Meeting of the Board of Directors

To be held in public

Thursday 26 March 2015 from 1:30pm

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

AGENDA

1.	Welcome and introductions:- Mrs Linda Wild, Publicly Elected Membership Councillor Mrs Eileen Hamer, Staff Elected Membership Councillor	Chairman	
2.	Apologies for Absence: Dr Linda Patterson, NED Ms Julie Hull, Executive Director of Workforce and OD	Chairman	
3.	Staff Story – "Changes in Community" presented by Diane Catlow, Lead Directorate Nurse – Families Senior Clinical Locality Manager	Executive Director of Nursing & Operations	**PRESENTATION**
4.	Declaration of interests	All	**VERBAL**
5.	Minutes of the previous meeting ▪ Held on 26 February 2015	Chairman	**APP A**
6.	**Action Log and Matters arising:** a. Voluntary Redundancy Scheme Update b. Rule 28	Chairman Executive Director of Finance Director of Nursing & Operations	**APP B** **VERBAL** **VERBAL**
7.	**Chairman's Report:-** a. West Yorkshire Chairs Meeting – 10.3.15 b. Update on meetings with local Chairs	Chairman	**VERBAL**
8.	**Chief Executive's Report:-**	Chief Executive	**VERBAL**
Keeping the base safe			
9.	**Integrated Board Report** - Responsive - Caring - Safety - Effectiveness	Executive Director of PPEF Executive Director of Nursing Executive Director of Nursing Executive Medical Director	**APP C**

	- Well Led - CQUINs - Monitor Indicators - Community - Finance Financial Position Update – Month 11	Executive Director of Workforce and OD Executive Director of Nursing Interim Director of Operations Executive Director of PPEF Director of Finance Executive Director of Finance	**APP C2**
10.	Board Assurance Framework	Company Secretary	**APP D**
11.	Risk Register	Executive Director of Nursing & Operations	**APP E**
12.	Care of the Acutely Ill Patient	Executive Medical Director	**APP F**
13.	Director of Infection Prevention and Control Report	Executive Medical Director	**APP G**
14.	Nursing and Midwifery Staffing – Hard Truths Requirement	Executive Director of Nursing & Operations	**APP H**
15.	Governance Report a. Use of Trust Seal – Oct 2014 – March 2015 b. Board Workplan c. Monitor Q3 Feedback	Company Secretary	**APP I**
Improvement and innovation through strategic alliance			
NO ITEMS			
Transforming Care			
16.	**Update from sub-committees and receipt of minutes** ▪ Quality Committee (Minutes of 24.2.15 and verbal update from meeting held 24.3.15)		**APP J**
Date and time of next meeting Thursday 23 April 2015 at 1.30pm Venue: Boardroom, Sub-basement, Huddersfield Royal Infirmary HD3 3EA.			

Resolution

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

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th March 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 26.2.15 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 26 February 2015.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

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

Appendix

Attachment:

APP A - MINS - public bod minutes - 26.2.15.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 26 February 2014 in the Boardroom, Huddersfield Royal Infirmary

PRESENT

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

IN ATTENDANCE

Anna Basford	Director of Commissioning and Partnerships
Kathy Bray	Board Secretary
Nick Blenkin	Member of the public (observer)
Victoria Pickles	Company Secretary CRH)

Item

18/15 APOLOGIES FOR ABSENCE AND INTRODUCTIONS

There were no Apologies to note

The Chairman welcomed everyone to the meeting.

19/15 PATIENT/STAFF STORY

Catherine Briggs, Matron, Medical Division, attended the meeting to share with the Board a patient story regarding an elderly patient who had been in hospital awaiting discharge to social services (green cross patient).

The Board heard about the admission of Molly (names were changed for the purposes of the presentation), an 80 year old patient with dementia through Medical Admissions Unit. She was subsequently transferred to Ward 4 for further investigations into her dehydration and malnutrition. Due to her confused state 1:1 nursing was necessary. At the end of October a Social Worker was requested and at that time her discharge was agreed. Molly's family were in agreement to her transferring to a nursing home. A panel meeting was held on the 6 November and feedback from this was received on the 19 November. A number of nursing home representatives visited the hospital to assess her but due to a deficit in the funding and the availability of an elderly mental illness bed this was proving difficult. On the 20 December there was no 1:1 nurse available and unfortunately Molly got out of bed and sustained a fall, but made a good recovery. Eventually, on the 19 February 2015 Molly was discharged to an EMI bed in a nursing home near her husband and has settled in well.

The Director of Nursing and Operations advised that this was not an unusual story. Concern was expressed by the Board that similar delays in discharge of green cross patients was challenging for the Trust and asked what could be done to alleviate this, bearing in mind the likely increase in patients with complex multi-conditions in the future. Following discussion it was felt that if the Trust is successful with the Care Closer to Home procurement process it would have more influence in the pathway for such cases.

The Board thanked Catherine for her presentation.

20/15 DECLARATION OF INTERESTS

There were no declarations of interest to note.

21/15 MINUTES OF THE MEETING HELD ON THURSDAY 29 JANUARY 2014

The minutes of the meeting were approved as a true record. The Chairman thanked the minute takers for preparing the minutes from the video-conference meeting.

22/15 MATTERS ARISING FROM THE MINUTES

a. 183/14a Voluntary Redundancy Scheme

The Executive Director of Workforce & Organisational Development advised that 514 applications had been received and to date 137 had been approved. The Executive Director of Finance reported that discussions were due to take place with Monitor, the Regulator, to discuss the financial position and effect on the Trust's cash position and risk rating. It was expected that there would be a payback period from the scheme in around 12 months. It was noted that the full position would be available in March 2015 and would be brought to the Board.

ACTION: BOD Agenda Item – March 2015 (JRH/KG)

The Chief Executive stressed that it was important that there was no incremental creep with increases in staffing and thanked everyone for their help in keeping staff on board during this challenging period.

23/15 ACTION LOG

a. **Intelligent Monitoring Report**

The Executive Director of Nursing and Operations advised that the CQC had acknowledged that greater clarity should be given over how the indicators will be applied. There had been a change in the CQC Relationship Manager and therefore it was not possible to confirm a timescale as to when this information would be available. All present agreed that this item should be removed from the Action Log.

ACTION: Remove from Action Log

24/15 CHAIRMAN'S REPORT

a. Informal MC/NED Workshop – 12.2.15 - The Chairman reported that although only a limited number of Membership Councillors had attended, this had proved to be a helpful meeting with open and free flowing debate. Feedback from the Membership Councillors was that they would like further meetings with a similar format. The Chairman would be discussing this further with the Deputy Chair and Associate Director of Engagement and Inclusion.

25/15 CHIEF EXECUTIVE'S REPORT

a. Institute for Fiscal Studies – Green Review - The Chief Executive reported that he had included this item on the agenda to draw the Board's attention to this annual review produced by the IFS and ICAEW which aimed to improve public debate about the fiscal position over the next 5 – 10 years and provided an independent analysis to further enrich debate around public finances in the future. The Board discussed the

fact that if NHS was ring-fenced then other departments would be affected significantly.

Discussion took place regarding the recent media announcement regarding the allocation of £6 billion of NHS funding to Greater Manchester and the Greater Manchester Hospitals alliances with the local authority and social services. The Chief Executive reported that a meeting of West Yorkshire Chief Executives and Local Authority Chief Executives was due to be held in March to discuss future provision.

26/15 INTEGRATED BOARD REPORT

The Executive Director of Planning, Performance, Estates and Facilities introduced the performance report as at 31 January 2014 and explained that each area would be presented in detail by the appropriate director.

Responsive - the Executive Director of Planning, Performance, Estates and Facilities highlighted to the Board the key issues from the executive summary commentary:-

- During January the Trust had over-performed on non-elective care. This had led to bed pressures resulting in both delays in discharging patients, and also increasing the number of outliers. There had been a significant number of surgical outliers at the start of the month, and this switched to medical outliers by the end of the month. This had continued into February. The increase in emergency patients, and the slow down on the movement of patients out of the hospital had also affected the Trust's A&E 4 hour wait target. In January the Trust achieved 91.89%, and the position to 15th February was 92.42% for quarter 4.
- The snow during January affected the DNA rates, which rose in month. This was against the recent trend where we have seen DNA rates slowly falling.
- There were still capacity issues in MRI and endoscopy creating problems for diagnostics being undertaken within the 6 weeks target. It was anticipated that the problems would be resolved by the year end.

Caring and Safety – the Executive Director of Nursing reported:-

- **A/E 4 hour response rate** – The Trust had not met its 4 hour A/E wait target for the quarter and year end position. Every effort was being made to improve performance during March although it was recognised that there was a risk that the full year target would not be met. Plans were in place to put measures in place to address internal processes i.e. review of front of house arrangements at certain parts of the day and a transfer team had been put in place. Thanks were given to staff for their help throughout this challenging period.
- **Complaints** – There had been a rise in the number of complaints reported in January which was felt to be due to seasonal adjustments. Complaint response times were beginning to improve but there was still a lot of work to do.
- **Family and Friends** – Work was still being undertaken to put a different system in place. The response rate was below target and staff were aware that the Trust needed to improve Family and Friends feedback.
- **Rule 28** – The Executive Director of Nursing reported that the Trust had received a Rule 28 from the Coroner, reporting that the nursing and clinical documentation reviewed as part of a case was not good enough. The Board asked for a timeline of this incident and whether it related to the CQC review of documentation undertaken in 2012. The Executive Director of Nursing and Executive Medical Director were discussing this further.

ACTION: BOD agenda item – March 2015 (JD)

Effectiveness – The Executive Medical Director reported**:-**

- **Mortality** – It was noted that the SHMI had slightly improved to a position of 110 based on June 2014 rebased figures. This has reduced from the 111 figure published in March 2014.
- **Fractured Neck of Femur** – Due to availability of theatres and orthopaedic surgeons the Trust was not meeting the target of 85%. An action plan was in place to address this.

Well Led – the Executive Director of Workforce and Organisational Development reported:-

- **Well Led Group** – The group had met recently. The Board were reminded of the 5 key lines of enquiry which the CQC would apply to all investigations.
    1. A clear vision and credible strategy to deliver good quality
    2. Governance Framework – responsibilities are clear and quality, performance and risk understood and managed.
    3. Leadership culture to reflect vision and values, encourage openness and transparency and promote good quality.
    4. How are people who use the service and staff engaged and involved.
    5. How are services continuously improved and sustainability ensured.

- **Sickness rates** – Disappointingly both short and long term sickness rates had increased. It was suggested that the percentage drop might be due to the reduction in workforce numbers. Further work was being undertaken by the Divisions to investigate this. The Chief Executive advised that the Trust was considering a deep dive into this issue.
- **Staff Survey** – It was noted that the results of the 2014 staff survey had been published and a link to the report sent to all board members. It was noted that the full results and action plan would be brought to the next meeting.

ACTION: BOD AGENDA ITEM – MARCH 2015 (JRH)

- **Missed Dose Drugs** - Peter Roberts expressed concern regarding the number of missed drugs. The Executive Director of Nursing reported that this could be due to transfer of patients or legitimate missed doses when not required ie. laxatives. This would be reviewed as part of the Rule 28 investigations. Areas of good practice for e-prescribing and bed base (Worthing and Bradford) would be investigated further.

Community – The Executive Director of Planning, Performance, Estates and Facilities reported that a great amount of work had been undertaken to develop the community indicators for both national and local targets. In general, although a lot were showing red, feedback from the Clinical Commissioning Groups was that they were happy with the services being provided and that the Trust may wish to review the targets. An update was received regarding Breast Feeding rates, percentage of women smoking at time of delivery, district nursing and home adaptation equipment and long term conditions compliance.

Dr David Anderson questioned whether the patients who die within preferred place of choice (90% target) referred solely to in-patients or whether this included out-patients. The Executive Director of Nursing agreed to investigate this.

ACTION: EXECUTIVE DIRECTOR OF NURSING

The Board noted the contents of the report regarding:

- CQINS – on track to achieve all targets by year end.
- Monitor Indicators

Finance – the Executive Director of Finance reported on the content within the Integrated Board report and also presented the narrative of the financial position at month 10:-

Summary Year to Date

- Additional activity in month has resulted in bed capacity pressures.
- The level of income protection offered by the fixed value contract stands at £5.06m in the year to date.
- The year to date deficit is £2.09m against a planned surplus of £2.56m.
- Capital expenditure of £17.35m against revised planned £19.05m, an underspend of £1.70m (£6.55m below original plan).
- The cash balance was £18.56m, versus a planned £19.99m, £1.43m lower than planned. A level of loan funded borrowing has supported the cash required for capital investment.
- The Continuity of Service Risk Rating (CoSRR) stands at 3, although underlying performance is at level 2.

Summary Forecast

- The deficit excluding 'exceptional' restructuring costs is forecast to be £1.65m against a planned £3.0m surplus. Due to their exceptional one-off nature, restructuring costs are excluded from the calculation of the CoSRR but these payments will adversely affect the cash balance.
- The year end forecast including restructuring costs is a deficit of £4.76m. This will result in a CoSRR of 2 for the year.
- CIP schemes are forecast to deliver £9.84m against the planned £19.53m. This is a shortfall of £9.69m and will have an impact on 2015/16.
- £1.5m has been committed to extra substantive nurse staffing; additional winter expenditure has been included within the forecast position.
- £1.5m additional income to support quality investments has been received and is reflected in the year to date and forecast position.
- The revised capital forecast, is a £22.69m spend, a reduction of £1.62m from the revised plan, (£6.51m lower than original plan).
- The forecast year end cash balance is £13.18m against the planned £22.71m.

RESOLVED: The Board approved the Integrated Board Report

27/15 RISK REGISTER REPORT

The Executive Director of Nursing and Operations reported the top risks (scored 20+) within the organisation which were similar to last month:-

- Finance: breach of licence
- Progression of service reconfiguration impact on quality and safety
- Failure to meet CIP
- Risk of poor patient outcomes due to dependence on middle grades
- Risk of poor patient outcomes and experience caused by blocks in patient
- flow
- HSMR & SHMI
- Overarching risk for Infection Control
- Modernisation Programme: conflicting priorities

It was noted that external work continued to review the risk register through the Risk and Compliance Group.

28/15 DRAFT BOARD ASSURANCE FRAMEWORK

The Company Secretary reported that meetings had taken place with individual Directors to get their input into the first Draft Board Assurance Framework. The Assurance Framework had been developed in line with the three lines of assurance model. It was noted that more details pertaining to each item was available. Discussion took place regarding some of the language used and criteria for scoring. It was suggested that the Risk Register and Board Assurance Framework might have the same format and it was agreed that further discussion would be held outside the Board Meeting with the Executive Director of Nursing and Operations, Company Secretary and other Board colleagues and the outcome reported back to the next meeting.

ACTION: BOD AGENDA ITEM – 26.3.15

29/15 DIRECTOR OF INFECTION, PREVENTION AND CONTROL (DIPC) REPORT

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

- C.Difficile cases – 4 cases had been reported in February. The total number of cases was now 26 – 8 of which were classed as avoidable and 18 unavoidable. It was mentioned that next years' target was likely to be increased to 21 cases.
- 1 MRSA bacteraemia (post admission) had been assigned to the Trust. No reported cases for January or February 2015.
- Aseptic Non-Touch Technique (ANTT) compliance is well below the 95% target and plans have been put in place to improve competency assessments. Current compliance was 66.5% for doctors and 73.3% for nurses.
- Isolation Breeches – due to Norovirus there had been some wards closed which had increased the pressure on beds.

RESOLVED: The Board received the report.

30/15 SAFEGUARDING ANNUAL REPORT 2013-2014

The Executive Director of Nursing presented the key points from the Safeguarding Annual Report which provided an overview of the safeguarding work that has been undertaken over the past year in order to ensure our services are fit for purpose and meet the needs of the Communities we serve. Particular mention was made to the work being undertaken to raise awareness of Mental Capacity and Deprivation of Liberty through training and supervision programmes.

It was noted that the national report into the Saville Enquiry had been published. No evidence had been found that Saville had been present within the Trust during the 1970's and at any time after then.

31/15 UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES

The following information was received and noted:-

- **Quality Committee** – The Board received the minutes of the 27.1.15 and a verbal update from the meeting on 24.2.15 which included:
  - Divisional Patient Quality Reports
  - CQC Plan
  - CIP, Performance, Quality – different approaches by Divisions – need to bring a corporate approach to this.
  - Complaints – upward trend – more work required acknowledged.
  - Appraisal Compliance – balance of timings required when appraisals completed.

- Leadership Walkrounds – “back to the floor” sessions being undertaken by Executive Directors.
- DNA CPR – in preparation for CQC visit – need a solution to co-ordinating, recording/collating information for the Quality Report.

The Chairman reminded the Board that the CQC visit would take place at some time between June and December 2015 and it was requested that pressure points and mitigations/plans are provided to the Board. The Executive Director of Nursing and Operations advised that a CQC/Turnaround Group had been established at director level and would report back to every Board Meeting.

ACTION: BOD to receive an update on CQC preparation via Quality Committee each month.

- **Strategic Health & Safety Committee Minutes** – 27.1.15 minutes received and contents noted.

- **Draft Audit & Risk Committee – 20.1.15** – Prof. Peter Roberts outlined the key issues discussed:-
  - Governance Report
  - Board Assurance Framework
  - Additional Internal Audits – CIP and OBC
  - Local Counter Fraud Work
  - External Audit Plan – discussed and agreed
  - Tour de France – Reimbursement of £200k from the CCG received.

- **Draft Membership Council Minutes – 20.1.15** – received and noted.

- **Risk Management Policy – Version 1** – received and approved.

32/15 DATE AND TIME OF NEXT MEETING

Thursday 26 March 2015 at 1.30 pm in the Large Training Room, Learning Centre, Calderdale Royal Hospital.

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

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Mr Andrew Haigh, Chairman Date

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th March 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: ACTION LOG - PUBLIC BOARD OF DIRECTORS - MARCH 2015 - The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 March 2015	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

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

Appendix

Attachment:

APP B - DRAFT ACTION LOG - BOD - PUBLIC - As at 1 MARCH 2015.pdf

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 March 2015 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
30.10.14 140/14	**PATIENT/STAFF STORY** 30.10.14 - 'Carol's Story' extract video. 27.11.14 – 'Mr P' – Drug Error 18.12.14 – Dr Sarah Hoye 29.1.15 – Dr Mary Kiely – Care of the Dying 26.2.15 – Catherine Briggs, Matron – Green Cross Patient	Executive Director of Nursing	Regular item on BOD Agenda going forward.	Monthly Reports		
18.12.14	**VOLUNTARY REDUNDANCY SCHEME – WORKFORCE PLAN** 27.11.14 – Draft proposal discussed in Private Board Meeting. Discussions to take place with Staff Representatives.	Executive Director of Workforce & OD	18.12.14 – Verbal update received 29.1.15 – Verbal update received 26.2.15 – Verbal update received	26.3.15		
25.7.13 113/13	**HSMR/MORTALITY/CARE OF THE ACUTELY ILL PATIENT** Presentation received from BC & HT. Action Plan discussed. Update on actions to be brought to BOD Meetings on a bi-monthly basis.	Executive Medical Director	Regular Updates to be brought back to BoD as plan progresses (bi- monthly). 26.9.13 – Update on worsened position received. Key themes and actions identified. Agreed that an updated plan would be brought back to the October 2013 BoD Meeting. 24.10.13 – Update and Action Plan received and note. Board endorsed plan and supported its implementation. Regular Updates to be brought back to BoD as plan progresses (bi- monthly). 19.12.13 – Update on progress received. Agreed that updated Action Plan would be brought to the Board in February 2014. 27.2.14 – Further work being undertaken by Divisions – roll out of mortality review process from March 2014 24.4.14 – Update received. 26.6.14 – Update received	March 2015		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 March 2015 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
			25.9.14 – Update received 27.11.14 – Update received 29.1.15 – Update received			
29.1.15 14/15	**QUALITY REPORT** Report received. Feedback welcomed to the Executive Director of Nursing and Operations.	Executive Director of Nursing & Operations	Progress against actions to be reported to the Board in March 2015.	24.4.15		
24.11.11 134/11b.	**APPOINTMENT OF VICE CHAIR & SINED** Role of Vice Chair and SINED split into two. Alison Fisher – Vice Chair and Jane Hanson – SINED. Effective from 1.12.11. To be reviewed October 2012.	Chairman/ Director of Workforce & OD	18.10.12 – Agreed that current arrangements continue for a further 12 months 26.9.13 – Appointments made:- Jan Wilson and Vice Chair, David Anderson, SINED. To be reviewed 25.9.14 25.9.14 – Appointments extended for 12 months for Vice Chair, SINED and Audit & Risk Committee Chair – to be reviewed in September 2015	24.9.15		
29.1.15 13/15	**REVALIDATION REPORT** Update on progress within Trust on medical revalidations and appraisals was received. Revalidation for nurses to be introduced by end of financial year. Information on implementation awaited.	Executive Medical Director Executive Director of Nursing and Operations	1. Full year report to be brought to Board in April. 2. Revalidation for nurses report to be brought to the Board in April.	23.4.15 23.4.15		
95/14 b.	**INTELLIGENT MONITORING REPORT** The Quality Committee had asked the CQC to explain how the indicators would be applied. Agreed that this would be brought back to the BOD at a future meeting.	Executive Director of Nursing & Operations		TBC		**CLOSED AT BOD 26.2.15**

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Catherine Riley, Assistant Director of Strategic Planning
Date: Thursday, 26th March 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: IBR - Integrated Board Report	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: WEB	
Governance Requirements: All	
Sustainability Implications: None	

Executive Summary

Summary:

N/A

Main Body

Purpose:

N/A

Background/Overview:

N/A

The Issue:

N/A

Next Steps:

N/A

Recommendations:

The Board is asked to review and comment on the contents of this paper

Appendix

Attachment:

Integrated Board Performance Report Feb15.pdf

Board Of Directors Integrated Performance Report

Report For: February 2015

THIS

Calderdale and Huddersfield NHS
NHS Foundation Trust

Contents

Executive Summary Commentary

February saw a continuation of overperformance on non-elective workload reported in January. This impacted through the system resulting in:
Delayed discharges
Not achieving % of discharges before 11am
A further increase in outliers
Despite this A/E improved 4 hour performance but were unable to achieve the 95% standard. A/E report this target is now unlikely to be achieved for year end.

The DNA rate has recovered and is now within target.

Capacity in Endoscopy has improved with the appointment of a locum consultant.
Additional mobile MRI capacity has been procured between now and the end of the year.

Report For: February 2015		Indicator Source	Report For: February 2015						Year To Date						Year End Forecast	Data Quality
			Target	Trust	Surgical	Medical	CWF	DATS	Target	Trust	Surgical	Medical	CWF	DATS		
Activity	% Elective Variance	Local	0.00%	-5.93%	-9.69%	1.35%	7.69%	3.33%	0.00%	-8.22%	-8.86%	5.57%	-17.97%	6.33%		
	% Day Case Variance	Local	0.00%	-1.85%	-1.04%	0.87%	-15.61%	-52.50%	0.00%	0.95%	6.07%	-5.07%	-9.81%	-27.53%		
	% Non-elective Variance	Local	0.00%	6.90%	-6.14%	2.80%	16.57%	-	0.00%	0.96%	-6.41%	-0.14%	5.41%	-		
	% Outpatient Variance	Local	0.00%	-0.42%	-0.28%	-0.13%	5.76%	-47.89%	0.00%	-0.34%	-1.97%	-0.07%	5.61%	-6.22%		
RESPONSIVE - Operational Targets	Trust Theatre Utilisation	Local	90.00%	93.30%	92.55%	-	104.60%	-	90.00%	91.94%	91.85%	-	96.58%	-		
	% Daily Discharges - Pre 11am	Local	28.00%	9.22%	11.22%	7.53%	9.35%	-	28.00%	9.27%	11.33%	8.53%	8.64%	-		
	Delayed Transfers of Care	Local	5.00%	5.20%	-	-	-	-	5.00%	5.06%	-	-	-	-		
	Number of Outliers (Bed Days)	Local	0	946	49	897	0	0	0	5933	1118	4815	0	0		
	First DNA Rate	Local	7.00%	6.98%	7.21%	6.05%	7.39%	3.51%	7.00%	7.34%	7.38%	6.73%	7.87%	9.03%		
RESPONSIVE:18 Weeks and Other Access Indicators	% Non-admitted Closed Pathways under 18 weeks	National	95.00%	98.87%	98.71%	99.20%	98.84%	100.00%	95.00%	98.71%	98.72%	98.51%	99.15%	94.84%		
	% Admitted Closed Pathways Under 18 Weeks	National	90.00%	92.17%	91.22%	100.00%	95.77%	93.75%	90.00%	91.85%	90.98%	99.91%	96.20%	76.92%		
	% Incomplete Pathways <18 Weeks	National	92.00%	94.39%	92.56%	99.58%	97.59%	80.52%	92.00%	94.39%	92.56%	99.58%	97.59%	80.52%		
	18 weeks Pathways >=26 weeks open	Local	0	302	295	1	1	5	0	252	238	4	8	2		
	% Diagnostic Waiting List Within 6 Weeks	National	99.00%	99.51%	98.27%	100.00%	-	99.84%	99.00%	98.90%	98.89%	99.94%	-	98.80%		
RESPONSIVE: Cancer	62 Day Gp Referral to Treatment	National	85.00%	85.34%	90.00%	77.78%	88.89%	-	85.00%	90.53%	92.93%	85.60%	94.07%	-		
	62 Day Referral From Screening to Treatment	National	90.00%	60.00%	55.56%	-	100.00%	-	90.00%	92.20%	91.92%	-	100.00%	-		
	31 Day Subsequent Surgery Treatment	National	94.00%	98.73%	99.43%	100.00%	-	-	94.00%	98.69%	99.41%	98.73%	-	-		
	62 Day Aggregated Gp Urgent Referral To Treatment And Screening Referral To Treatment	National	86.00%	83.46%	86.08%	77.78%	90.00%	-	86.00%	90.87%	92.85%	85.63%	94.58%	-		
	31 Days From Diagnosis to First Treatment	National	96.00%	100.00%	100.00%	100.00%	100.00%	-	96.00%	99.57%	99.56%	99.77%	97.87%	-		
	Two Week Wait From Referral to Date First Seen	National	93.00%	99.35%	99.25%	99.35%	100.00%	-	93.00%	98.10%	98.72%	95.65%	99.16%	-		
	Two Week Wait From Referral to Date First Seen: Breast Symptoms	National	93.00%	95.80%	95.80%	-	-	-	93.00%	95.92%	95.92%	-	-	-		
RESPONSIVE: Accident & Emergency	A and E 4 hour target	National	95.00%	93.76%	93.76%	-	-	-	95.00%	94.50%	94.50%	-	-	-		
	Time to Initial Assessment (95th Percentile)	National	00:15	00:22	00:22	-	-	-	00:15	00:20	00:20	-	-	-		
	Time to Treatment (Median)	National	01:00	00:17	00:17	-	-	-	01:00	00:19	00:19	-	-	-		
	Unplanned Re-Attendance	National	5.00%	4.63%	4.63%	-	-	-	5.00%	4.99%	4.99%	-	-	-		
	Left without being seen	National	5.00%	2.36%	2.36%	-	-	-	5.00%	2.70%	2.70%	-	-	-		

Calderdale and Huddersfield NHS
NHS Foundation Trust

Responsive/Operational Targets - Director of Operations

THIS

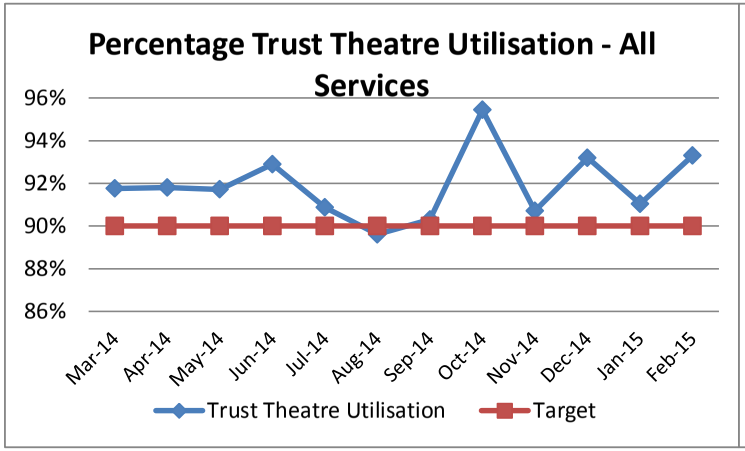
Report For: February 2015	Target	Trust	Surgical	Medical	CWF	DATS
Trust Theatre Utilisation	90.00%	93.30%	92.55%	-	104.60%	-
Outpatient Utilisation (Attendances Per Slot)	-	-	Indicator in Development			
% Daily Discharges - Pre 11am	28.00%	9.22%	11.22%	7.53%	9.35%	-
Delayed Transfers of Care	5.00%	5.20%	-	-	-	-
Number of Outliers (Bed Days)	0	946	49	897	0	0
First DNA Rate	7.00%	6.98%	7.21%	6.05%	7.39%	3.51%

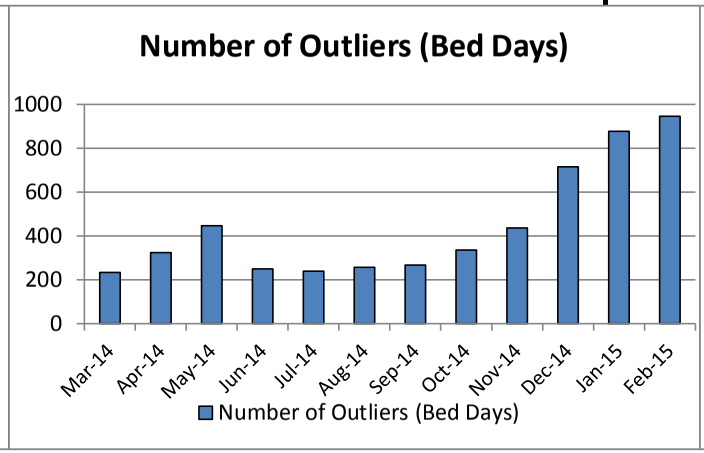
% Daily Discharges Pre 11am - discharge levelling targets require 28% of medical patients and 27% of surgical patients to be discharged before 11am. The vehicle for making this possible is Visual Hospital and Plan for Every Patient. Improvements have been seen but continued improvements are needed. A number of initiatives to improve performance have been implemented but not embedded consistently, work is on-going to achieve this and these have now become part of the Reduced LOS work stream of the PMO. Clinical Site Commanders will all be in post by end March, so we have not yet seen the benefits of these posts. There is also a big piece of work being undertaken involving both local Social Services to standardise pathways.

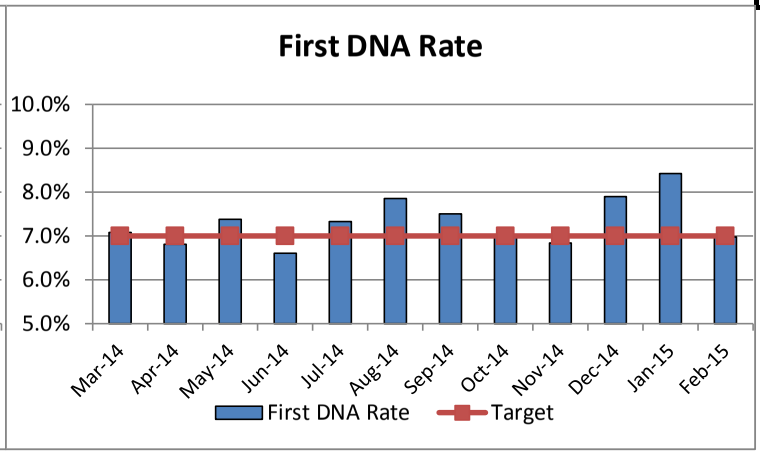
Outlier Rate (bed days) - target is no outliers. Increasing numbers of patients have outlied in month in both hospital sites due to winter pressures (this is a seasonal picture and we would expect to see it beginning to reduce from now). The work going on within the reduced LOS PMO work stream aims to address the outlier situation.

First DNA Rate - Target 7%, performance 6.98% - Performance has recovered and is within target levels. The SMS and Interactive Voice Messaging continues to deliver a reduction in missed appointments, and patients are now able to update contact numbers at the self checking kiosks. Evening staff have now been recruited to support the extended working in OP reception, the role includes telephoning potential DNAs as an added precaution - the work will focus on high DNA clinics and age ranges. Overall the DNA rate is in line with peer Trusts.

Theatre Utilisation - The Trust is slightly above target in overall Theatre Utilisation. It is recognised that not every Specialty is achieving this target individually. The Theatre Productivity Programme is engaging with each Specialty to drive through changes required to deliver 90% per Specialty in both Elective Inpatient and Day Case Surgery.







Calderdale and Huddersfield NHS
NHS Foundation Trust

Responsive - RTT - Director of Operations

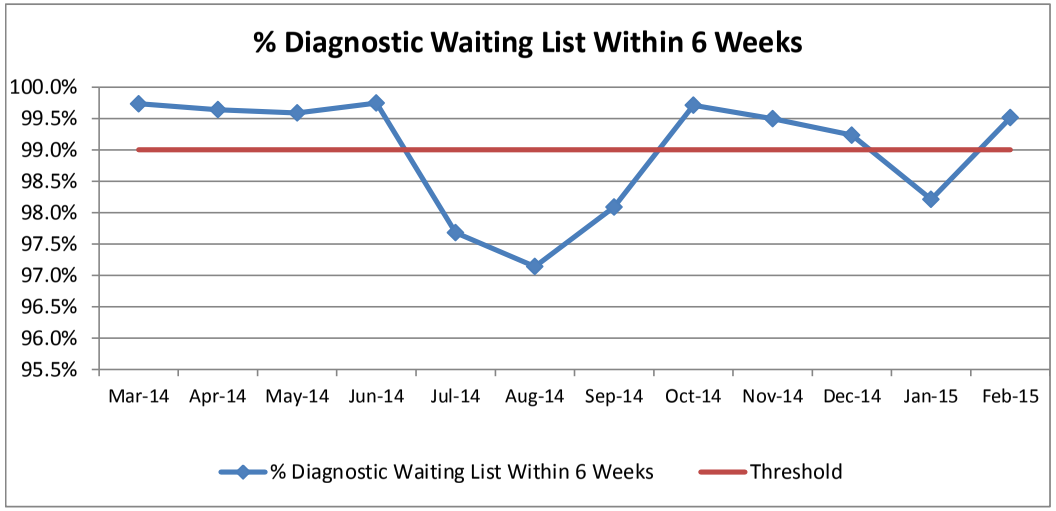
THIS

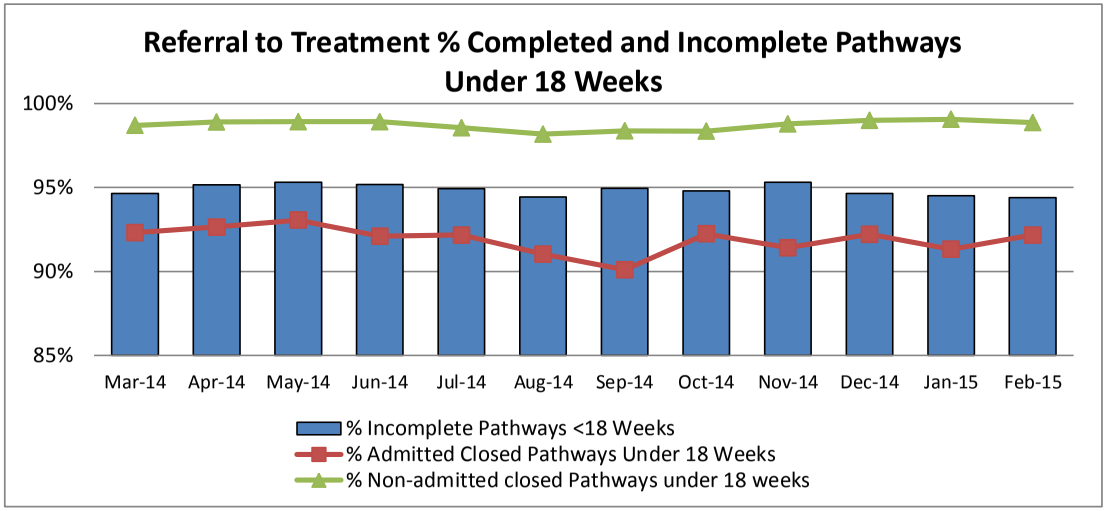
Report For: February 2015	Target	Trust	Surgical	Medical	CWF	DATS
% Non-admitted closed Pathways under 18 weeks	95.00%	98.87%	98.71%	99.20%	98.84%	100.00%
% Admitted Closed Pathways Under 18 Weeks	90.00%	92.17%	91.22%	100.00%	95.77%	93.75%
% Incomplete Pathways <18 Weeks	92.00%	94.39%	92.56%	99.58%	97.59%	80.52%
18 weeks Pathways >=26 weeks open	0	302	295	1	1	5
% Diagnostic Waiting List Within 6 Weeks	99.00%	99.51%	98.27%	100.00%	-	99.84%
% Last Minute Cancellations to Elective Surgery	0.60%	0.28%	0.85%	0.00%	0.00%	0.00%

RTT - Working together To Get Results Workshop to improve performance against incomplete pathways with Radiology and Surgery in March. We should see improvement to pathway and timelines of referrals in April. Plan to meet with surgery to address late referrals. Radiology capacity now back to normal. Date for improvement April 2015. For the 6 week target further additional mobile MRI scanning capacity is being procured between now & the end of the financial year. All other modalities are on track.

Endoscopy commentary – Locum consultant secured. Additonal capicity identified for March. All patients will therefore be treated and we do not anticipate any problems going into April. 2015.

Cancelled Operations for Elective Procedures. There has been a drop against the Trust target in February. The key factors were bed state, surgeon sickness and emergency cases. Where list over-run was the cause a daily performance report is being sent to Directorate Clinical Directors and the Surgeon whose lists are not performing as planned.





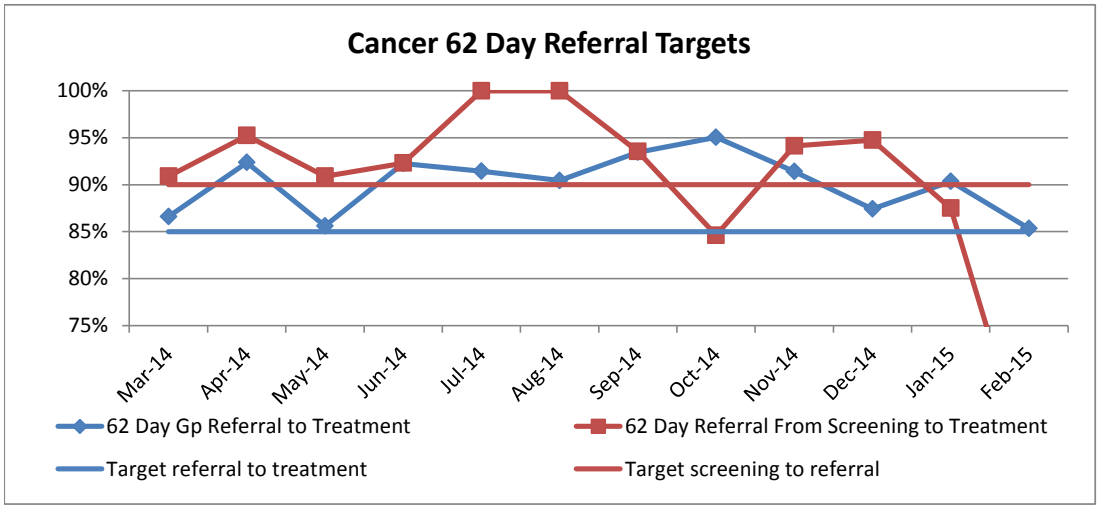
Report For: February 2015	Target	Trust	Surgical	Medical	CWF	DATS
Two Week Wait From Referral to Date First Seen	93.00%	99.35%	99.25%	99.35%	100.00%	-
Two Week Wait From Referral to Date First Seen: Breast Symptoms	93.00%	95.80%	95.80%	-	-	-
31 Days From Diagnosis to First Treatment	96.00%	100.00%	100.00%	100.00%	100.00%	-
31 Day Subsequent Surgery Treatment	94.00%	98.73%	99.43%	100.00%	-	-
31 day wait for second or subsequent treatment drug treatments	98.00%	100.00%	100.00%	100.00%	-	-
62 Day Aggregated Gp Urgent Referral To Treatment And Screening Referral To Treatment	86.00%	83.46%	86.08%	77.78%	90.00%	-
62 Day Gp Referral to Treatment	85.00%	85.34%	90.00%	77.78%	88.89%	-
62 Day Referral From Screening to Treatment	90.00%	60.00%	55.56%	-	100.00%	-

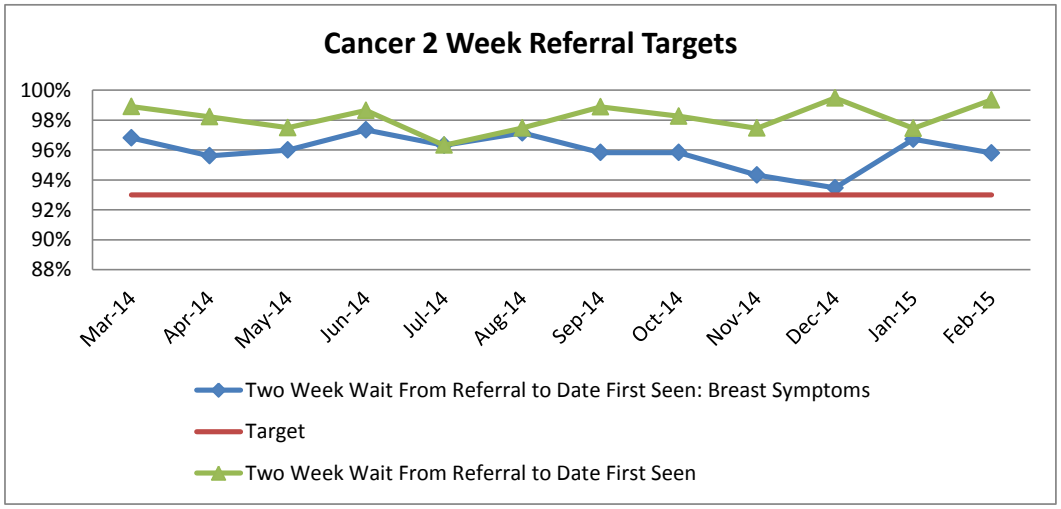
The numbers treated for screening were low again in Feb – only 5, specifically breast rather than colorectal.

There were 2 colorectal breaches meaning we would have had to have treated 20 pts min to achieve 90%.
The breaches were due to;
1 – pt. needed investigations for lung nodule found on CT, prior to surgery
2 - Clinic to colonoscopy = 38 days due to pt. cancelling because of work commitments.
3 – delay to surgery as pt. unfit.

I am unaware of any pending breaches for March but with 2.5 breaches already in the system it is highly likely that we will fail the Q4 target for screening.

We have only treated 10 pts in Q4 so far and will need to treat at least another 15 in March in order to achieve 90% and so far we have not treated any; therefore the Trust is likely to breach this target.





