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Calderdale and Huddersfield NHS
NHS Foundation Trust

**Meeting of the Board of Directors**
To be held in public
**Thursday 1 December 2016 from 9:00 am**

**Venue**: Boardroom, Huddersfield Royal Infirmary HD3 3EA

**AGENDA**

| REF | ITEM | LEAD | PAPER | PURPOSE OF PAPER/ UPDATE |
|---|---|---|---|---|
| 1 | **Welcome and introductions:**<br>Annette Bell<br>Brian Moore | Chair | **VERBAL** | **Note** |
| 2 | **Apologies for absence:**<br>Dr David Birkenhead, Executive Medical Director – Dr Alex Hamilton, Associate Medical Director to attend | Chair | **VERBAL** | **Note** |
| 3 | **Declaration of interests** | All | **VERBAL** | **Receive** |
| 4 | **Minutes of the previous meeting** held on 3 November 2016 | Chair | **APP A** | **Approve** |
| 5 | **Matters arising and review of the Action Log:**<br><br>**165/16 –** Board Assurance Framework | Chair<br><br>Company Secretary | **APP B**<br><br>**VERBAL** | **Review** |
| 6 | **Patient/Staff Story:**<br>To receive an 'update on the Sepsis Review' | Executive Director of Nursing and Assistant Director of Quality | **Presentation** | **Note** |
| 7 | **Chairman's Report**<br>a. Membership Council Meeting – 9.11.16<br>b. MC/BOD Workshop – 16.11.16<br>c. NHSI Courses and Conference | Chair | **VERBAL** | **Note** |
| 8 | **Chief Executive's Report:**<br>a. 'Financial Sustainability of the NHS Report' by the Comptroller & Auditor General, NAO | Chief Executive | **APP C** | **Note** |
| **Keeping the base safe** | | | | |
| 9 | Quarter 2 – Quarterly Quality Report | Executive | **APP D** | **Approve** |

| | | | | |
|---|---|---|---|---|
| | | Director of Nursing | | |
| 10 | Risk Register report | Executive Director of Nursing | **APP E** | **Approve** |
| 11 | Governance report<br>- Board Skills/Competencies Self-Assessment<br>- Review of Board of Directors Workplan<br>- Use of Trust Seal<br>- Integrated Performance Reporting Process | Company Secretary | **APP F** | **Approve** |
| 12 | Winter Planning | Chief Operating Officer | **APP G** | |
| 13 | Integrated Performance Report | Chief Operating Officer | **APP H** | **Approve** |
| **Financial Sustainability** | | | | |
| 14 | Month 7 – 2016 – Financial Narrative | Executive Director of Finance | **APP I** | **Approve** |
| **Transforming and improving patient care – no items** | | | | |
| **A workforce for the future – no items** | | | | |
| 15 | **Update from sub-committees and receipt of minutes & papers**<br>▪ Quality Committee – minutes of 31.10.16 and verbal update from meeting of 29.11.16<br>▪ Finance and Performance Committee – minutes of 1.11.16 and verbal update from meeting 29.11.16<br>▪ Workforce Well Led Committee draft minutes – 19.10.16<br>▪ Draft Nomination/Remuneration Committee Minutes (Membership Council) – 18.10.16 | | **APP J** | **Receive** |
| **Date and time of next meeting**<br>Thursday 5 January 2017 commencing at 9.00 am<br>**Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital** | | | | |

**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**

| |
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## Cover Sheet

| | |
|---|---|
| **Meeting:**<br>Board of Directors | **Report Author:**<br>Kathy Bray, Board Secretary |
| **Date:**<br>Thursday, 1st December 2016 | **Sponsoring Director:**<br>Victoria Pickles, Company Secretary |
| **Title and brief summary:**<br>PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 3.11.16 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 3 November 2016. | |
| **Action required:**<br>Approve | |
| **Strategic Direction area supported by this paper:**<br>Keeping the Base Safe | |
| **Forums where this paper has previously been considered:**<br>N/A | |
| **Governance Requirements:**<br>Keeping the base safe | |
| **Sustainability Implications:**<br>None | |

## Executive Summary

### Summary:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 3 November 2016.

## Main Body

### Purpose:

Please see attached

### Background/Overview:

Please see attached

### The Issue:

Please see attached

### Next Steps:

Please see attached

### Recommendations:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 3 November 2016.

## Appendix

### Attachment:

draft BOD MINS - PUBLIC - 3 11 16.pdf

# Minutes of the Public Board Meeting held on Thursday 3 November 2016 in the Board Room, Huddersfield Royal Infirmary.

**PRESENT**

| | |
|---|---|
| Andrew Haigh | Chairman |
| Dr David Anderson | Non-Executive Director |
| Helen Barker | Chief Operating Officer |
| Gary Boothby | Executive Director of Finance |
| David Birkenhead | Executive Medical Director |
| Brendan Brown | Executive Director of Nursing |
| Lesley Hill | Executive Director of Planning, Estates and Facilities |
| Karen Heaton | Non-Executive Director |
| Richard Hopkin | Non-Executive Director |
| Phil Oldfield | Non-Executive Director |
| Dr Linda Patterson | Non-Executive Director |
| Prof Peter Roberts | Non-Executive Director |
| Jan Wilson | Non-Executive Director |
| Ian Warren | Executive Director of Workforce & OD |
| Owen Williams | Chief Executive |

**IN ATTENDANCE**

| | |
|---|---|
| Anna Basford | Director of Transformation and Partnerships |
| Mandy Griffin | Director of The Health Informatics Service |
| Victoria Pickles | Company Secretary |
| Bev Walker | Associate Director for Urgent Care (for item 6) |
| Dr John Naylor | Consultant Physician (for item 6) |
| Marie Sullivan | Clinical Manager – Community (for item 6) |
| Charlotte Bowdell | Team Leader – Primary Care (for item 6) |

**OBSERVER**

| | |
|---|---|
| Lynn Moore | Membership Councillor |

**155/16 WELCOME AND INTRODUCTIONS**

The Chairman welcomed everyone to the meeting, with a particular welcome to Gary Boothby who had taken on the interim role of Executive Director of Finance following Keith Griffiths taking up the post of Director of Sustainability at East Lancashire Teaching Hospitals.

**156/16 APOLOGIES FOR ABSENCE**

There were no apologies to note.

**157/16 DECLARATIONS OF INTEREST**

There were no declarations of interest to note.

**158/16 MINUTES OF THE MEETING HELD ON 29 SEPTEMBER 2016**

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

**159/16 MATTERS ARISING FROM THE MINUTES / ACTION LOG**

**140/16 HFMA CONFERENCE** – It was noted that Prof Roberts had circulated the powerpoint presentation to Board Members.

**146/16 QUALITY REPORT** –

It was noted that the Quality Committee had been asked to do a 'deep dive' around compliance with the Sepsis Bundle and this would be brought back to Board in December as part of the patient/staff story and would be presented by the Executive Director of Nursing and Assistant Director for Quality.

**ACTION: BOD AGENDA ITEM 1.12.16**

**OUTCOME: The Board RECEIVED AND NOTED the updated Action Plan.**

There were no other items outstanding on the Action Log.

**160/16 PATIENT / STAFF STORY – SAFER PATIENT PROGRAMME**

Bev Walker, Dr John Naylor, Marie Sullivan and Charlotte Bowdell attended the meeting to give a verbal update to the Board on the SAFER Patient Programme around frailty and patient safety. Two examples of recent admissions were shared with the Board relating to patients who had been received by the hospital via ambulance transport. The patients had been invited and agreed to be part of the "Discharge to Assess Pilot" rather than being admitted to hospital. The pilot enables all tests and assessments to be undertaken at the patients' home and ensures that all equipment needed by the patient is available on the day/following day of discharge to the programme. At all times the multidisciplinary and stakeholder teams remain in communication with the patients and their family'. The enthusiasm of the team to make this pilot work was evident throughout the presentation, together with their commitment to put the patient first by ensuring that they are cared for in the right place.

Richard Hopkin declared an interest in this item due to his connections with 'Age Concern'. The team confirmed that the Trust was receiving support from 'Age Concern' and other agencies such as 'Hospital from Home'. It was noted that this was a pilot scheme and it was hoped to provide this service from 8.00 am – 8.00 pm, 7 days per week in the near future. At all times the team facilitate partnership working and obtain the views of relatives and next-of-kin. Discussions had taken place with the ambulance service and they were supportive of the programme.

Prof Peter Roberts enquired about the Trust contacts with housing associations/arm's length providers. It was noted that the Trust was developing relationships with a number of local housing associations and related voluntary sector organisations to help identify those patients who may require early support to prevent admission. Linda Patterson stated that she saw this programme as a way of solving bed usage in the future, but the Trust needed to look at resources and ensure that shifting of resources into any new model was undertaken seamlessly. Supporting staff to make robust teams will provide care for patients and a more efficient and effective service.

The Chairman thanked the team for their informative presentation. The Chief Executive asked the Board to use their influence in respect of social care services to engage in conversations about changing services in the future.

**161/16 CHAIRMAN'S REPORT**

**a. Board to Board Meeting with Mid Yorkshire Hospitals NHS Trust (MYHT) - 24.10.16**

The Chairman reported on the meeting held on 24.10.16. The key issues discussed included:-

- Financial deficit positions of both Trust
- 4 hour Emergency Care standard position
- Centralisation of MYHT A/E services at Pinderfields
- EPR collaboration opportunities

**b. Appointment of Executive Director of Finance**

As reported earlier in the meeting it was noted that Gary Boothby had agreed to take

on the role of Executive Director of Finance for an interim period of 6 months.

**c. Clinical Commissioning Group (CCGs') Decision**
The Chairman reported that the CCGs had made a decision to progress to the development of a full business case at their meeting in public on the 20 October 2016.

Subject to further regulatory and government approval, the full business case would lead to the creation of the following:

- One emergency care centre at CRH
- One specialist planned care centre at HRI
- Two urgent care centres – one at each hospital
- Enhanced care provision in the communities

It was noted that the Kirklees Local Medical Committee had considered whether or not to take a vote of no confidence in the CCG at their meeting held on the 31 October 2016.

Thanks were expressed to the CCGs for taking the lead and progressing this decision.

**OUTCOME:** The Board **NOTED** the update from the Chairman.

**162/16 CHIEF EXECUTIVE'S REPORT**

**a. West Yorkshire Accelerator Zone**
The Chief Executive reported that West Yorkshire had been selected as the accelerator zone for delivery of the 95% Emergency Care standard for the month to March 2017 plus an increase of 30% in calls to telephone number 111. The initiative was a joint collaborative between NHS Improvement and NHS England. Further clarity was awaited on the level of funding that would be agreed to support this work and on the sanctions if the 'Zone' or individual Trusts do not meet the challenge.

Discussion took place regarding the Accelerator Zone risks and challenges particularly when the Trusts were about to enter the winter planning period. The Chief Executive agreed to circulate a presentation to Board members which detailed the delivery plan.

**ACTION: Chief Executive**

**b. Sustainable Transformation Plan (STP)**
The Chief Executive reported that work continued to finalise the STP. It was noted that the Board had received draft copies to date and once the final document was complete this would be circulated to the Board.

Discussion took place regarding the control totals challenge across the patch and the collective responsibility and ownership of these risks. It was noted that the Directors of Finance were asking for further clarification.

It was noted that it was likely that this would be released publicly week commencing 7.11.16.

**ACTION: Chief Executive**

**OUTCOME:** The Board **NOTED** the update from the Chief Executive.

**163/16 RIGHT CARE, RIGHT TIME, RIGHT PLACE - CONSULTATION UPDATE**

The Director of Transformation and Partnerships informed the Board that the Overview and Scrutiny Committee were meeting on 16 November 2016. They would be considering the CCGs' response to their recommendations following consultation and whether or not to refer the decision to the Secretary of State.

It was noted that further that on-going dialogue was taking place and that a submission for external support to help take forward a full business case was being made to the NHS Improvement team.

**OUTCOME: The Board NOTED the update on the Right Care, Right Time, Right Place consultation.**

**164/16 RISK REGISTER**

The Executive Director of Nursing reported on the top risks scoring 15 or above within the organisation. These were:-

6131 (20): Progression of service reconfiguration impact on quality and safety
2827 (20): Over-reliance on middle grade doctors in A&E
6345 (20): Staffing risk, nursing and medical
6503(20): Delivery of Electronic Patient Record Programme
6721 (20): Non delivery of 2016/17 financial plan
6722 (20): Cash flow risk
5806 (20): Urgent estates schemes not undertaken

**Risks with increased score**

Risk 5806 had an increased score from 16 to 20. This referred to urgent Estates work required on the Huddersfield Royal Infirmary (HRI) site. The Executive Director of Planning, Performance, Estates and Facilities explained that arrangements were in hand to mitigate the risks and an external review on the compliance structure had been undertaken. This was being monitored through the Health and Safety Group.

**Risks with reduced scores**

There are two risks that have been removed from the corporate risk register in the last month and are being managed within divisional risk registers:

- Risk 6594 – the risk relating to not acting on radiology results has been reduced to a score of 12 following the results of a recent audit providing assurance regarding the revised process. The first audit confirmed all urgent radiology results were opened by the relevant medical secretary team within a set period of time.
- Risk 6299 – the risk relating to failure of high risk medical devices has been reduced to a score of 12 due to improved levels of planned preventative maintenance.

**New risks**

The following three new risks were agreed at the 11 October 2016 Risk and Compliance Group meeting for addition to the corporate risk register:

- Risk 6822 - risk of not meeting sepsis CQUIN for 2016/17 –risk score of 16.
- Risk 5862 - risk of patient falls - risk score of 16
- Risk 6829 - Pharmacy Aseptic Unit – risk score of 15.

**Closed risks**

There were no risks which had been closed during the month.

Prof. Peter Roberts enquired whether the Internal Audit Report regarding Safeguarding should be captured within the Risk Register and the Company Secretary reported that this would be included in the report which was brought to the Board in December.

The Executive Director of Nursing advised that there had been no escalation of the Brexit issue within the register as it had not scored sufficiently to be included on the corporate risk register.

**OUTCOME:** The Board **RECEIVED** and **APPROVED** the corporate risk register.

**165/16 BOARD ASSURANCE FRAMEWORK**

The Company Secretary presented the updated Board Assurance Framework and highlighted an error on the heatmap where risk scores had not been adjusted following review.

As agreed at the Board meeting in September, the Board Assurance Framework had been reviewed to assess whether there is any amendment required to the Trust's strategic risks as a result of the changing NHS landscape and the challenges facing the Trust.

- One risk (004) had increased as a result of the Single Oversight Framework
- There were no new risks
- There were no closed risks

Discussion took place regarding whether the Trust is aligned with other Trusts in reporting risks on the BAF. It was agreed that the Company Secretary would look at other Trusts to asses the types of risks included on their BAF. The openness and honesty of the Trust with regard to detailing the facts was applauded.

**OUTCOME:** The Board **APPROVED** the recommendation that the BAF remain under review and **AGREED** to receive a further version at the meeting in February 2017.

**ACTION: VP & February 2017 BOD Agenda**

**166/16 RISK APPETITE STATEMENT**

The Executive Director of Nursing presented the Risk Appetite Statement. This was the first formal paper to the Board of Directors on risk appetite following on from a Board workshop in July 2016. The risk appetite had been shared with the Risk and Compliance Group on 13 September. It was reviewed by the Audit and Risk Committee at its meeting on 18 October 2016 and had been recommended to the Board of Directors for approval.

Prof. Peter Roberts confirmed that the Audit and Risk Committee would review the statement twice a year and the Board annually. This would give the Board a clear position on how to approach the decision making. The Chief Operating Officer advised that the statement would be shared with Divisional colleagues.

**ACTION: Company Secretary BOD Annual Plan – November 2017**
**Chief Operating Officer – Share risk appetite statement with divisions**

**OUTCOME:** The Board **APPROVED** the Risk Appetite Statement.

**167/16 PERFORMANCE MANAGEMENT FRAMEWORK – UPDATE ON PILOT**

The Chief Operating Officer detailed the work undertaken to establish and embed a performance management framework within the Divisions. The Chair suggested that Non-Executive Directors might be invited to observe the Divisional Performance Management Meetings to gain assurance on the work being undertaken.

The Company Secretary reported that a piece of work was being undertaken with the sub-committee secretaries to streamline the various workplans. This would hold Divisions to account and enable the sub-committees to give assurance to the Board. This piece of work was expected to take 3 – 6 months to complete.

**OUTCOME:** The Board **NOTED** the progress of the Performance Management Framework

**168/16 GOVERNANCE REPORT**

The Company Secretary presented the report which brought together a number of items that evidenced or strengthened the corporate governance arrangements and systems of internal control within the Trust. This included:-

**1. Annual Review of Non-Executive Director Roles**

The Chairman had reviewed the additional roles undertaken by Non-Executive Directors. The Board was asked to note that Jan Wilson will remain as the Deputy Chair of the Board of Directors and Dr David Anderson will continue as the Senior Independent Non-Executive Director and the Board lead for Whistleblowing. The Company Secretary added that Dr David Anderson had also agreed to be the lead Non-Executive for children.

**OUTCOME: The Board NOTED the additional roles.**

**2. Review of Board of Directors Terms of Reference**

The Company Secretary had reviewed the terms of reference. The only change was to remove reference to 'Monitor' and replace with NHS Improvement.

**OUTCOME: The Board REVIEWED and APPROVED the terms of reference.**

**3. Standing Financial Instructions (SFIs)**

The Audit and Risk Committee had considered changes to the tendering section of the SFIs and had recommended these for approval by the Board. The amendments reflected the electronic processes that are now in place for the issuing, opening, assessment and approval of tenders.

**OUTCOME: The Board APPROVED the amendments to the SFIs.**

**4. Single Oversight Framework**

At its meeting in September, the Board received a report setting out the new Single Oversight Framework as the means by which NHS Improvement will oversee and monitor the performance of the Trust. The Trust had now received notification that placed the Trust in segment three. As set out in the previous paper circulated to the Board, the assessment was made up of five key themes. Currently there was only clarity on the assessment criteria for the finance and use of resources theme where the Trust clearly scores a 3.

**OUTCOME: The Board NOTED the information received.**

**5. Well Led Governance Review**

At its meeting in June, the Board received an update against the Well Led Governance Review action plan. At that point there remained only two areas for further action, both of which were awaiting the Executive Director of Workforce and OD to come into post. A copy of the updated action plan was attached to the papers.

**OUTCOME: The Board APPROVED the closure of the Well Led Governance Review actions.**

**a. Multi-professional leadership** - there remained a requirement to ensure that multi-professional leadership would be captured in the Workforce Strategy. The Executive Director of Workforce and OD has confirmed that this is the case. The first draft of the strategy was discussed by the Workforce Committee at its meeting in October.

**b. Board development** - the remaining action was for the Executive Director of Workforce and OD to support the development of a programme for both executives

and non-executives. The Executive Board Development Programme was underway and it was agreed that the Board plan would come to the February meeting.

**ACTION: February BOD Agenda**

It was noted that there was a requirement from NHS Improvement to undertake another well led governance self-assessment in 2017. As part of the new oversight arrangements, NHS Improvement are looking to align their well led governance assessment more closely with the Care Quality Commission well led assessment. The Company Secretary was due to attend a workshop on this in November and will provide further feedback to the Board at a future date.

**ACTION: Update from Company Secretary date TBC**

**169/16 REVIEW OF PROGRESS AGAINST STRATEGY**

The Company Secretary presented an updated review of progress against the Strategy. It was noted that the MC/BOD Workshop scheduled for 16.11.16 would consider the questions raised by the Membership Council last year. It was agreed that the questions raised by them would be circulated prior to the next Workshop.

**ACTION: Company Secretary**

Discussion took place regarding the governance arrangements for the Pharmaceutical Manufacturing Unit commercial strategy and THIS Management Board and the Executive Director of Finance agreed to circulate a briefing note to the Board explaining the governance arrangements for the two ventures.

**ACTION: EXECUTIVE DIRECTOR OF FINANCE**

It was agreed that a further update on the progress against the Strategy would be brought to the Board in March 2017.

**OUTCOME:** The Board received and **APPROVED** the review of progress against the strategy and agreed that a further update would be brought to the Board in March 2017.

**ACTION: Board Agenda Item – March 2017**

**170/16 CARE OF THE ACUTELY ILL PATIENT (CAIP) REPORT**

The Executive Medical Director presented the updated CAIP report and highlighted the key issues within the report. Although mortality remained a concern there had been improvement work and progress in all themes with a noted reduction in HMSR Monthly monitoring of all the themes continues with reporting to Clinical Outcomes Group.

The highlights of the report included:-

- HSMR – currently 108.6 and expected to continue to fall.
- Crude Mortality – lower level than for some time.
- SHIMI – latest figures as at December 2015 were 113. It was expected to fall once the revised figures are released in approximately 6 months' time. A pack giving detailed information was being prepared to be presented to the NHS Improvement team.
- Mortality Investigations – The overall preventability rate over the last 12 months was 1.25%.
- Hospital Out of Hours Programme – Established at Calderdale Royal Hospital (CRH) – HRI to go live in December 2016.
- End of Life Care – Strategy continues to be developed.
- Care for Frail Patients – As outlined in the Patient/Staff Story earlier in the meeting the Trust continues to drive forward the SAFER Patient Programme.
- Coding – Depth of coding being work on and progress being made. Professor Mohammed had been appointed to work 1-2 days per month with the Trust.

**OUTCOME:** The Board **RECEIVED** and **NOTED** the Care of the Acutely Ill Patient Report.

**171/16 NURSING AND MIDWIFERY SAFE STAFFING – HARD TRUTHS REPORT**

The Executive Director of Nursing presented the Nursing and Midwifery Safe Staffing Update. He reported that this report should not be taken in isolation and needed to include other disciplines where temporary agency/bank workers were employed.

It was noted that international recruitment was planned through accredited agencies but this may take up to a year to before the effects are felt by the Trust.

A local recruitment fair had been held and this had been aimed at attracting staff that had left the employment of the Trust to return to work.

Lynn Moore, Membership Council questioned the entry requirements and student nurse grants available. It was noted that this varied throughout the country.

It was noted that the government planned to attract more junior doctors in the future and this will add further pressures on Trusts in future years as they are required to take on more trainee doctors.

**OUTCOME:** The Board **RECEIVED** the Hard Truths Report

**172/16 DIRECTOR OF INFECTION PREVENTION CONTROL (DIPC) QUARTERLY REPORT**

The Executive Medical Director presented the DIPC quarterly report. The contents were noted as the. highlights had already been discussed earlier in the meeting.

**OUTCOME:** The Board **NOTED** the contents of the DIPC quarterly report

**173/16 INTEGRATED PERFORMANCE REPORT**

The Chief Operating Officer highlighted the key points of operational performance for September 2016. It was noted that this report had been discussed in detail at the Executive Board, Quality Committee and Finance and Performance Committee. The key highlights from the Board were noted:

- September's Performance Score has improved to 68% for the Trust.
- The Trust has now seen an improvement of 14 percentage points since April.
- Within the Safe domain % Harm Free Care has gone below target hence domain has edged to an AMBER rating.
- 3 of the 6 domains improved in month with Safe, Caring and Responsive just short of Green ratings.

The Chief Operating Officer reported that there was an error in the 'Care Hours Per Patient per day' section of the report and this would be amended.

The Chief Operating Officer also agreed to bring a report on 'Winter Planning' to the December Board of Directors Meeting.

**ACTION: CHIEF OPERATING OFFICER – 3.12.16 BOD AGENDA**

**OUTCOME:** The Board **RECEIVED** the Integrated Board Report and **NOTED** the key areas of performance for September 2016.

**174/16 MONTH 6 – 2016 - FINANCIAL NARRATIVE**

The Executive Director of Finance reported the key financial performance areas. It was noted that this had been discussed in detail at the Finance and Performance Committee held on the 1 November 2016:

The year to date financial position stands at a deficit of £9.67m, a favourable variance of £0.08m from the planned £9.74m. The in-month, clinical contract activity position is above plan albeit at a slightly lower level than that seen last month. This drives an overall income position at Month 6 which is £2.25m above planned levels in the year to date. The in-month over-performance is seen across non-electives, outpatients and A&E attendances. The non-elective increase is due to success in discharging a number of long stay patients.

It continues to be the case that, in order to deliver activity and access standards across the Trust, there is reliance upon agency staffing. However, operational actions that have been put in place to curb the use of agency have started to impact positively. The total agency spend in month was £1.87m, compared with £2.17m last month. This improvement brings the agency expenditure in line with a revised trajectory that has been discussed with NHS Improvement.

- EBITDA of £2.59m, an adverse variance of £0.43m from the plan.
- A bottom line deficit of £9.67m, a £0.08m favourable variance from plan.
- Delivery of CIP of £6.73m against the planned level of £4.65m.
- Contingency reserves of £1.0m have been released against pressures.
- Capital expenditure of £7.98m, this is below the planned level of £11.82m.
- A cash balance of £2.95m, this is above the planned level of £1.94m, supported by borrowing.
- A Financial Sustainability Risk Rating (FSRR) of level 2, in line with the plan.

**OUTCOME:** The Board **APPROVED** the Month 6 financial narrative and **NOTED** the continued financial challenges.

**175/16 UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES**

The Board received an update from each of the sub-committees that had met in the previous month.

**a. Quality Committee**

The Chair of the Quality Committee reported the items discussed at the meeting held on 31.10.16:

- Sepsis – Work was on going and a report would be presented to the next Board meeting.
- Falls – patient safety group – work ongoing
- Complaints - reviewed
- Other reports which would be brought to a future Board meeting included:-
  - CQC Safeguarding report from Internal Audit
  - End of Life Strategy
  - Risk Management Strategy

**ACTION: BOD Annual Plan**

**OUTCOME:** The Board **RECEIVED** the verbal update and the minutes of the meeting held on 27.9.16.

**b. Finance and Performance Committee**

Phil Oldfield, Chair of the Finance and Performance Committee reported the items discussed at the meeting held on 1.11.16:

- CIP 2017/18 and beyond – paper received and circulated to Board in private session. The scale of challenges and opportunities of the CIP and STP were discussed at the Finance and Performance Committee.
- Carter Review Update
- BAF – risks reviewed in terms of finances
- Risk Ratings to remain at present level

- EPR implementation delays discussed.

**OUTCOME:** The Board **RECEIVED** the verbal update and the minutes of the meeting held on 26.9.16.

**c. Audit and Risk Committee**

Prof. Peter Roberts, Chair of Audit and Risk Committee confirmed that he had given a verbal update on the meeting in the November Board of Directors Meeting.
The key issues to escalate included:

- Safeguarding Team – to be invited to attend next meeting regarding the internal audit report.
- Declaration of Interests – unusually low level of declarations received by the Trust. All to be encouraged to declare interests
- Internal Audit – within the private meeting of the ARC it was agreed to market test internal audit services and this was being pursued.

The Company Secretary advised that NHS Improvement were undertaking a consultation on declarations, with the aim of standardising information held in all Trusts. It was noted that the CHFT did not have a system to manage an increase in the number of declarations and this was being reviewed. As further information was available this would be brought to the Board.

**ACTION: Company Secretary**

**OUTCOME:** The Board **RECEIVED** the draft minutes from the meeting held 18.10.16

**d. Workforce Committee**

Karen Heaton, Chair of Workforce Committee updated the Board on the highlights of the meeting held on 19 October 2016. This included:

- Establishing a Workforce Strategy – to be brought to the December BOD Meeting.
- Review of Terms of Reference
- Review of BAF and Corporate Risk Register
- Discussion on metrics of what items come to the Committee/Workplan
- WRES and Action Plan - reporting of progress and questions about the frequency of updates.

**OUTCOME:** The Board **RECEIVED** draft minutes from the meeting held on 19.10.16.

**e. BOD/MC Joint AGM draft Minutes – 15.9.16**

**OUTCOME:** The Board **RECEIVED** and **APPROVED** the draft minutes from the meeting held on 15.9.16. It was noted that these were to be approved by the Membership Council at its meeting on the 9 November 2016.

**176/16 DATE AND TIME OF NEXT MEETING**

Thursday 1 December 2016 commencing at 9.00 am in the Boardroom, Sub-basement, Huddersfield Royal Infirmary.

The Chair closed the public meeting at 11:45 am.

Calderdale and Huddersfield NHS
NHS Foundation Trust

**Approved Minute**

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## Cover Sheet

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

## Executive Summary

### Summary:

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

## Main Body

### Purpose:

Please see attached

### Background/Overview:

Please see attached

### The Issue:

Please see attached

### Next Steps:

Please see attached

### Recommendations:

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

## Appendix

### Attachment:

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

# ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 December 2016 / APPENDIX B

| Red | Amber | Green | Blue |
|---|---|---|---|
| Overdue | Due this month | Closed | Going Forward |

| Date discussed at BOD Meeting Date | AGENDA ITEM | LEAD | CURRENT STATUS / ACTION | DUE DATE | RAG RATING | DATE ACTIONED & CLOSED |
|---|---|---|---|---|---|---|
| 33/16<br>25.2.16 | **QUARTERLY QUALITY REPORT**<br>The Board agreed that the level of detail being reported to the Board should be reviewed by the Quality Committee. Juliette Cosgrove agreed to ascertain the level of information required for the various sub-committees and make recommendations accordingly. | DoN | Initial review of information across all Quality metrics complete.<br>Refreshed presentation of Quarterly quality report to commence in December 2016. | 1.12.16 | | |
| 106/16<br>30.6.16 | **RISK REGISTER – IMPACT OF RECENT REFERENDUM**<br>The question of whether the long term effects of the results of the EU referendum had any implications such as staff recruitment/vacancies and increased drug costs were required to be included on the Risk Register in the future. The Chief Executive acknowledged that the Trust was alert to the issues, would monitor the situation and once the Trust was fully aware of the issues would escalate as appropriate. The Board agreed that this position should be reviewed again in November 2016 and any material risk included in the Risk Register. | | 3.11.16<br>The Executive Director of Nursing advised that there had been no escalation of the Brexit issue within the register as it had not scored sufficiently to be included on the corporate risk register | | | 1.12.16 |
| 121/16<br>28.7.16 | **SUSTAINABILITY AND TRANSFORMATION PLAN**<br>The Board recognised that this work is complex and is moving at speed and there was a need to ensure that the Board was properly engaged in the development | OW/AB | 3.11.16<br>Work continued on STP. It was noted that once finalised the document would be circulated to Board members. Likely to be released publicly w/c 7.11.16 | | | Circulated 10.11.16 |

| 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 |
|---|---|---|---|---|---|---|
| | of the plan. It was agreed to provide a further update at the meeting in September. | | | | | |
| 162/16<br>3.11.16 | **CHIEF EXECUTIVE'S REPORT**<br>The Chief Executive agreed to circulate the Accelerator Zone presentation to Board members<br><br>To share the Sustainability and Transformation plan once released | OW<br><br>OW | Circulated following the meeting<br><br>Circulated by Company Secretary 10.11.16 | | | 3.11.16<br><br>10.11.16 |
| 165/16<br>3.11.16 | **BOARD ASSURANCE FRAMEWORK**<br>It was agreed to bring the Board Assurance Framework to the Board in February and for the Company Secretary to review other organisations' BAFs to assess the types of risks included | VP | | | | |
| 169/16<br>3.11.16 | **REVIEW OF PROGRESS AGAINST STRATEGY – PMU/THIS**<br>Discussion took place regarding the governance arrangements for the PMU commercial strategy and THIS Management Board and the Executive Director of Finance agreed to circulate a briefing note to the Board explaining the governance arrangements for the two ventures. | GB | | | | |
| | It was agreed to circulate the questions developed at the Board / Membership Council Workshop in | VP | | | | |

## ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 December 2016 / APPENDIX B

| Red | Amber | Green | Blue |
|---|---|---|---|
| Overdue | Due this month | Closed | Going Forward |

| Date discussed at BOD Meeting Date | AGENDA ITEM | LEAD | CURRENT STATUS / ACTION | DUE DATE | RAG RATING | DATE ACTIONED & CLOSED |
|---|---|---|---|---|---|---|
| | advance of the 16 November | | | | | |
| 168/16<br>3.11.16 | **WELL LED GOVERNANCE ASSESSMENT**<br>As part of new oversight arrangements, NHSI are looking to align their well led governance assessment more closely with the CQC well led assessment. The Company Secretary was due to attend a workshop on this in November and will provide further feedback to the Board at a future meeting. | VP | | | | |
| 173/16<br>3.11.16 | **INTEGRATED PERFORMANCE REPORT**<br>It was agreed to bring an item to the next meeting on the Trust's winter plan | HB | | | | |
| 175/16<br>3.11.16 | **UPDATE FROM SUB-COMMITTEES**<br>**Audit and Risk Committee**<br>The Company Secretary explained that there would be a change to the declarations of interest policy as new guidance was due to be published in December. An update would be brought to a future Board meeting. | VP | | | | |

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Calderdale and Huddersfield NHS
NHS Foundation Trust

**Approved Minute**

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## Cover Sheet

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|---|---|
| **Meeting:**<br>Board of Directors | **Report Author:**<br>Kathy Bray, Board Secretary |
| **Date:**<br>Thursday, 1st December 2016 | **Sponsoring Director:**<br>Victoria Pickles, Company Secretary |
| **Title and brief summary:**<br>FINANCIAL SUSTAINABILITY OF THE NHS REPORT - The Board is asked to receive and note the Financial Sustainability of the NHS Report' by the Comptroller & Auditor General, National Audit Office (NAO) | |
| **Action required:**<br>Note | |
| **Strategic Direction area supported by this paper:**<br>Keeping the Base Safe | |
| **Forums where this paper has previously been considered:**<br>N/A | |
| **Governance Requirements:**<br>Keeping the base safe | |
| **Sustainability Implications:**<br>None | |

## Executive Summary

### Summary:

The Board is asked to receive and note the Financial Sustainability of the NHS Report' by the Comptroller & Auditor General, NAO

## Main Body

### Purpose:

Please see attached

### Background/Overview:

Please see attached

### The Issue:

Please see attached

### Next Steps:

Please see attached

### Recommendations:

The Board is asked to receive and note the Financial Sustainability of the NHS Report' by the Comptroller & Auditor General, NAO

## Appendix

### Attachment:

Financial-Sustainability-of-the-NHS.pdf

National Audit Office

**Report**
by the Comptroller
and Auditor General

**Department of Health**

# Financial sustainability of the NHS

**HC 785 SESSION 2016-17 22 NOVEMBER 2016**

Our vision is to help the nation spend wisely.

Our public audit perspective helps Parliament hold government to account and improve public services.

The National Audit Office scrutinises public spending for Parliament and is independent of government. The Comptroller and Auditor General (C&AG), Sir Amyas Morse KCB, is an Officer of the House of Commons and leads the NAO, which employs some 785 people. The C&AG certifies the accounts of all government departments and many other public sector bodies. He has statutory authority to examine and report to Parliament on whether departments and the bodies they fund have used their resources efficiently, effectively, and with economy. Our studies evaluate the value for money of public spending, nationally and locally. Our recommendations and reports on good practice help government improve public services, and our work led to audited savings of £1.21 billion in 2015.

National Audit Office

Department of Health

# Financial sustainability of the NHS

Report by the Comptroller and Auditor General

Ordered by the House of Commons
to be printed on 21 November 2016

This report has been prepared under Section 6 of the National Audit Act 1983 for presentation to the House of Commons in accordance with Section 9 of the Act

Sir Amyas Morse KCB
Comptroller and Auditor General
National Audit Office

18 November 2016

HC 785 | £10.00

This report examines whether the NHS is on track to achieve financial sustainability.



11332 11/16 NAO

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Supporting local bodies to achieve financial sustainability 37

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**Appendix Three**
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The National Audit Office study team consisted of:
Andrew Bax, Rosie Buckley, Gethin Davies-Knapp, Elizabeth Hogarth, Amisha Patel, Tom Onions, Benjamin Osenius-eite under the direction of Robert White.

This report can be found on the National Audit Office website at www.nao.org.uk

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# Key facts

**£1.85bn**

net deficit of NHS bodies (NHS England, clinical commissioning groups, NHS trusts and NHS foundation trusts) overall in 2015-16

**£2.45bn**

net deficit of NHS trusts and NHS foundation trusts in 2015-16

**66%**

percentage of NHS trusts and NHS foundation trusts (156 out of 238) in deficit in 2015-16

| | |
|---|---|
| **32 out of 209 (15%)** | number of clinical commissioning groups reporting a cumulative deficit in 2015-16 |
| **£2.4 billion** | additional funding given to NHS trusts and NHS foundation trusts in financial difficulty as a cash injection, loan or other financial support in 2015-16 |
| **£1.8 billion** | funding for financial sustainability available for trusts in 2016-17 from the £2.14 billion Sustainability and Transformation Fund |
| **£461 million** | net deficit reported by NHS trusts and NHS foundation trusts in the first three months of 2016-17 |
| **£14.9 billion** | savings that NHS trusts, NHS foundation trusts and clinical commissioners need to make by 2020-21 to help close the estimated £22 billion gap between patients' needs and resources |

# Summary

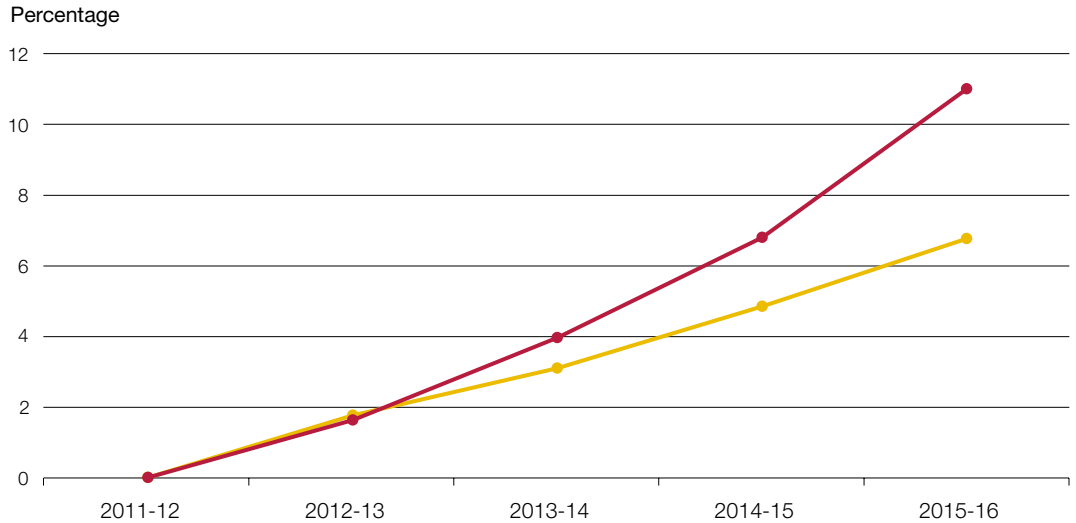
**1** This is our fifth report on the financial sustainability of the NHS. The health service must be financially sustainable to provide high-quality services for patients both now and in the future. Health is an area of public spending that has been protected in recent years. However, finances have become increasingly tight.

**2** NHS bodies achieve financial sustainability when they are able to successfully manage activity, quality and financial pressures within the income they receive. In recent years, the financial performance of NHS trusts and NHS foundation trusts has significantly declined. **Figure 1** shows that the growth in spending by trusts has outpaced growth in their income.

## Figure 1

Cumulative increase in NHS trusts' and NHS foundation trusts' income and spending since 2011-12

**Growth in trusts' income has not kept pace with growth in spending**




| | 2011-12 | 2012-13 | 2013-14 | 2014-15 | 2015-16 |
|---|---|---|---|---|---|
| Trusts' total spending (%) | 0 | 1.6 | 4.0 | 6.8 | 11.0 |
| Trusts' total income (%) | 0 | 1.8 | 3.1 | 4.9 | 6.8 |

**Notes**

1 NHS trusts' and NHS foundation trusts' spending and income figures are adjusted to remove the effects of impairments of assets, transfers of functions from or to other health bodies and charitable funds.

2 Figures are adjusted for inflation using the GDP deflator with the base year in 2015-16, as used by HM Treasury in setting departments' budgets.

Source: National Audit Office analysis of trusts' financial data

**3** In December 2015 we concluded that this continued deterioration in financial performance was not sustainable and that financial problems were endemic.
The Department of Health (the Department) has overall responsibility in central government for healthcare services. The Department is accountable to Parliament for ensuring that all spending by the Department, NHS England, NHS Improvement, other arm's-length bodies and by local NHS bodies is contained within the overall budget authorised by Parliament. It is responsible for ensuring that those organisations perform effectively and have governance and controls in place to ensure value for money. The Department has made NHS England and NHS Improvement responsible for ensuring that the NHS balances its budget in 2016-17.[1]

**4** The NHS *Five Year Forward View*, published in October 2014, set out proposed changes to healthcare services. The *Five Year Forward View* estimated that there would be a £30 billion gap between resources and patients' needs by 2020-21. It estimated that if the NHS had £8 billion more funding, the gap between resources and patients' needs would be £22 billion by 2020-21 if no action was taken. In November 2015 the government committed to increasing funding for the NHS by £8.4 billion by 2020. Included in this is £2.14 billion that the Department, NHS England and NHS Improvement set aside for the Sustainability and Transformation Fund in 2016-17, of which £1.8 billion will be used to help trusts sustain services and reduce deficits.

**5** In this report on financial sustainability in the NHS:

- We give a summary of the financial position of NHS England, clinical commissioning groups, NHS trusts and NHS foundation trusts (Part One).
- We look at what the Department, NHS England and NHS Improvement have done to develop a plan for achieving financial sustainability, and how they are managing the risks in implementing their plans (Part Two).
- We examine the support the Department, NHS England and NHS Improvement have given to local bodies, including NHS trusts, NHS foundation trusts and clinical commissioning groups, to ensure the future sustainability of the NHS (Part Three).

**6** We set out our audit approach in Appendix One and evidence base in Appendix Two. Technical notes explaining how we have used financial data are in Appendix Three.
The report does not look in detail at primary care, social care, public health or similar services, although the transformation of primary care and public health and the need to sustain social care services are key elements of the *Five Year Forward View*.

1 NHS Improvement includes Monitor, the regulator of NHS foundation trusts, and the NHS Trust Development Authority, which oversees NHS trusts.

## Key findings

### Trends in the financial performance of NHS bodies

7 **In 2015-16, NHS commissioners, NHS trusts and NHS foundation trusts reported a combined deficit of £1.85 billion.** This was made up of:

- NHS trusts and NHS foundation trusts reporting a combined deficit of £2.45 billion against their total income of £75.97 billion;
- clinical commissioning groups together achieving an overspend of £15 million, against the £72.24 billion available for locally commissioned services; and
- NHS England achieving an underspend of £614 million, spending £28.02 billion of the £28.64 billion available for its national functions and centrally commissioned services (paragraph 1.3).

8 **The financial position of NHS bodies overall has continued to decline.** The £1.85 billion deficit in 2015-16 reported by commissioners, NHS trusts and NHS foundation trusts together, shows that the financial position has worsened since a £574 million deficit was reported in 2014-15 and a £234 million surplus in 2013-14 (paragraph 1.3).[2,3]

9 **The number of NHS bodies reporting a deficit rose significantly between 2014-15 and 2015-16.** In 2015-16 two-thirds of NHS trusts (65%) and NHS foundation trusts (66%) reported deficits, up from 44% of NHS trusts and 51% of NHS foundation trusts in 2014-15. The number of clinical commissioning groups reporting cumulative deficits was 32 in 2015-16, up from 19 in both 2013-14 and 2014-15 (paragraphs 1.5 and 1.9).

2 The total deficit reported by NHS bodies in 2014-15 is different from that reported in our report *Sustainability and financial performance of acute hospital trusts*. This is because Doncaster and Bassetlaw Hospitals NHS Foundation Trust restated its 2014-15 position during 2015-16 (see paragraph 7, Appendix Three). The restated figures for 2014-15 are used throughout this report.

3 The financial performance of NHS bodies in 2013-14 and 2014-15 is different from that reported in our report *Sustainability and financial performance of acute hospital trusts*. This is because for consistency with NHS England's Annual Report and Accounts for 2015-16, we have restated the commissioner figures to use NHS England's non-ring-fenced budget. The non-ring-fenced budget excludes depreciation and impairment charges. Previously reported figures use NHS England's ring-fenced budget, which includes depreciation and impairment charges.

**10 Trusts' overall deficit grew by 185% to £2.45 billion, up from £859 million in 2014-15.**[4] This continued trusts' sharp decline in financial performance from a £91 million deficit reported in 2013-14, and a £592 million surplus in 2012-13. At 30 June 2016, trusts reported a deficit of £461 million and forecast an end-of-year deficit of £644 million (paragraphs 1.10 to 1.11).

**11 Trusts' performance against important indicators of financial health continued to decline in 2015-16.** Trusts' overall margin of average earnings before interest, tax, depreciation and amortisation (EBITDA) fell for the fifth consecutive year. EBITDA is used as a measure of operating efficiency and underlying financial sustainability. At the end of 2015-16 the average EBITDA margin for NHS trusts fell sharply to 0.8% from 3.5% in 2014-15; for NHS foundation trusts, it had fallen from 3.6% to 2.2%. In 2015-16 trusts' balance of net current assets, showing how much capital trusts are generating and using, was negative for the first time. This suggests trusts are finding it difficult to finance their day-to-day operations. Trusts are increasingly struggling to pay suppliers on time with 77% paying their invoices within 30 days in 2015-16, compared with 81% in 2014-15 and 82% in 2013-14, against the Department's target that 95% of invoices are paid on time (paragraphs 1.12 to 1.15).

## Reliance on financial support

**12 NHS trusts and NHS foundation trusts under financial stress continue to rely on financial support from the Department and NHS England.** The Department provides additional funding, mainly in the form of loans, so that trusts in difficulty have the cash they need to pay creditors and staff and to fund essential building works. NHS England provides income support to trusts to cover historically agreed transactions and private finance initiative payments. In 2015-16 the total amount of financial support funding provided by the Department and NHS England was £2.4 billion. This was an increase of 32% from £1.8 billion in 2014-15 (paragraph 1.17).

4 Trusts' 2014-15 deficit is different from that reported from our report *Sustainability and financial performance of acute hospital trusts*. Doncaster and Bassetlaw Hospitals NHS Foundation Trust restated its 2014-15 position during 2015-16 (see paragraph 7, Appendix Three).

## Achieving NHS targets and meeting quality requirements

**13 There are indications that financial stress is having an impact on access to services and quality of care.** Trusts' performance against important NHS access targets has worsened. For example, the target that a minimum of 95% of patients attending accident and emergency departments (A&E) must be discharged, admitted or transferred in under four hours was not met in 2015-16, with 91.9% spending fewer than four hours in A&E compared with 93.6% in 2014-15. We found an association between trusts' financial performance and trusts' overall Care Quality Commission rating (which does not include measures of actual financial performance). The trusts that achieved lower quality ratings also reported poorer average financial performance. We found that the five trusts rated 'outstanding' between December 2013 and August 2016 had a net deficit equal to 0.02% of their total income in 2015-16. The 14 trusts rated 'inadequate' had a net deficit equal to 10.4% of their total income in 2015-16 (paragraphs 1.18 to 1.20).

## Impact of interventions to manage the 2015-16 financial position

**14 The growth in trusts' spending on agency and contract staff has slowed, although their spending on these staff is still significant.** Trusts spent 7.6% of their total staff costs on agency and contract staff in 2015-16, up from 7.1%, 5.6% and 4.8% in 2014-15, 2013-14 and 2012-13 respectively. The Department, Monitor and the NHS Trust Development Authority introduced controls on agency spending in October 2015. However, the amount trusts spent on agency and contract staff remained high. They spent £3.7 billion in 2015-16, compared with £3.3 billion in 2014-15. It may take years to resolve workforce issues that affect the successful recruitment and retention of permanent staff, and reduce the need for agency staff (paragraphs 1.22 to 1.25).

**15 The Department has transferred funding for capital to funding for day-to-day spending; this has helped it to manage the NHS' financial position in 2015-16, but could risk trusts' ability to achieve sustainable service provision.** In February 2016 the Department transferred £950 million of its £4.6 billion budget for capital projects, such as building works and IT, to revenue budgets to fund the day-to-day activities of NHS bodies. Of this, £331 million was exchanged for revenue support for 93 trusts, to fund healthcare services. The Department did not assess the long-term effects of transferring this funding to cover day-to-day spending. This means it does not know what risks trusts may face in future as a result of addressing immediate funding needs (paragraphs 1.27 to 1.29).

## Managing financial sustainability

**16 The Department, NHS England and NHS Improvement have a shared plan to close the estimated £22 billion gap between patients' needs and resources by 2020-21.** Together, the Department, NHS England and NHS Improvement estimate that they can make £6.7 billion of efficiencies by capping public sector pay, renegotiating contracts, implementing income-generating activities and reducing running costs. They estimate that trusts and commissioners can make a further £14.9 billion by moderating the growth in demand for healthcare services and achieving 2% productivity and efficiency improvements (paragraphs 2.2 and 2.3).

**17 Plans to close the estimated £22 billion gap have not been fully tested.** The Department, NHS England and NHS Improvement used a financial model to estimate the gap between patients' needs and resources by 2020-21, and the savings their programmes need to achieve to close this gap. We found limited testing by the Department, NHS England and NHS Improvement of their estimates of how much they expect to generate from their savings programmes. This raises concerns about whether planned savings can be achieved. For example, plans assume that growth in trusts' acute activity (including specialised acute services) will be reduced from 2.9% to 1.3% through transformation and efficiency programmes such as Right Care, new care models and the Urgent and Emergency Care programme. However, NHS statistics show this will be challenging as hospital admissions, a key driver of activity, grew by 2.8% a year between 2013-14 and 2014-15 (paragraphs 2.4 to 2.7).

**18 The NHS is implementing its plans to make the NHS financially sustainable from a worse than expected starting point**. Plans to achieve financial sustainability were based on trusts ending 2015-16 with a combined deficit of £1.8 billion. The fact that trusts ended the year with an even larger deficit means that the level of deficit to be recovered is significantly greater than expected. This means that the trusts affected will need to catch-up by making more savings than planned to reach the intended starting position. For example, trusts with deficits greater than expected at the end of 2015-16 will need to make operational efficiencies above the 2% savings level applied to all providers of healthcare services in 2016-17 or subsequent years (paragraphs 1.8 and 2.8).

**19 National bodies have not assessed the impact of all the wider cost pressures faced by local NHS organisations in plans for achieving financial sustainability.** The Department, NHS England and NHS Improvement expect trusts and commissioners to invest in transformation programmes. But they do not yet know what level of investment is required or whether local bodies will be able to make the changes at the scale and pace needed. Furthermore, the government has made a commitment that the health and social care system in England will be fully joined together by 2020. We have previously reported that local authority spending on adult social care fell by 10% in real terms between 2009-10 (£16.3 billion) and 2014-15 (£14.6 billion). The accounting officer for NHS England told the Committee of Public Accounts that "over the next two or three years, there is likely to be a widening gap between the availability of adult social care and the need for social care. That, will, inevitably show up as delayed discharges and extra pressure on hospitals." However, in our review of the plans for financial sustainability, we did not see any estimate of the impact of pressures on social care spending on NHS bodies (paragraphs 2.6 to 2.13).

## Supporting local NHS organisations to achieve financial sustainability

**20 NHS England's and NHS Improvement's financial 'reset' announced in July 2016 outlined the steps they are taking to cut trusts' deficits.** NHS Improvement placed five trusts in 'financial special measures' and it continued to monitor trusts against the financial targets (control totals) that it introduced in January 2015. Trusts must meet these targets in order to access the £1.8 billion of sustainability funding from the Sustainability and Transformation Fund. In 2016-17 NHS England and NHS Improvement continued to implement their controls on trust spending that began in 2015-16, for example by limiting spending on agency staff (paragraph 3.2).

**21 Despite efforts by NHS England and NHS Improvement to join up to support local NHS bodies, a lack of incentives and unrealistic targets remain.** We heard from five of the 21 local bodies we spoke to that the pressure to meet the financial targets set by NHS Improvement for their individual organisation did not incentivise them to work with other bodies in their local area to develop sustainability and transformation plans as required by NHS England and NHS Improvement. Furthermore, in May 2016 the Committee of Public Accounts concluded that the 4% efficiency target for trusts set by NHS England and Monitor (now NHS Improvement) in 2015-16 was unrealistic and damaging to trusts' finances. For the 2016-17 financial year, NHS England and NHS Improvement reduced the efficiency target to 2%. But, by July 2016, NHS Improvement said it expected that trusts will need to achieve an efficiency target greater than 2%, partly because of the higher than expected trust deficit at the end of 2015-16 (paragraphs 3.4 and 3.7 to 3.10).

## Conclusion on value for money

**22** The messages in our two previous reports on NHS financial sustainability have been consistent and clear in stating that the trend in NHS trusts' and NHS foundation trusts' declining financial performance was not sustainable. In 2015-16 trusts' financial performance worsened considerably. Efforts to get NHS finances on track, such as large savings and efficiency targets, have damaged trusts' financial positions and contributed to the current situation. With more than two-thirds of trusts in deficit in 2015-16, we repeat our view that financial problems are endemic and this is not sustainable.

**23** Delivering financial stability in 2016-17 will be vital if the NHS is to make the changes needed to improve the quality and timeliness of healthcare services. The Department, NHS England and NHS Improvement must make sure their plans for restoring NHS finances to a stable position are achievable. They have put considerable effort and funding toward stabilising the system, but the starting position in 2016-17 was considerably weaker than assumed. The Department, NHS England and NHS Improvement have a way to go to demonstrate that they have balanced resources and achieved stability as a result of this effort. Therefore, value for money from these collective actions has not yet been demonstrated.

**24** The National Audit Office (NAO) perceives differences in the position articulated by the Department – which views the funding for the NHS as having been adequate over the last few years, and in line with what NHS England set out it would need to deliver the NHS *Five Year Forward View* – and NHS England itself. Confronted as NHS England is by the pressures of rising demand for services, these signs of differences do not help build a confident feel about the future of the NHS.

## Recommendations

a **The Department, NHS England and NHS Improvement should test the assumptions in both national plans as well as local sustainability and transformation plans.** The Department, NHS England and NHS Improvement have identified savings programmes for closing the estimated £22 billion gap between patients' needs and resources by 2020-21. They should test national plans as well as local sustainability and transformation plans and use this testing to identify the risks that need to be managed. They should be clear on who these risks are owned by.

b **NHS England and NHS Improvement should set realistic efficiency and savings targets for local bodies to achieve.** Setting overly optimistic efficiency and savings targets for local bodies could result in short term and ineffective interventions. NHS England and NHS Improvement should set informed efficiency and savings targets for providers and make sure the combined effect of these targets is achievable.

c **The Department should evaluate the impact and risks to future financial stability of the one-off measures used to manage the 2015-16 financial position, including the transfer of capital funding to resource.** The Department, NHS England and NHS Improvement took action to manage the financial position of the NHS in 2015-16 and address the growing deficit of trusts. While their measures are technically justifiable, they should not form the basis of a credible plan to secure the financial sustainability of the NHS in England. It is unclear what impact one-off measures will have on the future sustainability of the NHS or whether there is sufficient capital to renew existing assets and support the vision in the *Five Year Forward View*. The Department should assess its capital requirements and evaluate the impact and risks of transferring capital budgets to support routine spending.

d **The Department, NHS England and NHS Improvement should analyse the impact to the NHS of pressures on social care funding, and the cost of implementing seven-day services.** Local bodies are faced with wider cost pressures in addition to the need to achieve financial sustainability. However, not all of these have been taken into account in national plans for financial sustainability.

e **NHS England and NHS Improvement should assess whether current and planned incentives are helping local bodies to work together, plan for and achieve long-term financial sustainability.** The legislative and accountability framework for local NHS organisations is seen by some as a barrier to helping local bodies to work together. But NHS England and NHS Improvement could do more within the existing regulation and accountability framework to create the incentives for local bodies to collaborate. They should evaluate whether recent changes to the financial planning process for local bodies are working effectively and should have alternative plans if new approaches do not work as intended.

# Part One

## Financial performance in the NHS

**1.1** In this part of the report we examine the financial position of NHS bodies (clinical commissioning groups, NHS trusts and NHS foundation trusts) and trends in the performance of clinical commissioning groups, NHS trusts and NHS foundation trusts. We also look at measures of financial sustainability for NHS trusts and NHS foundation trusts.

### NHS funding and spending in 2015-16

**1.2** In 2015-16, the Department of Health (the Department) gave £100.9 billion to NHS England to plan and pay for NHS services.[5] The greatest share of the budget was spent by 209 clinical commissioning groups, which largely bought healthcare from 86 NHS trusts and 152 NHS foundation trusts. These provide hospital, community, ambulance, and mental health and disability services. **Figure 2** gives a summary of the financial performance of NHS commissioners, NHS trusts and NHS foundation trusts in 2015-16.

**1.3** NHS bodies overall ended 2015-16 with a £1,848 million (£1.85 billion) deficit. This was significantly greater than the £574 million deficit recorded in 2014-15 and the £234 million surplus in 2013-14.[6,7] In 2015-16 the deficit was made up of:

- NHS England reporting an underspend of £614 million, having spent £28,024 million of the £28,638 million available for national functions, centrally commissioned services and legacy claims;
- clinical commissioning groups reporting an overspend of £15 million against the £72,244 million available for locally commissioned services; and
- NHS trusts and NHS foundation trusts reporting a combined deficit of £2,447 million against their income of £75,966 million.

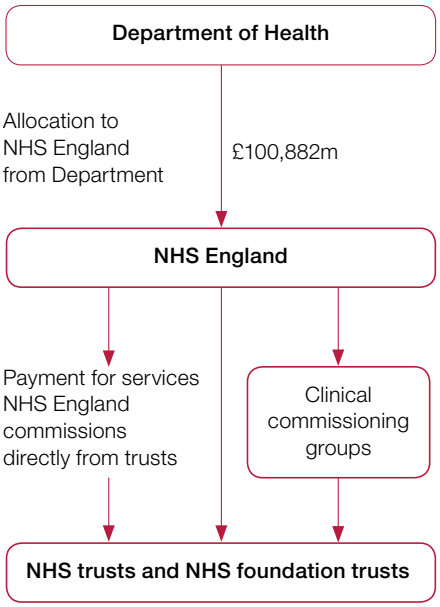
5 The £100.9 billion is NHS England's revenue budget for day-to-day spending. It is its non-ring-fenced budget, meaning it excludes depreciation and impairment charges.

6 Trusts' 2014-15 deficit is different from that reported in our report *Sustainability and financial performance of acute hospital trusts*. This is because Doncaster and Bassetlaw Hospitals NHS Foundation Trust restated its 2014-15 position during 2015-16 (see paragraph 7, Appendix Three). The restated figures for 2014-15 are used throughout this report.

7 The financial performance of NHS bodies in 2013-14 and 2014-15 is different from that reported in our report *Sustainability and financial performance of acute hospital trusts*. This is because for consistency with NHS England's Annual Report and Accounts for 2015-16, we have restated the commissioner figures to use NHS England's non-ring-fenced budget. The non-ring-fenced budget excludes depreciation and impairment charges. Previously reported figures use NHS England ring-fenced budget, which includes depreciation and impairment charges.

## Figure 2

Summary of the financial performance of NHS commissioners, NHS trusts and NHS foundation trusts in 2015-16




| | Allocation/ income 2015-16 (£m) | Underspend/ overspend 2015-16 (£m) | Underspend/ overspend 2014-15 (£m) |
|---|---|---|---|
| Centrally-commissioned services including primary care, specialised services and public health) | 28,638 | 614 Underspend (surplus) | 200 Underspend (surplus) |
| Clinical commissioning groups | 72,244 | 15 Overspend (deficit) | 85 Underspend (surplus) |
| NHS trusts and NHS foundation trusts | 75,966 | 2,447 Overspend (deficit) | 859 Overspend (deficit) |
| **Net overspend by NHS commissioners and NHS providers** | | **1,848 Overspend (deficit)** | **574 Overspend (deficit)** |

**Notes**

1 NHS England's total revenue budget (including depreciation and impairment charges) was £101,708 million. The core measure for NHS England's financial performance is its non-ring-fenced revenue budget of £100,882 million, which excludes depreciation and impairment charges.

2 NHS trusts and NHS foundation trusts generate income as opposed to receiving 'allocations'. This is because they work on a more commercial basis than NHS England and clinical commissioning groups, which work within an annual resource limit.

3 NHS trusts and NHS foundation trusts receive income from clinical commissioning groups, NHS England and other trusts, including from services they provide to other trusts. The £75,966 million income shown here is the gross income from all these sources.

4 NHS England and clinical commissioning groups also buy healthcare services from other providers.

5 Several NHS trusts and NHS foundation trusts dissolved in 2015-16. Figures shown here include the results for these trusts up until the point of dissolution. All other data are for the whole 2015-16 financial year.

6 The 2014-15 balance is different from that reported in our December 2015 report *Sustainability and financial performance of acute hospital trusts*. Doncaster and Bassetlaw Hospitals NHS Foundation Trust restated its 2014-15 position during 2015-16 (see paragraph 7, Appendix Three).

7 The combined underspend of NHS England and clinical commissioning groups was £599 million.

8 Underspend or overspend on the legacy Continuing Healthcare claims programme have been included in the figures for centrally commissioned services.

Source: National Audit Office analysis of Department of Health, NHS England and NHS Improvement data

## Trends in the financial performance of healthcare commissioners

**1.4** The financial performance of clinical commissioning groups is measured against the planned position at the end of the financial year agreed between each clinical commissioning group and NHS England. Any differences between the actual and planned position are reported as either underspends or overspends. NHS England asks clinical commissioning groups to balance their finances and not overspend by the end of the financial year. They must also report any underspending. In 2015-16 the £15 million overspend was made up of two components:

- a collective overspend of £28 million on locally commissioned services bought by clinical commissioning groups; and
- an underspend of £13 million on the Quality Premium programme.[8]

**1.5** NHS England calculates clinical commissioning groups' financial position compared with their funding allocation each year. Any surplus or deficit is added to previous years' calculations to create a cumulative surplus or deficit for each group. In 2015-16:

- the number of clinical commissioning groups reporting a cumulative deficit increased to 32 clinical commissioning groups, up from 19 in 2014-15 and 19 in 2013-14; and
- the total net cumulative surplus fell to £328 million from £731 million in 2014-15, indicating that clinical commissioning groups needed to use their reserves as well as their allocated funding to commission healthcare services.

**1.6** In 2015-16 NHS England underspent by £614 million against its central and direct commissioning budget. It achieved this by reducing the costs of restructuring; spending less than planned on programmes, which saved £340 million; achieving an underspend of £192 million on legacy Continuing Healthcare claims and making additional savings of £82 million from direct commissioning.[9] Many of these savings were one-off in nature. NHS England's budget for 2016-17 onwards has been adjusted to reflect likely future performance. This means NHS England will continue to operate under financial constraint in 2016-17.

8 The Quality Premium programme rewards clinical commissioning groups for improving the quality of services they commission and for associated improvements in health outcomes.

9 The NHS Continuing Healthcare programme provides free care outside of hospital that is arranged and funded by the NHS. Clinical commissioning groups now provide funding, but NHS England is responsible for accounting for claims made before the healthcare system was reorganised following the Health and Social Care Act 2012.

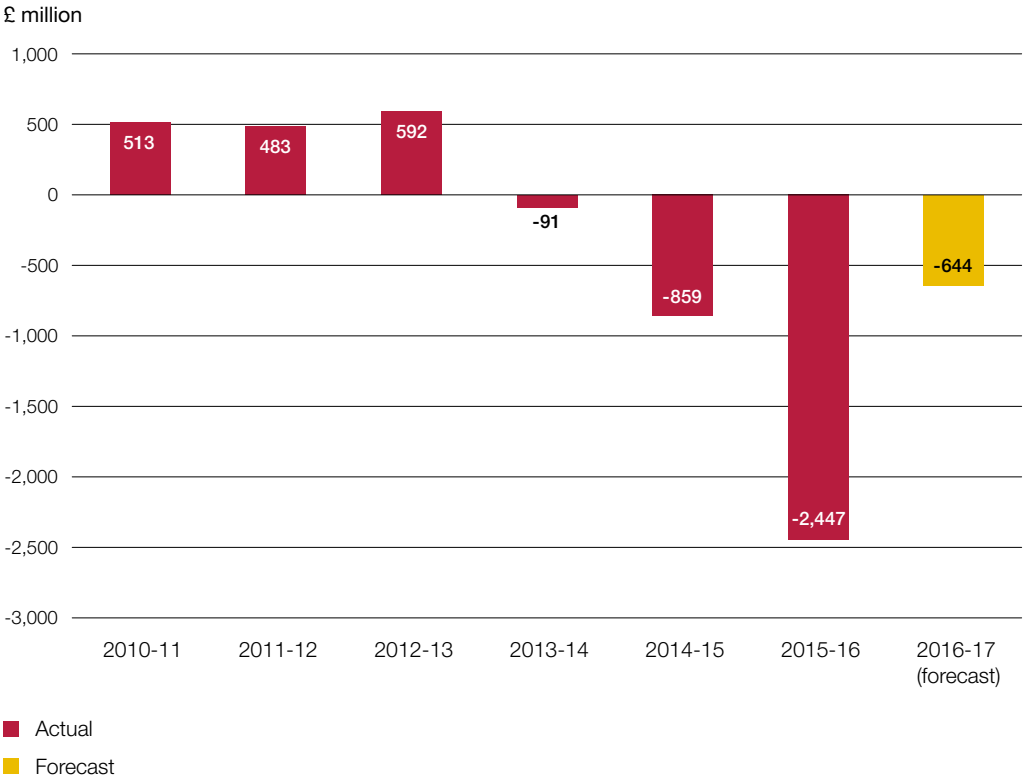
## Trends in the financial performance of NHS trusts and NHS foundation trusts

**1.7** **Figure 3** shows that, between 2013-14 and 2015-16, the financial performance of NHS trusts and NHS foundation trusts deteriorated considerably. Trusts have forecast that their financial performance will improve by the end of 2016-17. They expect a net deficit of £644 million by 31 March 2017. This improvement is expected to come largely from trusts accessing £1.8 billion of sustainability funding during 2016-17 (see paragraph 3.2).

### Figure 3

Surplus/deficit of NHS trusts and NHS foundation trusts, 2010-11 to 2015-16, and forecast for 2016-17

**There was a significant decline in the financial position of NHS trusts and NHS foundation trusts in 2015-16 with trusts forecasting an improved position by the end of 2016-17**




**Notes**

1 The 2016-17 forecast figure is taken from NHS Improvement, *Quarter 1 sector performance report*, May 2016.

2 The 2014-15 balance is different from that reported in our December 2015 report *Sustainability and financial performance of acute hospital trusts*. Doncaster and Bassetlaw Hospitals NHS Foundation Trust restated its 2014-15 position during 2015-16 (see paragraph 7, Appendix Three).

Source: National Audit Office analysis of trusts' financial data, and 2016-17 forecast data from NHS Improvement

**1.8** Trusts' financial deficit at the end of 2015-16 was greater than the deficit forecast in their financial plans submitted in May 2015. In September 2015 the NHS Trust Development Authority gave each NHS trust a target to improve its forecast overall deficit. NHS foundation trusts were asked to show improved forecast outturn positions. Despite efforts to improve trusts' finances, the net deficit at 31 March 2016 (£2,447 million) was significantly greater than both the end-of-year deficit forecast in April 2015 (£2,075 million) and the final planned deficit of £1,800 million estimated after NHS trusts had been given their stretch targets.[10]

**1.9** In 2015-16 there were 238 trusts, made up of 86 NHS trusts and 152 NHS foundation trusts. **Figure 4** shows that a growing number of trusts have reported a deficit since 2012-13, when just 25 trusts overall reported a deficit. At the end of 2015-16 this had risen to 156 trusts. In 2015-16:

- 65% of NHS trusts (56 of 86) reported a deficit up from 44% in 2014-15 (40 of 90), 23% in 2013-14 (23 of 98), and 5% in 2012-13 (5 of 100); and
- 66% of NHS foundation trusts (100 of 152) reported deficits, up from 51% (76 of 150) in 2014-15, 28% in 2013-14 (41 of 147) and 14% in 2012-13 (20 of 145).

**1.10** In 2015-16 the overall deficit of NHS trusts and NHS foundation trusts (£2,447 million) was 2.8 times the size of the deficit in 2014-15 (£859 million).[11]

- NHS trusts' overall deficit increased to £1,337 million in 2015-16 from £514 million in 2014-15.
- NHS foundation trusts overall deficit increased to £1,110 million in 2015-16 from £345 million in 2014-15.
- For all trusts that had a deficit, their combined deficit was £2,800 million in 2015-16 up from £1,268 million in 2014-15.

**1.11** At 30 June 2016, trusts reported a deficit for the first quarter of 2016-17 of £461 million. If the size of the deficit is maintained, it would mark a significant improvement in the financial performance of trusts from the £2,447 million deficit reported in 2015-16. However, it will be challenging for trusts to go from a £461 million quarter one deficit to meet their forecast end-of-year deficit of £644 million. The quarter one deficit of £461 million includes £450 million of sustainability funding. Without this funding the deficit would be £911 million, compared with a deficit of £930 million for the first quarter of 2015-16.

10 HC Committee of Public Accounts, *Sustainability and financial performance of acute hospital trusts*, Thirtieth Report of Session 2015-16, HC 709, March 2016, available at: www.publications.parliament.uk/pa/cm201516/cmselect/cmpubacc/709/709.pdf

11 Doncaster and Bassetlaw Hospitals NHS Foundation Trust restated its 2014-15 position during 2015-16 (see paragraph 7, Appendix Three).

## Figure 4

Surpluses and deficits of NHS trusts and NHS foundation trusts, 2012-13 to 2015-16

| | 2012-13 | | 2013-14 | | 2014-15 | | 2015-16 | |
|---|---|---|---|---|---|---|---|---|
| | Number of trusts in surplus | Number of trusts in deficit | Number of trusts in surplus | Number of trusts in deficit | Number of trusts in surplus | Number of trusts in deficit | Number of trusts in surplus | Number of trusts in deficit |
| NHS trusts | 95 | 5 | 75 | 23 | 50 | 40 | 30 | 56 |
| NHS foundation trusts | 125 | 20 | 106 | 41 | 74 | 76 | 52 | 100 |
| **Total** | **220** | **25** | **181** | **64** | **124** | **116** | **82** | **156** |
| | **Surplus (£m)** | **Deficit (£m)** | **Surplus (£m)** | **Deficit (£m)** | **Surplus (£m)** | **Deficit (£m)** | **Surplus (£m)** | **Deficit (£m)** |
| NHS trusts | 238 | -139 | 217 | -424 | 120 | -634 | 97 | -1,434 |
| NHS foundation trusts | 651 | -158 | 432 | -316 | 289 | -634 | 256 | -1,366 |
| Gross total | 889 | -297 | 649 | -740 | 409 | -1,268 | 353 | -2,800 |
| **Net total** | **592** | | **-91** | | **-859** | | **-2,447** | |

**Notes**

1 The number of trusts are those were in existence on 31 March for each year. Trusts that stopped providing services during the year through mergers or break-ups are not counted.

2 Surpluses and deficits of trusts ceasing to provide services in each year are added to the successor trusts' surpluses and deficits.

3 Figures exclude NHS Direct.

4 The 2014-15 figures for NHS foundation trusts are different from those reported in our December 2015 report *Sustainability and financial performance of acute hospital trusts*. Doncaster and Bassetlaw Hospitals NHS Foundation Trust restated its 2014-15 position during 2015-16 (see paragraph 7, Appendix Three).

Source: National Audit Office analysis of trusts' financial data

## Indicators of trusts' financial sustainability

**1.12** The EBITDA margin (earnings before interest, tax, depreciation and amortisation, expressed as a percentage of income) is a measure of operating efficiency and underlying financial sustainability. The average EBITDA margin for both NHS trusts and NHS foundation trusts has fallen over the past five years, reflecting the widening gap between income and expenditure (**Figure 5**). In 2015-16 the margin was 0.8% for NHS trusts and 2.2% for NHS foundation trusts, down from 5.7% and 6.6% respectively in 2010-11.

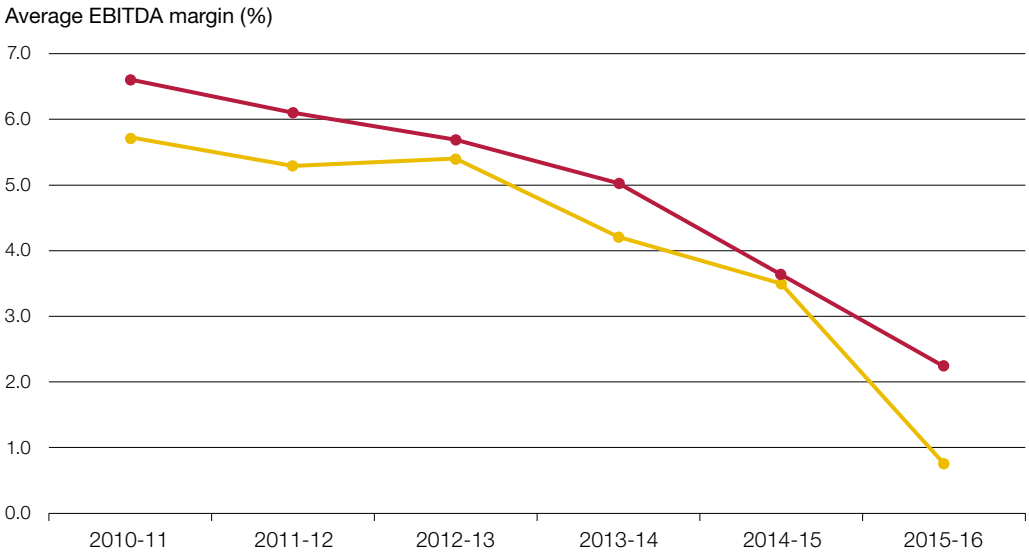
**1.13** The balance of net current assets held by trusts indicates how much capital trusts are generating or using through day-to-day activities. If net current assets are negative, it may indicate that a trust is having difficulty financing its day-to-day operations. **Figure 6** shows that in 2015-16:

- trusts reported a negative total net current assets balance of £25 million for the first time, down from £1,328 million in 2014-15;
- net current assets held by NHS trusts fell considerably (198%) to a negative balance of £593 million, from a negative balance of £199 million in 2014-15; and
- net current assets held by NHS foundation trusts fell by 63% to £568 million, down from £1,527 million in 2014-15.

**Figure 5**

Average EBITDA margins for NHS trusts and NHS foundation trusts, 2010-11 to 2015-16

**The average EBITDA margin has fallen over the past six years**




| | 2010-11 | 2011-12 | 2012-13 | 2013-14 | 2014-15 | 2015-16 |
|---|---|---|---|---|---|---|
| NHS trusts | 5.7 | 5.3 | 5.4 | 4.2 | 3.5 | 0.8 |
| NHS foundation trusts | 6.6 | 6.1 | 5.7 | 5.0 | 3.6 | 2.2 |

**Note**

1 The 2014-15 figures for NHS foundation trusts are different from those reported in our December 2015 report *Sustainability and financial performance of acute hospital trusts*. Doncaster and Bassetlaw Hospitals NHS Foundation Trust restated its 2014-15 position during 2015-16 (see paragraph 7, Appendix Three).

Source: National Audit Office analysis of NHS trusts and NHS foundation trusts accounts data, 2010-11 to 2015-16

## Figure 6

Cash and other current assets and liabilities at the end of the financial year, 2012-13 to 2015-16

| | 2012-13 | | | 2013-14 | | | 2014-15 | | | 2015-16 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | NHS trusts (£m) | NHS foundation trusts (£m) | Total (£m) | NHS trusts (£m) | NHS foundation trusts (£m) | Total (£m) | NHS trusts (£m) | NHS foundation trusts (£m) | Total (£m) | NHS trusts (£m) | NHS foundation trusts (£m) | Total (£m) |
| Cash and cash equivalents | 1,308 | 4,483 | **5,791** | 1,269 | 4,213 | **5,482** | 1,005 | 3,971 | **4,976** | 790 | 3,344 | **4,134** |
| Other current assets | 1,714 | 2,388 | **4,102** | 2,290 | 3,138 | **5,429** | 2,312 | 3,580 | **5,892** | 2,239 | 3,799 | **6,038** |
| Current liabilities | -3,174 | -5,087 | **-8,261** | -3,656 | -5,590 | **-9,247** | -3,516 | -6,024 | **-9,540** | -3,622 | -6,575 | **-10,197** |
| Net current assets | -152 | 1,784 | **1,632** | -97 | 1,761 | **1,664** | -199 | 1,527 | **1,328** | -593 | 568 | **-25** |

**Notes**

1 Current assets and current liabilities include balances between trusts (figures are gross, not netted off for transactions between trusts).

2 Data exclude trusts' charitable funds.

3 Data are taken from trusts' statements of financial position on 31 March in each year; balances of trusts that dissolved in-year are included in the balances of the successor trusts for that year. Balances of trusts that became NHS foundation trusts during the financial year are included in the NHS foundation trust figures for that year.

Source: National Audit Office analysis of NHS trusts and NHS foundation trusts accounts data, 2012-13 to 2015-16

**1.14** Figure 6 shows that cash balances for trusts continued to fall in 2015-16. Trusts may have fewer reserves that they can easily draw on in times of need, so there is a higher risk that trusts in difficulty will still need financial support from the Department. In 2015-16, the amount of cash held by:

- all trusts had fallen by 29% since 2012-13, to £4,134 million down from £5,791 million;
- NHS trusts had fallen by 40% since 2012-13, to £790 million down from £1,308 million; and
- NHS foundation trusts had fallen by 25% since 2012-13, to £3,344 million from £4,483 million.

**1.15** Trusts are increasingly not paying their bills on time. The Department's Better Payment Practice Code (BPPC) states that trusts should pay 95% of all undisputed invoices "within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed".[12] Trusts paid 77% of invoices on time in 2015-16 compared with 81% in 2014-15 and 82% in 2013-14.[13]

**1.16** A significant number of trusts face severe financial pressures. In 2015-16, there were 57 trusts with deficits that made up more than 5% of their income. Appendix Four, published alongside this report, shows which trusts these were.

## Trusts' reliance on financial support

**1.17** Trusts in financial difficulty received £2.4 billion of extra financial support from the Department and NHS England in 2015-16 compared with £1.8 billion in 2014-15: an increase of 32%. Historically, the Department gave trusts in financial difficulty cash in the form of public dividend capital (PDC). This gave them money to pay creditors and staff and to fund essential building works and continue delivering services. To encourage financial recovery, in March 2015, the Department introduced interest-bearing loans and fee-bearing PDC for trusts in difficulty. In 2015-16:

- the Department gave £1,996 million of revenue-based support to trusts in difficulty to help them meet their day-to-day operating expenses, up from £960 million in 2014-15;[14]
- the Department gave trusts in difficulty £255 million of capital support for essential building works (this was less than the £308 million provided in 2014-15, reflecting system-wide constraints on capital spending); and
- NHS England gave £154 million of financial support (compared with £554 million from the Department and NHS England in 2014-15) as income to trusts in difficulty. Income support affects the reported surplus or deficit and is provided to support trusts that have undergone mergers and to trusts with private finance initiative (PFI) schemes.

12 Department of Health, *Group manual for accounts 2015-16*, May 2016.
13 NHS foundation trusts are not required to disclose their performance against BPPC, therefore we only have complete data for 88 (out of 152) NHS foundation trusts. Monitor, *NHS foundation trust annual reporting manual 2015/16*, November 2015.
14 Our figures exclude £2.4 million that was paid to Mid Staffordshire NHS Foundation Trust. Our analysis throughout the report does not include any balances relating to the trust in 2015-16, as it ceased to provide services on 1 November 2014 and exists as a shell company (see Appendix Three).

## Trusts' achieving NHS access targets and meeting quality requirements

**1.18** There are indications that trusts are struggling to manage activity within their budgets and meet NHS access targets. Performance against key access targets declined consistently from 2012-13 to 2015-16, and into the first quarter of 2016-17 (**Figure 7**). **Figure 8** overleaf shows that the downward trend in performance against key targets is mirrored by a worsening trend in financial performance.

### Providing quality services

**1.19** Poor financial performance can affect the quality of a trust's clinical services and may reflect poor leadership. The Care Quality Commission (CQC) aims to "monitor and inspect services to see whether they are safe, effective, caring, responsive and well-led". It produces ratings against these five inspection areas as well as an overall rating.[15]

**Figure 7**

Trusts' performance against key access targets, 2012-13 to 2016-17

**Performance against key access targets has declined over the past four years and into the first quarter of 2016-17**

| Target | Target (%) | 2012-13 (%) | 2013-14 (%) | 2014-15 (%) | 2015-16 (%) | Q1 2016-17 (%) |
|---|---|---|---|---|---|---|
| **Incomplete referral to treatment pathways**: Patients waiting for treatment at the end of each month, waiting within 18 weeks | **92** | 94.1 | 93.5 | 93.0 | 91.2 | 91.0 |
| **A&E**: Patients should be admitted, transferred, or discharged within four hours of arrival in A&E | **95** | 95.9 | 95.7 | 93.6 | 91.9 | 90.3 |
| **Ambulance**: Red 1 calls (highest priority) should result in an emergency response arriving within eight minutes | **75** | 74.0 | 75.6 | 71.9 | 72.5 | 70.4 |

**Notes**

1 For 2014-15, 2015-16 and 2016-17, the ambulance data only include eight of the 11 ambulance trusts. The remaining three trusts are participating in a trial and do not report against this target.

2 The incomplete referral to treatment data set represents incomplete activity at a point in time. The figures reported are for performance at the end of March each year.

3 Our data set for incomplete referral to treatment covers NHS providers only and so may not match NHS England's publically reported figures, which also include independent providers.

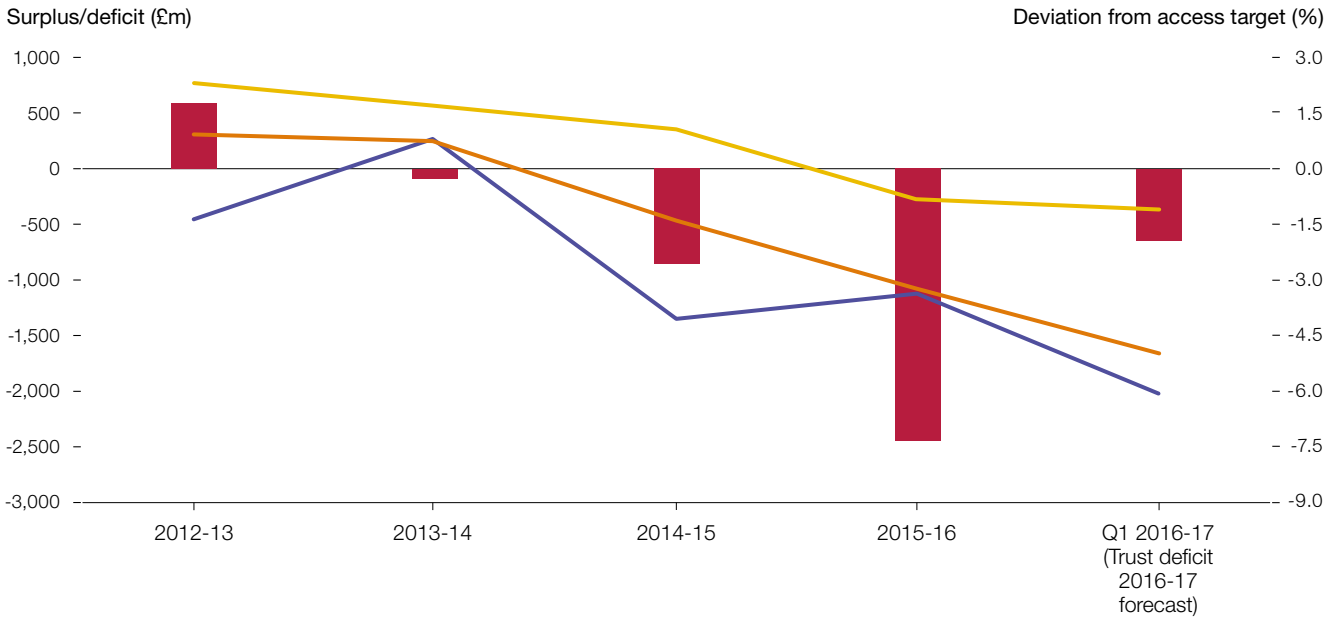
Source: NHS England's performance against access targets data set

15 Care Quality Commission, *Annual report and accounts 2015/16*, HC 467, July 2016, available at: www.cqc.org.uk/content/annual-report.

