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Meeting of the Board of Directors

To be held in public

Thursday 30 July 2015 from 1:30pm

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

AGENDA

1.	**Welcome and introductions:-** Marlene Chambers, Publicly Elected Membership Councillor Bob Metcalf, Nominated Membership Councillor	Chairman	
2.	Apologies for Absence: Ms Julie Hull, Executive Director of Workforce and OD Dr Linda Patterson, NED	Chairman	
3.	Declaration of interests	All	**VERBAL**
4.	Minutes of the previous meeting ▪ Held on 25 June 2015	Chairman	**APP A**
5.	**Action Log and Matters arising:** c. 97/15 Workforce Race Equality Standard	Chairman	**APP B** **VERBAL**
6.	**Chairman's Report:-** a. Board to Board with SWYPFT – 29.6.15 b. Board to Board with Mid Yorkshire Hospital Trust – 30.7.15	Chairman	**VERBAL**
7.	**Chief Executive's Report:-** a. Kings Fund Report b. Carter Review c. Rose Review d. Care Closer to Home Tender	Chief Executive	**)** **) APP C** **)** **VERBAL**
Keeping the base safe			
8.	**Integrated Board Report** - Responsive - Caring - Safety - Effectiveness - Well Led - CQUINs - Community - Monitor Indicators	Executive Director of PPEF/Associate Director of Community/Operations Executive Director of Nursing Executive Director of Nursing Executive Medical Director Interim Director of Workforce and OD Associate Director of Community/Operations	**APP D**

	- Finance	Executive Director of PPEF Executive Director of Finance	
9.	Risk Register	Executive Director of Nursing & Operations	**APP E**
10.	Director of Infection Prevention and Control Report	Executive Medical Director	**APP F**
11.	**Governance Report** a. Well Led Governance Review Feedback b. Board of Directors Terms of Reference c. Board Assurance Framework update	Company Secretary	**APP G**
12.	Safeguarding Adults and Children Update Report	Executive Director of Nursing and Operations	**APP H**
Financial Sustainability			
13.	Month 3 – June 2015 Financial Narrative	Executive Director of Finance	**APP I**
Transforming and Improving patient care			
A Workforce for the future			
No Items			
14.	**Update from sub-committees and receipt of minutes** ▪ Quality Committee (Minutes of 23.6.15 and verbal update from meeting held 28.7.15) ▪ Audit and Risk Committee – Verbal update from 21.7.15) ▪ Finance and Performance Committee (Minutes of 24.6.15 and verbal update from meeting held 21.7.15)		**APP J** **VERBAL** **APP K**
Date and time of next meeting Thursday 27 August 2015 – 1.30 pm Venue: Boardroom, Sub Basement, Huddersfield Royal Infirmary Thursday 17 September 2015 Healthfair and AGM commencing at 5.00 pm and 6.00 pm respectively Venue: 3rd Floor, Acre Mill Outpatients Building, Acre Street, Lindley, Huddersfield Thursday 24 September 2015 at 1.30pm Venue: Boardroom, Huddersfield Royal Infirmary Large Training Room, Learning Centre, Calderdale Royal Hospital HX3 0PW.			

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, 30th July 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 25.6.15 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 25 June 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 25 June 2015.

Main Body

Purpose:

The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 25 June 2015.

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 25 June 2015.

Appendix

Attachment:

MINS - public bod minutes - 25.6.15.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 25 June 2015 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/Deputy Chief Executive
Keith Griffiths	Executive Director of Finance
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities
Philip Oldfield	Non-Executive Director
Dr Linda Patterson	Non-Executive Director
Jeremy Pease	Non-Executive Director
Prof Peter Roberts	Non-Executive Director
Jan Wilson	Non-Executive Director

IN ATTENDANCE/OBSERVERS

Helen Barker	Associate Director of Community Services and Operations
Anna Basford	Director of Commissioning and Partnerships
Jacqui Booth	Communications Officer
Kathy Bray	Board Secretary
Jackie Green	Interim Director of Workforce and Organisational Development
Nick Lavigueur	Huddersfield Examiner Reporter
Victoria Pickles	Company Secretary
John Playle	Nominated Membership Councillor
Johanna Turner	Publicly Elected Membership Councillor

1 observer from Department of Health – David Stead
1 observer from Redcentric Software – Mr Simon Dale

Item

86/15 APOLOGIES FOR ABSENCE AND INTRODUCTIONS

Apologies were received from:

Julie Hull	Executive Director of Workforce and Organisational Development
Owen Williams	Chief Executive

The Chairman welcomed everyone to the meeting.

87/15 DECLARATION OF INTERESTS

There were no declarations of interest to note.

88/15 MINUTES OF THE MEETING HELD ON THURSDAY 28 MAY 2015

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

87/15 MATTERS ARISING FROM THE MINUTES

73/15 Fractured Neck of Femur

The Executive Director of Planning, Performance Estates and Facilities gave a detailed update on the work currently underway to improve this indicator and achieve best practice tariff. The Board noted the significant work being undertaken to improve utilisation of theatre capacity through co-ordinated working across both sites. It was agreed that if the position has not improved by the next quarter the Board

would consider further actions, including a re-review of the service by an external team.

88/15 ACTION LOG

There were no outstanding issues.

It was noted that due to the lengthy agenda no Patient Story had been included at this meeting.

The Chairman reported that a number of items had been added to the workplan and would therefore be removed from the action log for the next meeting.

89/15 CHAIRMAN'S REPORT

a. Yorkshire Chairs' Meeting – The Chairman updated the Board on the agenda topics from the West Yorkshire Chair and Chief Executive Meeting and key issues from the agenda were noted:

- 7 Day Services
- Integrated Care agenda
- Devolution in Manchester
- What is beyond the FT Model
- Procurement collaborative
- Urgent care and system resilience – West Yorkshire footprint
- Vanguards
- West Yorkshire Association of Acute Trusts (WYAAT

b. NHS Providers Chair/CE Meeting – 16.6.15 – The Chairman gave feedback to the Board on the discussions held at this meeting. This included:

- Very Senior Managers' Pay – Trusts to respond to Secretary of State by 6 July
- State of the nation including finances, agency spend, cap on management spend, 5 year forward view, health and prevention, care closer to home, government focus on mortality at weekends, cancer targets, mental health services, and 7 day working.

90/15 CHIEF EXECUTIVE'S REPORT

a. Email from David Williams, Director General – Finance, Commercial and NHS

It was noted that the Remuneration Committee (Executives) were to consider the issue of senior managers' pay at a meeting later that day. It was noted that a template was required to be submitted to Monitor by 6 July 2015, on behalf of the Secretary of State, outlining the Trust's position.

b. NHS – 5 Year Forward View : Time to Deliver

The Board received and noted the contents of these two documents. It was noted that work was being undertaken locally to respond to the matter of very senior managers' pay, turnaround fees and agency workers.

91/15 INTEGRATED BOARD REPORT

The Executive Director of Planning, Performance, Estates and Facilities introduced the Integrated Board report as at 31 May 2015 and explained that each area would be presented in detail.

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

- Improved theatre utilisation by focusing on scheduling patient flow, staff and skill mix and theatre scheduling.
- Working with partners to reduce the number of delays due to external issues and improving processes within the hospitals where there are issues with patient flow.
- Outpatient activity was slightly under plan.
- A/E 4 hour wait performance achieved 94.8% against 95% target. HRI have achieved the standard for the last 3 weeks – site specific issues causing challenge at CRH – expected resolution by July.
- A drive to close complaints in the required time continued.
- Two cases of MSSA were detected in May. Both had been reviewed and this indicated that neither were hospital acquired infections.
- A reduction in SHMI during May to 109. HSMR currently at 108.53. A review of the Care of the Acutely Ill Patient took place at the end of May and a refocused programme will look to be formed in the next month. Work continues on the Mortality review process and lessons learnt are being fed back to the appropriate forums and clinical teams.
- Time to theatre for fractured neck of femur patients continues to be off plan. Current performance was 72.5% against a target of 85%. A recovery plan for performance in peak times will be in place by the end of June.

RESPONSIVE

The Associate Director of Community Services and Operations reported:

- **Emergency Care Standard and Patient Flow –** Current performance was noted as 94.8% - May, 95.2% June and 95.02% for the quarter. Credit was given to the operational teams in the Divisions for securing this performance.
- **Green Cross/Delayed Discharge** – No changes in May but hopefully some improvements were expected in June/July. New action plan had been developed with improved ownership and reduced outliers. No individual patient ward moves to take place after 10.00 pm at night, unless by clinical need.
- **Theatre Utilisation** – External help to focus utilisation of theatre time has been received through the PMO office and full roll out was expected to be completed by July 2015. It was therefore hoped improvements would be seen in utilisation figures over the next two months.
- **Community** – It was noted that this section had been removed due to a restructure of the divisions and the performance was currently highlighted in the DATs and Medicine Divisional information. Updated Community data would be available for the next Board meeting.

CARING/SAFETY

The Executive Director of Nursing and Operations reported:

- **Complaints** – The Executive Director of Nursing reported that there had been some improvement in the timeliness of complaints responses and there remained only one outstanding complaint response of over 2 months.
- **Duty of Candor –** There was one outstanding case for May which was being downgraded by the CCG following investigation. On-going training was underway with staff regarding having discussions with patients and families.

EFFECTIVENESS

The Executive Medical Director reported:-

- **C.Diff/MRSA/MSSA/HSMR –** information reported earlier in the meeting was noted.

- **Mortality/Coding –** A deep dive was being undertaken. The inability to recruit qualified coders was noted and clinical engagement to improve record keeping was underway.

WELL LED/WORKFOCE

It was noted that the Well Led section of the report had been amended since it had been published and work would be undertaken on this section in future months to improve the quality of the report.

The Interim Director of Workforce and Organisational Development reported:-

- **Sickness** – It was agreed that doing more of the same would not achieve and improvement in sickness absence. It was noted that the level of long term sickness (over 4 weeks) had increased. A deep dive was being undertaken and improved information/guidance would be provided to managers.
- **Mandatory Training** – A new mandatory training programme had been introduced from 1 June 2015 which staff should find easier to access and undertake. Discussion took place regarding 'e' learning and it was noted that access for staff without electronic devices was availableThe Quality Committee would be reviewing the performance at their next meeting together with any mitigation actions required

FINANCIAL ACTIVITY

The Executive Director of Finance agreed to report on the financial position later in the meeting when he delivered the Month 2 – May 2015 financial narrative.

- **CQUINS**
  The information contained within the report was received and noted.
- **Monitor Indicators**
  The information contained within the report was received and noted.

RESOLVED: The Board approved the Integrated Board Report

92/15 RISK REGISTER

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

- Progression of service reconfiguration impact on quality and safety
- Risk of the Trust failing to achieve its financial plans for 2015-16
- Risk of poor patient outcomes due to dependence on middle grades
- Hospital Standardised Mortality Ratio (HSMR) & Summary Hospital-Level Mortality Indicator (SHMI)

Risks with increased score:-

- There had been no risks with an increased score.

Risks with reduced score:-

- Shortage of Consultants in Ophthalmology, reduced from 20 to 12 due to appointments made.
- Complexities of working with Bradford Teaching Hospitals, reduced from 15 to 10 as appropriate governance arrangements were in place and working
- Tactical solutions for EPR – now scored at 10 due to better monitoring and additional resources in place.

New Risk added:-

NHS e-Referrals, increased score to 16 reflecting the introduction of the new system that has replaced Choose and Book.

Other issues arising from the debate included:-

- The Executive Director of Nursing and Operations advised that a future risk which may be added was around not having training paediatric nurses in A/E and the model of care on the HRI site. A review was underway and the issue being discussed by the Executive Board.
- A review of policies and procedures was underway following receipt of two Rule 28 enforcement notices
- Philip Oldfield advised that following discussion with Monitor and their concerns around EPR working, it was agreed that this issue would be taken back for inclusion in the risks in the future.
  Peter Roberts highlighted that some work was required to consider whether there were a number of lower scoring risks resulting in a higher scoring overall risk, such as the implications of not reconfiguring hospital services.

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

93/15 DIRECTOR OF INFECTION PREVENTATION AND CONTROL (DIPC) REPORT

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

- **MRSA** – 1 unavoidable case had been allocated to the Trust in April.
- **C.Diff** – 2 cases had been reported in April (1 avoidable and 1 unavoidable). The ceiling was 21 cases for the year to March 2016.
- **Isolation Breaches** – 22 isolation breaches had been recorded for the Trust in May. The year to date performance ceiling was 54. This was a challenge to the Trust with the current geographical layout.
- **The NHS National Benchmarking Network** had undertaken a pharmacy project. CHFT had submitted data which included MRSA and C.Diff in 2013/14, as well as information on bed numbers and hospital spells. Currently the performance against other peers was good. Results to be finalised mid-June.
- **ANTT compliance –** Rate had improved but further work was on going.

RESOLVED: The Board received the report.

94/15 REVALIDATION REPORT – DOCTORS

The Executive Medical Director updated the Board on the progress of the Trust's management of medical appraisal and revalidation since the introduction of revalidation in December 2012.

- As at 31.3.15, 318 doctors had a prescribed connection to the Trust.
- In 2014/15 revalidation year (1.4.14-31.3.15) 92 non training grade medical staff had been allocated a revalidation date by the GMC
- Based on headcount 86.8% of non-training grade appraisals were completed and submitted in the appraisal year. 11.9% of non-training grade medical staff were not required to complete an appraisal (due to recently joining the Trust/maternity leave etc).

It was noted that a review of the process was being undertaken by NHS England to give a baseline for the future.

RESOLVED: The Board received the report.

95/15 GOVERNANCE REPORT

The Company Secretary presented the quarterly Governance Report which included:

a. Board work plan – The updated document was received and noted.

b. Use of Trust seal – Use of the Trust seal during the period 5.3.16 to the 25.6.15 was received and noted.

96/15 NATIONAL INPATIENT SURVEY

The Executive Director of Nursing and Operations presented the National Inpatient Survey for 2014. It was noted that 840 discharged patients had been asked to take part in the survey. Overall 420 patients had returned completed questionnaires, giving a response rate of 49%. This was slightly lower than the previous two years which had been 51% and 50% respectively. It was noted that the Trust had received some very positive feedback and similar patterns were being seen year on year. The positive aspects had been care, confidence in staff and cleanliness of the hospital. The negative comments included staffing, food and general communications. It was agreed that more work would be undertaken through Communications to promote this information to both staff and patients. It was noted that a workshop had taken place when this feedback had been shared with nursing staff. The Executive Director of Nursing reported that further work would be undertaken and outcomes included in the Quality Report.

The Director of Planning, Performance, Estates and Facilities was disappointed with the feedback regarding hospital food although it was noted that since this survey had been undertaken a great amount of work had been undertaken to improve hospital food.

RESOLVED: The Board received the report.

97/15 WORKFORCE RACE EQUALITY STANDARD

The Interim Director of Workforce and Organisational Development presented the Workforce Race Equality Standard (WRES) paper based on workforce data as at 1 July 2015. It was noted that the WRES comprised 9 indicators. This included workforce metrics for white and BME staff, along with the composition of the Board of Directors. The timetable for publication of this data was noted along with the detailed information contained within the paper. Discussion took place regarding the need to clarify roles and responsibilities in the narrative.

RESOLVED: It was agreed that Jan Wilson would work with the Interim Director of Workforce to agree a signed off version of this document.

98/15 MONTH 2 – MAY 2015 FINANCIAL NARRATIVE

The Executive Director of Finance presented the finance month 2 report (included within the Integrated Board). It was noted that this information had been discussed in detail at the Finance and Performance Committee held the previous day:-

Summary Year to Date:

- The year to date deficit is £5.22m, no contingency reserves were released.
- Elective activity is slightly behind planned levels whilst non-elective continues to be above behind planned levels whilst non-elective plan in the year to date.
- The main area of on-going expenditure pressure is non-contracted pay, supporting vacancy cover and extra bed capacity.
- Capital expenditure year to date is £3.08m, against the planned £3.33m with slippage on

both Estates and IT Schemes.

- Cash balance is £2.18m below plan at £13.31m. This includes £10m loan funded borrowing for capital expenditure.
- CIP schemes delivered £1.70m in Month 1 against a planned target of £1.27m.
- The Continuity of Service Risk Rating (CoSRR) stands at 2 against a planned level of 2. The underlying trading position is CoSRR level 1, this is falsely inflated in the short term by the cash receipt of loan funding.

Summary Forecast:-

- The forecast is to deliver the year end position, however at present this relies on the use of £0.7m contingency reserves.
- The Trust must remain responsive to meet the capacity requirements between elective and non elective activity at Divisional level in a financially efficient way.
- The plans incorporate CIP delivery at £14m, however the Trust is aiming to exceed this to deliver a stretch target, against which detailed schemes are in place to the value of £17.24m. At present the forecast I&E position includes CIP delivery to the value of £14.24m with the balance of the stretch target being held back at this early stage against potential slippage or other pressures.
- The year-end cash balance is predicated on external cash support being received from September onwards.
- The year-end capital expenditure is forecast to be in line with plan at £20.72m. The year-end CoSRR is forecast to be at level 1 as planned

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

99/15 UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES

The following information was received and noted:-

- **Quality Committee** – The Board received the minutes of the 26.5.15 and a verbal update from Jeremy Pease on the meeting held on 23.6.15. Matters arising from the meeting included:-
    - Review of employment checks and safe storage of insulin and saline following the recent deaths at Stepping Hill
    - Quality Impact Assessments – CIP – matrix discussed with Monitor at quarterly meeting. Further information would be brought to a future Board meeting.
    - Risk Register – reviewed in detail
    - Rule 28 Enforcement – 2 reports received. Action plans to embed learning within the organisation developed. Learning being fed back through inductions and clinical record keeping awareness.
    - CQC Action Plan – Paper developed to highlight the main risks to the organisation by divisions and assurance that issues are being addressed would be brought back to the Board.
    - IBR – discussed. Focussed discussion on Appraisal/Mandatory Training. Position to be reviewed at the next Quality Committee.

- **Audit and Risk Committee** - The Board received the minutes of the 28.5.15

- **Finance and Performance Committee** - The Board received the minutes of the 28.5.15 and a verbal update from Peter Roberts (Acting Chair) on the meeting held on 24.6.15 which included:-
    - **PMU** – A presentation was received from the PMU staff on the business plan to take the unit forward in the future and the options available. Those present agreed that this was a very good

presentation and the team were encouraged to proceed and produce a detailed business case in the next few months to support the development.

The Chairman thanked everyone for their attendance and contributions.

100/15 DATE AND TIME OF NEXT MEETING

Thursday 30 July 2015 at 1.30 pm in the Large Training Room, Learning Centre, Calderdale Royal Hospital HX3 0PW

The Chairman closed the meeting at 3.20 pm.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 30th July 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: ACTION LOG - PUBLIC BOARD OF DIRECTORS - 1 JULY 2015 - The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 July 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 July 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 July 2015

Appendix

Attachment:

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

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 July 2015 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
30.10.14 140/14	**PATIENT/STAFF STORY** 30.10.14 - 'Carol's Story' extract video. 27.11.14 – 'Mr P' – Drug Error 18.12.14 – Dr Sarah Hoye 29.1.15 – Dr Mary Kiely – Care of the Dying 26.2.15 – Catherine Briggs, Matron – Green Cross Patient 26.3.15 – Diane Catlow – Families Senior Locality Manager 23.4.15 – Dr Mark Davies – Perfect Week 28.5.15 – Stroke Team - Patient Story/FAST Awareness 25.6.15 – No information received	Executive Director of Nursing	Regular item on BOD Agenda going forward.	Monthly Reports		
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	August 2015		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 July 2015 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

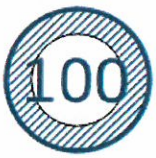
Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
			25.9.14 – Update received 27.11.14 – Update received 29.1.15 – Update received 26.3.15 – Update received 28.5.15 – Update received			
25.6.15 Private meeting	**WELL LED GOVERNANCE REVIEW** Key messages received in private session.		To be discussed and actions agreed at BOD Workshop to be held 15.7.15	30.7.15		
25.6.15 Private meeting	**BUSINESS CONTINUITY PLAN FOR OVERNIGHT CLOSURE OF AN EMERGENCY DEPARTMENT AT CHFT** Business Continuity Plan received and approved.		To be approved by UCB and taken publicly to BOD Meeting .	30.7.15		

1. Health care surveys

This quarter's report is based on an online survey of the following groups.

NHS trust finance directors

clinical commissioning group (CCG) finance leads



NHS trust finance directors

clinical commissioning group (CCG) finance leads

This report details the results of an online survey of NHS trust finance directors carried out between 5 June 2015 and 22 June 2015. We contacted 254 NHS trust finance directors to take part and 100 responded (39 per cent response rate). The sample included 44 acute trusts; 35 community and mental health trusts; 6 specialist trusts; 3 ambulance trust and 12 unknown.

In addition, we contacted 202 clinical commissioning group (CCG) finance leads and 53 responded (26 per cent response rate). Between them these finance leads covered 58 CCGs (27 per cent of CCGs).

Respondents were asked about their organisation's financial situation and the financial outlook for their local health economy over the past financial year; the state of patient care in their area; the financial situation looking ahead to 2016/17; the key organisational challenges facing trusts and CCGs; and workforce issues following recent announcements regarding proposed new controls on agency staff.

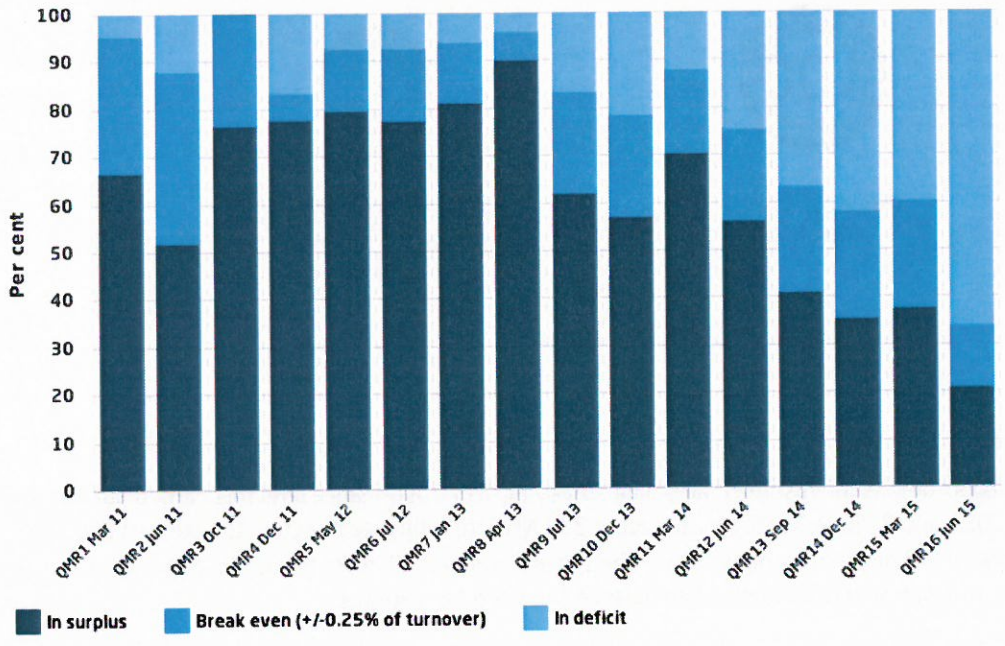
2. Projected end-of-year financial balance: 2015/16

Nationally, NHS foundation trusts' financial performance declined significantly in 2014/15, for the first time ending the year with an overall net deficit of £349 million. A total of 77 foundation trusts reported a deficit for 2014/15, totalling £636 million (Monitor 2015). For NHS trusts, at the end of 2014/15 the NHS Trust Development Authority reported deficits in 40 trusts and an overall net deficit of £472.6 million (NHS Trust Development Authority 2015). NHS England reported that CCGs in aggregate ended the year (2014/15) with a surplus of £151 million (0.2 per cent of allocation) (NHS England 2015).

Against that backdrop, our first survey of 2015/6 shows a deepening crisis across trusts, with around two-thirds (66 per cent) of all providers forecasting a deficit for the end of year (2015/16) and 89 per cent of acute trusts expecting to overspend. (Figure 1). This is the worst position for trusts since we began the survey. On the other hand, only around 10 per cent of CCGs forecast an overspend by the end of 2015/16 (Figure 2). NHS Providers indicate that overspending by all trusts could amount to more than £2 billion by April 2016 (Wintour and Campbell 2015). Following the latest forecast deficit from all foundation trusts of £989 million for 2015/16, Monitor has warned the sector that their freedoms could come under pressure unless they demonstrate faster improvements in productivity (Monitor 2015).

NHS TRUSTS

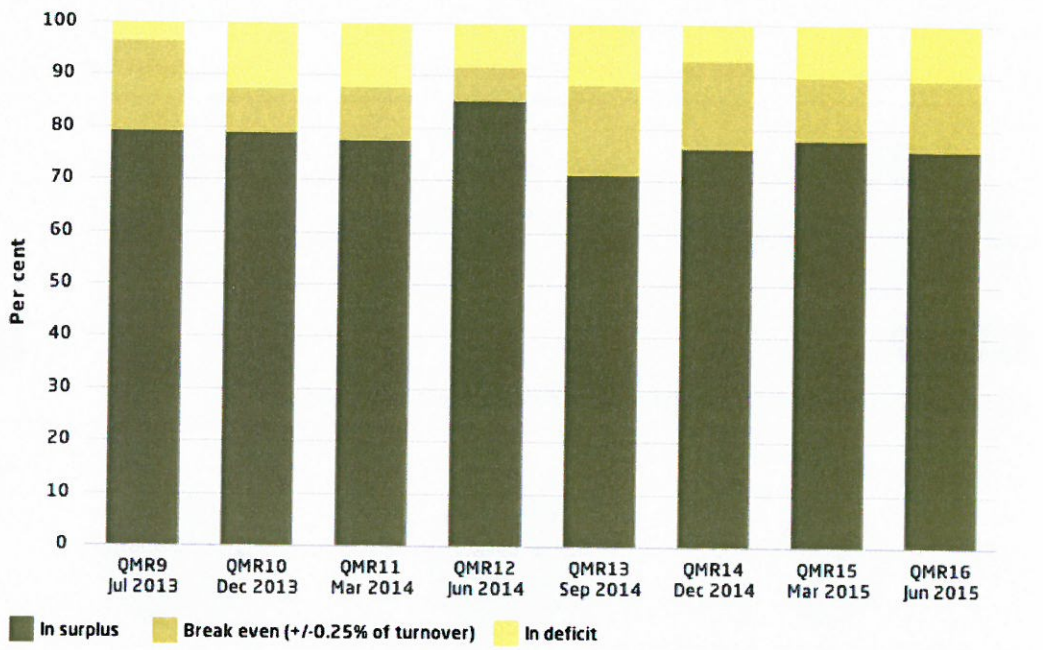
Figure 1: Trends: What is your organisation's forecast end-of-year financial situation



QMR 1-4 based on a panel of 50 trust finance directors

CCG LEADS

Figure 2: Trends: What is your organisation's forecast end-of-year financial situation?

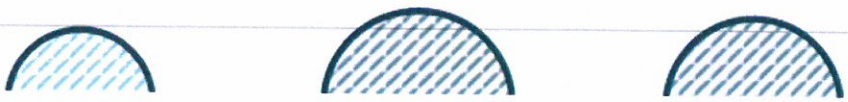


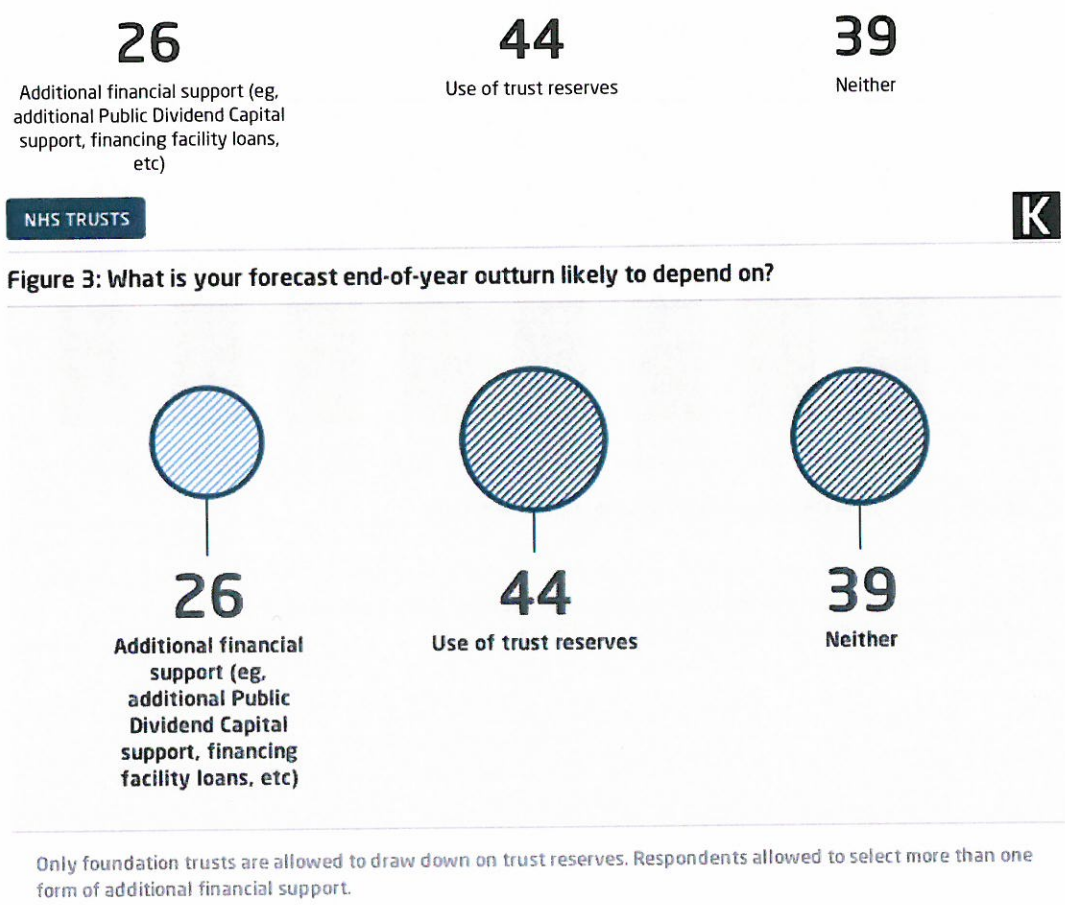
53 CCG finance leads answered this question for the 58 CCGs they cover collectively.
CCGs only surveyed since their establishment in April 2013.

3. In-year financial support

Just under two-thirds of finance directors reported that their forecast position this year would include additional financial support, either loans, additions to their Public Dividend Capital (PDC) from the Department of Health, or drawing on their own reserves (Figure 3).

Figure 3: What is your forecast end-of-year outturn likely to depend on?





4. Cost improvement and QIPP programmes (2015/16)

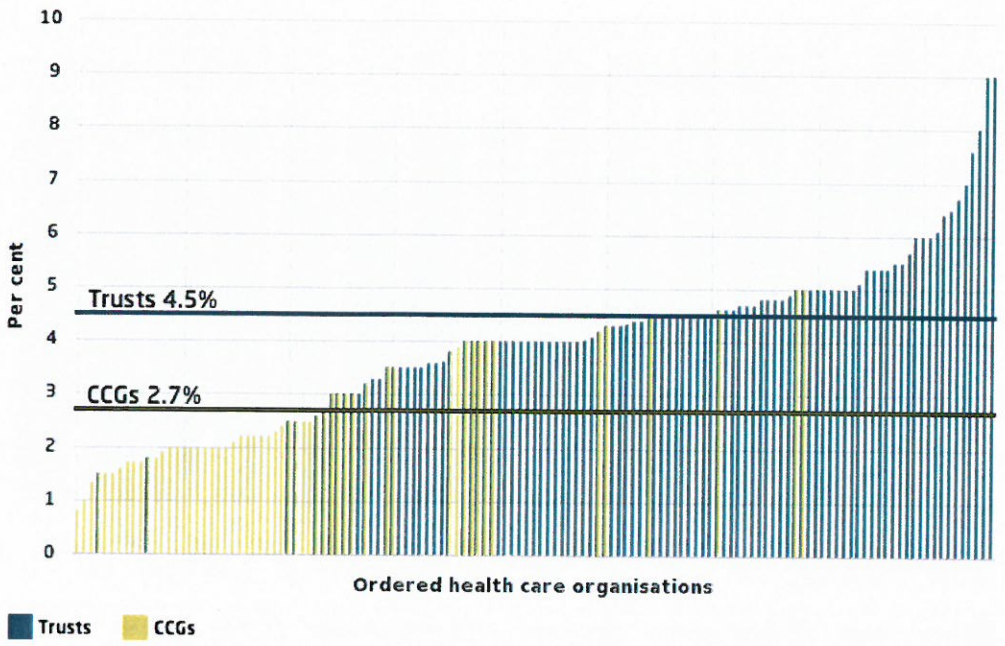
The average cost improvement programme (CIP) target for trusts for 2015/16 is 4.5 per cent, ranging from 1.5 per cent to 9 per cent of turnover. The average quality, innovation, productivity and prevention (QIPP) target for CCGs for 2015/16 is 2.7 per cent, ranging from 0.8 per cent to 5 per cent of allocation (Figure 4).

Confidence in achieving planned CIPs/QIPPs has been reducing each year since 2011. Around 40 per cent of all NHS trust finance directors now feel fairly or very concerned about achieving their CIP plans this year (Figure 5).

Similarly, around 30 per cent of all CCG finance leads were fairly or very concerned about achieving their QIPP plans this year (Figure 6).

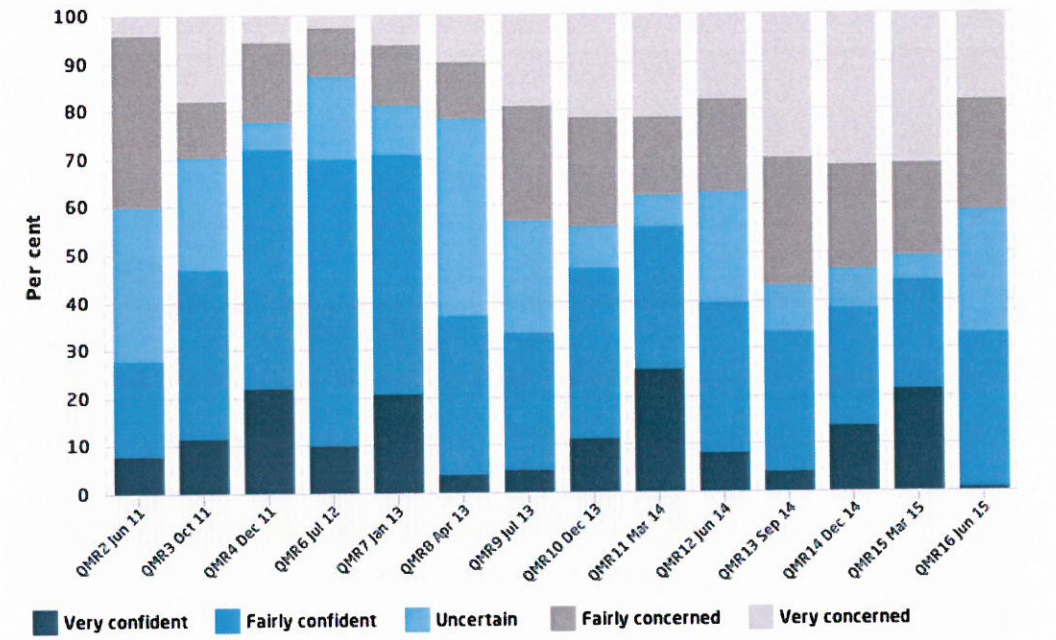
NHS TRUSTS CCG LEADS

Figure 4: What is your organisation's CIP/QIPP target for this financial year (2015/16) as a percentage of turnover/allocation?



NHS TRUSTS

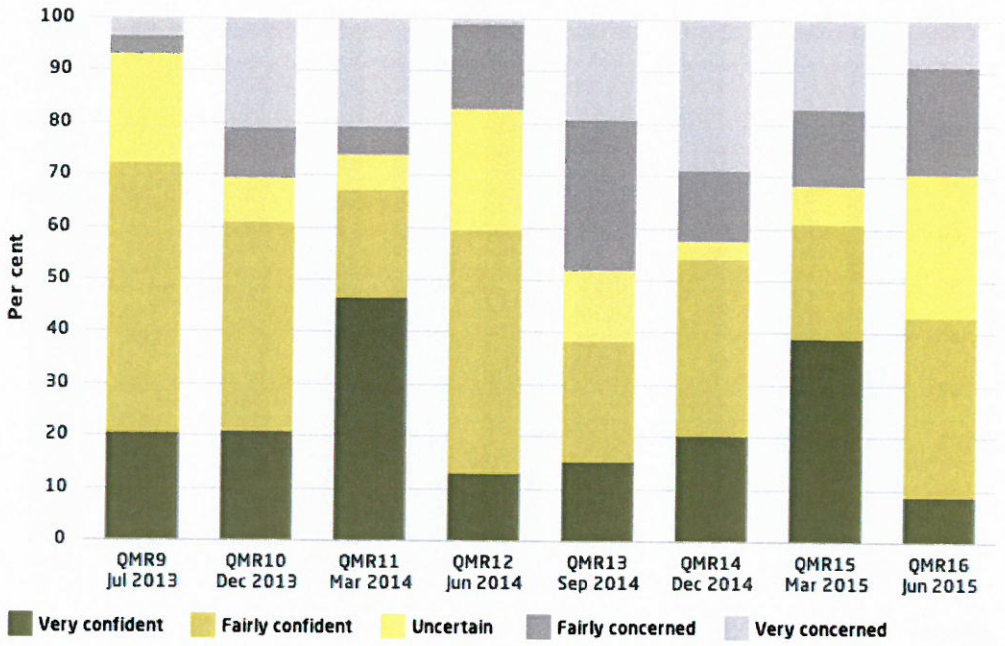
Figure 5: Trends: How confident are you of achieving your cost improvement programme (CIP) target?



QMR1-4 based on a panel of 50 finance directors. QMR1 and QMR5 excluded as wording of responses not compatible with other quarters' data.

CCG LEADS

Figure 6: Trends: How confident are you of achieving your quality, innovation, productivity and prevention (QIPP) target?



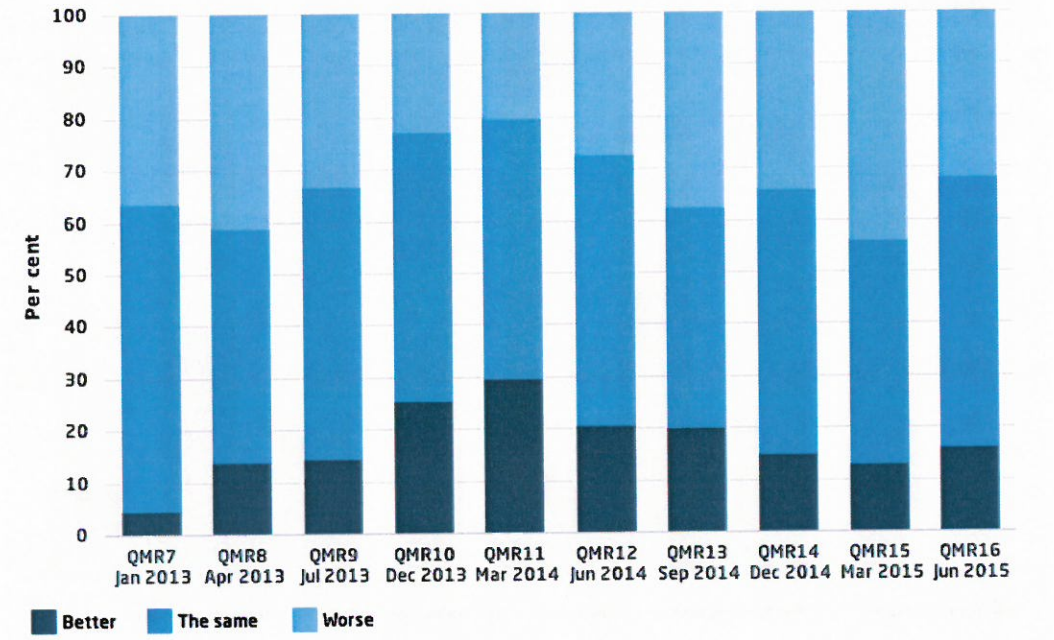
53 CCG finance leads answered this question for the 58 CCGs they cover collectively.
CCGs only surveyed since their establishment in April 2013.

5. The state of patient care

Around a third of both NHS trust finance directors and CCG finance leads felt that care in their local area had worsened over the past year (Figures 7, 8). For finance directors, this is broadly consistent with views expressed in previous surveys.

NHS TRUSTS

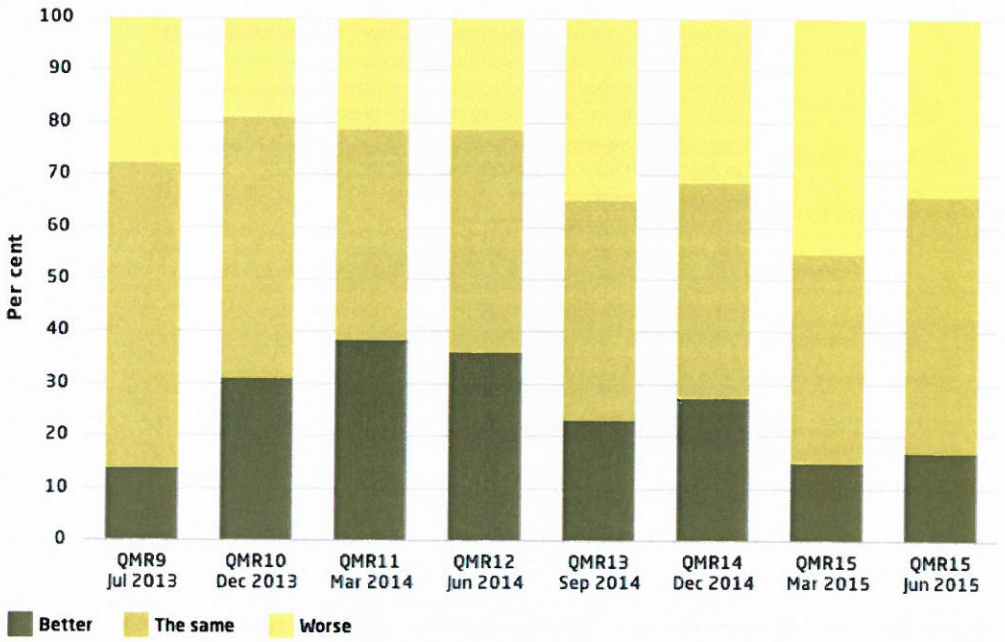
Figure 7: Trends: Thinking about the NHS in your local area, in the past 12 months, do you think it has got better, worse, or stayed the same in terms of patient care?



Question not asked before QMR6.

CCG LEADS

Figure 8: Trends: Thinking about the NHS in your local area, in the past 12 months, do you think it has got better, worse, or stayed the same in terms of patient care?



CCGs only surveyed since their establishment in April 2013.

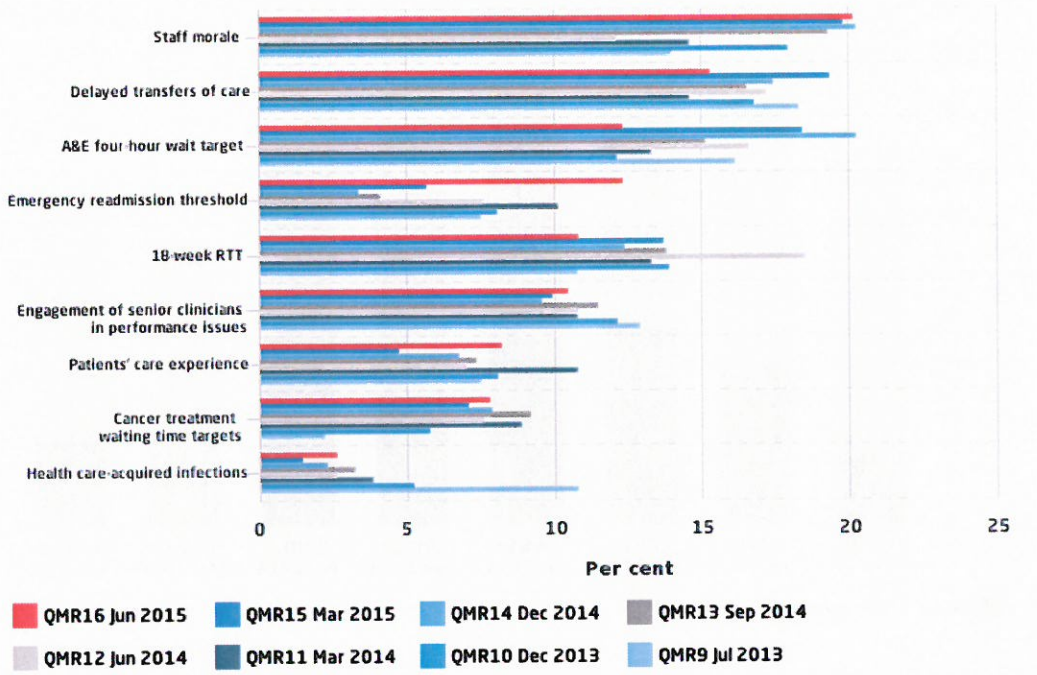
6. Organisational challenges

For trust finance directors, staff morale remains at the top of the list of concerns (the fourth quarterly survey in a row), along with the four-hour A&E waiting time target and delayed transfers of care (and the emergency readmission threshold) (Figure 9).

CCG finance leads continue to be most concerned about A&E and 18-week referral-to-treatment (RTT) waiting time targets and cancer treatment waiting times (Figure 10).

NHS TRUSTS

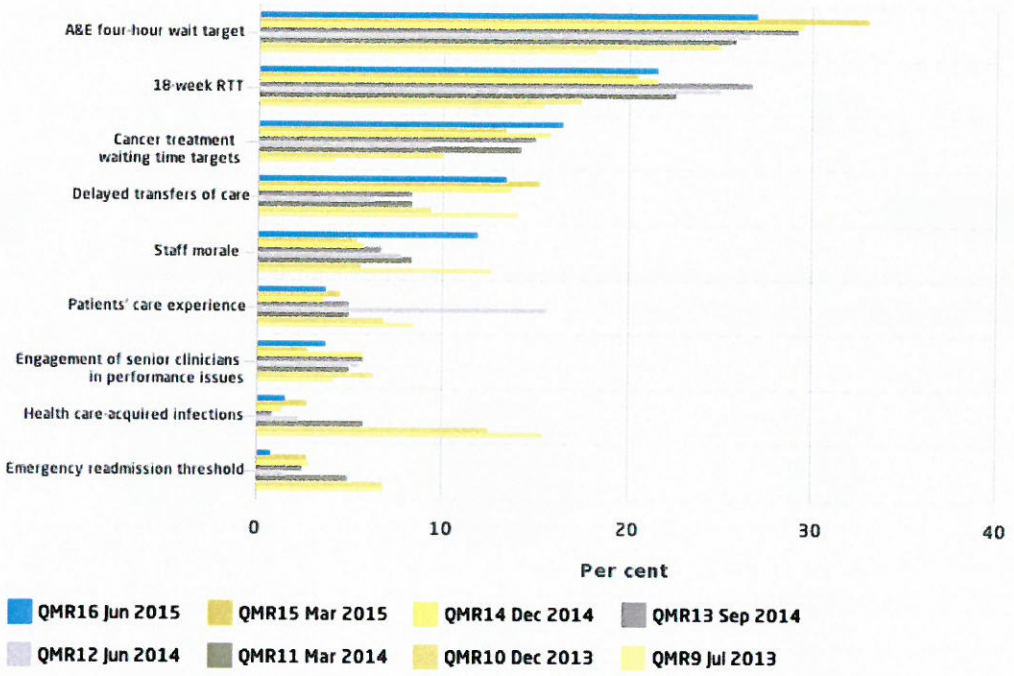
Figure 9: Trends: Which aspects of your organisation's performance are giving you most cause for concern at the moment? Please select top three



Respondents asked to choose their top three concerns. Figures expressed as a percentage of the total number of concerns in each survey.

CCG LEADS

Figure 10: Trends: Which aspects of your organisation's performance are giving you most cause for concern at the moment? Please select top three



Respondents asked to choose their top concerns. Figures expressed as a percentage of the total number of concerns in each survey.

7. Workforce

In June 2015, the government announced controls on spending on agency staff. The plans also included setting a maximum hourly rate for agency doctors and nurses and putting a cap on total agency staff spending for each NHS trust.

When asked whether the proposed controls would significantly reduce their agency spend, 61 per cent of NHS trust finance directors indicated that they were unlikely to reduce their agency spend (Figure 11). Respondents gave a number of reasons for this, including the importance of being able to fill short-term gaps in service with locums and the fact that providers are already purchasing locum services within the agreed framework. Just over a quarter of NHS trust finance directors thought the proposed controls could affect their ability to recruit the staff needed to provide safe care (Figure 12).

Figure 11: Do you think the government's proposed new controls on agency staff will significantly reduce your agency spend?

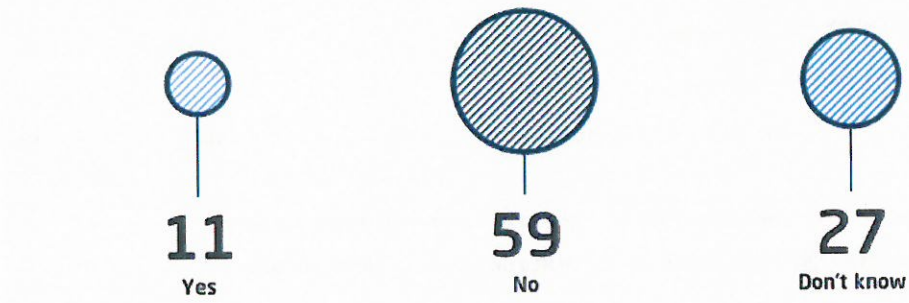
11 Yes

59 No

27 Don't know

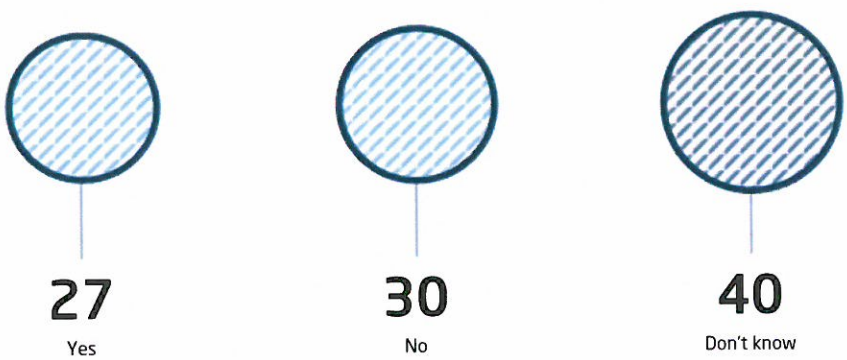
NHS TRUSTS

Figure 11: Do you think the government's proposed new controls on agency staff will significantly reduce your agency spend?



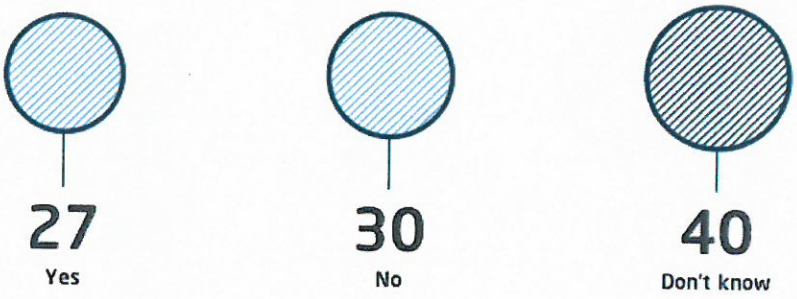
97 respondents (for whom the question was applicable).

Figure 12: Do you think the proposed new controls on agency staff will affect your ability to recruit the staff you need to provide safe care?



NHS TRUSTS

Figure 12: Do you think the proposed new controls on agency staff will affect your ability to recruit the staff you need to provide safe care?



97 respondents (for whom the question was applicable).

Three-quarters of NHS trust finance directors plan to increase the number of permanent nursing staff in the next six months (Figure 13). At the same time, 33 per cent of NHS trust finance directors plan to reduce the number of directly employed staff posts this year (2015/16) (Figure 14). Out of the 33 trusts planning to reduce their workforce, 19 plan to increase the number of nurses in the next six months (58 per cent). Comments from trust finance directors suggest that non-clinical staff will be most affected by the cuts in posts.

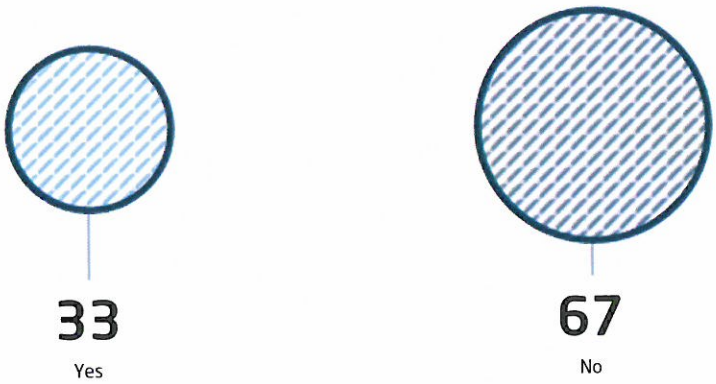
Figure 13: Is your organisation planning to increase the number of permanent nursing staff in the next six months?

NHS TRUSTS

Figure 13: Is your organisation planning to increase the number of permanent nursing staff in the next six months?