Calderdale and Huddersfield NHS Foundation Trust

Responsive/Accident & Emergency - Director of Operations

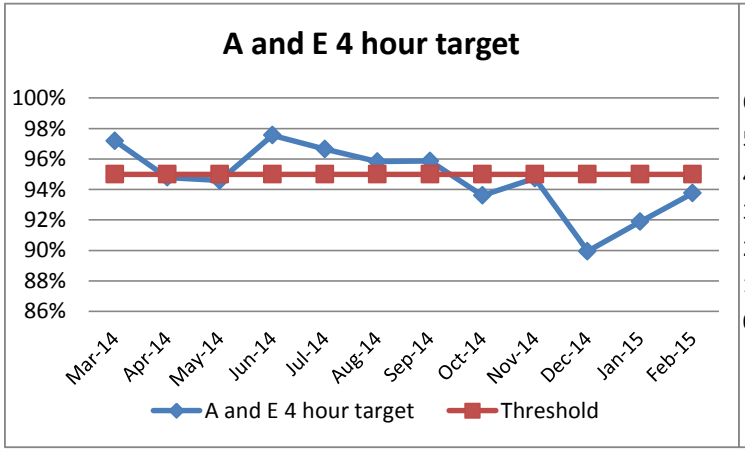
THIS

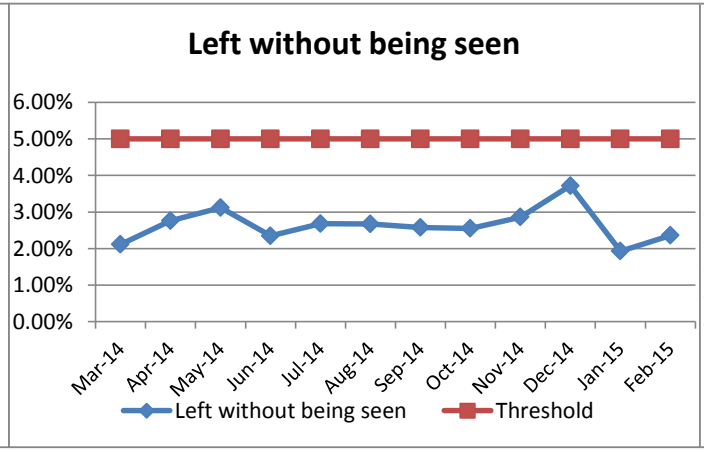
Report For: February 2015	Target	Trust	Surgical	Medical	CWF	DATS
A and E 4 hour target	95.00%	93.76%	93.76%	-	-	-
Time to Initial Assessment (95th Percentile)	00:15	00:22	00:22	-	-	-
Time to Treatment (Median)	01:00	00:17	00:17	-	-	-
Unplanned Re-Attendance	5.00%	4.63%	4.63%	-	-	-
Left without being seen	5.00%	2.36%	2.36%	-	-	-

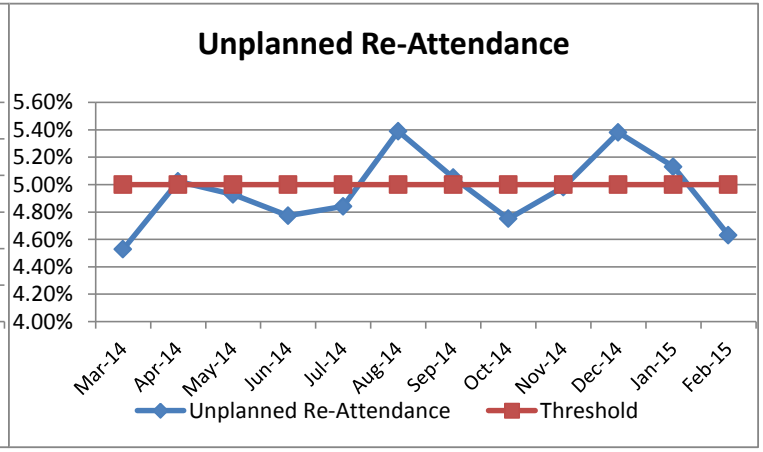
Continued increase in admissions. LOS and patients on the green cross pathway has shown a continued increase at both sites. Discharge levelling has generally not been achieved creating lengthy delays for patients. A 'Must Do' attendance by Nurse in Charge of Wards at 1pm bed meeting has been introduced to discuss leveling. It is expected that the appointment of Clinical Site Commander posts will have a significant impact on discharge levelling. It is highly unlikely that the Q4 and YTD required performance will be met. Impact of long waits in A&E for inpatient beds now seen on most of the A&E indicators. Improvement plan in place to keep the focus on A&E indicators and improvement in patient experience.

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

TIME TO TREATMENT - RAG RATING GREEN.
UNPLANNED REATTENDANCE - FORECAST GREEN. Further validation completed as data quality is an issue.
LEFT WITHOUT BEEN SEEN - FORECAST GREEN







	Report For: February 2015	Indicator Source	Report For: February 2015 Target	Trust	Surgical	Medical	CWF	DATS	Year To Date Target	Trust	Surgical	Medical	CWF	DATS	Year End Forecast	Data Quality
Caring	Number of Mixed Sex Accommodation Breaches	National	0	8	0	8	0	0	0	15	0	15	0	0		
	% Complaints closed within target timeframe	Local	95.00%	49.00%	53.00%	69.00%	100.00%	100.00%	95.00%	31.00%	33.00%	25.00%	32.00%	28.00%		
	Total Complaints received in the month	Monitor	-	47	16	19	7	5	0	562	258	156	91	43		
	Inpatient complaints per 1000 bed days	Monitor	-	0.9	2.5	0.9	0.5	-	-	-	-	-	-	-		
	Total Concerns in the month	Monitor	-	57	26	18	4	5	-	812	341	306	75	60		
	Number of Patients Surveyed (RTM) - (Quarterly)	Local	-	546	245	280	21	-	-	1772	725	946	101	-		
	Overall, How would you rate the care you received? (RTM)	Local	-	-	-	-	-	-	-	9.0	9.1	8.9	9.2	-		
	Have You Found Someone on the Hospital Staff to Talk to About Your Worries or Fears (RTM)	Local	-	-	-	-	-	-	-	8.9	9.0	8.7	9.6	-		
	% RTM Responses That are on or Above Target (Quarterly)	Local	-	59.30%	59.30%	59.30%	70.40%	-	-	66.70%	63.00%	65.40%	79.00%	-		
Caring - Friends & Family	Friends & Family Test (IP Survey) - Response Rate	CQUIN	30.00%	41.50%	43.00%	40.10%	37.60%	-	30.00%	39.90%	45.00%	35.40%	36.40%	-		
	Friends & Family Test (IP Survey) - % would recommend the Service	CQUIN	-	95.60%	96.00%	95.00%	98.00%	-	-	96.30%	97.00%	95.00%	98.80%	-		
	Friends & Family Test (IP Survey) - % would not recommend the Service	CQUIN	-	1.00%	1.00%	1.00%	0.00%		-	0.90%	0.70%	1.10%	0.50%			
	Friends & Family Test (Maternity Survey) - Response Rate	CQUIN	-	14.60%	-	-	14.60%	-	-	20.80%	-	-	20.80%	-		
	Friends & Family Test (Maternity) - % Would recommend the Service	CQUIN	-	95.70%	-	-	95.70%	-	-	93.00%	-	-	93.00%	-		
	Friends & Family Test (Maternity) - % Would not recommend the Service	CQUIN	-	2.30%	-	-	2.30%		-	3.50%	-	-	3.50%			
	Friends and Family Test A & E Survey - Response Rate	CQUIN	20.00%	11.70%	11.70%	-	-	-	20.00%	19.50%	19.50%	-	-	-		
	Friends and Family Test A & E Survey - % would recommend the Service	CQUIN	-	89.80%	89.80%	-	-	-	-	88.70%	88.70%	-	-	-		
	Friends and Family Test A & E Survey - % would not recommend the Service	CQUIN	-	6.00%	6.00%	-	-		-	6.00%	6.00%	-	-			
	Percentage of non-elective inpatients 75+ screened for dementia	CQUIN	90.00%	92.70%	-	-	-	-	90.00%	96.10%	-	-	-	-		

Caring - Director of Nursing

Report For: February 2015	Target	Trust	Surgical	Medical	CWF	DATS
Number of Mixed Sex Accommodation Breaches	0	8	0	8	0	0
% Complaints closed within target timeframe	95.00%	49.00%	53.00%	69.00%	100.00%	100.00%
Total Complaints received in the month	-	47	16	19	7	5
Inpatient complaints per 1000 bed days	-	0.9	2.5	0.9	0.5	-
Total Concerns in the month	-	57	26	18	4	5
Number of Patients Surveyed (RTM) - (Quarterly)	-	546	245	280	21	-
Overall, How would you rate the care you received? (RTM)	-	-	-	-	-	-
Have You Found Someone on the Hospital Staff to Talk to About Your Worries or Fears (RTM)	-	-	-	-	-	-
% RTM Responses That are on or Above Target (Quarterly)	-	59.30%	59.30%	59.30%	70.40%	-

Eliminating Mixed Sex Accommodation:
1. Why off plan? This breech occurred in the Coronary Care Unit and related to one patient affecting 7 of the opposite sex. There was failure to escalate according to the process.
2. Action to get back on plan: The policy has been recently reviewed and a daily handover form introduced into the patent flow team.
3. Achieved by date: The changes are in place, their impact will be monitored over the coming month.

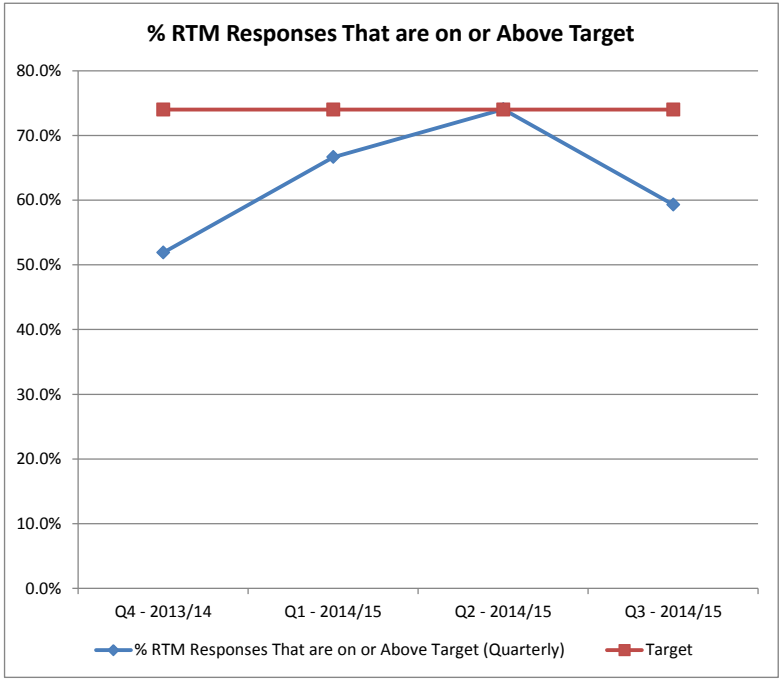
Complaints:
1. Why off plan? More complaints were closed in February compared to January and some progress has been made.
2. Actions to get on plan? Work is continuing with clinical divisions to ensure complaints performance is managed more closely at a senior level. Plan for every complaint was introduced on 24th November 14 which helps track progress more closely and schedules in reminders to divisions when actions are required. The risk management team have provided extra support to help divisions clear old cases.
3.Achieved by date: The plan for this month is to eliminate all complaints that are over 3 months old.

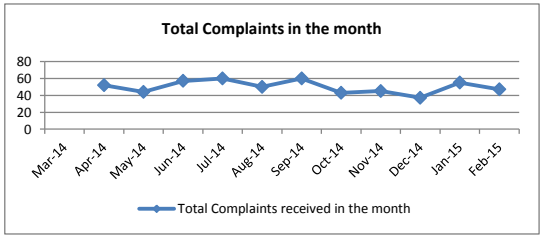
Real Time Patient Monitoring (RTPM)- NB - Quarterly process, data covers the period of Oct 14 - Dec 14

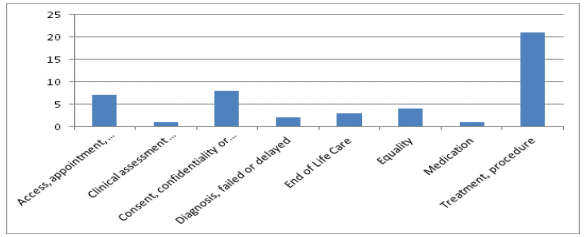
1. Why away from plan: All Divisions are scoring green (equivalent to top 20% of Trusts nationally) for the 2 questions listed. A local target has been set for 20 of the 27 questions asked to have a RAG rated 'green' score - this equates to 74%, this has not been achieved for quarter 3.

2. Action to get it back on plan: All improvement work is being monitored by the Patient Experience Group. Changes to the questions are being made to link more closely to the Patient Experience Improvement Plan and other key improvement work.

3. Achieved by Date: The changes in place by Q2 (July), tested in April to June.

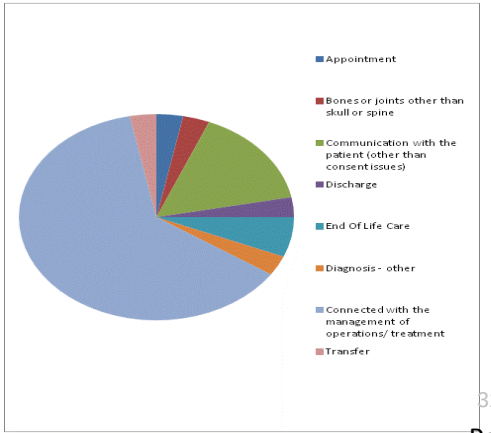






MONTH	Complaints Recevied		Variance	
	2013/14	2014/15	on year	on month
December	35	37	2	8
January	52	55	3	18
February	50	47	3	8

Complaints by Division and Severity	GREEN	YELLOW	ORANGE	RED
CWF	0	6	1	0
DaTS	0	3	2	0
Estates and Facilities	0	0	0	0
Medical Division	1	9	7	2
SAS	0	14	2	0
Totals:	1	32	12	2



Report For: February 2015	Target	Trust	Surgical	Medical	CWF	DATS
Friends & Family Test (IP Survey) - Response Rate	30.00%	41.50%	43.00%	40.10%	37.60%	-
Friends & Family Test (IP Survey) - % would recommend the Service	-	95.60%	96.00%	95.00%	98.00%	-
Friends & Family Test (IP Survey) - % would not recommend the Service	-	1.00%	1.00%	1.00%	0.00%	
Friends & Family Test (Maternity Survey) - Response Rate	-	14.60%	-	-	14.60%	-
Friends & Family Test (Maternity) - % Would recommend the Service	-	95.70%	-	-	95.70%	-
Friends & Family Test (Maternity) - % Would not recommend the Service	-	2.30%	-	-	2.30%	
Friends and Family Test A & E Survey - Response Rate	20.00%	11.70%	11.70%	-	-	-
Friends and Family Test A & E Survey - % would recommend the Service	-	89.80%	89.80%	-	-	-
Friends and Family Test A & E Survey - % would not recommend the Service	-	6.00%	6.00%	-	-	
Percentage of non-elective inpatients 75+ screened for dementia	90.00%	92.70%	-	-	-	-

Friends and Family Test Maternity:

1.Why off plan: Currently maternity responses are collected via text message, sent out automatically after women are discharged. The team feel this needs to be expanded to other means of collecting the information, giving people more choice and allow the midwives to prompt and encourage responses.

2.Actions to get back on plan: Work is taking place to increase the information collection methods, electronic tablets are being formatted for use in hospital to ask women to complete before they leave. From May 15 maternity will be moving across to an electronic patient record, giving midwives options to collect responses using different electronic media. There is an interim plan in place to use postcards for community post natal women to be given to women on their last visit to complete and return by post if the electronic system is delayed .

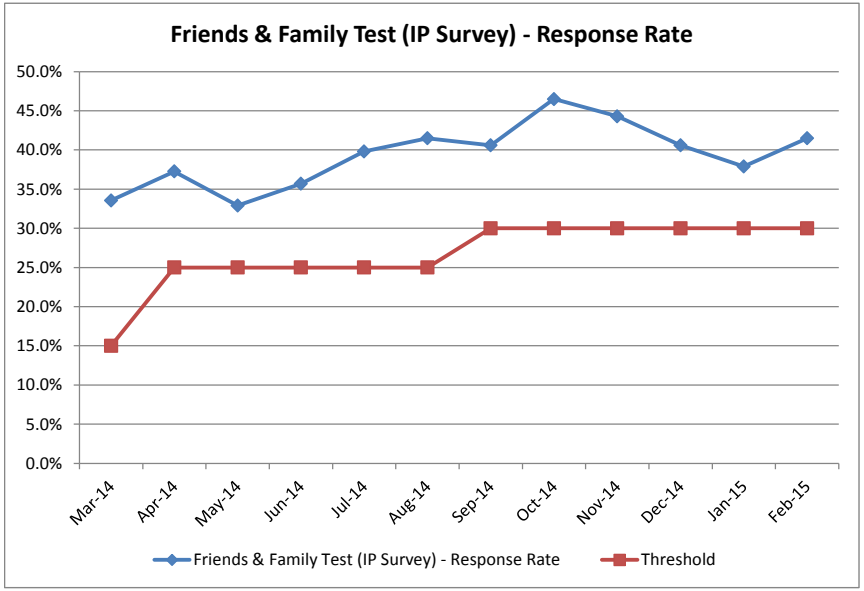
3.Achieved by date: Aim to start using the electronic tablets in patient areas in month. Work to use the new EPR will take place over the next 3 months.

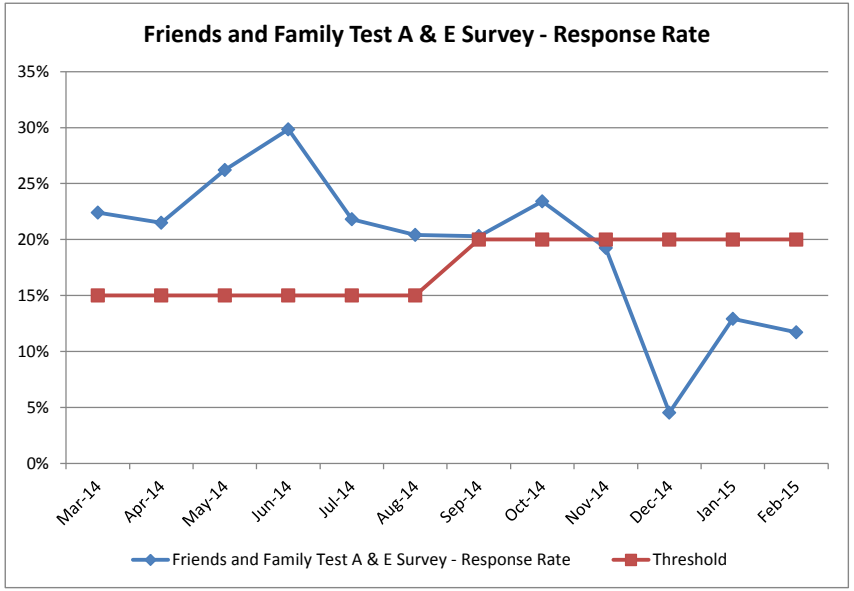
Friends and Family Test A & E Survey - Response Rate

1. Why off plan: Despite a number of focused efforts to increase the response rate, this has not been achieved.

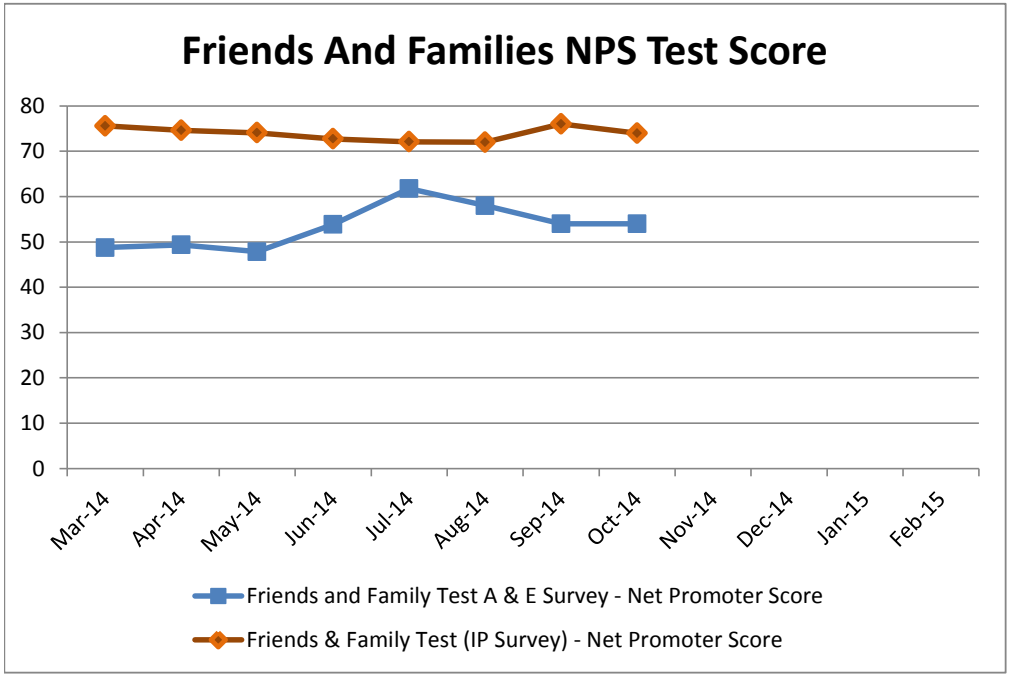
2 .Actions to get back on plan: There has been extensive engagement with the A&E team led by the matrons and senior sisters. This has included written information and group presentations with a clear message of the need to promote the test and encourage patients to complete the postcards, the team are revising the script when cards are handed to patients with reminders built into information giving when leaving the unit. There has been an increase in publicity, with large posters displayed in the clinic rooms and additional post-boxes located in the department to submit returns. In addition the team are considering text messages and a 'go see' to another A&E unit with better response rates.

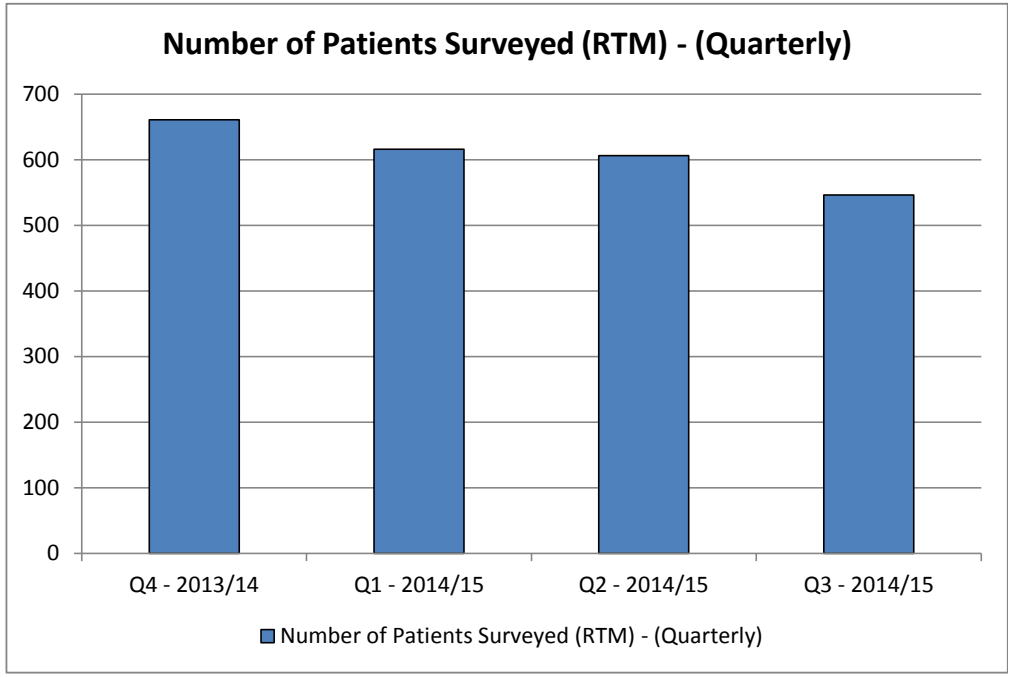
3. Achieved by date: A meeting is taking place week of the 16th March to discuss further actions required. It is not expected that any improvement will be seen for another 2 weeks.

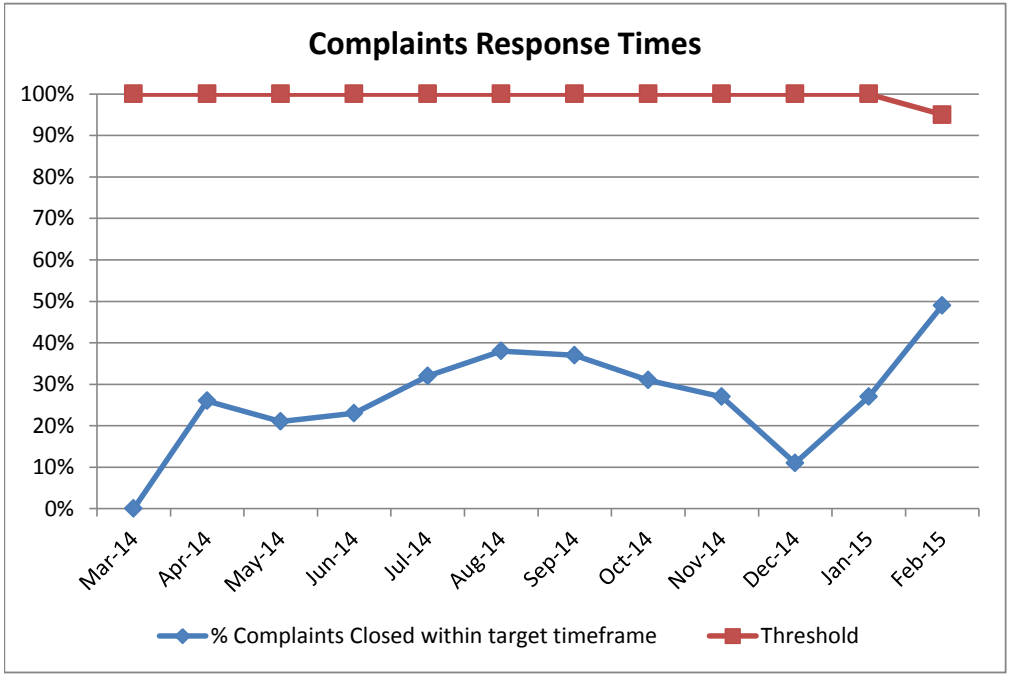




Caring - Director of Nursing







Safety Executive Summary - Julie Dawes Director of Nursing

	Report For: February 2015	Indicator Source	Report For: February 2015 Target	Trust	Surgical	Medical	CWF	DATS	Year To Date Target	Trust	Surgical	Medical	CWF	DATS	Year End Forecast	Data Quality
Safety	Inpatient Falls with Serious Harm (10% reduction on 13/14)	Local	2	3	2	1	0	-	20	15	6	9	0	-		
	All Falls (10% reduction on 2013/14)	Local	112	159	43	114	2	-	1231	1648	354	1260	34	-		
	Number of Trust Pressure Ulcers Acquired at CHFT	Local	11	9	2	7	0	-	119	172	62	109	1	-		
	Number of Grade 2 Pressure Ulcers Acquired at CHFT	Local	7	4	1	3	0	-	81	115	49	65	1	-		
	Number of Grade 3 Pressure Ulcers Acquired at CHFT	Local	0	5	1	4	0	-	0	54	13	41	0	-		
	Number of Grade 4 Pressure Ulcers Acquired at CHFT	Local	0	0	0	0	0	-	0	3	0	3	0	-		
Safety 2	Percentage of Completed VTE Risk Assessments	National	95.00%	95.10%	94.20%	94.10%	98.60%	100.00%	95.00%	95.30%	94.10%	95.30%	98.40%	100.00%		
	Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	National	100.00%	100.00%	100.00%	100.00%	-	-	100.00%	100.00%	100.00%	100.00%	100.00%	-		
	% Harm Free Care	CQUIN	95.00%	93.65%	94.79%	90.82%	99.76%	-	95.00%	93.70%	94.76%	90.88%	99.74%	-		
	Improving Medicines Safety Discharge Acuracy Checks		70.00%	70.07%	-	-	-	-	70.00%	67.60%	-	-	-	-		
Safety 3	Number of Patient Incidents	Monitor	-	524	141	273	80	26	0	6243	1616	3054	1175	347		
	Number of SI's	Monitor	-	11	1	10	0	0	0	86	14	68	4	0		
	Number of Incidents with Harm	Monitor	-	154	39	80	27	7	0	1702	387	854	385	66		
	Never Events	National	0	0	0	0	0	0	0	0	0	0	0	0		
	Serious hazards of transfusion	Local	-	-	-	-	-	-	0	0	0	0	0	0		
	Percentage of SI's reported externally within timescale (2 days)	Local	100.00%	100.00%	100.00%	100.00%	-	-	-	-	-	-	-	-		
	Percentage of SI's investigations where reports submitted with timescale (45 days unless extension agreed)	Local	100.00%	75.00%	-	80.00%	100.00%	-	-	-	-	-	-	-		
	Total Duty of Candour deadline within the month		-	8	3	4	1	0	-	58	16	32	8	1		
	Total Duty of Candour Compliance for the month		100%	100%	100%	100%	100%	-		-	-	-	-	-		

Report For: February 2015	Target	Trust	Surgical	Medical	CWF	DATS
Inpatient Falls with Serious Harm (10% reduction on 13/14)	2	3	2	1	0	-
All Falls (10% reduction on 2013/14)	112	159	43	114	2	-
Number of Trust Pressure Ulcers Acquired at CHFT	11	9	2	7	0	-
Number of Grade 2 Pressure Ulcers Acquired at CHFT	7	4	1	3	0	-
Number of Grade 3 Pressure Ulcers Acquired at CHFT	0	5	1	4	0	-
Number of Grade 4 Pressure Ulcers Acquired at CHFT	0	0	0	0	0	-

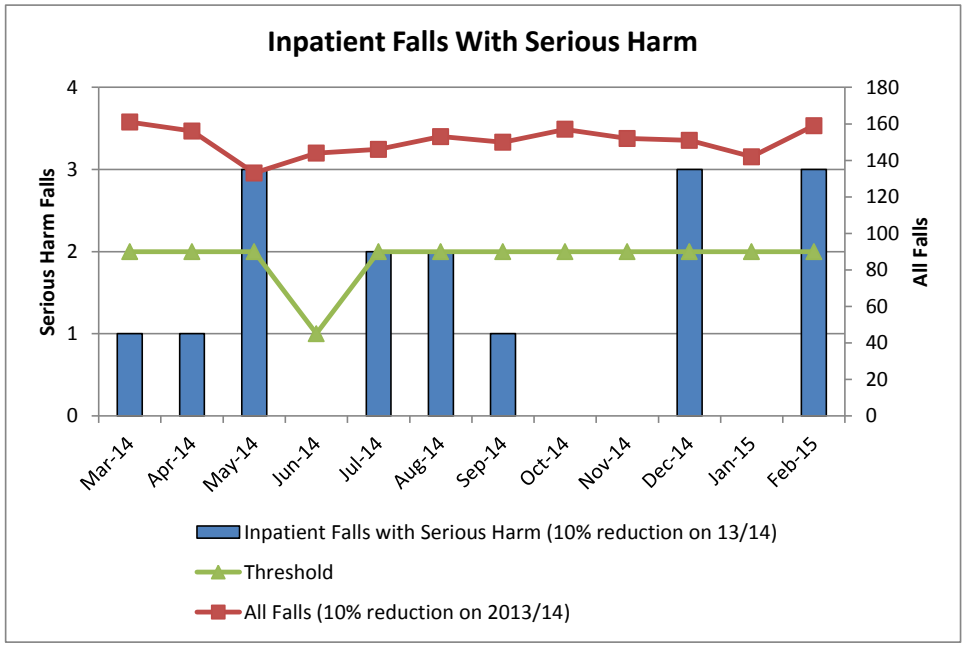
Pressure Ulcers Current Work: Evidence based targets for 2015/16 are to be agreed at the Patient Safety Group (this will be dependent on agreed CQUIN measures). All pressure ulcers grade 3 and above continue to be investigated and actions agreed in response.
- key work as a direct result of investigations is that nursing competencies that relate to pressure ulcer prevention are being reviewed as part of the development of a competency portfolio for band 5 nurses.
- The installation of higher specification pressure relieving mattresses has been completed at HRI; the mattresses will be installed at CRH during March 15

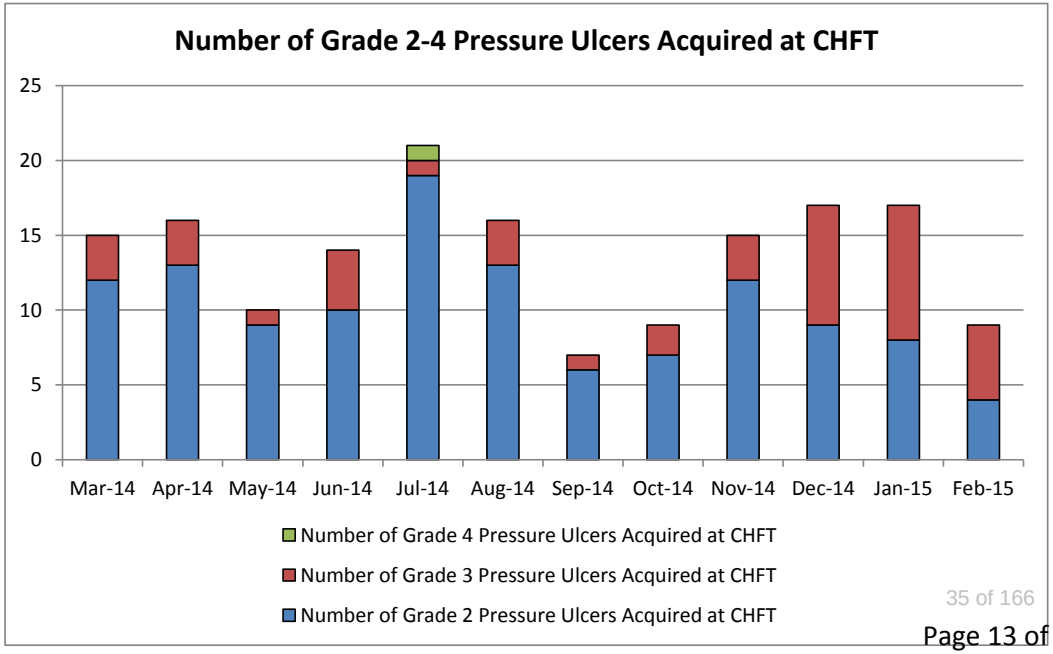
Falls:

1. Why off plan? Inpatient falls with serious harm – Feb15 the Trust had 3 against a target of 2; over the past 12 months the mean per month is 1.3, well within the target set. For all Falls, February experienced 47 falls over target.

2. Action to get back on plan: Working with the improvement academy building on the success of Wd 5 HRI who have gone 61 days without a patient fall. Linking in work around safety briefings with the Trusts falls avoidance and post falls care bundles to improve reliability. The core ideas will be spread to other areas. In the meantime the falls prevention and post falls documentation is on all ward areas and staff have been trained in their completion. In addition the improvement trajectory is being reviewed against national evidence to better understand the Trusts own falls data.

3. Achieved by (a specific date): Targets will be reviewed for the next IBR and quarterly quality report. There will be a link to the sucessful work that has taken plan in ward 5 around safety briefings.



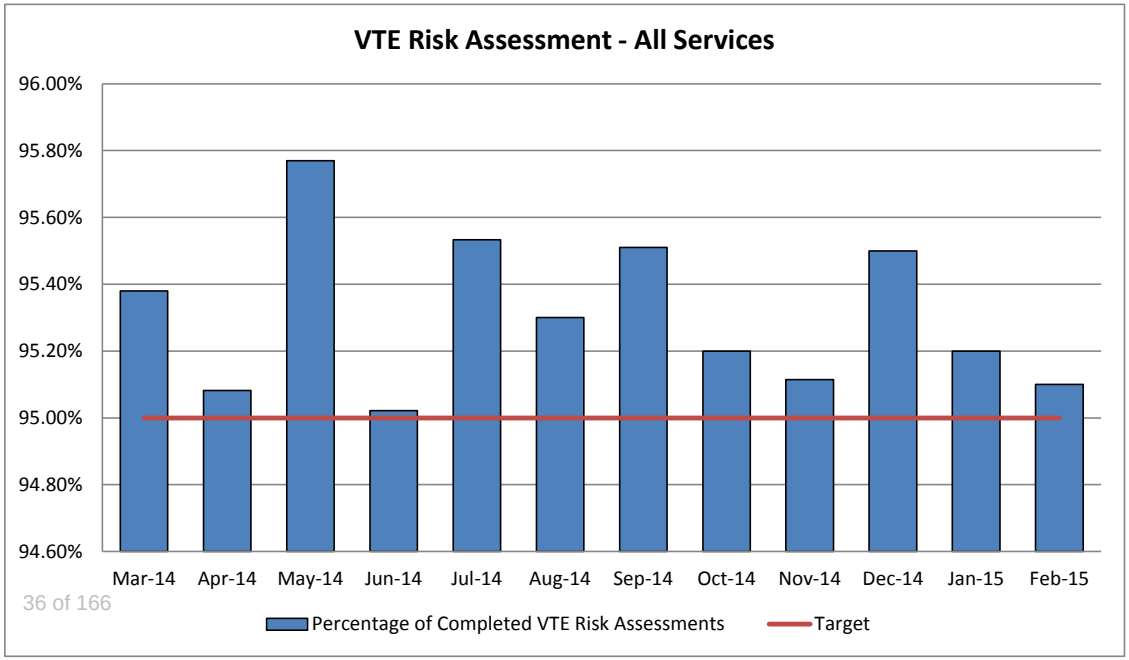


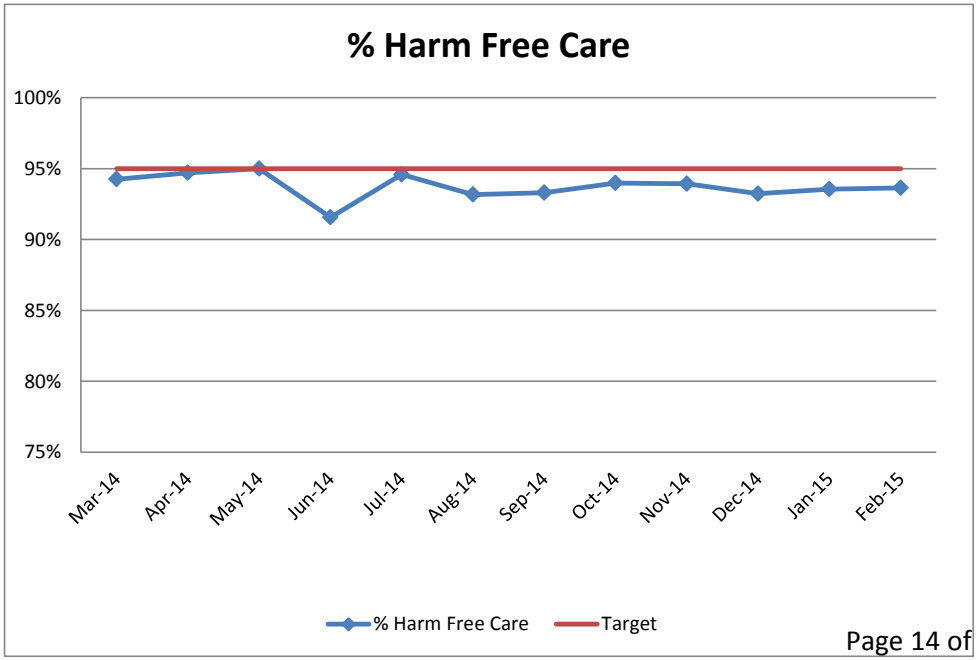
Report For: February 2015	Target	Trust	Surgical	Medical	CWF	DATS
Percentage of Completed VTE Risk Assessments	95.00%	95.10%	94.20%	94.10%	98.60%	100.00%
Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	100.00%	100.00%	100.00%	100.00%	-	-
% Harm Free Care	95.00%	93.65%	94.79%	90.82%	99.76%	-
Safeguarding Alerts made by the Trust	-	19	-	-	-	-
Safeguarding Alerts made against the Trust	-	5	-	-	-	-
Improving Medicines Safety Discharge Acuracy Checks	70.00%	70.07%	-	-	-	-

VTE: Both VTE risk assessment and RCA process are on plan. In February 2015 there were 9 hospital acquired thrombosis none of which were preventable. Following a recent audit an amended prescription chart is currently being trailed which has a specific prophylaxis section for medication. If this is successful it will be introduced throughout the trust with the exception of Maternity and paediatric services and will be in place by August 15.

Harm Free Care: **1. Why off plan?** The target is based on a one data point prevalence audit, it is dependent on other improvement work in the Trust (Falls, Pressure Ulcers, Catheters and VTE) having the desired impact. As pressure ulcers make up the largest proportion of harm, reduction in ulcers will see a positive impact on harm free care.
2. Actions to get it back to plan: There is on-going validation for in patient areas reporting pressure ulcers to ensure the data is accurate and provide advice and guidance from the specialist team. Along with other improvement work on pressure ulcers (see Safety 1 section).
3. Achieved by date: Trust is awaiting final 15/16 contract, changes to the scope of safety thermometer may be made.

Safeguarding Current Work: The vulnerable adult operational group established in Feb 2015. Bringing together safeguarding adults, dementia, mental health, learning disability, falls collaborative –with the remit of ensuring the Trust is working towards protecting vulnerable adults. Currently producing a work plan to look at key themes with actions, timescales and improvement targets.





Safety - Director of Nursing

Report For: February 2015	Target	Trust	Surgical	Medical	CWF	DATS	Estates and Facilities	Corporate
Number of Patient Incidents	-	524	141	273	80	26	3	1
Number of SI's	-	11	1	10	0	0	0	0
Number of Incidents with Harm	-	154	39	80	27	7	1	0
Never Events	0	0	0	0	0	0	0	0
Serious hazards of transfusion	-	-	-	-	-	-	-	-
Percentage of SI's reported externally within timescale (2 days)	100.00%	100.00%	100.00%	100.00%	-	-	-	-
Percentage of SI's investigations where reports submitted with timescale (45 days unless extension agreed)	100.00%	75.00%	-	80.00%	100.00%	-	-	-
Total Duty of Candour deadline within the month	-	8	3	4	0	1	0	0
Total Duty of Candour Compliance for the month	100%	100%	100%	100%	100%	-	-	-

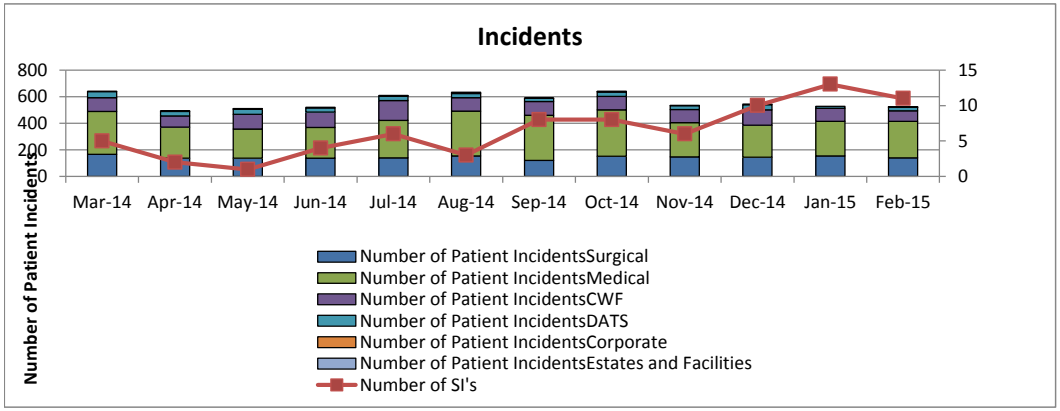
Percentage of SI's investigations where reports submitted with timescale (45 days unless extension agreed):

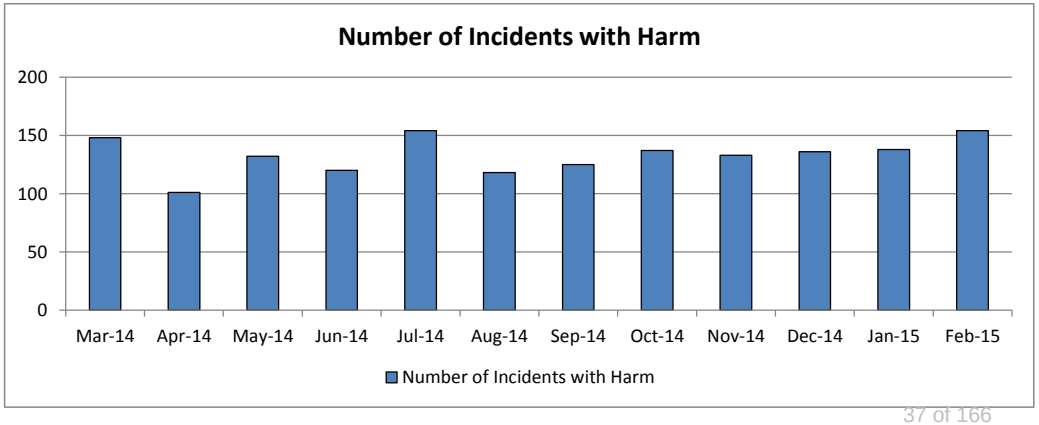
1. Why off Plan: Of the 10 reports due for submission in February: CWF - all were submitted on time, Medical - of the 5 due: 4 were submitted on time, 1 was 1 day late. An extension of time was submitted for one other due, SAS - 3 were submitted in time, one was 6 days late.