## Figure 8

Financial position of trusts against trusts' deviation from key access targets

**Trusts' financial performance and their performance against key access indicators have both declined over the previous four years**




| | | 2012-13 | 2013-14 | 2014-15 | 2015-16 | 2016-17 (forecast) |
|---|---|---|---|---|---|---|
| **Surplus/deficit (£m)** | | 592 | -91 | -859 | -2,447 | -644 |
| **Incomplete referral to treatment pathways:** Patients waiting for treatment at the end of each month, waiting within 18 weeks (%) **Target 92%** | Deviation from target | 2.3 | 1.7 | 1.0 | -0.8 | -1.1 |
| **A&E:** Patients admitted, transferred, or discharged within four hours of arrival (%) **Target 95%** | Deviation from target | 0.9 | 0.7 | -1.4 | -3.3 | -5.0 |
| **Ambulance:** Red 1 calls resulting in an emergency response arriving within eight minutes (%) **Target 75%** | Deviation from target | -1.4 | 0.8 | -4.1 | -3.4 | -6.1 |

**Note**

1 The 2014-15 balance is different from that reported in our December 2015 report *Sustainability and financial performance of acute hospital trusts*. Doncaster and Bassetlaw Hospitals NHS Foundation Trust restated its 2014-15 position during 2015-16 (see paragraph 7, Appendix Three).

Source: National Audit Office analysis of NHS trusts and NHS foundation trusts accounts data, 2012-13 to 2015-16, and NHS England's performance against access targets data set

**1.20** We found an association between trusts' latest CQC overall quality ratings (which do not include measures of actual financial performance) and trusts' financial performance in 2015-16. The group of trusts that were rated as 'outstanding' or 'good' reported a better average financial position than the trusts with a 'requires improvement' rating, where financial performance was measured as the surplus or deficit expressed as a percentage of income. The group of trusts that were rated as 'requires improvement' also reported a better average financial performance than trusts rated as 'inadequate'. We found that the five trusts rated 'outstanding' overall had a net deficit equal to 0.02% of their total income, compared with net deficits equal to 1.6% of their total income for the 67 trusts rated 'good'; 3.9% of their total income for the 124 trusts rated 'requires improvement'; and 10.4% of their total income for the 14 trusts rated 'inadequate' overall. Assessing the relationship between financial and clinical performance is challenging because of the range of influences and the difficulty of attributing cause and effect. But these findings, together with the downward trend in trusts' compliance with key access targets, may suggest that financial stress is having an impact on the quality of care.

## Impact of interventions to manage NHS spending in 2015-16

**1.21** In 2014-15 the Department came close to exceeding its £91.9 billion voted revenue expenditure budget authorised by Parliament, underspending by just £1.3 million or 0.001%.[16,17] In 2015-16 the Department underspent by £210 million or 0.22% against its £95.6 billion voted revenue expenditure budget authorised by Parliament. It achieved this by taking action with NHS England and NHS Improvement to manage the financial position of the NHS in 2015-16 and address the growing deficit of trusts.

### Reducing trusts' spending on agency staff and consultancy contracts

**1.22** In June 2015 the Department announced spending controls on agency and contract staff, which came into effect in October 2015. In 2015-16 the overall rate of growth in spending on agency and contract staff by trusts slowed, suggesting that controls to reduce spending have started to have an impact. On average, in 2015-16 trusts spent 7.6% of their total staff costs on agency and contract staff compared with 7.1% in 2014-15, 5.6% in 2013-14 and 4.8% in 2012-13 (**Figure 9** overleaf). However, trusts' spending on agency and contract staff is still at historically high levels, at £3.7 billion in 2015-16, compared with £2.1 billion in 2012-13 (an increase of 76.2%).

16 Parliament authorises two types of spending. Voted expenditure is approved by Parliament each year through a formal vote. Non-voted expenditure can be approved through statute without the need for an additional vote. The numbers presented here refer to the annual voted expenditure. The total revenue expenditure limit, made up of voted and non-voted expenditure, was £110.6 billion in 2014-15 and £114.5 billion in 2015-16.

17 The numbers reported here do not match those reported in our previous report *Sustainability and financial performance of acute hospital trusts.* We have previously reported the annual voted and non-voted expenditure.

## Figure 9

Trusts' spending on agency and contract staff, 2012-13 to 2015-16

| | 2012-13 | | | 2013-14 | | | 2014-15 | | | 2015-16 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | NHS trusts | NHS foundation trusts | Total | NHS trusts | NHS foundation trusts | Total | NHS trusts | NHS foundation trusts | Total | NHS trusts | NHS foundation trusts | Total |
| Agency and contract staff expenditure (£m) | 946 | 1,148 | **2,094** | 1,156 | 1,398 | **2,554** | 1,422 | 1,912 | **3,334** | 1,545 | 2,158 | **3,702** |
| Total staff expenditure (£m) | 19,009 | 24,907 | **43,915** | 19,006 | 26,460 | **45,466** | 18,314 | 28,955 | **47,269** | 18,211 | 30,653 | **48,864** |
| Agency and contract staff expenditure as a percentage of total staff expenditure (%) | 5.0 | 4.6 | **4.8** | 6.1 | 5.3 | **5.6** | 7.8 | 6.6 | **7.1** | 8.5 | 7.0 | **7.6** |

**Notes**

1 Expenditure of trusts that dissolved in-year is included in the expenditure of the successor trusts for that year. Expenditure of NHS trusts that became NHS foundation trusts during the financial year are included in the NHS foundation trust figures for that year.

2 NHS Direct NHS Trust closed on 31 March 2014, with no trust taking over its function. Therefore, figures for NHS Direct NHS Trust are not included. Its agency and contract staff expenditure amounted to £31.8 million in 2012-13 and £24.9 million in 2013-14. Its total staff expenditure amounted to £129.3 million in 2012-13 and £69.0 million in 2013-14.

3 Before 2014-15, NHS trusts' data did not differentiate between agency staff and bank staff (for example, NHS Professionals). For consistency, bank staff have been included in the agency and contract staff expenditure figures for 2014-15 and 2015-16. In 2014-15 bank staff expenditure amounted to £152.1 million and £44.4 million in 2015-16. Agency staff expenditure data published by NHS Improvement do not include bank staff.

4 Figures may not sum exactly due to rounding.

Source: National Audit Office analysis of NHS trusts and NHS foundation trusts accounts data, 2012-13 to 2015-16

**1.23** We found a statistically significant association between trusts' spending on agency and contract staff as a percentage of total payroll costs and their surplus or deficit expressed as a share of income. Trusts that spent a smaller percentage of their total staff costs on agency and contract staff also performed better financially and had smaller deficits.

**1.24** Limits on spending on agency and contract staff were introduced to control costs but have also highlighted that trusts have poor-quality data on agency staffing. Poor data prevent trusts from effectively and efficiently planning and allocating staffing resources. This means they are more likely to require agency staff to fill staffing gaps. NHS Improvement reviews weekly submissions from trusts to monitor their performance against the agency spending controls. This work has highlighted poor-quality data, including incomplete or missing information, misclassification of information and returns that were submitted without being authorised by trust executives. NHS Improvement has worked with trusts to improve their workforce data, including by visiting trusts and telephoning each week to check the data submissions. It also requires sign-off from executive members of the trust to encourage trusts' boards to discuss workforce planning problems.

**1.25** We and the Committee of Public Accounts have reported that agency caps do not address the underlying problem of increasing demand for agency staff and inaccurate staff planning.[18,19] The Committee reported that factors preventing trusts from successfully recruiting and retaining permanent staff (therefore increasing demand for agency staff) are likely to take years to resolve. These include the lack of affordable homes for NHS staff and cuts to nursing and midwifery bursaries.

**1.26** In June 2015 the Department set a £50,000 limit on the amount NHS trusts and NHS foundation trusts in receipt of financial support or in breach of their licence could spend on professional services consultancy contracts without needing sign-off from NHS Improvement. Trusts' total spending on consultancy contracts fell by 34% (from £385 million) in 2014-15, to £255 million in 2015-16. Trusts' spending on consultancy contracts as a proportion of their total non-staff operating expenditure decreased from 0.5% in 2014-15 to 0.3% in 2015-16.

18 Comptroller and Auditor General, *Department of Health, Managing the supply of NHS clinical staff in England*, Session 2015-16, HC 736, National Audit Office, February 2016, available at: www.nao.org.uk/report/managing-the-supply-of-nhs-clinical-staff-in-england/

19 HC Committee of Public Accounts, *Managing the supply of NHS clinical staff in England*, Fortieth Report of Session 2015-16, HC 731, April 2016, available at: www.publications.parliament.uk/pa/cm201516/cmselect/cmpubacc/731/731.pdf

## Transferring funding from capital to revenue budgets

**1.27** The Department's capital budget in 2015-16 was £4.6 billion. In February 2016, £950 million of this budget, intended for capital projects such as building works, was transferred to revenue budgets to fund day-to-day services. Trusts contributed £500 million of the £950 million. The remaining £450 million came from centrally managed programmes, including a £100 million super dividend from the Medicines and Healthcare products Regulatory Agency.

**1.28** This was the second year that the Department has used money originally intended for capital projects to cover a shortfall in the revenue budget. In 2014-15, the Department transferred £640 million to help mitigate the trusts' deficit. In the coming years, the Department plans to continue transferring capital funding into day-to-day spending under 2015 Spending Review agreements.

**1.29** Of the £500 million contribution from trusts, £331 million was exchanged by 93 trusts for revenue support to fund healthcare services. The revenue support reduced the deficit (or increased the surplus) reported by those trusts. But there is a risk that trusts have sacrificed long-term investment to meet the immediate needs of service provision. For example, some trusts may have delayed projects to fund day-to-day running costs.

## Administrative adjustments

**1.30** In 2015-16 the Department received £417 million in National Insurance contributions, more than originally anticipated. The Department did not notify HM Treasury of these extra receipts it received from HM Revenue & Customs and said this was because of an administrative error. Therefore neither HM Treasury nor Parliament has had the opportunity to consider whether to reduce the Department's budget by an equal and opposite amount. Without these extra receipts, the Department would have exceeded the budget authorised by Parliament by £207 million rather than underspending by £210 million.

# Part Two

## Managing financial sustainability

**2.1** In this part of the report, we look at what the Department of Health (the Department), NHS England and NHS Improvement have done to develop a plan to make the NHS financially sustainable, and how they are managing the risks to this plan.

### Planning to achieve financial sustainability

**2.2** In our December 2015 report, we said we would expect the Department and its arm's-length bodies to develop a plan that shows clearly how they will close the gap between resources and patients' needs at all levels of the NHS.[20] In May 2016 NHS England published broad estimates of the £22 billion expected gap between patients' needs and resources by 2020-21 if no action is taken. The Department, NHS England and NHS Improvement have agreed on their responsibilities for improving efficiency to close this gap. They recognise that savings across the NHS cannot be made only through asking NHS healthcare providers to meet efficiency targets linked to receiving tariff income. They have set out programmes to help the NHS make savings (**Figure 10** overleaf).

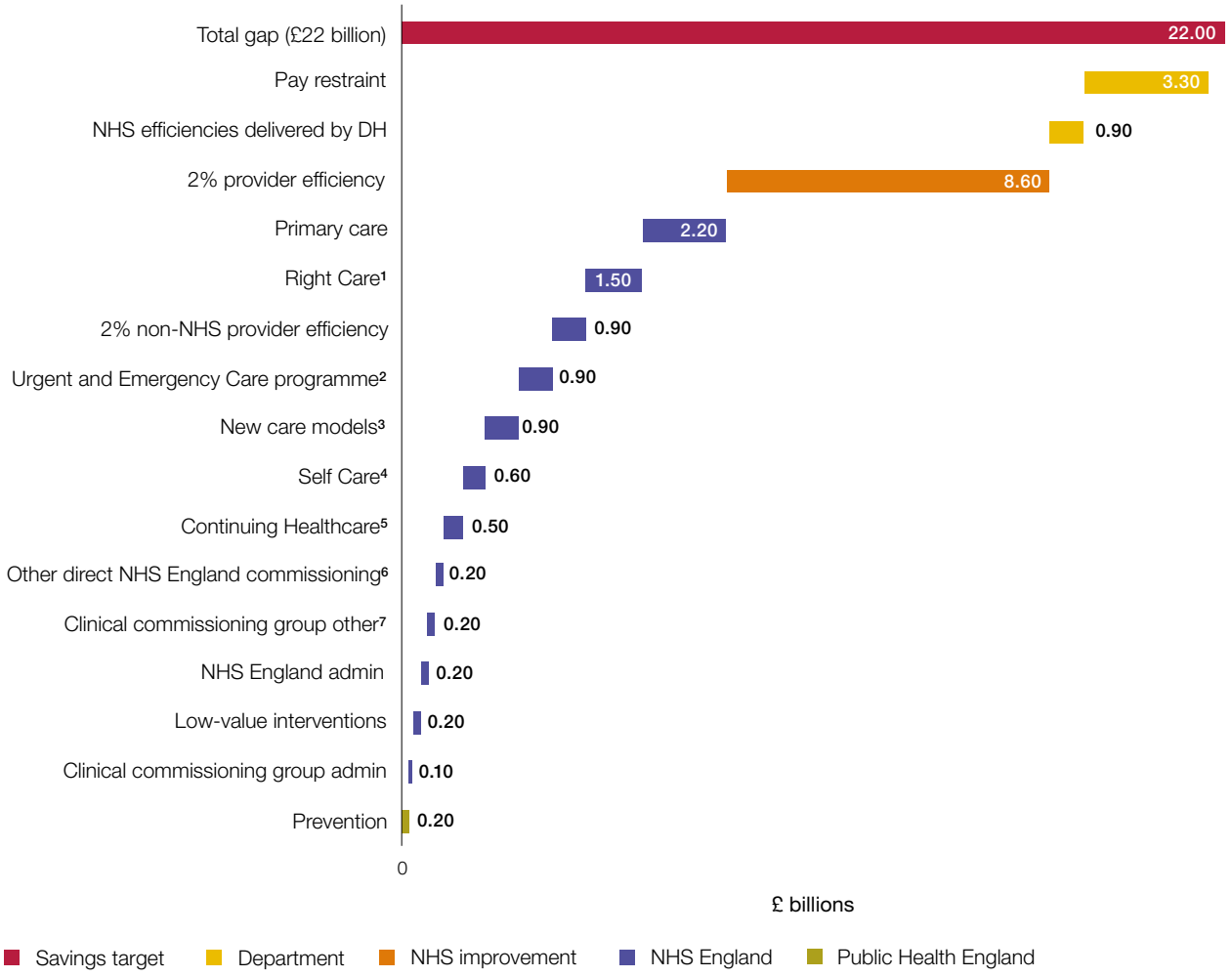
**2.3** The Department, NHS England and NHS Improvement plan for £6.7 billion of efficiencies to be delivered nationally by capping public sector pay, renegotiating the community pharmacy contract, implementing income-generating activities, reducing central budgets and admin costs, making efficiencies from non-NHS healthcare provider contracts and freezing the running costs of clinical commissioning groups. They estimate that local NHS bodies can make further savings of £14.9 billion by reducing the growth in demand for healthcare services through NHS England's initiatives such as Right Care, new care models and the Urgent and Emergency Care programme, and by NHS trusts and NHS foundation trusts achieving 2% productivity improvements each year, which will deliver £8.6 billion of the 14.9 billion.

20 Comptroller and Auditor General, *Department of Health, Sustainability and financial performance of acute hospital trusts*, Session 2015-16, HC 611, National Audit Office, December 2015, available at: www.nao.org.uk/report/sustainability-and-financial-performance-of-acute-hospital-trusts/.

## Figure 10

The Department's, NHS England's and NHS Improvement's proposed savings programmes

**The Department, NHS England and NHS Improvement have introduced savings programmes to close the estimated £22 billion gap between resources and patients' needs by 2020-21**




**Notes**

1 'Right Care' relates to NHS England's support to clinical commissioning groups to reduce wasteful and ineffective spending.

2 The 'Urgent and Emergency Care programme' relates to savings that are anticipated from implementing the recommendations of the Urgent and Emergency Care Review.

3 'New models of care' refers to savings expected from supporting clinical commissioning groups and providers to implement the new ways to organise care outlined in the *Five Year Forward View*.

4 The 'Self Care' programme aims to release savings by assisting people to manage their own healthcare.

5 'Continuing Healthcare' is healthcare funded by the NHS for ongoing healthcare needs provided outside of hospital. It is estimated that the Continuing Healthcare programmes can deliver 2% of efficiency savings each year until 2020-21.

6 'Other direct NHS England commissioning' includes savings from military and offender healthcare.

7 'Clinical commissioning group other' includes savings from NHS 111 and commissioning of enhanced GP services.

8 The savings programmes identified by the Department, NHS England and NHS Improvement add up to £21.6 billion.

9 Numbers shown in the above figure do not add up to £21.6 billion due to rounding.

Source: Department, NHS England and NHS Improvement's shared financial model

## Quality of long-term plans to achieve financial sustainability

### Making forecasts

**2.4** The plan to make the NHS financially sustainable is based on a number of assumptions about the future. These include the demands on NHS finances, demand for NHS services, workforce productivity and pay. The assumptions were used to forecast that:

- the gap between patients' needs and resources by 2020-21 will be £22 billion if no action is taken; and
- the savings programmes introduced by the Department, NHS England and NHS Improvement (Figure 10) will close the £22 billion gap.

**2.5** **Figure 11** overleaf shows four of the assumptions that underpin plans to achieve financial sustainability; the intended impact of national bodies' savings programme; and the challenge in achieving these savings.

**2.6** There has been limited testing of the assumptions supporting the calculation of the £22 billion gap between patients' needs and resources by 2020-21, meaning the real gap might be larger or smaller. We also saw limited testing of the assumptions that underpinned the estimated effect of savings programmes in closing the gap. Many of the savings programmes are innovative and untested. However, we would expect a degree of testing to understand the level of certainty about how effective the savings programmes are likely to be. The Department, NHS England and NHS Improvement intend to use sustainability and transformation plans, submitted by local bodies in October 2016, to test the realism of assumptions used in national planning.

**2.7** The Department, NHS England and NHS Improvement believe that aiming to make £22 billion of efficiency savings is a call to action rather than a precise estimate of the gap between patients' needs and resources by 2020-21. They believe their estimate, and the overall impact, of the savings programmes on NHS finances is reasonable and achievable.

## Figure 11

Examples of the underpinning assumptions of plans to achieve financial sustainability

| Assumptions if no action is taken | Assumptions in plans for achieving financial sustainability | Challenge to making savings in plans for financial sustainability |
|---|---|---|
| Activity, which is the quantity of healthcare provided, in acute hospitals will grow on average by 2.9% per year and will be 19% higher in 2020-21 compared with 2014-15. | NHS England estimates that if the Department's, NHS England's and NHS Improvement's savings programmes are successful the rate at which activity at acute trusts grows will be reduced to an average of 1.3% per year, which includes specialised acute services. This means that overall acute activity would be 6.6% higher in 2020-21 compared with 2015-16. | Hospital admissions grew by 2.8% between 2013-14 and 2014-15. The Nuffield Trust has estimated that activity growth of 1.5% per year would just keep up with population and ageing.[1] This implies that there would be little room for increased activity driven by changes to healthcare technology, increasing expectations and improving access to care. |
| Pay of non-agency staff will be 17.3% higher in 2020-21 compared with 2014-15. | The growth rate of pay for permanent staff is held down by the 1% public sector pay restraint. As pay is made up of elements other than the basic pay settlement, pay is assumed to grow by 1.9% per year. | The NHS *Five Year Forward View* stated that NHS pay will need to stay broadly in line with private sector pay in order to recruit and retain frontline staff. The Office of Budget Responsibility estimated that average earnings will grow by 3.3% per year on average between 2014-15 and 2020-21. If pay restraint is successful, NHS pay growth will diverge from the average pay growth of the rest of the economy. |
| Workforce productivity, which is the quantity of healthcare that each member of staff is able to provide in a given period of time, is assumed to not improve between 2014-15 and 2020-21. | Workforce productivity is assumed on average to improve by 2% per year. As the starting point in 2016-17 was worse than expected, the Department is now aiming to deliver improvements in workforce productivity of around 3% in 2016-17. | Workforce productivity improved on average by 1.4% per year between 2011-12 and 2014-15. It declined by 0.5% in the first three quarters of 2015-16. This was because growth in staff numbers exceeded growth in activity. |
| The total cost of agency staff for all trusts is assumed to grow on average by 6.5% per year from 2014-15 to 2020-21. This means that the total cost of agency staff is 46.1% higher in 2020-21 compared with 2014-15. | The total cost of agency staff is assumed to fall on average by 4% per year, and will be 26.3% smaller in 2020-21 than in 2014-15. Most of this decline will occur in 2016-17 when it is assumed that agency spend will fall to £2.5 billion compared with £3.7 billion in 2015-16. | The overall rate of growth in agency spending slowed in 2015-16, but was still at historically high levels. The National Audit Office and the Committee of Public Accounts have both reported that agency caps do not address the underlying workforce issues, which are likely to take years to resolve (see paragraph 1.25). |

**Note**

1 Nuffield Trust, *Feeling the crunch: NHS finances to 2020*, August 2016, available at: www.nuffieldtrust.org.uk/publications/feeling-crunch-nhs-finances-2020.

Source: Department, NHS England and NHS Improvement's estimates

### Setting the baseline

**2.8** NHS England's and NHS Improvement's plans to achieve financial sustainability were based on trusts' starting the financial year in 2016-17 with a combined deficit of £1.8 billion. The fact that trusts ended 2015-16 with a greater deficit (see paragraph 1.8) means that trusts overall will need to make more savings than planned to reach the intended starting position. For example, trusts with deficits greater than expected at the end of 2015-16 will need to make operational efficiencies above the 2% savings level applied to all providers of healthcare services in 2016-17.

### Including all cost drivers in plans

**2.9** Local bodies face other cost pressures in addition to becoming financially sustainable. It is not clear to us that the Department, NHS England and NHS Improvement are managing these wider cost pressures adequately.

- The £340 million transformation funding from the £2.14 billion Sustainability and Transformation Fund for 2016-17 will not fund all health transformation programmes. The Department, NHS England and NHS Improvement expect trusts and commissioners to fund and invest in savings programmes, such as implementing new models of care. However, they have not estimated the level of investment required by local bodies. Local bodies were required to set out the investment they needed in sustainability and transformation plans, submitted in October 2016, but it is not yet clear whether their requirements are within the available funding envelope. There is a risk that if plans for achieving financial sustainably do not deliver the expected savings in 2016-17, there will be less money available for delivering the changes and transformation set out in the *Five Year Forward View* in future years. NHS England had planned for a greater proportion of the Sustainability and Transformation Fund to be used on transformation after 2016-17, but it clarified in September 2016 that £1.8 billion would again be used for sustainability in 2017-18 and 2018-19.

- In February 2016 the Mental Health Taskforce reported that mental health services needed £1 billion a year to improve services. The NHS implementation plan for mental health shows that improvements in mental health are expected from 2016-17. However, as most funding for mental health is not ring-fenced, there is a risk that not all the additional funding intended for mental health will be spent by clinical commissioning groups to improve mental health services.

- In our review of the plan to achieve financial sustainability shared by the Department, NHS England and NHS Improvement, we did not see how the cost of implementing seven-day NHS services had been taken account of in plans for the NHS to achieve long-term financial sustainability.

- In our report on *Managing the supply of NHS clinical staff in England*, we found that around three-quarters of the increase in spending on temporary nurses from 2012-13 to 2014-15 was due to greater use of such staff, often to cover vacancies.[21] The shortage of nurses is expected to continue for the next three years.[22]

- The Committee of Public Accounts raised concerns that funding cuts and wage pressures will make it harder for local authorities to fulfil their Care Act obligations at a time when demand for social care is rising. We have previously reported that local authority spending on adult social care fell by 10% in real terms between 2009-10 (£16.3 billion) and 2014-15 (£14.6 billion).[23] The accounting officer for NHS England told the Committee of Public Accounts that "over the next two or three years, there is likely to be a widening gap between the availability of adult social care and the need for social care. That, will, inevitably show up as delayed discharges and extra pressure on hospitals."[24] We did not see in our review of the shared plan to achieve financial sustainability any estimate of the impact of pressures on social care spending on the NHS budget. The accounting officer for NHS England acknowledged that the effect of social care pressures "is not costed into the NHS funding envelope for the next five years".[25]

- Spending on specialised healthcare services has increased at a faster rate (6.3% a year) than the NHS as a whole (3.5% a year). It accounts for around 14% of the total NHS budget.[26] In July 2016 the Committee of Public Accounts concluded that, despite the large increase in the budget for specialised services, NHS England has not kept its spending within the budget it set itself. This has created a risk to the financial sustainability of the NHS. The Committee warned that if NHS England is unable to keep its spending on these services under control, this will affect its ability to resource other health services and the wider health transformation set out in the *Five Year Forward View*.[27]

21 Comptroller and Auditor General, *Department of Health, Managing the supply of NHS clinical staff in England*, Session 2015-16, HC 736, National Audit Office, February 2016, available at: www.nao.org.uk/report/managing-the-supply-of-nhs-clinical-staff-in-england/
22 HC Committee of Public Accounts, *Managing the supply of NHS clinical staff in England*, Fortieth Report of Session 2015-16, HC 731, April 2016, available at: www.publications.parliament.uk/pa/cm201516/cmselect/cmpubacc/731/731.pdf
23 Comptroller and Auditor General, *Department of Health, Discharging older patients from hospital*, Session 2016-17, HC 18, National Audit Office, May 2016, available at: www.nao.org.uk/report/discharging-older-patients-from-hospital/
24 Hansard HC, 13 July 2016, HC 76, available at: http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/public-accounts-committee/discharging-older-people-from-acute-hospitals/oral/34184.html
25 See footnote 24
26 Comptroller and Auditor General, *Department of Health, The commissioning of specialised services in the NHS*, Session 2015-16, HC 950, April 2016, available at: www.nao.org.uk/report/the-commissioning-of-specialised-services-in-the-nhs/
27 HC Committee of Public Accounts, *NHS specialised services*, Tenth Report of Session 2016-17, HC 387, July 2016, available at: www.publications.parliament.uk/pa/cm201617/cmselect/cmpubacc/387/387.pdf

## Strategic oversight and programme management

**2.10** The Department, NHS England and NHS Improvement have arrangements in place to oversee plans for financial sustainability.

- In June 2015 the Department established the Finance and Efficiency Board to monitor financial information and oversee the Department's efficiency initiatives. It is made up of the directors of finance or strategy from the Department, NHS England, NHS Improvement, the Care Quality Commission and Health Education England. Meetings of the Finance and Efficiency Board were suspended between November 2015 and May 2016 while the government made decisions about future health funding as part of the Comprehensive Spending Review. Since its re-instatement in May 2016, the Finance and Efficiency Board has met three times.

- The Department has also established Programme Challenge Groups, which have met since April 2016 to examine the Department's efficiency initiatives. The Programme Challenge Groups report to the Finance and Efficiency Board on the progress of initiatives. The lead of the programme being considered is invited and the meetings are chaired by the Department's director-general of finance. Membership includes the chief operating officer and NHS Improvement's director of productivity and efficiency. Other Departmental directors and representatives of HM Treasury's health team are invited to attend when the Department considers it appropriate.

- In June 2015 NHS England established the Financial Sustainability Programme Oversight group, which oversees NHS England's efficiency initiatives. It is chaired by NHS England's chief financial officer and its membership includes programme leads from each of the efficiency programmes for which NHS England is responsible, including Right Care, the Urgent and Emergency Care programme and new care models.

- HM Treasury is taking an active role in governing how local NHS bodies spend their funding. For example, the conditions for trusts to access the £1.8 billion of sustainability funding in the 2016-17 Sustainability and Transformation Fund were jointly developed by HM Treasury, the Department, NHS England and NHS Improvement, which meet on a quarterly basis to decide whether to release funds to trusts. HM Treasury also meets the Department, NHS England and NHS Improvement to discuss clinical commissioning groups' use of the 1% of their funding that they have been asked to hold uncommitted. Given the financial position of the NHS, we consider it appropriate that HM Treasury has increased its strategic oversight of how NHS funding is spent through dialogue with the Department, NHS England and NHS Improvement.

**2.11** NHS England and NHS Improvement have established programme management arrangements for the savings programmes they are responsible for.

- NHS England has established programme boards and appointed senior responsible owners for each of its savings programmes. These individual programme boards report to the Financial Sustainability Programme Oversight group. The senior responsible owners attend monthly meetings where they report against: the critical milestones for their programmes, such as whether support packages have been established; and progress metrics, for example, reductions in emergency admissions.
- NHS Improvement has established a new directorate of operational productivity to manage work originally led by Lord Carter of Coles to improve the operational productivity of acute trusts. Officials at the Department previously managed this work.

**2.12** Good programme management is vital in monitoring progress towards making savings and achieving financial sustainability. It enables individual programme plans and the overall plan to be revised and goals to be updated:

- The Finance and Efficiency Board is monitoring performance in closing the £22 billion gap by tracking the overall financial position of the NHS against what would be expected if all savings programmes were succeeding. The Programme Challenge Groups assess individual programmes and consider if they have clear milestones and quantified success measures.
- The Finance and Efficiency Board and the Financial Sustainability Programme Oversight group are monitoring milestones related to the implementation of individual programmes. However, many programmes designed to close the expected gap between patients' needs and resources are at an early stage of implementation, for example the Self Care programme. In some cases performance measures, which would show whether the programme is succeeding, are not yet being tracked.
- The Financial Sustainability Programme Oversight group does not plan to measure the savings achieved from individual programmes, because it says it will be hard to attribute success to any one programme due to their independencies. For example, many programmes aim to reduce emergency attendances and admissions and it will be difficult to determine the proportion of activity reduction attributed to each of them. The savings programmes are also interdependent – for example, programmes that aim to reduce activity in acute settings, such as Right Care, Self Care and the Urgent and Emergency Care programme, depend on more investment in general practice services.

**2.13** Many of the programmes that focus on reducing activity assume that most of the savings will occur in later years, as anticipated in the *Five Year Forward View*. For example, more than 60% of the savings associated with Right Care and the new care models are expected to be realised between 2018-19 and 2020-21. If savings programmes do not produce expected savings, it is not yet clear what the contingency plans are for bringing in line the cost of patients' needs and the resources available to meet these needs.

# Part Three

## Supporting local bodies to achieve financial sustainability

**3.1** This part considers the support the Department of Health (the Department), NHS England and NHS Improvement have given to local NHS organisations to support local bodies to achieve financial sustainability.

### Managing trusts' financial deficit

**3.2** To address the severe financial deficit reported by trusts in 2015-16, NHS England and NHS Improvement are taking steps to improve the financial position of trusts in 2016-17, through the financial 'reset' announced in July 2016.[28]

- In 2016-17 trusts must meet NHS Improvement's financial targets (control totals). They have been asked to take action to meet these targets and provide safe services. The Department, NHS England, NHS Improvement and HM Treasury will not give trusts funding from the Sustainability and Transformation Fund if they do not meet control totals.
- NHS England set aside £2.14 billion for a 2016-17 Sustainability and Transformation Fund, of which £1.8 billion will be used to help trusts sustain services and reduce deficits. NHS Improvement had expected trusts' deficit in 2015-16 to be £1.8 billion. This meant that the additional funding for sustainability would have cleared the deficit. However, the trusts' end-of-year reported deficit was £2.45 billion, which left a £650 million shortfall between the sustainability funding and trusts' deficit position.
- NHS England and NHS Improvement introduced a new intervention regime of 'financial special measures'. This will be applied to both trusts and clinical commissioning groups that are not meeting their financial commitments. In July 2016 five trusts were placed into financial special measures.
- NHS England has asked clinical commissioning groups to hold back 1% of their budget to insulate local areas from financial risks.
- The Department, NHS England and NHS Improvement have continued to implement the controls on agency and consultancy spending that were first applied in 2015-16 (see paragraphs 1.22 to 1.26).

28 NHS England and NHS Improvement, *Strengthening financial performance and accountability in 2016-17*, July 2016, available at: www.england.nhs.uk/publications/performance/

## Joined-up national working

**3.3** It is important that the Department, NHS England and NHS Improvement work together to coordinate their activities if they are to support local NHS bodies to achieve financial sustainability. If they do not, there is a risk that local NHS organisations will receive mixed messages or be faced with competing priorities. The Department, NHS England and NHS Improvement are working closely in some areas:

- The Department, NHS England and NHS Improvement each have a role in overseeing plans to achieve financial sustainability. They have agreed responsibilities for closing the £22 billion gap between patients' needs and resources by 2020-21 (see paragraphs 2.2 to 2.4).
- In December 2015, NHS England, NHS Improvement, the Care Quality Commission, Public Health England, Health Education England and the National Institute for Health Care Excellence published shared planning guidance that asked NHS organisations to produce two separate but interconnected plans:
    - a five-year local health and care system 'sustainability and transformation plan' that will cover the period from October 2016 to March 2021; and
    - a plan by organisation for 2016-17.
- From April 2016, Monitor (the regulator of NHS foundation trusts) and the NHS Trust Development Authority (which oversees NHS trusts) became a jointly led organisation, NHS Improvement. From October 2016, NHS Improvement has been overseeing all trusts using a single oversight framework, which assesses trusts against their contribution to local sustainability and transformation plans.
- In September 2016, to help NHS bodies to plan services with greater certainty, NHS England and NHS Improvement published guidance on a two-year NHS operational planning process for clinical commissioning groups, NHS trusts and NHS foundation trusts. This guidance was also intended to support the implementation of local areas' sustainability and transformation plans. NHS England and NHS Improvement also published the NHS National Tariff Payment System consultation in October 2016, which sets out its proposed prices and rules for healthcare providers. This is an improvement on previous years; for example, the 2016-17 NHS National Tariff Payment System consultation was published in February 2016 and concluded in March 2016, just one month before the start of the year to which it applied.

**3.4** In July and August 2016 we spoke to senior leaders from 21 local NHS bodies and local authorities, including: chief executives of trusts; clinical commissioning group accountable officers; local government directors of adult social care services and project managers of sustainability and transformation plans; to help us understand how the Department, NHS England and NHS Improvement were supporting local bodies to achieve financial sustainability (see Appendix Two). Five of the 21 local bodies we spoke to told us that NHS England and NHS Improvement were working more closely than in the past. They said that the messages they were receiving from these national bodies were more consistent. However, we heard from three local bodies that conflicting messages from NHS England and NHS Improvement remained an issue.

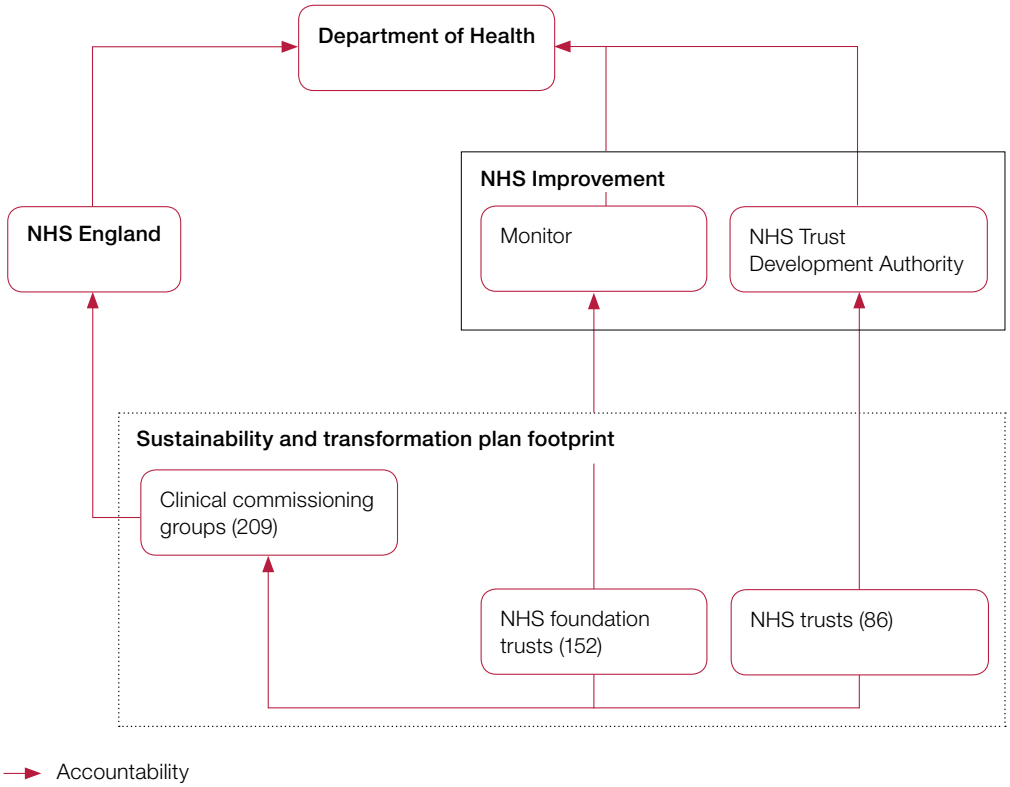
## Supporting joined-up working locally

**3.5** To develop sustainability and transformation plans, NHS England and NHS Improvement asked local health and care leaders, organisations and communities to come together in January 2016 to form 44 planning 'footprints'. Sustainability and transformation plan footprints are not statutory bodies. They do not replace existing local bodies or change local accountabilities. The legislative and accountability framework for local NHS bodies is set out in **Figure 12** overleaf.

**3.6** NHS England and NHS Improvement want sustainability and transformation plans to be a 'route map' for how local NHS bodies and its partners make a reality of the *Five Year Forward View*.[29] NHS England and NHS Improvement expected footprints to be locally defined, and based on natural communities and existing working relationships. However, in some cases NHS England played a role in defining the geographical boundaries of the footprint.

29 NHS England and NHS Improvement, *NHS shared planning guidance*, September 2016, available at: www.england.nhs.uk/wp-content/uploads/2016/09/NHS-operational-planning-guidance-201617-201819.pdf

## Figure 12
Accountability framework for local NHS bodies




**Note**

1 The figure is simplified to show accountability arrangements for sustainability and transformation footprints. It does not include primary care and NHS England's role in commissioning specialised services.

Source: National Audit Office

## Setting realistic expectations

**3.7** For the 2016-17 financial year, NHS England and NHS Improvement reduced the efficiency requirement in the national tariff payment that trusts receive for providing care. The efficiency requirement was reduced from 4% in 2015-16 to 2% in 2016-17. In its February 2016 review, Monitor (now part of NHS Improvement) found that, on average, trusts improved their efficiency by 1.4% per year between 2008-09 and 2013-14. It assessed that a 2% efficiency target was a more reasonable requirement. However, by July 2016, NHS Improvement said that healthcare providers will need to achieve an efficiency requirement significantly greater than 2%. This is partly because of the higher than expected trust deficit, commissioner losses during the contracting period and rising trust activity. NHS Improvement told us that if trusts

do not achieve efficiency savings greater than 2%, then their financial position will not improve over time. Overall, NHS Improvement said it was now planning for providers to achieve efficiencies of around 4% for 2016-17. This is concerning given the Committee of Public Account's conclusion in its March 2016 report that the previous 4% target set by NHS England and Monitor (now part of NHS Improvement) to make efficiencies was unrealistic and had caused long-term damage to trusts' finances. It is understandable that NHS England and NHS Improvement aim to recover last year's under achievement of targeted efficiencies from trusts but this makes significant assumptions about what can be delivered which is likely to vary from trust to trust.

**3.8** Footprints have developed their five-year sustainability and transformation plans without full awareness of national plans and the assumptions that underpin the *Five Year Forward View*. NHS England made public its broad estimates of the expected gap between patients' needs and resources by 2020-21 and how it plans to close this gap (see paragraph 2.4). However, the finer details of its estimates, such as how much demand for health services needs to be constrained, were not communicated to local NHS bodies. A lack of transparency creates uncertainty. For example, some of the clinical commissioning groups we spoke to told us that they did not know why NHS England had asked them to hold back 1% as a reserve fund. They were unclear about what would happen to this funding at the end of the financial year.

**3.9** Twelve of the 21 local bodies we spoke to told us that the original timetable for completing the sustainability and transformation plan was extremely ambitious. It did not allow enough time to build relationships across local areas and to determine the changes needed for local areas to achieve financial stability.

- NHS England and NHS Improvement had intended for local areas, including NHS and local authority organisations, to submit their five-year sustainability and transformation plans in June 2016. Local areas were first told about this new requirement in planning guidance published in December 2015.
- In May 2016, NHS England identified that local areas were at different stages of developing their sustainability and transformation plans.
- At this point NHS England decided to delay the requirement for local areas to submit their full plans by the end of June 2016. It asked local areas to set out their broad aims for the local area over the next five years by the end of June 2016 and to submit their finance plans in September 2016.
- By the end of October 2016 all footprints had submitted their sustainability and transformation plans to NHS England and NHS Improvement and were ready to start implementing these plans.

**3.10** We heard from five local bodies that NHS England and NHS Improvement had not set clear expectations about the required content of sustainability and transformation plans, while three said expectations were clear. Six said that expectations had changed over time, with new requirements added at short notice. For example, one organisation said that delays in providing the template meant they had to reproduce material, which they told us was an inefficient use of time and resources.

## Providing appropriate resources and guidance

**3.11** The local bodies we spoke to were supportive of the aim of local areas coming together to develop sustainability and transformation plans. However, several raised concerns about how plans will be implemented going forward.

- Five told us they were uncertain about the capacity in their organisations to meet the immediate requirement to improve their financial positions and at the same time implement changes that will support longer-term transformation of healthcare services.
- Five of the local bodies we spoke to raised concerns about achieving transformation at the scale and pace that is expected by NHS England and NHS Improvement.
- Six were concerned about whether there will be sufficient funding for 'double running' and to invest in capital and transformation.

**3.12** Footprints did not receive additional funding to cover the expense of developing sustainability and transformation plans and we heard that this impacted on the capacity of local leaders to develop plans alongside other priorities. Some local bodies told us that they had employed a contractor to support them in developing plans. Furthermore, we heard that NHS Improvement had given some footprints extra support to help them develop their financial plans.

**3.13** NHS England and NHS Improvement provided system leaders with guidance to support the development of sustainability and transformation plans, as well as information and data about their local areas. Three of the local bodies we spoke to told us this information was helpful. However, we heard from a further nine organisations that this information was shared late in the planning process and three said it contained old or obsolete data.

## Creating incentives to support collaboration

**3.14** Five of the NHS organisations we spoke to felt that NHS England and NHS Improvement could do more to create the right incentives to collaborate. For example, we heard from five of the local bodies that they are under immense pressure to meet their financial targets (quarterly control totals) in order to receive sustainability and transformation funding. They said that because these were set at an organisation level, rather than for the footprint as a whole, it forced local bodies to think about their own individual organisations' short-term financial position, and did not encourage a focus on longer-term planning or collaboration with other local bodies. In September 2016, NHS England and NHS Improvement announced that from April 2017, each sustainability and transformation footprint will have a financial control total which is the summation of individual organisational control totals. All organisations will be held accountable for delivering both their individual control total and system control total. However, it is unclear whether this goes far enough to address the concerns expressed by local bodies, or how individual bodies will be held to account for system control totals.

**3.15** The legislative and accountability framework for local NHS organisations was seen as a barrier to collaboration by seven of the local bodies we spoke to. NHS Improvement has statutory responsibilities for overseeing the performance of the individual organisations that it regulates. Local NHS organisations are accountable for their individual organisational plans and financial performance. We were told that these vertical lines of accountability acted as a barrier to local bodies coming together under sustainability and transformation plan footprints and integrating on a horizontal basis. We are also unclear how greater collaboration will fit alongside existing regulation on choice and competition and impact on ongoing tendering activities.

# Appendix One

## Our audit approach

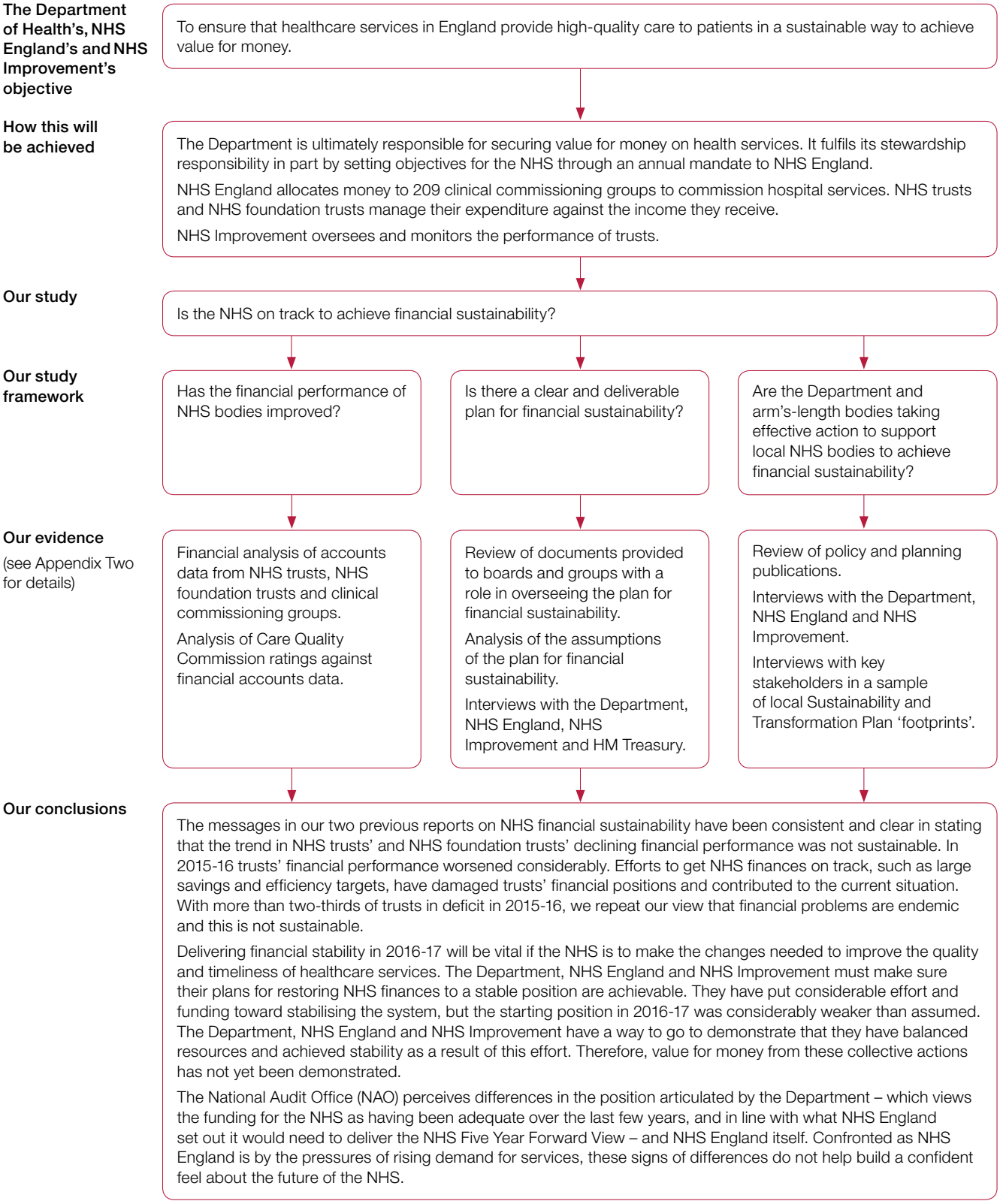
**1** This study examines the progress the Department of Health (the Department), NHS England and NHS Improvement have made towards achieving financial balance. We reviewed:

- the headline financial performance of the NHS overall;
- trends in the financial performance of clinical commissioning groups between 2013-14 and 2015-16 and trends in the financial performance of NHS trusts and NHS foundation trusts between 2012-13 and 2015-16, including financial indicators such as earnings before interest, tax, depreciation and amortisation (EBITDA), cash and other assets and average time taken to settle undisputed invoices;
- the financial support provided to NHS trusts and NHS foundation trusts in financial difficulty in 2014-15 and 2015-16;
- the correlation between financial performance and Care Quality Commission ratings;
- the impact on financial performance of controls on agency staff and consultancy contracts;
- the movement of funding from capital to revenue at a Departmental and local level;
- the actions, initiatives and governance arrangements that the Department, NHS England and NHS Improvement have implemented to improve the financial position of NHS bodies including their assumptions; and
- the support being provided to local NHS bodies to achieve financial sustainability, including the actions taken to establish the new sustainability and transformation plans.

**2** In reviewing these issues, we applied an analytical framework with evaluative criteria, to consider what arrangements would be optimal for moving the NHS towards financial sustainability. By 'optimal' we mean the most desirable possible, while acknowledging expressed or implied constraints. We used output-based criteria (for example, the trend in performance against key financial indicators) and adapted a National Audit Office framework on structured cost reduction to consider whether arrangements being put in place to restore financial sustainability met good practice.

**3** Our audit approach is summarised in **Figure 13**. Our evidence base is described in Appendix Two.

## Figure 13
Our audit approach



# Appendix Two

## Our evidence base

**1** We reached our independent conclusions on whether the NHS is on track to achieve financial sustainability after analysing evidence we collected between May and September 2016. Our audit approach is outlined in Appendix One.

**2 We analysed existing financial data from NHS accounts and data provided by the Department of Health (the Department) and NHS Improvement:**

- an analysis of the overall financial position of the NHS in 2015-16;
- a time series analysis of clinical commissioning groups' finances against their planned and actual year-end positions;
- a time series analysis of the financial position of NHS trusts and NHS foundation trusts against surplus/deficit, income, EBITDA, current assets and current liabilities; and
- additional financial support compared with 2014-15.

**3 We compared existing financial data on NHS trusts and NHS foundation trusts to Care Quality Commission ratings.**

- We compared the average financial performance across trusts with different overall Care Quality Commission ratings. We took the Care Quality Commission ratings as at August 2016 and used 2015-16 NHS trust and NHS foundation trust accounts data.

**4 We analysed data relating to the controls the Department and NHS Improvement implemented in 2015-16:**

- a time series analysis of spending by trusts on agency and contract staff;
- a correlation analysis of trust spending on agency and contract staff compared with financial performance;
- a time series analysis of the percentage of agency and contract staff compared with full-time equivalent staff; and
- a time series analysis of consultancy expenditure as a percentage of total non-staff operating expenditure.

**5 We conducted a review of the 2016-17 planning process.**

We reviewed planning guidance and associated documents in order to:

- understand the actions taken by the Department, NHS England and NHS Improvement to manage financial sustainability in 2016-17; and
- assess the level of support being provided to local bodies including under the sustainability and transformation plan arrangements.

**6 We examined the plan developed by the Department, NHS England and NHS Improvement to close the gap between patients' needs and resources.**

To evaluate the plan we adapted an existing National Audit Office framework on structured cost reduction.[30] We used this framework to understand:

- whether the Department, NHS England and NHS Improvement have developed a plan which clearly shows how the gap between patients' needs and resources will be closed;
- whether the plan considers dependencies; and
- if there are clear governance, risk and project management arrangements in place to ensure delivery.

We examined governance documents from boards identified by the Department, NHS England and NHS Improvement as overseeing the plan. This included examining terms of references, minutes from meetings and documents stating risks, metrics and milestones being tracked for:

- The Department's Finance and Efficiency Board and finance, efficiency and delivery meetings and Programme Challenge Group; and
- NHS England's Finance Sustainability Programme Oversight Group and Five Year Forward View Board.

We examined parts of the shared financial model produced by the Department, NHS England and NHS Improvement as part of the 2015 Spending Review to identify:

- the assumptions that underpin the estimated size of the gap between patients' needs and resources and estimates of the savings from initiatives intended to close this gap;
- what scenario testing and sensitivity analysis had been carried out; and
- what investment is required to achieve the estimated savings.

30 A short guide to the National Audit Office's structured cost reduction framework is available at: www.nao.org.uk/wp-content/uploads/2010/06/short_guide_to_structured_cost_reduction.pdf

**7 We interviewed key stakeholders including the Department, NHS England, NHS Improvement and HM Treasury.**

The work was designed to understand:

- whether the Department, NHS England and NHS Improvement have developed plans which show how the gap between patients' needs and resources can be closed;
- what actions and initiatives are included in these plans; and
- whether the assumptions that underpin these plans and dependences and risks are well understood.

We also interviewed other stakeholders including The King's Fund and NHS Providers.

**8 We conducted interviews at a sample of six sustainability and transformation plan footprints in July and August 2016.**

This work was designed to understand:

- how local bodies worked together to produce sustainability and transformation plans;
- what support NHS England and NHS Improvement provided to help local bodies develop the sustainability and transformation plans; and
- what is the expected impact in the footprints of initiatives and actions implemented by the Department, NHS England and NHS Improvement to close the gap between patients' needs and resources.

In our review we did not try to examine the content of footprints' sustainability and transformation plans, nor did we attempt to draw wider conclusions about all sustainability and transformation plan footprints.

We selected our sample of six sustainability and transformation plan footprints by considering the following factors:

- a diverse range of relative financial performance selecting two footprints with relatively high financial performance across all constituent NHS bodies, two footprints with relatively low financial performance across all constituent NHS bodies and two footprints where trusts with relatively high financial performance were grouped with trusts with relatively low financial performance;
- a broad geographic spread across England;
- a range of rural and non-rural footprints;
- footprints with and without vanguards (sites receiving support from NHS England for early implementation of new care models); and
- a range of leadership including where the sustainability and transformation plan leader was from a trust, clinical commissioning group or local authority.

Overall, we met with 21 individuals including 11 trust chief executives, eight clinical commissioning group accountable officers as well others involved with developing the sustainability and transformation plans.

# Appendix Three

## Technical notes

**1** In preparing and analysing the data used throughout the report, we have made a number of assumptions and adjustments.

**2** Information on NHS trusts and NHS foundation trusts may differ to that reported by NHS Improvement due to the way we have treated trusts which changed their status in-year.

### Presentation of figures

**3** Except where otherwise noted, figures are presented in nominal terms and have not been adjusted for inflation.

**4** Where possible, income and expenditure figures are presented on a basis consistent with the underlying trusts' published accounts.

**5** Income figures for both NHS trusts and NHS foundation trusts include:

- income from patient care activities; and
- other operating income (including income from training activities, rental income and income from other miscellaneous sources).

**6** Expenditure figures for both NHS trusts and NHS foundation trusts include:

- staff costs, except those capitalised as part of the costs of non-current assets;
- operating costs, including purchase of healthcare services from other organisations, expenditure on medical supplies including drugs and other consumables, and transport costs;
- premises costs, including depreciation and amortisation and support services;
- net interest and other finance costs;
- public dividend capital dividends payable;
- other gains and losses, including share of profit or loss of associates and joint arrangements, gains and losses on disposals of assets, and other movements in fair values of assets;
- corporation tax expenses; and
- premiums payable for clinical negligence liabilities.

NHS trusts' and NHS foundation trusts' income and expenditure figures have also been adjusted for the effects of organisational changes, to report underlying performance by excluding the effects of one-off transactions.

## Adjusting for restated balances

**7** In our report *Sustainability and financial performance of acute hospital trusts*, we reported Doncaster and Bassetlaw Hospitals NHS Foundation Trust as having a surplus of £1.6 million in 2014-15. During 2015-16 it emerged that its financial position had been misreported by the trust – the corrected year-end position for 2014-15 is a deficit of £14.8 million. This increased the net deficit reported in 2014-15 for trusts to £859 million from £843 million and increased the net deficit for all NHS bodies by £16.4 million. The restated figures for 2014-15 are used throughout this report.

## Adjusting for the effects of organisational changes during 2015-16

**8** This report refers to 152 NHS foundation trusts in existence on 31 March 2016. This excludes Mid Staffordshire NHS Foundation Trust, which ceased to provide services on 1 November 2014. Mid Staffordshire NHS Foundation Trust recorded a deficit of £1.1 million in 2015-16. The costs relate to the payment of historic liabilities and the overhead costs of the shell company. Our analysis throughout the report does not include any balances relating to Mid Staffordshire NHS Foundation Trust in 2015-16.

**9** Two NHS trusts became NHS foundation trusts in 2015-16:

- Bradford District Care NHS Trust on 1 May 2015; and
- Oxford University Hospitals NHS Foundation Trust on 1 October 2015.

**10** We have treated these trusts in the totals for NHS foundation trusts. This has the effect of treating them as though they had been a foundation trust all year.

**11** Several mergers between trusts occurred in 2015-16:

- Torbay and Southern Devon Health and Care NHS Trust was taken over by South Devon Healthcare NHS Foundation Trust on 1 October 2015, at which point the trust was renamed Torbay and South Devon NHS Foundation Trust; and
- West Middlesex University Hospital NHS Trust was taken over by Chelsea and Westminster Hospital NHS Foundation Trust on 1 September 2015.

**12** For all these mergers of trusts, we have totalled the demising trusts' income, expenditure and surplus/deficit arising between 1 April 2015 and the date of merger and added it to the income, expenditure and surplus/deficit of the post-transaction trust. This has the effect of treating the merger as if it had occurred on 1 April 2015.

**13** Three clinical commissioning groups also merged in 2015-16. NHS Gateshead clinical commissioning group, NHS Newcastle North and East clinical commissioning group and NHS Newcastle West clinical commissioning group merged on 1 April 2015 to form NHS Newcastle Gateshead clinical commissioning group. This reduced the number of clinical commissioning groups from 211 to 209.

## Adjustments to NHS trusts' figures

**14** NHS trusts' figures are adjusted to report the underlying performance of trusts by excluding the effects of one-off transactions, and to be consistent with figures used by the Department of Health (the Department). Figures for NHS trusts' income, expenditure and surplus/deficit are reported:

- before net impairments;
- before the impact of absorption accounting for bodies that merged or were acquired by other organisations;
- before additional charges associated with bringing private finance initiative (PFI) assets onto the balance sheet due to the introduction of IFRS accounting in 2009-10 (IFRIC 12);
- before the impact of changes in accounting for donated assets and government grant reserves;
- before the consolidation of trusts' charitable fund subsidiaries; and
- after the effects of any income support provided by the Department and NHS England.

**15** All figures are presented on a gross basis; no adjustments are made to remove the effects of transactions between NHS trusts and NHS foundation trusts.

## Adjustments to NHS foundation trusts' figures

**16** NHS foundation trusts' figures are adjusted to report the underlying performance of trusts by excluding the effects of one-off transactions, and to be consistent with figures used by the Department and to be on the same basis as NHS Improvement reports them in the *NHS Foundation Trusts: Consolidated Accounts*. Income, expenditure and surplus/deficits for NHS foundation trusts are reported:

- before net impairments;
- before the impact of absorption accounting for bodies that merged or were acquired by other organisations;
- after additional charges associated with bringing PFI assets onto the balance sheet due to the introduction of IFRS accounting in 2009-10 (IFRIC 12);
- after the impact of changes in accounting for donated assets and government grant reserves;
- before the consolidation of trusts' charitable fund subsidiaries; and
- after the effects of any income support provided by the Department and NHS England.

**17** All figures are presented on a gross basis; no adjustments are made to remove the effects of transactions between NHS trusts and NHS foundation trusts.

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Calderdale and Huddersfield NHS
NHS Foundation Trust

**Approved Minute**

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| |

## Cover Sheet

| | |
|---|---|
| **Meeting:**<br>Board of Directors | **Report Author:**<br>Andrea McCourt, Head of Governance and Risk |
| **Date:**<br>Thursday, 1st December 2016 | **Sponsoring Director:**<br>Brendan Brown, Executive Director of Nursing |
| **Title and brief summary:**<br>Quarter 2 2016/17 Quality Report - This report provides an update on progress against contract, the Trust's quality account, national and local quality priority requirements, and provides an overview of quality performance during quarter 2 of 2016-2017 within the Trust. | |
| **Action required:**<br>Note | |
| **Strategic Direction area supported by this paper:**<br>Keeping the Base Safe | |
| **Forums where this paper has previously been considered:**<br>Quality Committee on 31 October 2016 | |
| **Governance Requirements:**<br>Keeping the base safe | |
| **Sustainability Implications:**<br>None | |

## Executive Summary

### Summary:

The quality report summarises quality performance and highlights for each quarter. It is structured into the 5 Care Quality Commission domains of safety, experience, effective, responsive and well-led.

## Main Body

### Purpose:

To assure the Board of Directors that progress on quality requirements and improvement priorities is being made.

### Background/Overview:

The Trust has an agreed framework for quality improvement for 2016-17 which includes:

2016/17 - 3 quality account priorities: reducing falls, hospital at night function to reduce mortality and improving patient experience in the community.
7 CQUINs which in addition to the quality account priorities include improvements relating to staff well being, sepsis, medicines / antibiotics and safety huddles.

### The Issue:

The attached report provides detail on quality improvements within the 5 CQC domains of safety, experience, effective, responsive and well-led.

For each domain a summary of highlights is given, with detailed information providing an overview of compliance with each indicator within the quality domain during the quarter and plans for future work.

### Next Steps:

The quarterly quality report will be produced for quarter 3 and quarter 4, linking with the end of year quality accounts process.

### Recommendations:

The Board of Directors is asked to consider progress during quarter 2 with quality improvement across the organisation.

## Appendix

### Attachment:

Q2 Quality Report 16-17 FINAL for Board 22.11.16.pdf

# Calderdale & Huddersfield Foundation Trust
# Q2 Quality Report
# 2016-17

| | |
|---|---|
| **Subject:** | Q2 2016-2017 Quality Report |
| **Prepared by:** | Juliette Cosgrove – Assistant Director of Quality<br>Andrea McCourt - Head of Governance and Risk<br>Lisa Fox – Information Manager |
| **Sponsored by:** | Brendan Brown - Director of Nursing |
| **Presented by:** | Brendan Brown - Director of Nursing |
| **Purpose of paper** | Discussion requested by Trust Board and Quality Committee<br>Regular Reporting<br>For Information / Awareness |
| **Key points for Trust Board members** | The report is structured into the five Care Quality Commission domains of safety, effective, experience, responsive and well-led. Each section has a summary providing an overview of compliance with each indicator and highlights.<br><br>During Q2 all CQUIN, Quality Account and contract requirements were achieved. Highlights from Q2 are below.<br><br>**SAFETY:**<br>• Falls prevention – falls lead and falls action plan in place, falls five paperwork agreed to ensure appropriate quality interventions are recorded.<br><br>• Safety huddles continue to be rolled out across the organisation.<br><br>• Pressure ulcers – work completed on clear definitions of hospital and community acquired pressure ulcers, which will enable realistic improvement trajectories to be set. Tissue Viability newsletter issued in Q2 on lessons learned from pressure ulcer incident investigations.<br><br>Equipment inventory audit has identified areas where appropriate use of mattresses can improve quality of care<br><br>• Medicines management – CQUIN for antimicrobial resistance continues to perform at a high level in Q2, 88% against a target of 50%.<br><br>• Sepsis – improvement in screening admissions in the |

| | |
|---|---|
| | Emergency Department for sepsis in Q2<br><br>• Maternity - Royal College of Obstetricians and Gynaecologists Invited Service Review took place between 26-28 July with positive verbal feedback, ongoing delivery of maternity CQC action plan and new Maternity Risk Management Strategy and meeting governance structure has been introduced to strengthen governance and learning from incidents and complaints<br><br>**EFFECTIVE:**<br><br>• Mortality – Hospital Standardised Mortality Ration (HSMR) shows a notable improvement from 111.62 in Q1 to 108.62<br><br>• Reducing Hospital Acquired Infection – 0 cases MRSA bacteraemia since Q2 2015/16, c difficile remains a challenge<br><br>• Fractured neck of femur – improvement from 2015 to 2016 (April to August) with stronger performance in all 6 areas where national averages are available<br><br>• Hospital Out of Hours programme (HOOP) Night - achievement of HOOP CQUIN for Q2 re: recruitment of staff<br><br>• End of Life – draft End of Life Care Strategy shared for consultation with membership councillors<br><br>• Safeguarding – work to increase safeguarding training compliance continues<br><br>• Stroke – national stroke data (SSNAP) shows an improved rating for stroke services from D to B. Increased frequency of therapy for patients.<br><br>**EXPERIENCE:**<br><br>• Dementia – consistently achieving 90% or above in each element of the dementia assessment documentation<br><br>• Improving the inpatient experience – work on the children's voice project, communication on a surgical ward and maternity patient experience continues |

| | |
|---|---|
| | • Community experience – community patient experience survey for out patient physiotherapy undertaken in Q2 for analysis in Q3<br><br>**RESPONSIVE:**<br><br>• Incidents, complaints, claims – increase in incident reporting in community division, against an overall reduction of 5% in incidents reported compared to Q1.<br><br>2 Ombudsman complaints not upheld.<br><br>Claims – small decrease in numbers of claims in Q2, NHSLA factsheet for 2015/16 confirms that obstetric claims payments were not in the top 20 Trusts nationally (£2.4 M).<br><br>• Appointment Slot Issues (ASIs)– levels are reducing at a time when nationally ASIs are increasing.<br><br>**WELL - LED:**<br><br>• Safe Staffing – preceptorship package launched September 2016, with year long education and training programme. International recruitment continues, 38 new nurses.<br>• Sickness and absence –shows an improved position from Q1 to 4.16% at Q2<br>• Mandatory training – business case approved for replacement learning and management system in Q2. Actions agreed at Executive Board to increase compliance with mandatory training and focus on 4 of the 10 subjects for the remainder of 2016/17: Infection Prevention and Control, Moving and Handling, Health and Safety and Information Governance<br>• Patient and Public Involvement (PPI)– in addition to formal consultation on service reconfiguration, two PPI projects undertaken in Q2, one on vascular services and one reviewing A&E activity with local Healthwatch organisations.<br>• Workforce Race Equality Standard – first meeting of BME (black and minority ethnic) network held in September |

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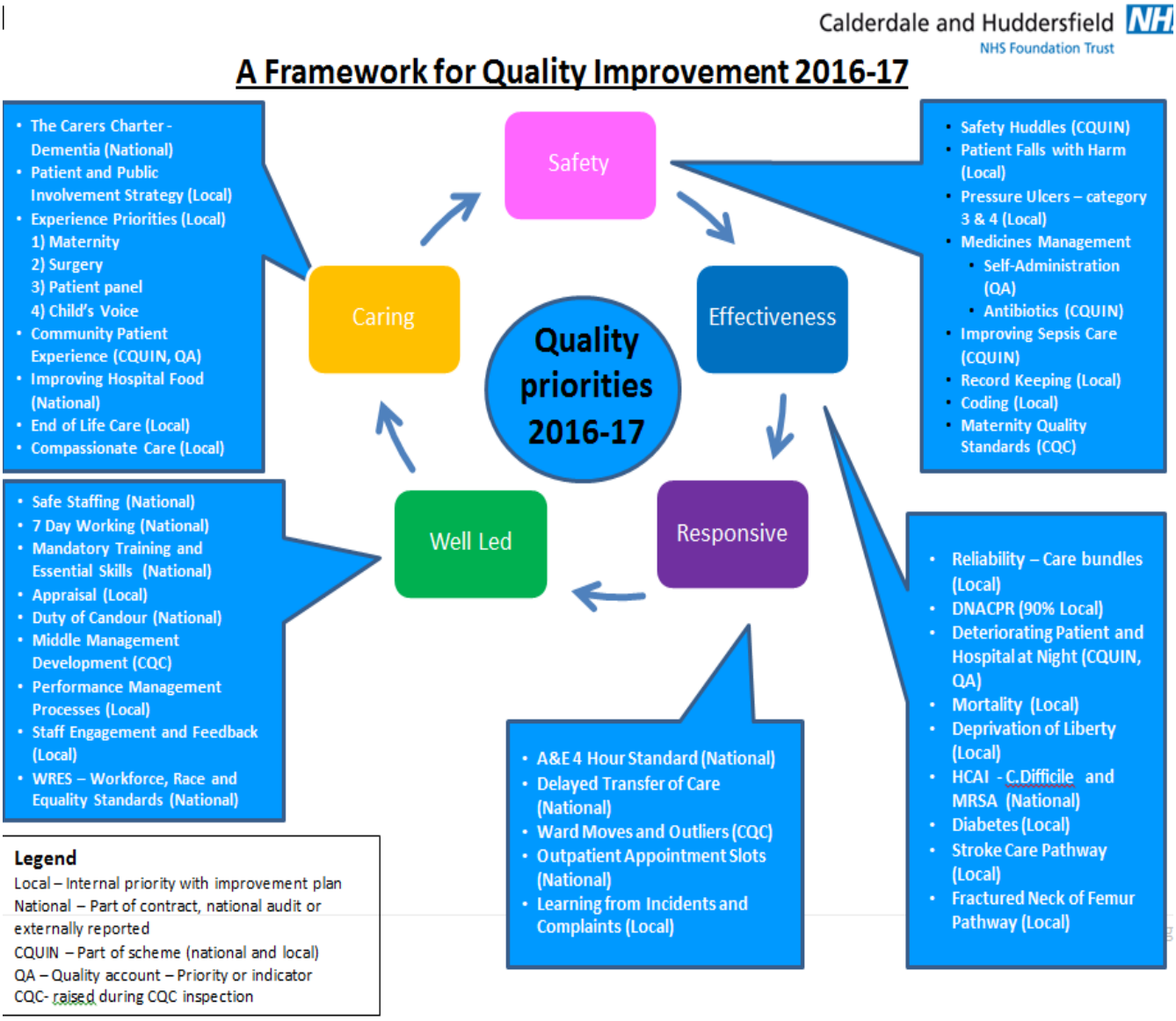
## Introduction

This quarterly quality report covers contractual, quality account, national and local quality priority requirements to provide a comprehensive overview of quality performance during each quarter of 2016-2017 within Calderdale and Huddersfield NHS Foundation Trust (the Trust).

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

The Care Quality Commission Intelligent Monitoring reports also provide a framework for determining quality priorities.

From all these sources the following diagram shows the Trust key priorities for 2016-17, these have been broken down into the 5 key CQC domains



Summary of Key Performance Frameworks:

**2016/17 Quality Account:**

There are three Quality Account priorities for 2016/17. These are listed below and further detail regarding progress can be found on the page number indicated

| Domain | Focus/Priority | More Details |
|---|---|---|
| Safety | Reducing Falls through the implementation of Safety Huddles | Pg 12 |
| Effectiveness | Implementation of Hospital at Night to reduce mortality | Pg 39 |
| Experience | Improving Patient Experience in the Community | Pg 51 |

**2016/17 CQUINS:**

There are seven CQUIN areas for 2016/17. These are listed below and further detail regarding progress can be found on the page number indicated. The information contained in the performance box provides a quick overview of target attainment during the most recent quarter, where applicable.

| | Indicator Name | Q1 Achievement | Page |
|---|---|---|---|
| 1a | Staff Well Being – Services | Y | - |
| 1b | Staff Well Being – HFFSB | Y | - |
| 1c | Staff Well Being – Flu Vaccination | N/A | **N/A** |
| 2a1 | Sepsis Screening – Emergency Admissions | Y | **Pg. 20** |
| 2a2 | Sepsis Antibiotics – Emergency Admissions | Y | **Pg. 20** |
| 2b1 | Sepsis Screening – Inpatient Admissions | Y | **Pg. 20** |
| 2b2 | Sepsis Antibiotics – Inpatient Admissions | Y | **Pg. 22** |
| 3a | Anti-Microbial Resistance | Y | **Pg. 16** |
| 3b | Antibiotic Review | Y | **Pg. 18** |
| 4 | Safety Huddle Implementation | Y | **Pg. 11** |
| 5 | Self-Administration of Medicines | Y | **Pg. 18** |
| 6 | Hospital at Night | Y | **Pg. 39** |
| 7 | Community Patient Experience | Y | **Pg. 51** |

## **Domain One – Patient Safety:** People are protected from abusive and avoidable harm.

**Patient Safety Compliance Summary**

| Indicator 2016-17 | Compliance |
|---|---|
| 1.1 Reducing patient falls with harm | Reporting only |
| 1.2 Introducing Safety Huddles | Reporting only |
| 1.3 Reducing pressure ulcers | Achieved |
| 1.4 Improving Medicine Management (CQUIN) | Partial |
| 1.5 Improving Sepsis Care (CQUIN) | Reporting only |
| 1.6 Record Keeping | Reporting only |
| 1.7 Maternity Quality Standards | Reporting only |
| 1.8 Coding | Reporting only |

Highlights:

- Falls prevention – falls lead and falls action plan in place, Falls five paperwork agreed to ensure appropriate quality interventions are recorded.
- Safety huddles continue to be rolled out across the organisation.
- Pressure ulcers – work completed on clear definitions of hospital and community acquired pressure ulcers, which will enable realistic improvement trajectories to be set. Tissue Viability newsletter issued in Q2 on lessons learned from pressure ulcer incident investigations. Equipment inventory audit has identified areas where appropriate use of mattresses can improve quality of care
- Medicines management – CQUIN for antimicrobial resistance continues to perform at a high level in Q2, 88% against a target of 50%.
- Sepsis – improvement in screening admissions in the Emergency Department for sepsis in Q2
- Maternity - Royal College of Obstetricians and Gynaecologists Invited Service Review took place between 26-28 July with positive verbal feedback, ongoing delivery of maternity CQC action plan and new Maternity Risk Management Strategy and meeting governance structure has been introduced to strengthen governance and learning from incidents and complaints

## 1.1 Reducing patient falls with harm

Falls in hospitals are the most common patient safety incidents reported in hospital trusts in England. The National Patient Safety Agency (2011) report 'Essential care after an inpatient fall' states that each year around 282,000 patient falls are reported in hospitals and mental health units. A significant minority result in death, severe or moderate injury. (including approximately 840 neck of femur fractures, 30, head injuries and 550 other fractures). Falls impact on the quality of life through pain, loss of confidence, loss of independence and increased mortality. Falls are estimated to cost the NHS more than £ 2.3 billion per year.

The National Institute for Clinical Excellence (NICE) – Guideline 161 (2013) 'Implementing Fall Safe' provides recommendations for the management and prevention of inpatient falls. CHFT has responded to these recommendations implementing 6 key actions.

- Commencement of a falls lead nurse within the trust to provide traction and drive project work.
- Roll out of safety huddles. Improve engagement with teams
- Review of equipment.
- Review of documentation supporting falls prevention and management that is compliant with guidelines.
- A communication and training strategy including reviews and learning
- Ensure following an in-patient fall patients get the best care to prevent harm and repeat falls.

The target for falls prevention for 2016/17 is to move away from the trajectory of a 10% reduction in falls that cause harm, this is because we know that as patients become more frail and elderly we will see an increase in falls in this group of patients and we know falls will happen.

The focus will continue to be on preventing falls but this will become a larger piece of work focusing on quality of care for patients. Falls will, therefore, become part of a larger project of reducing harm led by the Deputy Director of Nursing; this project will be a strategic piece of work which will focus on the overarching basic principles of care encompassing, safety, dignity, patient experience and reducing harm.

**Current Performance**

Since April 2016 up end of August 2016 (September 2016 data will be available in the Q3 report) there were 852 falls in total across the trust, the table below illustrates a breakdown by Division.

| | Quarter 1 2016/17 | | | Quarter 2 2016/17 | | |
|---|---|---|---|---|---|---|
| | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | YTD |
| Surgery | 24 | 41 | 30 | 33 | 29 | 157 |
| Medicine | 126 | 138 | 137 | 141 | 137 | 679 |
| FSS | 3 | 7 | 1 | 2 | 3 | 16 |
| Total | 153 | 186 | 168 | 176 | 169 | 852 |

**Falls with harm**
Since April 2016 up to the end of August 2016 there were 24 harm falls across the trust, a breakdown by division can be seen in the table below.

The first 2 months of quarter 2 in 2016/17 have seen 9 harms falls. This is a steep increase in falls compared to the first 2 months of quarter 2 in 2015/16 where 3 harm falls were reported – this is an increase of 6 harm falls on the previous year.

| | Quarter 1 2016/17 | | | Quarter 2 2016/17 | | |
|---|---|---|---|---|---|---|
| | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | YTD |
| Surgery | 0 | 0 | 0 | 0 | 1 | 1 |
| Medicine | 6 | 5 | 4 | 3 | 5 | 23 |
| FSS | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | 6 | 5 | 4 | 3 | 6 | 24 |

The national Audit Falls and fragility audit of inpatient falls (2015) reported the national average rate of falls per 1000 occupied bed dates (1000 OBDs) as a range of 0.82 -19.20, the mean being 5.6 for acute hospitals. CHFT reports at 8.42 (Per 1000 OBDs). The national reported range for falls resulting in harm was noted as 0.01 –2.00 (Per 1000 OBDs) – CHFT is reported at 0.09 (per 1000 OBDs).

The falls lead will continue to drive and work to an action plan to look at the following actions:

- Roll out of Falls five bundle across Medicine in Q3. Measuring 5 quality interventions as KPIs. Expecting improvement in risk assessment / appropriate intervention as described in Falls Five by Q4.
- Improve multidisciplinary working with regard to the assessment and management of patients at risk of falls
- Educate and empower ward staff to make small but effective innovation and change through the implementation of a falls quality improvement collaborative
- Introduce and monitor compliance with a Falls Investigation Prompt sheet to complement the CHFT root cause analysis (RCA) investigation tool developed by Effective Investigation Group (to improve quality of RCA).
- Amend the incident reporting module of Datix to mandate recording of Falls five interventions following a fall
- Support and monitor actions that were agreed at the CHFT first Harm Summit on 10th November 2015 , such as falls mapping, improving safety huddles, a review of footwear that is available for patients at CHFT and embedding bedside handover.
- Considered high risk patients presenting with a dementia and how environmental factors can support a reduction in falls , plan to implement sleep hygiene in 10 high risk ward areas
- Development of a falls policy / protocol to include post fall guidance
- Engage in a multidisciplinary approach to manage falls, including medication reviews, medical reviews.
- Initiation of safety huddle CQUIN to drive a reduction in number of falls

**Falls Lead actions to date**

- Work commenced with Electronic Patient Record (EPR) to ensure falls programme and assessment/care plans embedded.
- Falls five paperwork agreed to ensure appropriate quality interventions are recorded.
- Falls five rolled out across medicine , starting across surgery
- Multi - agency collaborative meeting monthly
- CQUIN for roll out of safety huddles on target
- Safety huddles will be rolled out to all non CQUIN wards by the end of Q4
- Engaging with senior clinicians on above wards to support safety huddles.
- Taken responsibility for all Trust training on falls in the new starter induction days including medical teams.
- Identified risks relating to equipment plan on target to address by end of Q4

**Plans for Q3 and Q4**

- Continue roll out of safety huddles to CQUIN wards as per plan
- Providing access to Knowledge Portal for wards to link directly to Datix on a daily basis to identify trends relating to falls and see what is happening in real time.
- Review and embed changes to existing Falls Prevention and Risk Management Care Plan on repository as past review date and currently written from a tissue viability perspective.
- Network with other Trust Falls Lead nurses where improvements and innovation has proved helpful in reducing falls and bring back learning.
- Liaise with Improvement Academy around more suitable icons for patient bed PIPA boards to reduce clutter and improve conformity.
- Work with A&E staff to ensure correct falls risk assessment is undertaken and appropriate referral to community services is completed in a timely way. Also to ensure that place of fall is recorded correctly as either patients home; nursing home /residential home or intermediate care bed as current data is proving unreliable (joint work with Community).
- Community team to liaise with GP's to determine why patients are coming to A&E with falls and what alternative actions there might be for some of these patients to reduce unplanned admissions.
- Embed falls investigation prompt sheet into Datix (adapted format from Improvement Academy Fishbone diagram) to improve learning from incidents such as trends in ward transfers, medications, AHP reports and recommendations around mobility for nursing team; times of day; days of the week; ages of patients; co-morbidities; staffing levels; dependency levels etc.
- Review and monitor quality interventions against falls five KPIs
- Work with Dementia team to ensure all recommendations are complied with at ward level.

## 1.2 Reducing Harm: Safety Huddles

**Background:**

Estimates suggest that approximately 5–10% of hospitalised patients in high-income countries experience harm and about one third of these harmful events are preventable.

The local, national and international patient safety initiatives that have been designed over the last decade have almost all failed to demonstrate significant impact. Reducing harm across a hospital requires behavioural change at a ward team level.

National programmes have piloted the use of the patient safety huddles and demonstrated a reduction in the number of falls, an increase in overall staff morale and improved teamwork.

These quality indicators are linked to financial CQUIN to improve care, reduce harm and prevent deterioration on inpatient wards.

**Current Performance**

NHS Trusts have developed and piloted 'patient safety huddles' to help reduce patient harm. The huddles are led by the most senior clinician and take place at a regular time each day for 10–15 minutes. They provide a non-judgemental, no-fear space in the daily workflow of ward staff. Team members develop confidence to speak up and jointly act on any safety concerns they have. They become a vehicle for ward teams to continually learn and improve.

The CQUIN for the roll out of multi- disciplinary team safety huddles to 14 wards (selected for high numbers of patients harms) is on target and will be rolled out to all non CQUIN wards by 31 March 2017. Work is taking place to engage senior clinicians to support safety huddles on wards.

During quarters 3 and 4 safety huddles will continue to be rolled out to wards as per the plan. The CQUINS performance group measures progress against the falls action plan.

Baseline data was collected monitoring number of pressure sores and falls on areas implementing safety huddles. To date there has not been any notable reduction in these measures. This is deemed to be due to the quality of huddles and a recognition safety huddles are not currently fully embedded across all multidisciplinary groups. The Improvement Academy is providing additional support to ensure the culture of a quality of a multidisciplinary safety huddle is embedded.

## 1.3 Reducing Pressure Ulcers

**Aims and Objectives of Work: Reduction of CHFT acquired pressure ulcers**

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

The prevalence of chronic wounds, including pressure ulcers and leg ulcers, is strongly related to age and the development of disease. Many chronic wounds are preventable and, if diagnosed and managed appropriately, can be healed within 24 weeks. However, ineffective clinical practice, including lack of proper diagnosis and inappropriate treatment mean that this is often not the case. Delayed healing increases the risk of complications

such as infection, which carry an additional cost burden. These costs can be reduced by ensuring healthcare professionals are properly trained in wound care

The pressure ulcer prevention and reduction programme is being overseen by the Safeguarding committee and Patient Safety Group which receives regular progress reports

**Tissue Viability (TV) Team**

The Tissue Viability service offers expert advice, across primary and secondary care, on acute and chronic wounds. The prevention and treatment of individuals with, or at high risk of, developing wounds, including pressure ulcers is the priority.

Further modernisation of the service is required in order to provide a comprehensive tissue viability service spanning primary and secondary care.

**Q2 Performance:**

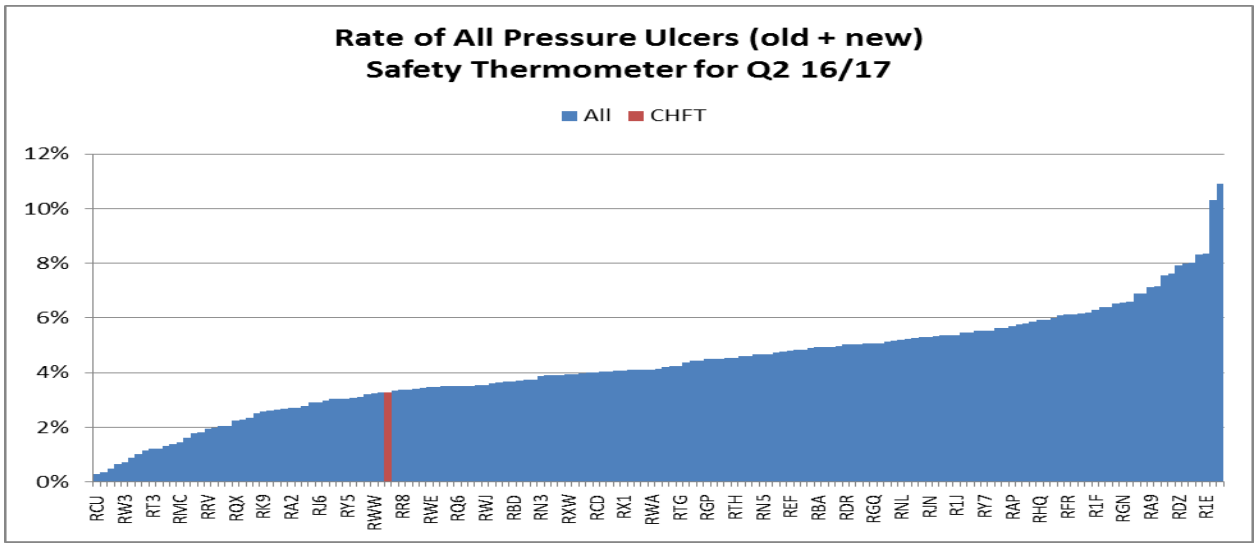
**Reported number of pressure ulcer incidences**

Definition of hospital acquired pressure ulcer and community acquired pressure ulcer has been agreed in Q2. This is available in the pressure ulcer root cause analysis (RCA) process on the repository. The impact of this will allow the Trust to have more confidence in the accuracy in the number of pressure ulcers being reported. This will provide the baseline for improvement trajectories for 17/18

**Safety Thermometer Performance**

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

When benchmarked against national data (obtained from HED) CHFT rate for all pressure ulcers is below the national average of 4.26% YTD at 3.92%.



