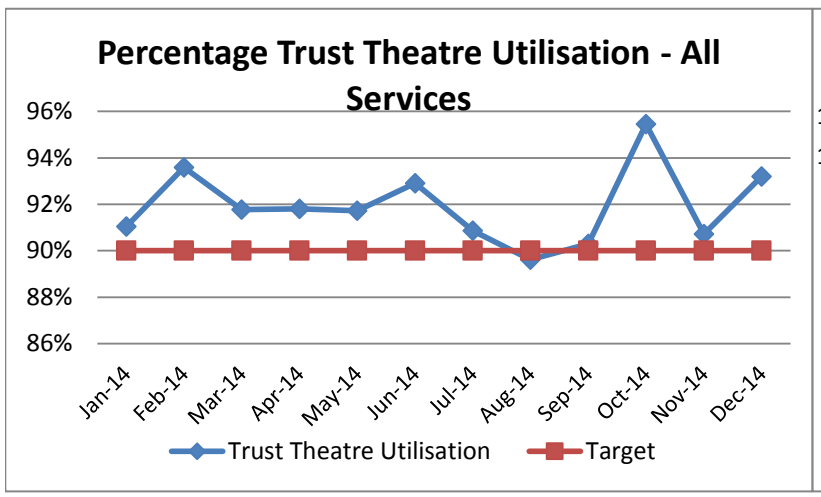
Report For: December 2014	Target	Trust	Surgical	Medical	CWF	DATS
Trust Theatre Utilisation	90.00%	93.20%	93.20%	-	98:93%	-
Outpatient Utilisation (Attendances Per Slot)	-	-	Indicator in Development			
% Daily Discharges - Pre 11am	28.00%	10.23%	10.75%	10.03%	10.09%	13.64%
% Daily Bed Demand - 3pm	-	-	-	-	-	-
Number of Outliers (Bed Days)	0	715	18	697	0	0
First DNA Rate	7.00%	7.90%	8.20%	7.60%	7.90%	5.60%

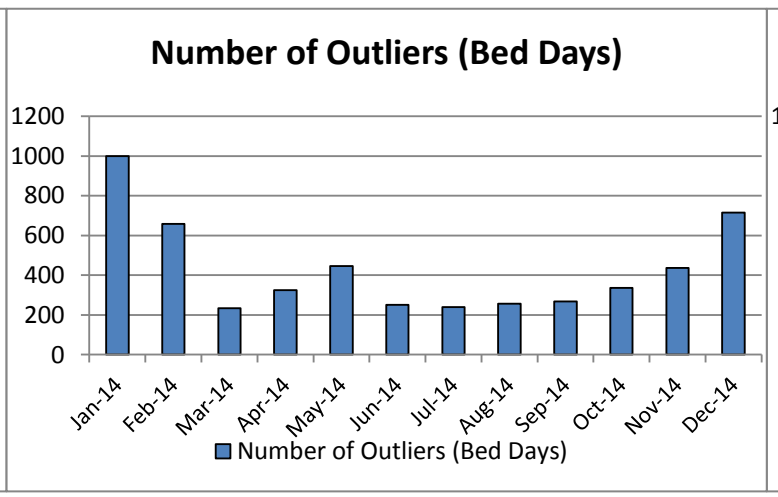
% Daily Discharges Pre 11am - discharge levelling targets require 28% of medical patients and 27% of surgical patients to be discharged before 11am. The vehicle for making this possible is Visual Hospital and Plan for Every Patient. Improvement have been seen but continued improvements are needed. A number of initiatives to improve performance have been implemented but not embedded consistently, work is on-going to achieve this. With the positive introduction of the Clinical Site Commander and complex discharge pathways further improvements are anticipated however this was challenging in December due to increasing numbers of complex patients who are now on a green cross pathway. Maternity and Paediatrics do not have levelling targets at the moment.

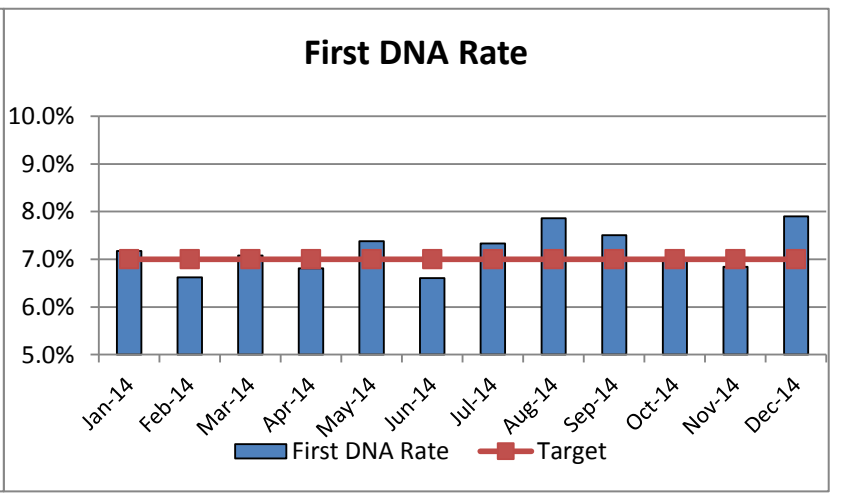
Outlier Rate (bed days) - target is no outliers. Increasing numbers of patients have outlined in month in both hospital sites due to winter pressures.

First DNA Rate - Performance dipped in the Month of December, which is a seasonal trend . The SMS and Interactive Voice Messaging continues to deliver a reduction in missed appointments. The DATs DNA rate has improved as a consequence of contacting these patients with a verbal reminder - this will continue to be monitored. All other clinical divisions have increased. The Trust DNA rate is 7.90%% against the same period last year of 8.4%. Overall the DNA rate is in line with peer Trusts.

Theatre Utilisation: The Trust is above target for theatre utilisation but work is ongoing to improve theatre productivity by specialty. Work streams are being set up and a weekly Theatre Productivity Group is meeting to drive through the changes needed.







Calderdale and Huddersfield NHS
NHS Foundation Trust

Responsive - RTT - Director of Operations

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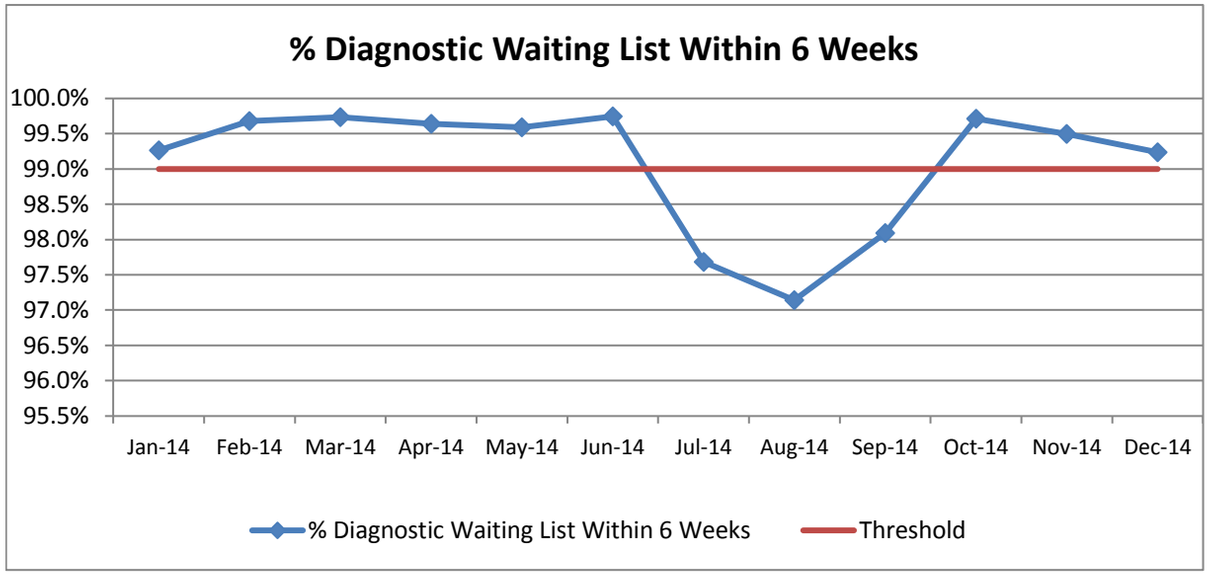
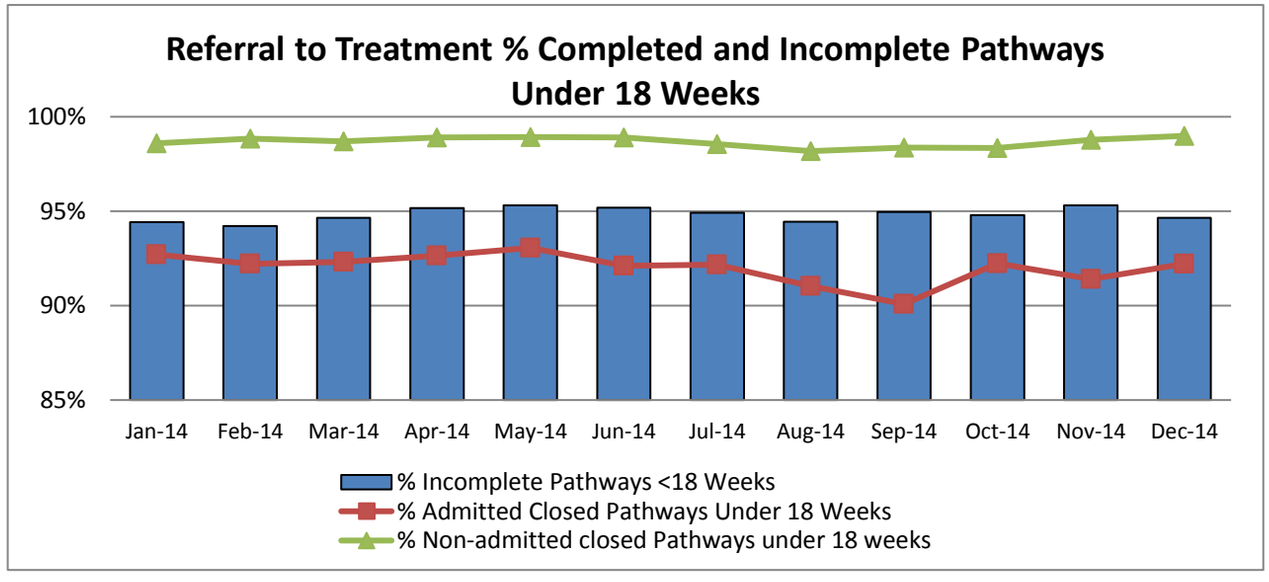
	Target	Trust	Surgical	Medical	CWF	DATS
% Non-admitted closed Pathways under 18 weeks	95.00%	99.00%	98.84%	99.25%	99.24%	96.30%
% Admitted Closed Pathways Under 18 Weeks	90.00%	92.21%	91.44%	100.00%	97.33%	72.00%
% Incomplete Pathways <18 Weeks	92.00%	94.65%	92.75%	99.68%	99.00%	92.00%
18 weeks Pathways >=26 weeks open	0	326	320	1	2	3
% Diagnostic Waiting List Within 6 Weeks	99.00%	99.24%	98.93%	100.00%	-	99.19%
% Last Minute Cancellations to Elective Surgery	0.60%	0.22%	0.56%	0.04%	0.03%	0.00%

All RTT national targets were met at Trust, Specialty and CCG level in December 2014. The end of financial year forecast for the Trust is green for all targets.
Complete assurance cannot be given regards specialty level admitted pathway compliance for the remainder of the year. The challenges of bed pressures, and increased emergency work and acuity of patients over the coming months may have a direct impact on available inpatient elective bed capacity, and the potential for elective cancellations. Any such reduction that results in patient cancellations particularly in General Surgery and Orthopaedics will compromise specialty level performance. The RTT for interventional radiology vascular surgery & radiology are meeting to examine the pathway to see where improvements can be made. For the 6 week target further additional mobile MRI scanning capacity is being procured between now & the end of the financial year. All other modalities are on track. Regards the Surgical Divisions open pathways over 26 weeks they have all been reviewed and assurance is given that no patients are clinically at risk.

Diagnostic waits - The 6 week diagnostic target on track & green for the remainder of the year.

Cancelled Operations for Elective Procedures. The Trust is currently at 0.22% against a target of 0.6%. This is an improvement. It has been identified that further work can be done and a work stream is being set up to look at further ways of reducing these. Improvements in the utilisation of the theatre space and time (work stream) is expected to realise benefits in cancelled operations through avoidance where possible of list over-run .





Calderdale and Huddersfield NHS Foundation Trust

Responsive - Cancer - Director of Operations

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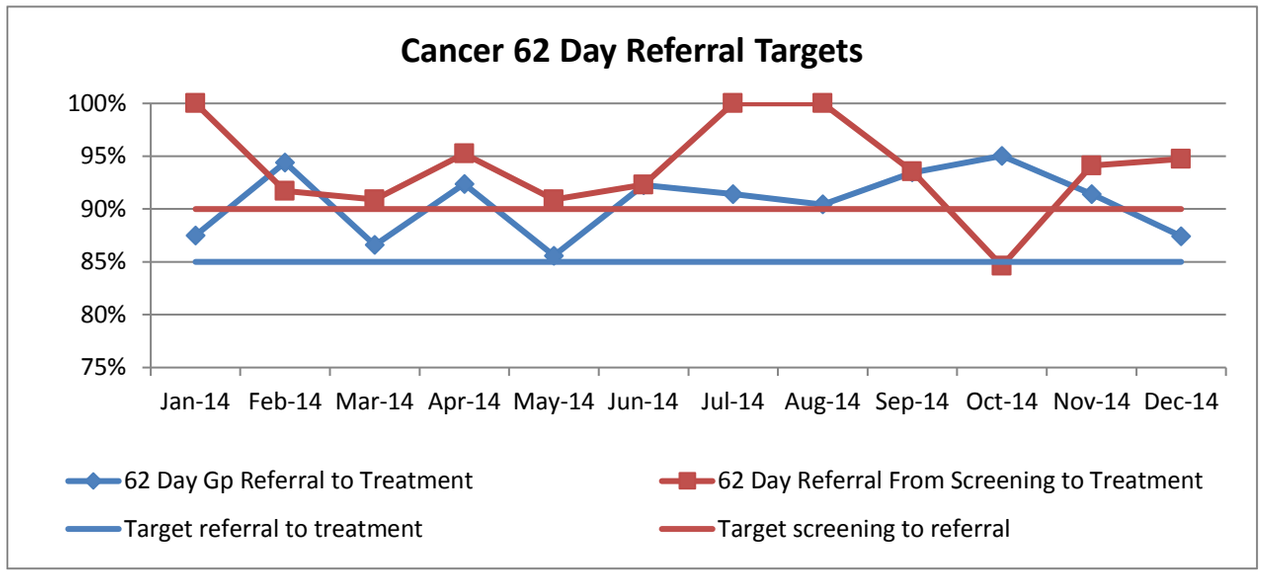
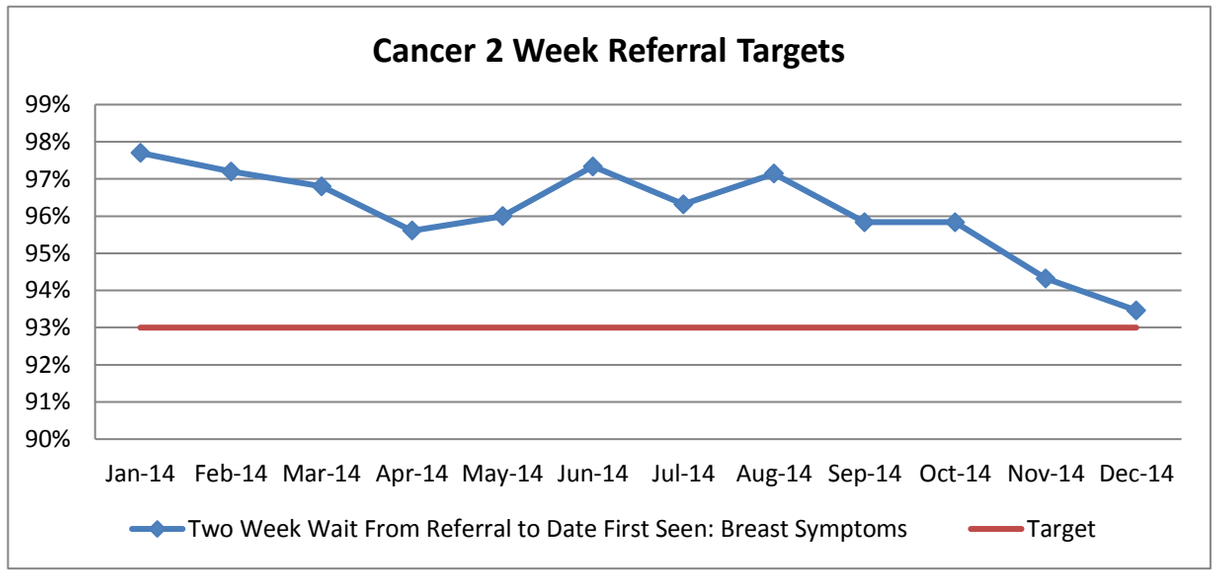
Report For: December 2014	Target	Trust	Surgical	Medical	CWF	DATS
Two Week Wait From Referral to Date First Seen	93.00%	99.47%	99.45%	100.00%	98.36%	-
Two Week Wait From Referral to Date First Seen: Breast Symptoms	93.00%	93.46%	93.46%	-	-	-
31 Days From Diagnosis to First Treatment	96.00%	100.00%	100.00%	100.00%	100.00%	-
31 Day Subsequent Surgery Treatment	94.00%	100.00%	100.00%	100.00%	-	-
31 day wait for second or subsequent treatment drug treatments	98.00%	100.00%	100.00%	100.00%	-	-
62 Day Aggregated Gp Urgent Referral To Treatment And Screening Referral To Treatment	86.00%	98.47%	91.74%	82.14%	100.00%	-
62 Day Gp Referral to Treatment	85.00%	87.42%	91.11%	82.14%	100.00%	-
62 Day Referral From Screening to Treatment	90.00%	94.74%	94.74%	-	-	-

Cancer-GP referral to treatment medical- Total of 5 breaches of these 2.5 breaches in lung, 1.5 of which were as a result of Leeds lack of capacity (sent before day 38 days) The other lung breach was unavoidable due to a complex pathway. The other 2.5 breaches were in Haematology caused by delays from the original referral sites to undertake diagnostics.





Calderdale and Huddersfield NHS
NHS Foundation Trust

Responsive/Accident & Emergency - Director of Operations

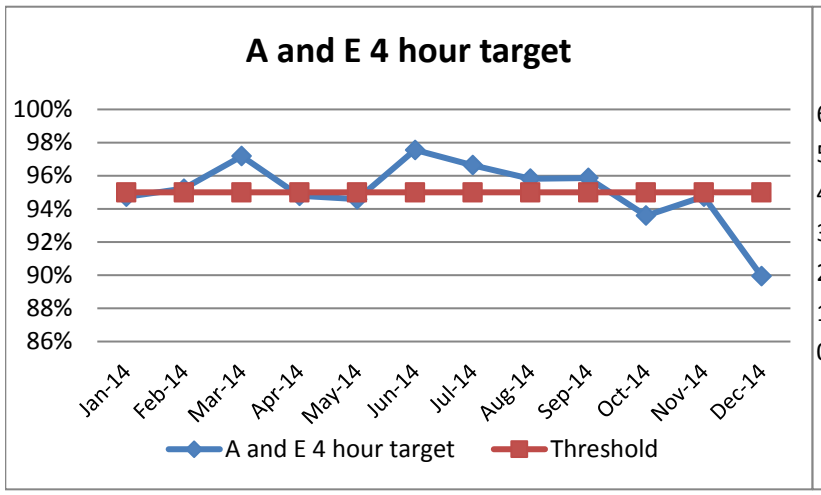
THIS

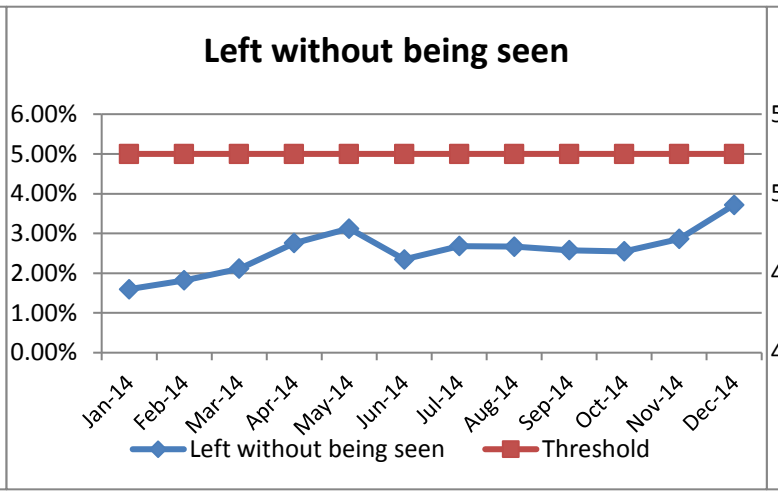
Report For: December 2014	Target	Trust	Surgical	Medical	CWF	DATS
A and E 4 hour target	95.00%	89.94%	89.94%	-	-	-
Time to Initial Assessment (95th Percentile)	00:15	00:25	00:25	-	-	-
Time to Treatment (Median)	01:00	00:18	00:18	-	-	-
Unplanned Re-Attendance	5.00%	5.38%	5.38%	-	-	-
Left without being seen	5.00%	3.72%	3.72%	-	-	-

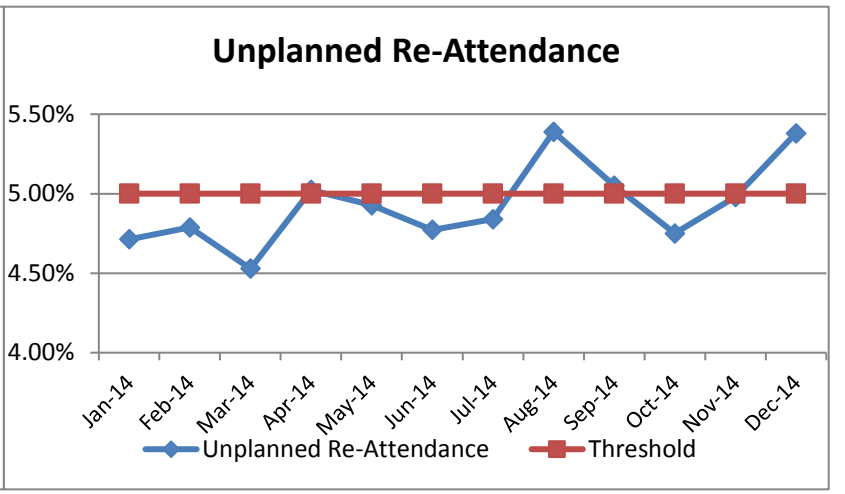
Continued increase in admissions. LOS and patients on the green cross pathway has shown a continued increase at both sites. Discharge levelling has generally not been achieved creating lengthy delays for patients waiting an inpatient bed in A & E which has an impact on their experience. It is expected that the appointment of Clinical Site Commander posts and adopting the ECIST SAFER model alongside the Perfect Week will have a significant impact on timely flow our of A & E. Forecast as yet has not improved and Quarter 3 overall was not achieved. Impact of long waits in A&E for inpatient beds now seen on most of the A&E indicators. Improvement plan to be developed to ensure delivery of 4 hour for the year, A&E indicators and improvement in patient experience.

TIME TO ASSESSMENT Lack of cubicle capacity has not enabled the achievement of the 15 minute assessment. An improvement in patient flow will create that capacity necessary to achieve. FORECAST AMBER.

TIME TO TREATMENT - RAG RATING GREEN.
UNPLANNED REATTENDANCE - FORECAST GREEN.
LEFT WITHOUT BEEN SEEN - FORECAST GREEN







Calderdale and Huddersfield NHS Foundation Trust

Caring Executive Summary - Julie Dawes Director of Nursing

THIS

	Report For: December 2014	Indicator Source	Report For: December 2014 Target	Report For: December 2014 Trust	Report For: December 2014 Surgical	Report For: December 2014 Medical	Report For: December 2014 CWF	Report For: December 2014 DATS	Year To Date Target	Year To Date Trust	Year To Date Surgical	Year To Date Medical	Year To Date CWF	Year To Date DATS	Year End Forecast
Caring	Number of Mixed Sex Accommodation Breaches	National	0	0	0	0	0	0	0	7	0	7	0	0	
	% Complaints closed in the month within target timeframe	Local	100.00%	11.00%	25.00%	0.00%	14.00%	0.00%	100.00%	28.00%	31.00%	22.00%	26.00%	28.00%	
	Total Complaints received in the month	Monitor	-	37	17	15	3	1	0	454	216	120	73	33	
	Inpatient complaints per 1000 bed days	Monitor	-	1.1	1.2	1.0	0.9	-	-	-	-	-	-	-	
	Total Concerns in the month	Monitor	-	60	29	22	3	6	-	681	294	253	59	50	
	Number of Patients Surveyed (RTM) - (Quarterly)	Local	-	546	245	280	21	-	-	1772	725	946	101	-	
	Overall, How would you rate the care you received? (RTM)	Local	-	8.9	9.0	8.8	9.3	-	-	9.0	9.1	8.9	9.2	-	
	Have You Found Someone on the Hospital Staff to Talk to About Your Worries or Fears (RTM)	Local	-	8.4	8.7	8.0	9.0	-	-	8.9	9.0	8.7	9.6	-	
	% RTM Responses That are on or Above Target (Quarterly)	Local	74.00%	59.30%	59.30%	59.30%	70.40%	-	74.00%	66.70%	63.00%	65.40%	79.00%	-	
Caring - Friends & Family	Friends & Family Test (IP Survey) - Response Rate	CQUIN	30.00%	40.60%	44.40%	38.10%	34.20%	-	30.00%	39.90%	45.90%	35.00%	36.50%	-	
	Friends & Family Test (IP Survey) - % would recommend the Service	CQUIN	-	95.20%	97.00%	93.00%	98.00%	-	-	96.40%	97.00%	95.00%	99.00%	-	
	Friends & Family Test (IP Survey) - % would not recommend the Service	CQUIN		1.10%	0.00%	2.00%	0.00%	-		0.80%	1.00%	1.00%	1.00%	-	
	Friends & Family Test (Maternity Survey) - Response Rate	CQUIN	-	19.00%	-	-	19.00%	-	-	21.80%	-	-	21.80%	-	
	Friends & Family Test (Maternity) - % Would recommend the Service	CQUIN	-	93.20%	-	-	93.20%	-	-	92.80%	-	-	92.80%	-	
	Friends & Family Test (Maternity) - % Would not recommend the Service	CQUIN		2.70%			2.70%			3.50%			3.50%		
	Friends and Family Test A & E Survey - Response Rate	CQUIN	20.00%	4.53%	4.53%	-	-	-	20.00%	21.10%	21.10%	-	-	-	
	Friends and Family Test A & E Survey - % would recommend the Service	CQUIN	-	83.20%	83.20%	-	-	-	-	88.40%	88.40%	-	-	-	
	Friends and Family Test A & E Survey - % would not recommend the Service	CQUIN		9.00%	9.00%					6.00%	6.00%				
	Percentage of non-elective inpatients 75+ screened for dementia	CQUIN	90.00%	96.10%	-	-	-	-	90.00%	96.10%	-	-	-	-	

Caring - Director of Nursing

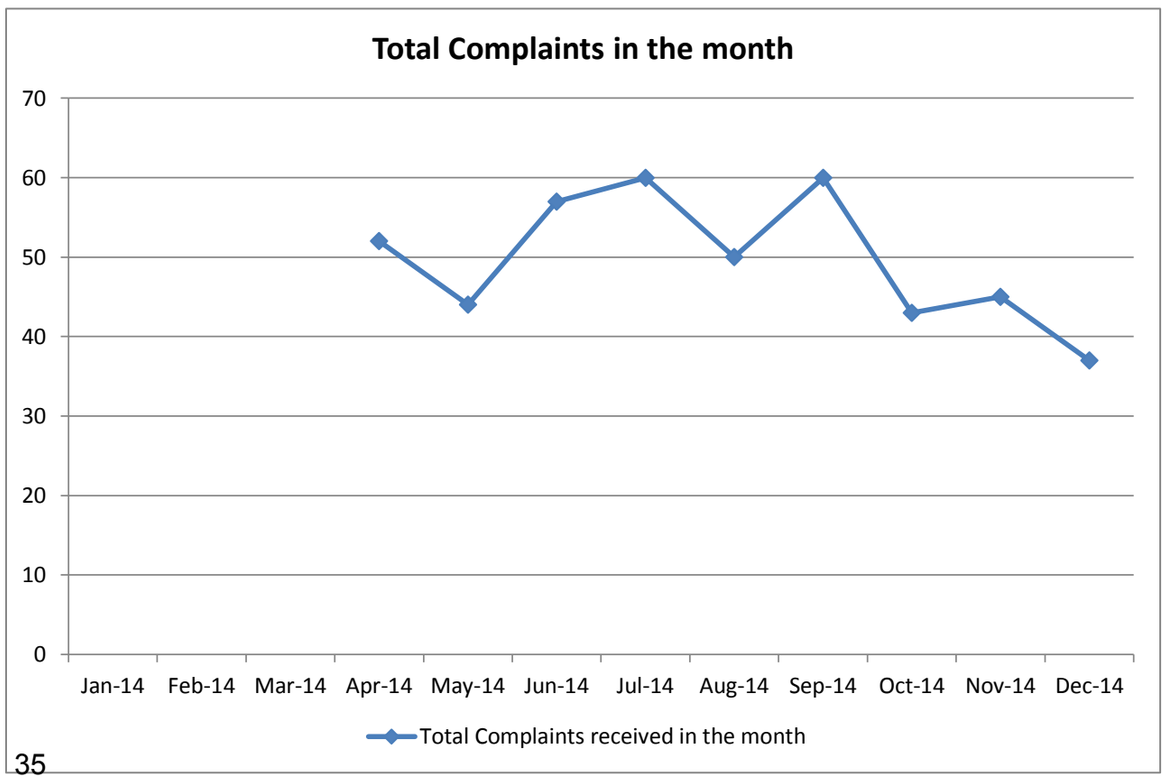
Report For: December 2014	Target	Trust	Surgical	Medical	CWF	DATS
Number of Mixed Sex Accommodation Breaches	0	0	0	0	0	0
% Complaints closed in the month within target timeframe	100.00%	11.00%	25.00%	0.00%	14.00%	0.00%
Total Complaints received in the month	-	37	17	15	3	1
Inpatient complaints per 1000 bed days	-	1.1	1.2	1.0	0.9	-
Total Concerns in the month	-	60	29	22	3	6
Number of Patients Surveyed (RTM) - (Quarterly)	-	546	245	280	21	-
Overall, How would you rate the care you received? (RTM)	-	8.9	9.0	8.8	9.3	-
Have You Found Someone on the Hospital Staff to Talk to About Your Worries or Fears (RTM)	-	8.4	8.7	8.0	9.0	-
% RTM Responses That are on or Above Target (Quarterly)	74.00%	59.30%	59.30%	59.30%	70.40%	-

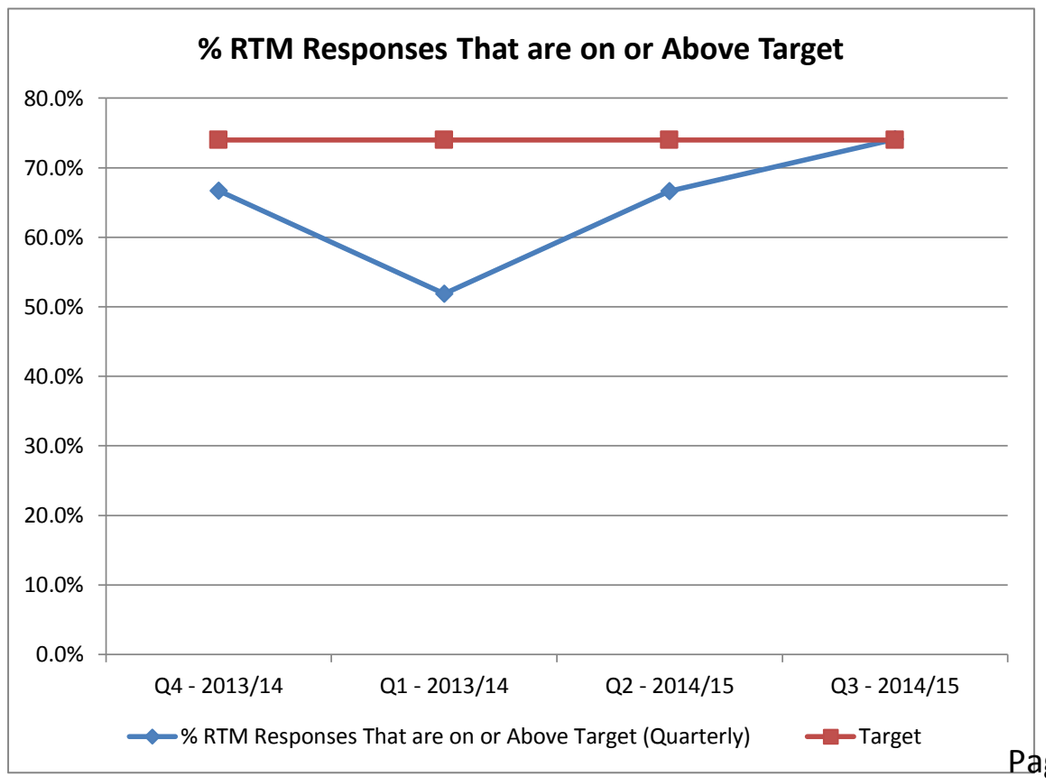
Real Time Patient Monitoring (RTPM)- PLEASE NOTE THIS IS A QUARTERLY PROCESS AND THERE THIS DATA COVERS THE PERIOD OCT - DEC 2014

All Divisions are scoring green (equivalent to top 20% of Trusts nationally) for the 2 questions listed. A local target has been set for 20 of the 27 questions asked to have a RAG rated 'green' score - this equates to 74%, this has not been achieved for quarter 3. All improvement work is being driven through the Patient Experience Group.

Complaints - 11% of the 65 complaints closed in December were in the agreed timescale. A concerted effort was made to address the backlog of open complaints and
65% of the complaint closed were from the backlog.

A significant reduction has been made in the number of complaint open, although the trajectory has not been met.
A new trajectory is being drawn up for the remainder of the financial year and improved monitoring introduced with a fortnightly breakdown to Divisions and a Plan for Every Complaint has been introduced in the Patient Advice and Complaints Team .





	TRUST	SAS	MEDICAL	CWF	DATS		TRUST	SAS	MEDICAL	CWF	DATS
% Complaints Closed in Month	11%	25%	0%	14%	0%	YTD	28%	31%	22%	26%	28%
Total Complaints Received	37	17	15	3	1		454	216	120	73	33
Total Concerns Received	60	29	22	3	6		681	294	253	59	50

COMPLAINTS

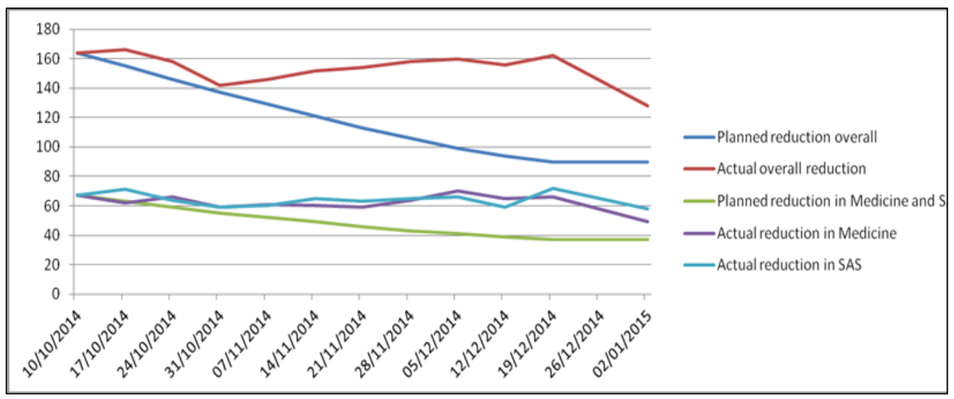
A total of 37 Complaints were received in December compared to 45 in November

MONTH	Complaints Recevied 2013/14	Complaints Recevied 2014/15	Variance on year	Variance on month
October	46	47	15	11
November	35	45	1	14
December	35	37	2	8

Complaints by Division and Severity	GREEN	YELLOW	ORANGE	RED	Total
Childrens Womens and Families Servic	0	3	0	0	3
Diagnostic and Therapeutic Services Div	0	0	1	0	1
Estates and Facilities	0	1	0	0	1
Medical Division	0	7	6	2	15
Surgical & Anaesthetics Services Divisio	1	12	4	0	17
Totals:	1	23	11	2	37

A total of 65 complaints were closed in December compared to 37 in November. 135 cases remain open compared to 167 in November.

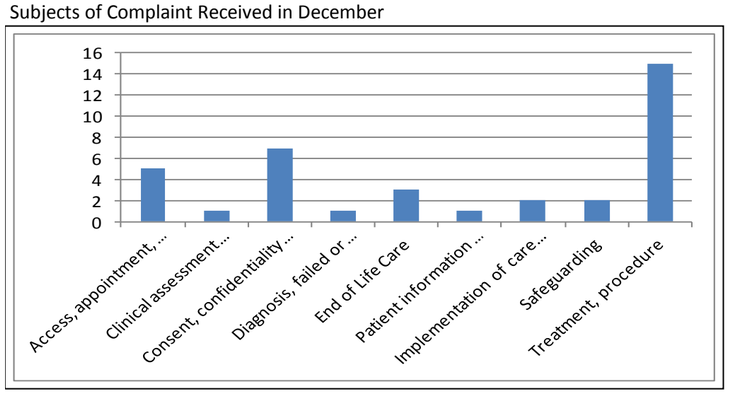
Only 11% of complaints closed this month were closed within timescale. A large proportion of the complaints closed (65%) were older complaints that had created a backlog, and hence were over the target timescale.
The trajectory for reducing the number of open complaint has not been achieved, although a significant reduction has been made.



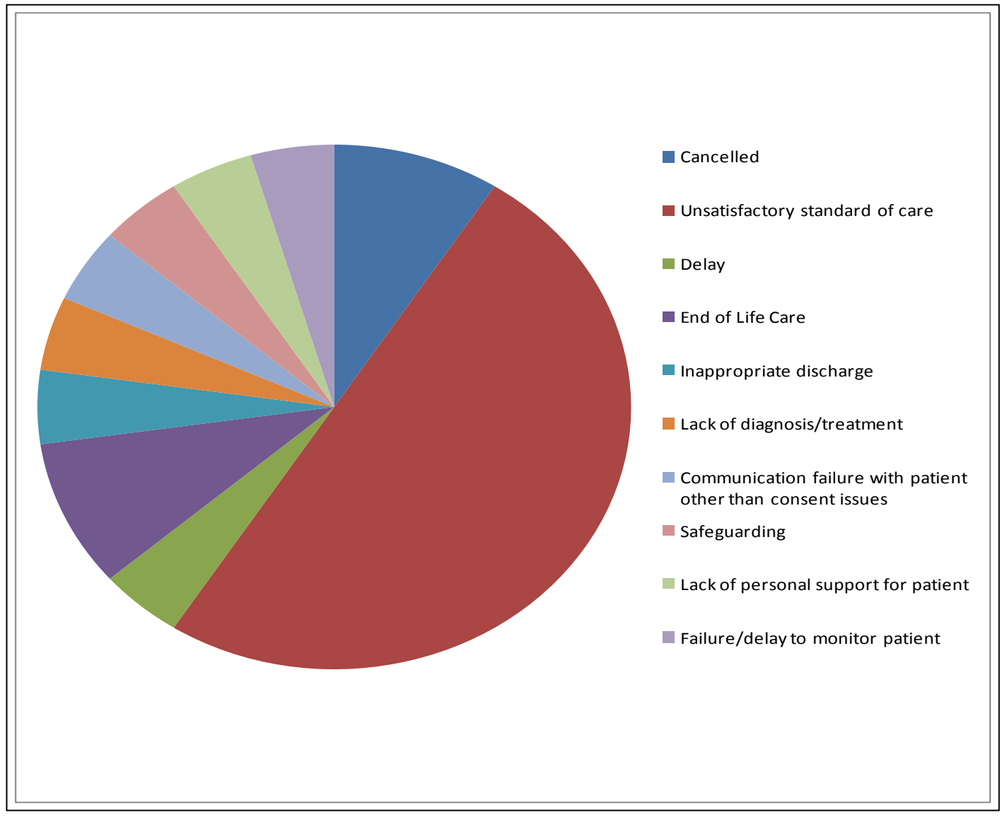
A revised trajectory is being created

A Plan for Every Complaint has been introduced in the Patient Advice and Complaints Team to improve the monitoring of individual cases.

Subjects of Complaint Received in December



Breakdown of Treatment Complaints



Report For: December 2014	Target	Trust	Surgical	Medical	CWF	DATS
Friends & Family Test (IP Survey) - Response Rate	30.00%	40.60%	44.40%	38.10%	34.20%	-
Friends & Family Test (IP Survey) - % would recommend the Service	-	95.20%	97.00%	93.00%	98.00%	-
Friends & Family Test (IP Survey) - % would not recommend the Service	-	1.10%	0.00%	2.00%	0.00%	-
Friends & Family Test (Maternity Survey) - Response Rate	-	19.00%	-	-	19.00%	-
Friends & Family Test (Maternity) - % Would recommend the Service	-	93.80%	-	-	93.80%	-
Friends & Family Test (Maternity) - % Would not recommend the Service	-	2.70%	-	-	2.70%	-
Friends and Family Test A & E Survey - Response Rate	20.00%	4.53%	4.53%	-	-	-
Friends and Family Test A & E Survey - % would recommend the Service	-	83.20%	83.20%	-	-	-
Friends and Family Test A & E Survey - % would not recommend the Service	-	9.00%	9.00%	-	-	-
Percentage of non-elective inpatients 75+ screened for dementia	90.00%	96.10%	-	-	-	-

The Friends and Family Test (FFT) -

Please note: reporting has changed this month to show the percentage of patients who would recommend the service (either extremely likely or likely). Next month's report will also contain the percentage who wouldn't recommend the service .

Inpatients: The Trust position for December 14 (response rate 40.6%) gives a favourable indicator towards achieving the Q4 CQUIN target -30% and the stretch CQUIN target of 40% (any month during quarter 4). Of note this month is an increased response rate on ward 12 HRI from 35% to 56% and ward 19 HRI who have improved from 26% to 40%

The new style of reporting is now in place and for the month of December, 95% of patients who responded to the inpatient FFT, said they would recommend our services.

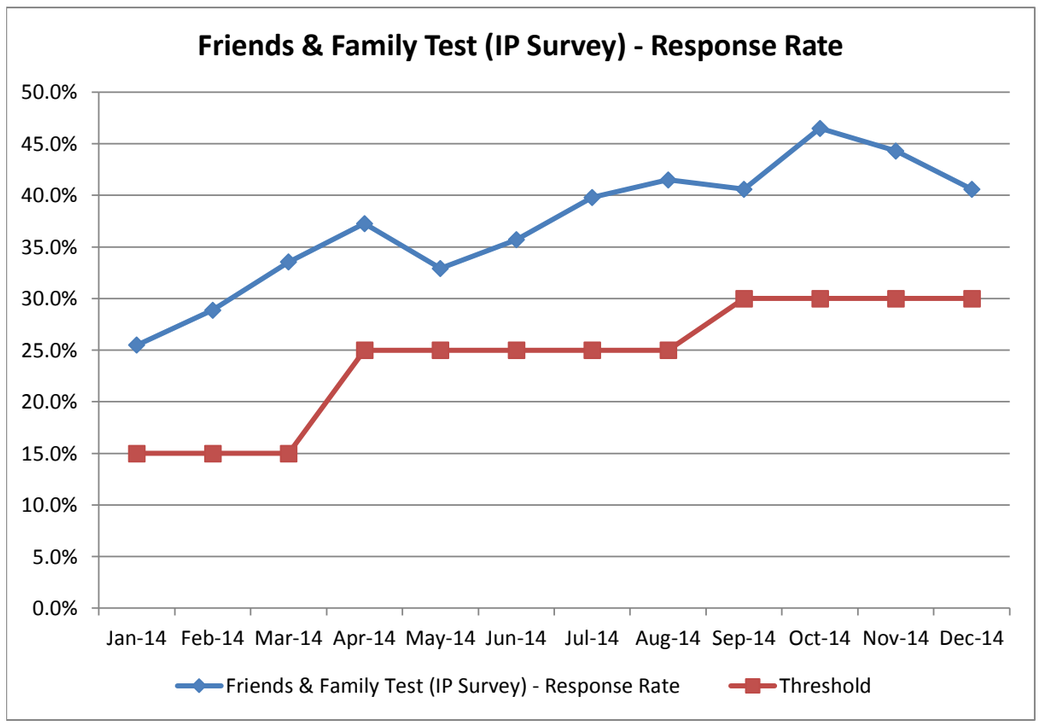
Maternity: Whilst there are no CQUIN requirements for maternity, continued emphasis is placed on improving both the response rate and the % who would recommend across all four maternity touch point. Processes have been introduced to increase engagement between midwives and women (FFT is sent by text message, therefore midwives have been asked to promote FFT, informing women that they will be receiving the text and encouraging them to respond). Improvement work is currently focused on the postnatal care at home, to increase continuity teams now have a buddy system for when they are on days off / annual leave and also giving a 2 hour time slot for when the midwife will visit

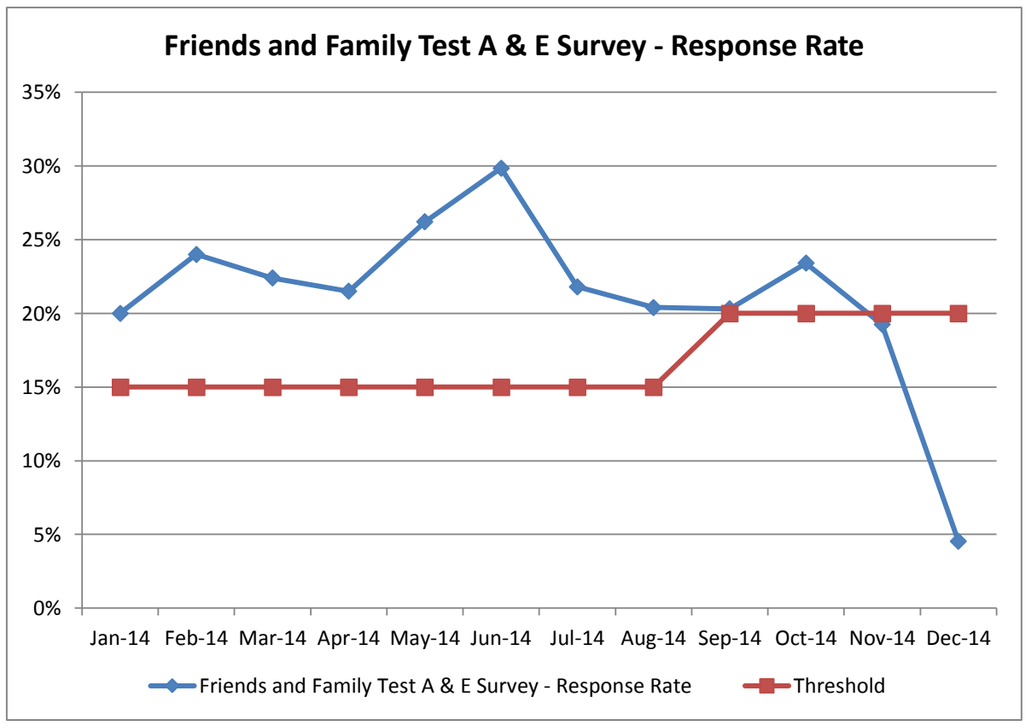
A&E: There has been a further drop in performance in A&E response rate this month (4.5%), taking us significantly below the Q4 target of 20%. This is attributed to the change in process (removal of tokens) on both sites.

There is some focused work to refine the processes, including staff awareness and engagement, this has included a briefing document for staff, reminding them of what FFT is about and informing them of their roles and responsibilities. A presentation is being delivered to staff, to generate discussion re how the department can work as a team to influence improvement. Posters are being placed in all treatment rooms to give clinical staff a visual prompt to discuss FFT with patients (contains you said, we did examples).

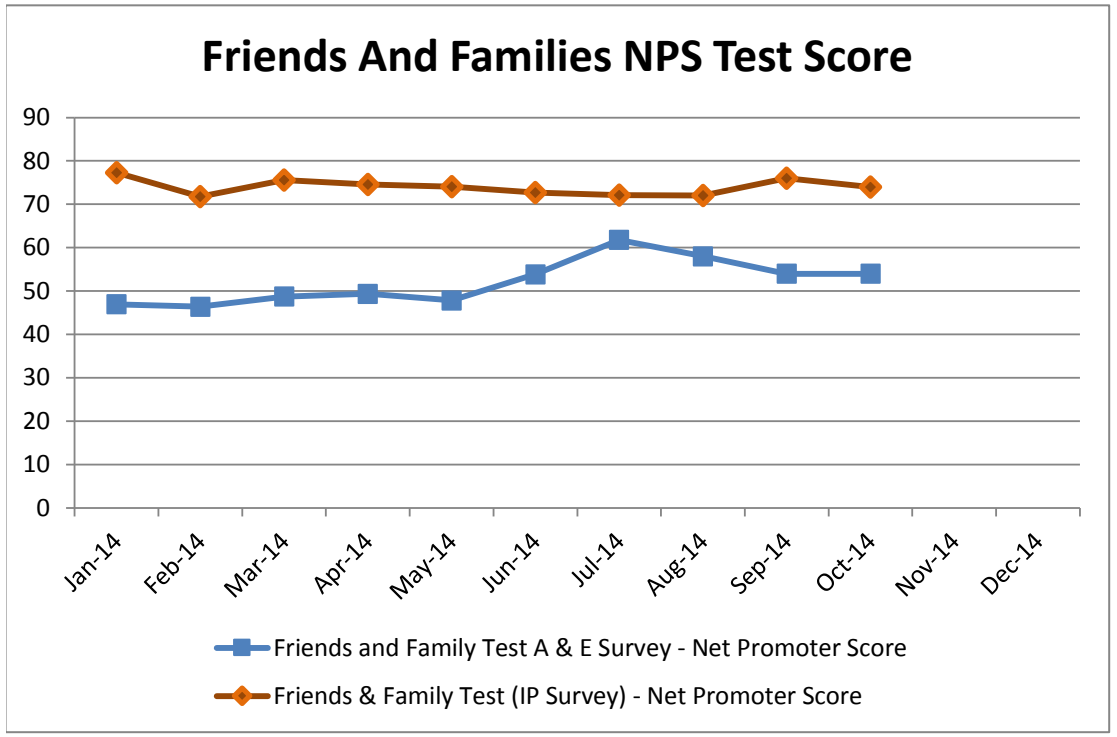
Outpatient FFT: went live on 16th October 2014, using a text messaging option.

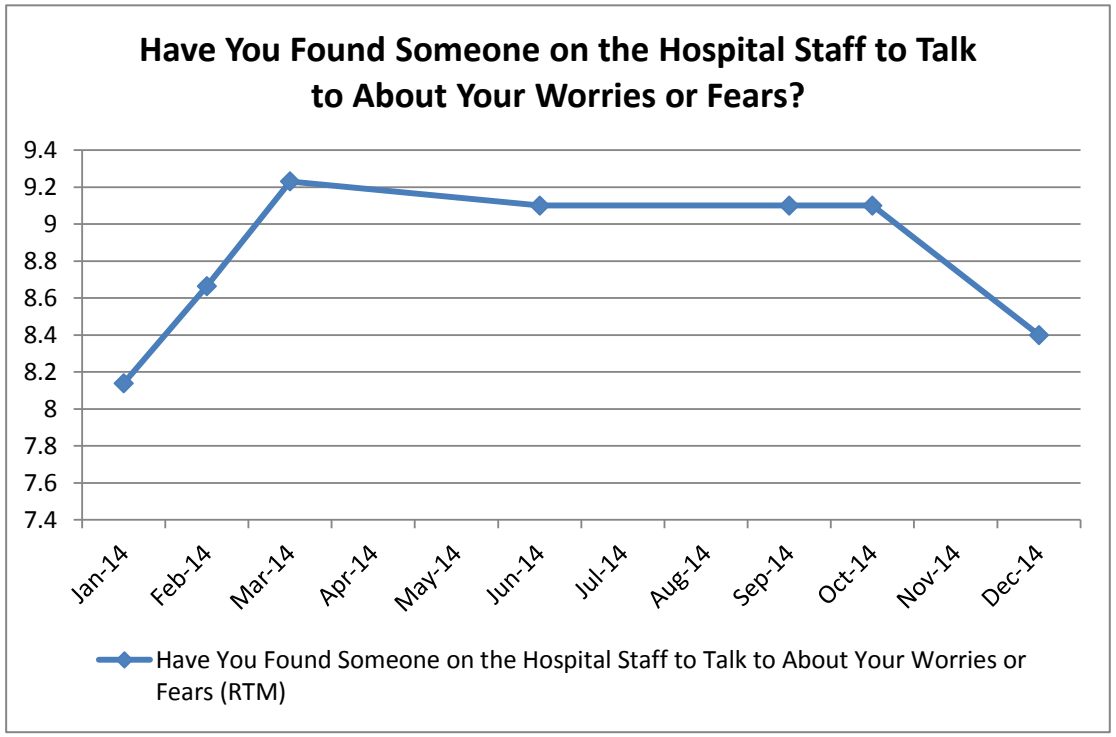
Community: plan to go live week commencing 19.1.15.

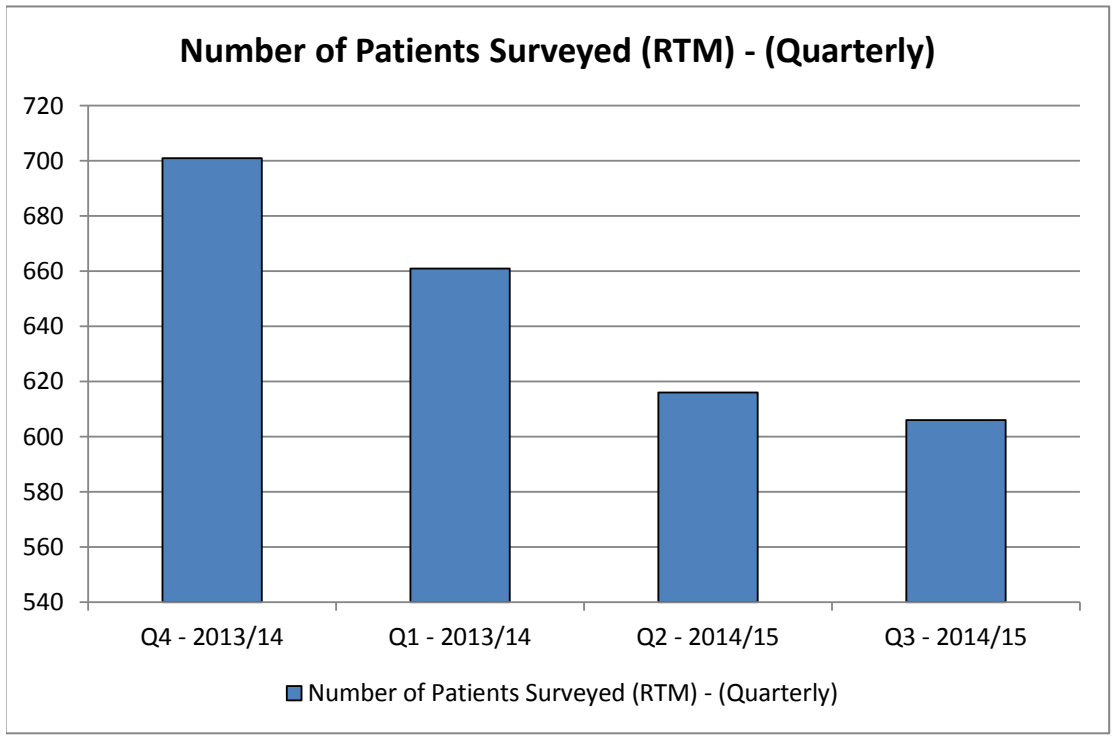


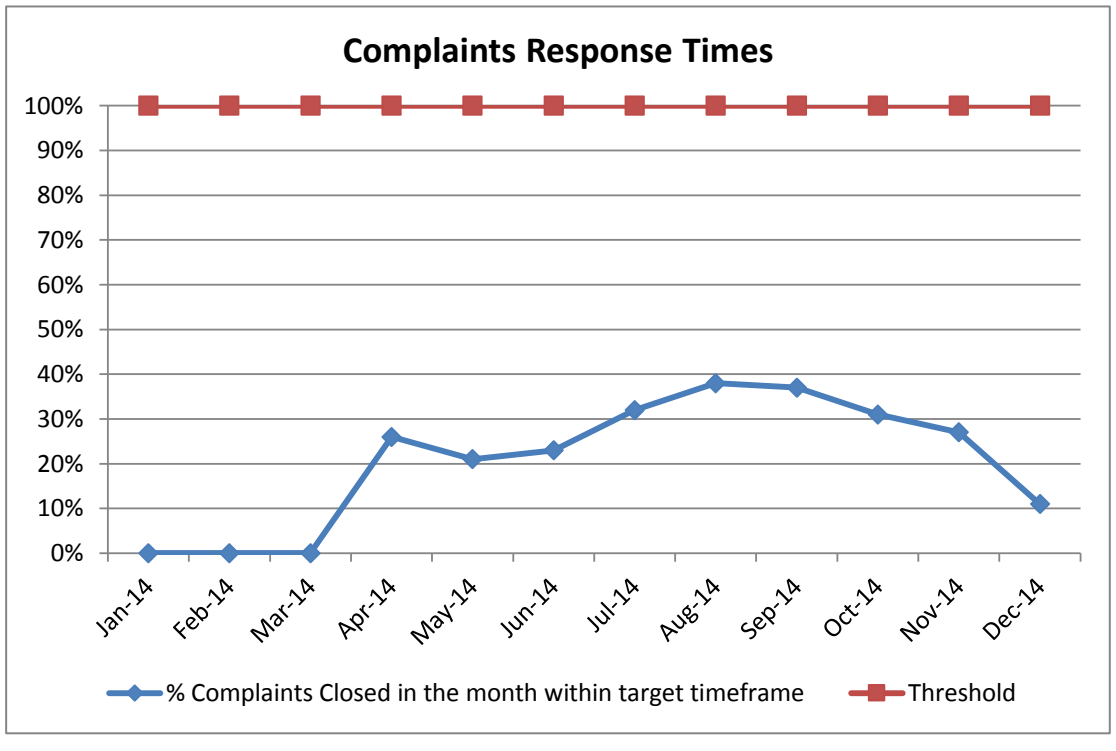


Caring - Director of Nursing









Calderdale and Huddersfield NHS Foundation Trust

Safety Executive Summary - Julie Dawes Director of Nursing

THIS

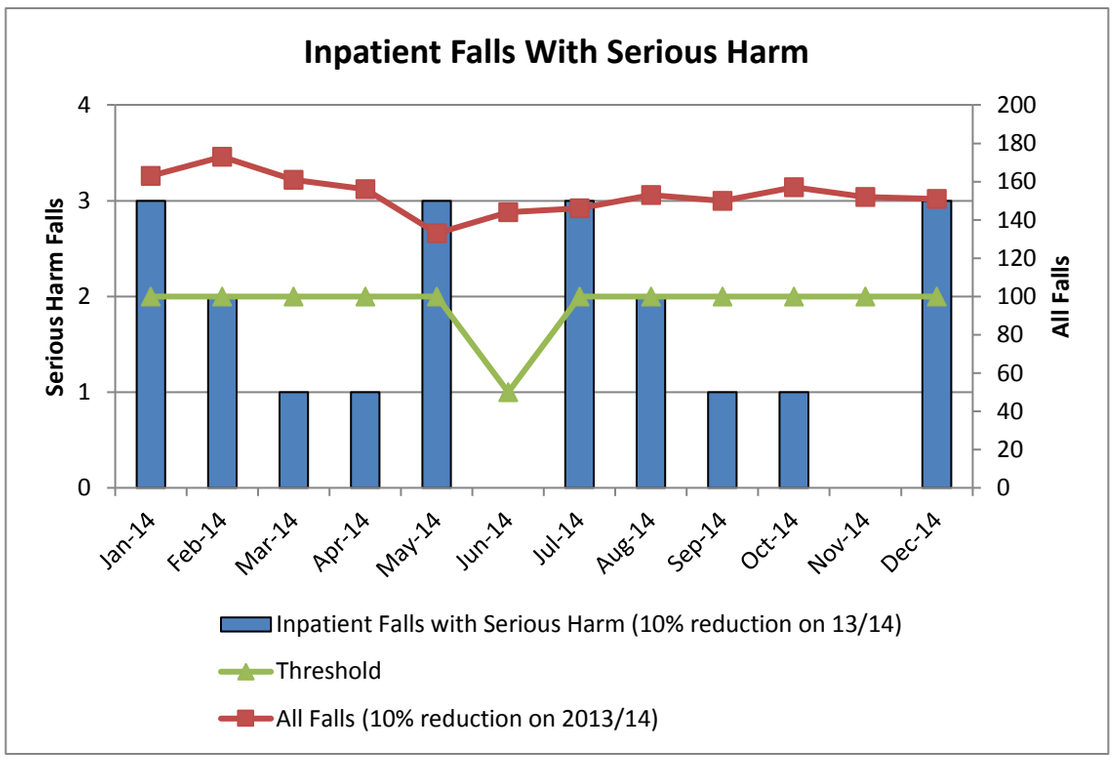
	Report For: December 2014	Indicator Source	Report For: December 2014 Target	Trust	Surgical	Medical	CWF	DATS	Year To Date Target	Trust	Surgical	Medical	CWF	DATS	Year End Forecast
Safety	Inpatient Falls with Serious Harm (10% reduction on 13/14)	Local	2	3	1	2	0	-	16	13	4	9	0	-	
	All Falls (10% reduction on 2013/14)	Local	112	151	30	119	2	-	1007	1342	273	1038	31	-	
	Number of Trust Pressure Ulcers Acquired at CHFT	Local	11	17	6	11	0	-	97	134	53	80	1	-	
	Number of Grade 2 Pressure Ulcers Acquired at CHFT	Local	7	9	4	5	0	-	66	100	43	56	1	-	
	Number of Grade 3 Pressure Ulcers Acquired at CHFT	Local	0	8	2	6	0	-	0	32	9	23	0	-	
	Number of Grade 4 Pressure Ulcers Acquired at CHFT	Local	0	0	0	0	0	-	0	2	0	2	0	-	
Safety 2	Percentage of Completed VTE Risk Assessments	National	95.00%	95.50%	94.52%	95.49%	97.89%	100.00%	95.00%	95.30%	94.00%	95.50%	98.40%	100.00%	
	Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	National	100.00%	100.00%	100.00%	100.00%	-	-	100.00%	98.57%	100.00%	98.57%	100.00%	-	
	% Harm Free Care	CQUIN	95.00%	93.23%	96.06%	89.44%	100.00%	-	95.00%	93.80%	94.50%	91.46%	99.67%	-	
	Missed Doses		5.00%	8.10%	-	-	-	-	5.00%	8.10%	-	-	-	-	
Safety 3	Number of Patient Incidents	Monitor	-	543	145	241	115	38	0	5171	1308	2531	990	296	
	Number of SI's	Monitor	-	10	4	6	0	0	0	57	12	41	4	0	
	Number of Incidents with Harm	Monitor	-	136	29	67	33	7	0	1185	280	663	196	39	
	Never Events	National	0	0	0	0	0	0	0	0	0	0	0	0	
	Serious hazards of transfusion	Local	0	1	0	0	1	0	0	6	1	0	2	3	
	Percentage of SI's reported externally within timescale (2 days)	Local	100.00%	90.00%	-	90.00%	100.00%	-	-	-	-	-	-	-	
	Percentage of SI's investigations where reports submitted with timescale (45 days unless extension agreed)	Local	100.00%	38.00%	-	-	-	-	-	-	-	-	-	-	
	Total Duty of Candor reported within the month		-	11	5	4	1	1	-	11	5	4	1	1	
	Total Duty of Candor outstanding at the end of the month		-	11	5	3	0	1	-	11	5	3	0	1	

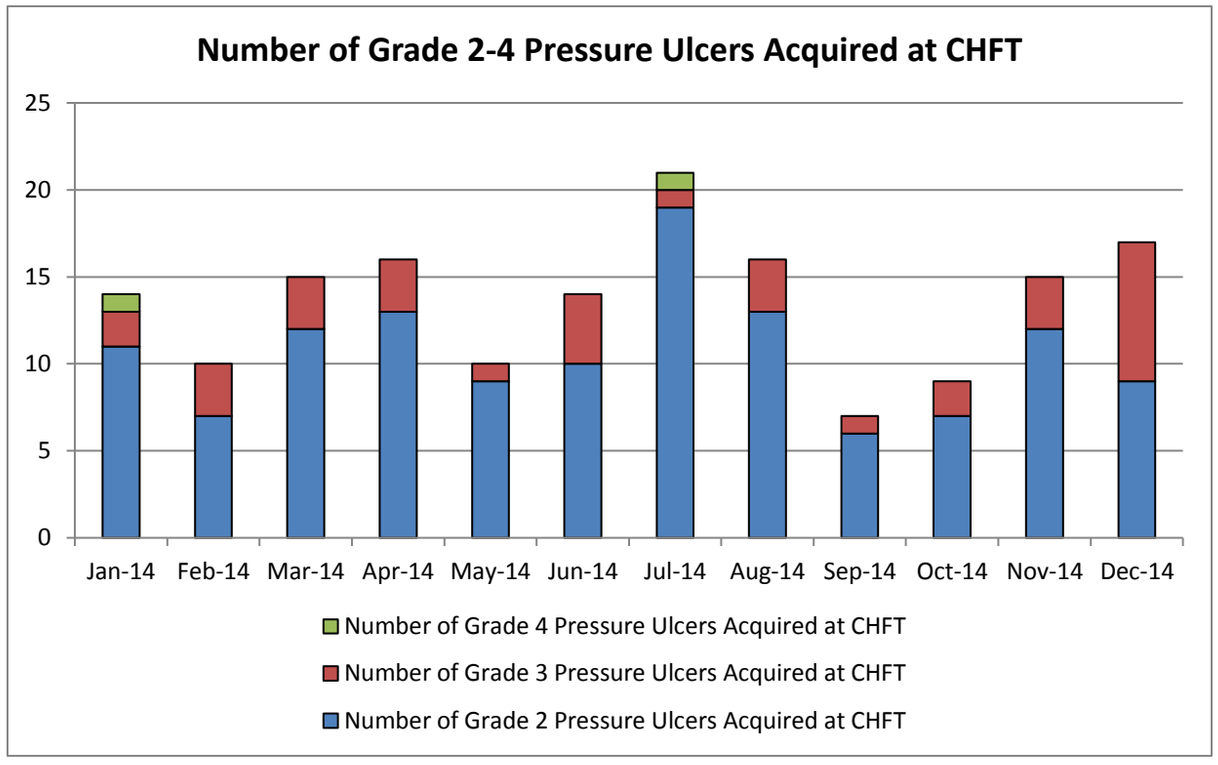
Report For: December 2014	Target	Trust	Surgical	Medical	CWF	DATS
Inpatient Falls with Serious Harm (10% reduction on 13/14)	2	3	1	2	0	-
All Falls (10% reduction on 2013/14)	112	151	30	119	2	-
Number of Trust Pressure Ulcers Acquired at CHFT	10.8	17	6	11	0	-
Number of Grade 2 Pressure Ulcers Acquired at CHFT	7.35	9	4	5	0	-
Number of Grade 3 Pressure Ulcers Acquired at CHFT	0	8	2	6	0	-
Number of Grade 4 Pressure Ulcers Acquired at CHFT	0	0	0	0	0	-

Pressure Ulcers

Action plan progress:• Root cause analysis of acquired pressure ulcers (category 2-4) to be reviewed by Senior Nurse team. Process in development – to commence in 2015.• Review pressure ulcer reporting and validation process - to include above review by senior nurse team.• Pressure ulcer prevention competencies are part of essential skills training - to be signed off by Board.• Safety thermometer validation exercise for pressure ulcers to be completed wards Jan-March for the wards with higher rates.• TVNs are continuing to focus support to high risk areas (Wards 19, 5, 8ab & 2ab).• Implementation of new research based risk assessment tool – visit to Leeds Teaching Hospitals regarding implementation & observing the tool in practice completed. Next steps – set up a group to support the implementation of the tool & review supporting documents/ processes. • New hybrid mattresses to be installed February/ March. King's Fund bedframes will also be replaced concurrently. Training to support appropriate use of pressure relieving mattresses is ongoing although attendance at training is low due to workload pressures.