2. Action taken: corporate team working closely with the divisional managers to ensure investigators are aware of submission deadlines, extensions to be authorised by the assistant director for quality in exceptional circumstances only.

3.**Achieved by:** This will be achieved within the next month.

Duty of Candour: On 27th Nov 14 the Statutory Duty of Candour came into effect. From Dec 14 we have recorded our compliance against this and developed a monitoring tool to ensure it is captured. January's figures show 8 cases Duty of Candour applicable. For all of these the duty has been complied with. To make the process more efficient the risk team are liaising with Divisions to ensure that we are able to record the date that contact with the patient/carer was made so full compliance can be maintained.





Calderdale and Huddersfield NHS
NHS Foundation Trust

Effectiveness Executive Summary

THIS

	Report For: February 2015	Indicator Source	Report For: February 2015 Target	Trust	Surgical	Medical	CWF	DATS	Year To Date Target	Trust	Surgical	Medical	CWF	DATS	Year End Forecast	Data Quality
Effectiveness	Number of MRSA Bacteraemias – Trust assigned	National	0	0	0	0	0	0	0	1	0	0	0	0		
	Total Number of Clostridium Difficile Cases	National	1	4	1	3	0	0	18	26	8	16	2	0		
	Total Number of Clostridium Difficile Cases – Trust assigned	National	0	2	0	2	0	0	0	9	6	3	0	0		
	Unavoidable Number of Clostridium Difficile Cases	National	1	2	1	1	0	0	18	17	4	12	1	0		
	Number of MSSA Bacteraemias - Post 48 Hours	National	2	0	0	0	0	0	24	9	2	6	1	0		
	% Hand Hygiene Compliance	Local	95.00%	99.95%	99.91%	99.96%	100.00%	100.00%	95.00%	99.82%	99.57%	99.99%	100.00%	99.90%		
	MRSA Screening - Percentage of Inpatients Matched	Local	95.00%	96.17%	94.74%	99.00%	100.00%	-	95.00%	98.00%	95.00%	99.00%	98.00%	-		
	Number of E.Coli - Post 48 Hours	Local	2	7	1	6	0	0	23	27	8	19	0	0		
	Central Line Infection rate per 1000 Central Venous Catheter days	Local	1.50	1.87	-	-	-	-	1.50	1.17	-	-	-	-		
Effectiveness 2	Emergency Readmissions Within 30 Days (With PbR Exclusions)	National	7.30%	7.08%	4.41%	11.31%	5.86%	12.20%	7.39%	7.35%	4.71%	11.84%	5.99%	6.10%		
	Local SHMI - Relative Risk - (1yr Rolling Data)	National	100	110	-	-	-	-	100	111	-	-	-	-		
	Hospital Standardised Mortality Rate	National	100.00	106.98	-	-	-	-	-	-	-	-	-	-		
	Rebased HSMR	National	-	-	-	-	-	-	-	-	-	-	-	-		
	Crude Mortality Rate	National	1.00%	1.54%	0.40%	4.29%	0.00%	0.00%	1.14%	1.28%	0.46%	3.36%	0.11%	0.00%		
	Average Diagnosis per Coded Episode	National	4.9	4.19	3.55	6.09	2.41	2.86	4.9	4.07	3.62	5.74	2.39	3.37		
Effectiveness 3	Number of Unplanned Adult Admissions to ITU		-	51	-	-	-	-	-	533	0	0	0	0		
	No of Spells with > 2 Ward Movements	local	-	128	17	84	27	-	-	1486	219	943	324	-		
	% of spells with > 2 ward movements (2% Target)	local	2.00%	2.42%	1.27%	5.16%	1.20%	-	-	2.32%	1.27%	5.15%	1.14%	-		
	No of Spells with > 3 Ward Movements	local	-	34	2	28	4	-	-	402	49	300	53	-		
	% of spells with > 3 ward movements (No Target)	local	-	0.64%	0.14%	1.72%	0.18%	-	-	0.63%	0.28%	1.64%	0.19%	-		
	No of Spells with > 4 Ward Movements	local	-	12	0	10	2	-	-	141	15	114	12	-		
	% of spells with > 4 ward movements (No Target)	local	-	0.23%	0.09%	0.61%	0.09%	-	-	0.22%	0.09%	0.62%	0.04%	-		
	No of Spells with > 5 Ward Movements	local	-	4	0	3	1	-	-	43	4	34	5	-		
	% of spells with > 5 ward movements (No Target)	local	-	0.08%	0.00%	0.18%	0.02%	-	-	0.07%	0.02%	0.19%	0.02%	-		
	Total Number of Spells	local	-	5287	1408	1627	2252	-	-	64116	17301	18308	28507	-		
	Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	National	85.00%	79.41%	79.41%	-	-	-	85.00%	64.71%	64.71%	-	-	-		

Report For: February 2015	Target	Trust	Surgical	Medical	CWF	DATS
Number of MRSA Bacteraemias – Trust assigned	0	0	0	0	0	0
Total Number of Clostridium Difficile Cases	1	4	1	3	0	0
Total Number of Clostridium Difficile Cases – Trust assigned	0	2	0	2	0	0
Unavoidable Number of Clostridium Difficile Cases	1	2	1	1	0	0
Number of MSSA Bacteraemias - Post 48 Hours	2	0	0	0	0	0
% Hand Hygiene Compliance	95.00%	99.95%	99.91%	99.96%	100.00%	100.00%
MRSA Screening - Percentage of Inpatients Matched	95.00%	96.17%	94.74%	99.00%	100.00%	-
Number of E.Coli - Post 48 Hours	2	7	1	6	0	0
Central Line Infection rate per 1000 Central Venous Catheter days	1.50	1.87	-	-	-	-

1. Why off plan?

C.,Difficile – 4 cases in Feb, YTD total 26 against a ceiling of 18. Of these, 9 classified as avoidable and 17 classed as unavoidable. There are no common themes in terms of the reasons behind the cases. Some issues identified around isolation of patients with Diarrhoea.

E.Coli – An analysis of the E. col bacteraemia (post 48 hour cases) is underway, the cause for the increase will not be known until completed.

Line infections - Root Cause Analysis pending for some cases. Of the RCA's that have been completed, no common themes have been highlighted.

2. Actions to get it back to plan

C Difficile - Nerve centre is being explored to aid early isolation decision. External review of cleaning has taken place, the results of which are awaited as cleaning has been identified as an issue in some of the avoidable cases.

E. Coli - Early indications are there are no common themes. Constipation guidelines are being reviewed as this a contributing factor for urine infections.

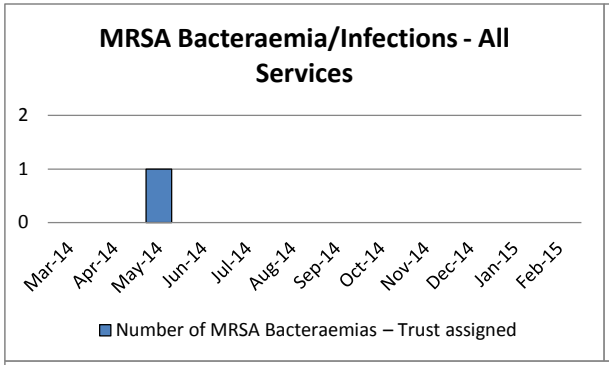
Line Infections - Outstanding RCA's will be completed within the next month with action plans where modifiable issues identified.

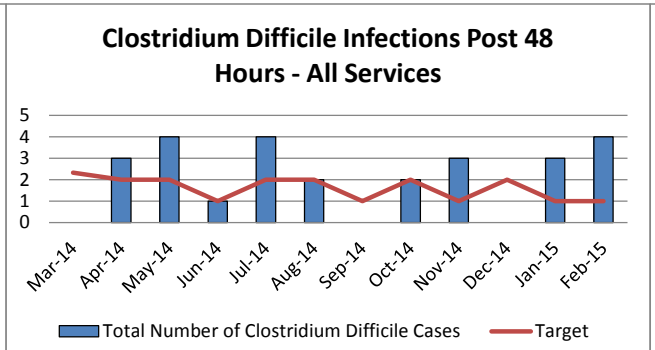
3. Achieved by:

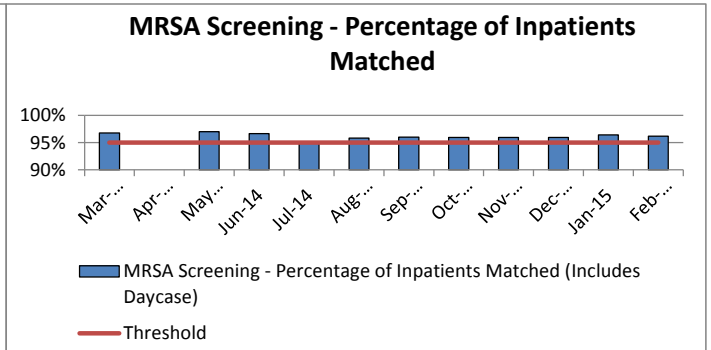
C Difficile – Nerve centre will not be site wide at CRH until May 15 so the changes will not be in place before then.

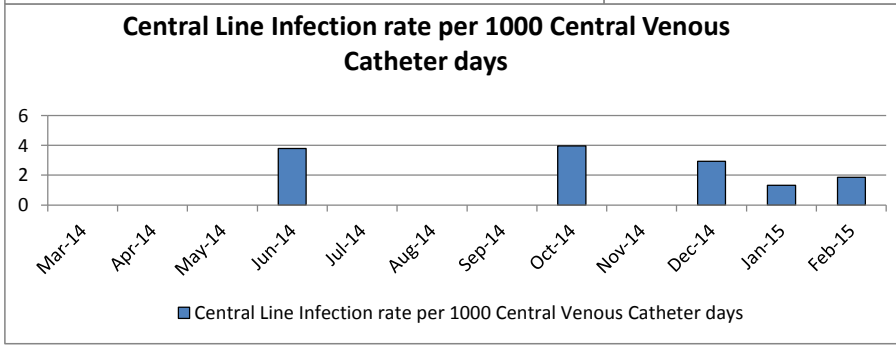
E. Coli – Constipation guidelines will be reviewed by May 15 analysis of E Coli cases will be completed by the end of April 15.

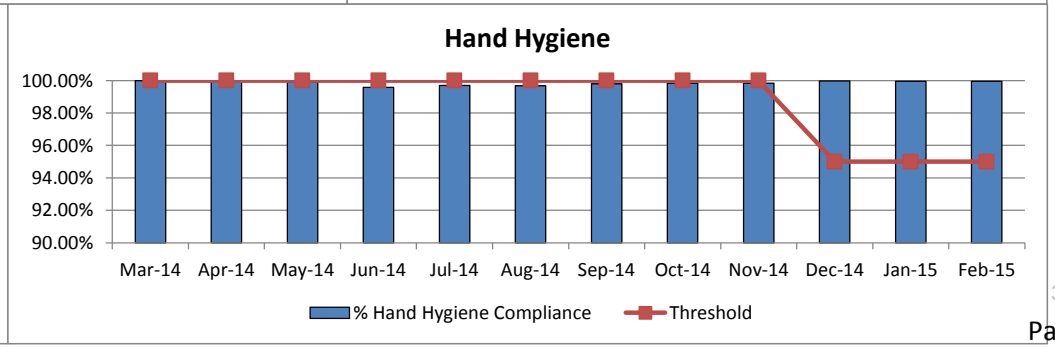
Line Infections - RCA's will be completed within the next month











Report For: February 2015	Target	Trust	Surgical	Medical	CWF	DATS
Emergency Readmissions Within 30 Days (With PbR Exclusions)	7.30%	7.08%	4.41%	11.31%	5.86%	12.20%
Local SHMI - Relative Risk - (1yr Rolling Data)	100	110	-	-	-	-
Hospital Standardised Mortality Rate	100	106.98	-	-	-	-
Crude Mortality Rate	1.00%	1.54%	0.40%	4.29%	0.00%	0.00%
Average Diagnosis per Coded Episode	4.9	4.19	3.55	6.09	2.41	2.86

SHMI/HSMR/Crude Mortality

1. Why it is off plan? The most recent released indicated a SHMI of 110 the 12 months of July 13 to June 14. This has reduced from the 111 published in April 13 - March 14 but is still higher than target. HSMR is measured against a national average of 100. The most recent 12 months data indicates a score of 106.21, which is a reduction of 1 point from previous release. Crude mortality is lower than the previous month, the rise in December and January has been noted and learning from mortality reviews will enable the trust to note the standard of care delivery in these high mortality months.

2.Action to get back on plan: Extra resources have been put into the mortality review process. Over 80% of December deaths have been reviewed and a full report will be submitted to clinical outcomes group and Quality Committee in March 15, there were no significate cross cutting issues identified. Work continues on The Care of the Acutely Ill Patient programme and the eight key themes which will help to reduce both SHMI and HSMR. These include reliable implementation of care bundles, focus on frail patients, coding and condition specific work where mortality rates appear to be outlying.

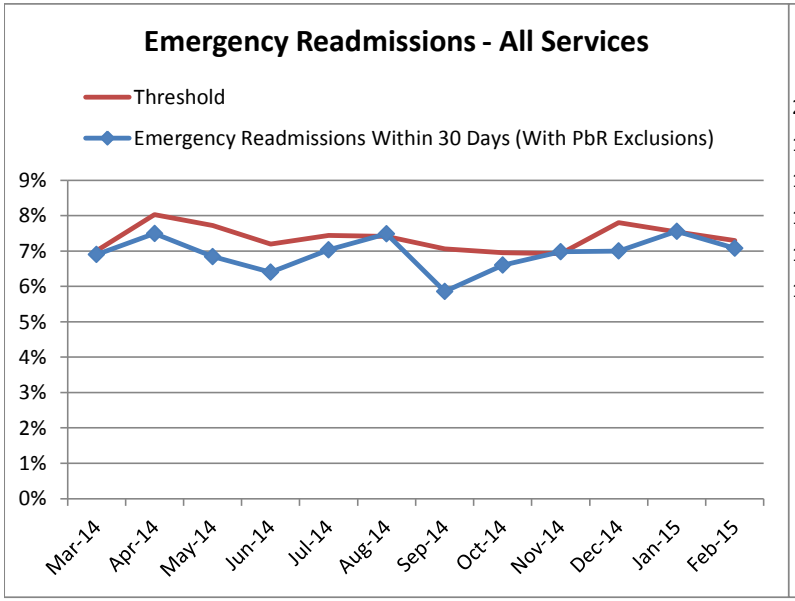
3.Achieved By: Timescales dependent on any action planning from the December mortality reviews. There is a target of over 80% of February deaths to be reviewed this month.

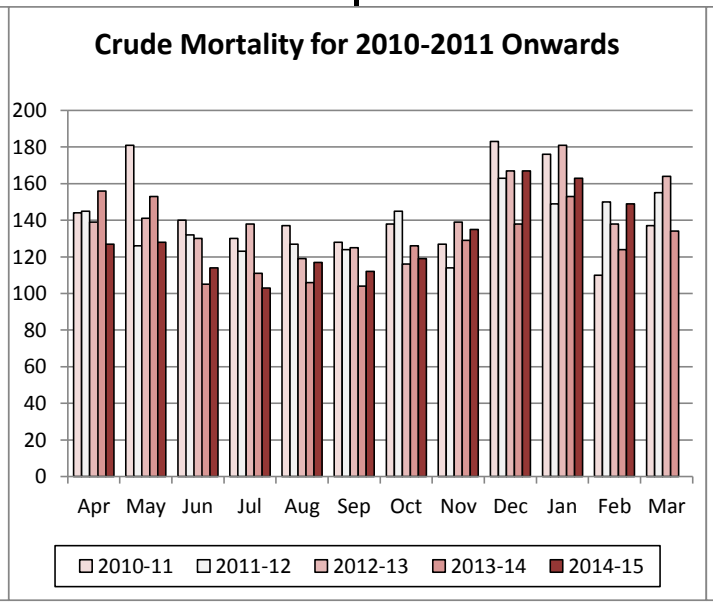
Average Diagnosis per Coded Episode

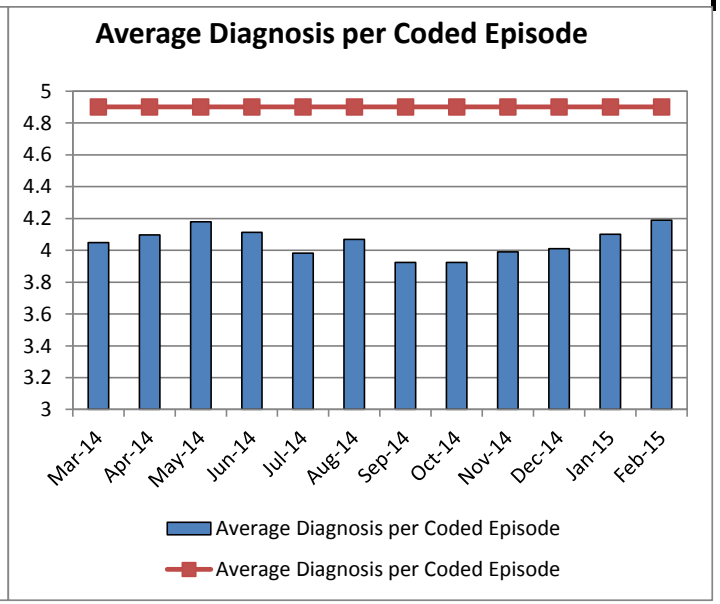
1. Why off plan? CHFT depth of coding is less than plan due to missed or undocumented relevant comorbidities within the coding source documentation. May also be due to incomplete coding documentation at the time of coding.

2. Action to get it back on plan: Extended to the Coding deadline to allow ward areas to ensure documentation is complete when it is sent for coding. Clinical engagement around the importance of documenting of co-morbidities within the current spell. Roll out of the co-morbidity form – weekly audit to monitor compliance.

3. Achieve by date: End of FY 2015/16







Effectiveness - Medical Director

Report For: February 2015	Target	Trust	Surgical	Medical	CWF	DATS
Number of Unplanned Adult Admissions to ITU	-	51	-	-	-	-
No of Spells with > 2 Ward Movements	-	128	17	84	27	-
% of spells with > 2 ward movements (2% Target)	2.00%	2.42%	1.27%	5.16%	1.20%	-
No of Spells with > 3 Ward Movements	-	34	2	28	4	-
% of spells with > 3 ward movements (No Target)	-	0.64%	0.14%	1.72%	0.18%	-
No of Spells with > 4 Ward Movements	-	12	0	10	2	-
% of spells with > 4 ward movements (No Target)	-	0.23%	0.09%	0.61%	0.09%	-
No of Spells with > 5 Ward Movements	-	4	0	3	1	-
% of spells with > 5 ward movements (No Target)	-	0.08%	0.00%	0.18%	0.02%	-
Total Number of Spells	-	5287	1408	1627	2252	-
Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	85.00%	79.41%	79.41%	-	-	-

% of spells with > 2 ward movements

1. Why off plan? Increased demand for acute beds. This has necessitated the opening of extra beds. The safest way to use these extra capacity areas has been as 'step down' beds, leaving acute beds for the patients most in need them. Whilst clinically this has been seen as the best available solution to pressures, it can inevitably lead to extra wards moves for patients.

2. Actions to get back to plan: Progressing work to remodel the bed base to reflect true demand. Initiatives to improve discharge processes and more effectively manage patients. This will reduce occupancy and mitigate the need for unplanned extra capacity.

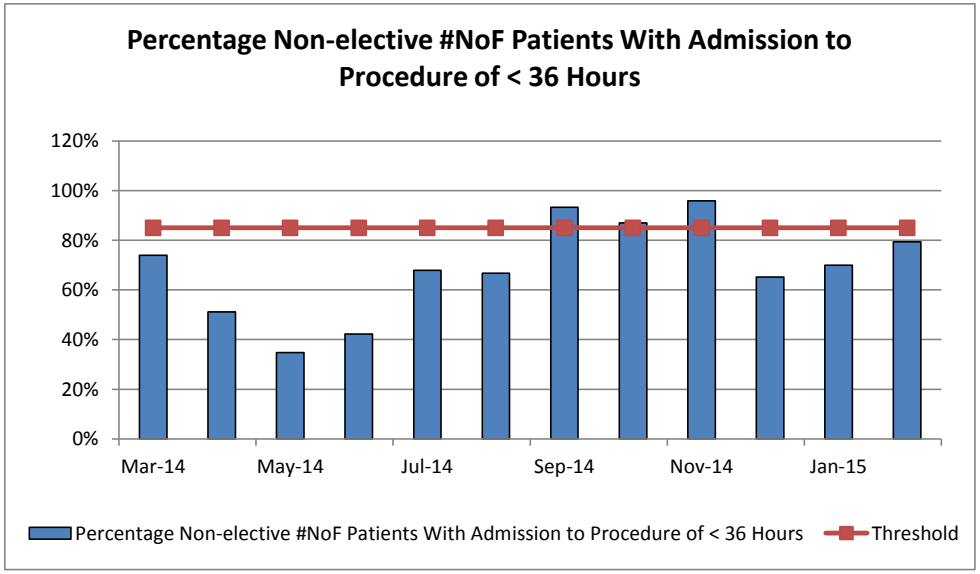
3. Achieved by date: April 2015

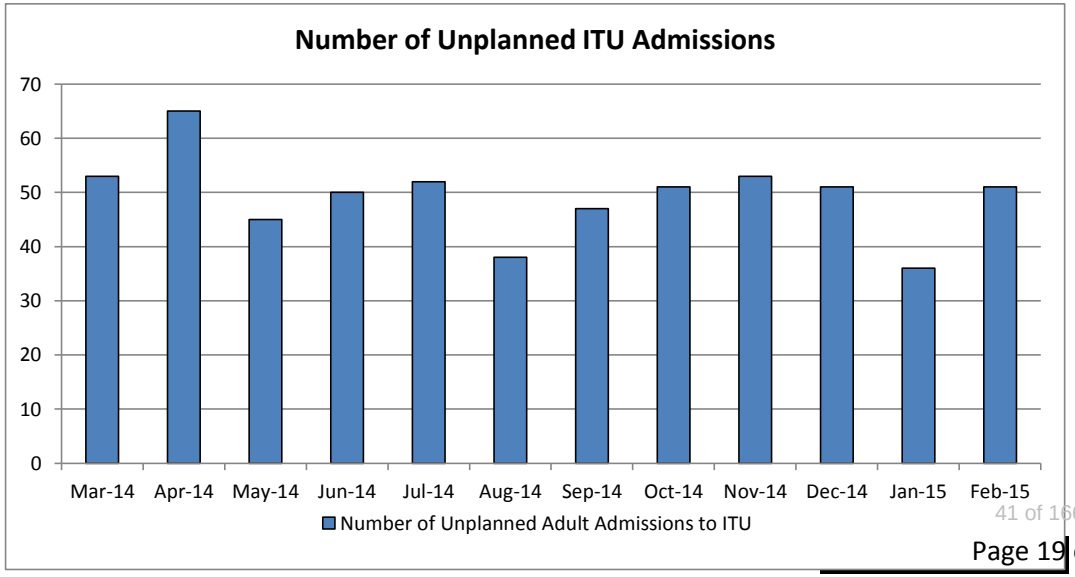
Non-Elective #NOF

1.Why off plan? February saw a higher % than normal of the fractured neck of femurs admitted who were not fit for surgery. Of the 7 patients who did not get to theatre in 36 hours 6 were for clinical reasons. Only one was attributed to the Directorate not having sufficient capacity. (March delivery on 13/3/15 is 94%)

2. Actions to get back on plan: The Directorate is investigating increasing the capacity of the Trauma Theatres, and backfilling with elective day case procedures (off a short call list) when there is low trauma demand (supported by the Director of Director of Planning, Performance, Estates and Facilities).

3. Achieved by date: If deliverable the piece of work outlined above will start to be implemented in 6 weeks.





Well Led / Workforce - Director of Workforce and Organisational Development

Calderdale and Huddersfield NHS
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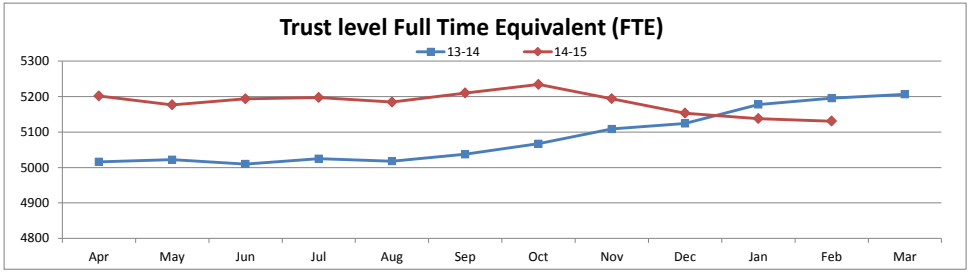
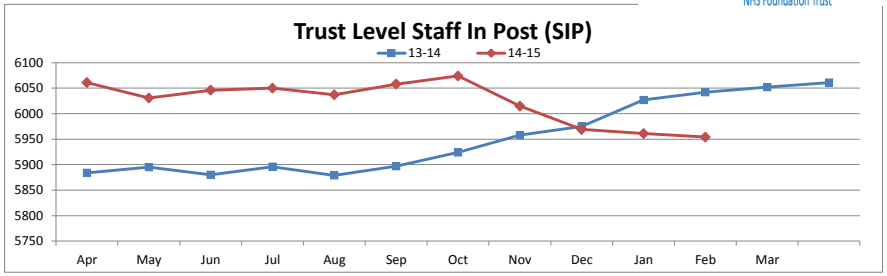
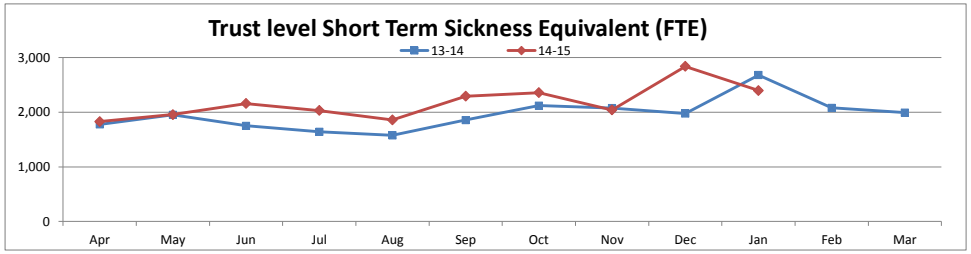
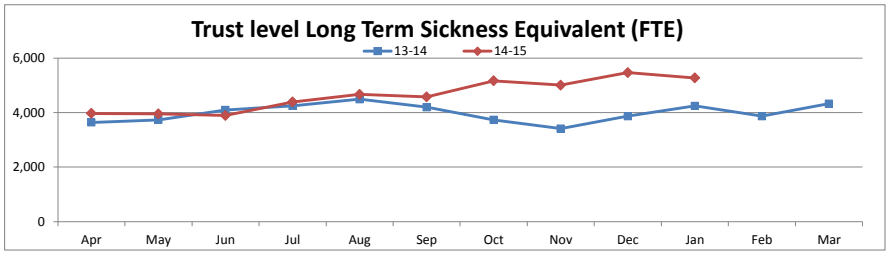








Director Lead	Report For: February 2015	Trust Threshold	Trust Actual	Surgery	Medical	CWF	DATS	Estates	Corporate	THIS
J.H	Sickness Absence rate (%) (1 Month Behind)	4.00%	4.80%	4.63%	5.25%	5.60%	3.72%	6.17%	1.79%	4.79%
J.H	Sickness Absence rate (FTE Lost) (1 Month Behind)		7645.03	1910.22	2640.88	1378.48	728.45	557.00	157.80	272.21
J.H	FTE Days Available (1 Month Behind)		159280.42	37356.67	45225.12	21888.42	17720.17	8114.09	8022.57	5134.64
J.H	Sickness Absence rate (%) - Year to date	4.00%	4.24%	4.40%	4.83%	4.66%	3.37%	4.67%	1.49%	2.56%
JH	Total Staff in Post (FTEs)		5,123.63	1,334.17	1,615.18	781.73	632.86	289.79	286.52	183.38
LH	Fire Safety Awareness	95.00%	82.40%	78.20%	73.00%	87.60%	95.80%	99.20%	84.80%	93.60%
LH	Fire Risk Assessments	95.00%	74% Audited							
MG	Information Governance - Rolling 12 Month	100.00%	70.30%	65.40%	64.60%	67.30%	86.50%	94.00%	67.80%	80.40%
JD	Risk Training - Rolling 12 Month	100.00%	64.50%	60.70%	52.90%	68.50%	75.00%	87.90%	71.10%	76.60%
JH	Appraisal- YTD	83%	49.68%	34.70%	32.30%	62.90%	73.00%	98.10%	45.00%	90.20%
JH	Appraisal - Rolling 12 Month	100.00%	63.01%	52.08%	51.96%	68.94%	81.01%	97.86%	57.69%	94.68%
DB	Appraisal Medical- YTD	100.00%	47.85%	45.90%	44.00%	46.30%	76.70%	-	100.00%	-
DB	Medical devices training	95.00%	82.00%	75.00%	75.00%	82.00%	87.00%	-	91.00%	-
JD	Safeguarding - Level 1 - Staff compliant		70.30%	65.40%	64.60%	67.30%	86.50%	94.00%	67.80%	80.40%
JD	Safeguarding - Level 2 - Staff compliant		50.70%	53.60%	59.00%	25.90%	55.50%	82.50%	58.70%	0.00%
JD	Safeguarding - Level 3 - Staff Compliant		81.70%	67.90%	89.50%	81.60%	83.30%	-	100.00%	-
JH	FFT Staff - Response Rate (Quarterly)		6.50%	-	-	-	-	-	-	-
JH	FFTStaff - Would you recommend us to your friends and family as a place to receive		81.00%	-	-	-	-	-	-	-
JH	FFT Staff - Would you recommend us to your friends and family as a place to work?		59.00%	-	-	-	-	-	-	-
JD	Hard Truths Summary Day - Nurses/Midwives	100.00%	81.37%	82.47%	79.10%	85.22%				
JD	Hard Truths Summary - Day Care Staff	100.00%	92.77%	89.06%	97.40%	82.00%				
JD	Hard Truths Summary - Night Nurses/Midwives	100.00%	89.87%	86.02%	90.41%	93.21%				
JD	Hard Truths Summary - Night Care Staff	100.00%	115.24%	111.51%	125.57%	84.29%				

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

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

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

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

Fire Safety Awareness - Fire Alarm Activations for February 2015

CRH 6 Activations - 5 for CHFT, I for SWYFT (Mental Health Villas) HRI 5 Activations - with 2 attendances from West Yorkshire Fire Service

CHFT Authorising Engineer has audited a 74% sample of Fire Risk Assessments across HRI and CRH. Whilst progress is being made against action plans there are still actions which require attention and closure.

CHFT have made significant inroads into training fire wardens, however, due to department moves and the increase in agile working there is a need to increase the number of fire wardens. This will ensure departments have robust and effective fire safetyplans in place and evacuation plans are executed safely as and when required.

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

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

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

YTD Information Governance - The monthly compliance target for Information Governance is 6%. Information Governance training compliance is measured on arolling year basis so figures will fluctuate throughout the year. YTD Compliance is at 70.3% Training awareness and compliance messages are being communicated via the Trust Information Governance and Records Strategy Group which is then cascaded throughout the divisions. There will be a final push for Training uptake during January, February and March 2015 with a year end predication of 85%.

Hard Truths - Maintaining staffing levels has remained a challenge due to the fluctuating demand this month. Increased transparency and accuracy in reporting staffing hours has been achieved through the implementation of the web based staffing tool, and further workis underway to ensure that the use of any long days is captured in the planned hours. This will prevent inaccuracies been reported where we have had the correct number of nurses in the area, but a shortage of hours due to nurses working 1 long shift ratherthan 2 nurses working short shifts which can produce a short fall in hours of 3.5hours.

We are currently focusing on "Red Flag" events related to safe staffing and the process for escalating, reporting and utilising these to inform future staffing reviews.
Robust recruitment continues with 42 candidates attending for Band 5 positions this month, although 25% of these are currently students. We are recruiting student nurses and offering engagement events between now and September when they will commence asqualified nurses with CHFT. We have had a further 12 international nurses commence within CHFT this month, and are scheduled to travel to Spain on 11.3.15 to recruit further.
This month we attend 2 local universities to promote CHFT for final year student nurses and midwives.

Revised new version:

		Trust Threshold	Trust Actual
Finance	Continuity of Service Risk Rating	3	2
	Operational Performance (Debt service cover)	3	2
	Cash & Balance Sheet Performance (Liquidity)	3	2
	Use of Capital	£22.05m	£19.71m
	Income and Expenditure	£2.12m	(£2.71m)
	Cost Improvement Programme (CIP)	£16.96m	£8.66m

Calderdale and Huddersfield NHS
NHS Foundation Trust

Contract income

THIS

		Year To Date Plan		Year To Date Actual		Year To Date Variance	
Division	Monitor POD	Plan YTD - Spells	Plan YTD - Value (Inc MFF) with CQUIN	Actual 1415 - Spells	Actual 1415 -Value (Inc MFF) with CQUIN	Variance - Spells	Variance - Value (Inc MFF) with CQUIN
CWF	DAYCASE	2,340	1,489,906	2,139	1,496,825	-201	6,918
	ELECTIVE	1,324	2,236,134	974	2,238,657	-350	2,523
	NON-ELECTIVE	13,608	16,022,968	13,115	16,039,011	-493	16,043
	OTHER NHS NON-TARIFF	44,593	20,180,090	40,570	19,618,330	-4,023	-561,760
	OTHER NHS TARIFF	14,097	10,338,267	13,749	10,332,500	-348	-5,767
	OUTPATIENT	36,595	5,579,656	38,398	5,668,788	1,803	89,132
CWF Total		112,557	55,847,021	108,945	55,394,111	**-3,612**	-452,910
DATs	DAYCASE	293	272,213	243	272,215	-50	2
	ELECTIVE	310	529,826	301	557,981	-9	28,156
	NON-ELECTIVE	5	29,501	1	13,561	-4	-15,940
	OTHER NHS NON-TARIFF	1,303,913	8,135,939	1,292,692	8,209,326	-11,221	73,387
	OTHER NHS TARIFF	55,944	5,051,176	60,886	5,170,598	4,942	119,422
	OUTPATIENT	0	0	0	0	0	0
DATs Total		1,360,466	14,018,654	1,354,123	14,223,681	**-6,343**	205,027
Medicine	DAYCASE	9,604	5,385,603	9,099	5,417,162	-505	31,559
	ELECTIVE	824	1,779,739	891	1,737,725	67	-42,014
	NON-ELECTIVE	19,808	37,767,928	19,522	37,913,038	-286	145,111
	OTHER NHS NON-TARIFF	66,524	42,622,647	63,953	40,448,945	-2,571	-2,173,703
	OTHER NHS TARIFF	10,596	2,969,848	10,239	2,826,786	-357	-143,063
	OUTPATIENT	84,142	10,866,948	84,146	10,908,480	4	41,532
Medicine Total		191,500	101,392,714	187,850	99,252,135	**-3,649**	-2,140,579
Surgery	A&E	129,254	12,766,286	130,099	12,838,997	845	72,710
	DAYCASE	25,016	20,077,762	25,320	20,069,875	304	-7,887
	ELECTIVE	6,365	18,792,205	5,481	18,404,891	-884	-387,314
	NON-ELECTIVE	12,820	22,296,280	11,881	22,275,803	-939	-20,477
	OTHER NHS NON-TARIFF	33,315	11,085,305	32,168	11,451,449	-1,147	366,143
	OTHER NHS TARIFF	16,870	1,533,754	16,384	1,549,709	-486	15,955
	OUTPATIENT	177,579	19,248,345	176,931	19,285,945	-648	37,600
Surgery Total		401,217	105,799,938	398,264	105,876,668	**-2,953**	76,730
Corporate	OTHER NHS NON-TARIFF	0	198,764	0	198,764	0	0
Corporate Total		0	198,764	0	198,764	0	0
Ops & Facilities	OTHER NHS NON-TARIFF	0	486,285	0	486,285	0	0
Ops & Facilities Total		0	486,285	0	486,285	0	0
Central	NON-ELECTIVE	0	0	0	0	0	0
	OTHER NHS NON-TARIFF	27	264,000	73	264,000	46	0
	OTHER NHS TARIFF	0	-97,433	0	-97,433	0	0
Central Total		27	166,567	73	166,567	46	0
Grand Total		**2,065,766**	**277,909,942**	**2,049,256**	**275,598,211**	**-16,511**	**-2,311,732**

Trust Financial Overview as at 28th Feb 2015 - Month 11

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

YEAR TO DATE POSITION: M11

CLINICAL ACTIVITY

	M11 Plan	M11 Actual	Var
Elective	8,823	7,647	(1,176)
Non Elective	46,241	44,519	(1,722)
Daycase	37,253	36,801	(452)
Outpatients	298,316	299,475	1,159
A & E	129,254	130,099	845

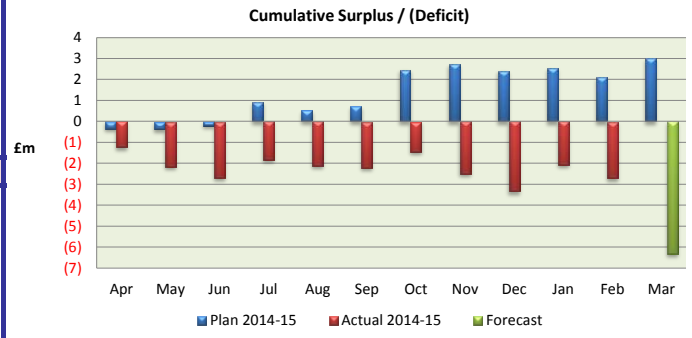
TRUST: INCOME AND EXPENDITURE

	M11 Plan	M11 Actual	Var
	£m	£m	£m
Elective	£23.34	£22.94	(£0.40)
Non Elective	£76.12	£76.24	£0.13
Daycase	£27.30	£27.26	(£0.04)
Outpatients	£35.73	£35.86	£0.13
A & E	£12.77	£12.84	£0.07
Other-NHS Clinical	£111.83	£112.71	£0.88
Other Income	£34.15	£34.08	(£0.07)
Total Income	**£321.23**	**£321.93**	**£0.69**
Pay	(£198.77)	(£202.25)	(£3.48)
Drug Costs	(£24.13)	(£26.24)	(£2.11)
Clinical Support	(£25.70)	(£27.54)	(£1.84)
Other Costs	(£36.76)	(£34.75)	£2.01
PFI Costs	(£10.56)	(£10.70)	(£0.14)
Total Expenditure	**(£295.92)**	**(£301.47)**	**(£5.55)**
EBITDA	**£25.31**	**£20.45**	**(£4.86)**
Non Operating Expenditure	(£23.19)	(£21.82)	£1.37
Deficit excl. Restructuring	**£2.12**	**(£1.37)**	**(£3.49)**
Restructuring Costs	£0.00	(£1.34)	(£1.34)
Surplus / (Deficit)	**£2.12**	**(£2.71)**	**(£4.84)**

DIVISIONS: INCOME AND EXPENDITURE

	M11 Plan	M11 Actual	Var
	£m	£m	£m
Surg & Anaes	£29.68	£26.43	(£3.25)
Medical	£26.59	£22.01	(£4.58)
CWF	£18.03	£17.34	(£0.69)
DATS	(£11.43)	(£12.83)	(£1.40)
Est & Fac	(£24.42)	(£24.32)	£0.10
Corporate / THIS	(£15.47)	(£17.43)	(£1.97)
Central Inc/Tech	(£20.06)	(£13.90)	£6.16
Reserves	(£0.79)	£0.00	£0.79
Surplus / (Deficit)	**£2.12**	**(£2.71)**	**(£4.84)**

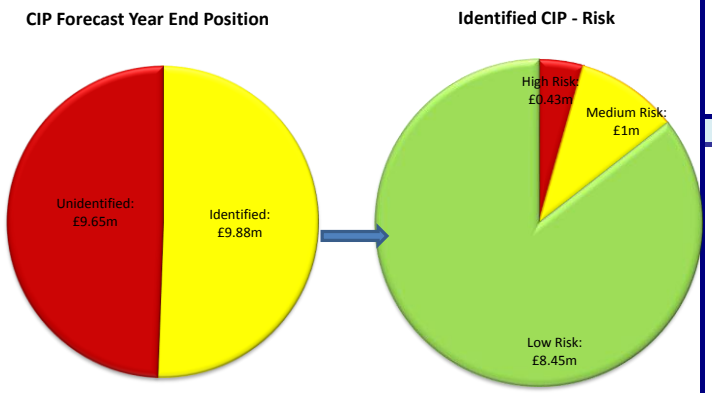
TRUST SURPLUS / (DEFICIT)



KEY METRICS

	Year To Date M11 Plan	Year To Date M11 Actual	Year To Date Var	Year End: Forecast Plan	Year End: Forecast Forecast	Year End: Forecast Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	£2.12	(£2.71)	(£4.84)	£3.00	(£6.29)	(£9.29)
Capital (Re-forecast Plan)	£22.05	£19.71	£2.34	£24.31	£22.39	£1.93
Cash	£22.56	£16.77	(£5.79)	£22.71	£10.79	(£11.92)
	Plan	Actual		Plan	Forecast	
Continuity of Service Risk Rating	3	2		3	2	

COST IMPROVEMENT PROGRAMME (CIP)



Total Planned: **£19.53m**

Total Identified: **£9.88m**

YEAR END 2014/15

CLINICAL ACTIVITY

	Plan	Forecast	Var
Elective	9,676	8,385	(1,291)
Non Elective	50,642	48,751	(1,892)
Daycase	40,851	40,320	(531)
Outpatients	327,239	328,454	1,215
A & E	141,505	142,431	926

TRUST: INCOME AND EXPENDITURE

	Plan	Forecast	Var
	£m	£m	£m
Elective	£25.60	£25.15	(£0.45)
Non Elective	£83.29	£83.42	£0.13
Daycase	£29.93	£29.77	(£0.16)
Outpatients	£39.20	£39.29	£0.09
A & E	£13.98	£14.06	£0.08
Other-NHS Clinical	£122.37	£123.80	£1.43
Other Income	£37.27	£37.35	£0.08
Total Income	**£351.64**	**£352.85**	**£1.21**
Pay	(£217.10)	(£221.09)	(£3.99)
Drug Costs	(£26.36)	(£28.69)	(£2.33)
Clinical Support	(£28.04)	(£30.11)	(£2.07)
Other Costs	(£40.29)	(£39.06)	£1.23
PFI Costs	(£11.52)	(£11.70)	(£0.18)
Total Expenditure	**(£323.31)**	**(£330.64)**	**(£7.33)**
EBITDA	**£28.33**	**£22.21**	**(£6.12)**
Non Operating Expenditure	(£25.33)	(£23.79)	£1.54
Deficit excl. Restructuring	**£3.00**	**(£1.58)**	**(£4.58)**
Restructuring Costs	£0.00	(£4.71)	(£4.71)
Surplus / (Deficit)	**£3.00**	**(£6.29)**	**(£9.29)**