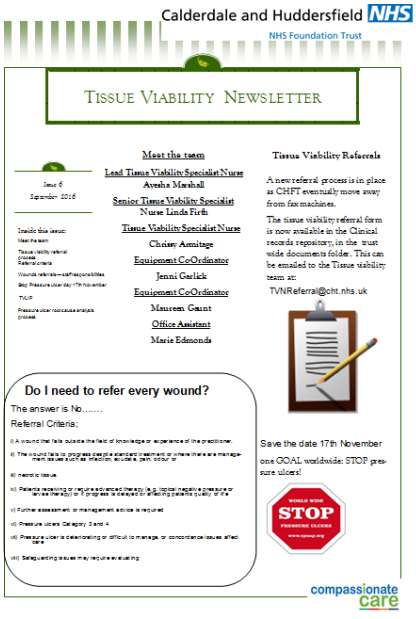
**Completed actions in Q2.**

- Tissue Viability team commenced validation of severe pressure ulcers (categories 3 and 4) although the timeliness of this continues to present a challenge due to clinical demand. –the expectation is that all category 3 and 4 pressure ulcers are reviewed by a Tissue Viability nurse within 24 hours.

- From September 2016 all severe (category 3 and 4s) CHFT acquired pressure ulcers are being investigated via a fortnightly panel which includes senior nursing colleagues.

- **The Q2 Tissue Viability** newsletter was distributed and focussed on lessons learnt following RCA panel, key messages included:

  - **Referral criteria**
  - **Root cause analysis process**
  - **Tissue Viability Link Practitioner (TVLIP) Roles & Responsibilities**
  - **Equipment selection**


Calderdale and Huddersfield NHS
NHS Foundation Trust

TISSUE VIABILITY NEWSLETTER

Issue 6
September 2016

Meet the team

Lead Tissue Viability Specialist Nurse
Ayesha Marshall
Senior Tissue Viability Specialist Nurse
Linda Firth
Tissue Viability Specialist Nurse
Chrissy Armitage
Equipment CoOrdinator
Jenni Garlick
Equipment CoOrdinator
Maureen Gaunt
Office Assistant
Marie Edmonds

Tissue Viability Referrals

A new referral process is in place as CHFT eventually move away from fax machines.

The tissue viability referral form is now available in the Clinical records repository, in the trust wide documents folder. This can be emailed to the Tissue viability team at:
TVNReferral@cht.nhs.uk

Do I need to refer every wound?

The answer is No.....

Referral Criteria;

Save the date 17th November one GOAL worldwide: STOP pressure ulcers!

STOP

compassionate care

- Following the reforming of the mattress management group objectives were set to carry on an equipment inventory audit this was carried out on September 21/22 this identified a number of areas where the trust could potential make savings and improve quality, these have been feed through the NMC committee and patient safety group for further consideration. The mattress management group has developed a project plan based on these findings. The audit will be repeated in Q4

- As part of tissue viability modernisation technology has been utilised more effectively. Referrals are now being received electronically for all areas except care homes; a solution is being explored with information governance which will look to use Systm 1 for future referrals. This will be achieved by the end of Q4.

- There is ongoing development of a wound assessment and management care plan for Systm 1 users, this will provide evidence that standards are being adhered to, using a standard template

- Definitions of roles and responsibilities of the Tissue viability link practitioner (TVLIP) has been approved at the September NMC committee. A quarterly programme has been developed to ensure these knowledgeable practitioners are kept up to date. The first session will take place in January 2017

- In Q2 the team attended the triangulation meeting with CCG to share patterns and trends around pressure ulcer incidents in care homes, information also shared with the Quest team.

- Regular team meeting and supervision has been embedded in the TV team to ensure reflective and supportive practice both of which will help develop the overall team culture.

## Improvement Plan for Q3 onwards

- The Tissue Viability and Governance and Risk teams are planning drop in sessions to support colleagues how to investigate pressure ulcers and complete the root cause analysis documentation.

- The Tissue Viability team have devised a competency based training programme for 2017 this includes module 1 pressure ulcer prevention and management and module 2 wound management. A competency framework is being developed which is expected to be available prior to the commencement of training in January 2017. This will ensure consistency in skills and knowledge.

- In Q3 the team will introduce the NHS England React to Red (R2R) training package to care homes working in partnership with the Quest team.

- Cost effective and evidence based wound management products are evaluated in partnership with the South West Yorkshire Area Prescribing Committee, which is led by Calderdale CCG. A wound policy statement has been produced and will be taken through the relevant forums during Q3/4

- As part of the West Yorkshire, North Yorkshire and York safeguarding adults policy, there are plans in place to work with internal and external safeguarding teams to encourage openness and transparency following investigation of category 3 & category 4 pressure ulcers and patient harms. This will be established within the next 6 months.

- In Q3 discussions with community division will take place looking to modernise the TV service and develop wound care clinics, to ensure wounds will be assessed in a dedicated specialised clinic, identifying dehisced surgical wounds, pilonidal sinus and other hard to heal wounds, therefore reducing hospital admissions. Support will be provided to the established community leg ulcer clinics to ensure safe practice and also reducing hospital admissions.

## 1.4 Medicines management

**Aims and Objectives of Work**

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

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

**Q2 Performance**: Missed Doses:

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

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

The last missed doses audit took place on 25th August 2016 and identified missed doses on 24th August 2016.

| | Q1 16/17 | Q2 16/17 |
|---|---|---|
| **For all missed doses** | 16.54% | 17.46% |
| **Intentional missed doses** | 7.01% | 9.9% |
| **Unintentional missed doses** | 9.54% | 8.38% |
| **Blanks** | 246 | 334 |
| **Ticks/crosses etc** | 125 | 19 |

The % of unintentionally missed doses has improved from 9.54% in Q1 to 8.38% in Q2.
The next Trust wide missed doses audit will take place during November/December 2016.

Data will be collected for one 24 hour period in order to establish the number of intentionally missed and unintentionally missed doses.

During this audit, the number of critical medicines unintentionally missed was examined. For the purposes of this audit critical medicines were:

- IV and oral antibiotics
- Anti Convulsants
- Anti parkinson's
- Oral anticoagulants
- Low molecular weight heparins
- Insulin

In Q1 there was 39 critical medicines unintentionally missed, this reduced to 32 in Q2. The list of critical medicines to be administered within one hour of the prescribed time will be reviewed. The importance of the administration of critical medicines has been further built into the RN/RM induction programme and has been highlighted and reinforced in Medicines Management Newsletters

Performance results continue to be fed back to all ward managers/matrons, the Nursing and Midwifery Practice Group and to the Nursing and Midwifery Committee.

There is an ongoing campaign to encourage patients to bring all their medicines and diabetes related equipment into hospital with them so they can manage their medicines if they are able and reduce the number of missed/delayed doses. Work continues with the Yorkshire Ambulance Service and other regional NHS Trusts. The plan is for a targeted approach to encouraging this practice. This would include the use of a 'sealable green medication bag' (that is currently being used for medicines when a patient is transferred or discharged) that would be used by ambulance staff when they bring patients from home to a Medical Assessment Unit, Surgical Assessment Unit, Accident and Emergency, Coronary Care. A decision has yet to be made about the use of the green bags throughout the region.

Wards continue to be encouraged to check prescription chart and administration records on each shift change/handover to check documentation and ensure doses have not been missed. It also gives the opportunity to 'challenge' colleagues. Identifying missed doses and raising any concerns with the nurse in charge is also part of the mock CQC medicines management audits. These audits are used to populate individual ward/departmental action plans for improvement.

There is now a Self-administration Collaborative and self-administration will be spread. It is anticipated that delays and missed doses will reduce in areas offering and encouraging self-administration. Currently staff on Ward 17 and 12 HRI and 8AB CRH have been re-trained in the self-administration of medicines. Ward 10 HRI will be the next ward to enter into the collaborative

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

## Self-administration Collaborative

It is important that patients who successfully manage their medication in community are also supported to manage this whilst in hospital. This reduces the risk of issues such as missed and can reduce the length of patients alongside encouraging their independence.

In Quarter 2 wards 17 and 22 HRI and 8AB CRH became part of the CQUIN. The target of 50% has been achieved.

In Quarter 3 ward 10 will become part of the CQUIN
In Quarter 4 two further wards will become part of the CQUIN

The work stream is led by a clinical lead who continues to be supported by other clinical, nursing and pharmacy colleagues. Project support is provided by clinical governance staff and the Health Informatics Service.

| Self Admin CQUIN % Compliance | | | | | | | |
|---|---|---|---|---|---|---|---|
| Month/Week | Patients Audited | Is the level written on the drug chart % | Is there a self-administering form in the notes % | Is a 7 stated in the prescription sheet % | No of patients willing and able to self care % | No achieved | % Achieved |
| **Apr-16** | **23** | **100%** | **96%** | **13%** | **17%** | **3** | **75%** |
| **May-16** | **24** | **83%** | **88%** | **8%** | **8%** | **2** | **100%** |
| **Jun-16** | **23** | **96%** | **91%** | **9%** | **9%** | **2** | **100%** |
| **Q1** | **70** | **93%** | **91%** | **10%** | **11%** | **7** | **88%** |
| **Jul-16** | **59** | **53%** | **75%** | **20%** | **24%** | **9** | **64%** |
| **Aug-16** | **74** | **80%** | **92%** | **20%** | **27%** | **15** | **75%** |
| **Sep-16** | **56** | **64%** | **89%** | **14%** | **23%** | **10** | **77%** |
| **Q2** | **189** | **67%** | **86%** | **19%** | **25%** | **34** | **72%** |

## Training ward staff

As each new ward become involved in the collaborative, nursing staff undertake a program of training in the elements of self-administration and self-management and the use of associated documentation. Training sessions are arranged on all the wards for Nursing/Midwifery staff and the sessions are delivered in the main by the Lead Nurse Medicines Management, remaining staff are trained by the Ward Manager/nursing representative. The Lead Nurse Medicines Management maintains contact with wards after self-care has been launched and ward staff are made aware to contact her should any problems arise of if any clarification is required.

It has been acknowledged by the Collaborative and the Nursing and Midwifery Committee that the training of ward staff in self-management self-administration of medicines can no longer be sustained using this approach due to the workload of the Lead Nurse, Medicines Management and capacity to release ward staff for training.

## Campaign

There is an ongoing campaign to encourage patients to bring all their medicines and equipment into hospital with them so they can manage their medicines if they are able and

reduce the number of missed/delayed doses. Work has now spread to the Yorkshire Ambulance Service and other regional NHS Trusts. The plan is for a targeted approach to encouraging this practice. This would include the use of a 'sealable green medication bag' (that is currently being used for medicines when a patient is transferred or discharged) that would be used by ambulance staff when they bring patients form home to a Medical Assessment Unit, Surgical Assessment Unit, Accident and Emergency, Coronary Care.

**Patient information**
Work is being done on the collaborative wards to ensure that patients receive a self-administration leaflet.

**Patient questionnaire**
A questionnaire was developed and introduced in Q1 in order to obtain qualitative feedback from patients about their experiences managing their medication and/or self-administering their medicines. This has continued throughout quarter 2 and will continue each quarter.

**Q3 Improvement Plan:**
- Ward 10 has been identifed as the next to be brought into the CQUIN in Q3 and a training programme is now in place for this ward..
- Continue to complete the qualitative questionnaire with patients managing their medication and/or self-administering their medicines.
- Continue to share progress with ward managers through the Collaborative, Nursing and Midwifery Practice Group and Nursing and Midwifery Committee and Pharmacy Board.

**CQUINS – Antimicrobial**

**a) Reduction in antibiotic consumption/1000 admissions**

The CQUIN looks for a 1% reduction in antibiotic consumption (DDDs/1000 admissions) compared to baseline of consumption in 2014/14. This is in the following areas:

- Total consumption
- Carbapenems
- Piperacillin-tazobactam

Internal monitoring indicates this will be challenging and this is a view shared with a number of other Trusts across the region.

Public Health England, PHE, is expected to publish data for 2013/14 (resubmitted), 2014/15 and 2015/16 by early October so that validation / benchmarking can take place.

The CQUIN has been discussed widely, internally and with the CCGs, and we are currently waiting for definitive consumption data so that we can suggest an achievable target for antimicrobial consumption for 2016/17.

We have identified that A&E and out patient prescribing accounts for 44% of antimicrobial consumption (July 2016) and we are targeting some audit work in these areas to understand how we can reduce consumption.

There are a number of other actions which are being followed up on and will be monitored through the CQUIN group. It has also been suggested that the sepsis CQUIN and Antimicrobial Resistance (AMR) CQUIN groups are merged to address some common areas for both CQUINs.

**b) Empiric review of antibiotic prescriptions**

As part of good antimicrobial stewardship it would be expected that a review of an antibiotic should take place within 72 hours (by day 4) of starting (day 1). This review would include documented evidence of either:

- Stop
- IV to PO switch
- Change antibiotic
- Continue
- OPAT

This information can be documented within the medical notes, on the medication chart or electronically.

A monthly audit is to be undertaken by pharmacists:

- Minimum 50 antibiotic prescriptions from a representative sample across wards and sites in the Trust
- Sampling criteria:
  - 12 wards – up to 6 antibiotic prescriptions
  - CRH – children's ward (3bcd), 2a, 4c, 5a, 6c, 8a
  - HRI – 10, 11, 15, 17, 21, ITU
  - Random sampling by bed numbers (start at bed 1, bed 2 etc until reached 6 antibiotic prescriptions per ward) on one day per month
  - Q2 additional wards added to data collection to ensure minimum 50 antibiotic prescriptions

| | Q1 total | Jul | Aug | Sept | Q2 total |
|---|---|---|---|---|---|
| Total number prescriptions | 155 | 46 | 50 | 61 | 157 |
| Number reviews documented within 72 hours | 136 | 41 | 43 | 55 | 139 |
| % | 87.7% | 89% | 86% | 90% | 88.5% |
| Target | 25% | 50% | 50% | 50% | 50% |

The CQUIN Q1 target was 25% and the Q2 target is 50% both of which have been exceeded. Further work is needed to ensure we achieve the 90% target for Q4.

## 1.5 Improving Sepsis Care

**Aims and Objectives of Work:**

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

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

In 2016/17 a national CQUIN continues and now aims to have:

- 90% of emergency admissions, and inpatients, being screen for sepsis where appropriate.

- 90% by Quarter 4 those patients who have been identified as Septic having received antibiotics within an hour of admission.

**Q2 Performance:**

*Q2 performance for the following is given overleaf:*

*A1 Screening*
*A2 Initiation of treatment and 3 day review*
*B1 Screening*
*B2 Initiation of treatment and 3 day review*

*A1 Screening*

| | Quarter 1 | | | | | | | | | Q1 | | | Quarter 2 | | | | | | | | | Q2 | | | YTD | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr-16 | | | May-16 | | | Jun-16 | | | | | | Jul-16 | | | Aug-16 | | | Sep-16 | | | | | | | | |
| | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total |
| Number of patients (in sample) with severe red flag or septic shock who received IV antibiotics < 1 hour | 13 | 0 | 13 | 8 | 0 | 8 | 15 | 1 | 16 | 36 | 1 | 37 | 18 | 1 | 19 | 0 | 1 | 1 | | | 0 | 18 | 2 | 20 | 54 | 3 | 57 |
| Number of patients (in sample) with severe red flag or septic shock who received a review after 3 days | 11 | 0 | 11 | 9 | 0 | 9 | 20 | 2 | 22 | 40 | 2 | 42 | 17 | 2 | 19 | 1 | 1 | 2 | | | 0 | 18 | 3 | 21 | 58 | 5 | 63 |
| Number of patients (in sample) with severe red flag or septic shock who received IV antibiotics < 1 hour and a review after 3 | 11 | 0 | 11 | 8 | 0 | 8 | 15 | 1 | 16 | 34 | 1 | 35 | 15 | 1 | 16 | 0 | 1 | 1 | | | 0 | 15 | 2 | 17 | 49 | 3 | 52 |
| Patients who had recorded evidence of severe, Red Flag or Septic Shock on emergency presentation who should have IV | 14 | 0 | 14 | 11 | 0 | 11 | 21 | 2 | 23 | 46 | 2 | 48 | 18 | 2 | 20 | 1 | 1 | 2 | | | 0 | 19 | 3 | 22 | 65 | 5 | 70 |
| % Patients with severe red flag or septic shock that received Iv antibiotics < 1 hour. | 79% | - | 79% | 73% | - | 73% | 71% | 50% | 70% | 74% | 50% | 73% | 83% | 50% | 80% | 0% | 100% | 50% | - | - | - | 79% | 67% | 77% | 93% | 60% | 90% |
| Target | Baseline | | | | | | | | | | | | Baseline | | | | | | | | | | | | | | |

*A2 Initiation of treatment and 3 day review*

| | Quarter 1 | | | | | | | | | Q1 | | | Quarter 2 | | | | | | | | | Q2 | | | YTD | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr-16 | | | May-16 | | | Jun-16 | | | | | | Jul-16 | | | Aug-16 | | | Sep-16 | | | | | | | | |
| | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total |
| Number of patients (in sample) with severe red flag or septic shock who received IV antibiotics < 1 hour | 13 | 0 | 13 | 8 | 0 | 8 | 15 | 1 | 16 | 36 | 1 | 37 | 18 | 1 | 19 | 0 | 1 | 1 | | | 0 | 18 | 2 | 20 | 54 | 3 | 57 |
| Number of patients (in sample) with severe red flag or septic shock who received a review after 3 days | 11 | 0 | 11 | 9 | 0 | 9 | 20 | 2 | 22 | 40 | 2 | 42 | 17 | 2 | 19 | 1 | 1 | 2 | | | 0 | 18 | 3 | 21 | 58 | 5 | 63 |
| Number of patients (in sample) with severe red flag or septic shock who received IV antibiotics < 1 hour and a review after 3 | 11 | 0 | 11 | 8 | 0 | 8 | 15 | 1 | 16 | 34 | 1 | 35 | 15 | 1 | 16 | 0 | 1 | 1 | | | 0 | 15 | 2 | 17 | 49 | 3 | 52 |
| Patients who had recorded evidence of severe, Red Flag or Septic Shock on emergency presentation who should have IV | 14 | 0 | 14 | 11 | 0 | 11 | 21 | 2 | 23 | 46 | 2 | 48 | 18 | 2 | 20 | 1 | 1 | 2 | | | 0 | 19 | 3 | 22 | 65 | 5 | 70 |
| % Patients with severe red flag or septic shock that received Iv antibiotics < 1 hour. | 79% | - | 79% | 73% | - | 73% | 71% | 50% | 70% | 74% | 50% | 73% | 83% | 50% | 80% | 0% | 100% | 50% | - | - | - | 79% | 67% | 77% | 93% | 60% | 90% |
| Target | Baseline | | | | | | | | | | | | Baseline | | | | | | | | | | | | | | |

*B1 Screening*

| | Quarter 1 | | | | | | | | | Q1 | | | Quarter 2 | | | | | | | | | Q2 | | | YTD | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr-16 | | | May-16 | | | Jun-16 | | | | | | Jul-16 | | | Aug-16 | | | Sep-16 | | | | | | | | |
| | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total |
| Number of patients who met the criteria for sepsis screening and were screened for sepsis | 4 | 0 | 4 | 5 | 0 | 5 | 1 | 0 | 1 | 10 | 0 | 10 | 2 | 0 | 2 | 9 | 3 | 12 | 2 | 2 | 4 | 13 | 5 | 18 | 23 | 5 | 28 |
| The total number of patients who met the criteria for sepsis screening according to the agreed local protocol | 46 | 4 | 50 | 45 | 5 | 50 | 45 | 5 | 50 | 136 | 14 | 150 | 48 | 2 | 50 | 46 | 4 | 50 | 18 | 2 | 20 | 112 | 8 | 120 | 248 | 22 | 270 |
| % Eligible patients screened for Sepsis | 9% | 0% | 8% | 11% | 0% | 10% | 2% | 0% | 2% | 7% | 0% | 7% | 4% | 0% | 4% | 20% | 75% | 24% | 11% | 100% | 20% | 12% | 63% | 15% | 9% | 23% | 10% |
| Target | Baseline | | | | | | | | | | | | 8.0% | | | | | | | | | | | | | | |

*B2 Initiation of treatment and 3 day review*

| | Quarter 1 | | | | | | | | | Q1 | | | Quarter 2 | | | | | | | | | Q2 | | | YTD | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Apr-16 | | | May-16 | | | Jun-16 | | | | | | Jul-16 | | | Aug-16 | | | Sep-16 | | | | | | | | |
| | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total | Adult | Paed | Total |
| Number of patients (in sample) with severe red flag or septic shock who received IV antibiotics < 90 mins | 0 | 1 | 1 | 2 | 3 | 5 | 1 | 2 | 3 | 3 | 6 | 9 | 1 | 1 | 2 | | 2 | 2 | | | 0 | 1 | 3 | 4 | 4 | 9 | 13 |
| Number of patients (in sample) with severe red flag or septic shock who received a review after 3 days | 1 | 2 | 3 | 2 | 5 | 7 | 2 | 4 | 6 | 5 | 11 | 16 | 1 | 1 | 2 | | 3 | 3 | | | 0 | 1 | 4 | 5 | 6 | 15 | 21 |
| Number of patients (in sample) with severe red flag or septic shock who received IV antibiotics < 90 mins and a review after | 0 | 1 | 1 | 2 | 3 | 5 | 1 | 2 | 3 | 3 | 6 | 9 | 1 | 1 | 2 | | 2 | 2 | | | 0 | 1 | 3 | 4 | 4 | 9 | 13 |
| Patients who had recorded evidence of severe, Red Flag or Septic Shock on emergency presentation who should have IV antibiotics < 90 mins | 3 | 2 | 5 | 2 | 5 | 7 | 2 | 4 | 6 | 7 | 11 | 18 | 1 | 1 | 2 | | 3 | 3 | | | 0 | 1 | 4 | 5 | 8 | 15 | 23 |
| % Patients with severe red flag or septic shock that received Iv antibiotics < 90 mins | 0% | 50% | 20% | 100% | 60% | 71% | 50% | 50% | 50% | 43% | 55% | 50% | 100% | 100% | 100% | - | 67% | 67% | - | - | - | 100% | 75% | 80% | 67% | 60% | 62% |
| Target | Baseline | | | | | | | | | | | | Baseline | | | | | | | | | | | | | | |

- is screening has been incorporated into the triage processes in both the Emergency Departments, which will have a significant impact on the 100% of patient undergoing a screening for sepsis.

- Targeted work is ongoing to MAU / SAU / W12 to ensure screening in place for all patients triggering as requiring a sepsis screen

- The Sepsis Improvement group continues the work of the previous year and now includes representation from children directorate

- Regional wide network group have been coordinated to share learning and best practice

- Consideration ongoing regarding tools to implement / monitor nice guidance approach to monitoring sepsis

- Medical leads identified supporting analysis of patients care

- Rollout of Bufalo/ Sepsis six boxes commenced to enable clinicians to recall sepsis six interventions.

- Nerve centre being amended to create trigger to screen for sepsis if a patient has a NEWS 5/ PAWS 6 in children

- Matrons monitoring / educating daily around sepsis trigger (NEWS 5) / sepsis 6 interventions on their ward areas daily

**Improvement plans for 2016/17:**

- To review the recommendations in the recent release of NICE guidance on sepsis and assess impact and application of guidelines.

- To undertake a deep dive of data to understand the causes of sepsis.

- Roll out Paediatrics screening tool as appropriate.

## 1.6 Improving Record Keeping

In 2013 the Trust prioritised improvement to our clinical records and documentation. A clinical lead for records was appointed and an in-depth review of governance took place, along with a complete revision and review of clinical documentation and awareness raising of professional standards. The intended result was to ensure a high quality record that is patient centred, involves the multidisciplinary team, involves the patient and tells the patient story.

The Clinical Records Management Board was established and remains in place to ensure improvement in the quality of clinical records is maintained. The group governs the process for agreeing new documentation, overseas performance, enables the transition to digital records and has oversight of information governance issues.

Quality of the record and record keeping is monitored through data collected using the Clinical Record Audit Standard (CRAS) tool. Monthly audits have been carried out since April 2013, covering 12 standards with 23 individual elements assessed. A RAG rated system is used to highlight those teams achieving the 95% target required to be compliant with the documentation against the 107 individual questions.

A number of standards have seen very little improvement; therefore a decision has been made to stand down the main CRAS audit until January 2017 to allow improvement interventions to be further developed over the coming months.

The focus of the work will be falls and fluid balance charts with a benchmark taken from September's data.

Three wards have attended weekly Executive Board and shared their experience, issues and successes in achieving compliance.

**Improvement Plans for 2016/17**

Transformational change is underway with the vision that the Electronic Patient Record (EPR) will enable the safest, most efficient and patient-centred organisation in the NHS.

CHFT jointly procured with Bradford Teaching Hospitals NHS Foundation Trust (BHTFT) the Cerner Millennium EPR to empower the Trust to work more effectively, so patients benefit from improved quality and experience specifically through having an accurate, timely, high quality patient record. It will be implemented fully in A&E and all inpatient wards including paediatrics, outpatients, community, and virtual wards.

Governance arrangements with regard to clinical documentation are currently being reviewed in line with this transformational change

## 1.7 Maternity

### Q2 Developments

- Royal College of Obstetricians and Gynaecologists Invited Service Review took place between 26-28 July. Verbal feedback at the time of the visit was positive and helpful, with no immediate actions recommended.

- Work continues to complete and embed actions on the maternity CQC action plan and Trust CQC action plan. Work is largely progressing in line with plan.

- New Maternity Risk Management Strategy and meeting governance structure has been introduced to strengthen governance and learning from incidents and complaints

- Notable improvements in Q2 include:
  - Increase in proportion of women receiving 1:1 care in established labour (99.79% in September 2016)
  - Month on month increase in normal delivery rates
  - Reduction in number of stillbirths
  - Reduction in 3 and 4 degree tears following normal birth
  - No cases of delays in repair of 3 and 4 degree tears (against internal Trust standard)
  - No cases of shoulder dystocia with harm
  - Reduction in delays for Category 2 caesarean section

- Four customer service workshops have been held with midwives, support workers and doctors. The workshops were facilitated by the National Patient Advisory Group. Following the workshops, each area is developing its own customer service pledge based on feedback from analysis of themes and trends of complaints and Friends and Family feedback.

- Business case developed to secure second middle grade obstetrician/ gynaecologist for night shifts and weekends. This investment will bring us into line with other providers and further reduce delays in terms of access to theatre and ED reviews of gynaecology patients.

- Development workshop for midwifery preceptors held in August. These were co-hosted with Huddersfield University and provided opportunity for preceptors to consider ways in which they could better support the transition of newly qualified midwives.

- One of the main sources of stress for midwives and support workers is lack of undisturbed break time during 12 hour shifts. The Trust have signed up to the Royal College of Midwives 'Caring for You' campaign and is working with colleagues to address this issue. A series of engagement events have been held to seek ways in which service delivery can be refined to support improved working practices.

- NHS England launched the SABINE (Saving Babies Lives in England) programme in 2015. The programme comprises of a care bundle and training programme. Trusts were to have achieved 75% compliance with the training programme by July 2016; CHFT compliance is in excess of 95% across all staff groups

**Improvements for 16/17**

- Further staff engagement events planned

- Maternity services are about to commence work with Healthwatch to ensure service user views are central to service improvements

- The maternity service and CCG have commenced the National Maternity Review Better Births work programme to ensure high quality and sustainable maternity services going forwards

## 1.8 Improving Clinical Coding

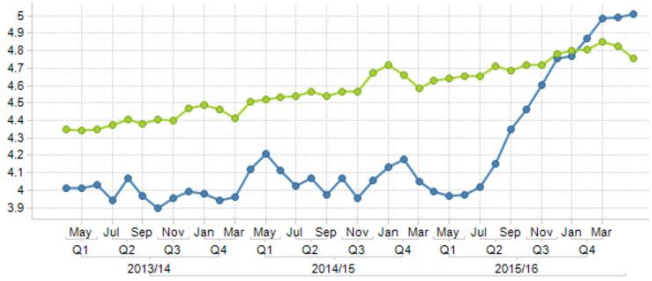
### Background

Clinical Coding is used to classify the diagnosis and treatment of every admitted patient. The system relies on the expertise of clinical coders, who extract data from documentation used to record clinical information. The quality (accuracy and completeness) of the documentation is also crucial to the quality of the coded data. CHFT performance against clinical coding KPI's (% Sign & Symptom, Depth of Coding and Average Charlson Score) were below the national average for the Trust and at specialty level. By improving the performance for each KPI's it would result in a positive impact on HSMR/SHMI. CHFT's aim is to be in the national upper quartile for the 3 coding KPI's and this is reliant on the documentation and the quantity and quality of the coders extracting the data.

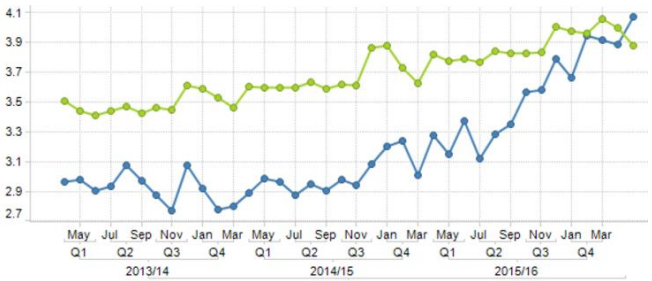
### Current Performance

There has been significant improvement in all coding KPI's within the last quarter and 12 months as a result of increased clinical engagement, improvements to clinical documentation to aid the clinical coding process, vacancies filled within the coding team and improved use of data to identify areas for improvement. All 3 of the clinical coding KPI's show a positive improvement as demonstrated in the graphs below.

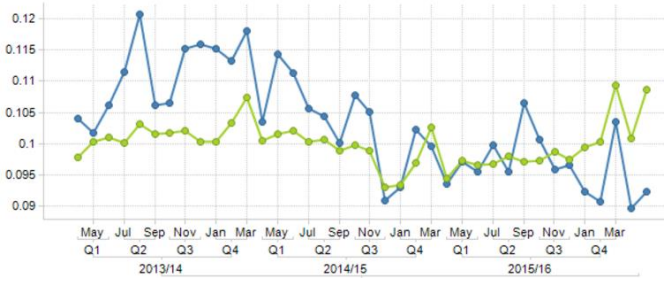
**Depth of Coding Apr 2012 – May 2016**




**Average Charlson Score Apr 2012 – May 2016**




**% Sign & Symptom Apr 2012 – May 2016**




*Source: HED. CHFT – Blue Line; National Average – Green Line*

However there is considerable variation at a specialty level as shown in table below.

**Coding KPI's by Specialty – August 2016**

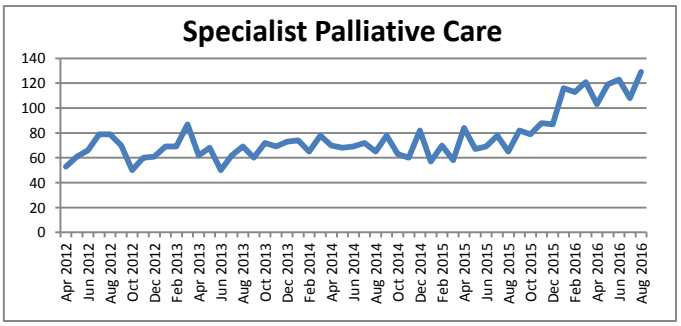
| Treatment function | Adjusted Charlson | Average diagnoses | Percentage signs and symptoms |
|---|---|---|---|
| 100 - General Surgery | 2.40 | 4.54 | 11.69% |
| 101 - Urology | 3.06 | 4.73 | 6.09% |
| 107 - Vascular Surgery | 7.37 | 8.85 | 3.85% |
| 110 - Trauma and Orthopaedics | 2.87 | 4.94 | 0.31% |
| 120 - ENT | 1.15 | 3.03 | 5.53% |
| 130 - Ophthalmology | 1.47 | 3.83 | 0.00% |
| 140 - Oral Surgery | 0.97 | 2.02 | 0.00% |
| 160 - Plastic Surgery | 1.00 | 2.34 | 0.00% |
| 191 - Pain Management | 2.90 | 3.74 | 3.10% |
| **Surgical Total** | **2.31** | **4.29** | **5.74%** |
| 180 - Accident & Emergency | 4.75 | 5.76 | 27.36% |
| 300 - General Medicine | 7.74 | 7.54 | 16.88% |
| 301 - Gastroenterology | 4.29 | 5.21 | 8.40% |
| 303 - Clinical haematology | 2.82 | 3.79 | 0.77% |
| 306 - Hepatology | 9.92 | 8.15 | 2.56% |
| 314 - Rehabilitation service | 8.12 | 9.97 | 3.45% |
| 320 - Cardiology | 6.47 | 6.97 | 11.00% |
| 328 - Stroke Medicine | 6.28 | 8.22 | 15.63% |
| 340 - Respiratory medicine | 8.31 | 9.31 | 4.24% |
| 370 - Medical Oncology | 9.49 | 5.01 | 0.47% |
| 400 - Neurology | 0.00 | 1.78 | 0.00% |
| 410 - Rheumatology | 1.81 | 3.54 | 0.00% |
| 430 - Geriatric Medicine | 12.44 | 10.81 | 6.79% |
| **Medical Total** | **7.05** | **6.69** | **11.63%** |
| 420 - Paediatrics | 0.11 | 2.14 | 8.62% |
| 501 - Obstetrics | 0.40 | 4.12 | 0.00% |
| 502 - Gynaecology | 0.90 | 3.73 | 6.21% |
| 560 - Midwifery | 0.21 | 3.30 | 0.00% |
| 811 - Interventional Radiology | 6.11 | 5.78 | 2.74% |
| **FSS Total** | **0.52** | **3.14** | **4.96%** |

| | | | |
|---|---|---|---|
| CHFT Total | 4.09 | 5.15 | 8.1% |

*Source: Standard Activity, Knowledge Portal. Red = Lower Quartile, Amber = Interquartile and Green = Upper Quartile*

## Improvement plans for 2016/17

- 4 out of 5 clinicians with PA for coding identified who are assisting with specific coding improvements particularly 'lost' co-morbidities, further improvements in source documentation used for coding and education/engagement sessions for clinical staff. It is hoped that role of the 5th clinician with PA for coding will be shared by clinicians from the surgical division.
- 6 trainees recruited and are nearing completion of the clinical coding foundation course. 1.0 wte has been recruited in the period balanced by 1.0 wte leaving the organisation. Therefore, there are currently 2.5 wte vacancies that will continue to be advertised as a rolling advert with the plan that if no suitable applicants by winter 2016 2 additional trainees will be recruited. In addition, there is 1.0 wte currently on maternity leave. Additional capacity will allow more time for coding and for clinical engagement to improve documentation.
- Roll out of 3M Encoder which will assist with the coding process especially for coding trainees. There is a strong belief that the software can support the clinical coding process and increase income through optimisation of the coding. It is acknowledged that pace has been slow in this area and with the deferral of the EPR deployment we will explore the potential to deploy the new encoder at the earliest opportunity.
- Roll out of Cerner Millennium - Cerner Millennium will 'pull-through' conditions documented in the LTC/Problem section of Millennium into clerking in section. Emphasis to be given in clinical training for this section of Millennium to be completed ASAP after go-live with all important co-morbidities (that impact on patient care, HSMR or SHMI). Plans are being discussed to mitigate the risk of undocumented co-morbidities at 'go-live'.
- Continue to work with wards and Specialist Palliative Care (SPC) teams regards importance of documenting SPC input and continue with the check process to ensure SPC involvement in care is not missed. Highest input to date from SPC was recorded in August 2016. Cerner Millennium should also assist with the process of documenting SPC input.




- Develop specialty specific coding awareness presentations for clinical teams with a view to attend clinical audit sessions.
- Continue to identify and work with areas/specialties where coding quality improvements are required.

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

**Effectiveness compliance summary**

| Indicator | Compliance |
|---|---|
| 2.1 Reducing Mortality | Partial Compliance |
| 2.2 Improving Reliability – Implementing Care Bundles | Reporting Only |
| 2.3 Improving the Management of Fracture Neck of Femur | Reporting Only |
| 2.4 Improving Diabetic Care | Reporting Only |
| 2.5 Reducing Hospital Acquired Infections (Contract) | Achieved |
| 2.6 Hospital at Night (CQUIN, Quality Account) | Achieved |
| 2.7 Deteriorating Patient | Reporting Only |
| 2.8 Improving End of Life Care | Achieved |
| 2.9 Deprivation of Liberty (DOLs) | Reporting Only |
| 2.10 Conditions of Interest – Stroke | Reporting Only |

**Highlights:**

- Mortality – Hospital Standardised Mortality Ration (HSMR) shows a notable improvement from 111.62 in Q1 to 108.62
- Reducing Hospital Acquired Infection – 0 cases MRSA bacteraemia since Q2 2015/16, c difficile remains a challenge
- Fractured neck of femur – improvement from 2015 to 2016 (April to August) with stronger performance in all 6 areas where national averages are available
- Hospital Out of Hours programme (HOOP) Night - achievement of HOOP CQUIN for Q2 re: recruitment of staff
- End of Life – draft End of Life Care Strategy shared for consultation with membership councillors
- Safeguarding – work to increase safeguarding training compliance continues
- Stroke – national stroke data (SSNAP) shows an improved rating for stroke services from D to B. Increased frequency of therapy for patients.

## 2.1 Learning from Mortality

The main outcome measure is the Summary Hospital Mortality Index (SHMI) calculated by the Health and Social Care Information Centre (HSCIC). The SHMI is the ratio between the actual number of patients who die within 30 days of discharge from the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the local patients.

The Hospital Standardised Mortality Ratio, HSMR, is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100).

The Trust aims to:

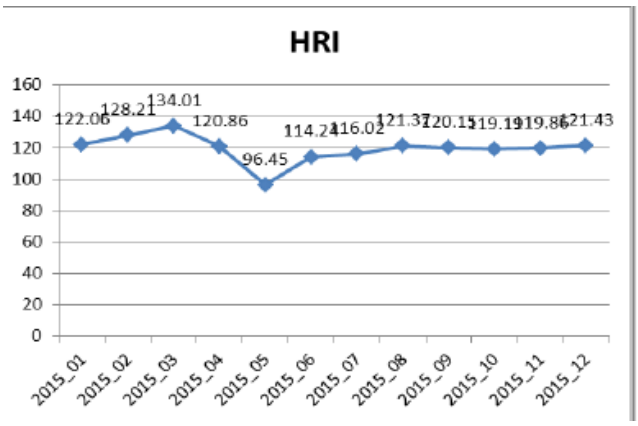
- Reduce the SHMI to 100
- To review 100% of all in hospital deaths each month

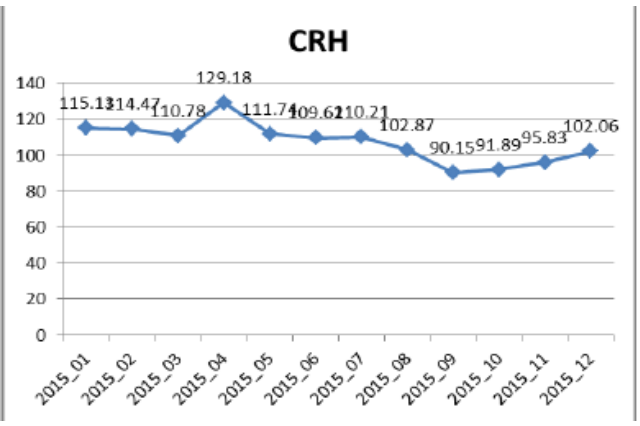
**SHMI update**

Data has been released in August for SHMI incorporating performance data up to **December 15**

- Looking at the rolling 12 month SHMI (January 15 – December 15), the score is **113.80**. This is a slight improvement from the previous rolling 12 month period of 113.88 (October 14 – September 15)

- The site breakdown shows HRI at 119.52 and CRH 107.27. The graphs below show the month on month SHMI for HRI and CRH.



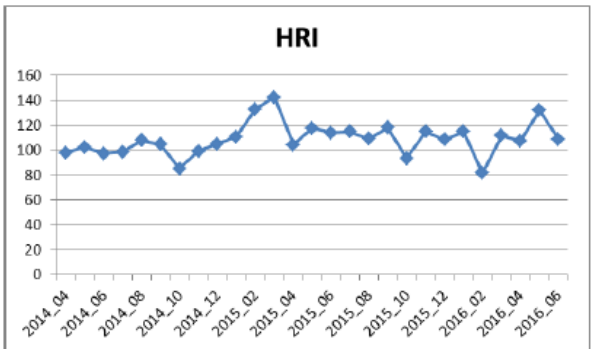



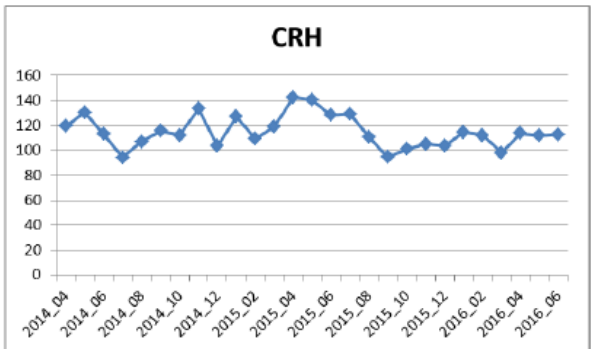

**HSMR update**

Data has been released in **September** for HSMR incorporating performance data up to **June 2016.**

- Looking at the rolling 12 month HSMR (July 15 – June16), the score is **108.67**. This is a notable improvement from 111.62 reported in the last report (Q1)

- The site breakdown for the same period shows HRI at 109.00 and CRH at 109.00. The graphs below show the month on month HSMR for HRI and CRH.




**Mortality Alerting Conditions**

The Trust is showing as an outlier in mortality for Acute Cerebrovascular Disease (ACD). A working group, led by the Medical Director, has highlighted some areas for improvement and has prompted an invited service review.

**Internal Mortality Review Process**

Mortality cases are reviewed internally using a two level process with the aim to review 100% cases at first level. These reviews are performed by a team of 'mortality reviewers' using a standard tool with a number of 'screening' questions to assess whether there were any preventability factors. The preventability is scored using the Hogan score of preventability on a scale of 1 to 6 as described below.

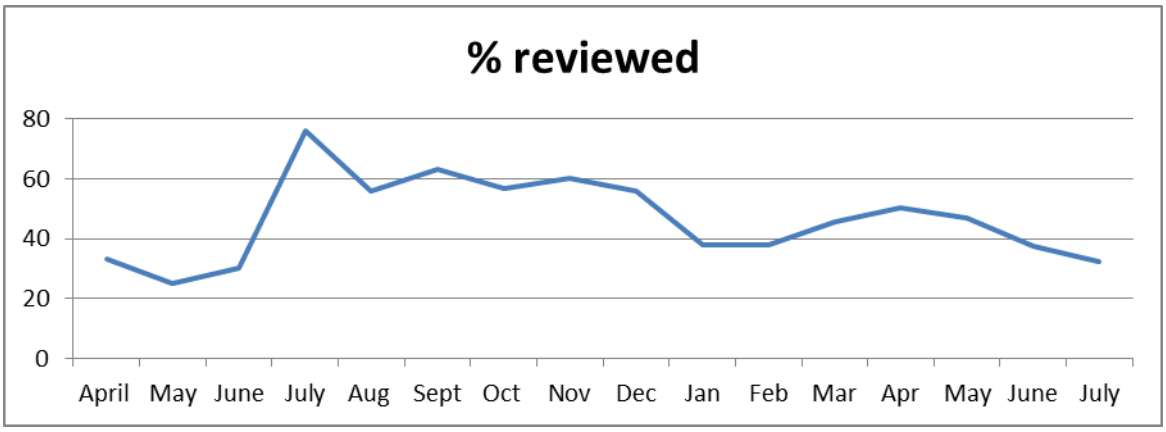
1. Definitely not preventable.
2. Slight evidence for preventability.
3. Possibly preventable but not very likely, less than 50–50 but close call.
4. Probably preventable, more than 50-50 but close call.
5. Strong evidence for preventability.
6. Definitely preventable.

In addition, the first level reviewers can provide some free text that captures useful information on preventability and provide a score of the care provided. All cases assessed as Hogan 3 or above are sent for a second level review with the purpose to provide a more in-depth review of the patients care and management to understand where the gaps have occurred.

In the last 12 months, there have been a 1,582 deaths, of these, 797 (50.4%) have been reviewed by the team of first level reviewers. The overall preventability rate over the last 12 months is 1.25%.

The top learning themes since July 2015 remain the same; delay in senior medical review, delay in medications including antibiotics and hospital acquired pneumonia including aspiration pneumonia.

Performance of the first level reviews has continued to decline. The chart below shows the % of mortality cases reviewed each month. The decline has been due to many of the senior nurses who perform the mortality reviews being required to manage other priorities in the Trust. Plans are being made to move to a consultant led process for mortality reviews by April 2017.

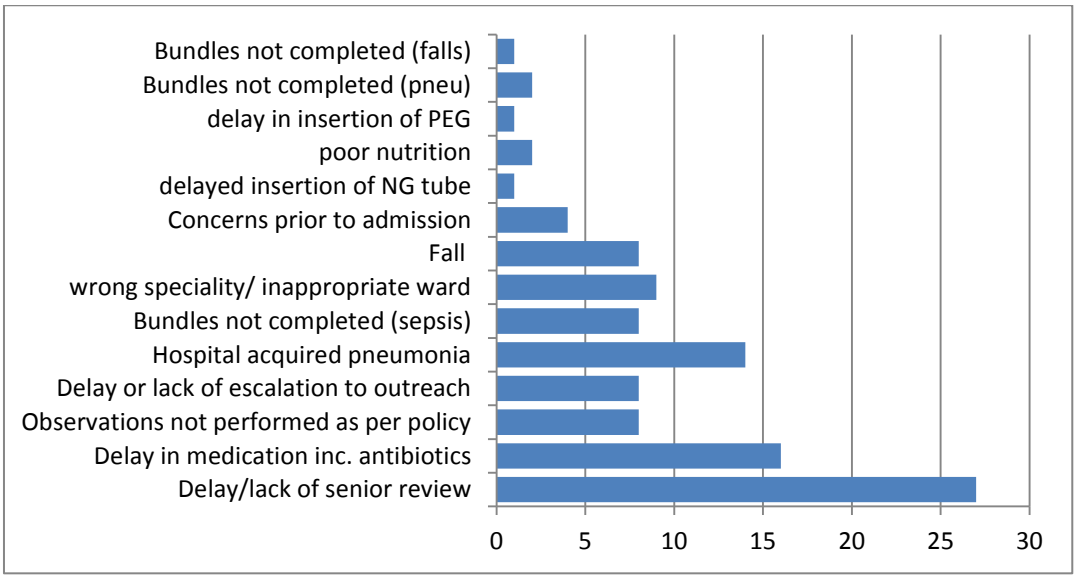



The second level reviews are currently performed by 3 senior doctors who were appointed in January 2016. Since January, 21 cases have been escalated for second level review. Of these, 16 cases have been completed resulting in 6 cases being downgraded with no further review, 10 cases reported as orange incidents on Datix with further divisional investigation and one case reported on STEIS as a red incident for a full investigation. 5 cases still need to be completed.

**Learning from mortality reviews**

Once the reviews have been performed, the data is added to the Knowledge Portal. In addition, data is being analysed on a monthly basis using the key learning themes from cases assessed as Hogan 2 and the more in-depth details gathered from the Hogan 3-5 cases. The 'Learning from Mortality Reviews' reports is shared with the reviewers, members of the newly formed Mortality Surveillance Group, Clinical Outcomes Group and Divisional Patient Safety and Quality Boards.

The following chart shows the themes identified by the first level reviewers since July 2015.




**Improvement Work**

The top themes from the reviews are aligned to various improvement work streams as identified below.

| Top themes | Improvement work |
|---|---|
| 1. Delay/lack of medical review | The SAFER programme is working on 7 day working and Hospital out of Hours Programme (HOOP) |
| 2. Delayed medications, mainly antibiotics | Work ongoing in the Sepsis Collaborative, revisiting the 'sepsis boxes' on the wards, promotion of stat doses, medical and divisional leadership |
| 3. Observations not performed as policy | Included in the Deteriorating Patient Group who are reviewing data on timelines of observations and pulling out themes for improvement. Also reviewing data on patients with NEWS 7 and above |
| 4. Delay or lack of escalation of NEWS | |
| 5. Incomplete bundles | AKI, COPD, Sepsis and pneumonia bundles are now included in the clerking-in documentation and work is ongoing to build these into the EPR |
| 6. Fluid balance recording | Matron led Clinical Records Group acting on audit data showing poor compliance with both input and output recording and working with band 6 sisters on ward based improvement work. |
| 7. Hospital acquired pneumonia (including aspiration pneumonia) | Include in the HCAI action plan |

## 2.2 Improving Reliability – Implementing Care Bundles

### Aims and Objectives of Work

Improvement theory suggests that care bundles allow clinical teams to focus their efforts on a small number of measurable strategies aimed at improving specified outcomes (BTS/NHSI; 2012). Protocol-based care also enables staff to quickly see what action should be taken, when and by whom. They allow practice to be standardised and reduce variation in the treatment of patients. They are also an important tool in improving the quality of care, as variance from the agreed care pathway can be measured easily, allowing systemic factors that inhibit provision of best care to be identified

There are five conditions identified within the Care of the Acutely Ill (CAIP) work stream where evidence-based care bundles have been developed to improve patient outcomes. These are;

- Asthma
- Acute Kidney Injury (AKI)
- Sepsis
- Chronic Obstructive Pulmonary Disease (COPD)
- Community Acquired Pneumonia (CAP)

These care bundles have been included in the medical clerking documentation and compliance is measured monthly by members of the audit team with a target compliance of 95%.

| | Indicator | Target | Apr-16 | May-16 | Jun-16 | Jul-16 | Aug-16 | Sep-16 |
|---|---|---|---|---|---|---|---|---|
| Theme 2: Reliability | Asthma - Bundle Started | 95% | 87% | 100% | 100% | 100% | 100% | |
| | Asthma - Bundle Completed | 95% | 46% | 50% | 42% | 25% | 56% | |
| | AKI - Bundle Started | 95% | 58% | 62% | 79% | 67% | 82% | 45% |
| | AKI - Bundle Completed | 95% | 39% | 38% | 48% | 19% | 44% | 33% |
| | Sepsis - Bundle Started | 95% | 88% | 91% | 86% | 77% | 70% | |
| | Sepsis - Bundle Completed | 95% | 41% | 45% | 39% | 22% | 47% | |
| | COPD - Bundle Started | 95% | 43% | 65% | 77% | 100% | 100% | |
| | COPD - Bundle Completed | 95% | 85% | 33% | 48% | 50% | 30% | |
| | Pneumonia - Bundle Started | 95% | 40% | 23% | 43% | 30% | 27% | |
| | Pneumonia - Bundle Completed | 95% | 67% | 20% | 77% | 67% | 50% | |

The completion of the bundles continues to be variable with better compliance at starting the bundles but further work is required to fully complete the bundles. Clinical leads have been identified to lead the improvement work for each of the bundles.

Each of the care bundles have now been incorporated in the medical and surgical clerking documentation to prompt the commencement of the appropriate bundle. This has probably contributed the improvement noted in some of the bundles and has allowed retrospective audit to take place. The bundles are being included in the first phase of the EPR (Electronic Patient Record).

**Future Plans**

1. Continue support with clinical lead for each of the bundles to gain a better understanding of why there is better compliance with some elements of each bundle and why we fail to comply or document other elements of the bundles.
2. Ensure progress is feedback to the Clinical Outcomes Board on a regular basis

## 2.3 Improving Management of Fracture Neck of Femur

**Introduction:**
The Best Practice Tariff (BPT) was introduced in 2010. It aims to act as a financial incentive for hospitals to optimize management of patients with neck of femur (NOF) fractures.

Where all the factors associated with best practice have been delivered a supplement of just over £1300 is added to the tariff.

**Aims and Objectives of Work:**

Seven factors were identified by NICE and require inputting into the National Hip Fracture Database (NHFD). Each of these factors relates to either patient experience or outcome.

The first of the factors relates to getting patients to theatre within 36 hours of admission, this target was set to ensure no patient ever spent more than one night in a hospital bed with a broken hip.

The directorate set the ambition to get to 85% for all components in October last year. For all aspects of the BPT standards we have achieved this ambition with the exception of time to theatre.

**Current Performance:**

In September the NHFD released its review of 2015, which offers the directorate the opportunity to benchmark itself against other organisations delivering care to patients who have sustained #NOF.

Comparing the data for April-September 2016 CHFT is above national average in all areas where one was provided.

| | 2014 | 2015 | National average | 2016 April-ytd |
|---|---|---|---|---|
| Surgery on day of or day after admission | 58.5% | 69% | 71.5% | 71.9% |
| Admitted under joint care | | 97.7% | | 99.6% |
| Admitted using agreed protocol | | 99.5% | | 99.1% |
| Orthogeriatric Assessment | 73.8% | 91.2% | 87.5% | 96.6% |
| Geriatrician led MDT | | 93% | | 97% |
| Falls assessment | 67.5% | 88.9% | 97% | 98.7% |
| Bone health assessment | 86.3% | 97.2% | 97% | 99.1% |
| AMMT pre operatively | 92.5% | 97.5% | 94.9% | 99.1% |
| All factors of BPT achievement | 27.9% | 55.9% | 66% | 67.2% |

The directorate plans to improve performance against the 36 hour target further by increasing the trauma capacity available on a routine basis.

Any improvement will further improve performance overall.

**Action Plan:**

| | | |
|---|---|---|
| Book all fallow laminar lists | May 2016 | Complete |
| Specialist trauma to go onto elective lists | May 2016 | Complete |
| Monday afternoon hand trauma list in day surgery | June 2016 | Complete |
| Second and third case slots on trauma list reserved for #NOF | May 2016 | Complete |

| | | |
|---|---|---|
| All staff to identify patients needing falls assessment, and facilitate with appropriate staff | June 2016 | Complete |
| Increase timetabled trauma theatre time and job plan surgeons to it. | November 2016 | On schedule |

In view of the improved performance a new action plan is being developed through the monthly meetings to improve performance in areas that are not part of BPT, but contribute to best practice.

| | |
|---|---|
| Proportion of general anaesthetic with nerve blocks. | CHFT needs to increase the use of nerve blocks for patients having general anaesthetic. |
| Intertrochanteric fractures treated with dynamic hip screw. | CHFT use dynamic hip screws where appropriate.<br>The NHFD has changed its reporting database to support improved data collection.<br>The new mechanism will support improved performance. |
| Return to original residence within 30 days. | CHFT is an outlier for length of stay, many of these patients need packages of care to return to original residence. |
| Add in new components of BPT and deliver above 85%. | From January performance will include 4 extra components. The Directorate is currently shadow reporting 2. |

## 2.4 Improving Diabetic Care

### Aims and Objectives of Work

People with diabetes admitted to hospital benefit most when they are cared for by appropriately trained staff, provided with access to a specialist diabetes team, and given the choice of self-monitoring and managing their own insulin (NICE quality standard).

A programme of work is underway to improve care of the diabetic patient and aligns with the self-administration of medicines CQUIN as discussed in the Medicine Management section at 1.4 above.

## 2.5 Reducing Hospital Acquired Infections

### Aims and Objectives of Work

The Trust is committed to providing a safe environment for patients including preventing healthcare associated infections (HCAI). Although significant reductions in HCAI have been made over the past few years, it is recognised that continued focus and effort is required to sustain the changes that have been successful in reducing our HCAI rate and ensure that we do not exceed the targets set for HCAI as detailed below.

In 2016/17 the Trust aims are to:

- Have 0 Trust assigned MRSA bacteraemias
- Have no more than 21 Clostridium difficile (Post 48-hour admission) infections

- Improve on the previous year's outturn of MSSA Bacteraemias, i.e. 9
- Improve on the previous year's outturn of E.Coli infections, i.e. 25
- Screen more than 95% of all elective in-patients for MRSA

**Current Performance**
Performance at the end of Q2:

| Indicator | YTD Performance | On Track? |
|---|---|---|
| Meeting the MRSA bacteraemia (Trust assigned) | 0 | On Track |
| Meeting the C-diff target (Post 48 hours) | 17 | Over Trajectory |
| MSSA Bacteraemias | 6 | Over Trajectory |
| E-coli rates | 22 | Over Trajectory |

**MRSA (Meticillin-resistant *Staphylococcus aureus*) bacteraemia:**
There have been no further cases of MRSA bacteraemia since Q2 of 2015/16. The main action identified from the last case was improvement work with ANTT (aseptic non-touch technique). The Infection Prevention and Control Team have trained an additional 80 ANTT assessors, and will implement a new e-learning package for junior medical staff from August 2016.

**MSSA (Meticillin-sensitive *Staphylococcus aureus*) bacteraemia:**
There have been 4 reported cases in Q2. These cases have not been linked. MSSA screening has commenced for patients with central venous access devices and patients undergoing vascular fistula formation. These are subject to case note review and any lessons fed into the Trust HCAI Action Plan.

**E.coli bacteraemia:**
There have been 17 post admission cases in Q2. These are subject to case note review and any lessons fed into the Trust HCAI Action Plan. In July there was a spike of 10 cases. All of these cases were distinct and are not part of an outbreak.

There is no national reduction target set for E. coli bacteraemia, however the Trust has set an internal target to not exceed the out-turn of cases (25) in 2015/16. This may be challenging to achieve as a review of all of last year's cases did not reveal many common areas for action. 4 were related to long term urinary catheters. Lessons from a former catheter project nurse are incorporated in the trust HCAI action plan to support the reduction in the use of urinary catheters.

***Clostridium difficile* (*C. difficile*):**
There have been 11 post admission C. difficile cases in Q2.
All are subject to RCA. Of the avoidable cases in the YTD, learning opportunities were identified: appropriate timeliness of stool specimens, clear documentation on normal bowel habits and when specimens have been taken and prompt isolation of patients with loose stools.

**Improvement Plans for 2016/17**

The Trust recognises the challenge to meet the target for *C.difficile* cases (external target). There is a comprehensive programme and action plan to reduce healthcare associated infections, the following actions are included within the action plan:

- The PIIP (Preventing Infection, Improving Prescribing) Group has been established, but attendance has been poor with 2 meetings being cancelled in quarter 1. This will report to the Infection Control Committee (ICC). In addition, the Divisions will be requested to provide information on their performance on reducing HCAI, particularly on the progress of their action plans with quarterly reporting to the ICC.
- The IPCT are leading an audit of Aseptic Non-touch Technique (ANTT) practice across the Trust.
- Work has been done to improve the timeliness of isolation of patients with suspected infective diarrhoea with support from the ADNs and matrons. MAU have been given 'read only' access to ICNet to give them access to the information required to make appropriate isolation decisions.
- Enhanced surveillance of surgical site infection is currently underway in orthopaedics
- Surveillance of cases of Hospital Acquired Pneumonia is currently underway to try to establish a benchmark for some improvement work
- Supporting the antimicrobial team in achieving the antimicrobial CQUIN.
- The IPCT will support the Flu Campaign in Q3.

## 2.6 Hospital at Night / Hospital Out of Hours Programme

**Background**

Patient care is generally described as delivered 'in-hours' - Monday-Friday 8am-5pm - or 'out-of-hours', evening, nights and weekends, including public holidays. This out-of-hours proportion accounts for over 70% of care time, with significantly reduced staffing across all healthcare professional groups. Increasing patient acuity and dependency means there are multiple demands on senior nurses and medical staff working out of hours.

Hospital at Night (H@N) is a set of national standards for how clinical care is delivered out-of-hours, with medical staff working together across specialty or division to share workload that is coordinated, usually by a senior nurse, to ensure prioritization and patient safety. H@N has evolved into the Hospital Out Of hours Programme (HOOP) to encompass all clinical and operational functions outside of routine working hours (8am-5pm Monday to Friday).

**Current Performance (prior to HOOP phase 1)**

At CHFT, medical and senior nursing staff are available variably across the out-of-hours period to support wards and clinical areas. There is currently no tracking system to identify tasks required or prioritisation, clinical night staff are dependent of ward staff bleeping them with individual tasks. Current staffing only accounts for clinical support/coordination overnight, leaving weekend/bank holiday days and evenings uncovered.

**Improvement plans for 2016/17 – HOOP phase 1**

As part of the Nervecentre system purchased through the Nursing Technology fund, H@N Task management has been scoped and is being implemented. This system uses the mobile/web application for Nervecentre to request tasks for clinical care outside the competencies of ward

based staff, which is then coordinated using mobile technology across all available clinical staff. The technology allows the Clinical Coordinator (band 6 nurse) to see individual workloads and allocate as patients require including to themselves. This system went live at CRH on 14th September 2016 and is now running for the full out of hours period on that site. It is planned to go live at HRI on 17th November 2016. The project team are currently collecting feedback from system users to allow further improvement of the system, although the reception has been generally positive from all areas. It is too early to understand how the system has impacted on patient care and performance against KPIs for the project. It is anticipated that this will be available for the next quarter in line with the locally agreed CQUIN.

There are however recruitment challenges for the band 6 Clinical Coordinator and the remaining post is again out to advert.

There was a working together to get results breakthrough event on the 5 August 2016 to look at a broader vision of all out of hours hospital care from which the H@N project evolved into the HOOP – Hospital Out Of hours Programme. The aim is to transform both clinical and operational responses out of hours to deliver better patient experience by reducing delays in moving patients from our EDs and responding to tasks in a more timely manner, improve patient outcomes by recognising and responding to our sickest patients, contribute to achieving our ED performance and improving the experience of our staff out of hours. The outputs from the breakthrough event are being analysed and in turn will be shared with those who attended before committing to further phases of HOOP. It is anticipated that there will need to be a senior led HOOP Management Board that will ultimately report into the Safer Programme.

## 2.7 Deteriorating Patients

**Background**
It is clear that whilst in hospital there is a risk of patients deteriorating which will undoubtedly affect their outcome. A recent (12 July 2016) patient safety alert from NHSI describes that 26% of preventable deaths arises from ‘inadequate monitoring’ for both adults and children. It advocates the use of EWS (Early Warning Scores) to identify deteriorating patients.

**Current Performance**
At CHFT EWS are in place throughout the organisation. With the introduction of Nervecentre (NC) all observations are electronic using hand-held devices in all inpatient areas. If a patient’s EWS is abnormal then the system prompts the nurse to either repeat observations sooner and/or manually escalate the patient to a doctor. For adult patients who score a NEWS of 7 or more are automatically escalated to outreach during the hours of 8am and 8pm every day. Hospital at night will respond to these escalations as described above.

The DPG (Deteriorating Patient Group) has been re-established after a brief hiatus. Since the last report to this forum there has been the following progress:

- NC (Nervecentre) is now in place across all inpatient areas (except maternity and both EDs) across the Trust.
- All inpatient observations are entered into NC and visible on both hand held devices and trust desktop computers. This means that doctors and nurses are able to see their patients’ observations ‘at a glance’ and remotely if there are signs of deterioration.
- Automatic alerting is in place for patients who score a NEWS of 7 or more to Outreach during the hours of 8am to 8pm 7-days a week. This means that these patients can be reviewed during these hours by the Outreach team in a more timely fashion but also allow for ongoing monitoring irrespective of the patient’s location in the hospital.

- Manual alerting is also possible through NC for those patients who have a score of less than 7 or those who are not responding to treatment to the appropriate medical team in normal working hours.
- NC is also supporting phase 1 of HOOP (Hospital Out Of hours Programme) using the out of hours task management system. This went live on 14 September 2016 at CRH with a planned go-live at HRI in November.
- As part of HOOP the clinical coordinators have the same visibility to respond to patients with a NEWS of 7 or more in the same way that outreach does in hours. These patients can be alerted to the most appropriate 'clinician' in the hospital out of hours and at weekends. If the clinician is unable to attend then the clinical coordinator can respond themselves.
- Handover and 'hand-off' (in the morning) has also been revised. The handover is 'chaired' by a clinical coordinator who will have more visibility of the sickest patients in the hospital as flagged by Outreach. This information is shared with the medical team at handover. Likewise in the morning 'hand-off' is more structured to ensure that those patients who have deteriorated overnight as flagged to Outreach coming on at 8am.
- The DPG is now focussing on an improvement plan ahead of the NPSA alert from July 2016. The alert requests that organisations review resources supplied and formulate an action plan to address areas for improvement by January 2017. At present it is not known how this improvement will be monitored and/or shared with NHSI.

Patient Safety Alert Stage 2 - Deterioration resources July 2016.pdf

**Improvement plans for 2016/17**
At present the following themes and actions have been identified:

- Escalation to medical staff is reliant on doctors logging into and acting upon alerts through their mobile devices. Uptake of this is variable but work is ongoing (through HOOP) to encourage junior doctors especially to access the system. At present devices are kept on inpatient wards and therefore junior doctors (and nurses) are expected to access these devices when on shift. There are currently not enough devices to allocate individual ones to each junior doctor but this is something that we are looking at to encourage uptake and usage. As part of HOOP junior doctors are given a device to log onto the system to ensure that they not only receive tasks whilst on shift but also be able to see patients' observations in case of deterioration.

- Data from NC has shown some early themes. One of these is the timeliness of observations and updating admission, discharges and transfer (ADT) within one hour of occurrence. Without timely ADTs observations cannot be entered onto NC. The ADNs are currently developing an action plan to address timely observations and will be shared at the October DPG meeting.

- There is an early suggestion from the Trust's mortality reviews that automatic alerting through NC is allowing for more timely assessment and intervention for patients with a NEWS score of 7 or more.

- However, data from patients who suffer a cardiac arrest suggests that a NEWS score of 7 or more will not identify all of these patients who may show signs of deterioration before they arrest. Analysis has shown that a NEWS score of 5 or more is a more suitable cut-off to identify the majority of patients who the arrest. There will undoubtedly be more patients who fall into this category and further work is needed to fully understand the impact of this.

- Another theme is looking at admissions to ICU. This is variable at present and no meaningful improvement has been seen as yet.

- A lead clinician is coordinating a quality improvement project involving junior doctors to audit a sample of patients who score a NEWS of 5 or more. This sample will include patients who arrest and potentially those who are admitted to ICU. It is anticipated that this audit will give a better understanding on specific areas for improvement in the recognition and management of the deteriorating patient. The audit is currently being planned and results should be known by the end of November. However, there is already a suggestion from mortality reviews that timeliness of medical review is a key factor in those patients who have died. I expect that the audit is likely to show the same and will most likely be a theme within the action plan to be addressed.

- A review of clinical incidents to identify themes that may also contribute to the deteriorating patient is taking place. At present the data with clinical incidents lacks sufficient depth however a sample will be reviewed in more detail. For example, incidents coded as 'delay' may mean delay in observations, medical review or treatment such as antibiotics. The findings will be presented at the November DPG.

- Sepsis is a well-known cause of deterioration. Whilst sepsis is not a focus for DPG there is a more robust link between the two leads to ensure that the two pieces of work are aligned.

- Finally, deterioration in children is also a new theme for DPG. A doctor and sister are looking at deterioration specifically to agree key actions for improvement in children.

## 2.8 End of Life Care inc DNACPR (Do Not Attempt Cardio Pulmonary Resuscitation)

The quality of end of life care delivered within CHFT remains an important priority. The recent CQC visit identified the fact that while there are elements of excellent practice, there is a need to fully embed its position within the organisation. A number of projects are now underway to address:

1. **CHFT End of Life Care Strategy**- The strategy has been sent out for internal verification, with a response deadline of early October and presentation to the Quality Committee for verification. The 3 key recommendations from the strategy are;

   Priority 1 – Identification of people in the last 12 months of life and high communication with them
   Priority 2 – Coordinated, timely and equitable access to good care
   Priority 3 – Good care in the last days and hours of life.

   It is crucial for all 3 priorities to be underpinned by education and training to ensure successful implementation

2 **End of life care (EOLC) implementation plan –** The implementation plan will be written and developed by the new EOLC steering group. This group will create a work plan to improve end of life care, with primary goals, secondary drivers and measureable outcomes. It is imperative

that there are better mechanisms in place to report progress, failings and potential developments.

**CQC action plan –** A meeting in early October will review the CQC action plan**.**

**3 National Audits – National Care of the Dying Patient audit -** since the previous audit, there has been a deterioration in some of the parameters, in particular, a reduction in time between recognising dying and patients' actual deaths. Significantly fewer patients were supported by an end of life care plan than the national average, and there remains poor documentary evidence of the holistic care given to patients and their families. We are below National average in all 5 of the clinical audit indicators. In the organisational indicators, there is no lay member on the Trust board with a responsibility for end of life care, and allied health professionals have not received formal training; neither are there formal end of life care facilitators.

**4 Local Audits – Bereaved Relatives Questionnaire -**feedback from bereaved relatives showed generally there were high levels of trust in clinical teams, and that staff did their best to address difficult symptoms. However, there is not universally good communication or care delivery for dying patients and their families. While many received good care, for others, there was little or poor information, and a perceived lack of compassion from staff. Many relatives felt that they were informed that their loved one was dying too late in the process, with opportunites for care missed.

**Use of ICODD (individualised care of the dying document) in anticipated deaths -**There is currently no way to identify anticipated deaths which would benefit from support by the ICODD, but an audit of all deaths in HRI during a 2 week period suggest that all but very small numbers can be anticipated, with a majority occuring in elderly patients and/or those with advanced long term conditions. The findings from this audit showed delays in agreeing goals of care in patients who were obviously acutely unwell and also the use of vague language, for example the 'patient is very poorly' instead of using the word 'dying'. Data from CRH has not yet been analysed.

**5 External partnership working**

5.2 **Hospice**- We have been working with Kirkwood Hospice to deliver 10 communication skills training days for all CHFT staff . We are also working with both hospices to look at the provision of end of life care education to enable a more unified approach. The end of life care training lead is also supporting staff at Overgate Hospice and CHFT to complete their end of life care competencies.

5.3 **End of Life Care Engagement event – November /December 2016 -**We are in the process of organising an engagement event for all that are involved in end of life care. This will be a health economy wide afternoon with speakers from the Trust and also speakers from other areas that have shown innovative ways of providing excellent end

of life care. We will invite , acute staff, community teams, GPs, hospices, care homes, home care. We will look at the barriers to providing excellent care and the vision for the future. The event is looking at embedding EOLC in all sectors so it is key that colleagues from all areas come, such as those from, Care of the Elderly , Respiratory and Cardiology, Gastroenterolgy and Renal medicine, Acute Medicine, fraility, Learning Diffficulties, Mental Health and Dementia etc.

5.4 **Patient , Carer and public involvement** – The draft EOLC strategy has been shared with membership councillors and Trust members to ensure we receive feedback from patients and carers to inform the strategy. We will hopefully also ask for public involvement with the engagement event.

5.5 **Celebrating Success**. The Community Specialist Palliative Care Team and Palliative Care out of hours team have reached the finals of Celebrating success in the working together get results category.

**6 End of Life Care Dashboard**.
For August 2016 – 42.5 % of patients that died were supported by the ICODD. In September the figure was 47.62 %. We have currently just finished an audit on all deaths across the Trust, looking at how many deaths should have been supported by the ICODD . The aim is to have 100% of anticipated deaths supported by the the ICODD.

**7 Training and Education** – A Trust wide training needs analysis developed by Overgate and CHFT has been sent out to all clinical staff to enable development of our End of life Care Training Strategy. The Trust is also working in partnership within Overgate, Greater Huddersfield CCG and Kirkwood Hospice to look at the training needs of our communities. The training needs analysis has been shared across both hospices.

## 2.9 Safeguarding Patients/ Mental Capacity Act and Deprivation of Liberty Safeguards

### Aims and Objectives of Work

CHFT is committed to ensuring that all staff follow the principles and practice of the Mental Capacity Act (MCA, 2005), and Deprivation of Liberty Safeguards (DoLS, 2009).The legal framework provided by the MCA 2005 is supported by the MCA Code of Practice, which provides guidance and information about how the Act works in practice. The Code has statutory force which means staff who work with and/or care for adults who may lack capacity to make particular decisions have a legal duty to have regard to relevant guidance in the Code.

The DoLS provides legal protection for those vulnerable people who are, or may become, deprived of their liberty within the meaning of Article 5 or the European Convention on Human Rights (ECHR) in a hospital or care home. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where Deprivation of Liberty appears to be unavoidable, in a person's own best interests.

The specific aims for the work are to:

(i) To ensure all patients who are deprived of their liberty have in place a legal Safeguard that authorises CHFT to detain the patient, whether it be under the DoLS, the Mental Health Act 1983 (amended 2007), or the Mental Capacity Act 2005.
(ii) Provide assurance that CHFT are compliant with all aspects of the MCA 2005 and DoLS 2009.

**Historical Data and Analysis**
Historically there have been in totality:

**In 2014**
Number of DoLS Applications 11/ Number of DoLS authorisations 5
(Reasons for non-authorisations 2 discharged, 1 regained capacity, 2 under MHA, 1 best interest decision)
**In 2015**
Number of DoLS Applications 194 / Number of DoLS authorisations 33, and 11 refused (Reasons for non-authorisations 94 discharged, 15 regained capacity, 10 under MHA, 15 died and 2 best interests.

**In 2016 (Q1 and Q2)**
Number of DoLS Applications 174 / Number of DoLS authorisations 25, and 4 refused- 27 pending (Reasons for non-authorisations 80 discharged, 18 regained capacity, 2 under MHA, 17 died, hospital transfer 3 (27 pending) and 2 best interests.

Data is now captured quarterly and reports are shared at the Safeguarding Committee meeting.

The MCA came into effect in 2007 followed by the DOLS on the 1st April 2009. The DoLS apply to vulnerable people aged 18 or over who have a mental health disorder including dementia, who are in hospital or a care home and who do not have the mental capacity to make decisions about their care or treatment. Those providing the care should consider all options, which may involve restricting the person's freedom, and should provide care in the least restrictive way possible. However, if all alternatives have been explored and the hospital believes it is necessary to deprive a person of their liberty in order to care for them safely, they must get permission to do this by following processes known as the Deprivation of Liberty Safeguards; and they have been designed to ensure that a person's loss of their liberty is lawful and that they are protected. A ruling from the UK Supreme Court in March 2014 has given a new ‘acid test’ for deprivation of liberty:

- being under continuous supervision and control; and
- not being free to leave; and
- lacking the mental capacity to consent to these arrangements.

The legislation includes a statutory requirement to keep clear and comprehensive records for every person deprived of their liberty. This includes records of applications for authorisations, details of the assessment process, information about the relevant person's representative and the documentation related to termination of authorisation.

There have been two MCA/DoLS audits last year (2015-2016) and improvement plans were developed to address issues identified and we continue to raise awareness in this area. Increased staff awareness has resulted in increased authorisations. Further audit is planned in November 2016.

**(i) Q2 Progress.**

From July to September 2016 there have been 81 urgent authorisations in total made to both Kirklees and Calderdale Metropolitan Councils regarding patients who are deprived of their liberty whilst being cared for as inpatients. CHFT can grant itself an urgent authorisation for up to a period of 14 days whilst the Local Authority determines whether or not to authorise the deprivation of liberty.

From these urgent authorisations made 8 progressed and the standard authorisation was authorised under the DoLS. Whilst this may appear to be small numbers, 49 of the authorisations were cancelled by the Trust; because the patient was discharged or they had died, it was more appropriate for the Mental Health Act to be used as the legal authorisation, or they regained capacity and therefore it was not lawful to continue with the deprivation of liberty. There are also 18 authorisations pending the Local Authority outcomes. So for the time the authorisation was in place it was appropriate under the legislation.

A small number of the urgent authorisations have lapsed. This occurs when the Local Authority do not complete all their assessments within 14 days of the urgent authorisation being applied. Unfortunately CHFT do not have any influence over the assessment timescales and Local Authority processes for managing this. In these cases the Safeguarding Team continues to monitor the patient to ensure that the deprivation is still valid, the patient still lacks capacity, all restrictions in place remain least restrictive whilst ensuring the patient remains safe on the wards, and that there are no objections to the DoL. In quarters 1 this totaled 9; 8 were Calderdale patients and 1 was Kirklees and quarter 2 this totaled 24; all patients were from Calderdale.

All DoLs applications are recorded and kept centrally within the Safeguarding Team records. A comprehensive database captures all contacts and records the outcomes of applications made. The CQC is notified of all DoLS authorisations and outcomes. This is in line with the requirements of the legislation. All patients who are subject to an urgent or standard authorisation are monitored by the team.

**ii) Assurance and Audit**

Since CHFT was inspected in March 2016 there is still some uncertainty with staff regarding the Interaction between DoLS and MCA legislation leading to delays in obtaining a timely Deprivation of Liberty and notification to the Safeguarding Team for advice and support.

Twice yearly audits to identify any gaps and good practice in relation to MCA DoLS are planned for November and March this financial year. In 2015 two audits were undertaken within CHFT which comparatively identified areas where patients were more likely to be who met the ‘acid test’ criteria for a DoL, and showed an increase in knowledge and awareness at the second audit by a significant increase in the number of authorisations applied for.

**iii) Training**

A significant piece of work has taken place to review all staff groups within CHFT and the level of safeguarding training that they are required to complete in line with the intercollegiate document for Safeguarding Children and the draft intercollegiate document for Safeguarding Adults. These new figures and compliance reflect the increased numbers of staff that are required to complete a higher level of training. MCA and DoLs is delivered as part of levels 2 and 3 Safeguarding Adults training.

**Healthcare and apprentice induction** – a package has been developed and is delivered at each induction training day which includes MCA/DoLs and capacity awareness. There is an expectation that staff undertake further training to enhance their knowledge.

**Level 1** training figures have remained fairly static at 79% compliance; a reduction of 2%. This is delivered by an eLearning package.

**Level 2** has increased from 64% to 65% (adults) and from 65 % to 67% (children). This is now delivered by a new eLearning package launched in February 2016.

**Level 3 Adults** – is a new data capture since the allocation of Level 3 to particular staff groups, and continues to increase from 22% to 25.5%. Additional training sessions have been planned. This training is delivered face to face

**Level 3 Children** has slightly decreased by 2% to 51%. This training is delivered face to face.

**Prevent** has remained static at 68%

**Further work to increase safeguarding training compliance includes;**

- Reviewing the delivery of Prevent training in line with the Prevent Competencies Framework and utilising eLearning. Currently all Prevent training is face to face.
- Work to capture compliance with medical staff in divisions
- Capturing and recording mandatory Children's Safeguarding Supervision and embedding into frontline practice
- Develop MCA DoLS as part of essential skills training; MCA DoLS training is ongoing within level 2 and level 3 safeguarding adults. Separate MCA/DoLS training can be facilitated and delivered to staff in more detail who require enhanced skills in MCA and DoLS.

**Improvement Plans for 2016/17**

- The Safeguarding Policies and Procedures for Children and Adults are currently being reviewed and updated in line with The Care Act 2014, Working Together 2015, and the Intercollegiate Document for Children 2014. The new Mental Capacity and Deprivation of Liberty Policy will be introduced with updated referral processes and pathways.
- The Safeguarding Team are now co-located within the same offices as Calderdale Local Authority Adult Health and Social Care Team. This is in line with the true spirit of the Care Act 2014. Joint working on some cases and the development of shared understanding of roles is ongoing.
- Priorities for 2016 will include compliance with The Mental Health Act (1983). This includes: securing honorary contracts to enable Mental Health Liaison Psychiatrists to act as Responsible Clinicians for CHFT detained patients, writing a Mental Health Act policy for CHFT to include roles and responsibilities processes and training strategies, finalising a service level agreement for the Mental Health Liaison Team service and servicing of Mental Health Act papers by SWYPT, training for Duty Matrons and Site Commanders on the receipt and scrutiny of mental health act papers, and understanding the role of security and use of restrictive interventions to enable appropriate detention of patients under the Act.
- A task and finish group has commenced and is reviewing the systems, processes and polices that relate to Domestic Violence and Abuse for both Kirklees and Calderdale.

## 2.10 Conditions of Interest – Stroke

### Aims and Objectives of Work

Strokes affects between 174 and 216 people per 100,000 population in the UK each year (Mant et al 2004), and accounts for 11% of all deaths in England and Wales. It is accepted that 85% of strokes are due to cerebral infarction, 10% due to primary haemorrhage and 5% due to subarachnoid haemorrhage. The risk of recurrent stroke is 26% within 5 years of a first stroke and 39% by 10 years (Mohan et al 2011). By focusing in improvement in stroke care, patient outcomes can be vastly improved,

The Trust has the following aims to strengthen and improve stroke services

- Reduce stroke mortality to a SHMI of less than 100,
- Improve functional outcomes for patients
- Reduce the length of stay by 20%
- Improve overall SSNAP score to "A"

To do this we will:

- Ensure all stroke patients are admitted directly to a stroke bed
- Ensure all patients received 45 minutes of therapy 5 times a week
- Ensure all appropriate patients receive thrombolysis within 60 minutes of arriving at hospital

### Current Performance

From the SSNAP (Sentinel Stroke National Audit Programme) data below is the number of patients treated in CHFT

| | 2013/14 | 2014/15 | 2015/16 |
|---|---|---|---|
| **Admissions included/locked to 72 hours** | 477 | 497 | 558 |
| **Discharges included/locked to discharge** | 405 | 477 | 567 |

The end of Q2 has seen significant improvement in key areas:

- SSNAPP data showed that the service had moved from a D to a B rating, next rating is out in November.
- Improvements noted in all indicators although ongoing work to achieve full compliance still continues.
- 90% stay on stroke ward now at 91.4%, this is further improvement
- 74.3% Stroke patients admitted directly to an acute stroke unit within 4 hours of hospital arrival. An improvement in month.

| | Jan 16 | Feb 16 | Mar 16 | Apr 16 | May 16 | Jun 16 | Jul | Aug | Sept |
|---|---|---|---|---|---|---|---|---|---|
| **Median Clock start* to scan** | 109 | 93 | 109 | 99 | 134 | 77 | | | |
| **Median Arrival** to scan (mins)** | 101 | 90 | 93 | 99 | 135 | 77 | | | |
| | | | | | | | | | |
| **Scanned within 1 hr** | 20/57 | 19/50 | 14/43 | 17/52 | 16/51 | 14/35 | | | |
| **%** | **35.1%** | **38.0%** | **32.6%** | **32.7%** | **31.4%** | **40.0%** | | | |
| **Scanned within 12 hr** | 52/57 | 46/50 | 38/43 | 51/52 | 44/51 | 33/35 | | | |
| **%** | **91.2%** | **92.0%** | **88.4%** | **98.1%** | **86.3%** | **94.3%** | | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Median Arrival to Thrombolysis (Door to Needle)** | 42 | 48 | 36 | 68 | 76 | 39 | | | |

**Progress during 2016/17 and future plans:**

The directorate has been conducting weekly meetings since July 2016 with an action plan to review many aspects of care from medication, leadership to improve documentation the clinical notes to facilitate accurate coding.

The following areas have seen improvement:

**Thrombolysis**

The team have completed "go see" to other areas, Scunthorpe, and planning to go to Aintree hospital that were performing on the national SSNAP data above CHFT. From this we have been able to review our practices e.g. the initial assessment of patients when arriving at hospital with a suspected stroke; it is widely known that the quicker the treatment for the patient the better the outcome long term. Now there is a bleep system that, from YAS picking up a suspected stroke patient, will alert all relevant staff i.e. thrombolysis nurse, Consultant, Radiology, porters and Accident and Emergency who will then greet the patient on arrival and escort them straight to the CT scanning unit. A walkthrough of this has been practiced and commenced on 1st August.