Falls - to reduce ALL FALLS INCIDENTS by 10%, this needs to be 1039 by the 31st March 2015 (we have already failed this target). We are currently on target to reduce HARM FALLS by 10% on the 2013/14 baseline





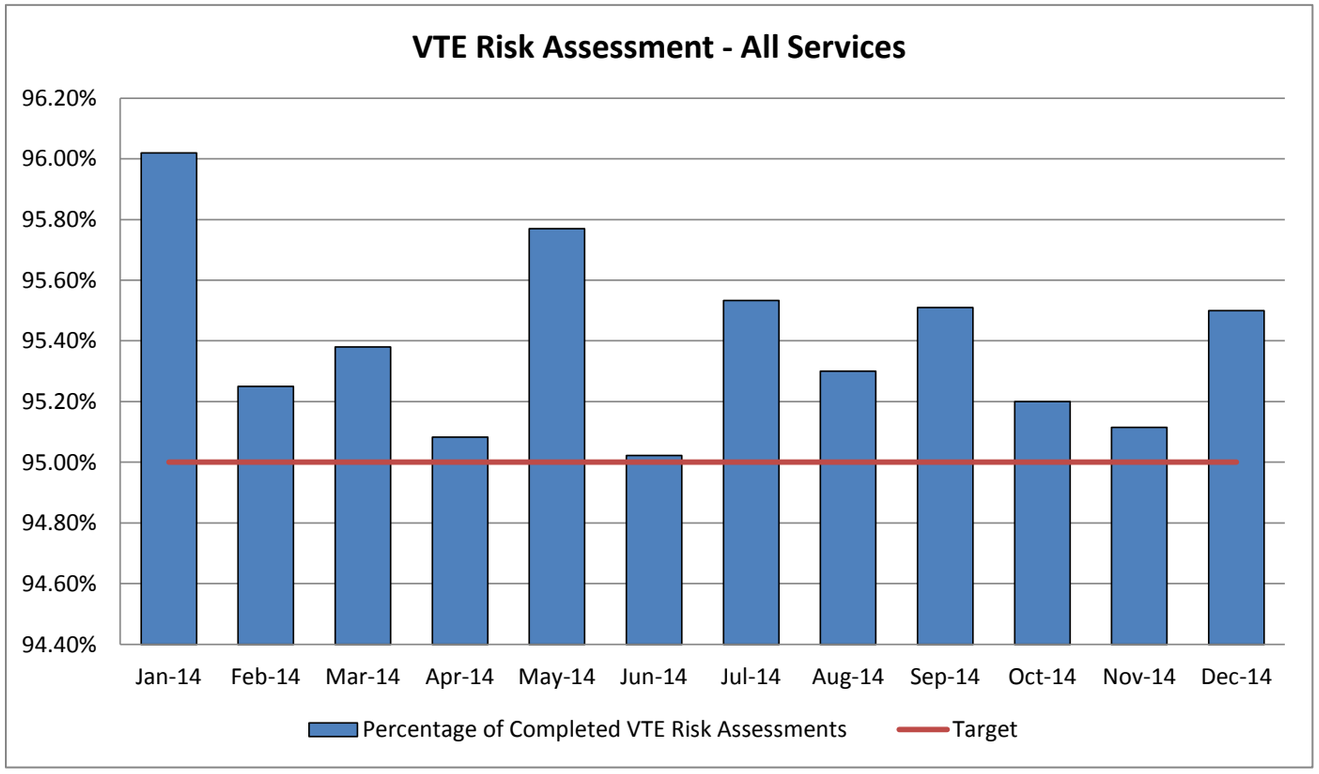
Safety - Director of Nursing

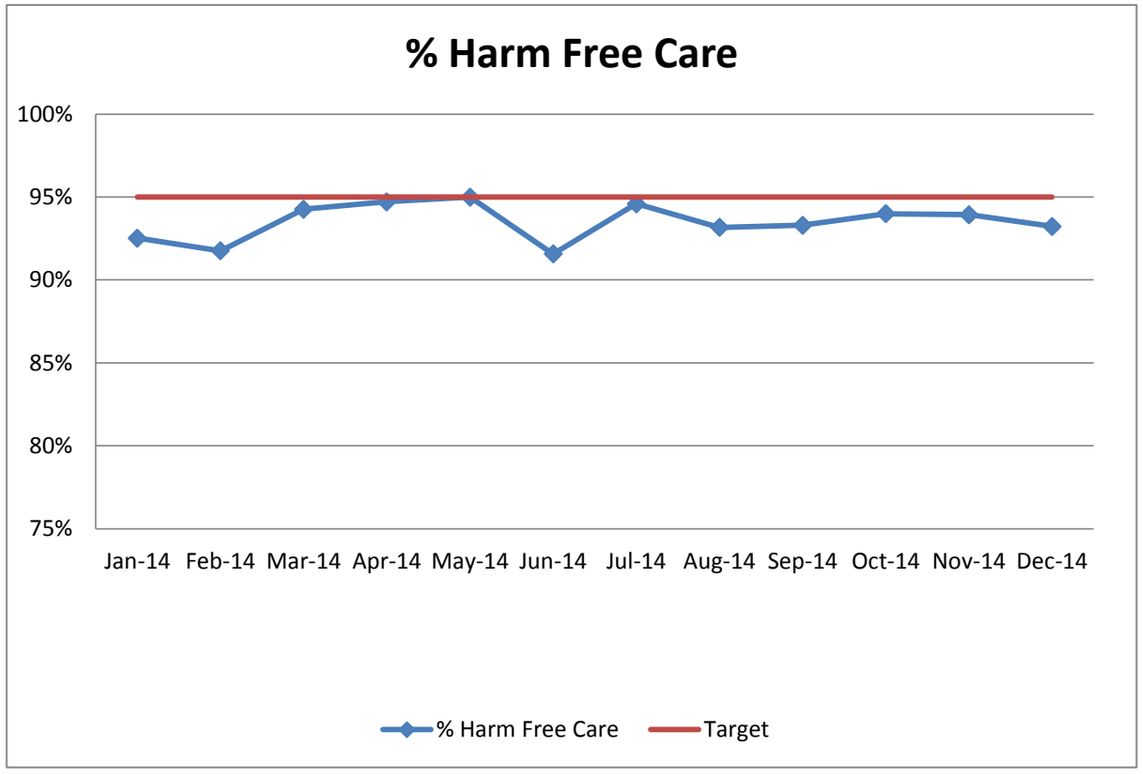
Report For: December 2014	Target	Trust	Surgical	Medical	CWF	DATS
Percentage of Completed VTE Risk Assessments	95.00%	95.50%	94.52%	95.49%	97.89%	100.00%
Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	100.00%	100.00%	100.00%	100.00%	-	-
VTE Prophylaxis Compliance			**Indicator in development**			
% Harm Free Care	95.00%	93.23%	96.06%	89.44%	100.00%	-
Missed Doses	5.00%	8.10%	-	-	-	--

VTE Risk Assessments - There is an on-going issue with the collection and validation of this data set, whilst there is no concern that VTE risk assessment is below target in any division a manual note pull is required at present to verify the numbers. It has been agreed to develop an electronic tool with 'nerve centre' funding is being obtained for this.

RCAS - There were 15 HAT episodes in December, all had a stage one RCA with no stage two's identified. One stage one RCA is still to take place from November as the notes are yet to be return from Holme Valley.

Harm Free Care - Monthly Point prevalence audits are carried out across the whole trust including community areas on the second Wednesday of each month. Improvement work is on-going on all the harm metrics captured to reduce prevalence. Because of the nature of the sampling monthly variation is to be expected. There is a extra CQUIN attached to pressure ulcers as measured by the safety thermometer, this target has not yet been reached.





Calderdale and Huddersfield NHS
NHS Foundation Trust

Safety - Director of Nursing

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Quality Priority	**Reduction in unintentional missed doses**
Aims and Objectives of work	The aim for the missed doses work stream is to reduce unintentional missed to a target of 5% by December 2015
Current Performance	The current level of unintentional missed doses in December 2014 is 8.1% which is an improvement on the September figure of 9.25%. There is concern about the number of missed doses per day for i.v. Antibiotics 25 and for Anticoagulants 19 and this will be fed back to the wards involved
Improvement plans for next 3 months (include process measures where possible)	The number of missed doses due to poor record keeping (the number of ticks, crosses and blanks) has improved from 386 in September 2014 to 338 in December 2014 but remains high in comparison with 145 in June 2014. Improvement work in the next quarter will focus on record keeping.
	Issues around the transfer of medicines with patients when they move from one word to another has been identified through missed doses audits, incident reports and activity follows. This will form the basis for further improvement work for the next quarter.

Safety - Director of Nursing

Report For: December 2014	Target	Trust	Surgical	Medical	CWF	DATS	Estates and Facilities	Corporate
Number of Patient Incidents	-	543	145	241	115	38	4	0
Number of SI's	-	10	4	6	0	0	0	0
Number of Incidents with Harm	-	136	29	67	33	7	0	0
Never Events	0	0	0	0	0	0	0	0
Percentage of SI's reported externally within timescale (2 days)	100.00%	90.00%	-	90.00%	100.00%	-	-	-
Percentage of SI's investigations where reports submitted with timescale (45 days unless extension agreed)	100.00%	38.00%	-	To be confirmed				-
Total Duty of Candor reported within the month	-	11	5	4	1	1	0	0
Total Duty of Candor outstanding at the end of the month	-	11	5	3	0	1	0	0

SI's reported to CCG: 10 serious incidents were reported to the CCG; all 10 related to Category 3 pressure ulcers (all hospital acquired).

SI Incidents reported within 2 days: 9 of the 10 SI's were reported to the CCG within the 2 days timescale. This delay was a delay in the Risk reporting process following validation.

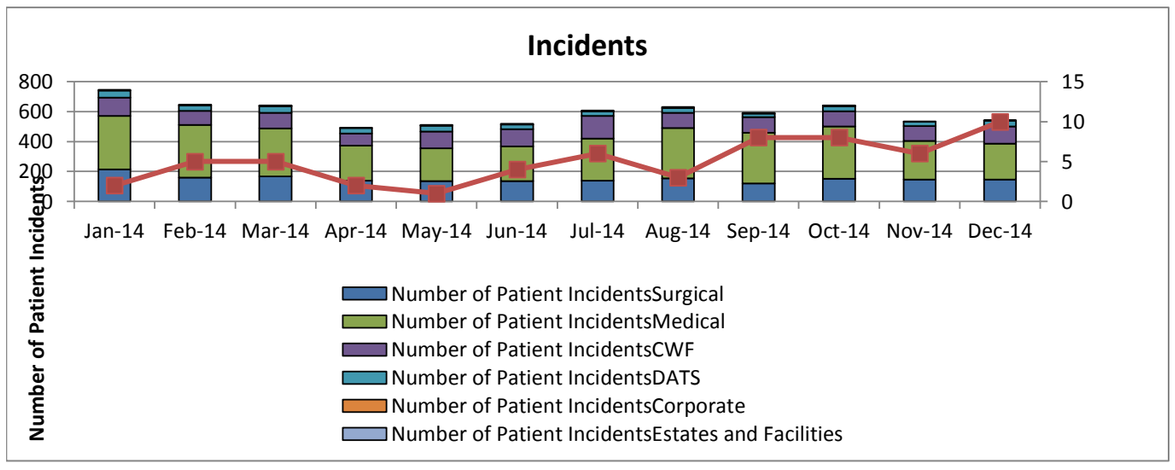
SI Incident reports submitted within timescale (45 days or within agreed extension): Of the 13 reports due for submission in December:

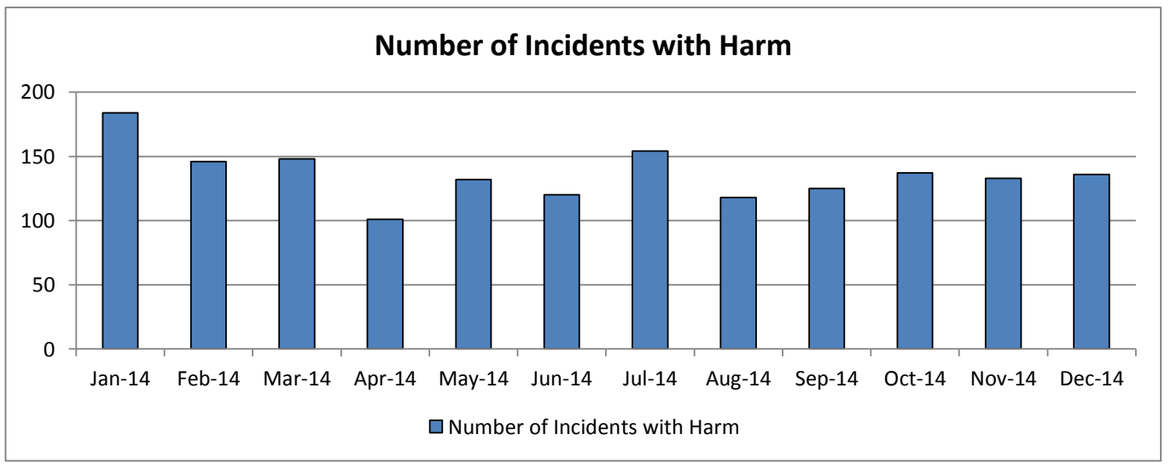
CWF - 1 due, an Extension of time was requested

Medical - of the 12 due: 4 were submitted on time; 3 were submitted late (4 days, 6 days and 7 days late; 5 have not been submitted or extensions applied for).

The CCG have contacted us with concerns as to the delays in submitting our RCA's (all of the reports late/not submitted relate to pressure ulcer incidents). An assurance was sought from them by 9 January that the backlog would be addressed and an assurance that we would submit on time in the future. 14 incidents either required RCA's/reports submitting or responses to further queries was raised. A total of 9 were submitted by 9 January. A total of 5 RCA's are outstanding. Applications for extensions for these incidents will need to be completed, which needs to include reasons for the delay. This has been escaled to the Senior Management team in the Medical Division.

Duty of Candour: On 27 November the Statutory Duty of Candour came into effect. From December we have been recording our compliance against this and have developed a monitoring tool to ensure this is captured. The figures for December show that there are 9 cases where we have not complied with the Duty. The monitoring of this is still in its early stages and we are continually liasing with Divisions to ensure that we are able to record the date that contact with the patient/carer was made. It is expected that recording of our compliance improves over the next month.





Calderdale and Huddersfield NHS
NHS Foundation Trust

Effectiveness Executive Summary

THIS

	Report For: December 2014	Indicator Source	Report For: December 2014 Target	Trust	Surgical	Medical	CWF	DATS	Year To Date Target	Trust	Surgical	Medical	CWF	DATS	Year End Forecast
Effectiveness	Number of MRSA Bacteraemias – Trust assigned	National	0	0	0	0	0	0	0	0	0	0	0	0	
	Total Number of Clostridium Difficile Cases	National	2	0	0	0	0	0	15	19	6	11	2	0	
	Total Number of Clostridium Difficile Cases – Trust assigned	National	0	0	0	0	0	0	0	6	5	1	0	0	
	Unavoidable Number of Clostridium Difficile Cases	National	2	0	0	0	0	0	15	13	3	9	1	0	
	Number of MSSA Bacteraemias - Post 48 Hours	National	2	3	0	2	1	0	18	7	1	5	1	0	
	% Hand Hygiene Compliance	Local	95.00%	99.97%	99.93%	100.00%	100.00%	99.95%	95.00%	99.82%	99.57%	99.99%	100.00%	99.90%	
	MRSA Screening - Percentage of Inpatients Matched	Local	95.00%	95.97%	95.92%	98.94%	100.00%	-	95.00%	95.94%	94.80%	98.75%	97.80%	-	
	Number of E.Coli - Post 48 Hours	Local	2	2	0	2	0	0	18	17	7	10	0	0	
	Central Line Infection rate per 1000 Central Venous Catheter days	Local	1.50	2.93	-	-	-	-	1.50	0.97	-	-	-	-	
Effectiveness 2	Emergency Readmissions Within 30 Days (With PbR Exclusions)	National	7.80%	7.00%	4.40%	11.00%	5.20%	4.70%	7.39%	7.28%	4.48%	10.86%	5.70%	5.20%	
	Local SHMI - Relative Risk - (1yr Rolling Data)	National	100	111	-	-	-	-	100	111	-	-	-	-	
	Hospital Standardised Mortality Rate	National	80.00	102.41	-	-	-	-	-	-	-	-	-	-	
	Rebased HSMR	National	-	-	-	-	-	-	-	-	-	-	-	-	
	Crude Mortality Rate	National	1.00%	1.61%	0.60%	4.21%	0.07%	0.00%	1.14%	1.22%	0.46%	3.17%	0.12%	0.00%	
	Average Diagnosis per Coded Episode	National	4.9	4.01	3.68	5.6	2.28	3.98	4.9	4.05	3.66	5.65	2.39	3.41	
Effectiveness 3	Number of Unplanned Adult Admissions to ITU		-	51	-	-	-	-	-	446	0	0	0	0	
	Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	National	85.00%	65.22%	65.22%	-	-	-	85.00%	61.82%	61.82%	-	-	-	

Effectiveness - Medical Director

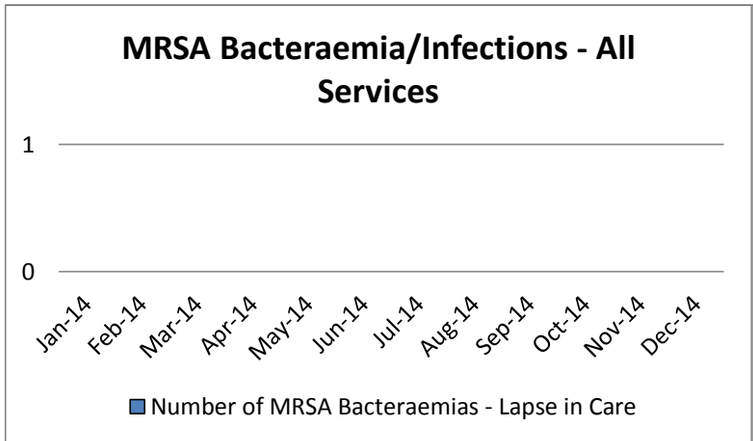
Report For: December 2014	Target	Trust	Surgical	Medical	CWF	DATS
Number of MRSA Bacteraemias – Trust assigned	0	0	0	0	0	0
Total Number of Clostridium Difficile Cases	2	0	0	0	0	0
Total Number of Clostridium Difficile Cases – Trust assigned	0	0	0	0	0	0
Unavoidable Number of Clostridium Difficile Cases	2	0	0	0	0	0
Number of MSSA Bacteraemias - Post 48 Hours	2	3	0	2	1	0
% Hand Hygiene Compliance	95.00%	99.97%	99.93%	100.00%	100.00%	99.95%
MRSA Screening - Percentage of Inpatients Matched	95.00%	95.97%	95.92%	98.94%	100.00%	-
Number of E.Coli - Post 48 Hours	2	2	0	2	0	0
Central Line Infection rate per 1000 Central Venous Catheter days	1.50	2.93	-	-	-	-

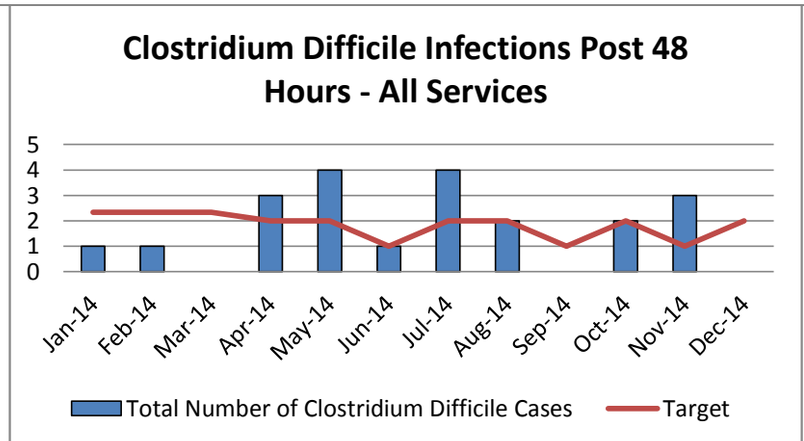
C. difficile. We have breached our target for this year (20 cases vs a ceiling of 18). RCA for all cases have been undertaken: 6 have been classed as avoidable, 13 as unavoidable. 1 RCA is pending.

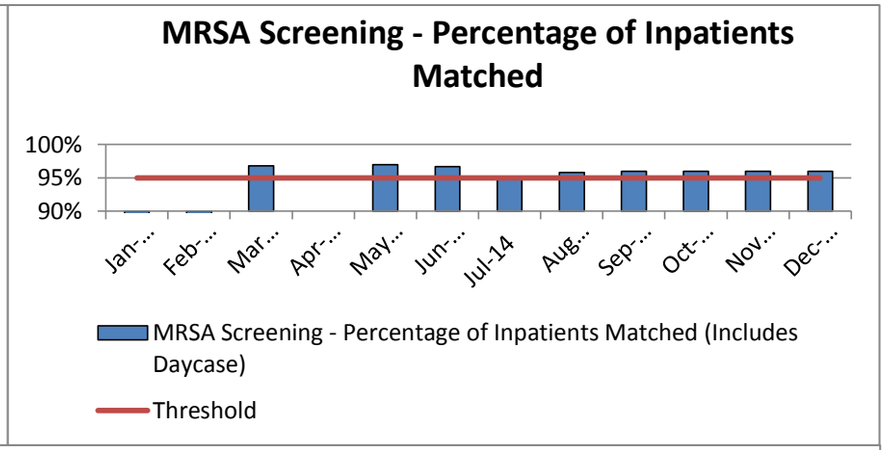
MRSA Bacteraemias - 1 remains assigned to the trust. Classed as unavoidable.

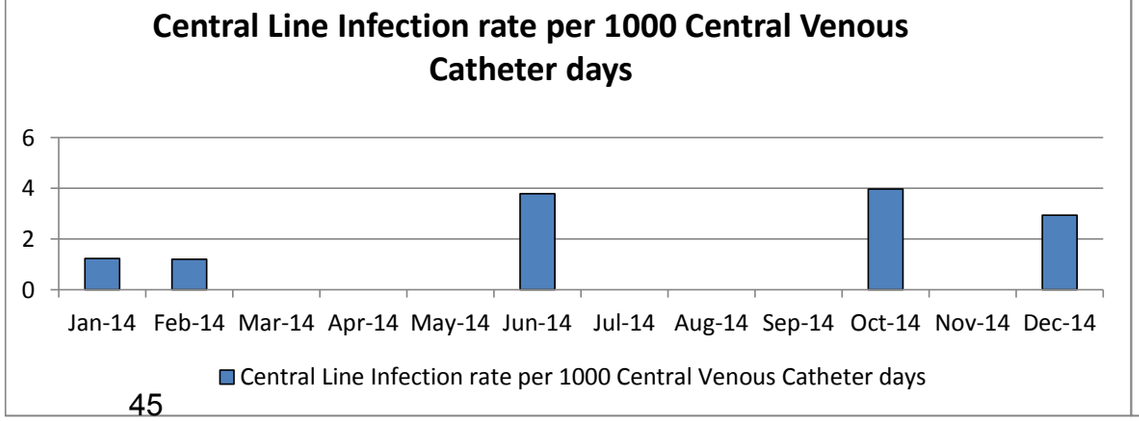
There were two line infections in December, both are being investigated using RCA investigations, although both were in haematology/oncology patients they were different organisms. Practice will be scrutinised in the investigation process.

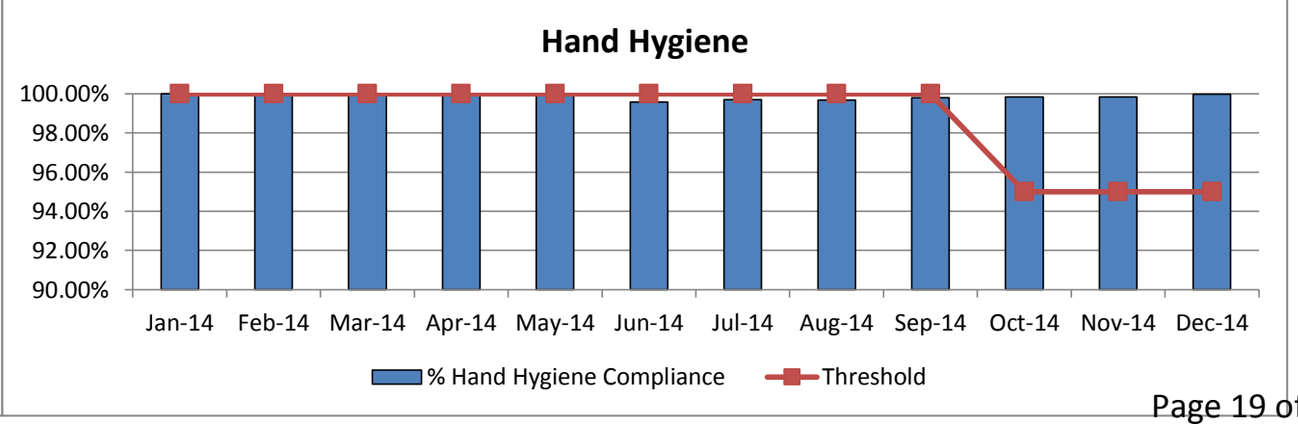
MSSA bacteraemia post 48 hours. 3 cases, 1 above target. No epidemiological link to suggest cross-transmission, these are endogenous infections. Surveillance continues with a plan to improve how we capture details of device related bacteraemias











Effectiveness - Medical Director

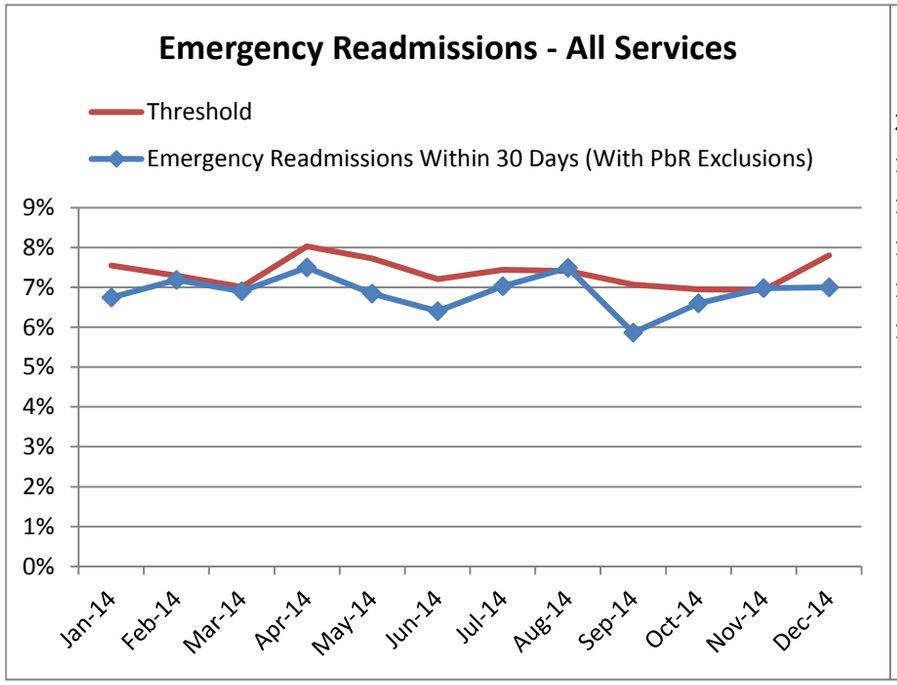
Report For: December 2014	Target	Trust	Surgical	Medical	CWF	DATS
Emergency Readmissions Within 30 Days (With PbR Exclusions)	7.80%	7.00%	4.40%	11.00%	5.20%	4.70%
Local SHMI - Relative Risk - (1yr Rolling Data)	100	111	-	-	-	-
Hospital Standardised Mortality Rate	80	102.41	-	-	-	-
Rebased HSMR	-	-	-	-	-	-
Crude Mortality Rate	1.00%	1.61%	0.60%	4.21%	0.07%	0.00%
Average Diagnosis per Coded Episode	4.9	4.01	3.68	5.6	2.28	3.98

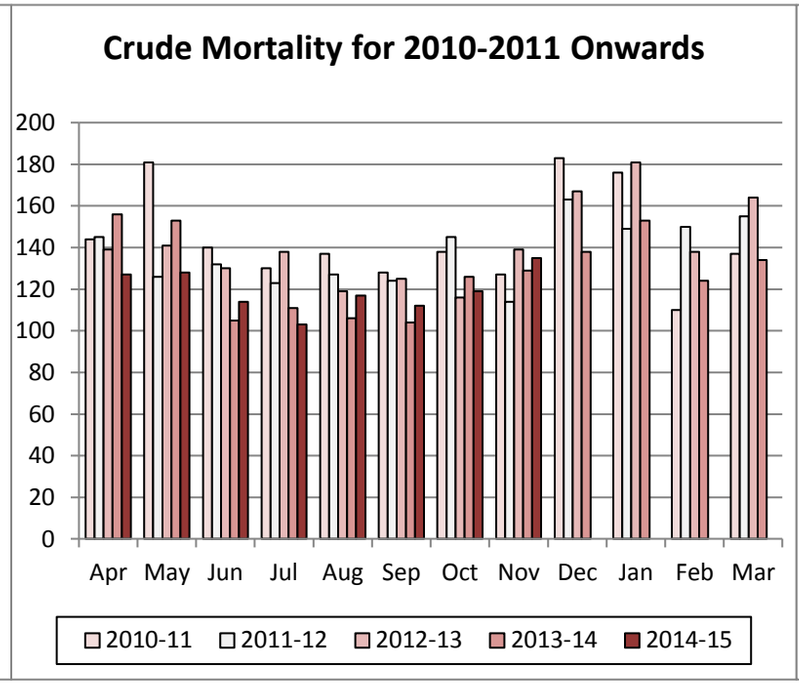
Readmissions - Readmissions target is an overall elective and emergency trust level target which takes into account the difference in patient cohort into each division. The target level varies each month and is based on the same point last year. Our current performance is within the target level. Future RAG rating - Green

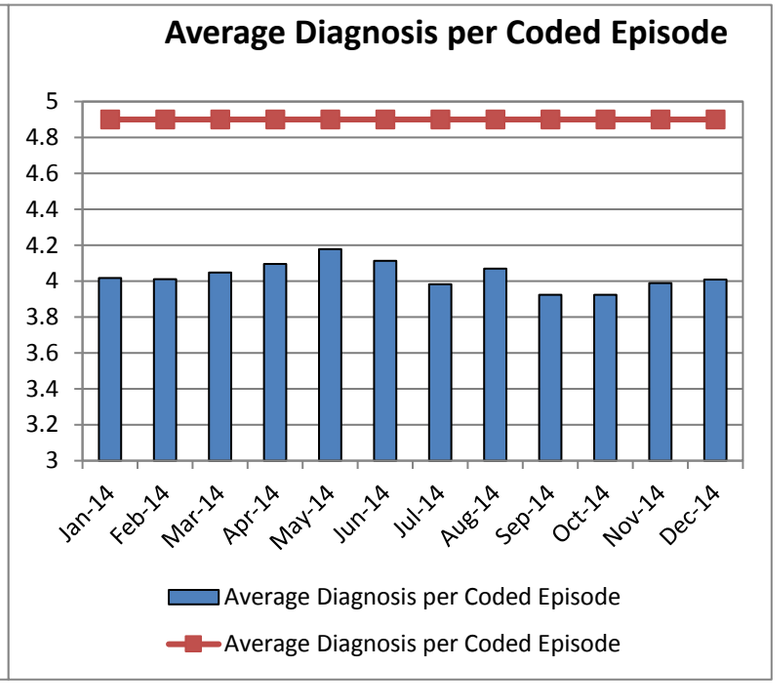
SHMI - SHMI is published quarterly, and reported as a rolling 12 month figure. The most recent released indicated a SHMI of 111 the 12 months of April 14 to March 14 which ranks the trust 129th out of 141.

HSMR – Dr Foster Intelligence(DFI) have rebased their model to now include the national averages from 13/14. This confirmed a rebased 13/14 year end figure of 106 against a national score of 100. The most recent 12 months data indicates a non-rebased 102.41 against the national average of 95.67. At present our rates are falling in line with the average. In order to achieve a HSMR of less than 100 i.e. lower than national average, we will need to observe a stronger local reduction. Work continues on The Care of the Acutely Ill Patient programme and the eight key theme which will help to reduce both SHMI and HSMR. These include reliable implementation of care bundles, focus on frail patients, coding and condition specific work where mortality rates appear to be outlying.

The Care of the Acutely Ill Patient programme has undergone a review and eight key themes will be addressed to help reduced our SHMI and HSMR. These include reliable implementation of care bundles, focus on frail patients, coding and services where mortality rates are outlying.





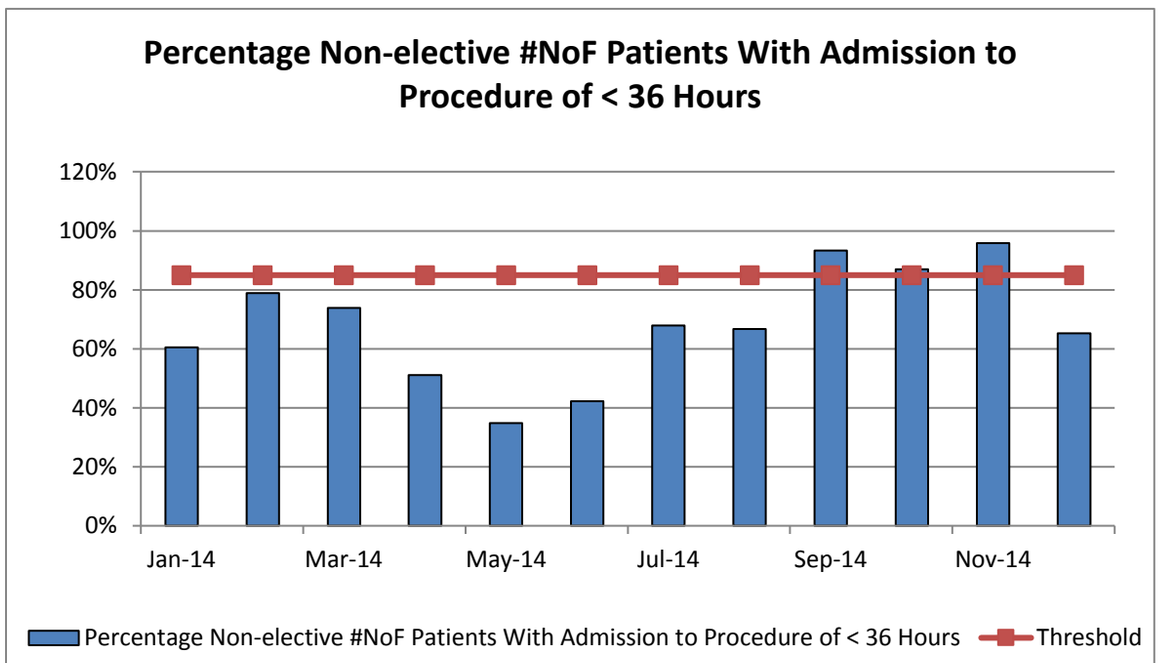


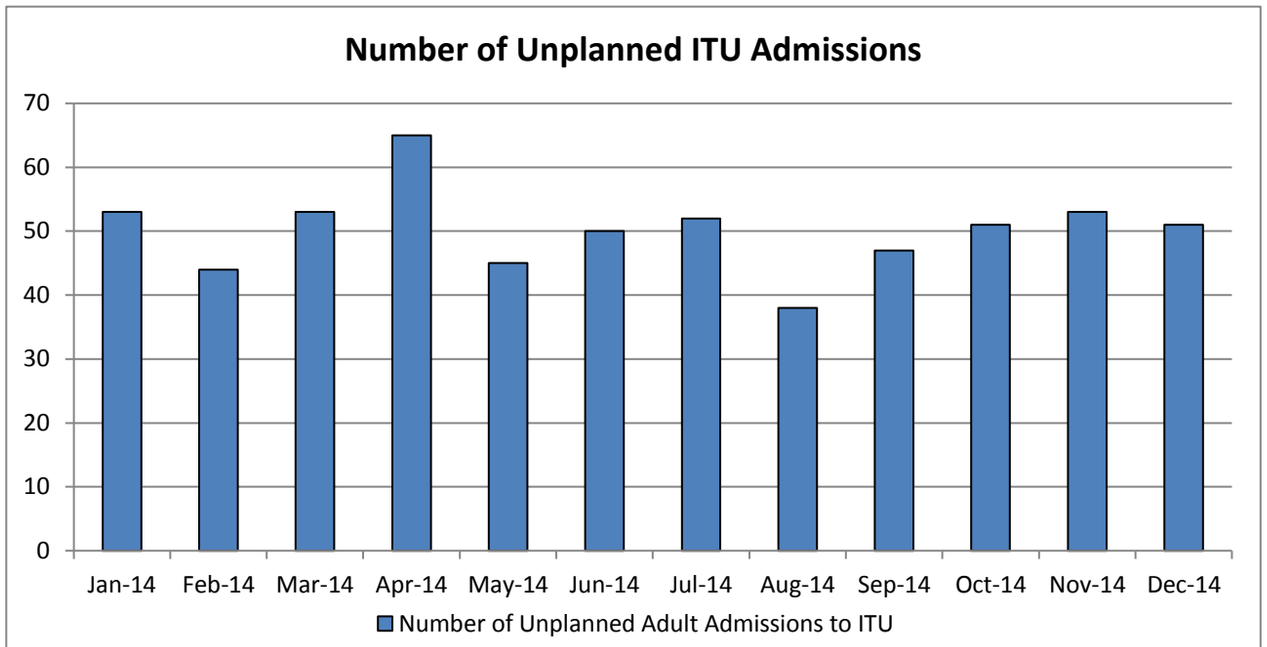
Effectiveness - Medical Director

Report For: December 2014	Target	Trust	Surgical	Medical	CWF	DATS
Number of Unplanned Adult Admissions to ITU	-	51	-	-	-	-
Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	85.00%	65.22%	65.22%	-	-	-

In December we admitted 61 patients with #NOF, this equates to a very high demand. These 61 did not come in steadily, there were up to 6 admitted in a day. Once we were behind it took days to catch up, we had to wait for a day with low admissions in order to be able to start delivering the patients to theatre within 36 hours.

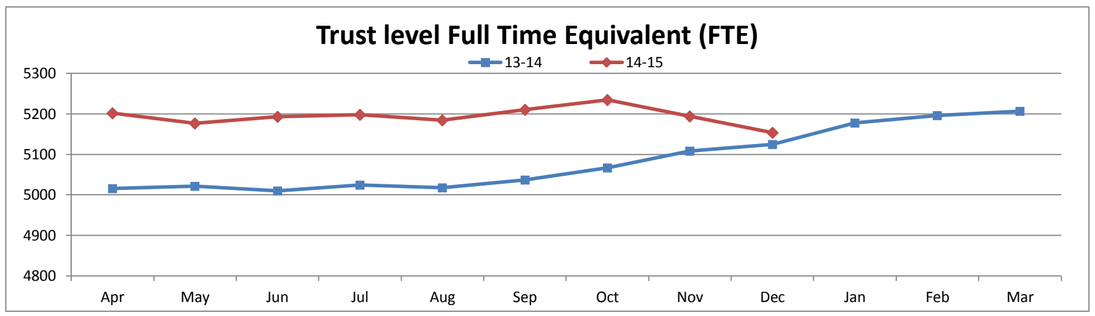
We were struggling with beds in general, and demand for other trauma was sometimes clinically prioritised over #NOF.

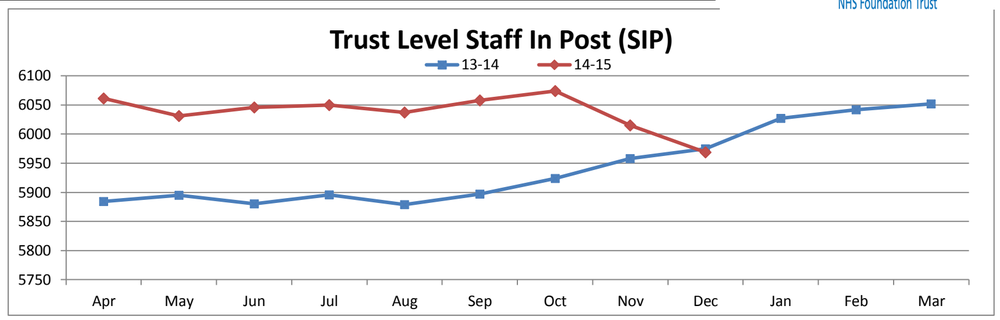


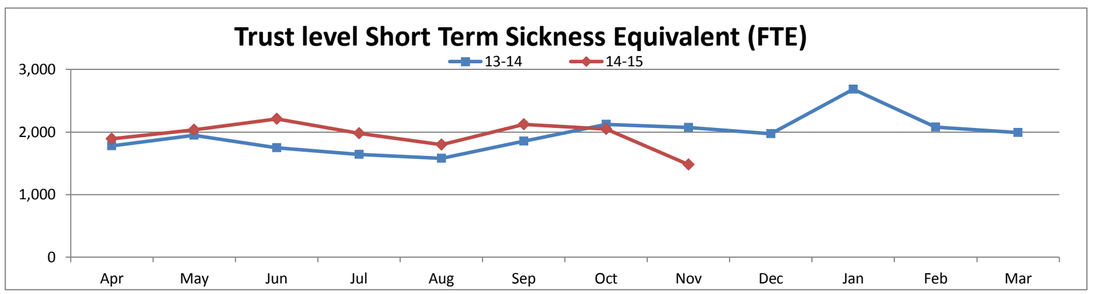


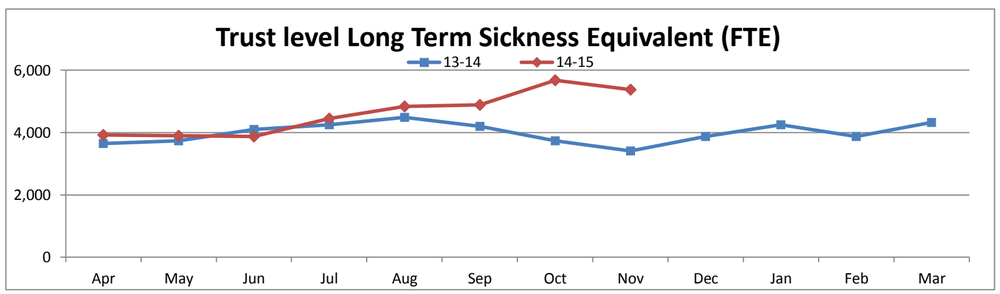
Well Led / Workforce - Director of Workforce and Organisational Development

Calderdale and Huddersfield NHS
NHS Foundation Trust









Director Lead	Report For: December 2014	Trust Threshold	Trust Actual	Surgery	Medical	CWF	DATS	Estates	Corporate	THIS
J.H	Sickness Absence rate (%) (1 Month Behind)	4.00%	4.43%	3.90%	5.13%	5.28%	3.95%	5.06%	1.75%	2.98%
J.H	Sickness Absence rate (FTE Lost) (1 Month Behind)		6918.04	1576.90	2542.12	1276.96	752.43	454.68	147.46	167.50
J.H	FTE Days Available (1 Month Behind)		156208.16	40385.08	49507.47	24192.42	19070.89	8985.14	8417.41	5623.74
J.H	Sickness Absence rate (%) - Nursing (1 Month Behind)	4.00%	4.84%	4.69%	4.50%	5.60%	6.36%	-	3.07%	-
JH	Total Staff in Post (FTEs)		5,153.48	1,332.35	1,625.72	798.14	633.78	293.83	282.29	187.38
LH	Fire Safety Awareness	95.00%	81.70%	77.80%	71.20%	87.20%	95.90%	99.70%	83.80%	93.20%
LH	Fire Risk Assessments	95.00%	18.00%	7.00%	16.00%	45.00%	0.00%	50.00%		
JR	Information Governance - **YTD**	100.00%	62.60%	65.70%	55.50%	60.20%	69.80%	77.50%	53.80%	74.60%
JD	Risk Training - **YTD**	100.00%	60.40%	61.40%	46.60%	66.60%	62.20%	86.30%	73.30%	73.50%
JH	Appraisal Non Medical- YTD	75.00%	38.41%	26.00%	31.30%	39.30%	39.30%	91.20%	39.20%	64.50%
JH	Appraisal - Rolling 12 Month	100.00%	72.24%	73.23%	66.57%	74.15%	65.09%	96.08%	73.90%	82.98%
DB	Appraisal Medical- YTD	100.00%	38.02%	34.90%	33.00%	40.40%	67.70%	-	100.00%	-
DB	Medical devices training	95.00%	80.00%	75.00%	77.00%	82.00%	78.00%	-	88.00%	-
JD	Safeguarding - Level 1 - Staff compliant		63.20%	66.10%	48.80%	71.30%	68.10%	81.90%	63.20%	89.10%
JD	Safeguarding - Level 2 - Staff compliant		63.30%	47.80%	50.90%	74.70%	44.60%	77.50%	85.20%	0.00%
JD	Safeguarding - Level 3 - Staff Compliant		79.30%	58.30%	82.60%	69.70%	80.00%	-	85.00%	-
JH	FFT Staff - Response Rate (Quarterly)		6.50%	-	-	-	-	-	-	-
JH	FFTStaff - Would you recommend us to your friends and family as a place to receive		81.00%	-	-	-	-	-	-	-
JH	FFT Staff - Would you recommend us to your friends and family as a place to work?		59.00%	-	-	-	-	-	-	-
JD	Hard Truths Summary Day - Nurses/Midwives (1 Month Behind)	100.00%	82.80%	84.80%	80.00%	86.40%	-	-	-	-
JD	Hard Truths Summary - Day Care Staff (1 Month Behind)	100.00%	94.40%	92.10%	101.30%	70.30%	-	-	-	-
JD	Hard Truths Summary - Night Nurses/Midwives (1 Month Behind)	100.00%	86.60%	88.80%	84.40%	88.10%	-	-	-	-
JD	Hard Truths Summary - Night Care Staff (1 Month Behind)	100.00%	122.20%	107.20%	140.90%	79.30%	-	-	-	-

Sickness Rates - A programme of work on 'high absence incidence' service areas has commenced . An internal taskforce is working to support divisional colleagues in managing attendance. The taskforce is taking a hands-on role in developing an overall approach to effective management in these service areas and in individual cases. This approach is supported by intensive briefing of colleagues with regard to how attendance impacts on our ability to deliver safe services and high quality patient care.

A line manager toolkit has been made available and further enhanced tools are being developed (the proposal is for a multi-channel approach with an extensive intranet resource package) supported by technical HR input. A programme of line manager breakthrough events are planned focusing on what improvements to how we manage and what good practice tools/resources are needed to deliver excellent attendance at work.

Data about absence is a critical part of an effective approach and information for individual service areas about their performance is available routinely. Attention is being paid to data quality and to the availability/timeliness of absence reports. Significant improvements in access to data as well as the quality of data capture and reporting will be delivered with the full implementation of ESR manager self-serve which is currently available on a pilot basis.
To help divisions manage sickness through ESR business intelligence (B.I) reports have been created which show sickness at ward levels, identify trends and provide detailed lists of all colleague's absence on an individual basis. This process has been shared with the Medical Division and will then be shared with over divisions.

Sickness FTE days lost - Is calculated by multiplying FTE against calendar days lost in current reporting month.

Fire Safety Awareness - 81.7% of colleagues are trained in fire safety awareness . Although a vast improvement in the training attendance has been achieved there are still large numbers of staff who are not compliant (over 1000).

Fire Training - A revised approach to mandatory and essential skills training has been designed and this approach will help improve and sustain compliance performance.

Fire Risk Assessments - All areas of the Trust's two hospitals have had fire assessments carried out. Other properties for which the Trust is responsible are currently being completed and should be issued shortly. Once risk assessments are issued to departments it is essential that those departments act upon this assessment, otherwise we will be in breach of our statutory duty.

Appraisal YTD - The monthly compliance target for appraisals is 8%. All areas forecast compliance of 100% at 31 March 2015. There is strong evidence that appraisal activity is concentrated in last 3 months of performance year. Resources provided by the Workforce Development team are still being added to the intranet available toolkit. For example, appraisal planning and appraisal preparation videos are new additions.

YTD Information Governance - The monthly compliance target for Information Governance is 6%. Information Governance training compliance is measured on a rolling year basis so figures will fluctuate throughout the year. YTD Compliance is at 71% Training awareness and compliance messages are being communicated via the Trust Information Governance and Records Strategy Group which is then cascaded throughout the divisions. There will be a final push for Training uptake during January, February and March2015 with a yearend predication of 85%.

Hard Truths - Maintaining staffing levels with an increasing and fluctuating demand has remained difficult. Increased staffing reviews throughout each day have been implemented to identify priorities and maintain a safe base. The development of a staffing forecast utilising the e-roster system has also been developed to assist identification of any areas with staffing flexibility. Increased agency usage is being monitored closely and an additional recruitment drive in December of non-qualified nurses was undertaken which will assist in achieving safe staffing levels and reducing agency spend from the first week in January. Two successful recruitment trips to Spain have been completed resulting in the offer of positions to 21 qualified nurses who are due to arrive in January 2015. The Web based safe staffing tool was successfully trialled and will be utilised to report nursing and midwifery staffing in inpatient areas from 1.1.15. In addition to providing accurate data the staffing tool will also collate professional judgement to inform future staffing plans.

FFT- This Information is for quarter 2. Friends and Family Test for Staff doesn't run in quarter 3 due to the Staff Survey.

Revised new version:

		Trust Threshold	Trust Actual
Finance	Continuity of Service Risk Rating	3	3
	Operational Performance (Debt service cover)	3	2
	Cash & Balance Sheet Performance (Liquidity)	3	3
	Use of Capital	£16.05m	£15.71m
	Income and Expenditure	£2.40m	(£3.34m)
	Cost Improvement Programme (CIP)	£11.90m	£5.54m

Calderdale and Huddersfield NHS
NHS Foundation Trust

Contract income

THIS

		Year To Date Plan		Year To Date Actual		Year To Date Variance	
Division	**Monitor POD**	**Plan YTD - Spells**	**Plan YTD - Value (Inc MFF) with CQUIN**	**Actual 1415 - Spells**	**Actual 1415 -Value (Inc MFF) with CQUIN**	**Variance - Spells**	**Variance - Value (Inc MFF) with CQUIN**
CWF	DAYCASE	1,923	1,224,381	1,788	1,229,535	-135	5,154
	ELECTIVE	1,088	1,837,704	802	1,824,950	-286	-12,753
	NON-ELECTIVE	11,198	13,194,844	10,892	13,227,257	-306	32,413
	OTHER NHS NON-TARIFF	36,618	16,499,964	33,442	16,101,075	-3,177	-398,889
	OTHER NHS TARIFF	11,534	8,458,582	11,350	8,436,796	-184	-21,786
	OUTPATIENT	30,068	4,584,432	31,668	4,658,078	1,600	73,646
CWF Total		92,429	45,799,908	89,942	45,477,692	**-2,488**	-322,216
DATs	DAYCASE	241	223,979	205	224,990	-36	1,011
	ELECTIVE	255	435,944	245	466,211	-10	30,267
	NON-ELECTIVE	5	24,290	1	11,165	-4	-13,124
	OTHER NHS NON-TARIFF	1,050,908	6,566,237	1,048,860	6,678,267	-2,048	112,030
	OTHER NHS TARIFF	45,616	4,124,584	49,632	4,214,977	4,016	90,393
	OUTPATIENT	0	0	0	0	0	0
DATs Total		1,097,024	11,375,034	1,098,943	11,595,610	**1,919**	220,577
Medicine	DAYCASE	7,900	4,429,802	7,505	4,455,993	-395	26,191
	ELECTIVE	678	1,464,330	727	1,399,975	49	-64,355
	NON-ELECTIVE	16,196	30,872,329	15,921	30,948,902	-275	76,573
	OTHER NHS NON-TARIFF	54,729	34,764,538	52,882	33,186,875	-1,847	-1,577,663
	OTHER NHS TARIFF	8,700	2,438,784	8,325	2,324,679	-375	-114,105
	OUTPATIENT	69,134	8,928,651	69,333	8,962,733	199	34,082
Medicine Total		157,337	82,898,433	154,693	81,279,156	**-2,644**	-1,619,277
Surgery	A&E	107,040	10,572,279	109,037	10,649,215	1,997	76,936
	DAYCASE	20,583	16,520,011	20,802	16,508,367	219	-11,644
	ELECTIVE	5,233	15,452,364	4,582	15,108,955	-651	-343,410
	NON-ELECTIVE	10,578	18,400,944	9,877	18,395,687	-701	-5,258
	OTHER NHS NON-TARIFF	27,262	9,016,269	26,429	9,326,880	-833	310,611
	OTHER NHS TARIFF	13,864	1,260,712	13,415	1,271,007	-449	10,294
	OUTPATIENT	146,001	15,826,614	146,399	15,854,009	398	27,395
Surgery Total		330,562	87,049,194	330,541	87,114,118	**-21**	64,925
Corporate	OTHER NHS NON-TARIFF	0	162,625	0	162,625	0	0
Corporate Total		0	162,625	0	162,625	0	0
Ops & Facilities	OTHER NHS NON-TARIFF	0	397,870	0	397,870	0	0
Ops & Facilities Total		0	397,870	0	397,870	0	0
Central	NON-ELECTIVE	0	0	0	0	0	0
	OTHER NHS NON-TARIFF	23	216,000	55	211,026	32	-4,974
	OTHER NHS TARIFF	0	-79,718	0	-79,718	0	0
Central Total		23	136,282	55	131,308	32	-4,974
Grand Total		**1,677,376**	**227,819,345**	**1,674,174**	**226,158,380**	**-3,202**	**-1,660,965**

Trust Financial Overview as at 31st Dec 2014 - Month 09

INCOME AND EXPENDITURE COMPARED TO ORIGINAL PLAN SUBMITTED TO MONITOR IN APRIL 2014

YEAR TO DATE POSITION: M09

CLINICAL ACTIVITY

	M09 Plan	M09 Actual	Var
Elective	7,255	6,356	(899)
Non Elective	37,977	36,691	(1,286)
Daycase	30,647	30,300	(347)
Outpatients	245,203	247,400	2,197
A & E	107,040	109,037	1,997

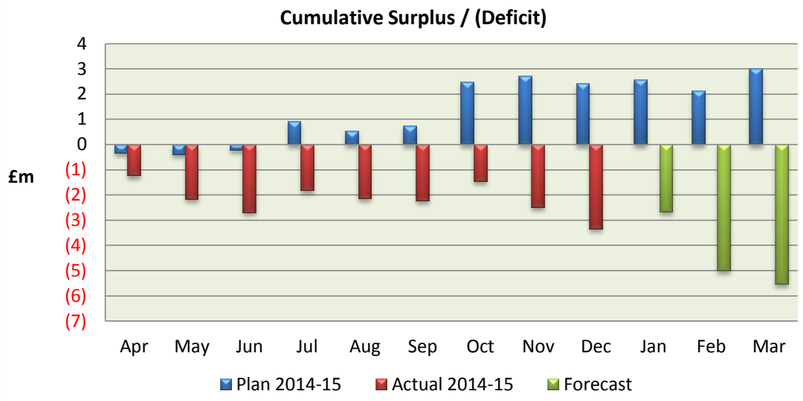
TRUST: INCOME AND EXPENDITURE

	M09 Plan	M09 Actual	Var
	£m	£m	£m
Elective	£19.19	£18.80	(£0.39)
Non Elective	£62.49	£62.58	£0.09
Daycase	£22.46	£22.42	(£0.04)
Outpatients	£29.37	£29.47	£0.10
A & E	£10.57	£10.65	£0.08
Other-NHS Clinical	£91.13	£90.57	(£0.56)
Other Income	£27.93	£27.93	£0.00
Total Income	**£263.14**	**£262.43**	**(£0.71)**
Pay	(£162.41)	(£164.85)	(£2.43)
Drug Costs	(£19.66)	(£21.73)	(£2.07)
Clinical Support	(£21.31)	(£22.40)	(£1.08)
Other Costs	(£29.79)	(£29.05)	£0.74
PFI Costs	(£8.64)	(£8.75)	(£0.11)
Total Expenditure	**(£241.81)**	**(£246.78)**	**(£4.97)**
EBITDA	**£21.33**	**£15.65**	**(£5.68)**
Non Operating Expenditure	(£18.92)	(£17.93)	£1.00
Deficit excl. Restructuring	**£2.40**	**(£2.28)**	**(£4.68)**
Restructuring Costs	£0.00	(£1.07)	(£1.07)
Surplus / (Deficit)	**£2.40**	**(£3.34)**	**(£5.75)**

DIVISIONS: INCOME AND EXPENDITURE

	M09 Plan	M09 Actual	Var
	£m	£m	£m
Surg & Anaes	£24.22	£22.50	(£1.72)
Medical	£22.39	£18.45	(£3.94)
CWF	£14.79	£14.45	(£0.34)
DATS	(£9.84)	(£10.95)	(£1.11)
Est & Fac	(£19.88)	(£19.95)	(£0.07)
Corporate / THIS	(£12.61)	(£14.04)	(£1.43)
Central Inc/Tech	(£15.89)	(£13.80)	£2.08
Reserves	(£0.79)	£0.00	£0.79
Surplus / (Deficit)	**£2.40**	**(£3.34)**	**(£5.75)**

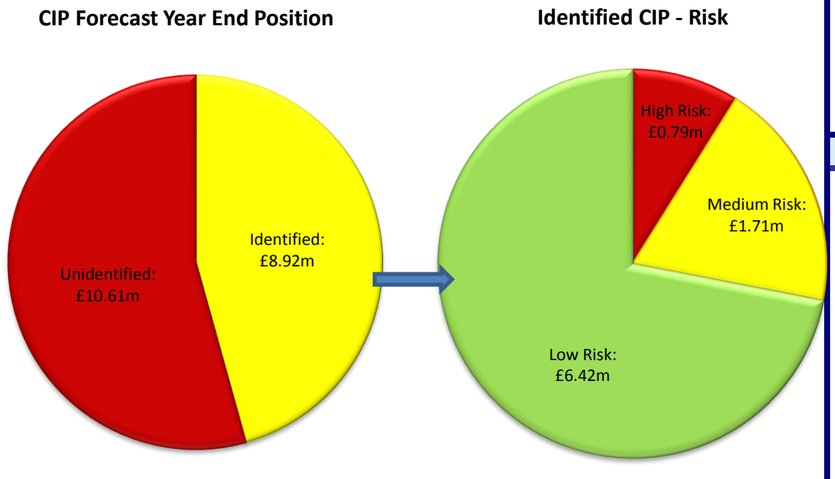
TRUST SURPLUS / (DEFICIT)



KEY METRICS

	Year To Date M09 Plan	Year To Date M09 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)	£2.40	(£3.34)	(£5.75)	£3.00	(£5.54)	(£8.54)
Capital (Re-forecast Plan)	£16.05	£15.71	£0.34	£24.31	£21.79	£2.53
Cash	£20.82	£15.46	(£5.36)	£22.71	£10.65	(£12.06)
	Plan	**Actual**		**Plan**	**Forecast**	
Continuity of Service Risk Rating	3	3		3	2	

COST IMPROVEMENT PROGRAMME (CIP)



Total Planned: £19.53m **Total Identified: £8.92m**

YEAR END 2014/15

CLINICAL ACTIVITY

	Plan	Forecast	Var
Elective	9,676	8,536	(1,140)
Non Elective	50,642	48,924	(1,719)
Daycase	40,851	40,327	(524)
Outpatients	327,239	329,941	2,702
A & E	141,505	144,145	2,640

TRUST: INCOME AND EXPENDITURE

	Plan	Forecast	Var
	£m	£m	£m
Elective	£25.60	£25.07	(£0.53)
Non Elective	£83.29	£83.40	£0.11
Daycase	£29.93	£29.83	(£0.10)
Outpatients	£39.20	£39.31	£0.11
A & E	£13.98	£14.08	£0.10
Other-NHS Clinical	£122.37	£123.64	£1.27
Other Income	£37.27	£37.05	(£0.22)
Total Income	**£351.64**	**£352.38**	**£0.74**
Pay	(£217.10)	(£220.97)	(£3.87)
Drug Costs	(£26.36)	(£29.17)	(£2.81)
Clinical Support	(£28.04)	(£29.73)	(£1.69)
Other Costs	(£40.29)	(£39.12)	£1.17
PFI Costs	(£11.52)	(£11.65)	(£0.13)
Total Expenditure	**(£323.31)**	**(£330.64)**	**(£7.33)**
EBITDA	**£28.33**	**£21.75**	**(£6.58)**
Non Operating Expenditure	(£25.33)	(£24.17)	£1.16
Deficit excl. Restructuring	**£3.00**	**(£2.42)**	**(£5.42)**
Restructuring Costs	£0.00	(£3.12)	(£3.12)
Surplus / (Deficit)	**£3.00**	**(£5.54)**	**(£8.54)**

DIVISIONS: INCOME AND EXPENDITURE

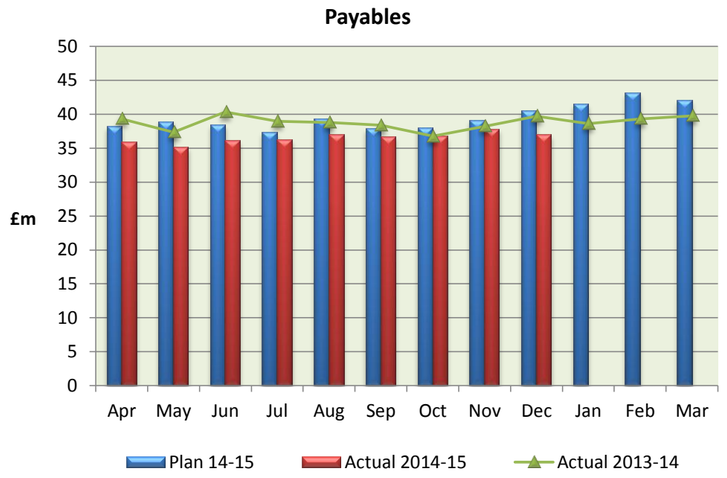
	Plan	Forecast	Var
	£m	£m	£m
Surg & Anaes	£33.11	£29.32	(£3.79)
Medical	£28.96	£24.02	(£4.94)
CWF	£19.85	£18.92	(£0.93)
DATS	(£12.19)	(£13.42)	(£1.24)
Est & Fac	(£26.71)	(£26.86)	(£0.15)
Corporate / THIS	(£16.89)	(£18.87)	(£1.97)
Central Inc/Tech	(£20.44)	(£18.51)	£1.92
Reserves	(£2.70)	(£0.14)	£2.56
Surplus / (Deficit)	**£3.00**	**(£5.54)**	**(£8.54)**

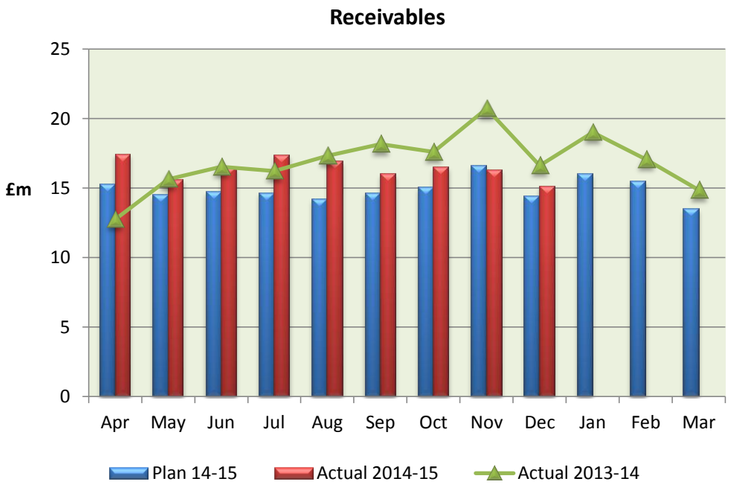
Trust Financial Overview as at 31st Dec 2014 - Month 09

CAPITAL AND CASH COMPARED TO ORIGINAL PLAN SUBMITTED TO MONITOR IN APRIL 2014

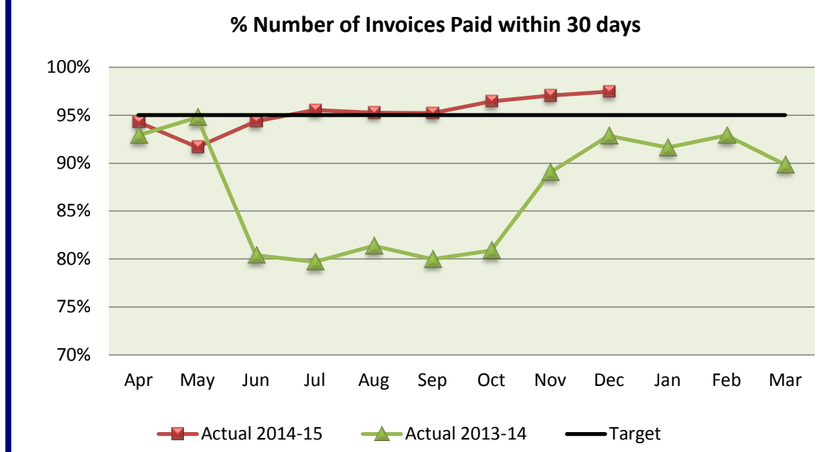
WORKING CAPITAL

	M09 Plan £m	M09 Actual £m	Var £m	M09
Payables	(£40.49)	(£36.97)	(£3.52)	
Receivables	£14.42	£15.14	(£0.72)	



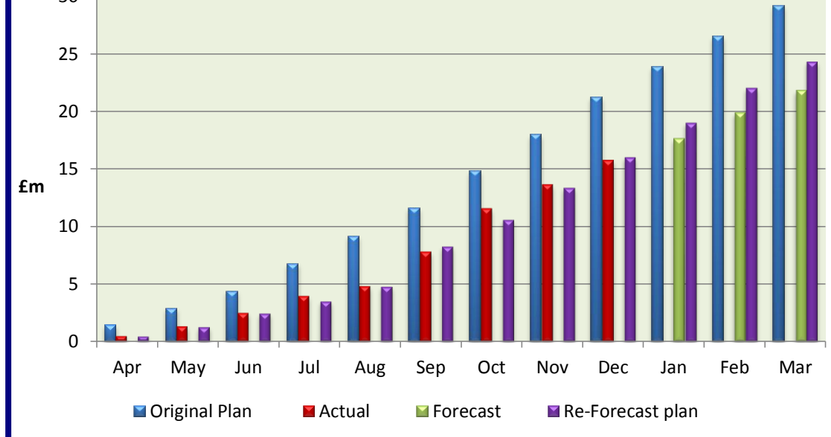


BETTER PAYMENT PRACTICE CODE



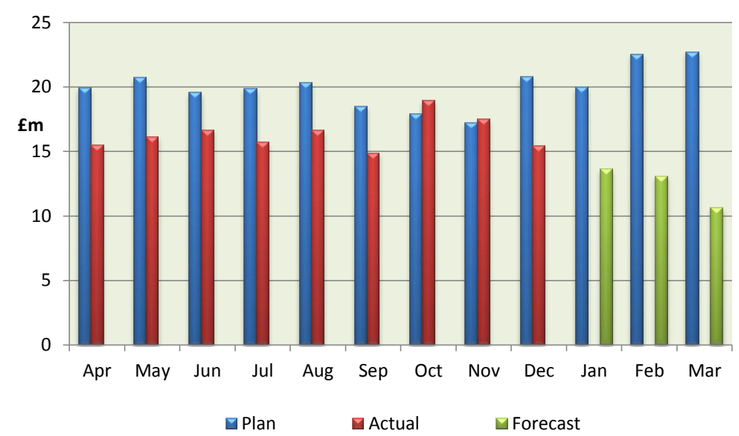
CAPITAL

	M09 Plan £m	M09 Actual £m	Var £m	M09
Capital (re-forecast plan)	£16.05	£15.71	£0.34	

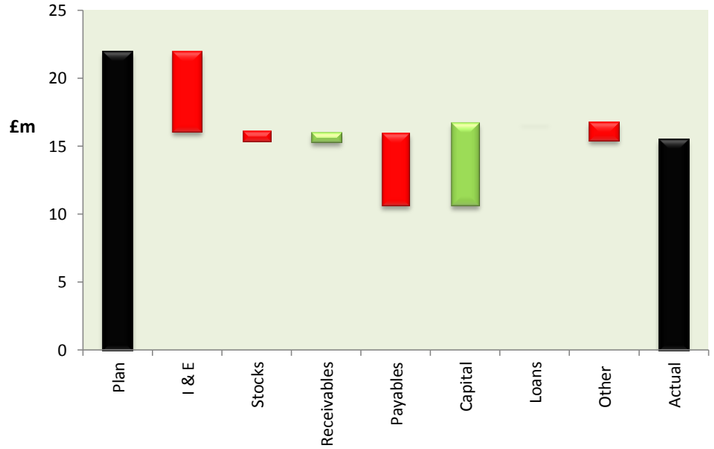


CASH

	M09 Plan £m	M09 Actual £m	Var £m	M09
Cash	£20.82	£15.46	(£5.36)	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- Additional activity in month has resulted in bed capacity pressures.
- The level of income protection offered by the fixed value contract stands at £4.33m in the year to date.
- The year to date deficit is £3.34m against a planned surplus of £2.40m.
- Capital expenditure of £15.71m against revised planned £16.05m, an underspend of £0.34m (£5.51m below original pla
- The cash balance was £15.46m, versus a planned £20.82m, £5.36m lower than planned. Total loan funded borrowing is as planned in the year to date.
- The Continuity of Service Risk Rating (CoSRR) stands at 3, although underlying performance is at level 2.
- The regulator, Monitor investigated the financial position and a turnaround process has been instigated by the Trust.