99 respondents (for whom the question was applicable).

Figure 14: Is your organisation planning/implementing an overall reduction in directly employed staff posts this year (2015/16)?



NHS TRUSTS

Figure 14: Is your organisation planning/implementing an overall reduction in directly employed staff posts this year (2015/16)?

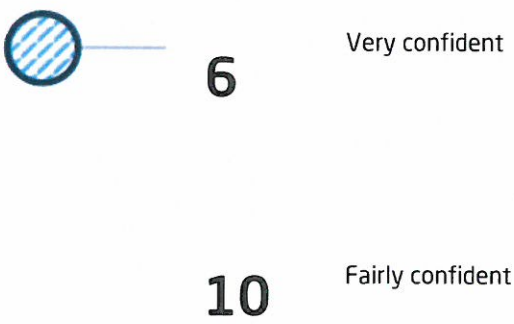
8. Funding for mental health services

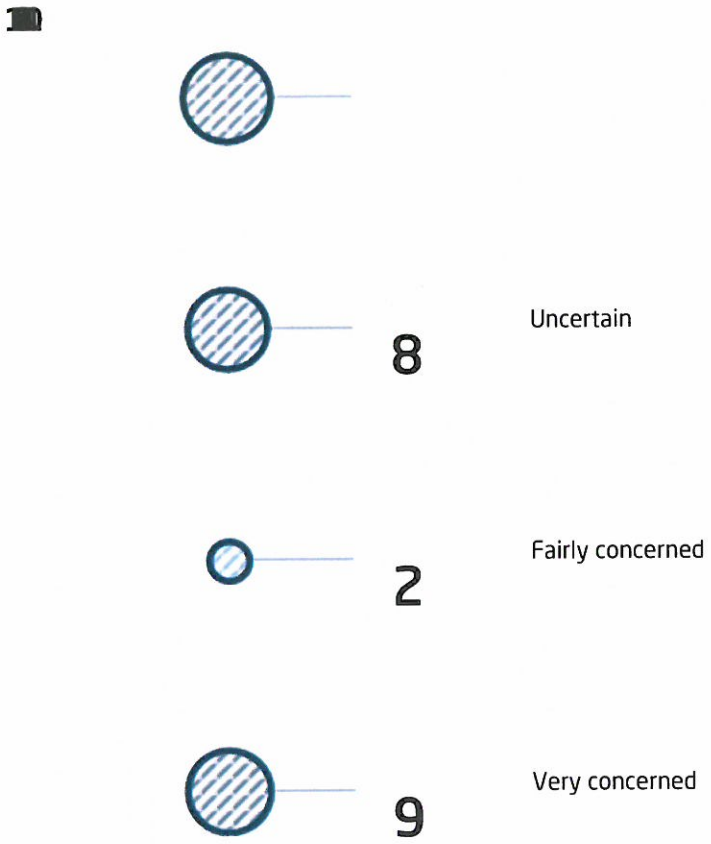
As part of the ambition to achieve parity of esteem between mental and physical health by 2020, CCGs are expected to increase spending on mental health services in 2015/16 in real terms, and grow by at least as much as each CCG's allocation increase (NHS England 2014).

Just under a third of all NHS trust finance directors working in mental health trusts are fairly or very concerned that the planned increase in funding for mental health services this year will be not met (Figure 15).

At the same time, around 8 in 10 of all CCG finance leads are fairly or very confident about making the planned increases in funding available for mental services this year (Figure 16).

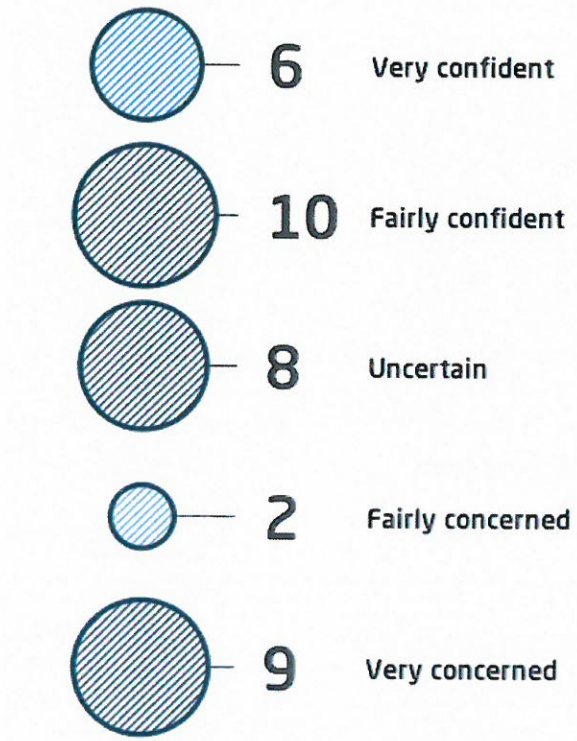
Figure 15: FOR MENTAL HEALTH TRUSTS ONLY: How confident are you that your commissioners will increase funding for mental health services in 2015/16 in real terms, in line with the NHS five year forward view?




8
Uncertain
2
Fairly concerned
9
Very concerned

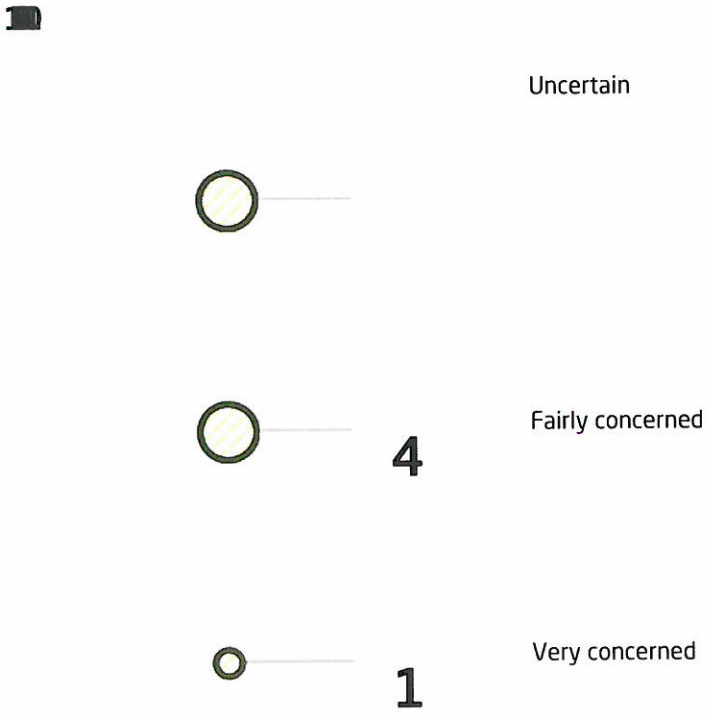
NHS TRUSTS

Figure 15: FOR MENTAL HEALTH TRUSTS ONLY: How confident are you that your commissioners will increase funding for mental health services in 2015/16 in real terms, in line with the NHS five year forward view?



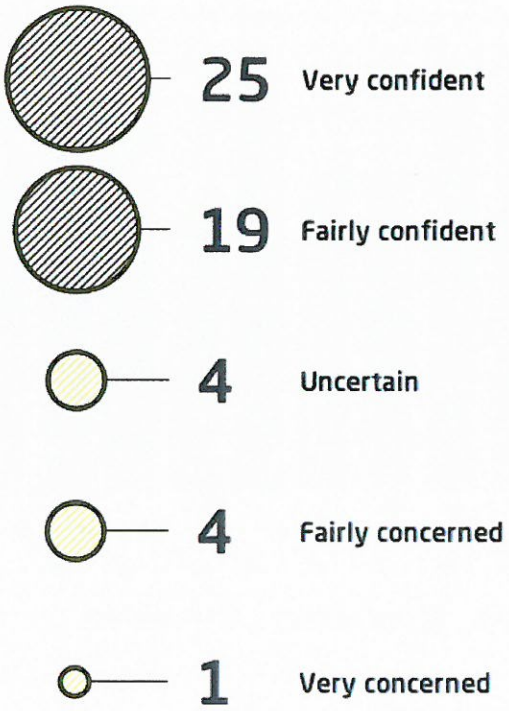
35 respondents (for whom the question was applicable).

Figure 16: How confident are you that you will be able to increase funding for mental health services in 2015/16 in real terms, increasing this at least in line with the CCG's overall growth as suggested by the NHS five year forward view?


Uncertain
Fairly concerned
4
Very concerned
1

CCG LEADS

Figure 16: How confident are you that you will be able to increase funding for mental health services in 2015/16 in real terms, increasing this at least in line with the CCG's overall growth as suggested by the NHS five year forward view?

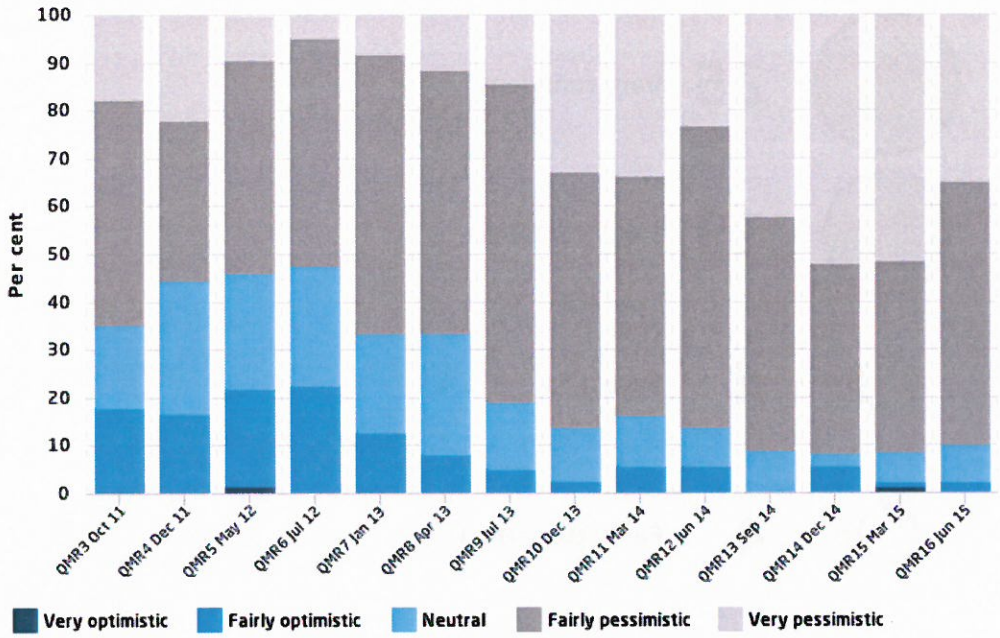


9. The financial state of local health and care economies over the next year

As for views about the financial state of their wider local health and care economy over this financial year, around 90 per cent of trust finance directors were fairly or very pessimistic (Figure 17). Similarly, 80 per cent of CCG finance leads feel fairly or very pessimistic (Figure 18). Both are slightly worse compared to our survey in June 2014.

NHS TRUSTS

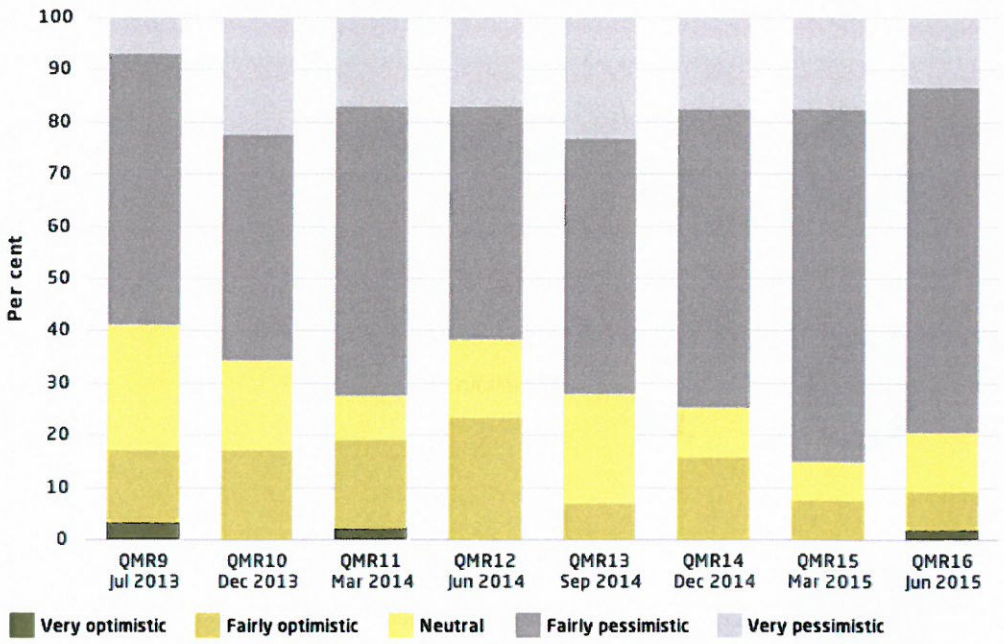
Figure 17: Overall, what do you feel about the financial state of the wider health (and care) economy in your area over the next year?



Question not asked before QMR3. QMR 1-4 based on a panel of 50 trust finance directors.

CCG LEADS

Figure 18: Overall, what do you feel about the financial state of the wider health (and care) economy in your area over the next year?



CCGs only surveyed since their establishment in April 2013.

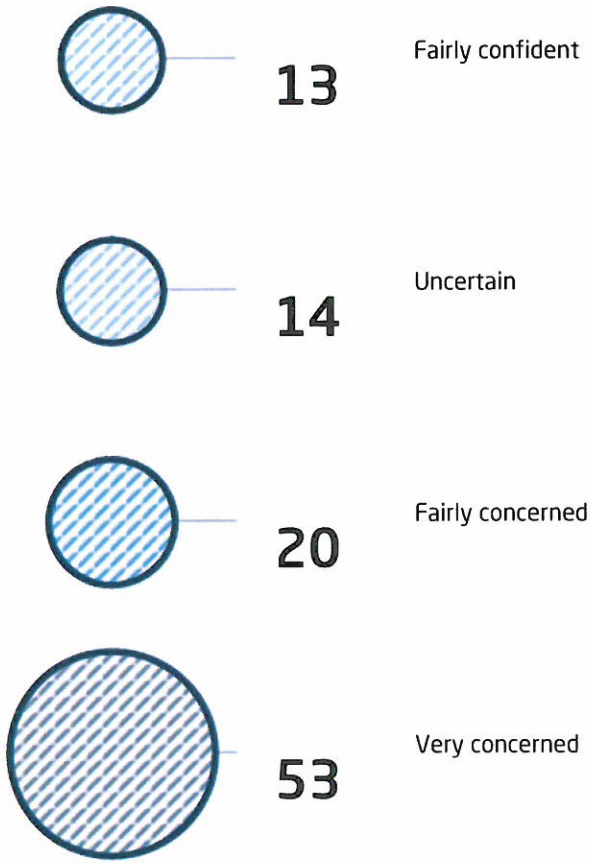
10. Looking ahead to 2016/17

With two-thirds of trusts forecasting an end-of-year deficit for 2015/16, the situation looks even worse for 2016/17. Just under three-quarters (73 per cent) of NHS trust finance directors are pessimistic about balancing their books next year (Figure 19).

Around 30 per cent of CCG finance leads felt fairly or very concerned about achieving financial balance in 2016/17, reflecting the greatest degree of pessimism for CCG finance leads since we started surveying (Figure 20).

Figure 19: Looking ahead, how confident are you that your organisation will achieve financial balance in 2016/17?

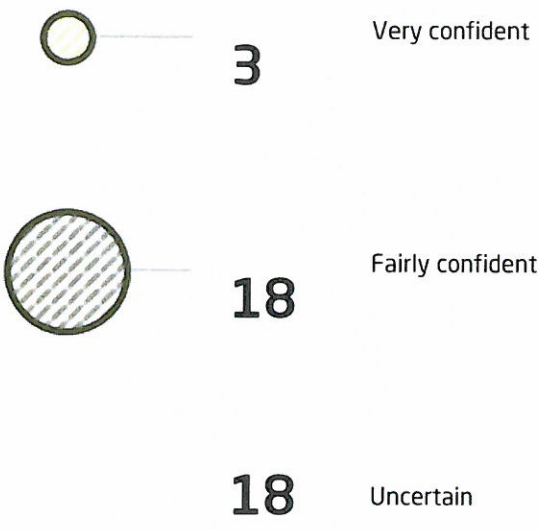
0 Very confident

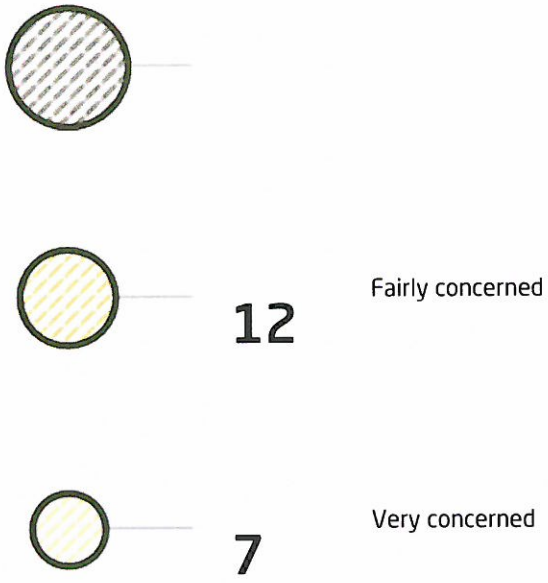

13
Fairly confident
14
Uncertain
20
Fairly concerned
53
Very concerned

NHS TRUSTS

Figure 19: Looking ahead, how confident are you that your organisation will achieve financial balance in 2016/17?

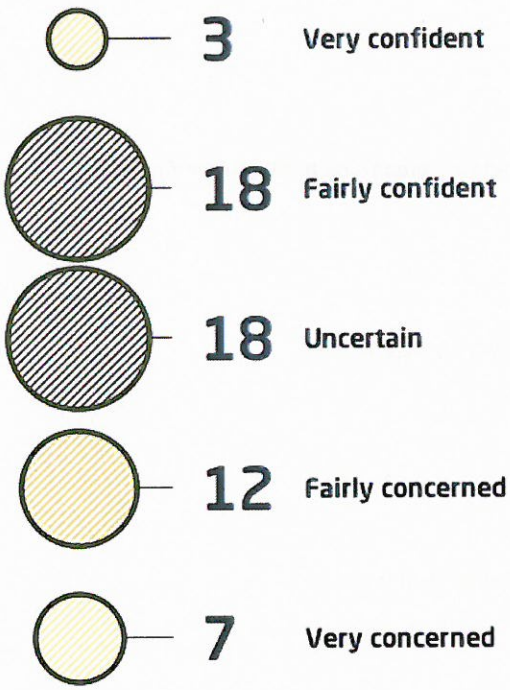
Figure 20: Looking ahead, how confident are you that your organisation will achieve financial balance in 2016/17?





CCG LEADS

Figure 20: Looking ahead, how confident are you that your organisation will achieve financial balance in 2016/17?



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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, 30th July 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: CHIEF EXECUTIVE'S REPORT - The Board is asked to note that a number of reports have been circulated including: a. Kings Fund Report - http://www.kingsfund.org.uk/publications/better-value-nhs/summary b. Carter Review - attached c. Rose Review - attached d. Care Closer to Home Tender Update - update will be given at the meeting.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board will note that a number of reports have been circulated separately including:
a. Kings Fund Report - please use the link: http://www.kingsfund.org.uk/publications/better-value-nhs/summary
b. Carter Review - copy attached
c. Rose Review - copy attached
d. Care Closer to Home Tender Update - a further update will be given at the meeting.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to note and comment on the circulated reports.

Appendix

Attachment:

COMBINED CHIEF EXECUTIVES REPORT.pdf

Review of Operational Productivity in NHS providers

Interim Report June 2015

An independent report for the Department of Health by Lord Carter of Coles.

Content

Foreword

To: Jeremy Hunt, Secretary of State for Health

Since its creation almost 70 years ago, the NHS has consistently looked to the future and led the world in the delivery of innovative and cost effective healthcare that helps people to live longer healthier lives. The introduction of new drugs and technologies, the committed and highly skilled workforce that delivers our modern health service and the fact that people are living longer in this country than ever before are all testaments to the continued success of the NHS.

However, while we celebrate this great achievement we must also recognise that our advances put great pressure on our finances and therefore we need evermore focus to ensure that the precious resources of the NHS are utilised as effectively as possible. I therefore have pleasure in submitting to you an interim report of my review of operational productivity in NHS hospitals in England, which you asked me to undertake.

We should also celebrate that in England we have some of the best hospitals in the world both in terms of quality, innovation and operational efficiency. The great challenge we face is to lift hospital efficiency to a consistently high standard in every area of every NHS hospital and, where we already perform well, innovate to improve further.

Whilst I am reluctant to set detailed targets, I believe from the data so far available we could look to savings of up to £5bn per annum by 2019/20 provided there is political and managerial commitment to take the necessary steps and funding to achieve these efficiencies. I believe up to £2bn could be delivered by improving workflow and containing workforce costs. Amongst other things, this includes increased productivity through having a stronger management grip on non-productive time (for example annual leave, sickness and training), better management of rosters and improved guidance on appropriate staffing levels and skill range for certain types of wards. I think a further £3bn could be delivered from improved hospital pharmacy and medicines optimisation, estates and procurement management (£1bn from each) by adopting best practices and modern systems for

example, creating a tightly controlled single NHS electronic catalogue for products purchased by hospitals. I am confident that within the next few years NHS Hospitals will go further than this by truly focussing on workflow and new ways of working leading to a significant change across the service that will deliver even greater efficiencies.

From the evidence received so far, I do not think there is any one single action we can take but I do believe there are significant benefits to be gained by helping hospitals, using comparative data, to become more productive. We have based this on examining workforce, hospital pharmacy services and medicines optimisation, estates management and procurement and observing how improved workflow in hospitals enhances both quality and productivity. Workforce costs is a particular priority; just 1% improvement in workforce productivity could represent as much as £400m in savings.

In formulating my early thoughts, I have found two of the key obstacles to be lack of quality data and the absence of metrics to measure relative performance. Accordingly, my first recommendation at this point is for the NHS to adopt and use the 'Adjusted Treatment Index' (ATI) developed with the cohort of 22 hospitals we have been working with. It is my belief that the ATI metric can serve as a barometer by which hospitals can compare themselves with their peers, taking account of complexity of care provided, and more importantly be a baseline for future improvement.

I have also concluded there is a need for a model to define what an efficient NHS hospital looks like. A 'model hospital' can show how good clinical practice, workforce management and careful spending lead to measurable efficiency improvements whilst retaining or improving quality. This is not a new concept, but coupled with the ATI metric, I believe we can bring it to life.

I am grateful to those who have worked on the project, particularly those 22 NHS hospitals who have engaged enthusiastically - and for the wise counsel of my NHS Procurement and Efficiency Board. I am now engaging in detailed conversations with the 22 to explore and confirm the opportunities outlined in this report and will provide a fuller update in the Autumn.

Yours sincerely

LORD CARTER OF COLES

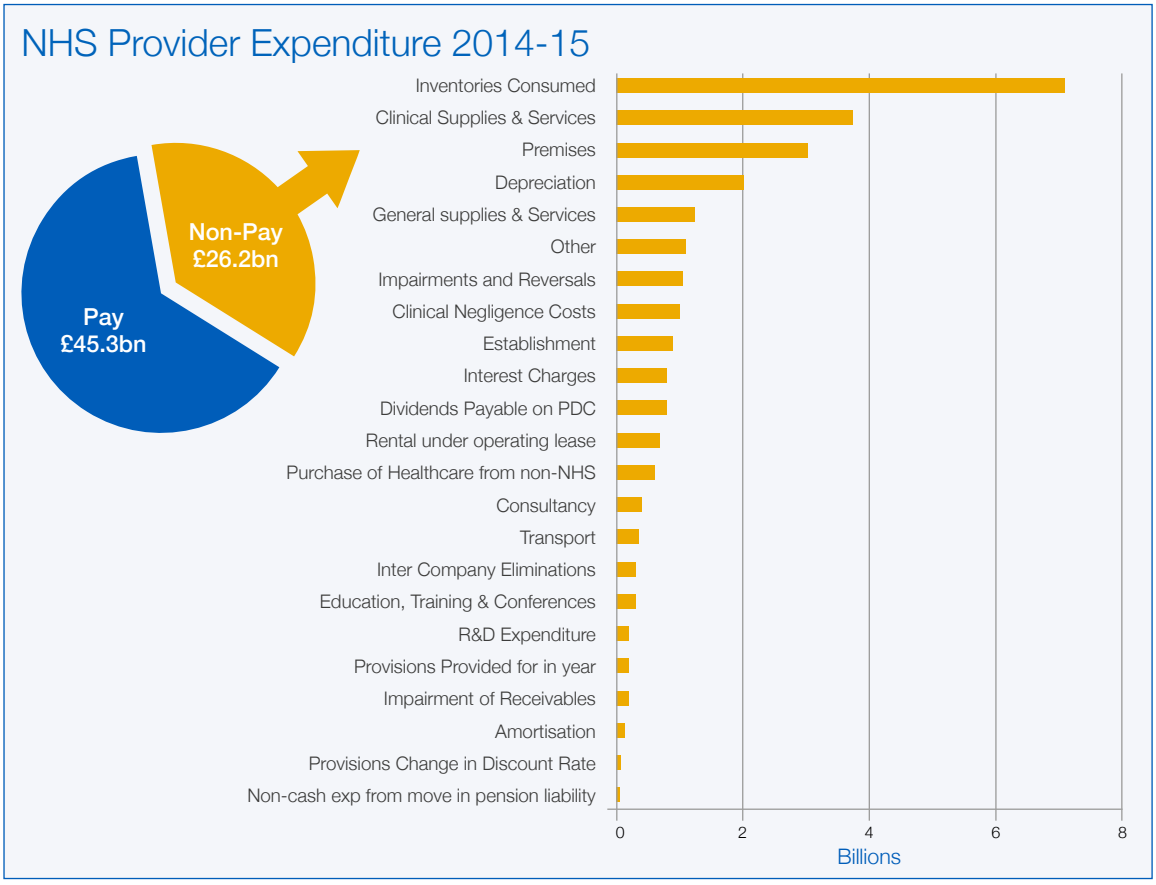
The NHS Efficiency Challenge

The NHS Five Year Forward View, published by NHS England last year, laid bare the financial challenges faced by the NHS over the next five years. To sustain a comprehensive high-quality NHS, it concluded that action is needed on three fronts – demand, efficiency and funding. Less impact on any one of these fronts will require compensating action on the other two.

The report highlighted that the NHS' long run efficiency performance has been 0.8% annually. This has risen to 1.5-2% in recent years largely due to pay restraint, but the NHS needs to repeatedly achieve 2% net savings for the rest of the decade (perhaps rising to 3% by the end of the period). The report identified the subsequent gap to be of the order of £22bn.

These are unprecedented challenges for the NHS. If they are to be achieved, we need to create a culture of relentless cost containment with a forensic examination of every pound spent in delivering healthcare. Everyone must play their part – from executive boards and managers to nurses and clinicians. No stone should be unturned and nothing sacred or exempt from examination.

In 2013-14 NHS hospitals spent £72bn to deliver healthcare to patients and £45bn of this was spent on workforce (63% of the cost).

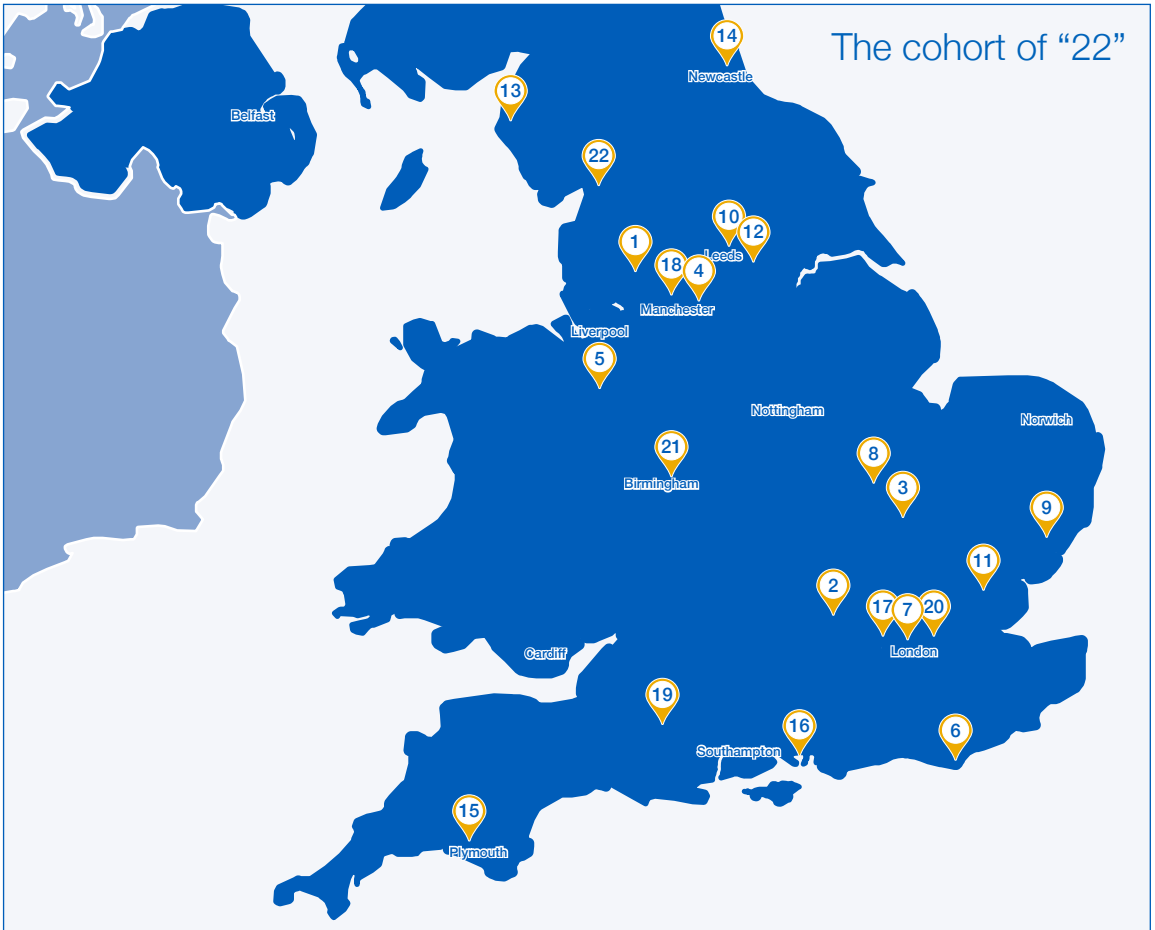


It is our view that unless workforce management and productivity are addressed, all other areas of opportunity pale into insignificance. Thus said, there is no one single action that can be taken and all areas of expenditure require close scrutiny if the efficiency challenge is to be met.

Our Approach

The NHS does not have a consistent approach to measuring efficiency, and so our aim was to develop an appropriate metric for NHS hospitals to compare themselves with their peers and help them identify opportunities for productivity improvement. We call this metric the **Adjusted Treatment Index** (ATI).

To develop the ATI and to learn from its application, we selected a cohort of 22 NHS hospitals to work with us. They are representative of different types and sizes of acute hospital ranging from large inner-city teaching hospitals to rural district general hospitals.



1 Bolton NHS Foundation Trust

2 Buckinghamshire Healthcare NHS Trust

3 Cambridge University Hospitals NHS Foundation Trust

4 Central Manchester University Hospitals NHS Foundation Trust

5 Countess of Chester Hospital NHS Foundation Trust

6 East Sussex Healthcare NHS Trust

7 Imperial College Healthcare NHS Trust

8 Hinchingbrooke Healthcare NHS Trust

9 Ipswich Hospital NHS Trust

10 Leeds Teaching Hospitals NHS Trust

11 Mid Essex Hospital Services NHS Trust

12 Mid Yorkshire Hospitals NHS Trust

13 North Cumbria University Hospitals NHS Trust

14 Northumbria Healthcare NHS Foundation Trust

15 Plymouth Hospitals NHS Trust

16 Portsmouth Hospitals NHS Trust

17 Royal Free London NHS Foundation Trust

18 Salford Royal NHS Foundation Trust

19 Salisbury NHS Foundation Trust

20 University College London Hospitals NHS Foundation Trust

21 University Hospitals Birmingham NHS Foundation Trust

22 University Hospitals of Morecambe Bay NHS Foundation Trust

All 22 hospitals have been impressively helpful and supportive, providing detailed information to allow us to assess the variations we were finding from the ATI data. We have engaged with a wide range of professionals from Finance Directors and Directors of Nursing, through to Chief Pharmacists and Heads of Procurement and Estates, exploring and understanding the variances we are seeing between hospitals.

Each hospital in the cohort received a pack of information containing the ATI analysis along with observations on the variances. This helped them identify opportunities for improving productivity, and has served to confirm the plans and thoughts they have in place for meeting the efficiency challenge. We are now in the process of visiting and speaking to each of the 22 to determine whether they believe the efficiencies can be realised.

To provide governance, guidance, support and advice, we established a Procurement and Efficiency Board made up of senior executives from the Department of Health, the NHS, and other Government departments (including the Cabinet Office and Treasury), as well as leading subject matter experts directly relevant to hospital efficiency or experience from other sectors where the programme could learn and benefit. The board has provided valuable advice on ways to improve hospital efficiency including national and international best practice from healthcare and other sectors.

"We have hugely valued being engaged in the work Lord Carter is leading. It is helping us address the financial challenges we are facing. We particularly appreciate the assistance the programme is providing to help optimise workforce effectiveness."

Tony Chambers,
Chief Executive of the Countess of Chester NHS Foundation Trust

"Any opportunity to transform the way we deliver services to patients is invaluable. That's why the work being undertaken by Lord Carter and his team is so important to us and why we are so keen to realise the benefits that it can help us deliver"

Sir Ian Carruthers,
Chair of Portsmouth Hospital NHS Trust

The 'Adjusted Treatment Index' and early reflections

The Commonwealth Fund Report 'Mirror Mirror on the Wall' rates the NHS as the most cost-effective health system in the world in terms of value for money for the taxpayer[1], but are our hospitals as efficient as their overseas colleagues in the day-to-day delivery of healthcare? To answer this question we need a measure of hospital efficiency.

Hospitals and hospital chains all over the world have adopted a common set of metrics to monitor and improve the productivity of their operations. Other countries have long since adopted measures of efficiency such as cost per adjusted admission to provide a consistent and accepted currency with which they can compare the relative performance of their hospitals. There is clear evidence that by adopting such an approach productivity improves – and until now we have not had a suitable metric for the NHS, so we have no way of comparing NHS hospital efficiency. By adopting the ATI, the NHS will be able to measure hospital efficiency and will align with global best practice.

We therefore set out to develop an appropriate metric for the NHS to allow hospitals to compare themselves with their peers, and help them identify opportunities for productivity improvement. We also set out to develop a process that supports hospitals on the journey of self-improvement; identifying those areas where support mechanisms, be they local, regional or national, might be needed. And finally we have been exploring how we could industrialise and embed the approach so that hospitals are able to regularly monitor their productivity improvement month-on-month, year-on-year.

In developing productivity metrics for the NHS, we have to account for hospitals of differing sizes, in differing geographies, and with varying degrees of complexity. Once we agree on a common method of measuring outputs, we can then apply it to the relevant inputs (for example, operating expenditure) to measure productivity. We have now developed such a metric – the **Adjusted Treatment Index**. Appendix 1 explains how the metric is derived, and an external technical assessment by subject matter experts has confirmed its appropriateness for use in the NHS. We believe the metric can be applied across the whole of the NHS and not just the acute sector.

Generating the ATI from nationally available data such as operating expenditure in hospitals' accounts has revealed variances between hospitals, and we need to determine whether these variances can be explained simply by differences in practices, or whether they are genuine opportunities for efficiency improvement. This is why we have spent considerable time gathering line level detail in key expenditure areas from the 22 hospitals and talked continuously to professionals in the NHS over the last six months to identify leading practices that appear to underpin better performance.

Our early findings are leading us to conclude that most NHS hospitals can demonstrate good practice in some areas, but all have room for improvement. One thing is clear; there is no silver bullet for delivering the efficiencies outlined by Five Year Forward View. Instead, it requires a relentless focus on a multitude of efficiency opportunities which when combined, have the potential to make a significant contribution to the £22bn.

[1] http://www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror

The Efficiency Opportunity

We have generated the ATI metric in a number of ways from nationally available data. Our main approach is to follow the money focusing our efforts on four major areas of spend:

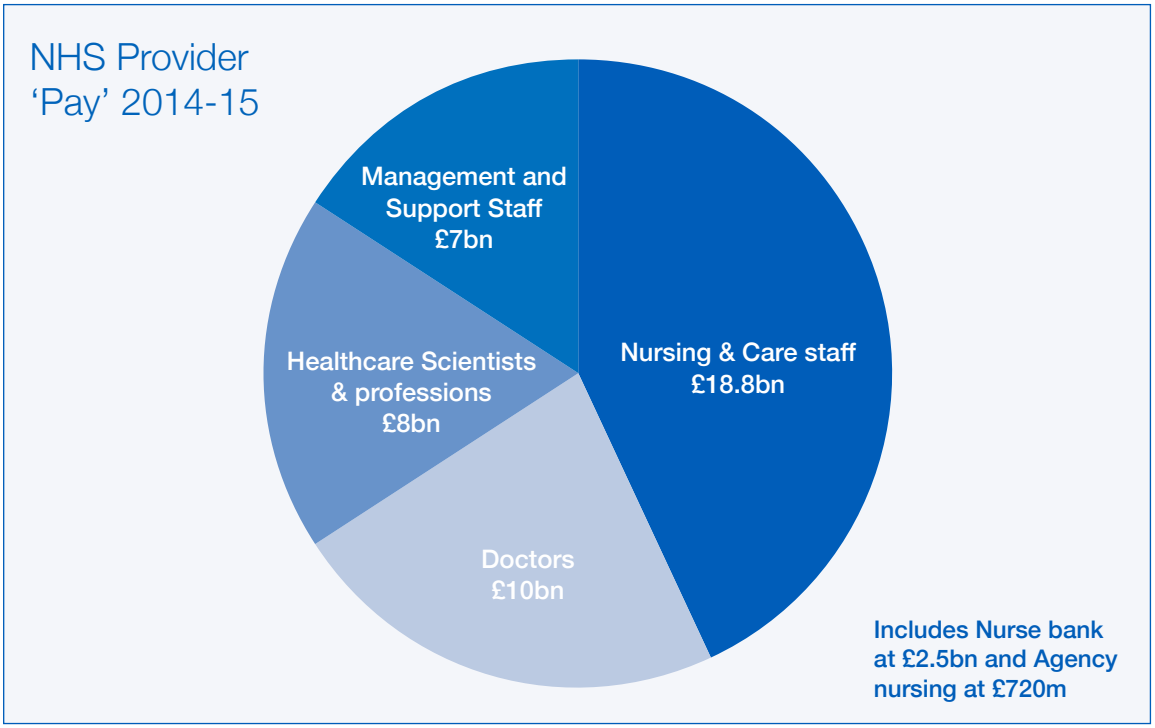
- Workforce
- Hospital Pharmacy and Medicines Optimisation
- Estates Management
- Procurement

For each of these areas, we have collected detailed data and information from the 22 hospitals to understand variances and good practice. Early indications for each area are below.

Workforce

The NHS employs 1.3 million staff performing over 300 different types of jobs across more than a 1000 different employers. These staff are the primary asset, heart and soul of the NHS. We know that most work extremely hard, often going above and beyond the call of duty, and are truly dedicated to the NHS to ensure the delivery of high quality care.

However, the pay bill for the NHS in 2013/14 was £45.3bn – the largest area of spend, so the sheer size of this necessitates scrutiny. Our early findings with the 22 hospitals have established significant differences between them in terms of the management of productive time, workforce rostering, effective utilisation of clinical time and management costs. Tight management of annual leave, sickness and use of appropriate training can account for differences of up to 4% in productive time and when you consider just 1% improvement in workforce productivity could represent around £400m in savings, it is easy to see why a stronger grip on workforce management can make a significant difference to costs.

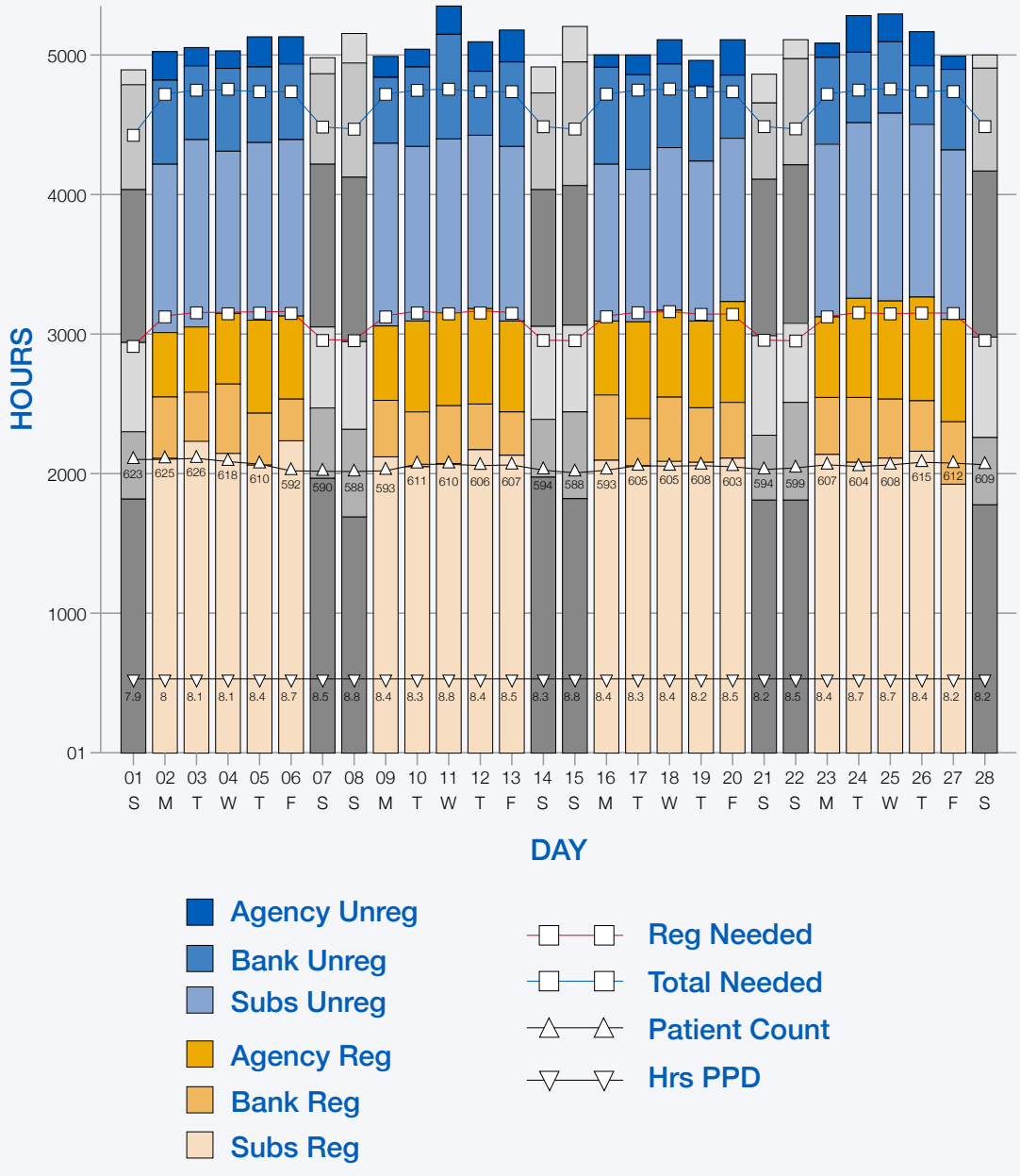


In 2013-14, the cost of nurses in the NHS was £19bn. With the increased focus on safer staffing and a 29% increase in the rate of nurses leaving the profession in the last two years, the dependency on agency nurses has risen significantly, doubling between 2012-2014[2].

The Secretary of State has already announced measures for addressing agency contract spend, including placing a cap on agency rates, and we need to place more focus on the root causes of the increased demand for such services.

Working with the cohort of 22, we collected data from nursing rosters from every ward for the whole month of February this year. This included hours worked (split by registered and unregistered nurses) and staff type – for example substantive, bank and agency staff. An example of the data from one hospital is below.

Example NHS Hospital Nurse Roster Analysis



[2] RCN Frontline First (February 2015) - http://www.rcn.org.uk/__data/assets/pdf_file/0005/608684/FF-report-Agency spending_final_2.pdf

This shows the hours worked by staff group plotted against the patient count highlighting the nursing hours per patient day. It identifies that on many days, there are not enough registered nurses and that there are also more staff than required against the patient count.

We also collected information and policies from each hospital and this has revealed differences between them. For example, non-productive time for nurses can vary from 22% to 26%, and there is considerable variation in how hospitals manage 'specialling' patients (one on one care), roster practice and flexible working policies.

We also identified that in some hospitals bank nurses are not remunerated in a way to attract them from going to or moving from agencies.

One provider examining their non-productive time found that sickness had crept up over recent years and was now 1.5% over the national average.

One provider established that it had 27 more nurses than it needed by examining their policies, comparing themselves to their peers and undertaking a skill mix review.

All of this leads us to assume there may not be enough nurses to meet the post-Francis demands of the NHS, and there are inequalities in how nurses are utilised with many nurses working longer hours than they are contracted for. Also, over and under-rostering suggests an over-flexibility in management practices. We are also aware of nurses being over-burdened with administrative duties for example in dealing with supplies issues that should be taken care of through better procurement and logistics management.

Over a 5 month period, across five NHS providers in a major conurbation, between them they used over 24,000 Agency workers- 25% of these also work in substantive posts, with over 4% working as agency workers in their own organisation.

One provider has identified that delays in the 'time to fill a vacancy' increased the need for agency staffing in order to meet safe staffing levels. A review of the recruitment process including pre-employment checks and health screening has resulted in the identification of provider 'hotspots'. A monitored action plan now tracks progress on resolving the delays.

One provider identified 20 cases of counter fraud when they reviewed and strengthened their sickness and annual leave reporting. Annual leave overpayments totalled £10,500 in one month alone. By tightening up on excess annual leave, sickness, flexible working practices, underutilisation of hours worked and rostering practice, the provider aims to deliver £750,000 savings this year.

Detailed examination of 2 of the 22 hospitals has identified there are clear opportunities in managing annual leave – the largest part of non-productive time is not systematically managed. Operational measures are not always visible across different wards and is not up to the Board which leads to weak management of the workforce.

Having said this, we have found some excellent examples of good practice where utilisation of substantive staff is optimised thus reducing reliance on bank and agency staff.

Workforce management good practices

- Regular review on appropriate headroom levels.
- Regular review of flexible working arrangements.
- Reviewing the incentives to ensure substantive staff work substantive shifts.
- Assisting workforce planning and rostering by promoting the use of eRostering systems and the adoption of best practice roster policies.
- Improving guidance on appropriate staffing levels and skill mix for particular ward types in collaboration with RCN and NICE.
- Reviewing the demand and supply of additional nursing hours, particularly with respect to specialling care.

Salford Royal NHS Foundation Trust used a '90 day innovation cycle' to test radically different approaches to delivering specialling with the aim of improving one-to-one care whilst reducing costs. From the start of this patient centred project a reductions in the cost of 1:1 care was seen. Salford Royal are anticipating a trust-wide saving of over £1m per year based on the results of the first few months.

We have also been looking at clinical productive time and management costs. At the highest level we are finding significant variances between hospitals in these areas.

Reviewing the management costs using the ATI metric across all NHS Hospitals has revealed a ten-fold difference; this requires further investigation over the coming months. One such area to explore will be the use of shared services for back and mid-office functions.

We need to gather more detailed data to understand these differences and will report further later in the year.

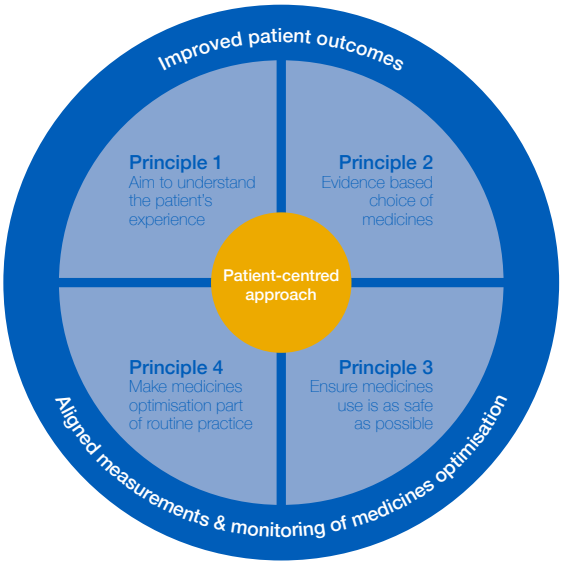
Hospital Pharmacy & Medicines Optimisation

Medicines are the most frequently used intervention in healthcare. In 2012/13, expenditure on hospital medicines was over £6.5 billion, accounting for 36.5% of total NHS medicines expenditure. Showing a rise of 11.1% over the previous year. Medicines use is increasing due to advances in medical technology and an ageing population. Medicines optimisation is a new and patient-centred approach to getting best outcomes and value from medicines.

The average cost of soluble Prednisolone is over £1.50 per tablet. The insoluble version of Prednisolone costs less than £0.02 per tablet. In reserving the use of soluble Prednisolone for paediatric patients and adults with swallowing difficulties as much as £40,000 a year is being saved by Bolton NHS Foundation Trust. We are now working with other providers to see if similar savings can be made.

There is large variation in the cost of inhaled anaesthetic gasses. By ensuring longer acting gasses are used for inpatients and shorter acting gasses are reserved for day-patient and more complex cases, early findings suggest that the cohort of 22 providers working with us may make a combined saving of as much as £1 million annually. When extended to the rest of the NHS, this approach could save many millions.

Summary of the Four Principles of Medicines Optimisation[3]



Optimising the use of medicines is recognised as a key role undertaken well by pharmacy teams which can lead to better outcomes, including improved safety whilst reducing waste and getting consistent, best clinical practice, thereby reducing variance and improving patient care. A wide range of approaches are already employed to deliver best value for money for medicines but there is a considerable amount of variation in the provision of hospital pharmacy services across the country.

We have gathered data from a number of sources to explore the difference between hospitals, and early evidence is showing us that there are variations in prescribing of medicines and variation in pharmacy staffing numbers, skills mix and deployment. A range of opportunities are starting to emerge for greater productivity whilst maintaining or improving outcomes.

The greater uptake of the use of electronic systems for medicines procurement may reduce the variation in stock holding levels between providers. Wider use of the national summary care record (SCR) will improve the quality and safety of medicines reconciliations. Use of the SCR could also save up to 50% of the time taken to confirm an accurate drug history for each patient.

Evidence is also emerging of the opportunities of innovative practices in individual hospitals where changes to traditional practices including prescribing, administration of medicines and logistic systems have delivered system wide efficiencies and supported:

- Urgent and Emergency Care pressures (pharmacists in the Emergency Department)
- Healthcare Professional shortages (Changes in Junior Doctor commissions being managed by increased use of pharmacist prescribers & alternative models for medicines administration where nursing staff cannot be recruited)

Opportunities to drive greater safety are also being identified as part of our work in areas such as the safe use of non-steroidal medicines by improving compliance with current NICE best practice recommendations to reduce the incidence of adverse cardiac events.
One thing has become clear, there is

By changing behaviours and moving to less expensive dry powder inhalers for respiratory conditions instead of higher use higher cost CFC free inhalers, an estimated £1 million can be saved across NHS hospitals.

no single initiative that will deliver major efficiency savings in the pharmacy and medicines area. Rather, system wide changes, including the use of a series of decisions and smaller initiatives such as those listed that when combined can make a significant contribution to the efficiency challenge when effectively shared across the wider NHS.

[3] http://www.rpharms.com/promoting-pharmacy-pdfs/helping-patients-make-the-most-of-their-medicines.pdf

Estates Management

The NHS operates over 1,200 hospitals as well as nearly 3,000 other treatment facilities, many of which operate 24/7 every day of the year. The occupied floor area of the NHS is nearly 25million m2 which is the equivalent of nearly 3,500 football pitches and costs over £7 billion per annum to run including the labour cost of over 88,000 staff.

The NHS estate has to be maintained to high standards to ensure a safe, clean patient environment for the delivery of health care whether part of our older estate, or new facilities such as the state of the art Proton Beam Therapy Treatment Centres being built in Manchester and London. The bill for cleaning alone costs the NHS over £900 million per annum.

The £50m NHS Estates Efficiency Fund is on track to deliver savings of 100.6 Mkg of carbon dioxide per year and some 2.4 % of the entire 2012 NHS building energy related carbon footprint. Savings for this project will add up to £69.8m in the first five years of operation.

With such diverse estates spread across cities and rural locations, the cost drivers vary widely and include size, age, condition, space utilisation, energy efficiency, availability and cost of labour. A detailed understanding of estates operations based on their local situation is required if hospitals are going to deliver greater productivity in this area. We are developing a diagnostic tool to help hospitals obtain a more detailed view of their estate and facilities so they can identify productivity opportunities.

The big picture is that the cohort of 22 spends £1 billion annually on Estates & Facilities. Early indications are that approximately 14.5% potential savings could be made from these costs if the cohort moved to the average efficiency of their NHS peers, which in terms of the overall running costs of the estate and its services, represents a £150 million annual saving. Set out below are some examples of the savings that could be made within the £150 million:

- Cleaning: £10 million;
- Energy £12 million;
- Building & Engineering £12 million;
- Laundry £4 million;
- Waste £3 million, and;
- Water & Sewage £1.7 million.