**Therapy triage/improved working times**

A huge improvement was made by the therapists, by changing their practice and completing a triage of the patients on admission this improves quality and effective rehabilitation form admission and improved communication with doctors and nursing staff around the plan of care that is needed. Also a larger percentage of patients received increased therapy 5 times a week for 45 minutes, this aids outcomes for patients. This increased the score from a B to an A on the SNNAP data.

**Real time data collection**

Documentation improved through a new integrated care pathway and different ways of working by real time data capture with the SADO being more visible on the ward areas.

**Coding and auditing, to include co morbidities**

A review of coding took place; a system was put in place so that the documents were returned timely so that data was inputted quickly on to the systems ensuring improved accuracy. The senior audit data officer, SADO, and assistant lead in coding created a process where patients that may have been coded as stroke but never reached a stroke ward their notes were reviewed, which aided learning for the future through the Trust and feed back to the stroke department about how we may be able to improve care for patients .

**Leadership**

There is daily presence of the matron on the wards, the number of senior staff band 6's have been increased for support and guidance. The General Manager has a regular presence on the wards and meeting with the teams to implement the changes and action plan facilitated.

**Working with the Palliative care team**

After discussion with the palliative care Consultants and nurses, the team has commenced weekly input from the palliative care Consultants who have been attending the ward to do board rounds to help staff in identifying patients that need end of life care and specialist palliative care input. Also staff are attending the course "one chance to get it right" which gives a fantastic insight into how to improve care for patients/ relatives and carers.

**CT Trial**

Working on a pilot with Radiology to improve the percentage of patients that received a scan within one hour, which again is a quality initiative to improve the patients outcome, has shown marked improvements on our SSNAP data achieving 66.7%., improving on SSNAP from a C to a B.

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

**Patient experience compliance summary**

| Indicator | Compliance |
|---|---|
| 3.1 Dementia | Reporting only |
| 3.2 Improving the Inpatient Experience | Reporting only |
| 3.3 Improving the Community Experience (CQUIN) | Achieved |
| 3.4 Improving Hospital Nutrition | Reporting only |
| 3.5 Improving End of Life Care | Reporting only |

**Highlights**

- Dementia – consistently achieving 90% or above in each element of the dementia assessment documentation
- Improving the inpatient experience – work on the children's voice project, communication on a surgical ward and maternity patient experience continues
- Community experience – community patient experience survey for out patient physiotherapy undertaken in Q2 for analysis in Q3

### 3.1 Dementia

**Aims and Objectives of Work:**

Improving services for patients with dementia has the potential to enhance the quality, of their care experience. In addition there are cost benefits by reducing length of stay and associated unnecessary costs. Dementia is not generally the prime reason for admission to hospital and therefore other clinical priorities can be of primary concern. However, early identification of the condition, maintaining a person-centred approach to care, and creating a dementia friendly environment reduces risk, such as delirium, falls and infection for example, and enhances care experience and outcomes.

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:**

**Improved Diagnosis:**

The dementia assessment is completed by the doctors on the ward for patients age 65 and over. This is a 3 part process which each part must achieve 90%.

- Part 1: How many patients have been asked the following question “Has the person been more forgetful in the past 12 months, to the extent that it has significantly affected their daily life?” If the answer is yes, part 2 must then be completed.

- Part 2: For patients that were yes in part 1, an abbreviated memory 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.

Prior to the assessment for dementia, a screen to identify the likelihood of delirium Is completed. If delirium is suspected a full assessment takes place.

**Partnership Working:**

A mental health liaison team employed by the mental health trust support assessment of people with dementia, and provide expert advice for patients and their families, and for staff. The principle aim of the service is to prevent unnecessary admission to hospital, often activating appropriate community services for support and care closer to, or at, home. The team also support timely discharge of people with dementia, activating appropriate community care as above.

5 actions to meet national requirements

- Assessment and diagnosis
- Training plan
- Carer support – designated projects to support carers and people with dementia
- Dementia friendly environments
- Person centred care – Butterfly scheme and POD (prevention of delirium) programme

Dementia friendly ward and department refurbishments and upgraded

**Training**

A training strategy addresses 3 levels of training. These are dementia awareness, dementia competent and dementia expert.

Dementia awareness is delivered to all staff via e-learning and is mandatory.

Dementia competent is currently delivered through education, ward/department based support, and care pathways:-

- Vulnerable adult leaders training
- Vulnerable adult champion training
- Person centred dementia training
- Butterfly scheme in place on all relevant adult wards, supported with training
- Memory care assessment tool to facilitate person centred care
- Prevention of delirium pathway (POD) included in clinical documentation
- Recruitment of volunteers – rolling programme whereby A level students receive training and induction each year to support people with dementia and delirium on the POD pathway (student enrichment scheme)
- Engagement and Care Support workers in post on wards 19 and 20.
- MYLIFE software to promote social engagement. 6 units now in use, 3 on each hospital site

A Dementia Operational Group oversees the dementia action plan and currently reports to the Patient Experience Group. A Dementia Strategic Group is to be introduced to oversee implementation and monitoring of the Dementia Strategy.

**Improvement Plans for Q3 onwards**

1. The Prevention of Delirium Project was introduced in August 2016. A clinical lead and project co-ordinator will:-

- Recruit, induct and train A level enrichment students

- Support and co-ordinate social engagement and care support workers and intergenerational student enrichment scheme. The aim of this project is to enhance care, improving experience and outcomes for patients and carers, improve staff experience, reduce incidents and need for 1:1 supervision.

- Promote the use of MyLife software which facilitates social engagement, reminiscence and life story work

- Embed the Butterfly Scheme as routine component of care ensuring that people receive care relevant to their needs and choices (‘See Who I Am)

- Promote John’s Campaign – welcoming carers to stay with patients whilst they are in hospital

2. Delivery of person centred care training

Principles into Practice ward based support from the vulnerable adult strategic leads is providing direct education and support regarding the care of people with dementia and/or delirium on adult wards

## 3.2 Improving the Inpatient Experience

### 1. Aims and Objectives of Work

Measuring patient experience is essential in order to assess the delivery of the Trust's vision**:** ***Together we will deliver outstanding compassionate care to the communities we serve*** along with the strategic goal of: ***Transforming and improving patient care.***

Analysis of patient feedback helps us to better understand our patients' expectations, their experience and their satisfaction. For example their views of the environment in which their care and treatment was delivered, whether they were kept informed, whether they treated with respect and dignity and how their interactions with staff made them feel.

It is important when we measure patient experience, that patients are also given the opportunity to tell us how we can make it better. This may often be about the small things as well as any large system changes.

The primary method of measuring the patient experience in the trust is through the Friends and Family test (FFT) which is now well established across all inpatient and day case, as well as in the A&E and outpatient departments areas, maternity services and across community services.

### 2. Local Quality Improvement Projects

This year four quality improvement projects have been identified, which will use FFT and other feedback data to direct the aspects of improvement. For each of these improvement priorities, there will be an objective to build into the project plan an element of service user involvement.

Description and current stage for each project:

### 2.1 Children's voice

Staff working with children and young people are looking for innovative ways to increase the opportunities of involving children and young people in their healthcare and also in how services are designed and delivered.

Methods have been used previously, e.g. young people included on recruitment panels, the 15 step challenge; however these tended to be one off initiatives. The aim of this approach will be to establish more robust principles for engaging with children and young people and putting their experiences central to our learning and improvements. These are being built around the Trust 4 pillars of behaviour; a framework for this will be developed during quarter 3.Examples from this quarter include:

**Go see -** A ward sister and a member of the play team have visited Pinderfields Hospital and the Forget me Not Childrens Hospice to look at how they have created spaces and resources for the different age ranges that their service covers. Of particular interest were the dedicated waiting areas (one for teenagers and one for younger children). This has helped prompt ideas for rooms on the Childrens Ward and also for the Rainbow Child Development Service to help with the planning for some young people accessing that service.

**Work together to get results -** Opportunities have also been taken on the Childrens ward to ask young people using the service to give their ideas for how a new teenagers 'chill out zone' should look. Young people were invited in to share their thoughts and ideas which have been captured on a graffiti board. The staff are asking teenagers who are admitted to the ward what

they would like to see and young people are helping with choices from paint colours to ideas for recreational activities.

Support has also been secured from Tesco's who will work with our children's services as part of their community programme. Further scoping includes working with local colleges to support the art work and purchase of equipment for the Chill Out Zone.

**Put the patient first**

Staff are putting the child's voice at the heart of learning - opportunities are being taken to learn from significant events, using these as a chance to work with colleagues and identify areas for improvements. Three recent examples:

- Learning from the impact of a delayed discharge for a young person with complex health needs who was moving to adult services
- Young person's suicide attempt on the ward – considering if this could have been managed differently to make the event less traumatic for the young person, the family and staff on the ward
- Care at the end of life – CHFT staff are working with Forget me not Trust Childrens Hospice to review current end of life care pathways for children and their families.

**Do the must dos**

The team take every opportunity to listen to feedback from children, their family and from organisations who review our services, and where indicated make changes. Recent feedback includes the Care Quality Commission inspection report and the Friends and Family Test (FFT) comments. In order to prevent issues arising an intervention has been introduced - the Matron / Senior Nurse have scheduled time each day to carry out a walkround of the clinical areas this provides an opportunity to guide and support staff with any concerns on the ward and talk to families to ensure they feel listened to and they are happy with the plan of care. Using the FFT feedback each area within Childrens services have developed their own action plan which is shared with the wider team at the Paediatric Forum on a monthly basis.

## 2.2 Effective communication on a busy surgical ward.

Surveys of patients' views have revealed that they are not always aware of their plan of care, with communication not always being as good as it could be. This project will further explore how communication takes place between the multidisciplinary team and how key information such as a patient's clinical condition, the treatment plan, and expected outcomes is shared with patients / relatives.

This work has commenced on one of the general surgical ward which receives post-surgery patients, where there can be as many as 11 ward rounds taking place each day. It is not possible for the nursing staff to chaperone each of these rounds and this can have a detrimental impact on communication with nursing staff relying on the medical records to get updates regarding plans of care.

Project planning has commenced following discussion with staff from the Yorkshire & Humber Improvement Academy, along with the ward manager and the matron. Phase 1 of the project will focus on gaining a better understanding of the ward processes and staff views about barriers that prevent effective communication regarding the patient's plan of care. This will involve the completion of a staff culture survey, holding a multi-disciplinary focus group and completion of patient surveys which will be carried out through face to face interview by a hospital volunteer

## 2.3 Maternity Patient Experience

Following the CQC inspection in March 16, a new Maternity Patient Experience Group was established to oversee the implementation of a 'Maternity services improvement plan' – the group is formed and terms of reference have been agreed and approved by the Maternity Forum.

The Maternity Patient Experience Group have identified three initial themes from feedback that will be the focus of their improvement work

1. Staff attitudes and behaviours
2. Professional Appearance
3. Environment

Each ward and department have also developed their own plan of issues specific to their areas.

An early intervention was attendance at an externally facilitated workshop - Putting the Patient First: Customer Care and Communication Skills in the NHS. This workshop is designed to look at an individual's attitudes and behaviours and how they impact on the provision of service to both service users and colleagues.

This was delivered by the NHS National Performance and Advisory Group, with four half day sessions run during August and September that included a focus on:

- Understanding the impact of your own behaviour on others
- How to handle challenging situations and people
- Effective communication techniques
- Understanding and managing patient expectations
- Identifying how and why perceptions are formed
- Proactive versus reactive behaviour
- Demonstrating a positive attitude
- Taking ownership

During quarter 3, the local Healthwatch will be working with the maternity team, carrying out some face to face interviews in order to better understand current views and experiences of women using the service.

## 2.4 Community CQUIN - Introducing new measures of feedback.

See section 3.3 below, Improving the community experience.

**Other patient experience feedback**

**CQC:** The Trust CQC report was published in August 2016, with predominantly positive feedback and many examples of good practice referenced in the body of the report, reflecting the compassionate care and emotional support provided by CHFT staff. The reports also described examples of how staff understand and involve patients and those close to them, how the trust meets the individual needs of patient, examples of engagement with the public, which includes how we obtain feedback, and how complaints and concerns have been used as learning opportunities.

Outputs from the Patient Experience and Caring Group were referenced throughout the CQC reports:

- The Trust had an established trust wide group working on improving in-patient experience; work had concentrated on the comments received through the friends and family test feedback
- Outpatients had carried out a patient experience workshop in 2015 and had produced an action plan from the patient feedback.
- The Trust commenced real time patient monitoring (RTPM) in the form of a questionnaire to monitor patient experience of care within the service. The questionnaire was based upon five key areas, 'Hello, my name is', compassionate care, regular information round, 'how can I help?' and reducing noise at night.
- The patient experience group (PEG) carried out a survey of bereaved relatives in October 2015. Feedback showed that relatives had confidence and trust in doctors and nurses caring for their loved ones at end of life.
- We saw information boards displayed around the departments. These provided specific information to patients and staff, including patient experience feedback.

The report also makes references to the impact of the Hello my name is… initiative which is a campaign promoted by the Patient Experience and Caring Group:

- Staff took time to introduce themselves to patients and give explanations for the treatment and care provided.
- We heard staff introduce themselves by name to patients. Staff all wore name badges and those working on reception desks had their names on display. This helped put people at ease.
- Patients we spoke with knew the name of their nurse and other members of the healthcare team.
- Patients told us that staff always introduced themselves and we saw this is in our observations.

**Workplan for 2017:**

The next Trust Patient Experience & Caring Group meeting in October 2016 will focus on pulling together themes from patient feedback including National surveys, FFT comments, Complaints and PALs as an opportunity to identify cross cutting improvement themes for the Trust. The output will be reported in the quarter 3 quality report.

## 3.3 Improving the Community Experience

Patients have a right to participate in giving feedback to the NHS (The Friends and Family Test, NHS England 2014), on their health and care experiences which should then be used to improve services (The NHS Constitution for England, DOH 2015).

The Community Division currently only uses one formal mechanism for patient Feedback – the Friends and Family Test. This has been in use in the Division since January 2015 and the Division uses a number of different methods for collecting this data. A number of informal methods are also used in individual teams, but the information is not easy to triangulate with the Trusts quality improvement processes. The Division has therefore developed a specific feedback questionnaire in one clinical team, which will enable assurance and measurement of patient experience and will be formally reported through the Divisional Patient Safety and Quality Board (PSQB). This was agreed as part of the Trust local CQUIN sceheme.

Friends and Family Test (FFT) – Current Performance Community Division

| | May 2016 | June 2016 | July 2016 | August 2016 |
|---|---|---|---|---|
| Response rate % | 12.5 | 12.6 | 14.0 | 13.1 |
| % would recommend | 87.1 | 85.4 | 87.8 | 88.5 |
| % wouldn't recommend | 2.5 | 3.8 | 3.0 | 2.5 |

The CQUIN has specific targets for each quarter

| **Milestones** (only complete if the indicator has in-year milestones) | | | |
|---|---|---|---|
| **Date/period milestone relates to** | **Rules for achievement of milestones (including evidence to be supplied to commissioner)** | **Date milestone to be reported** | **Milestone weighting (% of CQUIN scheme available)** |
| Quarter 1 | Develop collection tool and scope requirements | | |
| Quarter 2 | Start to gather feedback from identified client group.<br>Report on Q1&2 including numbers of data gathered | 31/10/2016 | 50.00% |
| Quarter 3 | Gather feedback from different identified client group | | |
| Quarter 4 | Gather feedback from different identified client group.<br>Final report to include learning from feedback through Q1-4. | 30/04/2017 | 50.00% |
| | | Total | 100.00% |

Q1 - Develop collection tool and scope requirements

Out-patient Physiotherapy has been identified as the initial team for data collection. The team currently operates from a number of sites, both hospital and community sites across Calderdale and Huddersfield. In 2015/16 the service received 27746 new patient referrals with patient facing contacts of 19261 new appointments and 51030 follow-ups.

The service has continually rated as red on the FFT as they consistently have a % wouldn't recommend rate of greater than 2.5%.

During quarter 1 a web based survey was designed and tested for use with the outpatient physiotherapy service. The service has developed a patient questionnaire based on the NHS National Outpatient Questionnaire, although the question numbers were reduced to try and facilitate a high survey return rate.

Q2 - Start to gather feedback from identified client group. Report on Q1&2 including numbers of data gathered

The questionnaire consists of 12 multiple choice answers and then a space for patients to add comments as required. The out-patient Physiotherapy questionnaire was developed as a web form and could therefore be completed electronically. The link to the survey is

http://surveys.this.nhs.uk/WebForm.aspx?ID=FF5ED8FBD6B94522881501E5B3F49998

The team also produced paper copies of the questionnaire for patients that preferred to complete it this way. Data collection started on 1st September 2016, and by the 30th September 2016 there had been 657 responses.

Plans for Q3 and Q4

- Analysis of data from out-patient Physiotherapy questionnaire
- Reformatting of the out-patient Physiotherapy questionnaire to focus on specific areas depending on responses
- Collection of further out-patient Physiotherapy feedback using new questionnaire
- Identification of a two different patient client groups
- Collection of data from one new patient client group in Q3 and from the other one if Q4
- Analysis of data from Q3 and Q4
- Monthly reporting to be developed for Divisional PSQB
- Results to be mapped as Outcomes against CQC action plan
- Production of a final report to include any lessons learnt and areas for further focus

## 3.4 Improving Hospital Nutrition

### Aims and Objectives of Work

Nutrition for patient's staff and the public is still classed as a priority for CHFT, following on from the ground work done in 15/16 as part of the CQUIN scheme.

### Introduction

The Soil Association's Food for Life Hospital Leaders Programme (FFL HL) at Calderdale and Huddersfield NHS Foundation Trust (CHFT) is funded by NHS Calderdale CCG for a two year period, running from 1st June 2015 to 31st May 2017. This funding follows a Big Lottery funded pilot at CHFT. The aims of the programme are to:

- Enhance the capacity of Calderdale and Huddersfield NHS Foundation Trust to sustain a change in food culture by supporting a Whole Hospital Food for Life Approach
- Enhance the capacity of Food for Life to support the development of interconnections between CHFT, public health and the wider community in the provision of high quality and safer services in the future

### Overview

Through the course of year 1, CHFT's FFL HL multidisciplinary steering group met on four occasions and has used this forum to drive forward progress, including CQUIN 295 (not a CQUIN for 2016/2017 )and the development of a Food and Drink Strategy.

### Progress in delivering a whole hospital approach to good food at CHFT:

- Food and drink strategy completed
- Work took place over the year to improve the catering quality including renewing the Food for Life Catering Mark for staff and visitor food in Calderdale Royal Hospital (CRH),

improvements in the range and temperature of delivered patient meals and a reduction in food waste
- Multi-disciplinary working and ongoing monitoring has driven an improvement in patient experience and new roles and processes have been implemented
- CHFT has developed its healthier vending principles and tender specifications supported by Joe Harvey, Food for Life Associate
- CHFT have established a popular fruit and vegetable stall in Huddersfield Royal Infirmary (HRI) and are working with providers on compliance with the staff health and wellbeing CQUIN's 'healthier food for NHS staff, visitors and patients' indicator. In October 2016 a fruit and veg stall will be available on the CRH site for one day a week
- Food growing on CHFT grounds has been established and new growing projects are confirmed for 2016/2017
- The Food for Life Hospital Leaders work at CHFT has been communicated to wider audiences through communication activities and events

**Facilitation support / expert input at Trust based meetings (4 per year)**

Key Food for Life staff were engaged in four steering group meetings in September 2016, December 2015, March 2016 and early June 2016 and included those from FFL, CHFT, NHS Calderdale CCG, Calderdale Council (Public Health), Kirklees Council (Health Improvement) and invited others.

In meetings FFL staff reported on a number of themes including vending, national policy updates (such as the national CQUIN on NHS staff health and wellbeing), food growing on the CHFT site (in association with Incredible Edible Aqua gardens and Rooting and Fruiting), links with wider 'whole systems' work planned in Calderdale, and workshop / seminar topics and feedback. FFL has also provided administrative support producing meeting minutes and actions and creating branded templates with partner logos.

**a. Expert briefings and bulletins supporting progress on the 6 thematic areas within the Food for Life strategic framework**

Expert briefing given on the NHS England drive to improve health and wellbeing and the national CQUIN on NHS staff health and wellbeing were given. Verbal updates on changes in policy and practice were given at steering group meetings.

**b. Specialist training workshops (2 per annum)**

A workshop on **Understanding & reducing food waste** was delivered to CHFT on 25th May 2016 by Food for Life. Twelve attended including staff from estates and facilities, Public Health Calderdale, catering (including ISS), dietetics, risk and compliance, energy and waste and facilities.

A ward level audit was carried out on Ward 17 in Huddersfield Royal Infirmary after the workshop and new audit methods taught.

Workshop feedback was positive:

- All agreed that they found the workshop useful and interesting
- All agreed that as a result of the workshop they had increased confidence to work in ways that minimise food waste

More detailed workshop feedback is available with some comments and pledges shown below:

- *excellent case study – great event*

As a result of the workshop the following pledges were made:

- *introduce audit of plate waste, star award, develop the business case for Nutritional Training Assistants, meet [key staff] and promote engagement and leadership*
- *Monitor my waste more closely and do re-training with staff members*
- *Work with CRH staff to introduce Refood [in place in HRI]. Look at metrics for volumes of waste produces*
- *Continue to liaise with MDT and training staff*

**c. Seminars supporting progress and strategy benchmarking with other trusts for key senior staff (3 per annum)**

Three seminars were delivered throughout the year.

**Seminar 1: Healthier Hospital Food Procurement: 13th April '16, co-hosted by Sustain & FFL**

- 34 attendees from the Department of Health, NHS England, Food for Life, The Campaign for Better Hospital Food, Sustain, 13 NHS Trusts and others
- Presentations given included on FFL HL work and event outcomes shared at the CHFT June steering group meeting

**Seminar 2: Making the most of volunteers to support food activities: 19th April '16, Packmore Community Centre, Warwick**

- 18 attendees from 6 NHS Trusts including the Matron Estates and Facilities and Learning Practice Facilitator, of CHFT
- Chief Executive of SWYPFT, opened the seminar emphasising the importance of food as medicine
- Learning Practice Facilitator presented on 'A' level 'enrichment placement' volunteers who support nutrition in the prevention of delirium work at CHFT
- In seminar feedback all strongly agreed / agreed that outcomes were positive (detailed feedback report available separately)
- The Learning Practice Facilitator noted that as a result of the event she will be reviewing using older volunteers and partnership organisations for support at CHFT

**Seminar 3: Engaging ward level staff in food: 23rd May '16, Calderdale Royal Hospital**

- Seminar was attended by 26 people from 6 NHS Trusts including 8 from CHFT
- The seminar was opened by Joanne Middleton, Associate Director of Nursing for surgery and anaesthetics at CHFT and Joanna Lewis, Strategy and Policy Director, Food for Life. Jane Crossley, Senior Strategy and Policy Manager, Patient Environment Team, Department of Health spoke on new national food policy and a presentation was given on behalf of Andy Jones from the Hospital Caterers Association (HCA) on 'the last 9 yards'
- Chris Bentley presented on improving patient experience at CHFT through multi-disciplinary working and Tracy Rawcliffe, General Manager, ISS Facilities Services at CHFT spoke on the newly created catering supervisor role in CHFT

- 58/59 responses strongly agreed / agreed that outcomes were positive ((detailed feedback report available separately)

**Food for Life Catering Mark specialist support (4 days per annum)**

ISS have been supported by FFL relating to the catering mark. They have achieved bronze status again and are currently working towards silver status.

**Community and partnerships**

**Key outcome:** *Food growing on CHFT grounds has been established and new growing projects are planned for year 2016/2017*Food growing has been introduced in the grounds of CRH supported by Incredible Aquagarden with funding from Calderdale Council (Public Health) and support from Calderdale CCG.

- A social enterprise called Rooting and Fruiting were awarded £10k to work with CHFT for 1 year on a growing project and will work closely with Incredible Edible. This work will be in partnership with Engie, Occupational Health, Occupational Therapy and rehabilitation wards .

**Patient Satisfaction**

- Estates and Facilities division asks patients on a monthly basis questions relating to their service. Included in this are questions around food based on the PLACE questions. A report will be completed on the results of this survey in December 2016 once more data has been received
- PLACE score for 2016 are the highest recorded. For HRI site we scored 90.56% and for CRH we scored 91.39%.

**MUST (Malnutrition Universal Screening Tool)**

- CHFT have been involved in the BAPEN audit (British Association Of Parenteral and Enteral Nutrition) national audit on a quarterly basis. In September 151 audits were submitted and the Trust currently compares well against other hospitals with compliance. This data is discussed through the Trust Nutritional Steering Group Meetings

**CQUIN1b (Healthy food for NHS staff, visitors and patients)**

- There is a 16/17 CQUIN which requires providers to submit national data on existing contracts with food and drink suppliers. This was supplied in Q1 and will be resubmitted following improvements in Q4.
- Updates with requirements for quarter 4 are on track for both hospital sites. ISS for their restaurant have already removed products high in fat, sugar and salt from their checkouts in the restaurant. Fresh fruit is now displayed.
- Any advertisement of products high in fats, sugar and salt have been removed in all outlets at CRH
- ISS retail are reviewing all products available in the Costa outlet CRH and re-designing any meal deals or offers they provide to ensure these meet the CQUIN criteria . They are

also reviewing any grab and go offers which are available near the tills to ensure compliance.

- ISS are holding a webinar session on 25th October which will fully explain the initiatives for CQUIN across all their retail outlets to ensure compliance
- For HRI compass Medirest have strategy in place for compliance with a deadline being November for their shop and restaurant on the HRI site. From 24th October all meal deals advertised will be the £3.50 deal which includes water, fruit and a sandwich which will not have any red labels and will be under 350 Kcals. There will be no promotion at till points for any products high in sugar,fats and salt.
- They are currently displaying fresh fruit stands selling 3 items of fruit for a pound
- In the restaurant there will an under 500 Kcal meal called “Wholesome”
- Compass are working with Costa relating to the CQUIN. By end of December all the syrups will be sugar free.

- Vending tender document completed for HRI site in line with the CQUIN . ISS are trialling on other sites healthy option vending

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

| Indicator | Compliance |
|---|---|
| 4.1 Learning from Incidents, Claims and Complaints | Reporting only |
| 4.2 Appointment Slot Issues | Reporting only |
| 4.3 Patient Flow and the SAFER programme | Reporting only |

**Highlights**

- Incidents, complaints, claims – increase in incident reporting in community division, against an overall reduction of 5% in incidents reported compared to Q1.

  2 Ombudsman complaints not upheld.

  Claims – small decrease in numbers of claims in Q2, NHSLA factsheet for 2015/16 confirms that obstetric claims payments were not in the top 20 Trusts nationally (£2.4 M).

- Appointment Slot Issues (ASIs)– levels are reducing at a time when nationally ASIs are increasing

## 4.1 Incidents, Complaints and Claims

**Key messages:**

- Suspected falls is the top reported incident in Q2, as in the last quarter.
- Medical Division is the highest reporter of incidents in Q2 (44.4% all incidents) by division.
- Labour Delivery recovery Post Natal Unit is the highest reporting department (234 incidents)
- 14 Serious Incidents (SIs) Q2.

### 1.1 Numbers of Incidents

For the period 1 April 2015 to 30 June 2016 a total of 2,411 incidents were reported by CHFT members of staff. Of these, 1068 were reported by the Medical Division.
The table below shows that the number of incidents reported has decreased by 126 incidents.

### 1.2 Incidents by Divisions:

The tables below show that the number of incidents reported in Quarter 1 per Division, against number of incidents reported in quarter 2 per division. With the Medical Division reporting 44.29% of total incidents in Q2.

| | Q1 2016-2017 | Q2 2016-2017 |
|---|---|---|
| **Community Division** | 65 | 83 |
| **Corporate Division** | 5 | 10 |
| **Estates and Facilities** | 36 | 42 |
| **Families and Specialist Services** | 804 | 707 |
| **Huddersfield Pharmacy Specials** | 1 | 1 |
| **Medical Division** | 1096 | 1068 |
| **Surgical & Anaesthetics Services Division (SAS)** | 530 | 500 |
| **Totals:** | 2537 | 2411 |

Incidents by division

A positive reporting culture remains in the Trust despite the reduction in the number of incidents reported. Incidents that occur in nursing homes which have previously been reported as CHT incidents and now are more accurately reported as non CHT incidents. The division with the greatest reduction in incidents reported in Q2 to Q1 is the Family and Specialist Services division with 97 fewer incidents reported. There are also reductions in Medical and SAS divisions.

## 2 . CHFT Incidents

### 2.1Top Incident Categories

The top 20 reported incidents for Quarter 2 are given below with suspected fall again being the top incident category reported, accounting for 15.5% of all incidents reported in this period. This is a slight rise from quarter 1 of 2016/17 where suspected fall accounted for 14% of all incidents.

There was a change in the approach to coding during Q1, with staff coding incidents from mid May 2016. The incident team is currently reviewing what impact this is having on the reporting of incident categories.

### Top 20 Incident categories Q2 2016/17

| Top 20 Q1 16-17 | |
|---|---|
| **Slips, trips, falls and collisions** | 529 |
| **Administration or supply of a medicine from a clinical area** | 167 |
| **Connected with the management of operations / treatment** | 146 |
| **Adverse events that affect staffing** | 115 |

| Top 20 Q2 16-17 | |
|---|---|
| **Slips, trips, falls and collisions** | 582 |
| **Adverse events that affect staffing levels** | 135 |
| **Other** | 57 |
| **Pressure sore / decubitus ulcer** | 86 |

| | | | | |
|---|---|---|---|---|
| **levels** | | | | |
| **Pressure sore / decubitus ulcer** | 99 | | **Transfer** | 107 |
| **Transfer** | 96 | | **Administration or supply of a medicine from a clinical area** | 91 |
| **Patient's case notes or records** | 83 | | **Infection control** | 77 |
| **Lack of/delayed availability of facilities/equipment/supplies** | 79 | | **Post-partum haemorrhage > 1,000ml** | 56 |
| **Discharge** | 72 | | **Medication error during the prescription process** | 62 |
| **Accident caused by some other means** | 69 | | **Abuse etc of Staff by patients** | 56 |
| **Communication between staff, teams or departments** | 64 | | **Accident caused by some other means** | 56 |
| **Abuse etc of Staff by patients** | 61 | | **Medical device/equipment** | 54 |
| **Transfusion of Blood related problem** | 58 | | **Labour or delivery - other** | 35 |
| **Appointment** | 50 | | **Transfusion of Blood related problem** | 49 |
| **Security incident related to Personal property** | 50 | | **Connected with the management of operations / treatment** | 56 |
| **Medication error during the prescription process** | 49 | | **Appointment, Admission, Transfer, Discharge - other** | 40 |
| **Administration of assessment** | 47 | | **Discharge** | 46 |
| **Infection control** | 46 | | **Treatment, procedure - other** | 39 |
| **Admission** | 45 | | **Patient's case notes or records** | 39 |
| **Medical device/equipment** | 42 | | **Implementation of care or ongoing monitoring - other** | 35 |
| **Totals:** | 1967 | | **Totals:** | 1762 |

## FALLS

Slips, trips, falls and collisions remains the highest incident category reported, with 582 incidents reported in Q2 2016/17, an increase from 529 falls reported in Q1 2016/17.

The data below shows an increase in the number of falls from height, bed or chair during the quarter, up from 33 in Q1 2016/17 to 54 in Q2 2016/17.

There have been 4 serious incidents relating to falls with harm and root cause analysis investigations are underway for each of these falls to identify learning and actions to prevent recurrence. Further details on falls is given in the Safe section of this report.

| Falls by Adverse Event | | GREEN | YELLOW | ORANGE | RED | Total | Comment |
|---|---|---|---|---|---|---|---|
| Unexpected collapse | Q1 16/17 | 5 | 1 | 0 | 0 | 6 | |
| | Q2 16/17 | 0 | 3 | 0 | 0 | 3 | ⇩ |
| Faint during procedure or treatment | Q1 16/17 | 0 | 2 | 0 | 0 | 2 | |
| | Q2 16/17 | 4 | 0 | 0 | 0 | 4 | ⇧ |
| Fall from a height, bed or chair | Q1 16/17 | 21 | 10 | 1 | 1 | 33 | |
| | Q2 16/17 | 40 | 13 | 0 | 1 | 54 | ⇧ |
| Collision with an object | Q1 16/17 | 0 | 1 | 0 | 0 | 1 | |
| | Q2 16/17 | 3 | 5 | 0 | 1 | 9 | ⇧ |
| Fall on level ground | Q1 16/17 | 51 | 27 | 2 | 1 | 81 | |
| | Q2 16/17 | 79 | 41 | 3 | 1 | 124 | ⇧ |
| Struck against furniture/object/fitting | Q1 16/17 | 0 | 2 | 0 | 0 | 2 | |
| | Q2 16/17 | 3 | 2 | 1 | 0 | 6 | ⇧ |
| Suspected fall | **Q1 16/17** | **277** | **113** | **7** | **2** | **399** | |
| | **Q2 16/17** | **275** | **93** | **6** | **2** | **376** | ⇩ |
| Tripped over an object | Q1 16/17 | 1 | 2 | 0 | 0 | 3 | |
| | Q2 16/17 | 1 | 5 | 0 | 0 | 6 | ⇧ |
| Totals: | Q1 16/17 | 356 | 159 | 10 | 4 | 529 | |
| | Q2 16/17 | 405 | 163 | 10 | 4 | 582 | ⇧ |

| Q1 16-17 LDRP | |
|---|---|
| Delay | 55 |
| Simple complication of treatment | 33 |
| Resulting in 3rd or 4th degree tear | 33 |
| Unexpected admission to Neo-Natal Unit | 11 |
| Lack of suitably trained /skilled staff | 10 |
| Lack of/delayed availability of operating theatre | 6 |
| Inter Uterine Death | 4 |
| No harm to mother/baby - transfered to hospital | 4 |
| Apgars <6 at 5 mins | 3 |
| Neonatal death | 3 |
| Failure to note relevant information in patient's record | 3 |
| Delay in opening second theatre | 2 |
| Delay / difficulty in obtaining clinical assistance | 2 |
| Lack of/delayed availability of beds (general) | 2 |
| Below normal body temp | 2 |
| Cord PH < 7.15 | 2 |
| Communication failure within the team | 2 |
| Medicine not administered | 2 |
| Verbal abuse or disruption | 2 |
| Wasted blood products | 2 |
| Resulting in Caesarian Section | 1 |
| Inadequate check on equipment | 1 |
| Staff competency issues | 1 |
| Delayed or Cancelled time critical activity | 1 |
| Delay in Medication | 1 |
| Injury from dirty sharps | 1 |
| Absconder / missing patient | 1 |
| Inadequate handover of care | 1 |
| Hospital Acquired Pressure Sore Grade 2 | 1 |
| Delay of 2 hours or more between admission for induction and beginning of process | 1 |
| Fetal laceration at time of incision | 1 |
| Lost/missing property/damaged property | 1 |
| Other IT malfunction | 1 |
| Failure of a device or equipment | 1 |
| Documentation - misfiled | 1 |
| Missing needle/swab/instrument | 1 |
| No Midwife | 1 |
| Not Meeting Specification (PMU) | 1 |
| Patient incorrectly identified | |
| Post-partum haemorrhage > 1,000ml | 1 |
| Stillbirth | 1 |
| Unplanned return to theatre | 1 |
| Treatment/procedure - inappropriate/wrong | 1 |
| Treatment / procedure - failed | 1 |
| Unplanned admission / transfer to specialist care unit | 1 |
| Wrong drug / medicine | 1 |

| Q2 LDRP | |
|---|---|
| Delay | 62 |
| Simple complication of treatment | 51 |
| Resulting in 3rd or 4th degree tear | 22 |
| Unexpected admission to Neo-Natal Unit | 14 |
| Lack of suitably trained /skilled staff | 7 |
| Unplanned admission / transfer to specialist care unit | 5 |
| Delay of 2 hours or more between admission for induction and beginning of process | 5 |
| Apgars <6 at 5 mins | 4 |
| Resulting in Caesarian Section | 4 |
| Cord PH < 7.15 | 4 |
| Inter Uterine Death | 4 |
| Wasted blood products | 4 |
| Unexpected re-admission or re-attendance | 4 |
| Second theatre opened | 3 |
| Delay in opening second theatre | 2 |
| Delay / difficulty in obtaining clinical assistance | 2 |
| Unintended injury in the course of an operation or clin task | 2 |
| Delay in Medication | 2 |
| Injury from dirty sharps | 2 |
| Access, admission, transfer, discharge other | 2 |
| Patient refuses to sign/give consent/treatment | 2 |
| Verbal abuse or disruption | 2 |
| Unable to provide continous 1-1 care and support to a woman during established labour | 1 |
| Medication prescribed to which p. had a known allergy | 2 |
| Collision with an object | 1 |
| Missed or delayed care (eg 60 mins or more in washing and suturing) | 1 |
| Eclamptic fit | 1 |
| Unsafe / inappropriate clinical environment | 1 |
| Failure to follow protocol | 1 |
| Fetal abnormality detected at birth | 1 |
| Fall from a height, bed or chair | 1 |
| Fetal laceration at time of incision | 1 |
| Lack of clinical or risk assessment | 1 |
| Failure of a device or equipment | 1 |
| Missing, inadequate or illegible healthcare record | 1 |
| No harm to mother/baby - protocols followed | 1 |
| Medicine not administered | 1 |
| Failure to note relevant information in patient's record | 1 |
| Accident of some other type or cause | 1 |
| Other medication incident | 1 |
| Failure to sign for medication | 1 |
| Fall on level ground | 1 |
| Suspected fall | 1 |
| No harm to mother/baby - transfered to hospital | 1 |
| Test results / reports - failure / delay to receive | 1 |
| | |

| | | | |
|---|---|---|---|
| **Diagnostic Images / specimens - mislabelled / unlabelled** | 1 | | |

### Labour Delivery Recovery Post-natal Unit (LDRP)

Delays have increased in Q2 from 55 to 62 and continue to be the highest incident type reported within LDRP. Simple complication of treatment has the highest rise from 33 to 51. 3rd and 4th degree tears have reduced over Q2. Otherwise incident reporting remains largely unchanged from Q1.

### 2.2 Incidents by Department:

The table below identifies the highest reporting ward/department (Top 10), with labour delivery recovery post natal unit continuing to be the department reporting the most incidents in Q2 2016/17. This is suggestive of an improved reporting culture in this area.

| Q1 16-17- Top 10 by Location | |
|---|---|
| **Labour Delivery Recovery Post-natal Unit** | 210 |
| **Accident and Emergency** | 130 |
| **Operating Theatre** | 97 |
| **Calderdale birth Centre WD1A** | 96 |
| **HWD19 Trauma** | 86 |
| **Outpatient Department** | 76 |
| **HWD5** | 73 |
| **HRI MAU** | 67 |
| **HWD8** | 65 |
| **Intensive Care Unit/High Dependency Unit** | 62 |
| **Totals:** | 962 |

| Q2 16-17 Top 10 by location | |
|---|---|
| **Labour Delivery Recovery Post-natal Unit** | 234 |
| **Accident and Emergency** | 115 |
| **Calderdale birth Centre WD1A** | 98 |
| **Operating Theatre** | 87 |
| **HRI MAU** | 74 |
| **HWD5** | 71 |
| **HWD19 Trauma** | 67 |
| **Intensive Care Unit/High Dependency Unit** | 59 |
| **Surgical Assessment Unit** | 58 |
| **CWD5D Complex Care** | 53 |
| **Totals:** | 916 |

## 2.3 Incidents by Severity:

The numbers of incidents by severity are:

| by severity | Q1 2016/17 | Q2 2016/17 |
|---|---|---|
| **GREEN** | **1962** | **1860** |
| **YELLOW** | **515** | **488** |
| **ORANGE** | **46** | **49** |
| **RED** | **14** | **14** |
| **Totals:** | **2537** | **2411** |

There is a 5% decrease in the number of incidents reported, and incidents reported with no or low harm have decreased. Moderate and severe harm remain in similar ranges to Q1, suggesting that incident reporting is in line with previous months. It is worth noting that incidents are now coded and categorised by the reporters and incident managers/handlers.

In Quarter 2, 14 incidents were identified as being "serious" and required reporting to the CCG/NHS England via STEIS. The types of incidents were:

| Serious Incidents reported to CCG/NHS England via STEIS. | **2016/17 Q2** |
|---|---|
| Disruptive/ aggressive/ violent behaviour meeting SI criteria | 2 |
| Slips/trips/falls meeting SI criteria | 4 |
| Treatment delay meeting SI criteria | 2 |
| Screening issues meeting SI criteria | 1 |
| HCAI/Infection control incident meeting SI criteria | 1 |
| Sub-optimal care of the deteriorating patient meeting SI criteria | 2 |
| Maternity/Obstetric incident meeting SI criteria: baby only (this include foetus, neonate and infant) | 1 |
| Diagnostic incident including delay meeting SI criteria(Including failure to act on test results) | 1 |
| Total | 14 |

All incidents were reported on STEIS within the 48hr timescale.

**Learning from Incidents Q2 2016/17**

Information on learning from incidents is shared within divisional Patient Safety Groups and for serious incidents via the Quality Committee. Learning identified from incidents during the quarter is given below.

***Learning the Lessons – Surgical & Anaesthetics Division– Incidents Q2***

| Issue | Findings | Learning |
|---|---|---|
| Patient infrequently reviewed, patient deteriorated, continued to vomit and was transferred to ICU | Found to have a severe acute kidney injury. 'Pink slip system' was used inappropriately. PASWeb had not been updated so doctors did not realise there was an outlier | 'Pink slip system' is to be stopped when consultants refer to each other. Incident discussed at forums |
| Delay in recognising deteriorating patient | Elevated NEWS score not escalated in a timely manner | Case discussed at Audit Half Days to heighten awareness of better communication and the need to escalate. Following the introduction of Nerve Centre software, escalation is happening in a more timely manner |
| Patient trying to pass urine, slipped on wet floor at side of bed and injured his head. Scan showed undisplaced fracture of sphenoid and zygomatic bones | No evidence of intracranial bleed. Documentation was poor and no falls care plan in place | All staff subsequently undertook the e-learning module on prevention of falls in hospital |
| Line infection | There were no nursing issues related to this infection | Poor communication between the Infection Control and CVAD Teams has been addressed |
| Surgery was performed prior to discussion at MDT meeting which did not follow Trust protocol | All patients with potentially operable cancer should be discussed at an MDT prior to surgery, unless exceptional circumstances. This was not an exceptional circumstance | All MDT members have been reminded of the protocol. A localised SOP (Standard Operating Procedure) has been introduced to make the process more robust. All MDT member use the SOP |
| On admission the patient did not have her regular medications prescribed, including Digoxin. The patient later went into fast AF as a result of the omitted medication (no acute MI) | Lack of prescribing and handover by admitting doctor triggered events. Lack of/and poor communication resulted in no action on the prescribing of medicines even though medication history available. Focus on surgical condition and not the whole clinical picture by | Orthopaedics – revision of the junior doctor's induction handbook has taken place. Development of the ACP role (2 year lead time) to reduce the reliance on short term locum cover<br>Pharmacy – Improved face to face communication between |

| | | |
|---|---|---|
| | surgical team. | doctors and pharmacists and less reliance on notes that do not get read. Wards have designated pharmacists where possible |
| ***Learning the Lessons – Family and Specialist Services – Incidents Q2*** | | |
| *Issue:* | *Findings:* | *Learning:* |
| <u>Gynaecology:</u><br><u>Incorrect identification of patient prior to examination:</u><br><br>Incorrectly identified patient was asked and gave permission for an examination by a doctor which was conducted with patient consent and in the presence of a nurse chaperone.<br>Patient had full capacity | Failure of the doctor and nurse to follow CHFT Chaperone Policy for Intimate Examinations and Policy for Consent for treatment | - Health care professionals carrying out an examination are responsible for ensuring that the patient understands and consents to the procedure.<br>- All health care professionals must complete thorough patient identification checks before undertaking an examination/procedure. |
| <u>Labour Delivery</u><br><br>Woman was not prescribed or given antibiotics in labour for a known Group B Streptococcus infection (GBS). | The medical and midwifery team did not undertake a full review of the woman's health care record. | - A detailed check of the woman's history should be carried out on admission<br>- Ensure that when women are informed of their GBS status and advise them to inform any health care professionals they come in contact of this fact. |
| | | |

| | | |
|---|---|---|
| <u>Pathology</u><br><br>The Pathology laboratory information system (LIS) suffered a serious hardware failure over a period of 5 days during April 2016. The laboratory reverted to a manual process for reporting results during this period.<br><br>Each specialty within pathology followed their business continuity plans to process urgent work which resulted in some delays communicating results back to Users. Communication to Users was made at the earliest opportunity with regular updates through 'walk arounds' and electronically. | The LIS hardware failure was an unforeseen event. There was no backup server available and the supplier failed to provide a working system within the expected time frame of 8 hours.<br>Resolution of the problem was hindered by the provision of engineers with a lack of experience to resolve the issue.<br>Business continuity plans and communications were actioned by each specialty in a timely manner.<br>Early indications show the system downtime did not result in any direct impact on patient care. | - The provision of a suitable interface through which the trust IT department can communicate with the APEX server is required.<br><br>- A suitable back-up system is required for use within 4 hours of a diagnosed system failure. |
| <u>Labour and Delivery</u><br><br>NEVER EVENT<br>Retained swab<br>On 5th February 2016 the Patient presented to the Maternity Unit two weeks post-delivery complaining of perineal pain and some perineal breakdown. This was post birth of her baby on 23rd January 2016 by a forceps delivery in obstetric theatre. The patient was found to have a "tightly rolled up X-ray detectable swab" retained within the vagina which had caused the discomfort. | Maternity Services Policy for Swab, Needle and Instrument counts for Obstetric Procedures, CHFT was not followed for swab counting and recording<br><br>Staff did not have a robust approach to the management of swabs in the Maternity Unit at CRH | These incidents will be added to the trust's embedding lessons agenda and will be discussed at appropriate local groups.<br><br>A further 'deep dive' in this clinical area is recommended to ensure learning in a targeted approach to improve clinical practice and safety.<br><br>Recommendations:<br>• Standard Operating Policy (SOP) for Theatre is in place for staff Guidance. - rewrite of this to give clarity between LDRP and theatre, thus minimising confusion. Staff must be fully aware of this so it is embedded within culture and practice. |

| | | |
|---|---|---|
| | | • For the service to continue with the handover sheet of swab count double signed and checked<br>• Video (e-learning) on importance of swab checks to be shown to all staff as part of induction and with agency staff during initial handover.<br>• Identified co-ordinator i.e. Named Midwife-or Principal midwife (as stipulated in the SOP) to be identified during the birth procedure and responsible for the swab making this clear to the MDT. This is then the responsible clinician for ensuring safety and for any handover to other clinicians during the delivery process.<br>• For the department to review any mentoring/preceptorship improvements for newly qualified midwives to ensure use and timing of birth packs/equipment are in line with standard practice and policy.<br>• For management to include review of swab control during the CRAS (clinical records audit standards)audit process efficiency and effectiveness on a Monthly basis<br>• For spot checks to be carried out periodically during the Labour ward to check compliance with robust swab control.<br>• For a reflective session to take place with the Midwives to review the findings and recommendations from these investigations, therefore facilitating learning and improving safety and clinical practice. |

| ***Learning the Lessons – Medical Division – Incidents Q2*** | |
|---|---|
| **Issue** | **Learning** |
| **Medication Incident : Dual Anti-Platelet Therapy (Serious incident)**<br><br>Confusion regarding patient's anti –platelet therapy following angioplasty post discharge.<br><br>The discharge summary and discharge prescription did not have the same instructions as the consultant's discharge letter with regards to the plan for the patient's antiplatelet and anticoagulant drugs. Because of the discrepancy in documents, the patient's expectation and the GP's repeat prescriptions conflicted and instead | Improve communication about the intended management of dual anti-platelet therapy post-discharge following cardiac stenting procedures.<br><br>Address the lack of alignment between the BNF list of interactions and current CHFT practice regarding the concurrent administration of omeprazole and Clopidogrel.<br><br>The primary care team should consider their local procedures for amending repeat prescriptions with information from patients recently discharge from hospital. |

| | |
|---|---|
| of being on one anti-platelet drug and one oral anticoagulant the patient was only on the latter. | |
| **Medication Incident : Warfarin**<br><br>Patient admitted with dyspnea. Found to be in atrial fibrillation.<br>Discharged the following day "rate stabilized on bisoprolol" and "warfarinised" Discharge note said bisoprololl 2.5mg daily patient had box of 1.25mg with instruction 1 daily. Patient discharged on 2mg warfarin - patient not aware of any arrangement for INR monitoring - could find no evidence of any warfarin counselling. Patient did not feel well enough or safe to be at home - admitted to private hospital at her request. | It is important to provide verbal and written information when starting warfarin. When patients are anxious they may not retain or understand all the information they are told prior to discharge.<br><br>Follow up of warfarin patients is paramount and if it is not possible to provide a follow up appointment at the point of discharge, patients should be given information as to when they will get to know when and where they will have their next blood test. |
| **Incident : No CT scan at first admission**<br><br>Pt attended in July @ 0100 with sudden onset of headache, loss of peripheral vision. PMH - diabetes. Discharged with analgesia- no CT scan performed. Patient has re-attended with severe headache and vomiting. CT scan shows infarct. Transferred over to stroke team at Calderdale. | The root cause of the failure to undertake CT scan in July was failure to undertake a full and thorough assessment of headache, and failure to undertake a full and thorough neurological assessment.<br>The Locum Middle grade should receive feedback regarding identification of a training issue in relation to his assessment of a patient with headache and neurological symptoms |
| **Falls Incident**<br>Attended to assist a call bell. Staff already present, patient sat on the floor with laceration to left arm. Assisted back to chair. No other visible injuries. Denied banging head witness confirms this. States was trying to pick up an object from off the floor. Advised against this in this future. | Ensure belongings are close by and in reach to prevent from leaning forward.<br>Utilise falls alarms, although, on this occasion this would not have prevented the patient falling as he had leant forward to pick something up from the floor.<br>Ensure that increase intentional rounding is in place for those patients who are deemed at risk of falls. |
| **Pressure Ulcer Incident**<br><br>Heel pressure ulcer, identified following discharge by carers.<br><br>Carers also state that they found a rolled up ball of granuflex dressing, stuck to the sheet that the patient had been discharged in. Out of hours district nurse team called and attended that evening, photographed the wound and an appropriate dressing was applied. The carers stated to the out of hours district nurse that, they had not been informed of any pressure wound to the patient and therefore no pressure relieving equipment was in place before patient's discharge. Carers state that the patients discharge paperwork made no mention of any pressure area damage or any request | 1) There was a lack of documentation to evidence the Registered nurses who were accountable for the holistic assessment, care interventions of the patient's needs, relating to skin care, nutritional care and medication administration which resulted in compromising patient care and delays in reporting adverse incidents.<br><br>2) The Registered nurse accountable for the patients care is to ensure all aspects of nursing documentation in electronic forma via the nerve centre is completed in full and evaluated on each shift at handover.<br><br>3) The discharge planning should be initiated at the point of admission with the involvement of all multi-disciplinary professionals who are |

| | |
|---|---|
| from the ward for follow up with the district nurses.<br>On examination of the patient, I noted a category three pressure ulcer to the inner aspect of the right heel. Carers completed a safeguarding alert and have informed the CQC. | involved in the patients care to minimise the period of hospitalisation and once the patient is deemed medically stable to be discharged to the appropriate care setting with support.<br><br>4) This patient with complex psychological needs and ongoing medical needs should not be transferred to an extra capacity wards. |
| **Pressure Ulcer Incident**<br>Patient found to have a category 3 sore on the bridge of the nose from his NIV also a category 2 to left side of nose and red to right side. | Patient seen by Tissue Viability Nurse (TVN). Pressure ulcer documented by TVN as cat 2 not cat 3 as first thought. The pressure ulcer was caused by the NIV mask. The wrong size was in use, this was corrected straight away. |
| **Blood results incident**<br>Case of missed pancreatitis due to blood results not being accurately checked. | All blood results must be reviewed by the doctor who ordered them before any patient is discharged from the department even if there are delays in processing them.<br>All returns to the department must re reviewed with new eyes and all previous investigations checked. |

## Improvements:

An update against improvement areas for 2016/17 is given below:

- Changes have been made to the incident reporting and investigation process. Incidents are categorised (coded) by the incident reporter and quality is checked by investigating managers. This process gives the incident administrators the opportunity to check and assure the quality of the information provided as well as to follow up on actions. The change was introduced mid May 2016. It is proving a challenge to ensure that coding, and therefore incident analysis information is accurate and it is important that incident reporters and investigating managers check coding accuracy. Individual feedback is being given to reporters and Datix drop in sessions are being held to support staff. The incident team and system super users have held sessions and been out to wards to train staff in the coding process and plan to continue this into Quarter 2.

- Ensuring that duty of candour is undertaken in a timely way for incidents with harm and evidencing this within the incident reporting system is also proving a challenge. This is being monitored closely and a toolkit is to be developed for staff, as well as a more prominent area within the recording system to record duty of candour discussion dates.

- Explore with divisions reasons for reduction in incident reporting with a view to increasing the number of incidents reported.

# Complaints

Complaints are a vital source of information for the Trust, helping to identify where the quality and safety of services and care require improvement for service users.

This section provides a quarterly summary of Patient Advice and Complaints contacts using information collected from the data held on the Trust's Patient Advice and Complaints database. This section includes information on:

- Performance re: complaints management in 2016/17
- Information on complaints by Division
- Learning from complaints
- Improving complaints management in 2016/17
- Areas for improvement

Key points detailed in the section below are:

- An increase of 7% in the number of complaints received in this quarter, compared to the same quarter in 2015/16; there has also been an increase 4% from quarter 1 of 2016/17.
- The majority of complaints (77%) were graded as yellow or green, ie no lasting harm / minimal impact on care
- Communication, clinical treatment and patient care (including nutrition / hydration) are the main subjects of complaints; this was the same as the financial year.
- Appointments (including delays and cancellations) remain the main subject of concern received.
- Medicine is the Division with the highest number of complaints; however, it is also the

largest Division and the number of complaints reflects its size. It should also be noted that there has been a 65% increase in the number of SAS complaints from quarter 1 to quarter 2.

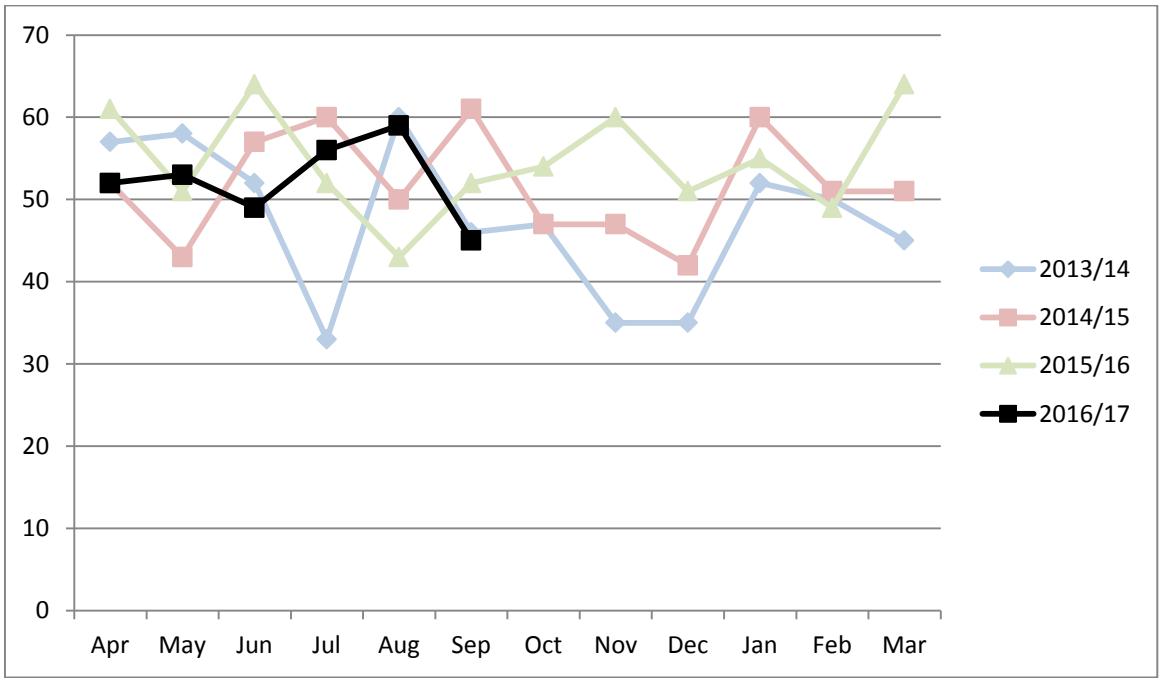
**Key Performance Indicators**

| Complaints 2016/17 | Q1 | Q2 |
|---|---|---|
| Number of new complaints received | 154 | 160 |
| % increase / decrease on 2015/16 | ↓ 6% (169) | ↑7% (150) |
| Number of complaints closed | 174 | 171 |
| % complaints upheld | 45% | 42% |
| % complaints partially upheld | 34% | 33% |
| % complaints not upheld | 18% | 23% |
| Number of complaints re-opened following final response | 19 | 17 |
| Number of complaints received from Ombudsman for investigation | 10 | 2 |
| Number of complaints upheld by Ombudsman (includes partially upheld) | 2 | 1 |
| Number of complaints not upheld by Ombudsman in quarter | 0 | 2 |

**Complaints Performance 2016/17**

**Comparison of complaints from 2013/14 to present:**

Complaints data reflecting the trends in the number of complaints for the past three years – including numbers for this quarter




**Complaints Received:**

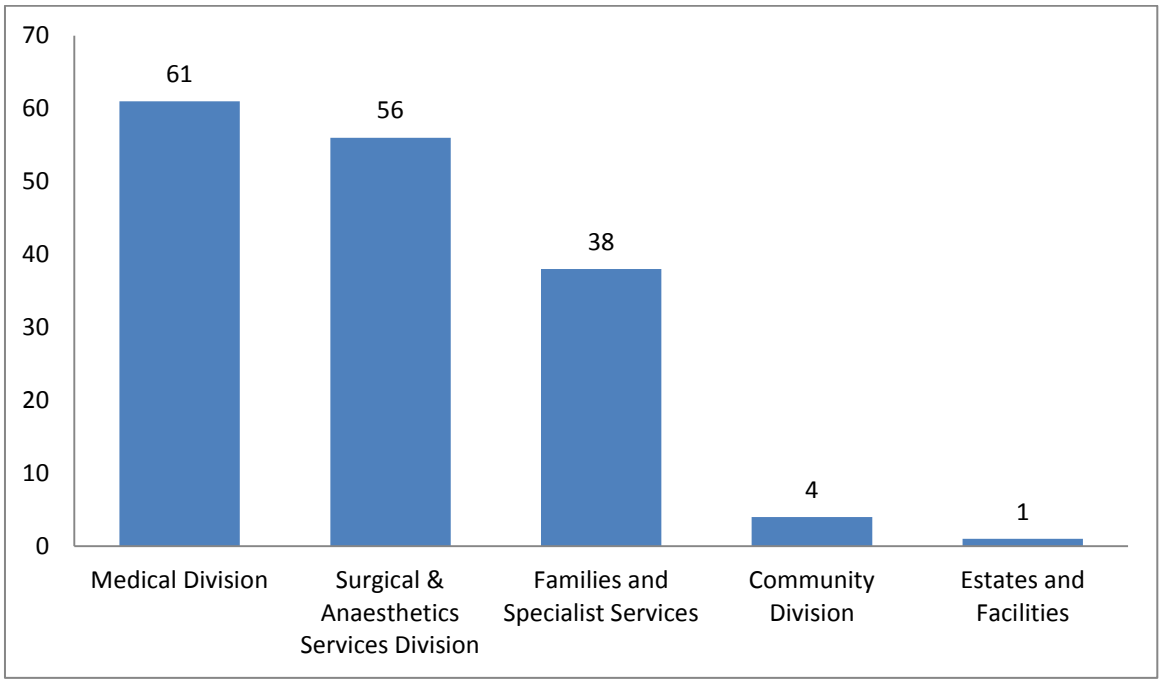
At the end of quarter 2 of 2016/17 the Trust received a total number 314 complaints. This is a decrease of 3% from the same quarter last year; however an increase of 3% from the same quarter in 2013/14. From the end of quarter 2 in 2013/14 to the end of quarter 2 in 2016/17 the Trust has an average rate of increase in complaints of 0.6%.

The total number of complaints received at the end of quarter 1 of 2016/17 for the region

(Yorkshire & Humber) was 2,978; the Trust represented 5% of this total. Total numbers of complaints at the end of quarter 1 for neighbouring Trust are as follows:

| NHS Hospital Trust | Number of Complaints |
|---|---|
| Airedale NHS Foundation Trust | 18 |
| Bradford Teaching Hospitals NHS Foundation Trust | 165 |
| **Calderdale and Huddersfield NHS Foundation Trust** | **149** |
| Harrogate and District NHS Foundation Trust | 58 |
| Leeds Teaching Hospitals NHS Trust | 155 |
| Hull and East Yorkshire Hospitals NHS Trust | 161 |
| Mid Yorkshire Hospitals NHS Trust | 431 |

**Quarterly Complaint Numbers by Directorate:**




Of the 160 Complaints received in quarter 2 of 2016/17:

- 38% of complaints received related to the division of Medicine, which is the largest division with Emergency Department services. This is a 9% decrease from quarter 1. The Emergency Network was the Directorate within Medicine with the highest number of complaints, a total of 35. Acute Medical and Integrated Medical both received a total of 13 complaints.

- 35% complaints received related to the Division of Surgery and Anaesthetic Services (SAS). This is a 10% increase from quarter 1. General and Specialist Surgery was Directorate within SAS with the highest number of complaints, a total of 28. Head & Neck received a total of 17 complaints, Orthopaedic a total of 10, and Critical Care received a total of 1.

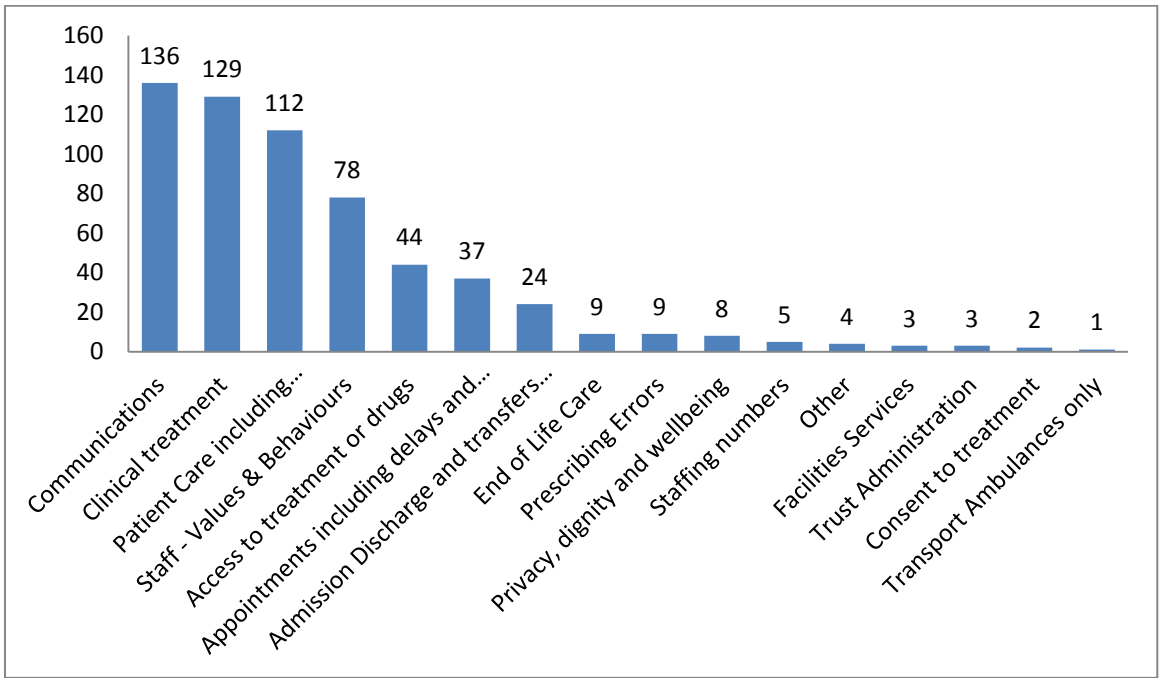
- 24% complaints received related to the Division of Family and Support Services (FSS), which was the same as quarter 1. Woman's Services was the Directorate within FSS with the highest number of complaints, a total of 23. Outpatient and Records a total of 6,

Radiology received a total of 5 complaints, Children's Services a total of 3, and Pathology received a total of 1.

- 2% complaints received related to the Division of Community, which was decrease of 1% from quarter 1. All the complaints received in quarter 2 were for Intermediate and Community Directorate.

**Analysis of Complaints by Theme**

Complaints are analysed below by primary subjects, within each complaint subject there will be a number of different sub categories with more detail relating to the complaint. There are often a number of issues logged for a single complaint, which is way the number of primary subjects differs from the total number of complaints received.



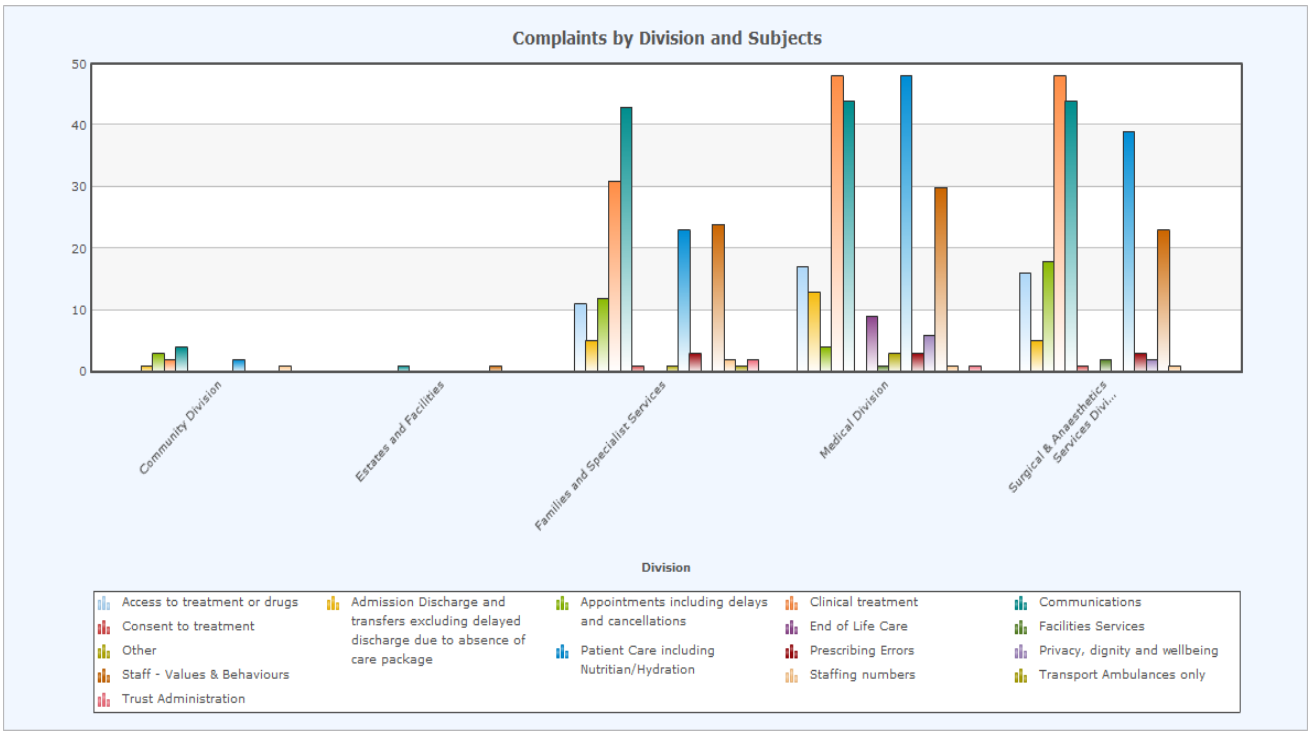

The top three subjects of complaints for the Trust are as follows:

| Subject | Percentage |
|---|---|
| Communication | 23% |
| Clinical Treatment | 21% |
| Patient Care (including Nutrition and Hydration) | 19% |

The top three complaint subjects above were the same as quarter 1 and in the same order, with marginal differences in percent.

**Quarter 2 Complaints received by Division and Primary Subject**

*Appendix One to Complaints




- The top subjects of complaint for Medicine were Clinical Treatment and Patient Care (including Nutrition and Hydration), which both represented 21% of all complaint subjects received for Medicine within quarter 2. Communication represented 19%.

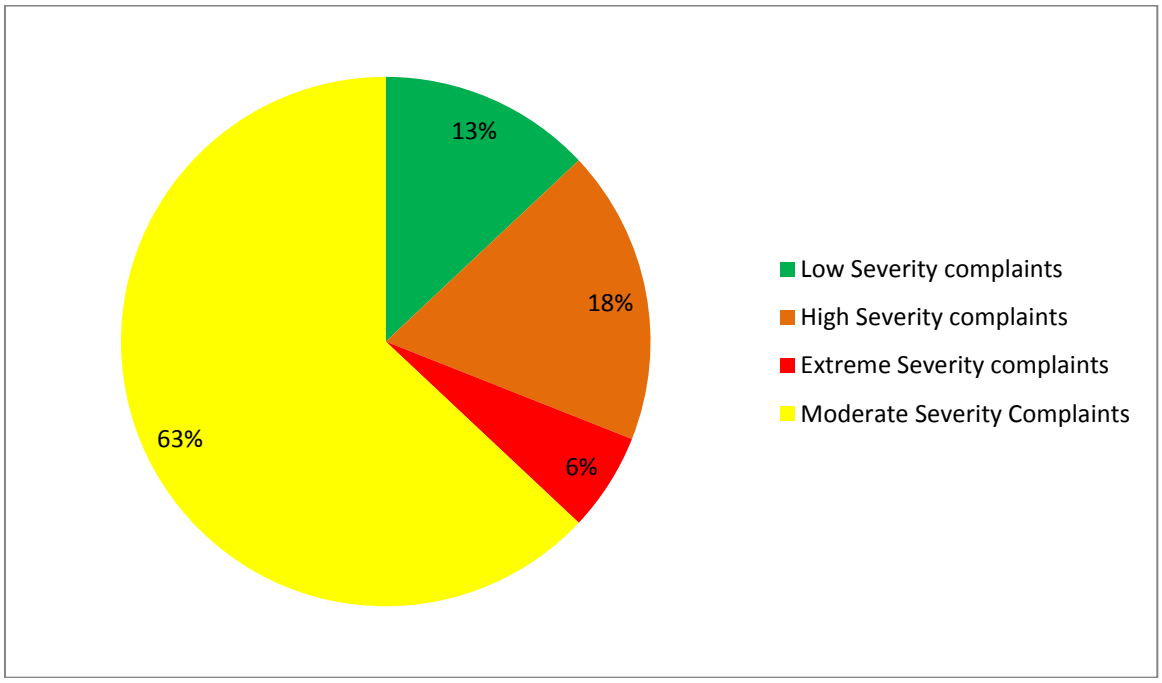
- The top subject of complaint for SAS was Clinical Treatment, representing 24% of all complaint subjects received for SAS within quarter 2. Communication represented 22% and Patient Care (including Nutrition and Hydration) 19%.

- The top subject of complaint for FSS was Communication, representing 27% of all complaint subjects received for FFS within quarter 2. Clinical Treatment represented 19% and Staff – Values & Behaviours 15%.

- The top subject of complaint for Community was Communication representing 31% of all complaint subjects received for Community with quarter 2. Appointments (including delays and cancellations) represented 23% and Clinical Treatment 15%.

**Severity of Complaints Received**

The majority of complaints received in are graded as yellow severity; no lasting harm (63%) in quarter 2. There was an 11% increase in yellow complaints in quarter 2 from quarter 1. 6% complaint received were graded red, which is a decrease of 3% from quarter 1.




Key: Green – no / minimal impact on care
Yellow – no lasting harm
Amber – quality care issues/ harm
Red – long term harm, death, substandard care

**Red Complaints Data**

A red complaint is a case where the patient, or their family, feels the action or inaction of the Trust have caused the death or significant and non-reversible harm to the patient. A complaint may also be graded Red, although the Trust has not caused the death or significant and non-reversible harm to the patient, if the complaint has had a significant impact on patient experience or Trust reputation.

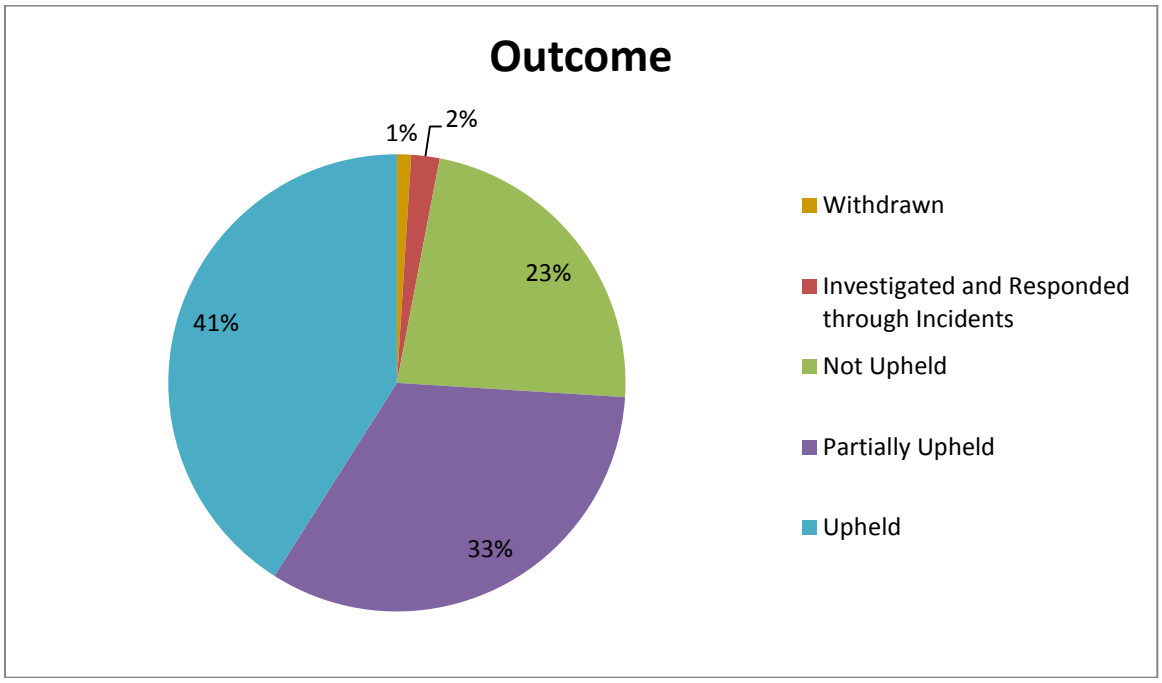
For quarter 2 of 2016/2017 the Trust received a total of 10 Red complaints, this is a 28% decrease from quarter 2. Of these 10 complaints 4 are linked to an incident.

**Acknowledgement Time**

100% of the 160 complaints received within quarter 2 of 2016/17 were acknowledged within three working days.

**Complaints Closed in Q2**

The Trust closed a total of 171 complaints within quarter 2 of 2016/17. This is a decrease of 2% from quarter 2. Of the 171 complaints closed, 41% were upheld, 33% were partially upheld (The HSCIC counts partially upheld complaints as upheld complaints so if looked at in this way the figure is 80%), 23% were not upheld, 2% were closed, investigated and responded to through incidents, and 1% was withdrawn.




**Re-Opened Complaints**

The Trust re-opened a total of 17 complaints in quarter 2 of 2016/17. This is an 11% decrease from quarter 2. The Trust will re-open a complaint for 1 of the following three reasons.

i. Response failed to address all issues and concerns
ii. New issue and concern
iii. Parliamentary and Health Service Ombudsman Investigation

In 2015/16 the Trust undertook a piece of work to improve the overall quality of its responses to complaints so that people received a full and detailed response to the issues they had raised. We introduced a robust quality checking process; the continued decrease in re-opened complaints would suggest an increase in the quality of complaints responses.

The Trust has developed a Patient Satisfaction questionnaire which will be sent out to complaints responded to in 2016/17. Responses from these will be used in conjunction with the continued monitoring of the re-opened complains to assess the quality of the responses provided by the Trust.

**Overdue Complaints**

Closing overdue complaints remains a primary focus for the Trust in 2016/17. The total number of overdue complaints at the end of quarter 2 of 2016/17 was 66. This is an increase of 18% from quarter 1.

The breakdown of overdue complaints at year end is as follows:

0 – 1 month overdue: 37 complaints
1 – 2 months overdue: 16 complaints
2 – 3 months overdue: 9 complaints
3 – 4 months overdue: 2 complaints
4 months+ overdue: 2 complaints

Weekly monitoring reports continue to be provided to divisions to ensure that all cases overdue are clearly identified and action plans are now being drawn up for overdue complaints to help ensure closure.

Work will also take place in Q3 with divisions to establish causes for delay and agree a recovery action plan.

**Parliamentary and Health Service Ombudsman Complaints (PHSO)**

A total of 2 complaints were received from the PHSO in quarter 2 of 2016/17. The breakdown for these complaints are as follows:

| Division | Directorate | Received | Description |
|---|---|---|---|
| SAS | Trauma and Orthopaedics | 18/07/2016 | Delay in treatment |
| SAS | General Surgery | 06/09/2016 | Care and treatment dating back to 2009. Delay of 6 years to receiving treatment, which resulted in extended pain and suffering during this period |

*The red line indicates a complaint graded and managed as a red complaint, i.e. where Trust actions / inactions caused death or significant and non-reversible harm.

3 PHSO complaints were closed in quarter 2 of 2016/17; of these 2 were not upheld and 1 was partially upheld. Learning from PHSO cases is address in learning section.

By the end of quarter 2 of 2016/17 the Trust had 15 active complaints with the PHSO under investigating.

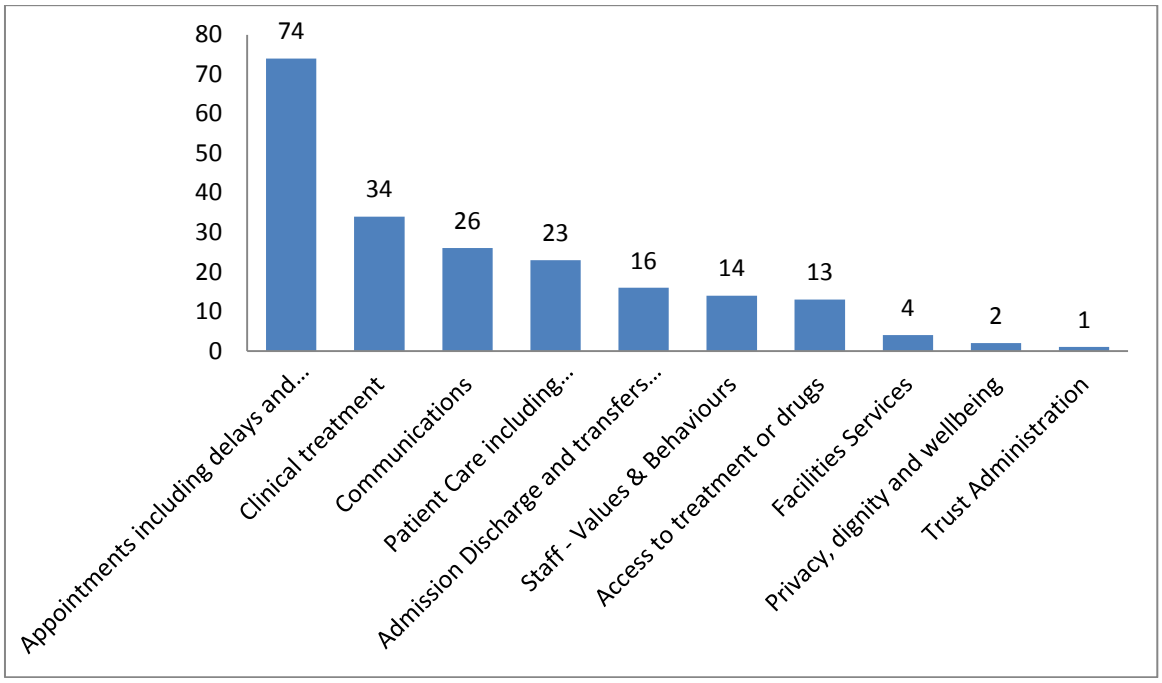
**Patient Feedback from Other Sources: Concerns, Patient Opinion and Compliments**

**Concerns**

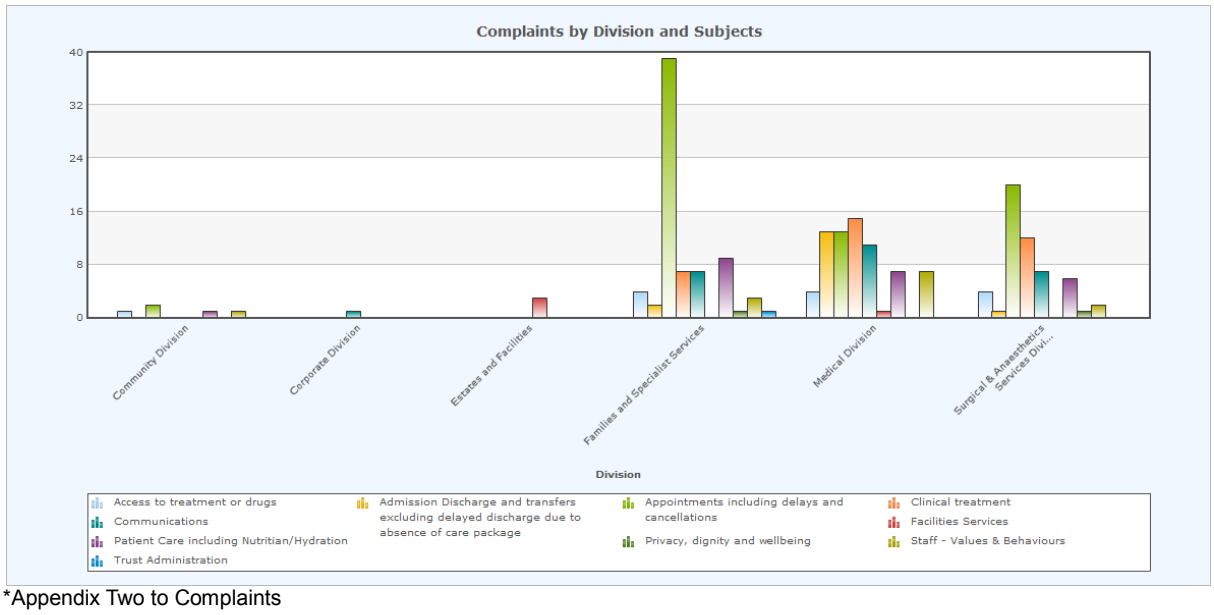
The Trust received a total number of 209 concerns in Quarter 2 of 2016/17. Concerns are issues raised by patients or relatives via the Patient Advice Team. This is only 2 less than less quarter; however there has been a 21% increase in the number of concerns received in quarter 2 of 2016/17 compared to the same quarter last year.

This year to date there has been a 25% increase in the total number of concerns received by the Trust.

## Analysis of Concerns by Theme




Appointments and Appointments including delays and cancellations was the top subject of concern in quarter 2 of 2016/17 representing 36%. This is similar to quarter 1 of 2016/17, were Appointments and Appointments including delays and cancellations represented 33% of all subjects. Clinical Treatment represented 16% of all subject received, which was the same in quarter 1. Communication has drop from 22% in quarter 1 of 2016/17 to 13% in quarter 2.




*Appendix Two to Complaints

- The top subject of concern for Medicine was Clinical Treatment, representing 21% of all concerns received for Medicine in quarter 2; this was also one of the top complaint subjects received for Medicine within quarter 2. Appointments (including delays and cancellations), Discharge and Transfers (excluding delayed discharge due to absence of care package) both represented 18%. It should also be noted that Communication reduced from 25% in quarter 1 of 2016/17 to 15% in quarter 2.