SUMMARY FORECAST

- The deficit excluding 'exceptional' restructuring costs is forecast to be £2.42m against a planned £3.0m surplus. Due to their exceptional one-off nature, restructuring costs are excluded from the calculation of the CoSRR but these payments will adversely affect the cash balance.
- The year end forecast including restructuring costs is a deficit of £5.54m. This will result in a CoSRR of 2 for the year.
- CIP schemes are forecast to deliver £8.92m against the planned £19.53m. This is a shortfall of £10.61m and will have an impact on 2015/16.
- £1.5m has been committed to extra substantive nurse staffing; additional winter expenditure has been included within the forecast position.
- Receipt of £1.5m additional income to support quality investments has been agreed by commissioners and included in the forecast.
- The revised capital forecast, is a £21.79m spend, a reduction of £2.53m from the revised plan, (£7.41m lower than original plan).
- The forecast year end cash balance is £10.65m against the planned £22.71m.

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)

TO BE DISCUSSED AT BOARD OF DIRECTORS MEETING		

CQUINS SCHEMES / INDICATORS - CHFT
FINANCIAL YEAR 2014/15
TRUST WIDE

Indicator Name	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3	Quarter 4			Q4
	Apr	May	Jun	Total	Jul	Aug	Sep	Total	Oct	Nov	Dec	Total	Jan	Feb	Mar	Total
1.1 - Friends and Family Test - Implementation of the staff FFT across the provider from April 2014 - reporting by end of Q1 One payment at end of Q1 (£319k total)																
Indicator 1.1 Reporting by end of Q1			YES													
1.1.1 - Friends and Family Test - Implementation of FFT across outpatient and day case department across the Trust - establish by end of Q2 and report fro onwards One payment at end of Q2 (£319k total)																
Indicator 1.2 Reporting from Q3							YES/NO									
1.1.2 - Friends and Family Test - Implementation of FFT across Community services - establish by end of Q3 and report from Q4 onwards One payment at end of Q3 (£319k total)																
Indicator 1.1.2 Reporting from Q4											YES/NO					
1.2 - Friends and Family - Response rate to F&F test question **Inpatient - Q1 25%, Q4 30%** **A&E - Q1 15%, Q4 20%** Two payments, end of Q1 and Q4 (£159k total)																
Indicator 1.2 Inpatient response rate to F&F test question	37.3%	32.9%	35.7%		39.8%	41.5%	40.6%		46.5%	44.3%	40.6%					
Indicator 1.2 A&E response rate to F&F test question	21.5%	26.2%	29.8%		21.8%	20.40%	20.3%		23.4%	19.2%	4.5%					

1.3 - Friends and Family - Response rate to F&F test question
Inpatient - further improvement requirement to achive 40% in any month during Q4.
One payment, end of Q4 (£159k total)

Indicator 1.3 Inpatient response rate to F&F test question	**37.3%**	**32.9%**	**35.7%**		**39.8%**	**41.5%**	**40.6%**		**46.5%**	**44.3%**	**40.6%**					

2.1 - Safety Thermometer (Quarterly payment conditional on use of thermometer in each of 3 months)
Quarterly payment (£159k total)

The collection of data on Patient Harm using the NHS Safety Thermometer Harm Measurement Instrument. Collects Falls, Pressure Ulcers, Catheter Infection & VTE

Indicator. Continued use of thermometer for monthly data collection	**Y**	**Y**	**Y**		**Y**	**Y**	**Y**		**Y**	**Y**	**Y**					

2.2 - Safety Thermometer - Reduction in the prevalence of pressure ulcers
One payment based on achievement of three consecutive months at or below required level
One payment (£478k total)

(100% payment <4.1%, 75% payment < 4.6%, 50% payment < 5%, 0% payment if >5%)

Numerator: Reduction in the prevalence of pressure ulcers using thermometer	47	39	57		39	47	49		43	48	53					
Denominator: Reduction in the prevalence of pressure ulcers using thermometer	1135	1119	1056		1091	1097	1059		1032	1048	1093					
Indicator. Reduction in the prevalence of pressure ulcers using thermometer	**4.14%**	**3.49%**	**5.40%**		**3.57%**	**4.28%**	**4.63%**		**4.17%**	**4.58%**	**4.85%**					

3.1- Dementia - Use of dementia screening tool, risk assessments, referrals for emergency admissions aged 75 and over (Target - 90% aggregate)

Quarterly payment based on achievement of all three elements (£478k total)

Dementia Screen - Emergency Admission 75 Years & Above (Target - 90% aggregate per quarter)

Numerator 1: No of Non Elec admissions of patients aged 75 and over reported as having been asked the SQUID question for case finding	461	469	456		457	441	436		468	396	396					
Demoninator 1. No. of Non Elec admissions of patients aged 75 and over, who were admitted as inpatients in an emergency minus the exclusions	494	491	472		463	457	439		503	412	412					
Indicator 1. Percentage of patients aged 75 and over admitted as inpatients who were screened for dementia	**93.3%**	**95.5%**	**96.6%**		**98.7%**	**96.5%**	**99.3%**		**93.0%**	**96.1%**	**96.1%**					

Dementia AMTS - Emergency Admission 75 Years & Above (Target - 90% aggregate per quarter)

Numerator 2: No of Non Elec patients admitted aged 75 and above, who have scored positively on the SQUID and reported as having had a dementia diagnostic assessment. (AMTS)	76	87	65		57	81	87		70	57	80					
Demoninator 2. No of Non Elective patients aged 75 and above admitted as inpatients, who have scored positively on the SQUID case finding question (figures should balance to Numerator 1)	76	87	65		57	81	87		71	58	82					
Indicator 2. Percentage of patients aged 75 and over admitted as inpatients who were appropriately risk assessed	**100%**	**100%**	**100%**		**100.0%**	**100.0%**	**100.0%**		**98.6%**	**98.3%**	**97.6%**					

Dementia Referral - Emergency Admission 75 Years & Above (Target - 90% aggregate per quarter)

Numerator 3:No of Non Elec Patients admitted aged 75 and above, who have had a positive diagnostic assessment, who are referred on for further diagnostic advice.	71	78	64		55	74	74		68	55	71					
Denoninator 3. No of Non Elec patients aged 75 and above admitted as inpatients, who underwent a diagnostic assessment (in whom the outcome is either "positive" or "inconclusive")	71	78	64		55	74	74		68	55	71					
Indicator 3. Percentage of patients aged 75 and over admitted as inpatients who were appropriately referred on to GP	**100%**	**100%**	**100%**		**100.0%**	**100.0%**	**100.0%**		**100.0%**	**100.0%**	**100.0%**					

3.2 - Ensuring 90% of wards have 1 WTE dementia 'expert' and 75% of wards to have 1 WTE 'competent' dementia lead

Report at end of Q2 and Q4

Two payments, end of Q2 and Q4 (£159k total)

Improve the quality of care for people with dementia

Percentage of applicable wards that have at least 1 full time member of staff (or equivalent WTE) that has been trained to **'expert'** level in Dementia			x% & report				x% & report
Percentage of applicable wards that have at least 1 full time member of staff (or equivalent WTE) trained to **'competent'** level in Dementia			x% & report				x% & report

3.3 - Dementia - ensuring carers feel supported - Bi-annal payment on submission of qualitative summary report

Two payments, end of Q2 and Q4 (£159k total)

Indicator 3. Number of interviews carried out in month (7 required)			**Report due**				**Report due**	
Indicator 3. Structured interviews conducted and qualitative summary of learning			**Report due**				**Report due**	

4.1 - ASTHMA Improving management of patients presenting with Asthma in A&E

Q1 - 60%, Q2 - 65%, Q3 - 70%, Q4 - 75%

Quarterly payment (£638k total)

Num 1. Number of patients admitted with Asthma as primary diagnosis who receive the following complete care bundle either prior to discharge or within 48 hours of discharge.
i. Provided with brief intervention advice to current smokers and referral to smoking cessation clinic if patient consents
ii. Assessment of suitability and/or enrolment into a pulmonary rehabilitation programme
iii. Provided appropriate education and written information on Asthma, Self-management and medication including oxygen if relevant, to patient and/or carers)
iii. Provide appropriate education and written information on Asthma, self-management and medication including oxygen if relevant, to patient (and/or carers)
iv. Documentation that patient has demonstrated good inhaler technique
v. Patient is re-established on their optimal maintenance therapy (including bronchodilator therapy).
vi. Appropriate follow-up arrangements once discharged from hospital are documented and included in discharge summary. Evidence that patient and/or carer are informed/aware.

	Quarter 1				**Quarter 2**				**Quarter 3**				**Quarter 4**			
Patient age split (number <20 years and >20 years. Total 50)	**18 Children / 32 adults**				**18 Children / 32 adults**											
Initial Set - Peak Flow	50	50	100.0%		44	50	88.0%									
Initial Set - Obs	50	50	100.0%		50	50	100.0%									
Salbutamol	49	50	98.0%		48	50	96.0%									
In Time	37	50	74.0%		45	50	90.0%									
Steroids	48	50	96.0%		50	50	100.0%									
In Time	43	50	86.0%		45	50	90.0%									
Second Set - Peak Flow	49	50	98.0%		47	50	94.0%									
Second Set - Obs	48	50	96.0%		46	50	92.0%									
Inhaler	40	50	80.0%		40	50	80.0%									
Discharge Px	43	50	86.0%		44	50	88.0%									
Follow Up	46	50	92.0%		46	50	92.0%									
Bundle Complaint	**33**	**50**	**66.0%**		**36**	**50**	**72.0%**									

4.2 - Pneumonia Care Bundle
Quarter 1 update report - / Quarter 2 & 3 - Quarterly reporting with no requirement / Quarter 4 - 55%)
Quarterly payment (£638k total)

Number of patients attending A&E and / or MAU with pneumonia who receive the CAP care bundle on admission to hospital.

The CAP Care Bundle reflects College of Emergency Medicines standards and BTS/Sign guidelines and includes all of the following measures:
1. Chest X-ray
2. Oxygen administration
3. CURB 65 severity score
4. Antibiotics administered.

	Quarter 1 - end of Q1		Quarter 2		Quarter 3		Quarter 4	
Chest X-Ray	Report Completed		Report due		Report due			
Oxygen Administration								
CURB 65 severity score								
Antibiotics administered								
Compliant with CQUIN								

5.1 - Diabetes Self Care (Q1 achieve 50% on 4 wards, Q2 achieve 50% on 6 wards, Q3+Q4 achieve 50% on 8 wards)
2 payments - end of Q2 and Q4
Two payments, end of Q2 and Q4 (£319k total)

Diabetes Self care

Target RAG Rating					Report												
Numerator. Number of patients supported to self care (fully compliant with bundle)	16				15				10								
Denominator. Number of patients admitted to cohort wards who have insulin dependant diabetes and are competent to self-administer	20				25				14								
Number of patients sampled who are admitted to cohort wards and have insulin dependant diabetes	31				37				29								
Assessed to self care	31	31	100.0%		32	37	86.5%		27	29	93.1%						
Care plan in place	29	31	93.5%		33	37	89.2%		24	29	82.8%						
Giving own Insulin	20	31	64.5%		30	37	81.1%		24	29	82.8%						
Adjusting the dose of insulin	20	31	64.5%		30	37	81.1%		24	29	82.8%						
Testing own blood sugars	18	31	58.1%		22	37	59.5%		22	29	75.9%						
Access to food and snacks	31	31	100.0%		37	37	100.0%		29	29	100.0%						
% Diabetes patients supported to self care (fully compliant with bundle)	**80.0%**				**60.0%**				**71.4%**								

5.2 - Diabetes (Q1 - 60% achievement, Q2-Q4 90% achievement)
Two payments, end of Q2 and Q4 (£159k total)

Diabetes - Management of hypoglycaemia patients in A&E, CDU and MAU

Target RAG Rating																	
Numerator. Patients attending A&E, CDU or MAU with diabetic hypoglycaemia who are referred to a specialist nurse and receive written educational support	3	8	12		6	12	7		7	20							
Denominator. Patients attending A&E, CDU or MAU with diabetic hypoglycaemia	4	8	12		6	12	7		7	20							
% Diabetes attending A&E, CDU or MAU referred to specialist nurse	**75.0%**	**100.0%**	**100.0%**		**100.0%**	**100.0%**	**100.0%**		**100.0%**	**100.0%**							

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 adm to hospital

Part 6.1 - Reconciliation (Quarterly payment conditional on: Q1-3 70% target. Q4 - 80%
Quarterly payment (£319k total)

Part A: Number of e-discharges checked by Pharmacy with medicines reconciled - numerator	1060	698	639		679	676	650		730	642	645						
Part A: The number of patients (admitted for longer than 24 hours) on acute medical wards - denominator	1185	753	733		778	744	736		832	747	759						
Part A: Reconcilliation of medicines on admission - total	**89.5%**	**92.7%**	**87.2%**		**87.3%**	**90.9%**	**88.3%**		**87.7%**	**85.9%**	**85.0%**						

Part 6.2 - Discharge Accuracy Checks (Quarterly payment conditional on: Q1 - 55%, Q2- 60%, Q3 - 65%, Q4 - 70%
Quarterly payment (£319k total)

Part B: 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 - numerator	1185	753	733		778	744	736		832	747	759						
Part B: The number of patients (admitted for longer than 24 hours) on acute medical wards - denominator	1826	1200	1106		1141	1104	1073		1179	1057	1093						
Part B: Discharge Medication - total	**64.9%**	**62.8%**	**66.3%**		**68.2%**	**67.4%**	**68.6%**		**70.6%**	**70.7%**	**69.4%**						

7 - End of Life

Part A - introduction of care bundle on two respiratory wards
Q2 - 30% of staff to have received training, Q4 - 90%
Single payment end of Q4 (£478k total)

Implementation of care bundle in two respiratory wards				Reporting Due				Reporting Due		

Part B - Join the TRANSFORM programme
Quarter 2 - Production of driver diagram to include key measures.
Quarter 4 - Demonstration of programme achievements as evidenced by a dashboard and key measures
Two payments, end of Q2 and Q4 (£478k total)

					Report due						Report due

8 - Nutrition

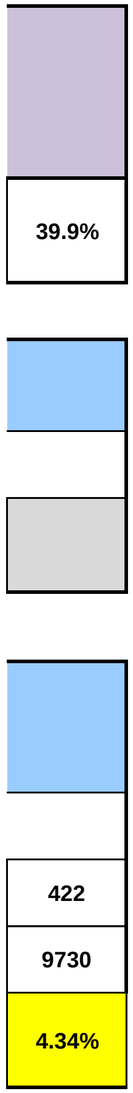
Establish a collaborative task and finish group to scope patient, staff and visitor food provision in order to understand the current catering services across the hospital settin view to achievement of the Food For Life Catering Mark and Government Buying Standards where feasible.

Q2 - Baseline Report on progress YTD, including Real Time Patient Monitoring (RTPM) baseline results
Q4 - Report including RTPM demonstrating improvement work carried out
Two payments, end of Q2 and Q4 (£319k total)

Reports due highlighting progress	Report Complete		Action Plan Implemented					Report due	

YTD

m Q3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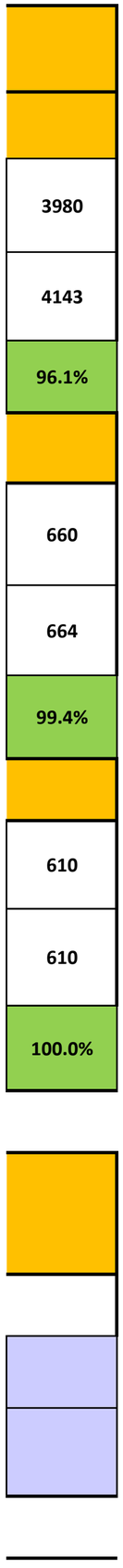
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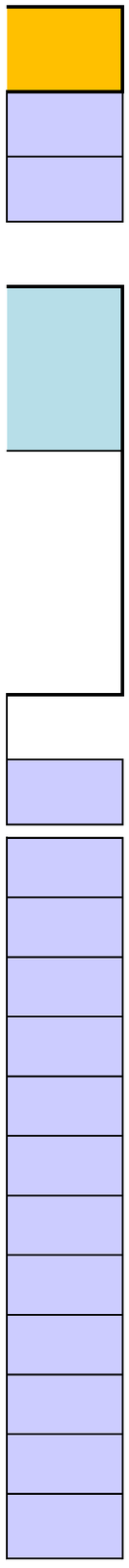


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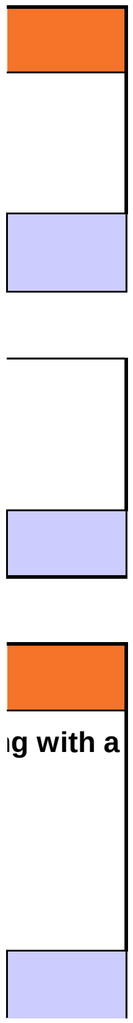
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Monitor Indicators

THIS

Indicators	Thresholds	Weighting	December 2014	Quarter 3	Comments
Incidence of MRSA Year to Date	0	1.0	0	0	
Incidence of Clostridium Difficile Year to Date	5	1.0	0	19	
Maximum Time of 18 Weeks From Point of Referral to Treatment - Admitted	90%	1.0	92.21%	91.95%	
Maximum Time of 18 Weeks From Point of Referral to Treatment - Non-Admitted	95%	1.0	99.00%	98.70%	
Maximum Time of 18 Weeks From Point of Referral to Treatment - Incomplete Pathways	92%	1.0	94.65%	95.32%	
62 Day Wait for First Treatment from Urgent GP Referral	85%	1.0	87.42%	93.33%	
62 Day Wait for First Treatment from Consultant Screening Service Referral	90%	1.0	94.74%	91.67%	
31 Day Wait for Second or Subsequent Treatment: Surgery	94%	1.0	100.00%	100.00%	
31 Day Wait for Second or Subsequent Treatment: Anti Cancer Drug Treatments	98%	1.0	100.00%	100.00%	
31 Day Wait from Diagnosis to First Treatment (All Cancers)	96%	0.5	100.00%	99.73%	
Two Week Wait From Referral to Date First Seen: All Cancers	93%	0.5	99.47%	98.41%	
Two Week Wait From Referral to Date First Seen: Symptomatic Breast Patients	93%	0.5	93.46%	94.77%	
A&E: Maximum Waiting Time of Four Hours from Arrival to Admission/Transfer/Discharge	95%	1.0	89.94%	92.74%	
Community care - referral to treatment information completeness	50%	0.5	100.00%	100.00%	
Community care - referral information completeness	50%	0.5	98.40%	98.32%	
Community care - activity information completeness	50%	0.5	100.00%	100.00%	
Overall Governance Rating			Amber-Green	Amber-Green	

Green:<1.0, Amber-Green: >=1.0, <2.0, Amber-Red: >=2.0, <4.0, Red: >4.0

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Claire Gruszka, Patient Safety Risk Manager - LSMS
Date: Thursday, 29th January 2015	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: Risk Register - Organisational risks scoring 15+. The attached papers provide details of the highest risk areas as at 21 January 2015.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: These papesr were presented at the 13 January 2015 Risk & Compliance Committee.	
Governance Requirements: .	
Sustainability Implications: None	

Executive Summary

Summary:

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Main Body

Purpose:

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Background/Overview:

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The Issue:

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Next Steps:

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Recommendations:

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Appendix

Attachment:

Combined Risk Register Reports.pdf

RISK REGISTER REPORT

Risks as at 21 January 2014

TOP RISKS

6131 (25): Progression of service reconfiguration impact on quality and safety
4706 (25): Failure to meet CIP
6150 (25): Finance: breach of licence

2827 (20): Risk of poor patient outcomes due to dependence on middle grades
2828 (20): Risk of poor patient outcomes and experience caused by blocks in patient flow
4783 (20): HSMR & SHMI
6136 (20): Overaching risk for Infection Control

RISKS WITH INCREASED SCORE

4706: Failure to meet CIP – this score increased from 20 to 25

RISKS WITH REDUCED SCORE

6117: No supplier for delivering EPR (reduced from 20 to 16)
3991: No fluroscopy service at CRH (reduced from 15 to 12)
4048: Lack of appointments for new referrals (reduced from 16 to 12)
6079: Lack of appointments for OP follow up (reduced 16 to 12)
4780: Failure to meet stroke target (reduced from 16 to 12)
6048: Failure to deliver Fracture Neck of Femure Best Practice tariff (reduced from 16 to 12)
6123: Modernisation Programme – Suppliers (reduced from 16 to 12)
6140: Fire Strikes (reduced from 16 to 12)

The above risks now scoring a 12 now sit on their local risk register.

NEW RISKS

The following new risks were discussed at the last Risk & Compliance Committee (13 January 2015):

6160: Children's Therapy Services (score of 15)
6143: Modernisation Programme – working with Bradford THT (score of 16)
6144: Modernisation Programme – Failure to realise benefits of EPR (score of 16)
6145: Modernisation Programme – Risk of financial penalty from failure to deliver services (score of 20)
6146 Modernisation Programme - Service improvement activity/EPR
6161: Issues with parts replacement for bronchoscopy (score 16)
6169: band 5 and 2 nursing post vacancies ward 19 (score 16)
6152: Anaesthetic cover
6105: Change in surgical technique in laporscopy (score of 15)
6107: Care packages in Children's services
6160: Children's Therapy Service tender

6171: Band 5 vacancies in Endoscopy (score of 15)
6174: Winter ward staffing capacity (score of 15)
6178: Modernisation Programme – Service Improvement management (score of 20)

For the above it was agreed that:

- THIS Modernisation Programme risks to be re-presentated at the next committee.
- Staffing level risks should be added to the existing risk.
- Further information needs to be sought and the risk either downgrade or represented at the next committee.

A new risk relating to Complaints backlog was also discussed, a severity grading of 12 being agreed.

CLOSED RISKS

5998: Unreliable urodynamics equipment (scored 15)
6115: Hysteroscopy equipment failure (scored 15)
6133: Possibility of THIS losing contrcat of YHCSU services (scored 16)

RISKS TO BE DISCUSSED AT NEXT RISK & COMPLIANCE COMMITTEE:

- THIS Modernisation risks
- All Divisions full risk registers
- Appraisal and Mandatory Training
- Paediatrics in A&E
- Safeguarding/Deprivation of Liberty

Trust Risk Profile as at 21 January 2015

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Rare (1)					
Unlikely (2)					
Possible (3)					= 6027 – Failure to meet Capital programme = 5024 – Ward 18 enviromental safety
Likely (4)				= 5792 – Shortage of Consultants in Opthalmology = 5937 – Nursing staffing levels = 6130 = Loss of income/reduction in profit related to competitive procedures = 6132 = Reduction in elective surgery market share and volume of work < 6117 = Modernisation programme - EPR	= 4783 - HSMR & SHMI rates = 6136 – Infction Control
Highly Likely (5)			= 5984 – Failure to provide insulin training	= 2827 – Dependence on middle grade locums in A&E = 2828 – Blocks in patient flow in A&E Glaucoma/macular service = 4783 – HSMR & SHMI = 6117 - No supplier for delivering EPR	= 6131 – Progression of service reconfiguration impact on quality and safety > 4706 – Failure to meet CIP > 6150 – Breach of Monitor licence

KEY: = Same score as last period < decreased score since last period
! New risk since last period > increased score since last period

Extreme and Major Risks (15 or over)

	Risk ID	Division	Directorate	Department	Date entered	Status	Strategic Objective	Risk Description plus Impact	Existing Controls	Initail	Current	Target	Further Actions	Review Date	Target Date	Resp. Committee	Exec Director	Lead
Extreme	4706	Trustwide	All Divisions	All Departments/Wards	Jun-2011	Active	Objective 2 - Keeping the Base Safe	Trust expenditure exceeds planned levels through failure to deliver Cost Improvement Programme (CIP) or budgetary overspend. The expenditure levels in 2014/15 carry forward into 2015/16 to give rise to an income an expenditure gap that is insurmountable through achievable savings levels. Potential Impact: The Trust does not generate a sufficient I&E surplus and cash to meet on-going commitments and connot remain a viable and sustainable organisation.	- Efficiency Programme Board monitoring CIP delivery on a fortnightly basis. - Remaining Trust reserves to mitigate against shortfall in part in 2014/15. - Monthly financial reporting and forecasting to allow remedial action.	15 5 x 3	25 5 x 5	25 5 x 5	- The Trust has engaged with PWC who are currently undertaking an operational and financial review of the organisation. Savings opportunities identified whether through this review or ongoing internal work to be seized. - Business planning for 2015/16 underway to capture the financial challenge and design service plans to address this.	Jan-2015	Mar-2015	WEB	Keith Griffiths	Kirsty Archer
Extreme	6150	Trustwide	All Divisions	All Departments/Wards	Nov-2014	Proposed for Acceptance	Objective 2 - Keeping the Base Safe	Risk that the Trust is found to be in breach of its licence and is unable to operate as a result of the current Monitor investigation into the deterioration of the financial position	Monthly report to Board, Finance and Performance Committee and WEB. Regular reporting to the Membership Council. EPB held every fortnight. Divisional Business meeting reporting. Workstream programme arrangements in place. QIA assessments undertaken. Independent review of financial position and CIP. Full review of budgets taking place.	15 5 x 3	25 5 x 5	5 5 x 1	- Action plan resulting from Independent report - Increased frequency of budget monitoring with all divisions / departments - Strengthening of programme arrangements - Strengthening of QIA process to be implemented	Jul-2011	Mar-2015	BOD	Keith Griffiths	Chris Benham

Extreme	6131	Corporate	Commissioning & Partnerships	Commissioning & Partnerships	Oct-2014	Active	Objective 2 - Keeping the Base Safe	Risk: The delay in being able to progress service reconfiguration creates the risk that the Trust will not be able to address important clinical quality and safety issues Background: The Outline Business Case identified service reconfiguration proposals that would mitigate and address significant clinical and quality safety issues associated with the current configuration of services across two sites. Clinical Commissioning Groups have decided that consultation on changes in configuration of hospital services will not commence in 2014 and will be delayed to a later stage after changes have been implemented to deliver care closer to home. Impact: The delay in being able to progress service reconfiguration creates the risk that the Trust will not be able to address important clinical quality and safety issues such as: • Non-compliance with many of the standards for Children and Young People in Emergency Care settings; • Paediatric medicine and surgery are not co-located on the same hospital site; • The two hospitals in Halifax and Huddersfield do not provide the same acute services and this leads to a frequent need for inter-hospital transfers • Non-compliance with the prescribed NHS England standards such as: □ All admissions seen by a suitable consultant within 14 hours of admission, or within 6 hours between 0800-2000, except patients who are very ill, where it should be 1 hour; □ Hospital inpatients must have scheduled seven-day access to diagnostic services; □ Support services, both in the hospital and in primary, community and mental health settings, must be available seven days a week.	To address this the Trust is reviewing and assessing possible actions and critical service changes that could be progressed in the interim period, and as quickly as possible, within the required statutory and regulatory processes so as to improve the clinical, quality, safety and sustainability of services. These proposals will be submitted for consideration by the Trust Board in October 2014.	25 5 x 5	25 5 x 5	15 3 x 5	Clinical commissioning Groups have established a Hospital Board to review the OBC and consider the risks related to current model of provision. The Trust will be working with CCGs to support development of possible risk mitigation strategies by the commissioner.	Nov-2014	Mar-2015	WEB	Anna Basford	Catherine Riley

Major	2827	Surgery & Anaesthetics	Accident and Emergency	A&E CRH / HRI	Apr-2011	Active	Objective 1 - Transforming Patient Care	Risk of poor patient outcomes, caused by dependence on locum middle grades, who at weekends and nights are the senior decision maker in the department. This quality/experience of locums is hugely variable. There have been 4 serious clinical incident in the past two years involving locum Middle grade Doctors. There is a national shortage of middle grade doctors in emergency medicine. December 2014- Risk reviewed - higher risk at present due to Speciality Doctor withdrawing from 2 weeks of nights. Also sickness within the consultant body is causing increased risk as more shifts including consultant on calls to cover. January 2015- consultant sickness reduced as one has returned to work.	- On-line ED guidelines. Senior Nurse Operationally managing the department- overview of all staff to support and advice, escalation of any issues to the on-call Consultant. - - Recruited longer term locums to improve continuity, provide improved decision making, improved supervision for junior medical staff and support to the Senior Nurse. - Recruited 4 new consultants, departmental cover from 8am until 10pm Monday to Friday. - Two SpR's now in post. - A&E Risk Management Strategy- guidelines available in each department.	20	4 x 5	20	5 x 4	4	1 x 4	-Oct 2014- Workforce review completed. 2 Senior Nurses training and developing the ANP role within the departments, with a 10 year plan to increase the number to 10. - first two ACP's will complete in March 2015 at SHO level- - Business case developed to provide direct clinical care consultant cover seven days a week, this has now been approved- recruitment process commenced. Consideration being given to NHS Locum Consultants being recruited. -BC for two consultant approved, out to recruit-October 2014 - Recruitment at middle grade level ongoing. - Exploration of reconfiguration of services underway, as described in the Strategic Outline Case.-2013/14-Contingency Plan being developed to mitigate the risk of having no available Middle Grade Doctors in the OOH period, this is to be agreed with Director of Operations as this contingency is to potentially close one site in the OOH period and divert to the opposite site. December 2014- Requested Locum consultant via agency. Out to all agencies for locum Specialty Doctors. Consultants 'acting down' to provide on site cover but extremely challenging due to gaps at consultant level and Speciality Doctor level cover. January 2015- One consultant has now returned from sick leave	Apr-2015	Dec-2015	UCB	Mags Barnaby	Dr Mark Davies/Mrs Bev Walker
Major	2828	Surgery & Anaesthetics	Accident and Emergency	A&E CRH / HRI	Apr-2011	Active	Objective 1 - Transforming Patient Care	Risk of poor patient outcomes and experience, caused by blocks in patient flow due to low numbers of discharges. This results in patients having prolonged waits in A&E until an appropriate bed becomes available. There is also a risk of breaching the A&E performance indicators, including the YAS turn around time. November 2014- worsening/increasing delays for patients transferring into inpatient speciality beds causing poor patient experience and blocking ED cubicles which impacts on the ability for patients to be assessed. January 2015- likelihood reduced as long waits not occurring daily.	- Senior Nurse co-ordinator to liaise with patient flow team. Use A&E escalation protocol to ensure A&E senior management aware. - Site co-ordinator to be informed to provide support/additional nursing resource. - Out of hours to contact Matron on site/on call manager. - Level discharges. - Plan for every patient which is monitored for each patient on a daily basis to reduce length of stay. - Strong multi-agency working relationships, overseen by the Urgent Care Board. -Escalation process in place- Surge and Escalation Plan	20	4 x 5	20	5 x 4	2	1 x 2	Strategic Outline Case aims to deliver effective, efficient responsive services.	Apr-2015	Mar-2015	UCB	Mags Barnaby	Sajid Azeb

Major	4783	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Aug-2011	Active	Objective 2 - Keeping the Base Safe	The HSMR and SHMI are higher than the national average, which indicates that there are more deaths than expected, according to these methodologies	- Communications plan. - Care of the acutely ill patient programme underway underpinned by a number of workstreams, reporting to Clinical Outcomes Board - Revised plan has been implemented, a Mortality dashboard down to ward level has been developed to improve monitoring. - The Medical Division has plans for 3 diagnostic outliers: COPD, Stroke and heart failure. - Improved understanding of proxy HSMR and SHMI measures are allowing us to map closer to real time the impact of the programme.	20 4 x 5	20 4 x 5	8 4 x 2	Implement action plan by: - Implementation of Outline Business Case - Reducing mortality rates - Early recognition of our deteriorating patients - Reliable delivery of care bundles - Improving care for frail patients - Investigating the cause of outlying SHMI conditions - Improving coding - Reducing patient transfers and outlying - Improved staffing and improved handover. - Clinical commissioning Groups have established a Hospital Board to review the OBC and consider the risks related to current model of provision. The Trust will be working with CCGs to support development of possible risk mitigation strategies by the commissioner.	Jan-2015	Mar-2015	COB	David Birkenhead	Juliette Cosgrove
Major	6136	Trustwide	All Divisions	All Departments/Wards	Oct-2014	Active	Objective 2 - Keeping the Base Safe	Infection Control The number of cases of post 48 hr C Difficile creates a risk to patient safety & experience, and could impact upon CHFT's governance rating. There has not been an outbreak, but isolated cases in different areas across both sites	Hand hygiene compliance audits Antibiotic prescribing & monitor according to Trust policy FLO audits completed Replacement of commodes to ensure that they can be effectively cleaned 24/7 cleaning available CCGs involved in C Diff RCAs to ensure learning across the health economy Standard isolation procedures, with any breaches incident reported C Difficile care plan to ensure best practice, with daily ICPN review External Review of Infection Control practice & procedures	25 5 x 5	20 5 x 4	15 5 x 3	- Share the learning from RCAs effectively - Implement the recommendations of the External Review - HPV of wards - Antibiotic ward rounds - Prompt isolation of patients	Jan-2015	Mar-2015	ICPB	David Birkenhead	Jean Robinson

Major	5792	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Apr-2013	Active	Objective 1 - Transforming Patient Care	As per Risk 3793 - but specifically for Macular and Glaucoma patients with Chronic eye disease where they are dependant upon CHFT in monitoring, reviewing and assessing their eye condition at specifically times intervals. The shortage of Consultants has led to difficulties in maintaining capacity, resulting in the risk of glaucoma/macular patients missing follow ups as CHFT are unable to provide an appointment at the correct interval. This could result in harm (i.e. deterioration of sight).	- Partial Booking introduced to assist with planning of follow up appointments - Some Consultants helping by undertaking WLI and allowing their clinics to be overbooked to see the urgent cases - Advertised x 2 for Consultants with poor response now have 2 long term locum Consultants in place as of 31 August with another scheduled to start on September 11 2014 - Maternity leave cover no longer required as Consultant due to return September 2014 - Action Newton revised clinic templates - Pathway work ongoing with CCGs to ensure that Primary Care initiatives are supported and utilised (PEARS scheme, Cataract Refinement, Ocular Hypertension follow ups) - Explored different ways of working to assist currently (employed additional Optometrists on bank) and in the future looking to employ additional Orthoptists and Optometrists and expand their practice so that can undertake reviews of Glaucoma patients(within agreed protocols) and undertake non medical prescribing and intra-occular injections. - reviewed clinical portfolio of existing Consultants and the Cornea Specialists now taking responsibility for the patients that are most vulnerable from their chronic condition - plan to remove Specialty on C&B for out of area referrals to reduce impact on already stretched capacity	25 5 x 5	16 4 x 4	4 2 x 2	- continue to explore opportunities to involve AHPs and expand their roles with protocols and pathways and additional training for non-medical prescribing to enable the Consultants to deal with the more complex cases The risk rating will be reduced once we are assured that all the 'pending' appointments have been actioned and no patients are waiting (other than for their own choice) 12.11.14 Consultant Appointments Committee set for December 2014, with 5 Candidates shortlisted	Feb-2015	Dec-2014	PCB	Mags Barnaby	Melanie Addy
Major	6117	Corporate	THIS	Modernisation Programme	Oct-2014	Active	Objective 1 - Transforming Patient Care	Programme Risk 1. There is no supplier with a proven record of delivering, in the UK, an EPR and associated systems to meet the standards set for an EMRAM level 7 hospital. There is a risk that the Trust may not be able to procure the systems needed to lead to this, because there is no available solution, or the Trust may procure a potentially acceptable solution which fails to deliver what is required.	the procurement process is set up in a way to ensure that all potential suppliers acknowledge that they will be expected to alter their offerings to more precisely meet the Trust's requirements - in effect forging a partnership for developing a solution.	20 4 x 5	16 4 x 4	12 3 x 4	Mitigation 1) other organisations are progressing with existing products which are maturing over time. As such, it is likely that there will be products in use in the near future. 2) we shall work with the supplier / product with the greatest potential, jointly developing an appropriate solution. 3) A HIMSS level 6 site is about to be announced in the UK. A site visit is planned to this Trust update - November 2014 : the potential suppliers are both fully committed to a joint development approach - the evaluation of supplier proposals due early January. There are now some UK sites with a high HIMMS score.	Feb-2015	Dec-2014	NA	John Rayner	Dave Lang

Major	5937	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Jan-2014	Active	Objective 2 - Keeping the Base Safe	Nurse staffing level on wards, departments and community teams falls below the Trust agreed establishments which are in line with RCN guidance of a 1 to 8 ratio during the day. Wards cannot always cover shifts adequately which may result in patients coming to harm and having a poor experience. Staff experience will also be poor which could result in low morale and job satisfaction (also known to impact on patient safety and experience). Training requirements may not be achieved due to inability to release staff for training. There may be difficulty for ward/department/team leaders/sisters achieving management function. Nurse staffing levels have been highlighted as a significant issue from a mock CQC inspection undertaken in September 2014. The concerns regarding nurse staffing levels is highlighted monthly through the Hard Truths report.	- Weekly nursing workforce meetings. - Operational meetings to review staffing requirements on a weekly basis. Every ward/department/team duty roster examined and priorities for cover agreed and actioned. - Matrons sign off duty rosters. - Frequent recruitment days to ensure a smooth process. - Hard Truths report and staffing numbers included in Board of Director report. - Daily risk, action and evaluation to ensure wards, departments and teams have sufficient staff to deliver safe effective care and experience.	16 4 x 4	16 4 x 4	6 2 x 3	- Develop recruitment and retention strategy. - Overseas recruitment January to March 2015. Aim to recruit 50 qualified nurses. - Develop preceptorship membership and supervision to retain staff. - Develop induction package to recruit and retain staff. - Grow the nursing workforce - OU courses, back to nursing courses. - Utilise the Calderdale framework to develop roles to support patient safety and experience. - Examine the function of the Flexible Workforce Department in order to ensure nurses are available to work as required. - Work with partners to ensure a well governed flexible workforce is available.	Jan-2015	Mar-2015	WEB	Julie Dawes	Lindsay Rudge/Jackie Murphy
Major	6132	Corporate	Finance	Corporate Finance	Oct-2014	Active	Objective 2 - Keeping the Base Safe	Risk: Reduction in elective surgery market share and volume of work undertaken by the Trust. Impact: Reduction in income that will impact on overall Trust viability. The current value of under performance against the block contract for elective surgery is £3m.	A recovery plan to increase the volume of procedures undertaken within existing capacity has been developed and is being implemented. The NHS England Elective Intensive Support Team have been contacted and asked to work with the Trust to develop capacity models for elective surgery specialities. The aim of this will be to optimise the productivity and efficiency of the service so as to enhance profitability and improve access to services. Work is being undertaken to work with consultant surgeons to explore the potential to develop new business models that will improve the ability of the Trust to make attractive and competitive offer for elective surgery.	20 5 x 4	16 4 x 4	8 2 x 4	The trust will develop GP and patient information to support the offer of choice and promote the services provided by the Trust.	Dec-2014	Mar-2015	WEB	Mags Barnaby	Julie Barlow

Major	6130	Corporate	Commissioning & Partnerships	Commissioning & Partnerships	Oct-2014	Active	Objective 2 - Keeping the Base Safe	Risk: Loss of income or reduction in profit related to competitive procurements There is a significant risk of the Trust losing income and market share of service provision through competitive procurements. This is caused by Greater Huddersfield CCG and Kirklees and Calderdale Local Authority decisions to undertake competitive procurement for services. Current tenders relate to: sexual health services in Calderdale and Huddersfield: anti-coagulation services in Huddersfield; school nursing services in Calderdale; a range of services in Huddersfield related to the Kirklees wide community services market testing (such as specialist nursing, podiatry, dietetics, community rehab, diabetes patient education services, intermediate care, pulmonary rehab, COPD early supported discharge, dermatology, stroke early supported discharge). The aggregate value of the risk of services currently exposed to competitive procurement is circa £12m. Even if the Trust is able to win tenders and secure continued service provision the bidding financial envelope defined by commissioners will mean a reduction in the existing profit margin on service delivery. Impact: The immediate impact of this risk is a potential loss of circa £12m service income, or the potential reduction in profitability of services. This could impact in 15/16 and have negative impact on Trust financial viability. Strategically the loss of a number of community based services creates risk to the Trust's reputation and credibility as an integrated provider of community and hospital based services. This could potentially generate further risk regarding continued provision of other services that are appropriate for care closer to home (e.g. diabetes, respiratory, rheumatology etc.).	There are proactive systems in place to ensure that we are aware of risk and opportunities related to competitive procurement. We are responding and submitting tenders to secure continued service delivery. We are working collaboratively with partners such as GP Federations, Locala, Mid Yorks, and SWYPFT to determine where a decision to collaborate may give more chance of success to secure continued service delivery and support business viability (whilst ensuring this in accordance with regulatory requirements related to choice and competition). We are redesigning services to meet the specifications and offer value for money. We have used bid writers to assist us in presenting tenders.	16 4 x 4	16 4 x 4	8 2 x 4	.	Nov-2014	Dec-2014	CISC	Anna Basford	Rob Aitchison & Lisa Williams
Major	5984	Medical	Acute Medicine	All	Mar-2014	Active	Objective 1 - Transforming Patient Care	There is a risk to diabetic patients as some staff caring for them are not trained in the safe prescribing and administration of insulin as per NPSA guidance.	- Administration processes and responsibilities described in Section 12 Medicines Code, which is updated at required intervals. - Staff requiring training identified lists shared with divisions. - Patients, where possible, are encouraged to administer their own insulin. - Any patient safety incident (including no harm) is reviewed and appropriate action taken. - Continuous monitoring of training uptake shared with Divisional teams and discussed at Risk Compliance Committee.	15 3 x 5	15 3 x 5	6 3 x 2	- Work with THIS to improve access, so that firm trajectories can be set for training. - Work with THIS to identify issues with access to online training and rectify. - Requirement for Insulin training highlighted at RCAC report outlining divisional performance sent through to each clinical divisional lead. - Monthly monitoring of compliance on going.	Jan-2015	Sep-2014	SC	David Birkenhead/Julie Dawes	Ellie Sheehan

Major	6027	Corporate	Finance	Corporate Finance	May-2014	Active	Objective 2 - Keeping the Base Safe	A failure to secure sufficient cash to pay for the planned Capital programme or meet ongoing commitments. The potential impact is: The Trust is unable to develop infrastructure in support of a sustainable future for the organisation.	Loan and drawdown profile agreed with the Independent Trust Financing Facility to support capital investment. Capital forecast revised further downwards in September to protect liquidiy. Robust management of working capital ongoing.	16 4 x 4	15 5 x 3	12 4 x 3	Opportunities under review to increase CIP delivery and improve I&E position will improve cash availability. Awaiting outcome of applications to secure central Department of Health capital funding for technology investments.	Jan-2015	Mar-2015	WEB	Keith Griffiths	Kirsty Archer
Major	5024	Children Womens & Family	Children's Services	PAOU	Jan-2014	Active	Objective 3 - Innovation & Partnerships	Estate risks Failure to maintain adequate environmental and safety standards on Ward 18 HRI leading to a failure to meet the requirements of the Infection Prevention Quality Improvement Audit in January 2014. Departmental score 84% (amber). Key issues identified include cracked flooring in bathrooms, corridors and kitchen, kitchen cupboard trims cracked, inadequate bathroom facilities resulting in an increased risk that privacy and dignity could be compromised.	Action Plan completed by Senior nurses and General Manager. Estates aware and jobs logged for repair works. Report shared with CWS Management Team. PAOU development plans as part of the Trusts service development strategy ongoing. Ward 18 remains on the capital programme for upgrade however, there is no confirmation as to when this work will take place.	9 3 x 3	15 5 x 3	4 2 x 2	Situation escalated to Director of Nursing by Division and DN/ CWF ADN visited clinical area on 09.07.14 to review issues. Review of paediatric inpatient services being undertaken with a view to defining level of investment required. Colleagues continue to make possible improvements, with weekly environmental monitoring by Lead PNP undertaken.	Feb-2015	Mar-2015	HSC	Lesley Hill	Gill Harries/Jenny Taylor

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, 29th January 2015	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Monthly DIPC report - Report on the position of HCAI	
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: Imroving patient experience - reducing HCAI	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

for information

Background/Overview:

Monthly update for Infection Prevetnion and Control

The Issue:

Update provided in the body of the report

Next Steps:

Report shared with the Infection Control Performance Board for action as required

Recommendations:

For the Board to note the content

Appendix

Attachment:

Monthly DIPC Report January 2015.pdf

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

Performance targets

Indicator	Month agreed target	Current month (December)	YTD agreed target	YTD performance	Comments
MRSA bacteraemia (post admission)	0	**0**	0	**1**	One case has been assigned the trust
C.difficile (post admission)	2	**0**	18	**19**	6 avoidable 13 unavoidable
MSSA bacteraemia	1	**3**	15	**7**	Local target – 13/14 outturn
E.coli bacteraemia	2	**2**	23	**17**	Local target – 13/14 outturn
MRSA screening (electives)	95%	**95.84**	95%	**95.81%**	November validated data

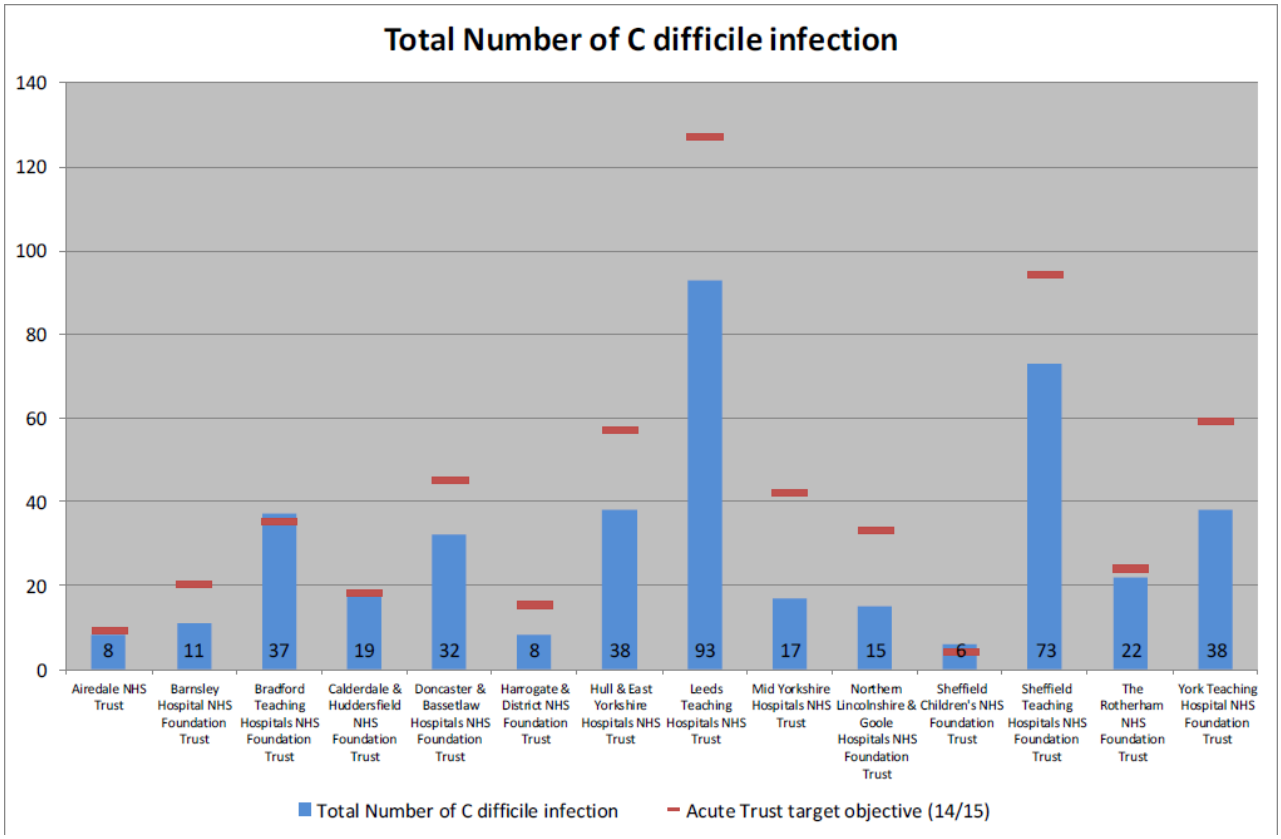
Quality Indicators

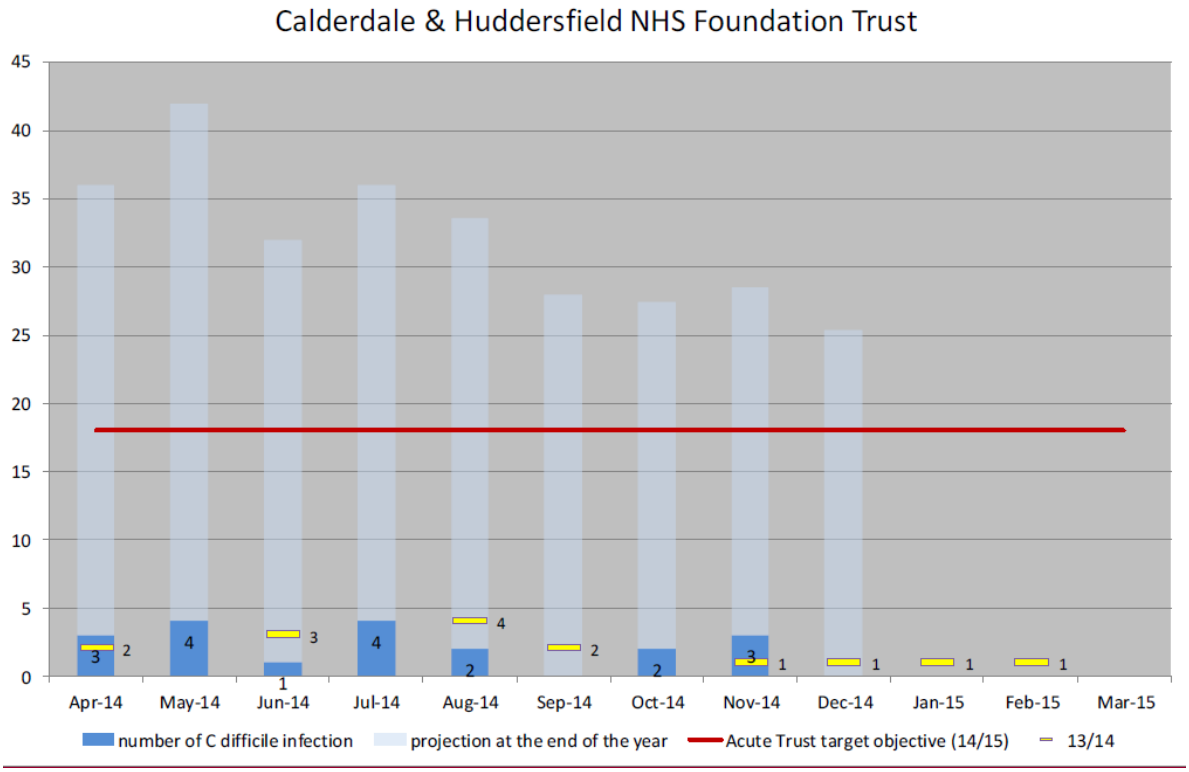
Indicator	Month agreed target	Current month (December)	YTD agreed target	YTD performance	Comments
MRSA screening (emergency admissions)		91.9%		86.8%	
Isolation breaches		24		167	
ANTT (doctors)			95%	**66.7%**	Competency assessments
ANTT (nurses)			95%	**73.8%**	
Blood cultures (doctors)				9.2%	
Blood cultures (nurses)				53.4%	
cleanliness	Not set	97.35%		97.4%	
Hand hygiene	95%	99.94	95%	99.83	
RTM Hand hygiene (doctors)	9.8	**9.7**	9.8	**9.7**	Real time patient monitoring based on Q3 performance
RTM Hand hygiene (nurses)	9.8	9.8	9.8	9.8	

Areas of concern/Outbreaks

- **Isolation breaches** recorded by the Infection Control Team during December were 24 compared to 23 in November. Of the 24 isolation breaches in December,
  - 14 were at CRH and 10 were at HRI
  - 20 were on medical wards, of these, 12 were on the MAUs
  - 3 were on surgical wards and one on SCBU

- **Norovirus** - MAU at HRI was closed to admissions due to Norovirus during December for 12 days resulting in 104 lost bed days.
- **Hospital acquired MRSA** - in December, there was one case identified in an orthopaedic ward; there have been a total of 23 cases of hospital acquired MRSA since April.
- **MSSA bacteraemia post 48 hours -** 3 cases in December, 1 above target. No epidemiological link to suggest cross-transmission, these are endogenous infections. Surveillance continues with a plan to improve how we capture details of device related bacteraemias
- **Influenza** - activity in the community has been picking up although this is beginning to show signs of settling. So far, 15 confirmed cases have been admitted to the organisation - similar levels so far to previous years. Further cases are expected. We now have the capacity to test locally (restricted to ICU or Microbiology approved cases)
- **Rise in number of VRE cases -** typing and epidemiology does not support an outbreak, probably reflects a rise being noted nationally
- **CVAD infections -** There were two central line infections in December, both are being investigated using RCA investigations, although both were in haematology/oncology patients they were different organisms. Practice will be scrutinised in the investigation process.
- **C.difficile** – We have breached our target for this year. RCA for all cases have been undertaken: 6 have been classed as avoidable, 13 as unavoidable. The first chart below show the comparison with other trusts in the Yorkshire and Humber. The second chart shows the predicted position at the year-end calculated from current performance.





Miscellaneous

- **Flu Vaccine Campaign –** currently the uptake in frontline staff is 64%
- **Hand Hygiene –** on-going work to increase compliance with hand hygiene focusing on the WHO 'five moments for hand hygiene'
    - Before patient contact
    - After patient contact
    - Before an aseptic technique
    - After contact with body fluids
    - After contact with the patients immediate environment
- **Commode audit –** 186 commodes were inspected across both hospital sites during November. Of the 186 commodes, 174 (94%) were observed to be clean.
- **Frontline Ownership (FLO) audits** – 39 out or 84 (46%) of monthly FLO audits were completed in December
- **Peer Review FLO audits** – The majority of the peer review FLOs have seen an improvement on the previous audit. There are still areas of concern around decontamination of patient equipment in some areas.
- **Aseptic Non-touch Technique (ANTT) –** the following actions are in progress to improve the competency assessments
    - Review the ANTT training Strategy
    - Develop a process for sharing the competency matrix to ensure appropriate actions are taken
    - Review the list of ANTT key trainers and ensure all clinical areas have access to at least one ANTT trainer
    - Embed ANTT into existing training sessions
        - IV training

        - Urinary Catheter
        - CVAD training
        - Induction training
        - Junior doctors induction
        - Infection Prevention and Control
    - Develop processes to assure sustainability
        - Annual audit to be performed and the data analysed
- **Peripheral Venous Cannula audit** – the IPCT performed a re-audit of cannulae in October. The audit provides the focus for improvement work, this will be led by the IV Strategy Group, the overall trust compliance is highlighted below
    - Insertion details relating to the cannula have been documented = 82%
    - Reason for cannulation documented = 63%
    - IV giving set lines used for intermittent infusions are discarded once disconnected = 100%
    - Appropriate IV dressings are applied to cover cannula sites = 100%
    - VIP score documented daily = 94%
    - VIP score correct to state of Cannula = 89%
    - Cannula removed 72 hours after insertion – if no is reason documented = 85%
    - PVC care plan available/in use = 94%

Quality Improvement Audits

- Only one re-audit was performed in December in the Podiatry Department at PRCHC. Some of the key issues identified below have been outstanding since the last audit and the audit scored red
    - Staining to a couch
    - Toilet cleaner not available
    - Drugs fridge used for staff food
    - Alcohol gel not available at the point of use
    - Sterile goods stored on the floor
    - Damage to walls
    - Cleaning schedules not available in all rooms
    - Unclean waste bin

Calderdale and Huddersfield NHS
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Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Melanie Johnson, General Manager, CGSU
Date: Thursday, 29th January 2015	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Care of the Acutely Ill Patient (CAIP) Programme - Bi monthly update on progress of the care of the acutely il patient programme towards its objectives.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: A vesrion of this paper is presented at Quality Committee on a monthly basis	
Governance Requirements: Shows work in progress to address the higher than predcited mortality indicators.	
Sustainability Implications: None	

Executive Summary

Summary:

An overveiw of progress towards the outcome aims of the programme and showing work in progress agaist each of its 8 themes.

Main Body

Purpose:

To show progress and highlight barriers to the work

Background/Overview:

Thsi paper is presented each 2 months to show progress of the work and highlight key concerns

The Issue:

The aim of the programme is to improve quality of care, measured by key outomes around mortality rates.

Next Steps:

the board to provide ongoing scrutiny of progress of the work.

Recommendations:

Recommendations are contained in the report.

Appendix

Attachment:

BOD Jan 15 final.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Care of the Acutely Ill Patient (CAIP) Programme Board of Directors

Update: January 2015

Subject	**Care of the Acutely Ill Patient Programme**
Reporting Month	January 2015
Authors	Lisa Fox - Information Manager Mel Johnson - General Manager CGSU
Summary	Report to inform the Board on the progress against outcomes for the Care of the Acutely Ill Patient (CAIP) Programme

Contents

1. Introduction

The Care of the Acutely Ill Patient programme contains the following 8 themes:

1 Reducing Mortality (Overall outcome measures)

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

3 Delivering high standard of care through reliable delivery of care bundles.

4 Frailty

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

6 Focus on SHMI Conditions of Interest

7 Well Led Organisation

8 Coding

Action plans and targets have been revised and oversight of the work will continue to be provided by the Clinical Outcomes Group (COG) reporting through Quality Committee on a monthly basis.

Theme 1: Reducing Mortality

Two key outcome measures:

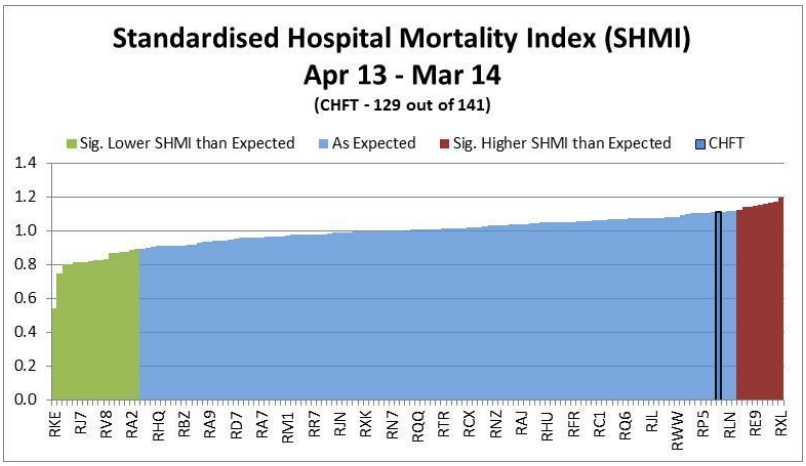
A) Standardised mortality:

The Standardised Hospital Mortality Index (SHMI) is published each quarter 6 months in arrears. SHMI takes into consideration all deaths which occur in hospital and up to 30 days post discharge. It does not take into consideration any element of Palliative Care.

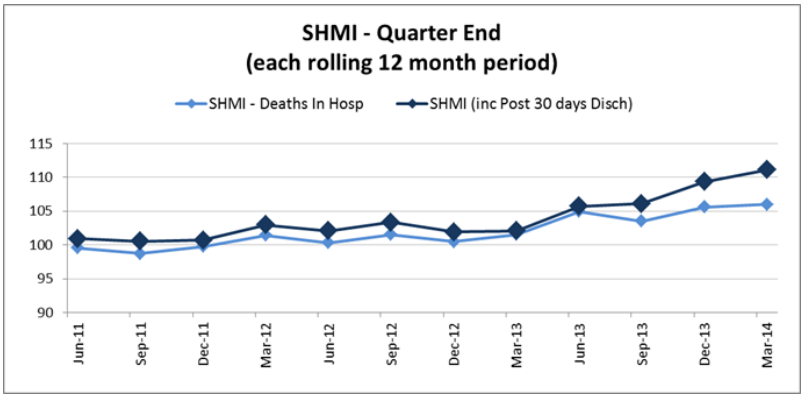
The aim is to achieve a SHMI of 100 between January and December 14. This data will be published in June 2015.

- The SHMI for April 2013 to March 2014 is 111.11 which Ranks the Trust as 129th out of 143 comparable trusts as defined by the Health and Social Care Information Centre (HSCIC).

- The next SHMI is due to be released at the end of January 15. This will incorporate data for the time period July 2013 - June 2014.



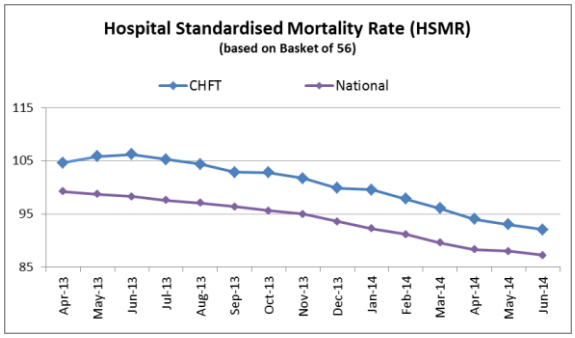
- This is higher than our previous 12 month SHMI (January 2013 – December 13) of 109.

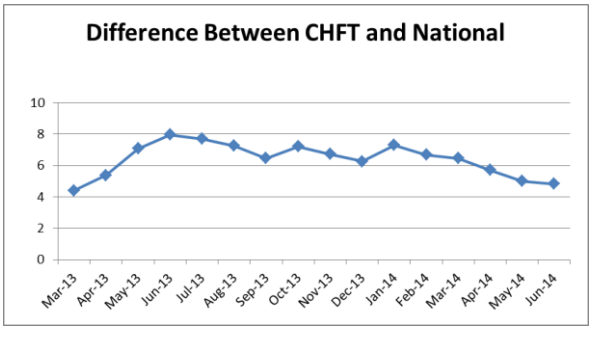


It is possible to glean how SHMI is calculated for both in hospital and up to 30 day post discharge deaths (see chart above).

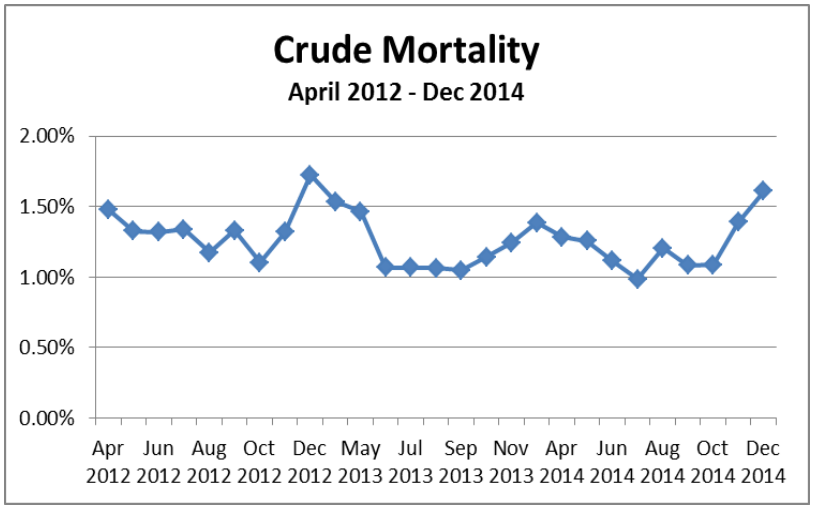
As you can see the gap between out in hospital and out of hospital deaths appears to be widening, the Trust is working with our Clinical Commissioning Group (CCG) colleagues to ascertain how to gather information on those patients who die post discharge.

There are other measures of mortality which are less in arrears and enable us to track likely SHMI scores. The Hospital Standardised Mortality Rate (HSMR) is one such indicator. Since January 2014 we are beginning to see the gap between ourselves and the national narrowing.





Crude Mortality (below) was showing a reduction until July 14 but has increased since November. It is of note that crude mortality in December 14 was the highest since 2012. It is unknown what impact this will have on the other mortality indicators at this stage.



Another outcome aim for the programme is to ensure we learn from mortality through our process of mortality reviews. The initial target of ensure mortality reviews are carried out on all adult patents has not been achieved. To try and address this the review process was simplified and reintroduced at the beginning of January 15.

The level 1 review can be completed singly by one of the trained reviewers; there is an expectation that each reviewer will complete at least 4 per month. Any cases where concerns have been raised will receive a peer review; the second tier tool still needs testing.

The database will also be changed to reflect the new process; a weekly performance report will be generated for each division showing how many reviews are taking place.

A more detailed report on findings and any themes emerging from mortality reviews is presented monthly at COG.