During a recent merger between two NHS providers, it became apparent that one provider's energy costs were much greater than the other's. Further investigation revealed that this was down to the excessive use of oil because of the age and condition of the boiler, and they were not aware it was out of kilter in its energy until the merger. Year on year budget setting had topped up the estates budget to meet the rising costs of the demand for oil. This demonstrates the power the ATI metric can have in helping providers recognise where they become outliers, and encourage them to act to bring their costs back in line.

By generating the ATI metric and reviewing the data all hospitals submit as part of their ERIC[4] returns, we believe there is potential for improvement. For example, in terms of total running costs if all hospitals reduced costs to match the average of their peers, the NHS could save several hundred million pounds. We need to do more to understand this opportunity. Accepting there will always be differences between hospitals in this area, simple comparisons do reveal opportunities.

Procurement

After considering workforce, medicines and estates, the remainder of operating expenditure in the NHS is traditionally viewed as 'procurement' – some £9bn each year which can be broken down to three main areas:

- Everyday consumables – dressings, syringes and so on (around £2bn)
- Hi-value medical devices – hip joints, cardio devices and so on (around £3bn)
- Common goods and services – transport, stationery and so on (around £4bn)

The values above are estimates because data on volumes and prices paid for products and services is patchy. We know this because we collected all accounts payable and purchase order data from the 22 hospitals for the last two years and only 18% could be matched.

We also know inventory management practices and the adoption of electronic catalogue systems vary significantly across hospitals, with both good and bad practice. This makes it difficult to obtain reliable information on volumes of products used by hospitals thereby negating meaningful comparisons using the ATI metric. However, we do believe there are greater savings to be had by managing the demand for products through better inventory management rather than price reductions. And we do think a target of £500m – 1bn savings on the £9bn procurement spend is realistic.

Every day Consumables

In the procurement of supplies we know that global best practice for everyday consumables is a catalogue of around 6,000 – 9,000 product lines with price variances of 1-2%. In the NHS it is as much as 500,000 lines with price differences sometimes over 35%.

We also know that hospital systems around the world have strong adherence to a 'core list' of products with compliance levels of over 90%. Furthermore, if any product is changed on the list, compliance levels of over 80% are achieved within a month of implementation. In a devolved NHS we do not have this level of compliance with hospitals making their own decisions about what they want to use – thus reducing the opportunity to use NHS purchasing muscle with suppliers.

The NHS Supply Chain contract was not set up to deliver this kind of approach. Instead we have pursued a retail type model without commitment from hospitals which has led to the proliferation of products used across the NHS. We have already taken steps to address and will explore how we can align with global best practice. We have been working with Chief Nursing staff across the NHS and the Royal College of Nursing to see if we can agree a radically reduced range of products to be channelled through NHS Supply Chain. Early indications are that such an approach will deliver 10-20% savings on the NHS everyday consumables bill.

High-value medical devices

We estimate the NHS spends around £3bn on products and consumables where clinicians make choices for their patients. Whilst we would always acknowledge that clinicians must retain the authority for making such decisions, we do believe that such choices could be better informed. Often times, such decisions are made between clinicians and sales representatives from the medical companies without proper recourse to all the facts and evidence.

[4] ERIC - The ERIC (Estates Return Information Collection) is collected and published by the HSCIC on behalf of the Department of Health. It is the main central data collection for estates and facilities services from the NHS containing information dating back to 1999/2000

Our collaborative work with Professor Tim Briggs, Orthopaedic Surgeon at The Royal National Orthopaedic Hospital Stanmore and previous President of the British Orthopaedic Association, has identified huge variations in practice and outcomes in terms of device and procedure selection, clinical costs, infection rates, readmission rates, and litigation rates in the discipline of orthopaedics. There is scope to address many of these variations to drive short, medium and longer-term improvements in quality through adopting best practice and reducing costs to generate efficiency savings across the NHS. The evidence and data surrounding this work is robust and compelling, and was verified by Professor Tim Briggs in his 'Getting it Right First Time' Report published 16th March 2015[5].

We have been working with Professor Tim Briggs to look at the types used and review the prices paid for the most commonly used implants. A review of a sample of prices across a sample of hospitals established that there is significant variation as illustrated in the table below:

Prosthesis type	Lowest price	Highest price	% Variation
Primary cemented hip with an acetabulum, femoral stem, and metal femoral head.	£595	£854	44%
The cement restrictor and three mixes of antibiotic loaded cement (including the mixing system).	£123	£270	120%
Primary uncemented hip with an acetabulum, polyethylene liner, femoral stem and metal femoral head.	£1,266	£1,977	56%
Primary uncemented hip with an acetabulum, polyethylene liner, femoral stem and ceramic femoral head.	£1,457	£2,219	52%
Primary uncemented hip with an acetabulum, ceramic liner, femoral stem and ceramic femoral head.	£1,636	£2,420	48%
Hybrid primary hip with a cemented femoral stem, uncemented cup with a polyethylene liner, and a metal femoral head.	£1,097	£1,399	28%
Hybrid primary hip with a cemented femoral stem, uncemented cup with a polyethylene liner, and a ceramic femoral head.	£1,288	£1,641	27%
The cement restrictor and two mixes of antibiotic loaded cement (including the mixing system).	£82	£180	120%
Primary knee replacement.	£943	£1,674	78%
One mix of antibiotic loaded cement (with the mixing system).	£41	£90	120%

National Joint Registry Pilot, consisting of data from 35 NHS Providers and Local Health Boards across England and Wales, identified that in some instances, the prices paid do not always have any correlation to the volumes used.

One such compelling example is the fixation method chosen by clinicians for patients, with the average age of a hip replacement being 68 and evidence that using cemented prostheses in patients over 65 can have a direct correlation with reducing revision rates, infection rates and the cost of implants. The type of fixation method used might also contribute towards a hospital making a surplus instead of a loss against tariffs for orthopaedic procedures.

Despite the evidence, we are still seeing the usage of uncemented in over 65s ranging between 0-100%. We took a sample of activity across ten providers and looked at their levels of cemented versus uncemented, and taking the median prices for prosthesis that we established, this identified the following potential savings in prosthesis cost by moving from uncemented to cemented:

[5] A copy or the "Getting It Right First Time" report and recommendations published 16th March 2015 can be found here: http://www.boa.ac.uk/latest-news/press-release-girft-report/

*The price range variation illustrated is based upon the most widely used implants as identified from data within the National Joint Registry (2013), with pricing information provided by NHS Supply Chain from mini-competitions for the systems detailed. All mini-competitions included a standard supplier representative service, consigned implant and instrument stock provided by the manufacturer, and commitment to volume over 12 months.

Level of conversion from uncemented to cemented (based on the price ranges illustrated above, and the activity of the sample providers.)	Saving against existing practice based on median price (10 NHS Providers)
If you moved activity so that 90% was cemented at median price plus extra theatre time cost and the rest uncemented at median price, the impact would be:	£799,836
If you moved activity so that 90% was cemented at minimum price plus extra theatre time and the rest uncemented at minimum price, the impact would be:	£1,619,798
If you moved activity so that 70% was cemented at miniminum price, 20% hybrid at minimum price both with extra theatre time cost and 10% uncemented at minimum price, the impact would be:	£1,233,372

If you were to implement this approach nationally, the savings based on the above could range between £11m and £17m. Additional savings would also be delivered (above and beyond the cost of prosthesis) by improving quality outcomes, and reducing revision and infection rates.

This is not to say that robust approaches to procurement at local level can also secure better prices for medical devices such as implants.

Two years ago North Bristol hospital reported dramatic cost savings and improvements in the quality of care for patients undergoing total hip replacement (THR). As the implants are about a third of the cost of a primary THR, an initiative to streamline the number of different types of prosthesis used by the provider was done to increase buying power. This process was also in conjunction with a policy change (agreed by all consultants involved) to perform cemented THRs in patients over the age of 70. As a result of these changes, a nominated lead consultant and management were able to achieve a 20 per cent reduction against previous spending on the implants used, which resulted in a year's saving of £277,000 to the provider. Within 12 months, hip replacement surgery was transformed from a loss of 22 per cent per primary THR, to a surplus of 8 per cent.

This case study was published in the Health Service Journal, see http://m.hsj.co.uk/5078056.article

One of the challenges we face in addressing the costs of high-value medical devices is the relationship between clinicians and representatives of the medical device companies. Whilst there will always be a need for companies to provide clinical support for NHS clinicians (particularly in the use of new and innovative products and procedures) this is often clouded by the need to make sales. The proliferation of sales representatives selling in the NHS is a huge cost which neither the NHS or its suppliers want or need if alternative models of doing business could be developed.

In one hospital, there were 650 sales reps targeting the hospital with 65 on site at any one time. Those sales forces not only have a big influence on choices made – they also have big costs that in the end we pay for.

We are keen to explore new models of doing business. This will require changes in behaviour on both sides. To start this process, we are exploring how we can change the decision-making for choosing medical devices taking learning from global

best practice. This may include the creation of decision-making groups – possibly above the level of individual hospitals – and the use of electronic catalogues. It will also require the creation of national specifications and standards for key product groups.

The Sunshine Act in the US requires manufacturers of drugs, medical devices, biological and medical supplies to collect and track all financial relationships with physicians and teaching hospitals and to report this centrally. The goal of the law is to increase the transparency of financial relationships between health care providers and pharmaceutical manufacturers and to uncover potential conflicts of interest.

We are also looking at incentives and levers for securing clinical engagement in these groups and their decisions. For example, we are exploring whether there is a need for a 'Sunshine Act' similar to that in place in the United States.

Developing a single NHS electronic catalogue

We believe the quickest way to solve the problem of poor procurement data on prices and volumes is to accelerate the implementation of a single NHS electronic catalogue, and so we have been working on a national solution. Our research around the world has told us that the best way to control expenditure on products used in the delivery of healthcare is to have a tightly controlled electronic catalogue in place supported by strict policies so that employees and suppliers know there are no alternatives. We will say more about this work later in the year.

Levels of Inventory held within the NHS are currently circa £800m with an additional estimated £500million of 'consigned stock'. Some hospitals have invested in modern inventory management systems and processes in their theatres, allowing them to manage their stocks more effectively and to allocate costs to surgeons and patients ensuring they have greater control of their costs of surgery. The introduction of GS1 and PEPPOL standards[6] will allow every NHS hospital in England to save on average up to £3 million each year while improving patient care.

An investment by a London provider in an additional supply chain expert led to an immediate cost reduction. In the month before the change over, the Theatre team ordered approx. £75k of inventory – this was consistent with the average run rate. In the following month the ordered inventory reduced to less than £25k and this pattern was sustained over the next 4 months with over £200k (69%) of expenditure avoided (Jun-Sept14). This was achieved by simply knowing what was already in stock and the lead times of suppliers to replenish.

A South West provider invested in an Inventory management system & processes for its 23 theatres enabling inventory held and waste reduction and item level costing and traceability to patient.

The solution is now being used by theatre staff to capture the detail and cost of all items used for surgery, from anaesthetic through to surgical mesh.

All items used are recorded (with product specific codes) against the patient's code and once the operation is over, all the recorded billing materials are checked for accuracy before being committed to the system. This generated an in-year saving of £230K for the first year.

[3] NHS eProcurement strategy - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/344574/NHS_eProcurement_Strategy.pdf

A model NHS hospital

Many hospitals have told us they would welcome more detailed guidance on what good looks like. We therefore believe it would be appropriate to publish, in stages, what a model NHS hospital could look like in terms of operational productivity and cost.

This would include such modules as Emergency Department, different types of wards, operating theatres, pathology, radiology and administration costs. We intend to develop such a model over the summer.

"The idea of creating a modular hospital and using metrics for pay and non-pay costs is a very exciting contribution to clinical teams taking better ownership to deliver better value and better care. There are real opportunities if more national contracts are in place for common use item and easier requesting systems/ processes resulting in more time to care. It is time for bold decisions on service configuration so we have a better balance between access to a substantive workforce and local access to services so patients receive similar if not better outcomes and the taxpayer gets better value"

Ann Farrar, Chief Executive
North Cumbria University Hospitals NHS Trust

Early recommendations and next steps

I was asked by Secretary of State in July last year to review the operational productivity of NHS hospitals to establish the opportunity for efficiency savings across the NHS. Ten months on, I have reached the preliminary conclusion that there are significant efficiencies to be made but there is no magic wand for delivering them. It will require systematic and sustained hard work, with commitment and dedication from staff across the whole of the service from top to bottom, and strong leadership and support from the centre.

I am encouraged that most of the cohort of 22 are already embracing the efficiency challenge. Indeed, some have said to me that our work has been valuable in validating plans they already have for delivering cost improvements in 2015/16.

I still have more work to do over the summer to validate the opportunity and to work with more hospitals to understand the barriers they face in delivering them, and I have already identified a number of issues that need to be addressed. I believe there are three major areas of opportunity:

- The first is about hospitals getting a stronger grip on the utilisation of their resources, particularly in the four categories I have focused on in this report: workforce, hospital pharmacy and medicines, estates management and procurement.
- The second is about achieving greater productivity in hospital workflow (how patients move through the system) and the subsequent use of assets such as theatres.
- The final area is about gaining a better understanding of the need for hospitals to develop sub-acute services- either on their own or in collaboration with others, to facilitate discharge of patients. Nearly all the hospitals I have spoken to highlighted the difficulties they face in discharging patients who were medically fit to leave expensive hospital beds but were unable to discharge them because they had nowhere to go.

Acting upon these areas will enable hospitals to treat more patients at lower cost, and more work is needed to understand how these opportunities can be realised. In the meantime, I have a number of interim recommendations which need to be started to ensure there is no loss of momentum in meeting the efficiency challenge outlined in *Five Year Forward View*.

Interim recommendations

1. Adopt the Adjusted Treatment Index (ATI) across the NHS Provider sector to enable them to review their performance against their peers and create a baseline for improvement.

2. Develop a 'model NHS hospital' to help providers aspire to best practice across all areas of productivity.

3. In workforce, establish standards and best practice policies on productive time, rostering, Specialling and skill range. Embed business process to manage and monitor staff productive time.

4. In hospital pharmacy and medicines optimisation, design a model approach to the delivery of hospital pharmacy services and the supporting infrastructure. The aim will be to deliver increased productivity and value from both hospital pharmacy and medicines, whilst maintaining or improving patient outcomes.

5. In estates, develop a package of support to help providers improve their efficiency to at least the average of their peers, including the creation of a capital programme focused on energy and operational efficiency.

6. In procurement, develop product specification and a single national electronic catalogue for products used in the delivery of healthcare. Explore the need for a 'Sunshine Act' and greater use of sales representative tracking systems.

7. Create national 'productivity collaboratives' around the four categories of workforce, hospital pharmacy and medicines optimisation, estates and procurement to identify and share best practice.

8. There are further areas that require investigation, such as diagnostics (radiology and pathology), IT, clinical IT and moving into primary care areas such as community pharmacy.

Next Steps

Whilst I am reluctant to set detailed targets, I believe from the data so far available we could look to make savings of up to £5bn per annum by 2019/20 providing there is political and managerial commitment to take the necessary steps. I am confident that by adopting the ATI metric, hospital boards will pay greater and more detailed focus to their costs, but I think they will need help and support in delivering the opportunities.

There is a delicate balance to be made between hospitals taking ownership and accountability for their own costs, and the level of support, incentives and intervention provided by the Department of Health, NHS England, TDA and Monitor. It is not my place to decide how this should be taken forward but my own personal thoughts are that a regulatory approach will probably fail to capture the imagination and engagement of hospital boards. It is more important that boards take ownership themselves and collaborate with each other to identify and share best practice. That said, I do believe they need support, and this support needs to be seen as helpful and non-directive.

I am convinced that adopting the approaches I have outlined in this interim report will stand the NHS in good stead for whatever configurations ministers decide should become health policy over the coming months.

Given this, I intend to continue with the work and propose the following steps for the next six months to keep the momentum going:

- Continue to work with the 22 cohort hospitals over the next three months to further identify and begin delivery of the savings already identified.
- Conduct a series of 'learning workshops' over the summer with hospitals to further validate savings to feed in to 2016-17 business planning during the summer.
- Add a further 10 hospitals to the cohort over the summer and take them through the same approach.
- Build a series of 'productivity collaboratives' focused on workforce, pharmacy, estates and procurement.
- Develop the 'model NHS hospital' in readiness for 2016-17 business planning during the summer.
- Develop a plan for creating a 'productivity performance system' for the NHS by October 2015, including the supporting infrastructure needed to industrialise the use of the ATI metric across the whole of the NHS.
- Publish a fuller report on NHS productivity in the Autumn 2015.
- Target early 2016 for the first cut of hospital level productivity data to be published.
- Identify the scale of investment required to ensure the savings are realised.

Appendix A

Adjusted Treatment Index

Data sources and application

At this stage, we have produced annual productivity measures using audited, publicly available data from the NHS Reference Cost collection and from the published accounts of NHS hospitals. We are supplementing this with the data collected from our participating cohort of 22 Hospitals who we are working closely with as representative of a wide range of NHS hospitals with whom we are iteratively developing the NHS Efficiency Metrics. As we move forward, the DH is examining a set of in-year measures using the same outline methodology with improved alternative data sources to enable the tracking of performance within a financial year.

Adjusted Treatment Index – calculation

Calculation of the headline metric requires two steps. Firstly, the volume of each type of treatment delivered by each hospital is weighted by the average cost across all hospitals of each type of treatment. The total of each weighted treatment volume for each hospital represents the cost-weighted output of that hospital, as in the table below:

Calculation 1

Treatment		**Trust 1**		**Trust 2**		**Trust 3**	
Type	National av cost	Volume	CWO	Volume	CWO	Volume	CWO
A	£5,000	2	10,000	8	40,000	1	5,000
B	£2,000	5	10,000	1	2,000	2	4,000
C	£500	10	5,000	1	500	5	2,500
D	£100	50	5,000	1	100	100	10,000
cost weighted output			**30,000**		**42,600**		**21,500**

Secondly, the actual costs of the hospital incurred in producing their cost weighted output is divided by the cost-weighted output. This generates an ATI to enable comparison between hospitals, as in the table below:

Calculation 2

	Trust 1	**Trust 2**	**Trust 3**
operating costs	£31,000	£38,000	£24,000
Cost weighted output	30,000	42,600	21,500
Adjusted treatment Index (x 100)	**103**	**89**	**112**

In this example, hospital 2 has the lowest cost per unit output or, conversely, it generates more valuable output per £ of input.

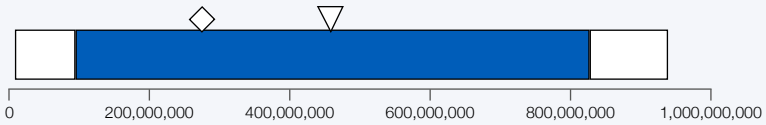
The above tables represent an illustrative example. For our actual calculations, the Cost Weighted Output is derived from the annual NHS Reference Cost Collection. The operating cost figures are taken from the published accounts of the hospital and adjusted for expenditure that is not included in the Reference Cost Collection for example, income for the provision of teaching and research.

We then use progressively detailed financial breakdowns around pay and non-pay costs taking lines from the accounts to arrive at a hierarchy of efficiency metrics that enable NHS hospitals to compare themselves against their peers at a whole-hospital level and at the level of specific cost lines such as workforce, clinical supplies and services, with a line of sight from the headline metric to each of the more progressively detailed metrics.

Level 0 Output Indicator: Total Cost-Weighted Output

Indicator 1 – Cost-Weighted Output | Level 0 Output Measure

OUTPUT
459,674,561



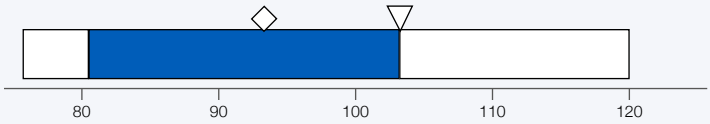
The total cost-weighted output for this provider. This is a measure of total clinical output and not productivity. No adjustments have been made to this figure.

Level 1 Productivity Indicator: Total Operational Expenditure

Indicator 2 – Operational Expenditure / Cost-Weighted Output | Level 1 Productivity Metric

METRIC
102.12

ADJ SPEND
£469,411



POSITION
148
/158

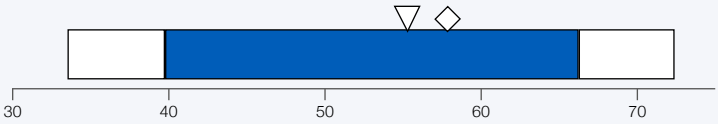
Operational Expenditure divided by cost-weighted output to produce a measure of productivity. The Operational Expenditure figure has been adjusted for clinical and non-clinical outputs not covered in Reference Costs. The Market Forces Factor has also been applied. The metric value has been multiplied by 100 for presentation.

Level 2 Productivity Indicators: Operational Expenditure Breakdown

Indicator 3 – Pay Spend / Cost-Weighted Output | Level 2 Productivity Metric

METRIC
54.53

ADJ SPEND
£250,678



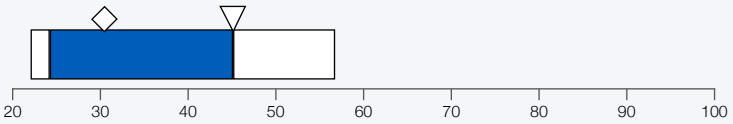
POSITION
48
/158

Pay Spend divided by cost-weighted output to produce a measure of productivity. The spend figure has been adjusted for clinical and non-clinical outputs not covered in Reference Costs. The Market Forces Factor has also been applied. The metric value has been multiplied by 100 for presentation.

Indicator 4 – Non-Pay Spend / Cost-Weighted Output | Level 2 Productivity Metric

METRIC
44.43

ADJ SPEND
£204,242



POSITION
155
/158

Non-Pay Spend divided by cost-weighted output to produce a measure of productivity. The spend figure has been adjusted for clinical and non-clinical outputs not covered in Reference Costs. The Market Forces Factor has also been applied. The metric value has been multiplied by 100 for presentation.

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Better leadership for tomorrow

NHS Leadership Review

Lord Rose

June 2015

Contents

Foreword

Early in 2014 the Secretary of State for Health, the Rt Hon Jeremy Hunt MP, asked me to review what might be done to attract and develop talent from inside and outside the health sector into leading positions in the NHS; and to recommend how strong leadership in hospital Trusts might help transform the way things get done and to report my findings by the end of the calendar year, which I duly did. Early in 2015 the Secretary of State requested that I extend this report to consider how best to equip Clinical Commissioning Groups to deliver the *Five Year Forward View*, which had been published late 2014[1].

I started this Review in March 2014. I have met and listened to a wide range of stakeholders at meetings, briefings, visits and roundtables (details of this are contained at the end of this report). I have also read a significant amount of literature. I focused my attention on acute and secondary care (both NHS Trusts and Foundation Trusts, referred to together in this document as Trusts) as well as commissioning: there is no specific coverage here of primary care. There are specific recommendations for those in leadership positions within commissioning and provider organisations but in reality many of the recommendations are for the whole of the NHS.

I would make the following observations:

[1] *Five Year Forward View*, (October 2014), NHS England, www.england.nhs.uk/ourwork/futurenhs/5yfv-ch1/

- First, the NHS consistently delivers great service through a committed and passionate workforce of 1.38m staff in England[2]. During my Review I heard many great stories (only a few not so great). Mostly I found staff motivated and focused, often running on goodwill in a tough environment; some places felt more positive than others.
- Second, I saw and heard for myself the massive change that the NHS is embracing post 2012. This change needs to be allowed to settle down. There is genuine concern within the service that further restructuring will be imposed upon the system, which would be unhelpful. This is despite the current Government making no indication of wishing to do so. Through no fault of their own, people are often ill-prepared or ill-equipped to implement the changes asked of them.
- Third, the NHS performs an extraordinary service and is staffed by some extraordinary *people*, but the whole organisation could and should be made more effective by the application of some common-sense tactical and strategic thinking.

What I discovered and the evidence presented to me, would come as no surprise to anyone in any large organisation operating on the same scale. The NHS is not alone in facing the challenges highlighted in this Review.

There must be a shared vision; attention must be paid to its people, and those people must be helped, guided and assessed in their performance and delivery.

[2] NHS Choices, www.nhs.uk/NHSEngland/thenhs/about/Pages/overview.aspx

The recommendations of this Review are made in the areas of training, performance management, bureaucracy and management support.

In making them, I acknowledge that readers may feel review-fatigue; so I have kept this as succinct as possible. I also recognise that the NHS is immensely complex, and that one apparently straightforward recommendation will have many implications and perhaps unintended consequences; but because we are intimidated by complexity and scale there is equally a danger of doing nothing. The way to handle complex matters is to simplify them wherever possible. It is a risk we should take.

This Review is deliberately practical in its enquiry and recommendations. It builds on themes uncovered in the 2013 Mid-Staffordshire NHS Foundation Trust Inquiry[3] (Francis Report) and on other more recent reviews (Dalton 2014[4], King's Fund 2014 and 2015)[5] and the *Five Year Forward View* (NHS 2015); Simply put, this Review aims to make people better qualified to manage and to lead.

It is striking that the NHS has a central resource for quality but not for people, and these recommendations set out to address the fact that the people of the NHS are its main asset. What emerges is a range of recommendations (listed in

[3] *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, Volume 3, Chapter 24- Leadership, page 1545, (6 February 2013), www.midstaffspublicinquiry.com/sites/default/files/report/Volume%203.pdf
[4] *Dalton Review: options for providers of NHS care* (5 December 2014), www.gov.uk/government/publications/dalton-review-options-for-providers-of-nhs-care
[5] *System Leadership: Lessons and learning from AQuA's Integrated care discovery communities* (14 October 2014), The Kings Fund, www.kingsfund.org.uk/publications/system-leadership and http://www.kingsfund.org.uk/publications/leadership-and-leadership-development-health-care

the Executive Summary and in Recommendations), from the promotion of *one vision of the NHS* to an initiative to *cut bureaucracy*: simple enough ideas, tough to implement well on the scale required, and perhaps all the more important because of that.

Everyone should know what great leadership looks like; and even though not every job will require leadership qualities, some parts of every job will. We should not try to prescribe from any particular discipline. We should aim to develop, recognise and reward appropriately leadership qualities across the whole NHS workforce. Leadership qualities should be celebrated across all disciplines and job grades.

We should also recognise that we must work with what we have. A few simple things would make a huge difference: some centralised effort on training; or helping middle managers keep their confidence and focus; or knowing that the top leaders of tomorrow may be doctors, nurses or administrators. At the start of their NHS career, everyone should have adequate training; in mid-career they should have adequate support and clear pathways to progression as managers; and top leaders should have the appropriate support and experience to enable them to make correct decisions.

From my perspective of a manager from the private sector, these recommendations are simple remedies that could make the NHS more effective,

recognising that it is neither private sector nor centralised. Clearly, a patient is not a customer in the same sense, yet any organisation with the scope and reach of the NHS requires strong leadership and management *at all levels and in all parts of the system*. Everything comes down to its people, both right now and in the future: so we must pay attention now if we are to expect results in 10, 15, 20 years. People are long-term.

The recommendations apply to the whole NHS, but they will not and cannot find universal support or answer all issues. However, a way needs to be found to implement them in what is essentially a federation. The development of people and sharing of best practice should not be left to chance. There is much good practice and good leadership out there. I urge the means to share it and to join it up so that best practice may be spread more rapidly.

The NHS is one of our society's proudest achievements, but the challenges it faces could hardly be more daunting. The NHS remains a comprehensive service, free at the point of delivery, regardless of the ability to pay, and funded from general taxation. However, rising demand and treatment costs; the need for improvement in certain kinds of care; and the state of the public finances means that "Simply doing things in the same way will no longer be affordable in the future."[6]

[6] *Government response to the NHS Future Forum report* (20 June 2011), Department of Health, www.gov.uk/government/publications/government-response-to-the-nhs-future-forum-report

The *Five Year Forward View* has a clear vision of what the future should look like; but not enough focus on leadership and skills that will be needed to implement it. I leave you with three questions related to my central themes:

- Leadership is the key to making changes stick. How is great leadership recognised across the NHS?
- How do we find and nurture the people that are needed to lead the NHS over the next 10 years?
- How do we help all NHS staff become the best versions of themselves at work?

This Review offers some answers to these questions.

Lord Rose

June 2015

Executive Summary and Recommendations

The NHS has most of the resources it needs to deal effectively with the issues identified in this review. The key strengths that the Review found include: the commitment of staff at all levels and in all parts of the NHS; the profound goodwill of its stakeholders, and the strong support of its funder, the Department of Health.

The quality of NHS clinical care, which is highly regarded, is not always matched by its ability to identify, assess, and manage its staff consistently. Some of the systems and procedures necessary for this do not exist, or where they do exist are only partially effective.

The level and pace of change in the NHS remains unsustainably high: this places significant, often competing demands on all levels of its leadership and management. The administrative, bureaucratic and regulatory burden is fast becoming insupportable. There are three areas of particular concern:

1. Vision: There is a lack of One NHS Vision and of a common ethos.
2. People: The NHS has committed to a vast range of changes however; there is insufficient management and leadership capability to deal effectively with the scale of challenges associated with these.
3. Performance: There is a need for proper overall direction of careers in management across the medical, administrative and nursing cadres.

Many of these problems are chronic and have been unaddressed over an extended period and by different Governments. Clearly, some of these recommendations are of a strategic nature; others tactical and operational. Several are interrelated and overlapping, as one would expect them to be in a complex organisation.

Recommendations:

There are two pre-conditions that must be met before any of these recommendations can be effected: These are simple and profound:

R1: Form a single service-wide communication strategy within the NHS to cascade and broadcast good (and sometimes less good) news and information as well as best practice to NHS staff, Trusts and Clinical Commissioning Groups.

and

R2: Create a short NHS handbook/ passport/ map summarising in short and/ or visual form the NHS core values, to be published, broadcast and implemented throughout the NHS.

Training:

R3: Charge Health Education England (HEE) to coordinate the content, progress and quality of all NHS training including responsibility for the

coordination and measurement of all management training in the NHS. At the core of this is a 90-day action cycle. HEE must promote cross-functional training in all disciplines and at all levels, coordinating the teaching of management basics such as appraisal, motivation, negotiation and leadership

R4: Move sponsorship of the NHS Leadership Academy from NHS England into HEE

R5: Include accredited/ nominated training establishments as part of a diverse training effort.

R6: Review, refresh and extend (x10) the NHS graduate scheme; establish career pathways, a greater variety of placements and a guaranteed job after three years' training (quality and assessment permitting).

R7: Refresh middle management by training and a more porous approach both from within the NHS and externally (recruitment from, and secondment to, other sectors).

R8: Require senior managers to attend accredited courses for a qualification to show that consistent levels of experience and training have been reached across the NHS. On completion of this course they will enter a senior management talent pool open to all Trusts.

Performance Management

R9: Set, teach and embed core management competencies and associated expected behaviours at each management level.

R10: Establish a mechanism for providing on-going career support for all those in a management role allowing individuals to increasingly take charge and identify their own development needs.

R11: Establish and embed an NHS system of simple, rational appraisal (a balanced scorecard for individuals) supported by a regular course in giving and receiving appraisals as part of the core provision of the single training body. At a senior level, these appraisals should be standardised across the NHS.

Bureaucracy

R12: Review the data demands of regulators and oversight bodies; these can then be rationalised and harmonised in order to produce consistent, clear and simple reporting that does not distract staff from patient care.

R13: Merge the oversight bodies, the Trust Development Agency (TDA) and Monitor.

R14: Spend time, on a regular basis, at all levels of the NHS to review the need for each data returns being requested and to feed any findings to the Executive and Non-Executive Teams to review.

R15: Establish and maintain a clearer system of simple rational appraisal (balanced scorecard for the organisation).

R16: Health and Social Care Information Centre (HSCIC) should develop an easily accessible Burden Impact Assessment template and protocol.

Management Support

R17: Create NHS wide comment boards. Website and supporting technology to be designed and implemented to share best practice.

R18: Set minimum term, centrally held, contracts for some very senior managers subject to assessment and appraisal.

R19: Formally review Non-Executive Director (NED) and CCG lay member activity (including, competence and remuneration); and establish a system of volunteer NEDs from other sectors.

Background to the Review

The NHS has recently undergone one of the largest and most radical changes in its 66-year history in the form of the 2012 Health and Social Care Act ("the 2012 Act")[7] and (two years earlier) *Liberating the NHS*[8]. The 2006 Act as amended by the 2012 Act is the legislation in force at the time of this Review.

This wave of change was designed in part to remove day-to-day management of the NHS from the centre of Government. GPs would commission services and the National Commissioning Board (now NHS England) would be given a mandate from Government that sets out the strategic direction in the form of objectives it must achieve; this would limit micromanagement of the NHS by the Department of Health and distance management of the NHS from Government.

The 2012 Act changed the landscape of the NHS fundamentally. Previously the Secretary of State for Health oversaw the NHS through 10 Strategic Health Authorities (SHAs) that in turn oversaw 151 Primary Care Trusts (PCTs). These PCTs commissioned services from hospitals, GPs and all others providing front-line NHS care. The 2012 Act increased the level of oversight by replacing SHAs and PCTs with a number of new bodies including NHS England which includes four regional commissioning offices, a number of Commissioning Support Units and 27 NHS England Area Teams which oversee Clinical Commissioning Groups (CCGs). Money flows from NHS

[7] Health and Social Care Act (2012), www.legislation.gov.uk/ukpga/2012/7/contents/enacted
[8] *Equity and Excellence: Liberating the NHS*, (12 July 2010), www.gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf

England directly to the CCGs which then purchase care in hospitals, Mental Health and Community Services. Specialist services and primary care services are commissioned directly by NHS England, though this too is changing. Local Authorities can also commission some public health services. New levels of accountability were also created. Devolution of accountability away from the centre of government will take time to work.

Clinical Commissioning Groups (CCGs) are autonomous statutory bodies accountable to their members through a governing body. They work closely with other organisations such as local Health and Wellbeing Boards and NHS England. While CCGs are independent, there are a number of duties that they must fulfil which are set out in the [NHS Act 2006, as amended by the] Health and Social Care Act 2012. In late November 2014 some restructuring of NHS England took place with the 24 area teams outside London being replaced by 12 sub regions[9].

Background to the General Themes:

This is a time of extraordinary and rapid change, and this above all else shapes the evidence gathered here. A clear picture emerges of an organisation with many strengths and opportunities both to control the present and to plan for the future. But the picture also includes significant

[9] www.england.nhs.uk/2014/11/28/director-appointments/

shortcomings in the management of staff, and of a lack of local strategic oversight indicative of broader issues in the NHS.

This ought to be a time for great transformation *without structural reorganisation*: the NHS is facing both urgent and important issues. There is an urgent need for more efficiency savings, increased pressure on services from an aging population with multiple needs, and there are the unintended consequences of medical progress such as people living longer with multiple conditions. There are both risks and opportunities.

In funding, for example, the NHS has been rated by the US Commonwealth Fund as the most efficient health care system in the developed world: the NHS scores highest on quality, access and efficiency; it spends the second-lowest amount on healthcare among the 11 nations surveyed (£2,008 per head).[10] Yet the NHS is now being asked to make further massive savings of the order of those that Sir David Nicholson set out for 2011-2015[11]. There is estimated to be a potential deficit of £30bn by 2020-2021.[12] This is placing NHS staff under greater pressure.

The *Five Year Forward View*[13] is welcome and commonsense. It focuses on three things: *managing demand*, *improving efficiency* and *additional funding*. This thinking has helped to shape the context in which this Review made its

[10] *Mirror, Mirror on the wall, 2014 update: How the US health system compares internationally* (16 June 2014), The Commonwealth Fund, www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror
[11] www.stockport.nhs.uk/websitedocs/2010_11_25_Item_6.PDF page 2: *Department of Health Business plan 2011-2015*, (8 November 2010)
[12] *The NHS belongs to the people: A call to action*, (July 2013), NHS England, www.england.nhs.uk/wp-content/uploads/2013/07/nhs_belongs.pdf
[13] *Five Year Forward View*, (October 2014), NHS England, www.england.nhs.uk/ourwork/futurenhs/5yfv-ch1/

findings. The *Five Year Forward View* brings a long overdue emphasis on prevention and a continuing and renewed commitment to patients being given more control of their own care. As many have pointed out, it is an "adapt or die" message.

The *Five Year Forward View*[14] recognises that there is a funding gap, a need to join up primary care, social care and acute care and show a practical route to making things more efficient. The vision set out will likely cost an extra £8bn, on top of the £22bn efficiency savings the NHS may be able to make on its own, to implement:

> "If the NHS achieves all the efficiencies identified in the plan – an extremely tall order in itself – leaders say that an extra £1.5bn a year above inflation will be needed, or around £8bn in total, to eradicate a £30bn deficit"[15].

The *Five Year Forward View* sets out the need to move away from the short-term answers into longer term more radical solutions. However, it does not dwell on the most important resource alongside money: people.

The story is the same in the 2012 Act. This put clinicians at the centre of commissioning, freed up providers, continued to empower patients, and brought the NHS, public health and adult social care together for the first time in Health

[14] *Five Year Forward View*, (October 2014), NHS England, www.england.nhs.uk/ourwork/futurenhs/5yfv-ch1/
[15] British Medical Journal (1 Nov 2014)

and Wellbeing Boards. The 2012 legislation created a number new structures, including CCGs, and enhanced roles for the Care Quality Commission; and removed others, including SHAs. The 2012 Act presaged radical change, and it is still too early to say if or how those changes will be successful. Yet wherever structures change, people need to be equipped to run them. Equally, the *Five Year Forward View* says little of the challenges for NHS staff from either the provider or commissioning side. A report from The King's Fund (December 2014) makes clear where some of these challenges currently sit:

> Talent management is key. The responsibility for developing future leaders needs to be taken seriously… It is important that a culture of development and support should pervade – one that allows senior leaders the time and space to try new things… one where they are free from the weight of scrutiny and blame that dominates today.[16]

It lists the well-established need to fill gaps in leadership training, to establish an NHS leadership strategy and development plan, and to remove the disincentives to innovate and take risks. The King's Fund report touches on many things noted in this Review: structural uncertainty, the regulatory burden, career development, talent management, and CEO tenure, all issues which have shaped the recommendations here.

[16] *Leadership Vacancies in the NHS: What can be done about them?* (2014), Ayesha Janjua, The Kings Fund,

Findings & Interpretations

There are seven **General Themes** that emerged; the Review grouped the general themes under the following headings:

1. **NHS vision & ethos (*one vision of the NHS*)**
2. **Leading constant change (*one vision of the NHS, its People*)**
3. **Training (*one vision of the NHS, its People*)**
4. **The management environment (*its People*)**
5. **Performance management (*its Performance*)**
6. **Bureaucracy (*its Performance*)**
7. **Trusts (*its Performance*)**

1 NHS Vision & Ethos

There is a huge opportunity here. The NHS has a great story to tell; but there is no focused vision given to the NHS workforce as a whole. The full-time workforce (1.38m) has grown by 160,000 since 2000[17]. There is an opportunity and need to instill an NHS-wide vision along the lines of "shared values – locally delivered".

[17] *Health and Social Care Information Centre, Annual Workforce Census, (2013*), www.hscic.gov.uk/catalogue/PUB13724/nhs-staf-2003-2013-over-rep.pdf

There have been many initiatives announced by successive Governments, most recently the *Five Year Forward View* (2014)[18] and the Dalton Review (2014). It is the aim of this Review to complement their work and to set out the necessary skills needed across the whole NHS workforce in order to make their visions a reality.

An agreed, shared, vision would give the NHS a united ethos and a consistent approach to getting things done. This would have a direct impact on what good leadership looks like, and on how it is recognised and felt. The NHS needs to focus all the more intently on a single ethos and vision to counteract its increasingly devolved structure. This is because the NHS is essentially a federation made up of individual organisations. Each varies by size and geography; and each has an identity shaped by practice and culture. However though there may be different organisations in the system, the leadership skills needed throughout are the same.

Unfortunately at no point has the time been taken to consider the skills and talent needed to drive the NHS system forward together.

The NHS, as a whole, lacks a clear, consistent, view of what 'good' or 'best' leadership look like. In 2013, Sir Robert Francis QC set out in his public inquiry report some of the criteria for what good leadership in healthcare might be, including visibility, listening, understanding, cross-boundary thinking, challenging, probity, openness and courage. Principal among these is "the

[18] *Five Year Forward View*, (October 2014), NHS England, www.england.nhs.uk/ourwork/futurenhs/5yfv-ch1/

ability to create and communicate vision and strategy."[19] This is a set of values that need to be broadcast more effectively within the NHS.

The lack of leadership based on values throughout the NHS has led to some of the most negative comments given to the Review, including; *there is a culture of fear*; *it's all too difficult*; *there is an obsession with targets* and *it is impossible to operate in the current climate of suspicion and change*. Or *What is its plan? What is its vision?*

A lack of good, clear, leadership in some areas is concerning. Some see the NHS, both internally and externally, as full of people making excuses for poor care, passing the buck and shrugging off responsibility. Some people remain afraid to raise concerns fearing that either nothing will happen or that if something does there will be a negative consequence to it. There is a lack of basic training for leaders and managers on how to listen to people and an increased feeling of unconscious pressure being brought to bear to achieve targets at the expense of staff who are willing to raise issues. Greater emphasis is needed now on the skills and development needed to support change and to assist in the delivery of the vision set out in the *Five Year Forward View*.

However, it is not just the lack of leadership that is creating problems. While individual hospitals and Trusts can usually (and rightly) articulate their own vision, for the NHS this seems to be lacking. When people were asked: *what*

[19] *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, Volume 3, Chapter 24- Leadership, page 1545, (6 February 2013),www.midstaffspublicinquiry.com/sites/default/files/report/Volume%203.pdf

does a good NHS look like, what would success be? shockingly there was no single answer. Despite what was set out in the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, many had no answer at all.

Innovative care models depend on people to run them, on porters, receptionists, nurses, consultants, specialists, technicians, therapists, GPs, service commissioners and many others. These care models will never become a consistent and well-understood reality across the UK unless there is a single NHS vision effectively communicated and understood by all NHS staff.

This review also found that there was no consistant clear picture for CCGs of what 'good' commissioning performance looks like. CCGs are new bodies, understandably trying to find their feet; but without such a vision their leaders will find it difficult to secure services of a high standard and, over time, to recruit and retain high quality individuals.

2 Leading Constant Change

The *Five Year Forward View* rightly says: "we detect no appetite for a wholesale structural reorganisation.[20]" This puts it too mildly: there is widespread change fatigue and an irritation that new changes are not given sufficient time to bed in.

[20] *Five Year Forward View*, (October 2014), NHS England, www.england.nhs.uk/ourwork/futurenhs/5yfv-ch1/

A lack of stability is felt across the NHS, with a deep-rooted concern over the many and varied messages sent from the centre of Government. For a number of years there have been a range of initiatives and changes of emphasis: Patient safety and quality of care (Lord Darzi's *High Quality Care for All*[21]); Financial performance (derived from the Foundation Trusts reforms); and Performance efficiency (in light of current financial constraints). In other areas of the system we have seen shifts of emphasis between Local Authority commissioning, centralized commissioning through PCTs and more recently clinical commissioning, with a strong emphasis on a lead role for GPs.

None of these changes have been supported by the deliberate development of the skills needed to deliver them. That needs to be put right, with a greater focus on the whole NHS workforce and on developing the talent and skills of its future leaders: they need to be better prepared for the daily challenges of leading a Trust, a team, a ward, a clinical or specialist group or a CCG [over the long term].

This has implications for leadership (which provides the motivation and inspiration) and management (which provides the implementation). As the Dalton Review (2014) points out, "leadership is key to change" [22]. Strong and capable leadership is key to driving transformational change and often involves taking bold decisions. More support is needed for leaders to develop large-scale

[21] *High Quality Care for all: NHS Next Stage Review Final Report,* (June 2008), Department of Health
[22] *Dalton Review: options for providers of NHS care* (5 December 2014), Theme 5, www.gov.uk/government/publications/dalton-review-options-for-providers-of-nhs-care

change management, strategic and commercial skills and the ability to lead in a networked or group structure are becoming more important.

This is important throughout the NHS, and especially for the relatively new CCG Chairs and leaders, so they can fully implement the vision set out in the *Five Year Forward View*. The current level of support given to CCG Chairs and other senior individuals such as Accountable Officers and Chief Clinical Officers is woefully inadequate. There is no 'step up' for these individuals: either they have the necessary leadership skills or they don't. A systematic way to identify and develop this group is needed. Some CCGs do well planning for the future but instances of this are the exception rather than the rule.

Centrally and throughout the NHS there is concern that more structural change means a greater risk to services being delivered below standard. More generally, some argue that the time to take risks was when the NHS had money, and not now. However, this Review argues that the greater risk now lies in doing nothing.

It is widely accepted that the NHS requires transformation in places: most large scale organisations do. To make changes stick, more stable management is required. There will always be those that accept change in any organisation, and those who do not. The former are invariably in the minority. Leaders must ensure that the organisation understands the

necessity to change, and must find ways to bring their staff along with them. However, to do this, time and head-room are essential.

There are signs of growing frustration amongst those in CCG leadership roles at their inability to 'make a difference': some commented that with the publication of the *Five Year Forward View* they are looking to move from commissioning to provider roles. This frustration needs addressing. The models of care set out in the *Five Year Forward View* require strong leadership throughout the system to implement the vision and change needed.

3 Training

NHS management careers depend too much on chance. Training and development are often sporadic. There is limited investment in systematic leadership training for staff and as a consequence capability suffers which is ultimately poor for the patient.

There are several training institutions responsible for training NHS staff,[23] and no mandatory requirement to use them. A significant number of Trusts therefore develop their own training programmes with the help of external consultants. Many of these are of a high calibre but this plurality of provision results in a lack of consistency in the level of training and development received; both depend on the organisation, the area in which it is located and

[23] For instance the NHS Leadership Academy, Health Education England, the NHS Staff College

the individual ward or part of the hospital itself. This Review has found that all forms of initial training tend to lack a consistent, cross-disciplinary approach.

The NHS recruits high calibre graduate trainees, but the numbers are far too low (approx. 100 per year). Although these trainees receive excellent initial training, they are not subsequently managed, monitored and developed. While they are successfully retained, their potential could be better optimized. Some examples of how this could be achieved could be to develop specific roles for those recently graduated, or for there to be greater encouragement for secondments to a variety of NHS posts such as in a commissioning organisation or role. There does not appear to be the level of communication required between those who may have a need for a first year graduate, the graduates themselves and the NHS leadership academy. A number of organisations commented that they would welcome a first year graduate, particularly in the commissioning sector, but were unable to secure one.

Clinical students are not taught either early enough or in sufficient detail during their training about how the NHS works. Many reported that it took them a considerable amount of time to ascertain how the NHS worked as a whole. Neither is there a clear career development structure for clinicians wanting to take on management or leadership positions. The role of Clinical Director is a key role in a successful Trust and development for those clinicians who wish to take on this challenge must be supported and encouraged. While not all will wish to take on management responsibility, there is still a need for all to be able to show leadership skills.

The key leadership relationships within a Trust are between the Chief Executive, the Clinical Director and Chief Nurse, and between the Chief Executive and the Chair. A crucial relationship also exists between the Executive and the Non-Executive Team. There is a need for each group to undergo cross functional training (that is, training not specific to one area or organisation within the NHS) together to build their capability and resilience as well as their combined ability to lead.

The CCG Chair is the lynchpin of the system. Relationships between CCG Chairs in a geographical area, and between Chairs and their provider organisations, are key relationships. Cross-functional training for local Chairs, their top teams and local providers will build better communication between them.

The level of service integration envisaged in the *Five Year Forward View* highlights an opportunity to take joint training one step further. The creation of training programmes, open to all across the health and care sector would have a significant impact on leadership, in particular on the promotion of good practice and of positive collaboration throughout the system.

The NHS Leadership Academy (NHSLA) provides extensive training for large numbers of provider staff at all levels, but does not enjoy the following or

status necessary to make it the key provider for people development in the NHS. If it is to enjoy that status it needs to be bulked up and given the appropriate credibility and status to deliver. This might best be done under the aegis of another organisation such as Health Education England (HEE): at present the NHSLA is too light for heavy work and too heavy for light work. The NHS Staff College delivers similar leadership training to a diverse group of people including executive and ward teams. It too does not currently have the status or scale necessary for it to become the key provider for people development in the NHS.

Together the NHS Leadership Academy and the NHS Staff College working with other key leadership organisations (the NHS Staff College in particular already works with the British Military) should be able to develop and accredit a number of tailored courses, offered in a variety of lengths to suit the needs of the individual (such as a number of courses the NHS Leadership Academy currently provides) and/or organisation. All must be of a recognised and uniform standard.

Training across the NHS should be more mobile, flexible and agile. A variety of locations are needed with oversight from a single organisation. Training could be provided from other public facilities (eg military, education) already known to provide high quality leadership training.

Senior management development needs to be better served – both for the development of those from within the NHS and those recruited externally. Just

as graduate trainees need to be taught about how the NHS works early in their career, so too should those coming in at a more senior level so that they become effective quickly.

Whilst there should be more, and more consistent, promotion from within, there often appear to be barriers to recruiting externally. Reasons given to the Review were that the NHS is too complicated, the pay too low, or the media perception too negative. The current "fast track" scheme appears an expensive – and as yet unproven - way to develop/attract future top talent in sufficient numbers.

The NHS needs to be more porous, encouraging managers to join from other sectors, or leave to rejoin the NHS later; yet its main effort should be in developing its own. Retaining and developing existing staff will always be more cost effective than filling from outside. The Review found no systematic approach to developing managers and leaders (as there is for instance in the Department of Health or Civil Service more broadly)[24].

There is a lack of permeability or interchange of managers between providers and commissioners, yet the *Five Year Forward View* advocates greater integration. Moreover, CCG staff with a wider demographic view of health rather than an organisational one would be advantageous. Equally, a Trust employee moving to a commissioning organisation would provide the commissioner with a better understanding of the services it procures.

[24] *Civil Service high Potential Stream; A talent strategy for the Civil Service 2013/14 – 2016/17, https://civilservicelearning.civilservice.gov.uk/sites/default/files/corporate_talent_strategy_v0f.pdf*

Much more can be done to encourage those working in CCGs to take part in courses offered by the NHSLA and the NHS Staff College. This provision needs to be supplemented by a new training programme for the specific needs of those working in commissioning.

4 The Management Environment

There is a widespread and deep-rooted perception that management is "the dark side". Doctors and nurses can be seen and often position themselves in opposition to management. This is unhelpful.

Management itself is often far too tactical in its behaviour; there is not enough strategic thinking. Great commercial organisations tend to spend more time thinking about the future.[25] The short-termism of NHS management thinking derives from two things: the need for constant regulatory data, and the fear of not being able to change fast enough.

The management structures are various and complex. What became clear is that no one model fits all circumstances.[26] In a plural management environment, two things tend to happen: first, those leaders who are best able to read the rules and interpret the system will prosper (and this may be entirely serendipitous).

[25] *Tapping the strategic potential of boards,* (2014), Bhagat, Hirt & Kehoe, McKinsey and Company www.mckinsey.com/insights/strategy/tapping_the_strategic_potential_of_boards

[26] For example: service-level chain; multi-site trust; federation, joint venture; franchise; multi-service chain; integrated care organisation.

Second, in an uncertain environment, the quality of outcome depends all the more heavily on the quality of the people.

For example, many of the best leaders are successful despite the system; or they had found a way to work it to achieve what they needed. They knew there was no single or mandated way to get things done. For the better leaders, this presents an opportunity to solve or work around a problem; but for weaker and/or newer leaders in less well-resourced areas, this presents a real problem and erodes morale.

Risk taking within acceptable clinical and commercial parameters is not encouraged, recognised or rewarded. An avoidance of failure is often noticed more than drive for innovative success.

At executive level, Chief Executives in particular need a strong team around them for support. Once a solid executive team is formed in a Trust it will often move with them; this practice should be encouraged where appropriate and viable.

Discussions during the Review highlighted the churn of Trust Chief Executives and the unsettling effect this has on Trusts. 7% of all CEO positions were reported as unfilled[27]; and the average tenure was 700 days. There is little clarity on the accuracy of tenure; but these statistics paint a picture of frequent arrivals and departures of senior leadership, of unsettled leadership teams

[27] *Leadership vacancies in the NHS* (December 2014), The Kings Fund. The report states that 7% of all trusts were without a substantive CEO which increased to 17% for trusts in special measures

and of initiative fatigue as yet another Chief Executive brings in yet another fresh approach.

Trusts in special measures or which are poorly performing often have an experienced and well respected Chief Executive brought in to turn around the Trust. However, the reality is that the centre of government does not always give enough time for a new, experienced leader to analyze what is happening, to identify any issues and subsequently to bring in a new team to stabilise any problems found before being overrun with numerous, often unnecessary and, on occasion, heavy handed inspections. These inspections often come with the expectation of *immediate* improvement and when, unsurprisingly, an immediate, service-wide improvement has not been delivered, leaders and their teams are placed at fault. To identify, analyze, rectify and implement all take time; they are not a linear process, especially as poor practice comes to light. Changing embedded culture and increasing staff morale through mutual understanding and respect takes time to deliver. Whilst there are reasons behind the increasing number of inspections, balance is still lacking. Further work needs to be conducted on reflecting the need for the Care Quality Commission (CQC) in particular to continue to respond to concerns raised to them whilst recognising the time a new CEO may need to identify problems and issues and to begin turning round a failing Trust.

By treating leaders in this position impatiently, the NHS is missing a pool of experienced leaders who could be unwilling to put themselves and their careers under scrutiny without the assurance that they will receive the time

and space to consider and effect any necessary transformation. The addition of leadership as part of the CQC inspection under its "well-led" domain, while welcome has added additional pressure/scrutiny on staff.