DIVISIONS: INCOME AND EXPENDITURE

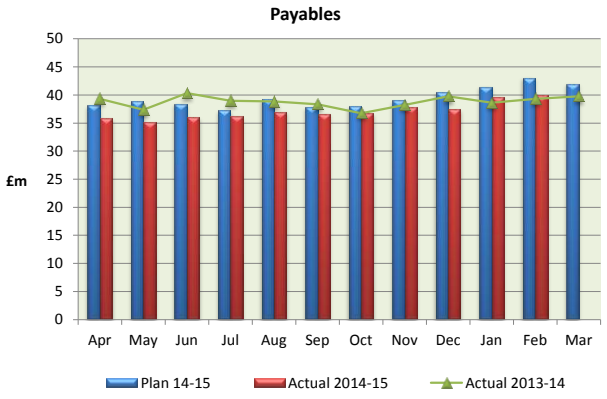
	Plan	Forecast	Var
	£m	£m	£m
Surg & Anaes	£33.11	£28.39	(£4.71)
Medical	£28.96	£23.92	(£5.04)
CWF	£19.85	£18.88	(£0.97)
DATS	(£12.19)	(£13.54)	(£1.36)
Est & Fac	(£26.71)	(£26.68)	£0.02
Corporate / THIS	(£16.89)	(£19.33)	(£2.44)
Central Inc/Tech	(£20.44)	(£17.79)	£2.65
Reserves	(£2.70)	(£0.14)	£2.56
Surplus / (Deficit)	**£3.00**	**(£6.29)**	**(£9.29)**

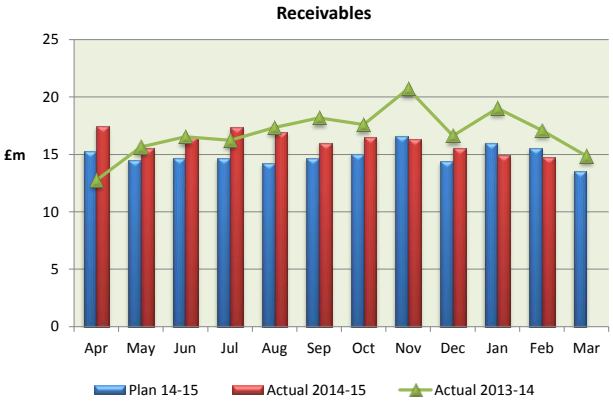
Trust Financial Overview as at 28th Feb 2015 - Month 11

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

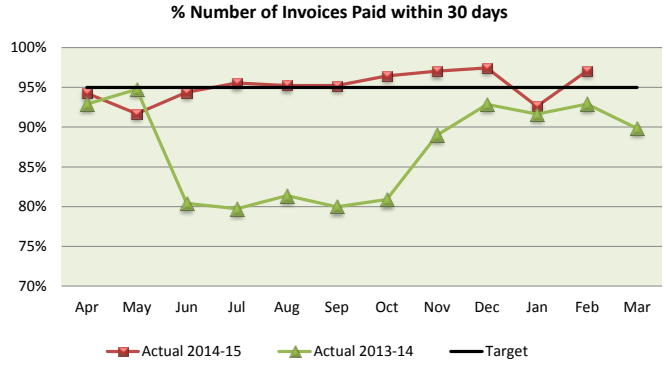
WORKING CAPITAL

	M11 Plan £m	M11 Actual £m	Var £m	M11
Payables	(£43.09)	(£39.98)	(£3.11)	
Receivables	£15.52	£14.80	£0.72	



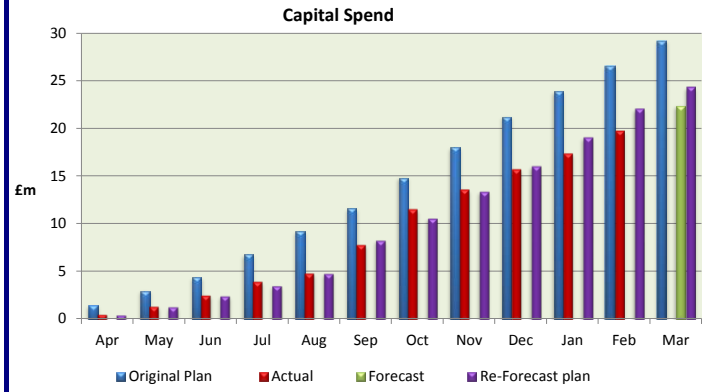


BETTER PAYMENT PRACTICE CODE



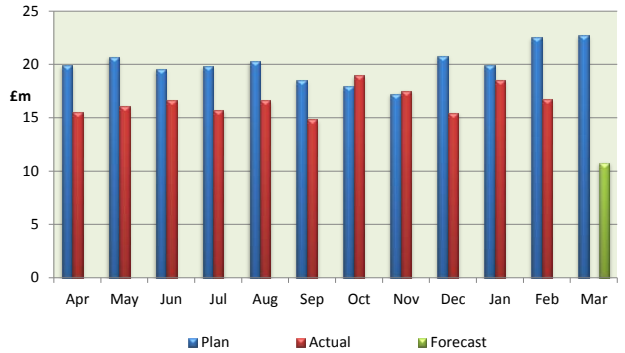
CAPITAL

	M11 Plan £m	M11 Actual £m	Var £m	M11
Capital (re-forecast plan)	£22.05	£19.71	£2.34	

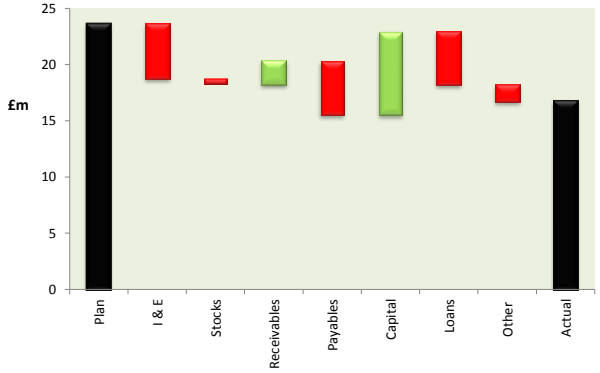


CASH

	M11 Plan £m	M11 Actual £m	Var £m	M11
Cash	£22.56	£16.77	(£5.79)	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- Bed capacity pressures continue. Elective activity remains below planned levels.
- The level of income protection offered by the fixed value contract stands at £5.68m in the year to date position.
- The year to date deficit is £2.71m including restructuring costs of £1.34m, against a planned surplus of £2.12m.
- Capital expenditure of £19.71m against revised planned £22.05m, an underspend of £2.34m (£6.83m below original plan).
- The cash balance was £16.77m, versus a planned £22.56m, £5.79m lower than planned. A level of loan funded borrowing has supported the cash required for capital investment.
- The Continuity of Service Risk Rating (CoSRR) stands at 2 against a planned level of 3.
- The regulator, Monitor investigated the financial position and a Trust led turnaround process is now in operation.

SUMMARY FORECAST

- The deficit excluding 'exceptional' restructuring costs is forecast to be £1.58m against a planned £3.0m surplus. Due to their exceptional one-off nature, restructuring costs are excluded from the calculation of the CoSRR but these payments will adversely affect the cash balance.
- The year end forecast including restructuring costs is a deficit of £6.29m. This will result in a CoSRR of 2 for the year.
- CIP schemes are forecast to deliver £9.88m against the planned £19.53m. This is a shortfall of £9.65m and will have an impact on 2015/16.
- £1.5m has been committed to extra substantive nurse staffing; additional winter expenditure has been included within the forecast position.
- £1.5m additional income to support quality investments has been received and is reflected in the year to date and forecast position.
- The revised capital forecast, is a £22.39m spend, a reduction of £1.93m from the revised plan, (£6.81m lower than original plan).
- The forecast year end cash balance is £10.79m against the planned £22.71m.

RAG KEY: (Excl: Cash)

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

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

RAG KEY - Cash:

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

Calderdale and Huddersfield NHS NHS Foundation Trust

Community Executive Summary

THIS

			Report For: February 2015						Year To Date							
	Report For: February 2015	Indicator Source	Target	Trust	Surgical	Medical	CWF	DATS	Target	Trust	Surgical	Medical	CWF	DATS	Year End Forecast	Data Quality
Community - CWF	Antenatal Health Visiting Contact by 32 Weeks	National	70.00%	86.00%	-	-	86.00%	-	70.00%	79.50%	-	-	79.50%	-		
	Health Visiting - Post Birth Visits within 14 days	National	-	87.00%	-	-	87.00%	-	-	82.50%	-	-	82.50%	-		
	Health Visiting - Breast Feeding drop off rates-initiation to GP 6-8 week check	National	-	43.80%	-	-	43.80%	-	-	44.30%	-	-	44.30%	-		
	Immunisations - % of 8 year old girls HPV immunised	National	90.00%	91.60%	-	-	91.60%	-	90.00%	91.60%	-	-	91.60%	-		
	Paediatric Therapies - 18 week RTT in SLT	National	95.00%	97.30%	-	-	97.30%	-	95.00%	92.32%	-	-	92.32%	-		
	Paediatric Therapies - 18 week RTT in Physiotherapy	National	95.00%	100.00%	-	-	100.00%	-	95.00%	97.37%	-	-	97.37%	-		
	Paediatric Therapies - 18 week RTT in Occupational Therapy	National	95.00%	100.00%	-	-	100.00%	-	95.00%	90.34%	-	-	90.34%	-		
	Family Nurse Partnership	Local	TBC	TBC	-	-	TBC	-	TBC	TBC	-	-	TBC	-		
Community - CWF 2	Midwifery - % Home Births	National	-	1.20%	-	-	1.20%	-	-	1.80%	-	-	1.70%	-		
	Midwifery - % of Antenatal Bookings done with 12 weeks and 6 days	National	90.00%	90.80%	-	-	90.80%	-	90.00%	92.20%	-	-	92.20%	-		
	Midwifery - % women smoking at time of delivery	National	11.90%	12.50%	-	-	12.50%	-	11.90%	11.80%	-	-	11.80%	-		
	Sexual Health - % Referrals seen within 48 Hours	Local	-	97.00%	-	-	97.00%	-	-	96.80%	-	-	96.80%	-		
	Sexual Health - % Patients offered a HIV Test	Local	-	100.00%	-	-	100.00%	-	-	100.00%	-	-	100.00%	-		
	CDU	Local	TBC	TBC	-	-	TBC	-	TBC	TBC	-	-	TBC	-		
	Communituy - Children's Nurses		TBC	TBC	-	-	TBC	-	TBC	TBC	-	-	TBC	-		
Community	Home equipment delivery < 7 days	National	95.00%	93.10%	-	93.10%	-	-	95.00%	95.90%	-	95.90%	-	-		
	% of patients under the care of the community specialist matron who have been readmitted to hospital with the same LTC in less than 30 days (one month behind)	Local	10.00%	1.50%	-	1.50%	-	-	10.00%	1.40%	-	1.40%	-	-		
	% of leg ulcers healed within 12 weeks from diagnosis	Local	75.00%	92.00%	-	92.00%	-	-	75.00%	96.12%	-	96.12%	-	-		
	Number of community acquired grade 3 or 4 pressure ulcers	National	6.3	5	-	5	-	-	To be agreed	20	-	20	-	-		
	Community AHP - 18 week RTT Snapshot at month end	National	95.00%	78.70%	-	78.70%	-	-	95.00%	83.70%	-	83.70%	-	-		
	Percentage of Community Staff equipped with mobile device	Local	-	-	-	-	-	-	-	77.00%	-	77.00%	-	-		
	% district nursing patients with a care plan	Local	90.00%	95.00%	-	95.00%	-	-	90.00%	94.60%	-	94.60%	-	-		
	Number of patients with a Calderdale care plan - (this is a self management plan incorporates the emergency care plan)	Local	90.00%	41.00%	-	41.00%	-	-	90.00%	42.00%	-	42.00%	-	-		
	District Nursing Performance Active caseload	Local	-	4348	-	4348	-	-	-	4244	-	4244	-	-		
	District Nursing Performance New referrals in month	Local	-	1018	-	1018	-	-	-	15415	-	15415	-	-		
	District Nursing Performance Urgent referrals seen within 4 hours	Local	80.00%	61.00%	-	61.00%	-	-	80.00%	70.40%	-	70.40%	-	-		
	District Nursing Performance Non urgent referrals seen within 2 days	Local	80.00%	57.00%	-	57.00%	-	-	80.00%	60.90%	-	60.90%	-	-		
	Community Friends & Family Test - % Would recommend the Service	CQUIN	-	90.00%	-	90.00%	-	-	-	90.50%	-	90.50%	-	-		
	Community Friends & Family Test - % Would NOT recommend the Service	CQUIN	-	5.00%	-	5.00%	-	-	-	5.00%	-	5.00%	-	-		
	Patients who died at their preferred place of choice	Local	75.00%	75.00%	-	75.00%	-	-	75.00%	89.00%	-	89.00%	-	-		

Report For: February 2015	Target	Trust	Surgical	Medical	CWF	DATS
Antenatal Health Visiting Contact by 32 Weeks	70.00%	86.00%	-	-	86.00%	-
Health Visiting - Post Birth Visits within 14 days	-	87.00%	-	-	87.00%	-
Health Visiting - Breast Feeding drop off rates-initiation to GP 6-8 week check	-	43.80%	-	-	43.80%	-
Immunisations - % of 8 year old girls HPV immunised	90.00%	91.60%	-	-	91.60%	-
Paediatric Therapies - 18 week RTT in SLT	95.00%	97.30%	-	-	97.30%	-
Paediatric Therapies - 18 week RTT in Physiotherapy	95.00%	100.00%	-	-	100.00%	-
Paediatric Therapies - 18 week RTT in Occupational Therapy	95.00%	100.00%	-	-	100.00%	-
Family Nurse Partnership	TBC	TBC		-	TBC	-

Family Nurse Partnership (FNP)

Family Nurse Partnership indicator to be confirmed as the service reports on multiple indicators to NHS England. NHS England raised no concerns at the recent advisory board. We will narrow down to one indicator for the next report.

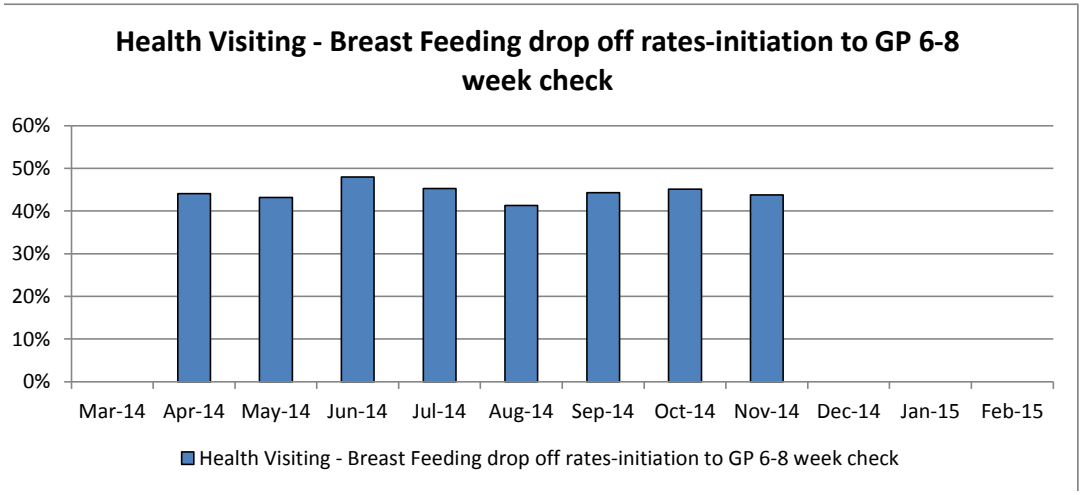
Antenatal Health Visiting Contact by 32 Weeks - The target will increase to 80% for quarter 4. Work is currently being done within teams to ensure this will be achieved. Individual practitioners are also being monitored.

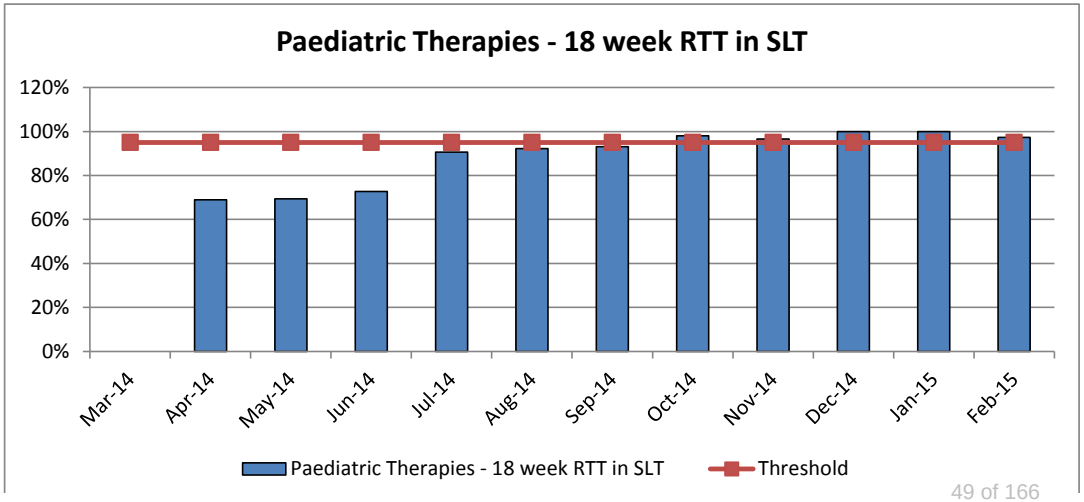
Health Visiting - Post Birth Visits within 14 days - The target will increase to 95% for quarter 4. Work is currently being done with teams to review compliance against the target. Data validations and exception reports to be added by NHS England so show where patients were offered an appointment, but this has not be accepted.

Health Visiting - Breast Feeding drop off rates-initiation to GP 6-8 week check - Turning the Curve group in place to optimise uptake and increase our percentage – This is being led by the Consultant in Public Health. The Best Beginnings Programme to be rolled out to support uptake and increase target outcome

Immunisations - % of 8 year old girls HPV immunised - Was a red flag indicator from NHS England as we had not reached our target. Action plans were put in place and target has now been achieved – Dedicated immunisation team in place from April 1st. All outcomes will be closely monitored.

RTT 18 Weeks Activity - Processes being closely managed by the Service.



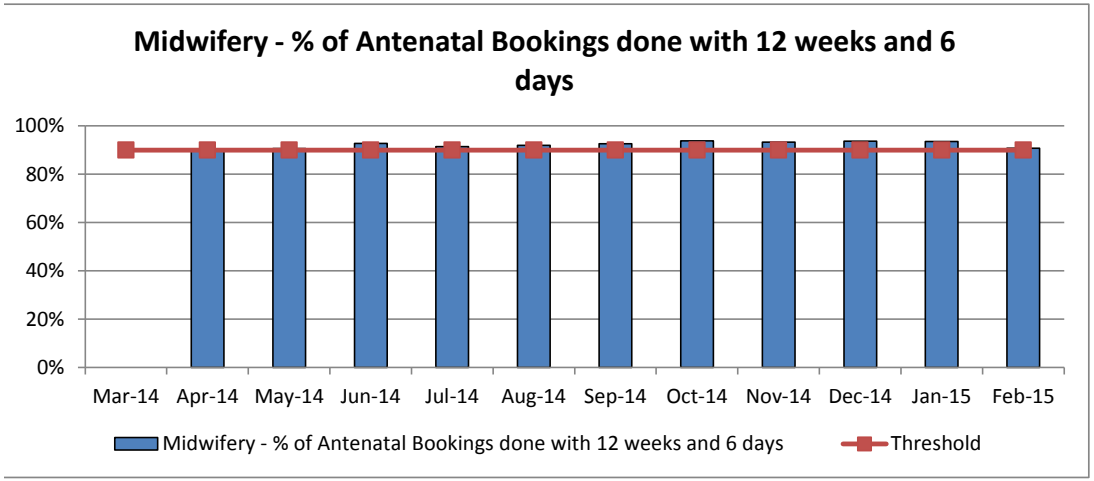


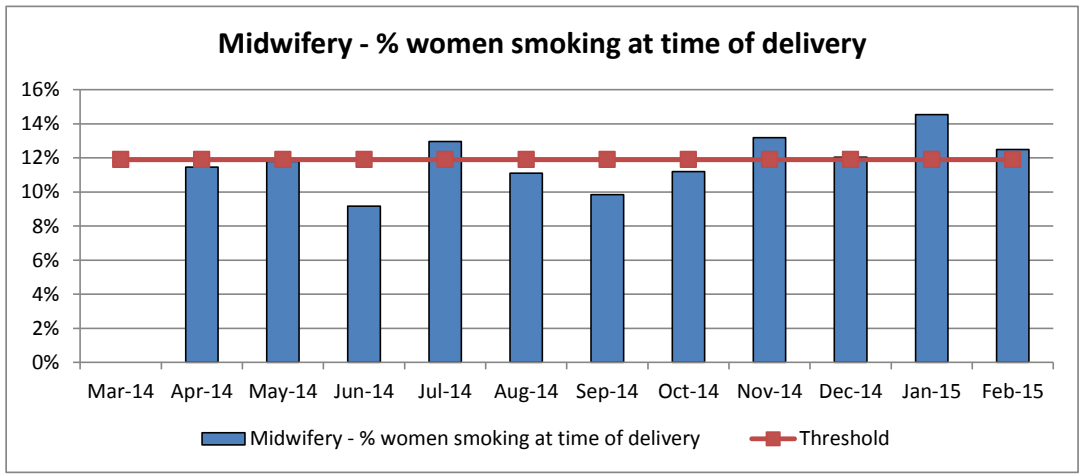
Report For: February 2015	Target	Trust	Surgical	Medical	CWF	DATS
Midwifery - % Home Births		1.20%	-	-	1.20%	-
Midwifery - % of Antenatal Bookings done with 12 weeks and 6 days	90.00%	90.80%	-	-	90.80%	-
Midwifery - % women smoking at time of delivery	11.90%	12.50%	-	-	12.50%	-
Sexual Health - % Referrals seen within 48 Hours	95.00%	97.00%	-	-	97.00%	-
Sexual Health - % Patients offered a HIV Test	100.00%	100.00%	-	-	100.00%	-
CDU	TBC	TBC	-	-	TBC	-
Community - Children's Nurses	TBC	TBC	-	-	TBC	-

Midwifery - % women smoking at time of delivery - Relevant women being referred to a specialist service, this is expected to see a reduction in a the percentage of women smoking at delivery.

CDU - Indicator to be devised for the next report

Community - Children's Nurses - indicator to be devised for the next report





Report For: February 2015	Target	Trust	Surgical	Medical	CWF	DATS
Home equipment delivery < 7 days	95.00%	93.10%	-	93.10%	-	-
% of patients under the care of the community specialist matron who have been readmitted to hospital with the same LTC in less than 30 days (one month behind)	10.00%	1.50%	-	1.50%	-	-
% of leg ulcers healed within 12 weeks from diagnosis	75.00%	92.00%	-	92.00%	-	-
Number of community acquired grade 3 or 4 pressure ulcers	6.3	5.0	-	5.0	-	-
Community AHP - 18 week RTT Snapshot at month end	95.00%	78.70%	-	78.70%	-	-
Percentage of Community Staff equipped with mobile device	100.00%	-	-	-	-	-
% district nursing patients with a care plan	90.00%	95.00%	-	95.00%	-	-
Number of patients with a Calderdale care plan - (this is a self management plan incorporates the emergency care plan)	90.00%	41.00%	-	41.00%	-	-
District Nursing Performance Active caseload	-	4348	-	4348	-	-
District Nursing Performance New referrals in month	-	1018	-	1018	-	-
District Nursing Performance Urgent referrals seen within 4 hours	80.00%	61.00%	-	61.00%	-	-
District Nursing Performance Non urgent referrals seen within 2 days	80.00%	57.00%	-	57.00%	-	-
Community Friends & Family Test - % Would recommend the Service	-	90.00%	-	90.00%	-	-
Community Friends & Family Test - % Would NOT recommend the Service	-	5.00%	-	5.00%	-	-
Patients who died at their preferred place of choice	75.00%	75.00%	-	75.00%	-	-

78.7% percent of **community staff equipped with a mobile device** - Handover and training sessions of laptops taking place. The smart phone rollout continues. The change management process for this impletion has been completed. A request has been made for further capital to complete the project. Once we have the request formalised further laptops and phones will be ordered . The plan will be that the roll out for the remaining 21% of staff receive their Kit and training by June 2015 .

% Leg ulcers healed with 12 weeks from Diagnosis - YTD 198/206 of leg ulcers diagnosed by the team were supported to heal within 12 weeks. There has been extensive work in the healing of leg ulcers and only 8 patients out of 206 did not have their leg ulcer healed within 12 weeks.

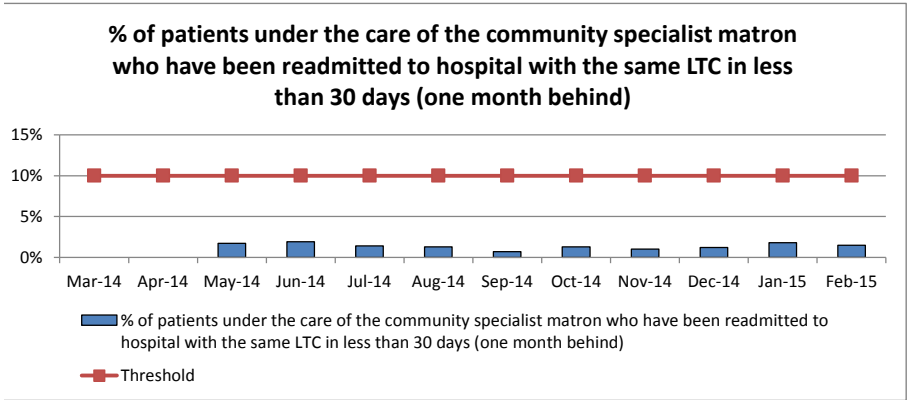
LTC Patients with a Calderdale Care Plan - The target around LTC patients and Calderdale Care plan is linked to the self -management plan and is only recorded on the community matrons caseload.

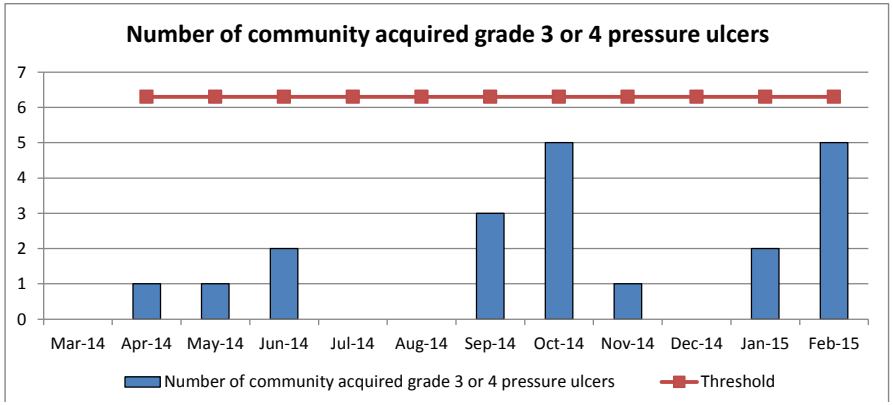
Community Friends and Family Test - First months data has been reported

District Nursing Performance target discussed at CCG contract meeting - agreed to change the criteria and how this is counted as these timescales are not valid 01/05/15

Community AHP RTT - due to Podiatry, OTAS, Adult SALT and Hudds PRG. Podiatry have recently undergone a full service review and identified a new model of service provision, which when agreed will reduce waiting times. OTAS service is not being recommissioned and service provision will stop at end of March. Adult SALT did not have a voice service for 9 months - this posthas now been filled and the new postholder is working her way through the waiting list. Hudds PRG is a commissioned service and service demand is greater than capacity

The patients who have died in their preferred place of choice needs further work as staff will need to check that what is recorded on the electronic record is actually what happened . The Clinical S1 is working with staff to ensure this is consistently recorded. These figures will be small any omissions will radically alter the %





Calderdale and Huddersfield NHS Foundation Trust

MES / INDICATORS - CHFT
FINANCIAL YEAR 2014/15
TRUST WIDE

Indicator Name	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3	Quarter 4			Q4	YTD
	Apr	May	Jun	Total	Jul	Aug	Sep	Total	Oct	Nov	Dec	Total	Jan	Feb	Mar	Total	
1.1 - Friends and Family Test - Implementation of the staff FFT across the provider from April 2014 - reporting by end of Q1 One payment at end of Q1 (£319k total)																	
Indicator 1.1 Reporting by end of Q1			YES														
1.1.1 - Friends and Family Test - Implementation of FFT across outpatient and day case department across the Trust - establish by end of Q2 and report from Q3 onwards One payment at end of Q2 (£319k total)																	
Indicator 1.2 Reporting from Q3 - Daycase (including endoscopy, day surgery and day procedures).							YES		26.3%	26.0%	25.2%						
Indicator 1.2 Reporting from Q3 - Outpatient							YES		16.7%	16.3%	11.5%						
1.1.2 - Friends and Family Test - Implementation of FFT across Community services - establish by end of Q3 and report from Q4 onwards One payment at end of Q3 (£319k total)																	
Indicator 1.1.2 Reporting from Q4											YES						
1.2 - Friends and Family - Response rate to F&F test question **Inpatient - Q1 25%, Q4 30%** **A&E - Q1 15%, Q4 20%** Two payments, end of Q1 and Q4 (£159k total)																	
Indicator 1.2 Inpatient response rate to F&F test question	37.3%	32.9%	35.7%		39.8%	41.5%	40.6%		46.5%	44.3%	40.6%		37.9%	41.5%			
Indicator 1.2 A&E response rate to F&F test question	21.5%	26.2%	29.8%		21.8%	20.40%	20.3%		23.4%	19.2%	4.5%		12.9%	11.7%			

Calderdale and Huddersfield NHS Foundation Trust

MES / INDICATORS - CHFT
FINANCIAL YEAR 2014/15
TRUST WIDE

Indicator Name	Quarter 1 Apr	May	Jun	Q1 Total	Quarter 2 Jul	Aug	Sep	Q2 Total	Quarter 3 Oct	Nov	Dec	Q3 Total	Quarter 4 Jan	Feb	Mar	Q4 Total	YTD
1.3 - Friends and Family - Response rate to F&F test question **Inpatient - further improvement requirement to achive 40% in any month during Q4.** One payment, end of Q4 (£159k total)																	
Indicator 1.3 Inpatient response rate to F&F test question	**37.3%**	**32.9%**	**35.7%**		**39.8%**	**41.5%**	**40.6%**		**46.5%**	**44.3%**	**40.6%**		**37.9%**	**41.5%**			**39.9%**
2.1 - Safety Thermometer (Quarterly payment conditional on use of thermometer in each of 3 months) Quarterly payment (£159k total)																	
The collection of data on Patient Harm using the NHS Safety Thermometer Harm Measurement Instrument. Collects Falls, Pressure Ulcers, Catheter Infection & VTE																	
Indicator. Continued use of thermometer for monthly data collection	**Y**	**Y**	**Y**		**Y**	**Y**	**Y**		**Y**	**Y**	**Y**		**Y**	**Y**			
2.2 - Safety Thermometer - Reduction in the prevalence of pressure ulcers **One payment based on achievement of three consecutive months at or below required level** One payment (£478k total)																	
(100% payment <4.1%, 75% payment < 4.6%, 50% payment < 5%, 0% payment if >5%)																	
Numerator: Reduction in the prevalence of pressure ulcers using thermometer	47	39	57		39	47	49		43	48	53		44	59			**525**
Denominator: Reduction in the prevalence of pressure ulcers using thermometer	1135	1119	1056		1091	1097	1059		1032	1048	1093		1087	1067			**11884**
Indicator. Reduction in the prevalence of pressure ulcers using thermometer	**4.14%**	**3.49%**	**5.40%**		**3.57%**	**4.28%**	**4.63%**		**4.17%**	**4.58%**	**4.85%**		**4.05%**	**5.53%**			**4.42%**

Calderdale and Huddersfield NHS NHS Foundation Trust

MES / INDICATORS - CHFT
FINANCIAL YEAR 2014/15
TRUST WIDE

Indicator Name	Quarter 1 Apr	May	Jun	Q1 Total	Quarter 2 Jul	Aug	Sep	Q2 Total	Quarter 3 Oct	Nov	Dec	Q3 Total	Quarter 4 Jan	Feb	Mar	Q4 Total	YTD
3.1- Dementia - Use of dementia screening tool, risk assessments, referrals for emergency admissions aged 75 and over (Target - 90% aggregate) Quarterly payment based on achievement of all three elements (£478k total)																	
Dementia Screen - Emergency Admission 75 Years & Above (Target - 90% aggregate per quarter)																	
Numerator 1: No of Non Elec admissions of patients aged 75 and over reported as having been asked the SQUID question for case finding	461	469	456		457	441	436		468	396	396		530				**4510**
Demoninator 1. No. of Non Elec admissions of patients aged 75 and over, who were admitted as inpatients in an emergency minus the exclusions	494	491	472		463	457	439		503	412	412		572				**4715**
Indicator 1. Percentage of patients aged 75 and over admitted as inpatients who were screened for dementia	**93.3%**	**95.5%**	**96.6%**		**98.7%**	**96.5%**	**99.3%**		**93.0%**	**96.1%**	**96.1%**		**92.7%**				**95.7%**
Dementia AMTS - Emergency Admission 75 Years & Above (Target - 90% aggregate per quarter)																	
Numerator 2: No of Non Elec patients admitted aged 75 and above, who have scored positively on the SQUID and reported as having had a dementia diagnostic assessment. (AMTS)	76	87	65		57	81	87		70	57	80		90				**660**
Demoninator 2. No of Non Elective patients aged 75 and above admitted as inpatients, who have scored positively on the SQUID case finding question (figures should balance to Numerator 1)	76	87	65		57	81	87		71	58	82		92				**664**
Indicator 2. Percentage of patients aged 75 and over admitted as inpatients who were appropriately risk assessed	**100%**	**100%**	**100%**		**100.0%**	**100.0%**	**100.0%**		**98.6%**	**98.3%**	**97.6&%**		**97.8%**				**99.4%**
Dementia Referral - Emergency Admission 75 Years & Above (Target - 90% aggregate per quarter)																	
Numerator 3:No of Non Elec Patients admitted aged 75 and above, who have had a positive diagnostic assessment, who are referred on for further diagnostic advice.	71	78	64		55	74	74		68	55	71		52				**610**
Denoninator 3. No of Non Elec patients aged 75 and above admitted as inpatients, who underwent a diagnostic assessment (in whom the outcome is either "positive" or "inconclusive")	71	78	64		55	74	74		68	55	71		52				**610**
Indicator 3. Percentage of patients aged 75 and over admitted as inpatients who were appropriately referred on to GP	**100%**	**100%**	**100%**		**100.0%**	**100.0%**	**100.0%**		**100.0%**	**100.0%**	**100.0%**		**100.0%**				**100.0%**

Calderdale and Huddersfield NHS Foundation Trust

MES / INDICATORS - CHFT
FINANCIAL YEAR 2014/15
TRUST WIDE

Indicator Name	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3	Quarter 4			Q4	YTD
	Apr	May	Jun	Total	Jul	Aug	Sep	Total	Oct	Nov	Dec	Total	Jan	Feb	Mar	Total	
3.2 - Ensuring 90% of wards have 1 WTE dementia 'expert' and 75% of wards to have 1 WTE 'competent' dementia lead **Report at end of Q2 and Q4** Two payments, end of Q2 and Q4 (£159k total)																	
Improve the quality of care for people with dementia																	
Percentage of applicable wards that have at least 1 full time member of staff (or equivalent WTE) that has been trained to **'expert'** level in Dementia					**Report completed**								x% & report				
Percentage of applicable wards that have at least 1 full time member of staff (or equivalent WTE) trained to **'competent'** level in Dementia					**Report completed**								x% & report				
3.3 - Dementia - ensuring carers feel supported - Bi-annal payment on submission of qualitative summary report Two payments, end of Q2 and Q4 (£159k total)																	
Indicator 3. Number of interviews carried out in month (7 required)					**Report completed**								**Report due**				
Indicator 3. Structured interviews conducted and qualitative summary of learning					**Report completed**								**Report due**				

Calderdale and Huddersfield NHS Foundation Trust

MES / INDICATORS - CHFT
FINANCIAL YEAR 2014/15
TRUST WIDE

Indicator Name	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3	Quarter 4			Q4	YTD
	Apr	May	Jun	Total	Jul	Aug	Sep	Total	Oct	Nov	Dec	Total	Jan	Feb	Mar	Total	
4.1 - ASTHMA Improving management of patients presenting with Asthma in A&E **Q1 - 60%, Q2 - 65%, Q3 - 70%, Q4 - 75%** Quarterly payment (£638k total)																	
Num 1. Number of patients admitted with Asthma as primary diagnosis who receive the following complete care bundle either prior to discharge or within 48 hours of discharge. i. Provided with brief intervention advice to current smokers and referral to smoking cessation clinic if patient consents ii. Assessment of suitability and/or enrolment into a pulmonary rehabilitation programme iii. Provided appropriate education and written information on Asthma, Self-management and medication including oxygen if relevant, to patient and/or carers) iii. Provide appropriate education and written information on Asthma, self-management and medication including oxygen if relevant, to patient (and/or carers) iv. Documentation that patient has demonstrated good inhaler technique v. Patient is re-established on their optimal maintenance therapy (including bronchodilator therapy). vi. Appropriate follow-up arrangements once discharged from hospital are documented and included in discharge summary. Evidence that patient and/or carer are informed/aware.																	
Patient age split (number <20 years and >20 years. Total 50)	**18 Children / 32 adults**				**18 Children / 32 adults**				**37 Children / 13 Adults**								
Initial Set - Peak Flow	50	50	100.0%		44	50	88.0%		42	50	84.0%						
Initial Set - Obs	50	50	100.0%		50	50	100.0%		47	50	94.0%						
Salbutamol	49	50	98.0%		48	50	96.0%		46	50	92.0%						
In Time	37	50	74.0%		45	50	90.0%		36	50	72.0%						
Steroids	48	50	96.0%		50	50	100.0%		45	50	90.0%						
In Time	43	50	86.0%		45	50	90.0%		36	50	72.0%						
Second Set - Peak Flow	49	50	98.0%		47	50	94.0%		45	50	90.0%						
Second Set - Obs	48	50	96.0%		46	50	92.0%		46	50	92.0%						
Inhaler	40	50	80.0%		40	50	80.0%		36	50	72.0%						
Discharge Px	43	50	86.0%		44	50	88.0%		48	50	96.0%						
Follow Up	46	50	92.0%		46	50	92.0%		47	50	94.0%						
Bundle Complaint	**33**	**50**	**66.0%**		**36**	**50**	**72.0%**		**27**	**50**	**54.0%**						

Indicator Name	Quarter 1 Apr	May	Jun	Q1 Total	Quarter 2 Jul	Aug	Sep	Q2 Total	Quarter 3 Oct	Nov	Dec	Q3 Total	Quarter 4 Jan	Feb	Mar	Q4 Total	YTD
4.2 - Pneumonia Care Bundle **Quarter 1 update report - / Quarter 2 & 3 - Quarterly reporting with no requirement / Quarter 4 - 55%)** Quarterly payment (£638k total)																	
Number of patients attending A&E and / or MAU with pneumonia who receive the CAP care bundle on admission to hospital. The CAP Care Bundle reflects College of Emergency Medicines standards and BTS/Sign guidelines and includes all of the following measures: 1. Chest X-ray 2. Oxygen administration 3. CURB 65 severity score 4. Antibiotics administered.																	
	Quarter 1 - end of Q1				**Quarter 2**				**Quarter 3**				**Quarter 4**				
Chest X-Ray	**Report Completed**				**Report Completed**				**Report submitted**								
Oxygen Administration																	
CURB 65 severity score																	
Antibiotics administered																	
Compliant with CQUIN																	

Calderdale and Huddersfield NHS Foundation Trust

MES / INDICATORS - CHFT
FINANCIAL YEAR 2014/15
TRUST WIDE

Indicator Name	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3	Quarter 4			Q4	YTD
	Apr	May	Jun	Total	Jul	Aug	Sep	Total	Oct	Nov	Dec	Total	Jan	Feb	Mar	Total	
5.1 - Diabetes Self Care (Q1 achieve 50% on 4 wards, Q2 achieve 50% on 6 wards, Q3+Q4 achieve 50% on 8 wards) **2 payments - end of Q2 and Q4** Two payments, end of Q2 and Q4 (£319k total)																	
Diabetes Self care																	
Target RAG Rating					Report								Up to Feb				
Numerator. Number of patients supported to self care (fully compliant with bundle)	16				15				16				22				**69**
Denominator. Number of patients admitted to cohort wards who have insulin dependant diabetes and are competent to self-administer	20				25				20				31				**96**
Number of patients sampled who are admitted to cohort wards and have insulin dependant diabetes	31				37				46				45				**159**
Assessed to self care	31	31	100.0%		32	37	86.5%		40	46	87.0%		34	45	75.6%		**137**
Care plan in place	29	31	93.5%		33	37	89.2%		40	46	87.0%		35	45	77.8%		**137**
Giving own Insulin	20	31	64.5%		30	37	81.1%		38	46	82.6%		37	45	82.2%		**125**
Adjusting the dose of insulin	20	31	64.5%		30	37	81.1%		37	46	80.4%		37	45	82.2%		**124**
Testing own blood sugars	18	31	58.1%		22	37	59.5%		35	46	76.1%		34	45	75.6%		**109**
Access to food and snacks	31	31	100.0%		37	37	100.0%		46	46	100.0%		45	45	100.0%		**159**
% Diabetes patients supported to self care (fully compliant with bundle)	**80.0%**				**60.0%**				**80.0%**				**71.0%**				**71.9%**

5.2 - Diabetes (Q1 - 60% achievement, Q2-Q4 90% achievement) Two payments, end of Q2 and Q4 (£159k total)																	
Diabetes - Management of hypoglycaemia patients in A&E, CDU and MAU																	
Target RAG Rating																	
Numerator. Patients attending A&E, CDU or MAU with diabetic hypoglycaemia who are referred to a specialist nurse and receive written educational support	3	8	12		6	12	7		7	20	18		19	13			125
Denominator. Patients attending A&E, CDU or MAU with diabetic hypoglycaemia	4	8	12		6	12	7		7	20	18		19	13			126
% Diabetes attending A&E, CDU or MAU referred to specialist nurse	**75.0%**	**100.0%**	**100.0%**		**100.0%**	**100.0%**	**100.0%**		**100.0%**	**100.0%**	**100.0%**		**100.0%**	**100.0%**			**99.2%**

Calderdale and Huddersfield NHS Foundation Trust

MES / INDICATORS - CHFT
FINANCIAL YEAR 2014/15
TRUST WIDE

Indicator Name	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3	Quarter 4			Q4	YTD
	Apr	May	Jun	Total	Jul	Aug	Sep	Total	Oct	Nov	Dec	Total	Jan	Feb	Mar	Total	
6 - Improving Medicines Safety																	
Support the effective transfer of information about medicines when patients are being transferred from one provider to another following an unplanned admission to hospital																	
Part 6.1 - Reconciliation (Quarterly payment conditional on: Q1-3 70% target. Q4 - 80% Quarterly payment (£319k total)																	
Part A: Number of e-discharges checked by Pharmacy with medicines reconciled - numerator	1060	698	639		679	676	650		730	642	645		590	609			7618
Part A: The number of patients (admitted for longer than 24 hours) on acute medical wards - denominator	1185	753	733		778	744	736		832	747	759		694	707			8668
Part A: Reconcilliation of medicines on admission - total	**89.5%**	**92.7%**	**87.2%**		**87.3%**	**90.9%**	**88.3%**		**87.7%**	**85.9%**	**85.0%**		**85.0%**	**86.1%**			**87.9%**
Part 6.2 - Discharge Accuracy Checks (Quarterly payment conditional on: Q1 - 55%, Q2- 60%, Q3 - 65%, Q4 - 70% Quarterly payment (£319k total)																	
Part B: The number of patients (admitted for longer than 24 hours) on acute medical wards having their e-discharge prescription approved and reconciled against the inpatient prescription chart by a pharmacist - numerator	1185	753	733		778	744	736		832	747	759		694	707			8668
Part B: The number of patients (admitted for longer than 24 hours) on acute medical wards - denominator	1826	1200	1106		1141	1104	1073		1179	1057	1093		1035	1009			12823
Part B: Discharge Medication - total	**64.9%**	**62.8%**	**66.3%**		**68.2%**	**67.4%**	**68.6%**		**70.6%**	**70.7%**	**69.4%**		**67.1%**	**70.1%**			**67.6%**
7 - End of Life																	
Part A - introduction of care bundle on two respiratory wards **Q2 - 30% of staff to have received training, Q4 - 90%** Single payment end of Q4 (£478k total)																	
Implementation of care bundle in two respiratory wards					**Report completed**								Reporting Due				
Part B - Join the TRANSFORM programme **Quarter 2 - Production of driver diagram to include key measures.** **Quarter 4 - Demonstration of programme achievements as evidenced by a dashboard and key measures** Two payments, end of Q2 and Q4 (£478k total)																	
					Report completed								Report due				

Calderdale and Huddersfield NHS Foundation Trust

MES / INDICATORS - CHFT
FINANCIAL YEAR 2014/15
TRUST WIDE

Indicator Name	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3	Quarter 4			Q4	YTD
	Apr	May	Jun	Total	Jul	Aug	Sep	Total	Oct	Nov	Dec	Total	Jan	Feb	Mar	Total	
8 - Nutrition																	
Establish a collaborative task and finish group to scope patient, staff and visitor food provision in order to understand the current catering services across the hospital setting with a view to achievement of the Food For Life Catering Mark and Government Buying Standards where feasible. Q2 - Baseline Report on progress YTD, including Real Time Patient Monitoring (RTPM) baseline results Q4 - Report including RTPM demonstrating improvement work carried out Two payments, end of Q2 and Q4 (£319k total)																	
Reports due highlighting progress	Report Complete				Action Plan Implemented								Report due				

Calderdale and Huddersfield NHS
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Monitor Indicators

THIS

Indicators	Thresholds	Weighting	February 2015	Quarter 3	Comments
Incidence of MRSA Year to Date	0	1.0	0	0	
Incidence of Clostridium Difficile Year to Date	5	1.0	4	26	
Maximum Time of 18 Weeks From Point of Referral to Treatment - Admitted	90%	1.0	92.17%	91.95%	
Maximum Time of 18 Weeks From Point of Referral to Treatment - Non-Admitted	95%	1.0	98.87%	98.70%	
Maximum Time of 18 Weeks From Point of Referral to Treatment - Incomplete Pathways	92%	1.0	94.39%	95.32%	
62 Day Wait for First Treatment from Urgent GP Referral	85%	1.0	85.34%	93.33%	
62 Day Wait for First Treatment from Consultant Screening Service Referral	90%	1.0	60.00%	91.67%	
31 Day Wait for Second or Subsequent Treatment: Surgery	94%	1.0	98.73%	100.00%	
31 Day Wait for Second or Subsequent Treatment: Anti Cancer Drug Treatments	98%	1.0	100.00%	100.00%	
31 Day Wait from Diagnosis to First Treatment (All Cancers)	96%	0.5	100.00%	99.73%	
Two Week Wait From Referral to Date First Seen: All Cancers	93%	0.5	99.35%	98.41%	
Two Week Wait From Referral to Date First Seen: Symptomatic Breast Patients	93%	0.5	95.80%	94.77%	
A&E: Maximum Waiting Time of Four Hours from Arrival to Admission/Transfer/Discharge	95%	1.0	93.76%	92.74%	
Community care - referral to treatment information completeness	50%	0.5	100.00%	100.00%	
Community care - referral information completeness	50%	0.5	98.40%	98.32%	
Community care - activity information completeness	50%	0.5	100.00%	100.00%	
Overall Governance Rating			Amber-Red	Amber-Green	

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

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Chris Benham, Deputy Director of Finance
Date: Thursday, 26th March 2015	**Sponsoring Director:** Keith Griffiths, Director of Finance
Title and brief summary: Month 11 - Financial Narrative - Month 11 - Financial Narrative	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Finance and Performance Committee	
Governance Requirements: .	
Sustainability Implications: None	

Executive Summary

Summary:

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Main Body

Purpose:

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Background/Overview:

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The Issue:

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Next Steps:

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Recommendations:

The Board of Directors is asked to note the contents of the paper

Appendix

Attachment:

Month 11 Financial Narrative - BoD.pdf

Calderdale and Huddersfield NHS FT

Month 11, February 2015 Financial Narrative

Purpose

This paper provides a narrative to accompany the monthly financial dashboard and will focus on the key messages within the year to date and forecast year end positions, making reference to 15/16 and beyond, as appropriate. This paper has previously been discussed at the Finance & Performance Committee on the 17 March 2015.