Theme 2: Ensuring the recognition and prompt treatment of our deteriorating patients

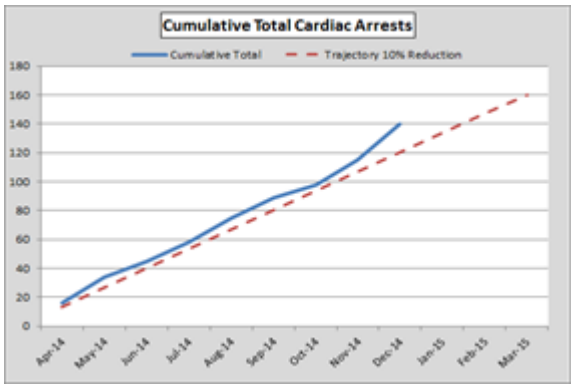
There are 3 key actions in this work stream, firstly the move to 'Nerve Centre' (the electronic observations and escalation system). The second action is focused on ensuring our escalation teams are correctly organised to respond to deteriorating patents and the third action is around appropriate and timely end of life care decisions.

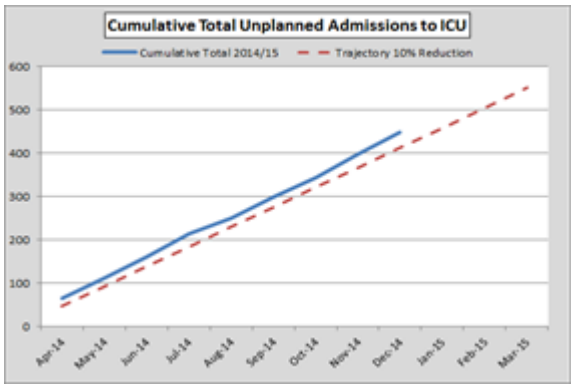
'Nerve Centre' is commencing on the 2 pilot wards on February the 9th 2015. Following this there will be an initial test period of 8 weeks when changes can be made and the system improved. From here planned roll out to other wards will take place at 2 wards per week. A team are in place supporting this work and will be working on the wards actively supporting the implementation.

More work needs to take place around ensuring we have the correct models of care and teams in place to support the expected increased escalation, this work will initially focus on Hospital at Night to tie in with introduction of this module as part of 'Nerve centre' implementation.

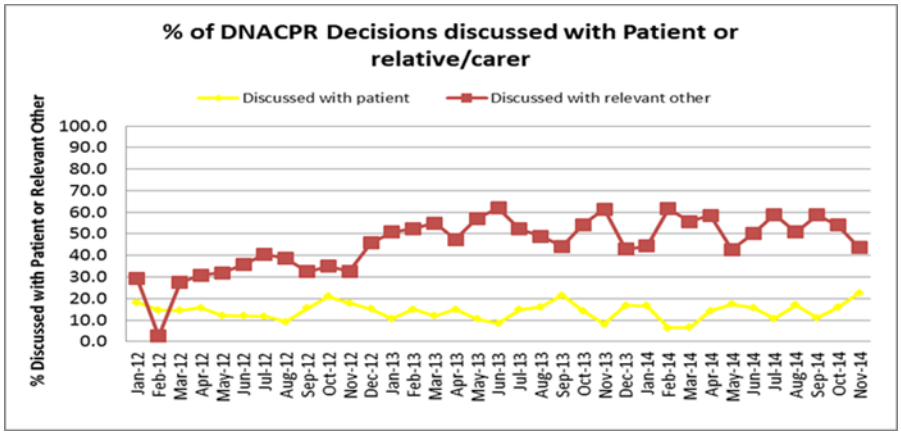
The outcome measures for this work are unplanned admissions to ICU and number of cardiac arrests

This theme has as its key outcome measures cardiac arrests and unplanned admissions to ICU, baseline data has been collected. These two measures plus data around the completion of observations and responses to deterioration will be used to track the progress of the work.





The other focus of the work is around DNACPR – The data has failed to show any improvement over the past 18 month in communications around the decision. A point prevalence audit is taking place on the 14th January; this will focus on communication, documentation in the notes and review. The end of life lead is presenting information at clinical audit half days over the next few months.



Theme 3: Delivering high standard of care through reliable delivery of care bundles

Care bundles are a group of actions that if properly validated and implemented are proven to lead to improved clinical outcomes for the condition or symptom to which they apply. As such if chosen correctly they will support the Trusts high level aims to reduce harm and mortality.

Collecting accurate compliance data for this theme has been an issue, the clinical audit team are now collecting weekly data on initiation of the bundles (below) and this has been reported to COG from December. This will be coupled with more in depth audit around outcomes collected by the specialist clinical teams.

3. High standards of care through reliable delivery of care bundles	Asthma - Bundle Started	95%	22%	95.0%	TBC	Patients who had a bundle in the notes
	Asthma - Bundle Completed	95%	100%	95.0%	TBC	Number of bundles which were complete
	AKI - Bundle Started	95%	0%	95.0%	TBC	Patients who had a bundle in the notes
	AKI - Bundle Completed	95%	n/a	95.0%	TBC	Number of bundles which were complete
	Sepsis - Bundle Started	95%	90%	95.0%	TBC	Patients who had a bundle in the notes
	Sepsis - Bundle Completed	95%	85%	95.0%	TBC	Number of bundles which were complete
	COPD - Bundle Started	95%	50%	95.0%	TBC	Patients who had a bundle in the notes
	COPD - Bundle Completed	95%	50%	95.0%	TBC	Number of bundles which were complete
	Pneumonia - Bundle Started	95%	100%	95.0%	TBC	Patients who had a bundle in the notes
	Pneumonia - Bundle Completed	95%	0%	95.0%	TBC	Number of bundles which were complete
	Heart Failure	Design Phase				

The heart failure bundle is in early design; it has been simplified for the version tested 2 years ago. Its implementation will be tied in with the acutely ill patient bundle – now in version 2 and being tested. This testing has been delayed due to pressures on the MAU wards through the end of December/early January. Discussions are continuing to take place with the leads around how the discharge elements will fit into the new process.

Theme 4: Frailty

Care of frail patients is a theme that has emerged from some of the mortality alert reviews and via on going trust improvement work e.g. Dementia. These patients tend to have a complex pathway of care, coming into contact with multiple teams and support services.

A Frailty measure tool has been produced and is on QlikView. This is being amended to include all frail patients not just those deceased.

Scope of the work was been discussed, an action plan will be presented to February Outcomes Group detailing what is being proposed and linking in all on-going work to avoid any duplication.

This work links to Theme 6 – 'SHMI conditions of interest and theme 3 around the use of care bundles for patients with chronic conditions.

Theme 5: Effective

These aims are all being delivered through the Courage to Put the Patient First Programme who have their own measures dashboard.

More work has been commissioned by Outcomes Group to clarify some of the key KPI's namely re how outliers are calculated and also ward moves. Data is presented at COG by division.

The date for the first project board has now been confirmed and some work has been done to establish the make-up and programmes for the four project groups.

Work still continues to manage and embed the changes seem in last year's programme, particularly around Plan for Every Patient and support services. The Echo booking system and process has now changed to allow service to work to Takt.

Some design work has begun on the pacemaker loop.

	Indicator	Month Agreed Target	Current Month Performance	Rolling 12 Month Target/YTD	YTD Performance	Comments
5. Effective	Bed Occupancy	-	88%	-	85%	
	Number of Outlying Bed Days	-	1119	-	6999	
	% of Patient Ward moves less than three	98%	96.8%	98.0%	94.0%	Novembers data
	Average length of Stay (ALoS)	-	3.4	-	3.4	

Theme 6: SHMI Condition of Interest - Over View

In order to drive down the trusts SHMI a sensible approach is to maitain a focus on those conditions that either alert or have a higher mortality rate than expected. There has been no new dat relaeases since the last report.

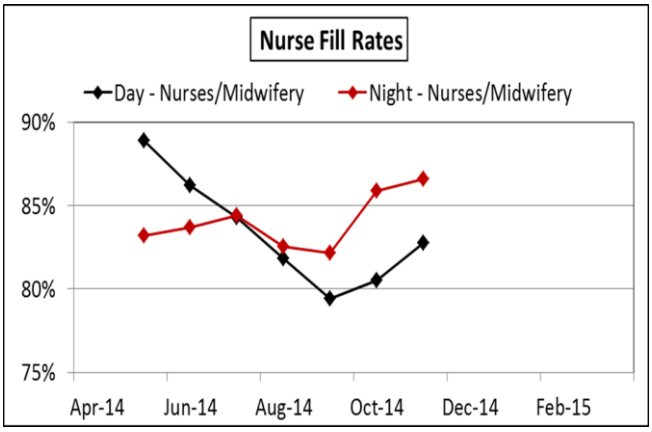
Data is monitored for any conditions of concern from the data sets and any concerns highlighted to COG. Conditions already highlighted i.e. Stroke and Heart failure have work streams led by medical division in place.

A report has been requested for progress around the Stroke action plan for February outcomes board.

	Indicator	Month Agreed Target	Current Month Performance	Rolling 12 Month Target/YTD	YTD Performance	
7. Conditions of Interest	COPD - HSMR	100	129	100	118	Sept13 - Aug 14
	COPD - SHMI	100	118	100	118	Apr 13 - March 14
	Heart Failure - HSMR	100	132	100	106.66	Sept13 - Aug 14
	Heart Failure - SHMI	100	117	100	117	Apr 13 - March 14
	ACD (inc Stoke) - HSMR	100	120	100	95	Sept13 - Aug 14
	ACD (inc Stoke) - SHMI	100	128	100	128	Apr 13 - March 14

Theme 7: Well Led Organisation

The actions contained in theme 7 are all designed to ensure that key barriers to support the programme aims are overcome. There is ongoing work improving the metrics for this theme.

Leadership walk round process.	Acuity & Dependency Audits. Nurse Staffing Levels meeting the acuity of patients
A new proposal re strengthening visual leadership was passed in December by WEB. This is now being operationalized with a view to starting the new process in February 2015. In short there will be 5 strands: • NED walk rounds – as current announced walk round process, these will need to include community areas and OOH. • Executive Directors -Monthly walk rounds in dedicated geographic area – to cover estate as well as clinical issues. • Senior Management team – Back to the floor Fridays 1/2 day once a month. • Matrons – Weekly back to the floor. Per revise included. • Other – e.g. Chairman's surgeries, focus groups etc.	Data sets and reporting is in place for nursing. Acuity audit completed in November, results will be published end of December and action planning will take place in January. HCA fill rates to be added to the data sets. 
Update to Communications plan	**Out of Hours Medical Cover - Divisional Reports**
A plan has been drawn up re rolling communications around the plan each month. The first information will be released in February 2015	Meetings in place, some TOR to be designed to ensure outcmes and measurement are more robust.
% of reporting against national mark. (NRLS)	**Human Factors**
The investigations group has been set up, it will report directly to COG. An action plan and driver diagram is in place. Detailed plans are being worked out commencing on improving tools for investigation, then training and skills and finally looking at the whole investigations process including data capture (simplifying Datix reporting) and sharing learning.	Measures around culture of safety are being investigated as part of this work. Initial focus will be around redesigning the current Root Cause Analysis processes; some measures will be devised to track the progress of this.
Handover module on Nerve Centre.	**Implementation being led by senior clinicians**
Plans are in place re introducing the handover module as part of nerve centre roll out. First pilot wards are scheduled to commence in February 2015. Work to address identified issues with hospital at night need to be resolved in a short timescale so they can be included as soon as possible in the nerve centre roll out so full benefit can be realised.	Support structures for the revised themes is on the action plan.

Theme 8: Coding

A detailed action plan is in place and being implemented through the Clinical Coding Steering Group.

The immediate focus for the work is to ensure the co morbidities document is in medical admission packs and is being completed reliably. This will then be spread to the surgical division.

Focussed work on some specialties has already shown marked improvement in the depth of coding.

	Indicator	Month Agreed Target	Current Month Performance	Rolling 12 Month Target/YTD	YTD Performance
8. Coding	Average Charlson Score	4	3.35	4	3.14
	% Sign and Symptom	9.5%	-	9.5%	9.20%

The Board is asked to note:

- The increase in crude mortality December 14.
- New process for mortality reviews, commenced in January 2015.
- Delays to start date of 'Nerve Centre' implementation, new date for pilot wards February 9th 2015. Team now in place to support wards.
- Failure to see improvement in measures around DNACPR communication with patients and or carers and current plans for improvement.
- Action planning around Frailty to ensure there is no duplication of work and to clarify aims.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Sue Burton, Medical Education Manager
Date: Thursday, 29th January 2015	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Revalidation and Appraisal of Non Training Grade Medical Staff - The purpose of this paper is to update the Board of the progress of the Trust towards the management of medical appraisal and revalidation since the last report in December 2013.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: None	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

Please see attached PDF Document

Main Body

Purpose:

Please see attached PDF document

Background/Overview:

Please see attached PDF document

The Issue:

Please see attached PDF document

Next Steps:

Please see attached PDF document

Recommendations:

The Board is asked to receive this report

Appendix

Attachment:

Revalidation and Appraisal Board of Directors - January 2015.pdf

REVALIDATION AND APPRAISAL OF NON TRAINING GRADE MEDICAL STAFF - ANNUAL REPORT

1. Executive Summary

This report describes the progress of the Trust towards the management of medical appraisal and revalidation since the last report submitted in December 2013.

Summary of key points:

- As at 31st December 2014, 312 doctors had a prescribed connection to Calderdale and Huddersfield NHS Foundation Trust.
- In the current appraisal year (1st April 2014 – 31st March 2015) 55% of all doctors with a prescribed connection had been appraised by 31st December 2014 and their appraisal submitted to the Revalidation Office. Based on the request that doctors complete their appraisal during their month of birth the completion rate is currently 76%.

2. Purpose of Paper

This is the second annual report to the Trust Board on the development and operation of systems to support the appraisal and revalidation of medical staff in non-training grade posts.

3. Background

3.1 Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim to improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

3.2 Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under Responsible Officer Regulations and it is expected that provider boards will oversee compliance by:

- monitoring the frequency and quality of medical appraisals in their organisations;
- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients and colleagues is sought periodically;
- ensuring that appropriate pre-employment background checks are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

4. Revalidation Cycles

4.1 The first revalidation cycle started in January 2013 and ends in 2016. During this period all doctors for whom the Trust is a designated body will have a recommendation made by the Trust's Responsible Officer (RO).

4.2 Since the last Executive Board report in December 2014 the RO has made the following recommendations:

4	Positive Recommendations	Recommendation Deferred
Year 2, Quarter 1 (April 2014 – June 2014)	20	1 – deferred (insufficient evidence presented to the RO)
Year 2, Quarter 2 (July 2014 – September 2014)	20	1 – deferred (maternity leave)
Year 2, Quarter 3 (October 2014 – December 2014)	20	1 – deferred (maternity leave)
Year 2, Quarter 4 (January 2015 – March 2015)	27	2 – deferred (insufficient evidence presented to the RO)
Total:	**87**	**5**

5. Appraisal Compliance

5.1 Medical Appraisal underpins the revalidation process.

5.2 The appraisal year runs from 1st April – 31st March. The table below shows the current compliance rate as at 31st December 2014. Doctors are required to complete their appraisal during the month of their birth, however the table bellows shows all completed appraisals which have been submitted to the revalidation office since 1st April 2014.

5.3 Medical Appraisal compliance as at 31st December 2014

The table below shows the compliance rate based on the total number of doctors in non-training grades for whom Calderdale and Huddersfield is the Designated Body.

Staff Group	Compliance Rate %		
	Total Number of Staff to be appraised	Number of Appraisals received	
Consultants, Staff Grades, Associate Specialists, Specialty Doctors, Trust Doctors, Locum Appointments for Service	312	172	**55%**

(Staff Numbers sourced from GMC Connect list – 31st December 2014)

Based on the request that doctors complete their appraisal during their month of birth the completion rate is currently 76%.

5.4 The breakdown rates for Divisions is shown below

Medical Appraisal Compliance by Division (as at 31st December 2014)

The figures in (red brackets) show percentage completion rate at this stage in 2013.

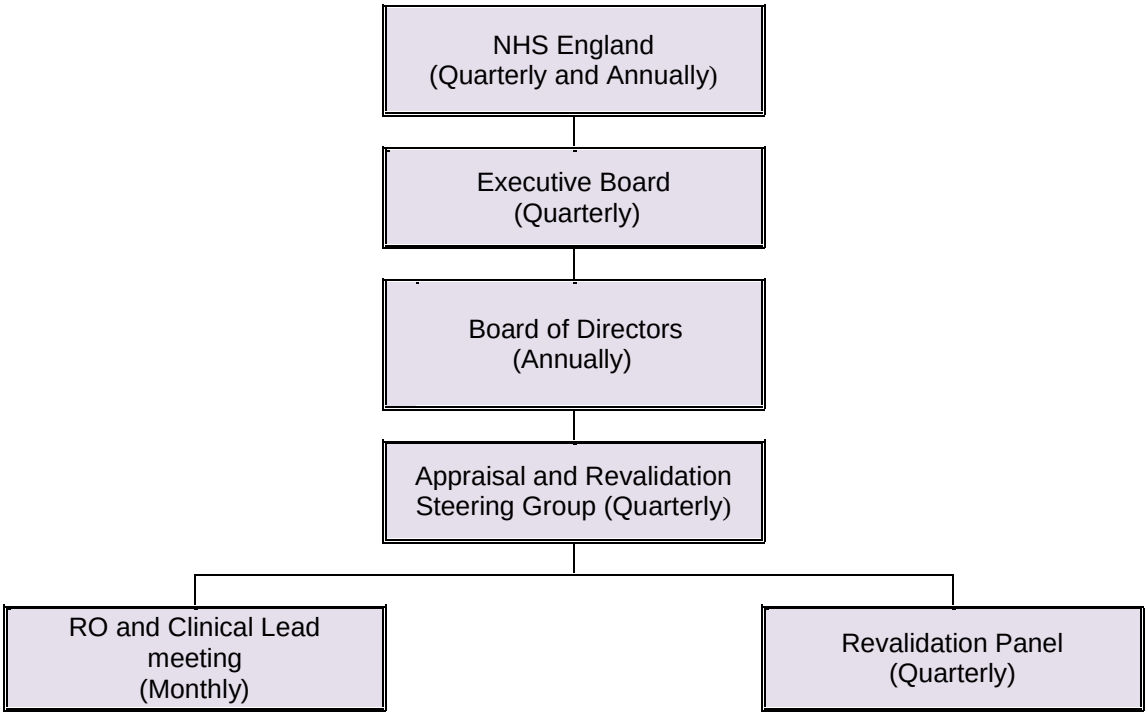
	April 2014 – December 2014
Head and Neck	**59% (23%)**
Surgical Specialties	**51% (33%)**
Acute Medicine	**68% (33%)**
Emergency Medicine	**45% (43%)**
Anaesthesia	**65% (50%)**
Trauma and Orthopaedics	**80% (53%)**
Integrated Specialty Medicine	**52% (69%)**
Women's	**73% (70%)**
Radiology	**82% (75%)**
Pathology	**91% (87.5%)**
Paediatrics	**83% (93%)**

6. Trained Appraisers

6.1 There are currently 91 trained appraisers (Consultant and Specialty Grades). As at 31st December 2014 16 of the trained appraisers had not appraised anyone since 1st April 2013. Of those appraisers who have conducted appraisals the figures range from 20 appraisals to 1 appraisal over the two year period. The Revalidation Office will be forwarding the appraiser figures to Divisional Directors so action can be taken to help ensure equitable distribution of the role.

7. Governance Reporting Structure

7.1 The Trust's governance reporting structure for medical appraisal and revalidation is shown below:



7.2 GMC Connect

GMC Connect is the General Medical Councils (GMC) database used by Designated Bodies (ie Calderdale and Huddersfield NHS Foundation Trust) to view and manage the list of doctors who have a prescribed connection with the Trust.

The database is managed by the Revalidation Office on behalf of the Responsible Officer. The Trust's Electronic Staff Record management system (ESR) is used as the main source in relation to starters and leavers. A calibration exercise between ESR and GMC Connect is undertaken quarterly.

GMC Connect also allows doctors to directly add themselves onto the system. In these instances this is validated by the Revalidation Office.

7.3 Policy

Version 2 of the Trusts Appraisal Policy for Medical Staff (Non Training Grades) was ratified by the Trust Board in May 2014. The revised policy includes further rigour for managing non engagement in the process (involvement of clinical and divisional directors and if necessary escalation to the GMC)

7.4 Revalidation and Appraisal Steering Group

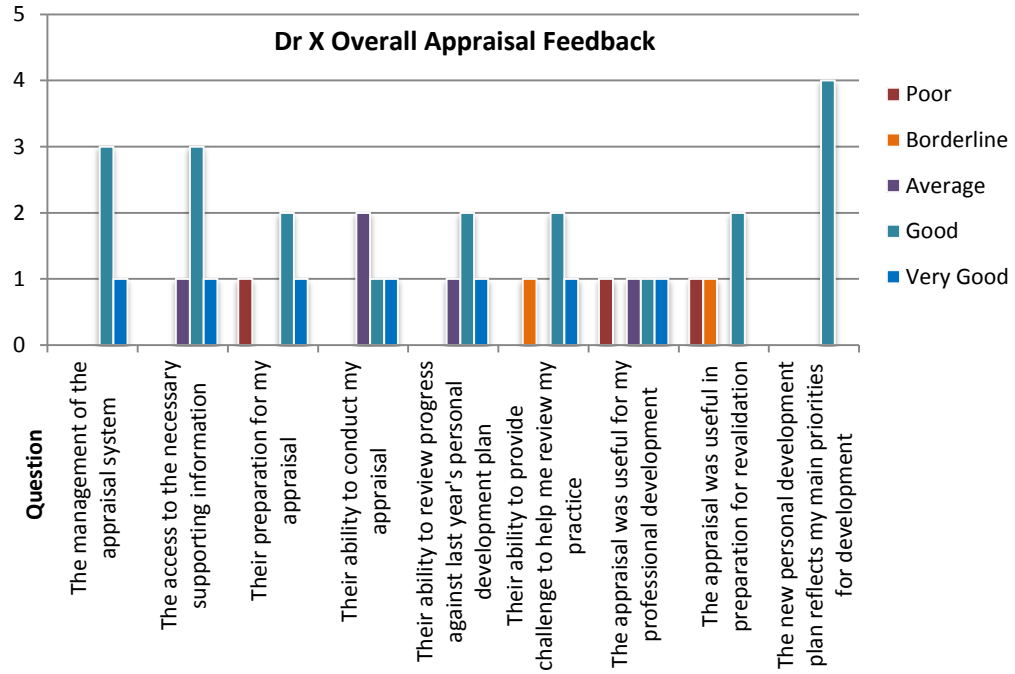
The Revalidation and Appraisal Steering Group and Panel continue to support the RO with the revalidation agenda, within the prescribed terms of reference.

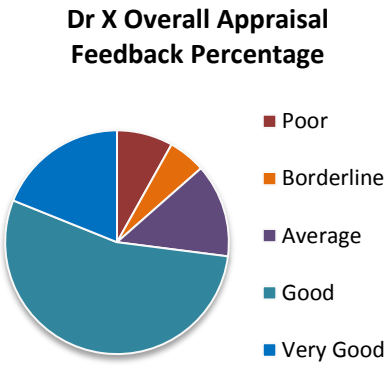
8. Quality Assurance of the Process

8.1 The process used monitor the quality of the medical appraisers is for the doctors to rate their appraisal experience in relation to:

- The organisation of the appraisal
- The appraiser
- The appraisal discussion

The questionnaire was introduced in July 2013 and the response rate was initially slow. The Revalidation Office now remind appraises to complete the form and anonymised information will be sent to appraisers in the format below.





Comments		
THE ORGANISATION	Comments to help improve the process	Guidance on how to use the appraisal form.
THE APPRAISER	Comments to help your appraiser improve their skills	Very detailed process with constructive advice on aspects such as PDP.
THE APPRAISAL DISCUSSION	Comments to help improve the appraisal discussion	Would suggest half day meetings on tips to help doctors prepare for appraisal.

Year	No of Appraisal
12-'13	4
13-'14	4
14-'15	3

9. Next Steps

a) Appraisal Completion Rate

To aim to ensure 90% of all medical staff in non-training grade posts have completed an appraisal by 31st March 2014. The figure is not 100% since it is based on the total non training grade workforce and there will be a cohort of doctors who will not have completed an appraisal for various reasons (joined the organisation in the last 6 months, maternity leave, sabbatical, long term sick leave etc).

The appraisal completion rate is higher than at this time last year (54% as compared to 36%) but there is still considerable progress to be made:

- Compliance reports will continue to be sent to divisional and clinical directors on a monthly basis.
- Continue to stress the need for appraisals to be completed during the month of birth.

b) Quality Assurance

- To ensure an initial screening of the appraisal documentation for completeness sake is undertaken by the Revalidation Office.
- To generate meaningful feedback from the appraisee questionnaires.

c) Appraiser Support

- To make more formal the support offered to appraisers by establishing an appraiser forum

10 Action Required of the Board

The Executive Board is asked to:

(i) to accept this report.

Dr David Birkenhead
Medical Director/Responsible Officer
Calderdale and Huddersfield NHS FoundationTrust
January 2015

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Melanie Johnson, General Manager, CGSU
Date: Thursday, 29th January 2015	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: Calderdale & Huddersfield NHS Foundation Trust Quarterly Quality Report - Report highlighting compleinec with CQC quality domains and actions being taken where gaps identified.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: A version of this paper was presented at Quality Committee in December 2014.	
Governance Requirements: Shows work ongoing to meet the CQC quality domains and internal improvement targets.	
Sustainability Implications: None	

Executive Summary

Summary:

The paper is arranged as the 5 CQC quality domains, highlighting the key areas and compliance with the standards. Where gaps have been identified it shows work ongoing to redress, this work is focussed on Q4, progress against these actions will be reported in the subsequent report to be presented in April 15.

Main Body

Purpose:

Progress against quality standards.

Background/Overview:

This is the first attempt to pull all the quality standards together in one report. It is arranged around the 5 domains of quality.

The Issue:

Ongoing work to ensure the Trusts is meeting quality standards and working towards internal stretch improvement targets.

Next Steps:

Ongoing work is set out in te report, progress will be reported back in April 15.

Recommendations:

These are set out in the report.

Appendix

Attachment:

Quarterly BOD Quality Report Final Jan 15.pdf

Calderdale & Huddersfield NHS Foundation Trust
Quarterly Quality Report
For Board of Directors
Q3 Oct - Dec 2014

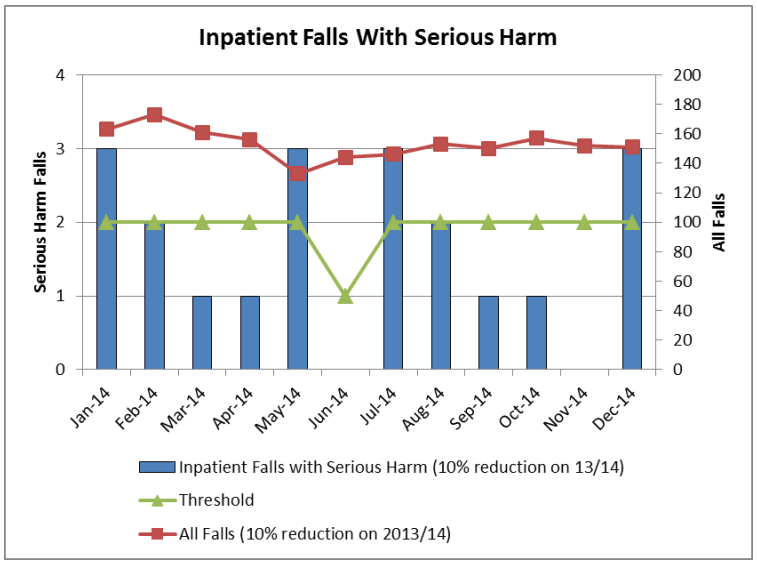
Report Overview

This report provides an overview of the current performance of key quality indicators up to the end of Q3 2014. Where indicators show targets are not being reached a narrative is included setting out key interventions for the next 3 months. The next quarterly quality report (April 15) will report on progress against these interventions.

Contents

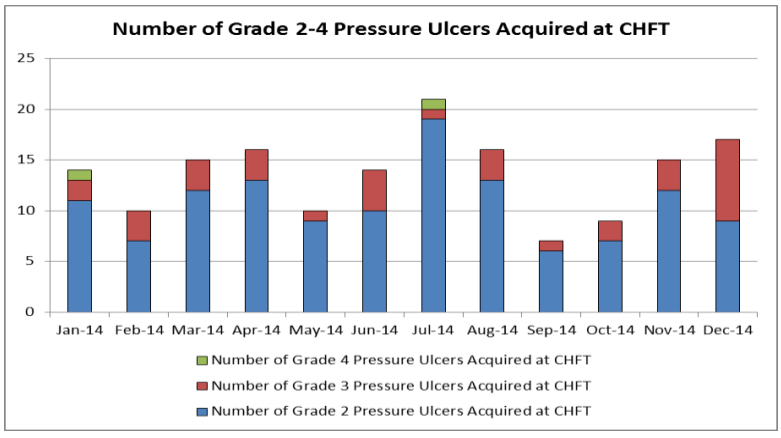
Domain 1 – Safe: People are protected from abusive and avoidable harm

Report For: Q3 2014/15	Q3 Target	Q3 Trust	YTD Target	YTD Trust	Year End Forecast
Inpatient Falls with Serious Harm	5	3	16	13	
All Falls (10% reduction on 2013/14)	336	459	1007	1342	
Number of Trust Pressure Ulcers Acquired at CHFT	33	50	97	134	
Number of Grade 2 Pressure Ulcers Acquired at CHFT	22	31	66	100	
Number of Grade 3 Pressure Ulcers Acquired at CHFT	0	19	0	32	
Number of Grade 4 Pressure Ulcers Acquired at CHFT	0	0	0	2	
% Harm Free Care	95%	93.7%	95%	93.80%	
Percentage of Completed VTE Risk Assessments	95%	95.3%	95%	95.3%	
Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	100%	96.7%	100%	98.57%	
Number of Patient Incidents		1718		5171	
Number of SI's		24		57	
Number of Incidents with Harm		406		1185	
Never Events	0	0	0	0	
Serious hazards of transfusion	0	2	0	9	
Percentage of SI's reported externally within timescale (2 days)	100%	90% (Dec)	100%	90%	
Percentage of SI's investigations where reports submitted with timescale (45 days unless extension agreed)	100%	38%	100%	46.7%	

Quality Priority	Reducing Patient Falls
Aims and Objectives of Work	For all Falls with harm the aim is to achieve a 10% reduction on the 2013/14 baseline.
Current Performance	The Trust is currently on trajectory to meet the 10% reduction in the number of patients who experience harm as a result of a fall. Of the 1342 (April to December 14) patients who have suffered a fall, 13 of these have resulted in serious harm (1.0%). The chart below shows both the numbers of falls (right hand axis) per month (red line), and falls that resulted in serious harm (left hand axis and blue blocks) The improvement trajectory (for serious harm falls) is represented by the green line.  **Falls Prevention Care Bundle Snap shot audit** The table below show results from a 2 week audit carried out the clinical audit team on MAU's (both sites), the aim was to test the audit tool and ascertain if the falls prevention process was in place.

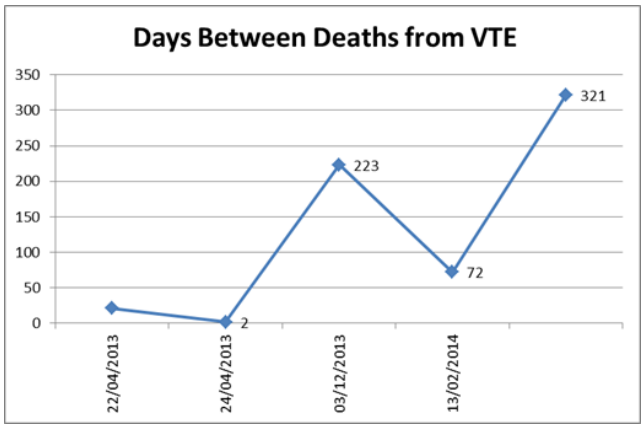
	Pt assessed for falls risk.	Falls care plan commenced	Bundle fully completed: Medical	Bundle fully completed: Therapists	Bundle fully completed: Nursing	Has patient sustained In Patient fall?
CRH n=13	92%	92%	0%	0%	8%	0/13
HRI n=10	100%	100%	0%	0%	0%	0/10

Improvement Plans for next 3 Months	The falls collaborative has a detailed action plan overseen by the patient safety group. The falls group is focusing effort over the next 3 months on embedding the new falls prevention process. Specific actions to be delivered in the next 3 months are as follows: • Ensuring that the falls prevention bundle, in-patient post falls bundle and falls prevention management plan are being used in practice. Audit of 5 patients per week on the MAU's on both sites was completed to test the audit tool (see data above). Tool to be rolled out to all adult wards from February supported by ward sisters and matrons. This will help address findings from the thematic review findings (see below) as whilst completing this audit senior nurses will be prompting and educating ward staff. • In addition to checking that all falls are being reported an exercise has taken place asking ward staff about falls in their areas and cross referencing this to make sure they were reported on DATIX. This was completed during perfect week in January 15 and is still to be analysed. • The first thematic review of red and orange incidents for falls took place on the 25 November 2014. This highlighted poor compliance with bundles and lack of person centred care planning. This is being addressed through implementation of the care bundles on all areas with Trustwide audit to highlight areas of poor compliance. All the necessary tools will be available on the documentation repository from the 19th January 2015.

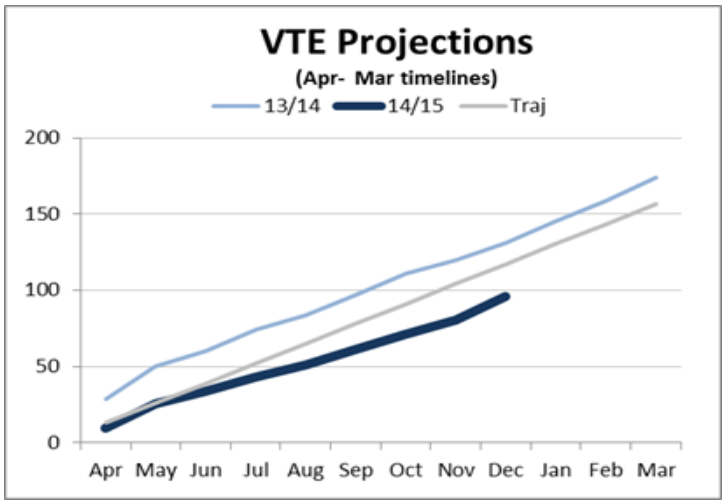
Quality Priority	**Pressure Ulcers**
Aims and Objectives of Work	A trajectory of 10% reduction for all hospital acquired category 2, 3 & 4 pressure ulcers was agreed at the beginning of 2013 for 2013/14, the same improvement trajectory has been carried forward to 2014/15.
Current Performance	Current performance for 2014/15 is above trajectory. 

Improvement Plans for next 3 Months	The pressure ulcers collaborative have a detailed action plan overseen by the patient safety group. The pressure ulcers group is focusing effort over the next 3 months on improving accuracy of data, training for hospital and community teams and introducing new mattresses. The specific actions to be delivered in the next 3 months are as follows: • Each month a report on the themes from investigations of hospital acquired pressure ulcers is discussed at Patient Safety Group. Grade 3 and 4 pressure ulcer investigation performance is monitored. The purpose of this scrutiny is primarily to ensure rigour in the investigations and ensure recommendations and action plans are robust. All acquired category 4 pressure ulcers will be presented to Director of Nursing and category 3's to Assistant Directors of Nursing. The details will be agreed over the next 2 months. • A review of the pressure ulcer reporting and validation process with the community teams is taking place, currently district nursing clinical managers are validating community pressure ulcers. The process for categories 3 and 4 will be as above. The aim of this work is to ensure robustness of the data and improve the timeliness of reporting so actions can be taken. • Competencies for qualified nursing staff have been developed and tested ready to incorporate pressure ulcer prevention competencies as part of essential skills training. Timeframes awaited for implementation. • Safety thermometer – Tissue viability nurses (TVN's) have validated all pressure ulcers reported on the data collection day across both hospital sites. Results from both sites show some discrepancy in reporting – for the next 3 months the TVNs will validate data on those areas on each site where highest discrepancies/ numbers were reported. This will help ensure the accuracy of the data; it is also being used as an opportunity for educating ward based nurses re correct classification of pressure ulcers. • TVNs to provide additional support to high risk areas for category 2 pressure ulcers (Wards 19, 20, 8ab & 2ab). Training on how to prevent development of pressure ulcers specific to these areas has also been delivered/ is being planned. Training is aimed at ensuring there is no further deterioration and also that staff have the skills and knowledge to reduce incidence in the first place. • Implementation of a new research based risk assessment tool – a visit to Leeds Teaching Hospitals regarding implementation and observing the tool in practice took place on the 3rd December. Implementation of this tool at the Trust is to be explored so that current processes and changes such as links to EPR can be considered. Collaboration with Locala will be included in our approach as it is important that the same risk assessment scale is used across the patch to reduce confusion around pressure ulcer risk.

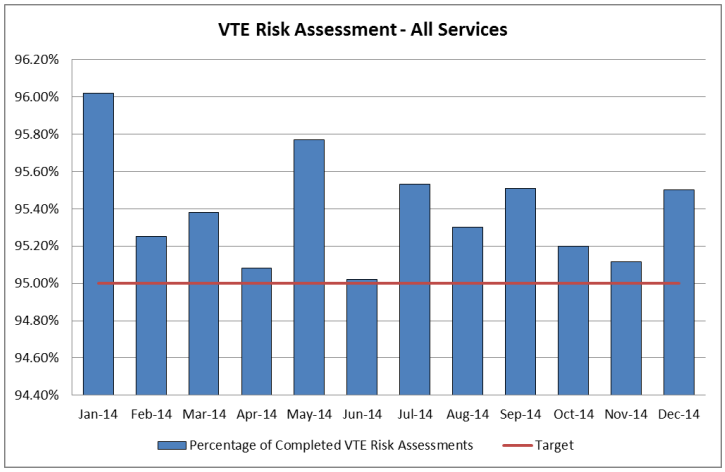
	• New static pressure relieving mattresses are being introduced, training to support their appropriate use has commenced. Installation of new mattresses was due to take place 17/18th Jan but due to current pressures will now take place in February. The CRH site will have new equipment installed in March. • Outcome measures for community services acquired pressure ulcers have now been agreed and include the number of pressure ulcer incidents. More detailed breakdown of data will include the numbers acquired on each caseload by category and caseload team and numbers of equipment incidents e.g. equipment not delivered. Data collection commenced this month. Once baseline data is analysed trajectories will be set. This information will be reported into the community pressure ulcers group for action and by exception to the patient safety group.

Quality Priority	**Reducing Harm and Death from Hospital Acquired Thrombosis (HAT)**
Aims and Objectives of Work	• 10% reduction in hospital acquired VTE's (from baseline 2013-14) • 300 days without an avoidable hospital acquired VTE death.  The aims and objectives are due to be reviewed at the end of January 2015 following the amalgamation of the Thrombosis Committee and the Acutely Ill Patient VTE Work Stream.
Current Performance	• To date the second aim has been achieved with over 300 days since the last Hospital acquired VTE death. • Definition of a HAT is when a patient develops a VTE in a current admission >72hours or has had a previous admission within the last 90 days. • All HAT cases are reviewed to ensure that the Trusts VTE Assessment and Prevention Policy has been followed.

- On average there are 10 HATS per month cross site. Since April 2014 one preventable HAT has been identified. The patient had been assessed as being a high risk for developing a VTE, however prophylaxis was not initially prescribed and it wasn't until 5 days later that this omission was identified. The patient went on to develop a pulmonary embolism. A 2nd stage RCA has now been completed and the incident details shared with the staff involved. An action plan has been agreed and is being implemented it includes consultants agreeing to check VTE prophylaxis on post take wards rounds. The incident will also be shared via clinical groups and patient safety and quality boards, sisters meetings and ward based pharmacy teams to ensure wider learning.



VTE Risk assessment Compliance

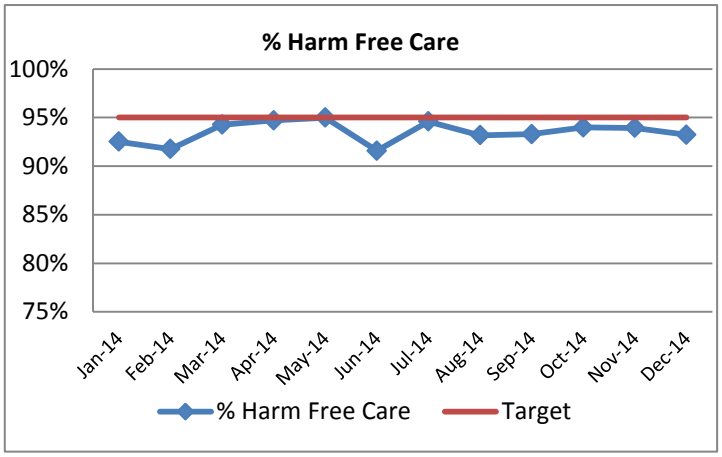


Improvement Plans for next 3 Months	The focus for the Thrombosis committee around VTE for the next 3 months will be to get the data collection issues resolved and plan actions around improving prophylaxis. **Percentage of Completed VTE Risk Assessments, 24 hour review and appropriate prophylaxis**

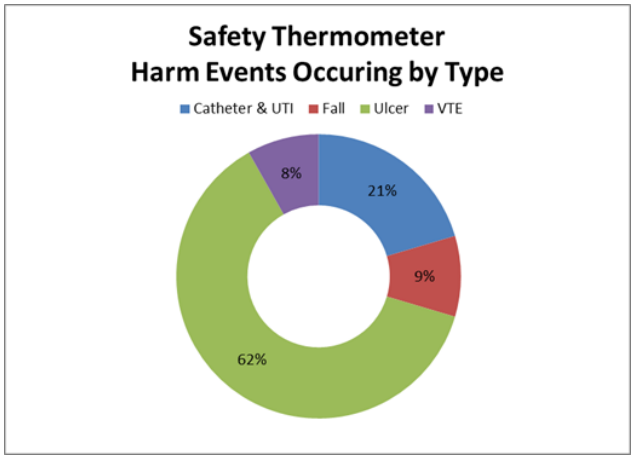
	• There is an on-going issue with the collection and validation of this data set, whilst there is no concern that VTE risk assessment is below target in any division a manual note pull is required at present to verify the numbers. Funding has been secured for the assessment and 24 hour review as part of the 'Nervecentre' project. Scoping is taking place currently. • An audit is currently taking place looking at VTE prophylaxis; it is yet to be completed. Actions will be agreed when results are known. **Hospital Acquired Thrombosis** • To revisit our aims, objectives and agree new trajectories and terms of reference for the newly amalgamated VTE group in February 2015. • Continue to monitor all HAT episodes, investigate cause and complete actions where necessary.

Quality Priority	Safety Thermometer
Aims and Objectives of Work	The Safety thermometer is a national monthly point prevalence audit, it includes both hospital and community data and is deigned to collect a snapshot audit for all patients being treated in the Trust on one day a month. The aim is to count how many 'Harms' have been experienced by patients in our Care. The harms included are: • Pressure ulcers – Old (developed prior to coming into our care) and new pressure ulcers (after coming into our care). • Falls (in past 72 Hours) – these are collected from low harm, to death • Both Catheter and UTI data is collected but only counted as harm when the 2 are present together for any patient • VTE – only VTE's that develop in our care are counted as harm The initial target for safety thermometer was to achieve a 95% harm free rate. The harm, rate' is expressed as a % i.e. the % of our patients who experienced 1 or more harms in the survey. The Safety thermometer is a national CQUIN, there are 2 targets set, one to complete the survey each month (this has been achieved to date). The second is a specific target around Pressure ulcers; the aim is to achieve a mean of less than 4.1% (from the total sample collected) over any 3 consecutive months.

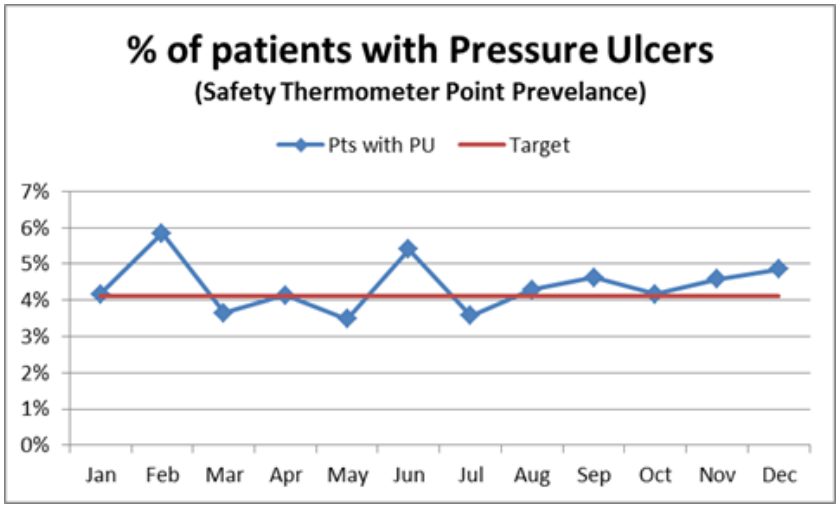
Current Performance



So far we have failed to achieve a sustained improvement in the overall Trust harm free care rate.



Pressure ulcers have consistently made up the largest proportion of harm; this is in line with other Trusts reported data, the specific CQUIN's target is still to be met.



Improvement Plans for next 3 Months	The focus around Safety Thermometer over the next 3 months will be to continue to validate the data around pressure ulcers and ensure everything has been done to achieve the CQUIN Target. Once details of the contract are known planning work will take place to ensure the Trusts can continue to deliver this data monthly. • Because we have not yet met the specific target the team will continue to verify every ulcer reported in hospital. There is also improvement work taking place around pressure ulcers – see pressure ulcers section for more details. • Safety Thermometer will cease to be a CQUIN target at end of March 15. Guidance is awaited regarding requirements to continue to collect data in this way after this date; this will form part of the main contract with our commissioners.

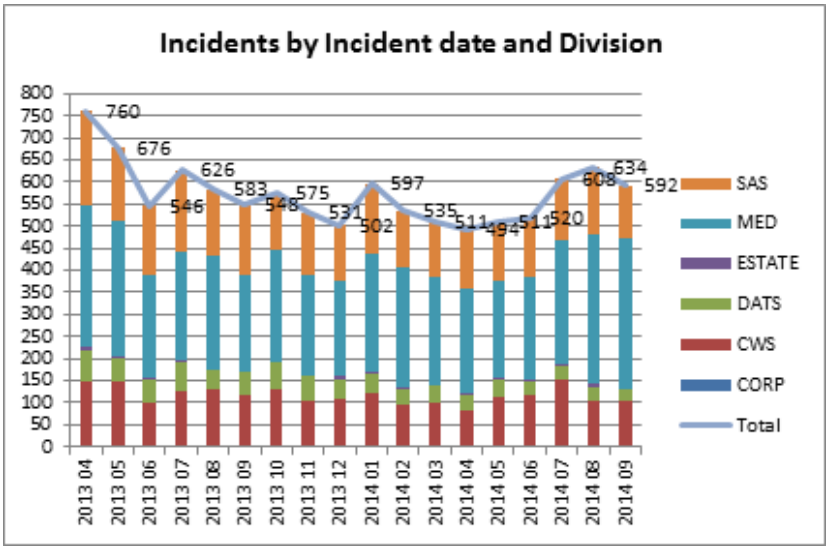
Quality Priority	**Number of Patient Incidents**
Aims and Objectives of Work	The aim of incident reporting is to provide access and opportunity for all staff to identify issues of safety and quality and is a cornerstone of a culture of safety and learning. The Trusts objective is to improve the number of incidents reported by making incident reporting as accessible as possible for staff. Numbers are reported each month to the Patient Safety Group and we aim to improve the Trusts position in the NRLS benchmarking figures produced at six monthly intervals. Open and prompt investigations are essential to improving safety. Key Performance indicators for the review and investigation of incidents and the actions taken are being developed and performance will be monitored through the Safety Committee and quarterly through the Quality Report. Compliance with our Duty of Candour is monitored monthly through the Safety Committee and quarterly through the Quality Report. Performance will be illustrated by Division and Directorate.

Current Performance

Please note Q3 data has not been analysed yet.

In Quarter 2 of 2014/15 a total of 1834 patient related incidents were reported. The numbers of incidents reported each month has remained fairly stable, there was a reduction following the introduction of DatixWeb in Q3 2013

(see table below).



Incidents by Severity and Type

A breakdown of the incidents reported in Quarter 2, by Division and Severity

	GREEN	YELLOW	ORANGE	RED	Total
Corporate	1	0	1	0	2
CWF	239	106	8	2	355
DATS	73	17	0	0	90
Estates and Facilities	12	2	0	0	14
Medical	717	214	12	17	960
SAS	315	85	9	0	413
Totals:	1357	424	30	9	1834

Our top 3 incident areas are:

- Falls
- Staffing levels
- Medication

A full breakdown of the Top 10 incidents are shown in the table.

Suspected fall	341
Lack of suitably trained /skilled staff	309
Fall on level ground	96
Simple complication of treatment	45
Breach of Isolation Policy	37
Hospital Acquired Pressure Sore Grade 2	36
Resulting in 3rd or 4th degree tear	34
Medicine not administered	33
Dose or strength was wrong or unclear	30
Unexpected admission to Neo-Natal Unit	29
Totals:	990

Serious Incidents (Externally Reportable)

In Quarter 2, 18 incidents have been reported to the CCG as serious incidents. A breakdown of the incident type and the number per Division is set out in the table below:

	CWS	MED	SAS	Total
Admitted with Pressure Sore Grade 4	0	1	0	1
Hospital Acquired Pressure Sore Grade 3	0	5	1	6
Hospital Acquired Pressure Sore Grade 4	0	1	0	1
Communication failure within the team	0	1	0	1
Neonatal death	1	0	0	1
Unexpected admission to Neo-Natal Unit	1	0	0	1
Protocols not followed	0	1	0	1
Pressure Sore Grade 3	0	3	0	3
Pressure Sore Grade 4	0	1	0	1
Fall on level ground	0	1	0	1
Suspected fall	0	1	0	1
Totals:	2	15	1	18

	The Trust is required to report all confirmed serious incidents to the CCG within 48 hours of confirmation. A target of 45 days is then set for submission of the investigation report and action plan. Future reports will provide statistics as to our performance against these targets. **Never Events** There have been no Never Events to date in 2014/15. **Serious Hazards of Transfusion** There have been no serious hazards of transfusion reported in Q2.
Improvement Plans for next 3 Months	Actions to be taken over the next 3 months: • A review of the current reporting process is being undertaken and trial of a reduced version will be tested and assessed. Making it quicker and easier to report an incident will increase the rate of reporting. • The report of open SI's is being shared with Divisions on a weekly basis, and divisions are chasing completion, measures are in place to track the impact this has. • A trajectory is being developed for closure of older investigations. • KPI's are being developed to enable performance monitoring of incident management. • The Effective Investigations Group has been created to develop a toolkit, training programme and to review the investigations process overall; aimed at improving investigations to ensure the root cause is identified and appropriate actions taken to address. The focus over the next 3 months will be around designing effective tools and the training programme to support these. Tied in with this work will be improvements to the feedback processes for staff who report incidents, so they can see actions taken as a result – this will aid the aim of increasing reporting.

<table>
<tr><th>Quality Priority</th><th>Adult and Child Safeguarding</th></tr>
<tr><td>Aims and Objectives of Work</td><td>Aims for the work are to:
(i) Safeguard children and vulnerable adults 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
(iii) To ensure that effective multi-agency and single agency training in relation to safeguarding is delivered, with a measurement of outcomes on practice being embedded across agencies</td></tr>
<tr><td>Current Performance</td><td>The table below shows the number and types of referral (Q3 data not yet available).

<table>
<tr><th>Type of Referral</th><th>Q1</th><th>Q2</th></tr>
<tr><td>Adult Concerns reported Acute -Calderdale Category 1</td><td>48</td><td>42</td></tr>
<tr><td>Referrals to Gateway Acute - Calderdale Category 2</td><td>9</td><td>8</td></tr>
<tr><td>Adult Concerns reported Acute - Kirklees 1</td><td>46</td><td>53</td></tr>
<tr><td>Referral to Gateway Acute - Kirklees 2</td><td>13</td><td>12</td></tr>
<tr><td>Adult Concerns reported (community)- Calderdale 1</td><td>26</td><td>53</td></tr>
<tr><td>Referral to Gateway Community Calderdale 2</td><td>5</td><td>8</td></tr>
</table>
Training

Safeguarding training is delivered at level 1, 2 and 3 within the organisation. Level 1 and 2 combined children’s and adults, whilst level 3 is delivered separately. Level 1 is basic awareness training for all staff. Level 2 is face to face training aimed at all staff (clinical and non-clinical) that come into contact with children and adults on a regular basis. Level 3 is aimed at clinical staff involved in safeguarding adults processes.

Level 1 safeguarding continues to be delivered via induction, written updates and briefings across the workforce it is currently at 100%.

Level 2 safeguarding training (adults and children) runs over a 3 yearly cycle. There has been a slight improvement in the uptake of training the Trust position is 51.3% (December 2014).
The trajectory for this has been set by the director of nursing at 95% by the end of March 2015

Level 3 safeguarding children training continues to improve and currently is at 79.3% (December 2014).
The trajectory for this has been set by the director of nursing at 95% by the end of March 2015</td></tr>
</table>

Improvement Plans for next 3 Months	**Key improvement work for the next 3 months includes:** • Safeguarding continues to be a priority within the Trust, with significant developments being made to strengthen and develop partnerships across the health and social care economy. There continues to be representation on all 4 safeguarding boards and sub-groups from CHFT. In Kirklees there is a challenge event planned for the Kirklees Adult Safeguarding Board to provide assurance on how CHFT meets the safeguarding board's standards. This includes partnership working. • Learning from experience and from complaints and incidents is crucial if we are to embrace a culture of openness and transparency. To achieve this the safeguarding team now receives copies of all safeguarding incidents to assist with identifying patterns and trends and facilitating a more integrated approach to managing these. The learning from these is cascaded to staff via safeguarding training and Trust forums. • Training figures are discussed at the patient safety quality boards on a quarterly basis. These are also discussed at the Trust safeguarding committee and operational groups, all of which have divisional representation. Training dates are available on the Trust intranet, with additional sessions being available upon request. • **PREVENT** - Implementation of the PREVENT Strategy is now underway across the organisation, with significant progress being made. There is a full training programme available for 2015, with extra sessions available upon request. CHFT is considered an exemplar site in relation to the number of staff trained. There is a clear training plan in place and there are established links with the Police who respond promptly to any concerns raised. • A recent mock CQC inspection highlighted a lack of awareness across all clinical staff about the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards. All clinical staff should have the 5 statutory principles of the MCA in the forefront of their thinking and at their fingertips when working with adults who lack capacity. • Presumption of capacity • Provision of appropriate help to enable the person to make their own decision as far as practicable • The right to make unwise decisions • Best interests • Least restrictive option A plan is in place to provide simple key message cards to all relevant staff backed up by checks of understanding and ward based support and training by the safeguarding team aimed at application of principles in practice; this work will commence in December 2014.

	• From January 2015 – March 2015 extra funding has been received from NHS England to support focused ward level application into practice.

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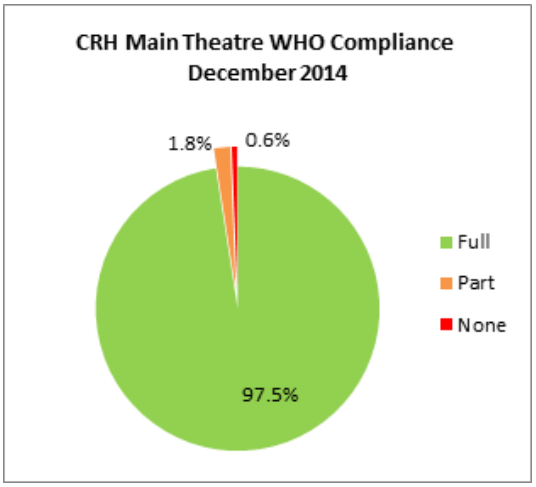
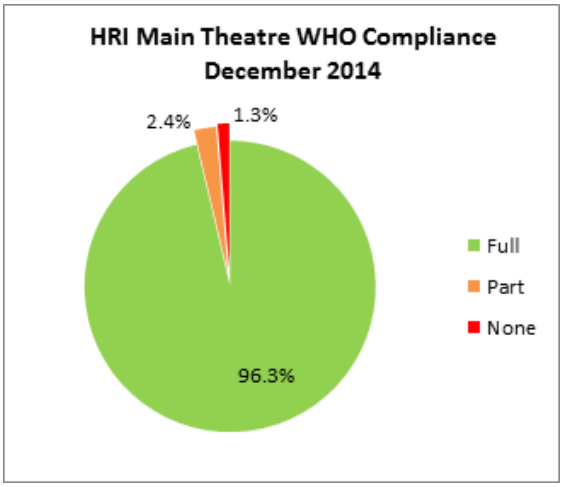
Quality Priority	WHO Theatre Checklist
Aims and Objectives of Work	The aim is to ensure a checklist is completed for all patients undergoing procedures in Theatre. There is a wealth of evidence that if the checklist is completed properly the rate of incidents relating to safe theatre practice will decline.
Current Performance	Improvement is being seen in the WHO checklist compliance, following the installation of the new theatre system which is enabling all data to be captured. There are three stages to the check list these are: • SIGN IN (prior to induction of anaesthesia) • TIME OUT (prior to start of surgical intervention e.g. skin incision) • SIGN OUT (before any team member of the team leaves the operating theatre) Performance is strong with compliance with the first 2 stages of the checklist, but the non-compliance occurs in relation to the post-operative section of the process.  
Improvement Plans for next 3 Months	• Work is on-going to change the culture around the post-operative section of this process. The message is constantly reinforced by review of compliance and timely challenge around the non-compliance, which will lead to an appreciation of the importance of all measures. • The Trust receives a daily compliance report from Bluespier so know exactly which patient had not had a fully completed WHO check sheet. The

	report is sent to the Senior Theatre Sister on both sites as well as Matrons, CD and GM. The band 7 at CRH challenges the theatre teams where there are incomplete check sheets daily. However, on challenging, it appears that in some instances, the third part of the check sheet has been completed, but if not saved and closed appears not to have taken place. This is a training issue that has been addressed with the theatre staff at CRH. This work will take place at HRI over the next 3 months.

Quality Priority	Reduction in unintentional missed doses
Aims and Objectives of Work	The aim for this work is to reduce unintentional missed doses to achieve a target of 5% or less by December 2015. There are specific targets for the CQUIN's scheme around the reconciliation of medication on admission and discharge accuracy checks. For admission the Q4 target is 80%. On discharge the targets are 65% for Q3.
Current Performance	The current level of unintentional missed doses in December 2014 was 8.1% which is an improvement on the September figure of 9.25%. This is measured by a point prevalence audit of all in patients carried out on one day looking at the previous 24 hours. There is concern about the number of missed doses per day for I.V Antibiotics (25) and for Anticoagulants (19) (data collected via the audit as above) and this will be fed back to the wards involved. CQUIN - medicines reconciliation on admission: actual in Nov 2014 was 86%. This target has been achieved and needs to be sustained until March 2015. For discharge checks the performance for Nov 2014 was 71%. The Trust is on trajectory to deliver this CQUIN.

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

Part 6.1 - Reconciliation (Quarterly payment conditional on: Q1-3 70% target. Q4 - 80%
Quarterly payment (£319k total)

Part A: Number of e-discharges checked by Pharmacy with medicines reconciled - numerator	1060	698	639		679	676	650		730	642	645					6419
Part A: The number of patients (admitted for longer than 24 hours) on acute medical wards - denominator	1185	753	733		778	744	736		832	747	759					7267
Part A: Reconcilliation of medicines on admission - total	**89.5%**	**92.7%**	**87.2%**		**87.3%**	**90.9%**	**88.3%**		**87.7%**	**85.9%**	**85.0%**					**88.3%**

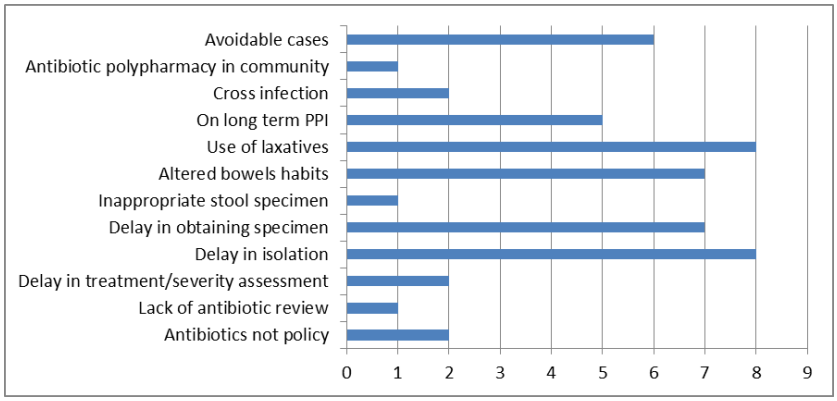
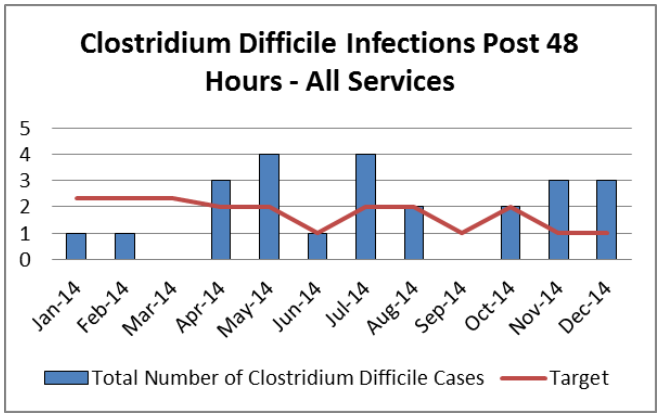
Part 6.2 - Discharge Accuracy Checks (Quarterly payment conditional on: Q1 - 55%, Q2- 60%, Q3 - 65%, Q4 - 70%
Quarterly payment (£319k total)

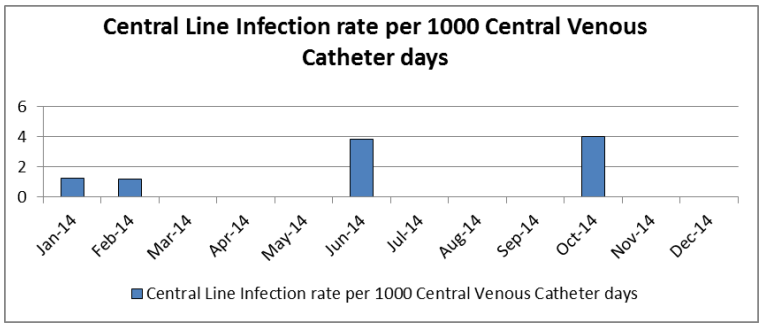
Part B: The number of patients (admitted for longer than 24 hours) on acute medical wards having their e-discharge prescription approved and reconciled against the inpatient prescription chart by a pharmacist - numerator	1185	753	733		778	744	736		832	747	759					7267
Part B: The number of patients (admitted for longer than 24 hours) on acute medical wards - denominator	1826	1200	1106		1141	1104	1073		1179	1057	1093					10779
Part B: Discharge Medication - total	**64.9%**	**62.8%**	**66.3%**		**68.2%**	**67.4%**	**68.6%**		**70.6%**	**70.7%**	**69.4%**					**67.4%**

Improvement Plans for next 3 Months	• The number of missed doses due to poor record keeping (the number of ticks, crosses and blanks) has improved from 386 in Sept 2014 to 338 in Dec 2014 but remains high in comparison with 145 in June 2014. Improvement work in the next quarter will focus on record keeping, details will be presented to the exemplar ward committee and links made to improvement work being undertaken around bedside handover and senior nurse checks. • Issues around the transfer of medicines when patients move from one ward to another has been identified through the missed doses audits, incidents reports and activity follows. This has shown that green transfer bags are not being used reliably, resulting ultimately in delayed/missed doses and in some cases medications having to be re dispensed. The medicines specialist nurse is undertaking some focussed work on barriers to reliable medications transfer over the next month. • Observation work carried out has highlighted the time taken to mix Tazocin (an IV antibiotic) on the wards. The pharmacy team have explored the possibility of purchasing the drug ready mixed but it is not possible to source the quantities required. An alternative solution is going to be tested (a docking device) which will make the mixing of the drug less time consuming for ward staff. 2 wards are going to test the product over the next month so a decision can be made. • There is an on-going issue with delays caused to IV drug administration due to waiting for patients to be cannulated. Solutions to this issue are being explored currently.

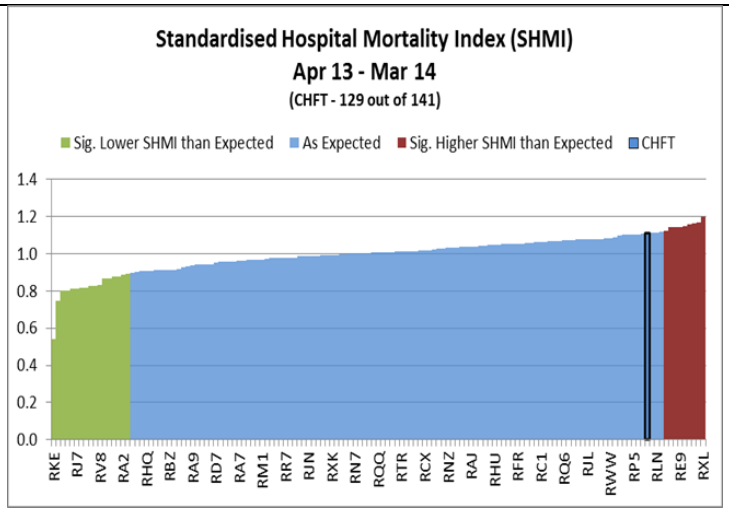
Domain 2 – Effective: Peoples care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence

Report for Q3 2014/15	Indicator Source	Quarter Threshold	Quarter Actual	YTD Threshold	Trust Actual	Year End Forecast
Number of MRSA Bacteraemias	National	0	0	0	0	
Total Number of Clostridium Difficile Cases	National	5	5	15	19	
Avoidable Number of Clostridium Difficile Cases	National	3	2	11	6	
Unavoidable Number of Clostridium Difficile Cases	National	5	3	15	13	
Number of MSSA Bacteraemias - Post 48 Hours	National	6	4	18	7	
% Hand Hygiene Compliance	Local	95%	99.8%	95%	99.82%	
MRSA Screening - Percentage of Inpatients Matched	Local	95%	95.97%	95%	95.94	
Number of E.Coli - Post 48 Hours	Local	6	10	18	17	
Central Line Infection rate per 1000 Central Venous Catheter days	Local	1.5%	2.23%	1.5%	0.97%	
Emergency Readmissions Within 30 Days (With PbR Exclusions)	National	7.5%	6.8%	7.39%	7.28%	
Local SHMI - Relative Risk - (1yr Rolling Data)	National	100	111	100	111	
Hospital Standardised Mortality Rate	National	100	102	100	102	
Crude Mortality Rate	National	1.25%	1.36%	1.22%	1.22%	*Against last years rates*
Average Diagnosis per Coded Episode	National	4.9	4.03	4.9	4.05	

Quality Priority	Infection Control
Aims and Objectives of Work	For Clostridium Difficile the target to end of March 2015 is 18 cases. For central lines the Trust aspires to achieve a rate below 1.5 per 1000 catheter days. There is a 0 tolerance for MRSA bacteremias.
Current Performance	C. Difficile - We have breached our target for this year (19 cases vs a ceiling of 18). Root cause analysis (RCA) for all cases have been undertaken: 6 have been classed as avoidable, 13 as unavoidable. A summary of contributory factors from these investigations is below.   Hand Hygiene observed from real time monitoring (RTM) data shows a reduction in compliance in the first 5 months of the year. MRSA screening compliance continues to be above the target of 95%. Compliance with cleaning is in line with the national specifications standard and cleaning Scores remain high for all areas of the trust. For central lines the cumulative infection rate is currently at 1.02 per 1000 catheter days, this exceeds the Trusts internal target of 1.5 per 1000 catheter days.