In essence, since the beginnings of the professionalisation of general management in the 1980s as a result of the Griffiths Report[28], authority was given to the administrators whilst delivery remained with clinicians. An atmosphere of mutual distrust persists between clinicians and managers. It is particularly noticeable in Trusts which are not performing well rather than those that are; the latter tend to be a more cohesive team. There is no unifying ethos across all disciplines. Little has been done to rectify this. There is not enough management by walking about and listening. The NHS remains stubbornly tribal.

A number of CCG Chairs reported difficulties in balancing their role as Chair and their responsibilities as practicing GPs. More should be done to support these clinical leaders. Continuing in practice should be welcomed as it strengthens the authority and credibility of the individual. Without the necessary support and headroom a similar problem emerges where Chairs are managing rather than leading their CCG.

There remains tension between CCGs and provider organisations. In part this is due to the fragmented nature of commissioning (a single hospital for example will have multiple commissioners of the same service). More should

[28] The Griffiths Report, (October 1983), http://www.sochealth.co.uk/resources/national-health-service/griffiths-report-october-1983/

be done to encourage greater collaboration and integration of working between CCGs and providers. A good example of this is in East London where a strategic programme brings together providers of acute and mental health care with the local authorities, the three local CCGs, NHS England and the TDA. The publication of the *Five Year Forward* View creates an opportunity to rethink management structures and back office services. Co-location of different area management teams would be one way to achieve this, although for reasons of geography or historic credibility it may not be possible for all.

5 Performance Management

There is little differentiation between the good, the bad and the ugly. All Trust Chief Executives are paid similarly, although those in Foundation Trusts are likely to be paid more than those in NHS Trusts (executive salary tends to increase in larger NHS organisations). The NHS is unable to clearly state and identify in specific areas what they do well and what they could do even better; and this it seems makes the job of leaders even harder. For CCGs the differentiation is even harder to see.

In terms of remuneration CCG Chairs were able to negotiate their own salaries. Without the means to understand what areas are doing well and not so well there is no way to help share best practice, to drive up performance, or to understand if a salary is appropriate for an individual in a specific area.

The Review heard that a CCG scorecard is currently under development and this is to be welcomed.

Performance management of individuals is haphazard and weak. It is too often a form-filling exercise; staff are not held to account, praised and developed in equal measure. Done well, this is a good way to improve organisational performance or quality. There is work ongoing but it does not go far enough and is not embedded throughout the NHS. The 2013 NHS staff survey results stated that 84% of staff had received an appraisal while only 38% said that their appraisal had been well structured. This resonates with what this Review heard.

Performance management means thinking about how best to train, equip and assign the right people to the right roles; it should help managers and others plan their own careers and acquire the necessary professional skills. However, throughout the NHS the phrase 'performance management' when applied to individuals is synonymous with something negative; when it should mean a communication process that occurs throughout the year between manager and employee to support both the employee's and the organisation's objectives, it can equally be considered as a regular conversation on an individual's career development.

As a whole the performance management culture within the NHS is lacking: objective setting, reviewing, and clear lines of responsibility and accountability are absent. Agenda for Change should have addressed this but more work is

still required to embed this within local management structures. Moreover, due to the infancy of a thorough performance management system in the NHS there appears to be a lack of a transparent 360 degree feedback system.

There is suspicion throughout the NHS, quite understandably, that as performance management is not consistently applied, it becomes a case of *why to me and not to them*? How often individual managers, units, wards request feedback for their staff from patients is unclear.

Closely related to performance management is talent management. There is no central talent pool or NHS-wide structured talent management scheme in place. This is the case for general management, for clinicians and for both Trusts and CCGs. The creation of a talent pool on a national scale has been attempted by the NHS on a number of occasions; clearly one size cannot fit all NHS organisations; but there must be a rational attempt to improve what there is now. While there is currently greater emphasis being placed on developing and 'spotting' talent in Trusts this report has less concern in this area than in the commissioning sector where there is not such a large pool of individuals to draw upon. There is no lack of talent here, rather there is no longer a joined up approach to both talent and succession planning. Encouraging greater flow of individuals between provider and commissioner organisations would utilise this untapped talent.

Talent cannot be managed without a single competency framework for all NHS staff. There isn't one. This absence, combined with the lack of a systematic appraisal, makes development and deployment of key talent almost impossible. Consistent use of competency frameworks and appraisals help set standards. Throughout the NHS there appears to be a marked lack of holding people to account for their performance. The NHS is still seen to routinely move staff upwards or sideways, not out, even when they're not performing. This must stop.

Clinicians contributing to this Review felt they were treated differently from general managers in that they find themselves under greater and more stringent scrutiny. Moving a poorly performing manager essentially rewards incompetence or semi-competence; although it is extremely difficult to sanction or remove a clinician, the stakes are high for that individual (he or she can be struck off the medical register). There is a need here to level the playing field.

At Board level, performance management is also vital. The quality of Non-Executive Directors (NEDs) on Trust boards appears highly variable as do lay members of CCGs. NHS Trust NEDs receive comparatively poor pay and are required to commit significant time to the role particularly in comparison to those working in a Foundation Trust. For NHS Trusts the current rate for NEDs is £6,157 and for Chairs between £18,621 and £23,600 depending on turnover. These rates can be increased by the Secretary of State for Health on an exceptional basis. Foundation Trusts are able to set their own levels of

remuneration necessary to successfully fill their posts. This means that though many NEDs are of a high calibre and are dedicated to their role, the NHS is mostly limiting itself to those with time to devote to the task; these people are often retired and sometimes lack currency in day-to-day management. This is particularly pronounced in NHS Trusts and CCGs, where there is a real need to make these roles more attractive.

There is a lack of clarity about the value NEDs bring. The key question is: *are they holding Trusts to account*? Many seem diligent; but how can their expertise be better shared across the system? How can it be amplified? NEDs need to see beyond their own institutions. This is difficult given the commitment to an individual institution and the fragmented structure of the NHS. The story is similar for lay members in CCGs.

The lack of performance management and talent management has three severe consequences for the NHS.

- First, management cannot improve without the means to do so. Yet there appears to be an embedded reluctance in asking for help; support is viewed as a weakness. There are instances of bullying in this area. There are few role models (particularly in medical management) and not enough shared leadership practices (for example, some of the best leaders leave around 30% of their time

unscheduled so that they can walk around, listen and know and understand what they are driving).

- Second, there is a chronic shortage of good leaders in the NHS. Leadership can be taught and learned. Bringing into the NHS people at higher levels is not the whole answer. Rather the NHS needs greater *diversity* by bringing people into leadership at all levels.

- Third, management standards are not recognised or applied across the organisation. For example, there are obvious inconsistencies in simple practices, systems and communication across wards and hospitals. For instance, there is a wide difference in the quality of notice, patient and ward communication boards, patient documentation, IT systems and nurse staff uniform colours.

Performance management should relate to an organisation's values. But for the NHS, there are many competing values: the NHS is stuck in a circle of *finance - quality - safety - efficiency* as operational priorities. All should be classed as an NHS priority equally. Performance must be managed throughout by means of a more balanced scorecard.

6 Bureaucracy

In 2013 *The regulation and oversight of NHS Trusts and NHS Foundation*

Trusts promised:

> "In [the] future, this division of roles will be simpler and clearer: the Care Quality Commission will focus on assessing and reporting on quality and Monitor and the NHS Trust Development Authority will be responsible for using their enforcement power to address quality problems[29]".

However, the NHS is drowning in bureaucracy. This is evident at all levels. There are two reasons for this: first, the NHS is too vertically structured; and second there are too many regulatory organisations making too many reporting requests.

The number of oversight bodies has grown as the NHS has become more fragmented and more distant from Government. Each of the bodies responsible for monitoring and compliance (eg CQC / Monitor / TDA) has its own mandate; each issues its own demands for data as well as requests directly from CCGs. This has spawned an industry of data collecting. Requests for data are often made regardless of whether the data has been collected in a different format elsewhere and irrespective of the impact on daily business. Regulators appear to be in overdrive and whilst some of this is understandable there needs to be a renewed focus on the sharing of information between regulators and for their perspective to change to consider outcomes rather than inputs.

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[29] *The regulation and oversight of NHS Trusts and NHS Foundation Trusts (May 2013), www.gov.uk/government/uploads/system/uploads/attachment_data/file/200446/regulation-oversight-NHS-trusts.pdf*

Requests to Trusts from CCGs are often the product of a central (DH/NHS England) demand. Requests made in this manner put needless strain on all areas of the system from Trusts, CCGs and indeed NHS England area teams.

It is a commonly held belief that there are one too many oversight bodies and the findings of this Review support that view. This was also the view of the Francis Report and the thrust of one of its recommendations. Since then CQC, Monitor and NHS TDA have built closer working relationships, but there is still some way to go[30].

Monitor's role as a health service oversight body is to ensure NHS Foundation Trusts are well-led and that essential services are provided should a Foundation Trust get into difficulties, it also has a wider remit as the sector regulator. The NHS Trust Development Authority provides a similar role to NHS Trusts, overseeing their performance and governance, as well as progress toward NHS Foundation Trust status. These two bodies operating as a single oversight body would significantly clarify the NHS regulatory and accountability structure.

The Review notes that the influence of targets, regulators and inspectors is seen as ubiquitous and wearing. Bureaucratic reporting has made both individual Trusts' and the NHS' views short-term. And if short-termism also

[30] *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, (6 February 2013), www.midstaffspublicinquiry.com/sites/default/files/report/Volume%203.pdf Recommendation 19 – There should be a single regulator dealing with both corporate governance, financial competence, viability and compliance with patient safety and quality standards for all trusts

means the lack of a long view, it is an unintended consequence of the lack of a strategic intermediary; the disappearance of the Strategic Health Authorities means there is no one to lead any region in a collaborative reconfiguration over the longer term.

Although it has been suggested that CCGs should undertake this important role, it would be unreasonable to expect that most of these relatively new organisations have capacity or authority to do so – at least for now. This means that a significant gap in regional leadership remains; many continue to mourn the loss of SHAs.

Too much is being done by numbers. Within the NHS, everyone is managing upwards by means of complying with data requests; for good leadership to flourish, they should be delegating downwards. People need to be and to feel trusted beyond compliance.

7 Balkanization of Trusts & Silo Working

There are currently 211 CCGs, 158 Acute Trusts, 10 Ambulance Trusts, 51 Mental Health Trusts and 31 Health and Care Trusts as part of the NHS federation as well as a myriad of other providers of care. The landscape of this federation has become fragmented in terms of both the numbers and activities of Trusts; within many Trusts silo working is endemic. This means that any activity within a Trust is horizontally separated from the same activity in other Trusts and vertically separated from other activities in its home Trust.

The same is true for CCGs, where there is a need for greater local and regional collaboration. Yet collaboration is more difficult in an environment that has been designed to create competition. Better communication between Trusts and CCGs would help reduce fragmentation of the landscape. There are too many “city-states” and not enough cooperation between them.

The current Trust system is inimical to collaboration; it is not a proper open market as Trusts cannot share with each other commercial information such as price with their suppliers. While their suppliers have a complete picture of the commercial territory. All recent reforms have been about devolving the system. Now there is no one system leader; so all are vying for territory. The loss of the Strategic Health Authorities, for example, means there is no mandate for system leadership, and no eye on what is happening across the system.

The Review heard that the system is creaking and that competition is causing harm, even that there has been too much competition. It is notably absent from the *Five Year Forward View*. Foundation Trusts have been a good development, but left to their own devices and without a framework for competition and cooperation, they are part of a system that is dangerously centrifugal. There is a need for a new balance between competition and cooperation to be considered for the good of the patient and for good practice to be more widely shared.

There are two classes of Trust. The rich have got richer and the poor poorer.

Big has become beautiful and bigger Trusts are becoming richer and therefore more successful with few exceptions. There is no predisposition to close that gap.

Given that Trusts tend to work in isolation from each other, Chief Executives reported the difficulty in being given the room to make decisions that benefit their *regional* health economy but are against the Foundation Trusts' (in particular) best interest. In some cases, the best decision in local health terms has exposed the Foundation Trust to scrutiny from Monitor.

Trusts are resolutely separatist, silo organisations; often they think tactically rather than strategically. They are therefore not keen to lend out staff, and consequently both the individual and the organisation feel unable to grow (this is a particular problem at middle management level). Chief Executives expressed concern over the challenge of taking on the more difficult Trusts: they saw them as isolated outposts with no central protection.

There are a number of notable collaborations[31] within the commissioning landscape in particular in and around London. The NHS must consider these, and other, areas of best practice and look to share and disseminate lessons learnt. There is no place in the vision outlined by the *Five Year Forward View* for individualistic, separatist Trusts and CCGs.

[31] For instance http://www.swlccgs.nhs.uk/ and http://integration.healthiernorthwestlondon.nhs.uk/,

In summary

First, change in the NHS is constant, at times radical, unwelcome and uncertain. Second, over time the NHS has become more devolved, more market-like, more local, more distant from the Department of Health, and hence more fragmented. Third, patients have a greater voice, as do regulators like the CQC and Monitor; each with their own priorities and demands.

These three clear observations place huge demands on NHS staff, on doctors, nurses and administrators alike. None are fully trained or equipped for the extra uncertainty brought about by constant change, the extra complexity brought about by the proliferation of NHS Foundation Trusts, the introduction of CCGs and the increased demands for data and performance metrics brought about by a regulated approach.

This has produced a critical leadership tipping point in the NHS. This point has coincided with a set of internal and external challenges. The answer is not more management but better leadership; not more attention to resources but more focus on how to handle change and uncertainty. The NHS is operating with unprecedented levels of demand, and with limited funding, and its people are under pressure not previously felt. There is an undeniable and urgent need for all NHS leaders to be more visible and to be seen as embodying the culture and values of the NHS. A value-based leadership culture is noticeably absent.

There is a feeling of too many undoable jobs; of over-stretching targets given the available resources; of no time or space (“bandwidth”) to think; of limited available mentoring and support; and of the intense scrutiny (top-down command and control, even comments of bullying) that is stopping staff (all types: nurses, general managers, doctors, specialists) wanting to take on extra responsibility and leadership roles.

Managing and leading in the NHS is now harder than ever; the capacity for managers to think through strategic changes and embed them is limited. There is constant fire-fighting in a data-hungry environment closely governed by targets set and monitored by regulators and inspectors. This has led to a high degree of bureaucracy and upward management which is time-consuming and often distracts leaders from focusing on patients.

The complexity and requirement for continuous reporting has caused distraction from delivering the big picture. There is a preoccupation with targets. Data collection in acute Trusts is not always appropriately managed, and there is little Board oversight. Furthermore the NHS has moved from a space of too much ‘underlap’ pre-Francis where one regulator assumes another is dealing with the data, to a place where there is too much overlap and duplication.

Unfortunately this is compounded by the three prominent staff groups “the triumvirate” of disciplines (Nurses, Doctors and General Managers) who often

do not understand each other's priorities. Despite the importance of clinical leadership a gulf remains between clinicians and managers; it can be hard to get clinicians to sit around a table and be accountable for the organisation as a whole.

Imagine an organisation where everyone understands and values the role of others, however seemingly small; where the main effort is clear; where local variations can apply without bureaucratic censure; where people trust each other and seek to be trusted; where delegation, training and personal and professional growth are seen as aspects of the same thing. This is what an organisation with effective leadership looks like. It is an organisation equipped both for long-term planning and also for the immediate uncertainties and complexities required of any group of people (especially a large one) that seeks to provide the full range of health care to a large and changing population.

A lack of cohesive leadership will produce an organisation where relations between staff and patients are merely transactional, doggedly contractual, obsessed with data and lacking in innovation and inspiration.

There is no less capability or capacity in the NHS than in the private sector; this Review addresses the question of how to harness them so people can give their best. The NHS has all that is needed to be an extraordinary organisation in which values produce the leadership qualities and behaviours necessary for it to thrive in the future.

Recommendations

The Review's findings shaped its seven main themes. These strategic elements are common to any organisation that seeks to achieve anything remarkable; there must be a shared vision; attention must be paid to people, and those people must be helped, guided and assessed in their performance. These themes flow through everything that is recommended here, and have a bearing on the success of all the recommendations. Most importantly, two conditions (R1 and R2) are a necessary prelude to all the recommendations. These are simple yet profound, and they set the scene for success.

1. First, *the NHS needs a collective vision.* A federation as large and plural as the NHS cannot afford to be disjointed. It must think collectively and act locally. The NHS is full of very good people, but it must do more to communicate and share good practice, celebrate success and foster a united ethos. There should be a concentrated effort to create a communications strategy in order to do this. Focusing on the positives within the NHS will bring up and drive out the negatives (it tends to be counter-productive to focus too much on negative behaviour). A collective effort depends on a collective understanding.

R1: Form a single service-wide communication strategy within the NHS to cascade and broadcast good (and sometimes less good) news and information as well as best practice to NHS staff, Trusts and CCGs.

2. *The second prerequisite condition is cultural. The NHS needs to create a values-based culture*. A large and complex organisation can be made more effective if all of its people behave in ways that are ethically consistent, and in ways that show they share the same values and base what they do on those values. There is already the ground work for this: the NHS Constitution includes a Staff Handbook, and Trusts communicate the NHS values contained within it in a variety of ways. But there needs to be a consistency in approach. Values must be easily and quickly understood across the NHS. Great leadership must be understood and fostered in staff at every level; the three military services are good examples of how this can be achieved across an organisation. A new and more visual format will promote this.

R2: Create a short NHS handbook/ passport/ map summarising in short and/ or visual form the NHS core values to be published, broadcast and implemented throughout the NHS.

The Review's further recommendations fall into four practical areas. **Training (R3-R8), Performance Management (R9-R11), Bureaucracy (R12-R16), and Management Support (R17-R19)**. In practical terms, the Review recommends what can and must be done. These areas are inter-related: the first two focus on providing what is not yet there, and the last two on removing barriers to great performance and effective, satisfying work.

Every one of these recommendations is aimed at supporting staff and patients of the NHS. They are practical, realistic and sometimes pragmatic: in a word,

commonsense. They have to work for all concerned, and are designed to make people's jobs easier, to release potential, and to optimize performance.

There is some overlap between them but this is only in terms of impact; something to be expected in a complex organisation such as the NHS. Some of these recommendations are strategic, others are tactical and operational. There is no recommendation to do nothing: in fact, the risks of inaction (although this can be a proper decision in some circumstances) are considerable. The Review urges that 2015 must not be yet another year when these much needed changes are left undone.

Training (R3–R8)

3. *The NHS needs a central body to coordinate its training effort and resources*. The NHS is a federal organisation. The performance of its management depends on its capacity and ability to set and maintain standards in management, to set and support the right kinds of behaviour, and to share across the organisation those things that it does best. Performance management of individuals must link to core competencies, values and objectives with time set aside to discuss and central oversight of this. Support and training needs to be given at all levels to do this. There are a number of places that these universal competencies could be taken from including the CQC 'well led' competencies or the NHS Leadership Academy's Clinical Leadership Competency Framework. Other organisations that achieve this do so by concerted training overseen by a centre that can

coordinate what things are taught, why they are taught, and where and how they are taught. Without such a body and the clarity it must be charged with bringing, the NHS is at extreme risk of wasting management effort and resources. In order to make training consistent, replicable and responsive across the organisation, such a body would be responsible for a consistent training regime across clinical, administrative and nursing / ancillary disciplines. Moreover, such a training body should be set up to be alert and sensitive to changing needs, and should have at its core a 90-day cycle of training requirement set by a body of more junior or middle-ranking staff: their body informs the core what their staff training needs are, and in 90 days the core reports back; in a further 90 days, the training must be in place.

R3: Charge HEE to coordinate the content, progress and quality of all NHS training including responsibility for the coordination and measurement of all management training in the NHS. At the core of this is a 90-day action cycle. HEE must promote cross-functional training in all disciplines and at all levels, coordinating the teaching of management basics such as appraisal, motivation, negotiation and leadership.

4 *People must be equipped for the changes the NHS has asked them to make.* There has been enormous change in the NHS in the last two years. This has come at a time when catalytic change has been the only constant. Yet little has been done to equip people either personally or professionally to manage change and to make themselves properly able to do what is asked of them. The NHS must help its people manage their performance by moving

towards a single competency framework – with one locus (not necessarily a central establishment) of delivery. There needs to be a single training hub to co-ordinate all aspects of training for all individuals across the NHS. There are valuable examples across the military (much could be learned from the Joint Services Command & Staff College, for example). Training must take the form of competencies across all disciplines: leadership, project management, finance, negotiation, motivation, and HR etc. To work, it must be consistent. There must therefore be a single body responsible for the coordination of all training levels, including management training in the NHS.

R4: Move sponsorship of the NHS Leadership Academy from NHS England into HEE.

5. *It is important to maintain quality, pluralism and innovation in training courses,* These should be available in various locations across the country. Training courses should have status, appeal and impact for those staff taking them; they should also be substantial enough to allow people time to reflect on what they have learned, and to form cohorts with their peers. For the NHS these courses should be diverse, accredited, and flexible. This form of collective and action learning is invaluable in developing both individual and organisational competence.

There should be greater diversity of training programmes, some directed at specific organisational needs, such as those working in the acute sector or in the commissioning sector. Others should be directed at increasing collaboration across the sectors bringing together leaders from a variety of

sectors such as local government, Public Health, acute, commissioning and primary care.

R5: Include accredited/ nominated training establishments as part of a diverse training effort.

6. *The graduate scheme is woefully small and under-powered.* The scheme needs to be reviewed, refreshed and extended tenfold with larger numbers of individuals joining each year. To produce managers who see the bigger picture across the NHS, a wider range of postings should be undertaken (NHS acute, mental health, ALBs, CCGs) with an assessment necessary at the end of the tenure to ensure consistency of standards; this approach might better support a flexible and innovative programme of graduate recruitment.

R6: Review, refresh and extend (x10) the NHS graduate scheme; establish career pathways, a greater variety of placements and a guaranteed job after three years' training (quality and assessment permitting).

7. *As managers progress, they must be supported by being exposed to the learning they need in order to do their job*; this learning must of course be current, but equally it should be maintained, such that there is little "skill fade" or stagnation. Exposure to other forms of management and leadership, in other sectors, would be of great benefit.

R7: Refresh middle management by training and a more porous approach both from within the NHS and externally (recruitment from, and secondment to, other sectors).

8. As management is identified and nurtured from within the NHS, and encouraged from outside the NHS, *standards must be maintained and benchmarked against internal and external data*. This is not a call for new measurement or burdensome reporting, but an answer to the need for consistency in performance across all Trusts. One way of achieving this is by an accredited qualification. This has two benefits: external talent can measure itself by qualifying for entry into the NHS management cadre; internal talent can, by registering for and passing this checkpoint, begin to form a *talent pool* on which the entire organisation can draw.

R8: Require senior managers to attend accredited courses for a qualification to show consistent levels of experience and training have been reached across the NHS. On completion of this course they enter a senior management talent pool open to all Trusts.

Performance Management (R9-R11)

9. *It is crucial for the future of the NHS that it creates and supports a cadre of capable, trained and current managers from all disciplines and increases its level of cultural diversity to better reflect its staff.* In order that its training effort can be rational and effective, the NHS must identify and

broadcast core management skills and competencies across the organisation and expectations for delivery at clearly structured management levels. The NHS must begin cross-disciplinary (doctor, nurse and administrative) leadership and management training earlier in individuals careers.

R9: Set, teach and embed core management competencies and associated expected behaviours at each management level.

10. As a consequence of a more highly trained and self-aware management cadre in the NHS, with recognised and developed competencies, *there will be a need for some form of through-career support* to guide individuals as they progress. Individuals should be encouraged to increase their personal accountability for their training needs. Existing talent must therefore be identified and nurtured: More resource should be applied to the development of all management careers in the NHS. Training gates / experience points should be established as part of career progression. A widespread HR programme of talent-spotting, mentoring, networking and inside/outside secondment should be established.

R10: Establish a mechanism for providing on-going career support for all those in a management role allowing individuals to increasingly take charge and identify their own developmental needs.

11. In step with a more rational training programme, better career handling, and recognised leadership and management competencies, *the ways in which people give and receive praise or encouragement or advice need to be codified and made more uniform*. The Review noted that there is little

consistency in how appraisals are conducted, and this must be addressed urgently; this is in part to support the one vision of the NHS (inculcating NHS values into the training and appraisal environment), and in part so that everyone can reasonably expect the same from their appraisal, process wherever they work[32]. The best leaders give *feedback that is both constructive and thought- provoking*. Both positive and negative feedback should be descriptive – given with openness, transparency and candour. This should be built into any new framework.

R11: Establish and embed an NHS system of simple, rational appraisal (a balanced scorecard for individuals) supported by a regular course in giving and receiving appraisals as part of the core provision of the single training body. At a senior level, these appraisals should be standardised across the NHS.

Bureaucracy (R12-R16)

12. *There is an unnecessary burden of bureaucracy*: the NHS is justified in its complaints that there are too many organisations asking for similar returns of data for compliance and monitoring purposes. Reviews have looked into this before (the latest by HSCIC) but they need to go further. There is a need to move from a system where information is *pushed to the centre* to a system where information is *pulled from the centre.*

[32] *NHS Staff Management and Health Service Quality* , Michael West and Jeremy Dawson www.gov.uk/government/uploads/system/uploads/attachment_data/file/215454/dh_129658.pdf , Shows that a good appraisal correlates to lower levels of patient mortality and increases staff engagement

R12: Review the data demands of regulators and oversight bodies; these can then be rationalised and harmonised in order to produce consistent, clear and simple reporting that does not distract staff from patient care.

13. *Clarity is needed within the NHS's accountability and regulatory structure*: bringing together the two current oversight bodies the NHS TDA and Monitor would significantly contribute to this. While any further structural reform needs to be fully justified, the publication of the *Five Year Forward View* provides a stimulus to consider the future oversight model for the NHS. Furthermore, a review of the TDA is now due, as when originally established it was agreed that there would be a review into its continued existence within three years[33]. In the past there may have been good reasons for viewing Foundation Trusts and NHS Trusts differently. However, given that both sets of organisations now display a wide range of performance, it makes sense if support is provided by a single body which has the necessary breadth of experience, staff and contacts.

R13: Merge oversight bodies, the NHS Trust Development Authority and Monitor.

14. *There is an urgent need to improve the management environment by cutting bureaucracy*. As part of an initiative to make the NHS less bureaucratic, and to clean out its attic, the whole organisation needs to undertake an effectiveness review to simplify, standardise and share best

[33] http://www.legislation.gov.uk/uksi/2012/901/memorandum/contents

practice. Further, there is a need for a 'good housekeeping' review of necessary / unnecessary data returns to be taken periodically and an effectiveness review to take place to simplify, standardise and share best practice in data management. Committee work and administrative burden must be lessened. Non-Executive Directors in Acute Trusts would be well placed to consider the level of reporting requested and to communicate concerns around feasibility of requests to the organisation concerned. They could also be instrumental in considering the level of data needed to discharge their duty in holding the Trust to account**.**

R14: Spend time on a regular basis at all levels of the NHS to review the need for each data return being requested and to feed any findings to the Executive and Non-Executive Teams to review.

15. *The NHS must know how to recognise the good, the bad and the ugly*: this can be achieved by annual appraisals and merit awards, all matched against a single vision and ethos. The NHS requires a *consistent balanced scorecard* in which each critical area is given equal prominence. Through enhanced performance management at all levels and in all disciplines, the NHS should be able to identify both the good and poor performers and be able to seek new ways of working together to accomplish strategic goals.

R15: Establish and maintain a clearer system of simple rational appraisal (balanced scorecard for the organisation).

16. This Review has commented on the specific level of data burden felt by Trusts from data requests from CCGs. Many of these requests are driven

directly by NHS England and the Department of Health (DH). A greater level of independence and power should be given to CCGs by means of an accountable SRO (at either Director of Commissioning, Chief Information Officer or Caldicott Guardian level) for ensuring that data requests are not creating additional burden on the system and are necessary and proportionate. It would be their responsibility to ensure that for each data request a Burden Impact Assessment had been produced by the initial requestor (NHS England or DH) and to share it on demand from a Trust Board when discharging their duty to review all requests.

R16: Health and Social Care Information Centre (HSCIC) to develop an easily accessible Burden Impact Assessment template and protocol.

Management Support (R17-R19)

17. *The NHS must simplify, standardise, and share best practice*. The NHS can and must make use of its diversity and scale by sharing experience and best practice. People must be able to talk between Trusts, organisations and across distance. This will break down barriers between organisations, inform managers, doctors and nurses, and above all benefit patients by bringing the collected wisdom of the organisation to bear on their treatment. This will make the spread of best practice more consistent, more urgent, and more speedy. Individual NHS organisational identities should not shirk sharing

between one another, and between sites; nor should they be a barrier to asking for help.

R17: Create NHS wide comment boards. Websites and supporting technology to be designed and implemented to share best practice.

18. Some senior managers and senior leaders will be attracted to turning around poor Trusts. *The NHS needs a team of turnaround specialists ready to apply their expertise to failing Trusts – an elite cadre of known and trusted individuals* implicitly trusted by the regulators, and paid centrally. In order to do so, they need time to assess the situation, assemble their team, and execute their strategy. In order to give good leaders the headroom and protection needed to take on the more challenging Trusts the TDA and Monitor should consider creating a shared resource of individuals willing to be on two year fixed term contracts able to work in an agile manner, deployed to a variety of Trusts.

R18: Set minimum term centrally held contracts for some very senior managers subject to assessment and appraisal.

19. *Trust boards, their Non-Executive Directors and CCG lay members must be better trained.* Research by McKinsey & Co across 770 companies in commercial and not-for-profit sectors showed that better performing boards spent over twice the amount of time than poorly performing boards when it came to talent management, performance management and strategy[34].Trust Executive and Non-Executive Teams require a training programme to allow

[34]McKinsey Quarterly (2014, Number 2), McKinsey and Company, www.mckinsey.com/~/media/mckinsey/dotcom/insights/sustainability/mckinsey%20quarterly%202014%20number%202%20issue%20overview/mckinsey%20quarterly_2014_number%202.ashx.Page 14

them to develop as a cohesive group of leaders. Consideration must be given to increasing the base level of remuneration as standard across NHS Trusts in order to increase the number of potential candidates. This is the same for CCG lay members. The time commitment of Non-Executive Directors and lay members can be extensive, and there is a need to review the expectations of a NED, or the way in which they are brought into the organisation. For instance a single NED job could be shared between two people, shorter terms of employment could be examined or a system of volunteer NEDs from other parts of the health service or other sectors could be considered. There is a role for Boards in Leadership Development and this should be fully explored. A talent pool of potential NEDs and lay members should be considered for the future.

R19: Formally review NED and CCG lay member activity (including, competence and remuneration) in line with the CQC Well Led initiative; and establish a system of volunteer NEDs from other sectors.

Acknowledgements / References

Acknowledgements

The questions asked of me by the Rt Hon Jeremy Hunt MP

- What more could be done to attract top talent from within and outside the health sector into leading positions in NHS hospital Trusts, and;
- How strong leadership in hospital Trusts can be used as a force for good to transform organisational culture

were by necessity wide ranging and focused on acute Trusts. However during the course of my review I found that leadership challenges in the NHS are not confined to these areas alone. I therefore welcomed the request to consider the whole system, following the publication of the NHS's Five Year Forward View.

I hope that my recommendations can be taken as a blueprint going forward for the NHS as a whole, whatever part of the system.

Over the course of the Review, I have had the opportunity of visiting many health care organisations across the length and breadth of the country, including Foundation Trusts, NHS Trusts, Mental Health Trusts and CCGs.

In each location I met with many enthusiastic, dedicated and passionate people, administrative, medical and nursing staff at all levels. These people work incredibly hard and through difficult times, yet were prepared to find the time to meet with me and openly share their thoughts and views on leadership across the NHS. They have helped shape this review and their contributions have been invaluable.

I have met with a number of health sector experts, too many to name here but I would like to thank them all, including those from the Kings Fund and the Nuffield Trust, for giving their considered opinions.

I would like to thank the Care Quality Commission, Monitor, Health Education England, NHS Leadership Academy, Trust Development Agency, NHS England, NHS Confederation and the Foundation Trust Network.

I must also acknowledge Sir David Dalton (Salford Hospital), Sir Robert Francis QC and those individuals from the Shelford group. The wealth of experience and understanding that they shared with me has been instrumental in delivering this review and they each have provided me a valuable insight into the intricacies of the NHS.

Andrew St George (Aberwyswyth University and Cass Business School) has been my source of broader knowledge and information on leadership challenges and has been key in bringing together this report; my thanks go to him.

Lastly thanks must be given to officials at the Department of Health who have been a great source of support, guidance and knowledge to me during this process, to David Thorpe and especially Joanna Edwards who was a tireless source of help and coordinated the many moving parts of this report.

Thank you to each and every individual from the organisations below and their patients who gave their time so generously to speak to me individually and in roundtables. Your insights were invaluable.

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Hampshire NHS Foundation Trust, Basingstoke Hospital
King's College Hospital NHS Foundation Trust
Medway NHS Foundation Trust
Sherwood Forest NHS Foundation Trust
Buckingham NHS Trust, Amersham Hospital

Birmingham Children's Hospital NHS Foundation Trust
Calderdale and Huddersfield NHS Trust
North Cumbria Hospital visit
Hertfordshire Partnership University NHS Foundation Trust
Camden CCG
Waltham Forest CCG

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David Behan (CEO, Care Quality Commission)
David Bennett (CEO Monitor)
Ian Cummings (CEO, HEE)
Sir David Dalton (Chief Executive Salford Hospital, author of the Dalton Report)
Giles Denham (DH Director, Leadership)
Dr Michael Dixon (Chairman NHS Alliance)
Nigel Edwards (Chief Executive, Nuffield Trust)
David Flory (CEO, TDA)
Sir Robert Francis QC (Author of the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry)
Sir Malcom Grant (Chairman, NHS England)
Dame Barbara Hakin (COO & Deputy CEO, NHS England)
Professor Aidan Halligan (NHS Staff College)
Professor Chris Ham (CEO, Kings Fund)
Chris Hopson (CEO, FTN)
Professor Sir Bruce Keogh (Medical Director, NHS England)
Sir Alan Langlands (Vice-Chancellor University of Leeds)
Clare Marx (President, Royal College of Surgeons)
Dr Keith McNeil (CEO, Cambridge University Hospitals)
Dame Gill Morgan (Chair, NHS Providers)
Sir Robert Naylor (CEO, University College London Hospitals NHS Foundation Trust)
Sir David Nicholson
Una O'Brien CB (DH Permanent Secretary)
Professor Sir Mike Richards (Chief Inspector of Hospitals, CQC)
Ed Smith (Deputy Chairman, NHS England)
Dr Julia Smith (NHS England)
Jan Sobieraj (Managing Director, NHS Leadership Academy)
Simon Stevens (CEO NHS England)
Rob Webster (CEO, NHS Confederation)

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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, 30th July 2015	**Sponsoring Director:** Lesley Hill, Director of Planning, Performance, Estates and Facilities
Title and brief summary: INTEGRATED BOARD REPORT - The Board is asked to receive and note the Integrated Board Report	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Weekly Executive Board - 23.7.15 Quality Committee - 28.7.15	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

There was an overall improvement in June across several metrics with a fully compliant Monitor scorecard for the month and the quarter and contract penalties are minimal however when triangulating this with finance there is a cost to some of the achievement which is being scrutinised through Divisional meetings.

The key areas to note are:
Responsiveness
• The Trust delivered the Emergency Care Standard for June and recovered to deliver the quarter at 95.08% with improved ambulance turnaround maintained
• Patient flow requires ongoing focus with outlier numbers and patient movement still higher than acceptable
• All referral to treatment and cancer standards were met
• Appointment slot issues continue but actions have been identified and implementation plans are in progress
• Cancelled operations have improved to within contract levels
• Non elective activity remains high in June and some improvements have been seen in elective activity but particular focus is required on outpatients and day cases which is now monitored weekly

Caring
• Complaint performance is improving despite lots of overdue complaints being cleared in month with teams focussed on designing new processes to rapidly turnaround newly received complaints and prevent recurrence of backlog
• Friends and Family tests continues to be challenging as new areas are brought online with particular pressures following the introduction of day case and the ongoing challenge of AED delivery
Safety
• Falls continue to increase with 3 falls resulting in serious harm
• Pressure ulcer,category 3, shows a further reduction with particular focus around community services
Effectiveness
• Overall HCAI delivery is good but a small peak in EColi noted within the Medicine Division for June
• Emergency Readmissions within 30days is slightly above target relating to service changes within Locala, Trust delivered activity remains within target
• HSMR has further increased and is a key source of concern with specific improvement actions initiated
• Depth of Coding has not seen the performance improvement intended with some agreed processes not embedded and staffing still a concern. Finance and Performance Committee supported the recommendations to address staffing which are being implemented
• # Neck of Femur has delivered 85% for the month
Well led
• Sickness remains higher than target in all but 2 areas with the majority of Divisions/Directorates showing a deterioration in month around long term absence
• All Mandatory training metrics are red and is a particular focus of local performance meetings
• 3 Divisions are showing above 80% for appraisal with trajectories requested from all Departments
• There has been an improvement in the number of staff who would recommend the Trust as a good place to work
• Hard Truths staffing levels remain a significant concern and reflects both the additional capacity still in place and sickness levels. There remains ongoing challenges in securing permanent and temporary nurses but overseas recruitment continues.

A weekly performance meeting has been established focussing on forecast delivery to ensure corrective actions are timely to secure the required improvement and ensures our patients receive the best possible experience; this includes a weekly look ahead at activity to secure delivery against contract as a minimum. To compliment this a new Performance Management Framework is in development along with a review of the metrics reported and accountability this will be presented to the Board in due course.

Main Body

Purpose:

The Board is asked to receive and note the Integrated Board Report

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to receive and note the Integrated Board Report

Appendix

Attachment:

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Board Of Directors Integrated Performance Report

Report For: June 2015

Calderdale and Huddersfield NHS
NHS Foundation Trust

compassionate care

Contents

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• Pressure ulcers, there was 1 category 4 ulcer.

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	Report For: June 2015	Indicator Source	Report For: June 2015 Target	Report For: June 2015 Trust	Report For: June 2015 Surgical	Report For: June 2015 Medical	Report For: June 2015 Families and Specialist Services	Report For: June 2015 Community	Year To Date Target	Year To Date Trust	Year To Date Surgical	Year To Date Medical	Year To Date Families and Specialist Services	Year To Date Community	Trend (Rolling 12 Month)	Year End Forecast	Data Quality
Activity	% Elective Variance against Plan	Local	0.00%	-4.70%	-5.70%	3.80%	-6.20%	-	0.00%	-2.30%	-3.60%	-3.60%	5.40%	-			
	% Day Case Variance against Plan	Local	0.00%	-4.10%	-3.00%	-8.10%	0.70%	-	0.00%	-2.30%	-2.30%	-4.40%	7.30%	-			
	% Non-elective Variance against Plan	Local	0.00%	6.00%	1.10%	8.20%	5.10%	-	0.00%	2.90%	-3.30%	5.20%	2.80%	-			
	% Outpatient Variance against Plan	Local	0.00%	0.10%	0.90%	0.50%	-3.50%	-	0.00%	0.60%	-0.30%	-1.40%	0.10%	-			
RESPONSIVE - Operational Targets	Theatre Utilisation (TT) - Main Theatre - CRH	Local	92.50%	87.10%	85.32%	-	100.77%	-	92.50%	87.31%	85.58%	-	100.77%	-			
	Theatre Utilisation (TT) - Main Theatre -HRI	Local	92.50%	96.08%	96.86%	-	-	-	92.50%	94.47%	94.47%	-	-	-			
	Theatre Utilisation (TT) - HRI DSU	Local	92.50%	76.41%	74.61%	-	90.00%	-	92.50%	76.40%	75.13%	-	90.00%	-			
	Theatre Utilisation (TT) - HRI SPU	Local	92.50%	83.48%	83.48%	-	-	-	92.50%	82.71%	82.71%	-	-	-			
	% Daily Discharges - Pre 11am	Local	28.00%	10.42%	13.99%	8.71%	9.66%	-	28.00%	10.15%	12.81%	8.74%	9.74%	-			
	Delayed Transfers of Care	Local	5.00%	6.20%	-	-	-	-	5.00%	6.60%	-	-	-	-			
	Green Cross Patients (Snapshot at month end)	Local	40	90	-	90	-	-	40	96	-	96	-	-			
	Number of Outliers (Bed Days)	Local	523	813	299	514	0	-	1707	2414	783	1634	0	-			
	First DNA Rate	Local	7.00%	6.24%	6.22%	6.17%	6.35%	2.90%	7.00%	6.48%	6.33%	6.23%	7.11%	2.70%			
	% Hospital Initiated Outpatient Cancellations	Local	17.6%	14.80%	15.10%	14.60%	14.20%	-	17.6%	16.80%	17.30%	18.20%	13.40%	-			
	Appointment Slot Issues on Choose & Book	Local	5.00%	12.99%	11.44%	18.08%	4.64%	-	5.00%	15.00%	12.25%	22.56%	7.38%	-			
	No of Spells with > 2 Ward Movements	Local	-	129	21	82	26	-	-	407	66	254	87	-			
	% of Spells with > 2 ward movements (2% Target)	Local	2.00%	2.11%	1.29%	4.68%	0.95%	-	2.00%	2.21%	1.42%	4.79%	1.02%	-			
	No of Spells with > 5 Ward Movements	Local	-	4	1	3	0	-	-	13	1	12	0	-			
	% of spells with > 5 ward movements (No Target)	Local	-	0.07%	0.06%	0.17%	0.00%	-	-	0.07%	0.02%	0.23%	0.00%	-			
	Total Number of Spells	Local	-	6124	1628	1751	2745	-	-	18457	4663	5302	8492	-			
RESPONSIVE:18 Weeks and Other Access Indicators	% Non-admitted Closed Pathways under 18 weeks	National & Contract	95.00%	98.63%	98.69%	98.34%	99.20%	-	95.00%	98.62%	98.66%	98.48%	98.77%	-			
	% Admitted Closed Pathways Under 18 Weeks	National & Contract	90.00%	92.67%	92.08%	100.00%	94.20%	-	90.00%	92.26%	91.56%	100.00%	94.64%	-			
	% Incomplete Pathways <18 Weeks	National	92.00%	95.44%	94.45%	98.69%	96.22%	-	92.00%	95.44%	94.45%	98.69%	96.22%	-			
	18 weeks Pathways >=26 weeks open	Local	0	246	230	5	11	-	0	246	230	5	11	-			
	18 weeks Pathways >=40 weeks open	National	0	4	4	0	0	-	0	10	6	2	2	-			
	% Diagnostic Waiting List Within 6 Weeks	National & Contract	99.00%	99.89%	100.00%	100.00%	99.83%	-	99.00%	99.84%	100.00%	100.00%	99.78%	-			
	Community AHP - 18 Week RTT Activity	National	95.00%	92.70%	-	-	-	92.70%	95.00%	97.20%	-	-	-	97.20%			
	Paediatric Therapies - 18 Week RTT Speech Therapy	National	95.00%	96.10%	-	-	-	98.50%	95.00%	94.40%	-	-	-	94.40%			
	Paediatric Therapies - 18 Week RTT Occupational Therapy	National	95.00%	95.00%	-	-	-	95.00%	95.00%	89.70%	-	-	-	89.70%			
	Paediatric Therapies - 18 Week RTT Physiotherapy	National	95.00%	98.50%	-	-	-	98.50%	95.00%	97.70%	-	-	-	97.70%			
	% Last Minute Cancellations to Elective Surgery	National & Contract	0.60%	0.50%	0.81%	0.00%	0.00%	-	0.60%	0.73%	0.92%	0.04%	1.19%	-			
	28 Day Standard for all Last Minute Cancellations	National & Contract	0	0	0	0	0	-	0	0	0	0	0	-			
	No of Urgent Operations cancelled for a second time	National & Contract	0	0	0	0	0	-	0	0	0	0	0	-			

Calderdale and Huddersfield NHS
NHS Foundation Trust

Responsive Executive Summary - Helen Barker Associate Director of Operations

compassionate care

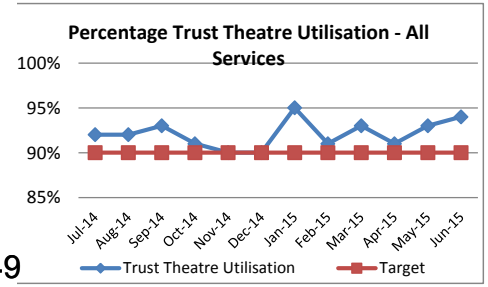
Report For: June 2015		Indicator Source	Report For: June 2015						Year To Date						Trend (Rolling 12 Month)	Year End Forecast	Data Quality
			Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community			
RESPONSIVE: Cancer	62 Day Gp Referral to Treatment	National & Contract	85.00%	90.00%	87.00%	93.75%	100.00%	-	85.00%	90.63%	91.04%	90.86%	85.71%	-			
	62 Day Referral From Screening to Treatment	National & Contract	90.00%	100.00%	100.00%	-	-	-	90.00%	96.15%	95.83%	-	100.00%	-			
	31 Day Subsequent Surgery Treatment	National & Contract	94.00%	100.00%	100.00%	100.00%	-	-	94.00%	98.15%	100.00%	88.89%	-	-			
	31 day wait for second or subsequent treatment drug treatments	National & Contract	98.00%	100.00%	100.00%	100.00%	-	-	98.00%	100.00%	100.00%	100.00%	100.00%	-			
	62 Day Aggregated Gp Urgent Referral To Treatment And Screening Referral To Treatment	National & Contract	86.00%	90.61%	88.29%	94.20%	100.00%	-	86.00%	91.02%	88.29%	91.48%	88.46%	-			
	31 Days From Diagnosis to First Treatment	National & Contract	96.00%	99.24%	98.80%	100.00%	100.00%	-	96.00%	99.73%	99.57%	100.00%	100.00%	-			
	Two Week Wait From Referral to Date First Seen	National & Contract	93.00%	96.55%	98.21%	92.62%	98.02%	-	93.00%	97.06%	98.45%	92.92%	99.19%	-			
	Two Week Wait From Referral to Date First Seen: Breast Symptoms	National & Contract	93.00%	94.92%	94.92%	-	-	-	93.00%	94.40%	94.40%	-	-	-			
RESPONSIVE: Accident & Emergency	A and E 4 hour target	National & Contract	95.00%	95.44%	-	95.44%	-	-	95.00%	95.08%	-	95.08%	-	-			
	Time to Initial Assessment (95th Percentile)	National	00:15:00	00:17:00	-	00:17:00	-	-	00:15:00	00:21:00	-	00:21:00	-	-			
	Time to Treatment (Median)	National	01:00:00	00:17:00	-	00:17:00	-	-	01:00:00	00:17:00	-	00:17:00	-	-			
	Unplanned Re-Attendance	National	5.00%	5.04%	-	5.04%	-	-	5.00%	5.06%	-	5.06%	-	-			
	Left without being seen	National	5.00%	3.27%	-	3.27%	-	-	5.00%	3.34%	-	3.34%	-	-			
	A&E Ambulance 30-60 mins	National	0	3	-	3	-	-	0	35	-	35	-	-			
	A&E Trolley Waits	National	0	0	-	0	-	-	0	0	-	0	-	-			
	Improving recording of diagnosis in A&E	CQUINS	85.00%	87.20%	-	87.20%	-	-	85.00%	86.10%	-	86.10%	-	-			

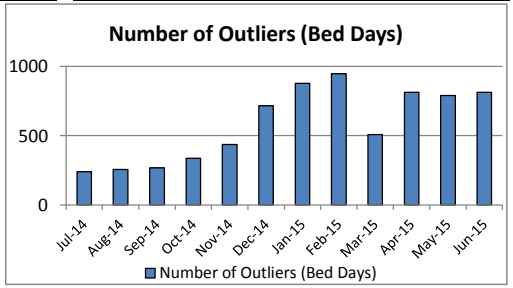
Calderdale and Huddersfield NHS
NHS Foundation Trust

Responsive/Operational Targets - Associate Director of Operations

compassionate care

Report For: June 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Theatre Utilisation (TT) - Main Theatre - CRH	92.50%	87.10%	85.32%	-	100.77%	-
Theatre Utilisation (TT) - Main Theatre -HRI	92.50%	96.08%	96.86%	-	-	-
Theatre Utilisation (TT) - HRI DSU	92.50%	76.41%	74.61%	-	90.00%	-
Theatre Utilisation (TT) - HRI SPU	92.50%	83.48%	83.48%	-	-	-
% Daily Discharges - Pre 11am	28.00%	10.42%	13.99%	8.71%	9.66%	-
Delayed Transfers of Care	5.00%	6.20%	-	-	-	-
Green Cross Patients (Snapshot at month end)	40	90	-	90	-	-
Number of Outliers (Bed Days)	523	813	299	514	0	-
First DNA Rate	7.00%	6.24%	6.22%	6.17%	6.35%	2.90%
% Hospital Initiated Outpatient Cancellations	17.60%	14.80%	15.10%	14.60%	14.20%	-
Appointment Slot Issues on Choose & Book	5.00%	12.99%	11.44%	18.08%	4.64%	-
No of Spells with > 2 ward movements	-	129	21	82	26	-
% of Spells with > 2 ward movements (2% Target)	2.00%	2.11%	1.29%	4.68%	0.95%	-
No of Spells with > 5 Ward Movements	-	4	1	3	0	-
% of spells with > 5 ward movements (No Target)	-	0.07%	0.06%	0.17%	0.00%	-
Total Number of Spells	-	6124	1628	1751	2745	-





Daily discharge before 11am

1. Why off plan? There is currently no specific focus on the performance management of early morning discharge to ensure key themes are identified and actions. Early review suggests a link between late ward rounds and the writing of TTOs.

2. Actions to get back on plan: An improvement programme for patient flow is being developed which will include early morning discharge and use of the discharge lounge. Visits to the discharge lounge highlighted opportunities to use this to enhance the patient experience and safety through the location of a pharmacist in the unit to manage medicines discharge information and this is also being explored.

3. Achieved by date: A clear improvement trajectory is expected by September 2015

Appointment Slot Issues

1. Why off plan? Performance remains around the 13% mark which is a significant deterioration on previous performance but we remain one of the better performers nationally especially when triangulating with referrals volumes. A detailed review has been undertaken with external support and visits to other Trusts with a series of recommendations agreed with Divisions and implementation plans in progress. It should also be noted that the service, nationally moved to the new E-referral system in June which was a difficult migration for many Trusts, some of whom had to close their system for several days. CHFT managed this change well and was one of the more stable during transition.

40% of our issues sit with 3 specialties Ophthalmology, ENT & General Surgery (inc gastro) and these are all areas with known capacity and demand issues. Plans have been put forward and approved for additional Consultant recruitment so this will give some sustainable improvement but will have a lead time. The focus of our plans in the short term is the other 60% which sit across a range of specialties with the following proposed:

2. Actions to get back on plan: Autonomy for appointment centre to convert slots. Currently any changes to clinic sots have to have consultant permission e.g. if a slot is for planned follow ups or fastrack but not filled we still have to ask permission to fill with another patient. Plan is to agree autonomy to use these if not filled by 48hrs before the clinic, this will give us capacity to use for ASI risks

Flexibility if 'polling'. Polling is the window open for e booking e.g. will show 6 weeks of clinic slots. Currently this is foxed and any increase to the window has to be authorised by the specialty. By the time this is done we have lost to opportunity to avoid an ASI. By allowing this to happen at source it will impact on ASIs (this is an area of learning in particular from other Trusts). We have to ensure we then close this back down when the pressure is reduced to avoid creeping waiting times but is manageable.

Effective and efficient use of e-referral. Not all specialties or individuals review the e referral in a timely manner which means often patients are booking into the wrong clinic or were inappropriate referrals which wastes capacity. Timely review will reduce these and provide more capacity for other referrals

The above items are very ASI specific but will be implemented alongside some more generic improvements including

- Review of leave booking to ensure timely and no disproportionate impact on clinical activity
- Review of the management of DNAs – currently in the policy to discharge back to GP following a 'sense check' by Consultants but evidence to suggest most patients are offered a 2nd appointment
- Outpatient clinic utilisation – as part of the PMO we are looking at overall utilisation both of clinics and in-session utilisation as believe there is more capacity than currently being utilised.

There is a concern that once a patient goes on the ASI list i.e. they didn't book their appointment electronically they can sit on the 'to book' list for too long which is a patient experience issue, a potential clinical risk and a performance pressure. We propose to implement an internal standard of appointment confirmed within 11days of receipt of referral and will build the monitoring of this into monthly Divisional performance reviews

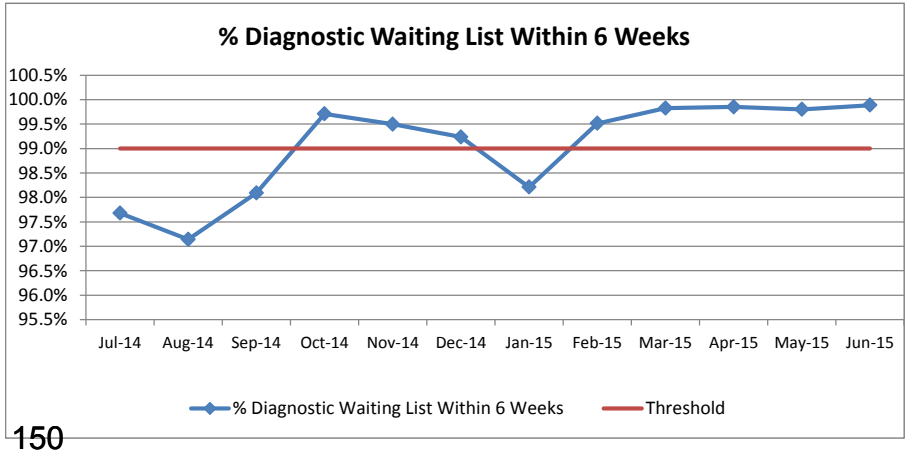
3. Achieved by date: Once there is a clear implementation plan agreed a date for return to compliance will be confirmed.