The comparisons and reference points within this paper are consistent with the reforecast dashboard highlighting actual performance against the Reforecast plan as submitted to Monitor in September 2014 and must be seen in the context of non-achievement of the original planned surplus of £3.0m.

Executive Summary

The Trust has delivered the year to date financial position in-line with the reforecast plan and is forecasting to achieve its year end deficit consistent with the Monitor reforecast plan.

The financial headlines are detailed below with more detailed narrative supplied on the following pages.

The financial position to the end of February 2015 shows:

- A year to date deficit of £1.37m (excluding 'exceptional' restructuring costs), a favourable variance of £2.58m from the reforecast planned £3.95m deficit, driven by £1.50m quality investment by commissioners to support hard truths nursing expenditure, donated asset income of £0.4m together with over delivery of CIP of £0.30m.

- When the restructuring costs of £1.34m are included, the deficit increases from the £1.37m described above to £2.71m. This is a favourable variance of £1.23m from the reforecast plan;

- Over delivery of CIP schemes of £8.66m against a reforecast planned level of £8.34m;

- Capital expenditure of £19.71m versus a reforecast planned level £20.02m;

- A cash balance of £16.77m against a reforecast planned position of £16.41m;

- The year to date Continuity of Service Risk Rating (CoSRR) is level 2 against the reforecast plan of level 2.

The forecast year end position shows:

- At an operational financial performance level, the Trust is in-line with the reforecast plan submitted to Monitor. Although the forecast deficit stands at £1.58m, as with the previous month's forecast, there are items that require adjustment to ensure the deficit is comparable to the reforecast position of a deficit of £4.29m. These adjusting items relate to non-recurrent income that total £2.60m and consist of £1.50m of Commissioner non-recurrent income for 'hard-truths' and A&E investment, £0.40m of charitable funds income and a forecast benefit of £0.70m as a result of lower than anticipated depreciation charges. These adjustments are laid out in appendix 1 and demonstrate that the forecast is equivalent in trading terms to the reforecast plan and is consistent with last month's forecast.

- When the forecast restructure costs of £4.71m are included, the Trust's position is a deficit of £6.29m against a reforecast deficit of £4.29m. This negative variance is excluded from the CoSRR calculation but becomes an un-forecast cash pressure for the Trust.

- Delivery against CIP schemes of £9.88m against a planned £9.86m.

- Capital expenditure of £22.39m versus a reforecast planned £21.32m;

- A cash balance of £10.79m against a reforecast planned position of £14.76m;

- CoSRR for the full year of level 2 in line with reforecast plan.

Activity and Capacity

- At an aggregated level, elective activity, which includes inpatient, daycase and outpatient activity, is under-performing at the end of February 2015. With the exception of daycase work all other elective activity is under-performing – a noticeable shift within outpatients has been witnessed moving from over-performance at the end of January to underperformance at the end of February. As consistent with last month's report only daycase activity is expected to over-perform by the end of the year.
- Non-elective activity including A&E attendances has seen an under-performance at the end of February. The trend of emergency admissions seen in December and January has continued with an in-month switch of fewer short stay emergency admissions to a greater number of long stay admissions. The forecast position for the remaining part of the year is consistent with the year to date position.
- Direct access diagnostic services continue to over-perform particularly within imaging services and are forecast to over-perform by the end of the year.
- The activity for specialist commissioned services continues to over-perform against the year to date reforecast planned level. The areas of high cost drugs and ICDs carry direct pass through costs that result in a nil gain within the I&E.
- Appointment Slot Issues (ASIs) are being monitored closely and remain challenging in certain specialties. The national issue of lack of availability of the Choose and Book system within January has been rectified within February and equated to an additional 500 referrals being recognised within February in relation to the January issue.
- An elective outsourcing programme for Calderdale patients using CCG non-recurrent funding is being implemented. The cases identified for outsourcing are: 45 Orthopaedic cases and 20 General Surgery cases. We will maintain 18 week performance at aggregate CCG level however as we are targeting treatment for a higher proportion of longer waiters we have agreement from Commissioners that we may breach 18 weeks at speciality level. This will not have any negative impact on external 18 week performance.
- As referenced in previous reports the unplanned bed capacity to meet operational pressures within December and January has continued within February. On average an additional 50 beds were open within the month. As described in the previous months report, an additional £0.50m for winter costs had been provided for, over and above the reforecast expenditure levels and the Trust has been able to bear these pressures without detriment to the achieving the overall reforecast financial position.
- As reported previously, CQUIN performance has been maintained and achieved throughout the first half of the year, however operational pressures in the later part of the year bring a risk to full achievement against the individual targets. Whilst the majority of the financial pressure is mitigated through the fixed value contracts an element of this performance standard carries an immaterial financial risk of £50k through non-delivery. This financial risk has been mitigated through the recent agreement of a year-end position with specialised commissioners.
- As previously reported the activity plans for 2015/16 based on forecast outturn, demographics and deliverable capacity were completed on 16 January and is the basis of the 2015/16 contract negotiations with commissioners. This activity plan is currently being scrutinised by Commissioners with significant queries being raised and further assurance being sought to ensure deliverability. Work continues across the Finance and Contracting teams to ensure agreement can be achieved on this plan. To re-state, this piece of work concludes that there is a potential £5m reduction in income driven by this level of activity. This amount is consistent with the protection being offered within 2014/15 by the fixed value contract arrangements.

Income

- Clinical income has over-performed within the year to date position driven by the £1.50m quality investment by commissioners to support hard truths nursing expenditure and additional specialist commissioning and 'out of area' activity. The former is partially offset by pass through costs as described above and remains below contracted levels at a year to date position.
- The underperformance on activity against the main two commissioners contracted levels has resulted in a significant increase in the financial protection offered by the contract. The in-month contract protection has increased by £0.5m leading to a cumulative financial protection of £5.54m.

- Non-clinical income remains above planned levels primarily due to charitable funded income to support the pacing room at CRH. This income has no bearing on the calculation of the risk rating and must be removed when assessing operational financial performance.
- Commercial activities, namely PMU and THIS, continue to be below reforecast plans for the year to date and forecast positions. The PMU contribution risk of £200k highlighted within the previous months report remains within the year end forecast, though significant work continues to aim to recover this.
- Smaller benefits around education and training income have also been recognised.
- There is no recognition of income relating to the sub-contracting arrangements that have been described above to secure Orthopaedic and General Surgery RTT performance. Any income that will be received will have an equal and opposite cost associated with it resulting in a £nil impact within the year end I&E position.

Expenditure

- Substantive pay costs continue to under-spend but are compensated for by the use of non-contracted pay within the areas of agency, bank, overtime and waiting list initiative payments. The substantive whole time equivalents (wte) equates to 5,227 wte against a budgeted amount of 5,532 wte resulting in vacancies against budgeted levels of 305 wte. The non-contracted pay elements have been estimated on average pay rates to be equivalent to 421 wte. Within the year to date position this results in a marginal overspend within total pay of £0.4m. This position is forecast to continue with a year-end over-spend forecast at £1.2m.
- Medical workforce spend is in line with reforecast plan and recognises the continued reliance within the middle grade medical workforce within A&E and the significant spend attached to this. Specialties that have medical workforce gaps are filling with locum/agency as appropriate recognising that significant variation in cost is being experienced.
- Nursing workforce spend is ahead of reforecast plan and is experiencing variability within shift fill rates. This variability is due to a combination of lower than anticipated benefits from the overseas recruitment campaign and the variability in the capability of the Trusts preferred supplier to fill shift requests. The Trust has planned further overseas recruitment visits in the final quarter of the year and has recently engaged with Thornbury nursing agency. This agency has significantly higher charge out rates than the majority of other agencies and this remains a potential financial risk for the Trust. Weekly monitoring of shift requests and fill rates is being undertaken.
- Drug expenditure is over-spending against reforecast plans but this is in the context of the specialist commission activity over-performing and is supported by additional income within these areas.
- Further expenditure of £300k has been included within the year forecast position in recognition of additional Management Consultancy and Turnaround costs. The total impact of these costs within the year end forecast stands at £900k. The shape and impact of these arrangements are yet to be defined and quantified within the plans for 2015/16.

Exceptional costs

- Exceptional costs of MARS have been recognised within the year to date position with additional costs forecast in relation to the VR scheme that closed at the end of January 2015. The VRS panel has concluded the validation and approval process of all the applications. The approved applicants have been written to with arrangements being made to confirm exit dates. A minimal level of saving has been included within the year end forecast but the full year effect into 2015/16 will be far greater.
- The forecast amount of exceptional costs now stands at £4.7m, will be a cash pressure for the Trust but does recognise the Trust's desire to maximise the full opportunity that the VR scheme has offered. This will create an additional cash pressure for the Trust at the year end 2014/15 and into 2015/16.
- Although the cash benefit of the Commissioner sponsored quality investment of £1.5m, as described earlier, will partially offset the impact of this, the Trust has proactively discussed the cash impact with Monitor and has the necessary support from Monitor upon the CoSRR impact and the potential timing of cash support within 2015/16.

CIP

- The year to date CIP position has over delivered against the reforecast plan by £0.30m with a high level of confidence that the year-end reforecast of £9.86m will be achieved, if not bettered.
- **The focus remains to support the rapid development of 2015/16 schemes as this remains the highest financial risk.**
- Movements have been seen within categories from the previous month forecast recognising offset by additional elements within divisional housekeeping and budgetary control.
- A reduction in the CIP high risk element to £0.43m of the total identified for 2014/15. The main element of this is the additional contribution target from the Pharmacy Manufacturing Unit.
- The non-recurrent element of this year's forecast is £3.8m with the full year effect of current year schemes into 2015/16 being valued at £6.2m.
- As described above the VR scheme closed on 31 January 2015 with a minimal amount of savings recognised within the year end forecast. The full year effect within 2015/16 is currently recognised within the CIP plans for 2015/16.
- The Turnaround Executive review on a weekly basis the PMO led workstream areas that are currently proposed for 2015/16. Not all workstreams have been fully tested but progress along the agreed business planning timeframes using the revised process of gateway review is happening. This must conclude as a matter of urgency to inform 2015/16 and beyond, strategic, operational, estates, workforce and financial plans. As a minimum, this programme must release £14m recurrent, cash savings.

Capital

- Consistent with the prior month, the capital spend to date is £0.31m under the reforecast plan but is forecast to overspend by £1.07m by the end of the year. This overspend is primarily within the areas of IT and is recognising opportunities to accelerate specific schemes from 2015/16 into the current year. Maternity EPR and the Trust wide EPR are the key drivers, with additional infrastructure spend and investment within agile working equipment to assist with the decanting of colleagues from the administration block at HRI, making up the balance.
- In addition to the IT spend, a maternity department development at CRH of £225k is included within the forecast over-spend. However, this development is funded from centrally available funds and as such has a zero cash impact for the Trust.
- The theatre refurbishment programme continues to progress and the impact of this programme has been factored in when considering the 2015/16 activity plan.
- The associated cash flows are being monitored and managed as any movements in schemes will have a timing impact within the cash position at year end and into 2015/16.
- There has been no further drawdown on the capital loan facility. Following the October loan drawdown of £7m the remaining facility of £23m is being reviewed in the overall capital review for 2015/16 and beyond.
- The Trust has been informed that the recent success in securing £900k of additional, centrally available technology funds has now been withdrawn. As reported previously, the Trust had not forecast these funds due to the uncertainty of the timing of the cash flows, however the Trust is following up with the Department of Health, on this more recent news.
- The affordability and prioritisation of capital spend over the next 5 years continues, with the position for 2015/16 being recognised within the overall draft 2015/16 business plans of £18m.

Cash

- The cash collection of aged debt remains strong although the increase in value of the aged debt that was reported last month remains. This relates to one NHS customer in relation to THIS activity. The amount of £800k was previously reported as being agreed for payment but the debt remained un-paid at the end of the month. The Trust has escalated, including Monitor and NHS England finance contacts, with £400k of this debt being cleared in March. The remaining £400k is being chased proactively including discussions with THIS management to review the options that include the potential of service removal. A continual focus within this area remains.
- The in-month deterioration reported last month has reversed with an increase in compliance within the Better Payment Practice Code and has achieved a cumulative 97% against the

targeted level of 95%. In light of the challenges within 2015/16 this area of compliance will be looked at as a potential source of a one-off cash benefit.

- As described above the impact of the capital programme is being monitored and managed.
- The year-end forecast cash balance and cash protection strategies will be further explored as part of the 2015/16 business planning process ensuring robust connections to I&E, capital expenditure and disinvestments. This includes alternative loans/payment profiling as appropriate.

CoSRR

- The year to date Continuity of Service Risk Rating (CoSRR) is a level 2 in line with the reforecast plan.
- The forecast for year-end remains a 2 and is line with the reforecast plan.
- The initial and current view of 2015/16 is a CoSRR of 1.

Other issues

- The progression of the CC2H tender continues with the response to the Invitation to Tender submitted on 30 January 2015. The Trust is conscious that this will have one of two impacts within 2015/16 of a loss £5m income or a growth in income of £30m, both with associated costs. The Trust is currently modelling the status quo but recognises that an appropriate narrative will have to be made explaining to Monitor the risk and/or the opportunity.
- The EPR full business case has been approved and the immediate capital implications have been described above. The wider financial implications are being modelled within the 2015/16 business plans.

Recommendation

The Board of Directors is asked to note the contents of this report.

Keith Griffiths 26/3/2015

Appendix 1 – Underlying trading position

	Reforecast Plan Submitted to Monitor £m	Adjustments: CCG Quality Investment £m	Adjustments: Donated Income £m	Adjustments: Depreciation £m	Adjustments: Restructuring Costs £m	Adjustments: Total £m	Reforecast Plan Adjusted £m	Reported at M11 £m	Variance £m
Year to Date M11									
EBITDA	**18.6**	**1.5**	**0.4**	**0.0**	**0.0**	**1.9**	**20.5**	**20.5**	**0.0**
Surplus / (Deficit) excluding restructuring costs	(4.0)	1.5	0.4	0.6	0.0	2.5	(1.5)	(1.4)	0.1
Restructuring costs	0.0	0.0	0.0	0.0	(1.3)	(1.3)	(1.3)	(1.3)	0.0
Surplus / (Deficit)	**(4.0)**	**1.5**	**0.4**	**0.6**	**(1.3)**	**1.2**	**(2.8)**	**(2.7)**	**0.1**
Year End Forecast at M11									
EBITDA	**20.3**	**1.5**	**0.4**	**0.0**	**0.0**	**1.9**	**22.2**	**22.2**	**0.0**
Surplus / (Deficit) excluding restructuring costs	(4.3)	1.5	0.4	0.7	0.0	2.6	(1.7)	(1.6)	0.1
Restructuring costs	0.0	0.0	0.0	0.0	(4.7)	(4.7)	(4.7)	(4.7)	0.0
Surplus / (Deficit)	**(4.3)**	**1.5**	**0.4**	**0.7**	**(4.7)**	**(2.1)**	**(6.4)**	**(6.3)**	**0.1**

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th March 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: BOARD ASSURANCE FRAMEWORK - The Board is asked to review and comment on the Board Assurance Framework	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Strategic Executive Board - 16.3.15	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to review and comment on the Board Assurance Framework.

Main Body

Purpose:

The Board Assurance Framework (BAF) is a strategic document that the Board uses to obtain assurance on the achievement of the organisation's principal objectives. Over the last four months work has been done to develop the BAF and the latest draft is presented to the Board for review.
The draft BAF is presented to the Board for approval as the 2014/15 document.

Background/Overview:

Following the Board workshop, a further workshop was held with the executive directors to identify the key risks to the delivery of the Trust's strategic objectives. This risk horizon is attached for information. Following this meetings have been held with each of the directors to go through the detail of the risks, the mitigating actions and to score the risks.

The Issue:

At the meeting in February the Board asked for greater detail on controls and assurance as well as clear links to the risks on the risk register. These have been incorporated into the version presented for sign off at this meeting.

Next Steps:

The 2014/15 BAF is presented for sign off. This will provide the basis for the development of the 2015/16 BAF which will support the strategy on a page currently being worked up. The 2014/15 BAF doesn't include risks relating to the Electronic Patient Record as the 2014/15 risks related to this programme were in relation to the selection of a partner, agreement with Bradford Teaching Hospitals and the signing of a contract. These have all now been achieved. Risks relating to benefits realisation and the implementation programme for the EPR are being written and will be included in the 2015/16 BAF>

Recommendations:

The Board is asked to comment on and approve the 2014/15 Board Assurance Framework

Appendix

Attachment:

Copy of BAF for March Board meeting.pdf

Board assurance framework summary for 14-15 corporate objectives

	Corp objective	The risk of failure……	Caused by…	Which could result in…	Primary Lead	Initial score S x L	Today's S x L	Acceptable S x L	Committee oversight	Links to risks on risk register
1	Transforming care	A failure to achieve good clinical outcomes and compassionate care	lack of adequate progress transform the way we work	unintended harm to patients (severe permanent harm or death).	JD	4 x 5 = 20	5 x 3 = 15	3 x 3 = 9	Quality Committee	4783 HSMR / SHMI 5806 Privacy & dignity 2827 Middle grade recruitment in A&E
2	Keeping the base safe	A failure of sufficient clinical leadership to inspire and facilitate change	a lack of capacity to engage	unintended harm to patients (severe permanent harm or death).	DB	0	4 x 4 = 16	3 x 3 = 6	Quality Committee [Well Led Group]	6234 Appraisal & Mandatory training
3	Keeping the base safe	A failure to deploy sufficient, talented staff	an inability to attract, recruit, retain, reward and develop them	unintended harm to patients (severe permanent harm or death).	JD	0	4 x 4 = 16	3 x 3 = 9	Quality Committee	2827 Middle grade recruitment in A&E
4	Keeping the base safe	A failure to remain financially sustainable	national austerity and slow transformation	unplanned financial deficit (and Special	KG	5 x 3 = 15	5 x 5 = 25	3 x 4 = 12	Finance and Performance Committee	6150 Breach of licence 4706 Failure to meet CIP
5	Improvement & innovation	A failure to compete vigorously	being too focussed internally	missed opportunities to retain or acquire	AB	0	4 x 4 = 16	3 x 3 = 9	Finance & Performance	6178 THIS modernisation programme 6143
6	Improvement & innovation	A failure to obtain stakeholder commitment to initiate change	political uncertainty and commissioners' own priorities	an exacerbation of all other significant risks (may result in regulatory escalation and	AB	5 x 5 = 25	5 x 5 = 25	3 x 5 = 15	Board	

Plan on a page 2014-15.

Calderdale and Huddersfield NHS
NHS Foundation Trust

We will work with partner organisations to understand the individual needs of patients and together, deliver outstanding, compassionate care which transforms the welfare of the communities we serve.

We put the patient first

Our patients and our staff will be able to describe what our vision and mission means to them. We will treat our patients, staff and partners in a way that we would be expected to be treated ourselves. We will use our resources (financial, human and estate) as a driver for change, rather than as a constraint.	We will improve access to care for patients and prioritise their safety, thereby also ensuring our regulatory compliance. We will improve real time patient information being at hand for us and our partners to provide the best and seamless care.	We will improve patient outcomes and experience through active and strategic collaboration within and outside CHFT.

We go see

TRANSFORMING CARE	KEEPING THE BASE SAFE	IMPROVEMENT & INNOVATION THROUGH STRATEGIC ALLIANCE
1. We're rolling out the Courage to Put the Patient First lean action plan. (LH, MB)	6. We're implementing action plans for both the Urgent Care Board and the Care of the Acutely Ill patient. (MB).	11. We're working with stakeholders including CCGs / HWB / NHS England to gain support for consultation to begin on the case for change (AB)
2. We're implementing the Colleague Engagement Plan (LH)	7. We're actively seeking a partner to modernise our IM & T systems and install an Electronic Patient Record. (JR)	We're working in collaboration with partners to improves services such as:
3. We're developing state of the art outpatient services at Acre Mill. (LH)	8. We're reviewing and making changes to governance (VP)	12. Bariatric surgery with Mid Yorkshire; (AB)
4. We're working to deliver the Trust's Efficiency Programme Board (EPB) activity for 2013-15 (MB)	9. We're implementing a Health & Safety action plan to make sure we have safe and suitable premises (LH)	13. Sexual health services with Mid Yorkshire and Locala; (AB)
5. We're modernising and prioritising our approach to patient engagement and complaints handling. (JD)	10. We're improving our commercial intelligence about future commissioning risks / opportunities. (AB)	14. Psychiatric liaison services with South West Yorkshire Partnership (AB).

We work together to get results

We do the must dos

This excerpt is taken from: 'Assurance Frameworks'; HM Treasury, December 2012.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/270485/assurance_frameworks_191212.pdf

Assurance mapping

2.6 Assurance mapping is a mechanism for linking assurances from various sources to the risks that threaten the achievement of an organisation's outcomes and objectives. They can be at various levels, dependent upon the scope of the mapping. An overview of the process is provided at Annex A.

Three Lines of Defence

2.7 Assurance can come from many sources within an organisation. A concept for helping to identify and understand the different contributions the various sources can provide is the Three Lines of Defence model. By defining the sources of assurance in three broad categories, it helps to understand how each contributes to the overall level of assurance provided and how best they can be integrated and mutually supportive. For example, management assurances could be harnessed to provide coverage of routine operations, with internal audit activity targeted at riskier or more complex areas.

2.8 It is likely to be helpful to adopt a common assurance "language" or set of definitions across the three lines to ease understanding, for example, in defining what is an acceptable level of control or a significant control weakness.

First line

2.9 Within the 'front-line' or business operational areas, there will be many arrangements established that can be used to derive assurance on how well objectives are being met and risks managed; for example, good policy and performance data, monitoring statistics, risk registers, reports on the routine system controls and other management information.

Nature of assurance

2.10 This comes direct from those responsible for delivering specific objectives or operation; it provides assurance that performance is monitored, risks identified and addressed and objectives are being achieved. This type of assurance may lack independence and objectivity, but its value is that it comes from those who know the business, culture and day-to-day challenges.

Second line

2.11 This work is associated with oversight of management activity. It is separate from those responsible for delivery, but not independent of the organisation's management chain. This could typically include compliance assessments or reviews carried out to determine that policy or quality arrangements are being met in line with expectations for specific areas of risk across the organisation; for example, purchase to pay systems, health and safety, information assurance, security and the delivery of key strategic objectives.

1 Institute of Internal Auditors Practice Advisory 2050-2

2.12 The developing discipline of Portfolio Management may be of particular use in supporting the second line regarding the assurance of major business change. Portfolio Management aims to provide a co-ordinated approach to enable the most effective balance of organisational change and business as usual. It seeks to take a strategic viewpoint, focused on key issues, to build on and better co-ordinate existing processes such as strategic planning, investment appraisal and project and programme management.

Nature of assurance

2.13 The assurance provides valuable management insight into how well work is being carried out in line with set expectations and policy or regulatory considerations. It will be distinct from and more objective than first line assurance.

Third line

2.14 This relates to independent and more objective assurance and focuses on the role of internal audit, which carries out a programme of work specifically designed to provide the Accounting Officer with an independent and objective opinion on the framework of governance, risk management and control. Internal audit will place reliance upon assurance mechanisms in the first and second lines of defence, where possible, to enable it to direct its resources most effectively, on areas of highest risk or where there are gaps or weaknesses in other assurance arrangements. It may also take assurance from other independent assurance providers operating in the third line, such as those provided by independent regulators, for example.

2.15 Other sources of independent assurance available include Major Projects Authority Integrated Assurance Reviews, external system accreditation reviews/certification (e.g. ISO/Risk Management Accreditation Document Sets), European Commission/European Court of Auditors and Treasury/Cabinet Office/Parliamentary scrutiny processes.

2.16 As an additional line of assurance, sitting outside of the internal assurance framework and the Three Lines of Defence model, are external auditors, chiefly the NAO[2], who are external to the organisation with a statutory responsibility for certification audit of the financial statements. It is important that internal audit and external audit work effectively together to the maximum benefit of the organisation and in line with international standards[3].

Nature of assurance

2.17 Independent of the first and second lines of defence. Internal audit operates to professional and ethical standards in carrying out its work, independent of the management line and associated responsibilities. External audit operates similarly and reports mainly to Parliament.

Board Assurance Framework 2014-15 year end position. Date on which data valid 16-Mar-15

Calderdale and Huddersfield NHS
NHS Foundation Trust

Corporate objective no.	1. Transforming care
Risk description:	A failure to achieve good clinical outcomes and compassionate care caused by lack of adequate progress to transform the way we work, may result in unintended harm to patients (severe permanent harm or death).

BAF risk no	1	Scoring	Initial	Today	Acceptable	RAG rating today's assurance position	Oversight
			4 x 5 = 20	5 x 3 = 15	3 x 3 = 9		Quality Committee
Risk owner	JD					A	

Links to risks on risk register
4783 HSMR / SHMI
5806 Privacy & dignity
2827 Middle grade recruitment in A&E

Control No	Control description	Gaps in control	Assurance from first line of defence (front line evidence)	Assurance from second line of defence (management evidence)		Gaps in assurance position	Further action or assurance required by committee / Board, with dates
1	The culture in which our people work.	Not yet completed the roll out of the colleague engagement strategy. Further work required on embedding the four pillars	Metrics on Induction, personal appraisal; mandatory training; attendance rates; staff turnover; discipline and grievance rates; staff and patient complaint analysis and response.	Staff survey result for 'Overall Staff Engagement'; Localised staff survey question on four pillars; Friends & Family test results. We have planned and trained for pressured and emergency situations, including winter pressures.	Patient feedback; CQC risk profile. CQC inspection reports. Picker Institute's national Staff survey result for 'Overall Staff Engagement'. Whistleblowing evidence.	Below trajectory on mandatory training and appraisal across the Trust.	Staff survey action plan due for sign off, to include response to four pillars question [Well Led Group- April; Board - April]. Integrated Board report for end of year to check if improvement in position regarding mandatory training and appraisal [Board - March] Colleague engagement update as part
2	The context in which our people work.	Work to embed the governance arrangements in divisions to ensure clear line of sight from board to ward. Development of the leadership walkabout and team brief cascade process required.	Clarity of job descriptions; role boundaries; escalation and performance management frameworks. Local induction of locum and agency clinical staff.	Policy and procedures over Registration; credentialling and privileging of clinicians; revalidation. Staff survey results in relation to effective appraisal.	Examples of whistleblowing; notification of whistleblowing from CQC; Foresight review of governance arrangements	No recent internal audit of HR processes; induction arrangements.	Independent assurance required over local clinical induction arrangements [Quality Committee - May] Development programme to introduce 7 day working [Quality Committee - June] Well Led Governance Review self assessment re divisional governance and leadership profile [Board - April]
3	Our medical devices and equipment (and mandatory training in how to use them) are registered, tracked, maintained and replaced in line with Trust and manufacturers guidelines.		Verbal feedback from staff during walk rounds by Execs and NEDs.	Monitoring reports on the effectiveness of the Medical Devices policy. Capital planning programme prioritised and risk assessed.	Internal Audit review of governance of medical devices & equipment.	Need further assurance that risks on register above 15 as at Nov 14 have been mitigated ? They include: No 5998 urodynamics equipment; No 3991 fluoroscopy equipment; and No 6115 hysteroscopy	Risks to be reviewed [Risk and Compliance Group - April]
4	Clinical practice meets standards deemed appropriate by professional bodies; NICE, MRHA, commissioners; NHS England etc.	Patient Safety and Quality Boards to track implementation and compliance of best practice and external directives	Ward to Board metrics in monthly Quality Account. Safety Thermometer. Reviews of incidents causing harm, near misses etc. (morbidity & mortality reviews).	Compliance with clinical guidelines, policies and procedures. To include adoption of National Early Warning Scores backed with clear escalation and response criteria. Monitoring of HSMR; SHMI and crude mortality rates in monthly Quality Account. SUI monitoring; reporting and learning. Care of the Acutely Ill Patient report to Board	Independent assurance on clinical audit strategy, programme, activity and results. External review of A&E.	SHMI and SHMR Mortality metrics suggest our results are worst than peer. We have too many vacancies in A & E to which we have failed to recruit. Assurance required about the effectiveness of the design and operation of new controls within the reorganised division. NCAT review of emergency care July 2013 showed risks.	Review of clinical audit plan for 15-16 to ensure appropriate linkages to challenged services and Board assurance framework and internal audit plan [Quality Committee - April] Stroke services review [Quality Committee - April].
5	Programmes; Acutely ill patient; patient flow and discharge improvement programmes; 'Courage to put the patient first' lean action plan; fractured neck of femur best practice; improvements to complaint handling; improved patient engagement; improvements to stroke service; macular & glaucoma services; diabetic service. Infection prevention & control programmes.	Need a formalised framework for recognising the characteristics of a potentially unsafe (under-resourced or under-performing) ward or service and escalating it.	PSQB reports; quality indicators; implementation of Nerve Centre.	Clinical Effectiveness and Outcomes Group reports; Urgent Care Board papers; 'Nursing & Medical directorate action plans. IPC team report low levels of HCAI and high levels of compliance against IPC practice standards. Post infection review & Root causes analyses. Compliance with Resuscitation training. Learning from Dec-Jan 'Our Perfect Week'. Bi-monthly Care of the Acutely Ill Patient report to Board. Compliance with anti-microbial prescribing policy and formulary controls.	Verbal feedback from patients and carers when Execs and NEDs undertake walkabouts. Coding data quality audits.	Need assurance that contingencies for critical care overload have been planned for and tested.	Care of the Acutely Ill Patient plan needs robust review [Board - March] Sept 14 Board report identified slippage in Put the Patient First lean action plan - requires follow up against 7 indicators. {Board - May] IA report CH04 / 2015 limited assurance on discharge planning, with 13 recommendations due for completion by Dec 14. Update required. [Audit and Risk Committee April]. Critical care review [PSQB - Surgery and Anaesthetics]
6	Clinical decisions and care we provide are based on high quality data.	We lack an Electronic Patient Record (EPR). We had 15 subsidiary risks on the risk register relating to controls within the purview of THIS in Jan 15.	Verbal feedback from staff during walk rounds by Execs and NEDs. Medical Records Policy compliance.	Transformation Board; IT enabled modernisation programme Board. IG Toolkit self assessment. Complaint, claims and incident analysis. Diagnostic reporting statistics reported to Board.	Clinical coding review	Cashable benefits' register has been assessed and attenuated after discussion with independent experts. West Yorkshire Audit Consortium are to provide independent assurance on the design and programme for our EPR. S28 received.	Monthly reporting by EPR Transformation Board. [Finance and Performance Committee - April] Regulation 28 report [Quality Committee - March]

Board Assurance Framework 2014-15 year end position. Date on which data valid 16-Mar-15

Calderdale and Huddersfield NHS
NHS Foundation Trust

Corporate objective no.	2. Keeping the base safe
Risk description:	A failure of sufficient clinical leaders to have the capacity to inspire and facilitate change caused by a lack of engagement may result in unintended harm to patients (severe permanent harm or death).

BAF risk no	2	Scoring	Initial	Today	Acceptable	RAG rating today's assurance position	Oversight	Links to risks on risk register
Risk owner	DB	S x L		4 x 4 = 16	3 x 3 = 6	A	Quality Committee [Well Led Group]	6234 Appraisal & Mandatory training

Control No	Control description	Gaps in control	Assurance from first line of defence (front line evidence)	Assurance from second line of defence (management evidence)	Assurance from third line of defence (independent evidence)	Gaps in assurance position	Further action or assurance required by committee / Board, with dates
1	Recognised, engaged divisional leadership.		Staff survey results; participation in developing strategic review;	There are programmes to support leaders behind the 4 pillars of behaviour; and an engaged leaders toolkit. Colleague engagement strategy;	Integrated Board Report showing performance against key metrics	Review of divisional governance to be undertaken. Assessment of to what degree our clinical leaders are engaged externally and joined up in the health economy and participating in multi-organisation initiatives; and taking on leadership roles in service development across the region.	Well Led Governance Review self assessment {Board - April] Well Led Group agenda item [May]
2	The devolved clinical structure incentivises and rewards clinical leaders to have an impact upon service design and quality of outcomes.	Lack of clarity of service improvement and redesign responsibilities	Staff survey results; participation in developing strategic review;	Established escalation framework for prioritising action to address weak services. Clinical level development and presentation of business cases. Clinical leads for all CIPs		Need a clear, communicated escalation framework which has been shown to be effective	Service redesign review - Weekly Executive Board [April] Escalation framework for clinical services to be considered [Quality Committee - TBC]
3	Clinical leaders lead on quality metric achievement (focussed on outcomes not activity)		Ward to Board quality metrics are used throughout the organisation to drive improvement	Escalation and performance management frameworks are used by clinicians to hold peers to account. PSQB reports to Quality Committee; Quality Account process which involved clinicians and public members	The clinical audit strategy is focussed on areas of clinical risk to support improvement in weak services.		Quality Account [Quality Committee - April] PSQB report [Quality Committee - May]
4	Clinical leaders are involved in the design and risk assessment of CIP programmes and service reconfiguration.		CIP programmes are consulted upon with the clinical body to determine quality impacts.	The PMO can demonstrate that CIP tactics have been qualitatively and quantitatively assessed for quality impact.	Internal Audit review of PMO process and the inclusion and use of quality impacts when CIP programmes are designed and implemented		Quality Impact Assessment process review [Quality Committee - ?]
5	Clinical leadership development - there is a formal development programme	Need clearly articulated clinical leadership development plan. Assessment to be done of the time clinical leaders have for leadership responsibilities.	Coaching circle; mentoring programme are in place. A clinical director leadership programme is being made available. Development programmes are being widened to Bands 1-4 and 8+.	We have developed the engaged leaders toolkit.		Acquire independent review from GMC of leadership arrangements.	Clinical leadership review [Well Led Governance Group - Quality Committee - May]
6	Clinical frameworks	Policies and guidelines remain out of date and need reviewing	Appraisal and training information shared and included in divisional level reports;	Revalidation report to Board	IIP accreditation	Clinical leadership framework to be reviewed	Clinical leadership review [Well Led Governance Group - Quality Committee - May]

Board Assurance Framework 2014-15 year end position. Date on which data valid 16-Mar-15

Calderdale and Huddersfield NHS
NHS Foundation Trust

Corporate objective no.	2. Keeping the base safe
Risk description:	A failure to deploy sufficient, talented staff caused by an inability to attract, recruit, retain, reward and develop them, may result in unintended harm to patients (severe permanent harm or death).

BAF risk no	3	Scores	Initial	Today	Acceptable	RAG rating today's assurance position	Oversight	Links to risks on risk register
Risk owner	JD	S x L		4 x 4 = 16	3 x 3 = 9	A	Quality Committee	2827 Middle grade recruitment in A&E

Control No	Control description	Gaps in control	Assurance from first line of defence (front line evidence)	Assurance from second line of defence (management evidence)	Assurance from third line of defence (independent evidence)	Gaps in assurance position	Further action or assurance required by committee / Board, with dates
1	Workforce planning and forecasting tools owned by Executive Team	Need clearly defined framework for recognising the characteristics of a potentially unsafe (under-resourced or under-performing) ward or service and escalating it.	reports to leadership walk rounds;	We are working to formalise a medical staffing tool to identify planned establishment of doctors by service. Consultant Recruitment Forum is being or will be engaged in its development and application.		Assurances we receive on staffing numbers show that long term gaps in teams continues, despite recruitment efforts. Need to ensure metrics are embedded in divisional performance framework. Comparisons could be made of the medical staffing model to Royal College, NICE staffing algorithms.	Workforce reporting through Integrated Board Report [Board - March]
2	e-rostering systems	Not yet fully implemented ? Doesn't yet apply across the optimum number of services and staff groups	e-rostering system delivery group.	Weekly staffing meetings. Nursing Workforce Group and Nursing and Midwifery Committee. Six weekly Divisional Business meetings.		Audit Committee report from Internal Audit Jan 2015 stated e-rostering not yet fully implemented; 13 recommendations of an earlier audit (CH014/2015)into bank and agency usage remain incomplete. Peer review of e-rostering system to be considered.	E-rostering implementation report to be reviewed [Quality Committee -
3	Access to flexible staffing back fill arrangements (bank and agency)		Staffing exceptions reported	Bank and staffing levels reported to WEB		12 overdue actions reported at Jan 15 Audit Committee.	Quality Committee to review actions from 13-14 limited assurance review by IA and ensure are resolved and effective
4	Multi-stranded and continuous recruitment activities	Recruitment and retention strategy to be developed	We are recruiting to numbers above establishment and we recruit based on values and organisational fit, rather than specific vacancies.	Hard Truths monthly Board report. Nursing Workforce Group and Nursing and Midwifery Committee. Staff turnover metrics in Integrated board report		Exit interview data to be shared; consider HR metrics from advert to induction. Number of leavers and staff turnover remains high.	Recruitment and retention report [Well Led Group - April]
5	Trust-wide engagement and participation initiatives	Don't have a mechanism for monitoring and reporting on engagement	Collect and report staff turnover data; Staff survey shows positive reports of communication from senior management	Colleague engagement strategy report to Board and quarterly follow-up report. Whistleblowing policy revised and re-launched; Staff FFT and survey reports to Board; Whistleblowing letter to Board members.	PCAW signed up to First 100.	Leavers information; staff perception information	PPI Plan [WEB - March]
6	Embedding and recruiting to the Trust's four behaviours		Development programmes are being rolled out to be accessible to all Trust staff.	We are devising new expressions or responsibility frameworks for communication;			

Board Assurance Framework 2014-15 year end position. Date on which data valid 16-Mar-15

Calderdale and Huddersfield NHS
NHS Foundation Trust

Corporate objective no.	2. Keeping the base safe
Risk description:	A failure to remain financially sustainable caused by national austerity and slow transformation may result in unplanned financial deficit (and enforcement).