- The top subject of concern for SAS was Appointments (including delays and cancellations), representing 38% of all concerns subjects received for SAS within quarter 2, unlike complaints subjects where Clinical Treatment was the largest complaint subject received for SAS within quarter 2. Appointments (including delays and cancellations) was also the top subject of concern for SAS in quarter 1; however, there has been a 2% reduction. Clinical Treatment represented 23% and Communication 13%.

- The top subject of concern for FSS Appointments (including delays and cancellations), representing 53% of all concerns subjects received for FSS within quarter 2, unlike complaints subjects where Communication was the largest complaint subject received for FSS within quarter 2. Appointments (including delays and cancellations) was also the top subject of concern for FSS in quarter 1; however, there has been a 8% reduction. Patient Care (including Nutrition and Hydration) represented 12% and Clinical Treatment 10%.

- The top subject of concern for Community was Appointments (including delays and cancellations), representing 40% of all concerns subjects received for Community within quarter 2, unlike complaints subjects where Communication was the largest complaint subject received for Community within quarter 2. Appointments (including delays and cancellations) was also the top subject of concern for Community in quarter 1; however, there has been a 26% reduction. Access to Treat or Drugs, Patient Care (including Nutrition and Hydration), and Staff - Values & Behaviours each represent 20% of the subject of concern received by Community.

Similar to quarter 1, whilst Appointments including Delays and Cancellations was top subject of concern in quarter 2 and the top subject for SAS, FSS and Community, it was not in the top three subjects of complaint, nor was it with the top three for Medicine, SAS or FFS. Again like quarter 1 this would suggest that the majority of these issues are resolved through the Patient Advice Service.

**Patient Opinion Feedback 2015/16**

Patient Opinion is an independent website about patient's experiences of health services, good and bad. The Patient Advice Team review comments receive and advise people leaving negative feedback to contact the service if they wish to take their concerns further.

**Compliments 2015/16**

10 compliments were recorded on the Datix risk management for quarter 2 of 2016/17. The numbers below under estimate the number of compliments received, as many compliments are made direct to teams and wards and are not captured in a central system. Work continues to improve the capturing of compliments received.

| Division | Number of Compliments recorded on Datix Q3 2015/16 by directorate |
|---|---|
| **Medicine** | 6 |
| **SAS** | 2 |
| **FSS** | 1 |
| **Community** | 1 |

**Learning from Complaints**

The feedback we receive from complaints gives the Trust a wealth of information that can be used to improve services as an individual complaint provides detailed insight into a patient's

experience.

As an organisation we aim to ensure that we learn from complaints so that we can:

- Share good practice
- Increase patient safety
- Improve the patient experience
- Reduce the number of complaints

Our complaints process includes identifying learning from each complaint and sharing this and each service and division is required to be clear:

- How the services records learning from complaints
- How this learning is disseminated within the service / directorate / division
- How it can point to changes arising from learning from complaints

Information on learning from complaints for each division is given below.

**Learning:**

| **FFS** | | |
|---|---|---|
| Issue: | Findings: | Learning: |
| <u>Community Midwifery:</u><br>Patient felt that taking her age and history of hypothyroidism into consideration, she should have been referred to CRH at the beginning of her pregnancy and raised this with the Community Manager when she was 12 weeks pregnant. Patient was not referred until 19+6 pregnant. | Patient not referred to a Consultant Obstetrician & Endocrinologist in a timely manner.<br><br>Correct screening offer not given. | Review of referral process to be undertaken<br><br>Consultant Endocrinologist to provide sessions to midwifes re: Thyroid/endocrine conditions and the effects on pregnancy & reasons for early referral.<br><br>Midwifes to refresh themselves with current A/N screening offer and referral criteria. |
| <u>Paediatrics:</u><br>Issues with administration of antibiotics to child with allergies | Staff knowledge of drug administration was found lacking. Staff have been asked to update their knowledge of the BNFC and its use | Both BNFc and Medicines for Children book are both used and can have conflicting information. This will be discussed with pharmacists and staff to ensure consistent approaches.<br><br>Nurses give conflicting information regarding drug administration. |

| | | |
|---|---|---|
| | | Previous allergies do not indicate allergic reactions to antibiotics. |
| <u>Outpatient and Records:</u><br>Letter received from patient unhappy that BSL interpreter not booked for his last three appointments and did not understand why the interpreting service had changed. | Due to an admin error a BSL interpreter flag was not added to the PAS record for the patient. Therefore interpreter was not booked. | To ensure that BSL flags are added to the patient's electronic record immediately upon receipt of a referral, which should identify the need of BSL services. |
| <u>Radiology:</u><br>Complaint regarding delay with biopsy procedure and lack of communication from various departments resulting in patient having to make own enquiries and ensuring appt was made. Unhappy with delays which has caused further stress and worry as to what the diagnosis is and way forward. | Lack of information on neck biopsy | To ensure that patients have all appropriate information for their procedure.<br><br>Patient Information Leaflet developed. |
| <u>Pharmacy:</u><br>Patient who was unhappy with pharmacy services as attended an out-patient clinic and given a prescription to take to the hospital pharmacy. When patient arrived at pharmacy noticed around 40 other people waiting so enquired with another patient whose prescription had been dispensed as to how long they had been waiting | There were serious staffing issues with WELL Pharmacy on that day. | Pharmacy to be adequately resourced and this will be monitored through the Contract Monitoring meeting. |

| | | |
|---|---|---|
| and informed waited an hour and a half. Patient therefore left as felt wait was too long and unable to take prescription to any other pharmacy so felt this 'created a monopoly and could breach competition and fair trading rules. | | |
| **SAS** | | |
| Issue: | Findings: | Learning: |
| <u>Misdiagnosis:</u><br>Mix up of breast specimens at Bradford leading to a misdiagnosis for breast cancer | Patient was caused unnecessary anxiety waiting for correct results | Multi Disciplinary Team (which includes CHFT) needs to improve communication with the patient to keep them fully informed |
| <u>Test Results:</u><br>Guidelines state that a clinician who orders tests should follow up the results with the patient themselves | The clinician who ordered the test was not available to see the patient in clinic for 2 weeks and no process in place for deputising | An assurance that there is a proper process in place for informing patients and keeping them informed throughout their care |
| <u>Delay in providing Results</u>:<br>Results of a CT scan showed changes from previous CT scan from 6 months ago. Changes were discussed at Upper GI Multi Disciplinary Team meeting held at Bradford and Leeds. Patient was not informed of this due to consultant being on leave and registrar not copying the letter to the patient | Patient was caused unnecessary anxiety waiting for update. Patient had lung cancer and potentially cancer of the pancreas | It is accepted that CHFT's communication process needs to improve and as a result all the secretaries have now been moved into one area to promote better communication between teams (Lung MDT and Upper GI MDT in this case) |

| Medicine | | |
|---|---|---|
| Issue: | Findings: | Learning: |
| Communication:<br>Concerns from family as felt nothing was being done for the patient. | Lack of communication with the family | If information is not passed on to family, it can appear that nothing has been done.<br><br>To ensure that patient care is discussed with family. To be reinforced at daily safety huddles. This will ensure that staff are reminded to discuss patient care with the patient and family to avoid this issue in the future. |
| Triage Assessment:<br>Concerns regarding triage assessment. | Triage nurse did not complete a full assessment at point of triage. | Further training on triage process to be completed by staff nurse involved with a note to be kept on their personnel file. This will prevent further omissions in full assessments taking place. |
| Falls:<br>Patient fall whilst in hospital. | Falls mat not in place for patient who was admitted to hospital as a result of a fall, who then fell whilst in hospital. | The fall may have been prevented if the correct equipment had been provided. A falls assessment had been undertaken. Ward sister will remind staff of the importance of using the correct equipment to prevent falls.<br><br>The newly created Lead Falls Prevention Nurse will review and revise the falls bundles and ensure that relevant actions are taken to prevent falls and to minimize the potential for harm. |

| | | |
|---|---|---|
| <u>Dementia Care:</u><br>Concerns regarding documentation of Butterfly Care Plan. | Failure to file Butterfly Care Plan in correct place in notes. As a result, 2 copies had been completed by family. | This can lead to lack of trust that information provided by the family is used to provide individualized care.<br><br>Ward sister to clarify with staff where the butterfly care plan should be filed so that staff know where to find them. |
| <u>Delay in diagnosis:</u><br>Delay in diagnosis of fractured finger. | EDIS documentation did not include details of injury or pain relating to a fractured finger following a road traffic accident. | Listening clearly to the presenting symptoms and ensuring accurate documentation of presenting symptoms is crucial to ensure that a thorough examination takes place and fractures are not missed. There was no documentation stating that the patient had complained of pain in the finger. |
| <u>Delay in diagnosis:</u><br>Delay in diagnosis of stroke. | MRI scan was not performed to exclude stoke as a diagnosis at a TIA clinic appointment. | Signs and symptoms in TIA clinic were not consistent with a stroke. MRI conducted by the neurology department almost a month after the TIA clinic appointment determined that the patient had actually had suffered 8 mini strokes and has since had surgery to remove a blockage from his neck. Increase of MRI slots to allow for scans to be undertaken in patients who present to clinic without any detectable stroke symptoms. |

| PHSO Complaints | | |
|---|---|---|
| Issue: | Findings: | Learning: |
| <u>Lymphoedema Services:</u><br>The Trust was unable to provide patient with, or refer her for, treatment for her lymphoedema for over three months, which resulted in the patient seeking private treatment.<br>The complainant also also complained about the Trust's handling of the complaint. | The PHSO have found no failings in relation to the care provided by the Trust. The PHSO acknowledged that the patient chose to pay for private treatment for her lymphoedema but they did not attribute this to a failing by the Trust.<br><br>The PHSO found that the Trust acknowledged a delay in arranging an appointment. However, they found there was no clinical need to urgently arrange an appointment and support was available in the meantime. The PHSO found a failing in the Trust's complaint handling as there were unexplained delays in responding to patient's complaint, as the Trust did not update the patient between August 2015 and November 2015 and has not acknowledged this delay. | Significant work has already been untaken to increase the responsiveness to Complaints and to keep the Complainant update throughout the complaints process. |

**Key National Publications**

**House of Commons Public Administration and Constitutional Affairs Committee -** Follow-up to PHSO Report on Unsafe Discharge from Hospital, 14 September 2016.

Following on from the PHSO's report in May 2016 (detailed in report for quarter 1), the Public Administration and Constitutional Affairs Committee (PACAC) sought to understand the scale of the problems highlighted in the PHSO's report and the extent to which the cases discussed within the PHSO's report point to wider issues in health and social care. The PACAC sought to assess the current measures for improving discharge practices and to clarify responsibilities and accountabilities across Government for ensuring that improvements are implemented and discharge processes are safe and effective.

The PACAC found that the incidence of unsafe discharge from NHS hospitals is much too high and this is unacceptable. Spending constraints and demand pressures can only make matters worse, but these in themselves are not an excuse for poor practice or failure to communicate, leading to unacceptable risk to patients. This is a challenge that can only be met by empowering staff and ensuring that their attitudes and procedures can guarantee that clinical judgment and humane common sense are not marginalised by the pressure to provide bed space to other patients. These pressures add to the challenge, and the PACAC paid tribute to all those on the front line of care who face this challenge.

The report advises that the PACAC expect the Healthcare Safety Investigation Branch (HSIB) to play a major role in investigating serious incidents of unsafe discharge, to learn lessons from each case, and to ensure that learning is disseminated and implemented throughout the NHS.

**Trust action taken**
Further to quarter 1 report, the lead matron for discharge, undertook a piece of work to review the Trust's discharge procedure, looking at the issues raised within the PHSO report. The PACAC report has been forward to the lead matron for discharge for inclusion into her report. This will be fed back through the Patient Experience Group during Q3.

**Parliamentary and Health Service Ombudsman – Learning from Mistakes: An investigation report by the Parliamentary and Health Service Ombudsman into how the NHS failed to properly investigate the death of a three-year old child, 18 July 2016.**

The report calls for a no-blame culture in which leaders and staff in every NHS organisation feel confident to openly investigate complaints, in order to learn from them and improve patient safety. The reports states that the NHS needs to build a culture which gives staff and organisations the confidence to find out if and why something went wrong so that they can learn from it.

An investigation by the Ombudsman service into the death of child, published in 2014, focused on the care and treatment he received and found that his death was avoidable. It fully upheld the family's complaint and the organisations complained about have taken action to put things right.

The report looks into how the NHS failed to uncover that the child's death was avoidable, which has lessons for the whole of the NHS in how it investigates such cases. It reveals how those involved in the local NHS investigations were not sufficiently trained, aware of the relevant guidelines or sufficiently independent of the facts complained about.

The report highlights how the local NHS investigation processes were not fit for purpose, they were not sufficiently independent, inquisitive, open or transparent, properly focused on learning,

or able to span organisational and hierarchical barriers, and they excluded the family and junior staff in the process.

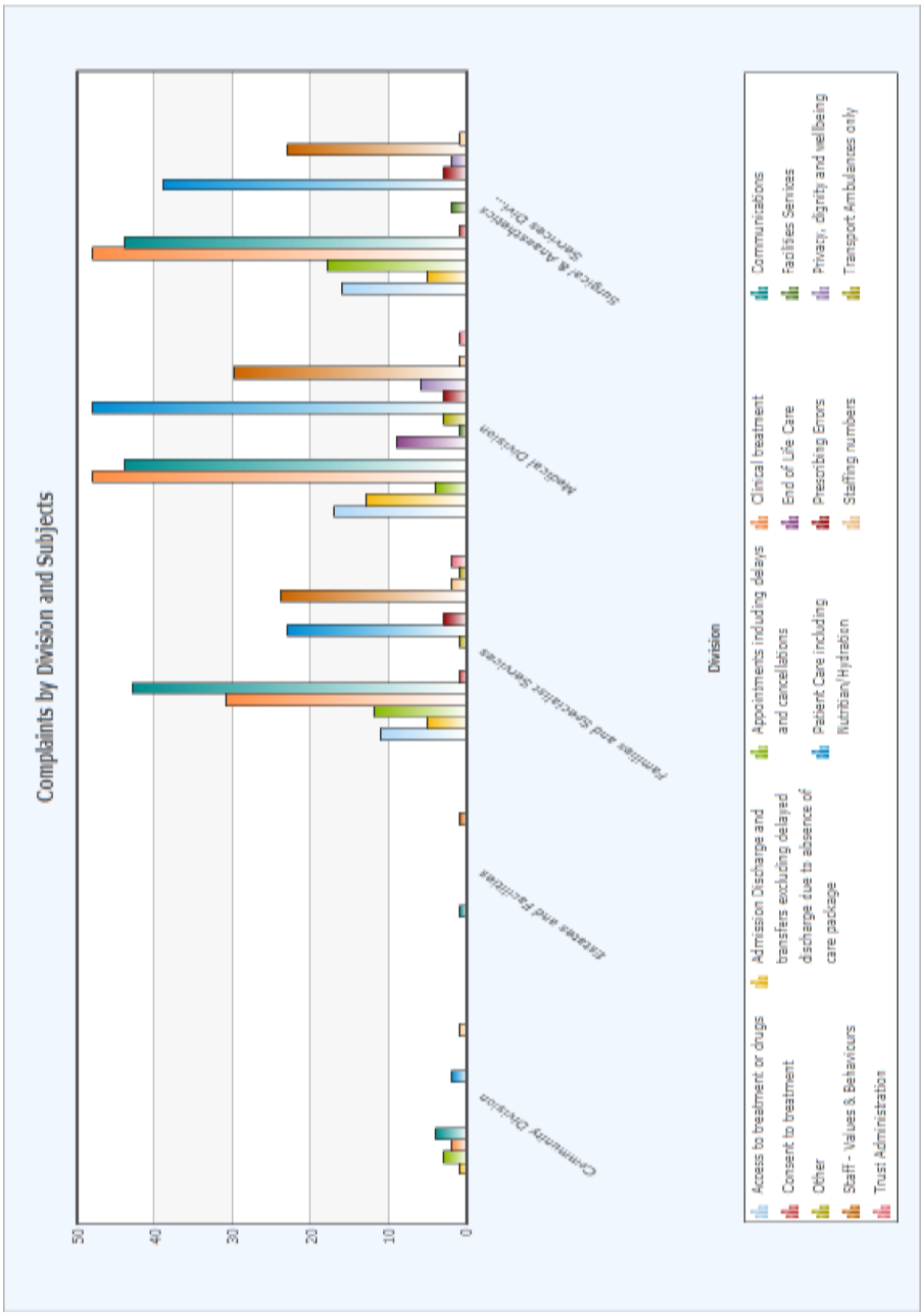
The findings in this report echo the Ombudsman service's recent review into the ***Quality of NHS investigations***, published last December, which found that 40 per cent of NHS investigations were not adequate at finding what had happened. Since January 2016, a further 436 complaints about potential avoidable death have been investigated by the Ombudsman service, of which 200 have been partly or fully upheld. A total of 29 of these 200 were fully upheld.

The report highlights how all NHS organisations can learn from mistakes, as well as the Parliamentary and Health Service Ombudsman. The report highlights how the family has contributed to how the Ombudsman service uses its casework to help NHS leaders drive through system improvements.

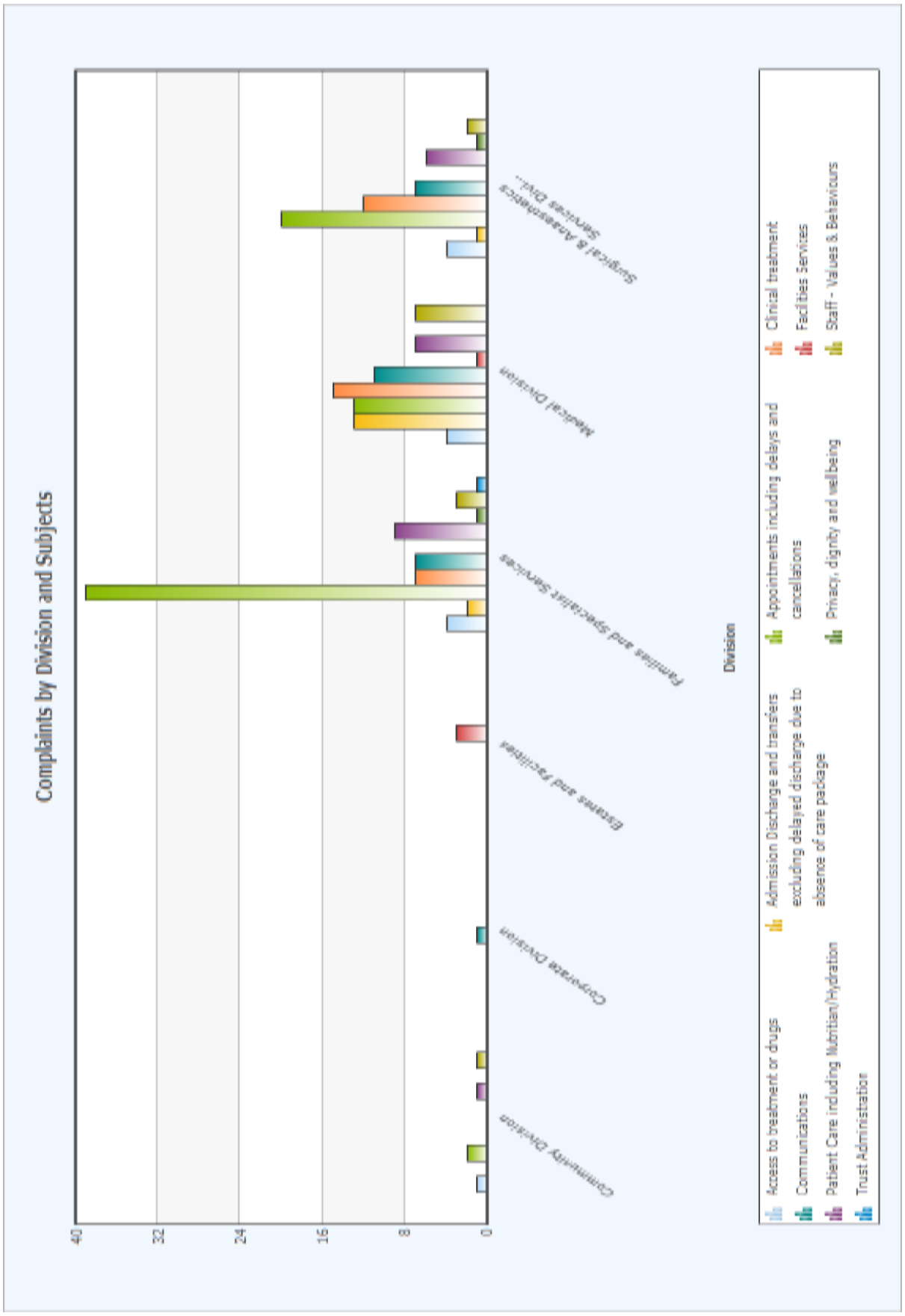
The report welcomes the creation of the Health Safety Investigation Branch (HSIB). However it highlights the importance of conducting good local NHS investigations, as HSIB will only investigate a small number of cases. This means that many families will still be reliant on local NHS investigations to get answers and to help ensure lessons are learnt.

**Trust action**
The key points relating to ensuring that investigations are fit for purpose will be included within the complaints investigation training course from Q3 onwards.

## Appendix One: Complaints by Division & Subject



## Appendix Two: Concerns by Division & Subject



## CLINICAL CLAIMS

The Trust is insured for clinical claims through its insurers the NHS Litigation Authority. This is paid for by an annual premium which reflects our claims history.

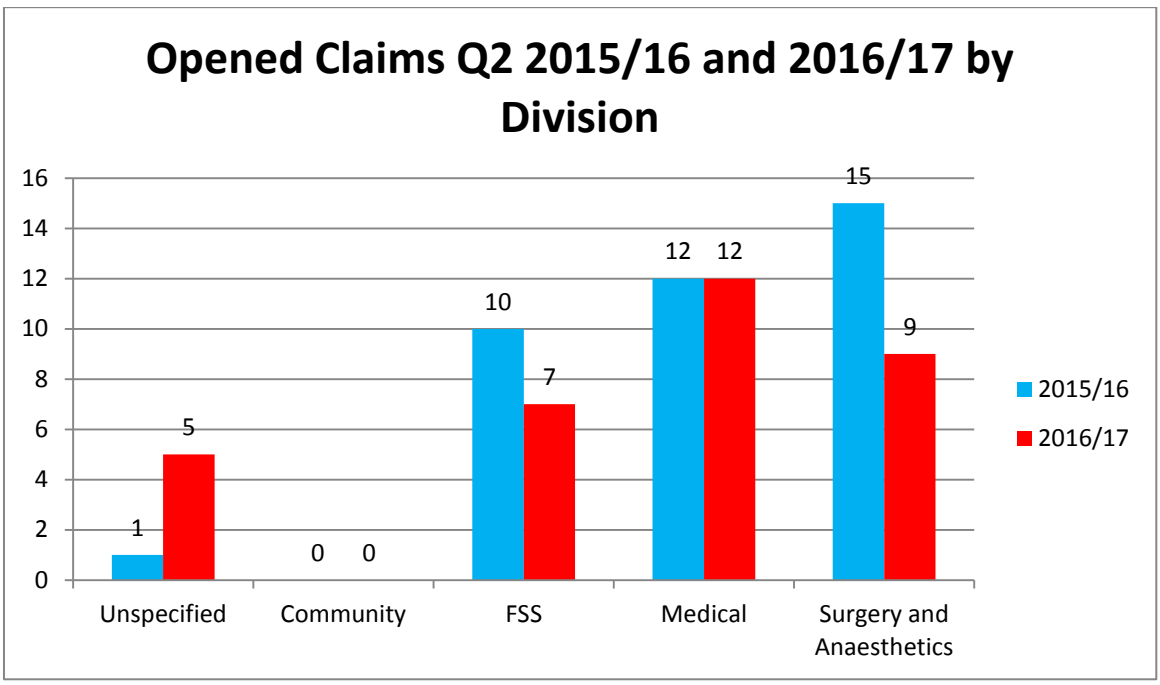
## Opened Claims

In Q1 2016/17 33 new clinical claims were opened. In the same quarter of 2015/16 38 new claims were opened. This represents a small decrease of 13.1%.

## Opened Claims by Division

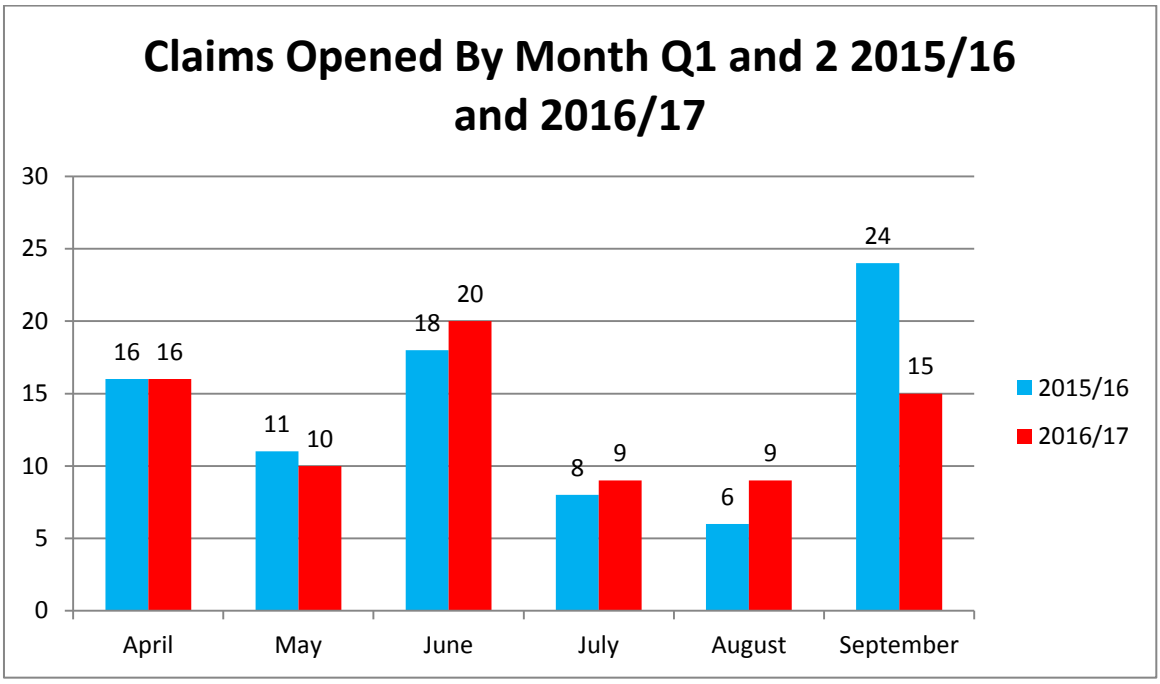
The graph below shows the number of opened claims over the comparable quarters by Division during Q2 of 16/17 and 15/16. Notable trends show a decrease in FSS from 10 to 7 claims (30%) and a large decrease in Surgery and Anaesthetics from 15 to 9 claims (40%).

Of note the 5 claims in Q2 of 2016/17 which are unallocated to a division. It is not uncommon for claimant solicitors not to specify the nature of the claim despite the Legal Services Team asking them to specify the nature of the intended claim in line with the Clinical Negligence Protocol.



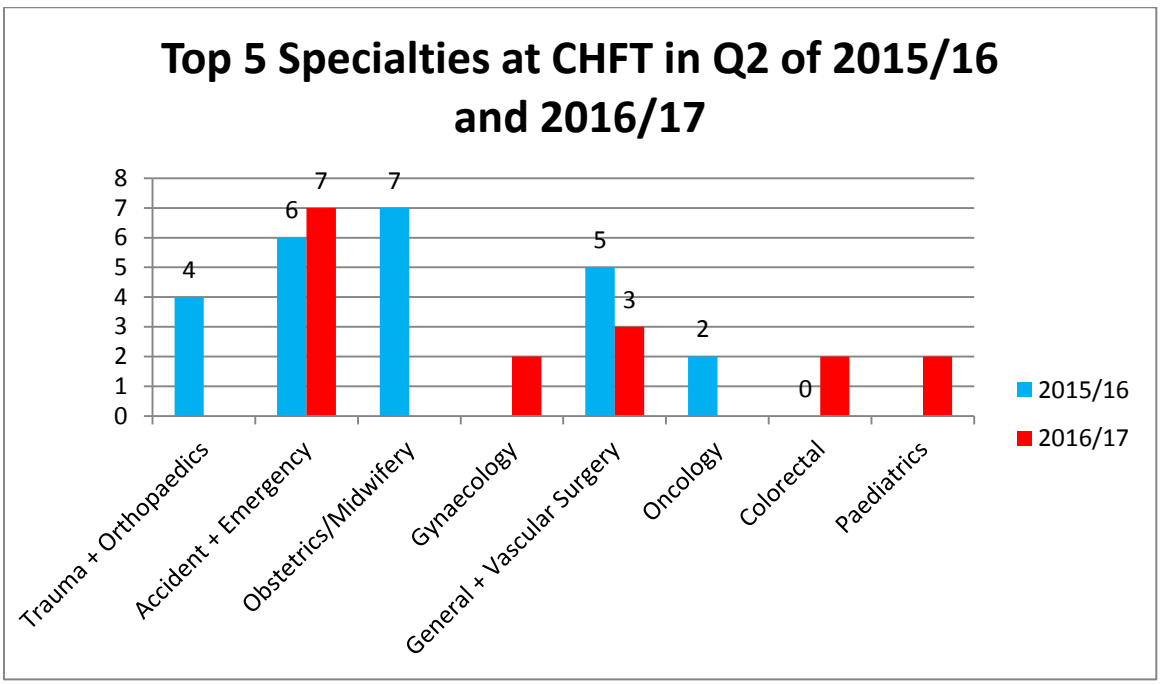

## Opened Claims By Month in Q1 and 2

Below shows the number of claims opened by month over the last two quarters over 2015/16 and 2016/17. Of note is that in July and August in both financial years there are marked decreases in the number of claims opened, with 83 claims opened in the first 6 months of 2015/16 and 76 during the first 6 months of 2016/17.




## Claims Opened by Specialty

The Top 5 specialties at CHFT for Q1 of 2016/17 and 2015/16 are detailed below.




In 2016/17 Trauma and Orthopaedics is no longer in the top 5 specialty, nor is Obstetrics/Midwifery. This is reassuring as claims within the latter specialty give rise to the multi-million pound settlements.

A+E has seen a small increase in the number of claims whilst still remaining in the top 5 specialty claim types for the same quarter in both financial years.

Gynaecology, Colorectal and Paediatrics have all entered in to the top 5 specialty in Q2 of 2016/17. Brief details of these claims is provided below:

a) **Gynaecology –** 1 case relates to a procedure allegedly undertaken without informed consent, the second case relates to clips retained following an operation.

b) **Colorectal –** 1 case relates to a failure to diagnose and treat peritonitis, the second relates to an alleged failure to perform surgery to an acceptable standard. Both cases are at the disclosure of medical records stage.

c) **Paediatrics –** 1 case relates to treatment in the A & E Department which has been investigated as a serious incident, the second case relates to an alleged failure to diagnose and treat appendicitis**.**

All cases are at the disclosure of medical records stage.

The top 5 specialties in Q1 of 2016/17 are below (see above for Q2):

A+E (6)

Obstetrics +Midwifery (4)

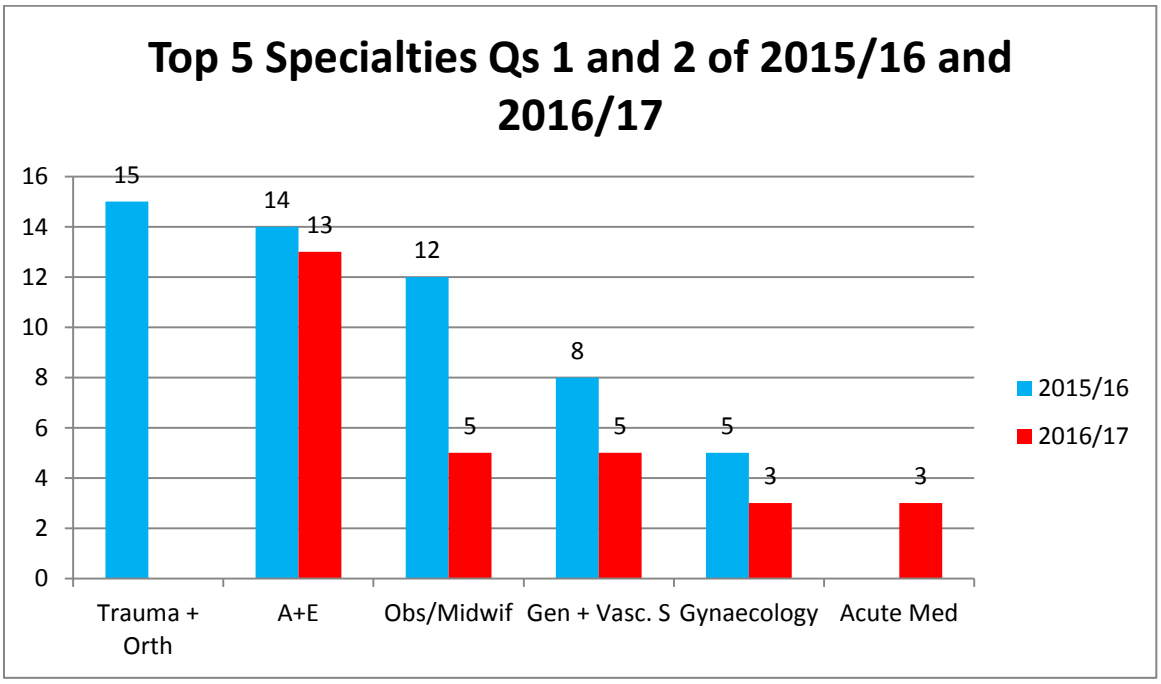
Trauma + Orthopaedics(3)

General +Vascular Surgery(2)

ENT(2).

**Top 5 Specialties in Q1 and Q2 of 2016/17 and 2015/16**

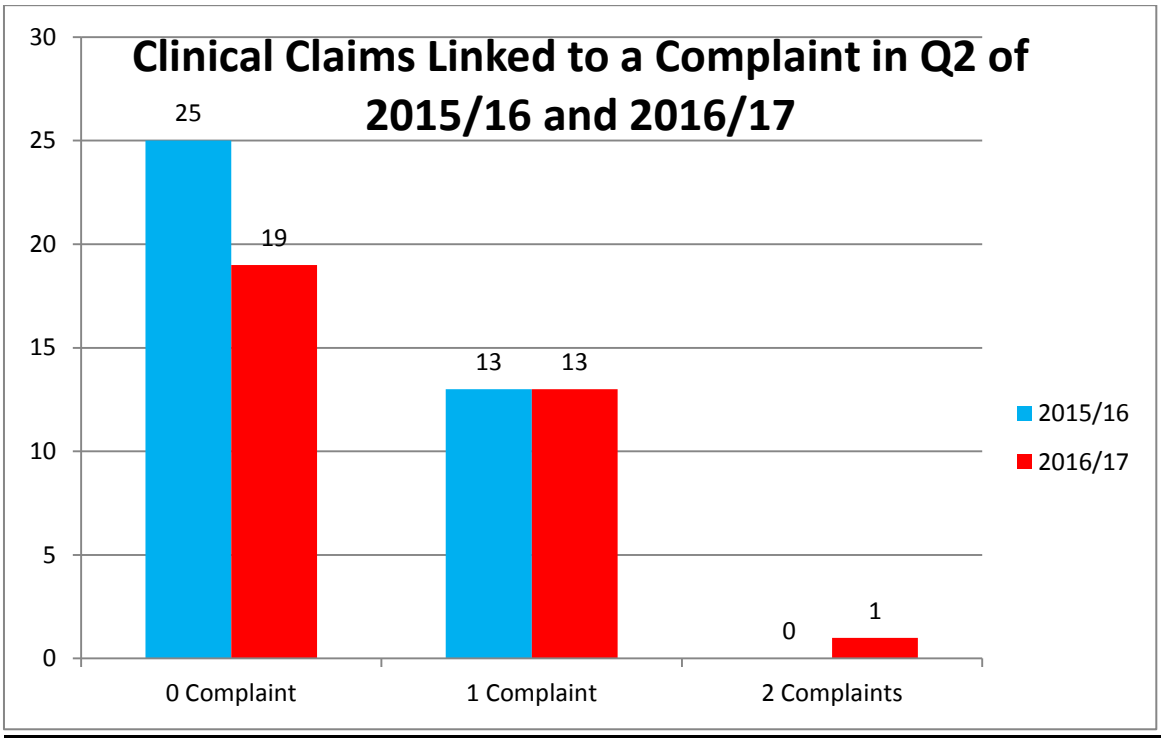
The bar graph below shows what the top 5 Specialties have been over the last 6 months (Qs 1 and 2) in 2016/17 and 2015/16. In 2016/17 Trauma + Orthopaedics fell out of the top 5 specialties and Acute Medicine now features in the top 5 specialty.



## Claims Linked to Complaints

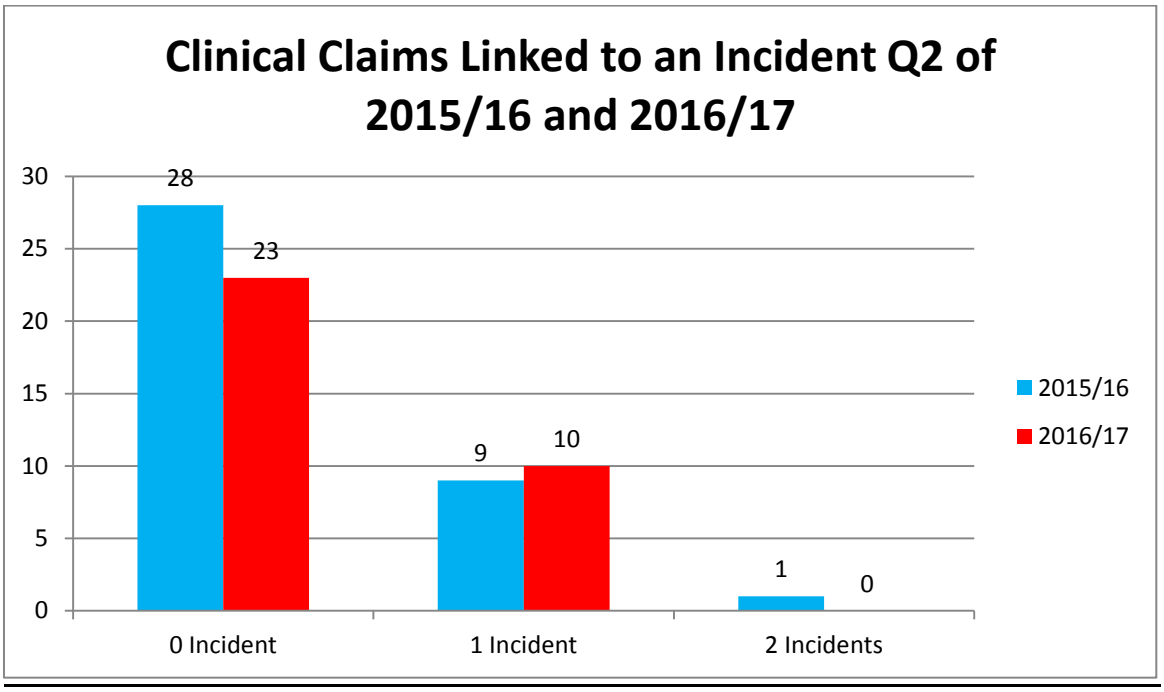
The bar graph below shows that in2016/17 14/33 (42.4%) claims were linked to at least one complaint. In the same quarter of 2015/16 13/38 (34.2%) claims were linked to a complaint. This shows a marked increase over the last two quarters. One reason for this is that pursuing a complaint is a cost effective way of establishing if there is merit in a claim.

The claim that is linked to two complaints is a concern that became a complaint, which relates to an alleged delay in diagnosis and treatment.




## Claims Linked to Incidents

The bar graph below shows the number of claims linked to an incident. In Q2 of 2016/17 10/33 (30.3%) of claims were linked to at least 1 incident. In Q2 of 2015/16 10/38 (26.3%) of claims were linked to an incident. There is a small increase in numbers of claims being linked to an incident in Q2 of 2016/17.




## Closed Claims

In Q2 of 2016/17, 21 claims were closed. Of the 21 claims that were closed 4 claims (19%) closed without any payments being made. Of the 17 claims that closed with payments, the highest payment was for a claim from the Medicine Division for a delay in diagnosing and treating severe sepsis and shock.

In Q2 of 2015/16, 17 claims were closed. 5/17 (29.4%) closed without any payments being made. The remaining 12 closed with a payment being incurred.

## NHSLA Fact sheet 2015/16

The Trust received adverse publicity for its obstetrics payments on the basis that 2014/15 saw CHFT being in the top 5 of trusts nationally for its obstetrics pay-outs (£ 9,357,422). The fact that a number of these claims were relating back to incidents (birth injuries) dating back many years was not reflected in the media.

The 2015/16 figures have now been provided by the NHSLA show that CHFT paid out £2,443,099 which does not figure in the top 20 Trusts nationally.

## Panel Solicitor's Update

In Q2 of 2016/17 good outcomes from the panel Solicitor managing claims included:

-One discontinued claim where the claimant alleged that there was an alleged delay in treating fracture. This claim has discontinued on the basis that the claimant was told of the risks of non-union of the fracture, and before his claim was settled against the other driver. CHFT has also been awarded reimbursement of its defence costs.

-One claim with a reduced settlement payment of one third of the original claim relating to delayed diagnosis of endocarditis allegedly leading to bleeding on the brain and consequent brain injury.

## Learning from Claims

Information on claims settled in quarter 1 was shared with divisions for them to evidence learning from the claims where the Trust made payments of damages to patients. This information is still awaited from divisions and will be shared in future reports. Meetings have been held with divisions to begin to embed the process.

Claims that closed between 1 July 2016 and 30 September 2016 resulting in a payment of damages to patients and staff have been circulated to the divisions for them to action and evidence what has and will be done to prevent or minimise a recurrence. A summary of the claim is provided below and divisions will be asked during October to provide evidence of learning.

| **Family and Specialist Services (FSS)<br>Childrens and Womens Services** |
|---|
| Inappropriate management by antenatal clinic. |
| Failures in management of delivery resulting in fourth degree tear. |
| Failure to identify abnormalities during an ultrasound scan. |
| **FSS<br>Diagnostic and Therapy Services (DATS)** |
| Following trauma to right ankle, failure to identify fracture. |
| **Medical Division** |
| Delay in treating severe sepsis and shock arising from infection following an operation. |
| Failure to diagnose testicular torsion in right testicle |
| Failure in not informing patient of treatment options for hip replacement surgery. |
| Medication administration error for patient known to be allergic to a medication. |
| Delay in diagnosis and management of pressure sore |
| Failures in nursing care resulting in the development of pressure ulcers. |
| **Surgical and Anaesthetic Services** |
| Nerve damage due to dental surgery. |
| Failure to correctly perform a colonoscopy |
| Failings in hernia repair. |
| Negligence in relation to spinal decompression surgery |
| Incorrect treatment for fractured leg |

## EMPLOYEE AND PUBLIC LIABILITY CLAMS

During the last 5 financial years up to 30 June 2016, CHFT has opened 110 new employee and public liability claims.

### Opened Claims

In Q2 of 2016/17 4 new claims were instigated against CHFT. In Q2 of 2015/16 5 claims were brought.

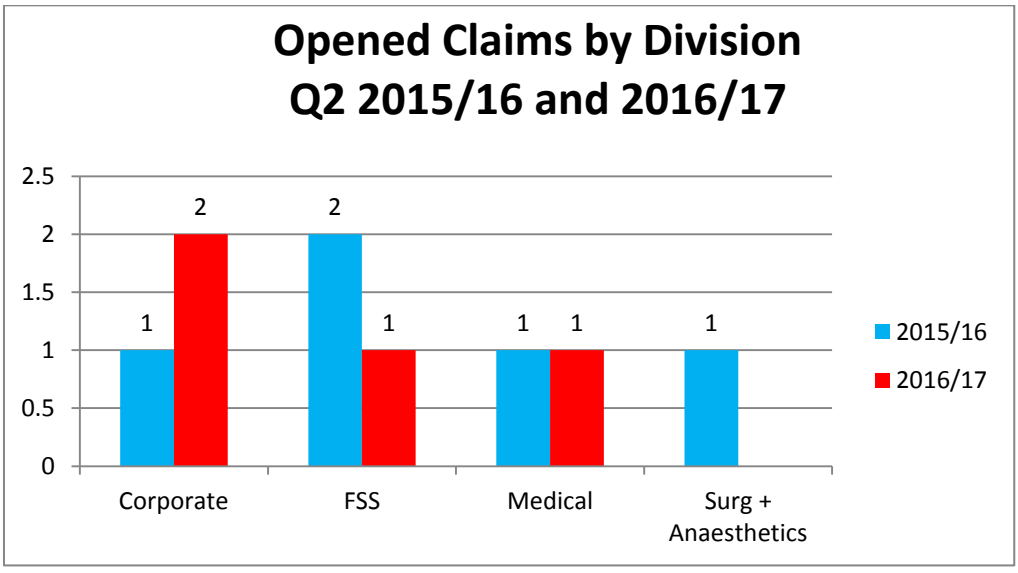
An extract of the claims descriptions brought in Q2 of 2016/17 is provided below.

| Ref | Description/Details |
|---|---|
| 3019 | Porter hurt her back whilst moving a patient. |
| 3060 | Failure to provide adequate protective equipment, masks to prevent inhalation of dust/asbestos |
| 3044 | Information governance breach by staff to patient records and disclosure. |
| 3046 | Cleaning chemical used caused/contributed to occupational asthma. |

### Claims by Division

The graph below shows the number of opened claims over the comparable quarters by Division during Q2 of 16/17 and 2015/16. The claims relating to Corporate Division come from the Estates and Facilities specialty. In 2016/17 2/4 (50%) of these claims related to a medical device/equipment.

See Table below:



## Claims Linked to Incidents

In Q2 of 2016/17, 2/4 (50%) claims were linked to an incident. In Q2 of 2015/16, 5/5 claims were linked to an incident. If a claim is not linked to an incident the Trust has the possibility of a reasonable defence.

## Closed Claims

In Q2 of 2016/17 4 claims were closed. ½ claims closed with a payment of damages to the claimant. ¼ claims closed with payment of damages to the claimant (a staff member). The claim relates to a member of staff working at the time of the incident and was near the kitchen pushing a trolley along the corridor. A colleague pushing the laundry basket behind her had caught Claimant's leg and caused her injuries a colleague pushing the laundry basket behind her had caught Claimant's leg and caused her injuries. Claimant was advised that the laundry basked was overloaded and due to the faulty wheels made it difficult to see the client. A breach of duty was admitted on the basis of the faulty equipment. The damages payment was £3,707.

From Q2 of 2016/17 the other case closed with payment of damages is that of a patient using the handle on the toilet wall which came away from the wall causing the claimant to fall and sustain soft tissue injury to right wrist and injury to right knee. The damages payment was £5,000.

# INQUESTS

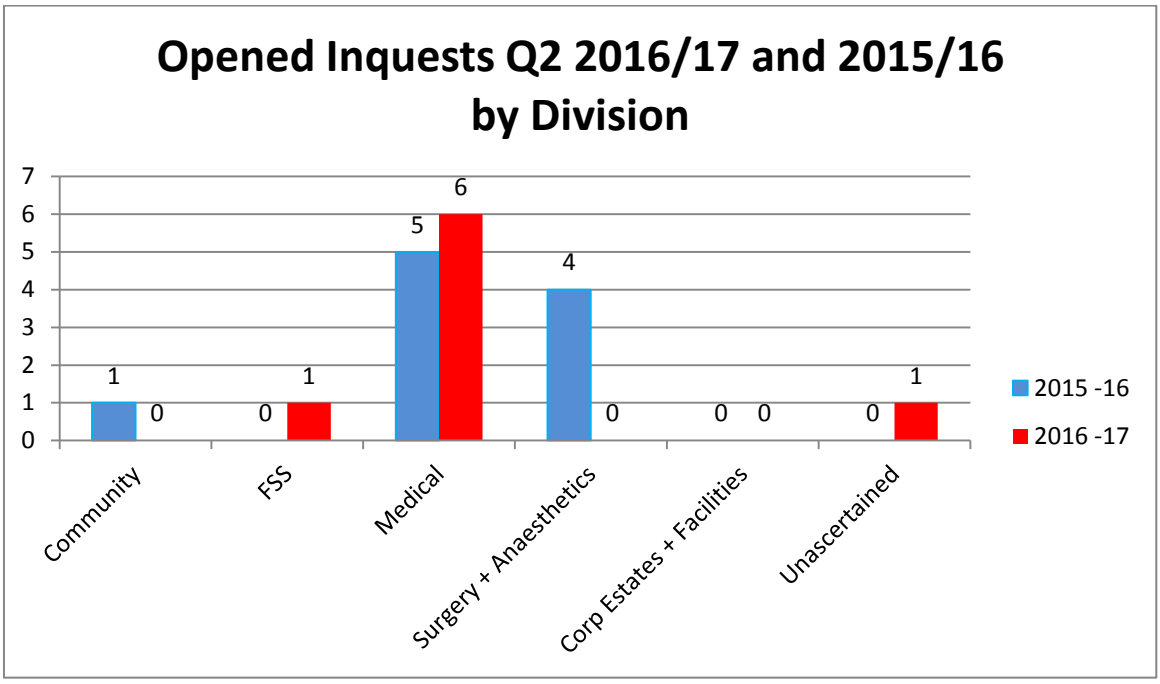
As at 30 June 2016 the Trust opened 62 inquest cases. An inquest by HM Coroner is held where here is a concern that the patient suffered a violent or unnatural death, or if the cause of death cannot be ascertained, and by a post mortem.

## Opened Inquests

In Q2 of 2016/17 8 new inquests were opened. In Q2 of 2015/16 10 new inquests were opened. This represents a decrease of 20% in the corresponding quarters.

## Opened Inquests by Division

The graph below shows the number of inquests opened by each division in Q2 over the last two financial years. Notable trends are that Medicine has seen a small increase in the number of inquests from 5 to 6 inquests over the corresponding quarters.




Looking at the 8 opened inquests for Q2 of 2016/17:

6/8 (75%) relate to Medical Division. Of these 6, 2 relate to A&E, 2 relate to Acute Medicine, 1 relates to Medicine for the Elderly and 1 relates to Elderly Care/Complex Care. There are no repetitious themes.

The remaining two inquests relate to Paediatrics specialty (child protection issues) and corporate (a staff suicide).

## Closed Inquests and Learning

In Q2 of 2016/17 1 inquest was closed. The closed inquest of Q2 of 2016/17 is detailed below.

One inquest that was concluded in Q2 of 2016/17 and concluded was the inquest as detailed below:

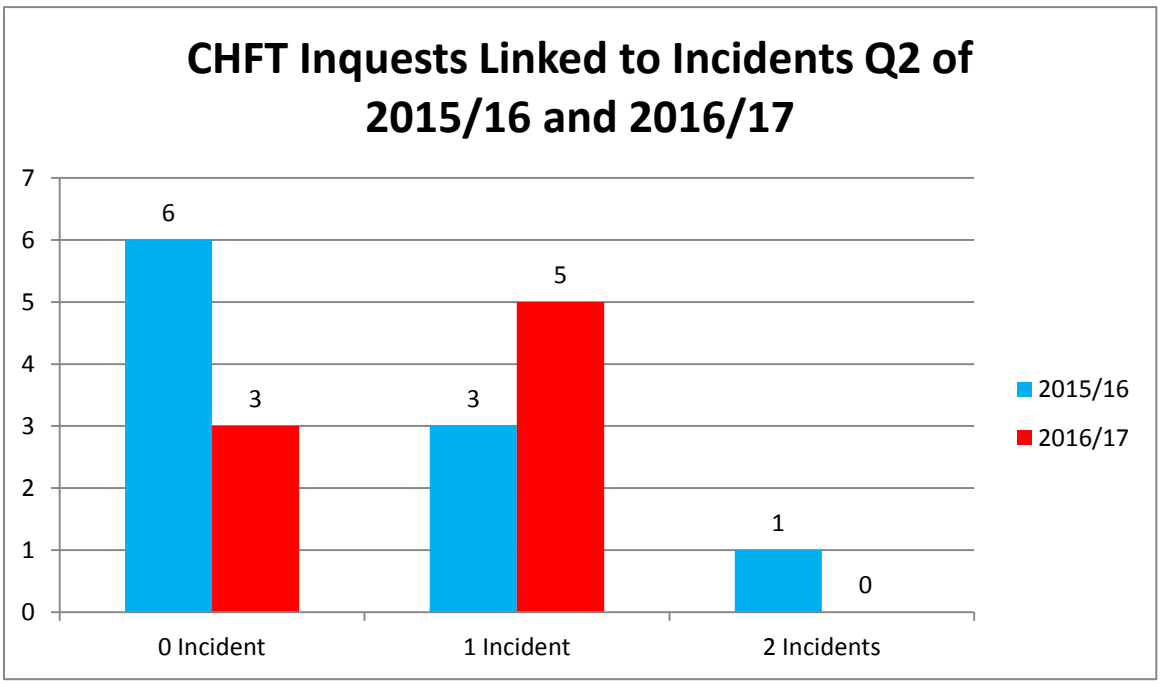
| ID | Description | Determination (at Inquest) and Learning |
|---|---|---|
| 2689 | Patient admitted with suspected overdose who left the hospital of own will, seen by passer-by in trouble on public road brought back in by police and subsequently died.<br><br>Open Verdict. No suggested Learning points. | Open verdict as, post-mortem toxicology and evidence from CHFT staff unable to ascertain a cause of death.<br><br>Clinical negligence claim intimated at end of September 2016. |

## Inquests Linked to Incidents and Complaints

The Legal, Complaints and Incidents teams are triangulating data from their respective areas to highlight and action where inquests are related to incidents and complaints so that better family, Trust and coronial engagement can take place.

Often families will use the inquest process as a vehicle to air their concerns where a complaint could resolve the issues that they have. Relationships are being forged to assist HM Coroner where our trust can deal with issues that relate to a complaint and leave the specific issues relating to the cause of death to HM Coroner. Working with the family at the earliest stage and HM Coroner leads to a better reputational outcome at the inquest and eases the family's distress at the earliest opportunity.

The graph below shows that in Q2 of 2016/17 5/8 (62.5%) inquests were linked to at least 1 incident.




In Q2 of 2016/17 no inquests were linked to a complaint.

## 4.2 Appointment Slot Issues (ASI)

**Background: E-Referral**

In order to understand the difference between national e-referral data and the CHFT reported position, a review of the May 2016 ASI position has been undertaken (the available data is 2 months in arrears).

In the month of May, 1033 patients were unable to book an appointment at the first attempt and were "deferred to provider" for booking. The data confirms that 488 (47.2%) of these patients were allocated appointments on the same or next working day. Excluding these patients who were given an appointment within 24 hours reduces the Trust's ASI position for May to just 7%.

This is similar to April and a month on month improvement (February 39% and March 40%). Early data for June 16 suggests this has again reduced to 12%.

**May 2016 data**

1033 Total ASI's

488 Total booked next working day

**47% % resolved next working day**

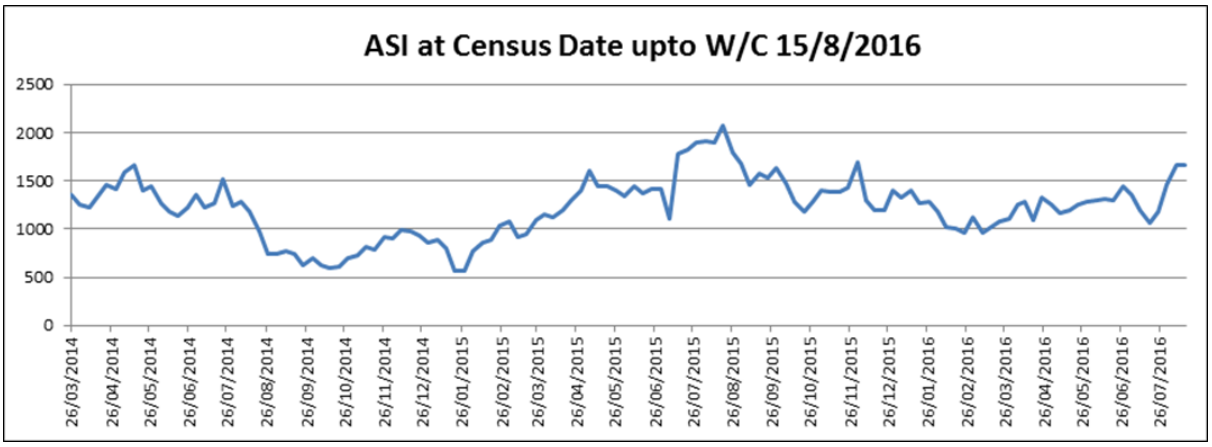
The elements supporting next day resolution are predominantly additional capacity becoming available through the nightly harvesting of slots (booked via the national telephone line or e-booking system), or lifting of the waiting time bar by the Appointment Centre where the numbers of ASIs are small and will not impact on the referral to treatment pathway.

**Trust Current Position**

As at 26th August there were 1496 referrals awaiting appointment of which 500 are e-referrals. This is a reduction of 328 referrals from the 22nd July 2015 position of 1824.

By way of illustration the average number of daily bookings via the e-referral service is 200. Assuming a current Trust ASI rate of 15%, this 200 can be summarised as follows:

- 170 patients get an appointment at the first time of asking (84%).
- Of the 30 patients who do not get an appointment at first time of asking 14 of these are successful within 24 hours
- The remaining 16 patients see a delay in getting an appointment with the Trust >1 day and would be placed onto the Trust's ASI list and managed in line with the process set out.
- It should be noted that of the 7% of patients who do not get an appointment within 24 hours, more than half of these referrals will be ERS and therefore the referral cannot be seen until an appointment is given.
- The longest wait for an e-referral appointment being from April 2016 (4 months), in the specialty of General Surgery. The average wait for those unable to get an appointment and still on the waiting list is 30 days.




The inability to place a patient into a clinic appointment at the first attempt results in a disruption to the patient's pathway and can also result in a significant amount of rework within the system in attempting to create additional clinical capacity within a necessary short period of time.

No patients should wait beyond the maximum waiting time to be seen by specialty. However the current ASI position regularly results in patients waiting beyond the recommended 6 (urgent) and 11 (routine) days for an appointment to be offered.

All paper referrals are triaged by Consultants as part of the registering process, however, triage of referrals received via ERS cannot be undertaken until an appointment has been allocated. This means that any reclassification of priority cannot be determined until an appointment is allocated.

**Capacity Requirements (as at** 26th August 2016**)**

The table below shows the number of patients waiting for appointment by time band :

| | Plastics | | | Ophthalmology | | | Maxillofacial | | | Colorectal | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | ERS | Paper | Total | ERS | Paper | Total | ERS | Paper | Total | ERS | Paper | Total |
| 0 Weeks | 0 | 0 | 0 | 22 | 0 | 22 | 0 | 0 | 0 | 2 | 4 | 6 |
| 1 Week | 0 | 2 | 2 | 11 | 3 | 14 | 1 | 66 | 67 | 8 | 4 | 12 |
| 2 Week | 0 | 1 | 1 | 21 | 18 | 39 | 1 | 81 | 82 | 21 | 9 | 30 |
| 3 Weeks | 0 | 3 | 3 | 19 | 22 | 41 | 0 | 54 | 54 | 21 | 10 | 31 |
| 4 Weeks | 1 | 8 | 9 | 26 | 36 | 62 | 0 | 32 | 32 | 11 | 9 | 20 |
| 5 Weeks | 0 | 9 | 9 | 25 | 17 | 42 | 0 | 57 | 57 | 8 | 3 | 11 |
| 6 Weeks | 1 | 13 | 14 | 27 | 10 | 37 | 0 | 31 | 31 | 15 | 6 | 21 |
| 7 Weeks | 6 | 3 | 9 | 6 | 23 | 29 | 0 | 0 | 0 | 5 | 4 | 9 |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 8 Weeks | 1 | 5 | 6 | 2 | 21 | 23 | 0 | 0 | 0 | 2 | 6 | 8 |
| 3 Months | 13 | 27 | 40 | 35 | 58 | 93 | 0 | 2 | 2 | 5 | 9 | 14 |
| 4 Months | 1 | 7 | 8 | 3 | 11 | 14 | 0 | 0 | 0 | 3 | 5 | 8 |
| 5 Months | 0 | 0 | 0 | 0 | 6 | 6 | 0 | 1 | 1 | 0 | 3 | 3 |
| 6 Months | 0 | 0 | 0 | 0 | 3 | 3 | 0 | 0 | 0 | 0 | 0 | 0 |
| >6 Months | | | | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | 23 | 78 | 101 | 197 | 228 | 425 | 2 | 324 | 326 | 101 | 72 | 173 |

**ASI Reporting and Validation**

The waiting list is managed centrally by the Appointment Centre; Appointment Slot Issues are added daily to the ASIS database from the E-Referral Service (ERS) report of patients unable to book an appointment, and the list of paper referrals unable to book. For small numbers of ASIs, the waiting time bar is lifted (on the day of receiving the ASI) in order to allocate an appointment.

The ASI database is accessible by all operational managers and appointment team leaders, and is populated with ASIs, special instructions and solutions. It includes a useful audit trail of patient contacts. On receipt of additional capacity (which can take days/weeks), contact is made with each patient in chronological order, and appointments booked.

**Action Plan**

The clinical divisions (at divisional Access meeting) regularly review current clinic capacity v demand in order to evaluate where there are / will be any capacity pressures. A gap analysis is undertaken at specialty level and shared with the operational managers for action.

Capacity and demand modelling is an integral part of the Access meeting and the Information Team regularly discuss with service leads in order to ascertain any pressures. Additionally they report on referral demand monthly by specialty, as any growth over contract will also cause a pressure on the ASI.

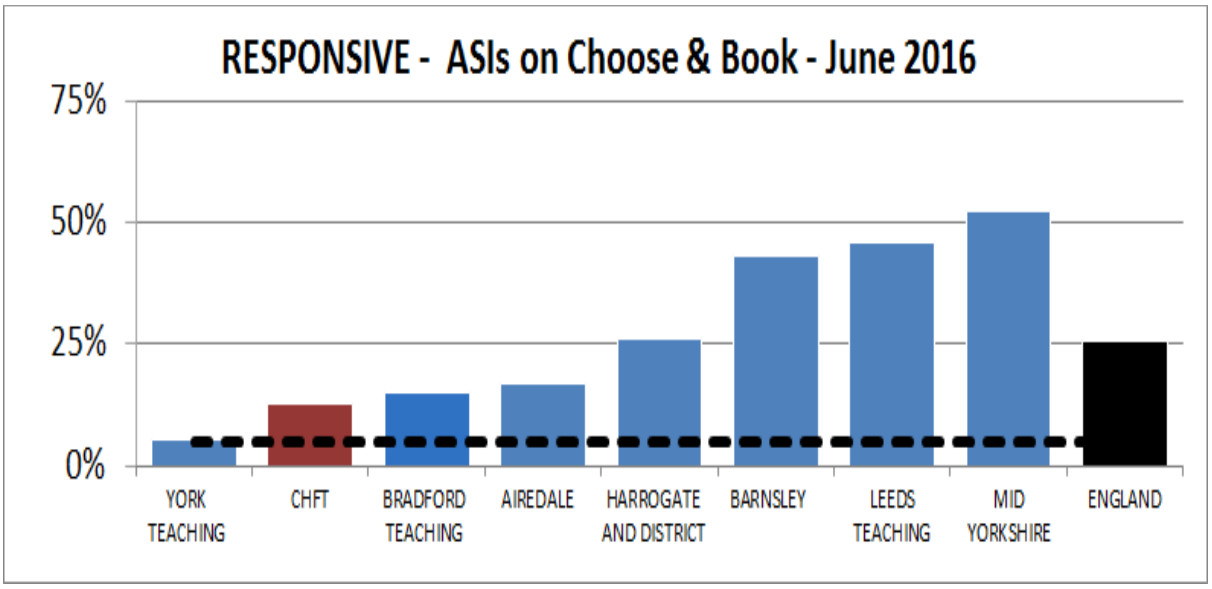
Current ASI Action Plan (appendix 1) which has been developed to reduce the current ASIs and maximise slot availability, and provides a timeline to improve the ASI position in those specialities which are currently most challenged.

Monitoring of the action plan takes place via the weekly Performance Meetings and progress reported to the monthly divisional business meetings.

**Benchmarking**

The graph below shows the E-referral ASI position in comparison to other local Trusts. Contact has been made with York Trust to understand the excellent ASI position (5%), which we now appreciate is achieved through extending the polling range for appointments beyond the 18

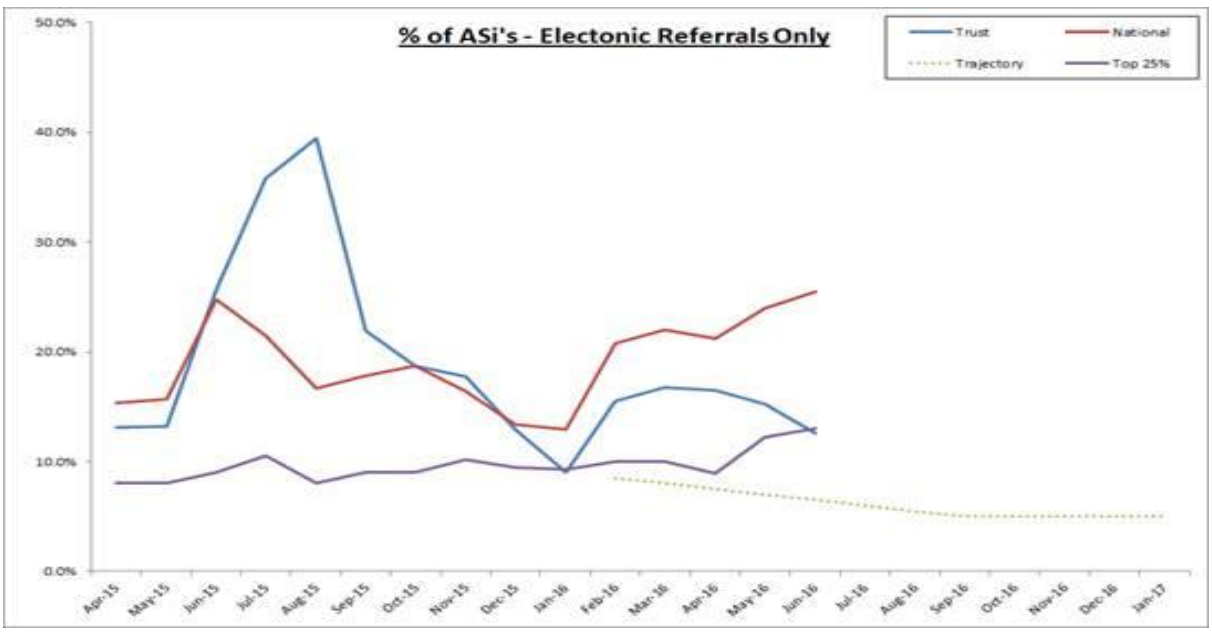
weeks ceiling. Incidentally, York's 18 weeks non admitted RTT performance is 95% and admitted 70%, in comparison to 86% and 98% at CHFT.




**Trajectory**

The graph below shows Trust ASI position in comparison to the national position and highlights that the Trust ASI levels are reducing at a time when nationally ASIs are increasing. The graph also includes the proposed trajectory to recover the ASI position based on the actions described above.

Subject to delivery of the actions described, it is anticipated that the ASI position of <5% will be achieved by November 2016. Performance against the <5% target, will continue to be monitored via the Performance and Outpatient Productivity Divisional Challenge meetings.



**Recommendations**

The following recommendations are proposed in order to reduce ASIs to the <5% threshold and ensure patients are seen in a timely manner, and any delays to treatment are within a clinically acceptable timeframe:

- Surgical Division to concentrate efforts on reducing ASIs in the on top 4 specialties of General Surgery, Maxillofacial, Ophthalmology and Plastic Surgery as the combined specialties represent 75% of the total waiting list.
- Clinical Divisions to review capacity and demand plans to minimise future ASIs.
- Clinical Divisions to support delivery of a Trust maximum standard of 11 working days from appointment identification to allocation to minimise impact on patient experience.

## 4.3 Patient Flow

**Executive Summary**

The SAFER Transformational Programme has a combination of committed and courageous leadership, workforce engagement and motivation, accountability and insights from data; all elements that are important for an ambitious transformation programme to succeed. In addition, we are part of 2 national collaborative and a supportive health and social care system both of which are significant enablers for impact.

Our organisational SAFER transformational programme is now aligned with our commissioner and primary care partner QIPP programmes; we have collaborative partners in all elements of the transformation work from Social Care to Locala Community Partnership and the voluntary sector.

We are engaging with staff, patients and the membership council through a continuously developing communication strategy.

The programme is in its second formal quarter and is managed through a formal programme governance structure with a monthly SAFER Board where the three main work streams are held to account for progress and improvement.

**The Programme is structured in three work streams:-**

1. Bed Avoidance
2. Bed Efficiencies
3. Bed Alternatives

Each work stream has two key themes identified from the 5 year plan and are those which are felt will deliver both the financial element and as importantly quality and safety and above all improved patient outcomes and experience in year one (16/17).

Update on overall progress;

- LOS had stabilised at around 5.5 days, the mean from December 2015 being 5.9. There could be an increase in LOS as a consequence of increasing ambulatory care patients. The patients with a LOS at present of 0-1 who will now go through AAU will be now 0 day LOS which will impact on the denominator. Work has commenced to ensure we can map this change effectively and ensure system agreement on the outcome.
- Increased collaborative working between CHFT discharge teams and Local Authority teams who are now co-located have contributed to a reduction in patients with a LOS over 100 days.
- At present the Trust has 694 adult beds open (excluding Obstetrics). This is a significant reduction from a high point of 749 at the onset of the programme and despite non elective demand, Green X patients and Excess bed days running higher than plan. The target is 680 in October. The Winter Plan for the Medical Division was to open an additional 39 beds. The introduction of work within each SAFER work stream enabled a revised plan to be developed of only 24 beds. However a continued reduction in the need for these beds is predicted with the planned increase in Ambulatory Care and the operationalising of an Acute Frailty model's, bed efficiency initiatives and improvements expected through new rehab processes.
- Targeted partnership collaboration is focusing on expediting the patient's with a LOS over 50 days, alongside a clinical review of patients with a LOS over 6 days reflecting one of the high impact initiatives recommended by NHSI.

**Work Stream Updates**

## 1. Bed Avoidance

### Theme 1: Ambulatory Emergency Care (AEC)

Work to date:
The AEC team, who are from across health and adult social care have joined the National AEC network and have completed various current state exercises that highlighted opportunities for further pathways and changes so that patients can be treated in AEC rather than to have full inpatient admission. This work is being undertaken across medicine and surgery. These pathways are being phased in with full clinical engagement and associated KPIs that are captured in a specific dashboard for the AEC Units. The first pathways were launched in medicine on the 22nd August. Support from senior clinical staff from each directorate has been essential to ensure pathways are progressed, for example, the new chest pain pathway will allow patients who historically stayed overnight due to the need for a blood test at 12 hours. These patients will now

have the test completed at 6 hours together with a risk assessment. This has challenged clinicians. Urology launched 3 ambulatory pathways on the 5th September.
The National AEC Team visited CHFT on the 3rd August where they had a tour of the Ambulatory Areas and met with the COO and have provided a report on our progress to date and recommendations for further work.

**Their Recommendations are:**

· Stop overnight bedding of medical and surgical AEC as a matter of urgency
· Consider co locating both surgical and medical AEC services near ED
· Develop consultant delivered services
· Work with primary care to improve volume and quality of referrals
· Instigate twice daily board rounds with ED from medical and surgical AEC and develop a poster campaign to reinforce the 'message'
· Develop 'simple rules' to ensure appropriate patient selection
· Work with ACPs to extend their skills
· Undertake an EBD study

These recommendations will from part of the project plan for AEC.

Finance Update:
The aim of both the AEC and acute Frailty is to prevent the need to open 15 beds over the winter period releasing the funding that had been allocated. The total savings identified £402k.

**Theme 2: Development and delivery of a Frailty model**

Work to date:
A core team from across health and adult social care have attended the launch of the national collaborative event to support and help develop acute frailty and community frailty care. In both acute hospitals senior community nursing are working with social care, therapy and on the HRI site with an Elderly Care consultant to scope out through PDSA's a model of care that will allow frail, predominantly elderly patients to return home rather than be absorbed into the speciality bed base with the associated danger of a loss of function and independence. This scoping is phase one of introduction of the model and data is being collated to identify the opportunity. This is in conjunction with testing out a Discharge to Assess Model using the same team. The Medical Division facilitated a care of the elderly consultant to join the MDT from the 12th September. This work continues to link to the Bed Alternatives work and rehabilitation model redesign.
This has also been identified as a priority in both the ECIST report and the Invite Service Review of Complex Care.

## 2. Bed Efficiencies

### Theme 1: Discharge systems and process, the clinical flow team, hospital at night and the discharge lounge

Work to date:
The mapping of the existing state has been completed. Significant work has been undertaken to develop our intelligence around reasons for delays in the discharge pathway. The matrons, discharge teams, social care and therapy staff are working collaboratively to take every opportunity to prevent delays, improve communication and the patient's experience.
Discharge to Assess- is being safely tested using PDSA cycles with full review of each patient's case managed through this process.
HOOP was launched on the Calderdale site in September 2016. Early indications are that it is progressing well.
Discharge lounge was closed on the Calderdale site and a new proposal to work with voluntary services to support patients in ED and the wards on the day of discharge is being developed.

Finance Update:
In relation to discharge planning, clinical flow team, hospital at night and the discharge lounge. Mapping of current process is being carried out with a view to re-profile the teams reflecting duplication and opportunities following the introduction of the EPR. The first release of CIP was achieved in September of £142K.

### Theme 2: Safer Bundles

This is the implementation across all wards and then clinical areas of the flow bundle. The acronym describes:

| | |
|---|---|
| **S** | Senior review daily |
| **A** | All patients will have an EDD with 24 hours of admission |
| **F** | Flow of patients to begin early to enable capacity in the assessment areas |
| **E** | Early discharge on base wards before 10am to allow for movement from assessment areas |
| **R** | Review as a team daily by enabling MDT board rounds and safety huddles |

Work to date:
This theme is seeing a high level of clinical engagement. The ADN for medicine is providing strong leadership to the matrons and ward managers who are engaging readily in the work. This

is being driven through the weekly 'Confirm & Challenge Meetings' on the wards. The aim is to stabilise LOS and minimise any waits from admission, in their clinical care, by improved discharge planning and review of plans. One of the key drivers of this Theme is to reduce medical outliers in surgery in order for the necessary reconfiguration of surgical beds to take place before winter but the SAFER bundle is to be rolled out in full across the organisation and evidence shows that this is a key facilitator for improved patient flow, efficiency, safety, patient quality and experience .
Improvements in partnership working with Calderdale Adult Social Care will also support this as the majority or patients in outlying areas are from that district.

A weekly review meeting has also been introduced with Senior Managers from CHFT and both Calderdale & Kirklees Adult Social Care to review and expedite patients with the longest LOS who have a discharge plan that is challenging to deliver.

**Theme 3: Planned Care: Reduction in surgical and gynaecology bed base and overall review of beds Trust-wide**

Work to date:
The plan from Surgery was a reduction of beds which aligned with the previous modelling from four eyes, this currently being re-validated through work with Simul8. This work will align to the SAFER ward improvements and ensure the speciality bed base is an accurate reflection of the needs of the patients that use our services however this has not yet progressed and has resulted in programme slippage.

Financial Update:
CIP planned for this scheme has slipped by one month and the timeline for recovery has yet to be confirmed by the Surgical Division

## 3) Bed Alternatives

**Theme 1: End of Life care**

Work to date:
This work has identified that there are multiple agencies and individuals looking to improve EOL care. Previously these were not always sighted on each other, leading to a slightly disjointed process that often duplicated effort. A priority for the leads of this theme was to bring all interested groups together to plan the work. This is the current focus before any large redesign takes place.

**Theme 2: Rehabilitation**

Work to date:
The Director of Operations for Community Services has led this work and is designing a 'community place' within the existing structure. This area would be initially within the hospital building but outside of the organisational structure, being managed by community and medically supported by GPs. The patients would receive functional reablement and this should reduce the level of social care support needed on discharge. This area is now largely designed and whilst an introductory date has not been set, could be operational before the winter period.
In addition to the 'community place' some work is also being undertaken by a senior community therapist to transform stroke rehabilitation practices in the hospital to provide more functional, focused pathways with the aim of reducing the LOS for this group of patients.

Finance Update:
Enabling scheme reviewing intermediate care, rehab, packages of care and timing of availability. High level opportunities included in previous Safer paper presented in March 16. Ongoing development required to understand operational impact and financial benefits achievable.

## 4) 7 Day Service & HOOP

These two complimentary themes are now a part of the SAFER programme and will be monitored at Programme Board.

See sections 2.6 and 2.7 for updates.

### Summary

Reliable and relevant metrics have now been established to monitor the continued effectiveness of the Programme and will be reviewed through a monthly reporting structure.

### Recommendations/Next Steps

To hold a 'market place' style event to showcase work and foster broader interest in the SAFER Programme for those not already involved.

Engagement with the membership council is one of the key ways in ensuring the SAFER programme has patient/carer involvement. An event will be held in November where the membership council, leads from each work stream and operational staff delivering transformational change through the programme will share and discuss the progress and impact.

The SAFER Programme asks for continued support of the Executive Board to develop a culture of transformation and to deliver the quality and efficiency improvements necessary for the organisation to deliver the 5 year clinical strategy.

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

Well Led Compliance summary:

| Indicator | Compliance |
|---|---|
| 5.1 Safe Staffing | Reporting Only |
| 5.2 Mandatory Training | Partial Compliance |
| 5.3 Appraisal | Partial Compliance |
| 5.4 Patient and Public Involvement | Reporting Only |
| 5.5 Operational Management and Succession Planning | Reporting Only |
| 5.5 Sickness and Absence | Reporting Only |
| 5.6 Staff Experience and Engagement | Reporting Only |
| 5.7 WRES | Reporting Only |
| 5.8 Duty of Candour (DOC) | Reporting Only |

**Highlights:**

- Safe Staffing – preceptorship package launched September 2016, with year long education and training programme. International recruitment continues, 38 new nurses.
- Sickness and absence –shows an improved position from Q1 to 4.16% at Q2
- Mandatory training – business case approved for replacement learning and management system in Q2. Actions agreed at Executive Board to increase compliance with mandatory training and focus on 4 of the 10 subjects for the remainder of 2016/17: Infection Prevention and Control, Moving and Handling, Health and Safety and Information Governance
- Patient and Public Involvement (PPI)– in addition to formal consultation on service reconfiguration, two PPI projects undertaken in Q2, one on vascular services and one reviewing A&E activity with local Healthwatch organisations.
- Workforce Race Equality Standard – first meeting of BME (black and minority ethnic) network held in September

## 5.1 Safe staffing

### Aim and Objectives of Work

The Nursing Workforce Strategy Group implements and lead the nursing and midwifery Workforce Strategy, providing monitoring and assurance of the nursing and midwifery workforce across the Trust.

Objectives include:

- To set direction of the nursing and midwifery workforce including defining, monitoring and continually updating the Trusts policies and procedures to ensure that the workforce is safe, effective and able to deliver high quality compassionate care consistently;
- To monitor and manage the Hard Truths requirements ensuring data is accurate, utilised to provide assurance and incorporated into workforce planning;
- To define standards for the workforce;
- To oversee nursing establishments which are linked to acuity and dependency studies, evidence based tools and professional judgement.

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- To monitor and manage the Hard Truths requirements ensuring data is accurate, utilised to provide assurance and incorporated into workforce planning;

- To define standards for the workforce;

- To oversee nursing establishments which are linked to acuity and dependency studies, evidence based tools and professional judgement.

1 Safe Staffing Levels

Average fill rates are monitored and reported to the Board each month. The report has been developed within the last quarter to include Care Hours Per Patient Day (CHPPD) data. Areas of concern are noted within the monthly report alongside mitigating action taken and any resulting impact from reduced staffing levels.

Areas with average fill rates of less than 75% for Registered Nurses (RN) have remained a challenge throughout the last quarter.

Table 1: Average Fill Rates Registered Nurses and Care Staff

| Average Fill Rates | | | | |
|---|---|---|---|---|
| | Registered Nurses | | Care Staff | |
| | Day | Night | Day | Night |
| July 2016 HRI | 79.86 | 91.43 | 105.90 | 118.93 |
| July 2016 CRH | 80.72 | 88.68 | 101.23 | 114.69 |
| August 2016 HRI | 81.78 | 90.63 | 102.64 | 117.44 |
| August2016 CRH | 78.97 | 86.39 | 100.74 | 115.17 |
| September 2016 HRI | 81.77% | 89.83% | 103.88% | 120.61% |
| September 2016 CRH | 80.22% | 88.09% | 103.49% | 118.76% |

Fill rates in excess of 100% have been reported for care staff within the last quarter. This has been attributed to supporting reduced fill rate for RN and providing 1-1 care requirements.

Average fill rates of less than 75% within the last quarter have been attributed to: increased bed capacity; sickness levels; vacancies and increased long days (resulting in the right number of nurses on shift, but reduced total nursing hours against planned per day.)

Average fill rates are reviewed by the senior nursing team at any point utilising the daily staffing tool, but as a minimum weekly reports are circulated to the senior nursing team.

During Q1 the nursing workforce team developed a roster efficiency tool which has been launched within divisions to aid weekly confirm and challenge sessions focussing on ensuring safe staffing levels and roster efficiency.

**2. Staffing Data**

The nursing workforce team have worked with health informatics and have begun to develop a dynamic dashboard to enable real time and accurate data to be available to assist in supporting safe staffing levels.

Quality dashboards developed by the nursing workforce team in 2015 are utilised and a task and finish group reviewing the content in light of recommended indicators to include following the recently published National Quality Board Guidance (2016).

Care Hours Per Patient Day. CHPPD, have been reported for the last five months externally and the nursing workforce team are reviewing planned against actual CHPPD each month for clinical areas.

As the efficiency portal is developed the nursing workforce team will review CHPPD against peers utilising the portal.

## 3. Recruitment and Retention

Best practice guidance published by Health Education England (2016) to inform retention of the nursing workforce has been reviewed by the nursing workforce strategy group and current practice mapped against this. A “Band 5” competency document based on the NMC’s standards for competency for registered nurses was launched to the nursing workforce in October 2015. Clinical teams are now utilising the document.

Following review of national frameworks and guidance in relation to preceptorship, CHFT have developed a new robust preceptorship document and support package for new registrants within the organisation. This was launched in September 2016 and will be supported by a yearlong education/training programme for new registrants to the organisation

Recommendations for action have been taken forward to the nursing workforce strategy group and form part of the retention strategy currently being reviewed by the senior nursing team.

Recruitment both local and international has continued. International recruitment has continued via skype interviews resulting in 38 nurses arriving in 2016 to join CHFT. The available pool of nurses from the EEA has been impacted upon by the introduction of the International English Language Test (IELT) requirement by the Nursing and Midwifery Council (NMC).

Recent approval has been received by the team to undertake an overseas recruitment campaign for 75 nurses which is being developed at pace.

A recruitment event is planned in Q3, 15th October, to attract potential nursing candidates to the organisation. The event has been publicised via social media, local Higher Education Institutions (HEI’s) and newspaper campaigns.

## 4. Additional roles within the Nursing Workforce

A task group has been reviewing additional roles and the potential benefits of introducing these at CHFT. Advance clinical practitioner roles; associate nurse roles and assistant practitioner roles have been considered.

Scoping of areas which would benefit from additional roles within the workforce has been completed and the nursing workforce team are currently working with partners to develop next steps. CHFT have submitted a partnership bid with other NHS and social care providers to become a test site for the nursing associate role. It will be revealed in early October 2016 which organisations have been awarded the bid.

## 5. Conclusion

The Nursing Workforce Strategy Group continue to implement and lead the nursing workforce to ensure safe staffing levels are reviewed, monitored and reported

## 5.2 Mandatory Training

### Aims and objectives of the work

The aim of mandatory training is to help enable employees achieve safety and efficiency in a timely manner. The mandatory training programme enables the Trust to demonstrate that employees regularly have mandatory training designed to ensure they can undertake their job roles safely and maintain a safe and healthy work environment. The approach describes what training employees are required to complete, how often they are required to complete the training and how to access the training.