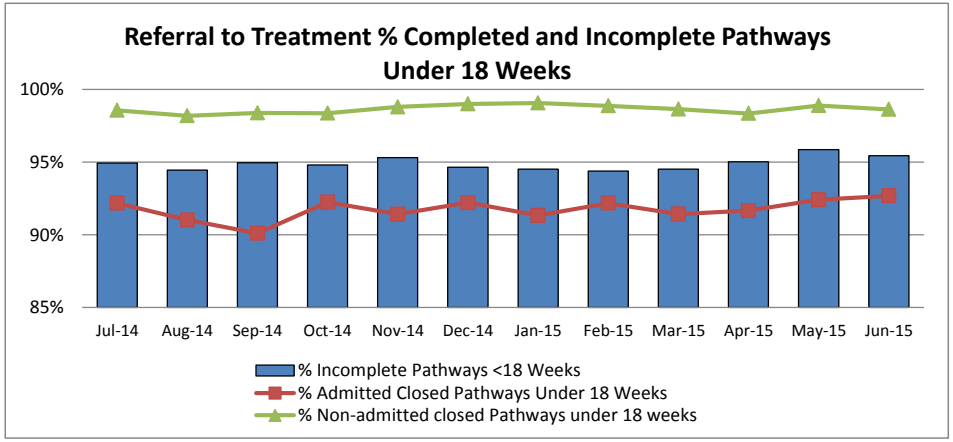
Report For: June 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Non-admitted closed Pathways under 18 weeks	95.00%	98.63%	98.69%	98.34%	99.20%	-
% Admitted Closed Pathways Under 18 Weeks	90.00%	92.67%	92.08%	100.00%	94.20%	-
% Incomplete Pathways <18 Weeks	92.00%	95.44%	94.45%	98.69%	96.22%	-
18 weeks Pathways >=26 weeks open	0	246	230	5	11	-
18 weeks Pathways >=40 weeks open	0	4	4	0	0	-
RTT Waits over 52 weeks Threshold > zero	0	0	0	0	0	-
Community AHP - 18 Week RTT Activity	95.00%	92.70%	-	-	-	92.70%
Paediatric Therapies - 18 Week RTT Speech Therapy	95.00%	96.10%	-	-	-	98.50%
Paediatric Therapies - 18 Week RTT Occupational Therapy	95.00%	95.00%	-	-	-	95.00%
Paediatric Therapies - 18 Week RTT Physiotherapy	95.00%	98.50%	-	-	-	98.50%
% Diagnostic Waiting List Within 6 Weeks	99.00%	99.89%	100.00%	100.00%	99.83%	-
% Last Minute Cancellations to Elective Surgery	0.60%	0.50%	0.81%	0.00%	0.00%	-
28 Day Standard for all Last Minute Cancellations	0.00%	0.00%	0.00%	0.00%	0.00%	-
No of Urgent Operations cancelled for a second time	0.00%	0.00%	0.00%	0.00%	0.00%	-

Community RTT

1. Why off plan? The understanding of RTT rules across some of the community services is patchy with lack of clarity on which pathways are included and a lack of clear process for administration of clock stops meaning there is some over reporting of breach numbers
2. Actions to get back on plan: Services are currently being reviewed to ensure within the scope of RTT, training for administrative and clinical staff is being reviewed and a validation
3. Achieved by date: September 2015

There are 4 patients showing as waiting over 40weeks for treatment which is currently being validated. A weekly report is now published showing all patients waiting over 26weeks which is being performance managed through the weekly meetings





Responsive - Cancer - Associate Director of Operations

Report For: June 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Two Week Wait From Referral to Date First Seen	93.00%	96.55%	98.21%	92.62%	98.02%	-
Two Week Wait From Referral to Date First Seen: Breast Symptoms	93.00%	94.92%	94.92%	-	-	-
31 Days From Diagnosis to First Treatment	96.00%	99.24%	98.80%	100.00%	100.00%	-
31 Day Subsequent Surgery Treatment	94.00%	100.00%	100.00%	100.00%	-	-
31 day wait for second or subsequent treatment drug treatments	98.00%	100.00%	100.00%	100.00%	-	-
62 Day Aggregated Gp Urgent Referral To Treatment And Screening Referral To Treatment	86.00%	90.61%	88.29%	94.20%	100.00%	-
62 Day Gp Referral to Treatment	85.00%	90.00%	87.00%	93.75%	100.00%	-
62 Day Referral From Screening to Treatment	90.00%	100.00%	100.00%	-	-	-

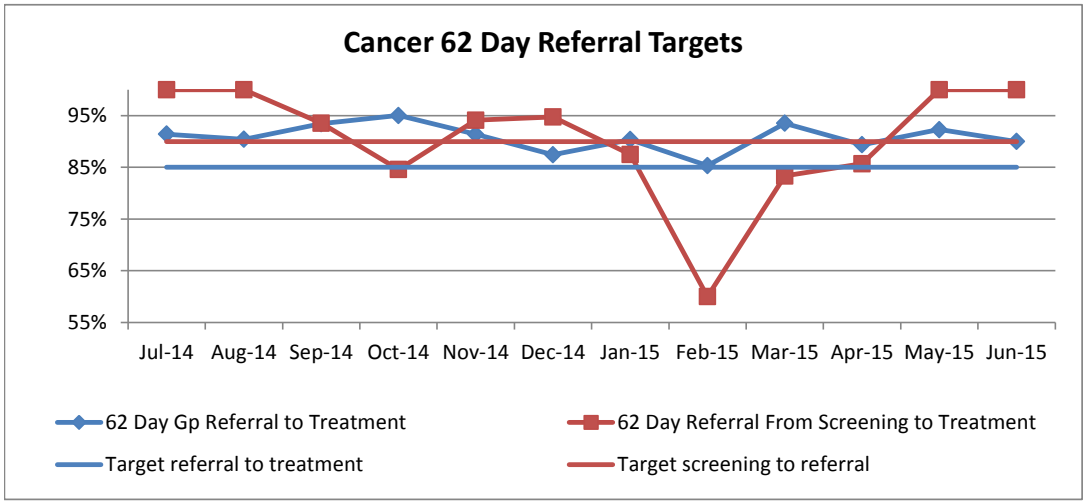
The 2 Week Wait Referral - Medical

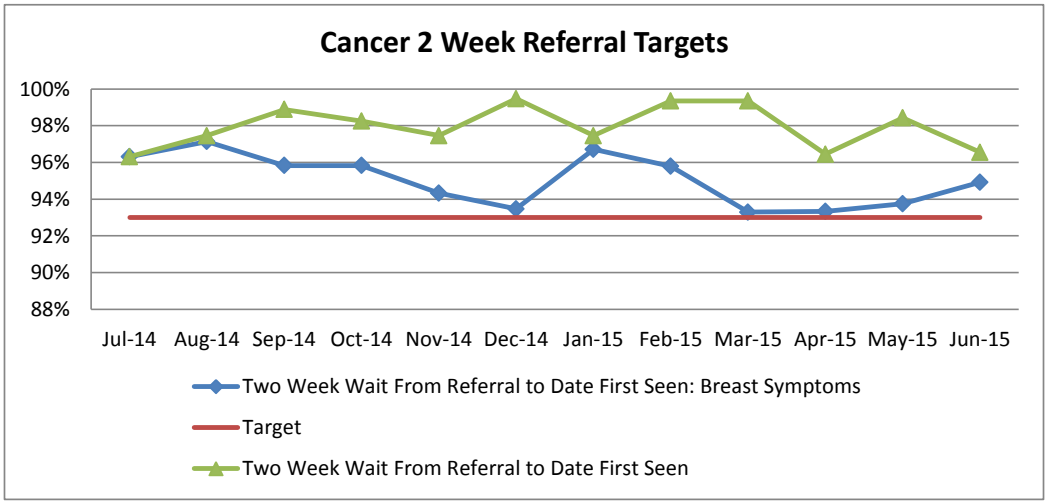
1.Why off plan?: The failure was mainly in Dermatology 17 was due to lack of capacity, 4 were due to patient choice and 1 DNA. The trust has only 2 Locum Consultants who see all the fast tracks and only one Consultant is allowed off at any one time though in June we had 3 weeks with only one Consultant. In quarter 1 we had 561 fast track referrals and in quarter 4 we had 407 fast track referrals, which is a 72% increase.

2.**Action to get back on plan** : A discussion has taken place with locala about setting up a Lesion clinic to reduce the number of referrals into the service however they are struggling to set this up at present. The only other referral was a Haematology breach due to the Bank holiday. Medical staffing for Dermatology is a regional issue and there is the potential to connect with other Trusts to look at a network solution to service delivery.

3.Achieve by date : This issue due to lack of Consultants will be on going and we will need to get the extra Locum Consultant periodically. However in July the Trust will achieve the target.

There are known peaks in Dermatology relating to summer as well as national campaigns. The Division are tracking these to ensure responsive to these in the delivery of timely access.





Responsive/Accident & Emergency - Associate Director of Operations

Report For: June 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
A and E 4 hour target	95.00%	95.44%	-	95.44%	-	-
Time to Initial Assessment (95th Percentile)	00:15:00	00:17:00	-	00:17:00	-	-
Time to Treatment (Median)	01:00:00	00:17:00	-	00:17:00	-	-
Unplanned Re-Attendance	5.00%	5.04%	-	5.04%	-	-
Left without being seen	5.00%	3.27%	-	3.27%	-	-
A&E Ambulance 30-60 mins	0	3	-	3	-	-
A&E Trolley Waits	0	0	-	0	-	-
Improving recording of diagnosis in A&E	85.00%	87.20%	-	87.20%	-	-

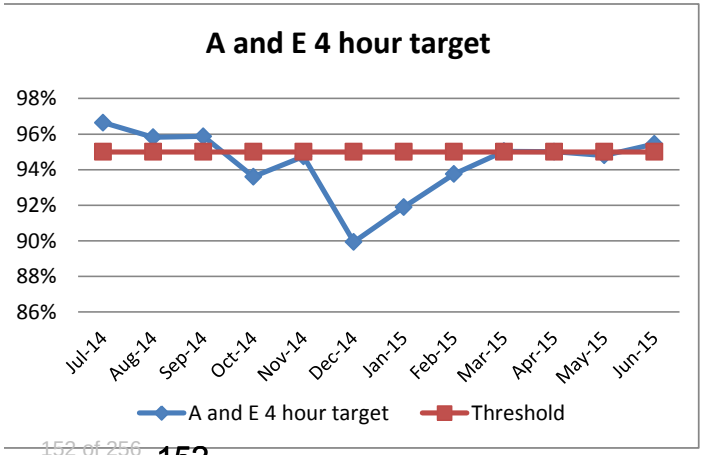
Time to Initial Assessment & Ambulance Turnaround

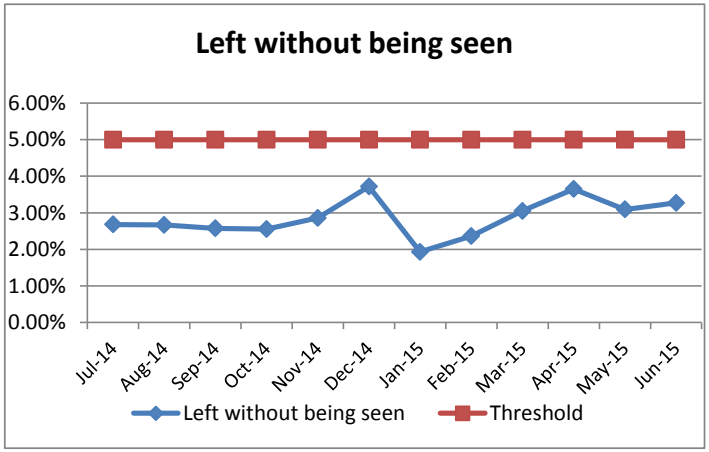
The operational teams worked hard in June to secure delivery both of the month and quarter with managers and clinicians covering across the 7 days throughout the month. Flow issues remain a concern with performance fluctuating daily and the patient experience variable. Additional medical cover was put in place each Monday which had a positive impact on safety and flow; this model is being reviewed by the Division who are keen to identify a way of sustaining this.
A wider improvement programme for patient flow is being developed using the Trust 'working together to get results' methodology and Healthwatch have also been asked to support this with some specific patient experience studies of people who waited longer than 4 hours in AED.

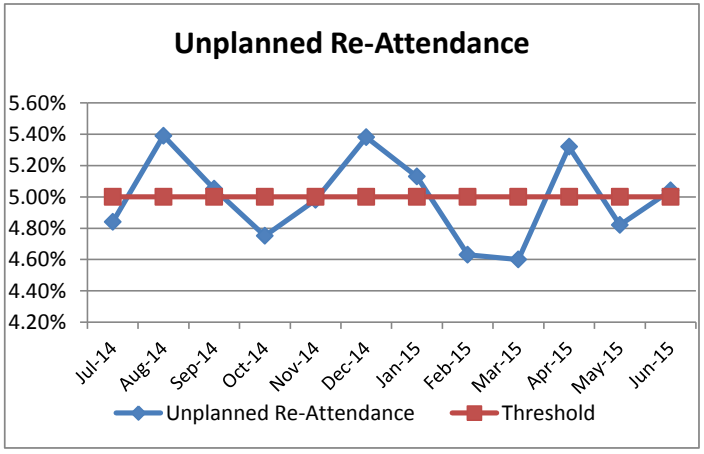
Activity to reduce delayed transfer of care continues with the meetings and governance structure embedding and improved relationships between partners. Work to ensure clarity of the clock start has been a priority alongside implementation of a single responsible manager for each site to oversee the work of the discharge coordinators ensuring consistency of recording.
The Trust have recommended to System Resilience Group that a system Capacity & Demand analysis be undertaken as a priority and a decision is expected by the end of the month. This is an increasing priority given recent confirmation by both Local Authorities that there is the real potential of a further reduction in Nursing Home beds within the next few weeks
An emergency conference call took place on 16th July and further work has been commissioned to ensure both short and long term plans are in place to mitigate the risk

Time to Initial Assessment – HRI achieved the required standard over the last 3 weeks, site specific issues still causing challenges at CRH. A & E turnaround action plan in place, co-ordinator training, introduced safety huddles and increased Matron 'shop floor' presence. Expected anticipated date to achievement September 2015.

Ambulance Turnaround performance remains positive with only 3 breaches of 30minute and no breaches of 60 minute. The improvement work continues and we are now attracting attention from other Trusts keen to learn from our experience.







Calderdale and Huddersfield NHS
NHS Foundation Trust

Caring Executive Summary - Julie Dawes Director of Nursing

compassionate care

			Report For: June 2015						Year To Date							
	Report For: June 2015	Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Year End Forecast	Data Quality
Caring	Number of Mixed Sex Accommodation Breaches	National & Contract	0	0	0	0	0	-	0	0	0	0	0	-			
	% Complaints closed within target timeframe	Local	100.00%	65.00%	64.00%	67.00%	76.00%	100.00%	100.00%	40.00%	28.00%	39.00%	50.00%	33.00%			
	Total Complaints received in the month	Monitor	-	58	21	19	7	2	-	169	57	56	34	5			
	Complaints acknowledged within 3 working days	Local	100.00%	77.00%	77.00%	76.00%	72.00%	0.00%	100.00%	85.00%	79.00%	92.00%	80.00%	20.00%			
	Total Concerns in the month	Monitor	-	64	22	21	14	1	0	158	49	53	37	4			
	% of diabetic patients supported to self-care	CQUINS	50.00%	85.71%	-	85.71%	-	-	50.00%	74.29%	-	74.29%	-	-			
	End of Life Care Plan in place	CQUINS	-	36.50%	-	-	-	-	-	36.01%	-	-	-	-			
	Percentage of non-elective inpatients 75+ screened for dementia	CQUIN	90.00%	90.72%	-	-	-	-	90.00%	91.49%	-	-	-	-			
	Nutrition and Hydration - Reducing Hospital Food Waste (reported quarterly)	CQUINS	-	6.13%	-	-			-	5.70%	-	-					
	Nutrition and Hydration - Improving Vending facilities (Reported quarterly)	CQUINS	-	82.49%	-	-			-	78.18%	-	-					
Caring - Friends & Family	Friends & Family Test (IP Survey) - Response Rate	Contract	40.00%	21.94%	22.20%	20.55%	25.19%	-	40.00%	23.58%	23.68%	26.24%	20.04%	-			
	Friends & Family Test (IP Survey) - % would recommend the Service	Contract	95.00%	97.37%	97.85%	96.39%	98.13%	-	95.00%	97.12%	97.65%	96.02%	97.47%	-			
	Friends and Family Test A & E Survey - Response Rate	Contract	30.00%	8.60%	-	8.60%	-	-	30.00%	8.50%	-	8.50%	-	-			
	Friends and Family Test A & E Survey - % would recommend the Service	Contract	90.50%	91.10%	-	91.10%	-	-	90.50%	90.80%	-	90.80%	-	-			
	Friends & Family Test (Maternity) - % would recommend the Service	Contract	95.00%	95.30%	-	-	95.30%	-	95.00%	92.70%	-	-	92.70%	-			
	Friends and Family Test Community Survey - % would recommend the Service	Local	95.00%	90.68%	-	-	-	90.68%	95.00%	90.30%	-	-	-	90.30%			

Report For: June 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Number of Mixed Sex Accommodation Breaches	0	0	0	0	0	-
% Complaints closed within target timeframe	100.00%	65.00%	64.00%	67.00%	76.00%	100.00%
Total Complaints received in the month	-	58	21	19	7	2
Complaints acknowledged within 3 working days	100.00%	77.00%	77.00%	76.00%	72.00%	0.00%
Total Concerns in the month	-	64	22	21	14	1
% of diabetic patients supported to self-care	50.00%	85.71%	-	85.71%	-	-
End of Life Care Plan in place	-	36.50%	-	-	-	-
Percentage of non-elective inpatients 75+ screened for dementia	90.00%	90.72%	-	-	-	-
Nutrition and Hydration - Reducing Hospital Food Waste (reported quarterly)	-	6.13%	-	-		
Nutrition and Hydration - Improving Vending facilities (Reported quarterly)	-	82.49%	-	-		

% Complaints closed within target timeframe

1. Why off plan? The performance rate has improved in month to 65% in June (from 47% in May), but still below target. The drive to conclude all cases ongoing over timescale continues. At the end of June , 33 complaints were ongoing over timescale. Three complaints were overdue by 1 month and seven between 1 - 2 months overdue. Three complaints were between 3 and 5 months overdue: 1 in the community division and 2 in the surgical division. Whilst older complaints are being completed there will be an effect upon timeframe performance.

2. Actions to get on plan? Weekly performance report with detailed reports of open cases continue to be provided with increased monitoring both within Division and the Patient Advice and Complaints team.

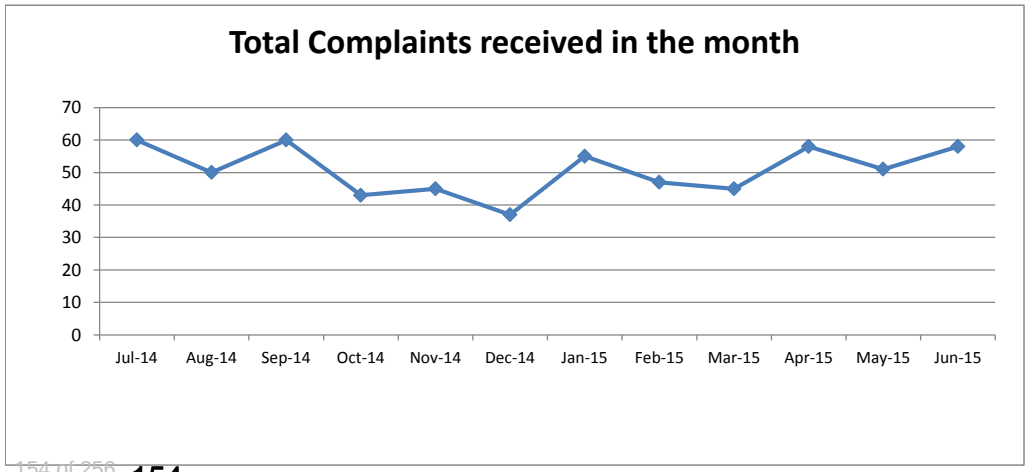
3.Achieved by date: All cases ongoing over target to be completed as a matter of urgency. All new and remaining cases to be managed in target.

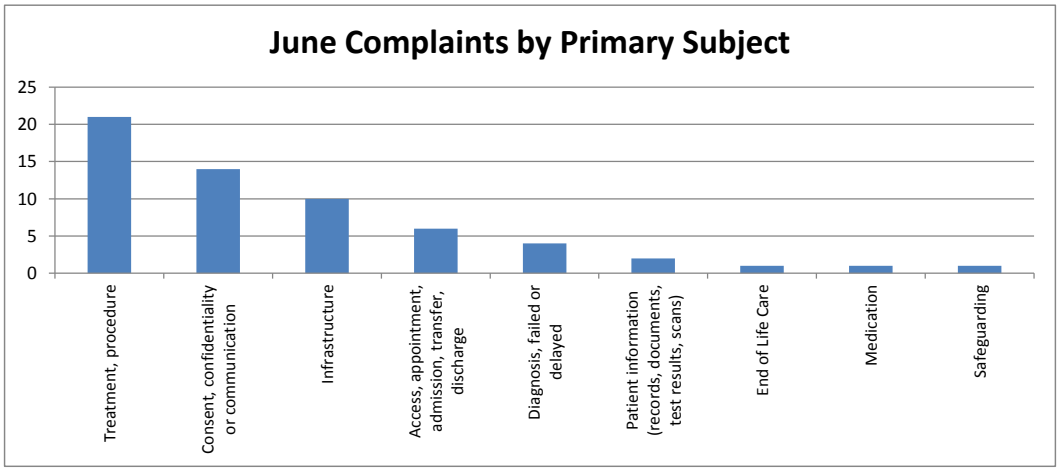
Complaints acknowledged within 3 working days

1. Why off plan? There has been a drop in timeliness of acknowledgement of complaints (within 3 working days) due to annual and sick leave within the team, together with increased workload to close overdue complaints.

2. Actions to get on plan? There is flexible use of other administrative staff to improve resilience though this is limited. July performance is expected to improve, though will be less than 100%.

3.Achieved by date: 100% Performance expected to return from August 2015 onwards





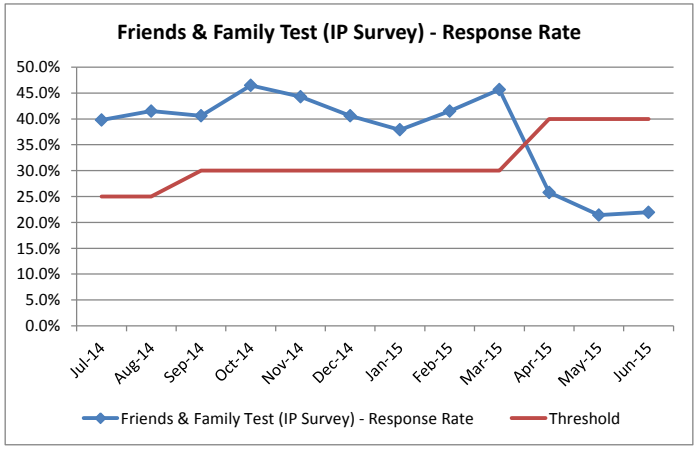
Caring - Director of Nursing

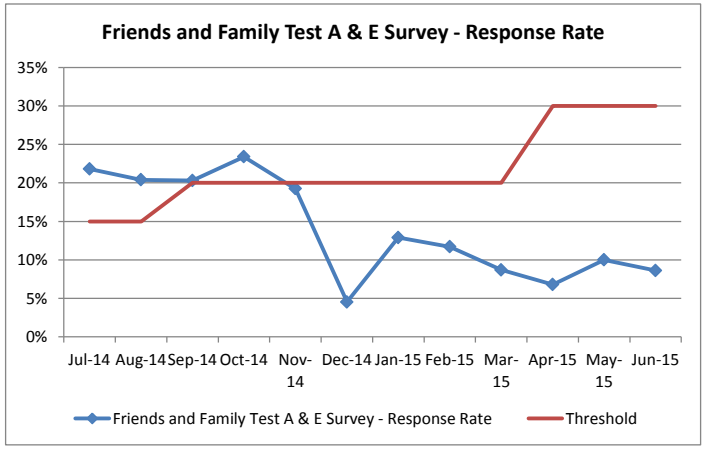
Report For: June 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Friends & Family Test (IP Survey) - Response Rate	40.00%	21.94%	22.20%	20.55%	25.19%	-
Friends & Family Test (IP Survey) - % would recommend the Service	95.00%	97.37%	97.85%	96.39%	98.13%	-
Friends and Family Test A & E Survey - Response Rate	30.00%	8.60%	-	8.60%	-	-
Friends and Family Test A & E Survey - % would recommend the Service	90.50%	91.10%	-	91.10%	-	-
Friends & Family Test (Maternity) - % would recommend the Service	95.00%	95.30%	-	-	95.30%	-
Friends and Family Test Community Survey - % would recommend the Service	95.00%	90.68%	-	-	-	90.68%

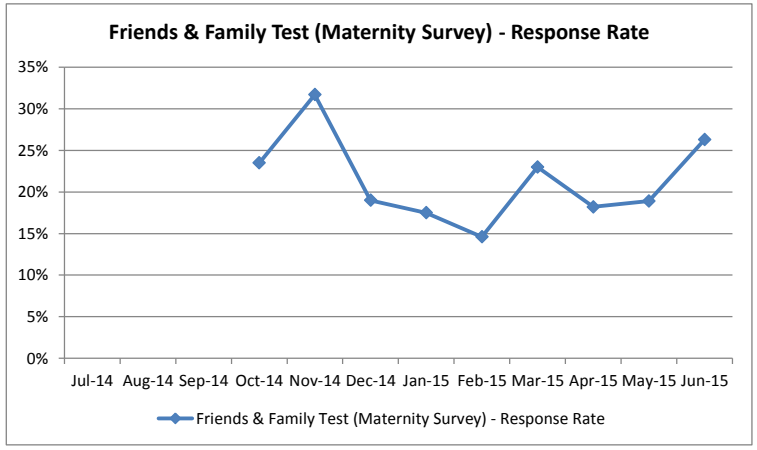
Inpatient FFT Response Rate:
Why off plan: The reduction in performance continues to be related to the requirement for including all admissions regardless of whether there has been an overnight stay, prior to April 2015 this was not the case
Actions to get back on plan: The data has been thoroughly investigated to understand any gaps. Divisional FFT leads are liaising with the relevant teams to notify them of the need to commence the FFT process for this patient group.
Achieved by date: Some improvement in the response rate is expected in the July 15 data, and back on target by August 2015

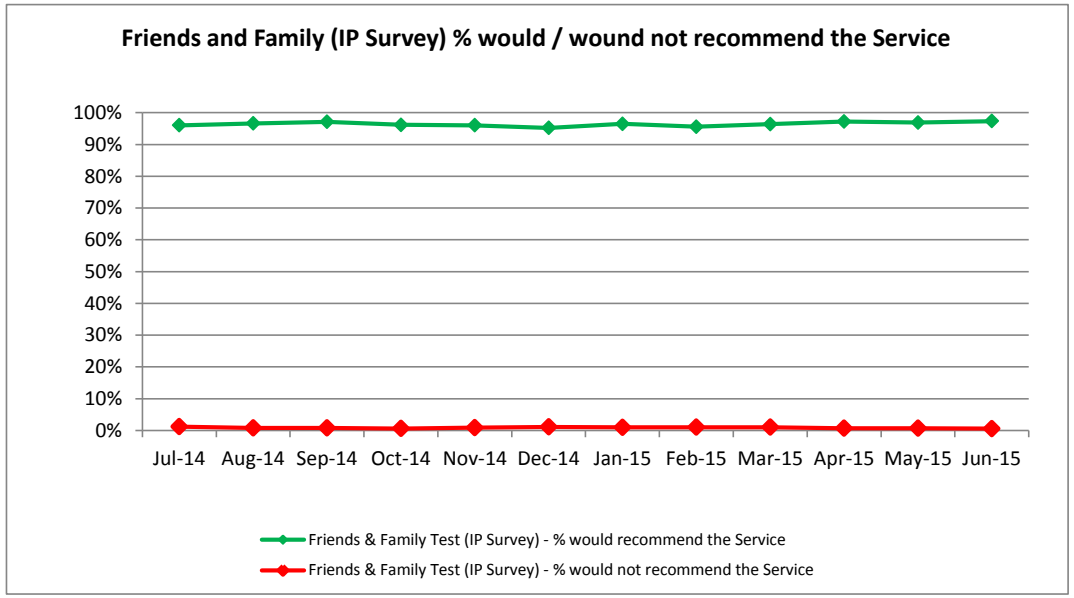
A&E FFT:
Why off plan: The A&E response rate continues to be a challenge, whilst there have been some slight improvement the position remains a long way from the target
Actions to get back on plan: A process of each member of staff being given cards to issue as part of the safety huddle was introduced last month and continues to be delivered, however this is not having the required level of Impact. It is planned to introduce the use of text messaging and this is currently being managed through the Health Informatics support
Achieved by date: Given the current level of performance and the need to introduce a new system, it is anticipated that improvements will be seen from September 2015 onwards.

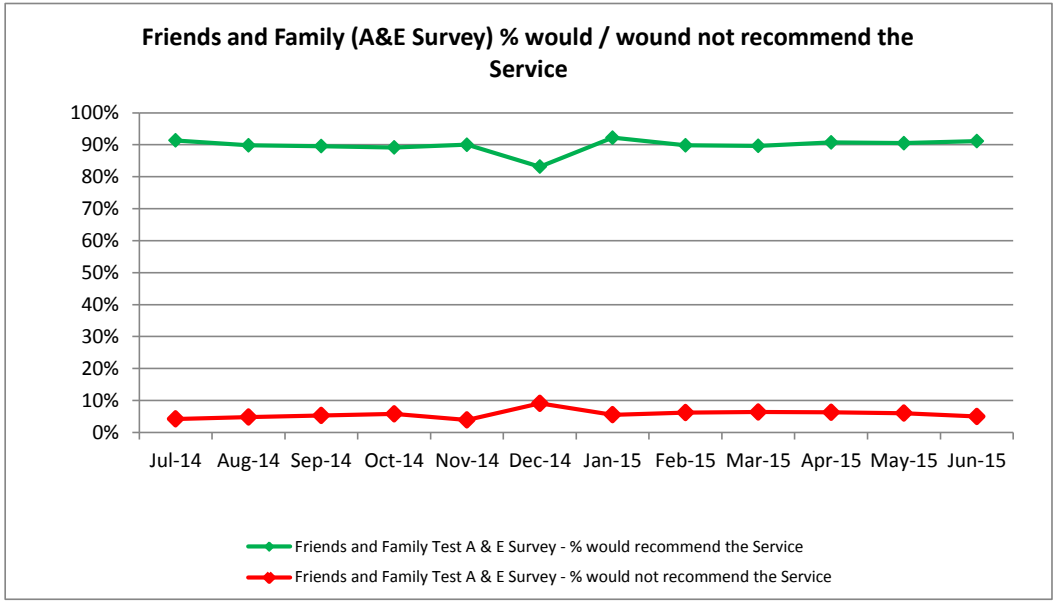
Community FFT:
Why off plan: Community FFT performance is continues to be around 90%. The only method of data collection at present is using SMS text messaging. This method does not allow comments to be related back to the individual service.
Actions to get back on plan: The team continues to review performance and will meet at the end of July to address this further.
Achieved by date: Improvements expected over the next quarter.

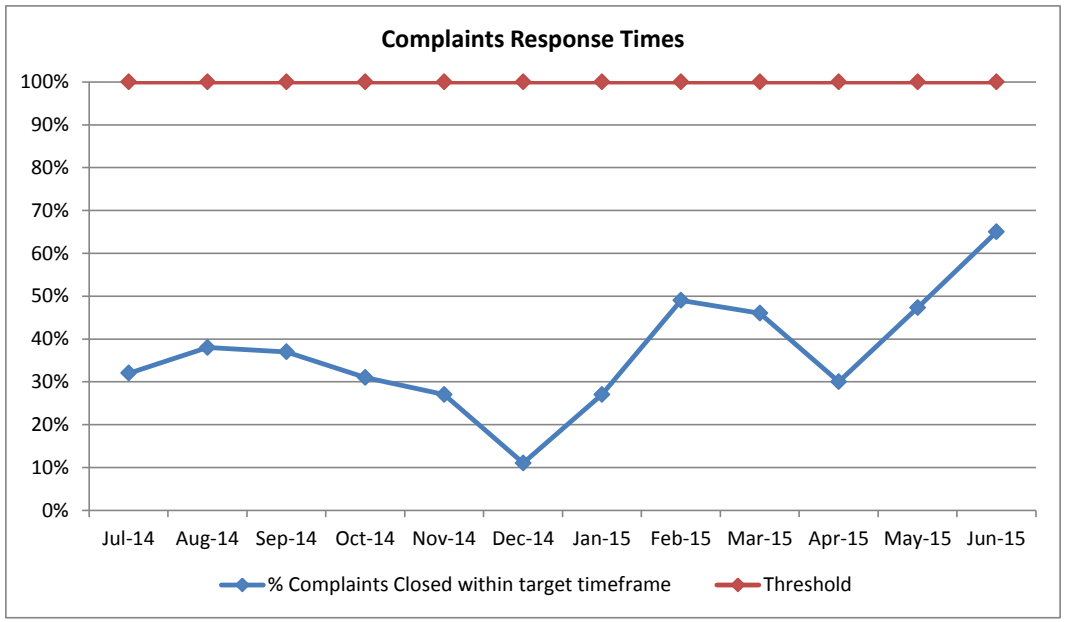


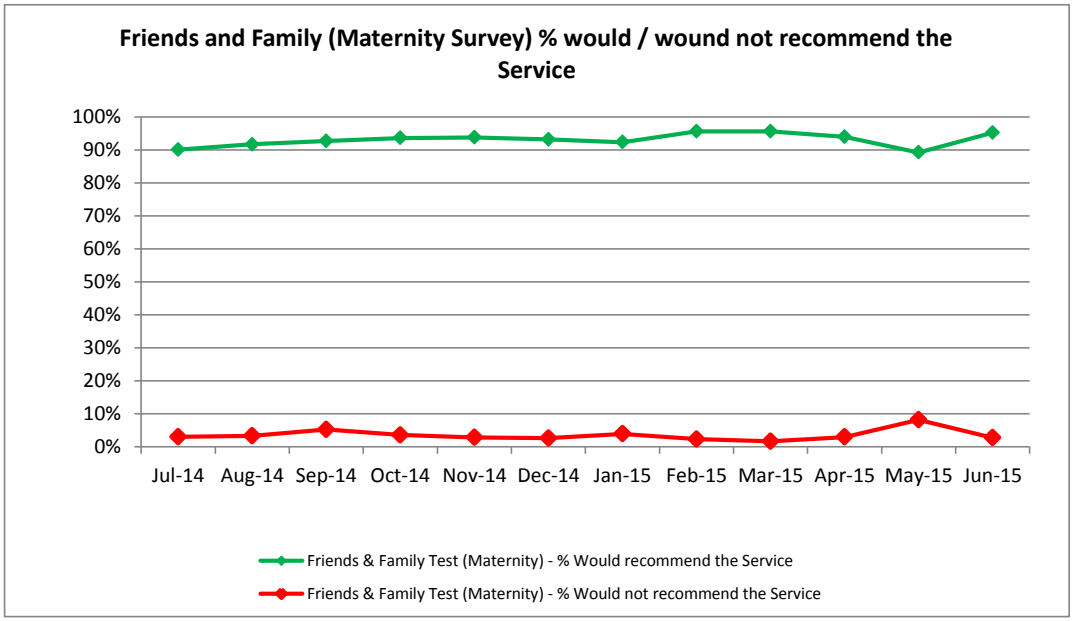





Friends and Family (IP Survey) % would / wound not recommend the Service
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jul-14 Aug-14 Sep-14 Oct-14 Nov-14 Dec-14 Jan-15 Feb-15 Mar-15 Apr-15 May-15 Jun-15
Friends & Family Test (IP Survey) - % would recommend the Service
Friends & Family Test (IP Survey) - % would not recommend the Service


Friends and Family (A&E Survey) % would / wound not recommend the Service
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jul-14 Aug-14 Sep-14 Oct-14 Nov-14 Dec-14 Jan-15 Feb-15 Mar-15 Apr-15 May-15 Jun-15
Friends and Family Test A & E Survey - % would recommend the Service
Friends and Family Test A & E Survey - % would not recommend the Service


Complaints Response Times
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jul-14 Aug-14 Sep-14 Oct-14 Nov-14 Dec-14 Jan-15 Feb-15 Mar-15 Apr-15 May-15 Jun-15
% Complaints Closed within target timeframe
Threshold


Friends and Family (Maternity Survey) % would / wound not recommend the Service
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
Jul-14 Aug-14 Sep-14 Oct-14 Nov-14 Dec-14 Jan-15 Feb-15 Mar-15 Apr-15 May-15 Jun-15
Friends & Family Test (Maternity) - % Would recommend the Service
Friends & Family Test (Maternity) - % Would not recommend the Service

			Report For: June 2015						Year To Date								
	Report For: June 2015	Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Year End Forecast	Data Quality
Safety	Inpatient Falls with Serious Harm (10% reduction on 14/15)	Local	1	3	0	3	0	-	4	7	1	6	0	-			
	All Falls	Local	-	158	31	123	4	-	-	501	91	398	12	-			
	Number of Trust Pressure Ulcers Acquired at CHFT	Local	16	24	6	18	0	-	47	68	17	49	2	-			
	Number of Category 2 Pressure Ulcers Acquired at CHFT	Local	11	16	5	11	0	-	32	49	13	34	2	-			
	Number of Category 3 Pressure Ulcers Acquired at CHFT	Local	0	7	1	6	0	-	0	18	4	14	0	-			
	Number of Category 4 Pressure Ulcers Acquired at CHFT	Local	0	1	0	1	0	-	0	1	0	1	0	-			
	Number of Category 3 & 4 Pressure Ulcers Acquired at CHFT	Local	0	8	1	7	0	-	0	8	4	15	0	-			
Safety 2	Percentage of Completed VTE Risk Assessments	National & Contract	95.00%	95.20%	95.40%	94.00%	96.70%	-	95.00%	95.20%	94.90%	94.50%	97.10%	-			
	Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	Local	100.00%	100.00%	100.00%	100.00%	-	-	100.00%	100.00%	100.00%	100.00%	-	-			
	% Harm Free Care	CQUIN	95.00%	94.69%	96.47%	91.64%	100.00%	95.19%	95.00%	94.39%	96.73%	90.75%	100.00%	95.10%			
	Safeguarding Alerts made by the Trust	Local	-	18	-	-	-	-	-	48	-	-	-	-			
	Safeguarding Alerts made against the Trust	Local	-	9	-	-	-	-	-	24	-	-	-	-			
	Improving Medicines Safety – Reconciliation (Effective Transfer of Medicines)	CQUINS	80.00%	78.31%	-	-	-	-	80.00%	79.81%	-	-	-	-			
	Improving Medicines Safety Discharge Accuracy Checks	CQUINS	70.00%	75.02%	-	-	-	-	70.00%	73.26%	-	-	-	-			
	World Health Organisation Check List	National	100.00%	97.49%	-	-	-	-	100.00%	97.72%	-	-	-	-			
	Missed Doses (Reported quarterly)	National	10.00%	7.80%	9.63%	7.10%	6.55%	-	-	7.80%	9.63%	7.10%	6.55%	-			
Safety 3	Number of Patient Incidents	Monitor	-	622	115	289	156	50	-	1980	380	919	516	161			
	Number of SI's	Monitor	-	15	1	7	0	7	-	45	4	17	2	22			
	Number of Incidents with Harm	Monitor	-	201	22	101	38	34	-	616	83	291	142	100			
	Never Events	National	0	0	0	0	0	0	0	0	0	0	0	0			
	Percentage of SI's reported externally within timescale (2 days)	Local	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	-	-	-	-	-	-			
	Percentage of SI's investigations where reports submitted within timescale (45 days unless extension agreed)	Local	100.00%	50.00%	100.00%	66.00%	-	-	100.00%	45.45%	25.00%	46.15%	100.00%	-			
	Total Duty of Candour reported within the month	National & Contract	100.00%	100.00%	100.00%	100.00%	-	100.00%	-	-	-	-	-	-			
	Total Duty of Candour outstanding at the end of the month	National & Contract	0	0	0	0	-	0	0	5	3	4	0	0			

Report For: June 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Inpatient Falls with Serious Harm (10% reduction on 14/15)	1	3	0	3	0	-
All Falls	-	158	31	123	4	-
Number of Trust Pressure Ulcers Acquired at CHFT	16	24	6	18	0	-
Number of Category 2 Pressure Ulcers Acquired at CHFT	11	16	5	11	0	-
Number of Category 3 Pressure Ulcers Acquired at CHFT	0	7	1	6	0	-
Number of Category 4 Pressure Ulcers Acquired at CHFT	0	1	0	1	0	-
Number of Category 3 & 4 Pressure Ulcers Acquired at CHFT	0	8	1	7	0	-

Falls with Serious Harm

Why off plan:

There have been 7 falls in the first three months of the year against a 10% reduction target of 4, 6 falls in medicine and 1 in surgery.

All 3 incidents are within the major harm category in June (nasal #, L shoulder # and subdural haematoma) and 2 falls occurred on the same ward area.

Actions to get back on plan:

Medical Division Falls collaborative has been convened to focus upon improvements in medicine. Vulnerable Adults Operational Group to review falls action plan in view of thematic review

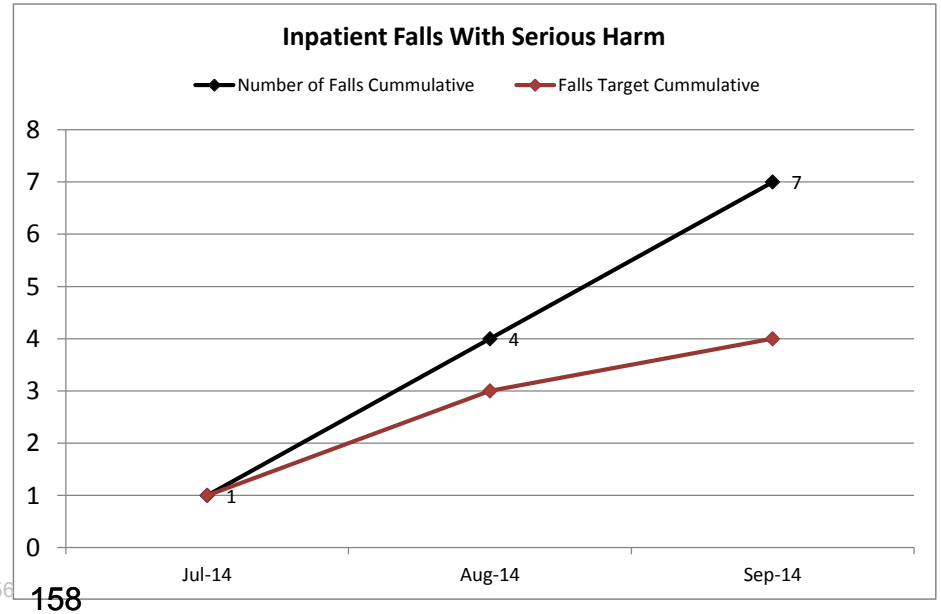
Time scale: End August for medicine Collaborative.

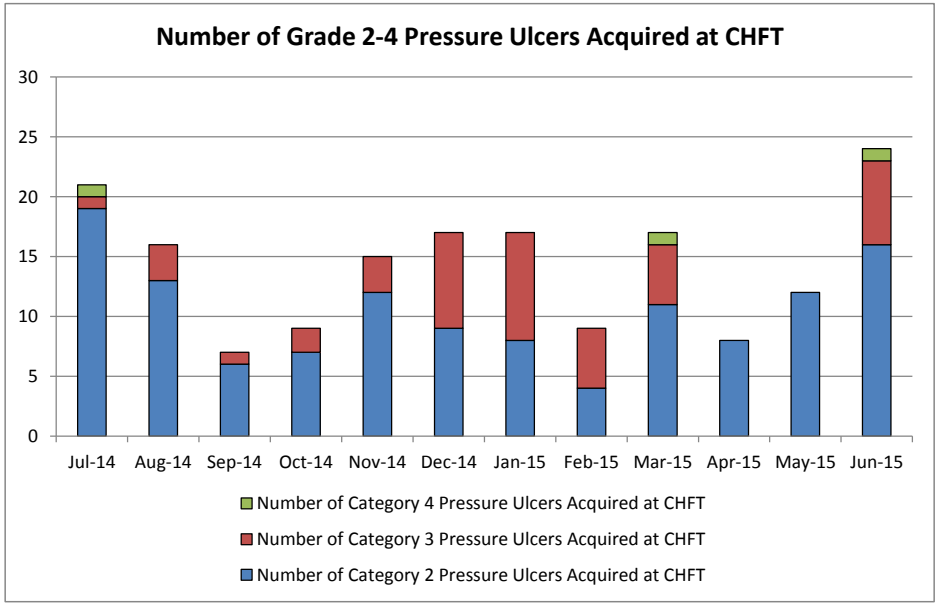
Pressure Ulcers - Category 3 & Category 4.

1.Why off plan? There were seven category 3 ulcers noted in June and 1 category 4.

2. Actions to get back on plan: Wards with the highest reported incidences continue to review ward level action plans and develop plans to support improvement . Tissue Viability (TV) support is being provided to help ward staff in the recognition of high risk patients and devise appropriate treatment plans. A thematic review is being undertaken in the next 4 weeks to further understand the issues behind the rise in ulcers, and will look at the spilt between avoidable and unavoidable cases.

3. Achieved by date: Following the thematic review and action plan will be put in place, with improvements expected from September 2015 onwards.





Report For: June 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Percentage of Completed VTE Risk Assessments	95.00%	95.20%	95.40%	94.00%	96.70%	-
Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	100.00%	100.00%	100.00%	100.00%	-	-
% Harm Free Care	95.00%	94.69%	96.47%	91.64%	100.00%	95.19%
Safeguarding Alerts made by the Trust	-	18	-	-	-	-
Safeguarding Alerts made against the Trust	-	9	-	-	-	-
Improving Medicines Safety – Reconciliation (Effective Transfer of Medicines)	80.00%	78.31%	-	-	-	-
Improving Medicines Safety Discharge Accuracy Checks	70.00%	75.02%	-	-	-	-
Missed Doses (Reported quarterly)	10.00%	7.80%	9.63%	7.10%	6.55%	-
World Health Organisation Check List	100.00%	97.49%	-	-	-	-

Improving Medicines Safety – Reconciliation

Why are we off plan? During the month of June there were significant staff pressures in pharmacy, due to staff sickness and annual leave.

Actions to get back on plan: Remedial action in place to ensure future months are compliant.

Achieved by when: July 2015

Harm Free Care (medicine): 1. Why off plan?

Harm free care for the division for the month is at 91.64% against a target of 95%. The point prevalence study undertaken on a monthly basis supports the identified risk relating to increasing number of pressure ulcers and falls with harm.

Actions to get back to plan: Falls – Improvement collaborative has been re-established within the division and focussed work will be undertaken with key ward areas. Additional areas of work will be actioned through the vulnerable adults operational group.

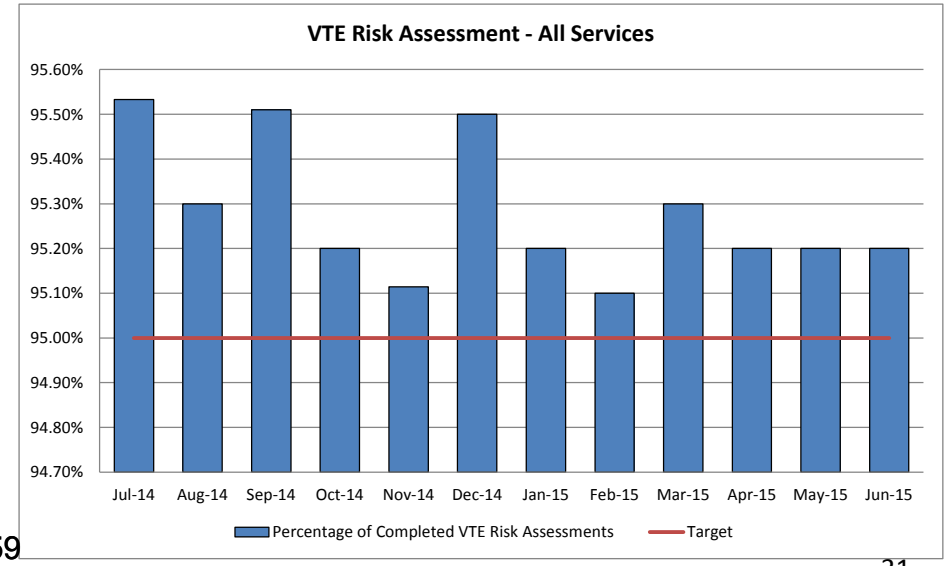
Pressure Ulcers – Key ward areas e.g. Ward 11 are undertaking work with the improvement academy to introduce safety huddles. Ward 5AD & 6BC are currently undertaking a documentation audit, skill mix review and training on the classification of pressures ulcers. Learning from these areas will be transferred across to other wards within the division. **Achieved by date**: September 2015 due to the need to embed the improvement.

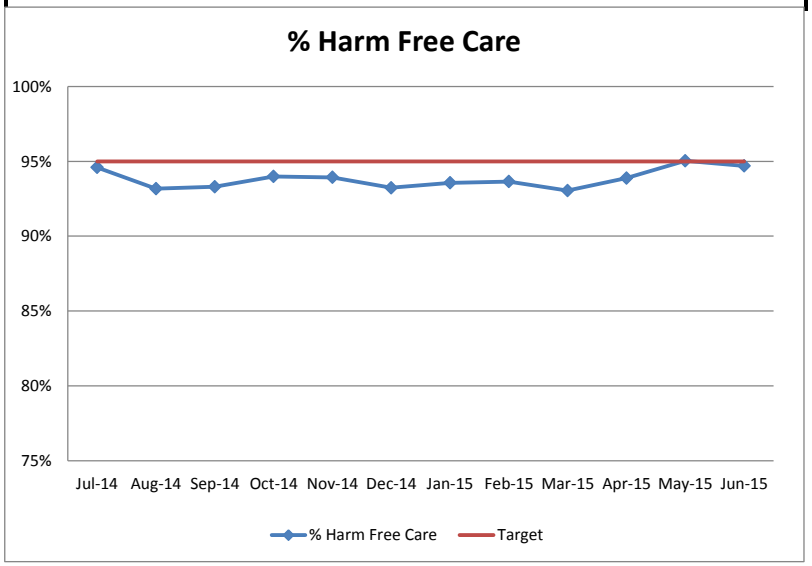
World Health Organisation Check List

1. Why off plan? There are groups of patients who don't require the WHO checklist. The current theatre system is unable to exempt these cases. There are also a few technical issues where part of the form is not saved which leads to an uncompleted case being noted. It is very rare event that a person does not have a checklist completed.

2. Actions to get it back on plan: Performance monitoring for the small number of non-compliant cases, leading to engagement work in the clinical teams. For the exempt patients a theatre system upgrade has been requested to have a N/A option included.

3. Achieved by date: The next system upgrade will be in September 2015. Engagement working expected to have an impact in May/June 2015.