BAF risk no	4	Scoring	Initial	Today	Acceptable	RAG rating today's assurance position	Oversight	Links to risks on risk register
Risk owner	KG		5 x 3 = 15	5 x 5 = 25	3 x 4 = 12	A	Finance and Performance Committee	6150 Breach of licence 4706 Failure to meet CIP

Control No	Control description	Gaps in control	Assurance from first line of defence (front line evidence)	Assurance from second line of defence (management evidence)	Assurance from third line of defence (independent evidence)	Gaps in assurance position	Further action or assurance required by committee / Board, with dates
1	CIP programme governance		Engagement plan for all staff around PMO; Trust staff working alongside PWC staff in PMO.	Turnaround Executive reports;	Turnaround Director and PMO reports. PMO is staffed by PWC. Fortnightly monitoring and reporting.	Well-led governance review in 2015 will address a gap in assurance but identify new controls. Finance & Performance Committee established late 2014.	Well Led Governance review self assessment [Board - April] Finance and Performance Committee effectiveness review [F&PC - April; Audit and Risk Committee - May]
2	Budgetary control processes		Clinicians actively engaged in coding. Service manages have access to activity reports.	Reviewed of coding capability and performance. We actively negotiate contracts allowing over-performance.	Internal Audit report on budgetary control (limited assurance). NHS England Intensive Support Team have been engaged to assist in improving capacity models for elective surgery.	Further improvement to budgetary controls required (see Jan 15 IA report CH10/2015). Monitor have launched investigation as it is not assured.	
3	Effective financial strategy.			Progress reviewed monthly by Board. Divisional performance reviews result in action to address variances.	internal audit review of divisional and performance management arrangements		Finance and Performance Committee to acquire assurance as to plans to put in place a working capital facility.
4	Performance management framework		Performance management undertaken at Divisional Business meetings;	Integrated Board report and finance paper to Board; Turnaround executive reports; Reports to finance and performance committee.	Foresight report into governance; PWC review of financial performance (December 2014)		
5	Quality Directorate overview of CQUIN and other discretionary reward schemes		CQUIN information in divisional reports	CQUIN information in integrated Board Report		CQUINs not achieved for 2014/15	Review of CQUINs at Quality Committee [April]
6	Capital allocation & rationing			Capital plan for 15-16 evidences prioritising on a risk based approach and addresses risks of failure identified in risk register. Report to Finance and Performance Committee on capital plan and draw down facility.			Capital plan risk report to Finance and Performance Committee [April]

Board Assurance Framework 2014-15 year end position. Date on which data valid 16-Mar-15

Calderdale and Huddersfield NHS
NHS Foundation Trust

Corporate objective no.	3. Improvement and innovation
Risk description:	A failure to compete vigorously caused by being too focussed internally may result in missed opportunities to retain or acquire activity, talent, capital, services (losses of £1-£5M). (Competitive forces).

BAF risk no	5	Scoring	Initial	Today	Acceptable	RAG rating today's assurance position	Oversight	Link to risks on the risk register
				4 x 4 = 16	3 x 3 = 9			
Risk owner	AB					A	Finance & Performance	

Control No	Control description	Gaps in control	Assurance from first line of defence (front line evidence)	Assurance from second line of defence (management evidence)	Assurance from third line of defence (independent evidence)	Gaps in assurance position	Further action or assurance required by committee / Board, with dates
1	Clear, communicated and well understood corporate strategy; and with specific, measurable objectives and KPIs.		Staff feedback shows clear understanding of OBC.	Management engaging with NHS England Intensive Support Team to improve the elective surgery competitiveness.	Picker Institute staff surveys. Monitor engagement with health economy.	As at Feb 2015 the plan on a page for 2015-16 and objectives with smart KPIs are still under discussion.	Strategy development process dates planned in [April / May]
2	A robust system of governance enables risk to be identified, treated, taken or avoided.	Risk management process not fully embedded	Better risk identification and reporting	The Trust has a revised the risk management policy. Committee review process in place.	Coscienza Consulting assisting Feb 15 in strengthening risk management and assurance processes and practice. Work has been progressed to strengthen divisional risk registers; tactics for improving the recording of controls gaps have been identified; the need for further training for staff has been identified and the Board's assurance framework has been refreshed.	Not all internal audit recommendations are completed on time; Well-led governance review 2015 will dig deeper. In late 2014-15 the non-executive involvement in chairing a wide range of assurance committees has been refreshed.	Committee effectiveness reviews taking place [All Committees - April] Review of internal audit recommendation implementation [Audit and Risk Committee - April]
3	A high performing Board is a source of competitive edge for the Trust.		Perfect Week led to greater senior management and executive visibility across the Trust;	Clear information from divisions up to the Board and back. New governance arrangements implemented in 2014. Remuneration Committee review Exec Team performance and establish 15-16 objectives for them. Membership Council review Non-Executive performance	Foresight Review of Board governance recommendations implemented. Timetable in place for Well Led Governance review in April / May.	Development plan for Board still outstanding from Foresight recommendations; Well Led Governance Review to take place; Leadership walk rounds programme to be implemented.	
4	Business intelligence activity and commercial strategy		Business plans and activity planning done 'bottom up' from Divisions based on clear business planning guidance and templates	In Sept - Oct 2014 management developed 3 strands of commercial strategy to mitigate delay in OBC progression: reconfiguration of services across hospital sites; reconfiguration to deliver best practice models of care; reconfiguration along patient pathways involving tertiary and community care providers	The Board approved a Commercial Strategy Sept 14 Board workshop on CC2H tender progress and update given on outcome of successful and unsuccessful tenders.	Commercial strategy requires update on progress Assurance required that commercial progress being made incrementally despite non-progression of the OBC	Commercial Strategy update [Board - May] Progress on tenders and OBC [Board - each meeting]

Board Assurance Framework 2014-15 year end position. Date on which data valid 16-Mar-15

Calderdale and Huddersfield NHS
NHS Foundation Trust

Corporate objective no.	3. Improvement & innovation.
Risk description:	A failure to obtain stakeholder commitment to initiate change, political uncertainty and commissioners' own priorities may result in an exacerbation of all significant risks (may result in regulatory escalation and Special Administration). (Community and two site strategy).

BAF risk no	6	Scoring	Initial	Today	Acceptable	RAG rating today's assurance position	Oversight	Links to risks on risk register
Risk owner	AB		5 x 5 = 25	5 x 5 = 25	3 x 5 = 15	A	Board	

Control No	Control description	Gaps in control	Assurance from first line of defence (front line evidence)	Assurance from second line of defence (management evidence)	Assurance from third line of defence (independent evidence)	Gaps in assurance position	Further action or assurance required by committee / Board, with dates
1	Outline Business Case makes compelling case for changing the service model ('OBC)'.	We can influence but not control the environment / CCG priorities.	We are unassured from first line of defence as we are aware of non-compliance against some standards (see risk 6131) incl. non-compliance with CYP in emergency care settings; paediatric medicine and surgery not co-located; high numbers of inter-hospital transfers; access to 7 day diagnostics for inpatients; and for mental health services.	Board has endorsed the OBC in 2014. Clear clinical engagement in the OBC. Risks associated with specific areas (e.g. A&E) considered by executive	The CCGs do not see the consultation on the 2 site strategy as more urgent that consulting on care closer to home and therefore it is not being prioritised. Monitor is supportive of the health economy engaging collectively. Meeting held with local commissioners, NHS England and Monitor in February 15.The Audit Committee commissioned an Internal Audit review of management of the risks of the OBC not progressing to implementation in 2014 (significant assurance).	Commissioners have declined to engage with the case for change before their other priorities are resolved. We must seek assurance that despite delays in external consultation, we make progress in addressing non-compliance in individual services.	Monitor convening multi-agency meeting follow up multi-agency meetings [Feedback to Board - April]
2	Tactical service reconfigurations led by relevant clinicians illustrate early success	Need to ensure that there is clarity on the identifiable elements of the governance structure are the forums for holding clinicians to account for leading on service sustainability	Clinical leads in PMO; clinical leaders for OBC.	Executive attendance at Divisional Boards.	Membership Council membership of DRGs.	What can be done to develop the arguments towards reconfiguring cardiology; respiratory; A&E; maternity; Paediatrics ?	
3	Media handling and reputation management		Staff survey reports good communication with senior management. Media handling policy in place;	Positive / negative assessment of media coverage shared with executive	Postive media coverage compares well across similar trusts.	Routine reporting of positive / negative media coverage no longer reported region wide.	
4	Action plan to address 6 facet review of the estate	Staff have access to a suggestion and can see visibility through communications of short and medium term investments.	Areas and services require investment which may not be available - e.g. Ward 18. Controlled by weekly environmental review.	PLACE inspection outcomes corroborate with patient feedback. Executive and Non-Executive leadership walk rounds. H & S Action Plan reviewed and progress chased by the H & S Committee	Ward 18 remains on risk register.	Leadership walk rounds to be developed further to include geographical areas	
5	Stakeholder engagement & management		Clear engagement and communications plan with staff pre-, during and post OBC	Engagement plan undertaken with Clinical Commissioners; Membership Council development plan to support their engagement with stakeholders and in holding the Board to account.	The Audit Committee commissioned an Internal Audit review of management of the risks of the OBC not progressing to implementation in 2014 (significant assurance). Positive feedback from stakeholders including Health watch on levels of engagement.		
6	Estates terrier	The estates terrier is incomplete. This exposes the Trust to income loss; capital loss; claims loss.	-	Management must provide assurances re strengthening the identified weaknesses at the H & S Committee.	Internal Audit review Jan 2015 identified weakness in the documentary record of the Trust's property assets, uses and income.	Finance and Performance Committee to acquire assurances that income opportunities are being systematically identified; terms benchmarked; legal advise used effectively to maximise opportunity and income.	Re-audit Sept 15. [Health and Safety Committee - tbc]

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

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Claire Gruszka, Patient Safety Risk Manager - LSMS
Date: Thursday, 26th March 2015	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: Risk Register - Organisational risk scoring 15+. The attached papers provide details of the highest risk areas as at 16 February 2015.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: These papers were presented at the 10 March 2015 Risk & Compliance Group.	
Governance Requirements: .	
Sustainability Implications: None	

Executive Summary

Summary:

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Main Body

Purpose:

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Background/Overview:

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The Issue:

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Next Steps:

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Recommendations:

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Appendix

Attachment:

COMBINED RISK REGISTER.pdf

RISK REGISTER REPORT

Risks as at 18 March 2015

TOP RISKS

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

2828 (20): Risk of poor patient outcomes and experience caused by blocks in patient flow
2827 (20): Risk of poor patient outcomes due to dependence on middle grades
6136 (20): Overarching risk for Infection Control
6178 (20): THIS Modernisation programme, Service improvement activity
4783 (20): HSMR & SHMI

RISKS WITH INCREASED SCORE

There are no risks which have increased in score.

RISKS WITH REDUCED SCORE

5937 – Nursing staffing levels

The above risk now sits on their local risk register.

NEW RISKS

The following new risks have been added/have been carried over since/from the meeting:

5806: Privacy & Dignity on Chemotherapy ward at HRI (16)
6143 (16): THIS Modernisation prog, working with BTHT
6144 (16): THIS Modernisation prog, tactical solutions to achieve ERP project
6234 (16): Completion of appraisal and mandatory training by 31.3.15
6126 (16): Non-compliance with ICO FOI requirements
6232 (16): Lack of Fire Wardens (predominetly Acre Mill)
6230 (15): Failure to deliver expected benefits of EPR

CLOSED RISKS

No risks were closed.

RISKS TO BE DISCUSSED AT NEXT RISK & COMPLIANCE COMMITTEE:

- SAS & DaTs Divisions full risk registers
- Paediatrics in A&E
- Safeguarding/Deprivation of Liberty
- Other new risks identified on risk register

Trust Risk Profile as at 18 March 2015

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Rare (1)					
Unlikely (2)					
Possible (3)					! 6230 – Failure to deliver expected benefits of EPR = 6027 – Failure to meet Capital programme
Likely (4)				= 5792 – Shortage of Consultants in Opthalmology ! 5806 – Privacy & Dignity issues on Ward 3, Chemo ward ! 6143 – THIS Modernisation prog, working with BTHT ! 6144 – THIS Modernisation prog, tactical solutions to achieve ERP project ! 6234 – Completion of appraisal and mandatory training by 31.3.15 = 6130 = Loss of income/reduction in profit related to competitive procedures = 6132 = Reduction in elective surgery market share and volume of work ! 6126 = Non-Compliance with ICO FOI requirements ! 6232 – Lack of Fire Wardens (predominently Acre Mill)	= 2828 – Blocks in patient flow in A&E Glaucoma/macular service = 2827 – Dependence on middle grade locums in A&E = 6136 – Infection Control ! 6178 – THIS Modernisation prog, Service improvement activity
Highly Likely (5)				= 4783 – HSMR & SHMI	= 6150 – Breach of Monitor licence = 4706 – Failure to meet CIP = 6131 – Progression of service reconfiguration impact on quality and safety

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

Extreme and Major Risks (15 or over)

	Risk No	Div	Dir	Dep	Opened	Status	SO	Risk Description plus Impact	Existing Controls	Initail	Current	Target	Further Actions	Review	Target	Dir RC	Exec	Lead
Extreme	4706	Corporate	Finance	Corporate Finance	Jun-2011	Active	Objective 2 - Keeping the Base Safe	The Trust's current expenditure exceeds planned levels through failure to deliver Cost Improvement Programme (CIP) or budgetary overspend. The expenditure levels in 2014/15 carry forward into 2015/16 to give rise to an income an expenditure gap that is insurmountable through achievable savings levels. This will result in the Trust not generating a sufficient I&E surplus and cash to meet on-going commitments and cannot remain a viable and sustainable organisation.	- Appointment of PWC to assist in the creation of a more robust PMO to develop, control and monitor the 14/15 CIP schemes. - A revised PMO approach which includes external and internal support and has been built on the ideas and schemes that were previously managed within the Efficiency Programme Board. - Appointment of a Turnaround Director to provide further direction and support to the PMO process under the overall leadership of the Turnaround Executive. - Weekly meetings with Turnaround Executive to review, challenge and escalate progression within the necessary workstreams. Remaining Trust reserves to mitigate against shortfall in part in 2014/15. Monthly financial reporting and forecasting to allow remedial action. Business planning for 2015/16 indicates that due to the size of the initial income and expenditure deficit position this cannot be met through CIP delivery. Therefore, cash support will be required within 2015/16 with discussions being held with Monitor and the Independent Trust Financing Facility (ITFF).	15 5 x 3	25 5 x 5	25 5 x 5	- Additional external resource will be considered based on need and specialist input identified within each workstream. - CIP schemes and delivery for 2015/16 will be monitored and progressed through the PMO driven disciplines under the guidance of the Turnaround Executive.	Mar-2015	Mar-2016	FPC	Keith Griffiths	Chris Benham

Extreme	6131	Corporate	Commissioning & Partnerships	Commissioning & Partnerships	Oct-2014	Active	Objective 2 - Keeping the Base Safe	Risk: The delay in being able to progress service reconfiguration creates the risk that the Trust will not be able to address important clinical quality and safety issues Background: The Outline Business Case identified service reconfiguration proposals that would mitigate and address significant clinical and quality safety issues associated with the current configuration of services across two sites. Clinical Commissioning Groups have decided that consultation on changes in configuration of hospital services will not commence in 2014 and will be delayed until September 2015.. Impact: The delay in being able to progress service reconfiguration creates the risk that the Trust will not be able to address important clinical quality and safety issues identified by NCAT such as: • Non-compliance with many of the standards for Children and Young People in Emergency Care settings; • Paediatric medicine and surgery are not co-located on the same hospital site; • The two hospitals in Halifax and Huddersfield do not provide the same acute services and this leads to a frequent need for inter-hospital transfers • Non-compliance with the prescribed NHS England standards such as: Ø All admissions seen by a suitable consultant within 14 hours of admission, or within 6 hours between 0800-2000, except patients who are very ill, where it should be 1 hour; Ø Hospital inpatients must have scheduled seven-day access to diagnostic services; Ø Support services, both in the hospital and in primary, community and mental health settings, must be available seven days a week.	To address this the Trust is reviewing and assessing possible actions and critical service changes that could be progressed in the interim period, and as quickly as possible, within the required statutory and regulatory processes so as to improve the clinical, quality, safety and sustainability of services. This review has been completed and the report and recommendations approved by the Trust Board in October 2014. The recommendations are now being implemented however in the absence of major reconfiguration the impact they will have on mitigating clinical and financial risk is limited.	25 5 x 5	25 5 x 5	15 3 x 5	Clinical Commissioning Groups have established a Hospital Board to review the OBC and consider the risks related to current model of provision. CCGs are now aiming to commence public consultation in September 2015. The options for consultation will build on the OBC proposals and are likely to include scope for West Yorkshire collaboration and also the new models of care described the NHS Five Year Future Forward.	Mar-2015	Sep-2015	WEB	Anna Basford	Catherine Riley
Extreme	6150	Corporate	Finance	Trustwide	Nov-2014	Proposed for Acceptance	Objective 2 - Keeping the Base Safe	The Trust is in breach of its licence.	- Monthly report to Board, Finance and Performance Committee and WEB. - Regular reporting to the Membership Council. - Divisional Business meeting reporting. Workstream programme arrangements in place. - QIA assessments undertaken. - Independent review of financial position and CIP. - Full review of budgets taking place. - Appointment of Turnaround Director - Turnaround processes in place - Strengthened programme arrangements - Strengthened QIA process	15 5 x 3	25 5 x 5	5 5 x 1	- Action plan resulting from Independent report - Increased frequency of budget monitoring with all divisions / departments - Compliance with the terms of it's breach of licences as agreed with Monitor	Mar-2015	Mar-2015	FPC	Keith Griffiths	Chris Benham

Major	2828	Surgery & Anaesthetics	Accident and Emergency	A&E CRH / HRI	Apr-2011	Active	Objective 1 - Transforming Patient Care	Risk of poor patient outcomes and experience, caused by blocks in patient flow due to low numbers of discharges. This results in patients having prolonged waits in A&E until an appropriate bed becomes available. There is also a risk of breaching the A&E performance indicators, including the YAS turn around time. The Trust has currently failed to meet the Qrt4 and year-to-date A&E target.	- Senior Nurse co-ordinator to liaise with patient flow team. Use A&E escalation protocol to ensure A&E senior management aware. - Site co-ordinator to be informed to provide support/additional nursing resource. - Out of hours to contact Matron on site/on call manager. - Level discharges. - Plan for every patient which is monitored for each patient on a daily basis to reduce length of stay. - Strong multi-agency working relationships, overseen by the Urgent Care Board. -Escalation process in place- Surge and Escalation Plan	20 4 x 5	20 5 x 4	8 2 x 4	- A&E Recovery Plan - Perfect Week	Mar-2015	Mar-2015	CG	Julie Dawes	Sajid Azeb
Major	2827	Surgery & Anaesthetics	Accident and Emergency	A&E CRH / HRI	Apr-2011	Active	Objective 2 - Keeping the Base Safe	Risk of poor patient outcomes, caused by dependence on locum middle grades, who at weekends and nights are the senior decision maker in the department. This quality/experience of locums is hugely variable. There have been 4 serious clinical incident in the past two years involving locum Middle grade Doctors. There is a national shortage of middle grade doctors in emergency medicine.	- On-line ED guidelines. Senior Nurse Operationally managing the department- overview of all staff to support and advice, escalation of any issues to the on-call Consultant. - - Recruited longer term locums to improve continuity, provide improved decision making, improved supervision for junior medical staff and support to the Senior Nurse. - Recruited 4 new consultants, departmental cover from 8am until 10pm Monday to Friday. - Two SpR's now in post. - A&E Risk Management Strategy- guidelines available in each department.	20 4 x 5	20 5 x 4	4 1 x 4	-Oct 2014- Workforce review completed. 2 Senior Nurses training and developing the ANP role within the departments, with a 10 year plan to increase the number to 10. - first two ACP's will complete in March 2015 at SHO level- - Business case developed to provide direct clinical care consultant cover seven days a week, this has now been approved- recruitment process commenced. Consideration being given to NHS Locum Consultants being recruited. -BC for two consultant approved, out to recruit-October 2014 - Recruitment at middle grade level ongoing. - Exploration of reconfiguration of services underway, as described in the Strategic Outline Case.-2013/14- Contingency Plan being developed to mitigate the risk of having no available Middle Grade Doctors in the OOH period, this is to be agreed with Director of Operations as this contingency is to potentially close one site in the OOH period and divert to the opposite site. December 2014- Requested Locum consultant via agency. Out to all agencies for locum Specialty Doctors. Consultants 'acting down' to provide on site cover but extremely challenging due to gaps at consultant level and Speciality Doctor level cover. January 2015- One consultant has now returned from sick leave December 2014- Risk reviewed - higher risk at present due to Speciality Doctor withdrawing from 2 weeks of nights. Also sickness within the consultant body is causing increased risk as more shifts including consultant on calls to cover. January 2015- consultant sickness reduced as one has returned to work.	Apr-2015	Oct-15	UCB	Julie Dawes	Dr Mark Davies/Mrs Bev Walker

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Melanie Johnson, General Manager, CGSU
Date: Thursday, 26th March 2015	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Care of the Acutely Ill Patient (CAIP) Programme Update paper - Provide a short update of progress against each of the 8 themes in the programme.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: A more in depth version of this paper is scheduled to be received by the Quality Committee on the 24th March.	
Governance Requirements: This work is designed to address issues around reducing mortality rates.	
Sustainability Implications: None	

Executive Summary

Summary:

This papers sets out key progress and barriers to achievement of the programmes key outcome aim: To achieve a SHMI of 100 between January and December 14. This data will be published in June 2015

Main Body

Purpose:

Update on progress of each of the programmes 8 key themes, including plans for improvement over the next 2 months.

1 Reducing Mortality (Overall outcome measures)
2 Ensuring the recognition and prompt treatment of our deteriorating patients.
3 Delivering high standards of care through reliable delivery of care bundles.
4 Frailty
5 Effective (inc a focus on Site Differences)
6 Focus on SHMI Conditions of Interest
7 Well Led Organisation (leadership to improve quality with pace)
8 Coding

Background/Overview:

A paper is presented to BOD every 2 months to share progress of the programme. The last paper was presented in January 2015. It links with the quarterly quality report next due in April 15.

The Issue:

The primary issue is that the Trust has above predicted death rates (as measured by HSMR and SHMI). The programme was designed to address this issue and more generally to improve care quality.

Next Steps:

Please note final section. The programme is working to a detaied action plan.

Recommendations:

Please see page 15 final section.

Appendix

Attachment:

BOD Mar 15 v1.pdf

Calderdale and Huddersfield NHS
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Care of the Acutely Ill Patient (CAIP) Programme Board of Directors

Update: March 2015

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

Contents

1. Introduction

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

1 Reducing Mortality (Overall outcome measures)

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

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

4 Frailty

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

6 Focus on SHMI Conditions of Interest

7 Well Led Organisation

8 Coding

Oversight of the work is provided by the Clinical Outcomes Group (COG) reporting through Quality Committee on a monthly basis.

Theme 1: Reducing Mortality

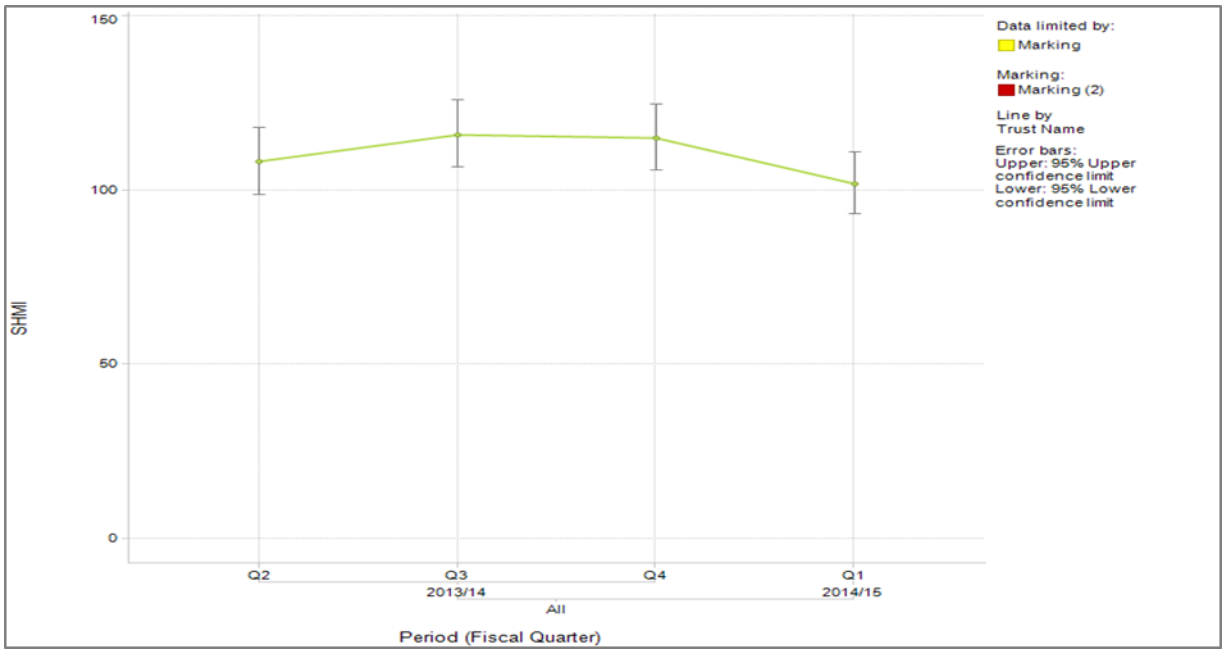
Two key outcome measures:

A) Standardised mortality:

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

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

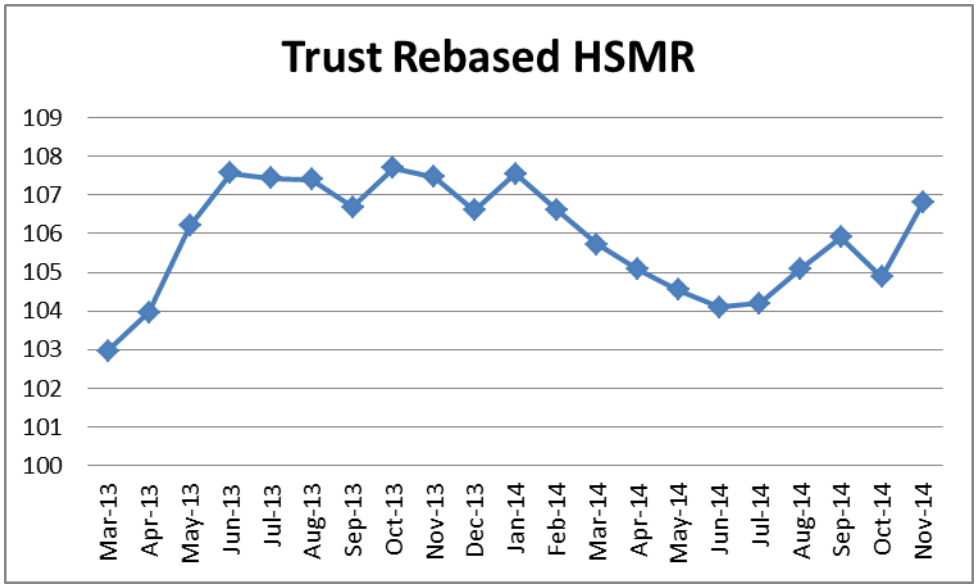
- The most recently published SHMI for July 2013 - June 2014 is 110 which is 2157 deaths above the predicted number of 1956.74.
- The proportion of patients dying during Jul 2013 – Jun 2014 was marginally lower than the Apr 13 – Mar 14 period, with a SHMI Crude mortality rate of 2.92% compared to 2.99%.
- This means that despite a lower proportion of patients dying in Jun 13 – Jul 14, the reduction was not enough to ensure our SHMI was lowered significantly.
- Looking at the quarters which make up the SHMI, the most recent Quarter has seen a fall in value to 101.



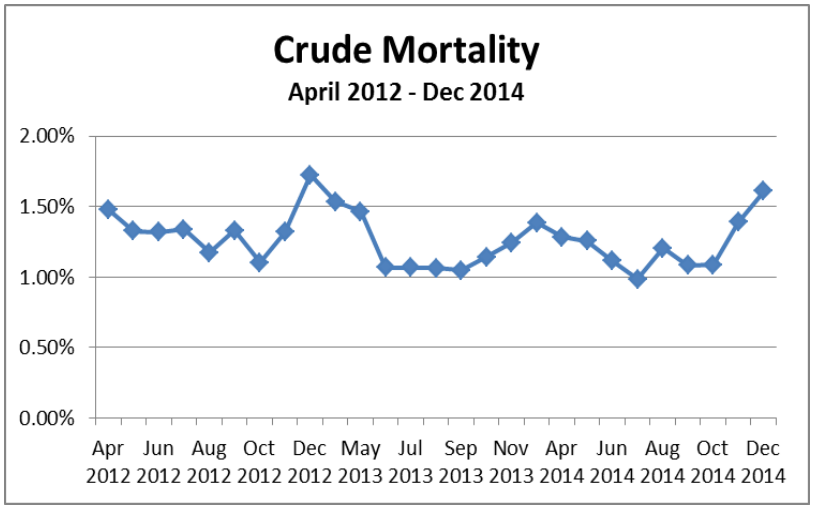
There are other measures of mortality which are less in arrears and enable us to track likely SHMI scores. The Hospital Standardised Mortality Rate (HSMR) is one such indicator.

Data was released in February for HSMR incorporating performance data up to October 2014.

The 2013/14 rebased score is now available and shows the Trust to be 106.03. This ranks the Trust as 114th out of 141 Trusts.



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



The trust has recently purchased HED (Healthcare Evaluation Data) system licence. This new system will allow prediction of both HSMR and SHMI only 1 month in arrears.

Another outcome aim for the programme is to ensure we learn from mortality through the Trust process for mortality reviews.

Due to the rise in December's mortality rate focus has been placed on reviewing as large a sample as possible to ensure learning is gathered and where necessary work is initiated and changes put into place. 87% of December deaths were reviewed, in 12% of these reviewers felt that a more detail second level review was required.

Results of Level 1 Reviews

Of the 149 deaths reviewed, 118 were admitted via A&E (79%); the remaining 21% admitted through MAU. It was deemed appropriate that 116 died in hospital (78%) and not in another care setting or at home.

The length of stay ranges from 0 to 120 days. The average LOS is 15 days. 41 of the 149 patients died during the weekend (28%).

DNACPR: Of the 149 patients 138 had a DNACPR in place (93%). Of those 138, 30% were discussed with the patient, 76% were discussed with the carer and 45% had a review date in place.

A crash call was placed for 4 patients. 3 of those were deemed unavoidable; one however was felt likely due to a missed clinical intervention.

There are no underlying themes that can be pulled from the data.

Summary of level 2 reviews completed

The preventability scale used is as below:

1.. Definitely not preventable
2. Slight evidence of preventability
3. Possible 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 of preventability
6. Definitely preventable

Out of the 149 reviews completed 18 were referred on for a level 2 review (12%). To date 13 have been completed leaving 5 still to do. 3 have been deemed at level 3 or above. 2 had already been identified as serious incidents and were under investigation, 1 had not been reported and is now under investigation.

More detailed analysis from December deaths will be undertaken and reported to April executive board.

February deaths are now in the process of being reviewed.

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

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

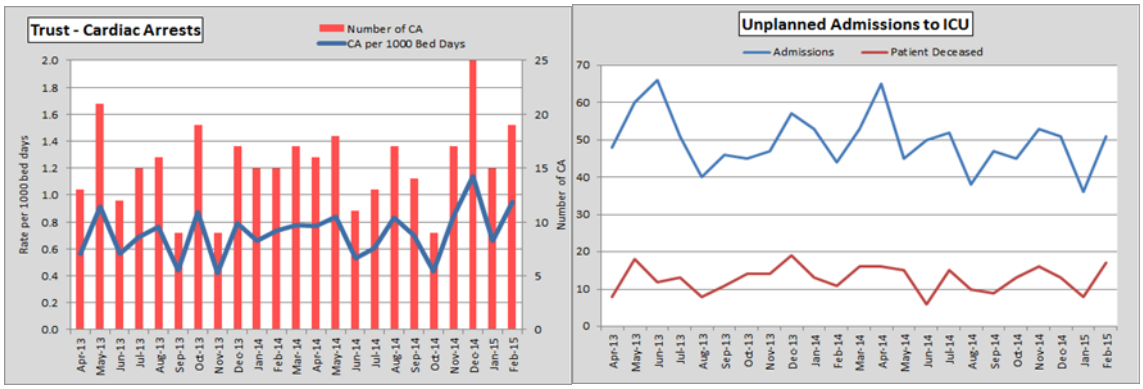
‘Nerve Centre’ has been in place on the 2 test wards for 6 weeks, a medical respiratory and elective orthopaedics ward. Once the initial test period is over and the necessary changes made it is planned other wards will be integrated at a rate of 2 per week (from the end of April 15). A team are in place now and are working on the wards actively supporting the implementation.

More work needs to take place around ensuring we have the correct models of care and teams in place to support increased escalation, this work will initially focus on Hospital at Night and weekends, a paper was presented at COG in March, key principles were agreed and a business case will now be developed.

As well as escalation and observations ‘nerve centre’ also includes handover modules – currently separately for nursing teams and medical staff. These are also being tested on the 2 wards and will be further refined as the project moves forward.

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

There has been no impact yet on either of these 2 measures. This is not surprising as the impact of nerve centre will not be seen until implemented on more areas. Trajectories for improvement are currently being calculated for the next year.

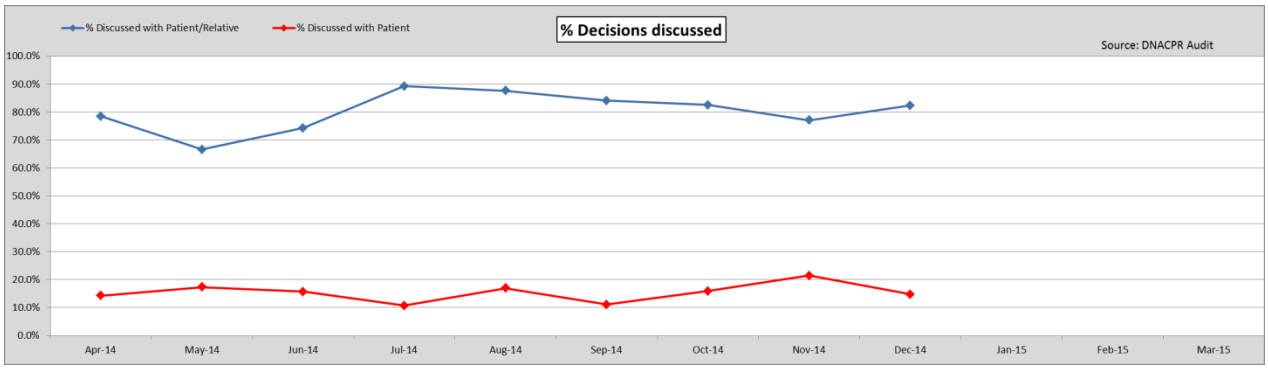


The other focus of the work is around DNACPR – The data has failed to show any improvement over the past 18 month in communications around the decision or review dates being completed.

To try and address this the plan is for the end of life and DNACPR work to be implemented through a project management office process linked to the CQC preparation work, this will accelerate the pace of change and help define clearer improvement interventions.

Measures will include:

- Continued compliance with CQUIN – staff trained around end of life on targeted wards.
- Triangulation of the data on DNACPR to give a more accurate picture – ensuring data is fed back to the frontline teams in a timely manner.
- The end of life clinical leads will discuss issues around DNACPR compliance at clinical audits half days in April.
- Focus on fast track discharges – to understand issues with discharge planning for this vulnerable group of patients and plan improvements.



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

Care bundles are a group of actions that if properly validated and implemented are proven to lead to improved clinical outcomes for the condition or symptom to which

they apply. As such if chosen correctly they will support the Trusts high level aims to reduce harm and mortality.

Some of the barriers to implementing bundles reliably from discussions with junior staff are:

- Unawareness the bundle exists
- Uncertainly re which bundle to use
- Unable to get hold of correct bundle quickly
- The electronic record system in A&E cannot be adapted easily to prompt and include bundles.

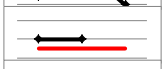
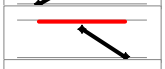
The plan is to screen all acutely unwell patients on admission for respiratory distress, AKI and sepsis. Where elements of these exist the document signposts to the associated care bundles for treatment and diagnosis. This project is behind schedule, new timescales have been set for testing and implementation, the latest screening tool is being discussed with clinical staff on admission areas, and initially tested, the aim is then to test from mid-April on the MAU's and A&E's.

This ties in with the new national CQUIN's for Sepsis and AKI that were released on the 3rd March and are tied in with the care bundle process. Implementation targets and trajectories will be same as for CQUIN's for Sepsis and AKI, currently under negotiation with the CCG's.

Collecting accurate compliance data for this theme has been an issue; the clinical audit team are now collecting weekly data on initiation of the bundles (below), however this is only a small sample and relies on ward staff being aware that patents have these conditions. There is more detailed audit completed by the specialist teams.

Actions over the next two months will include:

- Testing of admission signposting tool on admission areas
- Detailed gap analysis from current process to aid compliance with 2 new CQUIN's - changes to be made over next 4 weeks so ready to capture data.
- Initial planning re work needed to improve compliance.
- Targets and improvement trajectories to be same as CQUIN's for Sepsis and AKI.

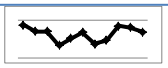
Theme 3: High standards of care through reliable delivery of care bundles	Asthma - Bundle Started	95%	0%	95.0%	33%	
	Asthma - Bundle Completed	95%	n/a	95.0%	100%	
	AKI - Bundle Started	95%	55%	95.0%	52%	
	AKI - Bundle Completed	95%	3%	95.0%	53%	
	Sepsis - Bundle Started	95%	87%	95.0%	91%	
	Sepsis - Bundle Completed	95%	42%	95.0%	68%	
	COPD - Bundle Started	95%	79%	95.0%	82%	
	COPD - Bundle Completed	95%	45%	95.0%	53%	
	Pneumonia - Bundle Started	95%	83%	95.0%	83%	
	Pneumonia - Bundle Completed	95%	80%	95.0%	70%	
	Heart Failure	Design Phase				

Theme 4: Frailty

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

There are many definitions of frailty, the Trust currently uses a modified LACE tool as part of the discharge planning process for referral to virtual ward to reduce risk of readmission. This tool looks at length of stay, acute admission, Charlson comorbidity score and A&E visit in the last 6 months.

A model has already been developed to pull data on this via 'Qlik View', this is based more simply on patients 80+, with 3+ Comorbidities and 3+ previous admissions in previous 12 months. This equates to an average of 13% of in hospital deaths.

Theme 4: Fragility	% frailty Deaths (as a proportion of all deaths)	-	13.4%	-	12.9%	

It is important that the scope of current work on-going is understood so duplication does not occur. To reduce the risk of this occurring there is an action plan looking at all aspects of frailty linked to the themes that have emerged from mortality reviews. This encompasses:

- Dysphagia pathway,
- Frailty screening,
- Establishment of frailty pathways,
- Care plans to patient being transferred back to care homes.
- Pilot of nurse led comprehensive geriatric assessment
- Checking with care homes on admission re patients normal functional ability
- Assessing efficacy of the frail safe model
- Improving links to end of life pathways and decision making

- Review of existing care bundles and applicability for frail patients.

Agreement of definition of frailty for use in the trust and key metrics will be the next stage in the work.

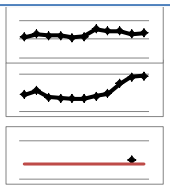
Theme 5: Effective

The trust is actively bed modelling for 2015-16 based on patient demand, cross divisional work to use beds more effectively. This work is inherent in efficiency savings plans for the Trust.

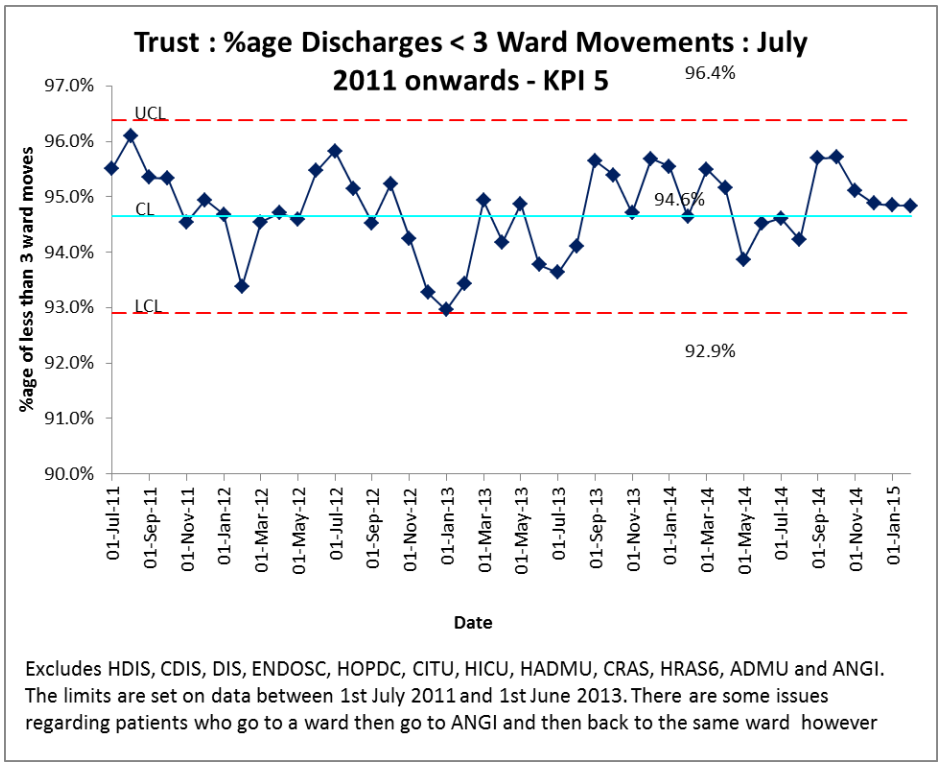
All the length of stay enablers (Pacemaker loop, plan for green crosses, PFEP, plan from every review, level discharges etc.) are now all being managed through the project management office. Detailed workbook and rigorous KPI's in place being monitored and escalated on a weekly basis where required.

Focussed actions over the next 2 months include:

- Focussed work on reducing numbers of green crosses
- Work on design of site commander role and other staff managing beds
- Plan for every review –In medicine - process been tested and refined, spread plans being agreed, in surgery - process being tested in Trauma.

Theme 5: Effective	Bed Occupancy %	-	86.8%	-	85.5%	
	Number of Outlying Bed Days	-	946	-	5933	
	% of spells with > 2 ward movements (2% Target)	2%	2.5%	2%	2.5%	
	Average length of Stay (ALoS)	-	3.6	-	3.4	

The chart below from the courage to put the patient first dashboard – displays the information slightly differently – aiming for 98% of patents experiencing less than 3 ward moves. The charts shows normal variation with an average of 94.6% of patients having less than 3 ward moves. However, the last 6 values are above the mean. If this continues next month the Trust will be in a position to change the limits and report an increased achievement against this target.

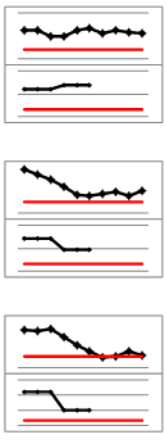


Excludes HDIS, CDIS, DIS, ENDOSC, HOPDC, CITU, HICU, HADMU, CRAS, HRAS6, ADMU and ANGI. The limits are set on data between 1st July 2011 and 1st June 2013. There are some issues regarding patients who go to a ward then go to ANGI and then back to the same ward however

Theme 6: SHMI Condition of Interest - Over View

Conditions initially idetfied as being of concern from the SHMI data are monitored through this theme.