	
Improvement Plans for next 3 Months	• From the C. Diff RCA investigations a theme emerged around the timeliness of isolation. Focused work is being planned with the patient flow team monitoring the time requested for isolation to actual isolation of the patient. The aim is to provide a baseline understanding of time taken to isolate patients that will enable accurate reporting against the 2 hour target and a better understanding of the issues so improvements can be planned. • The drop in hand hygiene compliance earlier in the year has now improved; further work around the 5 moments for hand hygiene and peer review observations of compliance are planned for the next quarter. This work is to be developed through the HAI operation group. • Through the CVAD (central vascular access device) steering group improvement work continues to reduce the risk of infection from CVADs. This includes review of the CVAD pathway, training and competency framework and the appropriate lines inserted are both timely and utilising the best practice.

Quality Priority	Mortality Rates
Aims and Objectives of Work	**SHMI – Standardised Hospital Mortality Index** The Standardised Hospital Mortality Index (SHMI) is published each quarter 6 months in arrears. The Trusts aim is to reduce the SHMI to 100 between January and December 14 (data will be published in June 2015) is the primary outcomes aim of the Care of the Acutely Ill Patient programme (CAIP).
Current Performance	The SHMI for April 2013 to March 2014 is 111.11 which Ranks the Trust as 129th out of 143 comparable trusts as defined by the Health and Social Care Information Centre (HSCIC). A further release of data is expected at the end of January 2015.

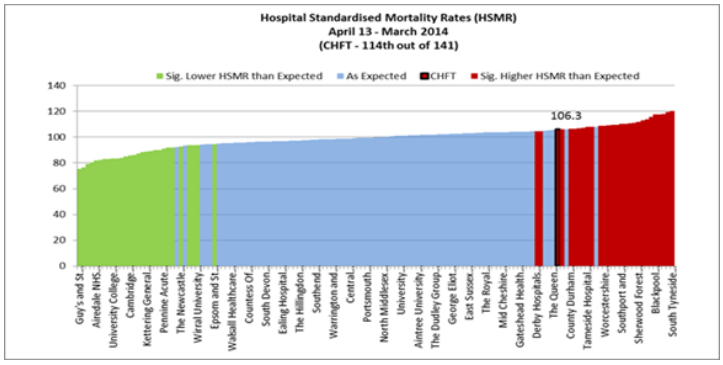


Other measures of Mortality

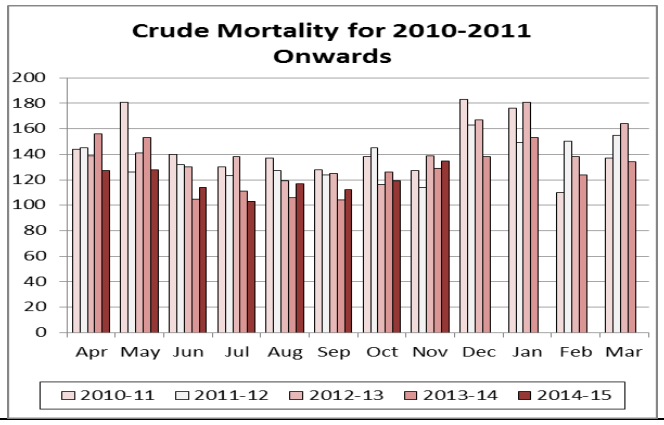
Because of the delayed availability of SHMI data the CAIP programme also tracks Trust performance against other key mortality metrics, Hospital Standardised Mortality rates (HSMR) and Crude Mortality.

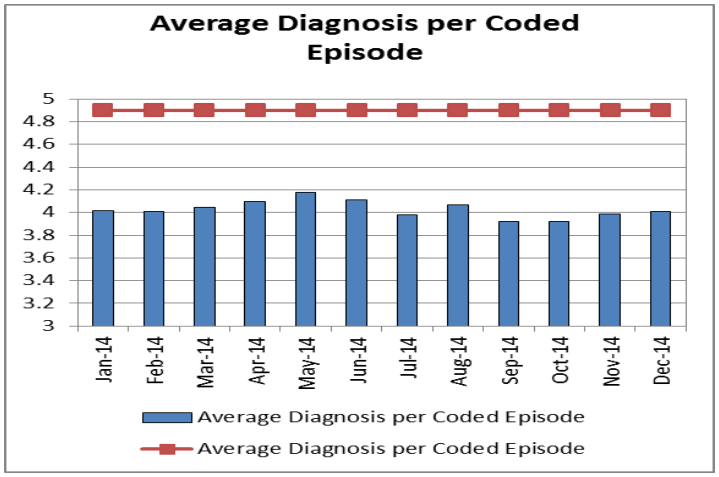
Using these other measures enables the Trust to track likely SHMI scores. The chart below shows that since January 2014 we are beginning to see the gap between ourselves and the national narrowing.

HSMR rebased: The 2013/14 rebased score is now available and shows a rolling 12 month rate of **106.03**. This ranks the Trust as 114th out of 141 **Trusts.**



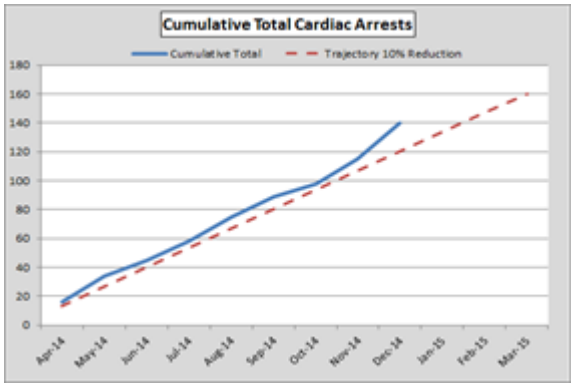
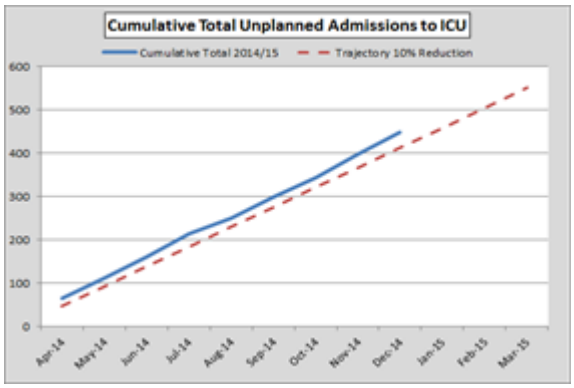
Crude Mortality



	Average Diagnosis per Coded Episode Because it is understood that the capture and coding of appropriate co morbidities for patients has a major effect on relative risk and therefore expected number of deaths for the population, ensuring depth and accuracy of coding is one way to ensure SHMI and HSMR are as accurate as possible. Investigations undertaken show that the Trusts average diagnosis per coded episode is less than for other comparative Trusts, this is having a detrimental effect on relative risk scores such as SHMI and HSMR. 
Improvement Plans for next 3 Months	**I**mprovement Work is being delivered primarily through the Care of the Acutely ill Patient programme, this has been running since November 2013 and was revised in September 2014 and now consists of 8 themes: 1 Reducing Mortality (Overall outcome measures) 2 Ensuring the recognition and prompt treatment of our deteriorating patients. 3 Delivering high standard of care through reliable delivery of care bundles. 4 Frailty 5 Effective (focus on the Courage to Put Patient First programme). 6 Focus on SHMI Conditions of Interest 7 Well Led Organisation 8 Coding These themes have detailed actions plans in place. Performance management against these is carried out by the Clinical Outcomes Group.

	Improvement in the depth of coding: There is a detailed coding action plan (theme 8 of the CAIP programme) being implemented. This action plan focuses on 2 areas for improvement: • Ensuring clinicians document all relevant co-morbidities so they can be captured by clinical coders by the introduction of mandatory comorbidity capture sheets. • Ensuring the accuracy of clinical coding by ensuring the team is properly resourced and the case note is complete before coding happens. CHFT depth of coding is lower than the peer group meaning it has more patients with fewer diagnostic clinical codes than the peer group. This may be as a result of missed relevant comorbidities identified within coding source documentation. The content and quality of the case note may also play a part - incorrectly filed sheets or case notes that aren't complete with all documentation at the time of coding. Detailed actions for the next 3 months include: ● Roll out of co morbidities proforma into other areas also scheduled to take place in from the beginning of January 15. ● Start recruitment process for coders Jan 2015 ● Work on HRG NZ patients to be completed by April 15 ● External visit to Salford to take place ● Ensure SAS breakthrough event takes place, scheduled for Jan 26th and 27th. Clearly define actions as a result. ● Monthly audit of compliance with form will take place from mid-January Early work on comorbidity documentation is starting to show improvement in this key measure as demonstrated by focussed work with the Rheumatology, Gastroenterology, Haematology and Oncology teams.

Quality Priority	**Deteriorating Patients**
Aims and Objectives of Work	The aim of reducing mortality and harm is closely linked and driven by the deteriorating patent work. The ability to detect and then respond quickly to patients who are deteriorating is the key to improving clinical outcomes. The aim of the work is to reduce Cardiac Arrests & Unplanned admissions to

	ICU by 10% by October 2015.
Current Performance	The charts below show performance against the trajectories set, for both key outcome measures these improvements have not yet been realised.  
Improvement Plans for next 3 Months	The focus for the work over the next 3 months will be to implement nerve centre onto the pilot wards ready for roll out and ensure the response teams are able to respond to the predicted increase in demand. More detailed actions over the next 3 months include: • The move to 'Nerve Centre' (the electronic observations and escalation system) is a key intervention for the work. Implementation will commence February 9th on 2 pilot wards; a roll out plan will be followed for other clinical areas. A team of staff has been recruited to support this work on the wards. In preparation for the start date this team are collecting some baseline data so improvements can be shown, working with the initial wards to identify any potential process barriers (PAS ward transfers etc.) and getting ward staff trained and ready for implementation. • The second action is focused on ensuring escalation response teams are correctly organised to respond to deteriorating patents. Having this in place and working effectively is the key to 'Nerve Centre' delivering the improved outcomes predicted. Gaps have been identified and a workshop has taken place to understand these better and discuss other models of care. Initial focus for the next 3 months will be around

	ensuring hospital at night is resourced and working effectively, this will tie in with the launch of the hospital at night model as part of 'Nerve Centre'. • The third action is around appropriate and timely end of life care decisions. Ensuring goals of care are discussed and understood by patients, clinical teams and carers will help ensure appropriate interventions. The introduction of the individualised care of the dying document (ICOD) and work as part of this year's end of life CQUIN (training clinical teams for end of life planning) will help re-enforce this aim.

Quality Priority	**Improving the reliability of care using Care Bundles**
Aims and Objectives of Work	Care bundles are a group of evidence based actions that when delivered are proven to lead to improved clinical outcomes supporting the Trusts high level aims to reduce harm and mortality. Presently there are 5 care bundles included in this work: • Sepsis • Acute Kidney Injury • COPD • Community Acquired Pneumonia • Asthma in patient and A&E attenders Heart failure is in the process of being designed and tested and will be included. 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. Once this has been achieved the work will support the introduction of other care bundles.
Current Performance	Current performance – this data is collected by the clinical audit team and focuses on uptake and whether the stickers are being completed. Leads conduct more detailed audit of compliance with the individual elements. The heart failure bundle is in early design; it is yet to be thoroughly tested.

3. High standards of care through reliable delivery of care bundles	Asthma - Bundle Started	95%	22%	95.0%	TBC	Patients who had a bundle in the notes
	Asthma - Bundle Completed	95%	100%	95.0%	TBC	Number of bundles which were complete
	AKI - Bundle Started	95%	0%	95.0%	TBC	Patients who had a bundle in the notes
	AKI - Bundle Completed	95%	n/a	95.0%	TBC	Number of bundles which were complete
	Sepsis - Bundle Started	95%	90%	95.0%	TBC	Patients who had a bundle in the notes
	Sepsis - Bundle Completed	95%	85%	95.0%	TBC	Number of bundles which were complete
	COPD - Bundle Started	95%	50%	95.0%	TBC	Patients who had a bundle in the notes
	COPD - Bundle Completed	95%	50%	95.0%	TBC	Number of bundles which were complete
	Pneumonia - Bundle Started	95%	100%	95.0%	TBC	Patients who had a bundle in the notes
	Pneumonia - Bundle Completed	95%	0%	95.0%	TBC	Number of bundles which were complete
	Heart Failure	Design Phase				

Despite these care bundles being in place for around 3 years they have still not been reliably implemented. Work has been undertaken to ascertain the causes for this, namely:

- Fast turnaround of junior medical staff making it difficult to ensure key messages around bundles and their use are communicated.
- Confusion re which bundle to prioritise
- Duplication and contradictory actions across the bundles in use.
- Lack of real time data around implementation so poor compliance can be challenged.

Asthma – A&E attenders

Data is collected via a different route for CQUIN requirements.

Bundle Complaint Q1	**33**	**50**	**66.0%**	Q2	**36**	**50**	**72.0%**

Targets have been met for Q1 and Q2. Data has yet to be collected for Q3.

Community Acquired Pneumonia (CAP)

As above there is also a separate CQUIN requirement for CAP. The target is to have achieved 55% compliance by Q4.

Data is yet to be finalised for Q3, compliance for Q2 is as bel

Measure (n=60)	Frequency	%
CURB 65 Score documented	54	90%
Prescribe antibiotics according to CURB 65 score and local guidance	46	77%
Assess SpO2 and perform ABGs if SpO2 <94% on air	57	95%
Chest x-ray done	60	100%
Overall Bundle Compliance	28	47%

Improvement Plans for next 3 Months

The focus for the care bundle work over the next 3 months is to aid staff to use care bundles effectively as part of the admission process.

- The focus of the work moving forward is to implement a document that takes staff through the thought process re which bundle to use, reduces duplication and pulls some bundle elements together. This document is now in its second version and will be tested throughout January 15.
- A communications campaign to support this decision making tool.
- The clinical audit team is collecting point prevalence data on the wards re initiation and completion of the bundles, this information is now available at ward levels and data will be to fed back to clinical teams via divisional routes.
- For Sepsis it is known that there will be national CQUIN for 2015-16. The detailed guidance is awaited but as soon as released an action plan will be designed to plan necessary work to meet compliance.
- There is a separate CQUIN target for patients attending A&E (not admitted) with Asthma, The target for this CQUIN is 70% Q3 and 75% Q4. Data is still to be collected for Q3. On-going improvements include close scrutiny of the data for non-compliance, this is challenged. There is education around Asthma care provided in both A&E's, picking up all new starters and re enforcing good practice.
- For the CAP bundle the data will be discussed at the pneumonia collaborative where detailed actions will be agreed. The focus will be on antibiotics as this is the weakest element, the work will test prompts and observe junior doctors in practice to assess for lack of understanding around antibiotics prescribing.

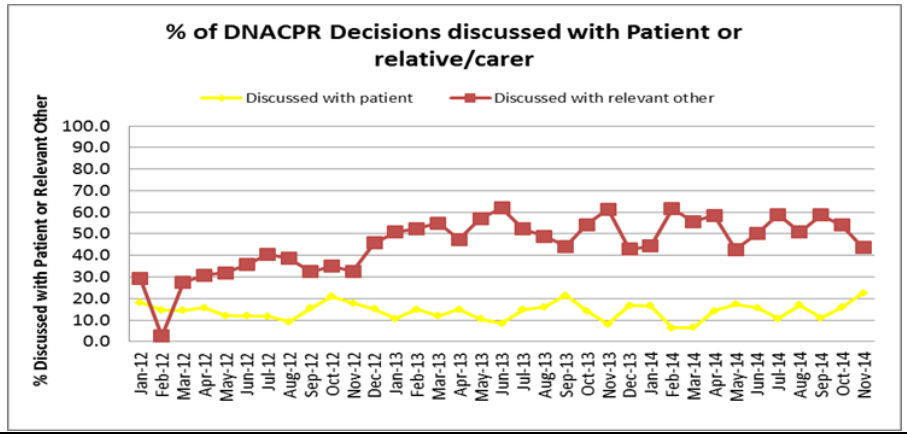
Quality Priority	Clinical Audit
Aims and Objectives of Work	To meet the terms of the Trusts contract we are required to participate in all national clinical audits relating to services we provide. The trust has a robust process in place for ensuring audits take place, reviewing results, agreeing actions where necessary and monitoring the changes put in place as a result.
Current Performance	CHFT are currently participating in 97% of national clinical audits and 100% national confidential enquiries which it is eligible to participate in. Many of the national clinical audits included in the quality accounts process form part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). This programme is managed by the Healthcare Quality Improvement Programme (HQIP). CHFT have not been submitting data to the National Prostate Cancer Audit. The audit was identified very late and problems have been encountered nationally with data collection. Plans are in place to submit data from January 2015. The table below shows progress with the 2014/15 audit programme.

2014/15 programme	Medicine	S&A	CWF	DaTs
Improvement Work / Complete	3	4	6	-
Ongoing	41	62	23	37
Report stage	6	10	6	4
Monitoring / Outcomes	13	-	26	-
Abandoned / On Hold	0	1	0	-
Not started	6	11	2	15
TOTAL 2014-15	**69**	**88**	**63**	**56**
Includes b/fwd from 2013-14	23	7	8	4
Number of audits in each category	**Medicine**	**S&A**	**CWF**	**DaTs**
National Audits	38	32	13	10
NCEPOD studies	3	3	0	-
NICE guidance & Quality Standards	2	15	12	-
CAIP	6	6	NA	NA
Peer Review / Accreditations	5	-	2	19
CQUINS / Outcomes/CQC	6	8	26	-
Independent Audits	9	24	10	27
TOTAL	**69**	**88**	**63**	**56**

NICE

The table below shows the current level of compliance with the technology appraisals / clinical guidelines / interventional procedures from April 2009.

		Technology Appraisals	Clinical Guidelines	Interventional Procedures
	Fully Compliant	107	38	15
	Partially Compliant and working towards full compliance	0	20	0
	Partially Compliant and **not** working towards full compliance	1	19	0
	Non-Compliant	0	0	0
	Awaiting assessment	12	10	4
	Not applicable / Not done at the Trust	31	17	190
	TOTAL	**151**	**104**	**209**
Improvement Plans for next 3 Months	There are no gaps currently identified in the Trusts compliance with national clinical audits and therefore no specific actions are required for the next 3 months, the clinical audit team will continue to ensure audits are completed to timescale.			

Quality Priority	**DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation)**
Aims and Objectives of Work	This work aims to ensure 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 chart shows the percentage of DNACPR decisions that have been discussed with either the patient or the 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. 

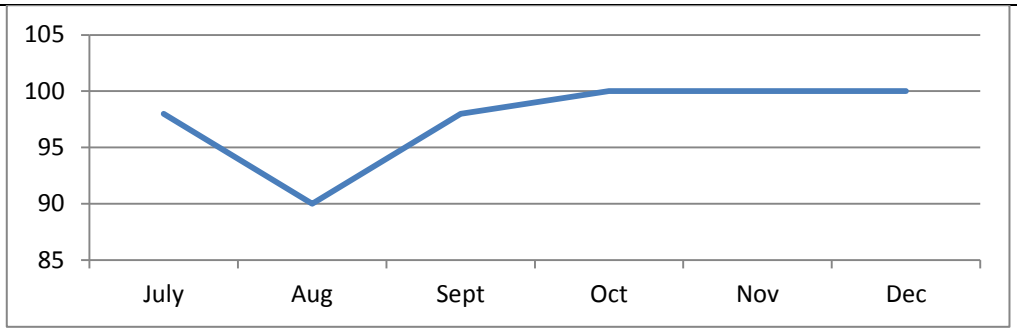
	As demonstrated by the chart the Trust has failed to show any improvement in this process since July 2013.
Improvement Plans for next 3 Months	In light of the recent ruling a meeting has recently take place with divisions representatives to discuss what further actions can take place to lead to improvement. Actions agreed include: • Compliance audit documentation has been updated to capture if both the patient and the family have been spoken to by a clinician regarding DNACPR. This data will be sent to divisions every two months for discussion at their PSQBs. A new decision algorithm has been added to the revised resuscitation policy. • DNACPR status is included as part of the handover module of the new electronic 'Nerve Centre' platform. Rollout starts in February 15 but it won't be in place everywhere for around 8 months. • Work with the intensivists regarding the decision making process in relation to patients not suitable for escalation to ICU. Intensive care consultants have been briefed about a process for flagging up the need for DNACPR and family discussions. • Outreach staff and other specialist nurses to support conversations where the parent team are struggling to meet with family members (and consent allows). • Point prevalence audit will be carried out on14th January to provide baseline data of all patients with a DNACPR decision and provide detailed reasons for non-discussion so necessary actions can be planned.

Domain 3 – Experience (Caring): Staff involve and treat people with compassion, kindness, dignity and respect

	Qrt Trust Threshold	Quarter Actual	YTD Threshold	Trust Actual	Year End Forecast
Number of Mixed Sex Accommodation Breaches	0	7	0	7	
% Complaints closed in the quarter within target timeframe	100%	19%	100%	28%	
Total Complaints received in the quarter	-	129	-	454	
Number of Patients Surveyed (RTM) - (Quarterly)	-	456	-	1772	
Overall, How would you rate the care you received? (RTM)	-	8.9	-	9	
Found Someone on the Hospital Staff to Talk to About Worries/Fears (RTM)	-	9.1	-	8.9	
% RTM Responses That are on or Above Target (Quarterly)		59.3%		66.7%	
Friends & Family Test (IP Survey) - Response Rate	30%	43.9%	30%	39.9%	
Friends & Family Test (IP Survey) - % would Recommend (new)	-	95.8%	-	96.4%	
Friends & Family Test (Maternity Survey) - Response Rate	-	24.5%	-	21.8%	
Friends & Family Test (Maternity Survey) - % would Recommend (new)	-	93.6%	-	92.8%	
Friends and Family Test A & E Survey - Response Rate	20%	16.0%	20%	21.1%	
Friends and Family Test A & E Survey - % would Recommend (new)	-	88.9%	-	88.4%	
Percentage of non-elective inpatients 75+ screened for dementia	90%	96.1%	90%	96.1%	

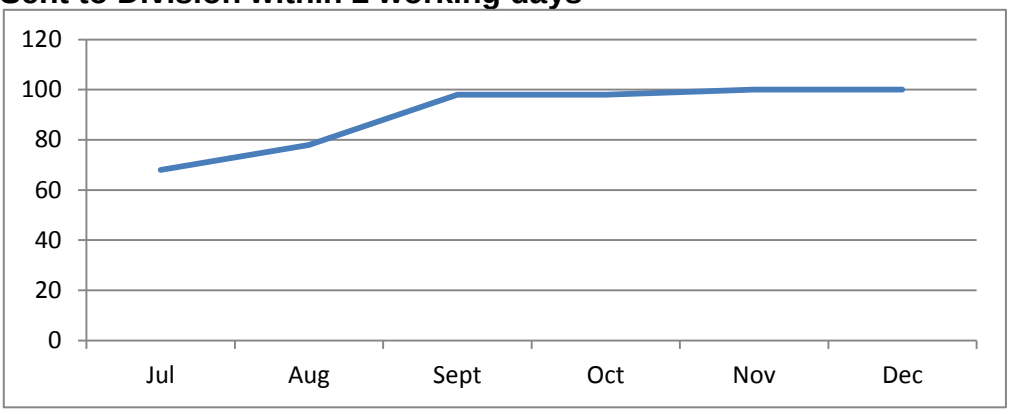
Quality Priority	Mixed Sex Accommodation
Aims and Objectives of Work	To ensure there are no mixed sex breaches for in patients on clinical areas.
Current Performance	There were 7 mixed sex breaches reported in Q3.
Improvement Plans for next 3 Months	The breach was investigated and related to 1 lady admitted to a bay containing 6 men, this was on a specialist coronary care unit, and there were no other suitable specialist beds available at the time. The process is that within 4 hours the patient needs to have been moved. The guidance has been recirculated and highlighted in the patient flow team.

Quality Priority	Complaints Process
Aims and Objectives of Work	The aim of effective handling of concerns and complaints is to provide a responsive service to people who raise issues; whilst using the issues raised to improve the service we provide. Responding openly and promptly to issues raised is measured by monitoring of key performance indicators reviewed monthly through the Patient Experience and Caring Group and quarterly through the Quality Report. Performance will be illustrated by Division and Directorate. Through thematic analysis of the issues being raised, areas of action being taken will be identified and reviewed.
Current Performance	**Key performance Indicators** **Acknowledgement of Complaints within 2 working days**



In Q3 100% of complaints were acknowledged within the performance measure of 48 hours.

Sent to Division within 2 working days

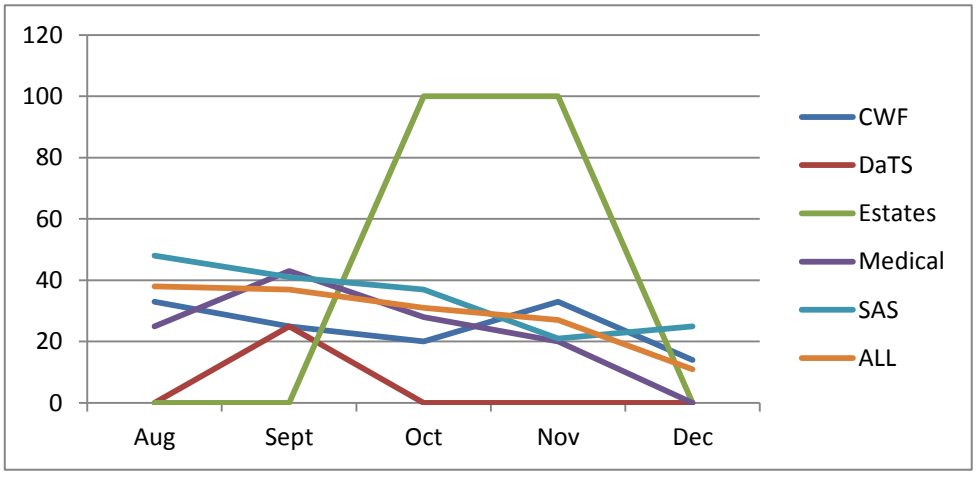


In Q3 98% of complaints were sent to Divisions within the performance measure of 48 hours.

Contact with Complainant Documented – collection of data still under development

Reviewed in 48 hours – collection of data still under development

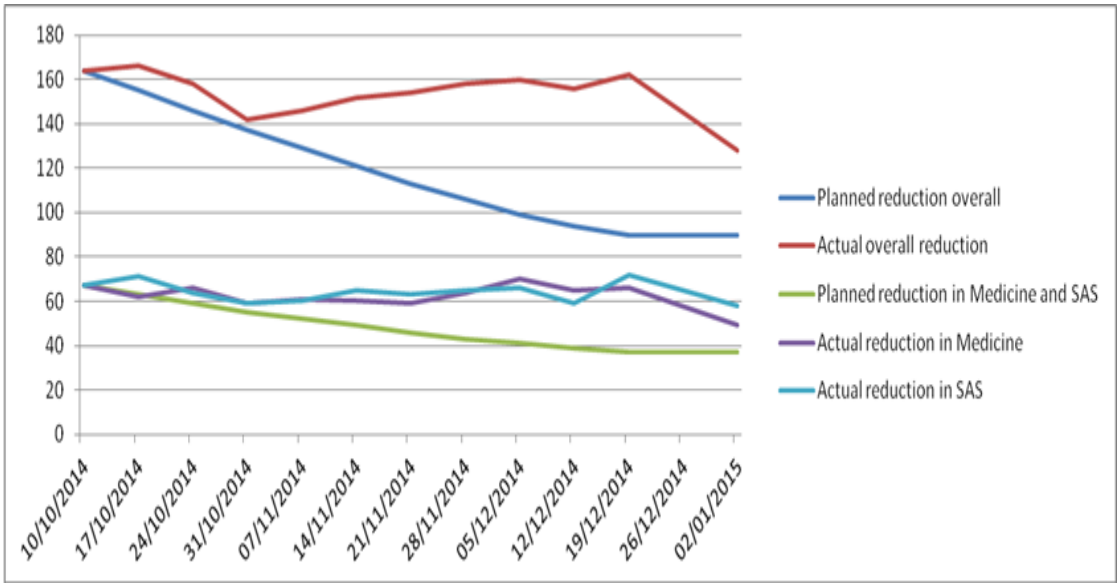
Responded within Timescale (maximum of one extension)



Response Performance	AUGUST		SEPTEMBER		OCTOBER		NOVEMBER		DECEMBER	
CLOSED	Nos	% in Target	Nos	% in Target	Nos	% in Target	Nos	% in Target	Nos	% in Target
CWF	15	33	8	25	20	20	6	33	7	14
DaTS			4	0	1	0			7	0
Estates	1				1	100	2	100	0	0
Medicine	12	25	13	43	25	28	10	20	26	0
SAS	25	48	16	41	42	37	19	21	24	25
TRUST	53	38%	41	37%	89	31%	37	27%	63	11%

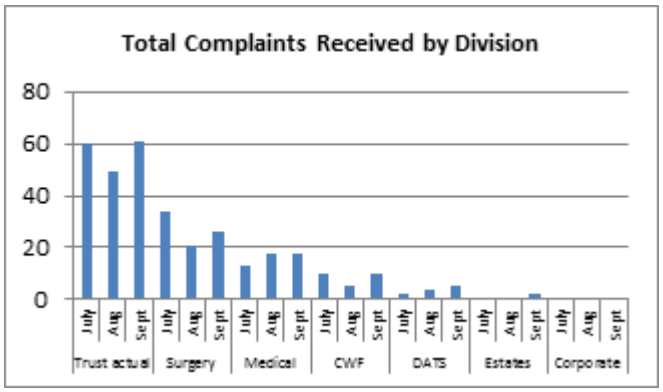
Reduction in Complaints Trajectory

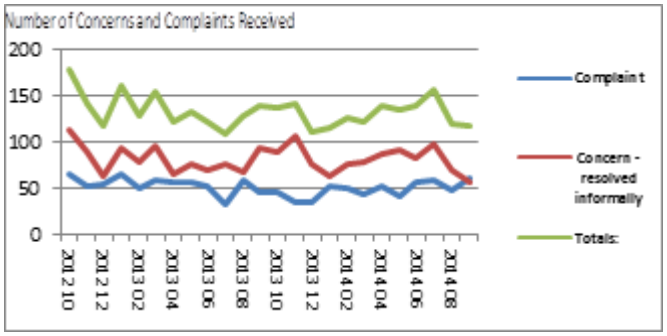
We did not meet our trajectory for the end of December 14, however there was a significant push which as you can see from the trajectory below, some progress has been made.



A revised trajectory has been introduced and escalation systems are being established with Divisional Leads to support zero tolerance for complaints not being resolved within target.

Complaints and Concerns received





The number of complaints and concerns received has remained stable for the past 2 years.

The top three issues being raised as both Complaints and Concerns

	Complaint	Concern	Total
Access, appointment, admission, transfer, discharge	25	88	113
Consent, confidentiality or communication	42	52	94
Treatment, procedure	48	24	72

Communication Complaints and Concerns by Directorate

Top issues in Communication by Directorate	ATTITUDE	CARE	DELAY	COMMUNICATION WITH PATIENT	COMMUNICATION WITH RELATIVES	Total
Acute Medical	2	0	2	8	7	22
Appointments and Health Records	1	0	0	1	0	5
Children's Services	0	1	0	0	0	2
Emergency Network	7	4	2	4	6	30
Facilities	3	0	0	0	1	4
Families Directorate	1	1	0	0	0	2
General & Specialist Surgery	1	2	1	6	1	17
Head & Neck	3	1	1	5	0	13
Intermediate and Community	3	0	0	0	0	5
Integrated Medical	3	0	2	4	0	10
Operating Services	1	0	0	2	0	6
Orthopaedic	1	1	1	1	0	9
Pathology	0	0	0	0	0	1
Radiology	3	0	0	0	0	3
Women's Services	5	4	0	6	0	19
Totals:	34	14	9	37	15	148

Access and treatment Concerns by Directorate

Main issues in Access, Appointment by Directorate	ACCESS	CANCEL	DELAY	Total
Acute Medical	3	5	4	19
Appointments and Health Records	2	4	2	11
Emergency Network	0	0	1	10
Families Directorate	0	0	0	2
General & Specialist Surgery	2	2	11	25
Head & Neck	2	5	8	19
Intermediate and Community	2	1	6	11
Integrated Medical	3	5	4	17
Operating Services	0	0	1	2
Orthopaedic	3	0	4	14
Radiology	0	1	1	2
Womens Services	0	1	1	5
Totals:	17	24	43	137

Top issues in Treatment by Directorate	STANDARD OF CARE	DELAY
Acute Medical	3	1
Childrens Services	1	0
Emergency Network	15	4
Families Directorate	1	0
General & Specialist Surgery	4	5
Head & Neck	2	0
Intermediate and Community	2	1
Integrated Medical	0	3
Operating Services	1	0
Orthopaedic	4	1
Pathology	0	0
Womens Services	8	0
Totals:	41	15

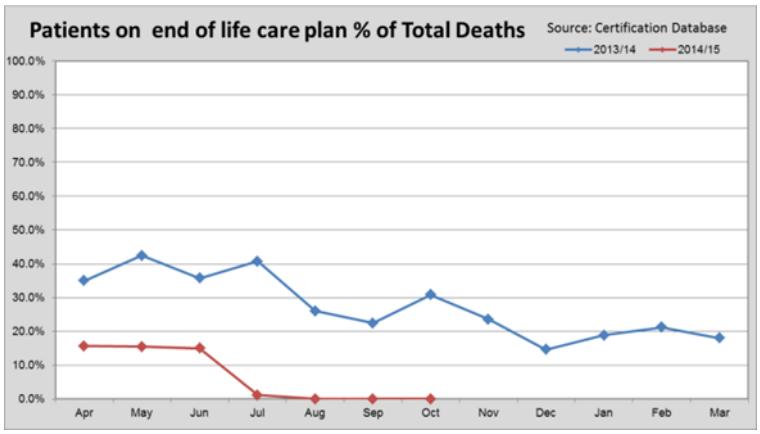
Improvement Plans for next 3 Months	Complaints process improvements over the next 3 months: • A trajectory was established aiming by mid-December to have reduced the number of open cases to 90; this trajectory has not been achieved. A new fortnightly complaints report has been developed which will be sent to Divisions to provide actions for the complaints outside ongoing outside target. This will be sent out every two weeks to arrive first thing on Monday mornings. • In addition 'Plan for every Complaint' has being introduced; this will help operationally mange the process and understand where barriers and delays exist so they can be addressed. Escalation processes are being agreed with Divisional Leads to ensure that the delays and barriers identified in the Plan for Every Complaints are addressed.

Quality Priority	**Patient Reported Experience**
Aims and Objectives of Work	The aim of this work is to ensure we have up to date information relating to our patent experience, this information is used for focused improvement work.
Current Performance	**Real Time Patient Monitoring (RTPM)** The Trust has scored green (equivalent to top 20% of Trusts nationally) for the 2 RTPM questions listed. A local target has been set for 20 of the 27 questions asked to have a RAG rated 'green' score - this equates to 74%. This has not been achieved for Q3. All improvement work is being driven through the patient experience group. **Friends and Family Test (FFT):** **Inpatients:** Whilst the response rate is consistently above the nationally set threshold continued importance is being giving to further increasing this. The current response rate indicates a likely achievement of the Q4 CQUIN target (30%), and we are also in a favourable position to achieve the stretch target of 40% for any month during Q4. The Trust position for December 14 is 40.6%. **Maternity:** Whilst there are no CQUIN requirements for maternity, there is significant emphasis being placed on improving the response rate and the percentage that would recommend across all four maternity touch points.

	A&E: There was a further drop in the A&E performance for response rate in December (4.5%). This takes the Trust significantly below the Q4 target of 20%. This is attributed to the change I process (removal of tokens) on both sites. **Outpatient FFT**: went live on 16th October 2014, currently using a text messaging option. Reporting has commenced.
Improvement plans for next 3 Months	**Friends and Family Test (FFT):** **Maternity:** Recent result have shown particular concern for postnatal community services, current work centres around ensuring that woman are aware that this particular touch point is about post natal care and not anything experienced in hospital. Feedback also highlights their desire to have more details around when they can expect a post natal visit and whether they can see the same midwife as their antenatal care to increase continuity. Each community midwife has been issued with an A5 laminated card to carry with them in their diary and have been asked to use these to engage with the women during their postnatal care. Also to advise women that they will receive a text at 10 days following their discharge from hospital and to ask them to focus on their postnatal community care when responding to this text. The aim is to give the midwives more opportunity to promote the text and encourage completion of the card. **A&E:** The deadline for removing the tokens is April 2015; This has taken place on both sites and has resulted in a drop in response rate as above. This is a significant challenge for the Q4 CQUIN target of 20% Q4. A number of actions have taken place to increase engagement with both staff and patients: - A document has been produced and distributed to all staff members, this reminds them of what FFT is about and informs them of their roles and responsibilities re the FFT - a presentation has been developed to share with staff in order to generate team discussion re how the department can work together to influence improvement - Posters have been designed and will be going into each of the treatment rooms – these will give the clinical staff the opportunity to further promote the test with patients, there is an image of the card on the poster and shows some you said, we did examples. There will be a supply of postcards in the rooms in case patients weren't issued one at reception **Community:** discussions have taken place regarding the engagement plan with community settings; aiming to start using FFT from 19th January 2015.

Quality Priority	Dementia
Aims and Objectives of Work	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
Current Performance	The dementia assessment is completed by the doctors on the ward for patients age 65 and over. This is a 3 part process which each part must achieve 90%. • Part 1: How many patients have been asked the following question "Has the person been more forgetful in the past 12 months, to the extent that it has significantly affected their daily life?" If the answer is yes, part 2 must then be completed. • Part 2: For patients that were yes in part 1, an abbreviated mini mental test score (AMTS) must be completed. • Part 3 For those patients that had an AMTS score of 8 or below they must now be referred to their GP We consistently achieve 90% or above in each element. The assessment is included in the clerking in document. The assessment is then included as a mandatory field on the electronic discharge system with the option to refer those appropriate back to their GP for further assessment. Doctors are trained on induction for the dementia assessment. Senior nursing staff have had vulnerable adult training which includes this process, and they provide leadership on the ward areas to ensure this is completed. Other key Achievements: Assessment and diagnosis integral to EDS and embedded in practice Dementia matron employed by mental health trust 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 champions

Improvement Plans for next 3 Months	Over the next 3 months focus will be on: • Maintaining compliance with all 3 aspects of the CQUIN • Vulnerable adult agenda – new team structure to be introduced • Person centred dementia training • Butterfly scheme in place on all relevant adult wards, supported with training • Person centred care assessment tool to facilitate person centred care • Prevention of delirium pathway included in nursing documentation • Recruitment of volunteers – 60 new students currently receiving training and induction • 3 Engagement and Care Support workers appointed on wards 19 and 20. • MYLIFE software to promote social engagement – pilot on ward 19. 4 units now in use and available on both hospital sites • Dementia friendly ward and department refurbishments and upgraded

Quality Priority	**End of Life Care**
Aims and Objectives of Work	Improve end of Life care
Current Performance	The number of patients who died whilst being supported by an end of life care plan - The Liverpool Care Pathway (LCP) was withdrawn from use in July 2014 following an independent review, published in July 2013. The individualised Care of the Dying Document (ICODD) has been implemented in the Trust at the beginning of November 2014.  The chart shows a reduction in the Patient who are on an End of life care plan who then go onto die, however this is expected to improve with the introduction of the ICODD.

	The ICODD is a care plan that helps clinical staff who are caring for patients who are dying and in the last hours or days of their lives. It guides them in delivering the best care that they can in order to meet the needs of patients and their families. It should be used when the patient is dying from an irreversible condition, and a decision has been made that the focus of care is now on quality and comfort.
Improvement Plans for next 3 Months	• Education and training to continue in end of life care on respiratory wards to meet Q4 CQUIN target of 90% of staff trained. • Review end of life related complaints using the criteria of death during admission or within 3 months of discharge. Identify any themes. • Continue to monitor use of the ICODD

Domain 4 – Responsive: Services are organised so that they meet people's needs

Report for Q3 2014/15

	Qrt Threshold	Qrt Actual	YTD Threshold	Trust Actual	Year End Forecast
% Non-admitted Closed Pathways under 18 weeks	95.00%	98.70%	95.00%	98.66%	
% Admitted Closed Pathways Under 18 Weeks	90.00%	91.95%	90.00%	91.87%	
% Incomplete Pathways <18 Weeks	92.00%	95.32%	92.00%	95.32%	
18 weeks Pathways >=26 weeks open	0	252	0	252	
% Diagnostic Waiting List Within 6 Weeks	99%	99.51%	99%	98.91%	
62 Day GP Referral to Treatment	85.00%	90.8%	85.00%	90.73%	
62 Day Referral From Screening to Treatment	90.00%	91.7%	90.00%	94.12%	
31 Day Subsequent Surgery Treatment	94.00%	100%	94.00%	98.84%	
62 Day Aggregated GP Urgent Ref To Treat And Screening Ref To Treat	86.00%	90.9%	86.00%	90.75%	
31 Days From Diagnosis to First Treatment	96.00%	99.7%	96.00%	99.49%	
Two Week Wait From Referral to Date First Seen	93.00%	98.4%	93.00%	98.00%	
Two Week Wait From Referral to Date First Seen: Breast Symptoms	93.00%	94.8%	93.00%	95.86%	
A and E 4 hour target	95.00%	92.74%	95.00%	94.83%	
Time to Initial Assessment (95th Percentile)	00:15	00:23:00	00:15	00:20	
Time to Treatment (Median)	01:00	00:18:00	01:00	00:20	
Unplanned Re-Attendance	5.00%	5.04%	5.00%	5.01%	
Left without being seen	5.00%	3.05%	5.00%	2.81%	

Quality Priority	% Diagnostic Waiting List within 6 Weeks
Aims and Objectives of Work	National target for all diagnostics to ensure initial diagnostic tests are delivered within 6 weeks or less. The threshold for performance is >99% in any month. The target was introduced to assist with the delivery of 18 week referral to treatment initiative as diagnostics are integral to the majority of pathways.
Current Performance	The radiology element of the 6 week diagnostic target is on track for the remainder of the year following July, August & September where it fell below the 99% threshold. The latter was mainly due to capacity problems within the MRI service.
Improvement Plans for next 3 Months	Additional mobile MRI capacity secured for the remainder of the financial year to ensure monthly performance at > 99%. At an operational level monthly capacity & demand meetings are held within radiology to track performance across all modalities & ensure corrective actions are put in place to avoid any breach of the target.

Quality Priority	Cancer Pathways
Aims and Objectives of Work	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. • To see Fast Track patients within 7 days • To provide diagnostics tests within 7 days • IPT by day 38 • Commence treatment of patient by day 62 • 31 Day Subsequent Surgery Treatment
Current Performance	All Pathways are meeting their targets All the MDT's have been working hard to improve pathways of care for patients. The improvement for first appointment to be seen in 7 days has been particularly impressive and has helped to speed the patient journey along; the Trust is at present the best within the West Yorkshire network. Unfortunately the 7 days to Diagnostics target which was an aspiration of WEB has not been successful yet. The Trust has issues meeting the target of referring 85% of patients to Tertiary centres by day 38 of their pathway. For November 70% was achieved which is excellent progress from baseline.

Improvement Plans for next 3 Months	• Re 7 days to diagnostics - work has been undertaken with the DATS division regarding this issue and they are working hard to change their systems and processes. However at present the Trust is achieving the target, by micromanagement of patients. • For referral to tertiary centres any patient who is not sent by day 38 is now discussed and a pathway provided to see what the hold ups are. As a Trust we have sent an action plan to Leeds to say we will achieve this by March 2015 and to enable this to happen the 7 days to Diagnostics (inc Endoscopy) would need to be implemented.

Quality Priority	**A&E**
Aims and Objectives of Work	The required performance against the 4 hour A&E target is 95%. **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. **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. **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. **Time to Initial Assessment:** This is an indicator only for patients brought in via Ambulance. The aim is that 95% of the patients attending via ambulance should have been assessed by a qualified member of staff within 15 minutes of arrival at A&E. **Time to Treatment:** This indicator is measured by the median (middle) time. Aim is that all patients attending the A&E Department should wait no more than 60 minutes.
Current Performance	Q2 saw all A&E targets met, however more recent performance has not seen this success continue. The required performance against the 4 hour wait A&E target is 95%. The performance for quarter 3 is at present 94.23% (03/12/2104) with the first two months of this quarter also not achieving the required performance.

Sep-14		Att Seen < 4 Hrs	A&E Att	4 Hr Targ	Emerg Adm via A&E	% A&E Adms
RCF	Airedale	4024	4178	96.3%	932	22.3%
RAE	Bradford	9570	10038	95.3%	2628	26.2%
RWY	CHFT	10562	11018	95.9%	2091	19.0%
RR8	Leeds	14774	15577	94.8%	5483	35.2%
RXF	Mid Yorks	17195	17885	96.1%	3941	22.0%
		56125	58696	95.6%	15075	25.7%

Oct-14		Att Seen < 4 Hrs	A&E Att	4 Hr Targ	Emerg Adm via A&E	% A&E Adms
RCF	Airedale	4803	5019	95.7%	1115	22.2%
RAE	Bradford	11951	12471	95.8%	3248	26.0%
RWY	CHFT	12885	13739	93.8%	2678	19.5%
RR8	Leeds	18907	20053	94.3%	7023	35.0%
RXF	Mid Yorks	20507	21761	94.2%	4897	22.5%
		69053	73043	94.5%	18961	26.0%

Nov-14		Att Seen < 4 Hrs	A&E Att	4 Hr Targ	Emerg Adm via A&E	% A&E Adms
RCF	Airedale	2864	2958	96.8%	677	22.9%
RAE	Bradford	7205	7726	93.3%	1928	25.0%
RWY	CHFT	7768	8223	94.5%	1631	19.8%
RR8	Leeds	11065	12103	91.4%	4244	35.1%
RXF	Mid Yorks	12477	13026	95.8%	2910	22.3%
		41379	44036	94.0%	11390	25.9%

Top reasons for breaches Sept to November 2014.

Breach reason	% of breaches Sept to Nov 2014
Wait for medical bed	27.4%
A&E majors delay	17.4%
Continuing Care in dept	20.4%
Waiting for medical doctor	6.2%
Waiting for side room	3.4%

A&E Quality Indicators

Unplanned re attendances: The target for this is no more than 5% of A&E attendances should re-attend within 7 days of the original attendance.

September 2014 = 5.05% (600 patients out of 11879)
October 2014 = 4.75% (568 patients out of 11957)

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.

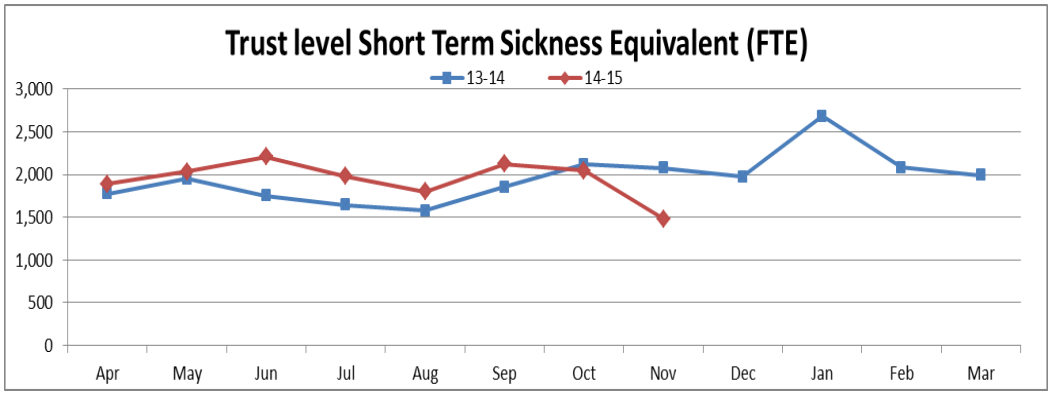
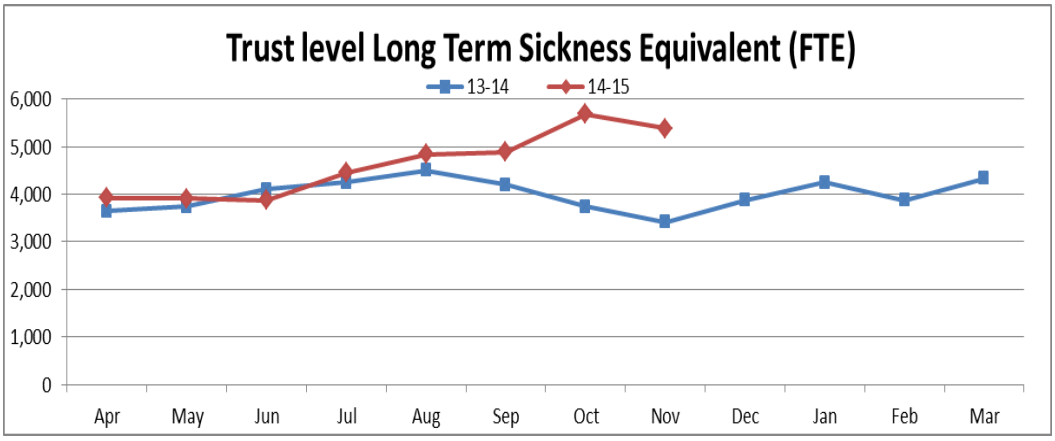
September 2014 = 3 hours and 58 minutes
October 2014 = 4 hours and 47 minutes (93.6% of patients had been

	discharged within 4 hours) November 2014 = 4 hours and 20 minutes (94.6% of patients had been discharged within 4 hours) **Left without being seen:** The target for this is no more than 5% of A&E Attendances should be leaving department without having been treated. September 2014 = 2.58% (306 patients out of 11879) October 2014 = 2.55% (305 patients out of 11957) November 2014 = 2.86% (344 patients out of 11977) **Time to Initial Assessment:** This is an indicator only for patients brought in via Ambulance. Again its measured by 95th percentile and shows 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. September 2014 = 18 minutes (93.1% of patients were assessed within 15 minutes) October 2014 = 21 minutes (90.9% of patients were assessed within 15 minutes) November 2014 = 22 minutes (90.8% of patients were assessed within 15 minutes) **Time to Treatment:** This indicator is measured by the median (middle) time. Of all patients attending the A&E Department, the median time should be no more than 60 minutes. September 2014 = 19 minutes October 2014 = 18 minutes November 2014 = 18 minutes
Improvement Plans for next 3 Months	**4 Hour Target** – actions to improve performance • Daily system wide conference calls which include NHS England, to enable our partners to understand present pressures within the Trust and escalate issues impeding discharge i.e. social delays. • Admission avoidance- Medical Consultants/Medical Registrars working in each A&E from 1-8 pm to support decision making and provide admission avoidance 5 days a week. • Increase flexible capacity through the winter period. • Provide a private ambulance service to prevent delays in discharge. • Daily review of patients on a green cross pathway with social services and clinical teams- lead person identified for each patient to expedite delays and discharge.

	• Full introduction of Plan for Every Patient (PFEP) to plan better for timely discharges. • Focus on achieving levelling discharge targets for each ward. • Additional community resource beds opened. • Perfect Week- Safer Model. **Unplanned re attendances -** Through monthly validation, reasons for not achieving the required performance have been identified, these are predominantly due to administration errors. These are being addressed with reception/admin staff. Some improvement noted but during the Christmas and New Year periods unplanned attendances increased. **Time to initial assessment** - Reasons for not achieving the required performance are due to lack of cubicle space to assess patients. Due in turn to lack of flow out of the department (liked to the 4 hour performance). On occasion staff have not completed the EDIS record timely and as the data is taken from the EDIS record this has an impact. It was found this is missed more often for patients admitted directly into the resuscitation room where care of the patient has to be the priority.

Domain 5 – 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.

Report For Q3 2014/15	Trust Threshold	Trust Actual
Sickness Absence rate (%) (1 Month Behind)	4.00%	4.43%
Sickness Absence rate (FTE Lost) (1 Month Behind)		6918.04
FTE Days Available (1 Month Behind)		156208.16
Sickness Absence rate (%) - Nursing (1 Month Behind)	4.00%	4.84%
Total Staff in Post (FTEs)		5,153.48
Fire Safety Awareness	100.00%	81.70%
Fire Risk Assessments	100.00%	18.00%
Information Governance - **YTD**	100.00%	62.60%
Risk Training - **YTD**	100.00%	60.40%
Appraisal Non Medical- YTD	75.00%	38.41%
Appraisal - Rolling 12 Month	100.00%	72.24%
Appraisal Medical- YTD	100.00%	38.02%
Medical devices training	95.00%	80.00%
Safeguarding - Level 1 - Staff compliant		63.20%
Safeguarding - Level 2 - Staff compliant		63.30%
Safeguarding - Level 3 - Staff Compliant		79.30%
FFT Staff - Response Rate (Quarterly)		6.50%
FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly)		81.00%
FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly)		59.00%
Hard Truths Summary Day - Nurses/Midwives (1 Month Behind)	100.00%	82.80%
Hard Truths Summary - Day Care Staff (1 Month Behind)	100.00%	94.40%
Hard Truths Summary - Night Nurses/Midwives (1 Month Behind)	100.00%	86.60%
Hard Truths Summary - Night Care Staff (1 Month Behind)	100.00%	122.20%

Quality Priority	Sickness
Aims and Objectives of Work	The aim to have a staff sickness rate of 4% or below.
Current Performance	  Sickness FTE days lost - Is calculated by multiplying FTE against calendar days lost in current reporting month.
Improvement Plans for next 3 Months	• A programme of work on 'high absence incidence' service areas has commenced. An internal taskforce is working to support divisional colleagues in managing attendance. The taskforce is taking a hands-on role in developing an overall approach to effective management in these service areas and in individual cases. This approach is supported by intensive briefing of colleagues with regard to how attendance impacts on our ability to deliver safe services and high quality patient care. • A line manager toolkit has been made available and further enhanced tools are being developed (the proposal is for a multi-channel approach with an extensive intranet resource package) supported by technical HR input. A programme of line manager breakthrough events are planned focusing on what improvements to how we manage and what good practice

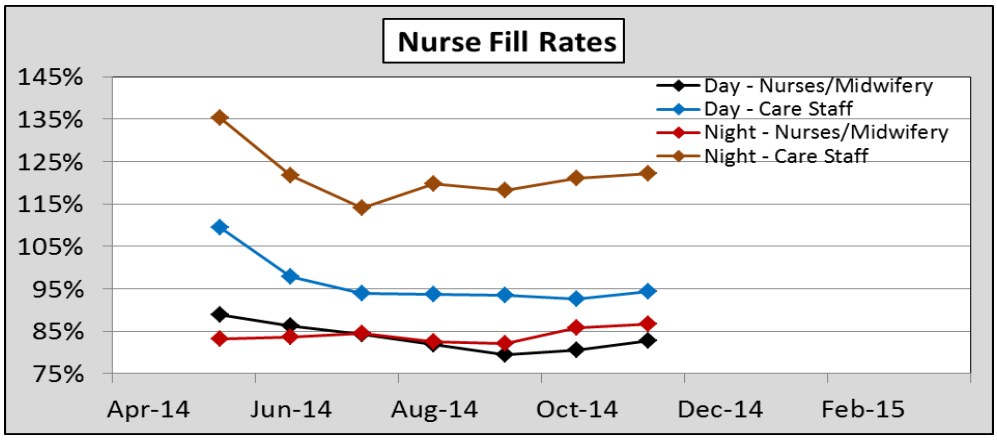
	tools/resources are needed to deliver excellent attendance at work. • Data about absence is a critical part of an effective approach and information for individual service areas about their performance is available routinely. Attention is being paid to data quality and to the availability/timeliness of absence reports. Significant improvements in access to data as well as the quality of data capture and reporting will be delivered with the full implementation of ESR manager self-serve which is currently available on a pilot basis. • To help divisions manage sickness through ESR business intelligence (B.I) reports have been created which show sickness at ward levels, identify trends and provide detailed lists of all colleague's absence on an individual basis. This process has been shared with the Medical Division and will then be shared with over divisions.

Quality Priority	**Training**
Aims and Objectives of Work	100% of staff to have completed mandatory training.
Current Performance	

Report For: Q3 2014/15	Trust Threshold	Trust Actual	Surgery	Medical	CWF	DATS	Estates	Corporate	THIS
Fire Safety Awareness	100.00%	81.70%	77.80%	71.20%	87.20%	95.90%	99.70%	83.80%	93.20%
Fire Risk Assessments	100.00%	18.00%	7.00%	16.00%	45.00%	0.00%	50.00%		
Information Governance - **YTD**	100.00%	62.60%	65.70%	55.50%	60.20%	69.80%	77.50%	53.80%	74.60%
Risk Training - **YTD**	100.00%	60.40%	61.40%	46.60%	66.60%	62.20%	86.30%	73.30%	73.50%
Appraisal Non Medical- YTD	75.00%	38.41%	26.00%	31.30%	39.30%	39.30%	91.20%	39.20%	64.50%
Appraisal - Rolling 12 Month	100.00%	72.24%	73.23%	66.57%	74.15%	65.09%	96.08%	73.90%	82.98%
Appraisal Medical- YTD	100.00%	38.02%	34.90%	33.00%	40.40%	67.70%	-	100.00%	-
Medical devices training	95.00%	80.00%	75.00%	77.00%	82.00%	78.00%	-	88.00%	-
Safeguarding - Level 1 - Staff compliant		63.20%	66.10%	48.80%	71.30%	68.10%	81.90%	63.20%	89.10%
Safeguarding - Level 2 - Staff compliant		63.30%	47.80%	50.90%	74.70%	44.60%	77.50%	85.20%	0.00%
Safeguarding - Level 3 - Staff Compliant		79.30%	58.30%	82.60%	69.70%	80.00%	-	85.00%	-

Improvement Plans for	**Fire Safety Awareness -** 81.7% of colleagues are trained in fire safety awareness, this is a vast improvement in the training attendance but there are still large numbers of staff who are not compliant (over 1000).

next 3 Months	**Fire Training** - A revised approach to mandatory and essential skills training has been designed and this approach will help improve and sustain compliance with performance. **Fire Risk Assessments** - All areas of the Trust's two main hospital sites have had fire assessments carried out. Other properties for which the Trust is responsible are currently being completed and should be issued shortly. Once risk assessments are issued to departments it is essential that those departments act upon this assessment, otherwise we will be in breach of our statutory duty. **Appraisal YTD** - The monthly compliance target for appraisals is 8%. All areas forecast compliance of 100% at 31 March 2015. There is strong evidence that appraisal activity is concentrated in the last 3 months of the performance year. Resources provided by the Workforce Development team are still being added to the intranet available toolkit. For example, appraisal planning and appraisal preparation videos are new additions. **YTD Information Governance** - The monthly compliance target for information governance is 6%. Information Governance training compliance is measured on a rolling year basis so figures will fluctuate throughout the year. YTD compliance is at 71%. Training awareness and compliance messages are being communicated via the Trust Information Governance and Records Strategy Group which is then cascaded throughout the divisions. There will be a final push for Training uptake during January, February and March 2015 with a yearend predication of achieving 85% compliance.

Quality Priority	Staffing levels
Aims and Objectives of Work	To ensure that staffing levels are adequate to provide safe, good quality care.
Current Performance	**Nurse Staffing**  **Midwifery Staffing**

The Local Supervisory Authority for Midwives (LSA) audit visit results for compliance for the statutory framework for the supervision of midwives:

	Met	Partially Met	Not Met	Overall Rating
Domain 1 (15)	6	7	2	40%
Domain 2 (20)	12	4	4	60%
Domain 3 (13)	8	4	1	61%
Domain 4 (10)	7	3	0	70% (*Revised)

Areas of significant good practice were noted within the report:

- The audit team could see the way that the supervision of midwives (SoM) day initiative was improving visibility and accessibility across the service. Midwives working across the maternity unit were able to universally articulate the benefits that this initiative had brought to the service. In particular the proactive communication through the 7 day week, 24 hour per day cycle was really valued and seen as being 'super supportive' as described by one of the midwives interviewed on the day and is an area of good practise.

- Every midwife interviewed could identify their named SoM and confirmed that they had an annual review in the last 12 months. The use of a standardised approach to the annual review was another significant area of good practise and one that the LSA would recommend to be shared across the region.

- Highly visible information for women about the role of the SoM (posters etc.)

- Clear evidence supporting women's choices in place of birth.

- Posters regarding the 'Year of Patient Safety' demonstrating to women how supervision is contributing to the patient safety agenda.

Improvement Plans for next 3 Months

The improvement work noted below is in response to the recommendations contained within the 'Hard Trusts - The Journey to Putting Patients First' report written in response to the Mid Staffordshire NHS Foundation Trust Public Inquiry.

Recruitment of qualified nurses remains a key focus to improve the fill rate required. Quarterly review of new starters is reviewed at the nursing workforce group. A further 14 posts were offered to qualified nurses at the

	December recruitment event held at CHFT and 15 offers to Spanish nurses made at an event in Madrid in December. The first 5 international nurses arrived at CHFT on 2.1.15. Weekly staffing hot spot meetings continue to highlight the priority areas which provide focus for the flexible workforce team to direct qualified nurses to. These meetings also incorporate additional staffing requirements which are reviewed daily as a minimum due to winter pressures. We have some concern over the accuracy of the data recorded for the nursing fill rate of shifts. A number of the inaccuracies in hours recorded are due to nurses working longer shifts to provide cover across the whole day. This results in a fill rate of 11.5 hours where two nurses working two shorter shifts across the same period results in a fill rate of 15 hours. Whilst the number of hours is reduced it is the overlap time of two nurses which is reduced – time often utilised for training and appraisal. By one nurse covering both an early and late shift we have no overlap and less nursing hours recorded but are often closer to the right number of nurses on the ward than the fill rate indicates. Work force models are been reviewed to incorporate longer shifts where appropriate and with the results of the acuity and dependency studies completed in November 2014. The web based safe staffing tool is being utilised to record staffing levels, professional judgement and increased / decreased beds for each area from January 2015. **Midwifery Staffing** Aims of improvement work: 1. Reducing supervisory caseload sizes 2. Providing access for SoMs to a dedicated quiet work area within the trust 3. Addressing SoMs reported inability to take the time allocated for supervision 4. Addressing the inequity of workload amongst the SoM group A business case was presented in July 2014 for a 0.4wte SoM to enable the team to reduce caseload sizes whilst succession plans come to fruition (It takes approx. 12 months to train a SoM), thus item 1 has already been addressed; In common with all children's, women and families (CWF) colleagues, the SoM team have open access the CWF meeting rooms. In the last 12 months only 2 incident forms have been received from SoM not able to take the allocated time (1 ½ days per month) for supervision.

Quality Priority	Regulation
Aims and Objectives of Work	To improve risk rating against the CQC standards.
Current Performance	CQC published the first Intelligent Monitoring Report (IMR) in October 2013. This measured the risk of non-compliance with a set of indicators, which were chosen by CQC as being the most important for monitoring risks to the quality of care in acute hospital services. CQC used their analysis of risk to place Trusts in risk bands ranging from 1 – 6, with band 1 being the highest risk of non-compliance.

October 2013	March 2014	July 2014	October 2014
Risk Band 3	**Risk Band 4**	**Risk Band 5**	**Risk Band 5**

Improvement Plans for next 3 Months

Risk	Score	Improvement Activity
The number of cases assessed as achieving compliance with all 9 standards of care measured within the National Hip Fracture Database	Elevated Risk 2 points	As anticipated, for the first time CQC have used data from 1/01/13 to 31/12/13, but this remains an elevated risk. The Division has an action plan
Consistency of reporting to the National Reporting & Learning System (NRLS)	Elevated Risk 2 points	This refers to the frequency of reporting. We became aware earlier in the year that due to staff changes. Inconsistencies had developed. Corrective action has been taken; we now have a system of weekly upload, which is performance managed. This was discussed a few weeks ago with our Compliance Inspector, who seemed satisfied that we knew about it & taken action.
Composite risk rating of ESR items relating to staff support /supervision	Risk 1 point	This relates specifically to the ratio of band 7 nurses to band 5/6 nurses. The measurement of this indicator is not well understood and has been discussed in recent weeks with our CQC Compliance Inspector. He has agreed to discuss this with Senior Analysts & to feed back to us
SSNAP Domain 2 overall team centred rating for key stroke unit indicator	Risk 1 point	The Sentinel stroke audit reports on a quarterly basis, & CQC have used data from April – June 2014. The Division have an action plan in response to the audit.

The Board of Directors is asked to note:

The Board of Directors is specifically asked to note issues around the following and the outlined plans for improvement included in this report:

- Pressure Ulcers
- Incident reporting
- Complaints process
- Safeguarding (linked to the mock CQC visit)
- Infection control
- Mortality rates and coding
- Friends and family test – A&E response rates
- A&E Performance
- Staffing.
- Mandatory training

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Ruth Mason, Associate Director of Engagement & Inclusion
Date: Thursday, 29th January 2015	**Sponsoring Director:** Julie Hull, Director of Workforce and Organisational Development
Title and brief summary: Equality & Diversity Report and Public Sector Equality Duty Compliance Evidence - To meet the statutory duty to publish progress against, and achievement of, agreed equality and diversity objectives.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: WEB - 29 January 2015	
Governance Requirements: Transform care, improve the patient experience, deliver the regulations, develop the organisation for the future.	
Sustainability Implications: Improve local conditions, especially in disadvantaged areas, eg encourage social inclusion, develop business and social enterprise or develop the workforce and labour market Reduce social and health inequalities	

Executive Summary

Summary:

As a public sector body, the Trust has a statutory duty to comply with the Equality Act 2010. In line with the specific duties of the Act, the Trust is required to publish an annual report, detailing the ways in which the Trust meets the general duties of the Act to:
• Eliminate unfair discrimination, harassment and victimisation
• Advance equality of opportunity between different groups
• Foster good relationships between different groups
This annual report, known as the Public Sector Equality Duty (PSED) report, must be approved by the Board for publication by the end of January each year.

Main Body

Purpose:

The first purpose of this paper is to present the latest PSED report to the Board for consideration. A copy is attached as Appendix 2.
A summary of the PSED report plus recommendations for actions is attached as Appendix 1.
The second purpose of this paper is to highlight recommendations for future action in readiness for a statutory review of objectives and migration to the use of the NHS' Equality Delivery System (EDS2).

Background/Overview:

Consultation with communities of special interest in 2011 indicated that they wanted the Trust to focus on areas of improvement that fall broadly into three categories and in March 2012 the Board of Directors agreed the following high level corporate objectives:
1. Access;
2. Information and communication;
3. Staff attitude, behaviour and training.
Every year the Trust is required to publish (by January 31st) a Public Sector Equality Duty (PSED) report highlighting progress against these agreed objectives.

The Issue:

Equitable, fair and diverse services across the Trust for all patients and staff.

Next Steps:

Following Board approval the Trust is required to publish equality compliance evidence by January 31st 2015.

Recommendations:

The Board is asked:
1. To note the achievement of statutory timescales in relation to production of the PSED report and agree its publication before the end of January 2015.
2. To note the additional organisational requirement to introduce EDS2 by end March 2015 and the Workforce Race Equality Standard (WRES) by March 2016.

Appendix

Attachment:

Appendix 1 + 2 (Board Report + PSED Report Jan-15).pdf

APPENDIX 1

Equality and Diversity Report to Board January 2015

1. BACKGROUND

The Trust is clinically led and has “compassionate care” as its primary focus.