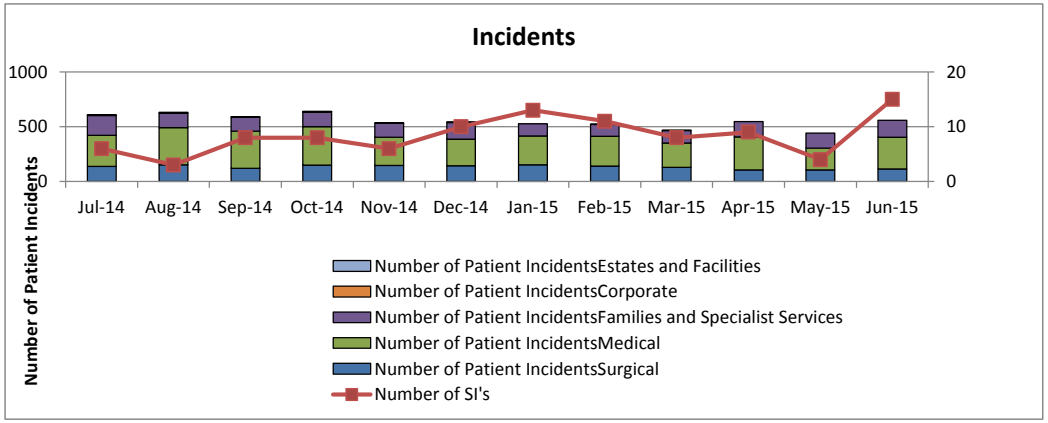


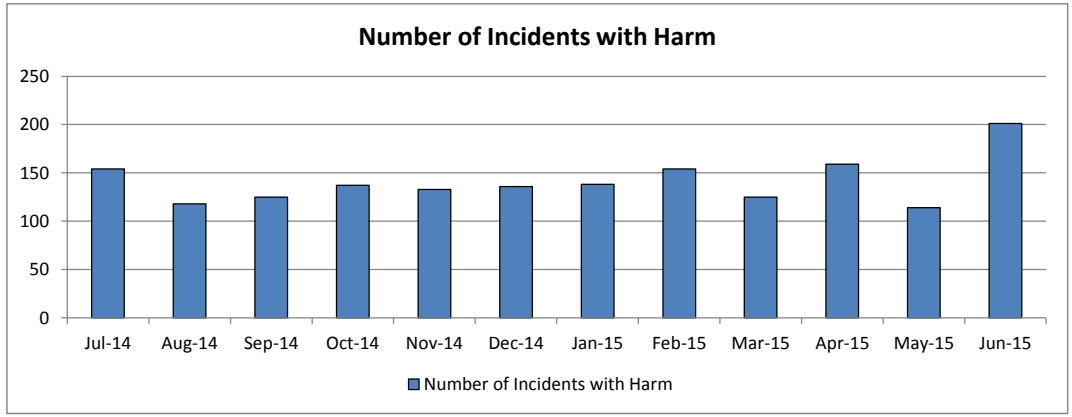


Report For: June 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Estates and Facilities	Corporate
Number of Patient Incidents	-	622	115	289	156	50	-	-
Number of SI's	-	15	1	7	0	7	-	-
Number of Incidents with Harm	-	201	22	101	38	34	-	-
Never Events	0	0	0	0	0	0	-	-
Percentage of SI's reported externally within timescale (2 days)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	-	-
Percentage of SI's investigations where reports submitted within timescale (45 days unless extension agreed)	100.00%	50.00%	100.00%	66.00%	-	-	-	-
Total Duty of Candour reported within the month	100%	100.00%	100.00%	100.00%	-	100.00%	-	-
Total Duty of Candour outstanding at the end of the month	0	0	0	0	-	0	-	-

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

1. Why off Plan: there were 4 reports due for submission in June, all related to pressure ulcers. The Medical division of the 3 due, 2 were submitted late. Surgical - 1 was due and submitted on time.
2. Action taken: There is a new process regarding presure ulcer reporting which will ensure the process is more timely going forward.
3.Achieved by: July 2015





Effectiveness Executive Summary

Report For: June 2015		Indicator Source	Report For: June 2015 Target	Report For: June 2015 Trust	Report For: June 2015 Surgical	Report For: June 2015 Medical	Report For: June 2015 Families and Specialist Services	Report For: June 2015 Community	Year To Date Target	Year To Date Trust	Year To Date Surgical	Year To Date Medical	Year To Date Families and Specialist Services	Year To Date Community	Trend (Rolling 12 Month)	Year End Forecast	Data Quality
Effectiveness	Number of MRSA Bacteraemias – Trust assigned	National & Contract	0	0	0	0	0	-	0	1	0	1	0	-			
	Total Number of Clostridium Difficile Cases - Trust assigned	National & Contract	2	1	1	0	0	-	21	3	1	2	0	-			
	Avoidable number of Clostridium Difficile Cases	National & Contract	0	1	1	0	0	0	21	2	1	1	0	-			
	Unavoidable Number of Clostridium Difficile Cases	National & Contract	2	0	0	0	0	0	21	1	0	1	1	-			
	Number of MSSA Bacteraemias - Post 48 Hours	National	1	1	0	1	0	-	12	3	1	2	0	-			
	% Hand Hygiene Compliance	Local	95.00%	99.29%	99.80%	99.70%	99.21%	100.00%	95.00%	99.74%	99.49%	99.80%	100.00%	100.00%			
	MRSA Screening - Percentage of Inpatients Matched	Local	95.00%	95.74%	93.66%	99.38%	94.64%	-	95.00%	95.26%	93.17%	99.30%	94.81%	-			
	Number of E.Coli - Post 48 Hours	Local	2	5	1	4	0	-	29	9	2	7	0	-			
Effectiveness 2	Emergency Readmissions Within 30 Days (With PbR Exclusions)	National	7.20%	7.75%	4.78%	11.12%	7.43%	-	7.63%	8.17%	4.50%	12.60%	6.60%	-			
	Local SHMI - Relative Risk (1yr Rolling Data Oct 13- Sept 14)	National	100	109	-	-	-	-	100	109	-	-	-	-			
	Hospital Standardised Mortality Rate (1 yr Rolling Data Apr 14 - Mar 15)	National	100	110.00	-	-	-	-	100.00	108.53	-	-	-	-			
	Mortality Reviews – April Deaths	local	100.00%	20.20%	26.30%	19.40%	-	-	100.00%	44.10%	41.20%	44.50%	-	-			
	Crude Mortality Rate (Latest Month June 15)	National	1.00%	1.19%	0.49%	2.78%	0.00%	-	1.00%	1.40%	0.46%	3.36%	0.07%	-			
	Completion of NHS numbers within acute commissioning datasets submitted via SUS	Contract	99.00%	99.90%	99.90%	99.90%	99.90%	-	99.00%	99.90%	99.90%	99.90%	99.90%	-			
	Completion of NHS numbers within A&E commissioning datasets submitted via SUS	Contract	95.00%	99.10%	-	99.10%	-	-	95.00%	99.10%	-	99.10%	-	-			
	Average Diagnosis per Coded Episode	National	4.90	3.94	3.39	5.46	2.23	-	4.90	3.95	3.41	5.50	2.26	-			
Effectiveness 3	Acute Kidney Injury (Reported quarterly)	CQUINS	Baseline	18.00%	-	-	-	-	-	21.33%	-	-	-	-			
	Sepsis Screening (Reported quarterly)	CQUINS	Baseline	100.00%	-	-	-	-	-	88.89%	-	-	-	-			
	Sepsis Antibiotic Administration (Reported Quarterly)	CQUINS	Baseline	27.27%	-	-	-	-	-	40.00%	-	-	-	-			
	Respiratory Care Bundle - Improving management of patients attending A&E with pneumonia (Reported quarterly)	CQUINS	60.00%	70.00%	-	-	-	-	60.00%	70.00%	-	-	-	-			
	Respiratory Care Bundle - Improving management of patients presenting with Asthma in ED (Reported quarterly)	CQUINS	65.00%	66.00%	-	-	-	-	65.00%	66.00%	-	-	-	-			
	Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	National	85.00%	86.21%	86.21%	-	-	-	85.00%	70.69%	70.69%	-	-	-			

Report For: June 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Number of MRSA Bacteraemias – Trust assigned	0	0	0	0	0	-
Total Number of Clostridium Difficile Cases - Trust assigned	2	1	1	0	0	-
Avoidable number of Clostridium Difficile Cases	0	1	1	0	0	0
Unavoidable Number of Clostridium Difficile Cases	2	0	0	0	0	0
Number of MSSA Bacteraemias - Post 48 Hours	1	1	0	1	0	-
% Hand Hygiene Compliance	95.00%	99.29%	99.80%	99.70%	99.21%	100.00%
MRSA Screening - Percentage of Inpatients Matched	95.00%	95.74%	93.66%	99.38%	94.64%	-
Number of E.Coli - Post 48 Hours	2	5	1	4	0	-

Avoidable number of Clostridium Difficile Cases:
Why are we off plan? There was one avoidable C.Diff this month due antibiotic treatment

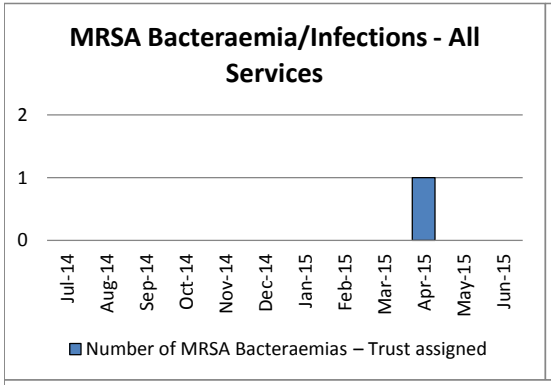
Actions to get back on plan? The RCA has been completed. The action plan from the RCA will covers the issues raised.

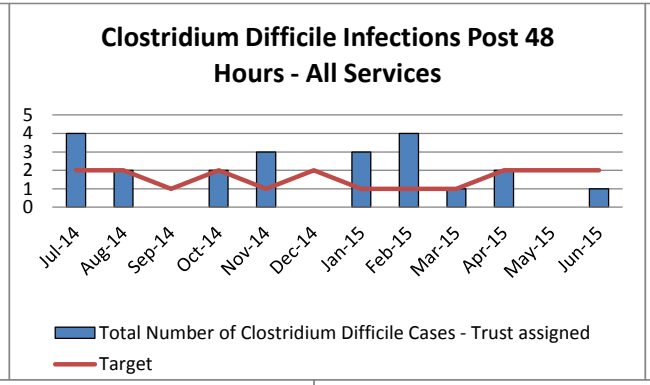
Achieve by date: TBC once action plan completed.

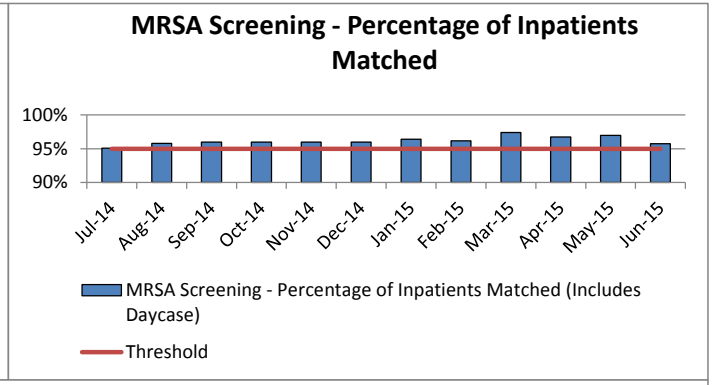
E.coli
Why are we off plan? Of the 5 E.coli's. 4 were urinary in origin, 2 with long term catheters. The non-catheterised patients were not assessed as being healthcare associated.

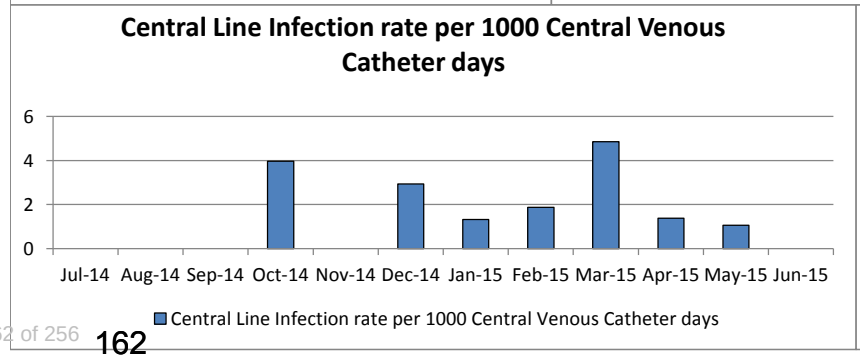
Actions to get back on plan? A programme of work, looking to promote the use of intermittent catherisation continues in the trust, with the aim of reducing the indwelling catheter rate and therefore the associated infection risk.

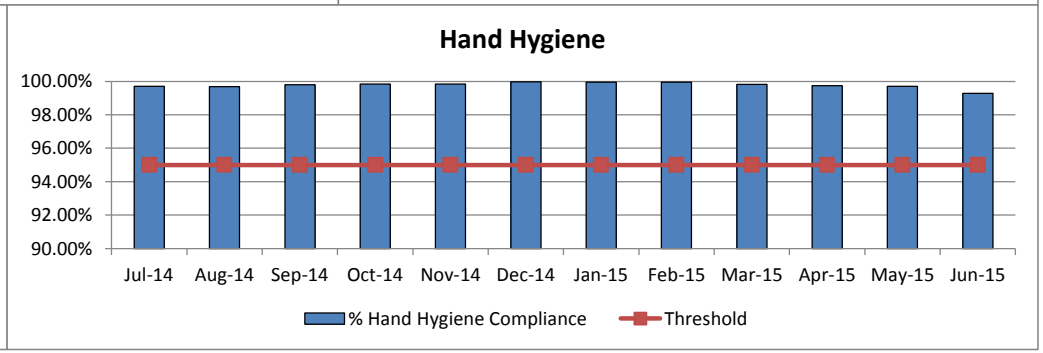
Achieve by date: Phase two of the Intermittent Catheter programme commences in July 2015. Phase one has already seen some reduction in long term indwelkling catherter use on ward 8AB. Futher reductions expected in the wards identified for phase two, by Sept 2015.











Report For: June 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Emergency Readmissions Within 30 Days (With PbR Exclusions)	7.20%	7.75%	4.78%	11.12%	7.43%	-
Local SHMI - Relative Risk (1yr Rolling Data Oct 13- Sept 14)	100	109	-	-	-	-
Hospital Standardised Mortality Rate (1 yr Rolling Data Apr 14 - Mar 15)	100	110	-	-	-	-
Crude Mortality Rate (Latest Month June 15)	1.00%	1.19%	0.49%	2.78%	0.00%	-
Mortality Reviews – April Deaths	100.00%	20.20%	26.30%	19.40%	-	-
Completion of NHS numbers within acute commissioning datasets submitted via SUS	99.00%	99.90%	99.90%	99.90%	99.90%	-
Completion of NHS numbers within A&E commissioning datasets submitted via SUS	95.00%	99.10%	-	99.10%	-	-
Average Diagnosis per Coded Episode	4.90	3.94	3.39	5.46	2.23	-

Emergency Readmissions Within 30 Days (With PbR Exclusions)

1.Why is it off plan?

The key delivery vehicles for readmissions are the virtual ward teams, for Calderdale this is a CHFT team for Kirklees this is managed by Locala.

CHFT readmissions is better than target and continues to manage high volumes with good outcomes; Locala are reviewing their model reducing the face to face contact, the Kirklees readmission % is now worse than target.

Action to get back on plan: the CHFT will continue to work as current plan and the Locala Senior officer will be contacted with the concerns regarding model changes and outcomes with a requirement to confirm their improvement plan.

Achieved by: Improvement plan with trajectory to be confirmed by 31st August 2015

SHMI/HSMR/Crude Mortality

1. Why it is off plan? The most recent release indicated a SHMI of 109 the 12 months of Oct 13 to Sept 14. This has reduced from the 110 published in June 13 - July 14 but is still higher than target. It does remain in the "as expected" category indicating that there are not significantly more deaths than would be expected for the trusts patient population. The most recent 12 months data for HSMR indicates a score of 110.59, which is an increase from previous release and is an outlying position. June's crude mortality is also higher than target . The number of mortality reviews carried out on April's deaths is under target.

2.Action to get back on plan: The Acutely ill Patient (CAIP) programme is being renewed, with external support to help further understanding why the position appears to be deteriorating which will include a detailed look at the formulation of the statistics and a deep dive into the quality of care delivered. A new process of getting deceased case notes to consultant reviewers is being trialled to get more timely learning and a broader number of reviews carried out.

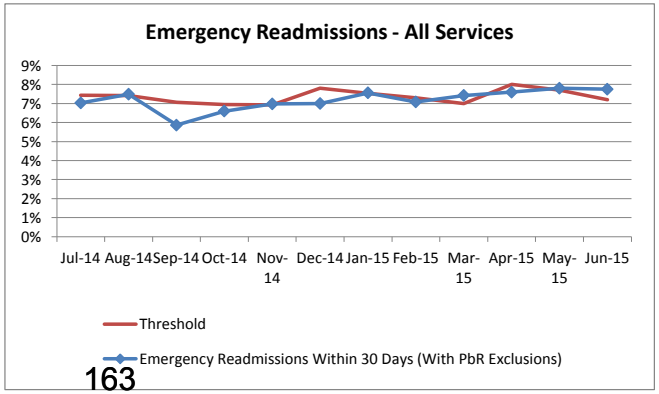
3.Achieved By: Improvements in Mortality Review compliance expected next quarter as new process becomes embedded

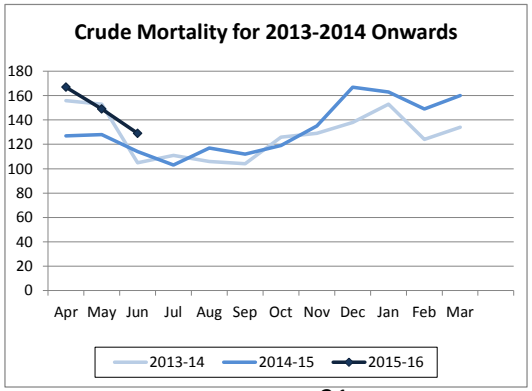
Average Diagnosis per Coded Episode

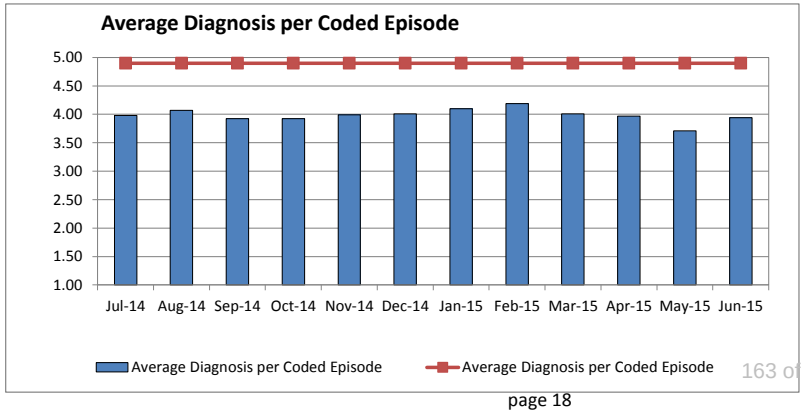
1. Why off plan? CHFT depth of coding is less than plan due to missed or undocumented relevant comorbidities within the coding source documentation. May also be due to incomplete coding documentation at the time of coding. Clinical Coding depth is falling largely due to the result of changes to coding rules at the start of April 2015. Prior to April 2015 patients admitted for blood transfusions, drug infusions, terminations, pain injections, eye injections codes were included to specify admission for drug therapy or admission for blood transfusion. From April 2015 under the new national coding rules these codes should not be included in the coding of the stay. Consequently the average diagnoses per episode has dropped quite dramatically. Omission of the codes does not affect the comorbidity score or income.

2. Action to get it back on plan: Clinical engagement and presentations continue around importance of complete and accurate documentation including work to develop existing documentation to assist coding process. Co-morbidity form compliance continues to be monitored on a fortnightly basis. Work is ongoing to address recruitment issues within the coding team.

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

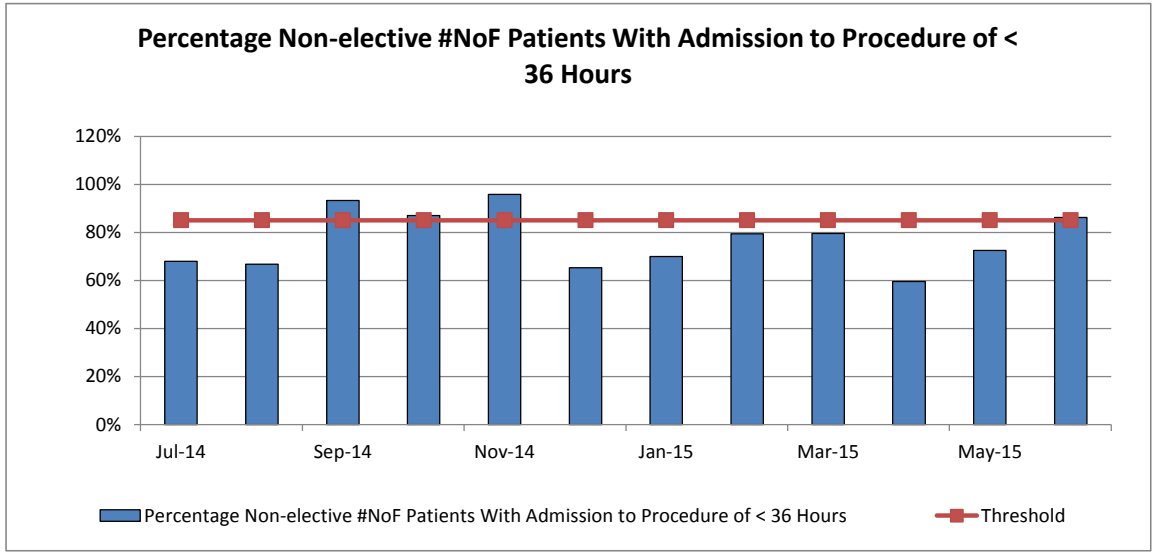






Effectiveness - Medical Director

Report For: June 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Acute Kidney Injury (Reported quarterly)	Baseline	18.00%	-	-	-	-
Sepsis Screening (Reported quarterly)	Baseline	100.00%	-	-	-	-
Sepsis Antibiotic Administration (Reported Quarterly)	Baseline	27.27%	-	-	-	-
Respiratory Care Bundle - Improving management of patients attending A&E with pneumonia (Reported quarterly)	60.00%	70.00%	-	-	-	-
Respiratory Care Bundle - Improving management of patients presenting with Asthma in ED (Reported quarterly)	65.00%	66.00%	-	-	-	-
Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	85.00%	86.21%	86.21%	-	-	-



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Workforce indicators

The row of tables below show sickness absence rates for CHFT during April and May 2015, broken down by division, identifying movement from the previous month, performance against the 4% threshold.

The second row of tables show the average length of a sickness episode, identifying movement from the previous month. The next tables look at the year to date performance of CHFT and the divisions against the 4% target. The final table looks at staff in post by headcount and full time equivalent (FTE).

FTE Days Lost is calculated by taking the FTE of the employee and multiplying by the length of sickness (in days). For example an employee on 0.5 FTE who is sick for 4 days would equate to an FTE Days Lost of 2.0

FTE Days Available is calculated by taking the FTE of the employee and multiplying by the number of days in the reporting period. For example during May an employee on 0.5 FTE would have 15.5 FTE Days Available.

Sickness Absence rate (%) (1 Month Behind)

Division	Apr-15	May-15	Movement
Surgery	4.13%	4.37%	↑
Medical	5.11%	5.49%	↑
Community	2.89%	3.51%	↑
FSS	4.60%	5.30%	↑
Estates	6.44%	5.81%	↓
Corporate	1.66%	2.26%	↑
THIS	5.52%	4.02%	↓
Trust	4.45%	**4.79%**	↑

Sickness Absence rate (%) (1 Month Behind)

Division	Short Term	Long Term	Overall %	RAG
Surgery	1.00%	3.37%	4.37%	🔴
Medical	1.40%	4.09%	5.49%	🔴
Community	0.89%	2.61%	3.51%	🟢
FSS	1.23%	4.07%	5.30%	🔴
Estates	1.64%	4.17%	5.81%	🔴
Corporate	0.83%	1.43%	2.26%	🟢
THIS	0.78%	3.24%	4.02%	🔴
Trust	**1.17%**	**3.62%**	**4.79%**	🔴

Sickness Absence full time equivalent (FTE) breakdown (1 Month Behind)

Division	Available FTE	Short Term FTE	Long Term FTE	FTE Days Lost
Surgery	33927.36	339.47	1144.38	1483.85
Medical	39377.96	549.51	1612.18	2161.69
Community	14741.05	131.63	385.26	516.89
FSS	44940.79	551.58	1829.29	2380.87
Estates	8567.65	140.79	357.17	497.96
Corporate	8337.57	69.24	119.00	188.24
THIS	5528.13	43.27	179.00	222.27
Trust	**155420.51**	**1825.48**	**5626.29**	**7451.76**

Sickness Average FTE Lost per Episode

Division	Apr-15	May-15	Movement
Surgery	10.28	11.16	↑
Medical	11.32	9.78	↓
Community	8.56	9.75	↑
FSS	9.39	11.34	↑
Estates	9.49	9.58	↑
Corporate	8.27	6.97	↓
THIS	13.55	11.70	↓
Trust	10.13	10.42	↑

Sickness Absence full time equivalent (FTE) breakdown Year to Date

Division	Available FTE	FTE Days Lost	YTD Sicknes %	RAG
Surgery	66800.68	2841.07	4.25%	🔴
Medical	77512.81	4109.54	5.30%	🔴
Community	28971.24	927.60	3.20%	🟢
FSS	88567.09	4390.85	4.96%	🔴
Estates	16974.92	1039.01	6.12%	🔴
Corporate	16297.98	320.55	1.97%	🟢
THIS	10921.13	520.40	4.77%	🔴
Trust	**306045.85**	**14149.02**	**4.62%**	🔴

Staff in Post Full Time Equivalent

Division	May-15	Jun-15	Movement
Surgery	1094.43	1076.32	↓
Medical	1270.26	1257.78	↓
Community	475.52	475.45	↓
FSS	1448.54	1430.94	↓
Estates	276.38	272.91	↓
Corporate	268.95	275.59	↑
THIS	178.33	179.33	↑
Trust	**5012.40**	**4968.32**	↓

Staff in Post Headcount

May-15	Jun-15	Movement
1223	1201	↓
1420	1405	↓
578	578	→
1712	1692	↓
361	357	↓
309	316	↑
185	186	↑
5788	**5735**	↓

Sickness Absence/Attendance Management at work

Why are we away from plan -
Community and Corporate are the only divisions with a % below the 4% threshold identified . Short term sickness absence for the Trust is at 1.17% long term absence at 3.62% . The May 2015 figure compares to a May 2014 figure of 1.21% short term absence and long term absence of 2.45%. The 2015-16 year to date sickness rate of 4.62% compares to a 2014-15 outturn sickness rate of 4.26%.

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

In-depth analysis of attendance management issues and key findings to be taken to the Board of Directors on 30 July 2015
Attendance management policy updated – to be taken to Policy Sub-Group and Staff Management Partnership Forum in July 2015
A comprehensive Health and Wellbeing Strategy is currently being developed and will be ready by the end of August 2015
Enhanced line manager resource toolkit including short videos to be launched August 2015
Line manager briefings/breakthrough sessions timetabled for September and October 2015
ESR Business Intelligence tool roll out into Medical Division as a pilot towards the end of August 2015

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Training indicators

Mandatory Training Indicators completed since April 2015								
Division	Prevent	Equality & Diversity	Information Governance	Infection Control	Health & Saftey	Manual Handling	Safe Guarding	Fire safety
Surgery	4.9%	13.60%	16.50%	8.90%	8.90%	8.40%	5.4%	13.60%
Medical	1.8%	9.00%	16.60%	7.30%	7.00%	7.00%	3.3%	11.80%
FSS	2.9%	11.10%	17.30%	8.90%	7.80%	8.30%	3.3%	25.70%
Community	3.6%	10.50%	14.80%	6.40%	5.10%	6.60%	3.0%	18.20%
Estates	0.6%	4.40%	9.10%	5.60%	5.00%	5.30%	2.6%	25.30%
Corporate	3.9%	14.30%	17.20%	13.00%	11.70%	12.00%	8.1%	31.80%
THIS	16.8%	19.00%	14.50%	14.50%	15.60%	15.10%	6.1%	14.50%
Trust	**3.5%**	**11.10%**	**16.10%**	**8.50%**	**7.90%**	8.10%	**4.0%**	**19.00%**

Non-Medical Appraisals - Completed Since April 2015		
Division	Compliance	YTD Target (24%)
Surgery	5.70%	●
Medical	9.00%	●
FSS	7.40%	●
Community	9.40%	●
Estates	1.80%	●
Corporate	2.00%	●
THIS	5.60%	●
Trust	**7.24%**	●

Medical Devices Training		
Division	Compliance	100% Target
Surgery	74.00%	●
Medical	75.00%	●
FSS	80.00%	●
Community	-	-
Estates	-	-
Corporate	92.00%	●
THIS	-	-
Trust	**80.00%**	●

Mandatory Training Indicators completed in last 12 Months								
Division	Prevent	Equality & Diversity	Information Governance	Infection Control	Health & Saftey	Manual Handling	Safeguarding	Fire safety
Surgery	17.90%	67.10%	64.20%	65.20%	65.00%	64.70%	64.00%	57.70%
Medical	25.50%	69.40%	71.00%	68.90%	68.80%	68.80%	68.20%	65.80%
FSS	40.30%	73.50%	76.10%	71.10%	70.80%	70.90%	69.60%	72.90%
Community	75.90%	79.90%	73.10%	78.80%	78.20%	78.60%	78.00%	75.20%
Estates	15.00%	93.20%	93.50%	93.20%	93.20%	93.20%	92.90%	70.90%
Corporate	31.50%	83.10%	75.30%	75.30%	75.00%	75.60%	73.70%	72.40%
THIS	19.00%	80.40%	78.20%	79.90%	79.90%	79.90%	76.50%	64.20%
Trust	**32.7%**	**73.80%**	**73.20%**	**60.77%**	**71.80%**	**71.80%**	**70.9%**	**67.80%**

Non-Medical Appraisals - Completed in last 12 Months		
Division	Compliance	100% Target
Surgery	66.90%	●
Medical	68.40%	●
FSS	84.30%	●
Community	57.10%	●
Estates	89.40%	●
Corporate	82.90%	●
THIS	64.00%	●
Trust	**73.90%**	●

Non-Medical Appraisal

Why are we away from plan

Absence of non-medical appraisal activity plans which spread activity across a 12-month period and / or non-delivery of appraisal activity plans

Action to get on Plan including timescales

In 2015/16 work with the divisions will focus on making more robust plans to spread non-medical appraisal activity over a 12 month period as the bulk of non-medical appraisal activity is currently focussed into the last quarter of the year. To assist with this an appraisal planning tool has been developed by THIS and Workforce In formation colleagues. The tool has been tested in Workforce and OD and will be available for use by divisional colleagues in late July. The tool will enable an assessment to be made of planned activity ag ainst actual activity each month facilitating a forecast position to be determined month by month. From August a 'comply or explain' approach will be adopted requiring divisional colleagues to identify barrie rs to improved performance/delivery of the monthly 8% compliance target and plans for moving performance into compliance. Individual meetings with divisional leads are being scheduled about the non-medical appraisal planning tool and compliance reporting approach in July.

NB: ESR is the only accepted reporting tool for non-medical appraisal compliance. The deadline for inputting non-medical appraisal activity data each month is 1st working day of month for previous month's appraisals. Activity recorded after this data will only be included in compliance reports in the following months.

Mandatory Training

Why are we away from plan?

The new mandatory training approch (the Core Skills Training Framework or CSTF) has been in operation for only 1 month (June) of Q1. Communication intervention and colleague engagement is still in the initial phase.

Action to get on Plan including timescales

-Monthly enhancements to the web portal
-Head of workforce development visiting numerous set-piece divisional and role specific meetings to promote the framework throughout July to September 2015
-Desk top sessions scheduled for the year to support individual colleagues with their e-learning throughout the year
-Divisional/Corporate Function leads to produce schedule of planned activity July/August 2015
-Improved staffing levels with newly qualified nurses and midwives recruited from September 2015

Medical Devices

Medical Devices Training is currently at 79% compliance across the Trust.
Action to get on Plan - (1) Regular reminders to all staff re Medical Devices training requirements via newsletter, intranet not ices, link nurse, matrons and department managers group emails (2)Discuss and remind Medical Devices training group and link nurse meeting members to cascade Medical Devices Training requirements throughout divisions. (3) Organise and promote medical devices training events (4) Contact all areas below 75% compliance (in the red) to develop an action plan to improve training compliance
By Who- (1) Director of Planning, Performance, Estates & Facilities, ADN's, Matrons, General Managers, Department Heads, Line Ma nagers and link nurses (2) Medical Devices Training Coordinator and Medical Devices Training support .
When- (1) On-going throughout the year

Well Led indicators

The first row of tables below show the performance against the Friends and Family test scores for the quarter 4 identifying movement from the previous quarters performance.

The second row of tables show the Hard Truths staffing level indicators.

FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly)			
Division	Quarter 4	Quarter 1	**Movement**
Surgery	**79.00%**	**79.00%**	→
Medical	**80.00%**	**77.00%**	↓
FSS	**34.56%**	**52.32%**	↑
Community	-	**77.00%**	→
Estates	**89.00%**	**85.00%**	↓
Corporate	**79.00%**	**84.00%**	↑
THIS	**75.00%**	**76.00%**	↑
Trust	**81.00%**	**77.00%**	↓

FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly)			
Division	Quarter 4	Quarter 1	**Movement**
Surgery	**55.00%**	**Data being confirmed, to follow.**	-
Medical	**54.00%**		-
FSS	**34.68%**		-
Community	-		-
Estates	**53.00%**		-
Corporate	**57.00%**		-
THIS	**66.00%**		-
Trust	**59.00%**		-

Hard Truths Summary Day - Nurses/Midwives		
Division	Jun-15	95% Target
Surgery	95.91%	
Medical	87.49%	
FSS	88.93%	
Trust	**90.07%**	

Hard Truths Summary - Day Care Staff		
Division	Jun-15	95% Target
Surgery	95.67%	
Medical	95.45%	
FSS	96.96%	
Trust	**95.68%**	

Hard Truths Summary - Night Nurses/Midwives		
Division	Jun-15	95% Target
Surgery	86.19%	
Medical	91.33%	
FSS	86.84%	
Trust	**88.81%**	

Hard Truths Summary - Night Care Staff		
Division	Jun-15	95% Target
Surgery	118.08%	
Medical	118.83%	
FSS	78.41%	
Trust	**113.16%**	

Hard Truths Staffing Levels

Why we are away from plan

The overall average fill rates by site have increased for qualified nurses (Day and Night) this month to over 90% on the HRI site and over 86% on the CRH site.
The rag rating for fill rates in June is demonstrated below:

	Qualified	Unqualified	Qualified	Unqualified
Red (less than 75% fill rate)	2	4	1	2
Amber (75 – 89% fill rate)	12	4	14	3
Green (90-100% fill rate)	13	9	16	9
Blue (greater than 100%)	6	16	2	18

There were 2 areas with average fill rates for Qualified Nurses (Day) of less than 75% compared to 6 areas within this bracket in May 2015.
In June 2015 1 area had an average fill rate for Qualified Nurses (Night) of less than 75% compared to 3 areas within this bracket in May 2015.
9 areas had average fill rates for Qualified Nurses (Day or Night) greater than 100% which can be attributed to supervisory hours being reflected in an over fill of planned hours, or where qualified new starters have been supported by additional staffing levels on some days where possible.
34 areas in comparison to 33 areas in April 2015 had average fill rates for Unqualified Nurses (Day or Night) greater than 100% which have provided support in areas requiring additional 1-1's for patients. 1506 hours of additioinal unqualified hours were provided in June to support 1-1's. Also the unqualified nurses supplement the depleted qualified nurse hours.
The board may also notice some change in fill rate as we have altered planned hours to reflect the actual hours the sisters actually undertake supervisory duties.

Analysis of reduced fill rate Qualified

Area	%	Reason for reduced fill rate (less than 75% Qualified Day / Night)
5AD	72.4% (Day)	Vacancies; Additional long days worked – estimated at 80% long days against planned 50% resulting in 11.5 hours instead of 15 hours of nursing time; Sickness.
4C	72.9% (Day)	Sickness; vacancies; service redesign.
8D	56.7% (Night)	Vacancies; Supporting additional capacity. Qualified hours supported by additional unqualified hours.

Analysis of reduced fill rate Unqualified

Area	%	Reason for reduced fill rate (less than 75% Unqualified Day / Night)
MAU CRH	61.3% (Day)	Vacancies; Supporting additional capacity; Sickness.
5C	68.2% (Day)	Supporting additional capacity
8D	67.2% (Day)	Reduced fill rate during the day as adjusted resource to support Qualified fill rate at night.
ICU	53.2% (Day)	Sickness
15	61.7%	Long term sickness
NICU	46% (Night)	Vacancies (fill rate for days 93.8%)
LDRP	70 % (Night)	Maternity Leave

There were 2 areas with average fill rates for Qualified Nurses (Day) of less than 75% compared to 6 areas within this bracket in May 2015.
In June 2015 1 area had an average fill rate for Qualified Nurses (Night) of less than 75% compared to 3 areas within this bracket in May 2015.
9 areas had average fill rates for Qualified Nurses (Day or Night) greater than 100% which can be attributed to supervisory hours being reflected in an over fill of planned hours, or where qualified new starters have been supported by additional staffing levels on some days where possible.
34 areas in comparison to 33 areas in April 2015 had average fill rates for Unqualified Nurses (Day or Night) greater than 100% which have provided support in areas requiring additional 1-1's for patients. 1506 hours of additioinal unqualified hours were provided in June to support 1-1's. Also the unqualified nurses supplement the depleted qualified nurse hours.
The board may also notice some change in fill rate as we have altered planned hours to reflect the actual hours the sisters actually undertake supervisory duties.

		Trust Threshold	Trust Actual
Finance	Continuity of Service Risk Rating	1	1
	Operational Performance (Debt service cover)	1	1
	Cash & Balance Sheet Performance (Liquidity)	1	1
	Use of Capital	£5.10m	£4.69m
	Income and Expenditure	(£6.59m)	(£6.53m)
	Cost Improvement Programme (CIP)	£2.18	£2.80m

Trust Financial Overview as at 30th Jun 2015 - Month 3

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

YEAR TO DATE POSITION: M03

CLINICAL ACTIVITY

	M03 Plan	M03 Actual	Var
Elective	2,106	2,058	(48)
Non Elective	12,213	12,607	394
Daycase	10,214	10,005	(209)
Outpatients	80,304	80,684	380
A & E	37,630	37,168	(462)

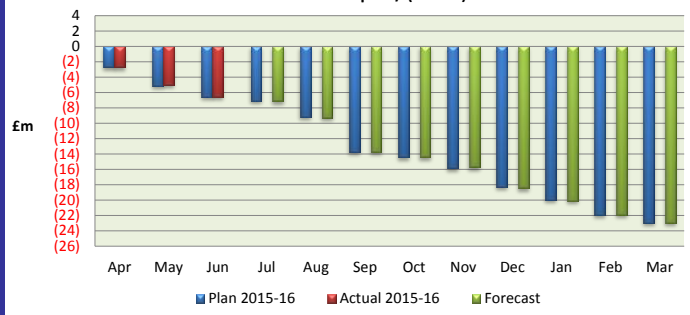
TRUST: INCOME AND EXPENDITURE

	M03 Plan	M03 Actual	Var
	£m	£m	£m
Elective	£5.25	£5.25	£0.01
Non Elective	£19.87	£20.75	£0.88
Daycase	£6.68	£6.47	(£0.21)
Outpatients	£9.64	£9.76	£0.12
A & E	£3.96	£3.99	£0.03
Other-NHS Clinical	£28.73	£29.54	£0.81
CQUIN	£1.66	£1.68	£0.03
Other Income	£9.31	£8.66	(£0.65)
Total Income	**£85.09**	**£86.09**	**£1.00**
Pay	(£55.59)	(£56.17)	(£0.58)
Drug Costs	(£7.68)	(£7.63)	£0.04
Clinical Support	(£7.62)	(£7.57)	£0.06
Other Costs	(£11.46)	(£12.01)	(£0.55)
PFI Costs	(£2.98)	(£2.95)	£0.03
Total Expenditure	**(£85.33)**	**(£86.34)**	**(£1.01)**
EBITDA	**(£0.24)**	**(£0.25)**	**(£0.00)**
Non Operating Expenditure	(£6.35)	(£6.28)	£0.06
Deficit excl. Restructuring	**(£6.59)**	**(£6.53)**	**£0.06**
Restructuring Costs	£0.00	£0.00	£0.00
Surplus / (Deficit)	**(£6.59)**	**(£6.53)**	**£0.06**

DIVISIONS: INCOME AND EXPENDITURE

	M03 Plan	M03 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	£4.48	£4.56	£0.09
Medical	£6.42	£6.03	(£0.39)
Families & Specialist Services	(£0.35)	(£0.29)	£0.06
Community	£1.07	£1.10	£0.03
Estates & Facilities	(£7.22)	(£6.65)	£0.57
Corporate	(£5.17)	(£5.52)	(£0.35)
THIS	£0.06	£0.10	£0.04
PMU	£0.72	£0.46	(£0.26)
Central Inc/Technical Accounts	(£5.69)	(£5.66)	£0.03
Reserves	(£0.90)	(£0.65)	£0.25
Surplus / (Deficit)	**(£6.59)**	**(£6.53)**	**£0.06**

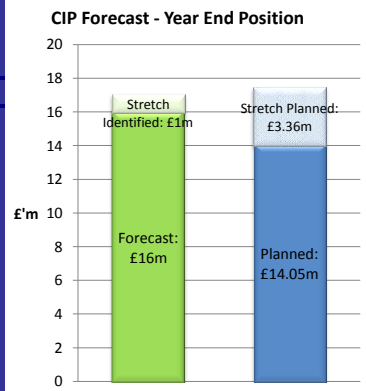
TRUST SURPLUS / (DEFICIT)

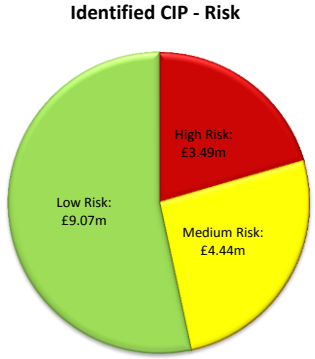


KEY METRICS

	Year To Date M03 Plan	Year To Date M03 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)	(£6.59)	(£6.53)	£0.06	(£23.01)	(£23.01)	(£0.00)
Capital (forecast Plan)	£5.10	£4.69	£0.41	£20.72	£20.59	£0.13
Cash	£10.90	£10.97	£0.07	£1.92	£2.08	£0.16
CIP	£2.18	£2.80	£0.62	£14.05	£16.00	£1.95
	Plan	Actual		Plan	Forecast	
Continuity of Service Risk Rating	1	1		1	1	

COST IMPROVEMENT PROGRAMME (CIP)





Total Planned: **£14.05m**

Total Forecast & Identified: **£17m**

YEAR END 2015/16

CLINICAL ACTIVITY

	Plan	Forecast	Var
Elective	9,185	8,634	(551)
Non Elective	49,263	50,646	1,384
Daycase	43,731	42,216	(1,515)
Outpatients	327,200	330,305	3,105
A & E	146,774	144,972	(1,802)

TRUST: INCOME AND EXPENDITURE

	Plan	Forecast	Var
	£m	£m	£m
Elective	£23.39	£22.45	(£0.94)
Non Elective	£79.89	£83.55	£3.66
Daycase	£30.25	£28.18	(£2.07)
Outpatients	£39.45	£39.97	£0.52
A & E	£15.49	£15.51	£0.02
Other-NHS Clinical	£117.49	£117.56	£0.07
CQUIN	£6.69	£6.87	£0.18
Other Income	£38.90	£38.38	(£0.52)
Total Income	**£351.55**	**£352.47**	**£0.92**
Pay	(£224.98)	(£226.98)	(£2.00)
Drug Costs	(£32.05)	(£31.44)	£0.60
Clinical Support	(£31.15)	(£30.74)	£0.41
Other Costs	(£45.94)	(£46.16)	(£0.22)
PFI Costs	(£11.92)	(£11.84)	£0.08
Total Expenditure	**(£346.04)**	**(£347.15)**	**(£1.11)**
EBITDA	**£5.51**	**£5.32**	**(£0.19)**
Non Operating Expenditure	(£25.52)	(£25.33)	£0.19
Deficit excl. Restructuring	**(£20.01)**	**(£20.01)**	**(£0.00)**
Restructuring Costs	(£3.00)	(£3.00)	£0.00
Surplus / (Deficit)	**(£23.01)**	**(£23.01)**	**(£0.00)**

DIVISIONS: INCOME AND EXPENDITURE

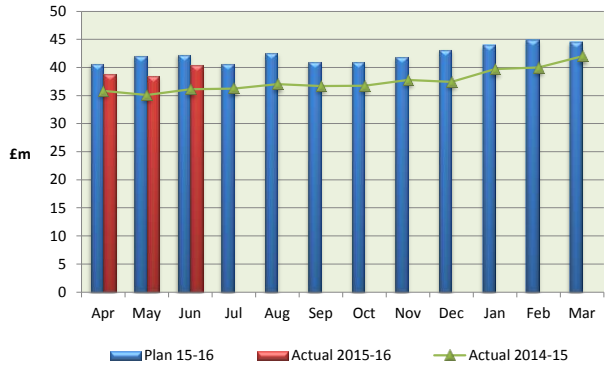
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	£21.66	£20.75	(£0.91)
Medical	£26.17	£23.93	(£2.24)
Families & Specialist Services	(£0.25)	(£0.17)	£0.08
Community	£4.38	£4.29	(£0.09)
Estates & Facilities	(£28.90)	(£28.58)	£0.32
Corporate	(£20.19)	(£21.11)	(£0.93)
THIS	£0.53	£0.53	(£0.00)
PMU	£3.16	£3.16	£0.00
Central Inc/Technical Accounts	(£25.23)	(£24.82)	£0.41
Reserves	(£4.35)	(£1.00)	£3.35
Surplus / (Deficit)	**(£23.01)**	**(£23.01)**	**£0.00**

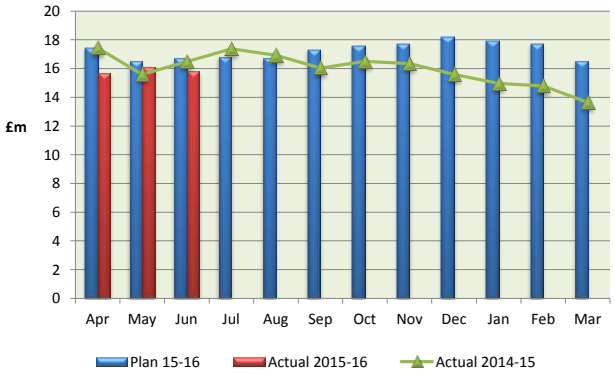
Trust Financial Overview as at 30th Jun 2015 - Month 3

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

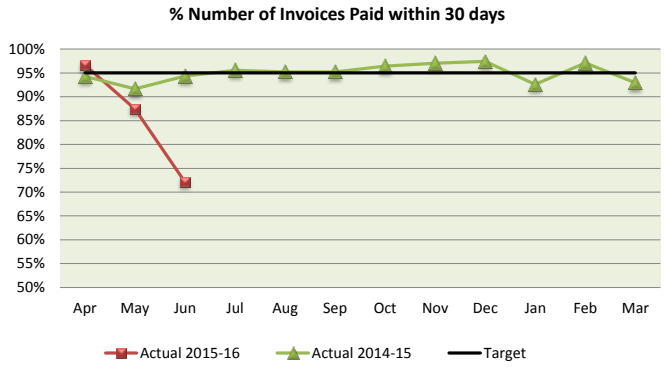
WORKING CAPITAL

	M03 Plan £m	M03 Actual £m	Var £m	M03
Payables	(£42.28)	(£40.34)	(£1.94)	
Receivables	£16.74	£15.81	£0.93	



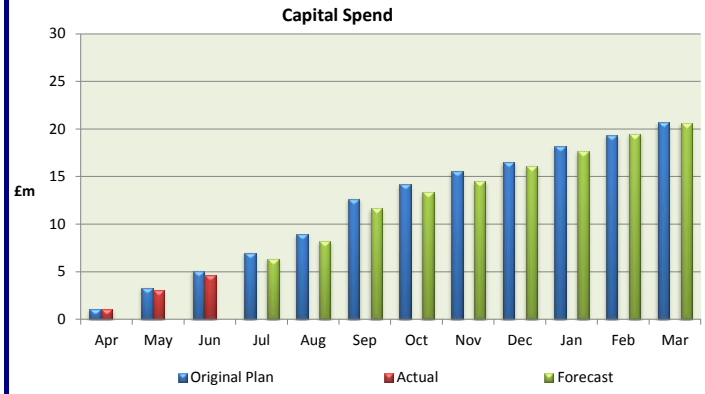


BETTER PAYMENT PRACTICE CODE



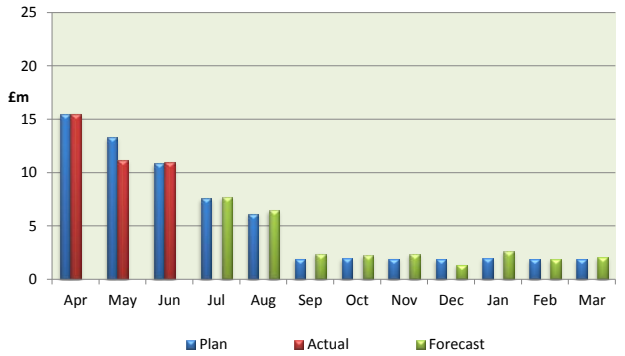
CAPITAL

	M03 Plan £m	M03 Actual £m	Var £m	M03
Capital	£5.10	£4.69	£0.41	

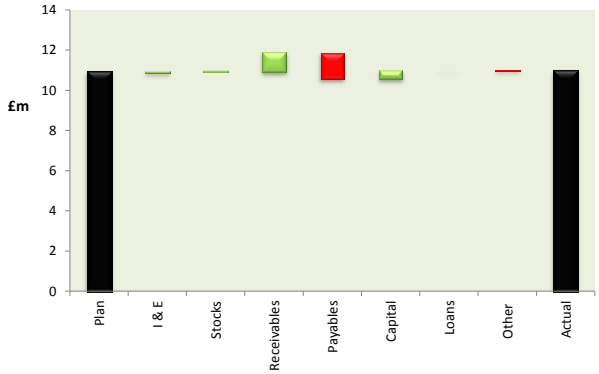


CASH

	M03 Plan £m	M03 Actual £m	Var £m	M03
Cash	£10.90	£10.97	£0.07	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The year to date deficit is £6.53m versus a planned deficit of £6.59m, this includes release of £0.1m contingency reserves.
- Elective and daycase activity is behind planned levels whilst non-elective continues to be above plan in the year to date.
- The main area of ongoing expenditure pressure is non-contracted pay, suppporting vacancy cover and extra bed capacity.
- Capital expenditure year to date is £4.69m against the planned £5.10m with slippage primarily on Estates schemes.
- Cash balance is £10.97m against a planed £10.9m. £10m of loan funding for capital expenditure was drawn down in April.
- CIP schemes delivered £2.80m in the year to date against a planned target of £2.18m.
- The Continuity of Service Risk Rating (CoSRR) stands at 1 against a planned level of 1.

SUMMARY FORECAST

- The forecast is to deliver the year end planned income and expenditure position in overall terms, however at present this relies on £1.5m contingency reserves being released unused and forecast delivery of £16m CIP against the originally planned £14m.
- The balance of contingency reserve has been ringfenced against investment to enable transformation and other known commitments.
- This mitigation has been called upon due to financial pressures driven by the extra bed capacity open over the first quarter of the year and the locum and agency pay expenditure linked to both this capacity and covering substantive vacancies.
- Efforts must therefore be focussed on securing the full value of CIP including the 'stretch' target as this is now crucial to delivery of the plan.
- The year end cash balance is predicated on external cash support being received from September onwards.
- Year end capital expenditure is forecast to be £20.59m slightly below the planned £20.72m. The year end CoSRR is forecast to be at level 1.