	Mortality Indicators	SHMI Latest =	Jul - Jun	HSMR Latest =	Nov - Oct
Theme 7: Conditions of Interest	COPD - HSMR	100	123	100	118
	COPD - SHMI (75)	100	115.92	100	
	Heart Failure - HSMR	100	119	100	110
	Heart Failure - SHMI (65)	100	116.22	100	
	ACD (inc Stoke) - HSMR	100	124	100	101
	ACD (inc Stoke) - SHMI (66)	100	128.38	100	



COPD - SHMI data available for Jul 13 - Jun 14, at 115.92. There is no reason to suspect the SHMI will have reduced in the future release

Heart Failure - Significant reduction in HSMR seen from the 12 month period of Jun 13 - May 14, since this point the HSMR has stayed around 110. SHMI data mimics this initial reduction and the Jul - Jun 14 data is comparable on both measures. As such it is likely that a further SHMI reduction will be seen in the next release.

ACD (inlcuding Stroke) - has seen the most dramatic reduction. From a high of 123 (Feb 13 - Jan 14) down to a score in line with the 100 average for the last 4 months of data released. SHMI data mimics the initial reduction and the Jul - Jun 14 data is also comparable to each other. It is likely that a further reduction in SHMI will be seen in the next release which is due in April 2015

It has been agreed that key quality metrics will also be included in the clinical outcomes group dashboard from April 15.

In addition to these original conditions of interest, work continues scrutinising the data released for any other concerns or alerts.

The lateset SHMI release for Jan 13 to June 14 when compated to the top 10 conditions leading to death in the previous release showing improvements in 7, 2 saw improvements only in the latest quarter, 1 was worse, highlighted in red below:

Description	**Jan13-Dec13**	Apr13-Mar14	**Jul 13 – Jun 14**	**Improvement?**
Acute cerebrovascular disease.	33.94	31.0989	10.4898	23.4502
Chronic obstructive pulmonary disease and bronchiectasis.	17.3	9.5706	10.2477	7.0523
Mental retardation, Senility & organic mental disorders.	15.91	14.6647	3.6682	12.2418
Peripheral and visceral atherosclerosis.	13.05	7.4874	3.3373	9.7127
Congestive heart failure; non-hypertensive.	12.23	14.4043	7.5	4.73
Superficial injury, contusion.	11.51	12.7388	10.3101	1.1999
Cancer of bone & connective tissue, Cancer of thyroid, Malignant neoplasm without specification of site	9.29	6.0056	6.7264	2.5636
Deficiency and other anaemia, Acute post haemorrhagic anaemia.	8.96	4.4311	7.1861	1.7739
Pneumonia (except that caused by tuberculosis or sexually transmitted disease).	8.95	-5.605	16.2744	-7.3244
Other inflammatory condition of ski, Chronic ulcer of skin, Other skin disorders.	8.88	9.9298	7.2761	1.6039

There are 3 additional conditions in the current top 10, they are:

	DENOMINATOR	OBSERVED	EXPECTED	SHMI	Difference between obs vs expected
Urinary tract infections	1229	87	67.10	1.30	19.90
Acute bronchitis	1575	76	60.58	1.25	15.42
Liver disease, alcohol-related	92	26	14.24	1.83	11.76

UTI has been recently invetsigated through a targeted mortality revew – there were no findings of concern. There is a review ongoing for liver disease.

Theme 7: Well Led Organisation

The actions contained in theme 7 are all designed to ensure that key barriers to support the programme aims are overcome.

Leadership walk round process.	Acuity & Dependency Audits. Nurse Staffing Levels meeting the acuity of patients
There will be 5 strands all with the primary aim of increasing the visibility of senior leaders and allowing staff an easy way to raise concerns and/or make suggestions for improvement. This work is closely tied in with preparation for the CQC visit. • NED walk rounds – as current announced walk round process, scheduled monthly from beginning of April • Executive Directors – visits in dedicated geographic area – to cover estate as well as clinical issues. • Senior Management team – Back to the floor Fridays 1/2 day once a month, scheduled from April15. • Matrons – Weekly back to the floor. • Other – e.g. Chairman's surgeries, focus groups etc.	The acuity and dependency results have been reviewed and are scheduled to be taken to Board. We are currently reviewing the pilot study results and guidance from the NHS England on measuring contact time with patients and will be identifying next steps to undertake a study of contact time (a necessary requirement to accurately assess acuity and dependency) on the wards in April. Developing a process to improve real time communication and reporting of the shift by shift monitoring of staffing, acuity and dependency on individual wards, the aim so to trial this by May 15. ● Acuity and dependency result to go to board ● Policy study results be to be reviewed re contact time with patients. ● Developing a process to improve real time comms and reporting by shift.
Update to Communications plan	**Out of Hours Medical Cover - Divisional Reports**
A plan has been drawn up re rolling communications around the plan each month. Logo has been designed; focus in March will be deteriorating patient.	Meetings in place, awaiting detailed action plan.
% of reporting against national mark. (NRLS)	**Human Factors**
The scope of the effective investigations group includes 3 groups of interventions ; • Tools for investigations (Standardise with core investigation and RCA principles) – a draft toolkit has been produced being finalised and tested. • Training for investigators – training for serious incidents to be scheduled in over the next 4 months. • Improving the investigations process to simplify reporting and improve feedback, ensuring learning and changes of practice – initial scope worked out re changes needed to reporter fields on DATIX.	Initial focus will be around redesigning the current effective investigations processes; some measures will be devised to track the progress of this.

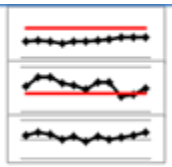
Handover module on Nerve Centre.	Implementation being led by senior clinicians
Handover module in place on the 2 pilot wards for doctors and nursing teams. Suggestions for improvement and changes will be made during post pilot phase (happening now to mid-April). Therapy teams have also requested access to handover fields both for awareness and access to add in key information.	Support structures for the revised themes is on the action plan.

Theme 8: Coding

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

Progress has been made in 3 of the 4 key metrics for this work but work is still required to get achieve the National Average:

- Average Charlson Score – continues to improve.
- % Sign and Symptom – this needs to be as low as possible currently at 9.40% against a target of 9.5%.
- Average Diagnosis – continues to improve

			Feb		YTD	
Theme 8: Coding	Average Charlson Score	4	3.39	4	3.20	
	% Sign and Symptom	9.5%	9.40%	9.5%	10.30%	
	Average Diagnosis	5	4.19	5	4.07	
	Co-morbidity capture	90%	16%	-		

Co morbidity capture relates to the tool now embedded in the clerking in document which should be completed by medical staff as patients are admitted. There is a weekly audit of co-morbidity form compliance which is fed back to divisional teams Compliance with this intervention remains poor (now 24% against a target of 90%). Methods of reporting Coding Quality performance back to divisions are being improved with a report going Divisional Business meetings and from next month the report will also be discussed the Divisional PQSB's.

There is targeted work taking place with specialist teams e.g. endoscopy and pre-op assessment to see if the co-morbidity proforma can be used in these areas to improve the average Charlson score.

From the coding teams perspective there is continued difficulty in recruiting suitable qualified staff to key specialist positions, interviews have taken place resulting in the recruitment of 1 clinical coder (non ACC qualified) and trainee clinical coder positions are due to be advertised by the end of March. The team are working through what arrangements are required to address recruitment issues.

During March and April plans are being made to look to if it is possible to deploy the 3M encoder ahead of original timescale including capital business case and understanding of requirements of technical staff to enable interfacing as necessary .

The Board is asked to note:

- Improvement in the latest 1/4ly SHMI release (data relating to April – June 14).
- Initial findings from December mortality reviews – no underlying themes identified to date, detailed analysis to be presented to April executive board.
- 'Nerve Centre' in place on pilot wards, on schedule to start spread from 20th April 15.
- Failure to see improvement in measures around DNACPR communication with patients and/or carers and review dates.
- Improvement in 7 of the 10 SHMI conditions with the highest mortality rates in the latest 1/4ly release.
- Improvement in 3 of the 4 KPI's for the coding theme. Poor performance on completion of the co morbidities proforma as part of the admission process.

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

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

Executive Summary

Summary:

The DIPC report is provided monthly to keep the Executive Board members and the Board of Dirctors infomed of the current position of HCAI and to highlight areas of concern and progress of prevention work.

Main Body

Purpose:

For information

Background/Overview:

Monthly update of the position of HCAI in the trust

The Issue:

Monthly update of the position of HCAI in the trust

Next Steps:

Report to be taken to the Infection Control Performance Board

Recommendations:

for the Board to note the content

Appendix

Attachment:

Monthly DIPC Report March 2015.pdf

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

Performance targets

Indicator	Month agreed target	Current month (February)	YTD agreed target	YTD performance	Actions/Comments
MRSA bacteraemia (trust assigned)	0	**0**	0	**1**	One case has been assigned the trust
C.difficile (trust assigned)	2	**4**	18	**26**	9 avoidable 17 unavoidable
MSSA bacteraemia (post admission)	1	**0**	15	**9**	
E.coli bacteraemia (post admission)	2	**7**	23	**27**	Analysis of the cases is underway. Early indications are there are no common themes as to the aetiology of these cases. Constipation guidelines are being reviewed as this a contributing factor for urine infections.
MRSA screening (electives) January validated data	95%	**96.17%**	95%	**95.82%**	

Quality Indicators

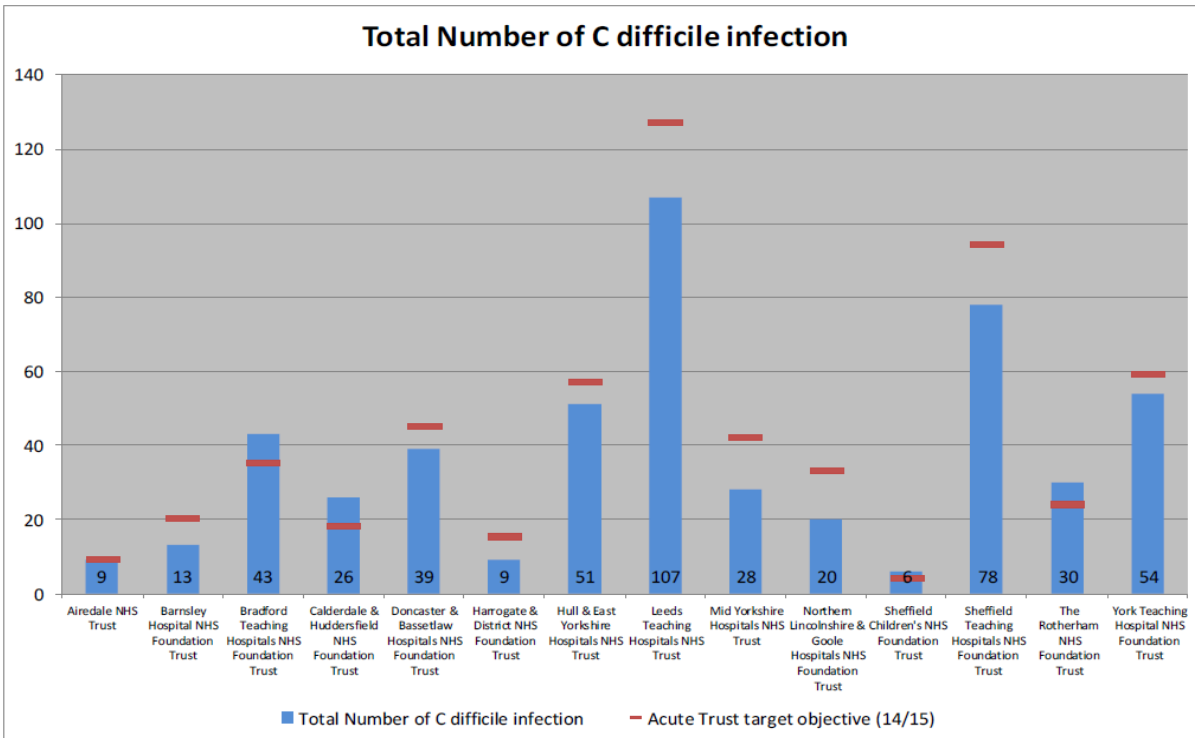
Indicator	Month agreed target	Current month (February)	YTD agreed target	YTD performance	Comments
MRSA screening (emergency)		**91.4%**		**87.7%**	
Central line associated blood stream infections (Rate per 1000 cvc days)	1.5	**1.88**	1.5	**1.01**	There was infection in February currently being investigated to establish if this case was avoidable. An appropriate action plan will be put in place and the learning shared at the CVAD steering group. The CVAD team are currently providing refresher training and competency assessment. The cumulative (12 month rolling) infection rate remains well below the target
Isolation breaches		**33**		**235**	All isolation breaches are carefully monitored by IPCT
ANTT Competency			95%	**70.5%**	Plan in place to assess junior

assessments (doctors)					and middle doctors during March and all ward managers contacted to ensure all nurses are assessed.
ANTT Competency assessments (nursing and AHP)			95%	**72.6%**	
Blood cultures Competency assessments (Drs)				**28.4%**	Blood culture competencies will be included in the ANTT plan above. Improvement shown since last month
Blood cultures Competency assessments (RN)				**53.4%**	
Cleanliness		**97.18%**		**97.4%**	
Hand hygiene	95%	**99.95%**	95%	**99.83%**	
Frontline Ownership Audits (% performed)		**57%**			47 out of 83 clinical areas completed FLO audits in February showing an improvement on last month. Further reminders to be sent out to matrons and managers

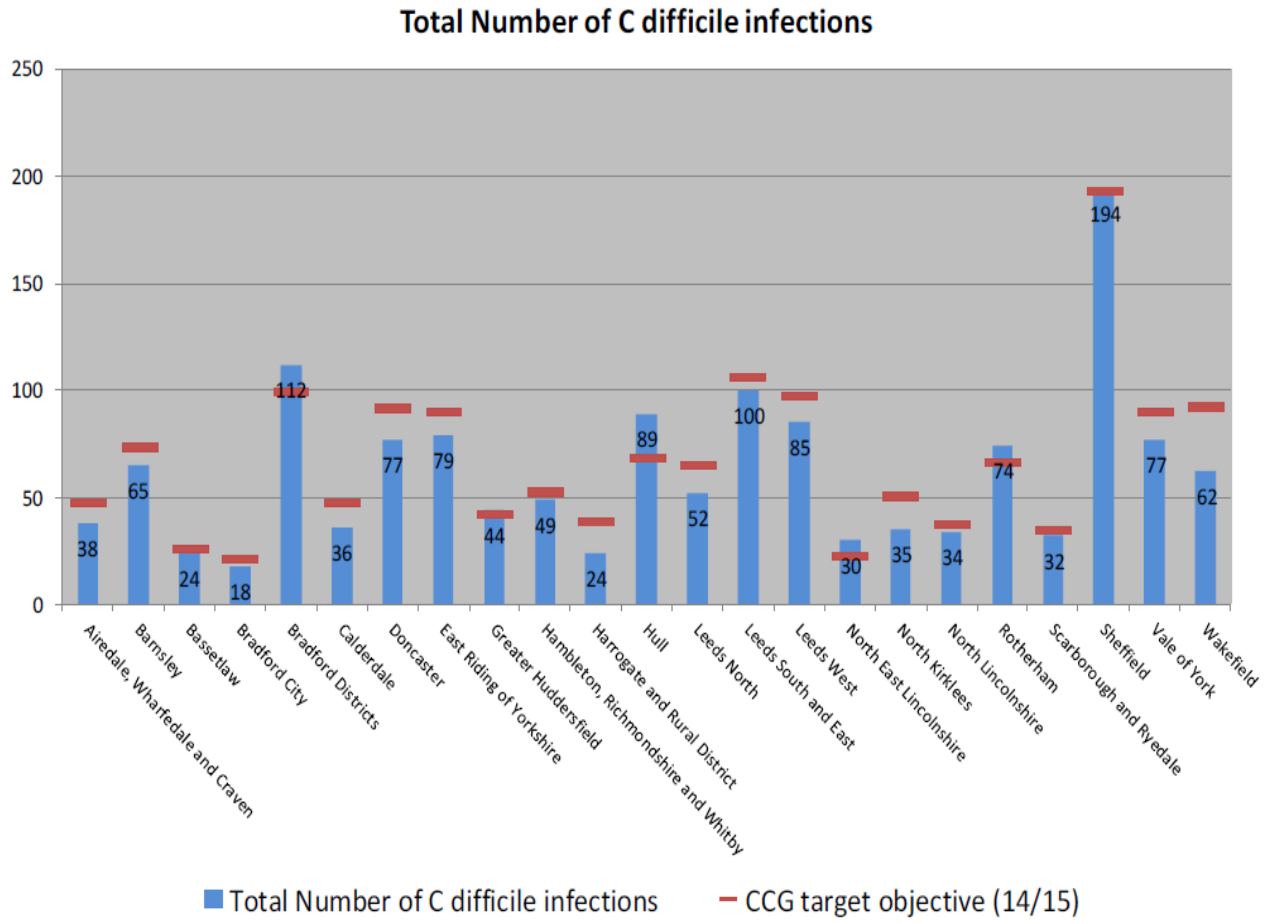
Clostridium difficile

4 post admission cases in February with the YTD total of 26 cases against a ceiling of 18. Of these 9 are classified as avoidable and 17 classed as unavoidable. Most of the cases are sporadic, there are no common themes in terms of the reasons behind the cases, although are common themes in terms of the management, particularly around isolation of patients with diarrhoea. We are still pursuing nerve centre as an electronic solution to aid early isolation decision. An external review of cleaning has taken place, the results of which are awaited as cleaning has been identified as an issue in some of the avoidable cases.

The chart below shows the regional position for acute trust (Public Health England)



The chart below shows the regional position for CCG apportioned cases (Public Health England)



The table below provides a summary of the four cases in February

Date and place of patient	**Summary of case**	**Key issues identified from RCA**
03.02.15 C7D MESS No 396393 Datix 115777	Admitted with reduced mobility and raised potassium to MAU 9th January. Developed a UTI on 19th January and was treated with antibiotics. Patient had episodes of constipation and loose stools.	• RCA meeting concluded this was an avoidable case • Delay in obtaining stool specimen • Low compliancy with FLO audits was attributed to shortage in staff
03.02.15 H22 MESS No 396404 Datix 115794	Admitted following a fall on 23rd January to MAU with a history of several falls and was not managing well at home. Developed urosepsis and retention of urine. He was treated with antibiotics and had developed diarrhoea prior to antibiotic therapy. Patient died	• RCA meeting concluded this was an unavoidable case • Delay in obtaining stool specimen
09.02.15	Admitted on 27th January to MAU	• RCA meeting concluded this was

H6 MESS No 397878 Datix 116045	with aspirational pneumonia and transferred to ward 6. He was treated appropriately with antibiotics. Received laxatives for constipation and was on nasogastric feeds.	an unavoidable case • Patients normal stool was not recorded on admission
17.02.15 **C6C** MESS No 398992 Datix 116286	Patient admitted on 5th February following an MI. Diagnosed with a lower respiratory infection on 8th February and prescribed antibiotics. Patient tested for C.difficile due to mucous in the stool but didn't have diarrhoea	• RCA meeting concluded this was an avoidable case • Long term PPIs • C.difficile not treated as not clinically indicated • Inappropriate antibiotics given according to patient age, acknowledged that guidance is not easily accessible

Areas of Concern/Outbreaks

- **Isolation breaches** recorded by the Infection Control Team during February were 33 compared to 35 in January. Of the 33 isolation breaches in,
    - 16 were at CRH and 17 were at HRI
    - 25 were on medical wards
    - 7 were on surgical wards
    - 1 was on a maternity ward

  The days of non -isolation ranged from 0-14 days at CRH and 1-5 days at HRI. Three of the breaches were on MAU at HRI when the ward was restricted with norovirus. Risk assessments were completed on all the breaches identified and there was no evidence of cross-contamination.
- **Norovirus** – HRI wards 4, 10 and MAU and CRH ward 2AB were closed to admissions due to Norovirus during February with a total of 180 lost bed days.
- **Hospital acquired MRSA** - in February, there was 1 case identified on a surgical ward. There have been a total of 27 cases of hospital acquired MRSA since April.
- **Pseudomonas HRI ICU** - There have been 3 pseudomonal infections in patients linked to Huddersfield ICU that are the same strain. Two of the patients have been discharged home, the other remains in hospital with complex medical problems unrelated to this infection. There is not a strong epidemiological link between the patients. Water sampling has been undertaken that has demonstrated all but one shower are free from pseudomonas (actions with respect to this underway). On-going surveillance over 4 weeks has not demonstrated any further cases. This is likely to be sporadic however a meeting involving the Public Health England is planned for week commencing 23rd March to document actions for assurance purposes.
- **Ebola** - A patient presented to Calderdale A&E on 6th March who had returned from Sierra Leone with a fever and diarrhoea. She was classed as 'high possibility, low probability' but tested negative for Ebola. In general the Ebola plan worked very well, however several issues were identified at a subsequent debrief meeting held on 10th March from which an action plan has been developed and most actions either completed or close to completion. The risk from Ebola is quickly subsiding; Liberia have not reported a new case in excess of 1 week, and in Sierra Leone/Guinea, only 48 new cases were reported in a week period in each country.

Quality Improvement Audits

- Two Quality Improvement Audits were performed in February
    - CRH 8AB – Scored Amber (90%)
        - Not all cleaned equipment labelled to state clean
        - Bath hoist and a commode observed to be dusty
        - Kitchen cupboards and drawers in need of a clean
        - Clean goods stored on the floor
    - HRI DSU – Scored Amber (88%)
        - Dusty shelves in dirty utility room
        - Overfilled sharps bin
        - Not all cleaned equipment labelled to state clean
        - Unclean stethoscope observed
        - Clean goods stored on the floor

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting:	**Report Author:**
Board of Directors	Vicki Drummond, Workforce Assurance Manager
Date:	**Sponsoring Director:**
Thursday, 26th March 2015	Julie Dawes, Director of Nursing

Title and brief summary:

NURSING AND MIDWIFERY SAFE STAFFING - PURPOSE: • To share the findings of the November 2014 Ward Based Staffing Review. • To bring to the attention of the Board any workforce risks • To make recommendations for investment or changes to the workforce models based on the findings, recent publications, national and professional guidance • To provide the Board of Directors with an update on the investment secured for the Nursing and Midwifery Workforce in May 2014 KEY POINTS: • Achieving safe staffing levels in nursing and midwifery are essential to provide safe and compassionate care. • This paper builds upon the Board Paper presented in December 2014 and presents the findings of the November 2014 Safer Staffing Review for in-patient wards. • It will provide: Recommended ward establishments based on the safer staffing review.

Action required:

Approve

Strategic Direction area supported by this paper:

Keeping the Base Safe

Forums where this paper has previously been considered:

NA

Governance Requirements:

This paper provides assurance to the Trust Board that nursing and midwifery staffing capacity and capability is monitored, reviewed, and established in line with the recommendations of the Hard Truths (2014) document; National Quality Board guidance (2013) and NICE Guidance for Safe Staffing of Adult Inpatient Wards (2014).

Sustainability Implications:

None

Executive Summary

Summary:

In summary this is a comprehensive report of the findings from the ward based staffing review. The report highlights areas that require investment based on the findings, recent publications, national and professional guidance to provide safe and compassionate care, which have been met through divisional investment and disinvestment to result in a safe and balanced plan.

Main Body

Purpose:

This paper sets out the evidence base underpinning the ward based staffing review as well as the execution and analysis of review findings. Current and potential workforce risks are highlighted, and recommendations made for investment or change to the workforce mode. The paper builds upon that provided to the Board in December 2015.

Background/Overview:

See paper - section 1.0

The Issue:

NA

Next Steps:

See paper - section 12.0

Recommendations:

The Board are asked to consider the presented evidence and approve the recommended staffing levels and support the next steps.

Appendix

Attachment:

feb 15 board report v 10 pdf.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Board of Directors: March 2015 **Agenda Item Number:**

Report to:	Board of Directors – March 2015
Subject:	**NURSING AND MIDWIFERY SAFE STAFFING**
Sponsored by:	Julie Dawes, Director of Nursing
Prepared by:	Jackie Murphy, Deputy Director of Nursing Vicki Drummond, Assistant to the Director of Nursing – Workforce Assurance Manager
Purpose of the Report:	• To share the findings of the November 2014 Ward Based Staffing Review. • To bring to the attention of the Board any workforce risks • To make recommendations for investment or changes to the workforce models based on the findings, recent publications, national and professional guidance • To provide the Board of Directors with an update on the investment secured for the Nursing and Midwifery Workforce in May 2014
Key Points for Trust Board Members:	• Achieving safe staffing levels in nursing and midwifery are essential to provide safe and compassionate care. • This paper builds upon the Board Paper presented in December 2014 and presents the findings of the November 2014 Safer Staffing Review for in-patient wards. • It will provide: Recommended ward establishments based on the safer staffing review.
Next Steps Future action:	The Board are asked to consider the presented evidence and approve the recommended staffing levels and support the next steps.
Strategic Aim	Keeping the Base Safe
Risk Register	
CQC Reference	

NURSING AND MIDWIFERY SAFE STAFFING

1.0 INTRODUCTION

1.1 This paper provides assurance to the Trust Board that nursing and midwifery staffing capacity and capability is monitored, reviewed, and established in line with the recommendations of the Hard Truths (2014) document; National Quality Board guidance (2013) and NICE Guidance for Safe Staffing of Adult Inpatient Wards (2014). This paper sets out the evidence base underpinning the ward based staffing review as well as the execution and analysis of review findings. Current and potential workforce risks are highlighted, and recommendations made for investment or change to the workforce mode. The paper builds upon that provided to the Board in December 2015.

1.2 The paper demonstrates the systematic approach taken to identify the required nurse to patient staffing levels to provide safe and compassionate nursing care across adult and children's inpatient wards in the acute setting.

1.3 A triangulated approach has been utilised to complete the review as we acknowledge that no one piece of guidance or patient to nurse ratio can be universally applied to determine safe staffing levels across a range of wards. Therefore data triangulation was used to draw on numerical data as well as professional judgement. Numerical data included acuity and dependency audit and scrutiny including review of the Safe Nursing Indicators.

1.4 This paper provides a staffing review of CHFT Emergency Departments' staffing. Further non ward based staffing reviews including Theatres are currently been undertaken.

2.0 INVESTMENT UPDATE 2014 / 2015

The £1.45m Hard Truths funding agreed by Board was allocated to Divisional budgets in 2014/2015 allowing the workforce models to be amended to incorporate the enhanced absence assumption at 20%, investment in critical posts and supervisory sister posts in Surgery.

The specific allocation made for investment in critical posts in 2014 / 2015 can be reviewed in **Appendix 1**.

2.1 The level to which the committed funding has been spent or is forecast to spend in the full year will be very much dependent upon the success in recruiting and or/filling shifts with non-contracted workforce. There are a number of posts which were vacant and shifts unfilled as reflected in the submissions to Unify and this will apply to the additional Hard Truths workforce in the same way that it applied to the staffing levels pre-this investment being committed.

2.2 In 2015/16 the nursing workforce models have been set to reflect the full year effect of the Hard Truths investments.

2.3 20% Uplift is now in place in all inpatient wards and 100% supervisory status is in place in all inpatient wards within the Medical and Surgical Division. Within Children, Women and Families ward 1D/9 has 50% supervisory status and Maternity Assessment Unit has 40% supervisory status which has been reviewed by the Head

of Midwifery and is satisfactory using professional judgement. All other areas within Children, Women and Families have 100% Supervisory status.

3.0 NICE GUIDANCE

The Nursing Workforce Group continue to review and progress the NICE Guidance to ensure CHFT 100% compliance.

3.1 Current areas which require focus to achieve 100% compliance with NICE Guidance are demonstrated in Table A.

Table A: CHFT Compliance with NICE Guidance

Priorities for Action from NICE Guidance	CHFT planned action December 2014	Progress against planned action March 2015
• A system in place for nursing red flag events to be reported by any member of the nursing team, patients, relatives or carers to the registered nurse in charge of the ward or shift. Management of red flag events.	• Agree and promote red flag events through Nursing Workforce Group. • Develop robust procedure for reporting available which is available to nursing team, patients, relatives and carers. • Develop process to ensure prompt escalation of red flag events. • Develop process for red flag events to be reported on sit-rep and matron's reports.	• Task and Finish Group has commenced to promote red flag events. • Work with Risk and Health Informatics is been undertaken to develop robust reporting. • Monitoring of Red Flag events is been developed through the task and finish group and will be utilised to inform future staffing reviews. • Red Flag incidents are been outlined in patient information leaflets to ensure patients, relatives and carers are aware of Red Flags and how to escalate concerns. • To be complete by May 2015.
• Increased flexibility of the nursing workforce to enable prompt action in response to nursing staff deficits.	• Continue with active recruitment to internal flexible workforce. • Recruit from increased number of agencies to increase fill rate required. • Consider using provider to manage flexible workforce for CHFT.	• Recruitment has continued to increase Flexible Workforce capacity. • Increased agencies commenced with increased fill rate. • Options appraisal completed for management of flexible workforce complete. • Complete
• Approaches to support flexibility of the nursing workforce.	• Consider implementing long days for nursing staff. • Develop Calderdale Framework within CHFT	• Proposed long day implementation into workforce models in Medical division in place. • Long day proposal for

	to assist with nursing skill mix been optimised safely.	Surgery in progress with scheduled completion of 30.3.15. • Review of support roles within nursing workforce utilising Calderdale Framework in progress and due for completion April 2015. • To be complete by May 2015.
• Keep records of on-the-day assessments of actual staff requirements and reported red flag events.	• Implement the web based safe staffing tool designed to capture the staffing requirements and incorporate agreed red flag incidents.	• Web based tool successfully implemented which records on the day assessment and includes professional judgement narrative. • Red Flag task and finish group commenced to develop the promotion, monitoring and action required as a result of red flag events. • To be complete by June 2015.

4.0 AVERAGE FILL RATES

4.1 Table 1 illustrates the average fill rates. Consultation with individual ward managers during the last quarter has identified that a number of nurses are working one long shift comprising of 11.5 hours in place of 2 nurses working 7.5 hours each.

This continues to affect the fill rate, as planned staffing hours for 2 nurses are calculated at 15 hours, but 1 nurse working a long shift results in the correct number of nurses on duty, but a decreased number of planned hours been worked.

4.2 All workforce models have been reviewed and a process for ensuring ward managers and the E Roster team are aware of the planned workforce model has been implemented.

4.3 The safe staffing tool provides an opportunity for ward managers to document when a long day has been used to safely cover the ward. This has been used as a strategy to maintain safe staffing levels on the majority of ward areas during the last quarter due to the increased number of patients.

Table 1: Average Fill Rates

	May	June	July	August	Sept	Oct	Nov	Dec	Jan
Average Fill Rate **Day** Qualified Nurse / Midwives %	89%	86%	87.6%	81.8%	79.4%	80.51%	82.8%	81.9%	83.6%
Average Fill Rate **Day** Non - Qualified Nurse / Midwives %	109%	98%	103.6%	93.7%	93.6%	92.67%	94.4%	92.4%	92.3%
Average Fill Rate **Night** Qualified Nurse / Midwives %	83%	84%	83.4%	82.6%	82.1%	85.90%	86.6%	85.9%	89.2%
Average Fill Rate **Night** Non - Qualified Nurse / Midwives %	135%	122%	128.6%	119.9%	118.2%	121.09%	122.2%	119.7%	116.6%

5.0 RECRUITMENT

We have continued to work across the multidisciplinary team to better understand our current vacancy position. We have implemented a vacancy verification process to identify vacancies which have been filled by successful candidates but are not yet evident on the financial ledger.

5.1 We are working towards implementing a TRAC software system which will enable CHFT to accurately track the recruitment pipeline and average time to recruit.

5.2 We continue to recruit robustly, and have scheduled recruitment events at 4 local universities within the next month.

5.3 This year we have started “keep in touch” events with students due to qualify in September 2015. Through this method we are encouraging students to apply to CHFT for a nursing position, and then engaging the successful candidates between now and September 2015 to ensure every opportunity is taken to ensure candidates take up a position.

5.4 Our international recruitment campaign has been successful and we currently have 20 international nurses working within CHFT. A further 16 are scheduled to arrive and we plan to undertake a further trip to Spain in March 2015 to recruit a further 10 nurses. Each of the international nurses has received a specific induction programme to assist with their development and safe integration into our workforce.

Table 2: Current Nursing and Midwifery Vacancies

	Vacancies (Nursing Workforce Position) March 2015 WTE
Qualified (Nurse / Midwife)	85.81
Non qualified	19.35

5.5 To increase retention rates we have implemented "new starter forums" for any new starters within the trust to attend. We have also commenced a "clinical skills assessment" and development plan for all new starters to ensure their competencies and development needs are addressed.

5.6 A training package to highlight and promote the vital role of preceptorship is currently been designed with a planned implementation of the package in April 2015.

5.7 A series of "Action Learning Sets" to support newly qualified nurses in September 2015 has been developed to ensure additional support for nurses to develop clinical skills and knowledge is easily accessible.

6.0 ACUITY AND DEPENDENCY REVIEW – THE TRIANGULATED REVIEW

6.1 Acuity and Dependency tools provide a relatively simple way of assessing safe numbers of nurses required for inpatient wards. Acuity and Dependency tools are used alongside professional judgement, safe nursing indicators, and on the day assessment to ensure safe patient care is delivered at CHFT. NICE (2014) recommended using an endorsed toolkit to identify optimal nurse staffing levels and we complied with this by using the Safer Nursing Care Tool (SNCT) from the Shelford Group to complete an acuity and dependency audit over a 20 day period in November 2014.

6.2 Acuity and dependency levels recorded over the 20 day period provided "multipliers" which have then been used to indicate nursing establishments inclusive of 20% uplift to allow for sickness; training and leave. The trend of multipliers can be seen in Tables 4 and 5 (Appendix 3).

6.3 For the first time in November 2014 we supplemented the SNCT results with a further calculation based on the NICE Guidance for Safe Staffing (2014) which can be seen in Tables 4 and 5 (Appendix 3). The value of the NICE calculation is that it includes the non-direct patient care time and throughput of patients which the SNCT does not consider.

We have moved at pace to incorporate the NICE guidance into this staffing review, and feedback from some neighbouring trusts indicates that they are yet to develop this element into their workforce planning which has limited the scope for benchmarking in this area to date.

6.4 The non-direct patient care time utilised for the NICE Calculation in November 2014 was calculated from activities undertaken through the Productive Ward initiative in

2012. Prior to undertaking the next review of ward establishments a further initiative will be completed to ensure the non-direct patient care time is a true reflection of the current reality. We will review the results of the NHS England pilot to review "contact time" published in November 2014 to identify the optimal method of establishing this data as we recognise that a review which establishes this data will ensure we maximise the productivity and effectivity of our nursing teams.

Table 3: Nice Calculator

WARD:	
MATRON:	
DATE OF ACUITY & DEPENDENCY AUDIT:	

Overall Mutiplier - *Comes from Acuity and Dependency*	
Mutiplier per Bed Day - *Comes from Acuity and Dependency*	
Nursing Hours Available Per Week *(Automatically calculates)*	0.00
Nursing Hours Available Per Day *(Automatically calculates)*	0.00
No. Of Beds on Ward	
Hours Needed Per Patient Per Day *(Automatically calculates)*	
Average Number of Patients Going Through Department in 24 Hours (Information to come from Health Informatics)	
Additional Hours Spent on Non Direct Patient Care (Information in Ward Reports in Productive Ward Folder)	
No. of Hours Per Patient Per Day *(Automatically calculates)*	
No. of Hours Per Year Available *(Automatically calculates)*	
No. of Hours Available Per Year per WTE *(Automatically calculates)*	1620.00
WTE Per Week Required *(Automatically calculates)*	

Current Workforce Split

No. of Registered Nurses	
No. of Health Care Assistants	
WTE Registered Nurse Needed *(Automatically calculates)*	
WTE Health Care Assistants Needed *(Automatically calculates)*	

6.5 Professional Judgement is essential in determining ward establishments to ensure local circumstances and the variability of CHFT patients' nursing needs are considered.

The Associate Director of Nursing has met with the senior nurse and ward manager to assess the current ward establishment including the current skill mix, shift patterns and a review safer nursing indicators. To ensure a standardised approach a tool was developed and utilised as the basis for professional judgement discussions (**Appendix 2).**

The safer nursing indicators included:

- Sickness
- Supervisory Status
- Ward Length of Stay
- Plan for every patient compliance
- Appraisal compliance
- Risk training compliance
- Percentage of Harm Free Care for the last 4 months
- Family and Friends results for the last 4 months
- Number of complaints for the last 6 months

6.6 The Board can be assured that the methodology of the systematic review has developed the following recommendations with the registered nurses who are providing care at ward level as recommended by NICE (2014). Additionally each Associate Director of Nursing has also completed the establishment review following a multidisciplinary approach by consulting with the divisional finance director and general manager.

7.0 RESULTS OF INPATIENT NURSE STAFFING REVIEW

7.1 The results from the SNCT and the NICE calculator produced a score which is the combined whole time equivalent (WTE) qualified and unqualified nurse to bed ratio.

The scores were reviewed alongside professional judgement against RCN Guidance for safe staffing levels (2013) and NICE Guidance for safe staffing levels (2014) which can be reviewed in Tables 5 and 6 (**Appendix 3)**

7.2 Recommended changes to nursing workforce models as a result of the SNCT and NICE scores in addition to national guidance and professional judgement have resulted in a number of recommendations for investment and disinvestment which are detailed in Appendix 3.

7.3 Registered Nurse to Patient ratio per shift has been reviewed to ensure that following the recommended changes in Appendix 3 to workforce models all in-patient areas will meet NICE Guidance for Safe Staffing levels (2014). Registered Nurse to Patient Ratio can be seen in detail in **Appendix 4.**

8.0 PROFESSIONAL JUDGEMENT

Professional judgement to support changes to workforce models (Appendix 3) are identified below.

8.1 **Medical Division:**

Ward 8 has a requirement to provide proportionately higher levels of 1-1's and to maintain this the HCA ratio has been maintained resulting in the skill mix of 54:46

Ward 6D requires an additional qualified nurse on the Late shift to support the Hyper Active Stroke Unit where professional guidance suggests 2 nurses to 4 beds.

MAU at CRH required 1 HCA each night to ensure HCA support for each side of the ward and support additional requirements of this area including supervising patients for transfer periods away from the ward whilst undergoing diagnostic investigations out of hours.

Ward 17 requires an additional 1.68 WTE qualified nurses to achieve recommended safe staffing levels.

Ward 7BC at CRH has been reviewed and an increase of 1wte band 5 to a band 6 post to support nursing leadership across stroke services is recommended .

Ward 5AD has been recommended to increase by 1 registered nurse on the early shift and decrease by 1 registered nurse on the night shift following a review of the dependency and acuity and professional judgement. This will provide a ratio of 1RN to 5.5 patients on the early shift and 1RN to 8 on the night shift.

Ward 6b and CCU currently have 1 Senior Sister Band 7 across this bed base which has a 32 bedded ward and 9 bedded CCU incorporating 4 procedure beds. The ward and the unit are not located in the same area. The Coronary Care Unit (CCU) and Angiography / procedure beds require dedicated clinical leadership to help take forward the necessary changes in cardiology. A review of the dependency and acuity and professional judgement recommends that there is a dedicated Band 7 for each of these areas.

8.2 **Surgical Division:**

Wards 19 and 22 have a skill mix below the recommended guidance for ideal, good quality care of 65:35 (RCN 2013), but above the basic safe care recommended skill mix of 50:50. The reviewed and recommended skill mix off 55:45 and 52:48 respectively remain our recommendation following the review. Both areas have nursing indicators within acceptable parameters.

One CHFT local target is to achieve a 1:10 nurse to patient ratio on nights (for which there are no recommended ratios). 3 areas do not currently achieve this on the recommended workforce model (wards 20; 15 and 22). Further work to consider whether a twilight shift would be beneficial will be considered in 2015 in these areas.

Ward 10 has been recommended as an area of investment due to the dependency of patients reported through the professional judgement review and the acuity and dependency audit. This resulted in our recommendation that the skill mix be increased to 3 qualified and 1 unqualified on a night shift replacing the current model of 2 qualified and 2 unqualified on a night shift.

Ward 8D is recommended to increase the qualified nurses on a night shift to the minimum of 2 qualified per night to meet the recommended minimum standard of 2 qualified nurses in any one area.

Ward 8AB has an establishment which assumes a decrease in clinical demand as beds are reduced each weekend. The risk of not achieving the planned closure of beds each weekend will affect the ability of the workforce model to provide safe care.

ICU (HRI and CRH)
Standards for Nurse Staffing in Critical Care Units are determined by The British Association of Critical Care Nurses, The Critical Care Networks National Nurse

Leads, and The Royal College of Nursing Critical Care and In-flight Forum. The nursing staff work flexibly within the current workforce model to support the challenges and varying level of patient need and at present due to this require no further investment at this time.

Ward 8C has recently transferred to the Surgical Division and the Workforce Model will require further review which is scheduled to be completed by March 2015.

It is recommended that ward 22 transfer largely from short days to working long days to provide the opportunity to implement the recommended changes within the surgical division.

8.3 Professional Judgement Children, Women and Families
The SNCT and the NICE calculator are not directly applicable in areas which are not adult inpatient wards. For these areas which are predominantly within the Children, Women and Families Division the SNCT and NICE calculator have not been used. Professional judgement and professional guidance has been utilised.

8.4 **Midwifery:**

Established methods of determining midwifery workforce include crude ratios of midwives to births (see table 7) and methodologies based on assessment of clinical risk and care needs of women and babies during labour, birth and the immediate post birth period (for example Birthrate Plus (BR+)). The current recommended midwife to birth ratio is 28 births per WTE midwife for hospital births (including all aspects of midwifery care in hospital and community) and 35 births per WTE midwife for home births (Royal College of Midwives 2009). Regionally the ratio is 1:30 with investment been made in some Trusts post CQC inspections to bring to 1:28 (specifically Bradford, Leeds, and Mid Yorks). CHFT is currently commissioned by the CCH for a ratio of no more than 1:30. Recommendations for community midwife caseload size are also made (BR+ recommends 1:96, RCM (2009) recommends 1:98).

Table 6: Crude Midwife to Birth Ratios (including midwives in managerial posts and excluding midwives in managerial posts)

Year	Births	WTE Midwives	WTE Midwives in Managerial Roles	Midwife to Birth Ratio All Midwives	Midwife to Birth Ratio Excluding midwives in managerial roles
2013 / 2014	5822	197.5	4	1:29.47	1:30
2014 / 2015 predicted	5815 Predicted	197.5	4	1:29.44	1:30.5

8.5 CWF commenced a 12 week BR+ acuity and dependency study in October 2014. This is the first time the Division has undertaken this study. Early results emphasised the extent to which midwife hours on the LDRP fell significantly below those required to meet acuity scores of women on the LDRP. Immediate changes were required to the model of care to better meet women's acuity and dependency needs and, on 9th December 2015, the focus of LDRP changed to a more traditional labour ward.

Women undergoing induction of labour are now cared for in a separate inpatient ward.

8.6 Paediatric nurse staffing levels are not currently mandated or defined by NHS England. Two professional organisations have provided core standards for the care of children and the staffing levels that should be in place: The Royal College of Nursing (RCN) Defining Staffing Levels for Children's and Young People's Services, updated July 2013 and the paediatric intensive care society standards.

A key risk in determining paediatric nurse staffing relates to the unpredictability of workload and the impact of High Dependency Unit or Critical Care on nurse staffing ratios across the ward area.

No acuity and dependency scoring has previously been undertaken in CHFT for paediatrics. The Division completed a critical review of available tools for reviewing acuity and dependency in paediatric areas in November 2014. Paediatric Acuity and Nurse Dependency Assessment (PANDA) tool developed by Great Ormond Street Hospital has been commissioned for use. The ratio of 1:3 (recommended by the RCN for children less than age 2 years) has been applied within this report.

Application of Acuity and Dependency tool in paediatrics may result in recommended changes for the next business cycle however review of workload against occupancy suggests that if an annualised approach is taken to nurse staffing currently no investment is required.