### Current performance

Mandatory training compliance as at 30 September 2016 is detailed below:-

| | Information Governance | Equality and Diversity | Infection control | Moving and Handling | Health, Safety and Welfare | Safeguarding | PREVENT | Fire Safety | Dementia Awareness | Conflict Resolution |
|---|---|---|---|---|---|---|---|---|---|---|
| **Medical** | 29.92% | 81.93% | 30.35% | 82.71% | 81.93% | 75.44% | 53.49% | 22.30% | 80.03% | 77.70% |
| **Corporate** | 32.93% | 86.83% | 32.34% | 85.33% | 86.83% | 77.84% | 78.74% | 34.73% | 82.93% | 80.84% |
| **Families & Specialist** | 34.33% | 91.20% | 32.70% | 92.01% | 91.20% | 85.38% | 75.29% | 30.60% | 90.12% | 88.02% |
| **Health Informatics** | 27.09% | 93.60% | 32.02% | 94.58% | 93.60% | 90.15% | 85.22% | 31.53% | 93.60% | 91.63% |
| **Surgery & Anaesthetics** | 23.24% | 87.51% | 22.90% | 88.46% | 87.51% | 81.70% | 65.39% | 26.02% | 86.82% | 83.26% |
| **Community** | 29.70% | 91.11% | 31.04% | 90.44% | 91.11% | 83.05% | 84.23% | 38.59% | 88.76% | 86.91% |
| **Estates & Facilities** | 23.56% | 81.94% | 23.82% | 81.41% | 81.94% | 73.04% | 48.69% | 17.02% | 80.89% | 78.53% |
| **Trust** | 29.26% | 87.24% | 29.17% | 87.71% | 87.24% | 80.70% | 67.35% | 27.68% | 85.77% | 83.32% |

### Improvement plans for 2016/2017

Issues:-

The functionality of the Oracle Learning Management (OLM) system in the national Electronic Staff Record (ESR) is limited and is not user friendly which has deterred some colleagues from using the tool enabling them to be fully compliant. A specific functionality limitation has been highlighted regarding refresher training and the length of 'window' prior to renewal. This is currently set at 3/12 months before compliance expires.

There is an absence of a sanction for non-compliance.

The PREVENT element of mandatory training is delivered on a classroom basis through the Safeguarding team and capacity to deliver sufficient sessions to facilitate full compliance is limited. The requirement to deliver this training in a classroom environment is a DH requirement placed on all public sector bodies.

Response:-

A business case for a replacement learning management system was considered and approved by the July Commercial Investment and Strategy Committee meeting.

Paper to Executive Board on 21 July 2016 for a link to incremental pay progression and mandatory training and appraisal compliance was approved. The proposal will be piloted in the Workforce and Organisational Directorate for roll out to the wider organisation on 1st April 2017. The following additional actions were agreed at Executive Board to improve compliance with mandatory training.

- Specialty level plans and set trajectories
- Mandatory training profilers
- Focus attention in divisions on low compliance service areas/teams to deliver biggest impact on compliance score
- Monitoring arrangements with divisional leads for targeted service areas
- Escalation process with divisional leads to remedy non-compliance with agreed action
- Support from HR Business Partners and Business Intelligence team
- One source of the truth for mandatory training – Electronic Staff Record (replacement Learning Management being procured – estimated 'go live' August 2017)

*How monitor?*

- Integrated Performance Report
- Divisional Performance meetings

*How escalate?*

- Director of Workforce and OD and Chief Operating Officer

Prevent paper was submitted to Safeguarding Committee in September 2016 by Head of Safeguarding. The paper describes a change in the delivery of the training and the introduction of eLearning for some staff in line with the Prevent Competencies Framework 2015, thus reducing pressure on the limited classroom places for WRAP sessions.

A paper describing the options to manage mandatory training compliance, as a consequence of EPR implementation in 2016, was agreed by Executive Board on 21 July 2016. The paper described a concentration for the remainder of 2016/17 on 4 of the 10 mandatory subjects. The subjects are Health and Safety, Infection Prevention and Control, Information Governance and Moving and Handling.

## 5.3 Appraisal

**Aims and objectives of the work**

A formal annual appraisal process provides employees with information around how they may be perceived within their team and organisation and offers constructive feedback about their performance at work. A good appraisal also helps colleagues understand the strengths they

should capitalise on and the weaknesses where improvement may be required. This helps to ensure that each individual in the team understands how their input contributes to the whole and how achieving their goals will ensure the organisations vision of compassionate care is delivered.

The aims of the work are:-

- To ensure all colleagues have access to a simple and effective appraisal structure
- To maximise progress using that simplified structure towards the 100% annual target (90% by 31 December)
- To facilitate effective and timely reporting for the organisation to ensure compliance
- To provide access to a high quality appraisal interaction

**Current Performance:**

| Jul-16 | Aug-16 | Sep-16 | YTD | Planned (at 30th Sept) |
|---|---|---|---|---|
| 11.33% | 18.22% | 31.16% | 31.16% | 52% |

**Improvement plans for 2016/2017**

**Issues:-**

There is an absence of a sanction for non-compliance.

The appraisal scheduler tool which captures planned activity has not in previous years been fully or consistently utilised.

Limited opportunity for appraiser training.

The quality of appraisal is reported through the staff survey as requiring improvement.

**Response:-**

Appraisal compliance is now monitored monthly through the divisional performance meetings. The following additional actions to improve compliance were also agreed at Executive Board;

- Specialty level plans and set trajectories
- Fully populate appraisal schedulers
- Test appraisal scheduler for each Division with reasons identified for non-delivery of plan and remedy
- Focus attention in divisions on low compliance service areas/teams to deliver biggest impact on compliance score
- Monitoring arrangements with divisional leads for targeted service areas
- Escalation process with divisional leads to remedy non-compliance with agreed action
- Support from HR Business Partners and Business Intelligence team
- One source of the truth for mandatory training – Electronic Staff Record (replacement Learning Management being procured – estimated ‘go live’ August 2017)

- By when: 30 September 2016

*How monitor?*

- Integrated Performance Report
- Divisional Performance meetings

*How escalate?*

- Director of Workforce and OD and Chief Operating Officer

Paper to Executive Board on 21 July 2016 for a link to incremental pay progression and mandatory training and appraisal compliance was approved. The proposal will be piloted in the Workforce and Organisational Directorate for roll out to the wider organisation on 1st April 2017.

A proposal for a pilot three-step appraisal training programme is being costed following the Standards for Managers task and finish group work, as part of a business case for resource for the Education and Learning Group.

An approach has been made to NHS Employers to commission an audit study of the quality aspect of appraisal.

## 5.4 Patient and Public Involvement

There has been a 14 week period of formal public consultation for the proposed hospital services reconfiguration and the purdah period surrounding the EU referendum. The report of findings from the public consultation was published in August and the Trust participated in a wide stakeholder event on 13 September 2016 to consider the report and identify actions to address the findings. During this time patient and public involvement events have been reduced to enable a clear focus on this work. However, there have been two projects of note:

1) NHS England, in conjunction with the University of Sheffield also held an engagement event in August with our patients on the provision of vascular services as part of NHS England's review of specialist services. The findings of this work will go to NHS England and will form part of the specification for the provision of vascular services moving forward.

2) The Trust has been working with HealthWatch in Calderdale and Kirklees to get a better understanding from patients as to why they attended one of the A&E departments. This engagement work will feed in to a West Yorkshire-wide review of A&E patient activity that has been commissioned by the West Yorkshire Clinical Commissioners and we hope to see a copy of the report in the next couple of months.

## 5.5 Operational Management & Succession planning

**Aims and Objectives**

- New Operational management structure with increased opportunities for management progression within CHFT
- Introduction of clear Clinical Leadership structure

- Development and Implementation of a Talent Management Strategy
- Development and implementation of management & leadership development programme

Action plans are in place as part of the CQC response group. Currently on track to meet interim objective which include:

- Operational structures fully populated with exception of Divisional band 6 posts.
- Assistant Divisional Directors renamed Directors of Operations with a divisional portfolio alongside a corporate lead as Deputy COO
- More formal deputy function at time of leave ensuring operational managers are exposed to forums across the organisation with positive feedback
- Ward manager development programme including awareness of management issues commenced
- Standards for managers review completed and ready for presentation to WEB
- Leadership programme specification in development
- Local management training programme in development

## 5.6 Sickness and Absence

### Aims and Objectives

The Trust aims to ensure that employees are able to make the most effective contribution, individually and collectively, to improving the services that that Trust provides. Managing sickness absence and improving sickness rates is an indicator of creating both a healthier and more efficient workplace.

### Current Performance

1) The table below shows the Trust's performance against the 4% threshold for Q1 and Q2.

| Quarter | CHFT (%) | Trust Threshold | RAG |
|---|---|---|---|
| 2016/17 Q1 | 4.45% | 4.00% | ● |
| 2016/17 Q2 | 4.16% | 4.00% | ● |

2) The table below shows the long term and short term sickness absence split for Q1 and Q2.

| Month | Available FTE | Short Term FTE | Long Term FTE | ST FTE % | LT FTE % | Total Sickness % |
|---|---|---|---|---|---|---|

| | | | | | | |
|---|---|---|---|---|---|---|
| 2016 / 04 | 152,036.09 | 2,322.67 | 4,354.42 | 1.53% | 2.86% | 4.39% |
| 2016 / 05 | 157,474.79 | 2,039.31 | 4,634.27 | 1.30% | 2.94% | 4.24% |
| 2016 / 06 | 152,746.84 | 2,334.84 | 4,901.57 | 1.53% | 3.21% | 4.74% |
| **2016/17 Q1** | **462,257.72** | **6,696.82** | **13,890.26** | **1.45%** | **3.00%** | **4.45%** |
| 2016 / 07 | 157,937.72 | 2,294.73 | 4,701.36 | 1.45% | 2.98% | 4.43% |
| 2016 / 08 | 159,289.10 | 1,997.21 | 4,621.11 | 1.25% | 2.90% | 4.15% |
| 2016 / 09 | 154,810.53 | 1,571.51 | 4,467.63 | 1.02% | 2.89% | 3.90% |
| **2016/17 Q2** | **472,037.36** | **5,863.46** | **13,790.10** | **1.24%** | **2.92%** | **4.16%** |

3) The table below shows the sickness absence rate for Q1 2016/2017 in comparison to Q4 2015/2016 broken down by Division:-

| Division | 2016/17 Q1 | 2016/17 Q2 | Change | Movement | Trust Threshold | RAG 2016/17 Q1 | RAG 2016/17 Q2 |
|---|---|---|---|---|---|---|---|
| Surgery | 4.73% | 5.18% | +0.45% | ↑ | 4.00% | ● | ● |
| Medical | 5.82% | 4.73% | -1.09% | ↓ | 4.00% | ● | ● |
| Community | 4.55% | 4.34% | -0.20% | ↓ | 4.00% | ● | ● |
| FSS | 3.78% | 3.19% | -0.59% | ↓ | 4.00% | ● | ● |
| Estates | 4.02% | 5.16% | 1.14% | ↑ | 4.00% | ● | ● |
| Corporate | 2.79% | 2.10% | -0.68% | ↓ | 4.00% | ● | ● |
| THIS | 1.17% | 2.20% | 1.03% | ↑ | 4.00% | ● | ● |

## Work undertaken in 2016/2017

100% of long term sickness absence have a ‘wrap round’ management plan. This is monitored on a routine basis and reported to the Board monthly.

Cases moving from short term to long term are monitored and reviewed by the end of the second week each month.

Return to work forms analysed to ensure short term absence is managed in accordance with policy triggers.

Return to work interview dates to be automatically transferred from e-roster to ESR - 31 August 2016.

On a monthly basis contact non-compliance areas to obtain an understanding of the reasons why return to work interviews are not undertaken or recorded - 31 July 2016.

Series of Roadshows held in October 2016.

5 worst performing areas identified in each division and meetings to be held with directorate managers to discuss action required - 31 August 2016.

## 5.7 Staff Experience and Engagement

## Staff Friends and Family Test

The Staff Friends and Family test aims to provide a simple, headline metric which can be used to drive cultural change and continuous improvements in the quality of the care received by NHS patients and the working conditions of its staff. The survey questions are:

**A –** Would you recommend your Trust as a place to receive treatment?
**B –** Would you recommend your Trust as a place to work?

The survey runs on a quarterly basis with the exception of Q3 (October to December) when the National Staff Survey takes place.

The 2016/17 Q2 survey was an on-line survey only and focused on Medicine, Corporate and Community. The results are as follows:

Staff who would recommend the Trust as a place to receive treatment:
Community – 79%, Corporate – 83%, Medicine – 80%
Staff who would recommend the Trust as a place to work:
Community – 61%, Corporate – 66%, Medicine – 58%

Analysis of the qualitative feedback received through the surveys and actions plans are produced within the respective divisions in order to identify themes and the necessary responses to improve colleague experience in the Trust. These actions are monitored by the Colleague Engagement, Health and Wellbeing Group and learning shared between divisions.

## NHS Staff Survey

The Trust will participate in the 14th national annual NHS Staff Survey in 2016. A total of 1,250 colleagues have been randomly selected by Picker Institute Europe, our survey administrator. A "mixed mode" approach is being used this year – paper and online surveys. The formal benchmarking results will be released by NHS England in February/March 2017. The Trust has incorporated local questions in the survey focusing on patient experience and raising concerns.

The following initiatives have been introduced in 2016/17:

- A Colleague Engagement Network for staff to improve engagement on the staff survey results, led by the Chief Executive, had its first meeting in September 2016. The network will meet on a quarterly basis.
- A BME staff network to improve opportunities for career progression, training and development, led by the Chief Executive, had its first meeting in September 2016. The network will meet on a quarterly basis.
- Thank you cards, which anyone can use to thank colleagues
- Mindfulness courses - five courses already run this year
- Our first "Great Day Out" proved popular and a second is planned for October - a day of relaxation and "me time" for CHFT staff, including resilience training and time to reflect
- Our "Hello my name is" campaign isn't just for patients – we're also asking colleagues to make sure they introduce themselves to staff members too

## Investors in People

The Trust was recently assessed against the national IIP Generation 6 Framework, in the first year of a three-year assessment process. 50% of Trust staff were surveyed (online), followed up by small groups meeting with an IIP Specialist. The assessment highlighted a number of

strengths, in particular “living the organisation’s values and behaviours” and “managing performance”. The Trust will use the Framework to drive improvements and realise high performance through the staged assessment process which will conclude in 2018.

**Developments for 2016/17**

- A recruitment and retention strategy, developed through involvement of key stakeholders
- Extend the Trust’s values-based recruitment approach to all staff groups (already operational for therapies and diagnostic staff)
- A network of “raising concerns” champions to signpost colleagues to appropriate resources and processes
- A communication strategy to support the “raising concerns” process
- A strategy to enhance appraisals, identify clear progression routes and support leadership & management development
- Our recent communications survey showed most colleagues value hearing news from their manager – so we’re reviewing the Team Brief/Information sharing process
- A health & wellbeing strategy to ensure we care as much for our colleagues as our patients

## 5.8 Duty of Candour

The Trust Being Open/Duty of Candour Policy and Incident Reporting Policy sets out that the Trust has a duty to limit the potential impact of clinical and non-clinical risks and put in place robust and transparent systems to make sure that all incidents which might cause actual or potential harm to patients, visitors and staff are identified, investigated and rectified.

In particular, it involves apologising and explaining what happened to patients who have been harmed as a result of their healthcare treatment or when in-patients or outpatients of the Trust. Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 sets out the legal obligation under-pinning the Duty of Candour.

During Quarter 2, there was 1 duty of candour breach and further analysis of Q1 data has confirmed there were 2 breaches in Q1, rather than 4 as previously reported, across red and orange incidents. Therefore there have been 3 breaches in total for the first 6 months of 2016/17 which were within the Medical Division.

The following has taken place to improve compliance with duty of candour:

- Improved internal monitoring of duty of candour compliance - work has taken place to improve monitoring and chasing of missing information on duty of candour compliance on the incident reporting module, with the information now tracked on a weekly basis rather than monthly basis to improve accuracy of information. The performance framework is now used to monitor duty of candour compliance at a divisional level.

- Clarification with commissioners, shared with staff, on the contractual reporting requirements for 2016/17 regarding duty of candour, with monitoring of duty of candour at the start of the incident only being a contractual requirement

- Agreement also reached with commissioners regarding duty of candour for incident investigations from mortality reviews to take place at the end of the investigation process as required to avoid unnecessary distress for relatives

- The recording section of duty of candour dates within the incident module has been restructured during Q2 to make it more obvious for staff where to record the duty of candour completion information. A section has been added for staff to explain any non-compliance.

- Discussion took place at the Risk and Compliance Group in September to ensure a consistent approach is taken to the initiation point of duty of candour for those incidents for which it is required. A flowchart on the duty of candour process will be developed in Q3 and shared with staff

- Progressing internal audit recommendations on duty of candour, revisions to duty of candour letter taking place to be shared in Q3

**Improvement Plans:**

Continued increased staff support in undertaking duty of candour with relatives from Senior Investigations Manager

Duty of candour flowchart finalised and shared with staff

Duty of candour letter finalised and shared with staff

Continued work to monitor compliance with duty of candour on completion of the investigation report and sharing with family and relatives.

Continued implementation of duty of candour internal audit report recommendations

## 5.9 7 Day Services

**Background**

7DS (7-day services) is a nationally driven quality improvement initiative and is a key area of focus on the trust's QI plan. It stems from an initial perspective that patients admitted over the weekend were at a greater risk of dying than patients admitted during the week. This has been subject to some controversy and the evidence to support is somewhat contradictory. Never the less the emphasis is now more about reducing variation in care over the seven days for better patient experience, reduced LOS (length of stay) and readmissions, and possibly improved patient outcomes such as mortality. The vehicle driving this improvement are the 7DS ten clinical standards described by Sir Bruce Keogh. Whilst these standards refer to unplanned admissions to hospital there is an emphasis on a multi-agency response to 7DS especially with respect to standard 9. For further information regarding the ten clinical standards:

http://www.nhsiq.nhs.uk/media/2638611/clinical_standards.pdf

NHS England (NHSE) has stipulated that standards 2 (time to first consultant review), 5 (diagnostics), 6 (consultant led interventions) and 8 (on-going review) are priority standards for implementation. CHFT, as part of West Yorkshire, is an early implementer of these priority standards aiming to achieve compliance by March 2017.

**Current Performance**

There has been little change from last quarter's update.

1. Action planning - the results from the two previous national surveys have been shared with clinical directorates with the request for action plans to improve the current position against the standards within current resources. These action plans are being aggregated into a trust view albeit still at a high level.

2. Resource - recently NHSE have offered additional resource to the trust to develop more detailed action plans for the four priority standards. The aim will be to more critically analyse the trust's position against the priority standards whilst challenging current perceptions and ways of working to move towards compliance. It is anticipated that this more detailed work will also result in a more realistic cost to fully implementing the four priority standards.

3. In dialogue directly with the Medical Director for NHSE the Trust, has declared that it will not be in a position to declare compliance by the expected date of March 2017. Much of the Trust's ability to meet compliance lays with the ongoing challenges with finance and difficulties recruiting to certain specialties and linked to the Trust's 5-year plan for a reconfigured hospital service.

4. Partnership working - The Trust also collaborated with clinical commissioners and other partners from health and social care to review 7-day services across the Calderdale and Huddersfield system. This was shared at the System Resilience Group meeting on 11 October 2016. The recommendations included a review of the current CCG led strategies (Care Closer to Home and the Right Care, Time and Place proposals) with respect to 7-day services. It was also proposed that the system considers a pilot of a 7-day approach in Frailty. The outcome was that a decision would be made at the next SRG meeting.

**Improvement plans for 2016/17**

Much of the plan for improvement for 2016/17 is detailed above. As stated Directorate action plans are being formed to support a trust-wide action plan for 7DS. It is anticipated that this trust-wide plan leads to a further more detailed analysis of the cost of implementing 7DS versus the qualitative and financial benefits from improved LOS.

## 5.10 Workforce Race Equality Standards (WRES)

**CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST**

**QUALITY REPORT - WORKFORCE RACE EQUALITY STANDARD (WRES)**

### 1. Introduction

The WRES is a national equality standard for employment against which all NHS organisations are assessed. The WRES first became operational from 1 April 2015 and organisations are required to publish their position against it on an annual basis. The Trust first published its position on 1 July 2015 and then again on 1 August 2016.which shows ?

The standard aims to improve workforce race equality across the NHS. It aims to improve the opportunities, experiences and working environment for (Black and Minority Ethnic) BME staff, and in so doing, help lead improvements in the quality of care and satisfaction for all patients.

The WRES requires organisations to develop an action plan to drive forward improvements against the indicators. The Trust invited BME colleagues to participate in a number of focus groups which were held between January and March 2016. The action plan was developed after hearing directly from BME colleagues about their experience of working in the Trust and what they identified as key areas for improvement. The action plan was approved by the Board of Directors in late May 2016 and is now incorporated into a combined WRES/staff survey action plan which is monitored by Executive Board.

The Trust has also established a BME Network which will meet quarterly and the first meeting took place in September 2016.

## 2. The WRES Indicators

The WRES comprises 9 indicators as detailed below. Indicators 1 and 9 have been revised since the last submission in July 2015 and now require additional information to be provided.

Four indicators compare workforce metrics for White and BME staff (1-4), four concentrate on staff survey responses (5-8) and one considers the composition of the Board of Directors.

| |
|---|
| 1. Percentage of staff in each of the AfC Band 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff. |
| 2. Relative likelihood of BME staff being appointed from shortlisting compared to that of White staff being appointed from shortlisting across all posts. |
| 3. Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. |
| 4. Relative likelihood of BME staff accessing non mandatory training and CPD as compared to White staff. |
| 5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months. |
| 6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. |
| 7. Percentage believing that the Trust provides equal opportunities for career progression or promotion. |
| 8. In the last 12 months have you personally experienced discrimination at work from your manager/team leader or other colleagues? |
| 9. Percentage difference between the organisations' Board voting membership and its overall workforce. |

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Calderdale and Huddersfield NHS
NHS Foundation Trust

**Approved Minute**

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## Cover Sheet

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|---|---|
| **Meeting:**<br>Board of Directors | **Report Author:**<br>Andrea McCourt, Head of Governance and Risk |
| **Date:**<br>Thursday, 1st December 2016 | **Sponsoring Director:**<br>Brendan Brown, Executive Director of Nursing |
| **Title and brief summary:**<br>Corporate Risk Register - Presentation of the significant risks facing the Trust as at November 2016 | |
| **Action required:**<br>Approve | |
| **Strategic Direction area supported by this paper:**<br>Keeping the Base Safe | |
| **Forums where this paper has previously been considered:**<br>Risk and Compliance Group reviewed the corporate risk register on 8 November 2016 | |
| **Governance Requirements:**<br>Keeping the base safe | |
| **Sustainability Implications:**<br>None | |

## Executive Summary

### Summary:

The Corporate Risk Register (CRR) is presented on a monthly basis to ensure that the Board of Directors are aware of key risks facing the Trust and is a fundamental part of the Trust's risk management system.

## Main Body

### Purpose:

To assure the Board of Directors that all risks are accurately identified and mitigated adequately through reviewing the risks identified on the corporate risk register.

### Background/Overview:

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

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

### The Issue:

The attached paper includes:

i. A summary of the Trust risk profile as at November 2016 which identifies the highest scoring risks (between 15 and 25), risks with either an increase or decrease in scores, new and closed risks.

ii. The Corporate Risk Register which identifies risks and the associated controls and actions to manage these

There is 1 new risk this month, risk 6886 relating to 7 day services.

Risk 6131,relating to reconfiguration, has been reduced in score from 20 to 15 following the CCG decision at the end of October to move to development of the full business case.

Discussion of the risk relating to the implications of Brexit took place at the Risk and Compliance Group in November and further work to identify workforce and finance implications was identified. The risk will be further reviewed at the Risk and Compliance Group on 13 December.

### Next Steps:

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

### Recommendations:

Board members are requested to:

I. Consider, challenge and confirm that potential significant risks within the Corporate Risk Register are being appropriately managed
ii. Approve the current risks on the risk register.
iii. Advise on any further risk treatment required

## Appendix

### Attachment:

corporate risk register combined report for Board Nov16.pdf

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# CORPORATE RISK REGISTER REPORT

**Risks as at 22 November 2016**

| **TOP RISKS** |
|---|
| 2827 (20): Over-reliance on middle grade doctors in A&E<br>6345 (20): Staffing risk, nursing and medical<br>5806 (20): Urgent estates schemes not undertaken<br>6503(20): Delivery of Electronic Patient Record Programme<br>6721 (20): Non delivery of 2016/17 financial plan<br>6722 (20): Cash flow risk |
| **RISKS WITH INCREASED SCORE** |
| None. There are no risks with increased risk scores. |
| **RISKS WITH REDUCED SCORE** |
| There is one risk that has been reduced in score on the corporate risk register during November:<br><br>Risk 6131 – There is a risk that the Trust will not be able to quickly progress service reconfiguration due to the requirements of a consultation process.<br><br>This risk has been reduced from 20 to a 15 due to reduction in likelihood as a result of the CCG decision in October to approve the development of the full business case. |
| **NEW RISKS** |
| The following new risk was agreed at the 8th November 2016 Risk and Compliance Group and was added to the corporate risk register:<br><br>• Risk 6886 - risk of non compliance with seven day services requirements, scored as a risk of 15. |
| **CLOSED RISKS** |
| None |

| Risk Ref | Strategic Objective | Risk | Executive Lead (s) | June 2016 | July 2016 | Septemb er 2016 | October 2016 | November 2016 |
|---|---|---|---|---|---|---|---|---|
| | | **Strategic Risks** | | | | | | |
| 6503 | Transforming & Improving Patient Care | Non delivery of Electronic Patient Record Programme - transformation | Director of THIS (MG) | 20 = | 20 = | 20 = | 20 = | 20 = |
| | | **Safety and Quality Risks** | | | | | | |
| 6131 | Transforming & Improving Patient Care | Progress of reconfiguration, impact on quality and safety | Director of Commissioning and Partnerships (AB) | 20 = | 20 = | 20 = | 20 = | ↓15 |
| **6886** | **Transforming & Improving Patient Care** | **Non compliance with 7 day services standards** | **Medical Director (DB)** | **-** | **-** | **-** | **-** | **!15** |
| 4783 | Transforming & Improving Patient Care | Outlier on mortality levels | Medical Director (DB) | 20= | 20= | ↓16 | 16 = | 16 = |
| 2827 | Developing Our workforce | Over –reliance on middle grade doctors in A&E | Medical Director (DB) | =20 | =20 | =20 | =20 | =20 |
| 6822 | Keeping the Base Safe | Not meeting sepsis CQUIN | Medical Director (DB) | - | - | - | !16 | =16 |
| 5862 | Keeping the Base Safe | Risk of falls with harm | Director of Nursing | - | - | - | !16 | =16 |
| 6829 | Keeping the Base Safe | Aspetic Pharmacy Unit production | Director of Nursing | - | - | - | !15 | =15 |
| 6841 | Keeping the Base Safe | Not being able to go live with the Electronic Patient Record – operational readiness | Chief Operating Officer (HB) | - | - | 15! | 15= | 15= |
| 5806 | Keeping the base safe | Urgent estate work not completed | Director of Estates and Performance (LH) | =16 | =16 | =16 | ↑20 | =20 |
| 6300 | Keeping the base safe | Risk of being inadequate for some services if CQC improvement actions not delivered | Director of Nursing (BB) | =16 | =16 | =16 | =16 | =16 |
| 6598 | Keeping the base safe | Essential skills training data | Director of Workforce and OD | =16 | =16 | =16 | =16 | =16 |
| 6694 | Keeping the base safe | Divisional Governance arrangements | Director of Nursing (BB) | =16 | =16 | =16 | =16 | =16 |
| 6715 | Keeping the base safe | Poor quality / incomplete documentation | Director of Nursing (BB) | =15 | =15 | =15 | =15 | =15 |
| 6753 | Keeping the base safe | Inappropriate access to person identifiable information | Director of THIS (MG) | - | 16! | =16 | =16 | =16 |

| Risk Ref | Strategic Objective | Risk | Executive Lead (s) | June 2016 | July 2016 | September 2016 | October 2016 | Nov ember 2016 |
|---|---|---|---|---|---|---|---|---|
| | | **Financial Risks** | | | | | | |
| 6721 | Financial sustainability | Non delivery of 2016/17 financial plan | Director of Finance (KG) | =20 | =20 | =20 | =20 | =20 |
| 6722 | Financial sustainability | Cash flow risk | Director of Finance (KG) | 20↑ | =20 | =20 | =20 | =20 |
| 6723 | Financial sustainability | Capital programme | Director of Finance (KG) | =20 | =20 | ↓15 | 15 = | 15 = |
| | | **Performance and Regulation Risks** | | | | | | |
| 6658 | Keeping the base safe | Inefficient patient flow | Chief Operating Officer (HB) | =20 | =20 | ↓16 | 16= | 16= |
| 6596 | Keeping the base safe | Timeliness of serious incident investigations | Director of Nursing (BB) | =16 | =16 | =16 | =16 | =16 |
| 6693 | Keeping the base safe | Failure to comply with the Monitor cap rules | Director of Workforce (IW) | =15 | | =15 | =15 | =15 |
| | | **People Risks** | | | | | | |
| 6345 | Keeping the base safe | Staffing - ability to deliver safe and effective high quality care and experience service | Medical Director (DB) ,Director of Nursing (BB), Director of Workforce (IW) | =20 | | =20 | =20 | =20 |

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

# Trust Risk Profile as at 22 November 2016

| LIKELIHOOD (frequency) | CONSEQUENCE (impact/severity) | | | | |
|---|---|---|---|---|---|
| | Insignificant (1) | Minor (2) | Moderate (3) | Major (4) | Extreme (5) |
| Highly Likely (5) | | | = 6693 - Failure to comply with monitor staffing cap<br><br>= 6715 - Poor quality / incomplete documentation | = 6345 - Staffing risk, nursing and medical | |
| Likely (4) | | | | = 4783 Outlier on mortality levels<br>= 6658 Inefficient patient flow<br>= 6300 Clinical, operational and estates risks outcome<br>= 6596 Serious Incident investigations<br>= 6598 Essential Skills Training Data<br>= 6694 Divisional governance arrangements<br><br>= 6753 Inappropraite access to patient identifiable data<br>= 6723 capital programme<br>= 5862 Falls risk<br>= 6822 CQUIN sepsis | = 2827 Over reliance on middle grade doctors in A&E<br><br>= 6503 Non delivery of EPR programme<br><br>= 6721 Not delivering 2016/17 financial plan<br><br>= 5806 Urgent estate work not completed |
| Possible (3) | | | | | = 6722 Cash Flow risk<br>= 6814 EPR operational readiness<br>= 6829 Pharmacy Aseptic Unit<br>↓ 6131 – service reconfiguration<br>! 6886 Non compliance with 7 day services standards |
| Unlikely (2) | | | | | |
| Rare (1) | | | | | |

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

# Corporate Risk Register

NHS
The Health Informatics Service
Informing Healthcare

## Significant risks Scores of 15+

Nov-16

| Risk No | Div | Opened | Objective | Risk Description plus Impact | Existing Controls | Gaps In Controls | Initail | Current | Target | Further Actions | Review | Target | RC | Exec Dir | Lead |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2827 | Medical | Apr-2011 | Developing our workforce | There is an over-reliance on locum Middle Grade Doctors at weekends and on nights in A&E due to staffing issues resulting in possible harm to patients, extended length of stay and increased complaints<br><br>***It should be noted that risks 4783 and 6131should be read in conjunction with this risk. | Associated Specialist and Regular locums for continuity appointed<br>Middle Grade Doctors moved within sites to respond to pressures<br>Part-time MG doctors appointed<br>Where necessary other medical staff re-located to ED<br>Consultants act down into middle grade roles to fill gaps temporarily | Difficulty in recruiting Consultants, Middle Grade and longer term locums<br>Relatively high sickness levels amongst locum staff. | 20<br>4<br>x<br>5 | 20<br>5<br>x<br>4 | 12<br>4<br>x<br>3 | Expedite Outline Business case for reconfiguration of services across sites to afford better deployment of medical staff<br>Explore use of ANP to fill vacant doctor posts<br>Business Continuity Plan awaiting approval of Urgent care Board covering ability to provide safe services for varying periods of time<br><br>July 2016 Update: No appropriate applications from overseas consultant recruitment. Senior clinical fellow (consultant level) commences 1st August. Advert out to attempt further MG recruitment<br><br>Sept 2016 Update: 2 Substantive consultants have resigned. Senior Clinical fellow appointed to Consultant level position. Currently 10 on consultant rota. One additional Specialty Doctor has been recruited.<br><br>**November 2016 Update:**<br>Advert out for specialty doctors and Emergency Department consultants. | Jan-2017 | Aug-2017 | WEB | David Birkenhead | Dr Mark Davies/Mrs |

| | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 6345 | Trustwide | Jul-2015 | Keeping the base safe | Risk of not being able to deliver safe, effective and high quality care with a positive experience for patients due to: lack of nursing staffing as unable to recruit to substantive posts, i.e. not achieving recommended nurse staffing levels , inability to adequately staff flexible capacity ward areas- lack of medical staffing as unable to recruit to Consultant / middle grade doctor / junior doctor vacancies across a number of specialties. Over-reliance on middle grade doctors meaning less specialist input ,dual site working and impact on medical staffing rotas - lack of workforce planning / operational management process and information to manage medical staffing gaps, lack of therapy staffing as unable to recruit to Band 5 & 6 Physio, Occupational Therapists, Speech & Language Therapists & Dieticians in both the acute and community across a number of different teams Resulting in increase in clinical risk to patient safety due to reduced level of service / less specialist input, negative impact on staff morale, motivation, health and well-being & patient experience. | Nurse Staffing: to ensure safety across 24 hour period: use of electronic duty roster for nursing staffing, approved by Matrons, risk assessment of nurse staffing levels for each shift and escalation process to Director of Nursing to secure additional staffing - staff redeployment where possible -nursing retention strategy - flexible workforce used for shortfalls (bank/nursing, internal, agency) and weekly report as part of HR workstream Active recruitment activity for Medical Staffing Medical Workforce Group chaired by the Medical Director. Active recruitment activity including international recruitment. -revised approvals process for medical staffing to reduce delays in commencing recruitment. -HR resource to manage medical workforce issues. - Exit interviews for Consultants being conducted. - Identification of staffing gaps within divisional risk registers, reviewed through divisional | Medical Staffing Lack of: workforce plan / strategy, dedicated resource for workforce model, centralised medical staffing roster (currently divisional) / workforce planning), system /process to identify, record and manage gaps in planned staffing, particularly for junior doctors, measure to quantify how staffing gaps increase clinical risk for patients Therapy staffing Lack of: workforce plan / strategy identifying level of workforce required , dedicated resource to develop workforce model - system to identify changes in demand & activity, gaps in staffing and how reflected through block contract - flexibility within existing funding to over recruit into posts/ teams with high turnover | 16 4 x 4 | 20 4 x 5 | 9 3 x 3 | Continue to recruit to vacant posts / skill mix review, progress international recruitment of medical staff, consider incentive schemes. (Director of Nursing, Medical Director) July Update - Nurse Staffing · Targeted recruitment for substantive Registered Nursing and Midwifery workforce underway. This is currently focused on local recruitment from graduate programmes and overseas recruitment· Liaison with staff who have recently left the Trust to commence, to ascertain reasons for leaving, and encourage return to the Trust · Specific recruitment to bank, night and weekend posts to commence · Focus on retention of existing staff underway and revisited with Ward leaders · Branded recruitment process under development, promoting CHFT as an exemplar employer · Development programmes for Ward Managers and Matrons to commence from September 2016· Standard Operating procedure for use and authorisation of temporary nursing staff launched ·Full workforce review of ward nursing establishments undertaken<br><br>**November 2016 Update:**<br>Divisions have identified opportunities where Specialty Doctors may be able to bridge the gap with Consultant vacancies. TTM are working with us to create an international recruitment plan to appoint Specialty doctors. The long term intention is to progress these doctors to Consultant level vis the CESR route.A deputy medical director is being recruited to support the Executive Medical Director with operational management of the medical workforce. | Nov-2016 | Nov-2016 | WLG | David Birkenhead, Brendan Brown, Ian Warren | Lindsay Rudge, Jason Eddleston & Claire Wilson |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | Negative impact on sickness & absence, mandatory training & appraisal compliance. Increased costs of interim staffing, delay implementing key strategic objectives (eg EPR) | governance arrangements Therapy Staffing - posts designed to be as flexible as possible - review of skill mix and development of Assistant Practitioners. - flexible working - aim to increase availability of flexible work force through additional resources / bank staff | | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 5806 | Estates & Facilities | May-2015 | Keeping the base safe | Risk of the HRI Estate failing to meet required condition due the age and condition of the building resulting in a failure of the Trust achieving compliance in a number of duties. This could result in closure of areas which will mean stopping of patient care, suspension of services, delays and stoppage of treatment, closure of buildings, harm caused by slips, trips and falls and potential harm from structural failure. | Each of the risks has an entry on the risk register and details actions for managing the risk. Many of these risks could lead to injury of patients and staff, closure of essential services, and inability for the Trust to deliver vital services.The estate structural and infrastructure continues to be monitored through the annual Authorising'sEngineers (AE)/ Independent Advisors (IA) report and subsequent action plan.This report details any remedial work and maintenance that should be undertakenwhere reasonably practicable to do so to ensure the Engineering and structural regime remains safeand sustainable. Statutory compliance actions are prioritised, then risk assessment of other priorities.When any of the above become critical, we can go through the Trust Board for further funding to ensure they are made safe again. | The lack of funding is the main gap in control. Also the time it takes to deliver some of the repairs required.In terms of the structure of HRI, this is beyond repair, so no further major structural work can now be undertaken. | 16x4 | 20x4 | 6 3 x 2 | October 2016 The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so. The level of risk to the services at HRI is increasing as the number of major building risks increases.<br><br>**November 2016**<br><br>The estates infrastructure continues to be monitored, repaired and maintained where reasonably practicable to do so. The sub-basement area is currently undergoing an environmental clean to enable various projects to recommence after a significant delay in the capital programme. | Dec-2016 | Mar-2018 | RC | Lesley Hill | Paul Gilling / Chris Davies |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 6503 | Corporate | Dec-2015 | Transforming and improving patient care | RISK of: non - delivery of Electronic Patient Record Programme due to failure to deliver the transformation associated with not achieving the key deliverables around timescales, engagement and financial targets causing CRB to not be realised, significant cost overruns which ultimately could make the programme unsustainable.<br><br>The Trust along with its partners BTHFT and Cerner are implementing an EPR system that will enable service transformation whilst improving patient safety and patient and clinician experience. This is a summary risk, EPR risks escalated at Transformation Group will be brought to R&C by exception.<br><br>This will impact on patient care, safety and patient experience and mean the expected financial benefits of EPR programme will not be realised. | A Well-developed Governance Structure in place underpinned by a contract between CHFT and Cerner and a partnership agreement between CHFT and BTHFT.<br><br>Management of EPR programme risks using Best Practice Managing Successful Programmes methodology and EPR specific risk register<br><br>Executive sponsorship of the programme with CEO's chairing the Transformation Board<br><br>Separate assurance process in place<br><br>Clinical engagement from divisions<br><br>Clearly identified and protected funding as identified in the Full Business Case.<br><br>All Risk and issues are recorded on the programme risk and issue register and managed by the EPR Risk Review Board.   | Further divisional engagement required - More understanding of the transformational change is required within the clinical divisions. The impact on activity during go live will be significant and the changes in processes post go live will be equally significant.<br><br>Financial offsetting for 16/17 to mitigate against the reduction in activity during go live and short term post go live.<br><br>Sign off the Operational Readiness plan by division<br>Lack of divisional engagement in some areas as raised at the EPR Operational Group. | 20<br>5<br>x<br>4 | 20<br>5<br>x<br>4 | 5<br>5<br>x<br>1 | Continual monitoring of actual programme risk and issues log<br>Any risks escalated to the Transformation Board.<br>Access to the full EPR Risk Log will be made available to R&C group any escalations from transformation group will be brought to R&C by programme leads.<br>Sept Update: To ensure patient safety, Plan for a launch/go-live next year, this plan will also separate the go-live. This will allow more time to engage and train staff, deliver the technical solutions that will support EPR and more test the system. This will help to mitigate the contributory factors outlined in this risk.<br>Oct Update: Now coming out of the re-planning phase after tabling a number of options at Transformation Board. The programme is following an incremental plan that will provide an indicative go-live period following successful testing during trial load 3 (November/December). Failure to meet the exit criteria will show the need for a trial load 4 resulting in a later go live date.<br><br>**November Update:**<br>Following the re-planning phase referenced above, the timeline for the programme will be based around the successful exit of Trial Load 3 (end of November). If this phase is successful then CHFT will continue to head towards a March go-live, the consequence of failure is the need for a Trial Load 4 (circa 8 weeks). We have met the entry criteria for TL3 and early indicators are positive. The risk score cannot be reduced at this point, further work is required on the Gaps in controls. | Dec-2016 | Sep-2017 | RC | Mandy Griffin | Mandy Griffin |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 6721 | Corporate | May-2016 | Keeping the base safe | The Trust is planning to deliver a £16.1m deficit in 2016/17. There is a risk that the Trust fails to achieve its financial plans for 2016/16 due to: - clinical activity and therefore income being below planned levels - income shortfall due to commissioner affordability - income shortfall due to contract sanctions / penalties based on performance measures or failure to achieve CQUIN targets - non receipt of Sustainability and Transformation Funding due to performance - failure to deliver cost improvements - expenditure in excess of budgeted levels - agency expenditure and premia in excess of planned and Monitor ceiling level | Standing Financial Instructions set spending limits Project Management Office in place to support the identification of CIP Turnaround Executive meeting weekly to identify CIP shortfalls and drive remedial action Accurate activity, income and expenditure forecasting Finance and Performance Committee in place to monitor performance and steer necessary actions Executive review of divisional business meetings Budget reviews hold budget holders to account Realistic budget set through divisionally led bottom up approach | Further work ongoing to tighten controls around use of agency staffing. For 2016/17 the Trust has been given a £14.95m ceiling level for agency expenditure by NHS Improvement. Agency spend must be reduced considerably if the Trust is to deliver the financial plan, not exceed the ceiling and secure the Strategic Transformation Funding. | 20 5 x 4 | 20 5 x 4 | 15 5 x 3 | **November update:** At Month 7, the year end forecast position is to deliver the planned £16.1m deficit (excluding exceptional costs). In addition, it continues to be assumed that the Trust will achieve the necessary conditions to secure the £11.3m Sustainability and Transformation Funding which is intrinsic to delivery of the planned deficit. Divisional financial recovery plans and additional savings plans must be implemented to ensure delivery of the Trust's forecast financial position.A revised forecast trajectory to reduce agency spend through the remainder of the year was submitted to NHSI based on operational actions. The Trust must drive the necessary reductions in agency expenditure whilst striving to maintain safe staffing levels and deliver standards and access targets. Against the £14m CIP target, £15.09m delivery is forecast and the risk profile of this has been reviewed, £1.32m of schemes remain as high risk. In addition, the new EPR system brings heightened risk of lost productivity through the implementation phase. Commissioner affordability challenges, shortfall on System Resilience Funding and seasonal operational challenges may bring further unplanned pressure. | Nov-2016 | Mar-2017 | FPC | Gary Boothby | Kirsty Archer |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **6722** | Corporate | May-2016 | Keeping the base safe | Risk that the Trust will not be able to pay suppliers, staff, PDC and loans due to cash flow timing or an overall shortfall of cash resulting in external scrutiny, significant reputational damage and possible inability to function as going concern. | * Agreed £5m capital loan from Independent Trust Financing Facility received in April 2016<br>* Cash forecasting processes in place to produce detailed 13 week rolling forecasts<br>* Discussed and planned for distressed funding cash support from Monitor<br>* Trust's Standing Operating Procedures for Treasury Management and Accounts Payable give authority to withold payments to suppliers<br>* Cash management committee in place to review and implement actions to aid treasury management<br>* Working capital loan facility in place (at 3.5% interest rate) for £13.1m to support cash in advance of progression of revenue support loan (at 1.5% interest rate) | Distressed cash support through "Revenue Support Loan" not yet formally approved by NHS Improvement.<br><br>The level of outstanding debt held by the Trust is increasing on a monthly basis, the majority of this is owed by other NHS organisations, this has increased the borrowing requirement in the year to date. | 15 x 3 | 20 x 4 | 15 x 3 | **November update**: Borrowing has been drawn down at a higher level than originally planned to allow settlement of outstanding creditor payments. Further action is being taken to maximise collection of receivables and the profile of cash management has been raised at Divisional level and agreement has been reached with the Trust's main commissioners to settle in-year contract activity overtrades in a more timely manner. Cash continues to be a high risk due to the knock on impact of I&E risks; the ongoing reliance on availability of commissioner cash funding; and the fine balance required in managing working capital.<br><br>The latest understanding from discussions with NHSI to convert our loan from a Working Capital Facility (at 3.5% interest) to a Revenue Support loan (at 1.5% interest), is that we will only move to the lower rate loan once the working capital facility has reached the level equivalent to 30 days operating costs. This will be in March 2017 based on current projections. | Dec-2016 | Mar-2017 | FPC | Gary Boothby | Kirsty Archer |

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| 6753 | Corporate | Jun-2016 | Keeping the base safe | The risk of inappropriate access to PID and CHFT Organisational data on some Trust PC's. This risk is increased by the inability to audit access either pre or post any incident. Due to :-Data being saved under Web-station log ins on communal PCs and associated network drives (wards etc) Resulting in:-Breach of confidentiality of patient or staff internally and organisational risk from a CHFT data breach. | - Only trust staff can access the PCs under the web-station login- Only PC's that are a member of a specified group will allow the use of web-station login- Policy mandates that no Data (especially PID) to be saved to local drives- Reduction of generic logons where possible (low impact)- Sophos encryption of disk drives for encrypted local disk data | Process to wipe the local drive on web-station PCs dailyRemoval of generic logons through roll out of single sign-on/VDI (Oct 2016)Password for web-station does not change every 3 months as per other user accounts Ability to save information to shared network drives associated with web-station account. This information is accessible by all who use the account. Not all PC's have Sophos Encryption installed (Ongoing) | 16 4 x 4 | 16 4 x 4 | 4 4 x 1 | Clarity around the extent of the problem through audit of PCs and network saved data<br>Sept Update - Short term - Unprotected PC's have been encrypted. Longer term - SSO/VDI hardware is in place, Configuration is underway, Ward 3 at CRH will be the initial test area in October. Roll out will commence in November.<br><br>October Update - As above, no further mitigation to the risk until VDI/SSO is rolled out from November.<br><br>**November Update**<br>VDI/SSO project is still on track for this month. Mitigation will be reported in the next update. | Dec-2016 | Dec-2016 | RC | Mandy Griffin | Rob Birkett |

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| 6822 | Medical | Aug-2016 | Keeping the base safe | CQUIN target at risk of not being met for 2016/17 based on current compliance for screening for sepsis, time to antibiotic and review after 72 hours and risk of non - compliance in line with new NICE guidelines for sepsis.<br><br>This is due to lack of engagement with processes, lack or process for ward staff to follow and lack of joined up working between nursing and medical colleagues.<br><br>The impact is the increased deterioration in patients condition and increased mortality if sepsis not recognised and treated within the hour and all of the sepsis 6 requirements delivered impact and financial penalties. | Sepsis CQUIN matron employed<br>Awareness and new controls for ward areas<br>Divisional plan, medical leads identified in all divisions<br><br>-Improvement action plan in place, improvements seen in data for Q2<br>-stop added to nerve centre to prompt screening<br>-new screening tool and sepsis 6 campaign to be launched ASAP, introducing the BUFALO system<br>-matrons promoting the and challenging for screening in the 9-11 time on wards<br><br>NICE guidelines - Cerner currently testing qSOFA and new NICE cut offs | Lack of engagement with processes<br>Lack of clear process for ward staff to follow<br>Lack of joined up working between nursing and medical colleagues<br><br>Compliance with NICE guidelines - sepsis matron to seek clarity and confirm compliance and noncompliance and add in improvement action plan if needed | 15x3 | 16x4 | 12x3 | Sepsis matron to set immediate controls for ward staff<br><br>**November Update**<br>Deep dive report into the causes of sepsis and barriers to implementing clinical standards completed and now being presented to the Quality Committee on 29.11.16. | Nov-2016 | Mar-2017 | PSQB | David Birkenhead | Tracy Fennell |

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| 5862 | Medical | Aug-2013 | Keeping the base safe | There is a risk of significant patient falls due to poor level of patient risk assessment which is not being completed to support clinical judgement, failure to use preventative equipment appropriately and staff training, failure to implement preventative care, lack of equipment, environmental factors, staffing levels below workforce model exacerbated by increased acuity and dependency of patients, resulting in a high number of falls with harm, poor patient experience and increased length of hospital stay. | Falls bundles; Vulnerable adult risk assessment and care plan. Falls monitors,falls beds/chairs, staff visibility on the wards, cohort patients and 1:1 care for patients deemed at high risk. Falls collaborative work on wards deemed as high risk; Staff education. All falls performance (harm and non harm) reported and discussed at Divisional PSQB meetings. | Insufficient uptake of education and training of nursing staff, particularly in equipment.<br><br>Staffing levels due to vacancies and sickness.<br><br>Inconsistent clinical assessment of patients at risk of falls.<br>Inconsistency and failure to recognise and assess functional risk of patients at risk of falls by registered practitioners.<br><br>Environmental challenges in some areas due to layout of wards. | 12<br>4<br>x<br>3 | 16<br>4<br>x<br>4 | 9<br>3<br>x<br>3 | Spread of falls improvement work and further staff education and training. Safety huddles to be embedded on all in patient areas with the co-operation of the whole multi -disciplinary team. Continue to undertake RCA on harm falls and ensuring learning is embedded.<br>Embed falls 5 across all areas and monitor quality improvements against this.<br><br>**November Update**<br><br>Medical Division has undertaken a deep dive into falls and is presenting this at their divisional performance meeting on 25.11.16.<br><br>Implementing new methods of care delivery to support managing vulnerable patients. | Dec-2016 | Mar-2017 | PSQB | Brendan Brown | Maggie Shepley |

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| 4783 | Corporate | Aug-2011 | Transforming and improving patient care | Risk of adverse publicity and regulatory intervention due to Trust falling below national standards for mortality as Trust SHIMI position is now outside the expected range; this may be due to issues regarding delivering appropriate standards of care for acutely ill patients/frail elderly patients and failure to correct accurate co-morbidity data for coding and may result in inaccurate reporting of preventable deaths, increased external scrutiny and a possible increase in complaints and claims.<br><br>***It should be noted that risks 2827 and 6131 should be read in conjunction with this risk. | Service reviews by Royal College of Physicians on Respiratory Medicine and Complex Medicine which give guidance on areas of further improvement. Action plans being developed based on preliminary report findings. Outlier areas are monitored (e.g. Stroke, Sepsis and COPD) Outliers investigated in depth to identify the cause. Improvement work via an action plan. Mortality dashboard analyses data to specific areas Monitoring key coding indicators and actions in place to track coding issues Written mortality review process agreed to clarify roles and to facilitate a greater number of reviews being completed, process for escalation, linking with other investigation processes e.g. SI panel review. August reviews of July deaths (using new process) compliance 70%.Monthly report of findings to CEAM and COG. Revised investigation policy clarifies process for learning from all investigations, including mortality reviews, and | Mortality reviews to assess preventable deaths which is indicating there isn't a problem but not yet performed for long enough or to sufficient depth to determine causes Mortality case notes review may not pick up all factors relating to preventability Coding improvement work not yet complete Improvement to standardised clinical care not yet consistent. Care bundles not reliably commenced and completed | 20 4 x 5 | 16 4 x 4 | 12 4 x 3 | To complete the work in progress CQUINS to be monitored by the Trust External review of data and plan to take place - assistance from Prof Mohammed (Bradford) August update The CQC inspection report referenced the work on going within the organisation in relation to mortality and has said that we must continue with the work we are doing to reduce avoidable mortality. We have received the final report from the Respiratory ISR and will commence a plan to deliver the actions. September update A new mortality review process will be implemented which will lead to a consultant led review into each death. Progress continues to be made with the management of sepsis and a lead nurse has commenced in post October updateThe action plans for the elderly and respiratory ISR's will be presented to the Medical Director this month. Dates for the stroke ISR have been agreed.<br><br>**November update**<br>The Medical Director to meet with Medicine Division to sign off invited service review action plans, the division have appointed a manager to oversee implementation of the plans. A deep dive into sepsis to be taken to Quality Committee in November. A revised care of the Acutely Ill action Plan to be taken to Clinical Outcomes Group in November | Dec-2016 | Mar-2017 | COB | David Birkenhead | Juliette Cosgrove |

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| | | | | | monitoring of actions CAIP plan revised, now focusing on 6 key themes: investigating mortality & learning from findings; reliability; early recognition & response to deterioration; end of life care; frailty, coding.Care bundles in place | | | | | | | | | |

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| 6598 | Corporate | Jan-2016 | Keeping the base safe | There is a risk of being unable to provide essential skills training data for some subjects and where data is available this is not always set against a target audience. Therefore the organisation cannot be assured that all staff have the relevant essential skills to practice safely. This is due to the data being held in a devolved structure with no required target audience setting mechanism or central gathering/recording process. This will result in a failure to understand essential skills training compliance against set targets across the whole of the organisation. Further essential skills subjects are being identified and added to the list with increasing frequency, extending the period of time the roll out project will take and re-prioritisation to establish which are the key priority essential skills to focus on first. | There is an agreed essential skills matrix now in place and an essential skills project plan to describe and implement the target audience for each essential skills subject (the project timeline extends until February 2017). Compliance measurement will be enabled as each TA is set although this is a lengthy process within the confines of the current Learning Management System. The business plan to commission an alternate learning management system has been approved therefore the tendering process is underway.The Education and Learning Group (ELG) has recently been established and any new requests for addition to the essential skills list need to be approved by this group which should help apply some control to the content of the list. | 1/ Essential skills training data held is inconsistent and patchy. 2/ target audiences setting to allow compliance monitoring against a target is inconsistent and patchy 3/ Functionality of the OLM system is limited and cannot facilitate disaggregated target audience setting. A manual system to facilitate the actions above will be require1/ Essential skills training data held is inconsistent and patchy. | 16 4 x 4 | 16 4 x 4 | 12 4 x 3 | **November Update**<br>To enable compliance reporting for the listed essential skills subjects, target audience agreement must be completed for each subject. The following subjects have been agreed as organisational priorities for this process: - aseptic non touch technique (ANTT) basic life support (BLS) documentation malnutrition universal screening tool (MUST) pressure ulcer care infection prevention and control end of life (EoL) care The priority subjects will be completed by September 2016 with the further matrix subjects being completed by 31st March 2017. This work will be led by Pam Wood. Alternate learning management systems (LMSs) are being explored with initial system demos on the 25th May 2016. Following the demos decisions about whether to progress to a full business case/tendering procurement process will be taken. Should this progress the tendering process will take 8 to 12 weeks to complete. Implementation will then require a further 4 to 8 months. The Education and Learning Group has the responsibility for reviewing mandatory and essential skills elements that form the overall programme. The Group has been established with Terms of Reference which will be reviewed when fully operational in June 2016. | Dec-2016 | Dec-2016 | NA | Jason Eddleston | Pamela Wood |

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| 6658 | Medical | Mar-2016 | Keeping the base safe | Risk of slow patient flow due to exit block preventing timely admission of patients to the hospital bed base at HRI & CRH. This results in the following: patient harm and death, increase in mortality of 1.5% per hour wait for a bed; poor patient experience from inability to access an appropriate clinical area for their care, waiting in hospital corridors within the ED with poor privacy and dignity; Risk to delivery of a safe ED service due to lack of capacity to manage and risk assess undifferentiated new ED patients; increased risk of violence & aggression towards staff and other patients; poor staff morale due to frustration of inability to undertake the work for which they are employed; poor compliance with reportable clinical indicators: 4 hour emergency access target; time to initial assessment; ambulance turnaround, resulting in financial penalties | 1 Patient flow team supported by on-call management arrangements to ensure capacity and capability in response to flow pressures.<br>2 Unplanned Care Lead focus across the organisation bringing expertise & coaching for sustainable improvement.<br>3 Daily reporting to ensure timely awareness of risks.<br>4 4 Hourly position reports to ensure timely awareness of risks<br>5 Surge and escalation plan to ensure rapid response.<br>6 Discharge Team to focus on long stay patients & complex discharges facilitating flow.<br>7 Active participation in systems forums relating to Urgent Care.<br>8 Phased capacity plan to reflect demand & facilitate safer flow.<br>9 Weekly emergency care standard recovery meeting to identify immediate improvement actions<br>10 Daily safety huddles to pro-actively manage potential risks on wards with early escalation.<br>11. Programme governance, multi Director attendance at Safer Programme Board and monthly reporting into WEB.<br>12. Single transfer of care list with agency partners | 1. Capacity and capability gaps in patient flow team 2. Very limited pull from social care to support timely discharge 3. Limited used of ambulatory care to support admission avoidance 4. Tolerance of pathway delays internally with inconsistency in documented medical plans 5. Unable to enhance winter resilience in a timely manner due to external funding reductions from 2014/15 levels as escalated to Board, Monitor and local System Resilience Group 6. Roving MDT (which supports discharge of complex patients) ceased pending Systems Resilience Group funding decision. 7. Lack of system resilience funding and a risk that previously agreed funding will be withdrawn. Action internal assessment meeting to understand the risk of this | 20<br>4<br>x<br>5 | 16<br>4<br>x<br>4 | 9<br>3<br>x<br>3 | **November Update**: Weekly meetings with Medicine division focusing on further actions to mitigate risk whilst implementing sustainable changes. These include improved end of life pathway, bed before 11pm initiative , daily debrief at 7am between flow and A&E co-ordinators and exploring direct commissioning of out of hospital capacity. July Update Safer patient flow programme fully operational with clear governance arrangements including monthly reporting to WEB to ensure full organisational awareness and ownership. Process to cross check patients with a long wait in A&E and outliers within the mortality review process. As per the bed plan a further 14 bed reduction on the HRI site which, with current demand is requiring more focused patient flow team input September 16 UpdateSingle transfer of care list in place and finalised with agency partners meaning that there is consistent prioritisation of discharge planning. Integrated the discharge and social care teams on both sites.New process in SAS and Medicine for matron reviews every morning identifying and actioning discharge planning. Associate Director in place focusing on urgent care and safer flow.Active participants in the NHS I Improvement Programme for Emergency Care.October 2016Continued progress on SAFER Programme improvement work.CHFT part of the WYATT Accelerator Zone- to deliver the ECS 95% standard. This is about system resilience, improved patient flow, creating capacity by improved discharge with social care involvement. | Dec-2016 | Mar-2017 | BOD | Helen Barker | Bev Walker |

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| 6300 | Trustwide | May-2015 | Keeping the base safe | As the Trust has been rated by the CQC, following our inspection, as "requires improvement" there is a risk that if we fail to make the required improvements prior to re inspection we will be judged as inadequate in some services. | - System for regular assessment of Divisional and Corporate compliance - Routine policies and procedures - Quality Governance Assurance structure - CQC compliance reported in Quarterly Quality and Divisional Board reports -Action plans in place for areas that have been identified as requiring improvements including those areas identified by the CQC during and after the inspection -A fortnightly meeting is being held to monitor progress with the action plans chaired by the Chief Executive - An external review of the maternity service, by the Royal College of Obstetricians and Gynaecologists, has been conducted | The inspection report has shown us to be in the "requires improvement" categoryAn action plan is being developed but not yet approved | 16 4 x 4 | 16 4 x 4 | 8 4 x 2 | CQC compliance Steering Group Implementation CQC Compliance action plan CQC Operational Group Further embedding of CQC assurance into the Divisions and Corporate Governance structures September update Governance arrangements for the oversight of the improvement plan are being approved by the Trust Board in September. A Quality Summit is planned for October. The Trust is confident that most actions are achievable in the short to medium term but still has some actions that will require service transformation October updateThe action plan has been reviewed at the Trust Board meeting in September. Core service improvement plans are also in development and expected to be completed at the end of October. The report from the RCOG relating to maternity services is due in month. **November update** RCOG report received and the maternity service are incorporating recommendations into their plans. A number of actions are completed that were due for October. All core services have approved or drafted action plans. Quality summit didn't identify areas for improvement that weren't already included in the action plan. A number of "Go See" visits have occurred including from the CQC and the CCG. | Dec-2016 | Mar-2017 | WEB | Brendan Brown | Juliette Cosgrove |

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| 6694 | Trustwide | Mar-2016 | Keeping the base safe | Risk that the divisional governance structures are not sufficiently standardised and mature to provide assurance on quality and safety due to inconsistent divisional governance systems and processes and lack of application of agreed terms of reference and divisional and directorate Patient Safety Quality Boards (PSQB) resulting in the Quality Committee having a lack of assurance on quality and safety at divisional and directorate governance level | Divisional PSQB terms of reference used for each divisional PSQB. Supplementary governance manager resource within divisions.Quarterly quality and safety report from divisional PSQB to quality committee and hoc reports to Quality committee on specific quality issues eg, Stroke, # Neck of Femur<br>Action plan in place to deliver improvements | Consistent application of PSQB terms of reference at Divisional and Directorate level.Variable quality quarterly PSQB reports to Quality Committee.Varied model of governance support into and within Divisions.<br>Varying structures and processes for quality governance at Directorate and Speciality level. | 16 4 x 4 | 16 4 x 4 | 8 4 x 2 | Review of governance support to divisions.<br>Application of standardised governance approach to PSQBs<br><br>September update<br>The CQC issued a requirement notice to ensure that divisional governance arrangement continue to be improved. A plan is in place to deliver the improvements.<br><br>October update<br>The Director of Nursing has met with 3 divisions to understand where some of the gaps are and to agree specific areas of improvement. Actions continue to be implemented.<br><br>**November update**<br>A set of Governance Standards are being developed for ward and departments. Sessions on the Ward Managers Development Programme in October have covered areas relating to governance. A review of divisional risk registers is to be undertaken in November. | Dec-2016 | Dec-2016 | QC | Julie Dawes | Juliette Cosgrove |

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| 6596 | Corporate | Jan-2016 | Keeping the base safe | Risk of not conducting timely investigations into serious incidents (SIs), due to not responding quickly enough to the new national SI framework introduced in March 2015, resulting in delayed learning from incidents, concerns from commissioners and delays in sharing the findings with those affected. | Incident Reporting Policy aligns with national framework, template reports, clarity on divisional sign off and Trust sign off of SIs. Weekly Director panels y to ensure quality assurance of final reports. Meet commissioners monthly.. Patient Safety Quality Boards review of serious incidents, progress & sharing of learning. Accurate weekly information for divisions ion serious incidents & timescales for completion of reports. Investigator Training - 1 day course held 3 monthly to update investigator skills and align investigations with report requirements. SI Review group chaired by Chief Executive to ensure senior Trust wide oversight & peer challenge of Sis. Investigations Manager supports investigators with timely & robust investigations reports and action plans, learning summaries from SIs presented to Quality Committee, SI Review Group monthly & shared with PSQB leads. | 1. Lack of capacity to undertake investigations in a timely way 2. Need to improve sharing learning from incidents within and across Divisions 3. Training of investigators to increase Trust capacity and capability for investigation | 16 4x4 | 16 4x4 | 8 4x2 | August update Reports still not always meeting the deadline and we still need to train more investigators. Those that are conducting investigations are getting more support from the Risk Management Team. One report was noted by the CCG as excellent. September update The CQC in their published report stated that we must train more investigators in the use of RCA tools and techniques, a plan is in place to deliver the required actions.<br><br>October updateThere remains concerns about the timeliness of reports but the quality is improving. A business case is being developed to recruit staff with specialised investigation expertise.<br><br>**November update**<br>A training day was held for 14 staff in October. All SI investigations now have a trained investigator allocated. Business case for investigators still being developed. | Dec-2016 | Dec-2016 | QC | Brendan Brown | Juliette Cosgrove |

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| **6723** | Corporate | May-2016 | Financial sustainability | Risk that the Trust will have to suspend or curtail its capital programme for 2016/17 due to having insufficient cash to meet ongoing commitments resulting in a failure to develop infrastructure for the organisation.<br><br>There is a risk that NHS Improvement will not approve the Trust's capital programme for 2016/17 due to national funding pressure also resulting a failure to develop infrastructure for the organisation. | Agreed £5m capital loan from Independent Trust Financing Facility (ITFF) received in April 2016 to support capital programme, specifically the Electronic Patient Record (EPR) investment.<br>Capital programme managed by Capital Management Group and overseen by Commercial investment Strategy Committee, including forecasting and cash payment profiling.<br>Discussed with NHS Improvement and planned for distressed cash support. | . | 20<br>5<br>x<br>4 | 15<br>5<br>x<br>3 | 12<br>4<br>x<br>3 | **November update:**<br><br>The forecast capital expenditure of £27.64m against the planned £28.2m is as per the submission made to NHSI in June, against which assurance has been received with regard to the availability of cash support. On this basis, after an internal review of our cash, operational, and legislative compliance requirements, the Trust continues to reprioritise spend within the overall value discussed with NHSI. Any changes to the make-up of the programme follow the completion of a full risk assessment. | Dec-2016 | Mar-2017 | FPC | Gary Boothby | Kirsty Archer |

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| 6829 | Family & Specialist Services | Aug-2016 | Keeping the base safe | Risk of Trust having insufficient capacity in 2018 for the Pharmacy Aseptic Dispensing Service to provide 50,000 pa ready to administer injectable medicines with short expiry dates for direct patient care, due to HRI and CRH Aseptic dispensing facilities not being compliant with national standards as identified by stat external audits EL (97) 52. Audits are by the Regional Quality Control Service on behalf of NHSE. Critical findings would be reported to the MHRA has statutory authority (under the Medicines Act 1968) to close the unit if it does not comply with the national standards. 20 year old HRI unit is a maximum life-span up to the end of 2018. resulting in lack of availability of high risk critical injectable medicines for urgent patient care non-compliance with national standards with significant risk to patients if unresolved. | Rigorous environmental and microbiological monitoring of the current facilities and the introduction of in-process controls to ensure no microbial contamination of final products.Self-audits of the unit External Audits of the units undertaken by the Quality Control Service on behalf of NHSE every 18 months.Audit findings and action plans are reported to the FSS Divisional Board with monitoring of non-compliance. | If a business case for the development of the Aseptic Service is not approved within this financial year then this will result in a 'critical non-compliance 'rating for the HRI unit by the external auditors in 2017 creating a major capacity problem in 2018.<br><br>Capital investment required for the development of capacity of the CRH unit & the compliance with national standards, | 15<br>3<br>x<br>5 | 15<br>3<br>x<br>5 | 0<br>3<br>x<br>0 | The procurement of manufactured ready to administer injectable medicines when available from commercial suppliers. The first phase will be the procurement of dose- banded chemotherapy as soon as regional procurement contracts have been approved. This will create some capacity.The business case for the future provision of Aseptic Dispensing Services to be produced by November 2016 with a view to consideration and approval by the Commercial Investment Strategy Group taking into account commercial procurement of some products. If the business case is approved then the risk will be reduced. The target risk of 0 will be achieved on completion of the refurbishment of the CRH unit. | Dec-2016 | Dec-2018 | DB | Brendan Brown | Mike Culshaw |

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| 6841 | Corporate | Sep-2016 | Keeping the base safe | Risk of: Not being able to go live with the Electronic Patient Record due to:<br>Lack of operational readiness, training, hardware, staff engagement, staff confidence and IT literacy amongst users.<br>Efficiency and productivity may reduce due to inexperience of using the system<br><br>Inability to report against regulatory standards<br><br>Resulting in reputational damage arising from inability to go live with the EPR , financial impact, impact at every point of patient care (appointments, patient flow, records, MDT s, payment ) and continued use of paper records which can impact on safe, efficient and effective patient care.<br>National and local targets may be put in jeopardy.<br><br>Contractual Penalties for the Trust. | Pre go-live<br>- A robust governance structure is in place to support the implementation of the EPR, including EPR specific risk register reviewed at weekly EPR meeting.<br>- Weekly EPR operational board with direct escalation to WEB (and sponsoring group)<br>- 90/60/30 day plans will aid control<br>- 1:1 consultant plan<br><br>Cut over:<br>- Strong cut over plan with a developed support structure for BAU post ELS.<br>- Command and control arrangements for cut over (Gold, Silver, Bronze)<br><br>Post go-live:<br>- gap | 1. Training – need to monitor uptake of EPR training (EPR team and divisions by mid-September 2016)<br>2. Need to identify capacity and activity gaps through divisional operational readiness reporting<br>3. Number of EPR Friends/effectiveness of EPR friends. | 15x3 | 15x3 | 10x2 | Engagement and operational readiness sign off closer to go live date via operational readiness checklist and EPR passport.<br><br>Closely monitor progress around training and staff feedback following the sessions.<br><br>Further work with the divisions to clearly communicate the operational groups expectations and measure progress through the divisions reporting back to the ops group. | Oct-2016 | Sep-2017 | RC | Helen Barker | Mandy Griffin |

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| 6715 | Corporate | Apr-2016 | Keeping the base safe | There is a risk to patient safety, outcome and experience due to incomplete or poor quality nursing and medical documentation. Poor documentation can also lead to increased length of stay, lack of escalation for when deterioration occurs, poor communication and multidisciplinary working. | Monthly clinical record audits with feed back available from ward to board. Monthly qualitative audit by Matrons that includes patient understanding . Medical audits. Analysis and action planning managed through divisional patient safety and quality board A multi professional clinical documentation group meets bi monthly to ensure documentation is ratified, standards on documentation are addressed. & receives reports and audits with regard to documentation and identifies to the divisions areas of concern as well as any specific areas of concern within a specific standard. Clinical records group monitors performance, highlighting best and worst performing wards. Action plans are developed and managed through divisions, including areas for improvement. | The number of audits undertaken can be low Unable to audit to allow and act on findings in real time The discharge documentation is under going review Fluid balance is being reviewed, the evidence base is being examined by the Deputy Director of Nursing | 20 4x5 | 15 3x5 | 8 4x2 | The Trust is developing an electronic patient record that will enable reports to be run in real time, audits can be undertaken by the ward or department lead when they deem it necessary (daily, weekly, monthly) There are alerts and stops within the system to prevent the user skipping documentation.<br><br>Oct: There is recognition that the improvement work required will take time to embed and therefore the CRAS audits have been suspended until January 2017. The revised falls documentation will be tested on wards 6 and 7 at CRH, over this period compliance with the documentation will be audited. Matrons will continue to work with teams to make improvement with fluid balance charts.<br><br>**November Update:**<br>The clinical record audits remain suspended with the divisions focusing on improving falls and fluid balance documentation. Progress reported through divisional PSQB.<br><br>The senior nurse team are reviewing ward assurance framework which includes documentation; the anticipated timeframe to test the revised assurance is January 2017. | Feb-2017 | Mar-2017 | QC | Brendan Brown | Jackie Murphy |

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| 6693 | Corporate | Mar-2016 | Keeping the base safe | Risk Of: Failure to comply with the Monitor cap rules. Due to: Bed capacity – The Trust has opened a significant number of additional beds in response to service pressures requiring safe staffing levels. No. of vacancies in the workforce – The Trust has a high number of vacancies across its workforce resulting in the requirement to engage agency staff (including national shortages). Resulting in: High usage of externally sourced agency workers, utilising agency that breaches the cap rate and in circumstances uses off-framework agencies. Regulator sanction – The Trust receiving a regulatory sanction given the number of breaches the Trust currently reports against the Monitor agency cap. Safety risk – The Trust is unable to fill vacant posts (Medical, Nursing, AHP, A&C) resulting in the risk of patient safety, quality and care. | Weekly information on breaches of the Monitor cap, reported to Monitor. Assurance via F &P and Well- led Group. Challenge sessions to review all existing long term breaches of the Monitor cap, integrate this review/challenge into the existing Divisional Business Meetings. Communication with all agencies (across all staff groups) requiring agencies to comply with the Monitor cap imposed. Nursing - centralised escalation process in place for the authorisation of requests to secure agency workers for Nursing staff (qualified and non-qualified), through to Nursing Director. Rich information on Nursing workforce, covering bank, overtime & agency to monitor for spend/bookings. Medical / AHP/ A&C – exec authorisation to secure agency workers/locums | Robust escalation and management information for all non-Nursing staff groups. Disparate data sets around agency use & spend making adequate overview difficult. | 15 3 x 5 | 15 3 x 5 | 9 3 x 3 | **November Update**<br>A Programme Board will be established to provide governance, support and structure to Trust wide initiatives to improve and embed a consistent model for medical, nursing, midwifery and AHP workforce utilisation and efficiency and subsequent reduction in the reliance on medical locums and overall use of agency medical and non-medical workforce.<br><br>I.T. system implementation to modernise the processes around job planning, Rostering and booking of flexible and interim workforce ensuring this is done through the most cost effective measures.An improved communications strategy to enhance the Trust's recruitment potential and retention across all staff groups. Work with agencies to ensure all agency/interim staff is engaged only where absolutely necessary and most cost effective route for the Trust.. Pay rates and commission rates enegotiated with each agency. All mid-long term agency staff contracts are to be reviewed and renegotiated where possible. Divisions action log / task list to negate the need for a mid/long term agency workforce.Increase and optimise the availability of bank staff, modernising access to the bank booking system. Work to improve Trust wide sickness levels and return to work initiatives. Actions to improve Trust's recruitment and retention strategy.<br><br>THIS engaged to provide solution to data set issue within 2 week turnaround. | Dec-2016 | Dec-2016 | WLG | Ian Warren, | Mark Borrington |

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| 6886 | Corporate | Nov-16 | Transforming and improving patient care | There is a risk of non-compliance with the four priority standards* in relation to 7-day services as an 'early implementer' by March 2017. *Priority standards 2, 4, 5 and 8.This is due to split site acute services, no additional investment for the extra consultants needed, consultant workforce vacancies and difficulties in recruiting will result in inconsistent service delivery over 7-days and especially weekends, which may impact on clinical outcomes, patient flow & patient experience. No contractual obligation or penalty in not achieving compliance with the four priority standards by March 2017. Potential impact on local and national reputational loss and be focus of future enquiry. | High level action plans are being reviewed with the aim of developing more detailed plans to review what can be achieved within current resources and current configuration of acute services. This will include details of workforce and skill mix, financial implications and full benefits such LOS and patient experience. This will need to take into account what can realistic be achieved with the scope of the 5-year plan. 7DS reports via the Safer Programme. | • Lack of funding to recruit consultants to meet compliance • Difficulties in retaining & recruiting to consultant posts within certain specialties • Split-site configuration of hospital services.Completion of detailed action plan will help identify possible solutions towards achieving compliance it is doubtful that within current resources and configuration of acute services that full compliance will be achieved. The national timeline for all trusts to achieve full compliance with the priority standards is 2020 which is before the likely 5-year timeline to reconfiguration of acute services. At present there is no financial penalty in achieving compliance, however this may change in the future. | 15x5 | 15x5 | 9x3 | Impact and in particular response to non-compliance from NHSI will require further monitoring. | Feb-17 | | David Birkenhead | Sal Uka |

Calderdale and Huddersfield NHS
NHS Foundation Trust

**Approved Minute**

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## Cover Sheet

| | |
|---|---|
| **Meeting:**<br>Board of Directors | **Report Author:**<br>Kathy Bray, Board Secretary |
| **Date:**<br>Thursday, 1st December 2016 | **Sponsoring Director:**<br>Victoria Pickles, Company Secretary |
| **Title and brief summary:**<br>GOVERNANCE REPORT - DECEMBER 2016 - This report brings together a number of governance items for review and approval by the Board. | |
| **Action required:**<br>Approve | |
| **Strategic Direction area supported by this paper:**<br>Keeping the Base Safe | |
| **Forums where this paper has previously been considered:**<br>N/A | |
| **Governance Requirements:**<br>Keeping the base safe | |
| **Sustainability Implications:**<br>None | |

## Executive Summary

### Summary:

This report brings together a number of governance items for review and approval by the Board:
- Board Skills/Competencies Self-Assessment
- Review of Board of Directors' Workplan
- Use of Trust Seal
- Integrated Performance Reporting Process

## Main Body

### Purpose:

This report brings together a number of governance items for review and approval by the Board:

### Background/Overview:

Please see attached

### The Issue:

1. Board Skills/Competencies Self-Assessment
The Board of Directors have all undertaken a self-assessment of their skills and competencies as part of an annual review. An anonymised composite report is attached at appendix 1. This will be used to help identify any required development and also the assessment of what skills are required when consideration is given to future board vacancies.
The Board is asked to NOTE the self-assessment.

2. Review of Board of Directors' Work plan
The Board work plan has been updated and is presented to the Board for review at appendix 2.
The Board is asked to consider whether there are any other items they would like to add for the forthcoming year and APPROVE the work plan.

3. Use of Trust Seal
Two documents have been sealed since the last report to the Board in September. These were in relation to:
- Transfer of the ATM machine to a different provider
- Lease of a police pod in the A/E department at HRI.
The Board is asked to NOTE the use of the Trust Seal.

4. Integrated Performance Reporting and Risk Management reporting processes
At its workshop on 16 November, the Board reviewed the reporting processes for the Integrated Performance Report to ensure that there is robust scrutiny and assurance of performance. It was agreed to update the process to reflect the input of the Membership Council and to map out the governance arrangements relating to risk alongside.
The Board is asked to NOTE the updated IPR and risk management reporting processes.

### Next Steps:

Please see attached

### Recommendations:

The Board is asked to receive the report and:-
1. Note the Board Skills/Competencies Self-Assessment
2. Approve the Board of Directors Workplan
3. Note the use of the Trust Seal

4. Note the Integrated Performance Reporting and risk management process

## Appendix

### Attachment:

COMBINED GOVERNANCE REPORT PAPERS.pdf

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Calderdale and Huddersfield NHS
NHS Foundation Trust

# BOARD SKILLS AND COMPETENCIES SELF-ASSESSMENT
## Template – 31 OCTOBER 2016
## COLLATED RESPONSES - ANON

The proposition for this assessment is that the Board can regard itself as competent if there is a good spread of in depth and working knowledge for each domain across the Executive Directors and Non-Executive Directors. This assessment is used to satisfy the Board that it is fit for purpose and to inform recruitment processes to ensure that any gaps that arise at short notice, or can be predicted through turnover, are filled.

The domains are determined by the Board, having regard to the provisions set out in the Code of Governance for Foundation Trusts by the Foundation Trust Regulator.