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)

Performance is formally assessed quarterly

High Risk	
Moderate Risk	
No known Risk	

Goals - CCG CQUINs **6,270,712**

Goal Number	Goal Name	Value of CQUIN (£)	Q1	Q2	Q3	Q4
1	Acute Kidney Injury	627,071	62,707	125,414	125,414	313,536
2a	Sepsis	313,536	78,384	78,384	78,384	78,384
2b	Sepsis	313,536		62,707	125,414	125,414
3	Urgent care	1,254,142	125,414	376,243	376,243	376,243
4.1	Dementia	250,828	62,707	62,707	62,707	62,707
4.2	Dementia	125,414		62,707		62,707
4.3	Dementia	250,828		125,414		125,414
5.1	Respiratory - Asthma	250,828	62,707	62,707	62,707	62,707
5.2	Respiratory - Pneumonia	376,243	94,061	94,061	94,061	94,061
6	Diabetes	627,071	156,768	156,768	156,768	156,768
7.1	Improving Medicines Safety	125,414	31,354	31,354	31,354	31,354
7.2	Improving Medicines Safety	501,657	125,414	125,414	125,414	125,414
8	End of Life Care	627,071		313,536		313,536
9.1	Hospital Food	250,828		125,414		125,414
9.2	Hospital Food	250,828		50,166	100,331	100,331
9.3	Hospital Food	125,414				125,414
	TOTAL	6,270,712	799,516	1,852,995	1,338,797	2,279,404

NHS England **421,193**

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

	Grand Total	**6,691,905**	**904,814**	**1,958,294**	**1,444,095**	**2,384,702**

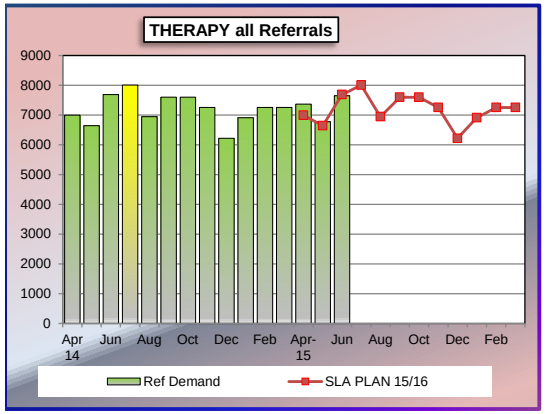
INTERMEDIATE CARE AND COMMUNITY DIRECTORATE

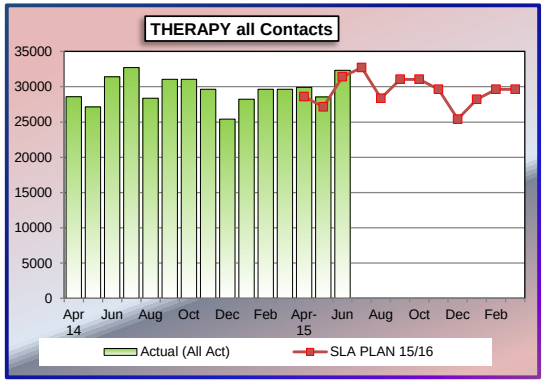
DIRECTORATE PERFORMANCE DASHBOARD

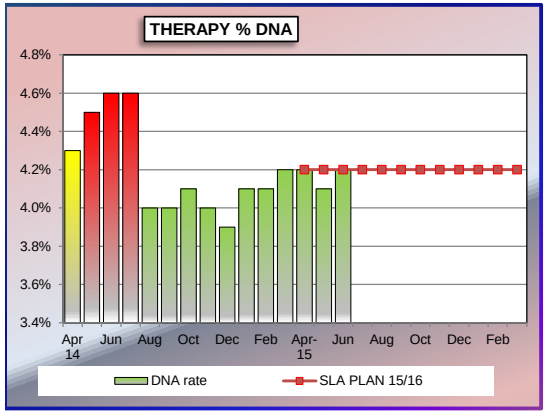
MONTH : JUNE 2015

compassionate care

CLINICAL THERAPY SERVICES







ACTIVITY EFFICIENCIES - PERFORMANCE v PLAN

ALL THERAPY CONTACTS (includes Inpatients & All Commissioners)

CLINICAL THERAPIES : Activity Metric	Curr Month	YTD actual	YTD PROFILE	Actual 14/15	POSITION
Referral Demand	7,649	21,792	21,325	86,372	2.2%
Initial Contacts	5,879	16,551	16,818	68,118	-1.6%
Follow Up Contacts	25,507	71,611	67,965	275,273	5.4%
Telephone Contacts	948	2,648	2,353	9,531	12.5%
THERAPY CONTACTS - including Inpatients	**32,334**	**90,810**	**87,136**	**352,922**	**4.2%**
CTR Podiatry	6,319	17,748	18,182	73,640	-2.4%
CTR Therapies Outpatients	6,057	17,213	17,056	69,082	0.9%
CTR Inpatient Therapies	9,614	27,582	23,293	94,342	18.4%
CTR Long Term Conditions and Rehab	5,568	15,358	15,806	64,018	-2.8%
CTR Acute & Planned Care is 'Other Outpatients'	1,709	5,000	5,070	20,534	-1.4%
CTR Childrens Therapies	2,119	5,261	5,376	21,775	-2.1%
Telephone Contacts	948	2,648	2,353	9,531	12.5%
THERAPY CONTACTS - including Inpatients	**32,334**	**90,810**	**87,136**	**352,922**	**4.2%**

First DNAs	260	763
First DNAs % Rate	4.2%	4.4%
Total DNAs	1449	3989
Total DNA % Rate	4.3%	4.2%

Patients on an 18 week RTT pathway - Waiting for Treatment	7,404

COMMUNITY ADULT : Activity Metric	Curr Month	YTD actual	YTD COMM	COMM PLAN	POSITION
Referral Demand	3,700	10,575	11,658	47,219	-9.3%
Referral Demand-YTD Comm. based on one referral	3,700	10,575	10,443	42,300	1.3%
Initial Contacts	2,372	6,495	8,549	34,624	-24.0%
Follow Up Contacts	21,000	62,078	64,066	259,482	-3.1%
Telephone Contacts	2,910	8,154	8,082	32,735	0.9%
ALL Clinical Contacts - Face to Face & Telephone	26,282	76,727	80,697	326,841	-4.9%

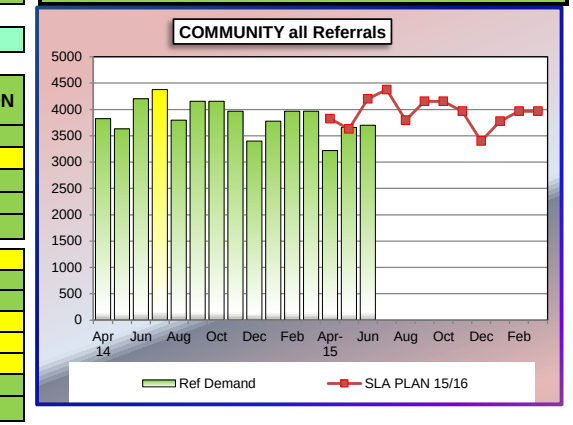
Total DNAs - No Access Visits + DNAs	688	1964
Total DNA (No Access) % Rate	2.55%	2.50%

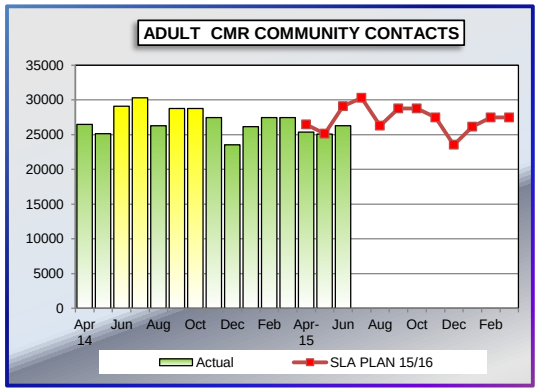
DIRECTORATE SUMMARY KPIs	Curr Month	YTD actual	YTD COMM	Actual 14/15	POSITION
Referral Demand	11,349	32,367	32,984	133,591	-1.9%
Total Contacts	54,758	156,735	157,398	637,497	-0.4%
Telephone Contacts	3,858	10,802	10,435	42,266	3.5%
TOTAL CONTACTS - ALL SERVICES	**58,616**	**167,537**	**167,833**	**679,763**	**-0.2%**
Total DNAs	2137	5953			
Total DNA % Rate	3.8%	3.7%			
Patients on an 18 week RTT pathway - Waiting for Treatment		7,404			

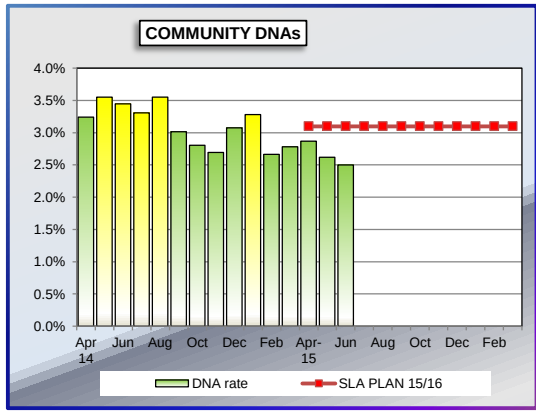
Community Referrals: Due to the changes introduced in July14 in how referrals are recorded in the system, the number of **New referrals** reported will show a reduction compared to 14/15, however this does not indicate a reduction of actual patient numbers through the service, caseload complexity, or a reduction in workload pressures

Due to the reduced number of referrals recorded, the number of discharges will also show a decrease compared to the previous year. The number of initial events will decrease as less referrals, means a decrease statistically.
Only having one referral per patient will also affect the Length of stay and will show a higher average as a referral is only ended when all a patients conditions have been treated.

CALDERDALE COMMUNITY ADULT







COMMUNITY DIVISIONAL PERFORMANCE REPORT & DASHBOARD

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

JUNE 2015

compassionate care

Key Points

June 2015
Performance Summary

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

(3c) Lack of clarity on AHP reportable pathways and no central validation means potential over reporting of over 18weeks. Being investigated by Divisional team for conclusion by end of August 2015.

(4a)% of patients in receipt of community nursing services that have had a pressure ulcer screening and this is documented in their care plan
A - Reporting restrictions in patient caseload list used and screening report means some patients may be included but no pressure ulcer screening will show for them
B - Create manual checks to include all eligible
C - 31st July
There is work to do around how we report this as the screening is reflected in the holistic assessment in all cases and in the care plans where there is an issue. We have developed outcome measures for completion when a pressure ulcer care plan has been performed, however, as these are new we need to push completion and compliance.

(4b) – there is a breakthrough session planned for the 27th July with DNs to re look at our action plan and feed into the wider organisational action plan which is going to CCG in 6 weeks.

(4f)% of staff undertaken Safeguarding training
A - Recording is over a 36 month period therefore the target for the year is not in line with the current calculation methodology
B - Investigations around how best to represent this indicator with the current information available is ongoing
C - 31st July

(5a)Community DNA rates
A - Number of patients have multiple DNAs and therefore inflate the percentage
B - Trial the use of proactive methods such as contacting the patient prior to the visit
New 'Housebound policy' being developed
C - 31st July

(5a) the housebound policy is in draft and has gone to CCG and primary care for comments. We need to sign up to a clear position around discharge from the caseload for repeat non attenders and the policy for clinic compliance is referenced in the housebound policy. We also need a decision around transport and to understand the potential impact on transport.

	1 Enhancing quality of life for people with a Long Term condition (LTC)	Target	Current Month	YTD	YTD 14/15	Var
a	Home equipment delivery < 7 days	95%	99.8%	99.0%	97.8%	4.0%
b	% Patient died in preferred place of death	95%	100.0%	100.0%	100.0%	5.0%
c	% of people that died who were expected to die and had an advance care plan	Indicator suspended pending new pathway				
d	% District Nursing Patients with a care plan	90%	98.0%	97.7%	94.1%	7.7%
e	% of patients with a LTC with a Calderdale Care Plan	90%	95.0%	86.3%	57.7%	-3.7%
f	% of patients under the care of the community specialist matron who have been readmitted to hospital with the same LTC in less than 30 days	<10%	12.3%	4.6%	1.8%	5.4%

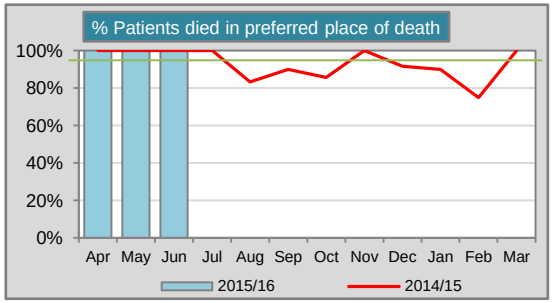
	2 Helping people to recover from episodes of ill health or following injury	Target	Current Month	YTD	YTD 14/15	Var
a	% of leg ulcers healed within 12 weeks from diagnosis	75%	93.8%	94.5%	97.2%	19.5%

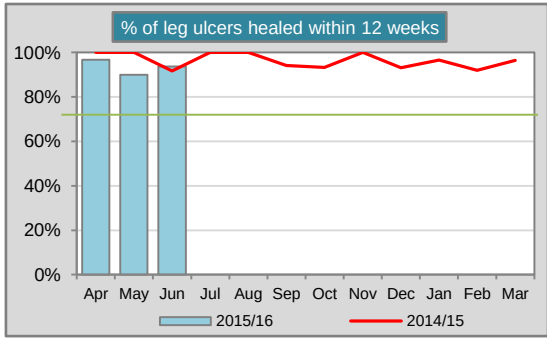
	3 Ensuring people have positive experience of care	Target	Current Month	YTD	YTD 14/15	Var
a	Number of complaints	n/a	2	5	5	
b	Number of complaints about staff attitude	n/a	0	0	0	
c	Community AHP - 18 week RTT Snapshot at month end	95%	83.9%	94.8%	89.9%	-0.2%
d	Community Friends and Family Test	n/a	91.0%	90.3%	N/A	N/A

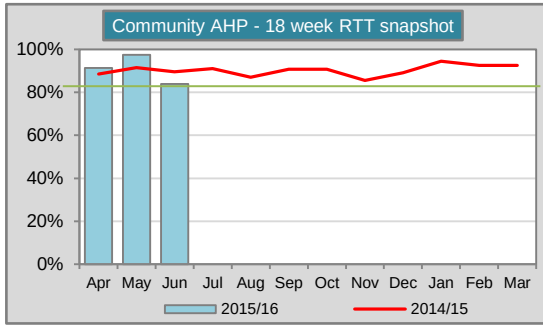
	4 Treating and caring for people in a safe environment; and protecting them from avoidable harm	Target	Current Month	YTD	YTD 14/15	Var
a	% of patients in receipt of community nursing services that have had a pressure ulcer screening and this is documented in their care plan	90%	86.0%	88.0%	90.0%	-2.0%
b	Number of community acquired grade 3 or 4 pressure ulcers	<1.8	2	8	4	6.2
c	Number of falls that caused harm whilst patient was in receipt of Comm Services	<1.1	1	6	7	4.9
d	Patient safety thermometer - coverage - Harm free	>95%	95.4%	95.3%	93.8%	0.3%
e	Patient safety thermometer - No of Harms Reported	<22.1	19	58	80	36
f	% of staff that have undertaken safeguarding / mental capacity act training	95%	65.5%	76.4%	65.5%	-18.6%

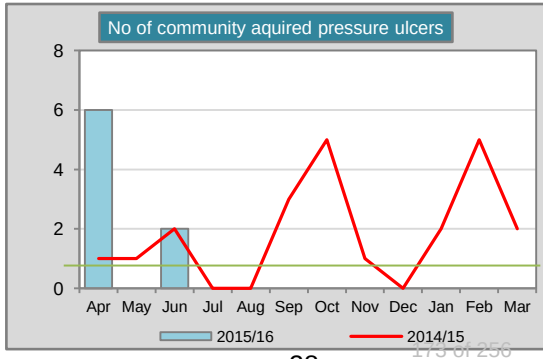
	5 Activity & Resource efficiency	Baseline	Current Month	YTD	YTD 14/15	Var
a	Community DNA Rates	<1%	1.2%	1.1%	1.1%	0.1%
b	Sickness Absence rate	<4%	0.0%	3.4%	4%	-0.6%

Target









Monitor Indicators

Indicators	Thresholds	Weighting	June 2015	Quarter 1	YTD
Incidence of MRSA Year to Date	0	1.0	0	1	1
Incidence of Clostridium Difficile Year to Date	6	1.0	1	3	3
Maximum Time of 18 Weeks From Point of Referral to Treatment - Admitted	90%	1.0	92.67%	92.26%	92.26%
Maximum Time of 18 Weeks From Point of Referral to Treatment - Non-Admitted	95%	1.0	98.63%	98.62%	98.62%
Maximum Time of 18 Weeks From Point of Referral to Treatment - Incomplete Pathways	92%	1.0	95.44%	95.44%	95.44%
62 Day Wait for First Treatment from Urgent GP Referral	85%	1.0	90.00%	91.02%	91.02%
62 Day Wait for First Treatment from Consultant Screening Service Referral	90%	1.0	100.00%	96.15%	96.15%
31 Day Wait for Second or Subsequent Treatment: Surgery	94%	1.0	100.00%	98.15%	98.15%
31 Day Wait for Second or Subsequent Treatment: Anti Cancer Drug Treatments	98%	1.0	100.00%	99.73%	99.73%
31 Day Wait from Diagnosis to First Treatment (All Cancers)	96%	0.5	99.24%	99.24%	99.24%
Two Week Wait From Referral to Date First Seen: All Cancers	93%	0.5	96.55%	97.06%	97.06%
Two Week Wait From Referral to Date First Seen: Symptomatic Breast Patients	93%	0.5	94.92%	96.15%	96.15%
A&E: Maximum Waiting Time of Four Hours from Arrival to Admission/Transfer/Discharge	95%	1.0	95.44%	95.08%	95.08%
Community care - referral to treatment information completeness	50%	0.5	100.00%	100.00%	100.00%
Community care - referral information completeness	50%	0.5	97.50%	97.80%	97.80%
Community care - activity information completeness	50%	0.5	100.00%	100.00%	100.00%
Overall Governance Rating			Green	Amber-Green	Amber-Green

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

Data Quality Assessment

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

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

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

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

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

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

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Claire Gruszka, Patient Safety Risk Manager - LSMS
Date: Thursday, 30th July 2015	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: Risk Register - The attached papers provide details of the organisational risks scoring 15 or higher as at 21 July 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 Risk & Compliance Group 14 July 2015 meeting.	
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:

To note.

Appendix

Attachment:

Risk Register Report 21.7.2015 (3 files merged).pdf

RISK REGISTER REPORT

Risks as at 21 July 2015

TOP RISKS
6131 (25): Progression of service reconfiguration impact on quality and safety 2827 (20): Risk of poor patient outcomes due to dependence on middle grades 6300 (20): CQC inspection outcome 4706 (20): Failure to meet CIP 4783 (20): HSMR & SHMI 6345 (20): Staffing risk 6346 (20): Service transformation risk
RISKS WITH INCREASED SCORE
6300 - CQC inspection outcome, increased from 16 to 20 4706 – Failure to meet CIP, increased from 15 to 20
RISKS WITH REDUCED SCORE
6136 – Infection control, reduced from 15 to 10
NEW RISKS
The following new risks have been added/have been carried over since/from the meeting: 6224 – NHS E-referrals, system outage – score of 16 6345 – Staffing risk – score of 20 6346 – Service transformation risk – score of 20
CLOSED RISKS
No risks have been closed.
RISKS TO BE DISCUSSED AT NEXT RISK & COMPLIANCE COMMITTEE:
• Paediatrics in A&E and Paediatric model of care

Trust Risk Profile as at 21 July 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
Likely (4)				= 2828 – Blocks in patient flow in A&E = 5806 – Privacy & Dignity issues on Ward 3, Chemo ward = 6078 – NHS E-referrals – appointment slots = 6130 = Loss of income/reduction in profit related to competitive procedures ! 6224 – NHS E-referrals - outage	= 2827 – Dependence on middle grade locums in A&E ↑ 6300 – CQC inspection outcome ↑ 4706 – Failure to meet CIP
Highly Likely (5)				= 4783 – HSMR & SHMI ! 6345 – Staffing risk ! 6346 – Service transformation risk	= 6131 – Progression of service reconfiguration impact on quality and safety

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

	Risk No	Div	Dir	Dep	Opened	Status	Strategic Objective	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Further Actions	Review	Target	RC	Exec Dir	Lead
Extreme	6131	Corporate	Commissioning & Partnerships	Commissioning & Partnerships	Oct-2014	Active	Transforming and improving patient care	There is a risk that the Trust will not be able to quickly progress service reconfiguration due to the requirements of a consultation process initiated by local CCG's resulting in delays to important clinical quality and safety issues e.g: Compliance with A&E National Guidance Compliance with Paediatric Standards Compliance with Critical Care Standards Speciality level review in Medicine Unable to meeting 7 day standards Difficulties in recruiting a medical workforce (increased reliance on Middle Grades and Locums) Increased gaps in Middle Grade Doctors Dual site working is one of the causes of the Trust;s underlying deficit. Delays in being able to reconfigure services will impact on the Trust's financial recovery plan. ***It should be noted that risks 2827 and 4783 should be read in conjunction with this risk.	The continued funding of medical staff on both sites Nurse led service managing Paediatrics Critical care still being managed on both sites High usage of locum doctors Frequent hospital to hospital transfers to ensure access to correct specialties The Trust has developed a contingency plan should it not be able to provide sufficient medical staffing to provide safe A&E services on two sites.	Financial plans of associated reconfiguration not yet completed or agreed with CCG's Estate limitations inhibit the present way of working Consultant rotas cannot always be filled to sustain services on both sites Interim actions to mitigate known clinical risks need to be progressed.	25 5 x 5	25 5 x 5	15 5 x 3	Joint working is in place with Commissioners to revisit the clinical model, activity, workforce and financial assumptions in the OBC. A joint Hospital Review Board has been established and external support arranged to refresh the OBC. A number of clinical workshops have been held. A Trust Assistant Director of Finance has been seconded to work jointly across the Trust and CCG. Update: June 2015 Monitor is advising the Trust on the review and development of the business case that will be submitted to Monitor and DH in September. The business case will be an important part of the Trust's longer term financial and sustainability recovery plan. It will be used to request funding support from the DH. A key issue related to refresh of the OBC is capital requirements and use of the PFI site. CCGs are keen to include GP led urgent care in the clinical model. The CCGs are developing a pre-consultation business case (that will be consistent with the Trust's business case) and aim to commence public consultation in Autumn 2015. Continue to ensure compliance with current estate pending a decision. Medical Workforce Plan to be developed by end of August 15 examining overseas recruitment. Interim actions to mitigate known clinical risks need to be progressed (paediatric service provision at HRI, cardiology and respiratory service configuration, Emergency Pregnancy Assessment configuration).	Sep-2015	Dec-2015	WEB	Anna Basford	Catherine Riley

Major	6300	Trustwide	All Divisions	All Departments/Wards	May-2015	Active	Keeping the base safe	A number of clinical, operational and estates risks causing increased risks to patients and non-regulatory compliance which may result in CHFT not achieving a CQC rating of good or outstanding (e.g. Estates risks; Paediatric Standard compliance; A&E National Standards compliance), which could cause the Trust to have breach of licence.	- System for regular assessment of Divisional and Corporate compliance - Routine policies and procedures - Quality Governance Assurance structure - CQC compliance reported in Quarterly Quality and Divisional Board reports - Weekly strategic CQC meetings	- Full Divisional and Corporate self-assessment still to be completed - Some out of date policies and procedures - Assessments show us to be be in the "requiring improvement" category	16 4 x 4	20 5 x 4	8 4 x 2	- CQC compliance Steering Group - Implementation CQC Compliance action plan - CQC Operational Group - Further embedding of CQC assurance into the Divisions and Corporate Governance structures	Sep-2015	Dec-2015	WEB	Julie Dawes	Juliette Cosgrove
Major	2827	Medical	Emergency Network	Accident & Emergency	Apr-2011	Active	Developing our workforce	There is a risk of poor clinical decision making in A/E due to a dependence on locum Middle Grade Doctors at weekends and on nights resulting in possible harm to patients, extended length of stay and increased complaints ***It should be noted that risks 4783 and 6131should be read in conjunction with this risk.	Associated Specialist and Regular locums for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Where necessary other medical staff re-located to ED Consultants act down into middle grade roles to fill gaps temporarily	Difficulty in recruiting Consultants, Middle Grade and longer term locums Relatively high sickness levels amongst locum staff	20 4 x 5	20 5 x 4	12 4 x 3	Expedite Outline Business case for reconfiguration of services across sites to afford better deployment of medical staff Explore use of ANP to fill vacant doctor posts 4 Consultant posts advertised currently. Closing date end of June 15 Business Continuity Plan awaiting approval of Urgent care Board covering ability to provide safe services for varying periods of time	Oct-2015	Oct-2015	WEB	David Birkenhead	Dr Mark Davies/Mrs Bev Walker

Major	6345	Trustwide	All Divisions	All Departments/Wards	Jul-2015	Active	Keeping the base safe	Staffing Risk Risk of not being able to deliver safe and effective high quality care and experience for patients due to: - lack of nursing staffing as unable to recruit to substantive posts, i.e. not achieving recommended nurse staffing levels (as per Hard Truths workforce model) - lack of medical staffing as unable to recruit to Consultant / middle grade doctor / junior doctor vacancies across a number of specialties (A&E, Opthalmology, Anaesthetics, Paediatrics, Histopathology, Radiology) - over-reliance on middle grade doctors meaning less specialist input - dual site working and impact on medical staffing rotas - lack of workforce planning / operational management process and information to manage medical staffing gaps resulting in: - increase in clinical risk to patient safety due to reduced level of service / less specialist input - negative impact on staff morale, motivation, health and well-being and ultimately patient experience - negative impact on staff mandatory training and appraisal - cost pressures due to increased costs of interim staffing - delay in implementation of key strategic objectives (eg Electronic Patient Record)	To ensure safety across 24 hour period: - use of electronic duty roster for nursing staffing, approved by Matrons - risk assessment of nurse staffing levels for each shift and escalation process to Director of Nursing to secure additional staffing - staff redeployment - staff skill mix, eg extend roles of nursing / Allied Health professionals - medical rotas (organised by division) - use of flexible labour where identified staffing shortfalls - bank/ additional hour payments (nursing), internal / agency locum cover - weekly report on usage of agency / bank staff and review of interim resource costs as part of control workstream by Director of HR Active recruitment activity, including international recruitment Retention strategy for nursing Integrated Board Report /Hard Truths report identifies nursing staffing levels below requirements Divisional management:specific staffing gaps identified on Risk Register and reviewed through governance structures, divisional business meetings identify staffing risks and plan to mitigate risk Contribute to Health Education England survey to inform future commissioning / provision of education / training	Lack of: - workforce plan / strategy for medical staff identifying level of workforce required - dedicated resource to develop workforce model for medical staffing - centralised medical staffing roster (currently divisional) / workforce planning for medical staff - system /process to identify, record and manage gaps in planned medical staffing, particularly for junior doctors - measure to quantify how staffing gaps increase clinical risk for patients International recruitment for medical staff yet to take place	16 4 x 4	20 4 x 5	9 3 x 3	Continue to recruit to vacant posts / skill mix review, progress international recruitment of medical staff, consider incentive schemes. (Director of Nursing, Medical Director) Secure resource to develop medical staffing workforce planning (Medical Director) Improved operational management of medical staffing workforce (Medical Director)	Dec-2015	Mär-15	WLG	David Birkenhead / Julie Dawes	David Birkenhead / Julie Dawes/ Jackie Murphy
Major	6346	Trustwide	All Divisions	All Departments/Wards	Jul-2015	Active	Transforming and improving patient care	Service Transformation Risk Risk of not achieving service transformation due to insufficient capacity and capability across the organisation to deliver the many transformation schemes underway (Electronic Patient Record (EPR), clinical administration review, financial turnaround and cost improvement schemes, CQC preparation, service reconfiguration, i.e. consultation and planning for Outline Business Case, Care Closer to Home Proposal) resulting in impact on delivery of safe clinical care for patients in the right setting and financial imbalance.	Programme Management Office established to managing schemes Strategic and Financial Turnaround Plan, 2015/166 financial plans and cost improvements Integrated Board report details Trust financial position monthly Well Led Governance Review identifies areas to strengthen governance across the Trust CQC Steering Group reviews progress with CQC action plan preparation to identify areas of risk of non-delivery EPR implementation programme OBC ? CCH ?	Assurance that the totality of transformation schemes can be delivered	16 4 x 4	20 4 x 5	9 3 x 3	To consider adding the risk to the Board Assurance Framework.	Sep-2015	Mar-2016	WEB	Julie Dawes	Director of Nursing, Julie Dawes

Major	4706	Corporate	Finance	Corporate Finance	Jun-2011	Active	Financial sustainability	There is a risk that the Trust fails to achieve it's financial plans for 2015/16 thereby breaching it's Monitor licence due to failure to deliver cost improvement plans or not adhering to good financial governance, resulting in compromised patient safety and increased external scrutiny.	Standing Financial Instructions set spending limits Turnaround structure in place which has created a more robust Project Management Office and the rigorous administration of cost improvement schemes Implementation of Turnaround Governance procedures (i.e. accurately reporting and projecting financial performance) Divisions can respond to activity targets on a specialty basis (e.g. additional theatre sessions/outsourcing if necessary) Formal Finance Our Future training Board to Budget Holders in place Budget reviews hold budget holders to account Accurate Income and Expenditure forecasting CIP target greater than actual savings required and contingency reserve established by the Director of Finance	Signed contracts not yet in place with main Commissioners for 2015/16. The unpredictability of Commissioners tendering process and possible decommissioning of services. Financial plans for 2015/16 not yet formally accepted by Monitor in line with the enforcement undertaking following the breach in 2014/15.	15 5 x 3	20 5 x 4	10 5 x 2	Contracts to be agreed and signed following arbitration (date not yet fixed) Plans to be agreed to manage gains or losses following tendering process Monitor review of Trust financial plans to take place on 22 and 23 June 15 Update: June 2015 Externally assessed Well Led Governance Review being undertaken with headlines reported to June 15 Board of Directors and final report to be concluded July 2015.	Aug-2015	Mar-2016	FPC	Keith Griffiths	Chris Benham
Major	4783	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Aug-2011	Active	Transforming and improving patient care	There is a risk that the Trust falls below national standards for mortality levels due to not delivering appropriate standards of care for acutely ill patients/frail elderly patients and possible incorrect clinical coding resulting in inaccurate reporting of preventable deaths, increased external scrutiny and a possible increase in complaints and claims. ***It should be noted that risks 2827 and 6131 should be read in conjunction with this risk.	Outlier areas are monitored (e.g. Stroke, Sepsis and COPD) Outliers are investigated in depth to identify the cause. Improvement work is implemented via an action plan Mortality dashboard analyses data to specific areas Monitoring key coding indicators and actions in place to track coding issues	Mortality reviews to assess preventable deaths which is indicating there isn't a problem but not yet performed for long enough or to sufficient depth to determine causes Coding improvement work not yet complete Improvement to standardized clinical care not yet consistent. To be completed by Dec 15	20 4 x 5	20 4 x 5	16 4 x 4	- To complete the work in progress - CQUINS to be monitored by the Trust - Plan is being revised - External review of data and plan to take place	Sep-2015	Dec-2015	COB	David Birkenhead	Juliette Cosgrove

Major	2828	Medical	Emergency Network	Accident & Emergency	Apr-2011	Active	Keeping the base safe	There is a risk of too slow patient flow and breaches of national targets in A/E due to bed blockages across the Trust, resulting in harm to patients through delayed treatment and increased external scrutiny for the Trust.	Escalation protocol in place which requires ED Co-ordinator to link with Patient Flow/Clinical Site Commander to ensure patients are moved from ED to a bed within national guidelines Site Commander can authorize additional beds by using flexible capacity Level discharges (required discharges at certain points of the day) plan in place. Site Commander to work with Ward Managers at 2 hourly meetings to ensure these happen All patients have a personal plan established by their Ward which includes discharge arrangements Medically stable patients are reviewed daily by the Discharge Team and Local Authority Surge and escalation plan in place to escalate to higher levels of authority (e.g. cancel next day surgery)	Despite the controls, the bed base in still insufficient at certain times The night period is particularly vulnerable. There is a reliance on locum middle grade doctors due to vacancies	20	4 x 5	16	4 x 4	12	4 x 3	Bed modeling review underway as part of the ED Action Plan. To be completed by mid-June 15 Capacity and demand modeling being undertaken (matching resources to peak activity periods). To be complete by mid-June 15 Urgent Care Board is accessible to consider new initiatives and act as an escalation decision making body in the case of very urgent situations. The Board has reserve resources Update: June 2015 - Silver Command put in place and escalation discussions re: whole system specific issues and creating more capacity. - Business case being developed for 10 additional step down beds at Oakmoor. Bed modelling to be presented to Star Chambers in June.	Sep-2015	Dez.15	CG	Julie Dawes	Sajid Azeb

Major	5806	Estates & Facilities	Estates, Planning & Contracting	Capital Team	May-2015	Active	Keeping the base safe	There is a risk that the following urgent Estates schemes cannot be undertaken due to insufficient resources, resulting in a poor patient experience, possible ward closures and harm caused by slips, trips and falls A) Failure to maintain privacy and dignity on the Chemotherapy Unit at HRI B) Poor/unsafe flooring in ICU at HRI C) Environmental/safety standards on Ward 18 at HRI D) Temperature control in winter on Ward 4 at HRI E) Poor environmental conditions on Ward 5 at HRI F) Uneven floor surface on Ward 19 G) Poor fitting windows on Ward 6 at HRI	A) Chemo unit- currently still on ward 3 but will be moving to new facilities on ward 7 in September. B) ICU- temporary repairs carried out as and when required but decant necessary for full floor replacement. C) Ward 18- Discharge lounge re-located onto Ward 18 which has been decorated & patient entertainment fitted. Ongoing concerns with Ward 18 (Childrens Area). Estates working with AM Henshaw to provide action plan for intermediate repairs (ward upgrade necessary) D) Ward 4- heaters were available for cold rooms. Ward 4 has now been connected to existing vent plant The heating system has been set up to enable the BMS system to control BMS valves within the ward to give better heating control within the area. ACTION COMPLETE E) Ward 5- now moved to ward 11 whilst the ward has works done and a minor upgrade. F) Staff aware of issue; decant to be planned to enable re-skimming of floor G) Ward 6- temporary solutions in place with the windows and heaters for cold rooms	A) The privacy & Dignity Issues are currently being managed by the ward themselves prior to moving to the new Ward. B) There are no further controls that can be put in place other than monitor the condition of the floor and bring forward the repair, as sections of the floor need to be repaired including skimming and this cannot be undertaken whilst the ward is live. C) Flooring repairs repairing Windows req Draft proofing Ceiling tiles req replacing & Painting Damaged doors require repairing safety Film required to be fitted to both sides of corridor Glazing D) No Gaps E) Issues highlighted for inclusion in the minor upgrade will be addressed prior to the Ward returning to Ward 5. F) There are no further controls that can be put in place other than monitor the condition of the floor and bring forward the repair, as sections of the floor need to be repaired including skimming and this cannot be undertaken whilst the ward is live. G) Superficial repair of Ward 6 windows (carried out Site Wide). Removed beading, replaced draught excluder and repainted / decorated surrounding area. Continue maintaining windows as is until window's replaced.	16 4 x 4	16 4 x 4	8 4 x 2	Chemo- full upgrade available from Sept Ward 18- putting in place a plan for a new discharge lounge, and seeking a solution for a new paed ward Ward 4, 5, 6- upgrades in place over the next 5 years as part of the estate strategy, subject to funding. G) Replace windows (when funding available)	Sep-2015	Mar-2016	QC	Lesley Hill	Paul Gilling

Major	6078	Diagnostics & Therapeutic Services	Appointment and Records	Appointments Service	Aug-2014	Active	Keeping the base safe	NHS e-referral – A failure to provide sufficient appointment slots to manage demand. Caused by an increase in referrals to services or reduced available capacity to manage demand. Resulting, poor patient experience, inability to access referral letter as e-referrals cannot be accessed until an appointment is allocated, increased administration (reliance on spreadsheets to track capacity requirements).	Process: Daily spreadsheet to Clinical Divisions highlighting capacity requirements. Regular communications with Specialty capacity leads. Reallocation of cancelled slots to maximise capacity.	Variations in capacity and demand plans. Consultant vacancy factor.	16 4 x 4	16 4 x 4	4 4 x 1	Capacity issues reported at Planned Care Board, and Clinical Specialties developed actions plans to reduce ASIs. Weekly x-divisional Access Meetings established (at ADD level) to monitor performance as position has worsened in months Jan - May. Update: June 2015 THIS are working on a live document that clinical and administrative leads can access to eliminate the emailing and filtering of spreadsheets on a daily basis. Locum Consultant in place and substantive post out to advert. Business Case for additional Consultant has been developed and hope to appoint to both posts. Changes to clinic templates undertaken which is providing increased capacity for new patient slots Two new consultants have commenced. Once consultant vacancy to be appointed to. Additional Clinics to continue to address shortfall. Additional clinics to be agreed to address the backlog. Review of capacity and demand plan to be undertaken to understand recent increase in demand. • Call wrap up time halved from 20 seconds to 10 seconds • Increased staffing at peak times • Monitoring downtime of call handlers • Reviewing hot spots (by hour) and flexing across core tasks as required • Reallocating and monitoring evening activity • Reviewing call handler KPIs and stretch targets • Review of call messages	Jul-2015	Nov.15	PCB	Julie Dawes	Emma Livesley

Major	6130	Corporate	Commissioning & Partnerships	Commissioning & Partnerships	Oct-2014	Active	Financial sustainability	There is a risk of a significant loss of income to the Trust due to Greater Huddersfield CCG and Kirklees and Calderdale Councils undertaking competitive procurements for a range of services (e.g.Care Closer to Home; Sexual Health; School Nursing). This could have negative impact by increasing the Trust's underlying deficit and on the clinical resilience and stability of retained services.	There is a robust system of horizon scanning in place to identify when services are to be tendered both within and beyond the catchment area. this ensure the Trust is able to repond and make decision of whether to submit tenders. New models of care have been developed in response to the requirements of tenders. A commercial strategy is in place which identifies core/non-core services by division and by immediacy of commercial risk (Clinical Services Model Wagon Wheel).	Need to anticipate weaknesses and gaps in services through risk assessments prior to tender processes to make service model changes rather than wait for pressure of a tender to force changes Use of Service Line Reporting needs to be strengthened to identify profitability of services and whether to bid against tenders or disinvest. Need to develop appropriate market exit strategies (disinvestment) to eliminate costs where income is lost.	16 4 x 4	16 4 x 4	12 4 x 3	Develop new models of care in advance of Commissioner tendering processes with advance notice of services likely to be tendered in the future Update: June 2015 Ensure where income is lost there is a managed and clear reduction in cost to minimise residual cost pressure.	Jul-2015	Dec-2015	CISC	Anna Basford	Rob Aitchison & Lisa Williams
Major	6224	Diagnostics & Therapeutic Services	Appointment and Records	Appointments Service	Feb-2015	Active	Not Stated	NHS E-referral system failure caused by national or local IT outage resulting in a backlog of appointment related work, and poor experience for users.	Manual systems. Business continuity plans. GPs revert to paper referral process. Update 24/6 Intermittent problems with access, speed and functionality have been experienced since implementation of the new system on Monday 15th June. Business continuity plans were immediately implemented, however, problems are continuing longer than initially reported by HSCIC , and is resulting in a backlog of work.	System processing delays impacts on speed of call handling, as accessing and working with ERS is taking longer than usual. Intermittent outage has resulted in some referrals not being fully processed at the GP end, leading to increased number of misplaced appointments that require manual intervention and increased workloads in Appointment	8 4 x 2	16 4 x 4	12 4 x 3	Regular contact with HSCIC via the Trust Service Desk. Upgraded version 4.1 to be implemented on 18/7 is expected to resolve system errors.	Aug-2015	Sep.15	PSQB	Helen Barker	Katharine Fletcher
Major	6230	Corporate	Finance	Corporate Finance	Feb-2015	Active	Transforming and improving patient care	There is a risk that the Trust will not be able to deliver the expected financial benefits of the Electronic Patient Record (EPR) system due to the implementation being impeded by financial and operational constraints (eg additional costs incurred due to time delays or lack of appropriate resource being made available) resulting in a failure to demonstrate return on investment or value for money. There are two elements to this risk: Implementation of tactical solutions (e.g. e-rostering; nerve centre; maternity; voice recognition; EDMS); and Project management delays, changes to specification and lack of capacity; clinical engagement and complexities with working jointly with Bradford Teaching Hospitals.	• Agreed loan from Independent Trust Financing Facility (ITFF) received in April 15 to support capital programme, specifically Electronic Patient Record (EPR). • Financial appraisal and selection of preferred supplier that included full benefits realisation and implementation plan. • Modernisation Programme Management and Governance structure to manage the implementation and roll-out of the EPR system within the Trust-wide IT Modernisation Programme. • Transformation Board meets on a monthly basis chaired at CEO level. • Creation of an Assurance Board that includes Non-Executive directors.	The full gap analysis of EPR processes against current working practices to be completed with the requirement to develop an associated change management programme.	15 5 x 3	15 5 x 3	5 5 x 1	EDMS being clinically assessed by end May 2015. Update: June 2015 A detailed project plan and timelines are being developed with Cerner (EPR Provider) and Bradford for the roll-out of the EPR.	Sep-2015	Apr-2016	FC	Keith Griffiths	Kirsty Archer

Calderdale and Huddersfield NHS
NHS Foundation Trust

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Cover Sheet

Meeting: Board of Directors	**Report Author:** Carole Hallam, Assistant Director of Infection Prevention Control
Date: Thursday, 30th July 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 experience - 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 Directors informed 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 state of HCAI in the Trust

The Issue:

Monthly update of the state of HCAI in the Trust

Next Steps:

Report to be taken to the Infection Control Performance Board for action as required

Recommendations:

For the Board to note the content

Appendix

Attachment:

Monthly DIPC Report July 2015.pdf

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

Performance targets

Indicator	Month agreed target	Current month (June)	YTD agreed target	YTD performance	Actions/Comments
MRSA bacteraemia (trust assigned)	0	**0**	0	**1**	
C.difficile (trust assigned)	2	**1**	21	**3**	2 avoidable 1 unavoidable
MSSA bacteraemia (post admission)	1	**1**	12	**3**	
E.coli bacteraemia (post admission)	2	**5**	29	**9**	The probable source in all cases was urinary tract with one patient having a catheter (1 in Surgery, 4 in medicine)
MRSA screening (electives)	95%	**95.74%**	95%	**97%**	May validated data
Central line associated blood stream infections (Rate per 1000 cvc days)	1.5	**0**	1.5		
ANTT Competency assessments (doctors)			95%	**61.4%**	On-going training being provided and increase in number of assessors. Plan in plan for new intake of junior doctors
ANTT Competency assessments (nursing and AHP)			95%	**66.6%**	
Hand hygiene	95%	**99.29%**	95%	**99.56%**	

Quality Indicators

Indicator	Current month (June)	YTD performance	Comments
MRSA screening (emergency)	**91%**	**89.4%**	May validated data
Isolation breaches	**17**	**72**	
Blood cultures Competency assessments		**54.3%**	Data only available for RN
Cleanliness	**97.1%**	**97.2%**	

HCAIs/Areas of Concern/Outbreaks

- **Isolation breaches** recorded by the Infection Control Team during June were 17, compared to 22 in May. Of these 17 isolation breaches,
    - 6 were at CRH and 11 were at HRI

- 9 of the breaches occurred in the medical assessment areas, 7 at HRI and 2 at CRH

- **MRSA** – there was one case of hospital acquired MRSA identified in June, this was a medical patient. There have been 6 cases in total since April.
- **C.difficile** – An investigation into 3 post 72 hour Clostridium difficile cases; 2 gene detected cases and one toxin positive case were identified on 7B at CRH between 01/04/15 – 11/06/15 all ribotype 078. The isolates have been sent for MVLA typing to further characterise them, which will provide definitive proof if these related strains. An outbreak meeting was held on the 24th June in accordance with Trust policy. Outbreak control measures have been implemented and the ward is currently being deep cleaned and high level disinfected using hydrogen peroxide vapour.

  There was one post admission case in June; the summary of the case is below.

Case details	Summary of C.difficile case	Key issues identified from RCA
01.06.15 **HRI 10** MESS no 416209 Datix 119533	Patient admitted to CRH for a planned cholecystectomy 13th May. Commenced IV Co-amoxiclav on 14th May for biliary sepsis. Transferred to SAU on 22nd May for insertion of drain due to fluid collection and IV antibiotics prescribed. Had intermittent type 5 stools from 22nd May but stool specimen not taken until 1st June.	• Agreed as an avoidable case • Delay in isolation • Delay in obtaining stool specimen • Antibiotics prescribing guidance not followed • Gaps in documentation

Quality Improvement Audits

- Six Quality Improvement Audits were performed in June
  - HRI Oral Maxillofacial Clinic – Scored Green (92%)
    - Two chairs require replacement
    - Dirty utility was cluttered and unclean floor
    - In need of decorating in some areas
  - HRI Ward 18 – Scored Amber (82%)
    - Damaged flooring and in need of replacement
    - Damaged woodwork
    - High and low level dust
    - Storeroom was cluttered
  - HRI Discharge Lounge – Scored Amber (88%)
    - Dusty shelves in the clean utility
    - Food debris found under sofa cushions
    - Crack noted on store room wall
    - Some kitchen tiles need replacing
  - CRH Ward 2AB – Scored Amber (86%)
    - Some minor wall and floor damaged noted
    - Storeroom cluttered and dusty
    - Dusty noted on the shelving units in the clean utility

        - Computer keyboard at the nurses station was dusty
    - HRI Surgical Procedure Unit – Scored Amber (88%)
        - High level dust in the storeroom
        - Trolley mattress was stained
        - Computer keyboard in theatre was dusty
        - Items stored on the floor in lots of areas
    - HRI A&E and Plaster Room – Scored Amber (79%)
        - One commode found unclean
        - Kitchen cupboards and fixtures were damaged and unclean
        - ANTT trolley had blood stains
        - Doctor was wearing a stoned ring
        - Some dust noted on ledges

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Calderdale and Huddersfield NHS
NHS Foundation Trust

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Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 30th July 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: GOVERNANCE REPORT - This report brings together a number of governance items for review and approval by the Board.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

This report brings together a number of governance items for review and approval by the Board:
- Progress with the Well Led Governance Review
- Terms of reference of the Board of Directors
- Update on progress in developing the Board Assurance Framework

Main Body

Purpose:

This report sets out the main areas of governance work over the previous month.

Background/Overview:

-

The Issue:

Well Led Governance Review

The Well Led Governance Review has now concluded. The final report was not available to be submitted with the papers for this meeting but will be circulated to Board members separately and the full report will come to a future meeting.
PWC held a workshop with Board members to present the findings from the review - a summary of those findings is attached at appendix A. The key themes stemming from the review were:
- Capacity
- Pace of Change
- Performance management
- Data quality
- Ability to forecast

These findings have also been shared with some of the Membership Council in their workshop this week.

Overall PWC concurred with the Trust's self assessment rating against each of the ten questions. This is positive in that it demonstrates a good self-awareness and there were no areas assessed as red and therefore requiring immediate and significant action. However it does present a challenge to the Trust as it demonstrates the need to make a shift across all areas of governance in order to improve. As such this fits with the transformation agenda in the Trust and Anna Basford has been identified as the executive lead for this work. It has been agreed that, rather than develop an action plan, the programme approach will be used to progress this work, wherever possible linking with existing agendas. The agreed programme of work will be presented to the Board at a future meeting.

Terms of Reference

The Board of Directors terms of reference have been reviewed. Only typographical amendments were made and the updated version is presented to the Board for approval.

Board Assurance Framework

The first draft of the strategic risks to reflect the revised strategy have been circulated to executive directors for comment and amendment. This could not be completed in time for this board meeting and so will come to the August Board. These have also been updated to reflect the findings from the Well Led Governance Review. The draft of the Board Assurance Framework will be circulated to all Board members for comment in advance of the Board meeting. Work is also underway between the Company Secretary and the Head of Governance and Risk to articulate how the corporate risk register and Board Assurance Framework will link.

Next Steps:

-

Recommendations:

The Board is asked to
- Note the findings from the Well Led Governance Review
- Approve the terms of reference for the Board of Directors
- Note the progress with the development of the Board Assurance Framework

Appendix

Attachment:

COMBINED GOVERNANCE REPORT.pdf

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BOARD OF DIRECTORS TERMS OF REFERENCE

1. CONSTIUTION

These terms of reference describe the role and work of the Board. They are intended to provide guidance to the Board, for the information of the trust as a whole and serve as the basis of the terms of reference for the Board's own committees. The practice and procedure of the meetings of the Board of Directors – and of its committees – are not set out here but are described in the Board's Standing Orders.

2. PURPOSE

The principle purpose of the Trust is to 'provide goods and services for the purpose of the health service in England related to the provision of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness, and the promotion and protection of public health.'

The Trust has a Board of directors which exercises all the powers of the Trust on its behalf and may delegate any of those powers to a committee of directors or to an executive director. In addition, certain decisions are made by the Membership Council and some decisions of the Board of directors require the approval of the Membership Council. The Board consists of executive directors, one of whom is the Chief Executive, and non-executive directors, one of whom is the Chair.

The Board leads the Trust by undertaking three key roles:

- Formulating strategy
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable.
- Shaping a positive culture for the Board and the organisation.

3. DUTIES

The general duty of the Board of Directors, and of each director individually, is to act with a view to promoting the success of the trust so as to maximise the benefits for the members of the corporation as a whole and for the public.

The Board of Directors collectively and individually has a duty of candour, meaning they must be open and transparent with service users about their care and treatment, including when it goes wrong.

Each director also has a duty to avoid conflicts of interest and not to accept benefits from third parties (as well as to declare interests in proposed transactions or arrangements with the Trust).

4. RESPONSIBILITIES

In fulfilling its responsibilities, the Board of Directors will work in a way that makes the best use of the skills of non- executive and executive directors.

4.1. General Responsibilities

The general responsibilities of the Board are:

- To work in partnership with patients, service users, carers, members, local health organisations, local government authorities and others to provide

safe, accessible, effective and well governed services for patients, [service users, and carers;

- To ensure that the trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity; and
- To exercise collective responsibility for adding value to the trust by promoting its success through direction and supervision of its affairs in a cost effective manner.

4.2. Leadership

The Board provides active leadership to the organisation by:

- Ensuring there is a clear vision and strategy for the trust that people know about and that is being implemented, within a framework of prudent and effective controls which enable risk to be assessed and managed;
- Ensuring the trust is an excellent employer by the development of a workforce strategy and its appropriate implementation and operation.

4.3. Quality

The Board:

- Ensures that the trust's quality of service responsibilities for clinical effectiveness, patient safety and patient experience, are achieved;
- Has an intolerance of poor standards, and fosters a culture which puts patients first;
- Ensures that it engages with all its stakeholders including patients and staff on quality issues and that issues are escalated and dealt with appropriately.

4.4. Strategy

The Board:

- Sets and maintains the trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives;
- Determines the nature and extent of the risk it is willing to take in achieving its strategic objectives;
- Monitors and reviews management performance to ensure the trust's objectives are met;
- Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required;
- Develops and maintains an annual business plan and ensures its delivery as a means of taking forward the strategy of the trust to meet the expectations and requirements of stakeholders.
- Ensure that national policies and strategies are effectively addressed and implemented within the trust.

4.5. Culture

The Board:

- Is responsible for setting values, ensuring they are widely communicated and that the behaviour of the Board is entirely consistent with those values;
- Promotes a patient centred culture of openness, transparency and candour;
- Ensures that high standards of corporate governance and personal integrity

are maintained in the conduct of foundation trust business;
- Ensures the application of appropriate ethical standards in sensitive areas such as research and development;
- Ensures that directors and staff adhere to any codes of conduct adopted or introduced from time to time.

4.6. Governance / Compliance

The Board:

- Ensures compliance with relevant principles, systems and standards of good corporate governance and has regard to guidance on good corporate governance (as may be issued by Monitor from time to time) and appropriate codes of conduct, accountability and openness applicable to foundation trusts;
- Ensures that all elements of the Monitor licence relating to the Trust's governance arrangements are complied with;
- Ensures that the trust has comprehensive governance arrangements in place that guarantee that the resources vested in the trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the trust fulfils its accountability requirements.
- Ensures that the trust complies with its governance and assurance obligations in the delivery of clinically effective, personal and safe services taking account of patient and carer experiences.
- Ensures that all required returns and disclosures are made to the regulators;
- Formulates, implements and reviews standing orders and standing financial instructions as a means of regulating the conduct and transactions of foundation trust business.
- Agrees the schedule of matters reserved for decision by the Board of directors;
- Ensures that the statutory duties of the trust are effectively discharged;
- Acts as a corporate trustee for the trust's charitable funds.

4.7. Risk management

The Board:

- Ensures an effective system of integrated governance, risk management and internal control across the whole of the trust's clinical and corporate activities.
- Ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement with regard to development of care plans, the review of quality of services provided and the development of new services.
- Ensures there are appropriately constituted appointment arrangements for senior positions such as consultant medical staff and executive directors.

4.8. Committees

The Board is responsible for maintaining committees of the Board of Directors with delegated powers as prescribed by the trust's standing orders and/or by the Board of Directors from time to time:

4.9. Communication

The Board:

- Ensures an effective communication channel exists between the Trust, its

membership councillors, members, staff and the local community.

- Meets its engagement obligations in respect of the Membership Council and members and ensures that membership councillors are equipped with the skills and knowledge they need to undertake their role;
- Holds its meetings in public except where the public is excluded for stated reasons;
- Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback;
- Holds an annual meeting of its members which is open to the public;
- Ensures that those Board proceedings and outcomes that are not confidential are communicated publically, primarily via the trust's website.
- Publishes an annual report and annual accounts.

4.10. Finance

The Board:

- Ensures that the trust operates effectively, efficiently, economically
- Ensures the continuing financial viability of the organisation;
- Ensures the proper management of resources and that financial and quality of service responsibilities are achieved;
- Ensure that the trust achieves the targets and requirements of stakeholders within the available resources;
- Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

5. ROLE OF THE CHAIR

The Chair is responsible for leading the Board of Directors and for ensuring that it successfully discharges its overall responsibilities for the trust as a whole.

The Chair reports to the Board of Directors and is responsible for the effective running of the Board and membership council and ensuring they work well together.

The Chair is responsible for ensuring that the Board as a whole pays a full part in the development and determination of the Trust's strategy and overall objectives.

The Chair is the guardian of the Board's decision-making processes and provides general leadership to the Board and the Membership Council.

6. ROLE OF THE CHIEF EXECUTIVE

The Chief Executive (CEO) reports to the Chairman and to the Board directly. All members of the management structure report either directly or indirectly, to the CEO.

The CEO is responsible to the Board for running the trust's business and for proposing and developing the trust's strategy and overall objectives for approval by the Board.

The CEO is responsible for implementing the decisions of the Board and its committees, providing information and support to the Board and membership council.

7. ACCOUNTABILITY TO THE MEMBERSHIP COUNCIL

The non-executive directors are accountable to the Membership Council for the performance of the Board of directors. To execute this accountability effectively, the

non-executive directors will need the support of their executive director colleagues. A well-functioning accountability relationship will require the non-executive directors to provide membership councillors with a range of information on how the Board has assured itself on key areas of quality, operational and financial performance; to give an account of the performance of the trust. The non-executive directors will need to encourage questioning and be open to challenge as part of this relationship. The non-executives also should ensure that the Board as a whole allows membership councillors time to discuss what they have heard, form a view and feedback.

8. FREQUENCY OF MEETINGS

The Board of Directors will meet at least 9 times a calendar year.

9. QUORUM

Six directors including not less than three executive, and not less than three Non-Executive Directors shall form a quorum. .

10. ATTENDANCE

A register of attendance will be maintained and reported in the Annual Report. The Chair will follow up any issues related to the unexplained non-attendance of members.

11. ADMINISTRATION

The Board of Directors shall be supported administratively by the trust secretary whose duties in this respect will include:

- Agreement of agenda for Board and Board committee meetings with the chair and chief executive
- Collation of reports and papers for Board meetings
- Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward
- Supporting the Chair in ensuring there are good information flows within and between the Board, its committees, the membership council and senior management
- Supporting the Chair on matters relating to induction, development and training for directors

A full set of papers comprising the agenda, minutes and associated reports and papers will be sent within the timescale set out in standing orders to all directors and others as agreed with the chair and chief executive from time to time.

12. REVIEW

The terms of reference for the Board will be reviewed at least every year.

13. EFFECTIVENESS

In order that the Board can be assured that it is operating at maximum effectiveness in discharging its responsibilities at set out in these terms of reference it shall self assess its performance following each Board meeting. Once a year a full review of effectiveness will be undertaken including attendance, decision making, assessment against responsibilities and completion of the business cycle.