The Trust’s colleague engagement strategy describes the Trust’s ethos for engaging with staff. The organisation is working with its staff to refine its approach and integrate this into everything that we do. The strategy focuses on four pillars of behaviour expected of all employees:

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

These clear and consistent messages help to ensure that high quality care is delivered to all of our patients. Our patients have a diverse range of needs and expectations and in addition may also identify with any of 9 protected characteristics. Consequently, as a public sector body, the Trust has a statutory duty to comply with the Equality Act 2010. In line with the specific duties of the Act, the Trust is required to publish an annual report, detailing the ways in which the Trust meets the general duties of the Act to:

- Eliminate unfair discrimination, harassment and victimisation
- Advance equality of opportunity between different groups
- Foster good relationships between different groups

2. PURPOSE

The organisational Public Sector Equality Duty (PSED) report must be approved by the Board for publication by the end of January each year.
The first purpose of this paper, therefore, is to present the latest PSED report to the Board for consideration and to gain its approval for publication. A copy is attached as Appendix 2.
In light of the evidence held within the report, and any other strategic aims of the organisation, the Trust is further required to annually review its objectives and update them if necessary. This work must be completed by the 5th April each year and published at least every four years. The Trust published its first statutory equality objectives in April 2012.
The second purpose of this paper, therefore, is to provide the Board with recommendations for further action required in the coming financial year.

3. CURRENT POSITION

In accordance with statutory timescales, the attached PSED report has been produced to evidence the extent to which the Trust has met its legal obligations under the Equality Act 2010. Within it, the Trust outlines its effectiveness in collecting and utilising equality data to inform decision making; its arrangements for engagement and collaborative working; its activity towards meeting the general duties of the Act; and its outcomes for people with protected characteristics during

2014. It contains separate sections relating to patients and staff. In demonstrating how the Trust meets its legal duties, an update is provided within the report on the extent to which the organisation is meeting its published equality objectives. A summary of key achievements within the report is provided below.

3.1 Equality Objectives

The Trust's overarching equality objectives for 2012-16 are:
Access - The Trust will demonstrate improvements in access to services for people with protected characteristics.
Information and communication - The Trust will demonstrate improvements in data collection, utilisation and analysis to inform service improvement for people with protected characteristics
Staff attitude, behaviour and training - The Trust will deliver training programmes that reflect the need for employees to respect equality, diversity and human rights

Underneath those three high level objectives, members of the Equality and Inclusion Group (workstream leads) are working towards specific actions – each with measurable dates and outcomes. Initially the workplan included 102 such actions. Following annual reviews of the objectives in December 2012, 2013 and 2014, the overall number of organisational objectives scheduled for completion before March 2016 has risen to 162. Of these 144 (89%) have been completed as at the end of December 2014 or are on track for completion by March 2015.

Key achievements are provided in the PSED report and include:
Access – A full access/wayfinding audit has been completed on both sites and physical access considerations are now built into capital work programmes; the establishment of a Mental Health Liaison Team (MHLT) with a 1-hour access target for patients with mental health issues presenting at A&E or MAU.
Communication – Introduction of 2-way text and e-mail service for patients with visual impairments; promotion of patient engagement activities in pregnancy and maternity services; enhanced staff engagement strategy
Training – Additional training provision relating to mental health, learning difficulties and spiritual care at end of life; dementia training targets exceeded; equality and diversity training to become mandatory, with a target of 90% compliance by December 2015.

3.2 Taking Equality into Account
The ways in which equality data is collected, monitored and utilised to improve patient services is included in the PSED report. This includes the use of equality analysis (impact assessments) by divisional managers during the formation of the Trust's "Balanced Plan" (to deliver a balanced financial position) across ten separate workstreams; the monitoring and analysis of data relating to patients with learning difficulties to examine any differences in admission, readmission and length of stay figures compared with other patient groups.

3.3 Learning from Experience
The ways in which the Trust learns from experience and spreads good practice are examined in the PSED report. Specifically, it explains how the Equality and Inclusion Group work together with patient complaints and patient experience colleagues to

investigate equality-related issues, and how learning is embedded throughout the organisation.

4. NEXT STEPS

Recommended development areas are provided in the PSED report. The high-level objectives relating to access, communication and training will be retained for 2015-16, with the aim of spreading and embedding good practice through greater collaborative working between the Equality and Inclusion Group and the Patient Experience Group.

Additionally, the NHS England Equality and Diversity Council have determined that all organisations must utilise the NHS Equality Delivery System (EDS2) and the NHS Workforce Equality Standard as the framework against which they evaluate their performance in relation to equality from the end of March 2015. Appendix A highlights in red the EDS2 outcomes which most closely correlate with the Trust's current objectives and which, therefore, will be the focus for action in 2015-2016. A further update will be provided to the Board in March 2015.

Finally, as part of NHS standard contracting arrangements for 2015/16 a new Workforce Race Equality Standard has been introduced. This puts the emphasis on everyone on an NHS Board to lead by example and champion race equality – not to simply comply with the new national standard, but as a strategic opportunity to demonstrate commitment to diversity, and to leverage its potential to improve patient care. The WRES will require NHS organisations to address the low levels of Black and Minority Ethnic (BME) employees within their organisations and specifically at Board level.

5. BOARD DECISION / ACTION REQUIRED

1. To note the achievement of statutory timescales in relation to production of the PSED report and agree its publication before the end of January 2015.
2. To note the additional organisational requirement to introduce EDS2 by end March 2015 and the Workforce Race Equality Standard (WRES) by March 2016.

Author: Ruth Mason, Associate Director of Engagement & Inclusion
Date: January 2015

Appendix A - The goals and outcomes of EDS2

Outcomes marked red are those which align most closely to the current organisational objectives.

Better health outcomes

Goal	Description of outcome
1.1	Services are commissioned, procured, designed and delivered to meet the health needs of local communities
1.2	Individual people's health needs are assessed and met in appropriate and effective ways
1.3	Transitions from one service to another, for people on care pathways, are made smoothly with everyone well informed
1.4	When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse
1.5	Screening, vaccination and other health promotion services reach and benefit all local communities

Improved patient access and experience

Goal	Description of outcome
2.1	People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds
2.2	People are informed and supported to be as involved as they wish to be in decisions about their care
2.3	People report positive experiences of the NHS
2.4	People's complaints about services are handled respectfully and efficiently

A representative and supported workforce

Goal	Description of outcome
3.1	Fair NHS recruitment and selection processes lead to a more representative workforce at all levels
3.2	The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations
3.3	Training and development opportunities are taken up and positively evaluated by all staff
3.4	When at work, staff are free from abuse, harassment, bullying and violence from any source
3.5	Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives
3.6	Staff report positive experiences of their membership of the workforce

Inclusive leadership

4.1	Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations
4.2	Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed
4.3	Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination

APPENDIX 2

CHFT Public Sector Equality Duty Annual Report 2014

Equality Act Compliance Evidence
Published January 2015

CONTENTS

1. Executive Summary

This Equality Report is to show the progress the Trust has made during 2014 in meeting its equality duties under:

- Section 149 of the Equality Act 2010 (the public sector equality duty) and
- The Equality Act 2010 (Specific Duties) Regulations 2011

This report provides assurance to the Board of how the Trust is meeting the requirements of the Public Sector Equality Duty. This report complies with the specific duties outlined within the Equality Act, which are legal requirements designed to help the Trust meet the General Equality Duty. The report also contains the **Equality in our Workforce Report** for the Trust[1]. The report is structured around the following 5 key themes:

- The Legal and Compliance Framework
- Strengthening Equality and Diversity
- Making Things Happen
- Learning from Experience
- Emerging issues and key priorities for 2015

In 2012, following Board approval, the Trust adopted three priority equality objectives which became the focus for our work on equality for the period 2012-16. Whilst much progress has been made against those objectives, covered in the "Making Things Happen" section of this report, it is important to note that these equality objectives do not cover all the work that is being carried out by the Trust with the aim of improving equality.

The Trust strives to provide the highest quality of service to all of its patients. Equality and diversity considerations are part of the Trust's work to improve the experience and health outcomes for everyone in its care. This report highlights our approach and work to address any additional needs of those patients who identify with a range of protected characteristics.

2. The Legal and Compliance Framework

Equality Act 2010

The Equality Act came into force from October 2010 providing a modern, single legal framework with clear, streamlined law to more effectively tackle disadvantage and discrimination. On 5 April 2011, the public sector equality duty came into force. The equality duty was created under the Equality Act 2010.

The equality duty consists of a general equality duty, with three main aims (set out in section 149 of the Equality Act 2010) and specific duties for public sector organisations. The Equality Act requires public bodies like Calderdale and Huddersfield NHS Foundation Trust (CHFT) to publish relevant information to demonstrate their compliance with the duty.

[1] Equality in our Workforce Report 2014 – see appendix 2

The Act applies to service users and Trust employees who identify with the following protected characteristics:-

- Age
- Disability
- Gender reassignment
- Marriage or civil partnership
- Pregnancy or maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

The duty has two parts – the general duty and the specific duties. The **general equality duty** means that the Trust must have due regard to the need to:

- Eliminate unfair discrimination, harassment and victimisation;
- Advance equality of opportunity between different groups; and
- Foster good relationships between different groups

By:

- Removing or minimising disadvantages suffered by people due to their protected characteristics;
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people; and
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

The **specific duties** are legal requirements designed to help the Trust meet the general equality duty. These require the publication of:

- Annual information to demonstrate our compliance with the Equality Duty published on our website by 31st January each year;
- Equality Objectives (which are specific and measurable) published for the first time by April 5th 2012, reviewed annually and re-published at least every four years.

Care Quality Commission Requirements

The Care Quality Commission (CQC) expects to find evidence that the Trust is actively promoting equality and human rights across all its services and functions. Performance in relation to equality, diversity and human rights is embedded into each of the core outcomes, requiring the Trust to mainstream effective equality management into our core business activities to successfully achieve compliance against this regulatory framework.

3. Strengthening Equality & Diversity

Governance Arrangements

Creating a culture of equality and diversity is the responsibility of everyone at the Trust. Our aim is to ensure that everyone can use our services and that we have a workplace that is free from discrimination and harassment. We take our legal responsibility seriously and want staff and patients to be treated fairly and with dignity and respect at all times. Equality and Diversity in the Trust is led by the Director of Operations and Director of Workforce & Organisational Development. A Non-Executive Director with a special interest in this area is closely involved in Trust monitoring and progress.

Equality issues have been reported to the Executive Board and Board of Directors on a regular basis with a summary of activity appearing in the Annual Reports. In 2011 the Trust established the 'Equality, Engagement and Experience Board' (subsequently renamed in 2013 as the 'Equality and Inclusion Group'), commissioned by and accountable to the Trust's Quality Committee, via the Well-Led Group. The Equality and Inclusion Group sits above specific workstreams related to service improvement for patients and staff with each of the protected characteristics. Each workstream has a "lead" from within the organisation, at a level of seniority sufficient to influence change and make improvements.

The age protected characteristic has been broken down to focus on the different needs of older and younger people and disability has been broken down to address the different needs of those with visual, hearing, physical, learning and mental health impairment. The Equality and Inclusion Group is chaired by the Director of Operations. The group meets on a quarterly basis and at the meetings each workstream lead presents a summary of their workstream activity.

An overview of the focus for each of the workstreams is presented below:

Age (Children and Young People):
The hospital and community services meet the local health needs of children and young people aged 0 to 16 years. The school nursing service (which forms part of community services for children) covers children from 5 to 19 years of age.

Inpatient services for young people at CHFT consist of: 10 Paediatric assessment beds at CRH; 25 Inpatient beds (of which 2 are High Dependency); 12 Paediatric assessment and observation beds and acute surgery at HRI. Once the patient has been discharged paediatric services are supported by the Children's Community nursing team which offers ongoing specialist nursing support in the home.

There are also 26 NICU (neonatal intensive care unit) cots (of which 6 are Intensive Care cots) based at CRH. We also offer neonatal outreach (24 cots) to support babies and their families once discharged from hospital.

Age (Older People)
The focus of this work stream is the care of people with dementia aged 65 and over. In Kirklees the number of people living with dementia is estimated to reach 6,349 by 2025, and in Calderdale is estimated to reach between 3,234 and 4,042 by 2030. Trust admissions data shows a steady rise in the number of admissions for this patient group over the past 7 years from 1,294 in 2007/08 to 2,098 in 2012/13. Data for the 8 month period April 2014 to November 2014 suggests that the number of admissions for the current year (2014/15) will rise to around 2,170. Nationally it is estimated that 25% of acute hospital beds are occupied by people with dementia aged 65 and over.

Disability (Physical Mobility)
The main Trust estate comprises two hospitals: Huddersfield Royal Infirmary [HRI], which was built in the 1960s and Calderdale Royal Hospital [CRH], a PFI build, opened in 2001. User involvement and information has resulted in substantial changes to the environment on both sites, such as lowered reception desks, ward upgrades, redesign of the CRH outpatient pharmacy and amendments to car parking processes. This work is still developing and despite restrictions on the capital budget, the Trust is committed to ensuring that access is a key feature in any upgrades or redevelopments. A wheelchair user representative of the Disability Partnership is a substantive member of the physically disabled patients group and is supporting this work through the testing of any changes made.

Mental Health
Many patients, carers and staff will suffer from a short term mental illness at some point in their lives (25% according to the government document, No Health without Mental Health 2012). A significant proportion of the population will go on to have a lengthy or even life-long mental health condition. This is particularly relevant for patients with long-term physical conditions as often the two are interconnected. We do not provide mental health services per se at CHFT, so are unable to identify all patients, carers or staff with mental health issues. This makes it difficult to establish the exact number of people with this characteristic within CHFT.

Pregnancy and Maternity
Services provided at the CRH site include:
Antenatal clinic; Maternity Assessment area; LDRP (Labour, Delivery, Recovery, Postnatal ward); Ward 9 (Antenatal/Postnatal area); Ward 1D (Post natal area/Caesarean Section ward); Maternity Obstetric Theatre, Calderdale Birth Centre; Gynaecology inpatients; Gynaecology Outpatients; Gynaecology Assessment Unit; Early Pregnancy Assessment Unit and Assisted Conception Unit.

Services provided at the HRI site include:
Antenatal clinics; Antenatal Day Unit; Huddersfield Birth Centre; Gynaecology Outpatient Services; Early Pregnancy Assessment Unit.

Community Midwifery and the Home Birth Team Services are provided across both Calderdale and Kirklees.

Visual Impairment
The number of people living with visual impairment, according to the RNIB, is nearly 2 million. Of these, 365,000 are registered sight impaired or severely sight impaired. By 2020 the numbers could increase to 2.25 million and 4 million by 2050.

The number of people registered either severely sight impaired (blind) or sight impaired (partially sighted) in Kirklees as of March 2014 is 1,895, and in Calderdale is 950. In Calderdale 465 people are registered severely sight impaired and 485 registered sight impaired. In Kirklees 790 people are registered severely sight impaired and 1,105 registered sight impaired. Between January 2014 and November 2014 a total of 179 people have been registered with a visual impairment – 95 at Calderdale and 84 at Huddersfield. The national figures show that the trend for registering people severely sight impaired and sight impaired has fallen over the last year.

The main causes of visual impairment are age related macular degeneration, glaucoma and diabetic retinopathy. In the ophthalmology outpatients at both hospitals between April 2013 and March 2014 we saw a total of 49,899 patients. Not all patients with visual impairment come through ophthalmology outpatients and there are many people living with visual impairment who have chosen not to be registered.

Religion and Belief
The religion workstream ensures that the Trust provides support to people of all religions and no religion. The 2011 census data for the population of Calderdale & Kirklees is shown below:

	Calderdale (%)	Kirklees (%)
Christian	56.3	53.4
Muslim	7.3	14.5
Hindu	0.3	0.4
Jewish	0.1	0.0
Buddhist	0.3	0.2
Sikh	0.2	0.8
No faith or religion	28.1	23.9
Not known	7.4	6.8

Sexual Orientation
CHFT provides acute and community based services across a wide geographical area. This area includes people who identify as lesbian, gay, bisexual, transgender and queer.

Hearing Impairment
This group is reviewing and enhancing services and support to those with a hearing impairment who access the Trust's sites.

Learning Disability
There are an estimated 7,500 to 8,300 adults with a learning disability living in Kirklees, of which 1,530 are known to Kirklees Council adult social care services. By 2030 this

will rise faster than nationally to between 8,300 and 9,400[2] and within Calderdale there are currently 777 adults with a learning disability[3].

Vulnerable Inpatient (VIP) data collected between 1 September 2013 and 31 August 2014 showed a total number of referrals to the Matron, Complex Needs Care Coordinator, of 1058. 489 were inpatient admissions of which 165 were planned admissions and 334 were new outpatient referrals.

Race
Kirklees has a higher than national average proportion of residents from minority ethnic communities, with the Pakistani and Indian communities representing the largest minority ethnic communities in Kirklees. In Calderdale, Halifax, Todmorden and Elland are also home to sizeable minority ethnic communities.

Gender
CHFT is committed to providing every patient with same sex accommodation, ensuring all patients are treated with dignity and respect of their sex, ensuring no patient sleeps in an area where there are patients of the opposite sex unless their clinical condition warrants it.

Equality and Diversity Training

The Trust is committed to ensuring that it provides a high quality of service for all of its patients and is an employer of choice in the local area. It also has a legal obligation under the Equality Act 2010 to provide services and employment in a manner that eliminates discrimination, advances equality and fosters good relationships between protected groups. The national NHS staff survey contains a specific question relating to equality and diversity training, against which CHFT was shown to be performing poorly in comparison with other acute NHS providers. To address this, the Trust introduced a strategy for equality and diversity training, which was endorsed by the Equality and Inclusion Group in May 2014.

The strategy underpins the programme of work required to achieve the Trust's 3rd objective around improving training provision and take-up in relation to equality and diversity and introduces 3 "levels" of training: Level 1 - Basic/Awareness (aimed at all CHFT colleagues except the Leadership team); Level 2 - Essential (aimed at colleagues working with patients with protected characteristics) and Level 3 – Expert (for the Leadership team and Directors). Delivery training methods vary according to level, and range from an e-learning package 'Equality and Diversity Awareness – Treating People Well' at Level 1 to a 3-hour face-to-face training session at Level 3.

The training is designed to improve both patient and colleague experience, leading to fewer patient complaints and fewer grievances/bullying and harassment claims by colleagues. Implementation of this training strategy evidences the Trust's commitment to equality for legal and regulatory purposes.

[2] Source: Kirklees LA Joint Strategic Needs Assessment
[3] Source: Calderdale LA

The Future

A governmental review of the efficacy of the Public Sector Equality Duty in 2013 found that those organisations which had mainstreamed equality activity had gained the most benefit in terms of patient outcomes. The Trust is therefore actively seeking to promote divisional as well as corporate ownership of equality objectives and outcomes.

During 2014 the Trust's Patient Experience and Caring Group was established. This strategic group aims to oversee and coordinate activity which is designed to improve the patients' experience whilst under the care of the Trust. Providing equitable and accessible care is one of the underlying principles of creating a good patient experience. To this end, members of the Equality and Inclusion Group are now attending the Patient Experience and Caring Group in order to help support an equitable and inclusive approach to providing an excellent patient experience.

Our Equality Objectives

Consultation with communities of special interest in 2011 indicated that they wanted the Trust to focus on areas of improvement that fall broadly into three categories and in March 2012 the Board of Directors agreed the following high level corporate objectives:

1. Access
The Trust will demonstrate improvements in access to services for people with protected characteristics.

2. Information and communication
The Trust will demonstrate improvements in data collection, utilisation and analysis to inform service improvement for people with protected characteristics.

3. Staff attitude, behaviour and training
The Trust will deliver training programmes that reflect the need for employees to respect equality, diversity and human rights.

Underneath these three high level objectives, each workstream group developed plans for action, with measurable dates and outcomes. This initially resulted in 102 individual objectives for completion during the 2012-2016 period. Following annual reviews of the objectives in December 2012, December 2013 and December 2014, the overall number of objectives scheduled for completion before March 2016 rose to 162. The high-level objectives have been retained for 2014-15 and 2015-16 and further actions beneath those headings will be reviewed and determined before April each year, in line with legislative requirements.

Involvement & Engagement

The Trust has a large membership which is assessed against our local population to ensure that we are engaging with the diverse communities that we serve[4]. Analysis of the latest census information shows that we have under representation in two different sectors of our communities (males and those with an ethnic group of Asian/Asian British) and a targeted plan of recruitment activity has been drawn up to address this.

The Membership Council is actively engaged through divisional reference groups and corporate sub-groups with members and service users about quality improvement and service change. Membership Councillors and Trust members volunteer to undertake Real Time Patient Monitoring surveys. Information from these bed side conversations is routinely fed back to ward and clinical staff in order to help improve services to patients. Other examples of involvement include regular 'walkabouts' into clinical areas where Trust members can observe services first hand and talk directly to staff and patients; and the involvement of members in recruitment panels for the appointment of hospital consultants and senior nursing staff. Specific public consultations have taken place across both boroughs in relation to major service changes over recent years.

Workstream groups involve and engage people from protected groups to help minimise and remove disadvantages experienced by people due to their protected characteristics. By involving and engaging users, the workstream groups have taken steps to remove disadvantage and have encouraged involvement and participation. An example of this is the involvement of a blind user of our services in the development of our new Acre Mill Outpatient facility.

Staff engagement is supported by Staff Management Partnership Forums at both Corporate and Divisional levels. Well established and robust organisational development and leadership programmes ensure that staff consultation and involvement is integral to any proposed service changes. Additional staff support is given through an accredited Occupational Health service, staff health and well-being programmes and supportive policy frameworks such as mediation.

During 2013/14 staff engagement at the Trust was underpinned by a 2-day 'Work Together Get Results' change management programme. This comprehensive programme offers tools and opportunities to explore how teams or individuals can give of their best to help achieve Trust goals. Tools such as "stand in their shoes" and "authentic speech" are helping all Trust colleagues to experience viewpoints and needs from the full diversity of staff and patients. Currently over 600 colleagues have benefitted from this programme.

[4] Appendix 3 – Membership Engagement Data

Involvement & Engagement in Decision Making

Below are some examples of how users are actively involved and engaged in decision making as part of the workstream activity.

The workstream group for **Physical Impairment** has representation from users. A patient advisory group was specifically convened and invited to help work with colleagues during the refurbishment of the Acre Mill site into a state-of-the-art outpatient facility. Members of this advisory group were able to bring their personal experience of their disability and/or access issues to help ensure specific adjustments required for users with protected characteristics were incorporated.
During 2014 a wheelchair user was involved in an exercise to test out a proposed renovation of a retail facility at CRH and this resulted in the retailer revising its plans to make the facility more accessible to physically disabled users.

The **Learning Disability** workstream consults with both Kirklees and Calderdale Learning Disability Partnership Boards. Members of the group attend the provider forums and carers sub group. The group also consult closely with Kirklees Involvement Network and have established a reader group in a local day centre.

The Mental Health workstream group continues to involve and engage users through active user groups as part of SWYPFT (Mental Health Trust).

Young people – we are awaiting the implementation nationally of a Young Person's Friends and Family test but in the meantime, young people are encouraged to complete the existing Friends and Family test and young people friendly collection boxes are provided.
Ward Managers are to start "courtesy" rounds, during which they would speak directly to young people to seek their views on the services provided.

Religion or Faith - The Trust chaplaincy seeks to be responsive in meeting the religious, pastoral and spiritual needs of all patients, respecting those of no belief who nevertheless wish to talk through issues facing them as a consequence of illness and hospitalisation. We seek to respond in a timely way to requests for care from faith community leaders, Trust staff and patients and carers. We work closely with the local SANDS (Stillbirth and Neo-natal Death Society) group in supporting parents who have lost children in pregnancy and at birth, and jointly organise with them memorial services twice a year in each hospital.
The Chaplaincy web pages have been updated with help from faith community representatives to give guidelines to staff on caring for patients of different faiths, together with contact details.
Christian and Muslim chaplains are employed by the Trust representing the two largest faith communities in the area, whilst there are Buddhist and Sikh volunteer chaplains. All chaplains form part of the quarterly chaplaincy meeting where decision-making and forward planning takes place. Volunteers are used as befrienders for patients and their carers.

LGBT – A member of the Equality & Inclusion Group now also attends the Calderdale Equality Forum in order to learn about relevant issues and exchange information.

The **Pregnancy and Maternity** workstream has updated their patient evaluation sheets to allow users of the service to add their contact details in order to communicate their ideas on service improvements in the future. The Maternity Family and Friends Test data is used to influence service provision and improvement via the Maternity Patient Experience Champion Group.

The **Visual Impairment** workstream links in with the Kirklees Blind and Low Vision Group, and has been instrumental in developing the Kirklees Visual Impairment strategy for 2014-20.

Partnership working

The Trust has well established relationships with a broad range of organisations, groups, forums, partnerships and networks[5].

4. Making Things Happen

Having appropriate policies and procedures in place to ensure compliance is a legal requirement but the real value of the Equality and Diversity work is evidenced in the outcomes we deliver for our patients and our staff. All the workstream groups have ongoing action plans aligned to the three objectives developed in 2012, and reviewed annually since, in order to improve equality, engagement and experience in CHFT. An update of progress against these action plans will be published by April 2015.

Initially, in 2012, the action plans developed by the workstream groups contained a total of 102 individual objectives for completion during the 2012-2016 period. Following annual reviews of the objectives in December 2012, December 2013 and December 2014, the overall number of objectives scheduled for completion before March 2016 has risen to 162. Of these 144 (89%) have been completed as at the end of December 2014 or are on track for completion by March 2015.

The tables below and overleaf contain highlights, rather than a complete list, of the work completed over 2014:

Objective 1 - Improved Access

Workstream	Action
Disability (Mental Health)	Our connections with substance misuse services have been strengthened as many people with mental health issues also have substance misuse problems and vice-versa. Making these connections has enabled us to put referral pathways in place.
	The Mental Health Liaison Team (MHLT) has been operational since April 2014. The team is based on site and has a 1-hour access target for patients presenting with mental health issues at A&E/MAU. This is a 24-hour, 7 days per week service, and the team includes 2 Consultant Psychiatrists.

[5] Appendix 4 – Partnership Activity 2014

Disability (Mobility)	The need to take into account those patients/users with physical disabilities is now firmly embedded in all capital work schemes, for example ward upgrades.
	The Trust has introduced a new car parking enforcement scheme on both sites which includes penalties for able-bodied patients/visitors parking in disabled parking spaces. The number of complaints from disabled patients/users has significantly reduced, which suggests that the introduction of the scheme has improved access for this group.
Disability (all)	A full wayfinding/access audit has been commissioned and undertaken on both hospital sites by an external organisation. The recommendations from the audit are being considered and we are working to improve signage as a result.
Disability (Visual)	Work this year has focussed on access around the new Acre Mill outpatient facility, not just in terms of access for ophthalmology patients but for all patients attending any department within the new facility who may have a visual impairment.
Disability (Learning)	All complaints regarding access are reviewed by the Matron Complex Needs Coordinator, to ensure reasonable adjustments are made.
Employment	The Trust continues to support the apprenticeship scheme. As at December 2014 the Trust employs 31 apprentices, which is comparable with the number employed at the same time the previous year, and the Trust is working towards a year on year increase in staff under the age of 25.
Age (Younger People)	An initial scoping exercise has been undertaken with a view to developing a website to provide information for younger people.
Pregnancy and Maternity	We have introduced appointment based community postnatal clinics across Calderdale and Kirklees which women can access at weekends.
Sexual Orientation / Civil Partnerships	A review of access to fertility services for same sex couples has been undertaken and communication with protected groups has been enhanced: data shows that the service has been accessed by same sex couples.
Religion & Belief	A full review of the chaplaincy service, using surveys completed by staff and patients, has been carried out and a report with recommendations has been published on the Trust's website.

Objective 2 - Improved Communication

Workstream	Action
Disability (Mental Health)	The introduction of the MHLT service has resulted in improved psychiatric liaison with wards for those patients who are admitted with a medical condition but may also have mental health issues.
Disability (Visual)	We have introduced new technology (a 2-way text service and e-mail service) for any patient who is registered, as a direct result of feedback from users.
Disability (Hearing)	Work is underway to add an alert to the Patient Administration System for deaf/hearing impaired patients, to improve their experience when attending the hospitals.

Religion and Belief	A register of local contacts, for staff use, has been compiled and is now available on the Trust's website.
Disability (Learning)	An internet site has been developed with clear links to partnership boards and a section has been created on the Trust internet which is clearly linked to the Kirklees and Calderdale Learning Disability Partnership Board website.
Employment	The Work Together Get Results learning programme, which equips staff to embrace change, has been extended and is now offered to all levels of staff.
Age (Older People)	A new pathway was introduced on ward 19, HRI to reduce the risk of older people developing delirium in hospital. In order to ensure the success of this, a volunteer led programme was devised to assist with mobility and movement, eating and drinking. This volunteer role is important in helping older people with their social engagement skills. These activities are known to reduce the risk of hospital acquired delirium, and also improve outcomes for people with existing delirium.
Pregnancy and Maternity	Evaluation forms have been amended to enable women to volunteer their details if they are interested in taking part in future focus groups on Maternity services.
All protected characteristics	The Trust's staff engagement strategy has been enhanced during 2014. Easy to read postcards and posters have been created and distributed, and the staff intranet has been refreshed and simplified. Examples include easy to use navigation buttons; and animation video demonstrations of Trust procedures such as how to conduct staff appraisals. Staff listening groups and a staff suggestion scheme also continue.

Objective 3 - Staff Attitude and Training

Workstream	Action
Disability (Mental Health)	The MHLT now offers formal training sessions on mental health issues for ward staff, together with informal one-to-one feedback sessions.
Disability (Mental Health)	Staff can now access Huddersfield University's Masterclass series on Mental Health for acute care professionals.
Employment	A simplified appraisal process has been introduced during the year, and the Trust has made significant progress towards achieving a target of 100% of staff having an appraisal by 31 December 2014. Appraisal rates amongst protected groups are being monitored.
Disability (Learning)	A learning disability awareness section is now available to all staff on the Trust intranet.
Employment	Take-up of equality and diversity training for staff is being monitored, via an e-learning module. This current national NHS e-learning module, though adequate, is due to be refreshed in order to include all the protected characteristics. However in 2015 the Trust plans to migrate to a comprehensive and more accessible

Workstream	Action
	tool as part of the UK Core Skills and Training Framework. The Trust aims to achieve a 90% completion of this e-learning E&D training by December 2015.
Age (Older People)	100% (against a target of 90%) of band 7 and 8 ward-based nursing staff have received dementia confident training. 90% of band 6 staff have been trained (against a target of 75%).
Religion and Belief	Training sessions for selected nursing staff on spiritual care needs at end of life have been delivered.
Sexual Orientation / Trans	The provision of Trans awareness sessions for staff has been explored and steps taken to ensure that internal training offerings cover trans issues.
All protected characteristics	An equality and diversity training strategy was endorsed by the Equality & Inclusion Group in May 2014.

Using Equality Data and Intelligence

The Trust utilises the Trust-wide data held in this report, including access data for protected groups[6], to signpost areas for development as part of its annual review of organisational objectives. In addition, the workstream groups routinely use equality data for their protected characteristics to inform decision making and influence service delivery. A number of examples are outlined below:

Learning Disability
All admission data for patients with a learning disability is captured and assessed looking at reason for admission, length of stay and re-admission. This data informs the wider health sub group.
An accessible easy read feedback form was issued to all inpatients with a learning disability who accessed our services in the month of July 2014 and the results have been shared with the Learning Disability Partnership Boards health sub groups at both Calderdale and Kirklees Local Authorities.

Pregnancy and Maternity
"How was it for you?" cards are circulated to service users and results are audited on an on-going basis. Local surveys and national surveys with demographic breakdowns of the results, are also utilised to improve the service.

Older People
A Dementia Dashboard has been developed and is monitored monthly to ensure that older patients are adequately assessed for dementia and receive the appropriate support and treatment.

Race
Analysis undertaken of requests for assistance with interpretation showed that significant numbers of speakers of Punjabi, Urdu, Polish, Czech and Hungarian languages access our services. In response to this, new information posters are being designed, to be displayed in all the Trust's main reception areas.

[6]Appendix 1 – Patient and Local Population Data

Integrating Equality and Business Planning

Within the Equality Act 2010, the legal requirement to carry out equality impact assessments was removed. However, the Act still contains the requirement to pay "due regard" to the general equality duty when making decisions relating to service provision and employment. Examples of how equality considerations are integrated into business planning processes are outlined below:

Sex
All new developments and refurbishments take into consideration the need for preserving single sex accommodation.

Religion or Faith
Resources have been made available to employ female Muslim spiritual advisers to specialise in working with Muslim women and children. A new Buddhist adviser and Sikh chaplain have been included in the team over the past year.

Older people
The dementia care pathway is aimed at improving equality for vulnerable older people who are often unable to articulate their needs and choices and are more likely to be exposed to risk, indignity and loss of function and independence.

Hearing impairment, Visual impairment, Physical impairment, Older People
Issues for patients were identified and considered in the planning and development of new service provision, eg the outpatient department at Acre Mill, Huddersfield.

Learning Disability/Difficulty, Physical Impairment
Workstream leads work with colleagues in Facilities to ensure that toilets within "new builds" meet the accessibility requirements of wheelchair users and meet the "Changing Places" standards.

All workstreams
During 2014 the Trust introduced "the Balanced Plan", with a view to delivering a balanced financial position. An extraordinary meeting of the Engagement and Inclusion Group was held in August 2014 to assess the equality impact of the 10 proposed workstreams of the Balanced Plan. An equality impact assessment was completed by divisional managers for each of the 10 workstreams and consideration was given to the potential positive and negative impacts on specific communities of interest and in particular those patients/staff with a protected characteristic.

5. Learning from Experience

The Trust has prioritised learning from patient experience as an important way of improving care, quality and experience at CHFT. In line with the Trust's approach to equality & diversity, the Patient Advice & Complaints Service has worked with the Equality and Inclusion Group to develop a way of assessing and reporting any complaints received which relate to an equality & diversity issue. As a result of this we have identified 23 complaints that have a link to a protected characteristic over

the 12 month period 1/12/13 to 30/11/14. The Trust identified 7 relating to age (older people); 7 to race; 3 to physical disability; 1 to hearing impairment; 2 to learning disability; 1 to Mental Health; 1 to Religion and 1 to Sexual Orientation. There were disparate reasons for the complaints and no additional themes were identified.

All complaints are investigated thoroughly and action taken/improvements made where appropriate. Additionally, workstream groups are able to demonstrate how they use complaints data to ensure learning from those complaints is used to improve services for patients. Examples are shown below:

Pregnancy & Maternity – All incidents and complaints related to pregnancy and maternity are reviewed via the Maternity Patient Safety Group on behalf of the CWF (Children, Women and Families) Patient Safety and Quality Board. A quarterly newsletter is published and circulated to all staff in the Children, Women and Families (CWF) Division highlighting any trends or issues (anonymously) so that staff can learn from patient experience.

Learning Disability – Any complaints around services for people with a learning disability are brought to the attention of the Matron Complex Needs Coordinator who will address any issues with ward sisters/matrons as necessary.

Age (Young People) – There are family friendly displays on the paediatric ward which encourage feedback about the service, and any complaints/concerns expressed are monitored via the monthly Paediatric Forum.

6. Emerging Issues and priorities for 2015

The Trust has made good progress in 2014 on the delivery of the Trust's equality objectives. However, we recognise that this is a continuing journey and the review of progress has identified emerging issues and priorities going forward. These are outlined below:

a) A governmental review of the efficacy of the Public Sector Equality Duty found that most gains were found in organisations that fully mainstreamed equality and diversity activity, rather than retaining it as a stand-alone, specialist function. In order to further mainstream equality work within the Trust, equality outcomes need to be considered at a divisional, as well as an organisational level. To achieve this at CHFT we are developing a process for flagging up equality and diversity issues to the Patient Experience and Caring Group. Workstream leads will have the opportunity on a monthly basis to feed any issues into that group, and this will ensure that divisional colleagues take ownership of any issues and take remedial action as necessary.

b) Whilst there is no longer an explicit legal requirement to carry out equality impact assessments, we do need to be able to demonstrate that we have paid due regard to the general equality duty when making decisions and setting policies. Policies are set at an organisational level, but many of the major decisions relating to service provision are made divisionally. A review of the

use of equality analysis is required to mainstream and embed equality analysis throughout the organisation.

c) Physical access issues remain a priority for the Trust. A full audit of premises by an external company was carried out early in 2014. The audit covered all aspects of physical access and signage across the Trust and resulted in an action plan which outlined priorities in these areas.

d) Despite the existence of an equality and diversity training strategy, take-up of training continues to be a challenge for the Trust. It is a legal requirement that all employees receive training in order to ensure that they appreciate their obligations in promoting equality. To support this, the Trust has recently agreed to adopt the UK Core Skills and Training Framework in 2015. This will ensure that all staff, whether paid or unpaid, receive training and assessment on equality and diversity issues. In the meantime, the supply of training compliance information to divisions is to be strengthened in order to ensure closer monitoring and better uptake of equality and diversity training.

e) Another finding of the governmental review of the PSED was that outcomes improved for patients and staff where organisations benchmarked their activity against other similar organisations. Many NHS Trusts currently utilise an optional framework for developing good practice in relation to equality and diversity – the NHS Equality Delivery System (EDS). The framework has now been reviewed and updated (EDS2) and from March 2016 it will be a requirement that all NHS Trusts use EDS2 to improve their equality performance

The purpose of EDS2 is to help NHS organisations to review and improve their performance for people with characteristics protected by the Equality Act 2010. It is a generic tool based on 18 outcomes, against which NHS organisations grade themselves. It is designed for both NHS providers and NHS commissioners and it is important to note that commissioners are asked to apply EDS2 in light of the performance of providers from whom they commission services.

By April of each year, the Trust is obliged to review its equality objectives as part of its specific duty to meet the requirements of the Equality Act 2010. This review will include an analysis of the Trust's progress towards achieving the 18 outcomes of EDS2.

7. Contacts and Enquiries

If you have any questions or comments on this report, or would like to receive it in alternative formats eg large print, braille, languages other than English, please contact Vanessa Henderson on 01484 347342 or by e-mail: vanessa.henderson@cht.nhs.uk.

APPENDIX 1 - TRUST PATIENT AND LOCAL POPULATION DATA

Inpatients

Age

Age profiles Dec 2013 to Nov 2014 (source CHFT Patient Administration System) compared with local population age profiles (source West Yorkshire Observatory website: http://www.westyorkshireobservatory.org/dataviews/)

Age Band	Percentage of admissions	Percentage of local population
0 – 15	13.19%	20.12%
16 – 29	14.07%	17.77%
30 – 44	15.23%	20.20%
45+	57.51%	41.91%
45+ age band broken down:		
45 – 54	10.02%	Not available
55 – 64	12.41%	
65 – 74	14.80%	
75 – 84	13.28%	
85 +	6.99%	

Ethnicity

Patient ethnicity profiles Dec 2013 to Nov 2014 (source CHFT Patient Administration System) compared with Local population ethnicity profiles (source West Yorkshire Observatory website: http://www.westyorkshireobservatory.org/dataviews/)

Ethnic Category Group	Percentage of patient population	Percentage of local population
White - British	81.03%	82.71%
White - Irish	0.57%	0.82%
Any other White background	5.15%	2.15%
Black - Caribbean	0.95%	0.84%
Black - African	0.39%	0.67%
Any other Black background	0.30%	0.13%
Asian - Bangladeshi	0.13%	0.61%
Asian - Indian	0.79%	3.12%
Asian - Pakistani	7.39%	6.15%
Any other Asian background	0.83%	0.49%
Chinese	0.18%	0.26%
Mixed White and Black African	0.11%	0.26%

Ethnic Category Group	Percentage of patient population	Percentage of local population
Mixed - White and Black Caribbean	0.60%	0.61%
Mixed White and Asian	0.34%	0.53%
Any other Mixed	0.32%	0.26%
Any other Ethnic group	0.74%	0.38%
Not Stated	0.18%	

Gender

Patient gender profiles Dec 2013 to Nov 2014 (source CHFT Patient Administration System) compared with local population gender profiles (source West Yorkshire Observatory website: http://www.westyorkshireobservatory.org/dataviews/)

Gender	Percentage of patient population	Percentage of local population
Male	40.18%	49.23%
Female	59.82%	50.77%

Religion

Patient religious group profiles Dec 2013 to Nov 2014 (source CHFT Patient Administration System) compared with local population religious group profiles (source West Yorkshire Observatory website: http://www.westyorkshireobservatory.org/dataviews/)

Religious group	Percentage of patient population	Percentage of local population
Not known	53.32%	7.50%
Christian	35.25%	67.99%
None	4.89%	14.81%
Muslim	4.84%	8.53%
Sikh	0.23%	0.51%
Hindu	0.07%	0.28%
Other	1.36%	0.21%
Buddhist	0.02%	0.13%
Jewish	0.02%	0.05%

Outpatient attendances and associated Did Not Attend appointment (DNA) rates

Age

Age profiles Dec 2013 to Nov 2014 – source CHFT Patient Administration System

Age Band	Attendances	DNA rate
00 – 04	16,816	13%
05 – 14	25,087	12%
15 – 24	27,312	14%
25 – 34	50,640	11%
35 – 44	44,236	10%
45 – 54	51,133	8%
55 – 64	56,863	6%
65 – 74	66,042	4%
75 – 84	54,192	5%
85 +	19,680	7%

Ethnicity

Ethnicity profiles Dec 2013 to Nov 2014 – source CHFT Patient Administration System

Ethnic Category Group	Attendances	DNA rate
White - British	328,956	7%
White - Irish	2,046	7%
Any other White background	20,921	9%
Asian - Bangladeshi	4,702	11%
Asian - Pakistani	1,526	13%
Asian - Indian	1,030	12%
Any other Asian background	524	10%
Black - African	3,871	10%
Black - Caribbean	29,841	12%
Any other Black background	4,031	14%
Chinese	768	6%
Mixed - White and Black Caribbean	272	11%
Mixed - White and Black African	2,083	14%
Mixed - White and Asian	1,102	13%
Any other mixed background	1,504	13%

Ethnic Category Group	Attendances	DNA rate
Any other ethnic group	3,057	10%
Not Stated	5,767	11%

Gender

Gender profiles Dec 2013 to Nov 2014 – source CHFT Patient Administration System

Gender	Attendances	DNA rate
Male	172,126	9%
Female	239,871	7%

Religion

Patient religion profiles Dec 2013 to Nov 2014 – source CHFT Patient Administration System

Religious group	Attendances	DNA rate
Not known	222,317	8%
Christian	132,662	7%
None	20,831	9%
Muslim	19,699	12%
Sikh	1,174	9%
Hindu	377	10%
Other	14,741	6%
Buddhist	120	8%
Jewish	75	8%

APPENDIX 2 – EQUALITY IN OUR WORKFORCE REPORT

1. Introduction

Calderdale and Huddersfield NHS Foundation Trust provides 24 hour acute healthcare services to around 435,000 people who live in the two areas served by the Calderdale and Kirklees councils. The Trust also provides community services for the Calderdale population.

The Trust also has patients who travel from further afield to access our services. The Trust employs over 6000 people and has an operating income of £343m.

The Trust's principal commissioners are Greater Huddersfield Clinical Commissioning Group and Calderdale Clinical Commissioning Group.

The Trust is clinically led and has "compassionate care" as its primary focus.

The Trust's colleague engagement strategy describes the Trust's ethos for engaging with staff. The organisation is working with its staff to refine its approach and integrate this into everything that we do. The strategy focuses on four pillars of behaviour for all of its workforce.

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

This report provides information about equality in the Trust's workforce. It is based on data that is held about the workforce as at 30 November 2014.

We have published this report because, under the Equality Act 2010, we have a duty to "publish information relating to persons who share a relevant protected characteristic who are its employees."

We also have a duty to "publish information relating to persons who share a relevant protected characteristic who are other persons affected by its policies and practices."

2. Staff profile

The staff profile shown in the graphs below are based on a 'snapshot' of all the staff working for the Trust as at 30 November 2014 against the previous four financial years.

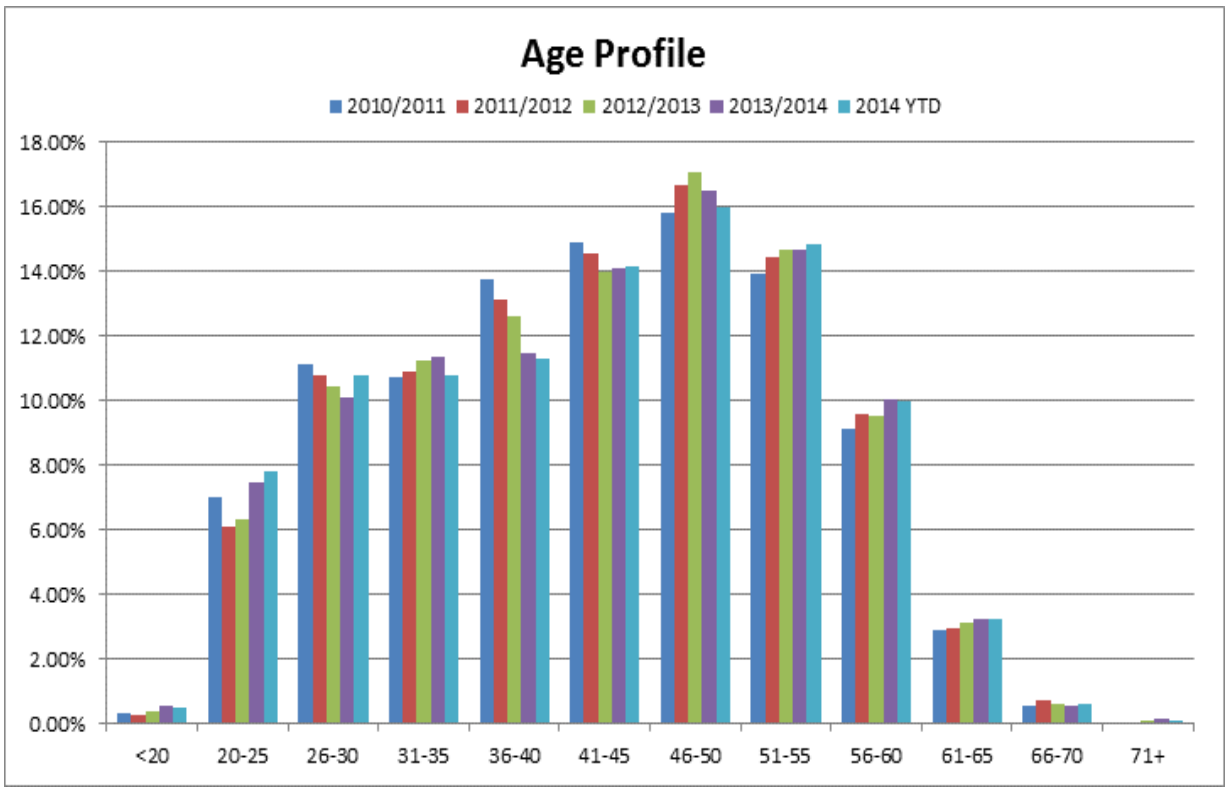
Following good practice in data protection and to ensure personal privacy, some categories have been combined. This helps to protect the anonymity of staff.

We have benchmarked against the Trust the last four years of information on key equality and diversity indicators to try and identify any significant trends in the data. The categories used are:

- Age
- Disability
- Ethnicity
- Gender
- Religious Belief
- Sexual Orientation

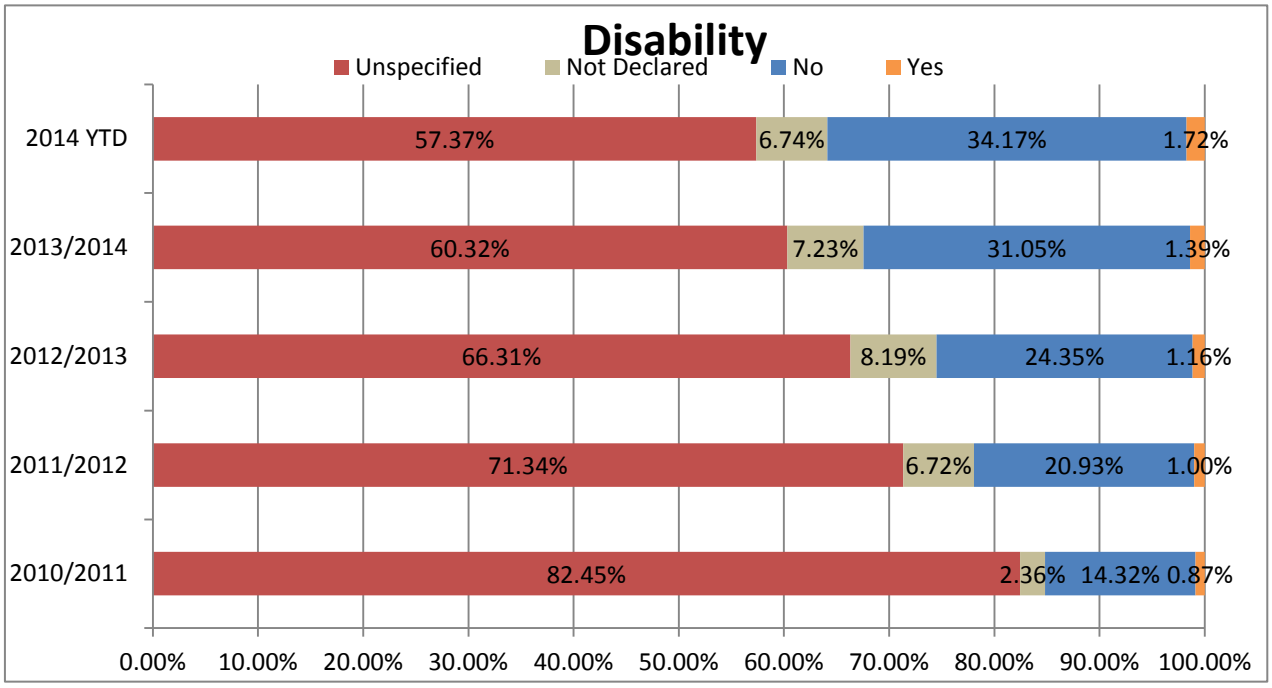
Age Profile

The highest proportion of Trust employees are aged between 46-50. The age bracket showing the most growth during the 2013/14 financial year was 31-35, with an increase of 0.58% from the previous year



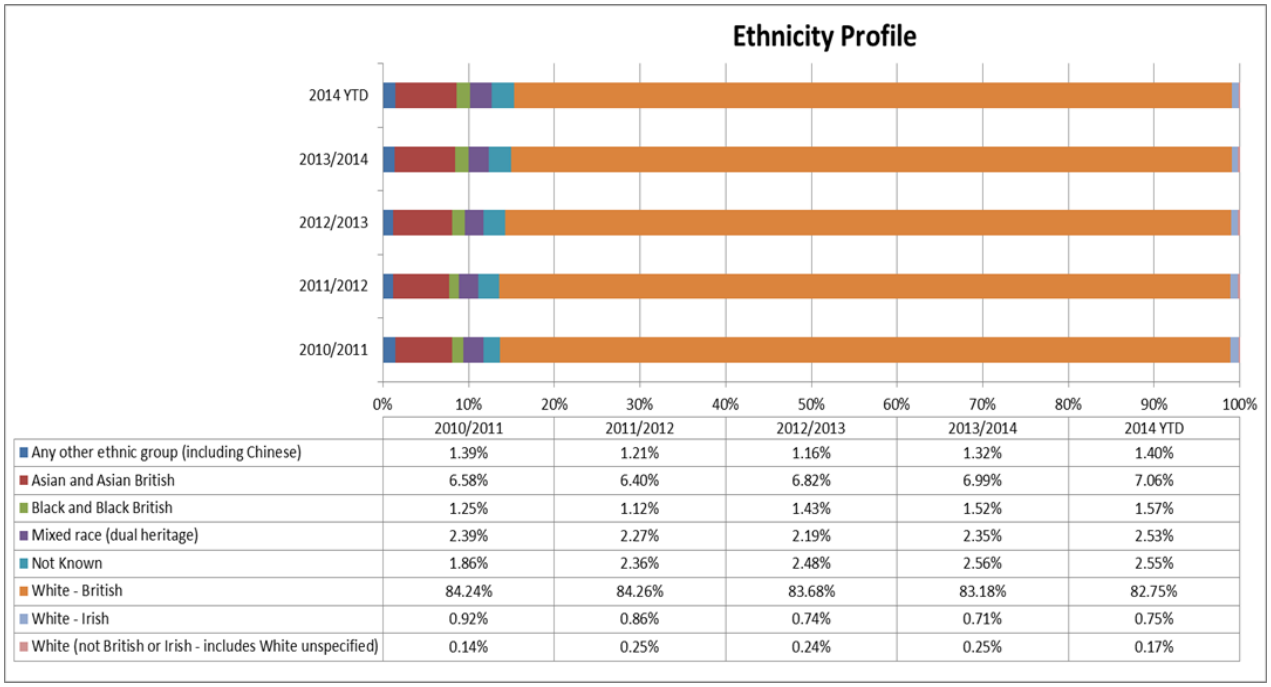
Disability

Information on the profile of the Trust's workforce in terms of disability is inadequate when analysing the data. Data quality has improved over the last 2 years; however there is still 57% of the workforce where information around disability is unknown. Progress has been made with regards data capture within the Trust's information technology systems. These are reviewed on an on-going basis and continuous improvements made.



Ethnicity Profile

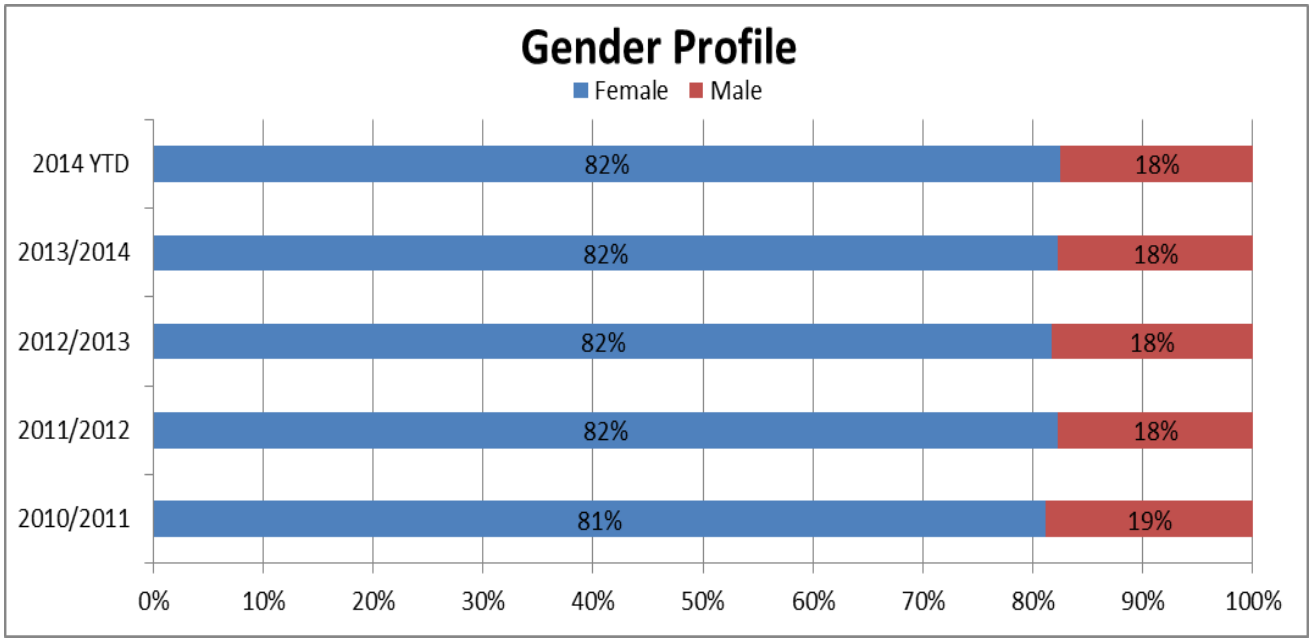
The ethnicity profile of the Trust has not shown much change over the last 4 years, the biggest profile remain white British (82.75%)



	2010/2011	2011/2012	2012/2013	2013/2014	2014 YTD
Any other ethnic group (including Chinese)	1.39%	1.21%	1.16%	1.32%	1.40%
Asian and Asian British	6.58%	6.40%	6.82%	6.99%	7.06%
Black and Black British	1.25%	1.12%	1.43%	1.52%	1.57%
Mixed race (dual heritage)	2.39%	2.27%	2.19%	2.35%	2.53%
Not Known	1.86%	2.36%	2.48%	2.56%	2.55%
White - British	84.24%	84.26%	83.68%	83.18%	82.75%
White - Irish	0.92%	0.86%	0.74%	0.71%	0.75%
White (not British or Irish - includes White unspecified)	0.14%	0.25%	0.24%	0.25%	0.17%

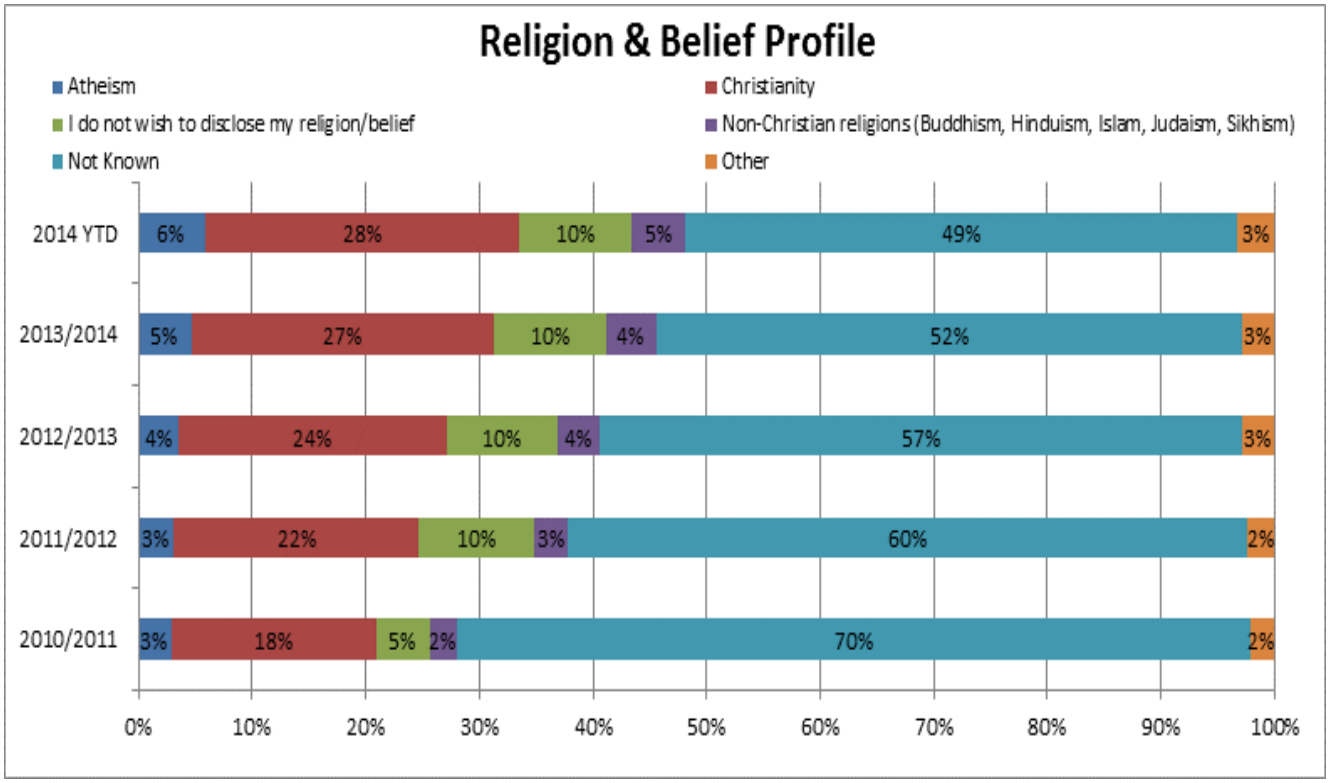
Gender Profile

The proportion of men working for the Trust is significantly lower than the national workforce. However, the health and social care sector traditionally employs more women than men.



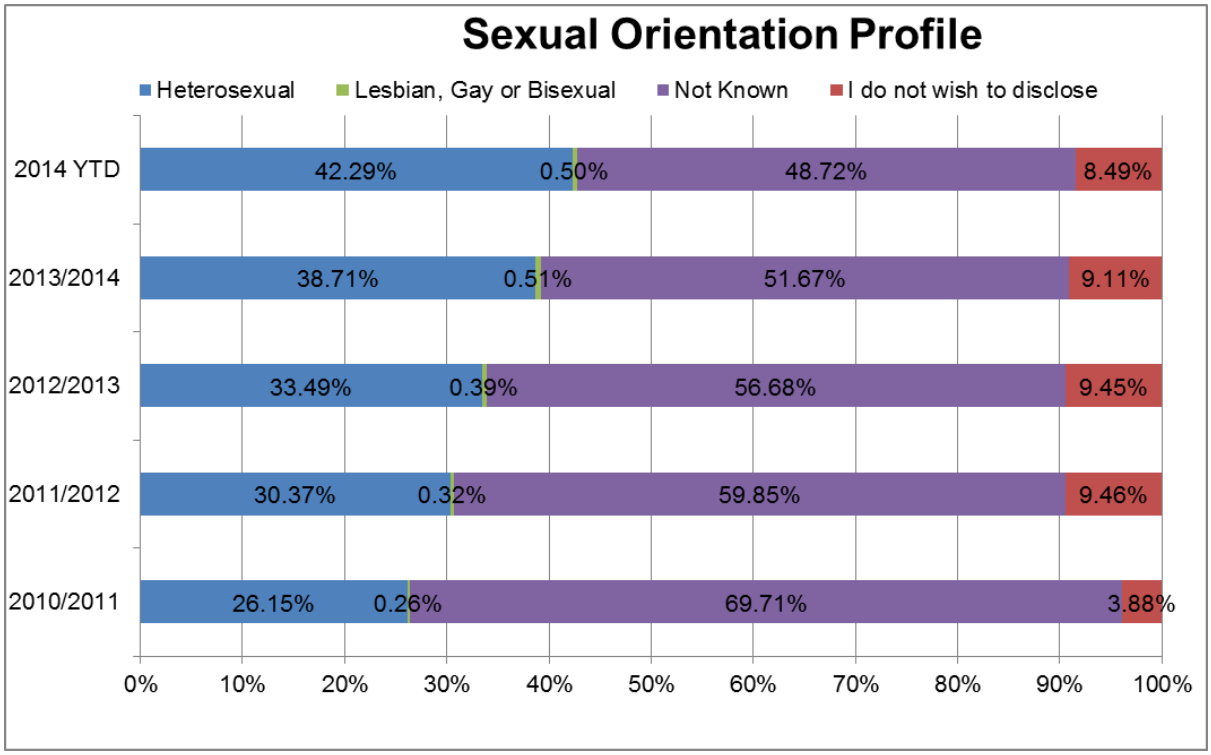
Religion & Belief

Data quality has continued to improve; however there is still 49% of the workforce where information around religious belief is unknown.



Sexual orientation

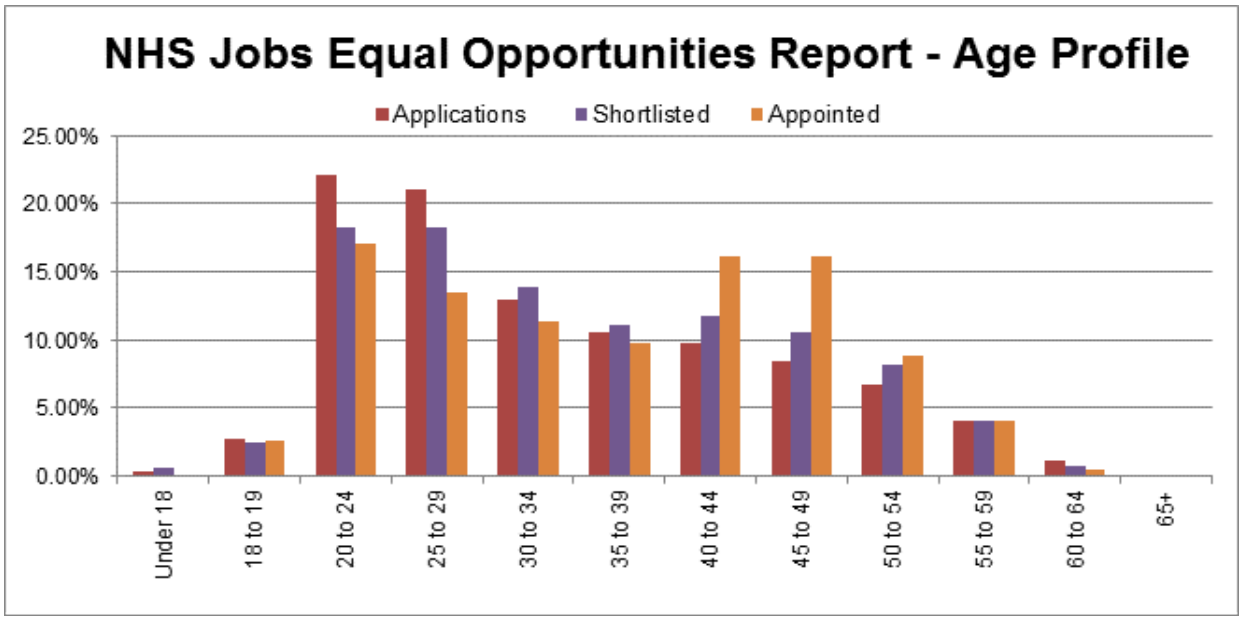
Data quality has continued to improve; however there is still 48.72% of the workforce where information around sexual orientation is unknown.