**KEY:**
**E – denotes Essential domain**
**D – denotes Desirable domain**
✓ - **Area of sufficiency or strength – considers self competent**
★ - **Area requiring some development – moderate experience or skill**
△ - **No or little experience/skill – development required**

| | | EXECUTIVE DIRECTORS | NON EXECUTIVE DIRECTORS |
|---|---|---|---|
| **DOMAIN** | | ✓ - Area of sufficiency or strength – considers self competent<br>★ - Area requiring some development – moderate experience or skill<br>△ - No or little experience/skill – development required | ✓ - Area of sufficiency or strength – considers self competent<br>★ - Area requiring some development – moderate experience or skill<br>△ - No or little experience/skill – development required |
| Strategic risk & governance management | **E** | 6 - ✓<br>1 - ★ | 7 - ✓<br>1 - ★ |
| Financial expertise & Economic expertise | **E** | 7 - ✓<br>1 - ★ | 5 - ✓<br>3 - ★ |
| Audit expertise | **E** | 4 - ✓<br>3 - ★<br>1 - △ | 6 - ✓<br>2 - ★ |

| DOMAIN | | ✓ - Area of sufficiency or strength – considers self competent<br>★ - Area requiring some development – moderate experience or skill<br>△ - No or little experience/skill – development required | ✓ - Area of sufficiency or strength – considers self competent<br>★ - Area requiring some development – moderate experience or skill<br>△ - No or little experience/skill – development required |
|---|---|---|---|
| | | **EXECUTIVE DIRECTORS** | **NON EXECUTIVE DIRECTORS** |
| THIS expertise | **E** | 5 - ✓<br>3 - △<br>1-★ | 4 - ✓<br>4 - ★ |
| Strategic thinking and practice | **E** | 6 - ✓<br>1 - ★<br>1 - △ | 8 - ✓ |
| System management and system thinking to include customer relationship management and partnership working | **E** | 8 - ✓ | 8 - ✓ |
| Current and future policy environment | **E** | 6 - ✓<br>2 - ★ | 5 - ✓<br>3 - ★ |
| Leadership and organisational development | **E** | 6 - ✓<br>2 - ★ | 7 - ✓<br>1 - ★ |
| Improvement and change management | **E** | 6 - ✓<br>2 - ★ | 8 - ✓ |
| Performance management | **E** | 6 - ✓<br>2 - ★ | 7 - ✓<br>1 - ★ |
| Health and Social Care experience | **E** | 5 - ✓<br>3 - ★ | 5 - ✓<br>2 - ★<br>1 - △ |
| Clinical quality & interdependencies | **E** | 4 - ✓<br>4 - ★ | 3 - ✓<br>2 - ★<br>3 - △ |

| DOMAIN | | ✓ - Area of sufficiency or strength – considers self competent<br>★ - Area requiring some development – moderate experience or skill<br>△ - No or little experience/skill – development required | ✓ - Area of sufficiency or strength – considers self competent<br>★ - Area requiring some development – moderate experience or skill<br>△ - No or little experience/skill – development required |
|---|---|---|---|
| | | **EXECUTIVE DIRECTORS** | **NON EXECUTIVE DIRECTORS** |
| Commercial focus & entrepreneurial skills | **E** | 4 - ✓<br>4 - ★ | 5 - ✓<br>2 - ★<br>1 - △ |
| Human resources management | **E** | 5 - ✓<br>3 - ★ | 5 - ✓<br>3 - ★ |
| Legal awareness | D | 5 - ✓<br>2 - ★<br>1 - △ | 2 - ✓<br>5 - ★<br>1 - △ |
| Health & Safety | D | 6 - ✓<br>2 - ★ | 5 - ✓<br>3 - ★ |
| Corporate communication/media | D | 5 - ✓<br>3 - ★ | 3 - ✓<br>5 - ★ |
| Community Development experience | D | 4 - ★<br>4 - ✓ | 5 - ✓<br>2 - ★<br>1 - △ |
| Ambassadorial skills to develop networks that complement the development of the Trust | D | 6 - ✓<br>2 - ★ | 6 - ✓<br>1 - ★<br>1 - △ |
| Equality & Diversity experience | D | 6 - ✓<br>2 - ★ | 4 - ✓<br>4 - ★ |
| Knowledge as a Corporate Trustee | D | 3 - ★<br>2 - △<br>2 - ✓ | 7 - ✓<br>1 - ★ |

| DOMAIN | | ✓ - Area of sufficiency or strength – considers self competent<br>★ - Area requiring some development – moderate experience or skill<br>△ - No or little experience/skill – development required | ✓ - Area of sufficiency or strength – considers self competent<br>★ - Area requiring some development – moderate experience or skill<br>△ - No or little experience/skill – development required |
|---|---|---|---|
| | | **EXECUTIVE DIRECTORS** | **NON EXECUTIVE DIRECTORS** |

| | | | |
|---|---|---|---|
| Formal Qualifications & Training – please specify field(s) | | - MRPharms, BPharm, MBA, GradIPD, Cert in Medico-Legal Management<br>- BA Hons, Post Grad PR, Member of CIPR, Member of ICSA<br>- M.B ChB, M.D., FRCPath<br>- Chartered Fellow of CIPD<br>MSc Strategic HR and OD<br>Post Graduate HR (CIPD)<br>- MA (Distinction) Counselling Studies<br>Advanced Health & Safety Certificate<br>Diploma in Higher Education<br>ENB 285 – Advanced Continuing Care of the Dying Patient<br>ENB 998 – Teaching and Assessing in Clinical Practice<br>ENB 931 – Care of the Dying Patient and Family<br>RGN<br>- Certificate in Health Service Management<br>- BA (Hons), ACMA, CGMA<br>- MBA, DMS, CBI | - Finance - ACA, Strategy/General Management – MBA<br>- Chartered Accountant, IT Risk & Gov, Corporate Gov, CASS Business School for New Chairs, BA(Hons) Economics & Accounting<br>- Trained Medical Doctor MB, BS FRCP<br>- MBA (Business Management), DMS (Business Management), BA (Social Welfare Administration (Research – Health & Social Care)<br>- BA, MA, DLitt, PGCE. MRTPI, FIED, AOU, FASS, FRSA<br>- Medical Qualifications<br>- MBA<br>Diploma in Training Management<br>Member of the Chartered Institute of Personnel and Development<br>- FCA (Accountancy) |

| Date of meeting | 28 April 2016 | 26 May | 30 June | 28 July | 25 Aug (NO MEETING) | 29 Sept | 27 Oct MEETING CANCELLED | 3 Nov | 1 Dec | 5 Jan 2017 | 2 Feb 2017 | 2 March 2017 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Date of agenda setting/Paper Review of drafts | 18.4.16 | 16.5.16 | 20.6.16 | 18.7.16 | 15.8.16 | 19.9.16 | | 24.10.16 | 5.12.16 | 19.12.16 | 23.1.17 | 20.2.17 |
| Date final reports required | 20.4.16 | 18.5.16 | 22.6.16 | 20.7.16 | 17.8.16 | 16.9.15 | | 26.10.16 | 7.12.16 | 21.12.16 | 25.1.17 | 22.2.17 |
| STANDING PUBLIC AGENDA ITEMS | | | | | | | | | | | | |
| Introduction and apologies | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Declarations of interest | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Minutes of previous meeting, matters arising and action log | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Patient Story | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ Sepsis Review | ✓ | ✓ | ✓ |
| Chairman's report | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Chief Executive's report | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Integrated Board report | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| REGULAR ITEMS | | | | | | | | | | | | |
| Board Assurance Framework (Quarterly) | - | - | ✓ | - | - | - | | ✓ | - | - | ✓ | - |
| DIPC report | - | ✓ | - | - | ✓ | - | | ✓ | - | - | ✓ | - |
| Risk Register | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| **Governance report: to include such items as:** | | | | | | | | | | | | |
| - Standing Orders/SFIs/SOD review (+ March 2017) | | | | | | | | ✓ | | | | |
| - Non-Executive appointments (+ Nov - SINED & Deputy) | | | | | | | | ✓ | | | | |
| - Board workplan | | | ✓ | | | ✓ | | | ✓ | | | ✓ |
| - Board skills / competency | | | | | | | | | ✓ | | | |

| Date of meeting | 28 April 2016 | 26 May | 30 June | 28 July | 25 Aug (NO MEETING) | 29 Sept | 27 Oct MEETING CANCELLED | 3 Nov | 1 Dec | 5 Jan 2017 | 2 Feb 2017 | 2 March 2017 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| - Code of Governance | ✓ | | | | | | | | | | | |
| - Board meeting dates | | | | | | ✓ | | | | | | |
| - Committee review and annual report | | | | | | | | | | | | ✓ |
| - Annual review of NED roles | | | | | | | | ✓ | | | | |
| - Use of Trust Seal | | | ✓ | | | ✓ | | | ✓ | | | ✓ |
| - Quarterly Feedback from NHSI | | | ✓ | | | ✓ | | | ✓ | | | ✓ |
| - Declaration of Interests (annually) | | | | | | | | | | | | ✓ |
| - Declaration of Interests Policy (Jan 2018) | | | | | | | | | | | | |
| - Declaration of Interest – outcome from Consultation | | | | | | | | | | ? | | |
| - Attendance Register (Apr+Oct 2017) | | | | | | ✓ | | | | | | |
| - BOD TOR + Sub Committees | | | | | | | | | | | | ✓ |
| - Constitutional changes (+as required) | | | | | | | | | | | ✓ | |
| - Compliance with Licence Conditions (April 2018) | | | | | | | | | | | | |
| | | | | | | | | | | | | |
| Care of the acutely ill patient report | ✓ | | | ✓ | | ✓ | | ✓ | | ✓ | | ✓ |
| CQC Assessment Update on Action Plan | | | | | | | | | | ✓ | | |
| Patient Survey | | | | ✓ | | | | | | | | ✓ |
| Quarterly Quality Report | | | ✓ | | | ✓ | | | ✓ | | | ✓ |
| Colleague Engagement /Staff Survey (NB - Gold Standard by 2018 and Platinum Standard by 2020 agreed at 25.2.16 BOD) | ✓ | | | | | ✓ | | | | | | ✓ |
| Nursing and Midwifery Staffing – Hard Truths Requirement | | ✓ | | | | | | ✓ (update following report to F&P) | | | | |
| Safeguarding update – Adults & Children | ✓ (Annual report) | | | | | ✓ | | | | | | |

| Date of meeting | 28 April 2016 | 26 May | 30 June | 28 July | 25 Aug (NO MEETING) | 29 Sept | 27 Oct MEETING CANCELLED | 3 Nov | 1 Dec | 5 Jan 2017 | 2 Feb 2017 | 2 March 2017 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Review of progress against strategy (Qly) | ✓ | ✓ | | | | | | ✓ | | | | ✓ |
| Quality Committee update & mins | ✓ | ✓ | ✓ | ✓ | ✓ | | | ✓ | | ✓ | ✓ | |
| Audit and Risk Committee update & mins | ✓ | ✓ | | ✓ | ✓ | | | ✓ | | ✓ | ✓ | |
| F&P Committee update & mins | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Well Led Workforce Committee update & mins | ✓ | ✓ | ✓ | ✓ | ✓ | | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Performance Management Framework – update on work from sub-committee workplans | | | | | | | | | | | ? Feb-May 2017 | ? ✓ |
| **ANNUAL ITEMS** | | | | | | | | | | | | |
| Annual Plan | | | | | | | | | | | | ✓ |
| Annual Plan feedback from Monitor | | | | | | ✓ | | | | | | |
| Annual report and accounts (private) | | ✓ | | | | | | | | | | |
| Annual Quality Accounts | | ✓ | | | | | | | | | | |
| Annual Governance Statement | | ✓ | | | | | | | | | | |
| Appointment of Deputy Chair / SINED | | | | | | ✓ | | | | | | |
| Board Development Plan | | | | | | | | | | | ✓ | |
| Emergency Planning annual report | | | | | | ✓ | | | | | | |
| Health and Safety annual report | | ✓ | | | | | | ✓ (UPDATE) | | | | |
| Capital Programme | | | | | | | | | | | | ✓ |
| Equality & Inclusion update | | | | ✓ (update) | | | | | | ✓(AR) | | |
| DIPC annual report | | | | ✓ | | | | | | | | |
| Fire Safety annual report | | ✓ | | | | | | | | | | |
| Medical revalidation & appraisal | | | | ✓ | | | | | | | | |

| Date of meeting | 28 April 2016 | 26 May | 30 June | 28 July | 25 Aug (NO MEETING) | 29 Sept | 27 Oct MEETING CANCELLED | 3 Nov | 1 Dec | 5 Jan 2017 | 2 Feb 2017 | 2 March 2017 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Whistleblowing Annual Report | | | | | | | | | | ✓ | | |
| Review of Board Sub Committee TOR | | | | | | | | ✓ | | | | |
| Risk Appetite Statement from Board (Nov 2017) | | | | | | | | ✓ | | | | |
| Winter Plan | | | | | | | | | ✓ | | | |
| ONE-OFF ITEMS | | | | | | | | | | | | |
| Membership Council Elections | ✓ | | | | | | | | | | | |
| Single Oversight Framework (VP/GB) | | | | | | ✓ | | | | | | |
| Hospital Pharmacy Transformation Plan (AB/Mike Culshaw) | | | | | | | | | | ?✓Jan or Feb | ?✓Jan or Feb | |
| Risk Management Strategy | | | | | | | | | | ✓ | | |
| Workforce Strategy | | | | | | | | | | | ✓ | |

| Date of meeting | 28 April 2016 | 26 May | 30 June | 28 July | 25 Aug (NO MEETING) | 29 Sept | 27 Oct MEETING CANCELLED | 3 Nov | 1 Dec | 5 Jan 2017 | 2 Feb 2017 | 2 March 2017 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **STANDING PRIVATE AGENDA ITEMS** | | | | | | | | | | | | |
| Introduction and apologies | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Declarations of interest | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Minutes of previous meeting, matters arising and action log | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Private minutes of sub-committees | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| **ADDITIONAL PRIVATE ITEMS** | | | | | | | | | | | | |
| Contract update | | | | | | | | | | ✓ | ✓ | ✓ |
| Board development plan | ✓ | | | | | | | ✓ | | | | |
| Feedback from Board development workshop | | | ✓ | ✓ | | ✓ | | ✓ | | | | |
| Urgent Care Board Minutes | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| System Resilience Group minutes | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Hospital Programme Board minutes | | | | | | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| EPR update (monthly) | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | ✓ |
| Property Partnership/St Luke's Hospital/PR (as required) | | | | | | ✓ | | | | | | Spring 2017 |
| Equality and Diversity (discussion) | | ✓ | | | | | | | | | | |
| Sustainability and Transformation Plan | | | | | | ✓ | | | ✓ (update) | | | |

**REGISTER OF SEALING OR EXECUTIONS**

| CONSECUTIVE NUMBER | DATE OF SEALING OR EXECUTION | DATE OF AUTHORITY | DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON | PERSONS ATTESTING SEALING OR EXECUTION |
|---|---|---|---|---|
| 249 | 26.10.16 | 26.10.16 | CRH ATM – Transfer of agreement from Lloyds Banking Group to Cashzone. Trust to receive £750 per annum towards running costs. | NAME:<br>Brendan Brown<br>  <br>TITLE:<br>Exec Director of Nursing<br><br>NAME:<br>Victoria Pickles<br>  <br>TITLE:<br>Company Secretary |

**REGISTER OF SEALING OR EXECUTIONS**

| CONSECUTIVE NUMBER | DATE OF SEALING OR EXECUTION | DATE OF AUTHORITY | DESCRIPTION OF DOCUMENTS SEALED OR EXECUTED PERSON | PERSONS ATTESTING SEALING OR EXECUTION |
|---|---|---|---|---|
| 250 | 26.10.16 | 26.10.16 | HRI – A&E Police Pod – Lease for 5 years with suitable clauses. Fixed service charge of £500 per annum. | NAME:<br><br>Brendan Brown<br><br>  <br><br>TITLE:<br><br>Exec Director of Nursing |
| | | | | NAME:<br><br>Victoria Pickles<br><br>  <br><br>TITLE:<br><br>Company Secretary |

# Integrated Performance Report and risk management
# Key areas of responsibility by Committee

| Name | Role regarding performance and risk | Frequency |
|---|---|---|
| **Trust Board** | Chaired by Trust Chair; overall responsibility for setting Trust Strategy; assures risks to delivery of strategy are mitigated through regular review of the Board Assurance Framework and oversight of risks scoring 15 or more. | Monthly |
| **Membership Council** | Chaired by Trust Chair: Reviews performance summary and high level risk log. | Quarterly |
| **Audit and Risk Committee (Board sub-committee)** | Chaired by non-executive director: ensures there are robust arrangements for the governance of performance and risk management. | Quarterly |
| **Quality Committee (Board Sub-committee)** | Chaired by non-executive director; Delegated responsibility from Trust Board for oversight of quality (clinical effectiveness, safety and patient experience) performance by assuring risks to quality are mitigated | Monthly |
| **Finance and Performance Committee (Board Sub-committee)** | Chaired by non-executive director; Delegated responsibility from Trust Board for oversight of financial performance, operational performance and planning. Reviews those risks on the Board Assurance Framework relating to finance and use of resources. | Monthly |
| **Workforce Committee (Board sub-committee)** | Chaired by a non-executive director; delegated responsibility from Trust Board. Scrutinizes in detail the performance metrics of the well led element of performance within the IPR and the risks on the Board Assurance Framework relating to workforce. | Monthly |
| **Weekly Executive Board** | Chaired by CEO; WEB is the Executive & Clinical management committee for the Trust and receives the Integrated Performance Report prior to Trust Board sub committees and Board of Directors. Key issues are discussed and agreed for communication/action. Reviews the high level risks scoring 15 or more. | Weekly with monthly review of performance |
| **Divisional Performance Review Meeting (DPRM)** | Division and agreed corporate departments; chaired by the COO[1] and attended by all Directors.<br><br>DPRMs are the single performance meeting for the Division bringing all elements of performance across the Executive portfolio. They are formal meetings where Divisional Teams are held to account by the Executive.<br><br>To be assured that action planning in response to adverse performance is adequate in content and responsiveness; monitoring performance and actions to improve performance, supporting Divisions with complex issues raised and confirmation on issues for escalation.<br><br>The output of DIPRs feed into the Trust Board Integrated Performance Report; approving target setting and detailed parameters for escalation.<br><br>Post DPRMs a review of outputs and agreement on further | Monthly but may vary depending on level of risk |

[1] For Operational Divisions, DCEO for corporate departments

| | | |
|---|---|---|
| | actions and internal 'go sees' are agreed<br><br>Key risks to the Division are reviewed along with mitigating actions. | |
| **Directorate Performance Reviews** | Replicating the responsibilities in the Divisional Performance Reviews but held between the Division and Directorates | Monthly |
| **Patient Safety & Quality Boards (PSQB)** | Chaired by the Divisional Director; responsible for the detailed review of clinical governance within Divisions, ensuring compliance with standards, adherence to national directives; monitoring effectiveness of Directorate Governance arrangements and ensuring learning within and across Divisions; ensuring robust processes are in place for identifying, managing and mitigating risks. | Monthly |
| **Operational Performance Meeting** | Chaired by COO a review and forward look at in month performance identifying risks and agreeing responsibilities for corrective action.<br>Identifies any immediate requirement for escalation into the WEB | Weekly |

| |
|---|
| Finance and Performance will consider metrics related to:-<br>• Contract Penalties<br>• CIP<br>• Activity and Income<br>• Productivity and Efficiency<br>• Finance<br>• Carter Dashboard<br>• Capital |
| Quality Committee will consider metrics related to:-<br>• Patient Safety<br>• Patient Experience<br>• Clinical Effectiveness<br>• CQUINs |
| Workforce Committee will consider metrics related to:-<br>• Sickness and Absence<br>• Training and Appraisal<br>• Recruitment and Retention<br>• Safe Staffing |
| Board of Directors will consider regulatory metrics and receive exception reports for each Committee. |

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Calderdale and Huddersfield NHS
NHS Foundation Trust

**Approved Minute**

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## Cover Sheet

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|---|---|
| **Meeting:**<br>Board of Directors | **Report Author:**<br>Sue Laycock, PA to Chief Operating Officer |
| **Date:**<br>Thursday, 1st December 2016 | **Sponsoring Director:**<br>Helen Barker, Chief Operating Officer |
| **Title and brief summary:**<br>Winter Plan 2016/17 - Plan developed to provide assurance to the Commissioners and NHSE of the Trust's preparedness for winter | |
| **Action required:**<br>Approve | |
| **Strategic Direction area supported by this paper:**<br>Keeping the Base Safe | |
| **Forums where this paper has previously been considered:**<br>This paper has been written following engagement with all Divisions | |
| **Governance Requirements:**<br>Delivery of regulatory standards | |
| **Sustainability Implications:**<br>None | |

## Executive Summary

### Summary:

The winter plan describes the structure within which operational pressures during the winter period will be anticipated and managed. It provides the framework for managers and clinicians in the Trust to work together and with other organisations. The winter period is normally defined as being from early November to late March, with specific emphasis on the 'Critical Period' early December to the end of January. However, with a revised Monitor Plan and dependency on the prevailing weather this critical period is expected to be extend further.

The objectives of the Plan are to support existing plans by increasing the operational focus on winter as an issue that challenges the resilience of the Trust, to provide a framework for the management of the winter response, to provide a framework for the development of other plans, to provide the basis for agreement and working with other organisations, to provide reference material for use in the Trust and to set out the information systems to be used to manage the response.

## Main Body

### Purpose:

Please see attached

### Background/Overview:

Please see attached

### The Issue:

Please see attached

### Next Steps:

Please see attached

### Recommendations:

The Board is asked to receive and approve the Winter Plan 2016/17

## Appendix

### Attachment:

Winter Plan 2016.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

# Winter Plan 2016/17

## Version 1

| **Document Summary Table** | | |
|---|---|---|
| **Unique Identifier Number** | | |
| **Status** | Draft 2 | |
| **Version** | 1 | |
| **Implementation Date** | December 2016 | |
| **Current/Last Review Dates** | October 2015 | |
| **Next Formal Review** | June 2017 | |
| **Author** | Associate Director of Urgent Care | |
| **Where available** | Preparing for Emergencies Section of the Trust Intranet. | |
| **Target audience** | Executive Directors, On-call General Managers, Directors on-call, Duty Matrons, Estates and procurement. | |
| **Ratifying Committees** | | |
| Weekly Executive Board | | November 2016 |
| **Consultation Committees** | | |
| **Committee Name** | **Committee Chair** | **Date** |
| A&E Delivery Board | | |
| | | |

| **Does this document map to other Regulator requirements?** | |
|---|---|
| Care Quality Commission | Outcomes 4B, 6D, 10E and 14A |

| **Document Version Control** | |
|---|---|
| 1 | Updated for Winter 2016/17 |
| 1.3 | Updated flowchart page 16 |
| 1.2 | Added Winter Weather YAS transport |
| 1.1 | Added appendix 7 |
| 1 | Plan developed to provide assurance to the Commissioners and NHSE of the Trust's preparedness for winter. |

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## 1. Introduction

The winter plan describes the structure within which operational pressures during the winter period will be anticipated and managed. It provides the framework for managers and clinicians in the Trust to work together and with other organisations.

The winter period is normally defined as being from early November to late March with specific emphasis on the 'Critical Period' early December to the end of January, however with a revised Monitor Plan and dependency on the prevailing weather this critical period is expected be extend further.

## 2. Purpose

The objectives of the Plan are as follows:

- To support existing plans by increasing the operational focus on winter as an issue that challenges the resilience of the Trust.
- To provide a framework for the management of the winter response
- To provide a framework for the development of other plans
- To provide the basis for agreement and working with other organisations
- To provide reference material for use in the Trust
- To set out the information systems to be used to manage the response.

NHS England has reiterated that trusts are expected to respond appropriately to the demands of winter through attention to the following areas:

- Handover of patient care from ambulance to acute trust
- Operational readiness (patient flow and capacity management, workforce, bank holiday arrangements and elective restarts1 )
- Out of hours arrangements
- NHS / social care joint arrangements
- Critical care services
- Infection Preventative measures (vaccination)
- Communications

## 3. Definitions

***Critcon -*** The status report that is used to manage intensive care capacity across the network

***Elective restarts -*** This is the point at which elective surgery is restarted, either completely or in part, following the planned stopping of it during a period of acute workload pressure.

***ImmForm*** - The monthly report on take up of influenza vaccination in staff.

***Organisational resilience*** - The ability to adapt and respond to disruptions to deliver organisationally-agreed critical activities

***Sitrep -*** A daily report to Monitor which highlights pressures in Trusts' capacity. Sign off will be required by 11:00, Monday-Friday.

## 4. Duties (roles and responsibilities)

**Associate Director of Urgent Care**

- Chair the Winter Planning Group
- Represent the Trust on the Joint Surge and Escalation Teleconferences
- Compile a situation report for the Joint Surge and Escalation Teleconferences
- Cascade the situation report from the Joint Surge and Escalation Teleconferences / Update the winter planning group and divisional leads of the situation across the local healthcare system
- Receive and cascade severe weather warnings, weather forecasts and flood warnings
- Respond to requests for assurance from the CCG and NHS England
- Benchmark and share good practice from partner organisations
- Ensure that winter plans are aligned with the Trust Emergency Management Arrangements and associated emergency plans
- Collate departmental plans for the Christmas and New Year period and ensure they are accessible to staff on-call and on-duty over the period

**Winter Planning Group (Division Winter Leads)**

- Ensure that appropriate plans are in place to manage an increase in activity through the winter period within the division
- Ensure that divisional plans are joined up across the organisation
- Ensure that contingency plans are in place for surge in emergency demand for inpatient capacity, severe winter weather and outbreaks of winter infectious diseases
- Ensure that key staff groups are aware of the risks and response arrangements for winter

**Estates, Clinical Site Commanders and Night Matrons**

- Liaise with Local Council Highways departments to clear roads for urgent patient transport requirements
- Contact alternative transport providers if required

**Estates and Facilities**

- Ensure that there is sufficient supplies of salt/grit for clearing car parks, pathways and roads on site
- Liaise with contractors to arrange access to 4X4 vehicles for transport services if required
- Ensure that additional staff accommodation is available if required

## 5. The Trust's Winter Strategy

The winter plan is based on the following strategic aims;

- To continue to provide high quality healthcare to the communities of Calderdale and Kirklees.
- To ensure that patients receive treatment in the most appropriate environment.
- To work collaboratively with other health and social care providers to effectively manager capacity
- To assess risks to continued service provision and put plans in place to manage those risks
- To put in place a communications strategy that assists the public in gaining access to appropriate health and social care services.
- NHSE- driving down occupancy levels over the winter period.

## 6. Winter planning arrangements

The Trust Lead for winter planning is the Associate Director of Urgent Care in collaboration with the Divisional Senior Management Teams.

The A&E Delivery Board has overall responsibility for ensuring that the health service in Calderdale and Huddersfield is adequately prepared to manage an expected increase in activity over the winter period. The CHFT Winter Planning Group reports to the A&E Delivery Board and, in addition to internal escalation arrangements, is responsible for ensuring that the Trust has plans in place for severe winter weather, seasonal infectious disease outbreaks and Christmas and New Year bank holidays.

## 7. Command, control and coordination

During the period 1 November – 29 February, a daily SitRep (Mon-Fri) will be completed for submitting to NHS England by the Health Informatics Service. The Monday SitRep will include details from the preceding weekend. SitReps will be signed off by the Director of Operations. Arrangements will be confirmed to ensure that there is adequate cover in case of absence.

To ascertain the bed alert status of acute hospitals within Yorkshire the Clinical Site Commanders will be contacted by Yorkshire Ambulance Service twice daily either by phone or email. The Clinical Site Commanders will be contacted at 09:00 each morning for REAP status for inpatient capacity and any associated comments noted by hospitals on the Daily Bed Alert Status Report.

| REAP Level | Command & Control Plan Activation Level | Action by |
|---|---|---|
| Normal (Level 1 - Green) | Normal Management | N/A |
| Concern (Level 2 - Yellow) | Standby | Clinical Site Commanders |
| Moderate Pressure (Level 3 - Amber) | Activate relevant service/directorate actions | Clinical Site Commanders |
| Severe Pressure (Level 4- Red) | Activate Divisional silver command | Director of Operations/Associate Director of Urgent Care |
| Critical (Level 5 - Purple) | Activate Gold Command | Director of Operations or Director of Nursing |
| Level 6 (Black) Potential Service Failure | | Chief Executive |

**Figure 1. Winter command and control arrangements (internal)**

A second assessment of capacity alerts will be made at 16:00 and the capacity status for each hospital again reported.

The three hourly SAFER Hospital Meetings chaired by the Clinical Site Commanders involving the patient Flow Team and Divisional Managers of the day, Matrons and on call managers/Matron of the day will monitor activity on each site and determine operational actions using a standard operating procedure and escalation policy to manage capacity issues. The Associate Director of Urgent Care will report direct into the partner organisations involved in the Joint Surge and Escalation Plan.

The Associate Director of Urgent Care for Calderdale and Huddersfield Foundation Trust is responsible for representing the Trust at the Calderdale, Kirklees and Wakefield Joint Surge and Escalation meetings where situation reports are shared and healthcare system-wide actions to manage demand and capacity are determined.

Each division and department is responsible for the successfully implementation of their Winter Plan and escalation plans. In the event that significant pressures are identified the Associate Director of Urgent Care or the Divisional Directors of Operations will decide to implement the Trust Emergency Management Arrangements (Gold and Silver).

# 8. Workforce

## 8.1 Staffing levels

Agreed workforce plans and skill mix are in place for all inpatient areas and community services. These will be used to assess the risk of reduced staffing due to absence and to assist in the redeployment of staff if necessary. Nurse rosters are signed off by Divisional Matrons to ensure robust cover arrangements especially over the x-mas and New Year period. **A further review will be completed weekly from the beginning of December with a final sign off and escalation of any risks with mitigation plans by the 12th December.**

## 8.2 Vaccination

The CQUIN target for this year for Calderdale and Huddersfield is to achieve at least 75% of frontline staff. The emphasis will be on staff in clinical and clinical support roles, but the vaccine will be available to all staff. The campaign this year has been well communicated and information on scheduled sessions, 'myth busting' and league tables of performance have been advertised on the intranet. Additional groups of staff have been trained to administer the vaccine so that it can be more accessible to staff. District nursing services provide flu vaccination to patients on their caseload as well as working with GPs to ensure that all vulnerable people are offered the vaccine.

## 8.3 Personal Winter Plan/Engagement Plans

All members of staff have a personal responsibility to ensure that they are available for work and that they have alternative arrangements for carer responsibilities and journeys to work. All staff will be reminded of preparations they should make for winter – seasonal flu vaccination, checking public transport alternative routes, vehicle preparation as well as contingency plans. This will continue to be reinforced through the business continuity management system and staff communications strategy. In severe weather conditions staff in District nursing will report to their nearest team to their home not necessarily where they usually work.
The Trust's attendance management, carer leave and adverse weather policies will be used to support staff and to maintain service levels.
Teams leaders

# 9 Strengthened Operational Management

Over the x-mas, New Year and first two weeks in January there will be senior management support into the Patient Flow team to ensure any surge in activity above expected levels are acted upon immediately and provide additional assurance that good control and command is in place.

### 9.1 Clinical Site Commander

The Clinical Site Commander will effectively manage the Trusts bed capacity, ensuring the patient's journey is safe and their experience is good. This is in conjunction with the Divisional operational teams.

### 9.2 Divisional Operational Teams

There will be a Divisional manager and Matron of the day who will support the patient's journey, ensuring safe effective admissions, transfers and discharge. They will work to a standard operating procedure.

### 9.3 "On call/site manager of the day"

There is an on call manager designated on site daily.

### 9.4 Duty Matron

There will be a duty matron on site daily.

### 9.5 Reducing admissions

Ambulatory Care in medicine and Medical Admission avoidance will be available on each hospital site to prevent avoidable medical. Surgical Ambulatory will be available on the HRI site and Gynaecology Ambulatory will be available on the CRH site.

### 9.6 Reducing delayed discharges to support length of stay reduction

SAFER Patient Flow Transformational Programme is supporting initiatives to improve flow, prevent avoidable admissions, reduce LOS and occupancy levels, reduce patients on a green cross pathway and find alternatives for patients who do not require acute hospital services. Transfers of care pathways for discharge have been agreed with CCG and Adult Social Care and will be implemented by January 2016.

A fortnightly senior management meeting for all partners to ensure robust discharge plans are in place for all patients on a green cross pathway.

With the introduction of Nervecentre Task Management there will be improved communication and joint working across all specialities. This will support earlier discharge throughout the winter period by prioritising tasks associated with discharge and liaising with the appropriate professionals to ensure that the task is completed timely. This may be a doctor, nurse, pharmacist or other.

### Pharmacy

Will ensure that flexible capacity wards are stocked with appropriate medicines, a regular clinical pharmacy visit will be established and maximise the use of pharmacist prescribers to assist with medicines reconciliation and transcribing TTOs.

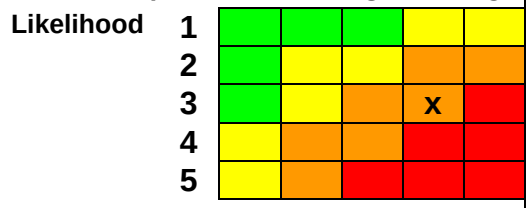
Ward based ATOs will be targeted to high turnover areas to assist with transferring medicines. Pharmacy staff will work with medical and nursing staff to

prioritise supply of medicines for discharge. Wards should identify patients due for discharge on all ward areas as soon as possible, and e-discharge should be sent to pharmacy in a timely manner so that these can be processed quickly. Ideally discharge prescriptions for patients who have monitored dosage systems (MDS) should be sent to pharmacy the day before discharge. Pharmacy and nursing staff should identify patients who already have sufficient supplies of medicines at home before a request is made for a supply for discharge, which will enable pharmacy to dispense items which are genuinely required more quickly.

### 9.6 Reducing readmissions

CHFT Calderdale community services have an established virtual ward programme. Using a risk stratification tool which has been modified from the LACE tool used in Toronto, patients due for discharge are identified for discussion on the virtual ward round and allocated a case worker who is responsible for the patient 30 days post discharge. The dedicated case worker team includes community nurses and domiciliary pharmacists.

## Surge in activity

| Overview | | |
|---|---|---|
| **Impact** | | |
| • Unpredicted increase activity in ED's, SAUs and MAUs<br>• Increase in bed occupancy across the Trust<br>• Increased pressure on community healthcare services to support discharges above predicted<br>• Potential of the need to outlie patients into another speciality.<br>• Greater potential for inpatient outbreaks of infection and outbreaks in nursing homes preventing discharges | Impact / Likelihood |   |
| **Proactive strategy- Actioned by the Director of Operations** | | |
| • Identify flexible beds that can be opened in the short term to support increased admissions and staffing requirements<br>• Trigger escalation | | |
| **Reactive strategy** | | |
| • Use of winter strategy & plan<br>• Implement the joint surge and escalation plan- Silver & gold<br>• Activate business continuity plans and escalation plans<br>• Increase inpatient capacity by opening flexible beds | | |
| **Trigger** | **Received by** | **Immediate action** |
| ED reporting of increased activity | Emergency department matron/manager | • Reallocate junior medical/nursing staff to support the Emergency Department<br>• Establish additional trauma lists as required<br>• Review the availability of trauma surgery equipment<br>• Move from elective beds to trauma as demand dictates |
| YAS reporting of increased activity | Emergency department.<br>Patient flow team | |

| | | |
|---|---|---|
| | | • Use of flexible capacity- short term<br>• Surge & Escalation plan actions to be followed |
| Low temperatures Met Office - proactive | Emergency Planning Officer | • Prepare for increased attendance by patients in the at-risk groups |
| Community nursing workload | General Manager – Adult Community Nursing | • Review community case load to prioritise at risk patients<br>• Trigger business continuity plans |
| Assess bed capacity issues in line with regional plan | Director Of Operations | • Implement the escalation policy.<br>• Implement joint partner surge & escalation plan |
| Requirement to expedite discharge | Clinical Site Commander<br><br>Discharge Matron/Discharge Team. | • Liaise with YAS to agree priority order for patient movement.<br>• Initiate spot purchasing agreements<br>• Start discharges with medicines to follow. (Use of taxis of transportation of medicines post discharge.)<br>• Use of day rooms and discharge lounges to facilitate expedite discharge. |

## 10. Winter Inpatient Flexible Capacity Plan

CHFT's Divisional teams have prepared their winter plans through analysing their expected demand, tracking assumptions against their business plans and understanding the impact transformational work is having.

| Division | Flexible Capacity | Trigger & Action | Lead |
|---|---|---|---|
| **Medicine** | **HRI**- Ward 11 x 2 Beds<br>Ward 12 x 1 Bed<br>Ward 1 x 2 Beds | Triggered through SAFER Hospital Meetings using demand management data/daily predicted discharges.<br>**Risk assessments must be completed.** | Divisional Manager/Matron/Clinical Site Commander. |
| | Ward 4 x 14 beds | Open Mon-Fri November – March. Plan developed if risk to capacity due to increasing winter demand to open Mon-Sunday. | Director of Operations |
| | **CRH-** Ward 8c | Phased plan to reduce beds as the Community Place Opens.<br>Daily tracking will be in place and Senior Divisional Team will monitor winter | |

| | | | |
|---|---|---|---|
| | Gynaecology Assessment Unit x 6 beds. | demand.<br>Plan to flex these beds as required.<br>Staffing Plan developed to provide flexible capacity overnight. | Divisional Manager/Matron/Clinical Site Commander |
| **Surgery** | **HRI-** Increased Trauma capacity x 3 theatre lists per week. Increased weekly surgical theatre lists (1-2) | | |
| **FSS** | **CRH-** 3 x flexible beds in paediatrics | | |

**Figure 2**

### 10.1 Medical Divisional Plans

The medical division has developed specific plans to provide flexible capacity to meet the expected increased demand on inpatient capacity. With the improvements seen in reducing the longest lengths of stay within the hospital these plans will be operationalised **only** if a surge in activity described in figure 1 impact on operational performance and patient safety.

### Additional medical staffing

The Emergency Department will have increased medical staff over the x-mas and new year period as mitigation against the expected increase in demand especially over the out of hours period.

### 10.2 Surgical Divisional Plans

From November 21 the surgical division will be delivering a further 3 Trauma lists per week (increasing the total number from 14 to 17). In order to deal with any excess trauma from the weekend and assist with the improving the time to theatre for patients suffering fractured neck of femur. These lists have been allocated on a Monday and Tuesday each week, with the third being allocated alternating Thursday/ Friday. The sessions also coincide with the Upper Limb surgeon's availability to minimise delays with the complex upper limb trauma. Improved timely access to theatre will reduce pre-op bed days and overall LOS for some Minor/intermediate and complex trauma. Performance will continue be monitored regarding delays to theatre.

### Reduction in elective Orthopaedic activity

The surgical division have a planned reduction in elective orthopaedic surgery in Line with the agreed activity profile. The planned a reduction will be from

**19.12.16 until 03.01.17.** This will enable ward 8B on the Calderdale site to close. During these 3 weeks, any surplus staff will be utilised to fill capacity gaps due to vacancies across the surgical division providing improved robust rostering over the x-mas and New Year period. Elective restart is anticipated that Ward 8b will be required to deal with elective activity from **05.01.17**

From January 3 the Surgical Division will introduce additional Laparoscopy Cholecystectomy lists per week, particularly when there is an Upper GI Surgeon on CEPOD week. This will improve the scheduling of acute/emergency patients with cholecystitis based on clinical urgency, over and above the CEPOD list. This will improve LOS for these patients, prevent readmission and improve patient experience.

The Division have progressively moved more work to day-case this year and from the 5th December will open a 5 day ward are exploring options to develop this further which may include a short stay unit, thereby reducing the risk of elective cancellations over the winter period?

**10.3 Community Divisional Plan**

**Quest for Quality**

CHFT have established a multidisciplinary team consisting of Community Matrons, pharmacist, therapist and consultant Geriatrician who caseload residents in all Residential and Nursing Homes in Calderdale .This schemes main role is to reduce the number of calls made to General Practitioners to prevent avoidable admissions .They use telecare and Tunstall telehealth to promote health and wellbeing to the residents within the Care Homes.

The team have a responsive function to the Care Homes dealing with calls that would have been received by a GP and managing the residents. They also provide support to the care home staff to better manage their residents through training and education.
The pharmacist role has greatly helped with reviewing patient medication, reduction in poly- pharmacy and education and training of care home staff.

**OPAT**

This Team provides anti biotic intravenous therapy to patients in their own homes. This has been commissioned for Huddersfield and Calderdale. Patients remain under the care of their Physician or Consultant. This prevents some admissions and certainly reduces the LOS for many more.

**Respiratory Team**

This team has been commissioned by Calderdale CCG to provide 7 day 9-5pm admission avoidance in the community to patients and early supported discharge from hospital. GP's, practice nurses and patients known to the service can refer via the Single Point of Access.

**Crisis intervention Team**

This team assess and support people to remain in their own home with support of up to 72 hours providing personal care support with medications and reabling people. If the individual is assessed as not being safe to remain at home they access an intermediate care bed via Gateway during the week and directly at the weekend.

**End of Life out of hours Crisis team**

This is collaboration between Overgate Hospice, Marie Curie and CHFT .This small team provide Crisis support to people out of hours who are near the end of their life. The specialist palliative nurse supports the person with symptom control, physical and emotional support and works with a Marie curie support worker. They provide support to the person carers and families.

**Community Place**

**This is a partnership arrangement between CHFT and Calderdale Council to test out a new way of working initially over the winter period.**
The service will assist in early identification of patients appropriate for discharge from hospital. Those that can be supported by Community services upon discharge and require a step down goal focused approach. There is an expectation that the individual can focus and be involved in higher level of rehabilitation functioning up to 6 times per day through goal led functional rehabilitation and a transition to self-care.
The ethos of the Community place will be self-management and individualised care planning within an MDT approach (Therapy, Support workers and Social Workers) with a view to maximising independence and returning home as planned with the most appropriate and proportionate care services that reduce continuing dependency on care and support services. This will serve to prevent prolonged hospital stays and premature admissions to long term residential care.
Personalisation and community are the key building blocks of the Community Place service, community membership, living in their own homes, maintaining or gaining employment and making a positive contribution to the communities they live in.

### 10.4 Escalation plans and business continuity plans

There are escalation plans that have been developed to support operations across all divisions. All escalation plans are found on the intranet, the ED and Paediatric escalation plan will be included in the On Call Managers Pack.

Each clinical division has identified the critical patient services they provide. Directorates have undertaken business impact analysis to identify what service functions can be reduced or suspended and have developed business continuity plans that describe the process for reducing non-critical activity and using the capacity generated to sustain critical patient services.

**Cancer Pathway and Elective Pathway**

The cancer agenda and targets will be maintained throughout winter. Elective surgery and cancer have rarely been cancelled due to bed pressures previously and this will continue to be the standard we adhere too.
Attendance at MDT's and performance will be maintained over Christmas time and throughout winter. This will be managed by authorisation/monitoring of the number of Consultants that are off at any one time over this period.

### 10.5 Accelerator Zone

In addition to the existing winter plan the Trust, as part of the West Yorkshire system, the Trust has been allocated a small revenue and capital resource to accelerate existing plans with a view to providing more certainty on securement of 95% Emergency Care Standard for the month of March 2017.

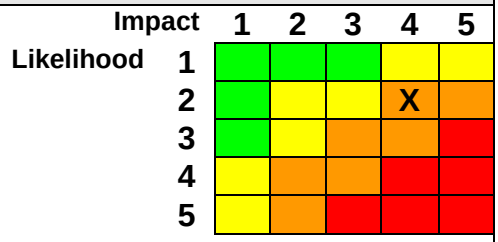
This will support increased streaming to primary care, 7day delivery of ambulatory care, increased social care capacity and additional medical cover at weekends. A process for development and monitoring of these is currently being agreed across the WYAZ (West Yorkshire Accelerator Zone) which will include submission of performance data and clarity on implications for individual organisations against an aggregate performance challenge.

## 11 Severe Winter Weather

**Overview**

**Business Impact**

- Absence of staff because they cannot get to work
- Difficulty for staff and patients to travel around and between sites
- Difficulty for community staff to access patienst homes
- Increase in minor injuries from slips, trips and falls
- Reduced patient transport service
- Difficulty discharging patients because reduced public transport, patient transport or impassable roads to their homes or other healthcare facilities
- Difficulty for suppliers to get supplies to hospital




**Proactive strategy**

- Adverse winter weather plan in place and reviewed.
- Weather forecasts and gritting information published on the local authority websites.
- Stockpile of salt/grit for car parks and access ways to Hospital sites.
- Access roads to CRH and HRI are on Local Council Highways Priority Gritting Routes.
- Yorkshire Ambulance Service winter plan.
- Secure contingency 4x4 vehicles through voluntary services to transport staff to and from their place of work.
- Community staff advised to work to nearest location to their homes

**Reactive strategy**

- Implement flexible working arrangements where possible (adult community nursing)
- Implement the joint surge and escalation plan
- Contact Local Council Highways to request roads are gritted for essential appointments and discharges (this will not always be possible).
- Provide accommodation for essential staff who cannot get home from work
- Request that the hospital transport service collect essential staff and bring them to work (this will not always be possible)

| Trigger | Received by | Immediate action |
|---|---|---|
| Met Office Cold Weather Alert | Estates/Associate Director of Urgent Care | • Cold weather alerts will be forwarded to members of the winter (surge) planning group for onward circulation to departments.<br>• Clinical Site Commanders will assess the consequences for discharges<br>• The Estates Department and VLL (CRH) have a planned process for maintaining the Hospital grounds.<br>• Review by the outpatients and surgical management teams of impact on performance. |
| YAS PTS notification that journeys are affected or have been stopped | Clinical Site Commander | |
| Significant number of out-patient DNA | Outpatient manager | |
| Staff absence reporting | Department managers | • All members of staff should make an early assessment of travel plans during inclement weather. It is the responsibility of staff to exhaust every potential transport arrangement that will enable then to attend for duty.<br>• Staff accommodation for inclement weather will be supported by the Trust as in previous years via the Accommodation Manager |

| | | |
|---|---|---|
| | | • All service areas will maintain up-to-date contact lists for all their staff<br>• Managers will use the Trust's adverse weather policy and the carer leave policy to manage staff absence.<br>• Staff will be reallocated according to service need. |

### 11.1 Cold Weather Alerts

| Alert trigger | Trust Actions |
|---|---|
| Level 1 Winter Preparedness | • Work with partner agencies to co-ordinate cold weather plans<br>• Work with partners and staff on risk reduction awareness<br>• Plan for a winter surge in demand for services<br>• Identify those at risk on your caseload |
| Level 2 Alert and readiness (60% risk of severe weather) | • Communicate public media messages<br>• Communicate alerts to staff and make sure that they are aware of winter plans<br>• Implement business continuity plans<br>• Identify those most at risk<br>• Check client's room temperature when visiting |
| Level 3 Severe Weather Action | • Communicate public media messages<br>• Activate plans to deal with a surge in demand for services<br>• Communicate with those at risk regularly<br>• Ensure that staff can help and advise clients<br>• Signpost clients to appropriate benefits<br>• Maintain business continuity |
| Level 4 Emergency Response Exceptionally severe weather of threshold temperatures breached >6days | • Activate emergency management arrangements<br>• Communicate public media messages<br>• Activate plans to deal with a surge in demand for services<br>• Communicate with those at risk regularly<br>• Ensure that the hospital sites are kept clear and accessible<br>• Maintain business continuity |

### 11.2 Road Clearance

In the event of severe winter weather requiring roads to be cleared of snow and ice Kirklees Council will clear the pavement outside HRI to the boundary of the hospital site as part of its planned snow clearance operations. Acre Street and Occupation Road are on priority gritting routes. The access roads to CRH (Dryclough Lane, Godfrey Road, Dudwell Lane and Huddersfield Road) are all on priority gritting routes. Information on the priority gritting routes can be found at –

http://www2.kirklees.gov.uk/winterUpdates/default.aspx
http://www.calderdale.gov.uk/transport/highways/winter-service/index.html

There may be occasions in severe winter conditions where the hospital requires urgent deliveries such as medical gases and the site road access is impassable. In these situations the Local Councils may assist with road clearance where possible.

Kirklees Council will be operating "gritter twitter" this winter which gives real time information on the council's response to the winter forecast. This information can be used to plan journeys and has been used by schools to assess whether or not to open. The link to twitter is can be found at the Kirklees Council weblink above. Calderdale Council regularly update their website with information about planned gritting routes during periods of severe weather.

Kirklees Council will do what is possible to help ambulances with gaining access to patients that require urgent treatment / transport to outpatient appointments and hospital discharges. Examples of urgent outpatient treatments include renal dialysis and administration of drugs for life threatening conditions. Any assistance will be on the basis that the hospital confirms that the situation is urgent. Kirklees Council Highways can be contacted 24hours a day on 0800 7318765. Any Trust patient phoning the council to ask for help will be directed to contact the relevant hospital department. The hospital department will inform the patient flow team who will be responsible for liaising with Kirklees Council Highways.

Calderdale Council Highways commit to responding to requests from the emergency services only but may be able to assist in the event of an urgent request from the Hospital to grit a particular highway. The Calderdale Council Highways can be contacted via the Street Care / Customer Care number 0845 2457000.

### 11.2 Transportation and 4X4 vehicles

Roads that are impassable to cars due to ice or heavy snow are sometimes accessible to four-wheel-drive vehicles. The Estates Department have access to a 4X4 vehicle. The Hospital Transport Service can also arrange to hire 4X4 vehicles through their vehicle contractor, Arrow.

The following voluntary organisations in Yorkshire and the Humber have access to 4X4 vehicles:

- St John's Ambulance
- British Red Cross
- Yorkshire 4X4 club (4X4 Response)
- Age UK

It is essential that community nursing teams are able to travel to visit service users in their homes. The adult community nursing team managers maintain a list of staff with 4X4 vehicles and ensure that the nursing teams have access to 4X4 vehicles in instances of severe winter weather. The adult community

nursing teams also work closely with Calderdale Council adult social care to make best use of resources.

### 11.3 Managing absence

The Trust Adverse Winter Weather Policy will be followed at all times to ensure that there is consistency across the organisation in the event that severe winter weather causes staff to be later, absent or work excess hours.

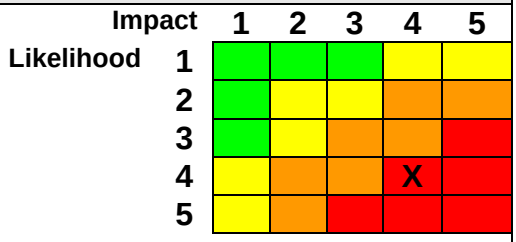
In the event that essential have difficulty getting to work and there are no alternate travel options including car sharing or public transport it may be possible for the hospital transport team to collect staff from their homes. Where staff have difficulty getting home from work and there are no other options hospital provided transportation is also an option. It may also be possible to provide additional staff overnight accommodation. Requests for additional hospital transport services or accommodation should be made by a matron or general manager to the General Manager of Operations and Facilities.

The adult community nursing team work flexibly in winter. Healthcare workers visit patients closest to their home address and are able to work from an alternative location that is closer to their home address.

### 11.4 Useful contact information

| Organisation | Contact Name | Telephone / Email |
|---|---|---|
| 4X4 Response | 24hr call out number | Available in patient flow office |
| British Red Cross | | |
| Calderdale Council Highways | | 01422 288002 |
| | | OOH 01422 288000 |
| | | |
| Calderdale Council Emergency Planning Team | | 01422 393134 |
| CHFT Accommodation | | Via General Office |
| CHFT Hospital Transport Service | | Via help desk |
| Kirklees Council Emergency Planning Team | | 01484 221000 |
| Kirklees Council Highways | | 01484 414818 |
| | | |
| | | |
| St John Ambulance | | |
| | 24hr pager | Via switchboard |

## 12 Seasonal influenza

| Overview | | |
|---|---|---|
| **Business Impact** | | |
| • Absence of staff due to influenza illness<br>• Spread of the virus to staff due to ineffective use of personal protective equipment<br>• Lack of available supplies of personal protective equipment<br>• Increase costs of delivering care because of requirement of FFP3 masks and fit testing in some clinical areas<br>• Lack of available side rooms to isolate infectious patients<br>• Lack of available capacity on intensive care units to treat flu patients with serious illness<br>• Closure of ward areas and loss of bed days due to outbreaks of infection<br>• Increased monitoring and reporting requirements for flu-related activity | |  |
| **Proactive strategy** | | |
| • Immunise staff for seasonal flu<br>• Community staff continue support people to stay at home<br>• Restate the risks and infection control requirements for managing flu patients<br>• Key messages reinforced by community staff<br>• Purchase additional supplies of face masks, gowns and goggles<br>• Create and manage a stockpile of FFP3 masks<br>• Fit test staff who may be required to use FFP3 face masks (medical, nursing and physiotherapy staff working in A&E, ICU, Respiratory and MAU) | | |
| **Reactive strategy** | | |
| • Promote key flu messages for patients (if you've got flu, stay at home)<br>• Follow standard infection control precautions for managing flu patients<br>• Reassign or redeploy staff in high-risk groups as appropriate<br>• Implement the joint surge and escalation plan<br>• Implement the escalation plan for critical care if required | | |
| **Trigger** | **Received by** | **Immediate action** |
| DH reporting - proactive | DIPC | • Alert forwarded by email rule to Director of Operations, Director of Nursing, Director of Infection Prevention and Control.<br>• Staff in the Emergency Departments and out patient departments will remind relevant patients to have their flu jabs if they have not already done so.<br>• Implement management of flu arrangements. |
| Surge in flu related activity | ED matron/CD | |
| Surge in flu admissions | Infection control team | |

### 12.1 Infection Control

Patients that require admission with suspected or confirmed influenza should be nursed in a side room with the door closed. A respiratory isolation sign should be displayed (further information on isolation of patients is available in the isolation policy section K). All staff must wear personal protective clothing (PPE) when entering the side room. When performing aerosolising procedures staff must wear an FFP3 mask and eye protection. Transfer and movement of patients around the hospital should be kept to a minimum.

In the event that there are number of admissions with confirmed or suspected influenza it may become appropriate to cohort patients in a single bed bay or ward area.

Some members of staff will be at greater risk from flu because of a pre-existing medical condition or pregnancy. The risks to staff should already have been identified and managed through existing occupational health protocols.

### 12.2 Personal Protective Equipment

Wards and departments should ensure that they have sufficient supplies of personal protective equipment including gloves, plastic aprons and surgical masks.

A central stockpile of surgical masks, gowns and eye protection will be established on each site. The stockpile will be managed by the materials management team and accessible to the relevant wards and departments.

FFP3 masks, gowns and eye protection are only required by staff performing cough inducing procedures for patients with suspected or confirmed influenza. FFP3 respirators must be used as an alternative to a surgical face mask when performing the following procedures.

- intubation and related procedures, e.g. manual ventilation and ET tube suctioning
- cardiopulmonary resuscitation
- bronchoscopy
- surgery and post-mortem procedures in which high-speed devices are used.

Staff performing these types of procedures will include A&E medical staff, Anaesthetists and Intensivists, respiratory physicians, medical physicians, physiotherapists (chest) and some nursing staff in ICU, respiratory and MAU. Other wards and departments should not routinely stock these masks.

A central stockpile of FFP3 masks will also be established on each site but will be managed by the infection control team. The site coordinator can be contacted out-of-hours if FFP3 masks are required.

### 12.3 Fit Testing

Prior to using a face mask respirator the user must first test that an air-tight seal can be attained. Face masks come in various shape sizes so users can determine the most effective.

There are fit test kits on all ward areas within the Trust. Fit test kits will be used to fit test initially. It is the responsibility of leads in each of the areas identified to fit test their staff, that perform aerosolizing procedures, and to record the type of mask that they require. For those staff that have been fit tested need adding onto the equipment training database to ensure an accurate training record is maintained.

Where a member or staff does not successfully fit test with the mask in the central stock areas (wards 1, 5, 6,18, ICU, SAU, Emergency Departments at HRI; wards 2AB, MAU, 3, CCU,ICU and Emergency Department at CRH); or a reusable mask held by the ward or department, each management team must put in place appropriate risk mitigation measures to protect the member of staff from contracting the flu virus at work. This may involve;

- Purchasing an alternative model of mask (if available)
- Reassigning to an alternative task
- Redeploying to a different area where they will not be required to perform aerosolising procedures with flu patients

There is an Ebola Plan available on the intranet with stocks of PPE stored in both Emergency Departments, Short stay wards, plus ward 3 and LDRP at CRH.
Training is being undertaken in both ED's and short stay areas with regards to use of PPE and reassuring staff around PPE.

### 12.4 Critical Care Escalation Plan

The Local Critical Care Network has developed a critical care network escalation plan that includes triggers and escalation levels (see appendix 2). The Trust Critical Care Escalation Plan details the arrangements for increasing level 3 capacity in the event of a surge in demand.

## 13 Christmas and New Year Bank Holidays

### 13.1 Staffing

The clinical divisions will have arrangements in place to ensure staff cover on the bank holidays over the Christmas, New Year period and the during this period when there is anticipated surge in emergency/acute demand. There will be senior divisional management cover over the Christmas and New Year period.

### 13.2 Reduced services

The Christmas and Bank Holiday arrangements for different services will be shared in the on call pack which will be available in each Patient Flow office. Copies of the operational arrangements for theatres and clinical support services over the Christmas and Bank Holiday period will be again available for the on call teams over the Christmas and New Year period.

### 13.3 Partner organisations

The Christmas and New Year cover arrangements for primary care, social care and safeguarding will be shared with the on call teams for the Christmas and New Year period and stored in the patient flow offices on both CRH and HRI sites.

## 14 Communications

The communications team will issue media statements during winter to reinforce key health messages.

When there is a community outbreak of diarrhoea and vomiting a press release will be issued promoting basic hand hygiene and asking the public to stay away from hospital if possible because they risk passing on an infection to vulnerable patients.

Prior to the Christmas and New Year period a press release will be issued reminding the public them when it is appropriate to use primary care services rather than accident and emergency departments and to stock of home medicines cabinets prior to the holiday.

In the event of a significant infection outbreak the Trust communications team will work with Calderdale and Greater Huddersfield CCG to implement a media and communications strategy utilising key messages which will include advice for visitors.

## 15 Training and Implementation of the Winter Plan

The winter planning group is overall responsible for ensuring that those with identified roles in the plan are familiar with the protocols set out in this document. This will be achieved by;

- Involvement of leads from each division in winter planning group
- Discussion at the appropriate divisional committees
- Cascade of messages to key staff groups through email circulation and Trust news;
- Publication of related documents on the Preparing for Emergencies section of the staff intranet;

- Publication of the plan on the Trust intranet; and,
- **Briefings for on-call manager, directors and matrons prior to the Christmas period**

## 16 Equality Impact Statement

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

## 17 Monitoring Compliance with this procedural document

The winter planning group is responsible for the successful implementation and monitoring of the winter plan. The winter planning group will continue monitor the plan (November 2016 to March 2017) to review its effectiveness and update the document where appropriate.

## 18 Associated Documents/Further Reading- Intranet

The Trust has a number of policies and plans that would be used in dealing with problems caused by winter conditions. They are both clinical and non-clinical and some are season-specific and others are for general use.

a. Adverse weather policy
b. Pandemic influenza
c. Major Outbreak of infection Policy
d. Emergency Management Arrangements
e. Escalation guidelines for the maternity units
f. Discharge policy/Transfer of Care policy

There are also some whole system plans that will be implemented as appropriate:

g. Joint Surge and Escalation Plan

## Appendix 3

| **SECONDARY CARE**<br>(including Acute, Specialist & Foundation Trusts etc) | |
|---|---|
| **DEFINITION** | **STATUS** |
| **NORMAL** | |
| *'Business as usual'*<br>• Normal, able to meet all critical care needs, without impact on other services.<br>• Current status as 'normal' for season | **CRITCON 0 (FLUCON 0)** |
| **LOW SURGE** | |
| *'Swine Flu impacting beyond 'normal' winter pressures'*<br>• May include limited local expansion, elective cancellation, and/or non-clinical patient transfers. | **CRITCON 1 (FLUCON 1)** |
| **MEDIUM SURGE** | |
| *'Unprecedented'*<br>• Level of pressure on critical care which is previously unseen in most organisations.<br>• May include significant expansion into non-ICU areas, and/or use of adult facilities for paediatric critical care.<br>• Staff working outside normal areas, or at increased patient:nurse ratios.<br>• Significant critical care transfers (clinical and non-clinical).<br>• Trusts beginning mutual aid and phased reduction of elective work as necessary to support critical care needs, by local decision.<br>• No triage (refusal or withdrawal of critical care due to resources).<br>• When a significant proportion of Trusts in Yorkshire and The Humber are reporting CRITCON 2 the SHA will assume command and control arrangements | **CRITCON 2 (FLUCON 2)** |
| **HIGH SURGE** | |
| *'Full stretch'*<br>• Maximum expansion for mutual aid with extensive impact on services.<br>• SHA instruction for all critical care units in region to double capacity (so all organisations in SHA move to CRITCON 3 in one step).<br>• Trusts at or near maximum physical capacity (may be more than double in some cases).<br>• Elective operating reduced to lifesaving surgery only.<br>• Elective medical and other procedures similarly prioritised to free staff, space, or equipment.<br>• No triage (refusal or withdrawal of critical care due to resources). | **CRITCON 3 (FLUCON 3)** |
| **TRIAGE** | |
| *'Last resort'*<br>• SHA will declare CRITCON 4 for all of region when region is unable to meet all critical care needs despite full surge capacity in place.<br>• Triage processes for accessing critical care will be instigated. This will result in adverse outcomes to one or more flu or non-flu patients due to resource limits caused by the pandemic.<br>• Will be reviewed every 12 hours. | **CRITCON 4 (FLUCON 3)** |

# Criteria and SOP for open and referral to flexible capacity

**Checklist on opening additional beds at CRH/HRI.**

**Date……Staff member opening beds……..**

| | ✓ | Signature | Comments |
|---|---|---|---|
| **Staff** available at least 2 full days in advance. Administration support | | | |
| **Ward keys** | | | |
| **Bed areas ;**<br>Beds/mattresses<br>Chairs<br>Tables<br>Lockers<br>Visitors chairs<br>O2/air/suction<br>Bed linen<br>Curtains | | | |
| Thermometer/pulse oximeter | | | |
| Dynamap | | | |
| Nervecentre technology | | | |
| Check patients admitted are on a hire mattress or bed and inform Huntleigh | | | |
| Weighing scales ad slings | | | |
| BM machine | | | |
| Crash trolley(or access to one) | | | |
| Sanichairs/urinals | | | |
| Computer /printer working | | | |
| Telephone working | | | |
| Linen skips | | | |
| Stock pharmacy including CD | | | |
| Disposables(non stock) | | | |
| Stationary | | | |
| Admission book | | | |
| Ward notices (visiting etc) | | | |
| Drinks trolley | | | |
| Cups | | | |
| Jugs | | | |
| Glasses | | | |
| **Check following department are aware of opening** | | | |
| ISS | | | |
| Catering | | | |
| Laundry | | | |
| Porters | | | |
| Pharmacy | | | |
| Switchboard | | | |
| Supplies | | | |

| | | | |
|---|---|---|---|
| General office | | | |
| Coding | | | |
| Infection control- prior to opening | | | |
| **Request full review from the following in the first 12 hours of opening or next working day** | | | **Please indicate below the date and time review of the ward took place** |
| Infection control | | | |
| Resus officer | | | |
| Manual handling(Margaret Ward) | | | |
| Pharmacy Senior manager | | | |
| | | | |

**If the ward is being opened to facilitate HPV of an area please ensure the following instructions are followed without exception.**

**1 For general opening/closing – Check and decontaminate all equipment, furniture and mattresses, if damaged, condemn as protocol.**

**2. Inform mattress coordinators of pending ward opening/closure.**

**3. In addition – if HPV cleaning is required (as determined by IPC) ensure the attached HPV guidance is followed (refer to page 8-10 of attached HPV work plan).**

**4.if you have any concerns please speak to the ICPN nurses on the respective hospital site**

| W/C | Date | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Name** | **Grade** | **Mon** | **Tues** | **Wed** | **Thurs** | **Fri** | **Sat** | **Sun** |
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| **EARLY** | | | | | | | | |
| **LATE** | | | | | | | | |
| **NIGHT** | | | | | | | | |

**WARD** **E = 7.00-15.00 L=12.45-20.45 N=20.30-07.30**
IF STAFF ARE BOOKED AND ARE MOVED ELSEWHERE PLEASE RECORD WHICH WARD MOVED TO AND THE TIME.

IF BOOKED STAFF DO NOT TURN UP WITHOUT CONTACTING THE WARD PLEASE INFORM STAFF BANK AND RECORD AGAINST THEIR NAME ABOVE AND INFORM SITE COORDINATOR.

IF THE EXTRA CAPACITY BEDS ARE NOT OPEN PLEASE AS STAFF BOOKED TO REPORT TO SITE CORDINATOR SO THEY CAN BE ALLOCATED TO WORK.

**THE MATRON COVERING THIS AREA IS ……**

**FINANCIAL CODE .....**

**Checklist on closing additional beds at CRH.**

**Date …… Staff member closing beds…….**

| | ✓ | Signature | Comments |
|---|---|---|---|
| **Staff** available at least 2 full days in advance.<br>Administration support | | | **Contact staff bank to cancel** |
| **Ward keys** | | | **Safe keeping on adjacent ward in CD cupboard inform matron which ward.** |
| **Bed areas ;**<br>Beds/mattresses<br>Chairs<br>Tables<br>Lockers<br>Visitors chairs<br>O2/air/suction<br>Bed linen<br>Curtains | | | **Flow meters and suction to be stored in medical physics / EBME** |
| Check patients discharged or transferred are on a hire mattress or bed | | | **Inform Huntleigh** |
| Thermometer/pulse oximeter | | | **Store in medical physics EBME** |
| Dynamap | | | **Store in medical physics EBME** |
| Weighing scales | | | |
| BM machine | | | **Store in medical physics EBME** |
| Crash trolley(or access to one) | | | **Inform resus officer if not shared with another ward area** |
| Sanichairs/urinals | | | |
| Computer /printer working | | | **Ensure there is no patient details or handover information stored on a icon on desktop** |
| Telephone working | | | |
| Linen skips | | | |
| Stock pharmacy including CD | | | **Inform pharmacy** |

| | | | |
|---|---|---|---|
| | | | **to return stock – remember to empty drug fridge of medication** |
| Disposables(non stock) | | | |
| Stationary | | | **Speak to matron who will arrange safe storage** |
| Admission book | | | **Speak to matron who will arrange safe storage** |
| Ward notices (visiting etc) | | | |
| Drinks trolley | | | **Speak to matron who will arrange safe storage** |
| Cups | | | **Speak to matron who will arrange safe storage** |
| Jugs | | | **Speak to matron who will arrange safe storage** |
| Glasses | | | **Speak to matron who will arrange safe storage** |
| **Check following depts are aware of closing** | | | |
| ISS/Domestic services | | | |
| Catering | | | |
| Laundry | | | |
| Porters | | | |
| Pharmacy | | | |
| Switchboard | | | |
| Infection control | | | |
| General office | | | |
| Coding | | | |
| Supplies | | | |
| Resus | | | |
| | | | |

**Please ensure all patients notes and diagnostic tests have been seen and filed appropriately.**

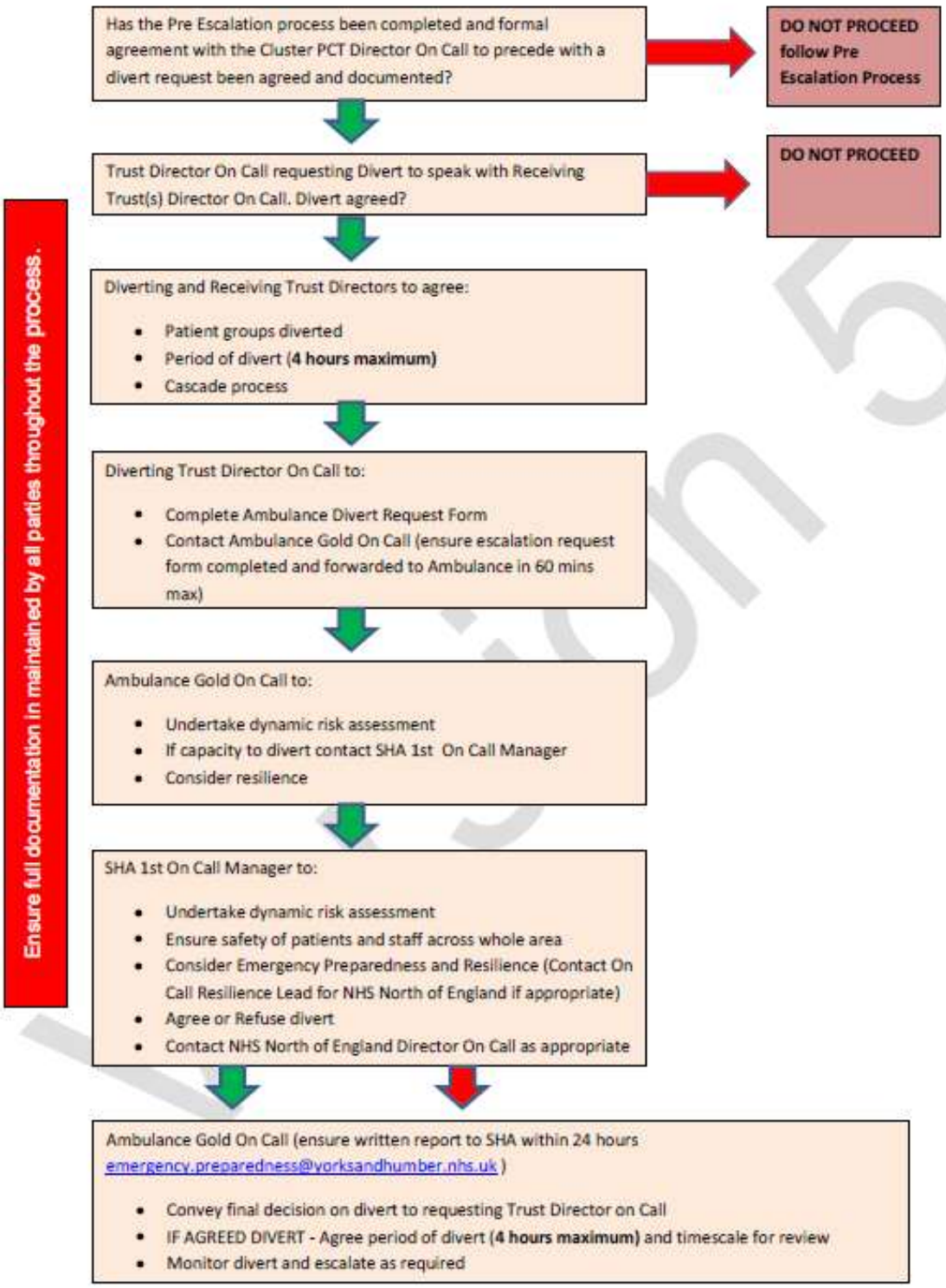
**Inform coding where notes can be picked up from and returned to so they are not left on an empty area.**

**Please check and clean all patient equipment and attach clean indicator tape/sticker.**

**All pressure relieving equipment needs to be appropriately bagged and returned to stores so it can be promptly used elsewhere.**

**Thank you**

**Escalation Request Flow – NHS North of England Yorkshire and the Humber Footprint**



**Appendix 5**

NHS Yorkshire and the Humber

Yorkshire Ambulance Service NHS

# YORKSHIRE AMBULANCE DIVERT REQUEST FORM

**All requests for an Ambulance divert involving YAS must be made by the Acute Trust Executive Director Level on call by telephoning YAS on 01924 584265 asking for Gold on call manager and followed up by emailing to roc@yas.nhs.uk or faxing on 01924 584266 a completed copy of this form within 60 minutes from the request.**

| **Section A: To be completed by executive Director at the Diverting Trust** | |
|---|---|
| Date | **Time** (24hr clock format) |
| Trust requesting divert | |
| Name of Executive Director requesting divert and contact number | Telephone: |
| Have all actions on the pre divert checklist been completed? | **YES NO** (Delete as applicable)<br>**If NO why not?** |
| Reason for divert request | |
| Estimated duration of divert (**4 hours maximum**) | |
| Communication updates agreed by diverting trust? State frequency of updates agreed | **YES NO** (Delete as applicable) |
| Details of patient divert (e.g. medical adult) | |
| Name of receiving trust who have agreed to accept the divert | |
| Name of Executive Director at the receiving trust who has agreed the divert | Telephone: Time: |
| Name of Executive Director for the PCT (Diverting Trust) who has been contacted | Telephone: Time: |
| **Section B : To be completed by YAS** | |
| Date initial request received: | Time initial call received: |
| Initial call request received from: | Initial call request received by: |
| Name of YAS Gold on Call dealing with request | Divert agreed? **YES NO** (delete as applicable) Provide details on log sheet. |
| Name of NHS Yorkshire and the Humber First on Call Manager contacted including time of contact. | Does this affect a neighbouring SHA / Ambulance service? **YES NO** (Delete as applicable) if YES complete details on log sheet. |

Issued 6th January 2012 (Version 5)

Calderdale and Huddersfield NHS
NHS Foundation Trust

**Approved Minute**

| |
|---|
| |

## Cover Sheet

| | |
|---|---|
| **Meeting:**<br>Board of Directors | **Report Author:**<br>Sue Laycock, PA to Chief Operating Officer |
| **Date:**<br>Thursday, 1st December 2016 | **Sponsoring Director:**<br>Helen Barker, Chief Operating Officer |
| **Title and brief summary:**<br>INTEGRATED BOARD REPORT - October 2016 - INTEGRATED BOARD REPORT - The Board is asked to receive and approve the Integrated Board Report for October 2016 | |
| **Action required:**<br>Approve | |
| **Strategic Direction area supported by this paper:**<br>Keeping the Base Safe | |
| **Forums where this paper has previously been considered:**<br>Weekly Executive Board (24th November 2016), Finance and Performance Committee (29th November 2016) and Quality Committee (29th November 2016) | |
| **Governance Requirements:**<br>Keeping the base safe | |
| **Sustainability Implications:**<br>None | |

## Executive Summary

### Summary:

October's Performance Score is 68% for the Trust. 3 of the 6 domains improved in month, with Responsive just short of a Green rating. Workforce peaked at 64% having achieved its overall sickness rate for the first time this year.

## Main Body

### Purpose:

Please see attached

### Background/Overview:

Please see attached

### The Issue:

Please see attached

### Next Steps:

Please see attached

### Recommendations:

The Board is asked to receive and approve the Integrated Board Report for October 2016 and note the overall performance score.

## Appendix

### Attachment:

Board Report (short) October 2016.pdf

# Board Report

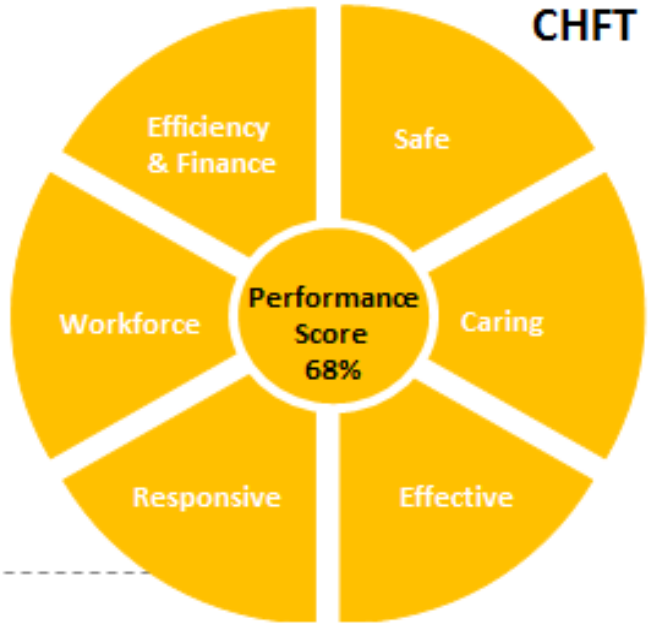
October 2016

# Performance Summary

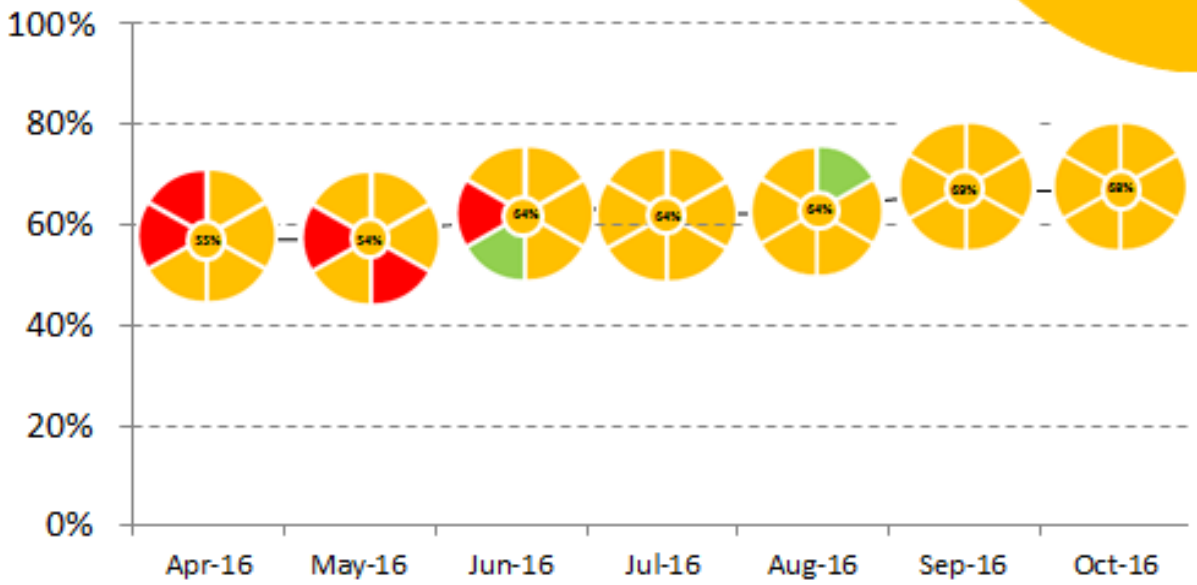
## Most recent month's performance

**RAG Movement**

October's Performance Score is 68% for the Trust (September improved to 69% following adjustment of Theatre targets). 3 of the 6 domains improved in month with **Responsive** just short of a Green rating. Within **Safe** Maternity had worst performance this financial year for its 5 KPIs. **Caring** maintained its 70% performance. **Workforce** peaked at 64% having achieved its overall sickness rate for the first time this year.




## Total performance score by month




| October Score by Domain | | |
|---|---|---|
| Safe | 67% | ↓ |
| Caring | 70% | ↔ |
| Effective | 61% | ↓ |
| Responsive | 73% | ↑ |
| Workforce | 64% | ↑ |
| Efficiency & Finance | 70% | ↑ |
| **Performance Score** | 68% | ↓ |

**Regulatory Targets**

| | |
|---|---|
| CDiff Cases 3 (0) | Cancer 62 day Referral to Treatment |
| Avoidable Cdiff 1 (0) | Cancer 62 day Screening to Treatment |
| ECS 4 hours 94.86% (95%) | Cancer 31 day targets x3 |
| RTT Incomplete Pathways | Cancer 2 Week Referral to Date first seen |
| Data Completeness Community Care x3 | Cancer 2 week Breast Symptoms |

**Other Key Targets**

| | |
|---|---|
| VTE Assessments | FFT targets x7 |
| Never events | FFT A&E 89.3% (90%) FFT OP 91% (95%) |
| MRSA | FFT Community 85% (96%) |
| SHMI 113.8 (100) | Stroke % admitted 4 hours 70.4% (90%) |
| HSMR 105 (100) | Diagnostics 6 weeks |
| Emergency Readmissions GHCCG CCCG | Net surplus/ (deficit) £130k |
| % Complaints closed 38% (100%) | Sickness |

## Carter Dashboard

| | | Current Month Score | Previous Month | Trend | Target |
|---|---|---|---|---|---|
| CARING | Friends & Family Test (IP Survey) - % would recommend the Service | 97.3% | 97.4% | ↓ | 96% |
| | Inpatient Complaints per 1000 bed days | 2.2 | 2.2 | ↔ | TBC |
| EFFECTIVE | Average Length of Stay - Overall | 5.1 | 5.0 | ↓ | 5.17 |
| | Delayed Transfers of Care | 2.80% | 2.04% | ↓ | 5% |
| | Green Cross Patients (Snapshot at month end) | 100 | 109 | ↑ | 40 |
| | Hospital Standardised Mortality Rate (12 months Rolling Data) | 105.00 | 106.12 | ↑ | 100 |
| | Theatre Utilisation (TT) - Trust | 85.80% | 83.43% | ↑ | 92.5% |
| RESPONSIVE | % Last Minute Cancellations to Elective Surgery | 0.52% | 0.65% | ↑ | 0.6% |
| | Emergency Care Standard 4 hours | 94.86% | 94.38% | ↑ | 95% |
| | % Incomplete Pathways <18 Weeks | 95.60% | 96.10% | ↓ | 92% |
| | 62 Day GP Referral to Treatment | 88.0% | 91.6% | ↓ | 85% |
| SAFE | % Harm Free Care | 95.78% | 93.71% | ↑ | 95.0% |
| | Number of Outliers (Bed Days) | 840 | 838 | ↓ | 495 |
| | Number of Serious Incidents | 5 | 7 | ↑ | 0 |
| | Never Events | 0 | 0 | ↔ | 0 |

### MOST IMPROVED

Improved: Sickness Absence rate has improved further in month and is now achieving target for the first time this year.

Improved: % Last Minute Cancellations to Elective Surgery - Lowest level at 0.52% in 12 months.

Improved: % Harm Free Care has improved to its best position in year following poor performance last month.

### MOST DETERIORATED

Deteriorated: Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge - Performance was 58.1% against a target of 85%, a reduction from the September figure of 86% (only month to achieve this year). YTD performance is 70.7%.

Deteriorated: RTT Total incomplete waiting list/RTT Waiting 18 weeks and over (backlog) - both numbers have peaked to highest levels in 12 months.

Deteriorated: Elective C-Section Rate - at 11.1% highest rate this calendar year.

**TREND ARROWS:**
Red or Green depending on whether target is being achieved
Arrow upwards means improving month on month
Arrow downwards means deteriorating month on month.

### ACTIONS

Action: A deep dive has been requested for January's PRM to look at how the Trust can improve and sustain performance.

Action: Action plans to ensure all RTT Pathways are validated over 15 weeks and suitable cover arrangements in place for RTT Tracking to cover sickness/leave.

Action: Setting up a task and finish group to look at pathways and criteria for Elecive Caesarean Section to ensure safe care for all women (December 2016).

| Arrow direction count | ↔ | ↑ | ↓ |
|---|---|---|---|
| | 3 | 9 | 7 |

| PEOPLE, MANAGEMENT & CULTURE: WELL-LED | Current Month Score | Previous Month | Trend | Target |
|---|---|---|---|---|
| Doctors Hours per Patient Day | | | | |
| Sickness Absence Rate | 3.9% | 4.2% | ↑ | 4.0% |
| Turnover rate (%) (Rolling 12m) | 12.7% | 12.8% | ↑ | 12.3% |
| Vacancy | 402.5 | 376.4 | ↓ | NA |
| FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q4 | 82.00% | Different division sampled each quarter. Comparisons not applicable | | |
| FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly) Q4 | 64.00% | Different division samples each quarter. Comparisons not applicable | | |

| OUR MONEY | Current Month Score | Previous Month | Trend |
|---|---|---|---|
| Income vs Plan var (£m) | £2.68 | £2.25 | |
| Expenditure vs Plan var (£m) | -£3.11 | -£2.68 | |
| Liquidity (Days) | | | |
| I&E: Surplus/(Deficit) var (£m) | £0.13 | £0.08 | |
| CIP var (£m) | £2.08 | £2.08 | |
| FSRR | 3 | 2 | |
| Temporary Staffing as a % of Trust Pay Bill | | | |

# Executive Summary

The report covers the period from October 2015 to allow comparison with historic performance. However the key messages and targets relate to October 2016 for the financial year 2016/17.

| Area | Domain |
|---|---|
| **Safe** | • **Percentage of SI's investigations where reports submitted within timescale (60 days unless extension agreed) -** 60% of reports were submitted within 60 days. Delays were caused by a mix of internal and external factors such as certain cases being with the Coroner or involving external agencies such as the Police and other Trusts and capacity of the investigators. Additional support is available from the Risk team when timescales become challenging.<br>• **Elective C-Section Rate -** at 11.1% highest rate this calendar year. Setting up a task and finish group to look at pathways and criteria for Elecive Caesarean Section to ensure safe care for all women (December 2016).<br>• **Maternity - Major PPH - Greater than 1000mls** - continues to be above target with an increase in month to 11.7% vs target of 8%. Target has only been met once this calendar year. CQC PPH action plan in place.<br>• **Number of Category 4 Pressure Ulcers Acquired at CHFT -** There was 1 Category 4 pressure ulcer in September in Critical Care. The safety huddles on the wards include patients with pressure ulcers as well as patients who may be susceptible. Improvement expected within Q3/Q4 following 6 month roll out project. |
| **Caring** | • **Complaints closed within timeframe** - 48 complaints in total were closed in October, a 32% decrease from September. Of the 48 complaints that were closed 38% were closed within the target timeframe. This is a further 4 point decrease from September. During regular meeting with Divisions and Complaints Team action plans are being drafted to focus on overdue complaints.<br>• **Friends and Family Test Outpatients Survey** - % would recommend has maintained last month's performance at 91% which is still below the target of 95%. Further work to continue as part of directorate action plan to achieve Q3 improvement trajectory (December 16). Each department with 3 or more consecutive months of < 95% performance has developed an action plan.<br>• **Friends and Family Test Community Survey** - FFT reports 4% of people would not recommend services. To provide alternative methods of responding the Community division has included paper forms in Outpatient areas and has ensured that the webform is available to all staff using laptops. An options paper for FFT recording will be presented at November PRM with a recommendation. |
| **Effective** | • **Total Number of Clostridium Difficile Cases/Avoidable number of Clostridium Difficile Cases -** There have been three clostridium Difficille cases reported in month with one case shown as unavoidable in Surgery following RCAs that have been undertaken. This takes the total number of cases to 20 as at the end of October against an annual plan of 21 however the number deemed avoidable and<br>• **Number of MSSA Bacteraemias - Post 48 Hours** - There were 4 post 48 hours E-Coli Bacteraemias reported in September, 2 of these occurred on surgical wards (ward 15 and ICU). An analysis of both incidents was undertaken and there were no common themes or links between the 2 cases.<br>• **Local SHMI - Relative Risk** (12 months Rolling Data April 15 - March 16) - Latest figures are still at 113. There is only one diagnostic group alerting in this release which is Acute Cerebrovascular Disease.<br>• **Hospital Standardised Mortality Rate** (12 months Rolling Data September 15 - August 16) - has shown a further fall to 105. The weekday/weekend split shows a 4 point difference with an improvement in Weekend HSMR from 111.87 to 108.03.<br>• **Mortality Reviews** - The completion rate for Level 1 reviews stands at 20% of September deaths having had a corporate level one review. This reduction was anticipated as internal processes are adapted to capture more robust data from Q3 onwards. Reviews are ongoing into alerting conditions, the Trust has also decided to undertake a review of sepsis mortality, HSMR is improving in this category but it remains a priority area.<br>• **Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours - BPT based on discharge** - In October a successful attempt to support patients onto the next part of their pathway led to Orthopaedics discharging a large number of long waiting green cross patients from the #NoF pathway. This resulted in a dip in performance as the data is based upon discharge rather than admission. The number of patients operated on within 36 hours of admission for fragility hip fracture was 25 out of a total of 43. The 18 breaches consisted of 8 organisational breaches and 10 clinical breaches. Performance was 58.1% against a target of 85%, a reduction from the September figure of 86% (only month to achieve this year). YTD performance is 70.7%. A deep dive has been requested for January's PRM following a 'go-see' visit to Boston. |

**Background Context**

Throughout October all divisions have been working on planning for 2017/18 and 2018/19 with 3 full day workshops having taken place.

Demand remains high and as a consequence in-month activity has been required to deliver above planned levels in all of the main points of delivery.

A&E has seen activity continue to over-perform in month 7 but at a lower level than seen in month 6. Activity is 2% above the month 7 plan and cumulatively 3.5% above plan but peaks Sunday/Monday continue.

Non-elective activity overall is 2.6% above the month 7 plan. This is an increase in activity when compared to month 6 when activity was 0.1% above plan. The in-month over-performance is mainly due to Paediatric admissions across both emergency and non-elective. Cumulatively activity is 0.3% below planned levels due to emergency long stay activity. The impact is that the Trust has continued to rely on additional capacity in October - Ward 14 closed at HRI and Ward 4 opened (4 days per week) as per the winter plan.

CCGs are currently working on demand management strategies which will need to be considered alongside new capacity plans internally. Through recent planning workshops options to support Commisioners with demand reduction strategies have been explored; this is also being discussed across West Yorkshire providers where the picture locally is reflected with the aim of maximising consistency.

Planned day case and elective activity has improved in month 7 with activity 2.7% above plan. This is driven by continued under-performance within inpatient elective activity some of which reflects a planned switch to day case activity which has over-performed against plan which is an improvement from being in line with plan at month 6.

The Safer programme continues with progress in ambulatory and Frailty via the collaboratives and our own internal teams enabling effective management of some of the increased demand, retaining a positive conversion rate from AED and consistent ECS delivery which sits in the upper quartile nationally.