8.7 The NICU workforce model is currently mid organisational change in line with the derogation plan.

8.8 Women's: based on crude midwife to birth ratios; a reduction of births in 2014/2015 (compared with number of birth 2013/2014); a reduction in maternity bookings during the second and third quarter of 2014/2015; It is not anticipated that investment will be required in the midwifery workforce for 2015-2016. The Division are planning to reduce the funded establishment of midwives by 3wte from April 2015 and will review midwifery staffing levels against projected activity to year end in September 2015.

9.0 EMERGENCY DEPARTMENT REVIEW

9.1 A review of nurse staffing within CHFT A&E Departments has been undertaken following the recommendation to specifically review staffing levels in A&E by the High Quality Care Now and for Future Generations: Transforming Urgent and Emergency Care Services in England Report (NHS England 2014), Francis Report and the Berwick report.

NICE guidance for safe staffing within A&E has been consulted upon and we await the publication in Spring 2015.

9.2 The staffing levels have been reviewed utilising the Royal College of Nursing's Emergency Care Association (ECA) Baseline Emergency Staffing Tool (BEST) in December 2012, June 2013 and at HRI in June 2014.

The BEST uses the validated dependency tool for Emergency Departments: Jones Dependency Tool (JDT) to categorise patients and capture the increased / decreased nursing workload over a 7 day period. The result is a nursing workload by hour calculated through BEST at 80th centile which will produce an area staffed adequately for 80% time. To staff for 100% would be inefficient due to the trend in attendances and workload.

9.3 Analysis of the review identified that A&E attendances are higher from 10am until just after midnight, therefore requiring staggered starts for nursing staff and twilight shifts to meet service demands.

The current shift model accounts for peaks in activity, with increased numbers during the afternoon and evening to midnight. The priority for any increase in the nursing establishment will be over the peak periods to 2am.

9.4 Table 8 identifies the recommended WTE required to achieve safe staffing levels on the 80th centile. The WTE excludes the clinical Decisions Unit, Emergency Nurse Practitioners and non-clinical staff.

Table 7

A&E Site	Current WTE	Recommended by BEST WTE	Gap WTE
HRI	47.1	52.5	5.4
CRH	40.33	49.7	9.4

9.5 Skill mix recommendations are made through BEST based on the Faculty of Emergency Nursing competence descriptors. **Appendix 6** identifies CHFT current skill mix against BEST recommended.

9.6 Additional skill mix consideration must be taken with regard for children within the A&E setting. Currently both sites accept children into the emergency department. RCPCH guidance states that at least one registered children's nurse should be on duty at all times in any area where children are seen.

It has been challenging to recruit paediatric nurses into the A&E setting particularly since the development of Project 2000 nursing where student nurses have since been required to be either Adult or Children trained.

As the level of paediatric attendances do not warrant a stand alone paediatric emergency department a RN child would also have to care for adults.

The Outline Business Case proposes the development of one Emergency Department with a co-located paediatric emergency department which we anticipate would be attractive and aid recruitment.

Table 8: RN Child requirements

Current RN Child WTE (across both sites)	Recommended RN Child WTE To meet RCPCH Guidance	Gap in WTE
2.0	5.5	3.5

9.7 There are 6 nurses who have completed a masters level module in care of the child. NICE Guidance is likely to suggest we need 1 RN Child per shift. Work is scheduled to continue to initiate a rotation between A&E and the children's ward.

9.8 The Minor Injury Service has also been reviewed identifying a capacity deficit within the Emergency Nurse Practitioner (ENP) service. Senior Medical Staff currently support the service due to high demand which peaks during the evening and into the early hours of the morning.

Shift patterns have been staggered to extend the ENP service until midnight. Additional shifts from 18.00 – 02.00 are anticipated to meet demand and prevent the need for senior medical staff.

9.9 **Table 9 - Summary of Total Emergency Department Investment indicated:**

Band	CRH WTE	HRI WTE	Total WTE	Investment required £	Priority Investment 2015 / 2016
7	1.33	2	3.33	203,396	1 additional nurse per shift per site
6	1.74	-	1.74	85,917	
ENP	4.3	3.3	7.6	375,272	
2	4.73	5.15	9.88	255,951	
TOTAL £				**920,536**	**440,000**

10.0 INVESTMENT 2015 / 2016

10.1 No additional investment is requested at this time for the Nursing Workforce 2015 / 2016. This is based upon recommendations following the triangulated review of the nursing workforce which have informed divisional investment and disinvestment to achieve a balanced position.

10.2 The caveat to this is the investment currently required in the Emergency Department which we currently aim to meet the essential £440,000 required through further disinvestment through the implementation of long shifts within the surgical division.

11.0 ADAPTING NURSING SHIFTS

11.1 Following the staffing review the Associate Director of Nursing for the medical division is recommending further changes to the workforce models by the introduction of a number of long days in some areas. This will reduce the handover time for each nurse working a long day saving 3.5 hours per nurse per long day.

Table 10: Summary of WTE changes from implementation of long shifts within Medicine

Division	Qualified WTE Change	Unqualified WTE change	Revised Establishment WTE
Medicine	-20.2	-15.5	-35.7

11.2 A review of the impact of progressing to long days on the skill mix on individual wards has been undertaken and can be reviewed in **Appendix 5**.

11.3 **Table 11: Summary impact of cost efficiencies to be realised from long shifts in medicine**

Division	Cost efficiencies from Changes to Long Shifts in medicine	Total £
Medical	834,483	834,483

11.4 If agreed by Board the areas where recommended changes to facilitate long days and provide a cost efficiency starting from 1.4.15 will be closely monitored. The indicators which will be monitored monthly are the sickness and absence levels, nursing quality indicators, safety thermometer, Friends and Family Test, complaints and clinical incidents.

12.0 NEXT STEPS

12.1 In 2015 – 2016 a further review of the shift patterns within the surgical division will be completed to assess the viability of reducing the workforce models without reducing the quality and safety of care provided to our patients through the implementation of long shifts in place of two short shifts to support the investment in Emergency Department.

12.2 As safe staffing guidance is available from NICE for the Accident and Emergency Departments the workforce models will be reviewed further.

12.3 The non-ward based staffing review will be completed and will include a number of roles that assist with the provision of safe nursing care within the CHFT who are not included in the nurse to bed ratio or skill mix figures, but do contribute to the care patients receive on the ward.

12.4 Non-direct patient time for each ward will be calculated through a further activity follows / contact time study.

12.5 Maternity workforce models will be reviewed by the Head of Midwifery following the publication of the NICE Guidance and the results from Birth Rate Plus and Intrapartum Score Card. Any recommended changes will be presented to the Director of Nursing and Nursing Workforce Group. The reivew will include:
• Skill mix of qualified midwives and maternity support workers in line with recommendations of Birthrate + (Up to 10% of recommended midwife WTE can be converted to HCA posts)
• a significant reduction in non-productive midwife hours for birth centre midwives

• a significant reduction in non-productive midwife hours across all service areas as a result of implementation of the maternity EPR, and changes in working practises of community midwives.

12.6 Acuity and Dependency study in paediatrics will be completed and identified changes to the workforce model in addition to the alignment of services appropriately actioned.

12.7 Completion of the Theatres Workforce Models Review.

12.8 Monitor the impact of changes to workforce models within the divisions and report back to the nursing workforce group anything of note.

13.0 SUMMARY

In summary this is a comprehensive report of the findings from the ward based staffing review. The report highlights areas that require investment based on the findings, recent publications, national and professional guidance to provide safe and compassionate care, which have been met through divisional investment and disinvestment to result in a safe and balanced plan.

Appendix 1

Specific Allocation made for investment in critical posts 2014 / 2015

Division	Ward	RN Band 6 £	RN Band 5 £	CSW Band 2 £	Total Part Year Effect 14/15 £	Total Full Year Effect 15/16 £
Medical	MAU Ward 1		91,194	52,793	**47,996**	143,987
Medical	MAU Ward 2CD		77,272	62,026	**46,433**	139,298
Medical	Ward 5 AD	41,531	(34,807)		**3,922**	6,724
Medical	Ward 5	41,531	(34,807)		**3,922**	6,724
Medical	Ward 6BC	41,531	229,378		**158,030**	270,909
Surgical	Ward 19		81,100		**47,308**	81,100
Surgical	Ward 20		105,813		**61,724**	105,813
Surgical	Ward 8ab		19,144		**11,167**	19,144
Surgical	Ward 8c		70,658		**41,217**	70,658
Total		**124,593**	**604,945**	**114,819**	**421,720**	**844,357**

Appendix 3

Table 4: Medical Division Nurse: Bed ratio and recommended changes to workforce models

CURRENT					RECOMMENDATIONS			
Ward	**Beds**	**Nurse to Bed**	**Skill Mix**	**AUKUH Jan 14**	**SNCT Nov 14**	**NICE Nov 14**	**Nurse: Bed**	**Skill Mix**
6D	15	2.12	63:37	1.13	1.33	1.78	2.23	65:35
7AD	26	1.58	59:41	1.59	1.54	1.90	1.58	59:41
7BC	26	1.58	59:41	1.54	1.48	1.89	1.58	59:41
21	18	1.49	60:40	1.29	1.25	1.63	1.49	60:40
Mau HRI	24	1.99	69:31	1.18	1.12	2.19	1.99	69:31
Mau CRH	24	1.92	73:27	1.15	1.22	2.87	1.92	73:27
6	23	1.60	68:32	1.35	1.26	1.75	1.60	68:32
2AB	31	1.38	65:35	1.24	1.24	1.73	1.38	65:35
8	21	1.79	54:46	1.43	1.66	2.15	1.79	54:46
4	15	1.62	59:41	1.54	1.31	1.73	1.62	59:41
5AD	31	1.54	63:37	-	1.50	1.90	1.51	63:37
17	24	1.47	57:43	-	1.37	1.76	1.43	63:37
5C	16	1.47	61:39	1.42	1.59	2.11	1.47	61:39
6BC	32	1.23	70:30	1.32	1.48	2.04	1.23	70:30
12	21	1.48	70:30	1.45	1.31	1.99	1.48	70:30
5	27	1.49	69:31	1.38	1.26	1.67	1.49	69:31
CCU & Angio	14	1.98	88:12				1.98	88:12

- 6D has an increased Nurse to Bed ratio due to a requirement to meet the Hyper Acute Stroke Unit Guidance which is additional to the SNCT and NICE included in Table 5

Table 5: Surgical Division Nurse: Bed ratio and recommended changes to workforce models

CURRENT					RECOMMENDATIONS			
Ward	**Beds**	**Nurse to Bed**	**Skill Mix**	**AUKUH Jan 14**	**SNCT Nov 14**	**NICE Nov 14**	**Nurse: Bed**	**Skill Mix**
3	15	1.45	65:35	1.20	1.65	2.21	1.48	66:34
10	20	1.44	65:35	1.50	1.75	1.80	1.41	73:27
15	27	1.17	70:30	1.50	1.32	1.79	1.17	70:30
19	22	1.78	57:43	1.60	1.42	1.83	1.82	55:45
20	30	1.39	59:41	1.50	1.15	1.38	1.50	62:38
22	23	1.22	58:42	1.20	1.18	1.76	1.23	52:48
SAU	25	1.28	76:24	0.92	1.05	2.03	1.28	76:24
8AB	32	1.08	57:43	-	1.07	0.83	1.09	60:40
8D	14	1.13	61:39	-	-	-	1.46	63:37
8C	16	1.26	63:37	-			1.26	63:37
ICU HRI	8	4.96	93:07	-	4.95	3.61	4.96	93:07
ICU CRH	5	5.42	88:12	-	5.42	5.82	5.42	88:12

Appendix 4

Medical Division: Patient to Registered Nurse Ratio pre and post recommended investment

Medicine			Current Model				Post Investment			
Ward	**Speciality**	**Beds**	**Patient: RN Early**	**Patient: RN Late**	**Patient: RN Night**	**Patient: RN Average**	**Patient: RN Early**	**Patient: RN Late**	**Patient: RN Night**	**Patient: RN Average**
6D	Stroke	15	4	5	5	5	4	4	5	4
7AD	Stroke Rehab	26	7	7	7	7	7	7	7	7
7BC	Stroke Rehab	26	7	7	7	7	7	7	7	7
21	Rehab	18	6	6	9	7	6	6	9	7
MAU HRI	Acute Medical	24	4	3	6	4	4	3	6	4
MAU CRH	Acute Medical	24	4	4	5	4	4	4	5	4
6	Short Stay	23	5	5	8	6	5	5	8	6
2AB	Short Stay	31	6	6	8	7	6	6	8	7
8	Complex Care	21	5	7	7	6	5	7	7	6
4	Complex Care	15	5	8	8	7	5	8	8	7
5AD	Complex Care	31	6	6	6	6	5	6	8	6
17	Gastro	24	6	8	8	7	6	6	8	7
5C	Respiratory	16	5	8	8	7	5	8	8	7
5	Cardiology	27	5	5	7	6	5	5	7	6
6BC	Cardiology	32	6	6	8	7	6	6	8	7
CCU	Cardiology	14	4	4	4	4	4	4	4	4
12	Oncology	21	5	5	7	6	5	5	7	6

Surgical Division: Patient to Registered Nurse Ratio pre and post recommended investment

Surgery			Current Model				Post Investment			
Ward	Speciality	Beds	Patient: RN Early	Patient: RN Late	Patient: RN Night	Patient : RN Average	Patient: RN Early	Patient: RN Late	Patient: RN Night	Patient: RN Average
3	Vascular	15	5	8	8	7	5	8	8	7
10	Colorectal and upper GI	20	5	7	10	7	5	7	7	6
15	Colorectal and upper GI	27	7	7	9	8	7	7	9	8
19	Orthopaedic	22	6	6	7	6	6	6	7	6
20	Orthopaedic	30	6	6	10	7	6	6	10	6
22	Urology	23	8	6	12	9	8	8	12	9
SAU	Surgical Assessment	25	5	5	6	6	5	5	6	5
ICU HRI	Intensive Care	8	1	1	1	1	1	1	1	1
ICU CRH	Intensive Care	5	1	1	1	1	1	1	1	1
8AB	Orthopaedic	32	8	8	16	11	7	7	9	7
8D	Ear, Nose, Throat	14	8	8	16	11	7	7	7	7
8C	Gynaecology	16	8	8	8	8	8	8	8	8

CWF: Summary of Patient to Nurse Ratio (No change to workforce model recommended)

CWF			Current Model			
Ward	Speciality	Beds	Patient: RN Early	Patient: RN Late	Patient : RN Night	Patient: RN Average
1D / 9	Womens	27	5	5	7	6
3	Paediatrics	35	4	4	5	4
4	Gynaecology	7	4	4	-	4
18	Paediatrics	12	4	4	4	4
Birth Centre	Maternity	14	4	4	4	4
LDRP	Maternity	20	2	2	2	2
MAC	Maternity	5	3	3	5	3
NICU	Paediatrics	24	3	3	3	3

Appendix 5

Skill Mix Ratio impact post investment / Disinvestment pre long shifts implementation and post long day implementation Medical Division

Ward	Skill Mix 2014 / 2015	Proposed Skill Mix 2015 / 2016 pre long Shifts	Proposed skill mix 2015/2016 post long Shift implementation	Nurse: Bed ratio change
6D	63:37	63:35	65:35	-0.02
7AD	59:41	59:41	59:41	-0.08
7BC	59:41	59:41	59:41	-0.08
21	60:40	60:40	61:39	-0.15
MAU (HRI)	69:31	69:31	69:31	-0.08
MAU (CRH)	73:27	73:27	73:27	-0.11
6	68:32	68:32	69:31	-0.14
2AB	65:35	65:35	65:35	-0.07
8	54:46	54:46	54:46	0.00
4	59:41	59:41	59:41	-0.09
5AD	63:37	63:37	63:37	-0.12
17	57:43	63:37	65:35	-0.15
5C	61:39	61:39	62:38	-0.08
5	69:31	69:31	70:30	-0.13
6BC	70:30	70:30	71:29	-0.06
CCU	88:12	88:12	89:11	-0.16
12	70:30	70:30	71:29	-0.10

Appendix 6

HRI Skill Mix Analysis

BEST Recommended Skill Mix	BEST % Recommended WTE	Current % HRI WTE	Gap between recommended and present WTE
10% leader of specialism of emergency nursing. Competent to work in any area of department without supervision. Typically a band 7 or 8.	5.3	3.47	2
30% senior A&E nurse able to take charge on shift basis. Typically a band 6 or 7.	15.8	8.1	7.7
40% competent A&E nurses, able to work in any area of department with some supervision. Typically Band 5 nurse following 1 year experience.	21	28.6	-7.6
20% support – un registered care assistants able to work under the supervision of a registered nurse.	10.5	5.65	5.15

CRH skill Mix analysis

BEST Recommended Skill Mix	BEST % Recommended WTE	Current % CRH WTE	Gap between recommended and present WTE
10% leader of specialism of emergency nursing. Competent to work in any area of department without supervision. Typically a band 7 or 8.	5.0	3.67	1.33
30% senior A&E nurse able to take charge on shift basis. Typically a band 6 or 7.	14.9	9.99	4.09
40% competent A&E nurses, able to work in any area of department with some supervision. Typically Band 5 nurse following 1 year experience.	19.9	22.15	-2.25
20% support – un registered care assistants able to work under the supervision of a registered nurse.	9.9	5.17	4.73

APPENDIX 2

Hard Truths Nursing Review - November 2014

Ward:	
Sister:	

Number of Beds open 24/7:	18
Number Beds open less than 27/4:	
Number of Trolleys/Chairs:	

	Budget	In Post	Vacant
Current WTE	0	0	0
Qualified			
Unqualified			

Nurse/Bed:	0	*This compares to the acuity results*
Skill Mix:	#DIV/0! : #DIV/0!	*Ideally work to 60:40*

Latest fill rate %:	Qual		UnQual	

Shift Pattern

		Mon	Tues	Weds	Thurs	Fri	Sat	Sun	Bed : RGN	Nurse:Bed
Early	Qual								#DIV/0!	#DIV/0!
	UnQual									
Late	Qual								#DIV/0!	#DIV/0!
	UnQual									
Nights	Qual								#DIV/0!	#DIV/0!
	UnQual									

Shift Start Time	Shift End Time	Break Time	Total shift
07:00	15:00	00:30	07:30
12:00	20:00	00:30	07:30
20:00	07:30	00:30	11:00

Please detail any staff who work shifts which do not fit with the above shift pattern:

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th March 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: GOVERNANCE REPORT - The report brings together a number of governance items for review and approval by the Board: - Use of the Trust Seal - Board Workplan - Monitor Q3 Feedback	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

The report brings together a number of governance items for review and approval by the Board:
- Use of the Trust Seal
- Board Workplan
- Monitor Q3 Feedback

Main Body

Purpose:

-

Background/Overview:

Use of the Trust seal
One of the responsibilities of the Board is to ensure that the Trust seal has been appropriately applied. The Board therefore receives a report twice a year detailing the document it was applied to and who authorised the sealing. The record of each seal is attached to this report and were related to premises leases. In all cases the seal was applied in line with Trust Standing Orders which authorises either two executives (not from the originating department) or an executive and the company secretary to do this on behalf of the Board.

Board Work plan
The work plan has been updated for the year. Following the approval of the 2014/15 Board Assurance Framework, any items identified for further board assurance will be added to the work plan as appropriate.

Monitor Q3 Feedback
A copy of the feedback from Monitor to the Trust's Q3 submission is attached for information. This letter is also available on the Monitor website.

The Issue:

-

Next Steps:

-

Recommendations:

The board is asked to review and approve the:
- Use of the Trust Seal
- Board Workplan
- Monitor Q3 Feedback

Appendix

Attachment:

COMBINED GOVERNANCE REPORT - MARCH 2015.pdf

Register of Sealings or Executions

Consecutive No.	Date of Sealing or Execution	Date of Authority	Sealing(s) or Execution(s)	Description of Documents Sealed or Executed	Persons attesting Sealing or Execution
217	28.8.14			CRH Confirmed Variation Instruction No. 56 - Annual Variation Wrap up 2013/2014 overall value £331,722.50 + additional £4,198.55 annual life cycle costs for year	
218	10.11.14			Local Care Direct Ltd Licence to occupy rooms @ CRH.	
219	10.11.14			Confirmed Variation Works LDRP Antenatal Triage CRH. Ins No 57	
220	2.2.14			Acre Mills - Licence to carry out work + lease Retail Unit - Costa Coffee	V Pickles. Julie Davies.
221	2.2.14			Acre Mills - 14 Documents - Guarantee, Contractors Warranty Sub-Contractors Warranty, Letter of Appointment	V Pickles. J Davies.

BO9

Register of Sealings or Executions

Consecutive No.	Date of Sealing or Execution	Date of Authority	Sealing(s) or Execution(s)	Description of Documents Sealed or Executed	Persons attesting Sealing or Execution
222	17.12.14			LICENCE TO UNDERLET PHARMACY UNIT IN ACREMILL TO BESTWAY PANACEA HEALTHCARE +FLOORPLANS.	V Pickles. Julie Davies
223	11.12.14			LICENCE TO CARRY OUT WORKS TO PHARMACY UNIT IN ACREMILL	V Pickles Julie Davies,
224	17.12.14			DEED OF VARIATION OF AGREEMENT - CHFT + BESTWAY PANACEA HEALTHCARE - PHARMACY UNIT	Julie Davies.
225	30.12.14			SUB-UNDERLEASE OF COFFEE SHOP UNIT AT CRH BETWEEN CALDERDALE SPC LTD, CHFT and ISS MEDICLEAN LTD.	V Pickles. J Davies.
226	26.1.15			DEED OF VARIATION WITH DENTAL CARE DIRECT (LGF, TR1 ROOMS) LICENSE FROM 13.2.15 TO 30.9.15	V Pickles. J Davies.

Register of Sealings or Executions

Consecutive No.	Date of Sealing or Execution	Date of Authority	Sealing(s) or Execution(s)	Description of Documents Sealed or Executed	Persons attesting Sealing or Execution
227	5.3.15			RENEWAL LEASE - CP SECURITY AT 62 ACRE ST, LINDLEY £36,274.00 p.a.	JDawes. VLPickles
228	17.3.15			OAK HOUSE, WOODHALE OFFICE PARK - RENEWAL LEASE £45,000 p.a + VAT	JDawes. VLPickles.

BO9

BOARD WORK PLANWORKING DOCUMENT – MARCH 2014 - LATEST update TO BOD 26.3.15

Date of meeting	23 April 2015	28 May	25 June	30 July	27 Aug Prov. mtg	24 Sept	29 Oct	26 Nov	17 Dec	Jan 2016	Feb 2016	March 2016
Date of agenda setting	During week before meeting date											
Date final reports required	15.4.15	10.5.15	17.6.15	22.7.15	19.8.15	16.9.15	21.10.15	18.11.15	9.12.15	TBC	TBC	TBC
STANDING PUBLIC AGENDA ITEMS												
Introduction and apologies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Declarations of interest	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of previous meeting, matters arising and action log	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chairman's report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chief Executive's report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Integrated Board report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
DIPC report	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Minutes of sub-committees	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
REGULAR ITEMS												
Board Assurance Framework		✓			✓			✓			✓	
Governance report: to include such items as: - Standing Orders / SFIs review - Non-Executive appointments - Board workplan - Board skills / competency - Code of Governance - Board meeting dates - Committee review and annual report - Annual review of NED roles - Use of Trust Seal - Quarterly Submission Feedback from Monitor			✓			✓			✓			✓
Care of the acutely ill patient report	✓		✓		✓	✓		✓		✓		✓
Patient Survey			✓									✓

BOARD WORK PLANWORKING DOCUMENT – MARCH 2014 - LATEST update TO BOD 26.3.15

Date of meeting	23 April 2015	28 May	25 June	30 July	27 Aug Prov. mtg	24 Sept	29 Oct	26 Nov	17 Dec	Jan 2016	Feb 2016	March 2016
Quality Report				✓								✓
Staff Survey					✓							✓
Staff Survey/Staff friends and family test results				✓			✓					
Nursing and Midwifery Staffing – Hard Truths Requirement		✓							✓			
Safeguarding update – Adults & Children				✓				✓				✓
Patient Experience, Engagement & Improvement Plan (to include learning from experience and friends and family test)		✓			✓			✓			✓	
Review of progress against strategy (Qly)	✓			✓			✓			✓		
Update on the Strategic Review	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quality Committee Update & Mins		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Audit and Risk Committee Update & Mins	✓	✓		✓	✓		✓	✓		✓	✓	
Finance and Performance Committee Update & Mins	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Health & Safety Committee Mins	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Strategic Health & Safety Committee Minutes (for info)	✓			✓			✓			✓		
ANNUAL ITEMS												
Annual Plan												✓
Annual Plan feedback from Monitor			✓									
Annual report and accounts (private)		✓										
Annual Governance Statement		✓										
Emergency Planning annual report	✓	✓										
Health and Safety annual report		✓										
Capital Programme												✓
Equality & Inclusion update				✓ (update)							✓ (AR)	

BOARD WORK PLANWORKING DOCUMENT – MARCH 2014 - LATEST update TO BOD 26.3.15

Date of meeting	23 April 2015	28 May	25 June	30 July	27 Aug Prov. mtg	24 Sept	29 Oct	26 Nov	17 Dec	Jan 2016	Feb 2016	March 2016
PLACE Report									✓			
Security Management annual report				✓								
DIPC annual report		✓										
Treasury Management annual report		✓										
Fire Safety annual report		✓										
Medical revalidation							✓					✓
Annual Organ Donation plan				✓								
End of Life Report										✓		

BOARD WORK PLANWORKING DOCUMENT – MARCH 2014 - LATEST update TO BOD 26.3.15

Date of meeting	23 April 2015	28 May	25 June	30 July	27 Aug Prov. mtg	24 Sept	29 Oct	26 Nov	17 Dec	Jan 2016	Feb 2016	March 2016
ONE OFF ITEMS												
Care Quality Commission												
Premises assurance model/Asbestos	✓											
Membership Council Elections	✓											
Readmissions (from minute 30.1.14)		✓										
Fractured neck of femur (from minute 30.1.14)		✓										
Results of consultation on Princess Royal				✓								
Calderdale Intermediate Care update						✓						
Calderdale Artefacts	✓											
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										✓	✓	✓
Outline Business Case	✓	✓	✓	✓								
Monitor quarterly submission	✓			✓			✓			✓		
Board development plan												
Feedback from March Board development			✓									
Urgent Care Board Minutes (to rec)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

5 March 2015

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

Monitor
Making the health sector work for patients

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E: enquiries@monitor.gov.uk
W: www.monitor.gov.uk

Dear Owen

Q3 2014/15 monitoring of NHS foundation trusts

Our analysis of your Q3 submissions is now complete. Based on this work, the Trust's current ratings are:

- Continuity of services risk rating - 3
- Governance risk rating - Red

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

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

In addition to the issues contained within the enforcement undertakings referred to above, the Trust has also failed to meet the A&E 4-hour target at Q3.

We expect the Trust to address the issues leading to the target failure and achieve sustainable compliance with the target promptly. Monitor does not intend to take any further action at this stage, however should these issues not be addressed promptly and effectively, or should any other relevant circumstances arise, it will consider what if any further regulatory action may be appropriate.

A report on the FT sector aggregate performance from Q3 2014/15 is now available on our website[1] which I hope you will find of interest.

We have also issued a press release[2] setting out a summary of the key findings across the FT sector from the Q3 monitoring cycle.

[1] https://www.gov.uk/government/publications/nhs-foundation-trusts-quarterly-performance-report-quarter-3-201415
[2] https://www.gov.uk/government/news/nhs-foundation-trusts-tackle-rising-patient-demand

If you have any queries relating to the above, please contact me by telephone on 02037470484 or by email (Kemi.Oluwole@monitor.gov.uk).

Yours sincerely

Kemi Oluwole
Senior Regional Manager

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

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 26th March 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: QUALITY COMMITTEE MINUTES - UPDATE - The Board is asked to receive a verbal update from the Quality Committee held on 24.3.15 and the minutes held on 24.2.15.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive a verbal update from the Quality Committee held on 24.3.15 and the minutes held on 24.2.15.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to receive a verbal update from the Quality Committee held on 24.3.15 and the minutes held on 24.2.15.

Appendix

Attachment:

QC Minutes 24.02.15 - draft.pdf

Minutes of the QUALITY COMMITTEE MEETING held on Tuesday 24 February 2015 in Discussion Room 2, Huddersfield Royal Infirmary, commencing at 3pm

PRESENT	Claire Gruszka, Patient Safety Risk Manager Julie Barlow, Assistant Divisional Director, Surgery & Anaesthetics Victoria Pickles, Company Secretary Jeremy Pease, Non-Executive Director (Chair) Jan Wilson, Non-Executive Director Juliette Cosgrove, Assistant Director to Medical and Nursing Director Lesley Hill, Executive Director of Planning, Performance, Estates & Facilities Linda Patterson, Non-Executive Director Lynn Moore, Membership Council Sajed Azeb, Assistant Divisional Director, Medical Division Jan Carter, Matron, Surgical Division
IN ATTENDANCE	Catherine Briggs, Matron, Medical Division (for Lindsay Rudge) Mike Culshaw, Director of Pharmacy, DATS Division Joyce Ayre, Senior Clinical Midwifery Manager Alison Wilson, Head of Estates, Estates and Facilities Division Stephanie Jones, PA (Minutes)

Item

1/02/15 WELCOME AND INTRODUCTIONS

The chair welcomed members to the meeting.

It was noted the meeting was an informal meeting due to key members attending a meeting with the CCG. The meeting was solely to receive the Divisional PSQB reports and receive an update on the CQC Action Plan. It was agreed the Quality Committee minutes from the meeting in January 2015 will be received by the Committee for approval at the Quality Committee meeting in March 2015.

2/02/15 APOLOGIES FOR ABSENCE AND ATTENDANCE REGISTER

Apologies for absence were received from:
David Birkenhead, Medical Director
Anne-Marie Henshaw, Associate Nurse Director, CWF Division/Head of Midwifery
Helen Marshall, General Manager, Risk Management
Jackie Murphy, Deputy Director of Nursing
Julie Hull, Executive Director of Workforce and Development
Keith Griffiths, Executive Director of Nursing
Kristina Arnold, Assistant Divisional Director, CWF Division
Ashwin Verma, Divisional Director, Medical Division
Julie O'Riordan, Divisional Director, Surgery and Anaesthetics Division
Lindsay Rudge, Associate Director of Nursing, Medical Division

Mags Barnaby, Interim Director of Operations
Julie Dawes, Executive Director of Nursing
Martin DeBono, Divisional Director, CWF Division
Sal Uka, Divisional Director, DATS Division

3/02/15 TO RECEIVE AN UPDATE ON THE CQC ACTION PLAN

Juliette Cosgrove, Assistant Director to the Medical and Nursing Directors, presented the updated CQC Action Plan.

All Divisions have now completed a self-assessments of their services against the five CQC domains and how they compare to the CQC ratings of outstanding, good, requires improvement and inadequate. Action plans have been formulated for those areas that require improvement or are inadequate. All evidence is being stored on a single drive, which Divisions are populating and providing links to, so they can be documented as evidence for the impending CQC inspection. The over-arching CQC action plan is monitored, updated and received monthly by the Quality Committee.

Work is ongoing in relation to the communication plan and an awareness campaign will start in April 2015 to ensure there is a trustwide cultural awareness of what a CQC inspection will mean for CHFT. Key learning around staff engagement from two Trusts in Liverpool is being looked into.

The Committee **received** and **noted** the contents of the CQC action plan.

4/02/15 TO RECEIVE THE DIVISIONAL PATIENT SAFETY AND QUALITY BOARD (PSQB) REPORTS

4.1 Surgical and Anaesthetic Division

Julie Barlow, Assistant Divisional Director, was in attendance to present the PSBB report for the Division. The following was noted:

Key exceptions
• DNACPR: results from the audit are a cause for concern. The Audit team are looking at further revalidation and clinical input into the audit process. ACTION: Division sought advice as to whether further planned training/awareness sessions were being considered. The chair agreed this would be discussed with Mary Kiely when she attends the Quality Committee in March 2015. This concern will also be brought to the attention of David Birkenhead (Medical Director) and Julie Dawes (Director of Nursing) as it is the responsibility of the medical and nursing staff to comply with. • Patient flow in A&E (95%): 4 hour target is currently at 94.8%. ICU are developing an operational SOP regarding patient step down to ensure patients are transferred from ICU in a timely manner. • #Neck of femur: poor experience due to transfer from HRI to CRH. A process is being devised to prevent unnecessary transfers.
Patient Safety
• Division currently have 7 serious incidents on the register which are reportable to the CCG. The majority of these incidents relate to grade 3 pressure ulcers. • 1 post 48 hour c.difficile was reported in October 2014 by ICU (HRI). • Staffing level hot spot areas noted to be A&E, Ward. Recruited 3 Spanish nurses and a further 4 nurses starting in September. • Safety thermometer fully compliant in Q3, however less than 98% consistently.
Patient Experience:
• FFT deteriorated due to no longer using tokens. Staff are being asked to ask patients.

• Compliance met in quarter for mixed sex accommodation.
Clinical Effectiveness:
• Current performance issues against compliance relate to VTE risk assessment and DNACPR. Improvement has been seen in the latter from 38% to 53%, however the Division continue to reinforce the message about DNACPR compliance.
Well Led:
• The Divisional Director and Associate Nurse Director have dates to carry out Leadership Management Walkrounds on all surgical wards with an aim to identify good practice in order to improve consistency and sustainability across the Division.
Risk and Compliance:
• A&E working on contingency plan in relation to shortage of medical staff. • There are currently 5 risks of 15+ on the Risk Register. These are being monitored by the Division and overseen by the Risk and Compliance Committee. • Mandatory training: Risk DVD = 74%, Information Governance = 80.9% and Fire = 77.8% • Appraisals: Non-medical staff = 26.3% and medical staff 64.74%
Responsive:
• QIA on CIP plans – total = £2,545, target = £6,401 leaving a gap of £3,856.
QUESTIONS PUT FORWARD TO THE DIVISION: • Mortality Reviews: The Division were asked their position on mortality review. Julie Barlow, Assistant Divisional Director confirmed these were ongoing. • A&E 4 hour target: The Division confirmed weekly meetings are being held regarding the A&E target, where the action plan is reviewed and monitored. • Quality / business: the Chair questioned how the Division are able to balance quality against CIP. Julie Barlow confirmed equal attention is given to quality and business.

4.2 Medical Division

Sajed Azeb, Assistant Divisional Director, was in attendance to present the PSQB report for the Division. The following was noted:

Key exceptions:
• Nursing fill rates: remain a concern as extra capacity open on both sites has had an impact. Some recruitment to posts has taken place following a recent Recruitment Fair. Overseas recruitment also taking place and a further visit overseas is planned for late March 2015. The Division are closely monitoring NQIs, FFT, complaints, and incident and infection rates on a weekly and monthly basis. • Complaints: divisional performance is below trajectory and this is being monitored on a weekly basis to bring performance back on line. • Mandatory training: divisional performance is below trajectory and each team within the Division has been asked to produce a recovery plan, which is being monitored on a weekly basis the ADD. A trajectory has been set to ensure 100% compliance by the end of March 2015. • Stroke Unit: stroke target is struggling to be achieved. Work is ongoing with YAS. • Additional capacity on medical wards: The Division has an additional 41 medical beds open at CRH across wards 5b, 6a and 4d. Medical outliers in surgical beds are creating an impact upon the nursing and medical workforce to support these inpatient areas. Close monitoring of the quality and safety metrics are in place. • C.difficile: 4 cases of c.difficile were noted, which were all classes as unavoidable.

QUESTIONS PUT FORWARD TO THE DIVISION:

Complaints and serious incidents: Juliette Cosgrove queried how confident the Division felt about improving performance. The Division confirmed that front end wards, such as MAU, were receiving extra manpower to ensure complaints are closed down more timely. Juliette Cosgrove emphasised the need for all Divisions to have a 'big push' on closing down complaints on time as the CQC will show particular interest in this area.

Mandatory Training: Lesley Hill, Executive Director, queried what actions the Division have in place to ensure mandatory training performance is brought back on track. The Division confirmed that weekly targets, which are being closely monitored, have been given to all Directorates to achieve.

It was noted, from 6 March 2015, weekly Divisional Turnaround meetings have been set up to focus on CIP, performance and quality. Each directorate will have 45 minutes to update on these areas.

Stroke beds: Linda Patterson, Non-Executive Director questioned, further to past discussions, whether the stroke beds had been ring fenced. The Division confirmed that they had not been ring fenced, but a policy had been put in place to ensure one stroke bed is always empty at all times.

Agency Staff: Jan Wilson, Non-Executive Director questioned whether there is a coloration between agency staff and nurse outcomes (i.e. pressure ulcers). The Division confirmed that extra capacity areas are always staff at sister level by member of CHFT staff. Agency staff are not left in charge of a ward.

Plan for every patient: Jan Wilson, Non-Executive Director questioned whether the plan for every patient includes the discharge plan. The Division confirmed the green triangle identifies the discharge date against each patient. Compliance currently stands at approximately 85% and this information is audit on a week by week basis.

4.3 CWF Division

Joyce Ayre, Senior Clinical Midwifery Manager, was in attendance to present the PSQB report for the Division. The following was noted:

Key exceptions:
• Maternity FFT continues to be a concern for the Division, with lack of ability to sustain any occasional improvements. Division looking at a solution to address this. • Rates of sickness, vacancy and maternity leave. Divisional proactively recruiting to address this. • Slow progress with reducing the number open red and orange incidents. • Appraisal and essential skills: currently not achieving trajectory for 4 key elements – appraisal, risk, IG and fire. Division addressing this with weekly drive and improvements are being seen.
Progress since last report:
• Risks: the division has no extreme or major risks, ward 18 environmental risk reduced to moderate, with weekly monitoring by the lead PNP • Incidents: reduced medication incidents in obstetrics • Complaints: further improvement in reducing number of open complaints and achievement of KPIs • FFT: Some excellent '% would recommend' scores in some areas of the Division and an improved score for postnatal community: wards 3, 18, NICU, & HRI Birth Centre – 100% would recommend to family. • Caring: Divisional Patient Experience Improvement plan developed; fits with recommendation to forming corporate one. • NICE compliance: Improved compliance position with 3 clinical guidelines

• CQC mock inspection: Majority of action plan complete / orange areas being progressed • 95.5% attendance at the Obstetric mandatory training programme across all professions in 2014.
Patient Safety:
• There have been two serious incidents in Q3 reported to CCG.
Patient Experience:
• The Division have made progress in implementing the revised complaints policy which includes great contact with the complainant. • The complaints back log is being proactively managed by the Divisional Patient Safety and Quality Lead. In the last report to the Quality Committee there were 14 open complaints that were outside the target.
Well Led:
• Exit interviews are being undertaken as a priority
QUESTIONS PUT FORWARD TO THE DIVISION: No questions were put forward to the Division.

4.4 DATS Division

Mike Culshaw, Pharmacy Director, was in attendance to present the PSQB report for the Division. The following was noted:

Key exceptions:
• 18 week pathway for Interventional Radiology ongoing. Concerns about coding and stop/starting the clock are being addressed. • CQC self-assessment complete, but the actions plans need to be reviewed to address compliance.
Progress since last report:
• 6 week wait for diagnosis back on track, fluoroscopy machine to be signed off by end of February.
Patient Safety:
• Risk 15+: 4 risks were on the register, but all have been down-graded from 16 to 12. • 4 orange incidents, one of which has since been closed.
Patient Experience:
• Safety alert notices were detailed within the report, along with progress against compliance. • Pharmacy RTPM: improvement seen in Q1&2, however slippage noted in Q3 and it if anticipated Q4 will also be amber due to high number of patients. • Highest number of complaints received in appointments and health records; however improvement has been seen in Q2, and Q3.
Well Led:
• Appraisal compliance: medical 90%+ and non-medical 80%+ • Information governance framework compliance: 88.5% • Risk management training: 95% • Fire training: 96%
Risk and Compliance:
• Divisional self-assessment against the five domains has been carried out and work is ongoing to address any areas that require improvement or are inadequate.
QUESTIONS PUT FORWARD TO THE DIVISION: • The Chair asked how the Division are managing with balancing performance against quality and CIP. Mike Culshaw, Pharmacy Director confirmed the CIP is taking up a lot of senior management time within the Division, however the Division are still monitoring performance through the

Divisional Board and the quarterly PSQB meetings.

• Juliette Cosgrove, Assistant Director to Medical and Nursing Directors, questioned whether there is any concern with regards to referral to report performance times as some are off track? The Division confirmed Heshan Panditaratne (Consultant Radiologist) and Mark Rodger (Radiology Manager) are working closely with front line clinical Divisions to manage this.

• In relation to the medicine CQUINs, the Chair questioned what is the process for 2015/16? The Division confirmed the CQUINs for medicine are being negotiated with the CCG to address some of the processes, as medical errors are still happening.

• Jan Wilson, Non-Executive Director, question whether improvement has been seen in relation to TTOs medication. The Division confirmed the delay is not always the Pharmacy Department, but often the delay in the junior doctor writing the prescription. Pharmacy expect junior doctors to explain to patients what medication they have been prescribed and why. E-discharges have to be done post ward round as clinicians needs access to a PC. Once EPR is in place this can be addressed via mobile technology.

4.5 Estates and Facilities

Alison Wilson, Head of Estates, was in attendance to present the PSQB report for the Division. The following was noted:

Key exceptions:
PLACE: annual assessments will see teams assessing how the environment supports patient's privacy, dignity, food, cleanliness and general building maintenance. PLACE documentation has been shared with Matrons, ADNs and key stakeholder and training will be delivered early April 2015. It is anticipated that PLACE assessment will take place before June 2015. CQUIN 295 – Hospital Food: CHFT, Calderdale CCG, Kirklees Heath-watch and both Kirklees and Calderdale Public Health have been working closely to review and improve hospital food. This work has been carried out in partnership with Food for Life and CHFT are one of 3 Trusts leading on this path finding work. Health-watch Kirklees survey patients during May 2014 on hospital food and a number of recommendations were made. Since that visit a task and finish group was established to look at and improve hospital food. Improvements have been seen since the survey in May 2014 and Health-watch Kirklees will re-survey patients during April 2015 to measure developments. Discussions are ongoing with Calderdale CCG regarding a further CQUIN target for 2015/16.
Progress since last report:
Since last PSQB report progress had been noted in the following areas: • patient catering: 2 meal sitting service has seen a reduction in food wastage. • linen services: scoping improved quality of linen bags. • cleaning services: reviewed working patters resulted in consistent cleaning service. Bed cleaning team in place, successfully piloted in 'Perfect' Week'. • business continuity: divisional business impact assessments now complete and work is taking place to develop robust business continuity plans. • health and safety: training being reviewed to deliver a focussed healthcare specific package for all managers/supervisors within CHFT. • fire safety: West Yorkshire Fire Brigade continue to hold strikes which impact on the standard of service provided. Looking at slightly different training for Fire Wardens (Band 7) and looking at fire

wardens for Acre Mill as currently a risk.
Patient Experience:
• number of complaints received from patients around car parking, particularly at CRH. Work has taken place with the patient group (West Riding Kidney Association) to ensure parking is available for this group of patients. • Patient surveys are being carried out in relation to patient meals with a 100 patients audited on both sites.
QUESTIONS PUT FORWARD TO THE DIVISION: No questions were put forward to the Division.

The Committee **received** and **noted** the content of all five Divisional reports and the Chair thanked the Divisions for their robust reports.

ACTION: Juliette Cosgrove requested that all future Divisional PSQB reports should include a Duty of Candour section. Steph Jones to feed back to Divisional contacts.

5/02/15

MATTERS TO BE ESCALATED TO THE BOARD OF DIRECTORS

- PSQB reports
- Links between CQC Action Plan and Engagement Plan
- Use of walkrounds, over the next couple of months, to drive CQC agenda

6/02/15

ANY OTHER BUSINESS

No further items of business were discussed

7/02/15

DATE AND TIME OF NEXT MEETING

Tuesday 24 March 2015
3pm – 5pm
Boardroom, HRI

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