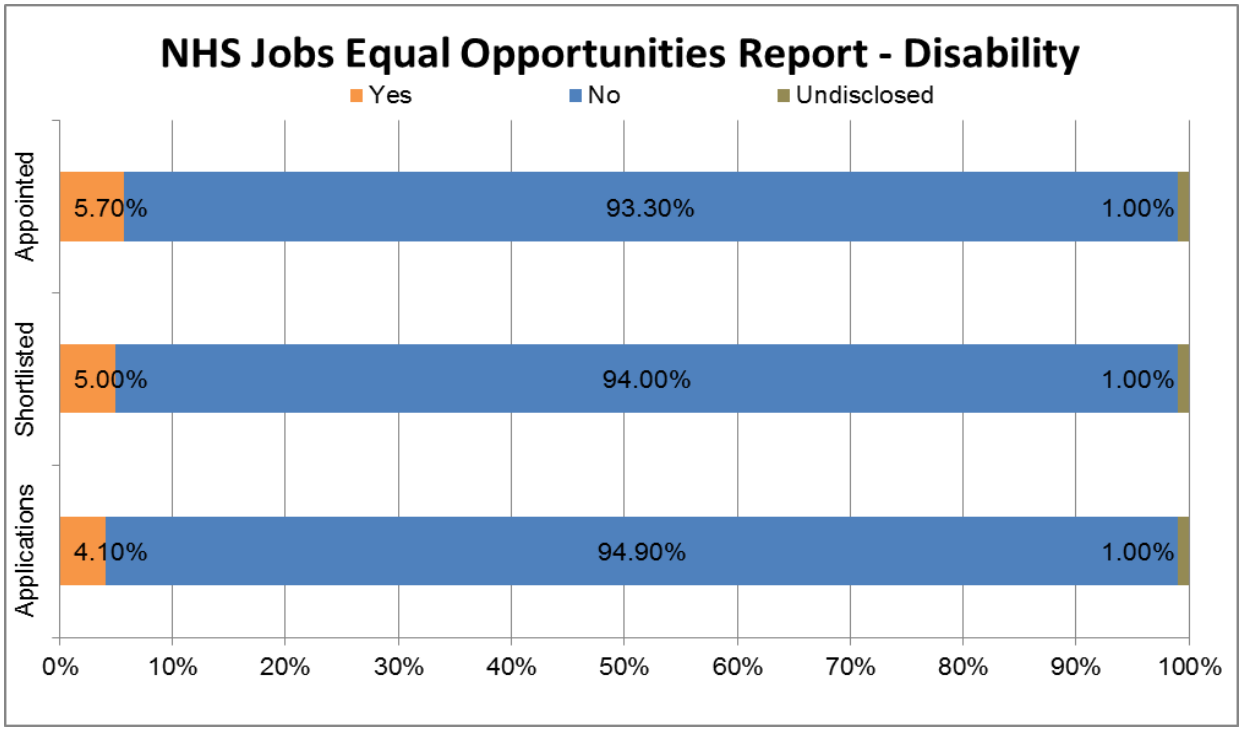


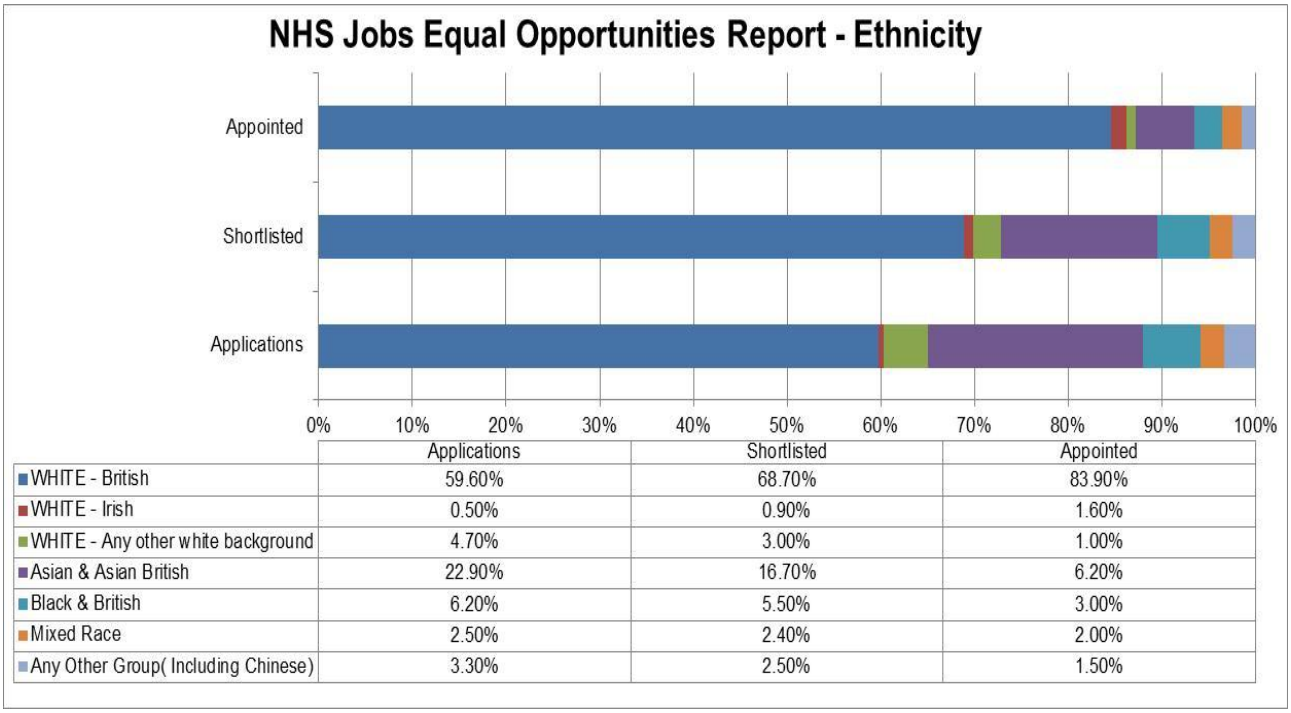
3. Staff joining the Trust

This section shows demographic data for the recruitment of staff and has been broken down using equality and diversity indicators. All information in this section comes from NHS Jobs, an online recruitment tool used by all NHS organisations.

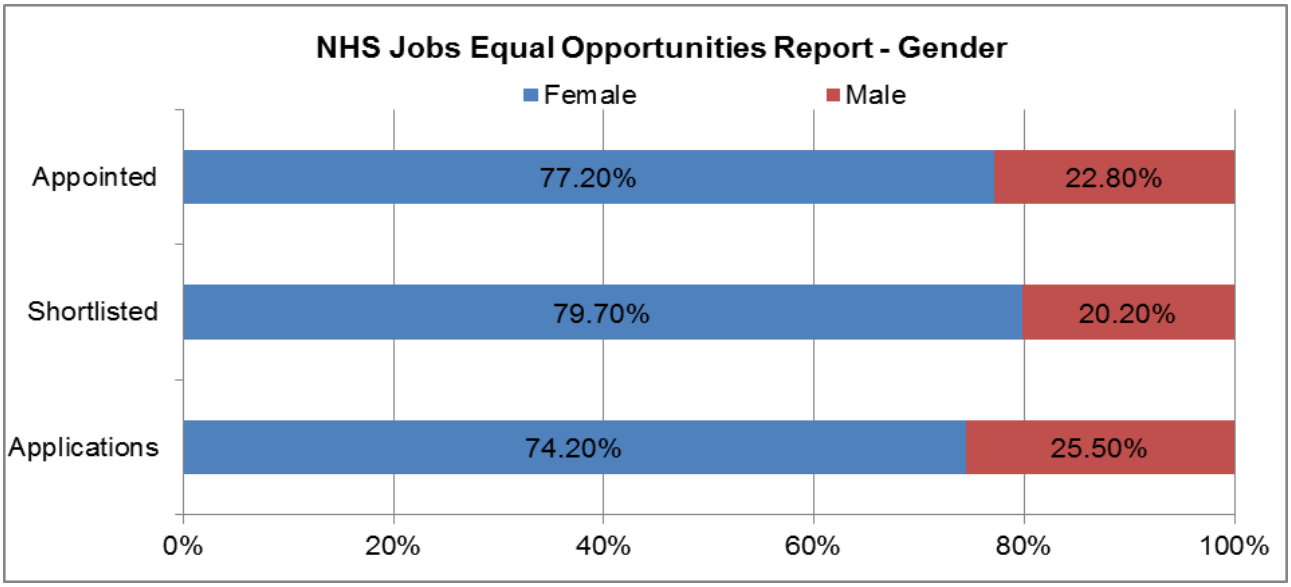
The data shown reflects all recruitment activity for the period 1 December 2013 to 30 November 2014 and provides a breakdown of number of applicants, number of applicants shortlisted and number of applicants appointed.

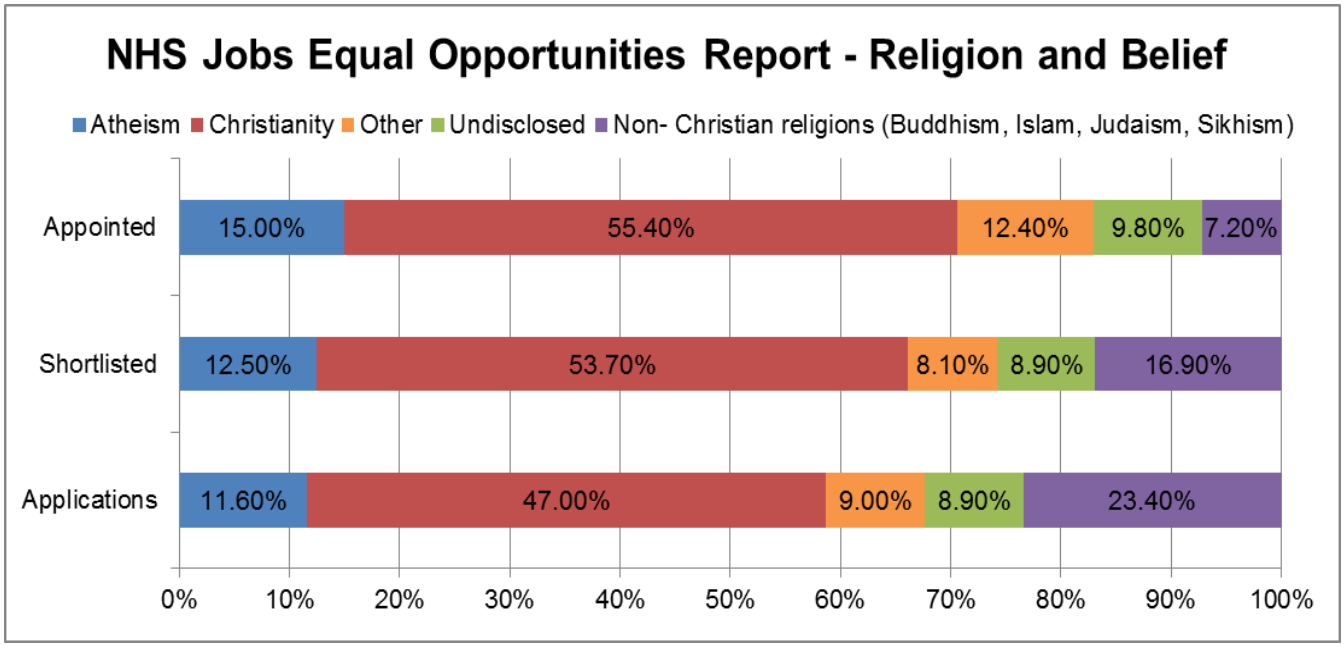


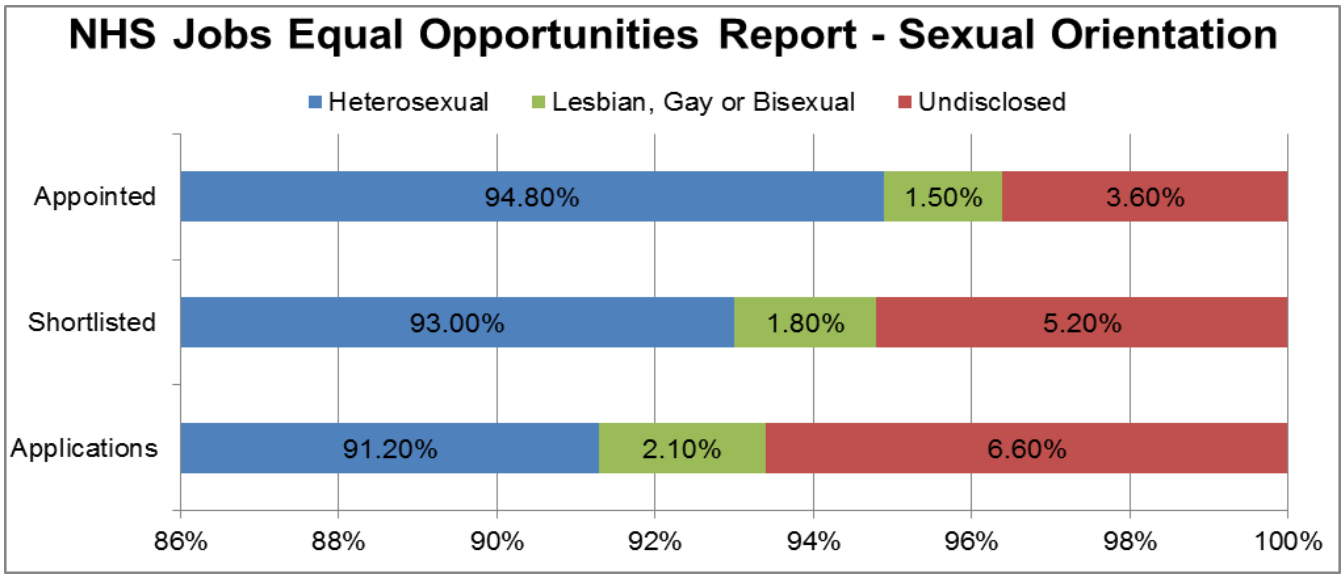




	Applications	Shortlisted	Appointed
WHITE - British	59.60%	68.70%	83.90%
WHITE - Irish	0.50%	0.90%	1.60%
WHITE - Any other white background	4.70%	3.00%	1.00%
Asian & Asian British	22.90%	16.70%	6.20%
Black & British	6.20%	5.50%	3.00%
Mixed Race	2.50%	2.40%	2.00%
Any Other Group(Including Chinese)	3.30%	2.50%	1.50%




NHS Jobs Equal Opportunities Report - Religion and Belief
Atheism
Christianity
Other
Undisclosed
Non- Christian religions (Buddhism, Islam, Judaism, Sikhism)
Appointed
15.00%
55.40%
12.40%
9.80%
7.20%
Shortlisted
12.50%
53.70%
8.10%
8.90%
16.90%
Applications
11.60%
47.00%
9.00%
8.90%
23.40%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

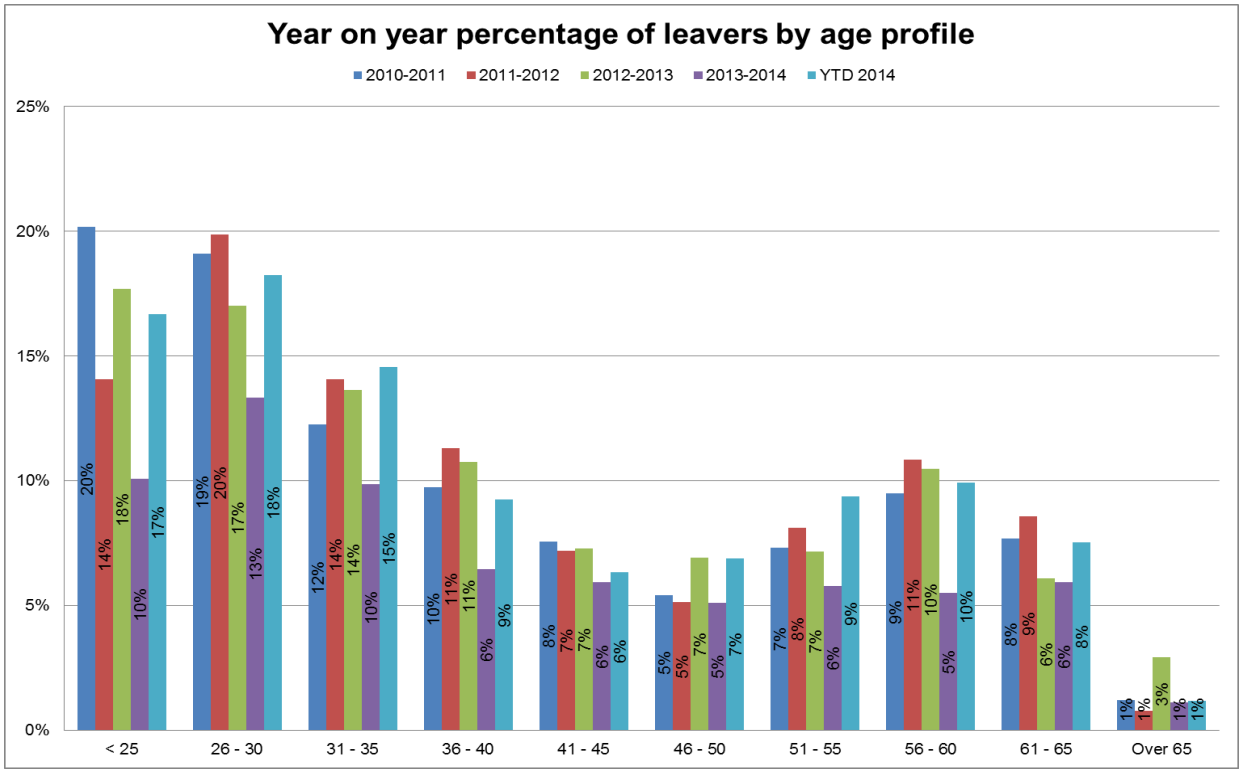

NHS Jobs Equal Opportunities Report - Sexual Orientation
Heterosexual
Lesbian, Gay or Bisexual
Undisclosed
Appointed
94.80%
1.50%
3.60%
Shortlisted
93.00%
1.80%
5.20%
Applications
91.20%
2.10%
6.60%
86%
88%
90%
92%
94%
96%
98%
100%

4. Staff leaving the Trust

This section shows data regarding staff that left the Trust between 1 April 2010 and 30 November 2014; broken down using the equality and diversity indicators.

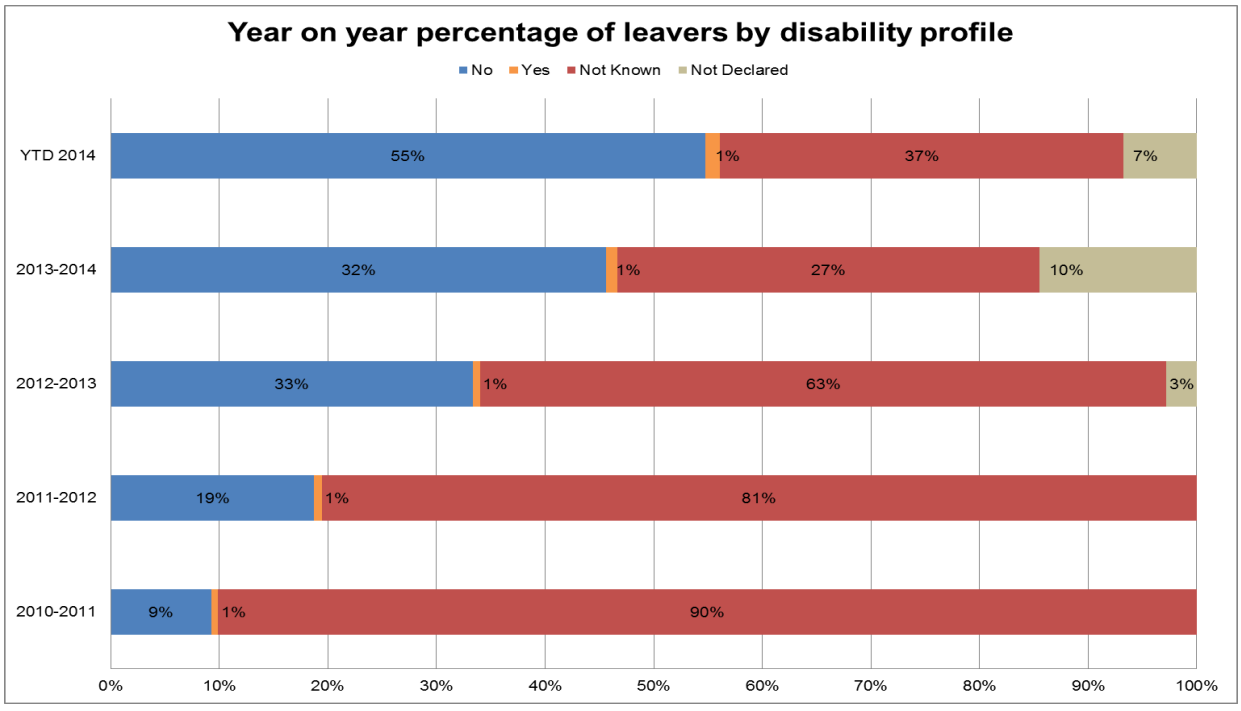
Age

During the current year to date, turnover is highest amongst staff aged 26-30 (18%).



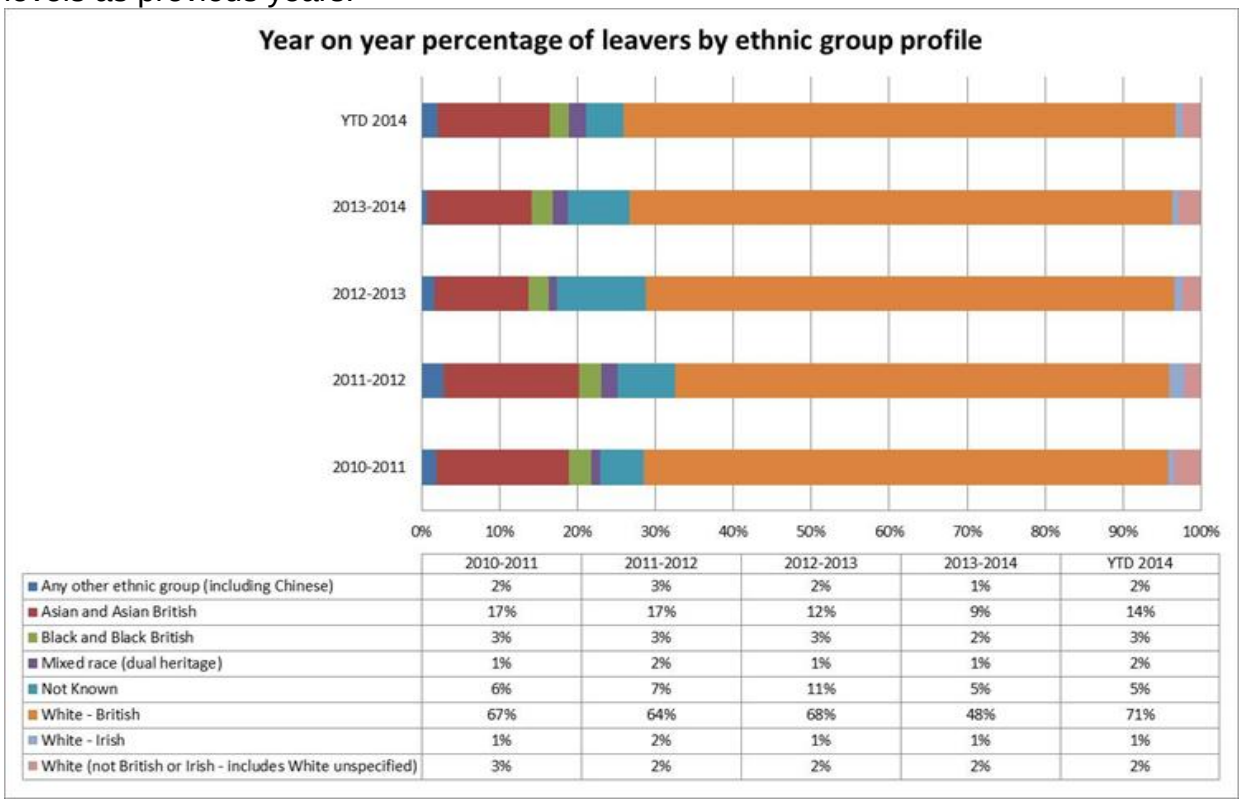
Disability

Data quality has improved in this area with a reduction of 10% in the 'not known' category.



Ethnicity Profile

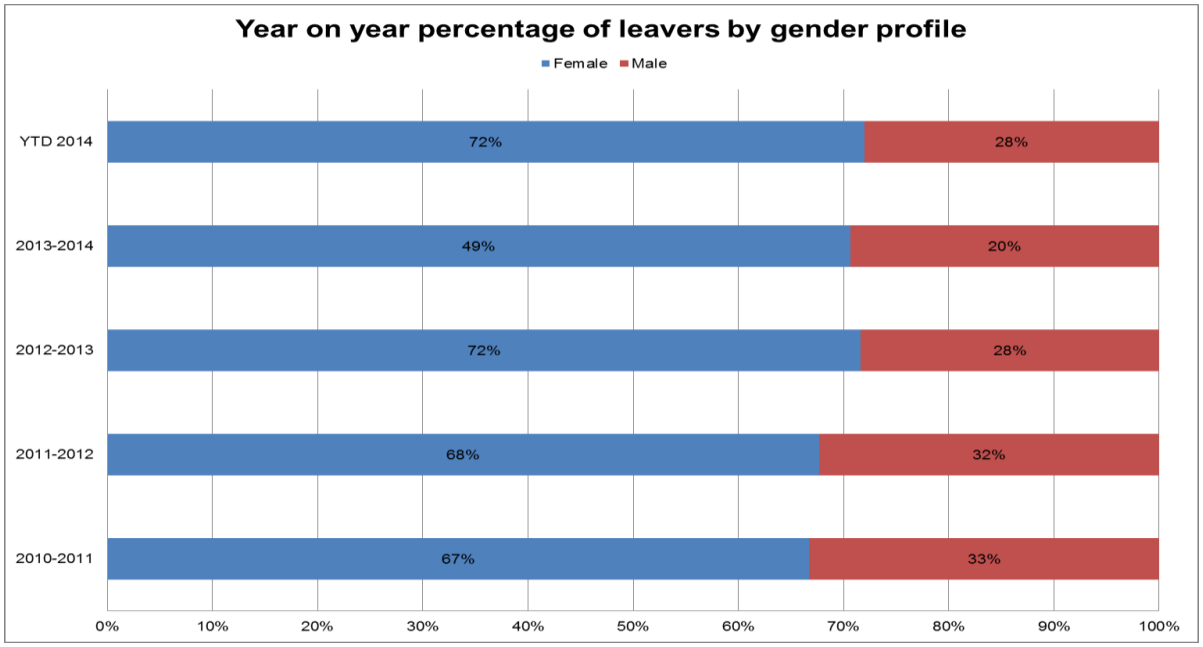
In the current financial year that has been an increase of 23% of 'White British' leavers in the Trust, the other ethnic category that showed a sharp rise was 'Asian & Asian British this has a rise of 5%. All other categories remained around similar levels as previous years.



	2010-2011	2011-2012	2012-2013	2013-2014	YTD 2014
Any other ethnic group (including Chinese)	2%	3%	2%	1%	2%
Asian and Asian British	17%	17%	12%	9%	14%
Black and Black British	3%	3%	3%	2%	3%
Mixed race (dual heritage)	1%	2%	1%	1%	2%
Not Known	6%	7%	11%	5%	5%
White - British	67%	64%	68%	48%	71%
White - Irish	1%	2%	1%	1%	1%
White (not British or Irish - includes White unspecified)	3%	2%	2%	2%	2%

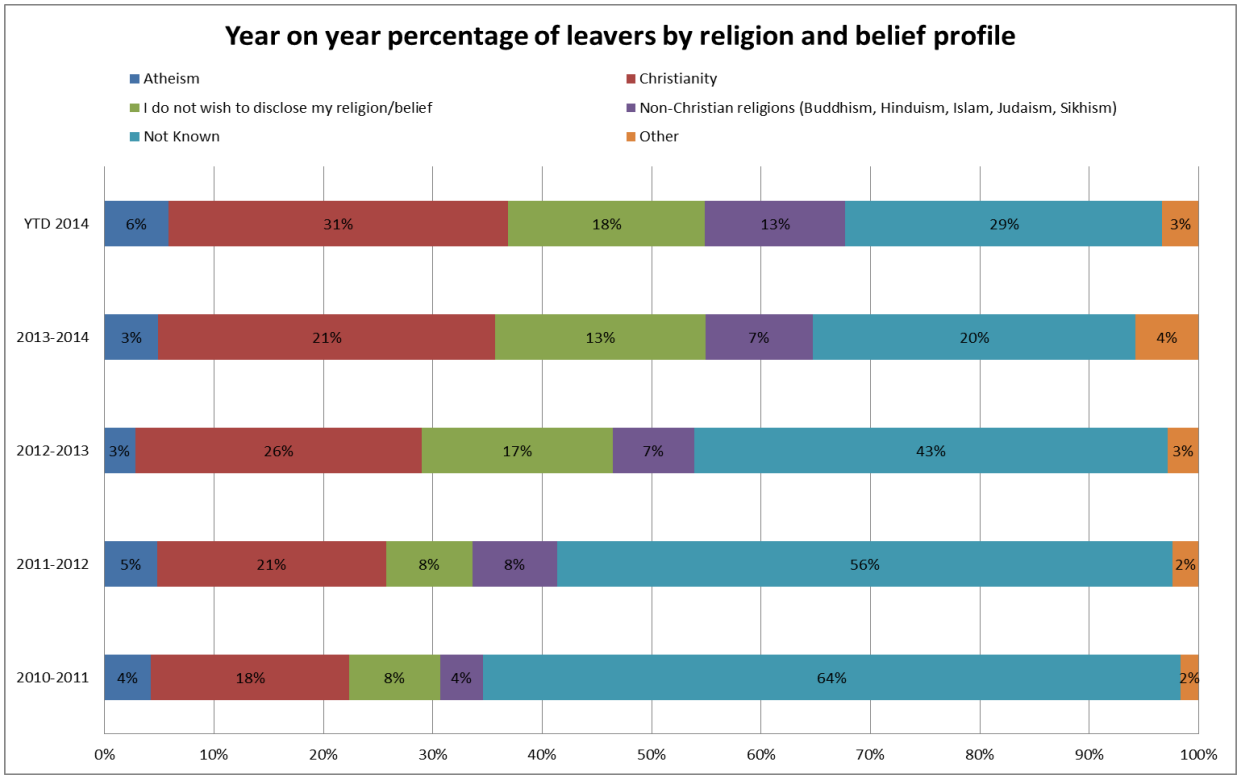
Gender

Turnover is higher amongst female employees (72%) but with the Trust employing a significantly higher amount of female to male employees this is expected.



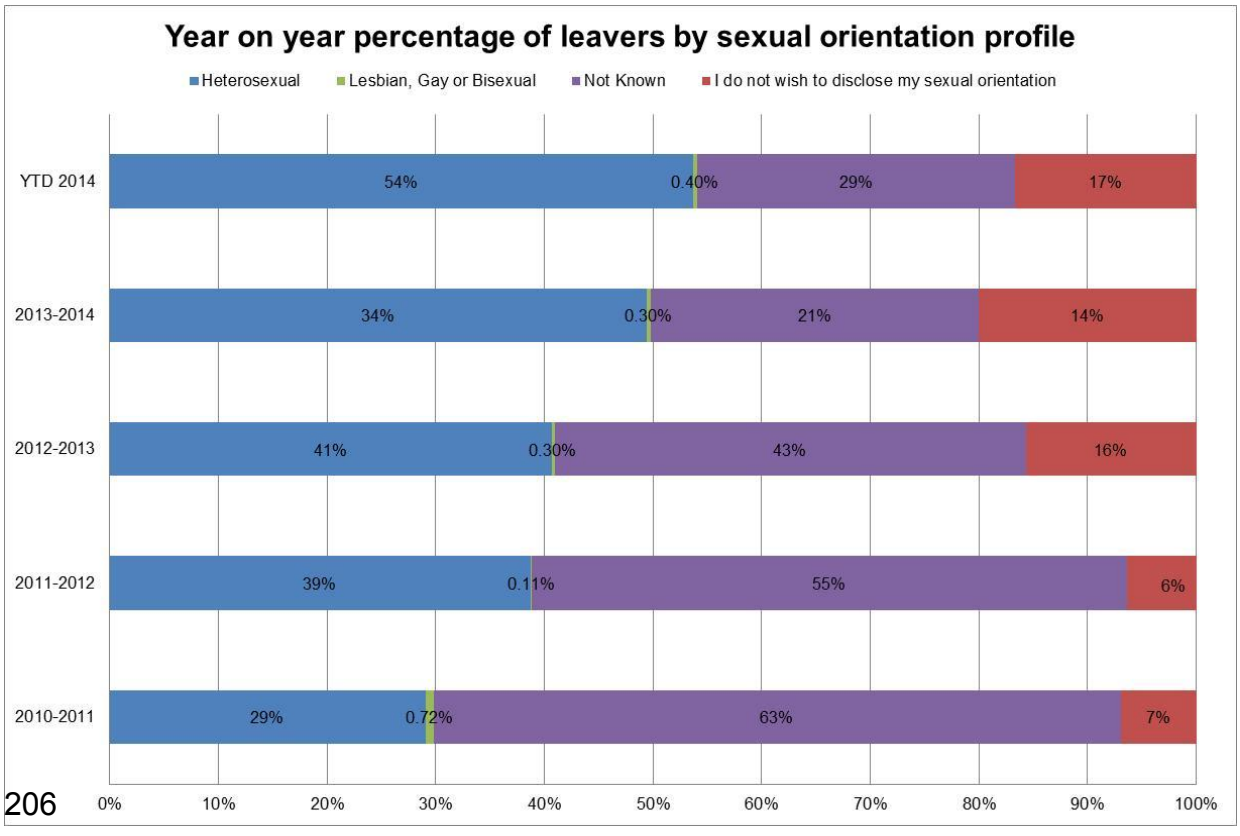
Religion & Belief

In the current year there has been a 9% increase in the 'not known' category, this is something the Trust will try and improve over the next 12 months.



Sexual Orientation

In the current year there has been a 9% increase in the 'not known' category, this is something the Trust will try and improve over the next 12 months.



5. Staff profile by pay

The data below is a 'snapshot view' of the pay levels for all Trust staff as at 30 November 2014.

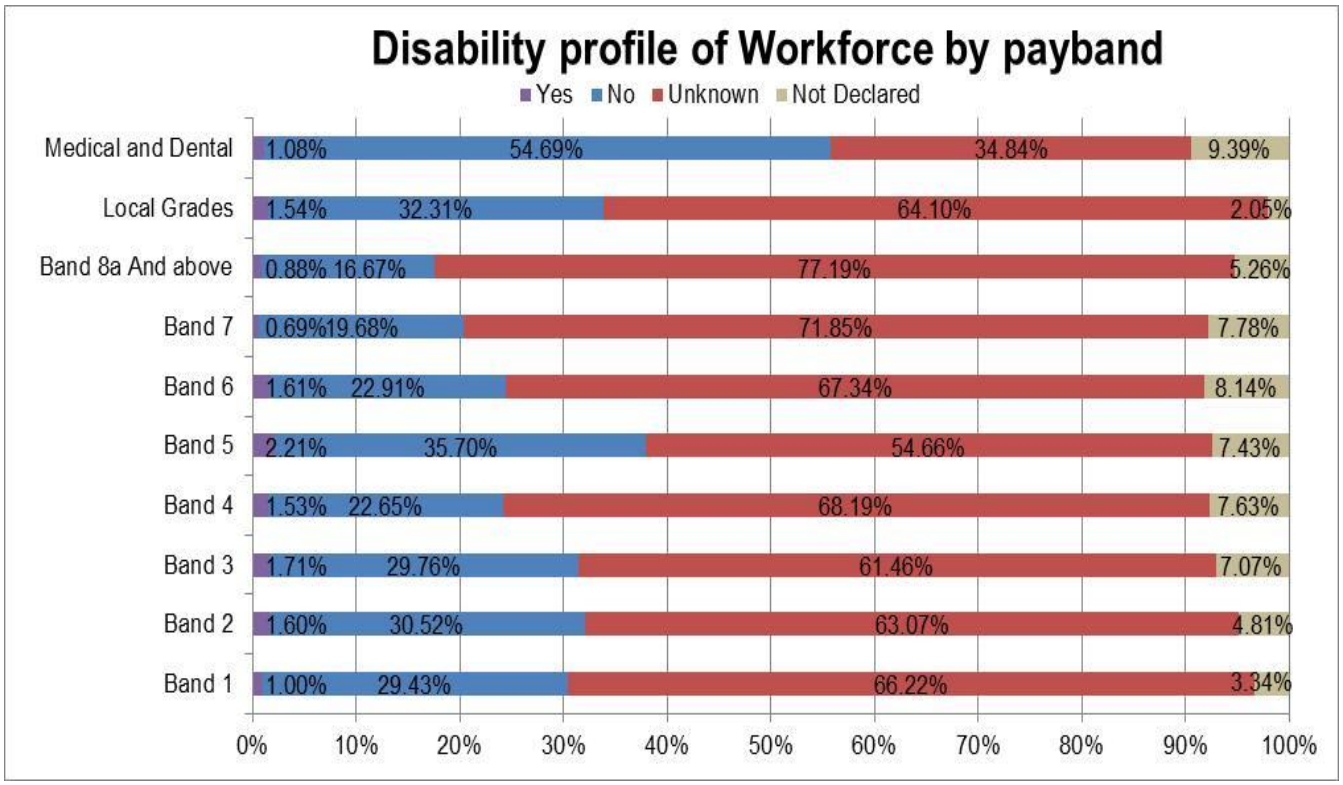
Age

The most common pay band in the Trust is band 5. 40.05% of people on this band are under 25.

Age Band	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a And above	Local Grades	Medical and Dental
<25	18.39%	27.32%	24.63%	29.26%	40.05%	33.83%	33.64%	29.82%	35.90%	14.26%
26 - 30	8.03%	12.82%	15.85%	12.47%	15.61%	16.81%	20.37%	20.18%	11.28%	20.04%
31 - 35	11.71%	14.25%	14.35%	18.32%	12.79%	14.99%	16.48%	14.04%	16.41%	25.09%
36 - 40	14.05%	13.58%	12.21%	15.78%	12.12%	13.38%	9.15%	11.40%	10.77%	26.53%
41 - 45	15.72%	14.42%	11.78%	12.98%	9.58%	9.96%	8.92%	10.53%	13.33%	9.21%
46 - 50	15.05%	8.94%	10.49%	7.12%	5.29%	5.35%	6.86%	7.02%	7.18%	2.17%
51 - 55	10.37%	4.64%	7.49%	3.05%	2.81%	3.43%	3.20%	3.51%	4.10%	0.72%
56 - 60	6.02%	3.63%	2.36%	0.51%	1.34%	1.82%	0.92%	2.63%	0.51%	0.72%
61 - 65	0.67%	0.42%	0.86%	0.51%	0.40%	0.43%	0.46%	0.88%	0.51%	0.72%
Over 65	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.54%

Disability

Information on the profile of the Trust's workforce in terms of disability is inadequate when analysing the data as the majority of information is unknown.



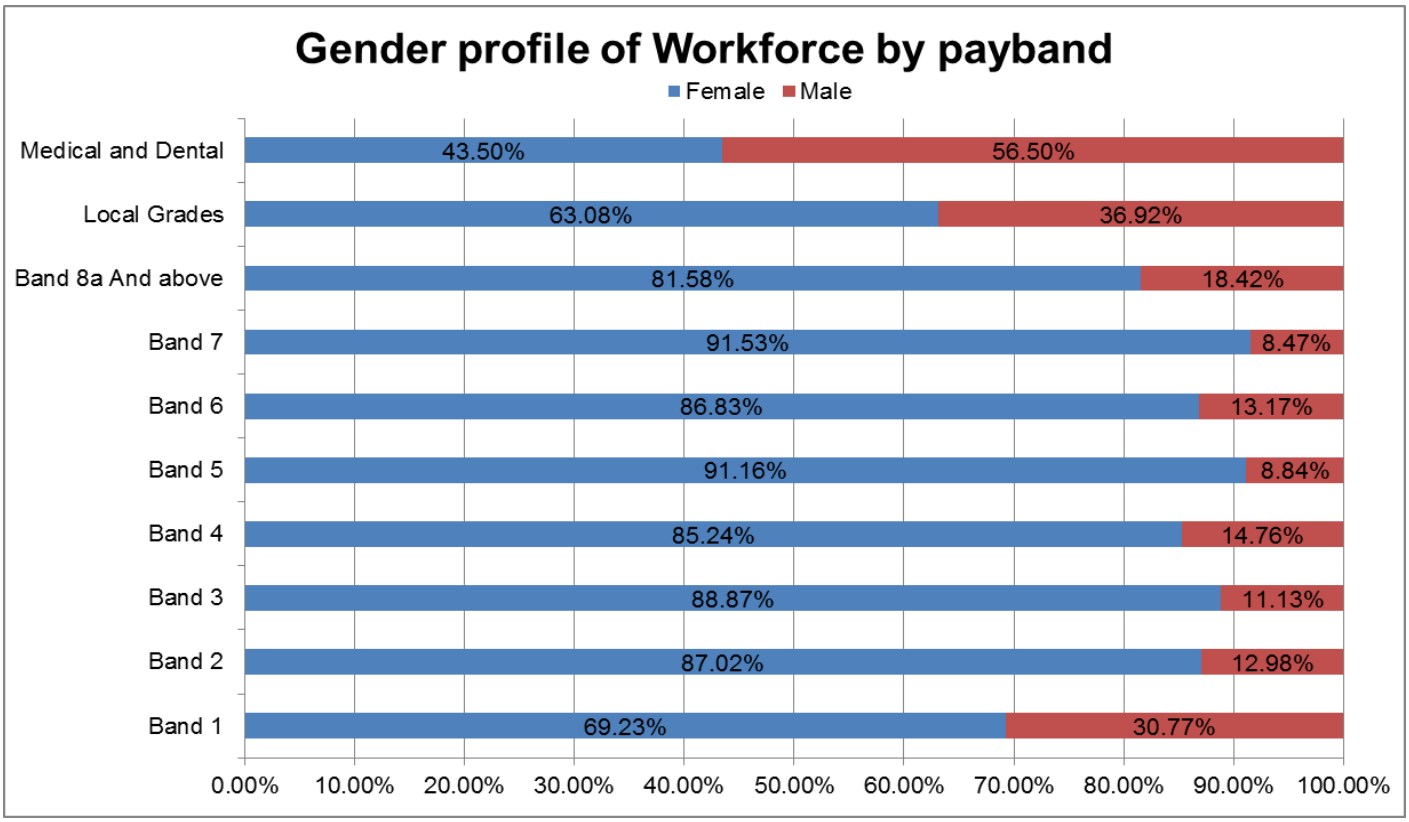
Ethnicity

Overall the Agenda for Change pay scales indicate that the majority of staff were White British. While Medical and Dental have a more even split between White and other ethnic backgrounds, with a large proportion of those being Asian/Asian British.

Ethnicity	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a And above	Local Grades	Medical and Dental
Any other ethnic group (including Chinese)	0.00%	0.51%	0.00%	0.25%	1.61%	0.96%	0.23%	1.75%	0.00%	7.22%
Asian and Asian British	4.35%	5.56%	3.64%	4.07%	5.22%	3.00%	1.60%	0.00%	7.69%	34.12%
Black and Black British	8.70%	2.87%	1.07%	2.80%	3.01%	0.86%	0.69%	0.00%	1.54%	2.89%
Mixed race (dual heritage)	3.01%	1.77%	1.50%	1.02%	1.14%	1.18%	2.06%	0.00%	1.54%	2.53%
Not Known	1.34%	2.36%	2.14%	1.78%	2.14%	2.78%	2.75%	0.00%	4.62%	4.69%
White - British	79.93%	85.58%	90.36%	88.30%	85.06%	88.54%	92.45%	98.25%	84.10%	41.16%
White - Irish	1.00%	0.67%	0.21%	0.25%	0.60%	1.50%	0.23%	0.00%	0.51%	1.44%
White (not British or Irish - includes White unspecified)	1.67%	0.67%	1.07%	1.53%	1.21%	1.18%	0.00%	0.00%	0.00%	5.96%

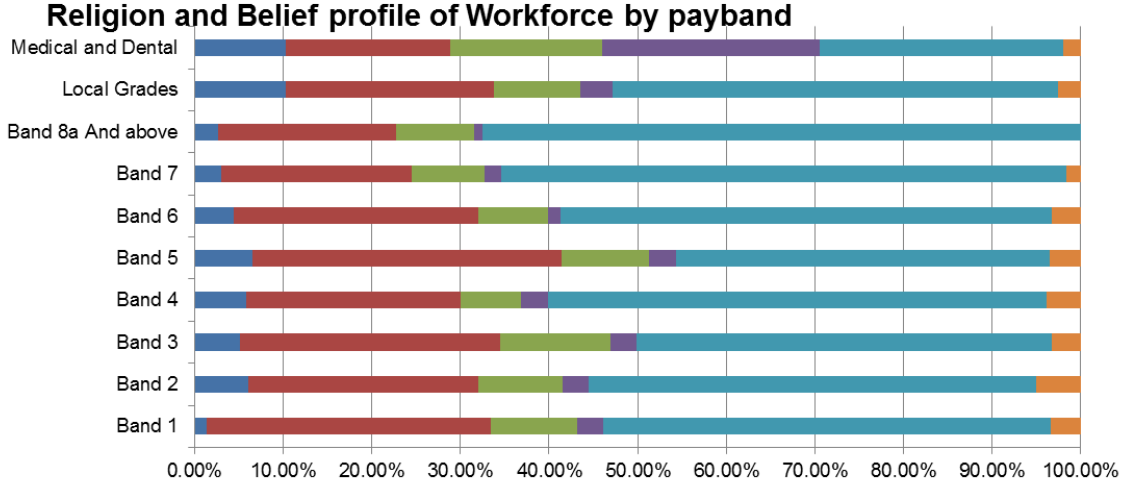
Gender

Men are over-represented in the Medical and Dental pay band (56.50%) compared with the workforce profile as a whole.



Religion and belief

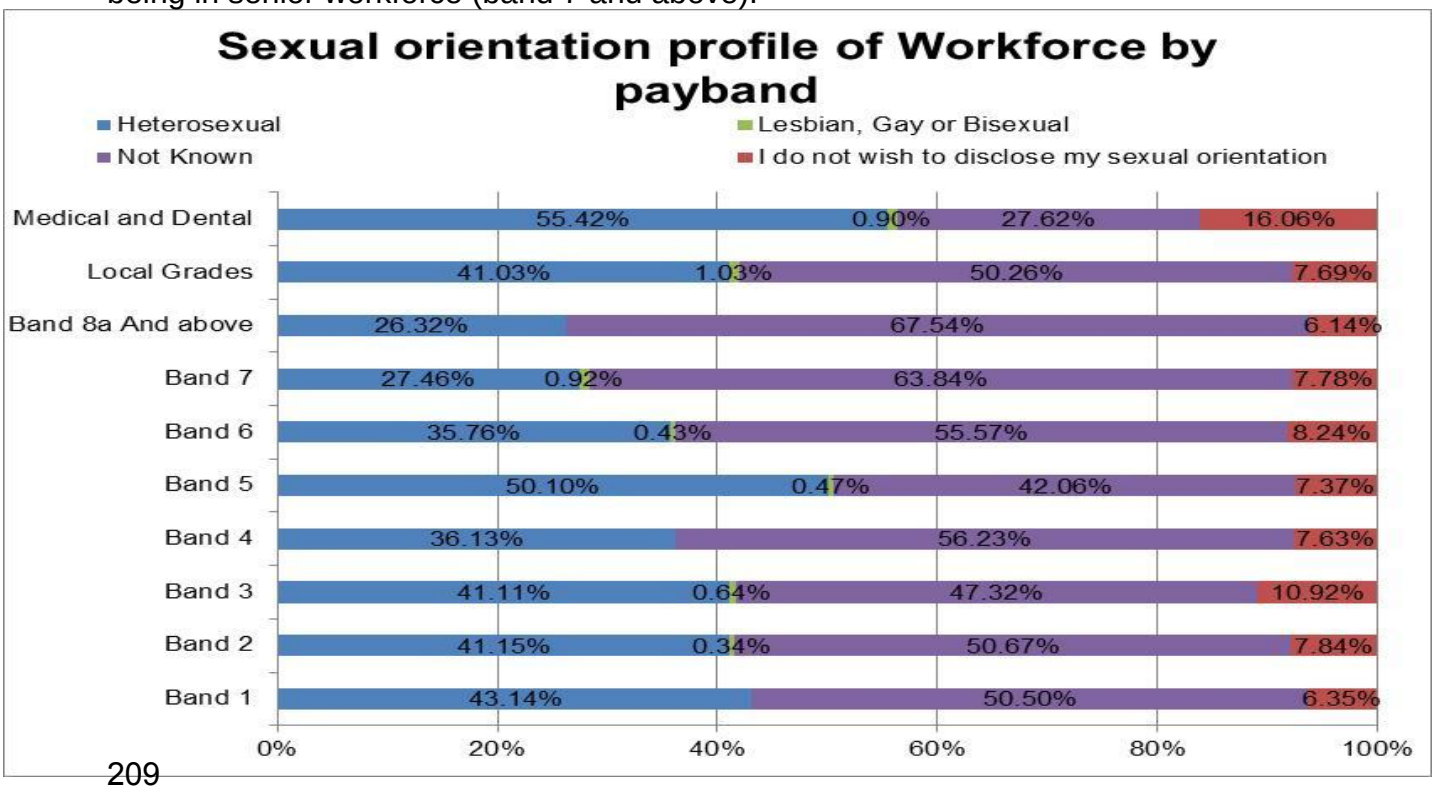
17.5% of Medical and Dental staff have chosen not to disclose their religion and belief. This is higher than any other pay band. 'Not known' information is predominant in all pay bands with the most significant being in Band 8a and above. Progress is been made with regards data capture within the Trust's information technology systems. These are reviewed on an on-going basis and continuous improvements made.



	Band 1	Band 2	Band 3	Band 4	Band 5	Band 6	Band 7	Band 8a And above	Local Grades	Medical and Dental
Atheism	1.34%	6.07%	5.14%	5.85%	6.56%	4.39%	2.97%	2.63%	10.26%	10.29%
Christianity	32.11%	25.97%	29.34%	24.17%	34.83%	27.62%	21.51%	20.18%	23.59%	18.59%
I do not wish to disclose my religion/belief	9.70%	9.44%	12.42%	6.87%	9.91%	7.92%	8.24%	8.77%	9.74%	17.15%
Non-Christian religions (Buddhism, Hinduism, Islam, Judaism, Sikhism)	3.01%	2.95%	3.00%	3.05%	3.08%	1.39%	1.83%	0.88%	3.59%	24.55%
Not Known	50.50%	50.59%	46.90%	56.23%	42.06%	55.46%	63.84%	67.54%	50.26%	27.44%
Other	3.34%	4.97%	3.21%	3.82%	3.55%	3.21%	1.60%	0.00%	2.56%	1.99%

Sexual orientation

Not known information is predominant in all pay bands with the most significant being in senior workforce (band 7 and above).

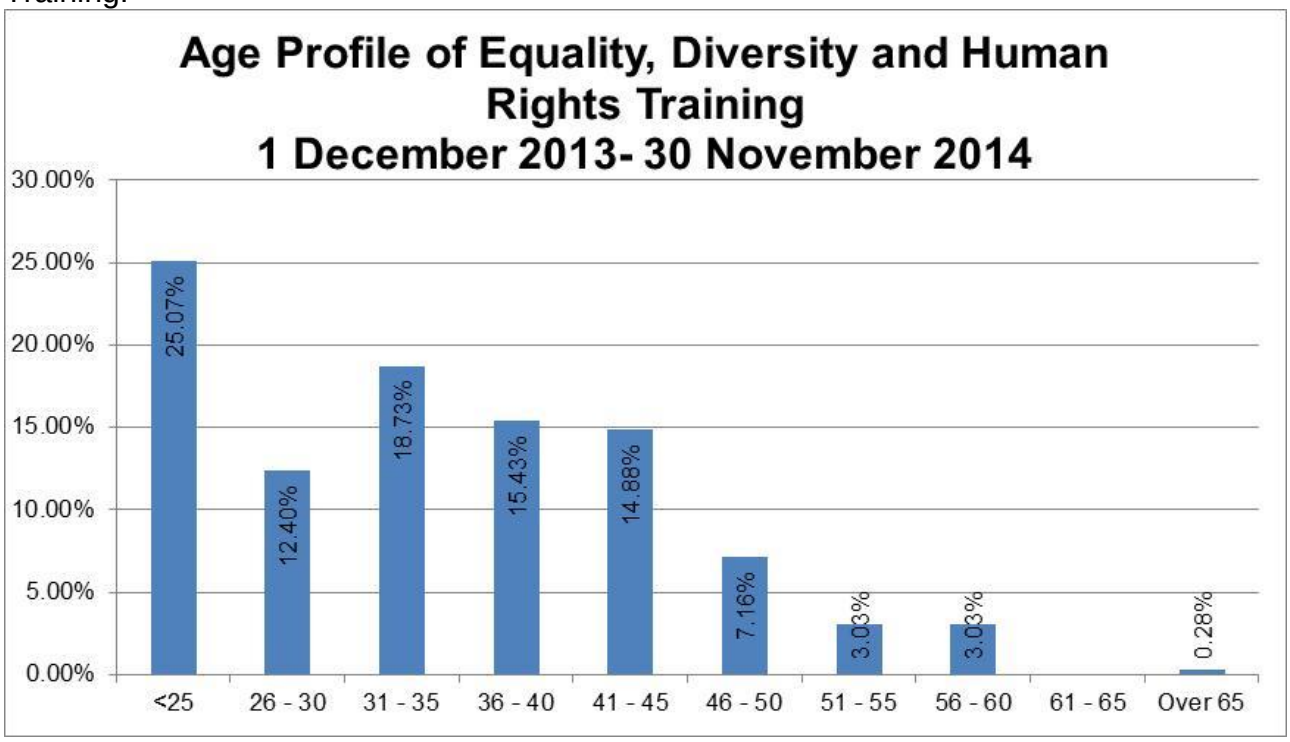


6. Equality & Diversity Training

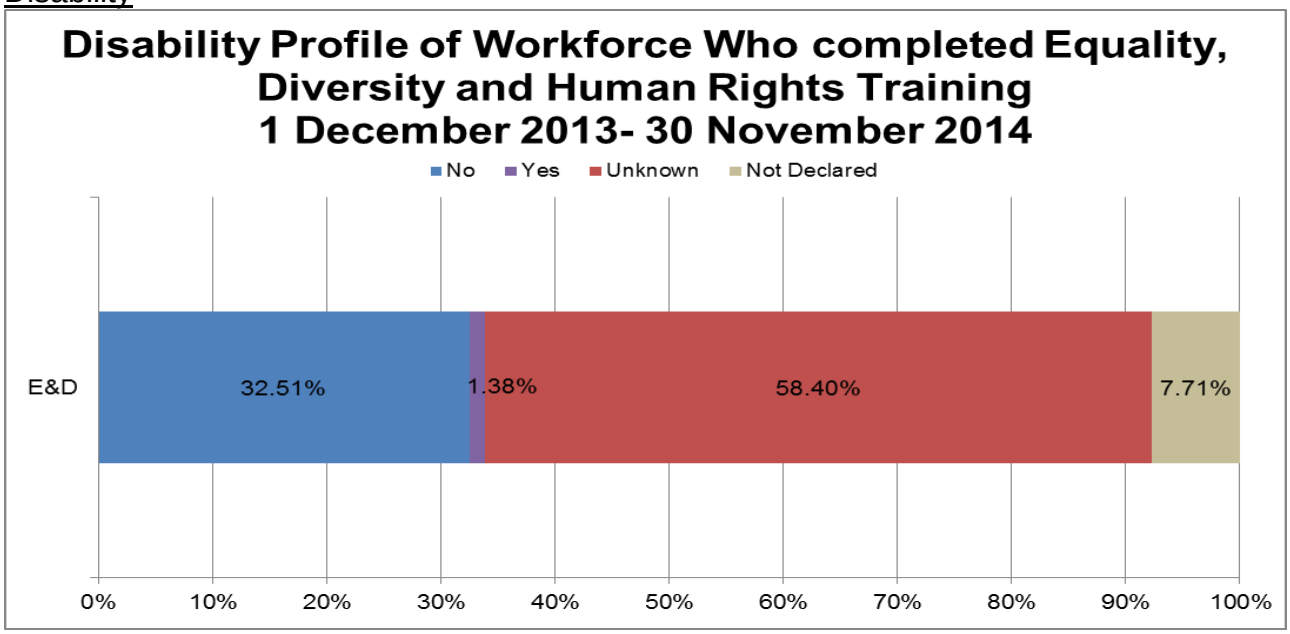
Equality & diversity Training for the period between December 2013 and November 2014 was completed by 363 colleagues. A breakdown of these colleagues, using the same equality indicators used previously can be found below.

Age Profile

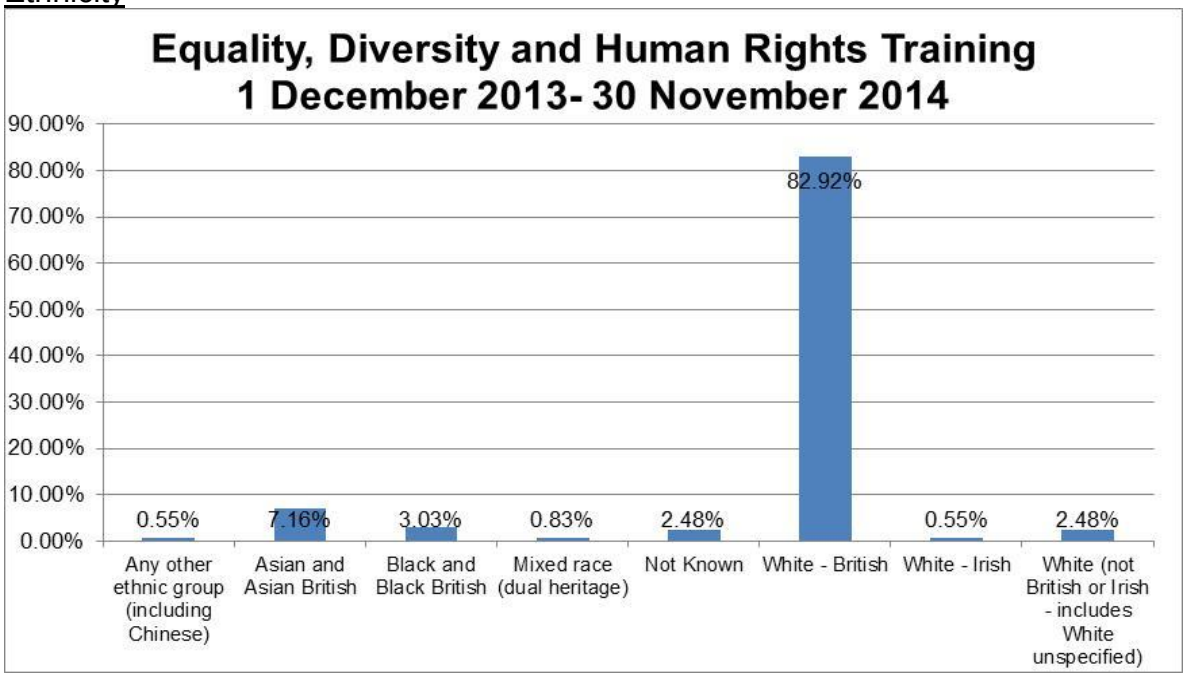
Under 25's are the age range with the highest proportion of staff attending E&D Training.



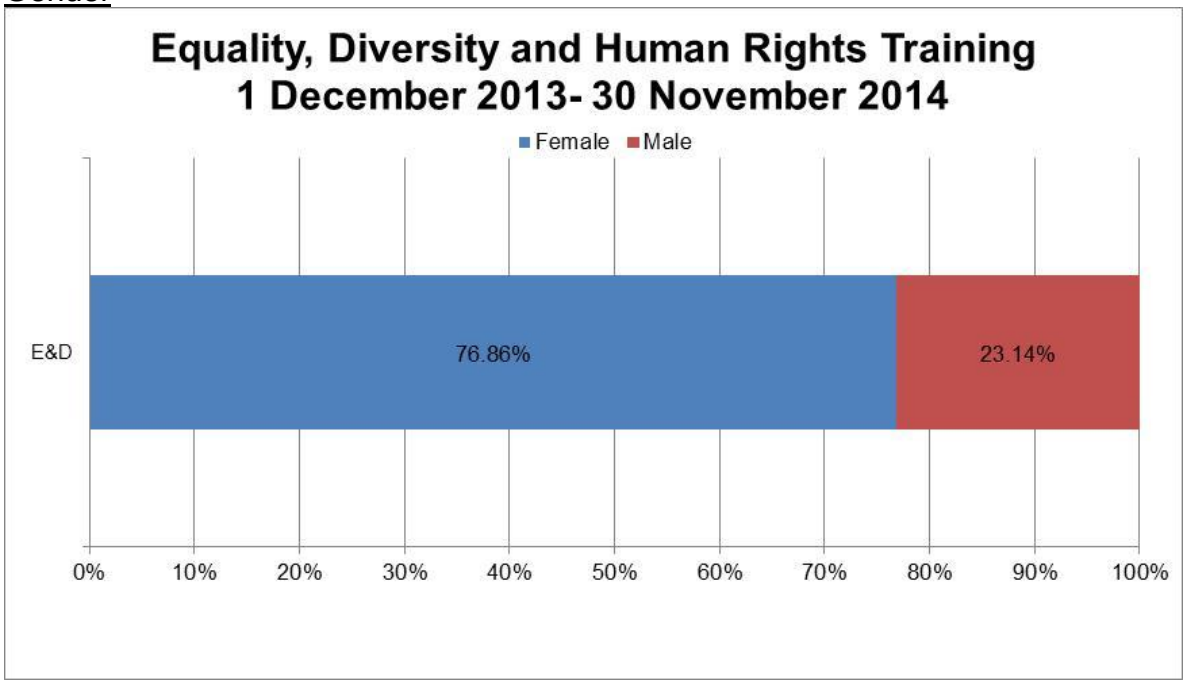
Disability



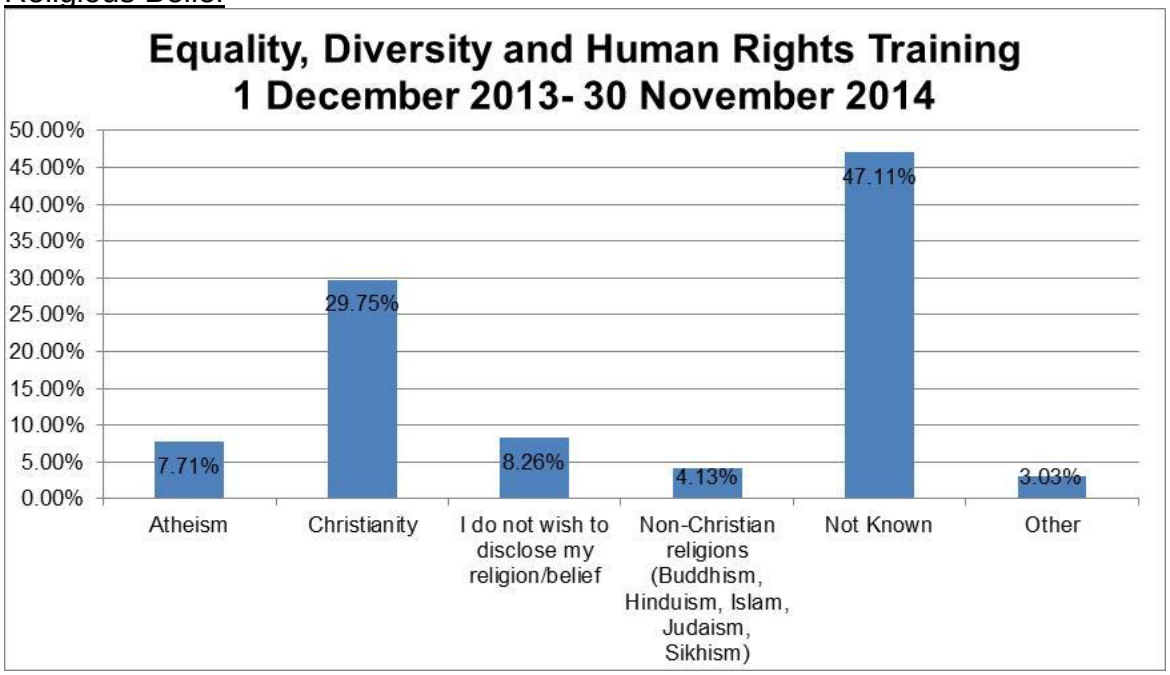
Ethnicity



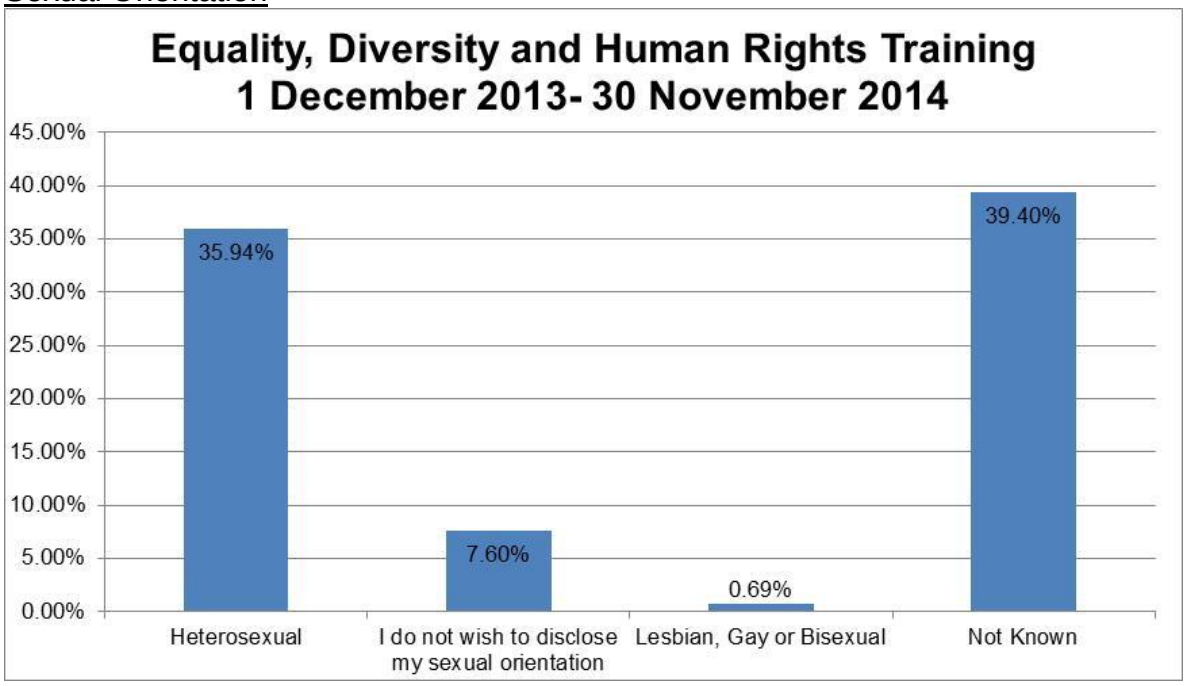
Gender



Religious Belief



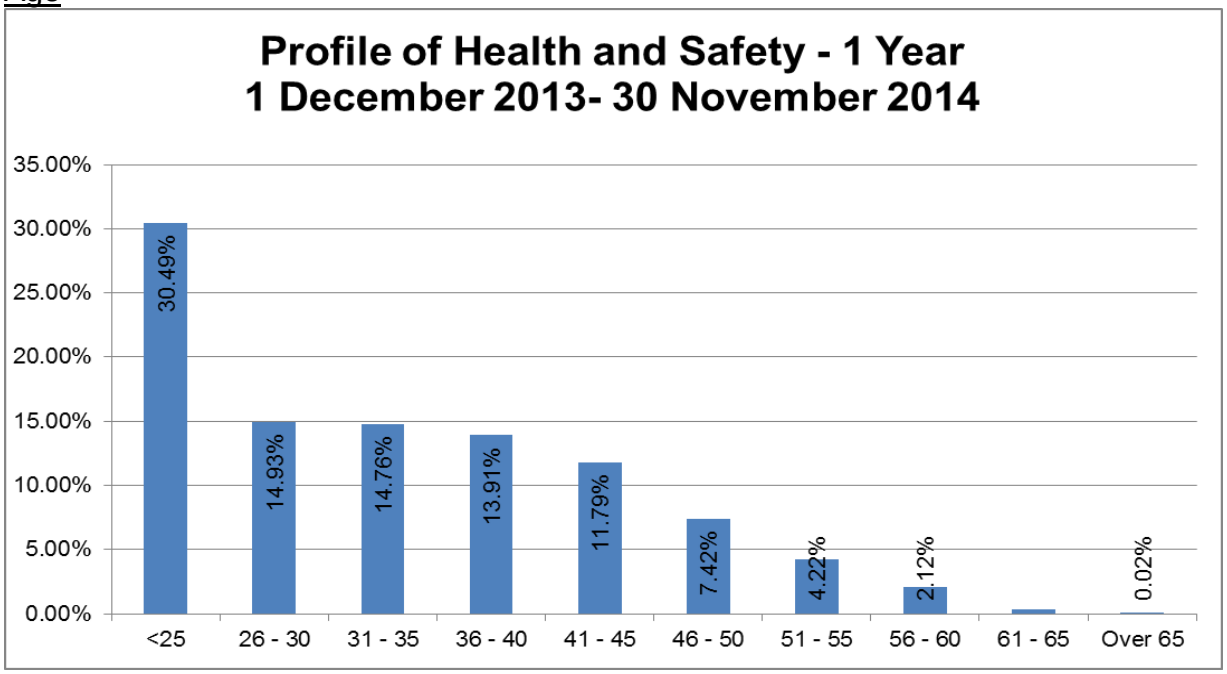
Sexual Orientation



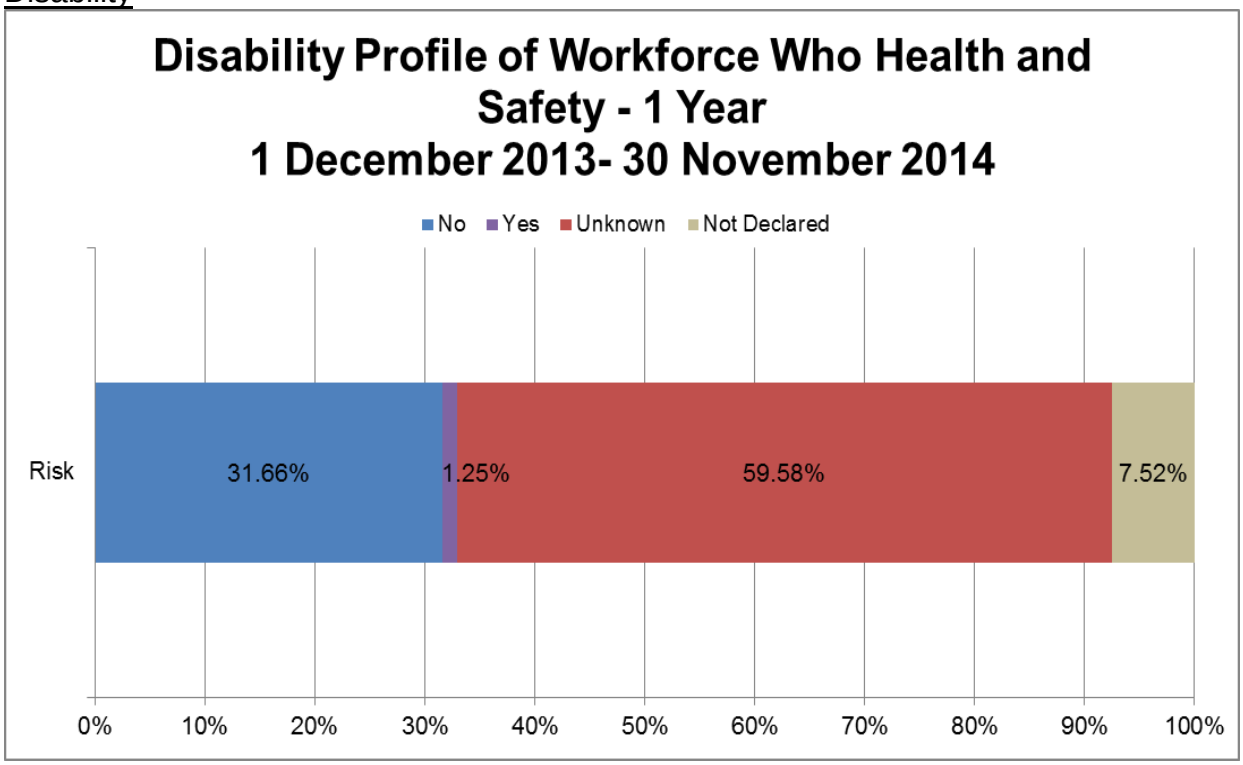
7. Health and Safety training

Health and Safety training for the period between December 2013 and November 2014 was completed by 4982 colleagues. A breakdown using the same equality indicators used previously can be found below.