# Executive Summary

The report covers the period from October 2015 to allow comparison with historic performance. However the key messages and targets relate to October 2016 for the financial year 2016/17.

| Area | Domain |
|---|---|
| **Responsive** | • **Emergency Care Standard 4 hours -** October's position was 94.86%, highest since June. CHFT will be working across WYAAT to deliver the expectations set out as part of being an Accelerator site.<br>• **Stroke -** Patients admitted to a stroke ward within 4 hours peaked in October at 70%. Patients scanned within 1 hour of arrival also improved. Discussions are ongoing between Medicine and FSS to improve scanning with FSS agreeing to prioritise Stroke patients. Stroke Invited Service Review (ISR) is planned for December.<br>• **RTT pathways over 26weeks** - numbers have fallen below 100 for the first time since November 2015. Work is ongoing with Medical secretaries to improve waiting list validation through focuessed application of the Access Policy.<br>• **38 Day Referral to Tertiary** remains a concern, with discussions between Surgery and FSS looking at long diagnostic waiting times and multiple MDT's and how this work can be better scheduled. A deep dive in Urology has highlighted potential areas to reduce the pathway.<br>• **Appointment Slot Issues on Choose & Book** - The Trust's position has improved to 10.9% which compares favourably with its peers. There has been a reduction of 562 referrals for patients awaiting appointment from the July position of 1,824. The top 4 specialties for E-referral ASIs backlog are: Ophthalmology, Respiratory, General Surgery and Colorectal. Specialty action plans are in place to continue to reduce the ASIs over the forthcoming weeks. |
| **Workforce** | • **Sickness Absence rate** has improved further in month and is now achieving target for the first time this year.<br>• **Return to work Interviews** have reduced for the first time since March and are still some way short of 100% target at 61%.<br>• **Mandatory Training and appraisal -** Information Governance, Fire Safety, Infection Control and Manual Handling. Currently just Manual Handling is off plan. Appraisal activity is now measured against planned activity. A more rigorous approach is being adopted at Divisional Performance Review Meetings to emphasise the need for improved appraisal coverage and quality. |
| **Efficiency/ Finance** | • **Finance:** Year to date: The financial position stands at a deficit of £11m, a favourable variance of £0.13m from the planned £11.13m. The in-month, clinical contract activity position is above plan at a similar level to that seen last month. This drives an overall income position at Month 7 which is £2.68m above planned levels in the year to date. The in-month overperformance is seen across non-electives, outpatients, day cases and A&E attendances. It continues to be the case that, in order to maintain safety and secure and regulatory access standards across the Trust with high vacancy levels, there is a reliance upon agency staffing. However, operational actions that have been put in place to curb the use of agency have started to impact positively, total agency spend in month was £1.79m, a stable position from last month which compares with expenditure in excess of £2.1m each month in the year to August. This improvement brings the agency expenditure in line with a revised trajectory submitted to NHS Improvement. The impact of this operational position is as follows at headline level:<br>• EBITDA of £3.34m, an adverse variance of £0.43m from the plan.<br>• A bottom line deficit of £11.00m, a £0.13m favourable variance from plan.<br>• Delivery of CIP of £8.35m against the planned level of £6.16m.<br>• Contingency reserves of £1.0m have been released against pressures.<br>• Capital expenditure of £9.14m, this is below the planned level of £14.94m.<br>• A cash balance of £2.62m, this is above the planned level of £1.95m, supported by borrowing.<br>• A Use of Resources score of level 3, in line with the plan.<br>• **Theatre Utilisation** has improved to 86% its best position since March. Having discussed the appropriateness of the 92.5% target it was agreed at Surgical Performance Review meeting to reduce the Trust and main theatres target to 90%, DSU 88% and SPU 85%. This will allow sufficient turnaround to clean theatres and prevent overrunning. |
| **CQUIN** | • **Staff Well Being Flu Vaccination** - Throughout October over 3,000 colleagues were vaccinated, just over 2,000 of these were classified as frontline. The Trust is on track to meet the partial payment threshold, however further campaign work is in place. A risk is being raised in achieving the third element, regarding 75% of front line staff receiving the Flu Vaccination. At the end of month one performance was 53.8%. |
| **Activity** | • **Activity** in-month activity is above planned levels in all of the main points of delivery. Cumulatively elective and daycase combined are above plan but there is still an increased waiting list whilst non elective activity is below plan. |

**Background Context**

The Trust has developed an improvement plan for agency spend 'Safer Staffing Workforce Utilisation and Efficiency Programme 2016/17'. The purpose of this plan is to define the overall improvements and a consistent model for medical, nursing, midwifery and AHP workforce utilisation, and efficiency. The plan links to the broader Workforce and Organisational Development work to improve recruitment, retention and staff engagement.

Divisions have completed and submitted Workforce Plans for 2017/2018. Emphasis has been on reshaping the workforce for the future, including new roles and role redesign which will reduce the number of vacant posts, agency spend and deliver the care that patients need.

Cancer waiting times continue to be a cause for challenge with some pathways extended due to diagnostic waiting times and multiple MDT's. The Surgery division is working closely with FSS to minimise pathway delays and also wishes to work with other Trusts across the patch to review clinical pathways.

The Medicine division is preparing to hand over a ward to the Community Services division to pilot an innovative ward configuration promoting independance and supporting active discharge called the Community Place. This has been developed in collaboration with Calderdale social care and is planned to "go live" in early December.

Diagnostics has been extremely busy responding to internally and externally driven demand but still maintaining access standards.

Adult Critical Care is below plan in month 7 by 28.7% which is a further decrease from the over-performance seen in month 6 by 5.2%. NICU has continued above plan in month 7 and is 24.6% in-month from 22% above plan at month.

Rehabilitation has seen a small improvement in month 7 to 3.5% above plan from being more in line with planned levels at month 6.

Demand continues to be high driving increased outpatient activity and work continues to ensure reductions in follow-up waiting times.

The over-performance in-month is across both first and follow-up attendances including procedures. The specialties with the more significant over-performances within first attendances are Oral, ENT, Paediatrics, Rheumatology, Gynaecology, Dermatology and Urology. General Surgery and Ophthalmology have continued to under-perform. Over-performance within follow-ups has continued within Gastroenterology and Gynaecology, while significant increases have been seen within Cardiology and Paediatrics. General Surgery has continued to under-perform. Cumulatively outpatient activity is now 2.9% above plan however with demand continuing at high levels this is not resulting in a reduced waiting list size.

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Calderdale and Huddersfield NHS
NHS Foundation Trust

**Approved Minute**

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## Cover Sheet

| | |
|---|---|
| **Meeting:**<br>Board of Directors | **Report Author:**<br>Kathy Bray, Board Secretary |
| **Date:**<br>Thursday, 1st December 2016 | **Sponsoring Director:**<br>Gary Boothby, Deputy Director of Finance |
| **Title and brief summary:**<br>FINANCIAL COMMENTARY TO NHS IMPROVEMENT - MONTH 7 - The Board is asked to approve Month 7 Financial Commentary | |
| **Action required:**<br>Approve | |
| **Strategic Direction area supported by this paper:**<br>Financial Sustainability | |
| **Forums where this paper has previously been considered:**<br>Finance and Performance Committee | |
| **Governance Requirements:**<br>Financial Sustainability | |
| **Sustainability Implications:**<br>None | |

## Executive Summary

### Summary:

he Board is asked to approve Month 7 Financial Commentary attached.

## Main Body

### Purpose:

Please see attached

### Background/Overview:

Please see attached

### The Issue:

Please see attached

### Next Steps:

Please see attached

### Recommendations:

The Board is asked to approve Month 7 Financial Commentary

## Appendix

### Attachment:

NHSI Financial Commentary Month 7 1617 final for submission.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

## MONTH 7 OCTOBER 2016, NHS IMPROVEMENT COMMENTARY ON THE FINANCIAL RETURN

The notes below provide a management commentary on the financial position of Calderdale & Huddersfield NHS Foundation Trust at the end of October 2016.

The report is structured into three sections to describe:

- Key messages;
- Detailed commentary for the period with variance analysis against the annual plan as submitted to NHSI;
- Use of Resources rating and forecast.

### 1. Key Messages

The year to date financial position stands at a deficit of £10.06m, a favourable variance of £1.07m from the planned £11.13m of which £0.94m is purely a timing difference on the accrual of Strategic Transformation Funding (STF) versus the planned quarterly profile. The underlying position is a £0.13m favourable variance from year to date plan.

The in-month, clinical contract activity position is above plan at a similar level to that seen last month. This drives an overall income position at Month 6 which is £2.68m above planned levels in the year to date. The in-month over-performance is seen across non electives, outpatients, day cases and A&E attendances. It continues to be the case that, in order to deliver activity and access standards across the Trust with high vacancy levels, there is reliance upon agency staffing. However, operational actions that have been put in place to curb the use of agency have started to impact positively, total agency spend in month was £1.79m, a stable position from last month which compares with expenditure in excess of £2.1m each month in the year to August. This improvement brings the agency expenditure in line with the revised trajectory submitted to NHSI.

**Month 7, October Position (Year to Date)**

| Income and Expenditure Summary | Plan £m | Actual £m | Variance £m |
|---|---|---|---|
| Income | 215.54 | 219.16 | 3.62 |
| Expenditure | (211.77) | (214.74) | (2.97) |
| **EBITDA** | **3.77** | **4.43** | **0.65** |
| Non operating items | (14.90) | (14.34) | 0.56 |
| **Deficit excluding restructuring costs** | **(11.13)** | **(9.92)** | **1.21** |
| Restructuring costs | 0.00 | (0.14) | (0.14) |
| **Deficit including restructuring costs** | **(11.13)** | **(10.06)** | **1.07** |

- EBITDA of £4.43m, a favourable variance of £0.65m from the plan.
- Of this operating performance £0.94m is driven by a timing difference on the accrual of Strategic Transformation Funding versus the planned quarterly profile.
- A bottom line deficit of £10.06m, a £1.07m favourable variance from plan.
- Delivery of CIP of £8.35m against the planned level of £6.16m.
- Contingency reserves of £1.0m have been released against pressures.
- Capital expenditure of £9.14m, this is below the planned level of £14.94m.
- Cash balance of £2.62m; this is above the planned level of £1.95m, supported by borrowing.
- Use of Resources score of level 3, in line with the plan.

## 2. Detailed Commentary for the Reporting Period

### Statement of Comprehensive Income (SOCI)

The year to date activity over performance sits alongside strong CIP delivery, achieving £2.19m in advance of the planned timescale. The combined benefit has not flowed through in full to the bottom line but has rather absorbed the activity related expenditure pressures and one off issues such as the Junior Doctors' strike action. However, of the £2m contingency reserves planned for in the year to date, £1m has not been released but rather has been held back to mitigate against pressures in the latter part of the year. This lesser reliance on contingency reserves in the year to date continues to be supported by the income over performance and CIP delivery.

In summary the main variances behind the year to date position, against the plan are:

| | |
|---|---|
| Operating income | £3.62m favourable variance |
| Operating expenditure | (£2.97m) adverse variance |
| **EBITDA** | **£0.65m favourable variance** |
| Non-Operating items | £0.56m favourable variance |
| Restructuring costs | (£0.14m) adverse variance |
| **Total** | **£1.07m favourable variance** |

**Operating Income**

There is a £3.62m favourable variance from the year to date plan within operating income. Of this operating performance £0.94m is driven by a timing difference on the accrual of Strategic Transformation Funding (STF) versus the planned quarterly profile. The £0.94m STF represents full achievement of financial and operational criteria in the year to date. There has been a slight under-performance against the A&E trajectory in individual months but this is overridden by the cumulative year to date performance which is above the agreed year to date trajectory. This will remain a challenging target for the Trust due to activity levels described below. The Trust is however seizing this challenge having been selected as an 'Accelerator' site for A&E performance and in October achieved a strong performance of 94.8%, very close to the 95% target.

The balancing £2.68m positive operating income variance is representative of the favourable trading position.

***NHS Clinical Income***

Within the £2.68m favourable income variance (excluding the timing difference on STF), NHS Clinical income shows a favourable variance of £3.84m. As described above, overall activity has again had a strong performance in month which augments the position seen in the year to date. The breakdown by point of delivery is as follows:

- Elective inpatient performance is below the month 7 and year to date plan but this is more than compensated by day case over performance. Cumulatively day case activity is 3.3% (739 spells) above plan.

- Non-elective activity overall is 2.6% (114 spells) above the month 7 plan. This is an increase in activity when compared to month 6 when activity was 0.1% (42 spells) above plan. In the year to date non elective activity is in line with planned levels.

- A&E activity has continued to over-perform but at a lower level than month 6. The month 7 activity is 2% (285 attendances) above plan and cumulatively is 3.5% (3,006 attendances) above plan.

- Outpatient activity overall has continued to see a further increase above plan of 5.1% (1,436 attendances). The over-performance in month is across both first and follow-up attendances, including procedures. Cumulatively activity is 2.9% (5,795 attendances) above plan.

- Adult critical care bed day activity is above plan by 106 bed days in the year to date which is driven by the discharge of 2 long-stay patients in month 5, coupled with the previously reported discharge of a 5-organ supported very long stay patient in quarter 1. NICU performance also remains above planned levels.

The clinical contract PbR income position is driven by these areas of activity over performance as well as Rehabilitation and Diagnostic testing & imaging. The non-elective activity level belies the favourable income position which is boosted by case mix.

This position continues to reflect an over-performance against the Trust's year to date plan and a greater over-performance against contracts with the Trust's Commissioners. The 2016-17 contracts with the Trust's commissioners incorporated a lower level of activity and income to the Trust plan in the main due to the CCG QIPP plans, Trust CIP plans and a differing view of baseline activity levels. The Trust remains in close contact with commissioners to highlight this position both from a point of view of securing cash relating to the overtrades in a timely manner and also to guard against unexpected challenges. Whilst the Trust is mindful of the affordability pressures to the health economy as a whole, it continues to be the case that no provision against PbR contractual challenges is reflected within the position.

The 2016-17 plan was inclusive of £1.97m of System Resilience funding which in previous months had been reflected in line with planned levels. Whilst the Trust is continuing to pursue this full value, commissioners are looking to hold back this funding on the grounds of affordability. The projects that are supported within the Trust with this funding are committed and embedded recurrently to aid improved patient flow and capacity in the context of pressures in the social care sector. Receipt of this funding is now not assumed in full in the forecast, placing a health economy risk entirely with the Trust and forcing the need for further compensating recovery actions to be implemented.

***Other income***

Overall other income is below plan by £1.14m in the year to date. This is mainly due the transfer of the West Yorkshire Audit Consortium to another host provider, which has reduced income by £0.57m cumulatively. The Trust also planned for Bowel Scope income as part of non-NHS Council funding which changed contractually to be funded through NHS England, showing below plan within non-NHS Clinical income, offset by over-performance within NHS Clinical income at a cumulative value of £0.41m.

**Operating expenditure**

There was a cumulative £2.97m adverse variance from plan within operating expenditure across the following areas:

| | |
|---|---|
| Pay costs | (£1.29m) adverse variance |
| Drugs costs | £0.85m favourable variance |
| Clinical supply and other costs | (£2.53m) adverse variance |

***Employee benefits expenses (Pay costs)***

Pay costs are £1.29m higher than the planned level in the year to date. The high vacancy levels in clinical staff groups continues to causing reliance on agency staffing with the associated premium rates driving contributing to the overspend.

For 2016/17 the Trust was originally given a £14.95m ceiling level for agency expenditure by NHSI. More recently, the Trust was given the opportunity to restate the agency trajectory for the year with the clear expectation that this would form a commitment by the Trust to reducing the agency costs.

The revised full year position is to reduce the run rate in the second half of the year and contain spend within a £24.31m total. The Trust understands that it will now be held to this commitment.

The drive to recruit staff is ongoing including advertising new types of roles to aid recruitment potential. The work to push down the contractual rates paid to Medical agencies and develop a tiered approach to bookings is now beginning to impact. The actions to curb agency usage are of the highest priority to the Trust with a weekly Executive Director level meeting focussing purely on this agenda. Total agency spend in month was £1.79, a stable position from last month which compares with expenditure in excess of £2.1m each month in the year to August. This improvement brings the agency expenditure in line with the revised trajectory submitted to NHSI.

It should be noted that £2.0m of contingency reserves are planned against pay across the first six months of the financial year. This contingency has been released against the pay position; meaning that the underlying divisional year to date pay overspend was over £3m. In overall terms, there has been a year to date benefit from releasing reserves of £1m to the bottom line, a provision has been made against the £1m balance of the available contingency for potential future risks. The accounting treatment for provisions is as a non-pay cost and as such this drives an overspend against this element of the plan.

***Drug costs***

Year to date expenditure on drugs was £0.85m below the planned level. The income and corresponding spend on 'pass through' high cost drugs is £0.72m below plan. Underlying drug budgets are therefore further underspent by £0.13m.

***Clinical supply and other costs***

Clinical supply and other costs, including PFI costs, are £2.53m above the plan. This overspend reflects activity related factors such as ward consumables and diagnostic test costs. There has been a considerable increase in MRI usage driving hire costs and outsourced reporting charges, with growth in internal diagnostics demand outstripping the overall activity increase. Another factor is high cost devices which are 'pass through' costs are £0.33m above the planned level, compensated directly by income.

As was the case last month, an element of the overspend in this area is driven by purely technical reasons. The annual plan includes £2.0m of contingency reserves all of which was planned as pay spend. There has been a release of £1.0m contingency reserves to the bottom line in the year to date position; a provision has been made against the £1m balance for potential future risks and commitments. The accounting treatment for provisions is as a non-pay cost and as such this drives an overspend against this element of the plan. The accounts for £1m of the total £2.53m overspend against clinical supply and other costs.

**<u>Non-operating Items and Restructuring Costs</u>**

Non-operating items and restructuring costs are £0.56m below the planned level. This is driven by a combination of lower than planned depreciation charges and Public Dividend Capital payable. The adoption of a different valuation method for the PFI site and a review of equipment asset lives have reduced the asset value upon which both depreciation and PDC are chargeable.

The year to date has also seen £0.06m gain on disposal against the sale of the old Occupational Health building which was surplus to Trust requirements. In full year forecast terms, the Trust also anticipates recognition of a loss on disposal £0.3m relating to Princess Royal Hospital due to the sale price being lower than the carrying Net Book Value. Both of these technical accounting movements are excluded from the measurement against the control total.

The year to date benefits are offset in part by higher than planned interest payable due to both the timing of drawing down borrowing and higher than planned interest rates. The greater impact of this interest pressure is included in the full year forecast where a continuing to bear the current interest

rate of 3.5% for a Working Capital Loan as opposed to the planned switch to a Revenue Support Loan at 1.5% will cost £0.5m more than plan.

Restructuring costs of £0.14m have been incurred in the year to date to fund redundancy costs which will deliver savings in the future periods.

**Cost Improvement Programme (CIP) delivery**

In the year to date, £8.35m of CIP has been delivered against a plan of £6.16m, an over performance of £2.19m. As was highlighted in previous months, whilst the level of over performance is positive news it should be noted year to date over performance is counterbalanced by forecast delivery in the latter half of the year being lower than the planned level. The £2.19m over performance against CIP plans in the year to date has not translated to an equivalent benefit to the Trust's bottom line financial performance but has rather offset other pressures. The issue that this raises is that this will lead to a budgetary pressure in the remainder of the year which will have to be mitigated and will need to form part of the divisional recovery plans.

The year end forecast CIP delivery has increased from £14.78m last month to £15.09m this month, this is offsetting other pressures and therefore the increase in the CIP forecast does not translate to an improvement in the overall year end forecast. The key areas of improvement in the forecast this month are against car parking and outpatient clinic utilisation efficiencies.

Work is ongoing to ensure that CIP delivery in the latter part of the year can be secured, this is where the highest risk schemes are due to commence in earnest, for example the complex SAFER programme focussing on operational productivity through improved patient flow. Additional savings opportunities also need to be progressed in support of the divisional recovery plans that are required to deliver the overall financial control total of £16.1m deficit. An Executive Director time-out was held in early September to generate ideas; these are progressing through the gateway process to delivery stage alongside the balance of the divisional recovery plans.

**Statement of Financial Position and Cash Flow**

At the end of October 2016 the Trust had a cash balance of £2.62m against a planned position of £1.95m, a favourable variance of £0.67m. This is due to receiving Learning and Development Agreement (LDA) income in advance of the anticipated timescale. As this receipt came on the final day of the month there was no opportunity to make further payments to suppliers.

The key cash flow variances against plan are shown below:

| Cash flow variance from plan | | Variance £m |
|---|---|---|
| **Operating activities** | Deficit including restructuring | 1.07 |
| | Non cash flows in operating deficit | (0.48) |
| | Other working capital movements | (10.37) |
| | **Sub Total** | **(9.78)** |
| **Investing activities** | Capital expenditure | 5.87 |
| | Movement in capital creditors | (3.05) |
| | **Sub Total** | **2.82** |
| **Financing activities** | Drawdown of external DoH cash support | 7.97 |
| | Other financing activities | (0.34) |
| | **Sub Total** | **7.63** |
| | **Grand Total** | **0.67** |

***Operating activities***

Operating activities show an adverse £9.78m variance against the plan. The favourable cash impact of the I&E position of £0.59m (£1.07m favourable I&E variance offset by £0.48m non-cash flows in operating deficit) is in addition to a £10.37m adverse working capital variance from plan. The working capital variance reflects the catch up of payments to suppliers. The performance against the Better Payment Practice Code has seen an improvement in month with 94.7% of invoices paid within 30 days against the 95% target, as many of the older outstanding invoices have flushed through in previous months and we are now paying recent invoices in the main.

Total aged debt based on invoices raised is £5.62m. Material invoices in this value include: Hepatitis C drugs charges to NHS England; charges for Care Packages to local CCGs; contract overtrade invoices to local and other commissioners; and System Resilience Funding. As previously described, with the exception of the System Resilience Funding, the Trust does not consider there to represent a risk of non settlement but rather a timing delay and active pursuit of these balances has resulted in greater assurance of payments being processed against a number of these issues in November.

***Investing activities (Capital)***

Capital expenditure in the year to date is £9.14m which is £5.80m below the planned level of £14.94m.

Against the Estates element of the total, year to date expenditure is £2.61m against a planned £5.12m. The main area of spend in month was on the continuation of the Theatre refurbishment programme with a year to date spend of £1.55m, this is coupled with spend on backlog maintenance including the continuation of fire compartmentation, fire detection and roofing work.

IM&T investments total £4.49m against a plan of £4.98m. The main areas of spend in month were the continuation of the Electronic Patient Record (EPR), and EDMS projects. The main reason for the underspend against plan is the delay in go live of EPR, however, this project is now forecast to spend £12.24m versus a plan of £4.74m due to the additional costs of the extended timescale.

Expenditure on replacement equipment in the year to date is also lower than plan.

The favourable cash impact of the £5.87m (£3.80m capital expenditure variance plus £0.07m funded by donated assets) under spend is offset by a £3.05m adverse variance against capital creditors as invoices have been forthcoming and paid in a timely way.

***Financing activities***

Financing activities show a £7.63m favourable variance from the original plan, of which £7.97m is due to additional cash support through borrowing. This position includes borrowing brought forward in earlier months to settle supplier invoices, a position which is being maintained versus the planned position which was to extend creditor payments. Extending creditor terms was not sustainable in operational terms in order to maintain key lines of supply.

Continuing to borrow at the current planned levels at an interest rate of 3.5% for the remainder of the year will bring a pressure of £0.5m, included in forecast, against the original plan which assumed a switch to the lower interest rate in-year. The latest understanding from discussions with NHSI to convert our loan from a Working Capital Facility (at 3.5% interest) to a Revenue Support loan (at 1.5% interest), is that we will only move to the lower rate loan once the working capital facility has reached the level equivalent to 30 days operating costs. This will be in March 2017 based on current projections.

## 3. Use of Resources (UOR) rating and forecast

### *UOR*

Against the UOR the Trust stands at level 3 in both the year to date and forecast position, in line with plan. This is equivalent to the Trust's previous rating of 2 against the Financial Sustainability Risk Rating, on the new inverted rating scale.

### *Forecast – Income and Expenditure*

The year end forecast position continues to be delivery of the planned £16.1m deficit and control total, prior to consideration of costs associated with EPR implementation.

The reported forecast year end deficit is £16.35m but includes exceptional costs of a loss on disposal of £0.3m relating to the disposal of Princess Royal. These exceptional technical accounting costs are excluded from the deficit for control total purposes and therefore have no impact on our STF allocation or UOR metric.

This position assumes delivery of £15.09m CIP and that recovery plans are delivered to offset ongoing pressures and risks. In addition, it continues to be assumed that the Trust will achieve the necessary conditions to secure the £11.3m STF which is intrinsic to and contingent upon delivery of the planned deficit.

It has been acknowledged in discussion with NHSI, both at the time of setting the plan and subsequently, that the £16.1m control total excluded any I&E or cash pressures for EPR 'go live'. It is now becoming clear at the mid-way point of 2016/17 that the likely costs that will be incurred in-year will be £3m. The revised timescale for implementation, now being at the latter end of 2016/17 and into 2017/18 means that the implementation costs will cross the financial years, bringing an additional £2m non-recurrent cost in 2017/18 in addition to the issues considered in the allocated indicative control total. The Trust looks to NHSI to support this position and recognise the associated cash backing requirement.

There are inevitably other areas of underlying pressure and risk emerging in year, including areas that have impacted in the year to date which are beyond the organisation's direct control, such as the Junior Doctor's strike action and the higher than planned rate of interest being borne on current borrowing. This pressure intensified in the remainder of the financial year as the Trust plans to deal with the combination of EPR implementation; delivery of complex CIP schemes with greater returns; managing winter pressures alongside quelling agency staff usage; and potential affordability related challenge from commissioners. The latter risk has heightened with the commissioners taking a stance that they will not support £1.97m of System Resilience funding to the Trust, against which expenditure commitments cannot be released.

Operational plans are in place and being constantly refined against the above. At the same time, the Trust's Divisions are required to financial deliver recovery plans to mitigate against issues in their respective areas of service. In addition there will need to be Trust wide action to address these risks and balance the need for innovative solutions with the maintenance of rigorous budgetary control.

### *Forecast – Capital and cash*

In overall terms the capital expenditure is currently expected to be £27.61m, £0.61m below the planned full year value of £28.22m. Due to the delay in go live of EPR which is forecast to increase spend against this element of the original plan by £7.5m, there has been some further re prioritisation of capital plan, resulting in reduced spend on the Estate and Equipment to offset the additional EPR cost.

This overall forecast is as per the submission made to NHSI in June, against which a level of assurance has been received with regard to the availability of cash support. On this basis, after an internal review of our cash, operational, and legislative compliance requirements, the Trust continues to reprioritise spend within the overall value discussed with NHSI. Any changes to the make-up of the programme follow the completion of a full risk assessment.

Total borrowing forecast to be drawn down in year remains in line with plan. The cash benefits of reduced forecast capital investment; and the sale of Princess Royal Hospital at £1.2m are offsetting the non-cash I&E benefit of lower than planned depreciation and supporting working capital pressures.

**Owen Williams**
**Chief Executive**

**Gary Boothby**
**Executive Director of Finance**

Calderdale and Huddersfield NHS
NHS Foundation Trust

**Approved Minute**

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## Cover Sheet

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| **Meeting:**<br>Board of Directors | **Report Author:**<br>Kathy Bray, Board Secretary |
| **Date:**<br>Thursday, 1st December 2016 | **Sponsoring Director:**<br>Victoria Pickles, Company Secretary |
| **Title and brief summary:**<br>UPDATE FROM SUB-COMMITTEES AND RECEIPT OF MINUTES - The Board is asked to receive the updates and minutes from each of the sub-committees | |
| **Action required:**<br>Note | |
| **Strategic Direction area supported by this paper:**<br>Keeping the Base Safe | |
| **Forums where this paper has previously been considered:**<br>As appropriate | |
| **Governance Requirements:**<br>Keeping the base safe | |
| **Sustainability Implications:**<br>None | |

## Executive Summary

### Summary:

The Board is asked to receive the updates and minutes from each of the sub-committees:-
Quality Committee - 31.10.16 minutes and verbal update from 29.11.16
Finance and Performance Committee - 1.11.16 and verbal update from 29.11.16
Workforce Well Led Committee - draft minutes from 19.10.16
Nominations and Remuneration Committee (Membership Council) - draft minutes - 18.10.16

## Main Body

### Purpose:

Please see attached

### Background/Overview:

Please see attached

### The Issue:

Please see attached

### Next Steps:

Please see attached

### Recommendations:

The Board is asked to receive the updates and minutes from each of the sub-committees:-
Quality Committee - 31.10.16 minutes and verbal update from 29.11.16
Finance and Performance Committee - 1.11.16 and verbal update from 29.11.16
Workforce Well Led Committee - draft minutes from 19.10.16
Nominations and Remuneration Committee (Membership Council) - draft minutes - 18.10.16

## Appendix

### Attachment:

COMBINED UPDATE FROM SUB CTTEES AND MINS.pdf

# QUALITY COMMITTEE

**Monday, 31st October 2016**
**Board Room, Sub Basement, Huddersfield Royal Infirmary**

## PRESENT

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| Linda Patterson | Non-Executive Director **(Chair)** |
| Rob Aitchison | Director of Operations, FSS Division |
| Helen Barker | Chief Operating Officer |
| Karen Barnett | Assistant Divisional Director, Community Division |
| Gemma Berriman | Deputy Associate Director of Nursing, Medical Division |
| Brendan Brown | Executive Director of Nursing |
| Juliette Cosgrove | Assistant Director of Quality |
| Carole Hallam | Senior Nurse Clinical Governance |
| Lesley Hill | Executive Director of Planning, Performance, Estates and Facilities |
| Andrea McCourt | Head of Governance and Risk |
| Lindsay Rudge | Associate Director of Nursing |
| Jan Wilson | Non-Executive Director |
| Michelle Augustine | Clinical Governance Secretary **(Minutes)** |

| ITEM NO | |
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| 195/16 | **WELCOME AND INTRODUCTIONS**<br><br>The Chair welcomed members to the meeting. |
| 196/16 | **APOLOGIES**<br><br>Asif Ameen — Director of Operations, Medical Division<br>David Anderson — Non-Executive Director / Committee Chair<br>Kirsty Archer — Deputy Director of Finance<br>Stuart Baron — Deputy Director of Finance<br>David Birkenhead — Medical Director<br>Elaine Brotherton — Patient Safety & Quality Lead - FSS Division<br>Diane Catlow — Associate Nurse Director, Community Division<br>Martin DeBono — Divisional Director, FSS Division<br>Jason Eddleston — Deputy Director of Workforce and Organisational Development<br>Tracy Fennell — Associate Nurse Director, Medical Division<br>Anne-Marie Henshaw — Associate Nurse Director/Head of Midwifery, FSS Division<br>Maggie Metcalfe — Matron for Operating Services<br>Joanne Middleton — Associate Nurse Director, Surgery and Anaesthetic Services<br>Lynn Moore — Membership Council Representative<br>Jackie Murphy — Deputy Director of Nursing, Modernisation<br>Julie O'Riordan — Divisional Director, Surgery and Anaesthetic Services<br>Vicky Pickles — Company Secretary<br>Kristina Rutherford — Director of Operations, Surgical Division<br>Nicola Sheehan — Head of Therapies, Community Division<br>Sal Uka — Divisional Director, 7 Day Service/Hospital at Night<br>Ian Warren — Executive Director of Workforce and Organisational Development |
| 197/16 | **DECLARATIONS OF INTEREST**<br><br>There were no declarations of interest to note |
| 198/16 | **MINUTES OF THE LAST MEETING**<br><br>The minutes of the last meeting held on Tuesday, 27th September 2016 were approved as a correct record. |

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| 199/16 | **ACTION LOG AND MATTERS ARISING**<br><br>▪ Invited Service Reviews<br>It was reported that paediatrics have had a peer review and the maternity Royal College of Obstetricians and Gynaecologists (RCOG) report will be deferred to November.<br>**ACTION:** Report to be circulated to the members of the Quality Committee members and presented at the next meeting<br><br>▪ Terms of Reference<br>See 218/16 |
| 200/16 | **CARE QUALITY COMMISSION (CQC) REPORT**<br><br>Brendan Brown (Executive Director of Nursing) reported on the circulated paper (Appendix C1) and the CQC post inspection action plan (Appendix C2). The report gave an update on the delivery of the Trust CQC plan, which is based on the 19 must do and 12 should do actions following the CQC inspection in March 2016.<br><br>The current position of the plan is:<br><br>▪ 3 actions are now complete (green)<br>▪ 28 actions are on track to deliver (amber)<br>▪ 1 action is not progressing to plan (red)<br><br>The CQC Response Group is meeting this afternoon and it is expected that further updates will be given on the progression of the above actions. Opportunities for members of the Response Group to 'go see' are also being agreed at each meeting, and the purpose is to test out, through observation and staff questioning whether actions being introduced are having the desired impact in reality and whether staff are engaged with the processes introduced. Go sees this month are planned for the Clinical Decisions Unit (CDU), Critical care / theatre recovery, Ward 18 (paediatric assessment unit) and maternity (CRH).<br><br>The CQC quality summit took place on Monday 17th October 2016, and was an opportunity to take forward the recommendations from the inspection report with partners from within the health economy and local authority. The Trust action plan was shared and it was agreed that further opportunities would be explored to work collaboratively on some of the system wide issues.<br><br>**OUTCOME**: The Quality Committee supports the approach being taken to deliver and monitor the action plan, and notes the progress to date. |
| 201/16 | **INTEGRATED PERFORMANCE REPORT (IPR)**<br><br>Helen Barker (Chief Operating Officer) presented the circulated Integrated Performance Report (Appendix D) for September 2016.<br><br>There was an increase in overall performance to 68% for the Trust, an improvement of 14% since April 2016. The safe domain has gone below target from green to amber due to a reduction in the percentage of harm free care. Regulatory targets scoring red this month were due to three Clostridium Difficile cases and Emergency Care Standards (ECS) 4 hours performance falling to 94.37% against a target of 95%. The other key targets still scoring red are:<br><br>▪ Summary Hospital-level Mortality Indicator (SHMI) – latest figure is 113.8 against a target of 100;<br>▪ Friends and Family Test (FFT) Community – reporting 87% against a target of 96%<br>▪ Stroke – patients admitted to a stroke ward within 4 hours and scanned within 1 hour is reporting at 69.09% against a target of 90%<br>▪ Complaints – the percentage of complaints closed is reporting at 42% against a target of 100% |

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| | Safe Domain:<br>▪ Falls – Work is ongoing and a go see is being arranged with Portsmouth NHS Trust to observe the work they have done in relation to falls.<br><br>Responsive Domain:<br>▪ Deterioration of Sentinel Stroke National Audit Programme (SSNAP) with stroke – there is a challenge with the Emergency Department (ED) and the radiology team as to which patients are scanned. There is a commitment from radiology that 50% of patients will be scanned within an hour. The medical division have been asked what the criteria would be to get the SSNAP rating from a B to A, and whether this can be afforded. This will be reported next month.<br>▪ Follow-up of backlog in appointment slots – teams have worked hard to reduce the backlog and will formally review in the next two weeks.<br><br>Carter Dashboard:<br><br>▪ Delayed Transfers of Care - It was reported that the Better Care Fund will be holding a summit next week to discuss challenges from the Commissioners.<br><br>**OUTCOME**: The Committee received and noted the content of the report. |
| 202/16 | **Q2 (2016-2017) QUALITY REPORT**<br><br>Andrea McCourt (Head of Governance and Risk) reported on the circulated Quality Report (Appendix E), which is structured into the five Care Quality Commissions domains of safety, effective, experience, responsive and well-led. During Q2, all Commissioning for Quality and Innovation (CQUIN) payments, Quality Accounts and contract requirements were achieved. Highlights from the Q2 report were:<br><br>▪ Safety<br>– Pressure ulcers - work completed on clear definitions of hospital and community acquired pressure ulcers which will enable realistic improvement trajectories to be set<br>– Medicines Management - CQUIN for antimicrobial resistance continues to perform at a high level, 88% against a target of 50%.<br>– Maternity – the Royal College of Obstetricians and Gynaecologists (RCOG) Invited Service Review took place between 26-28 July 2016 with positive verbal feedback - ongoing delivery of maternity CQC action plan, new Maternity Risk Management Strategy and meeting governance structure has been introduced to strengthen governance and learning from incidents and complaints.<br><br>▪ Effective<br>– Hospital Standardised Mortality Ratio (HSMR) shows a notable improvement from 111.62 in Q1 to 108.62<br>– Fractured Neck of Femur – improvement from April 2015 to August 2016<br>– Stroke – Sentinel Stroke National Audit Programme (SSNAP) data shows an improved rating for stroke services from D to B.<br><br>▪ Experience<br>– Dementia – consistently achieving 90% or above in each element of assessment documentation<br>– Improving the patient experience – work continues on the children's voice project, communication on a surgical ward and maternity.<br><br>▪ Responsive<br>– Incidents – increase in incident reporting in community division, against an overall reduction of 5% in incidents reported compared to Q1. Slips, trips, falls and collisions remains the highest incident category reported in both Q1 and Q2.<br>– Complaints – working with divisions to improve complaints being closed in a timely manner, need better understanding of why complaints are being closed late. Training session are planned for ward managers in the next few weeks. The number of re- |

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| | opened complaints is also monitored, and these have reduced.<br>– Claims - small decrease in numbers of claims in Q2<br><br>▪ Well-led<br>– Sickness and absence – this is showing an improved position from Q1 to 4.16% at Q2<br>– Patient and Public Involvement (PPI) – in addition to formal consultation on service reconfiguration, two PPI projects undertaken in Q2 - one on vascular services and one reviewing Accident and Emergency activity with local Healthwatch organisations.<br><br>▪ Sepsis<br>– Work is ongoing to improve sepsis care through documentation, and significant improvement with patients presenting with sepsis and being screened. A deep dive of data will be undertaken to understand the causes of sepsis, and also reviewing compliance with NICE guidance on sepsis. The report will be submitted to the Board of Directors meeting, in the first instance, in November and subsequently presented to the Quality Committee.<br><br>**OUTCOME**: The Committee received and noted the content of the report. |
| 203/16 | **BOARD ASSURANCE FRAMEWORK (BAF)**<br><br>The Board Assurance Framework (BAF) report was circulated (Appendix F1) and reviewed by the Committee. The BAF has developed significantly over the previous 12 months, and is reviewed more frequently and now has greater alignment with the risk register.<br><br>Following discussion at the Board meeting in September, the Hospital Standardised Mortality Ratio (HSMR) risk (as shown in Appendix F2) has been reviewed; however the score will not be reduced until further improvement in the HSMR has been seen. The 7-day services risk (also shown in Appendix F2) has been increased from 12 to 15. This increase in score reflects the fact that we are unlikely to achieve the required standards by end of March 2017.<br><br>**OUTCOME**: The Committee received and noted the content of the report. |
| 204/16 | **PATIENT SAFETY GROUP**<br><br>Juliette Cosgrove (Assistant Director for Quality) presented the circulated Patient Safety Group report (Appendix G), summarising matters discussed at the meeting on Thursday, 6th October 2016. Highlights included:<br><br>▪ Falls – An update was given on falls and the engagement with the medical division on the falls five plan. The focus of the Falls Collaborative was discussed and an update will be provided to the PSG on a monthly basis.<br>▪ Profiling beds and mattresses – Feedback was given regarding concerns on costs to repairing damaged beds and mattresses.<br>▪ Deteriorating Patient Group – Work ongoing with Associate Directors of Nursing (ADN) on timely observations.<br><br>A copy of the minutes from the meeting were also circulated.<br><br>**OUTCOME**: The Committee received and noted the content of the report. |
| 205/16 | **SERIOUS INCIDENTS**<br><br>Andrea McCourt (Head of Governance and Risk) presented the circulated report (Appendix H), which summarised the new and completed serious incidents for September 2016:<br><br>▪ Seven new serious incidents reported to the Clinical Commissioning Group (CCG):<br><br>– 4 falls leading to serious injury |

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| | – 1 delayed diagnosis in the Emergency Department (ED)<br>– 1 death in custody whilst in ED<br>– 1 delay in transfer to mental health bed (joint incident with South West Yorkshire Partnership NHS Foundation Trust (SWYPFT)<br><br>All falls with harm are now reported as red incidents and reviewed at a weekly serious incident panel meeting.<br><br>▪ Three serious incident reports submitted to commissioners during September 2016:<br><br>• STEIS 2016/16566, Datix 132116, missed diagnosis<br>• STEIS 2016/14635, Datix 131970, Delayed observations<br>• STEIS 2016/7028, Datix 129471, medication management<br><br>A case summary of the above reports were also included. Divisions will disseminate the learning from the case summaries via their Patient Safety and Quality Board (PSQB) meetings. The summaries will also be added to the Effective Investigations intranet page – see link - http://nww.cht.nhs.uk/divisions/corporate/quality-and-safety/ei/<br><br>**OUTCOME**: The Committee received and noted the content of the report. |
| 206/16 | **SAFEGUARDING ADULTS AND CHILDREN COMMITTEE REPORT**<br><br>Lindsay Rudge (Deputy Director of Nursing) presented the circulated review of health services for children looked after and safeguarding in Calderdale report (Appendix I2) and a full list of recommendations (Appendix I3), following a planned inspection.<br><br>Action plans were developed following the inspection and will be reviewed by the Safeguarding Committee to ensure they reflect the findings in the final report. The action plans will be submitted to Calderdale Clinical Commissioning Group (CCG) in line with governance arrangements in response to the publication of this report.<br><br>Immediate action has taken place by the Trust to ensure that the Contraception and Sexual Health (CASH) service have effective policy and guidance to support the robust follow-up of those under 18 years old who miss appointments. This has been audited and working well.<br><br>The Safeguarding Committee will review all actions from the report and will be in a position to share these in the next report due at the Quality Committee in January 2017.<br><br>**OUTCOME**: The Committee received and noted the content of the report |
| 207/16 | **RISK REGISTER**<br><br>Andrea McCourt (Head of Governance and Risk) gave an update on the circulated report (Appendix J), which summarised the risks for October 2016:<br><br>▪ Top seven risks:<br>– Progression of service reconfiguration impact on quality and safety<br>– Over-reliance on middle grade doctors in the emergency department<br>– Staffing risk - nursing, medical and therapy<br>– Delivery of Electronic Patient Record Programme<br>– Non-delivery of 2016/17 financial plan<br>– Cash flow risk<br>– Urgent estates schemes not undertaken<br><br>▪ Risk with increased score:<br>– Urgent estates schemes not undertaken has increased from score of 16 to 20<br><br>▪ New risks<br>– Not meeting sepsis CQUIN for 2016/17 – risk score of 16 |

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| | – Patient falls – risk score of 16<br>– Pharmacy Aseptic Unit – risk score of 15<br><br>▪ Risks removed in the last month and being managed on divisional risk registers:<br>– Acting on radiology results – reduced to a score of 12 following the results of a recent audit of the revised process<br>– Failure of high risk medical devices has been reduced to a score of 12 due to improved levels of planned preventative maintenance.<br><br>A copy of the full risk register was also circulated (Appendix J2).<br><br>**OUTCOME**: The Quality Committee received and noted the content of the report. |
| 208/16 | **RISK MANAGEMENT STRATEGY**<br><br>Andrea McCourt (Head of Governance and Risk) presented the circulated Risk Management Strategy (Appendix K) to ensure that it reflects the organisation's approach to the management of clinical risk. At present, there is a risk management policy in place, but no strategy, which is an identified gap. The strategy cover the following areas:<br><br>▪ Vision and Statement of Intent for risk management<br>▪ Components of the Risk Management Strategy<br>▪ Benefits of Managing Risk<br>▪ The Way We Work<br>▪ Risk Appetite<br>▪ Organisational Structure for Risk Management<br>▪ Accountabilities, Roles and Responsibilities and Organisational Framework<br>▪ Systems and Processes for Managing Risk<br>▪ Risk Management Training<br><br>The approval process will be the Audit and Risk Committee, Executive Board and then the Board of Directors. The Audit Committee Chair has been asked for comments and these are being awaited.<br><br>The Quality Committee were asked to review the document and particularly the following:<br><br>– Are the systems and process for clinical risk captured appropriately?<br>– Is the role of the Quality Committee for risk accurate (section 7)?<br>– Are the responsibilities for different areas of risk clear and reflect current governance arrangements?<br>– Any other comments<br><br>The Committee agreed that the wording of 'Associate Divisional Director' is amended to 'Director of Operations' in section 8.7 and that the strategy is reviewed on a yearly basis.<br><br>**OUTCOME**: The Quality Committee received and noted the content of the report. |
| 209/16 | **HEALTH AND SAFETY COMMITTEE REPORT**<br><br>Lesley Hill (Executive Director of Planning, Performance, Estates and Facilities) presented the circulated Health and Safety Committee update (Appendix L) from the meeting held on 21st September 2016:<br><br>▪ Fire Safety Training – training planned and positive feedback received from attendees. However, more staff required to attend the face to face training.<br><br>▪ Health and Safety training to re-commence and dates will be communicated soon.<br><br>▪ Health and Safety – Monthly staff incident reports going to divisions with the recommendation these are discussed at Divisional Patient Safety and Quality Board (PSQB) meetings. There are concerns over the number of staff related slips, trips and |

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| | falls. Action plan being developed to raise awareness.<br><br>▪ Moving and Handling – concerns over training and number of manual handling facilitators in areas. Patient slings are being replaced with disposable slings; awareness campaign to be communicated during implementation phase.<br><br>▪ Sharps – the Health and Safety Executive (HSE) have inspected a number of healthcare Trusts in 2015 however, this did not include CHFT. A number of Trusts have received actions from the HSE and CHFT have established a working group who have reviewed the HSE inspection tools. Support to be provided to divisions to carry out similar inspections with a view to reducing sharps / splash incidents locally.<br><br>▪ Medical Device Training – A number of divisions and departments are low on training, and staff are reminded that if they are not trained they must not use the medical device.<br><br>▪ Staff Side Health and Safety Risks<br>– Conflict Resolution Training – Staff have expressed concerns that the on-line training is not enough, and this has been recognised.<br>– Falls Alarms – a lot of patients seem to be wearing falls alarms who do not need to wear them. The protocol on how alarms are used is to be checked and feedback will be given at the next meeting.<br><br>**OUTCOME**: The Quality Committee received and noted the content of the report. |
| 210/16 | **CLINICAL AUDIT PLAN**<br><br>Juliette Cosgrove (Assistant Director for Quality) presented the circulated Clinical Audit Plan (Appendix M) which gave an update on progress of the audit programme, and an overview of projects from each division.<br><br>Discussion ensued on how to access further information on the audits, and this can be found in the audit report which is associated with the audits. It was also stated that audits can be used as evidence to relate to CQC actions, NICE guidance and NICE Quality Standards, etc. It was also asked if there was any connection with the Quality Improvement programme. The learning from audits was also discussed, and it was suggested that a list of all recommendations from audits should be included in the annual programme.<br>**ACTIONS:** To ensure that the Clinical Audit Group include a column on the plan to show if audits relate to CQC actions, NICE guidance, NICE quality standard, etc, and any other groups which monitor the audits.<br><br>That the learning from audit recommendations are included on the clinical audit annual summary report.<br><br>**OUTCOME**: The Quality Committee received and noted the content of the report. |
| 211/16 | **EMERGENCY CARE REPORT**<br><br>The Emergency Care Report will no longer report to the Quality Committee, as this is now being done through the Finance and Performance Committee.<br><br>**OUTCOME**: The Emergency Care Report to be removed from the Quality Committee's work plan. |
| 212/16 | **CLINICAL OUTCOMES GROUP**<br><br>Carole Hallam (Senior Nurse Clinical Governance) presented the circulated Clinical Outcomes Group report (Appendix O) which highlighted the key issues discussed at the last meeting on Monday, 19th September 2016:<br><br>▪ Clinical Effectiveness and Audit Group (CEAG) – the minutes of the meeting were acknowledged and the chair was noted to be taking action in relation to poor attendance |

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| | ▪ Invited Service Review (ISR) - a meeting to be arranged with the Medical Director and the Medical Division with regard to an action plan following the elderly ISR.<br>▪ Mortality<br>– Hospital Standardised Mortality Ratio (HMSR) (June 2015 - May 2016) = 109.3<br>– Summary Hospital-level Mortality Indicator (SHMI) (April 2015 - March 2016) = 113<br>▪ Care of the Acutely Ill Patient (CAIP) action plan – update on progress of the following elements<br>– Investigating mortality - the June report was circulated and highlighted performance at 40% of deaths reviewed in June. A further update was given on the amount of deaths reviewed in July (33%) and August (23%). The decline in mortality reviews is due to the reliance on senior nurses to undertake investigations, however, mortality reviews are now being built into consultant job plans for the future and it is hoped that an improvement would be evident from March 2017. Although reviews are declining, learning is still being captured which can be used to find out how reviews can be managed differently. Findings are being discussed at divisional Patient Safety and Quality Board (PSQB) meetings; however, progress is still needed in mortality reviews between now and March 2017.<br>– Reliability – overall compliance with completing bundles remains variable but there is now a clinical lead for each of the bundles to progress improvement work.<br>– End of Life care – the draft End of Life Strategy has been written taking into account the recent audit findings and the CQC report findings. A steering group has been set up to implement the policy and action plan.<br>– Frailty – a clinical manager and virtual ward team are scoping patients on the ward suitable for community interventions with 26 early discharges already expedited.<br><br>A copy of the minutes from the last Clinical Outcomes Group was also circulated, along with a copy of the Care of the acutely ill patient (CAIP) Dashboard for September 2016.<br><br>**OUTCOME**: The Quality Committee received and noted the content of the report. |
| 213/16 | **MORTALITY SURVEILLANCE GROUP**<br><br>Carole Hallam (Senior Nurse Clinical Governance) presented the circulated Mortality Surveillance Group report (Appendix P) which highlighted the key issues discussed at the last meeting on Friday, 7th September 2016:<br><br>▪ Percutaneous Endoscopic Gastronomy (PEG) insertion update - Dr Rana (Consultant Physician) presented the annual PEG audit and identified no issues.<br>▪ Pneumonia report - A review of 30 patients with pneumonia has been completed and no preventable deaths were noted.<br>▪ Child deaths - the operation procedure for the Joint Child Death Overview Panel was shared at the meeting. All deaths of children (birth to 18 years) are notified to the Calderdale and Kirklees Safeguarding Children Boards, and it was noted that the majority of expected deaths do not occur in hospital.<br><br>A copy of the learning from mortality reviews report for July 2016 was also circulated.<br><br>**OUTCOME**: The Quality Committee received and noted the content of the report. |
| 214/16 | **CARE OF THE ACUTELY ILL PATIENT REPORT**<br><br>Carole Hallam (Senior Nurse Clinical Governance) presented the circulated Care of the Acutely Ill Patient (CAIP) report (Appendix Q) which is divided into six themes:<br><br>▪ Investigating causes of mortality and learning from findings<br>▪ Reliability in clinical care<br>▪ Early recognition and treatment of deteriorating patients.<br>▪ End of life care<br>▪ Caring for frail patients<br>▪ Clinical coding |

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| | The CAIP programme is a working document and is reviewed with monthly updates to the Clinical Outcomes Group (COG). Discussion ensued on the connection with mortality on the last three reports, and it was agreed that a summary of the mortality plan and metrics will be made available for the meeting in January 2017.<br>**ACTION:** A summary report on mortality is provided for the meeting in January 2017.<br><br>**OUTCOME**: The Quality Committee received and noted the content of the report. |
| 215/16 | **END OF LIFE CARE REPORT**<br><br>Lindsay Rudge (Deputy Director of Nursing) presented the circulated End of Life Care report (Appendix R) updating on developments in the delivery and review of end of life care, as well as a review of the national audit on end of life care, bereavement audit and the Integrated Care of the Dying Document (ICODD) audit. The report also included a draft copy of the End of Life Care Strategy and the dashboard.<br><br>The Trust's findings from the national care of the dying patient audit show a deterioration in performance in relation to the national average, in the time between formal recognition that someone is dying and their eventual death, and evidence of documentation on the holistic assessment of patients and their family's needs. Training and education in end of life care is being reviewed to ensure successful implementation of all three priorities in the strategy: enhanced and advanced communication skills, an awareness of and recognition of the 12 months of life, and recognition of the dying phase and the role of the individualised care of the dying document to support patient care.<br><br>The Strategy will be taken to a system-wide engagement event in December 2016 or January 2017 to obtain sign-up and agreement of the implementation plan.<br><br>**OUTCOME**: The Quality Committee approved the content of the draft strategy. |
| 216/16 | **PATIENT EXPERIENCE AND CARING GROUP REPORT**<br><br>It was reported that the last Patient Experience and Caring Group meeting was not a formal meeting and focussed on the actions from the CQC report. The next report will outline what took place at the informal meeting and the results of the Friends and Family Test (FFT). |
| 217/16 | **QUALITY ACCOUNT - REVIEW OF PROGRESS**<br><br>Andrea McCourt (Head of Governance and Risk) presented the circulated Quality Accounts Report (Appendix T) which includes progress against the three local quality account priorities for 2016/17 agreed with our membership councillors:<br><br>▪ Safety - Reducing falls through the implementation of safety huddles – these will continue to be rolled out to 14 wards selected for high numbers of patient harms<br>▪ Effectiveness - Implementation of Hospital Out of Hours Programme (HOOP) to reduce mortality – the system will go live at CRH in November, and in December at HRI.<br>▪ Experience - Improving Patient Experience in the Community - The division has developed a specific feedback questionnaire in one clinical team - physiotherapy, which will enable assurance and measurement of patient experience and will be formally reported through the divisional Patient Safety and Quality Board (PSQB) meetings.<br><br>**OUTCOME**: The Quality Committee noted progress against the three priorities and that progress is on track. |
| 218/16 | **TERMS OF REFERENCE**<br><br>An updated copy of the terms of reference was circulated to the Quality Committee (Appendix U) for further review and amendments made (highlighted in red).<br><br>Discussion ensued on reviewing the work plan, membership, quorum and that Divisional Directors should be in attendance at the quarterly divisional report meetings. |

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| | **ACTION:** The chair, company secretary and assistant director of quality to meet to review<br>**ACTION:** To separate the roles of Executive Director of Nursing & Operations |
| 219/16 | **QUALITY COMMITTEE MEETING DATES 2017**<br><br>A copy of the meeting dates for 2017 were circulated for information. It was suggested that once a quarter, a meeting takes place on the Calderdale site. |
| 220/16 | **INFECTION CONTROL COMMITTEE**<br><br>A copy of the Infection Control Committee minutes from Tuesday, 18th October were circulated (Appendix W) for information.<br><br>**OUTCOME**: The Quality Committee received and noted the content of the minutes. |
| 221/16 | **MATTERS TO BE REPORTED TO THE BOARD OF DIRECTORS**<br><br>▪ Plan on sepsis to be presented to the Board of Directors next month<br>▪ Review of health services for children looked after and safeguarding in Calderdale report was submitted to the Quality Committee and assured that action plan is in place.<br>▪ Revised draft of the End of Life Strategy approved and will be submitted to the Board of Directors meeting in January<br>▪ The first Risk Management Strategy was submitted to the Quality Committee |
| 222/16 | **QUALITY COMMITTEE WORK PLAN**<br><br>A copy of the Quality Committee work plan was circulated (Appendix X) for information.<br><br>**OUTCOME**: The Quality Committee received and noted the content of the work plan |
| 223/16 | **ANY OTHER BUSINESS**<br><br>There was no other business. |
| | **NEXT MEETING**<br><br>Tuesday, 29th November 2016<br>2:00 – 5:00 pm<br>Board Room, Sub-basement<br>Huddersfield Royal Infirmary |

# Minutes of the Finance & Performance Committee held on Tuesday 1st November 2016 at 9.00am in Meeting Room 4, Acre Mill, Huddersfield Royal Infirmary

**PRESENT**

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| Helen Barker | Chief Operating Officer |
| Gary Boothby | Director of Finance |
| Lesley Hill | Director of Planning, Performance and Esates & Facilities |
| Richard Hopkin | Non-Executive Director |
| Phil Oldfield | Non-Executive Director (Chair) |
| Ian Warren | Director of Workforce & Organisational Development |
| Jan Wilson | Non-Executive Director |

**IN ATTENDANCE**

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| Kirsty Archer | Assistant Director of Finance |
| Stuart Baron | Assistant Director of Finance |
| Sue Burton | Project Director |
| Andrew Haigh | Chair of CHFT |
| Mandy Griffin | Interim Director of Health Informatics |
| Brian Moore | Membership Councillor |
| Victoria Pickles | Company Secretary |
| Betty Sewell | PA (Minutes) |

**ITEM**

**150/16 WELCOME AND INTRODUCTIONS**

The Chair welcomed Gary Boothby to the meeting as Director of Finance.

**151/16 APOLOGIES FOR ABSENCE**

Apologies for absence were received from:
Anna Basford – Director of Transformation & Partnerships
David Birkenhead – Medical Director
Brendan Brown – Director of Nursing
Owen Williams – Chief Executive

**152/16 DECLARATIONS OF INTEREST**

There were no declarations of interest.

**153/16 MINUTES OF THE MEETINGS HELD 26 SEPTEMBER 2016**

The minutes of the last meeting were approved as an accurate record with the following amends:-
Page 2 – Correct the spelling of Helen Barker's name.
Page 4 – Second paragraph should read: "It was acknowledged that any CIP for 2016/17 would be deferred….."
Page 6 – 146/16: Should read: "…..the financial position of the Trust at the end of August 2016…."

**141/16**: Director of Operations took the opportunity to update the Committee with regard to the Accelerator Zone, Helen confirmed that we have submitted two bids

which have been rejected, as it stands at the moment we are not planning to do anything extra than originally planned.

With regard to the removal of the System Resilience funding a formal QIA is being worked up to be presented to the System Resilience Group to show the impact this would have on quality.

**154/16 MATTERS ARISING AND ACTION LOG**

**Action Log**

**142/16:** The Director of Finance confirmed that reserves have been built into the monthly Finance Report – **action closed**.

**143/16:** The Director of Finance confirmed that NHS Improvement (NHS I) are aware of our capital position – **action closed**.

In terms of EPR and the delayed notices, it was noted that conversations have taken place, however, there was nothing to report back to this Committee at this time.

**144/16**: Duty of candour – It was noted that a process is now in place which will be monitored on a weekly basis with Divisions – **action closed**.

PHH & C-Section – It had been established that within the IPR the internal stretch target not the national target had been reported. In future the national target will be reported in the IPR and both the internal and national target will be reported in the weekly divisional performance meetings – **action closed**.

#NoF – Contact has been made to arrange a 'go-see' early in December – **action closed.**

Level of IPR reporting – This will be covered at the next Board timeout – **action closed.**

**Matters Arising**

**029/16 : SAFER Programme Star Chamber** –

The Chief Operating Officer announced that a formal Star Chamber for the SAFER Programme had taken place on the 19 October and reported from the presentation from that session. The panel included the Chief Operating Officer from Airedale, Stacy Hunter, who provided an external perspective. Helen Barker reported the latest position which included the confirmation that Ward 14 had been closed recently and staffing for the Community Place ward had been agreed at the latest Vacancy Control panel. It was noted that there is a more robust process going forward for key deliverables, the challenge for this year is the length of stay within Surgery and the division are working through the proposals of which wards to decommission. It was also noted the bed retraction plan for gynaecology at Calderdale had been deferred until the Community Place ward is established.

The Chief Operating Officer assured the Committee that if the right cohort of patients were not available to occupy a Community Place ward, which would be an active social care phase to try to get patients home, it will only take a week to flip back to a Medical ward. It was confirmed that East Lancs have a similar model and the team have had a 'go see'.

It was agreed that it was a good initiative and that the Star Chamber had been a very productive session with the external representative from Airedale adding challenge and value. As a consequence, there will be further collaboration between both operational teams.

**ACTION**: A review of progress to update the Committee will take place January 2017 - **HB**

**Carter Review**

Project Director, Sue Burton, presented the paper which updated the Committee with regard to progress against the plan to deliver the recommendations in the Lord Carter of Cole's reports which supports the required CIP savings.

The paper provided assurance that there is currently no risk to delivery of any planned efficiency savings associated with delays by other NHS agencies. The Trust continues to focus on the 'top 10' services, all clinical divisions have had a different approach but they are all being proactive.

The Committee noted the contents of the paper.

**FINANCE AND PERFORMANCE**

**155/16 MONTH 6 FINANCE REPORT**

The Assistant Director of Finance, Kirsty Archer, took the Committee through the Finance Report for Month 6, the following headlines were noted:

YTD

- The I&E position is slightly ahead of plan.
- The income position continues to be above planned levels.
- CIP is also ahead of plan.
- The combined benefits of income and CIP are absorbing expenditure pressures.
- Contingency reserves are being held back to mitigate against pressures in the latter part of the year.
- With regard to SRG funding, in full year terms, we are assuming we will not receive £800k of this funding.
- The conditions to secure the receipt of the Strategic Transformation Funding (STF) for the first six months have been achieved.
- Cash year to date is £1m above plan purely due to timing.
- Aged debt has increased from last month to £4.98m. The increase is driven by Hepatitis C drug charges to NHS England, care packages and overtrade invoices to Commissioners out of the area, payments are being pursued.

The Chief Operating Officer informed the Committee that SRG funding had been included as a separate line in the submission relating to the Accelerator Zone, in addition we are not anticipating taking any capacity out whilst in the process of completing the QIA.

Discussions took place with regard to the Aged Debt and the cash position and how realistic it is to correct the adverse variance for both debtors and creditors. It was noted that with regard to our creditors, at the end of the month all invoices authorised had been paid to suppliers, some of the outstanding creditors relate to specific queries on invoices and payment is not being released until the queries have been resolved. It was acknowledged that some of the increases in outstanding debt relate to the positive actions we have taken, such as raising over-trade invoices earlier than previously. It was also noted that one of the significant improvements

which has taken place over the last month has been the compromise agreement with Bradford Teaching Hospital FT to settle outstanding debts going back to 2014/15 and 2015/16.

It was agreed that there was a lot of good work happening with cash management but it is important for the Committee to note that working capital is adrift and it is hoped that over the next few months improvements will be seen.

The Director of Finance suggested that Cash should retain the score of 20 on the Risk Register

Forecast

- We continue to forecast achievement of a £16.1m deficit and control total, which excludes any additional costs or loss of income around the EPR implementation.
- Divisions are required to deliver recovery plans and further savings of at least £2m will be required.

The Director of Finance confirmed that following the closure of Month 7, the additional risks would be reviewed further.

Workforce

A downward trajectory for agency has been reported for September, however, a revised trajectory to year end has recently been submitted to NHS I and the Trust will be held to this commitment. The Director of Workforce & Organisational Development confirmed that a full detailed plan forms part of the Divisional Performance Review Meetings (PRM), to ensure we achieve this trajectory and vacancies are being challenged. It was agreed that a highlight report would be provided for the Committee at the next meeting.

It was noted that with regard to the full year impact of the Junior Drs contract this had been estimated at between £650k and £900k full year effect, however, no other organisation throughout West Yorkshire had been able to quantify. In terms of the CQC inspection, various meetings have taken place and costs this financial year are likely to be minimal.

The Director of Finance confirmed that with regard to EPR, conversations have taken place with NHS I to inform them that our year-end is likely to be an additional £3m through I&E. Whilst we have issues with regard to the implementation date, conversations have taken place with regard to being on track, we have suggested that £3m this year/£2m next. On track with £16.1 + £3m.

NHS I are also fully aware of our capital programme to spend £27.6m plus an extra £5m EPR, which includes the potential Cerner penalties.

## STRATEGIC ITEMS

**156/16 CIP 2017/18 AND BEYOND**

The Director of Finance took the Committee through the paper which gave an update on the progress and development of CIP for 2017/18 and beyond. Gary Boothby explained that as part of the original five year strategic plan, £12.1m had been identified as the savings total for 2017/18. However, there has been movement away from the original planning assumptions with a revised CIP target of £17m for 2017/18.

The scale of the 2017/18 challenges were outlined which included new pressures relating to CNST, Junior Doctors contract, EPR and the Apprenticeship levy. In summary, setting a CIP challenge of 4.5% or £17m is likely to be considered acceptable but would require a number of actions and caveats to be agreed with NHS I.

With regard to progress to date, work has taken place between the finance and PMO team reviewing the scale of high level opportunities, some of this information has been shared with the wider organisation and senior divisional teams at a two day planning workshop in October with a follow up day planned for 9th November. From a PMO process perspective, the high level opportunities will be developed into firmer ideas by the end of December with a view to having detailed robust plans by the end of March. Particular focus will be on cost out rather than income growth.

The Chair of the Committee appreciated the early sight of CIP which is a massive improvement in approach and deliverability. It was acknowledged there are challenges and it is very much work in progress.

The Director of Workforce & Organisational Development stressed that the risk assessment element of the report would be critical.

**ACTION**: The Committee requested a further update in January as plans develop – **AB/GB**

**157/16 EPR HIGHLIGHT REPORT & EPR UPDATE**

Firstly, the Assistant Director of Finance, Stuart Baron answered a question which was raised earlier in the meeting and confirmed that the original business case outlined a £30.2m saving split between cash releasing benefits of £26.4m and £3m for displaced IT systems.

Stuart went on to update on the key messages within the report as follows:-

- The Trust are working to a March 2017 go-live date, which gives more financial certainty and work has taken place to quantify this position.
- There will be an additional cost pressure for the Trust moving the go-live date from November to March.
- The operational impact of the EPR is being worked on to support the March go-live date.
- Financial pressure in month – YTD we remain ahead on our capital plan.

- Trusts are exploring options with Bradford for capitalisation of costs and the carrying value of the EPR. A further update will be provided to the Committee in due course.
- Work continues to deliver the operational plan to mitigate the impact of the EPR deployment.

Work with Bradford will continue to finalise a forecast plan for the March go-live in time for Month 7 reporting.

The Director of Health Informatics added with regard to the finances that following the Assurance Board there is still work to be done with regard to the effect on CHFT should there be any further delay by Bradford and their go-live date. This has been raised with Bradford and there should be a better understanding within the next 6 weeks.

It was noted that with regard to the three critical areas for go-live in March, namely data migration, e-prescribing and order coms progress is being made towards positive results. The main concern relates to Pathology and order coms, however, there is no reason to suggest that this will impact on a March go-live. The other area which is causing concern is training and the shortage of rooms and training materials.

A meeting with regard to the clinical risk still needs to take place with the main concern being around training which needs to happen in January for a March go-live.

In summary, the following points were noted:-

- March go-live is anticipated, subject to results of trial-load 3 and issues around order coms
- Clinical and Operational Risk Assessments around training to be confirmed
- Bradford go-live in July not yet confirmed
- CHFT issue – who will pick up costs for Bradford post go-live

**GOVERNANCE**

**158/16 INTEGRATED PERFORMANCE REPORT**

The Chief Operating Officer reported the key points from a finance and performance perspective as follows:-

The overall position for September is a slight improvement from the previous month. The two regulatory targets which are red relate to CDiff and ECS but we are not anticipating any challenge to our STF fund. A matrix on the Carter Dashboard relating to 'Care Hours per Patient Day' needs clarification and understanding. Our length of stay is improving which is positive and a credit to the team. It was noted that following a difficult meeting between Calderdale CCG had the local authorities with regard to the Better Care Fund a summit has been called and Helen Barker, Brendan Brown and Karen Barnett have been asked to attend. With regard to theatre utilisation, a detailed piece of work with the Surgical division has resulted in an alternative approach which will be introduced and monitored over the next six months.

It was also noted that there is a financial penalty relating to one <60 minute delay for an ambulance turnaround, however, the Committee were assured that at a meeting with the YAS team it was confirmed that this is not usually the case and as a Trust we usually perform well in this area. From a Stroke perspective a deep-dive was taken to Performance WEB last week and following that a proposal to deliver scans within an hour has been agreed between the Medicine Division and Radiology. With regard to our national audit data for stroke, we dipped from a 'B' to a 'C' this month, which relates to scans within an hour and access to the department, quite a number of transfer of care delays sits within the stroke bed base which is challenging.

It was noted that the flu campaign is doing well overall for CQUIN it is only front-line staff, which counts and is still a challenge. Sepsis is an area for concern for full achievement and a paper will be developed for Board.

The Committee noted the contents of the report.

**159/16 REFERENCE COSTS KEY FINDINGS**

The Assistant Director of Finance, Kirsty Archer talked the paper which concentrated on the Reference Cost feedback from the national collection. The feedback has allowed us to benchmark our activity and costs against the average for all submissions. From the benchmarking exercise our overall Reference Costs index is 99.9%, which means that we are exactly where we would expect to be. Focusing on our costs, the single largest area of activity is non-elective inpatients, accounting for just over a third of costs.

Although the total Trust costs are in line with national averages, there are areas where costs vary significantly and discussions took place with regard to length of stay, the number of medical rotas, the size of wards and the clinical engagement required for reconfiguration.

The Director of Finance confirmed that we have not be selected to be audited next year

The Committee noted the output of the submissions.

**160/16 BOARD ASSURANCE FRAMEWORK RISK REGISTER**

The Company Secretary highlighted three risks on the Risk Register monitored by this Committee.

Following discussions the following risk levels were agreed:-
Item 5 – Failure to successfully implement the Trust's EPR project – Hold at 15
Item 10 – Failure to achieve local and national performance targets – Hold at 16
Item 15 – Failure to deliver the financial forecast position – Hold at 15

In addition:
Item 19 – Failure to maintain a cash flow is a new risk at a score of 20

**161/16 MONTH 6 COMMENTARY TO NHS IMPROVEMENT**

The Committee received the paper which provides the Management Commentary on the financial position of the Trust at the end of September 2016 which has been

submitted to NHS I. It was noted that contrary to previous month's submissions there is no difference between internal and external reporting of the STF due to timing

The Committee noted the contents.

**162/16 WORK PLAN**

The Work Plan was received and noted by the Committee.

**163/16 MATTERS FOR THE BOARD AND OTHER COMMITTEES**

The Chair of the Committee highlighted the following items:-

- Control Total
- Forecast
- Cash
- EPR – Private Session
- Reference Costs

**164/16 ANY OTHER BUSINESS**

There were no items raised.

**DATE AND TIME OF NEXT MEETING**

Tuesday 29 November 2016, 9.00am – 12.00noon, Meeting Room 4, Acre Mill Outpatients building.

**CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST**

**Minutes of the WORKFORCE (WELL LED) COMMITTEE held on Wednesday 19 October 2016, 3.00 pm – 5.00 pm in Discussion Room 3, Learning and Development Centre, Huddersfield Royal Infirmary.**

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| **PRESENT:** | |
| David Birkenhead | Medical Director |
| Gary Boothby | Deputy Director of Finance |
| Jason Eddleston | Deputy Director of Workforce and Organisational Development |
| Karen Heaton | Non-Executive Director (Chair) |
| Rosemary Hedges | Membership Councillor |
| Vicky Pickles | Company Secretary |
| Phil Oldfield | Non-Executive Director, (Deputy Chair) |
| Ian Warren | Director of Workforce and Organisational Development |
| Jan Wilson | Non-Executive Director |
| **IN ATTENDANCE:** | |
| Chris Burton | Staff Side Chair |
| Tracy Rushworth | Personal Assistant, Workforce and Organisational Development |

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| 69/16 | **WELCOME AND INTRODUCTIONS:**<br><br>The Chair welcomed members to the meeting. |
| 70/16 | **APOLOGIES FOR ABSENCE:**<br>Asif Ameen, Director of Operations, Medical<br>Helen Barker, Chief Operating Officer<br>Brendan Brown, Executive Director of Nursing<br>Anne-Marie Henshaw, Associate Director of Nursing, Families and Specialist Services<br>Andy Lockey, Director of Medical Education<br>Kristina Rutherford, Director of Operations, Surgery and Anaesthetics<br>Ashwin Verma, Divisional Director, Medical |
| 71/16 | **DECLARATION OF INTERESTS:**<br><br>No declarations of interest were received. |
| 72/16 | **MINUTES OF MEETING HELD ON 14 JUNE 2016:**<br><br>The minutes of the meeting held on 14 June 2016 were approved as a true record. |

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| 73/16 | **ACTION LOG (items due this month)**<br><br>Terms of Reference<br>See item 75.16<br><br>**ACTION:** IW/VP<br><br>Sub-group structure<br>See item 75.16<br><br>**ACTION:** VP<br><br>Board Assurance Framework/Corporate Risk Register<br>Test the role of the Committee in ensuring the Board Assurance Framework / Corporate Risk Register is appropriately maintained.<br><br>**ACTION:** PO/JW/JE/VP<br><br>Visible Leadership: Process and Outcome of First Visits<br>To identify reports to be received by the Committee.<br>**ACTION:** VP<br><br>Human Resources Management Group<br>To consider as part of Terms of Reference review.<br>**ACTION:** IW/VP<br><br>CQC Inspection Update<br>LR to provide the Committee with an update once the final CQC report is received.<br>**ACTION**: LR<br><br>Care of the Acutely Ill Patient<br>To remove from the Committee agenda.<br>**ACTION: TR** |
| | **MAIN AGENDA ITEMS** |
| | **FOR DECISION** |
| 74/16 | **WORKFORCE STRATEGY**<br><br>The draft Workforce Strategy prepared by Jackie Green was shared with the Committee.<br><br>IW presented to the Committee the key elements of the workforce strategy which link into the Trust's 5 Year Strategy goal - A workforce for the future.<br><br>A 'Keep it Simple' theme identified the seven key areas of focus with supporting metrics required to deliver the strategy:<br><br>• Recruitment<br>• Retention<br>• Attendance |

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| | • Engagement<br>• Workforce Planning<br>• Productivity/efficiency (Carter)<br>• Future workforce/talent management<br><br>A 12 month workforce plan is to be developed for each metric to monitor progress.<br><br>The committee welcomed the focus and it was agreed that the Strategy will be presented formally in December 2016 for sign off. The Strategy will then be presented to the Board for approval.<br><br>**ACTION:** IW to develop workforce plans and refresh draft Workforce Strategy.<br><br>TR to add workforce plan to the December 2016 agenda.<br><br>**OUTCOME:** The Committee **RECEIVED** and **NOTED** the presentation. |
| 75/16 | **WORKFORCE (WELL LED) COMMITTEE AND SUB-GROUPS TERMS OF REFERENCE AND STRUCTURE**<br><br>The Terms of Reference had been approved by the Board of Directors, however it was agreed by the Committee that the focus of the Committee should be reassessed to determine its membership and sub-structures. The Terms of Reference would be refreshed and shared with the Committee before being re-submitted to Board for sign off. A picture of the sub-group structure will also be shared at the next Committee meeting.<br><br>**ACTION:** VP/IW to review the Terms of Reference.<br><br>VP to share the Governance reporting structure with the Committee. |
| 76/16 | **WORKFORCE (WELL LED) COMMITTEE WORKPLAN 2016/2017**<br><br>The Committee agreed the workplan should be reshaped to align to the workforce strategy.<br><br>**ACTION: IW/JE**<br><br>**OUTCOME:** The Committee **RECEIVED** and **NOTED** the update. |
| | **FOR ASSURANCE** |
| 77/16 | **NHS IMPROVEMENT SMART PLAN**<br><br>IW reported the Trust's SMART plan in relation to agency spend had been submitted to NHS Improvement (NHSI). IW advised that performance against the plan will be monitored (RAG rated) by the weekly Safer Staffing Utilisation and Efficiency Programme Board which is attended by Directors and the Programme Manager.<br><br>IW confirmed he is in conversation with NHSI and a Trust performance meeting with NHSI is due to take place in November 2016. It was noted the NHSI are to publish a list of Trusts with the highest agency spend. |

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| | **ACTION:** IW to report progress to next Committee meeting.<br><br>**OUTCOME:** The Committee **RECEIVED** and **NOTED** the report. |
| 78/16 | **BOARD ASSURANCE FRAMEWORK**<br><br>VP confirmed the BAF had been submitted to the Executive Board. The workforce elements of the framework were shared with the Committee and in particular noted the risk 'Failure to appropriately engage all colleagues and embed the culture of the organisation across all sites'.<br><br>**OUTCOME:** The Committee **RECEIVED** and **NOTED** the report. |
| 79/16 | **CORPORATE RISK REGISTER**<br><br>The position of the 4 risks were noted by the Committee.<br><br>**OUTCOME:** The Committee **RECEIVED** and **NOTED** the report. |
| | **PERFORMANCE** |
| 80/16 | **WORKFORCE MONTHLY TRUST REPORT (OCTOBER 2016)**<br><br>IW informed the Committee this is a first draft of a refreshed monthly report on key workforce metrics.<br><br>The Committee agreed it wanted to see a more pictorial report. The content should include a 13 month cycle, a 3 month trend and for comparison, 3 years of data.<br><br>Data validation is to be built into the workplan along with KPI links to the strategic elements of the workforce plan.<br><br>IW reported that the Stepchange recommendations are being implemented in the recruitment process. Plan to Committee 8 December.<br><br>**ACTION:** IW to progress amendments to the workforce report**.**<br><br>IW to update the workplan in terms of data validation and KPI links<br><br>JE to invite Rachael Pierce, Resourcing Manager to present to the December Committee meeting.<br><br>**OUTCOME:** The Committee **RECEIVED** and **NOTED** the report. |
| | **INFORMATION** |
| 81/16 | **2015 WORKFORCE RACE EQUALITY SCHEME (WRES)/STAFF SURVEY ACTION PLAN**<br><br>JE updated the Committee on the progress and implementation of the 25 actions. 9 actions have been delivered with 5 more on track. 11 actions are off track and zero actions off track with no plan. JE confirmed the Committee will be kept updated on progress and advised the action plan is retained live on the Trust's intranet. |

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| | The Committee questioned how realistic the deadlines were but agreed the action plan is a good piece of work and links well into the Workforce Strategy. The Committee suggested responsibility for the action plan should sit with one individual.<br><br>**OUTCOME:** The Committee **RECEIVED** and **NOTED** the action plan. |
| | **ITEMS TO RECEIVE AND NOTE** |
| 82/16 | **ANY OTHER BUSINESS:**<br><br>JW requested an update on the progress on the implementation of the Junior doctor contract. JE confirmed that good progress is being made and a cost of £750k had been advised to the Board. The Trust is adhering to the timeline for implementation given by NHS employers. A progress review meeting is to take place in November with regard to cost.<br><br>KH made some suggestions to the format of Committee papers - a front sheet to accompany each paper – highlighting executive summary, recommendations and decision(s) required. The possibility of uploading committee papers onto the BoardPad system is to be explored.<br><br>**Action:** TR to create front sheet replicating Trust standard format and follow up BoardPad use. |
| 83/16 | **MATTERS FOR ESCALATION:**<br><br>There were no matters identified for escalation to the Board of Directors |
| **DATE AND TIME OF NEXT MEETING:**<br><br>Thursday, 8 December 2016, 1.00pm – 3.00pm, Syndicate Room 1, Learning and Development Centre, Calderdale Royal Hospital. | |

# Minutes of the meeting of the Nomination and Remuneration Committee (Membership Council)

## Held on Tuesday 18 October 2016 in the Chair's Office, Trust Offices, Huddersfield Royal Infirmary at 2pm.

**MEMBERS**

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|---|---|
| Andrew Haigh | Chairman and Chair of the meeting (except for part of item 5) |
| Peter Middleton | Lead Membership Councillor and Chair of the meeting (for part of item 5) |
| Eileen Hamer | Staff Membership Councillor |
| Brian Moore | Publicly Elected Membership Councillor |
| Dawn Stephenson | Nominated Membership Councillor |
| Di Wharmby | Publicly Elected Membership Councillor |

**IN ATTENDANCE**

| | |
|---|---|
| Kathy Bray | Board Secretary (minutes) |
| Ian Warren | Executive Director of Workforce and OD |

**Item**

**01/16 APOLOGIES FOR ABSENCE**

Apologies for absence were received from:
Brian Richardson, Publicly Elected Membership Councillor

**02/16 DECLARATIONS OF INTEREST**

There were no declarations of interest to note. All present had declared at the last meeting that they had no interest in applying for a Non-Executive post at the Trust before March 2017 and this position remained unchanged

**03/16 MINUTES OF THE MEETING HELD ON 21 JULY 2016**

The minutes of the last Nomination and Remuneration Committee (Membership Council) meeting held on the 21 July 2016 were accepted as a correct record.

**04/16 MATTERS ARISING**

The Chairman reported that since the last meeting he had spoken to both Phil Oldfield and Dr Linda Patterson and both had confirmed their availability to continue their three-year tenures in the foreseeable future. It was noted that the additional remuneration allowance for the Chair of Finance and Performance had ceased with effect from 1 October 2016**.**

**05/16 DISCUSSION PAPER**

The Chairman introduced the paper which set out that the tenures of three Non-Executive Directors and the Chairman were due to expire in 2017:-

- Andrew Haigh - 6 July 2017
- Dr David Anderson – 22 September 2017
- Prof Peter Roberts – 22 September 2017
- Jan Wilson – 30 November 2017

In line with the constitutional arrangements the Committee were asked to consider:

- Whether or not it wishes to consider an extension to any of the existing posts.
- If not, then permission is sought to go out to advertisement for the vacancies.
- If the Committee does wish to consider extension it should decide how many of the individuals should be given a contract extension (this would be for a maximum of a year).
- If the Committee does wish to consider extension it should consider which individuals should be retained based on required skills and knowledge, and whether further advice on a decision-making process needs to be sought from the Director of

Workforce and Organisational Development for consideration at a future meeting.

The Committee considered the need to stagger the appointment periods so as to maintain continuity and stability on the Board, particularly focusing on the challenges being faced by the Trust at the current time. The need to maintain a balance between new appointments and not disrupting the Board was important. The clause in the Constitution which stated that in "exceptional circumstances a Non-Executive Director may serve longer than six years (two three-year terms) and any subsequent appointment would be subject to annual re-appointment)" was discussed.

It was noted that all four colleagues had indicated that they would be interested in serving a further tenure, with the exception of Dr David Anderson who had indicated that he may wish to serve a further one-year term and this would be confirmed in early 2017.

The Committee agreed to initially consider the tenure of the Chair and then Andrew Haigh would be asked to return to the meeting in order to discuss the other three Non-Executive Director tenures.

At this point in the meeting Andrew Haigh left the meeting. As Lead Membership Councillor, Peter Middleton chaired the meeting.

It was noted that in July 2017 the Chair will complete 6 years' tenure and therefore under the Constitutional arrangements the Committee could offer a further 1 year tenure (subject to ratification by the Membership Council).

The Committee considered the qualities, skills and knowledge of Andrew Haigh, along with the satisfactory appraisal which had been received by the Membership Council at its meeting on 6 July 2016. Under the present challenges facing the Trust such as potential hospital reconfiguration, the impact of WYAAT / STP / Accelerator Zone work and the need for more collaborative working, together with the implementation of the Single Oversight Framework, it was felt that to maintain stability in the Board of Directors, the Trust should offer a further one-year tenure to Andrew Haigh to continue his role as Chair.

**OUTCOME: The Committee considered the tenure of the Chair and agreed that due to the challenges facing the Trust over the next 12 months that the offer of a further one-year tenure be made to Andrew Haigh, effective from July 2017 (subject to ratification by the Membership Council at its meeting on the 9 November 2016).**

At this point the Chair returned to the meeting and resumed the Chair role.

Discussion took place regarding the other three Non-Executive Director tenures and it was noted that under exceptional circumstances it was possible to offer a further one-year tenure to any of the Non-Executive Directors. The Committee agreed that now that the Chair tenure had been agreed there was no urgency in agreeing the other tenures and therefore this decision was deferred until the next meeting to be held in February 2017. All present agreed that in order to maintain continuity and stability, a minimum of one Non-Executive Director would be recommended to roll over for a further 12 month period.

**OUTCOME: The Committee agreed to defer the decision regarding the three Non-Executive Director tenures until the next meeting to be held in February 2017, but in order to maintain continuity and stability during a time of considerable challenge for the Trust it was agreed that a minimum of one Non- Executive Director would be recommended to roll over for a further 12 month period.**

**ACTION: IW**

**The Director of Workforce and Organisational Development agreed to continue to offer advice and would establish a process for the Committee to enable them to make a decision at their next meeting in February 2017.**

**06/16 ANY OTHER BUSINESS**

Executive Director of Finance – It was noted that Keith Griffiths, Executive Director of Finance had been successful in being appointed to the post of Director of Sustainability at East Lancashire Teaching Hospitals and would be leaving the Trust at the end of October 2016. Those present wished Keith all the best for the future and it was noted that in the interim Gary Boothby would be taking on the role of Executive Director of Finance for 6 months.

**07/16 DATE AND TIME OF NEXT MEETING**

To be confirmed February 2017.

The Chairman closed the meeting at 4pm.