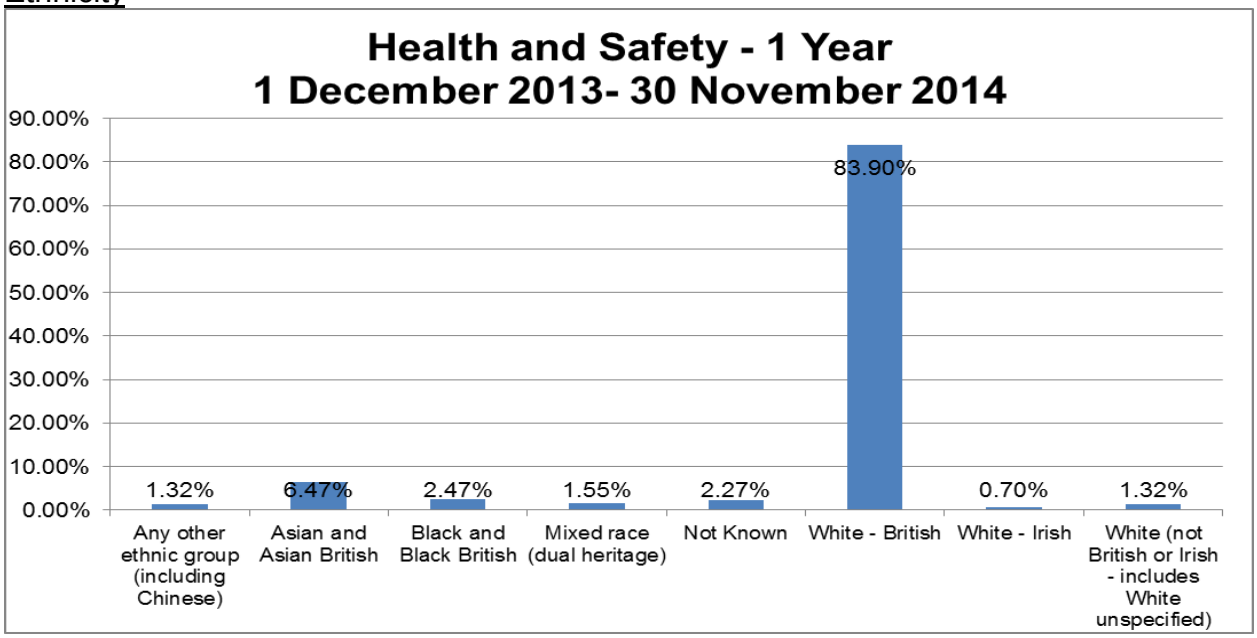
Age



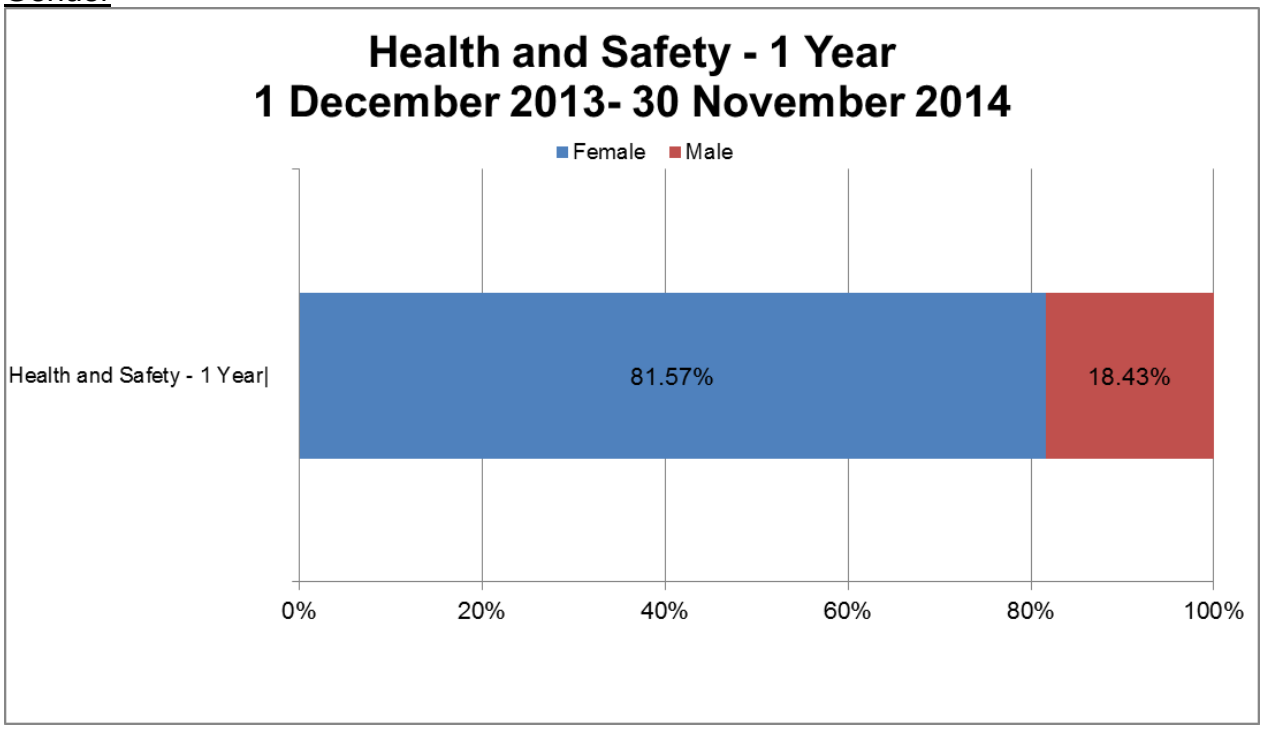
Disability



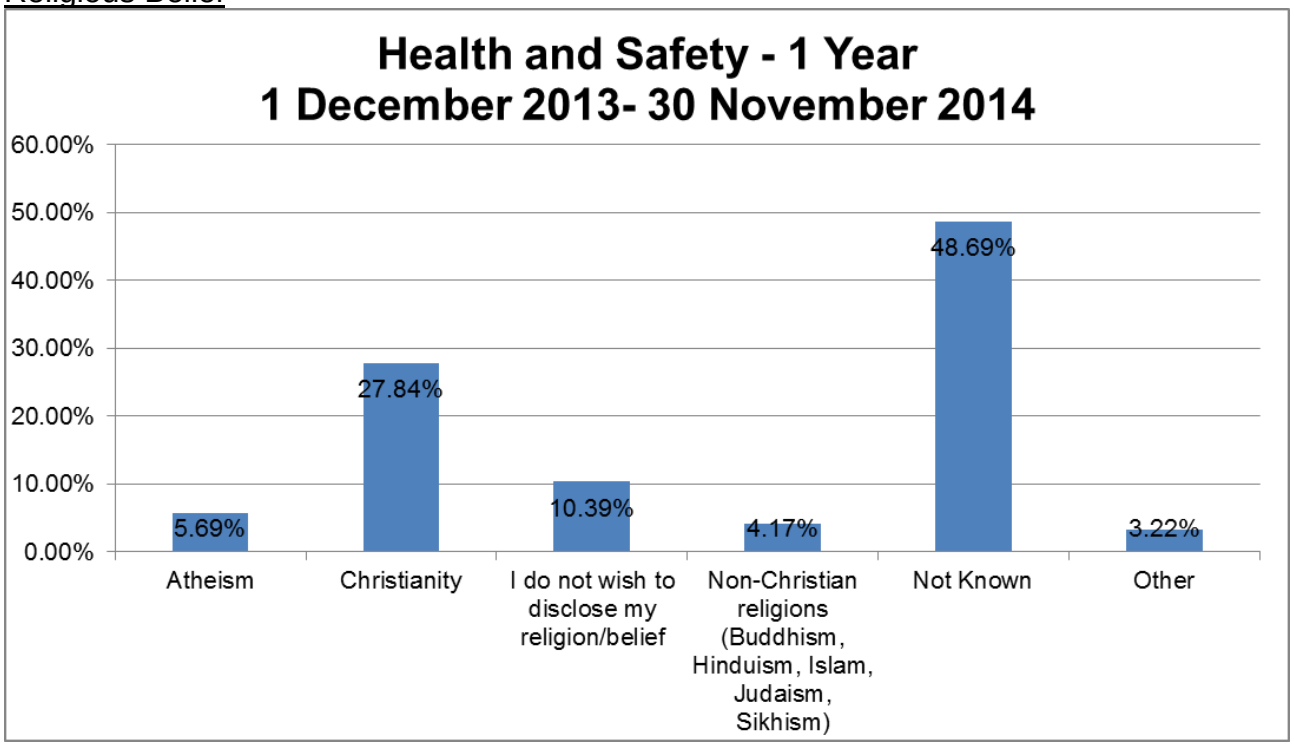
Ethnicity



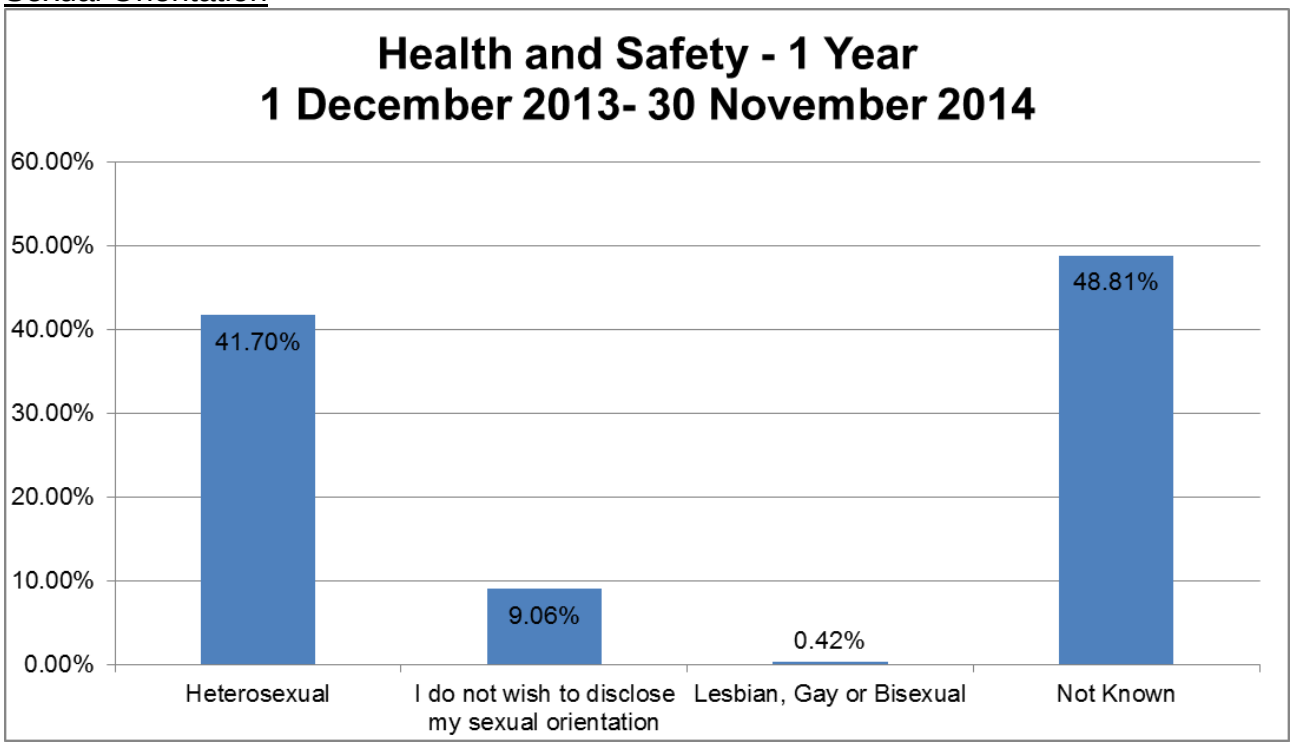
Gender



Religious Belief



Sexual Orientation

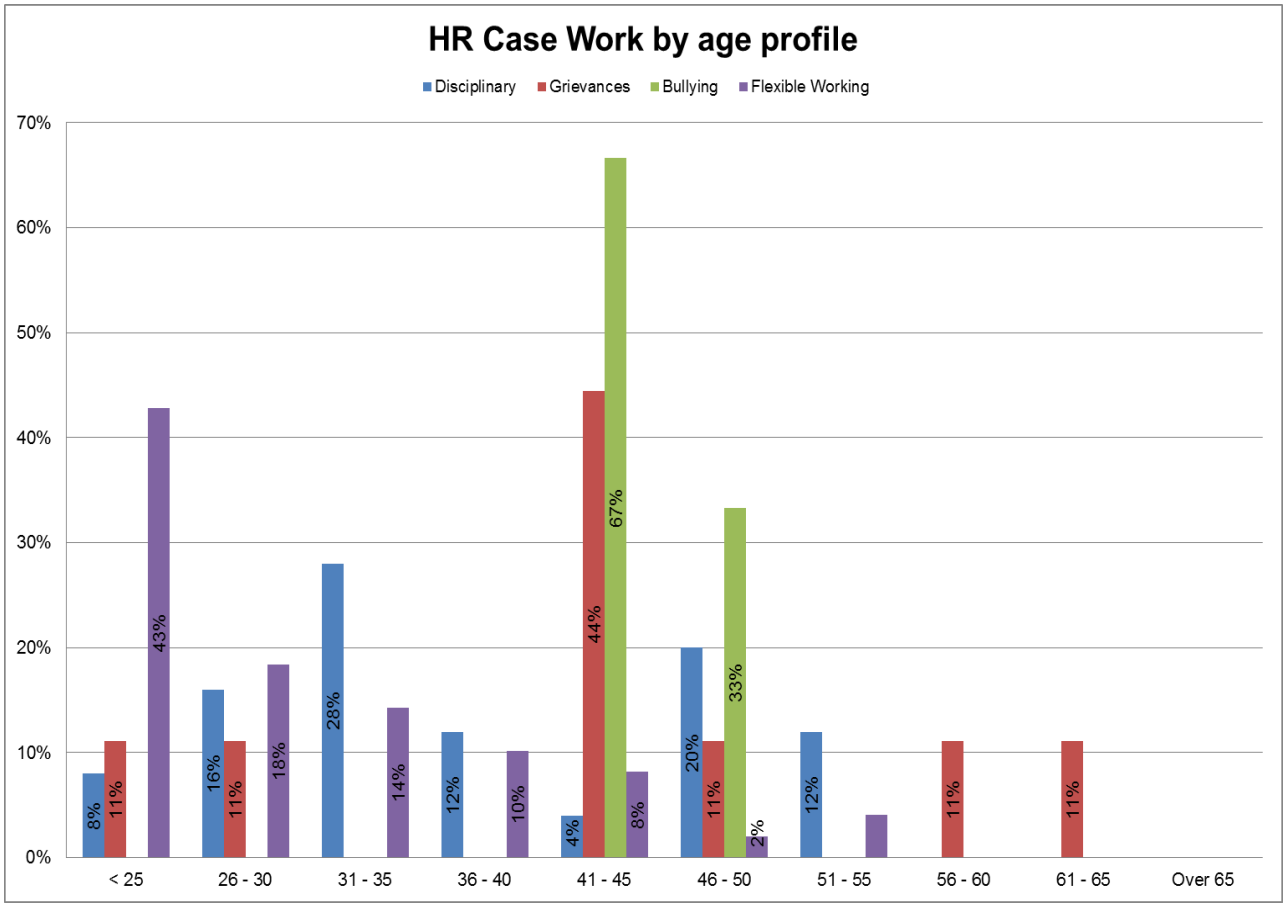


7. Disciplinary, grievance, flexible working and bullying and harassment

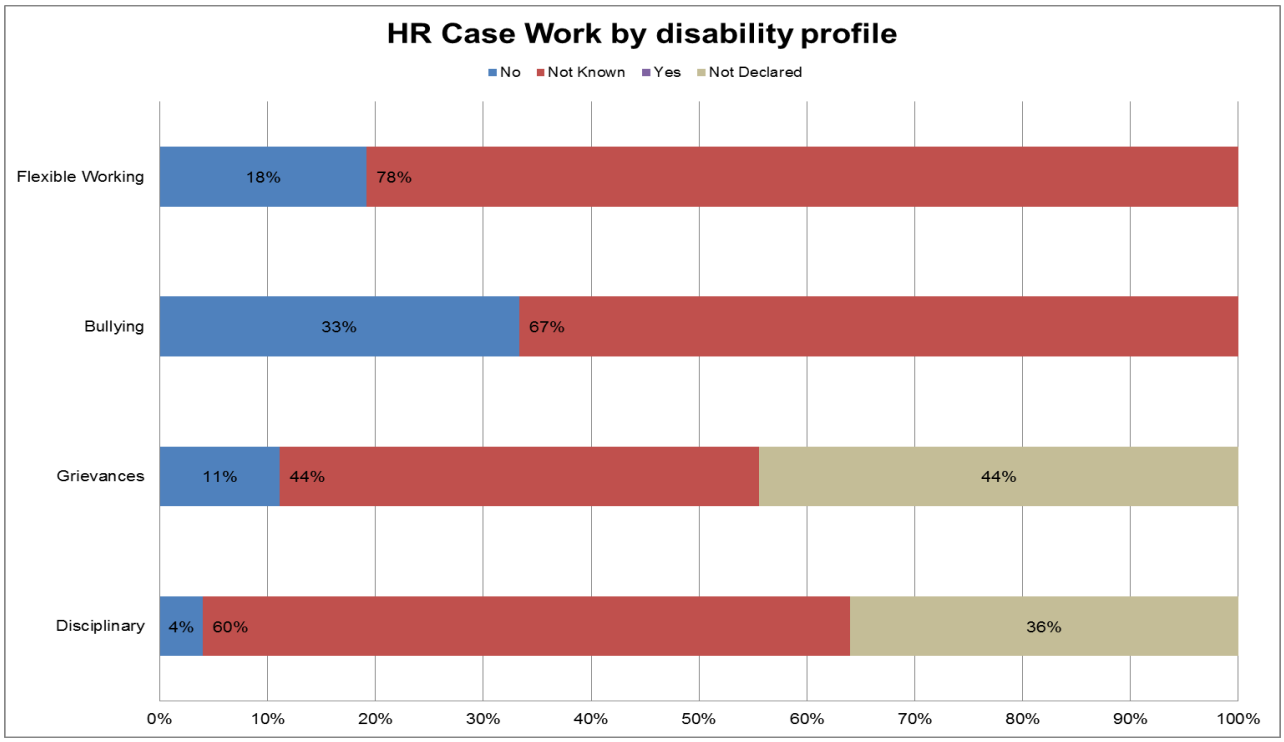
Overall, for November 2013 – December 2014 there were:

- 25 disciplinary investigations.
- 9 grievance investigations
- 22 flexible working applications
- 3 bullying and harassment investigations

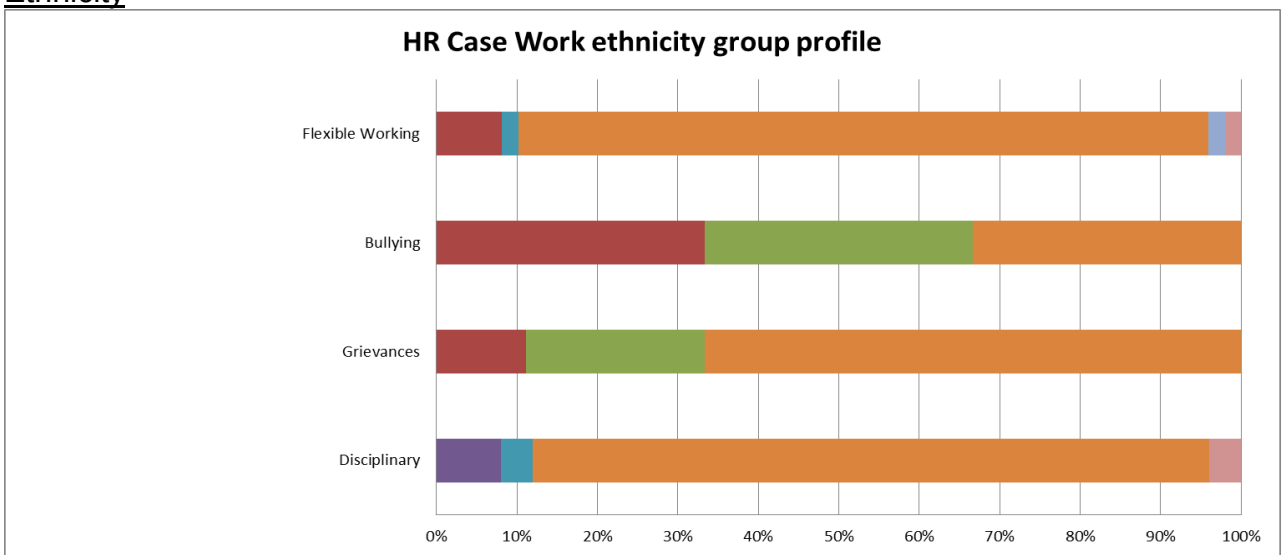
Age Profile



Disability

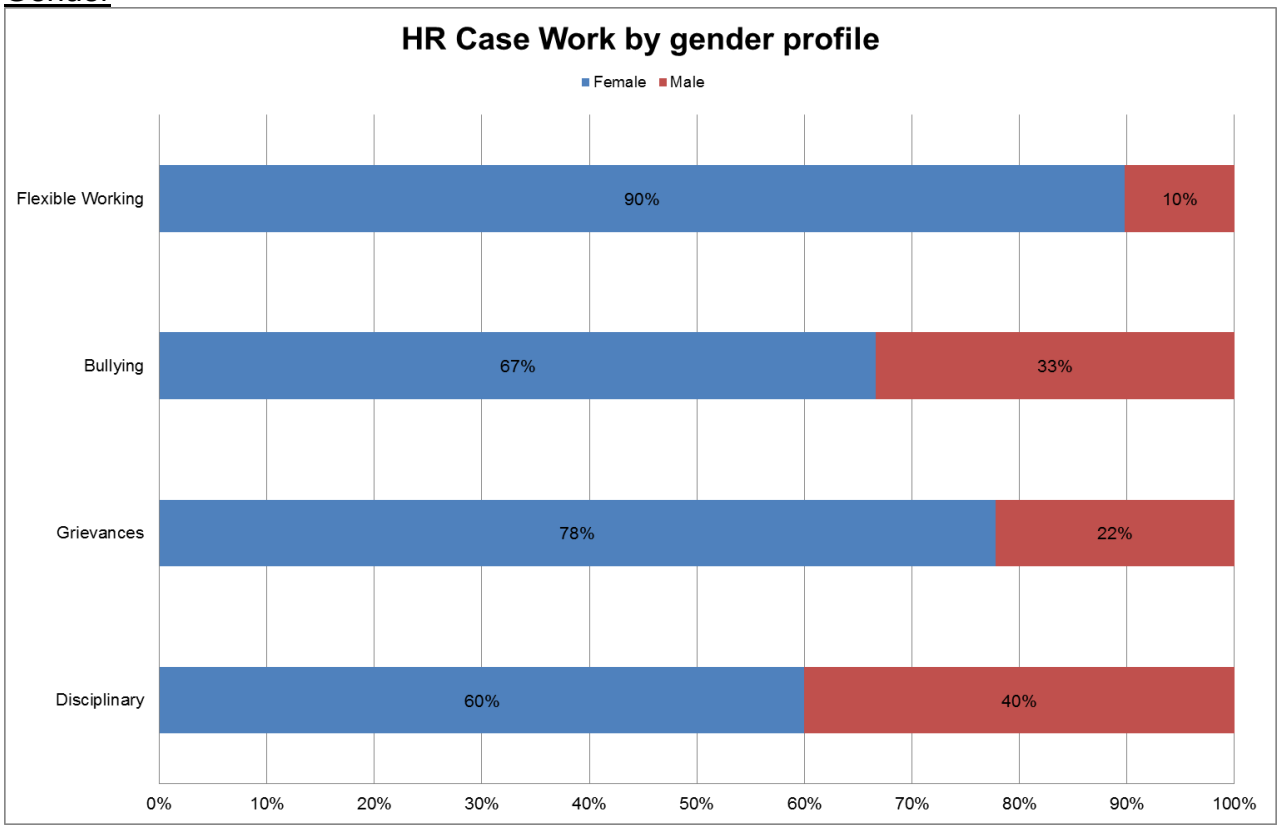


Ethnicity

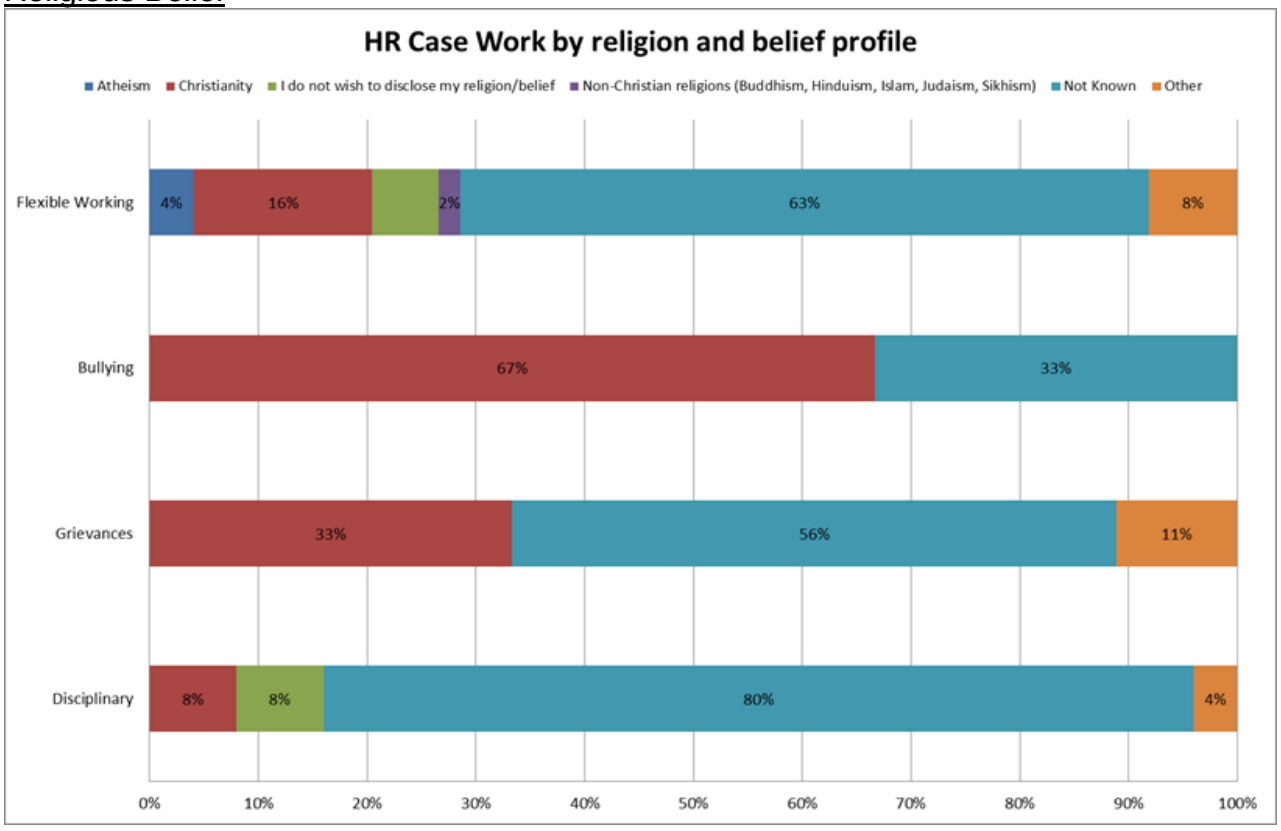


	Disciplinary	Grievances	Bullying	Flexible Working
Any other ethnic group (including Chinese)	0%	0%	0%	0%
Asian and Asian British	0%	11%	33%	8%
Black and Black British	0%	22%	33%	0%
Mixed race (dual heritage)	8%	0%	0%	0%
Not Known	4%	0%	0%	2%
White - British	84%	67%	33%	86%
White - Irish	0%	0%	0%	2%
White (not British or Irish - includes White unspecified)	4%	0%	0%	2%

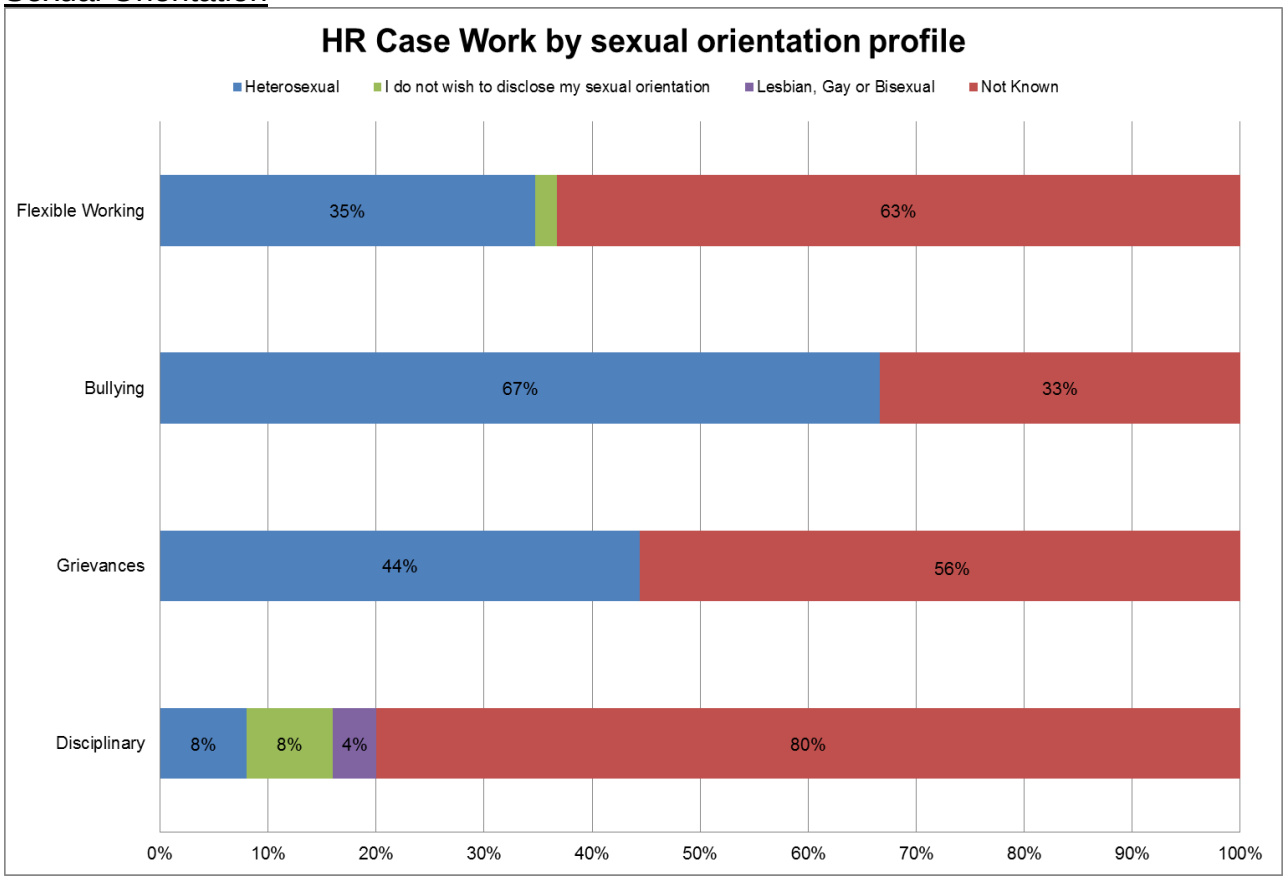
Gender



Religious Belief



Sexual Orientation



8. Policies and programmes in place to address equality issues

The Trust continually reviews its policy framework in order to ensure that it is meeting its legal obligations and providing a supportive workplace environment for all of its employees.

The Trust continues to undertake equality impact assessments which were initially introduced as part of the Equality Act 2010. These are no longer a legal requirement but the Trust recognises the importance of them and views them as good practice. The Trust will continue to review the usage of equality impact assessments in 2015.

The Equality and Inclusion Board Group is chaired by a Director and comprises leads for work streams on each of the protected characteristics within the Equality Act 2010.

The Trust introduced an apprenticeship scheme in 2012 for all posts at Agenda for Change pay bands 1 and 2, and continues to recruit to posts through the scheme. The Trust has recruited to healthcare assistant roles, administrative and clerical and gardeners using the scheme. The apprenticeship scheme supports people with disabilities, those without qualifications, those from ethnic communities and from areas of significant deprivation in to the employment market. The Trust is an active player in the local job market and through employment it can make a significant difference to life opportunities for its local population as well as impacting health and wellbeing.

The Trust launched a colleague engagement strategy in June 2013. The strategy adopts a consistent approach to change management with colleague engagement at its core. The strategy focuses on four behaviours that set out the Trust's values for employees.

The Trust's Occupational Health Department received a Safe Effective Quality Occupational Health Standards full accreditation award for five years (SEQOHS) in December 2013. The Standards measure that the Occupational Health Department meets minimum requirements, reflecting existing ethical and professional guidance and consensus and helps them achieve uniform good practice. The Occupational Health Department has a strong focus on the health and well-being of staff and will focus on initiatives like becoming a smoke free Trust and pathways to support staff and managers on mental health pathways moving forward.

9. Improving workforce equality data in the future

In 2014, we have:

- Improved the quality of data stored within the Electronic Staff Record (ESR) around ethnicity, sexual and religious beliefs for all new starters since April 2010. This is in line with the ESR central team and the Health and Social Care Information Centre validation and data quality reporting system, and the Workforce Validation Engine (WOVEN). Reports are received on a monthly basis and highlight improvements within ESR.
- Improved processes within the recruitment process for applicants who do not use NHS Jobs to make sure demographic information is captured in a timely manner.
- The Trust continues to support and recruit staff using the apprenticeship scheme.

10. Future requirements

As part of NHS standard contracting arrangements for 2015/16 a new Workforce Race Equality Standard has been introduced. This puts the emphasis on everyone on an NHS Board to lead by example and champion race equality – not to simply comply with the new national standard, but as a strategic opportunity to demonstrate commitment to diversity, and to leverage its potential to improve patient care. The WRES will require NHS organisations to address the low levels of Black and Minority Ethnic (BME) employees within their organisations and specifically at Board level.

APPENDIX 3 – MEMBERSHIP ENGAGEMENT DATA

Membership Representation as at 08/12/2014 by Age, Ethnicity & Gender

	Members at 08/12/2014	% of total members	Eligible membership*	% of eligible membership
Age (years)				
0-16	1	0.0%	10398	1.6%
17-21	678	7.5%	52215	8.2%
22+	8405	92.5%	573203	90.2%
Ethnicity				
White	7761	87.2%	529668	83.6%
Mixed	162	1.8%	9659	1.5%
Asian or Asian British	716	8.0%	79829	12.6%
Black or Black British	223	2.5%	10162	1.6%
Other	37	0.4%	3935	0.6%
Gender				
Male	3592	35.9%	309248	48.6%
Female	6419	64.1%	326568	51.4%

* 2011 Census Data

APPENDIX 4 – PARTNERSHIP ACTIVITY

In addition to the workstream-specific links shown below and overleaf, CHFT has also developed close partnership links with Kirklees Council and the Healthwatch organisation. We also have representation on Calderdale Equality Forum and Calderdale Carers Forum.

Workstream	Partnership Link
Age (Older people)	Calderdale & Kirklees Dementia Strategy Boards Older people's Partnership Board Living with Dementia Groups Alzheimer's society Yorkshire & Humber Acute Dementia Care Network Butterfly Scheme West Yorkshire Collaborative Group National Dementia Taskforce Dementia Alliance (local, regional and national) Carers Count (Kirklees)
Age (Younger People)	Professional forums Youth Council Professional focus group for delivering care closer to home Focus groups to seek families' opinions on future services Developing a health network with school clusters in Calderdale
Race	Calderdale Equality Forum Calderdale Race Forum
Learning Disability	Calderdale Learning Disability Partnership Board Kirklees Learning Disability Partnership Board Kirklees Involvement Network (KIN) Cloverleaf Kirklees Carers Group Kirklees Health Sub Group Calderdale Health Sub group Regional Access to Acute Group (A2A) Kirklees Learning Disability Provider Forum Calderdale Learning Disability Provider Forum Lifeways Mencap (Kirklees) Bridgewood Trust St Anne's Community Service
Sexual Orientation	Calderdale LGBT Group
Religion or belief	Calderdale Interfaith Council Ending of the fast during Ramadan Huddersfield Community Event Spirituality Special Interest Group, Huddersfield University Huddersfield Muslim Burial Council Local SANDS group Kirklees Faith Forum (KFF)

Workstream	Partnership Link
	Anglican Diocese – Chapter meetings
Mental Health	Mental Health Liaison Team Kirklees Suicide Prevention Strategy Group Branching Out - Substance Misuse (Younger People) in Calderdale The Base - Substance Misuse (Younger People) in Kirklees The Basement Project – Drug and alcohol support group
Pregnancy and Maternity	Clinical Forums including Maternity Forum Maternity Patient Safety Group Yorkshire and Humber Strategic Clinical Networks
Visual Impairment	Kirklees Blind & Low Vision Sub Group Action for Blind People and Eye Clinic Liaison Officer Kirklees Sensory Services and Transcription Service Calderdale Sensory Services Dewsbury and Batley Blind Society and Kirklees Vision Impaired Network Patient focus group – Visual Impairment and Disability

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 29th January 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: QUALITY COMMITTEE MINUTES - UPDATE - The Board is asked to receive a verbal update from the meeting held on 27.1.15 and minutes from the Quality Committee held on 16.12.14.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive a verbal update from the meeting held on 27.1.15 and minutes from the Quality Committee held on 16.12.14.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to receive a verbal update from the meeting held on 27.1.15 and minutes from the Quality Committee held on 16.12.14.

Appendix

Attachment:

Minutes QC 16.12.14 - draft.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the QUALITY COMMITTEE MEETING held on
Tuesday 16 December 2014 in Boardroom Huddersfield Royal Infirmary, commencing at 3pm

PRESENT	Jeremy Pease, Non-Executive Director (Chair) Claire Gruszka, Patient Safety Risk Manager David Birkenhead, Medical Director Jackie Murphy, Deputy Director of Nursing Julie Dawes, Executive Director of Nursing Julie O'Riordan, Divisional Director, Surgery and Anaesthetics Division Juliette Cosgrove, Assistant Director to Medical and Nursing Director Lesley Hill, Executive Director of Planning, Performance, Estates & Facilities Linda Patterson, Non-Executive Director Lindsay Rudge, Associate Director of Nursing, Medical Division Lynn Moore, Membership Council Mags Barnaby, Interim Director of Operations Martin DeBono, Divisional Director, CWF Division Sal Uka, Divisional Director, DATS Division
IN ATTENDANCE	Stephanie Jones, PA (Minutes) Joyce Ayre, Senior Clinical Midwifery Manager

Item

1/12/14 WELCOME AND INTRODUCTIONS

The chair welcomed members to the meeting.

2/12/14 APOLOGIES FOR ABSENCE AND ATTENDANCE REGISTER

Apologies for absence were received from:
Anne-Marie Henshaw, Associate Nurse Director, CWF Division/Head of Midwifery
Jan Wilson, Non-Executive Director
Julie Hull, Executive Director of Workforce and Development
Keith Griffiths, Executive Director of Nursing
Kristina Arnold, Assistant Divisional Director, CWF Division
Victoria Pickles, Company Secretary

3/12/14 MINUTES OF THE MEETING HELD ON TUESDAY 25 NOVEMBER 2014
The minutes of the meeting were approved as a true record.

4/12/14 ACTION LOG (Items due this month)

All items on the action log due this month were discussed under the main agenda.

End of Life Care (DNACPR): The Divisional Director for CWF reported that the CQC inspection carried out at Bradford Hospitals had highlighted a number of issues around End of Life care. The Trust needs to ensure there is a robust root and branch approach to DNACPR to identify any gaps. It was understood Mary Kiely (Consultant) has a list of issues that have been addressed with Bradford Trust. The Director of Nursing reported she had received a draft report from Mary Kiely regarding Individualised Care of the Dying that would go the Board in January 2015. Assurance was given that Mary Kiely has a good understanding of what is required to ensure the Trust are fully compliant, but this will take time to embed within the organisation.

The Associate Director of Nursing for Medicine reported a dashboard had been developed, an audit had taken place and staff have been trained in end of life care.

The Chair queried whether data is held by the Trust on the number of patients who choose to die in hospital as it would be useful to know the number.

ACTION:
1. Director of Nursing to discuss End of Life Care with Mary Kiely
2. The Chair to investigate independently the number of people who die in hospital at HRI/CRH.

5/12/14 MATTERS ARISING

5.1 Trial Perfect Week update
The Interim Director of Operations gave a brief update following the trial 'Perfect Week' (8th to 14th December 2014). It was noted towards the end of the week deterioration in A&E was seen.

The following headlines and issues were noted to be:
- **Transport (PTS):** not organised, which meant patients left hospital late and did not reach intermediate care facilities until after 6pm.
- **Paediatrics:** lack of paediatric beds across the region. Consultants were flexible in order to carry out review in A&E within a 2 hour period.
- **Green cross:** there were a high number of patients in hospital that were medically fit for discharge.
- **Outliers:** medical patients not being reviewed by a senior clinician until the afternoon.
- **Bed turnaround team:** had positive impact to have a dedicated cleaning service to support patient transfer.
- **Community in reach:** helped expediate safe discharge.
- **Additional capacity**: issues with staffing and equipment.
- **Frailty assessment:** complex care patients on MAU with extended length of stay.
- **Spot purchasing beds:** it would be helpful to have a list of available nursing home beds.
- **Radiology:** issue with patients not being where they are expected to be and arriving without a request, however it was helpful to have a centralised number but this was not publicised enough.
- **Referral to reablement:** discharges are delayed waiting for social worker referral for

reablement. It was suggested hospital therapists should be able to refer directly.

- **Discharge:** different levels of risk on discharge between acute and community.

In summary, the trial 'Perfect Week' was a very useful experience and a great deal was learnt. Feedback from wards regarding the physical presence of Executive Directors was appreciated. A de-brief session will take place on 17 December 2014 and an action plan will be developed.

The Divisional Director for DATS queried the likelihood of the action plan being implemented in time prior to the 'Perfect Week' taking place in January. It was confirmed the Silver and Bronze teams will take stock at the de-brief session on the 17 December and then further discussion will be had at the Weekly Exec Board (WEB) with Divisional Directors to ascertain whether it is feasible to carry out the 'Perfect Week' on the planned dates (7th to 13th January 2015).

ACTION: The Director of Nursing requested that the Board be updated on the trial 'Perfect Week' at the meeting on 18 December 2014.

5.2 Update on Independent Risk Management Support

The Director of Nursing reported that an independent risk consultant (Paul Moore) has been commissioned to work with the Trust for 15 days. Paul comes with a wealth of experience and has worked with many Trusts across the country such as Leeds, Manchester, Liverpool and Morecombe Bay. The work commissioned will be for 15 days and will cover a session with the Trust Board and a session with the SEB to look at the Board Assurance Framework. A number of 2 hours risk management master classes will be run over 17th, 18th and 22nd of December. Paul will also spend time with each Division on their risk registers and assist the Patient Safety Risk Manager with the Trust's Risk Policy. The risk support will help aid the Trust's preparation for a CQC inspection.

5.3 Manual Handling Training: update on staff accessing training

The Director of Nursing had discussed with the Associate Director for Risk Management the concerns raised at the Quality Committee meeting in September 2014 regarding staff unable to access manual handling training due to capacity issues. It was understood that despite 2 vacancies within the manual handling department there were no reasons why manual handling training could not be accessed. It was noted one vacancy has since been recruited to and all requests for training should go through the normal route. Any issues should be escalated back to the Director of Nursing.

6/12/14 CQC PREPARATION AND ACTION PLAN

6.1 CQC Action Plan

The CQC action plan was presented by the Assistant to the Medical and Nursing Director. The action plan focusses on planning for the CQC inspection next year. Following a recent meeting with the CQC, it is believed the Trust will undergo an inspection before December 2015 and will most likely take place in Q2.

The plan focusses on the more significant actions identified following the mock CQC inspection and intelligence gathered from other organisations regarding commonly identified areas for improvement. There is a more detailed action plan being delivered by the CQC group that deals with all the actions from the mock inspection. The plan has been developed around the 5 CQC domains; well led, safe, responsive, caring and effective. Behind each action sits a more detailed report.

The Divisions have been asked to carry out self-assessments looking across all domains which will form the basis of their improvement plans. These will come to the Committee in January 2015. Non-Executive Director, Linda Patterson, queried what arrangements are in place to ensure outpatients are covered which cuts across the Divisions. It was agreed once all the self-assessments are complete the Divisions need to look at cross cutting themes.

The Committee **received** the action plan and **noted** the work to date and plans for moving forward.

ACTION: The Committee requested a monthly update report on progress going forward.

7/12/14 RESPONSIVE

7.1 Integrated Performance Report

Responsive
The Integrated Performance Report was presented for November 2015. November saw a rise in the number and acuity of urgent and emergency patients. This has resulted in outliers in both Medicine and Surgery. Extra capacity has been opened on both hospital sites and additional flexible capacity was opened over the weekend of 13th/14th December 2014 to meet demand. Staffing issues during this period were noted to be a concern. Acute and emergency activity is below contracted levels for November.

The 4 hour access target was not achieved for November. This is the second month it has been missed and leaves the Trust in a vulnerable position in the delivery of this target for Q3.

Wards are still experiencing difficulties meeting their registered nurse staffing levels on each shift. Some shifts are being filled by bank and agency staff, however recruitment is underway.

HSMR stands at 102.41 against a target of 80. SHMI is 111. This puts the Trust in the bottom quartile of Trusts in the country.

C.diff to the end of November is 19 against an annual target of 18. It was unclear whether Monitor and the CCG look at the overall c.diff figure or just take into account the avoidable cases. It was agreed further clarification should be sought on this.

A&E Staffing: The Interim Director of Operations emphasised the need for the Trust to ensure a robust contingency plan is in place should one of the A&E departments cease to function safely due to shortages in medical cover. Across site there are 10 WTE A&E consultants, two of which are on sick leave. There are 10 WTE middle grades, 3 of which have permanent posts with the remainder being locums. There is the extra support of 2 registrars who cover nights.

ACTION: Urgent meeting with Surgical Division to be arranged to look at contingency plan for staffing.

The Medical Director has requested a spreadsheet detailing consultants and junior doctors in order to identify where the gaps are. This will then be discussed at WEB and could come to Quality Committee. The Executive Director of Nursing agreed that although it would be useful for the Committee to have sight of this information, the work should be led by the Well Led group.

The Deputy Director of Nursing reported an ANP would be starting in Orthopaedics and the Surgical Division is looking into recruiting agency ANPs.

Caring
Complaints: It was reported the good progress made on complaint response times has tailored off slightly and the pace needs to be picked up again.

Friends & Family Test: Due to a change in the FFT methodology there is no longer a NET promoter score. A&E FFT is struggling with low responses and green counters are no longer in use at CRH/HRI. A plan is in place to offset this.

Safety
The Director of Nursing briefed the Committee on the Duty of Candour (Regulation 20) which the Trust will be required to comply with from the 27 November 2014. The requirement is that all health service bodies must act in an open and transparent way in relation to care and treatment provided to patients. As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred (at the latest 10 days after the incident), a health service body must notify the relevant person and provide reasonable support to him or her in relation to the incident. The relevant person is the service user or a person acting on his or her behalf if the service user is deceased or under 16 years or lacks capacity.

The Divisional Director for Surgery and Anaesthetics felt that not all staff are aware of this new regulation and that a robust communication plan would be needed to ensure staff are briefed appropriately.

Effectiveness
- Still struggling with Mortality Reviews. Some changes had been made to the protocol.
- Awaiting Nerve Centre to be implemented although there may be a delay.
- Care bundles: single tool for completion which will be implemented shortly.
- Coding: the Finance Committee discussed coding in detail at its last meeting. Dr John Naylor (Consultant – Elderly) had undertaken some work on coding and it is hoped improvement will be seen going forward. It was noted the coding forms are currently at the printers and this needs speeding up.

Well Led
Divisions are currently noted to be underperforming against mandatory training & appraisals and progress needs to be made in this area.

SAFETY

8/12/14 8.1 Serious Untoward Incident Report and Register
The Patient Safety Risk Manager presented the Serious Incident report and register, as at 28 November 2014, which detailed the current position of all open serious incidents. Since the last meeting of the Committee 5 serious incidents have been closed and 13 new serious incidents have been reported to the CCG. These include:
1 x failure to recognise a deteriorating patient
1 x unexpected child death
1 x medication error
8 x category 3 pressure ulcers

A request for 1 incident to be de-logged was made to the CCG and is awaiting a response.

8.2 Patient Safety Group Update

The Executive Director of Nursing presented the draft minutes from the meeting of the Patient Safety Group on the 4 December 2014. The following highlights were noted from the minutes:

- The first edition of the monthly Patient Safety newsletter *'So what happened next…'* will be emailed out to staff in December. Copies of the newsletter will also go to the Membership Council and will be available on the Trust's website and intranet.

- The serious incident log was discussed in detail and improvements were noted by the group in the SI process to ensure a more timely and streamlined approach to incidents investigations.

- An update report and future plans on VTE was received by the group. Capturing data is proving challenging and time consuming since the QI nurse posts ceased at the end of March 2014. The Clinical Audit team have to pull and access approx. 300 sets of notes per month in order for the Trust to achieve the 95% target. There is also no data available on correct prescribing of prophylaxis, which is necessary to drive forward the improvement work that the Care of the Acutely Ill Patient work stream is striving to achieve. It is hoped once the Nerve Centre is up and running more reliable real time data will become available which will give more assurance around the process.

  The VTE work stream and Thrombosis Committee had recently merged and their terms of reference, agenda, targets and trajectories are being reviewed. The Executive Director of Nursing requested that this new group consider:
  - setting a baseline number and trajectory target
  - conclude whether any of the deaths were avoidable
  - establish how successful the Trust is at prescribing prophylaxis / is there a common reason for it not being prescribed (i.e. time of day/mealtime).

- A briefing on the Duty of Candour regulation 20 was received by the group.

8.3 Quarterly Quality Report

The Assistant Director to the Medical and Nursing Directors presented the first Quarterly Quality Report Q2 (July – September 2014). The report, based on the 5 Care Quality Commission domains, contains key metrics and more detailed assurance around the Trusts current position and any ongoing improvements where targets and standards are not being met. It is hoped the report will capture items that are not normally seen in the Integrated Performance Report and will give a broader picture.

The report also links into the Trusts Corporate Risk Register, specifically risk 4783 around HSMR and SHMI mortality and actions being taken to address this.

The Committee were specifically asked to note issues around the following areas and the plans for improvement detailed in the report:

- Falls
- Pressure ulcers
- Incident reporting
- Safeguarding
- Infection control
- Mortality

• A&E performance
• Staffing

The Chair queried the target audience of the report and it was confirmed it should be conserved as an assurance documents for the Committee. The Chair suggested an update should be received by the Membership Council.

ACTION: Quality Report to be submitted to the Board of Directors by the Assistant Director to the Medical and Nursing Directors.

The Committee **received** and **noted** the content of the report and in particular the areas that were brought to the Committee's attention as detailed above and the plans for improvement.

8.4 Emergency Service Department update report
The Committee received an update report on the Emergency Services Departments across both sites.

A&E 4 hour target: the performance target for Q1 and Q2 were achieved. For Q3 performance to date is 94.23%. The difficulties in the delivery of this target are predominantly related to patient flow and admitted patients into in-patient beds (40% of breaches are due to lack of speciality bed capacity).

Unplanned re-attendances: no more than 5% of A&E attendances should re-attend within 7 days of the original attendance. This was not achieved for September 2014 with the re-attendance rate being 5.05%, but was achieved for October 2014 at 4.75%.

Left without being seen: no more than 5% of A&E attendances should be leaving the department without having been treated. This target had been achieved for September, October and November 2014.

Time to initial assessment: This is an indicator for patients brought in via ambulance. 95% of patients being admitted via ambulance should have been assessed within 15mins. This has not been achieved for September (98.1%), October (90.9%) or November (90.8%)

Time to Treatment: indicator records the time from arrival to seeing a decision maker. It is measured against a median i.e. 50% of all patients are seen within 60 minutes of arrival; September (18 minutes), October (19 minutes) and November (18 minutes).

Key risks for the Emergency Department:
- Reliance on locum middle grade staff continues to be a risk for the department.
- Standards for young people and children in the emergency care setting; at present the department are non-compliant with several of the standards in this document.
- Excessive waiting for specialist assessment or beds; the provision of one integrated assessment unit would improve the flow of patients and the specialty assessment.
- No consultant cover in A&E at weekends; consultant are on call covering both sites.

Overall there are significant risks associated with continuing to deliver Emergency Department services on 2 sites. The three internal Emergency Department risks would be virtually eliminated by moving to one single site Emergency Department.

Mindful of the pressures the Emergency Department has experienced over the last few weeks and going forward, the Executive Director of Nursing questioned at what stage do the Division consider the Department not fit to operate on both sites. It was noted the Division are currently in discussion with key leads within the Department with regards establishing an escalation plan to address such an eventuality.

The Committee **received** and **noted** the update given.

COMPLIANCE

9/12/14 9.1 Corporate Risk Register

The Patient Safety Risk Manager presented the Risk Register, which detailed risks scoring 15 or above.

The Trust's current top risks are:

- 6131 (25): Progression of service reconfiguration impact on quality and safety
- 4706 (25): Financial risk
- 2827 (20): Risk of poor patient outcomes due to dependence on middle grades & locums
- 2828 (20): Risk of poor patient outcomes and experience caused by blocks in patient flow
- 4783 (20): HSMR & SHMI
- 6136 (20): Overarching risk for Infection Control

ACTION: It was noted further discussion at the next meeting should take place with regards to risk 6136 (20): Overarching risk for infection control and as previously discussed at the meeting clarification is required on whether all c.diff incidences are considered or just avoidable cases.

9.2 LSA Report and Action Plan

Joyce Ayre (Senior Clinical Midwife Manager) was in attendance to present the summary of the findings from the Yorkshire and Humber Local Supervising Authority (LSA) Audit of the Supervision and Practice of Midwives 2014-2015 (July 2014).

CHFT were assessed as being fully compliant with one of the four audit standards, partially with two of the four standards and non-compliant with one standard.

The report makes recommendations about monitoring the supervisory action plan to ensure compliance is achieved within the next quarter and to note local challenges to the audit process and reporting.

Verbal feedback from the LSA was given in the presence of the Chief Executive, Deputy Director of Nursing and the Safety and Quality Lead at Calderdale and Greater Huddersfield CCG was reported within the final audit visit report to be misleading. The audit team have reviewed their notes and have confirmed that some of the language used may have indicated a greater level of compliance than was intended. This has led to a change in approach to the feedback given on the day of ongoing LSA audit visits.

Some areas of good practice from the report were noted to be:

- The audit team could see the way that the SOM day initiative was improving visibility and accessibility across the service. Midwives working across the maternity unit were able to universally articulate the benefits that this initiative had brought to the service. In particular the proactive communication through the 7 day week, 24 hour per day cycle was really valued and seen as being 'super supportive' as described by one of the midwives interviewed on the day and is an area of good practise.
- Every midwife interviewed could identify their named SOM and confirmed that they had an annual review in the last 12 months. The use of a standardised approach to the

annual review was another significant area of good practise and one that the LSA would recommend to be shared across the region
- Highly visible information for women about the role of the SOM (posters etc.)
- Clear evidence supporting women's choices in place of birth
- Posters regarding the 'Year of Patient Safety' demonstrating to women how supervision is contributing to the patient safety agenda

Key areas for action noted in the report include:
1. Reducing supervisory caseload sizes
2. Providing access for SoMs to a dedicated quiet work area within the Trust
3. Addressing SoMs reported inability to take the time allocated for supervision
4. Addressing the inequity of workload amongst the SOM group

Board members will recall approving the business case presented in July 2014 for a 0.4wte SoM to enable the team to reduce caseload sizes whilst succession plans come to fruition (It takes approx. 12 months to train a SoM), thus item 1 has already been addressed.

Board members were asked to note that, in common with all CWF colleagues, the SoM team have open access the CWF meeting rooms;

Board members were also asked to note that in the last 12 months only 2 incident forms have been received from SOM not able to take the allocated time (1½ days per month) for supervision.

'Go See'
To ensure the team are able to develop at pace to address issues raised, a collaboration has been arranged with one of the teams recognised within the region as having achieved significant progress in terms of the interface with clinical governance and team working. This will include contact SoMs working in partnership and opportunity to attend the other teams meetings.

The LSAMO has been invited to attend the December team meeting to work through the feedback in more detail with the team and the programme manager for the Sheffield University Preparation Programme for Supervisors of Midwives has agreed to deliver a bespoke CPD session for the team.

The proposed action plan has been signed off by the LSAM and a member of the supervisory team will present to the CWF Divisional Board a monthly update on progress with the action plan until full compliance has been achieved.

The Committee **received** and **noted** the contents of the report and agreed that monitoring of the action plan should be carried out by the CWF Divisional Board, but any concerns should be escalated to the Quality Committee.

EFFECTIVENESS

10.1 Clinical Effectiveness and Outcomes Group
The Medical Director presented the report from the Clinical Outcomes Group.

The Committee **noted** the content of the report and the following risks to delivery:

10/12/14

- The Trust is behind trajectory for Mortality Reviews; this is a key outcome measure for the work and will allow us to understand the proportion potentially preventable. A simpler process was agreed; new tools are being designed and will be in place ASAP.

- Continued focus needs to be placed to support the deteriorating patient work and in particular implementation of Nerve Centre, more resources have recently been found to support the work. Pilot wards will go live in January 2015.
- A care of the acutely ill patient care bundle has been designed and is being tested, signposting junior staff to condition specific actions where needed.
- Significant improvement made in the avoiding readmission work.

11/12/14 WELL LED ORGANISATION

11.1 Well Led Organisation Group
The Director of Workforce and Development presented a brief report following the Well Led Organisation group meeting held on 4 December 2014:

Fit and proper person requirements for Directors: the group had received a briefing on the requirements for Directors and Director equivalent roles. The Board of Directors will shortly receive a full briefing.

Staff FFT: Q2 results -
Would you recommend us to your friends and family as a place to receive treatment? 81% of staff said yes (82% in the Q1 survey)
Would you recommend us to your friends and family as a place to work? 59% of staff said yes (66% in the Q1 survey).

Return to work: It was agreed to examine systems for the early identification of temporary alternative employment for colleagues experiencing health issues leading to potential long term absence from work from their substantive employment.

Dashboard: The data report for the group continues to develop. It was agreed to explore the opportunity to further breakdown the 'anxiety/stress/depression/other psychiatric illness' reason for sickness absence category, one of the top there reasons for absence, to assist in the identification of successful strategies to improve attendance at work.

12/12/14 CARING

12.1 Patient Experience and Caring Group
The Assistant Director to the Nursing and Medical Directors presented an update report from the Patient Experience Group. It was reported that all patient experience CQUIN targets (F&F, Dementia, End of Life and Nutrition) for Q2 were met.

Progress to date was noted in the following areas:
Food – a lot of work taking place linked to the Food for Life initiative, these developments cover food for patients, staff and visitors
PLACE – last PLACE inspections carried out in May 2014: the majority of the recommendations from the report have been addressed
Patient Experience plan –plan progressing, 2 elements discussed that require attention – establishing a Patient Reference Group and producing a ward dashboard via Qlikview
Patient Experience Improvement projects – whilst each of the 5 key projects have commenced, there is variation in the pace in which they are being progressed
Chaplaincy – review of service provision carried out, including client feedback. Action plan includes the need to further publicise the service and to conduct educational sessions for clinical teams and volunteers
FFT – commenced work to capture 'you said / we did', this information has been shared with

and well received by the West Yorkshire Patient Experience and Participation Network
Quality Account – helping patients with long term pain develop the skills needed to manage their condition: update received from the project manager and one of the course volunteers. Twelve new tutors have been trained so far this year (7 staff and 5 volunteers). This gives a total of 10 trained and active volunteers co-delivering the programme with a clinical tutor. A patient 'confidence' to self manage their pain is rated on a scale of 0 – 10 at the beginning and end of their programme – average initial score is 3.5 and average final score is 8.4
Complaints – a high number of complaints have been closed during October – 89, leaving approximately160 open complaints. This is not in line with the planned trajectory of 90 open complaints by 31.12.14

The Committee were asked to note:
- Change in NPS to percentage of 'Extremely Likely' & 'Likely' and the percentage of 'Unlikely' & 'Extremely Unlikely', commence reporting November 2014
- Behind trajectory for reducing the number of open complaints
- One of the 5 patient experience improvement projects has not moved beyond the initial planning stage – 'regular information round'

Schedule slippage:
- Delivery against the open complaints reduction target of 90 by 31.12.14
- Patient experience project – Regular information round is still at the very early planning stages, aiming for a breakthrough event late January 2015.

The Committee **received** and **noted** the contents of the report and received assurance that key areas for improvement were being addressed going forward.

13/12/14 HEALTH AND SAFETY ISSUES RELATING TO QUALITY AND CARE

13.1 Operational Health and Safety group minutes

The minutes from the Operational Health and Safety group were received for information.

14/12/14 MATTERS TO BE ESCALATED TO THE BOARD OF DIRECTORS

The Committee agreed the following items would be highlighted to the Board of Directors:
- Perfect Week
- CQC Action Plan
- A&E staffing fragility and escalation plans
- Duty of Candour (Regulation 20)
- LSA Audit report and action plan

15/12/14 ITEMS TO NOTE

15.1 Quality Committee Work Plan
The Committee received the work plan.

16/12/14 ANY OTHER BUSINESS

There was no further items of business discussed.

17/12/14 **DATE AND TIME OF NEXT MEETING**

Tuesday 27 January 2015
3pm – 5pm
Discussion Room 2, HRI

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 29th January 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: STRATEGIC HEALTH AND SAFETY COMMITTEE MINUTES - 23.12.14 - The Board is asked to note the contents of the minutes from the Strategic Health and Safety Committee held on 23.12.14.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to note the contents of the minutes from the Strategic Health and Safety Committee held on 23.12.14

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 note the contents of the minutes from the Strategic Health and Safety Committee held on 23.12.14

Appendix

Attachment:

Strategic Health Safety Committee minutes 23 12 14.pdf

Calderdale & Huddersfield Foundation Trust
Strategic Health & Safety Committee

Minutes
23rd December 2014

Present: J Wilson - NED (Chair)
L Hill – Executive Director, Planning, Performance, Estates & Facilities

Apols: P Pilcher – Staff Side
J Eddleston – Deputy Director of Workforce & OD
S Azeb – Assistant Divisional Director, Medicine
J Barlow – Assistant Divisional Director, Surgery & Anaesthetics
K Arnold – Assistant Divisional Director, CWF
E Livesley – Assistant Divisional Director, DATs
D Anderson- NED
M Culshaw – Director, Pharmacy
D McGarrigan – Associate Director, Estates & Facilities
A Wilson – General Manager, Estates & Facilities

1. **Minutes from Previous Meeting**
   The minutes were accepted as a true and accurate record.

2. **Outstanding Actions carried forward to January 27th Meeting:**
   1707-01 – Clarity required on health and safety audits. AW to provide a summary of current and proposed audits to incorporate suggestions following recent mock CQC inspection.

   1707-02 – "Go see" health and safety audit to be discussed and piloted at Operational Health and Safety Committee with a view to splitting the committee into small audit groups to inspect areas and feedback immediately. LH to discuss at next Operational meeting.

   1707-03 – AW to progress work on a health and safety performance report.

   1707-04 – Risk Assessment training to become part of health and safety training programme. AW / DM to progress with training provider.

   1707-06 – CHAS accreditation submitted; feedback expected by 31st October 2014. AW to feedback.

3. **Health & Safety**

   3.1 Update on annual health and safety plan
   AW provided an update on 2014 health and safety plan – circulated with agenda.

   3.2 Operational Health & Safety Committee
   Medical Devices training figures – attached.

4. Policies

4.1 Control of Substances Hazardous to Health (COSHH)

M Culshaw and D Jessett to present the revised COSHH policy and framework at the next meeting on 27th January 2015.

4.2 Fire Safety

More support is required to get the Fire Risk Assessment signed off - to be escalated by LH.

4.3 Business Continuity / Emergency Planning

H Kirk to present the Emergency Planning Policy at the next meeting on 27th January 2015.

4.4 Slips, Trips & Falls Policy

Circulated with the agenda and signed off.

4.5 Safety Alerts Broadcasting System

Circulated with the agenda and signed off.

4.6 Health & Safety Policy (Parts 1, 2 & 3)

Circulated with the agenda and discussed by LH and JW outside the meeting.

5. AOB

There was no other business to discuss.

6. Date of Next Meeting

27th January 2015 9.30 – 11.00 am in Discussion room 3, The Learning Centre, HRI.