WELL LED GOVERNANCE REVIEW

Feedback from PWC

Themes from the review

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Overarching themes:

- Capacity
- Pace of change
- Performance management
- Data quality
- Ability to forecast

		Trust self-assessment	PwC view
1A	Does the board have a credible strategy to provide quality, sustainable services to patients and is there a robust plan to deliver?		
1B	Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?		
2A	Does the board have the skills and capability to lead the organisation?		
2B	Does the board shape an open, transparent and quality-focused culture?		
2C	Does the board support continuous learning and development across the organisation?		
3A	Are there clear roles and accountabilities in relation to board governance (including quality governance?)		
3B	Are there clearly defined, well- understood processes for escalating and resolving issues and managing performance?		
3C	Does the board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?		
4A	Is appropriate information on organisational and operational performance being analysed and challenged?		
4B	Is the board assured of the robustness of information?		

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Recommendations

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Theme: Capacity

Good practice	Risks and areas for development	PwC recommendation

• Inclusion on the risk register
• Creation of new roles:
  • Operations
  • Transformation
  • PMO
	• No "red" risks, but a number of areas for development across the framework
	• Ongoing financial challenge
	• Risk of the unknown
	  • CQC
	  • EPR etc.
		The Trust must assess and reflect on the capacity of the Board and staff at all levels to deliver operational improvement and future strategic priorities, and therefore the resilience of the organisation and individuals.

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Recommendations

Theme: Pace of change

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Good practice

- Financial turnaround
- Proactive in seeking external scrutiny (e.g. peer review of quality)
- Use of "go see" methodology

Risks and areas for development

- Areas that have been issues for some time:
  - Fractured neck of femur
  - Care of the acutely ill
  - Coding
  - Payroll controls

PwC recommendation

The Board needs to be assured that the Trust is delivering its strategic priorities.
Information presented to the Board should be integrated and triangulated to enable to the Board to make efficient judgements as to whether strategic and operational objectives are being achieved as expected.
The Board should receive intelligence distilled from a more detailed review at the sub-committees.

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Recommendations

Calderdale and Huddersfield NHS
NHS Foundation Trust

Theme: Performance management

Good practice	Risks and areas for development	PwC recommendation
• Turnaround executive and PMO • Improved attendance at divisional business meetings • Greater action focus in sub-committees • Feedback from divisional leadership teams	• Performance management below divisional level • Understanding the consequences of failing to deliver • Clear priorities and acknowledgement of actions that must be postponed or halted.	The Trust should consider the introduction of a more formal accountability framework as an enabler to performance management and operational delivery. This internal contractual agreement between the Trust Board, divisions and directorates should be used as a basis to defined an appropriate level of devolution across the Trust.

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Recommendations

Calderdale and Huddersfield NHS
NHS Foundation Trust

Theme: Data quality and forecasting

Good practice	Risks and areas for development	PwC recommendation
• More forward looking activity data • Introduction of the data quality kite mark • Changes made to the integrated performance report	• Most data remains backward looking • Data quality kite mark relies on self-assessment • There are a number of data quality triggers (e.g. coding, payroll information).	Further development of the data quality kite mark will allow Board members to gain assurance over the reliability of each measure and could provide greater assurance that there are no unknown data quality issues. The Board should consider how the skills within the Trust (in particular, within the Health Informatics Service) could be leveraged to take a more transformation approach to data and data quality, and should consider the development of an information strategy to achieve this.

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Next steps

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- Finalised report to come from PWC
- Will be shared
- Programme approach to implementation of recommendations to be developed

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NHS Foundation Trust

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Cover Sheet

Meeting: Board of Directors	**Report Author:** Vicky Thersby, Safe Guarding Lead
Date: Thursday, 30th July 2015	**Sponsoring Director:** Jackie Murphy, Deputy Director of Nursing
Title and brief summary: Safeguarding Adults and Children Update July 2015 - Safeguarding Update : Safeguarding Adults and Children July 2015	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

The purpose of this report is to provide a brief update to the Board of Directors about safeguarding activity within the Foundation Trust, and to provide accurate and current information about the effectiveness of internal systems and processes to demonstrate the status of the Foundation Trust's compliance with statutory safeguarding requirements.

Main Body

Purpose:

please see attached

Background/Overview:

please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

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

Appendix

Attachment:

combined safeguarding report July 2015.pdf

Agenda Item
Enclosure

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

Title of Report:	**Safeguarding Children and Adults Update** **21st July 2015**

FOI Exemption Category:	**Private**

Responsible Director:	**Julie Dawes**

Report Author and Job Title:	**Victoria Thersby Safeguarding Lead**

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

Calderdale and Huddersfield NHS Foundation Trust

Safeguarding Update:

July 2015

1. Purpose

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

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

It is vital that Safeguarding standards are maintained and continue to improve, and, accountability remains clear and unambiguous. With this is mind it is critical that safeguarding remains a key priority within the Foundation Trust over the coming year, and that staff are fully supported in delivering safe and quality services.

2. Introduction

Safeguarding Adults and Children remains an integral aspect of patient care, and requires services to work effectively together, and across boundaries to prevent harm and intervene when harm, neglect, or abuse is suspected.

This update provides further plans and continued development for the forthcoming year, following the introduction of the Care Act 2014 in April 2015, which now legislates Adult Safeguarding and imposes a legal duty on NHS organisations. This legislation replaces the 'No Secrets' guidance. It not only addresses and recognises stopping abuse or neglect, preventing harm and reducing risk, but promotes an approach that improves the life for the adult concerned. The principles and values of adult safeguarding are built on empowerment, protection, prevention, partnerships, proportionality and accountability.

The Children Act 1989/2004 imposes a legal duty on all professionals to safeguard and protect children. 'Working Together 2015' further emphasises the collective interagency arrangements of how agencies including NHS organisations must work together, and how this is implemented locally.

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

CHFT is not only just one of the five West Yorkshire partner organisations which work within the West Yorkshire Safeguarding Adults Policies and Procedures; but the procedures now include North Yorkshire. The implementation of this policy ensures all West Yorkshire partners are working together and are aligned in their working practices.

3. Progress to date

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

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

Ofsted have further inspected Children's services in Calderdale earlier this year, and improvements have been made in a number of services across the District. The Local authority is aware of the improvements that are required and have a clear delivery plan to implement these. The Foundation Trust have been represented on the Calderdale Improvement Board and have contributed to Calderdale's Improvement journey, providing assurances and evidence about what we, as an organisation, are doing to improve outcomes for children. The Independent Chair of the Board continues to provide regular updates to Ministers about Calderdale's progress.

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

Key Challenges

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

Ongoing work

- *On-going work will continue to ensure existing partnerships and collaborative working is maintained in order to improve quality outcomes for vulnerable groups.*

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

Since a review of the safeguarding model within the Foundation Trust when the previous post holder ceased employment in January 2015, the Foundation Trust has recruited a new Head of Safeguarding to Lead the Adults and Children's Team in June 2015. Work is continuing to embed a safeguarding culture across all divisions and departments by ensuring that CHFT follow the principles into practice ethos of ensuring safe patient care (right patient, right place, right time); and that the four behaviours expected of all employees are followed. There is development of a safeguarding strategy ongoing to ensure that CHFT policies and procedures in relation to the Adults and Children's agenda seamlessly transfer information from admission to discharge and beyond.

In March 2015 CHFT contributed to 'Safeguarding Week' on behalf of Calderdale Adults and Children's Safeguarding Boards. The aim of this week was to raise awareness of the role of 'everyone' in safeguarding vulnerable children and adults at risk to highlighted available support and intervention in Calderdale. As part of this week:

- CHFT hosted Hempson's Solicitors to present a 'Consent update.' This event was open to all professionals across Calderdale. This evaluated extremely well.
- CHFT in collaboration with the Police hosted an event surrounding Domestic Abuse and Clare's Law on two occasions.
- CHFT also held a stall in the canteen and main entrance of CRH.

Peter Edwards Law spent a day at Huddersfield Royal Infirmary and presented a session in the morning and afternoon via video link to Calderdale Royal Hospital and presented a masterclass on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). This was extremely well attended by staff from both sites to approximately 350 staff.

Neil Allen; a barrister from 39 Essex Street attended in July to present a masterclass aimed at clinicians and clinical staff on the MCA and DoLS, and went into great depth regarding assessing capacity and when a deprivation of liberty needs to be authorised.

Internal lines of accountability and internal structures within the Trust have been strengthened to make sure that the organisation has a clear process in place for communicating with staff and to ensure safeguarding is at the heart of everything they do. The safeguarding team continues to work closely with the risk department to provide advice and support in relation to complaints and incidents where safeguarding concerns have been identified. Further governance work is ongoing in engaging with Divisions ensuring safeguarding continues to be a priority, and attendance at Divisional Patient Safety and Quality Boards is ongoing.

Key Challenges

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

Ongoing work

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

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

The Foundation Trust's Safeguarding Committee provides a forum to bring together key senior safeguarding professionals and other senior managers across CHFT to ensure the organisation's safeguarding responsibilities' are being discharged and disseminated effectively. It monitors CHFT's safeguarding activities and provides assurances, identifies gaps and provides regular updates to both commissioners and to the safeguarding boards with regard to our statutory safeguarding functions.
Due to the inconsistent attendance at the Foundation Trusts safeguarding Committee meeting and the operational groups for children and adults, the terms of reference and membership have been reviewed. This is now being monitored more closely and deputies are now asked to attend on behalf of Divisions.

3.3.1 Legislative Update

In April 2015 the introduction into primary legislation of the Care Act imposed legal duties in Adult Safeguarding. This includes duties for care providers: These duties include:

- Providers of care regulated by the CQC have a duty to report any allegations of abuse or neglect.
- Where there is an employee involved with a Section 42 formal enquiry, there will need to be an investigation by the provider and the sharing of information sufficient to include all facts in a Case Conference report.
- Employers must report all findings of abuse to the Disclosure and Barring Service and professional bodies.
- There is a Duty of Candour for Care Providers
- Local Authorities must cooperate with relevant partners, and those partners must cooperate with the Local Authority (The Care Act specifies NHS Trusts & hospitals, amongst others).
- There is in addition a greater emphasis on making safeguarding personal for patients in helping them achieve the outcomes that they want.
- The Foundation Trust should ensure that they have the mechanisms in place to enable early identification of risk and collaborate and work together, whilst considering the wishes of the adult on whose behalf they are working.

The legislation confirmed that:

- Safeguarding Adult Boards became statutory.
- There is a requirement to conduct Safeguarding Adult Reviews.
- Information sharing duties.
- The statutory organisations for the Safeguarding Adults Board are the Local Authority, the Police and the Clinical Commissioning Groups.
- All statutory agencies to have a Designated Adult Safeguarding Manager (DASM). A DASM would be involved where concerns are raised about an employee, volunteer or student, paid or unpaid. This role is recommended for members of Safeguarding Adults Boards

Ongoing Work

- *The safeguarding team is currently updating its policies and procedures to reflect both national legislative and local policy changes in both children and adult safeguarding.*
- *The role of the DASM will need to be identified and developed for CHFT*

Datix Incident Reporting

Further ongoing work is continued to ensure that systems are in place where safeguarding concerns are reported through the Foundation Trusts internal reporting mechanism. This work also includes ensuring the Foundation Trust is meeting its obligations in relation to the Care Act 2014 by involving the Local Authority partner organisation.

Key Challenge

- *Remains to continue to ensure that Divisions are represented at each strategic and operational meeting.*

Ongoing Work

- *The development of a CHFT safeguarding strategy and divisional action plan*

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

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

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

- Level 1 safeguarding continues to be delivered via written updates and briefings across the workforce in the form of the safeguarding newsletter which is circulated twice a year. It not only gives relevant information to meet the criteria for level 1 training, but it also supports levels 2 and 3 training and is currently at **100%**

- Level 2 safeguarding training (Adults and Children) has seen a slight decrease of 52.8 to 51.9 %. Training continues to be constantly reviewed and updated in order to maximise learning and meet the needs of the diverse workforce and overall evaluates well. This is now shortly being offered as an eLearning package which will be easier for staff to access and increase training compliance.

- Level 3 safeguarding children training has decreased in the last quarter from 82.8% to 73.4%

- Level 3 safeguarding adults training is not being recorded in %. Staff who require level 3 training have not been identified in a matrix and therefore further work is being carried out here.

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

- **PREVENT** - Implementation of the PREVENT Strategy is now underway across the organisation, with significant progress being made. The Trust now had 9 accredited trainers and a clear training programme is currently underway**.** NHS England and commissioners are happy with our Implementation of this strategy and training continues to evaluate well. All staff are identified on ESR who require this one off training. This training is not yet captured as a percentage

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

Key Challenges

- *Ensuring that training compliance increases consistently*

Ongoing Work

- *The safeguarding team is currently working with workforce development in relation to how target groups are defined and how training is recorded since a number of anomalies have been identified. An achievement plan is being developed to address this which will involve the further identification of divisional non-compliance and individual staff identification.*
- *The content of the level 2 training has been updated and the safeguarding team are awaiting the compilation of an eLearning package for staff in an attempt to address poor compliance at level 2.*

Other work has included;

- Further update and development of the Foundation Trusts Intranet pages to facilitate easier access to safeguarding information. The safeguarding icon is now clearly visible on the intranet pages, and work continues to develop the content in order to make it easier for staff to access up to date safeguarding information.

- Publication of the 7th edition the safeguarding newsletter in June 2015 provided further updates and information for staff.

- Promotion of district wide events hosted by the local Safeguarding Boards

- Production of a safeguarding banner on the main intranet page which includes topical information evolving from serious case reviews, domestic homicide reviews and local and national guidance.

4. Monitoring and Assurance

Section 11 of the Children Act 2004

Places a statutory duty on organisations, and individuals, to ensure their functions are discharged with regard to the need to safeguard and promote the welfare of children. The Trust has a clear systems and processes in place to monitor safeguarding activity and provides regular updates to partners in Clinical Commissioning Groups, as well as the Local Safeguarding Boards. The Section 11 self-assessment was submitted to Calderdale Safeguarding Children Board at the end of June 2015. Further work is planned in relation to the uptake of supervision, clarification of specific roles and responsibilities with a Volunteers handbook and policy development, DBS checks and ratification of policy, ratification of the updated Freedom of Speech policy which relates to 'Whistleblowing.' There is further work planned to develop processes to ensure staff follow correct processes when they have a concern for the welfare of a child or their family would benefit from additional help. There is planned work to develop regular meetings to disseminate the learning from Serious Case Reviews and Domestic Homicide Reviews both locally and nationally. The development of policy and reporting relating to Female Genital Mutilation (cases of FGM are reported to the Department of Health); ensuring that the views an wishes of children, young people and their families are identified and listened to. This work is planned to be completed through the safeguarding sub-groups of the Board.

MCA and DoLS Audit June 2015

An audit carried out in June 2015 Foundation Trust wide has identified knowledge gaps on wards in relation to the assessments of patients capacity in relation to decision specific criterion; the lack of the identification of patients who are deprived of their liberty but without a legal safeguard on the wards, and a lack of comprehensive policy relating to the MCA and DoLS. The acid test arose from a Supreme Court Judgement last year which lowered the threshold for DoLS. Patients who lack capacity; who are under continuous supervision and control; and are not free to leave require a legal safeguard. There were 27 patients at Huddersfield Royal Infirmary and 8 patients at Calderdale Royal Hospital who met the acid test.

A more comprehensive report has been prepared to action this.

Risk to the Foundation Trust

- *The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13 specifically refers to safeguarding people who use services from any form of suffering any form of abuse or improper treatment, while receiving care and treatment. Improper treatment includes discrimination or unlawful restraint, which includes deprivation of liberty under the terms of the MCA 2005.*
- *CQC can prosecute for a breach of some parts of this regulation (13(1) to 13(4)) if a failure to meet those parts results in avoidable harm to a person using the service or*

if a person using the service is exposed to significant risk of harm. A warning notice does not need to be served before prosecution.

- *The secondment for the member of staff in post to lead the development and implementation to the MCA and DoLS ends in September 2015 which will result in a deficit in the safeguarding adult's service.*

Supervision

Both **individual and group supervision** has been developed further and uptake is closely monitored. Target groups have been established identifying the type and frequency of supervision. Progress continues to be made regarding the uptake for safeguarding supervision over the past quarter.

Serious Case Reviews/Domestic Homicide Reviews

CHFT continue to work with the Local safeguarding boards and the Safer Stronger Partnerships to ensure lessons are learned following serious case reviews/domestic homicide reviews.

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

- KSCB – x1 SCR ongoing
- KSAB – x1 pending SAR/ x2 ongoing DHR's
- CSCB – X3 SCR's ongoing / x1 pending
- Out of area – x2 ongoing DHR/ x2 pending SCR

CHFT is required to work with partners to identify learning from these cases in order to improve practice and services for the communities that we serve. Training events have been planned to cascade learning from local and national serious case reviews and domestic homicide reviews and work continues to ensure the learning is reflected in policy and practice.

4. Conclusion

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

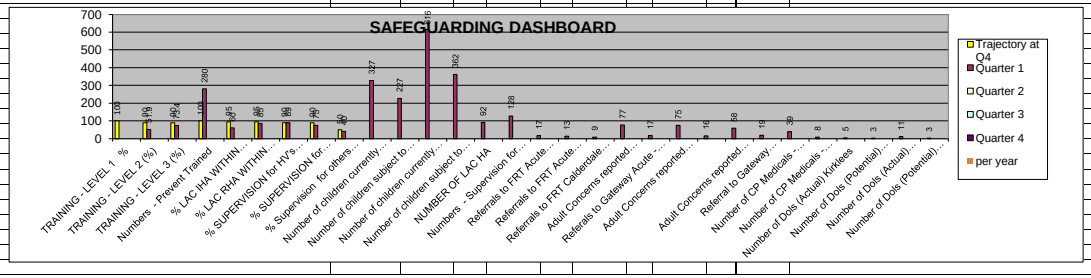
The Foundation Trust Safeguarding Team is committed to ensure that a Safeguarding culture is embedded into everyday practice for all staff who work for CHFT. Safeguarding is everyone's responsibility and should be part of everyone's practice, whatever their role. The safeguarding team is available Monday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

The Foundation Trust has developed a committed team which over the coming months will endeavour to support Divisions in developing their practice and devolving their safeguarding responsibilities. The Foundation Trust aspires to achieve a

safeguarding culture that safeguards and protects all of its patients and their families, by the principles laid down in primary legislation and local policy.

Victoria Thersby
Safeguarding Lead Children and Adults
18th July 2015

SAFEGUARDING ASSURANCES/DASHBOARD 2015/2016										where to obtain information
	Trajectory at Q	Quarter 1		Quarter 2		Quarter 3		Quarter 4	per year	Comments	
JOB DESCRIPTION	ALL JD's	Included		Included		Included		Included			Alison Edwards/Adam Matthews
TRAINING - LEVEL 1 %	100								100		Alison Edwards/Adam Matthews
TRAINING - LEVEL 2 (%)	90	51.9									Alison Edwards/Adam Matthews
TRAINING - LEVEL 3 (%)	90	73.4									Alison Edwards/Adam Matthews
Numbers - Prevent Trained	100	280								100 per month	Anne Brier/Debra Rees
% LAC IHA WITHIN TIMESCALES	95	60								Late notification to the LAC health team from CSC	Amanda Pickles
% LAC RHA WITHIN TIMESCALES	95	85								The second column is the actual figure submitted after the deadline. Still awaiting completed RHA's from OOA health providers	Amanda Pickles
% SUPERVISION for HV's and ScN	90	89								90% by Q4 Individual supervision where CP plan in place	Supervision Matrix on J: Drvie
% SUPERVISION for Specialist Midwives	90	75								90% by Q4 Individual supervision where ICP in place/Cause for Concern	Supervision Matris on J:Driv
% Supervision for others Children Services	50	40								50% by Q4 All supervision for all staff groups (individual and group)	Supervision Matrix on J: Drvie
Number of children currently Looked after (Calderdale)		327									Amanda Pickles
Number of children subject to CP Plan (Calderdale)		227									Weekly list from CSCB - saved on J: Drive under child protection, child protection conferences etc
Number of children currently Looked after (Kirklees)		616									email lesley.senior@kirklees.gov.uk
Number of children subject to CP Plan (Kirklees)		362									email lesley.senior@kirklees.gov.uk
NUMBER OF LAC HA		92								The second column is the actual figure submitted after the deadline.	Amanda Pickles
Numbers - Supervision for Adult Services		128								All supervision for all staff groups (individual and group)	Supervision Matrix on J: Drvie
Referrals to FRT Acute Kirklees (Children)		17									Safeguarding Data on J:Drive
Referrals to FRT Acute Calderdale (Children)		13									Safeguarding Data on J:Drive
Referrals to FRT Calderdale Community (HV/SCN)		9									Safeguarding Data on J:Drive
Adult Concerns reported Acute -Calderdale Category 1		77									Anne Brier
Referals to Gateway Acute - Calderdale Category 2		17									Anne Brier
Adult Concerns reported Acute - Kirklees 1		75									Anne Brier
Referral to Gateway Acute - Kirklees 2		16									Anne Brier
Adult Concerns reported (communiuty)- Calderdale 1		58									Anne Brier
Referral to Gateway Community Calderdale 2		19									Anne Brier
Number of CP Medicals - Calderdale		39									Safeguarding Data on J:Drive
Number of CP Medicals - Kirklees		8									Safeguarding Data on J:Drive
Number of DoIs (Actual) Kirklees		5									Anne Brier
Number of DoIs (Potential) Kirklees		3									Anne Brier
Number of DoIs (Actual) Calderdale		11									Anne Brier
Number of DoIs (Potential) Calderdale		3									Anne Brier
Number of children Kirklees attending A/E - Alcohol		6									Safeguarding Data on J:Drive
Number of children Calderdale attending A/E - Alcohol		8									Safeguarding Data on J:Drive
Number of children Kirklees attending A/E - Substances		7									Safeguarding Data on J:Drive
Number of children Calderdale attending A/E - Substances		6									Safeguarding Data on J:Drive
Number of children Kirklees attending A/E - self harm		10									Safeguarding Data on J:Drive
Number of children Calderdale attending A/E - self harm		13									Safeguarding Data on J:Drive
Number of Cause for Concern Forms in relation to - DV- Calderdale HV		7								The figures for q1 relate to the total number of forms for Calderdale and Kirklees in relation to DV. These will be split from q2	Safeguarding Data on J:Drive
Number of Cause for Concern Forms in relation to - DV- Calderdale SCN											
Number of Cause for Concern Forms in relation to - DV- Kirklees HV		4								The figures from q1 relate to the total number of forms for Calderdale and Kirklees in relation to DV. These will be split from q2	Safeguarding Data on J:Drive
Number of Cause for Concern Forms in relation to - DV- Kirklees SCN											
Number of FGM in Kirklees		1									Kath College
Number of FGM in Calderdale		0									Kath College
updated 03.02.15											



Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 30th July 2015	**Sponsoring Director:** Keith Griffiths, Director of Finance
Title and brief summary: MONTH 3 - FINANCIAL NARRATIVE - The Board is asked to approve the Month 3 Financial Narrative.	
Action required: Approve	
Strategic Direction area supported by this paper: Financial Sustainability	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Financial Sustainability	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the Month 3 - 2015 Financial Narrative.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

The Board is asked to approve the Month 3 - 2015 Financial Narrative.

Appendix

Attachment:

Month 3 2015_16 Financial Narrative BOD.pdf

Calderdale and Huddersfield NHS FT

Month 3, June 2015 Financial Narrative

Purpose

This paper provides a narrative to accompany the monthly financial dashboard and will focus on the key messages within the month and year-end forecast and is presented in the following three sections

- Executive summary;
- Month 3, June performance;
- Forecast risk and opportunities.

The comparisons and reference points within this paper are consistent with the dashboard highlighting actual performance against the plan as submitted to Monitor in May 2015.

This paper has previously been discussed at the Finance & Performance Committee on the 21 July 2015.

Executive Summary

The Trust has delivered the planned financial position for month 3 and is forecasting to achieve the planned position for the year-end 2015/16.

Month 3, June Position

Income and Expenditure Summary	Plan £m	Actual £m	Variance £m
EBITDA	**(0.24)**	**(0.24)**	**0.00**
Deficit	**(6.59)**	**(6.53)**	**0.06**

- A negative EBITDA of £0.24m, in line with plan.
- A deficit of £6.53m, a favourable variance of £0.06m from the planned position.
- Delivery of CIP of £2.80m against the planned level of £2.18m.
- Contingency reserves released of £0.1m against year to date pressures.
- Capital expenditure of £4.69m, below the planned level of £5.10m.
- A cash balance of £10.97m, below the planned level of £10.90m
- A Continuity of Risk Rating (CoSRR) of level 1, in line with plan.

Year-end Forecast Position

Income and Expenditure Summary	Plan £m	Actual £m	Var £m
EBITDA	**5.51**	**5.32**	**(0.19)**
Deficit excluding restructure costs	**(20.01)**	**(20.01)**	**0.00**
Restructure costs	(3.00)	(3.00)	0.00
Deficit including restructure costs	**(23.01)**	**(23.01)**	**0.00**

- An EBITDA of £5.32m, £0.19m under planned levels.
- A deficit before restructure costs of £20.01m, in line with the planned position.
- Restructure costs forecast to be at planned levels of £3.00m.
- A deficit including restructure costs of £23.01m, in line with plan.
- CIP delivery of £16.0m incorporated in the forecast position against planned CIP at £14.05m.
- Contingency reserves of £1.5m released unutilised to mitigate against financial pressures.
- The balance of £1.5m contingency reserve has been ringfenced against investment to enable transformation and other known commitments.
- Capital expenditure of £20.59m, slightly below the planned level and supported by the £10m capital loan drawdown in April.

- A cash balance of £2.08m, in-line with the planned level of £1.92m, including external cash support of £14.9m.
- A Continuity of Risk Rating (CoSRR) of level 1, in-line with plan.

Month 3, June Performance

The challenging operational pressures as described in the latter part of 2014/15 have continued into the first quarter of 2015/16.

As described within the Annual Plan for 2015/16 additional bed capacity had been planned for over and above the levels experienced within 2014/15. However, within the year to date, this additional planned capacity has been exceeded every month. A number of intermediate care nursing beds have recently been removed from the Calderdale community system until further notice. This is in addition to ongoing pressure within nursing / residential care capacity across both Calderdale and Kirklees which is impacting significantly on the CHFT bed base and is evidenced through increased levels of non-elective emergency admissions as described below.

This has brought an additional cost burden, particularly within pay, alongside ongoing difficulties in filling vacancies. The Trust has been able to bear these pressures in the year to date position without detriment to achieving the overall financial position and with only a minimal £0.1m of the £3m contingency reserves released, preserving the balance of £2.9m for future pressures and commitments. This has been accomplished through a combination of additional CIP delivery and clinical income over performance. The year to date trading position as represented at EBITDA level is in line with plan.

Activity and Income

There was a cumulative £1.00m favourable variance from plan within operating income.

Clinical Income

Of the £1.00m favourable income variance, £1.65m is driven by NHS clinical income, predominantly driven by a non-elective over performance valued at £0.88m plus £0.42m relating to invoices raised to Calderdale CCG for April system resilience pressures (additional bed and medical capacity) and May costs incurred following the closure of community Intermediate Care beds. As previously reported to Monitor, payment of these invoices remains in dispute with the CCG, in recognition of this stance a £0.42m bad debt provision has been made which is reflected within the non-pay position.

The clinical income contracts with the two main commissioners (Greater Huddersfield CCG and Calderdale CCG) remain unsigned at present pending the mediation process. In the meantime, until this is resolved, the Trust assumes operation under a full PbR contract in terms of activity, CQUIN delivery and the application of any contract penalties.

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

- Planned day case and elective activity has performed below the year to date plan. Cumulatively activity is now 2.1% below plan (257 spells).

- Non-elective admissions overall are above the plan in the year to date by 3.2% above plan (387 spells) with a continued increase in both emergency long and short stay admissions in month.

- A&E attendances are below the plan cumulatively by 1.2% (462 attendances).

- Outpatient attendances have over-performed in month 3 by 1.3% (371 attendances), with an over-performance in both first attendances (241 attendances) and follow-ups (130 attendances). This is a shift from the under-performance seen in Month 2. Cumulatively outpatient activity is now 0.5% above plans (366 attendances).

- Whilst Adult Critical Care and NICU saw a reduction in month, both remain above plan in the year to date by 11.8% and 13% respectively.

- High cost drugs and devices overall are in line with planned levels.

It should also be noted that the 2015-16 plan includes Urgent Care Board funding of £2.3m. As we are still awaiting the resolution of Urgent Care Board discussions, the month 3 position assumes receipt of this in line with plan. This includes an element of risk until the wider contract mediation process, of which this forms a part, is finalised.

In line with plan and in recognition of the income risks, allowance to the value of £0.5m has also been made in the anticipation of contract sanctions; any shortfall on CQUIN performance; and contract challenges under a full PbR contract.

Other income

Overall other income is £0.65m below the planned level. This is driven in part by a shortfall in commercial revenue generation by the Trust's Pharmacy Manufacturing Unit against a plan to exceed their prior year surplus delivery. This sits alongside a number of smaller adverse variances across other areas in the year to date which we expect to flow through to plan in the remainder of the year. The Health Informatics Service which is also hosted by the Trust and operates commercially is achieving revenue generation in line with plan in the year to date.

Expenditure
There was a cumulative £1.00m adverse variance within operating expenditure across the following areas:

Pay costs	(£0.58m) adverse variance
Drugs costs	£0.04m adverse variance
Clinical supply and other costs	(£0.46m) adverse variance

Pay costs

Pay costs are £0.58m above the planned level. Additional costs have been incurred in the year to date as a result of staffing additional bed capacity over and above the planned level, linked to dealing with the wider system resilience issues, supported by non-contracted medical and nursing staff.

The continued requirement to use agency staffing and a need to engage a wide range of providers including some at higher premium rates has been seen in spite of the fact that the additional bed capacity pressures have abated somewhat in recent weeks. The non-contracted pay spend remains at a high level in support of ward nurse staffing ratios and covering medical vacancies in areas with recruitment difficulties.

Controls remain in place around the use of non-contracted staffing and the Trust has now ceased further bookings the highest premium rate nursing agency and negotiated improved rates with another supplier. Overseas recruitment of substantive nursing staff is continuing and in addition is being considered for medical staff.

Within the pay position there is a benefit of £0.50m versus plan against contingency reserves. As previously described to Monitor, the annual plan includes £3.0m of contingency reserves of which £2.0m was planned as pay spend. There has been a release of just £0.1m contingency reserves to the bottom line in the year to date position as a provision has been made against the balance of the available contingency for potential future risks and commitments. The accounting treatment for provisions is as a non-pay cost and as such there is an underspend against this element of pay against plan. Excluding this benefit shows the true value of the pay pressures described above at £1.08m against year to date plan.

The pay position is illustrated at a more granular level of detail at Appendix 1.

Drug costs

Year to date expenditure on drugs was £0.04m above plan. The spend on 'pass through' high cost drugs is in line with plan matched corresponding income.

Clinical supply and other costs

Clinical supply and other costs, including PFI costs, are £0.46m above plan in the year to date position. This includes the creation of a provision against future risks and commitments to the contingency reserve as described above, driving £0.40m of the adverse variance and offsetting the pay benefit.

In addition, costs have been driven up by increasing the Trust's bad debt provision. This is mainly due to the inclusion of £0.42m against additional charges levied to commissioners as described above which remain in dispute. The Trust continues to take a prudent view in not recognising any benefit against this whilst negotiations continue with commissioners.

These costs and pressures from additional clinical activity are offset in part by the successful delivery of CIP over and above the planned levels. Further one-off non pay benefits have been seen as a result of pursuing rates and telephone services rebates and settlement of outstanding utilities accounts.

Costs against contracts for external support to the PMO function were incurred in June but these drew to a close in early July. The Trust has put in place structures to manage these elements through existing management capacity supplemented by a lower level of interim support. The cost of this structure alongside specialist external support to assist in designing and driving specific transformational efficiency changes has been approved by the Board as a future call on contingency reserves subject to the relevant approvals by Monitor against management consultancy investments.

The non pay position is detailed more full at Appendix 1.

Non-operating Items and Restructuring Costs

Non-operating items show a favourable £0.06m variance from plan. This is predominantly driven by lower than planned inflationary charges on the PFI contract with actual RPI being lower than the projected level.

Analysis also indicates that there is a potential benefit through lower than planned depreciation due to the impact of the year end asset revaluation exercise. As the Trust has a number of assets under review for disposal it is envisaged that there may be an adverse impact on capital charges. These issues will be considered in the round before any benefit is taken.

Cost Improvement Programme (CIP)

The CIP and revenue generation schemes have delivered in excess of plan in the year to date with £2.80m achieved against a planned £2.18m. The over performance is seen in the same areas as last month; through success in bringing forward delivery against a transformational scheme to increase theatre productivity in specific specialties; achieving additional revenue from greater depth of clinical coding; and delivery of additional non pay savings against utilities spend.

Achievement of savings is being closely monitored through the Turnaround Executive.

Capital

Capital expenditure in the year is £4.69m, £0.41m below the planned level of £5.10m.

Against the Estates element of the capital expenditure plan, £1.68m has been incurred in the year to date versus a planned £1.97m. The main areas of investment are the continuation of the ward and theatre upgrades on the Huddersfield Royal Infirmary site. The key reason for the variance is slippage on the ward upgrade works as a consequence of asbestos being found.

IM&T investments total £2.65m against a year to date plan of £2.72m. The main areas of expenditure are in the EPR, Electronic Document Management System (EDMS) and Electronic Observations software. Further expenditure was made on core IT infrastructure and hardware.

The favourable cash impact of this £0.41m under spend is offset by an adverse £0.93m variance against capital creditors, ringing an overall £0.52m pressure to the cash position versus plan.

Cash

At the end of June 2015 the Trust had a cash balance of £10.97m against a planned position of £10.90m, a favourable variance of £0.07m.

In addition to the cash pressure from capital creditors described above, further pressure is seen within working capital. At the end of last month, May, receipts against contractual payments for the smaller clinical contracts with local councils and NHS England were outstanding. These were actively pursued by the Trust resulting in the former being received in June and the latter in the first week of July.

These timing differences on receipt of income have had a direct impact on our ability to make payments to suppliers and have led to the Trust staging our payments in order to manage the cash position. Performance in the year to date against the Better Payment Practice Code was 88% against the 95% target of invoices being paid within 30 days. There has been a marked deterioration in this metric in June with the in-month performance standing at 72%. Whilst balancing the need for careful treasury management, the Trust continues to strive to meet its obligations to suppliers and maintain good relationships particularly with local businesses.

The Trust is aware that we will be unable to utilise distressed cash support to rebuild or improve a balance sheet position against creditors, and as such, is aiming to strengthen this position in the very short term through our own means, for example through seeking agreement from local commissioners to bring forward the timing of contractual payments across the year.

Preparation has commenced to allow the Trust to apply for a working capital facility with the Independent Trust Financing Facility as a precautionary measure to secure cash in advance of anticipated approval by Monitor and the Department of Health of a Revenue Support loan.

CoSRR

The CoSRR is at level 1 in line with the planned position.

Forecast risk and opportunities

As highlighted in previous reports, there will continue to be a variety of risks and opportunities within the forecast position. It was noted at month 2 that there was an emerging risk around the need to support additional bed capacity over and above planned levels as a result of system wide resilience issues. It has become clear over the last month that this financial pressure is tangible and ongoing and so this now forms part of the likely forecast year end position.

Reserves

The forecast is to deliver the year end planned income and expenditure position in overall terms, however given the financial pressure described above, at present this relies on the mitigation of £1.5m contingency reserves being released unused and forecast delivery of £16m CIP against the originally planned £14m. The balance of contingency reserve has been ringfenced for investment against specific commitments and to cover risks as described below.

- CIP – The plan submitted to Monitor relied upon CIP delivery of £14m, whilst the intention internally was to exceed this as mitigation against any shortfall or slippage in delivery of plans or against other pressures. The total value of schemes that have passed through the Gateway 2 standard exceeds £17m. However against this total £3.5m are described as high risk indicating a potential risk to full delivery.

- Vacancy factor – Against the budget for the full establishment a £3.05m vacancy factor was planned for financially. This was never designed to be a barrier to recruitment to vacancies which exist in predominantly clinical roles and therefore there is a risk if vacancies are recruited to at a greater pace than anticipated, or posts otherwise covered, that this will bring a financial pressure.

- A&E Nursing – Following on from the investment in nurse staffing ratios on the wards in 2014/15, nurse staffing levels in A&E are being reviewed. Any resultant recommendation for investment will be considered by the Trust's Commercial Investment and Strategy Committee. No specific development funding has been set aside for this and therefore a decision may be a call on reserves.

- 7 day services – Without support from commissioners, further internal investment would be required in order to facilitate extended working hours.

- Transformation support costs – There is commitment to invest in management capacity and appropriate external support to enable transformation.

- Potential impact of CQC – The Trust anticipates a CQC inspection in 2015/16, the resultant recommendations may require expenditure commitment.

- OBC related costs - there are likely to be costs associated with the work-up of the plans around the longer term reconfiguration of services.

- CQUIN – Under a live PbR contract there may be the need to invest in infrastructure to ensure delivery of these quality driven targets.

Activity and contract

All activity is assumed to be priced under PbR rules, a risk remains whilst the clinical contract with commissioners remains unsigned but the forecast income position is inclusive of an anticipated level of penalties, contract challenges and CQUIN performance risk.

Cash

Restructuring costs are planned at £3m to support the delivery of the CIP programme, the forecast position continues to assume these costs in I&E and cash terms in line with plan.

External cash support will be required to sustain the plan. In line with the guidance received, the plans assume receipt of £14.9m cash support in year in order to maintain a minimum cash balance at £1.9m which represents two working days operating costs and a maximum of £9.3m based on ten working days operating costs. These tolerances have recently been clarified by Monitor and allow a wider margin to operate within than had previously been understood.

In advance of anticipated approval by Monitor and the Department of Health of a Revenue Support loan the Trust will apply for a working capital facility with the Independent Trust Financing Facility as a precautionary measure to secure cash. There are no charges associated with having this 'overdraft' type facility in place unless the cash is drawn upon, in which case interest is payable at 3.5%. In the medium term the Revenue Support Loan will be the preferred source of cash support as it incurs lower interest charges at 1.5%.

Monitor approvals process

As previously reported, Monitor has written a letter to Foundation Trusts (FTs) concerning the challenge to simultaneously improve quality, meet access targets and drive up productivity. Included within this is the introduction of new approval processes, for those FTs who are in breach of their licence for financial reasons, around agency staffing costs and management consultancy.

The approval process for management consultancy costs comes into force with immediate effect, covering all new contractual commitments for spending greater than £50,000. These approval processes will include: a trust-specific ceiling on the percentage of staff that can be employed on an

agency basis; a cap on the maximum rates of agency pay for different types of staff; and a list of approved frameworks.

As described above, these are both areas where the Trust is incurring considerable spend and the new regulations will apply.

Care Closer to Home

The progression of the Care Closer to Home tender continues. 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 forecasting the status quo in line with the plan submitted to Monitor but recognises that there is a risk or opportunity dependent upon the ultimate outcome of the process.

Keith Griffiths 16/7/2015

Appendix 1

Pay and Non Pay Expenditure detail

JUNE 2015: Pay expenditure

	Pay Expenditure including Agency								
	M03 YTD Budget	M03 YTD Actual							M03 YTD Variance
	Total Budget	Total Actual	Substantive Pay	Agency	Bank	Locum	Overtime / WLI	Additional Basic Pay	
	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m	£'m
Clinical									
Consultants	8.51	8.36	7.33	0.59		0.33	0.11		-0.15
Junior Medical	6.26	6.96	4.75	1.77		0.31	0.13		0.71
Nurses and Midwives, incl Bank	22.18	22.84	20.33	1.28	0.61		0.46	0.16	0.66
Sci Tech & Ther	8.05	8.10	7.87	0.06	0.04		0.06	0.06	0.05
Social care staff	0.02	0.02	0.02						0.00
Non Clinical									
Chair & NEDs	0.04	0.04	0.04						0.00
Executives	0.26	0.24	0.24						-0.03
Admin & Clerical	5.96	6.14	5.49	0.44	0.12		0.04	0.05	0.18
Other non-clinical staff	3.73	3.48	3.26	0.04	0.04		0.07	0.06	-0.25
Pay Reserves	0.59								-0.59
TRUST TOTAL	**55.59**	**56.17**	**49.33**	**4.18**	**0.81**	**0.64**	**0.87**	**0.34**	**0.58**

JUNE 2015: Non Pay expenditure

	Non Pay Expenditure		
	M3 YTD Budget	M3 YTD Actual	M3 YTD Variance
	£'m	£'m	£'m
Drugs	2.23	2.22	-0.01
High Cost Drugs	5.44	5.41	-0.03
Blood	0.46	0.44	-0.02
Clinical supplies & services	7.04	7.12	0.08
CNST	2.83	2.83	0.00
Utilities	1.26	1.00	-0.26
PFI unitary payment	2.98	2.94	-0.04
Rates	0.52	0.43	-0.09
Other Costs (excl. depreciation)	6.71	7.12	0.41
Non Pay Reserves	0.27	0.65	0.38
TRUST TOTAL	**29.74**	**30.16**	**0.42**

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 30th July 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 28.7.15 and the minutes held on 23.6.15.	
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 28.7.15 and the minutes held on 23.6.15.

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 28.7.15 and the minutes held on 23.6.15.

Appendix

Attachment:

Minutes QC 23.06.15 - draft.pdf

Minutes of the QUALITY COMMITTEE held on Tuesday 23 June 2015, 2pm – 5pm held in Discussion Room 2, Learning & Development Centre, HRI.

PRESENT:
Andrea McCourt, Head of Governance and Risk
David Birkenhead, Medical Director
Jan Wilson, Non-Executive Director
Jason Eddleston, Deputy Director of Workforce and Organisational Development
Jackie Murphy, Deputy Director of Nursing/Interim ADN, Surgery & Anaesthetic Services Division
Jeremy Pease, Non-Executive Director (Chair)
Julie Dawes, Executive Director of Nursing & Operations
Lesley Hill, Executive Director of Planning, Performance, Estates and Facilities.
Helen Barker, Associate Director of Operations and Community Services
Julie O'Riordan, Divisional Director, Surgery & Anaesthetic Services Division
Lynne Moore, Membership Council Representative

IN ATTENDANCE:
Stephanie Jones, PA (Minutes)
Jacque Booth, Communications Department (Observer)
Alison Wilson, Head of Estates Operations and Compliance (Item 5.4)
Alison Lodge, Clinical Governance Manager (Full meeting)
Lois Mellor, Senior Clinical Midwifery Manager (Full meeting)
Catherine Briggs, Matron, Medical Division (Full meeting)
Andrea McCourt, Head of Governance and Risk (Full meeting)
PWC representatives (Observing as part of the Well Led Governance Review)

01/06/15	**WELCOME AND INTRODUCTIONS** The chair welcomed members to the meeting. The meeting was confirmed as quorate. There were no declarations of interest.
02/06/15	**APOLOGIES FOR ABSENCE AND ATTENDANCE REGISTER** **Apologies for absence were received from:** Juliette Cosgrove, Assistant Director to Nursing and Medical Directors' Keith Griffiths, Finance Director Linda Patterson, Non-Executive Director Victoria Pickles, Company Secretary Martin DeBono, Divisional Director, Family and Specialist Services Division Anne-Marie Henshaw, Associate Director of Nursing, Family and Specialist Services Division Lindsay Rudge, Associate Director of Nursing, Medical Division

03/06/15	**MINUTES OF THE MEETING HELD ON 27 MAY 2015** The minutes of the meeting held on 27 May 2015 were approved as a true record, with the following amendment: **CWF PSQB report - 23/15 (5):** the work around bullying and undermining behaviours is in response to national not local surveys about maternity workforce. We have not had a staff survey which cited bullying in the workforce.
04/06/15	**ACTION LOG & MATTERS ARISING** (Items due this month) **PSQB report Children's, Women's and Families Division:** Anne-Marie Henshaw was not present at the meeting to provide clarification in relation to appraisal figures. ACTION: Anne-Marie Henshaw to update the Committee at the July 2015 meeting.
05/06/15	**MAIN AGENDA ITEMS** **5.1 Updated Action Plan Update following Regulation 28 Letter from HMC (PRS)** The Deputy Director of Nursing presented an updated action plan, which had been developed following receipt of a Regulation 28 Letter from HM Coroner. The action plan focuses on two main areas: documentation and medicines management. In relation to documentation, it was reported all actions documented in the action plan have been delivered. In relation to medicines management, it was confirmed that although the re-introduction of the audit of medication has been done with nursing documentation and has been discussed at nursing forums, this has yet to be done robustly with medical documentation. The Medical Director confirmed a section had been added to the mortality review asking whether the medical documentation sufficiently explains the patient's story. The Chair suggested trends coming out of mortality reviews could be used as future learning. The importance of good documentation will be addressed with the new junior doctors that commence in August 2015 and onwards, so they are fully aware of the Trust's expectations. The action plan in relation to medicine management will be updated for the Committee meeting in July 2015. The Deputy Director of Nursing concluded that the Trust had met with family of the deceased who are happy with action plan and seem satisfied that the Trust are taking all the necessary action required. ACTION: Updated action plan to be received by the Committee in July 2015. The Committee **RECEIVED** and **NOTED** the updated action plan. **5.1 Action Plan following Regulation 28 Letter from HMC (JES)** Matron Catherine Briggs presented the action plan that had been developed by the Medical Division following the death of a patient in our care. The patient had suffered an

unwitnessed fall, which HM Coroner concluded is likely could have been prevented.

During the course of the HM Coroner's inquest there were matters that gave rise to concern to which the action plan responds directly to these concerns. The main issues raised within the letter were in relation to assessment of mobility. A Falls group has been set up within the Division to address this concern, with the first meeting due imminently. The action plan has been submitted to HM Coroner.

The Director of Nursing commented that investigation training in relation to serious incidents should be more robust and this should be addressed going forward.

ACTION: It was noted all actions within the action plan will be completed by the end of September 2015 and brought back to the Committee in October 2015. The Chair requested that the Regulation 28 Letter (anonymised) and investigation should also be presented with the action plan.

5.3 Annual Quality Report

In the absence of the Assistant Director to the Medical and Nursing Director, the Chair presented the Annual Quality Report. It was noted that the report had been received by and approved by the Board of Directors in May 2015.

The Executive Director of Nursing and Operations confirmed the Committee will receive a quarterly deep dive Quality Report going forward, which will feed a number of audiences, including the Membership Council.

ACTION: Divisional representatives were asked to ensure the report and learning from the report is widely shared within their Divisions.

5.4 Cleaning Services Report

Alison Wilson, Head of Estates, Operations and Compliance presented the Cleaning Services Report, which outlines the current operational status of cleaning services, performance management arrangements and future development at CHFT. The report, commissioned by the Trust, had been completed by an independent cleaning expert consultant, Lynn Webster.

The report detailed the current cleaning provision on both sites. It was noted whilst a good standard of cleaning is achieved at HRI, the report highlights inconsistencies and occasional poor standards occur across the Trust.

History: In-house cleaning is provided at HRI and PFI (ISS) at CRH. Huddersfield followed national cleanliness and PFI clean to output specification. Various cleaning audits of different cleaning teams. Performance report is based on 49 element audit carried out by cleaning services team. Variations were noted around what is understood to be achieved to what is actually being done. Cleaning teams – HPV has been really positive and really responsive team and have taken over bed cleaning.

	The Executive Director for PPE&F explained that the report had been commissioned as the Trust was aware of some concerns to which the report has subsequently highlighted. An action plan will be developed on the back of the report. The Executive Director of Nursing expressed concern that progress on the action plan was slow as the report had been carried out in February and action should be taken to move this forward. It was queried whether the appraisals of ward based domestic staff are carried out alongside the Ward Sister and that this should be considered going forward. It was suggested, if not already in place, there should be clear definitions of what is the job of the domestic staff and what is the job of the nursing staff. It was understood there is a document that outlines this although it was not thought to be a SOP format. The Chair questioned whether any costs had been identified and requested that the WEB be notified of these costs. ACTION: Action Plan to be brought to the Committee in July 2015 with details on progression made in relation to actions identified within the report. **5.5 Stepping Hill Hospital: Victorino Chua** The Executive Director of Nursing and Operations brought to the Committee's attention the recent case of Victorino Chua, a nurse at Stepping Hill Hospital in Manchester who had been convicted of murdering two patients and poisoning 20 others, by injecting insulin into saline bags and ampoules. The Executive Director of Nursing and Operations detailed some of the lessons that had been learnt and how CHFT could learn from this case. The Director of Nursing from Manchester NHS Trust has agreed to visit CHFT to share the lessons learnt and the processes they put in place. ACTION: The Executive Director of Nursing & Operations will produce a report, for the Committee going forward, that will detail the lessons learnt by Manchester NHS Trust and how they can be shared and incorporated within CHFT. **5.6 QIA process for CIP** The Executive Director of Nursing and Operations gave a verbal update on the Quality Impact Assessment (QIA) process for the Cost Improvement Programme (CIP). She explained the QIA process put in place identifies whether the CIP has any impact on service. The Project Management Office (PMO) function has a specific meeting on the QIA process and it has been agreed going forward that 2 or 3 specific areas will be reviewed as to whether CIP is having an impact on that specific area/service. It was noted that the quarterly Divisional PSQB reports will include an update on CIP.

	The PMO workstream meet weekly, where more detailed discussions takes place on any areas that are off-track and require further escalation. 'Go See' Fridays, which are undertaken monthly by the Executive Team also give Directors the opportunity to question directly with staff what impact CIP is having on their area/service. Non-Executive Director Jan Wilson queried the role of the Star Chamber. It was confirmed that this meeting was set to allow a deep dive into those areas that are off-track and also look at what impact the metrics are showing; these are looked at in more detail than the weekly Exec Turnaround Team. The Monitor document has been used to inform Star Chamber. ACTION: Action plan to come back to next meeting. (SJ to check with Julie) **5.7 Quality Committee Terms of Reference** The Quality Committee Terms of Reference were presented for review following a number of amendments by the Company Secretary. ACTION: Members commented that it would be useful to see the tracked changes from the original version. Stephanie Jones agreed to email it out to members. The Chair requested that we need to have clear definitions as to why the report is be brought to the Committee *i.e.; for approval, review, to note, information etc*. It was understood the Company Secretary is working with the Board Secretary to detail these definitions. The following amendments were suggested: • Objectives sub heading: Paragraph should be added around assurance from learning from adverse events. ACTION: Andrea McCourt to email some appropriate narrative to Stephanie Jones. • Membership sub heading: need to add DD or ADD next to Surgery.
06/06/15	**CQC PREPARATION AND ACTION PLAN** 6.1 Update on CQC Action Plan Alison Lodge, Clinical Governance Manager, presented the action plan developed in preparation for the CQC inspection. Since the last Committee meeting the design of the report has changed. The PMO tracker has been introduced as an overarching tool for monitoring progress with the CQC 90 day plans. There are 3 sections to the action plan: *Core Services, Division and Domains* each of which are rag rated and have an executive sponsor.

	Against each core service any concerns are highlighted which are overseen by the Senior CQC Steering Group at its weekly meeting. Each Division will have its own Divisional action plan. Community: a plan for the mock inspection of community services has been progressed. A head of the mock inspections a series of focus groups are scheduled covering the community professions. Communications: the first launch of the CQC launch events took place on 10 June 2015; good attendance was noted with representation from a variety of disciplines. ACTION: The Chair requested that the Executive Director of Nursing & Operations present a paper going forward to the Board of Directors to include common concerns in relation to each core service and what action is being taken to address these concerns. Assistant Director of Operations & Community Services, Helen Barker suggested this be discussed at the CQC Senior Steering Group meeting, which was due to take place later that day, as it was felt it would not be beneficial to submit such a report too early without all the necessary and robust information. It was suggested this paper could be submitted to the August Board of Directors. The Committee **RECEIVED** and **NOTED** the updated action plan.
07/06/15	**RESPONSIVE** <u>7.1 Integrated Performance Report</u> The Integrated Performance Report was presented and the following highlights were noted from the report: **Responsive:** • May was a busy month for activity, all inpatient and day case reported green. • Emergency care pulling back performance – getting teams to focus. • Key areas to focus on are reducing outliers. Medical Division are doing lots of work on understanding the bed capacity. • Outpatient activity is slightly under plan. • Delayed transfers of care; series of letters taken to WEB to formally implement process for patients moving on – this process has been implemented in line with our partners. • A&E 4 hour wait performance was 94.8% against 95% target and has continued to struggle which poses a slight risk for the quarter. Starting to look in more detail around longest waiting patients in A&E (i.e. 6, 8, and 10 hours) – report to be done for Divisions. • Non clinical moves after 10pm – work being done on this. • Ambulance handover (30-60mins): information submitted was pre-validated and is showing 36; however this has since been validated and should read 3. Helen Barker congratulated the Medical Division on this huge improvement. • Elective access and referral to treatment: deep dive done, which was received by WEB on 18 June 2015. Key issues; whilst delivering RTT need to get better to deliver constitution – need to focus. Follow up of back log; concern in the system that we are not seeing patients when we should and this concern should be escalated to the Quality Committee. **Caring:** • Complaints an ongoing issue in terms of closing them down in timely manner. The Chair questioned whether this is a capacity issue? Last month surgery made good progress to ensure a number of complaints were closed down. The Deputy Director of

	Nursing stated there is currently a lot of pressure on staff as the same staff are being asked to investigate complaints. • FFT- seeing decrease in our response rate – traditionally 40%, but we have now amalgamated day case with inpatient. • FFT (A&E): improvements have been seen in-month. **Safety:** • VTE: dip in % of stage 1 RCAs completed. Prescription charts include new prompts to ensure VTE is done. • Pressure ulcers: 4 category 3 pressure ulcers in May – lots of work being done around devices. Community are improving in terms of reporting. ACTION: The chair queried why there is a target of zero for category 3 pressure ulcers and whether this is ever going to be achievable. Jackie Murphy agreed to take his comment back to the Pressure Ulcer group. **Effectiveness:** • No cases of c.diff or MRSA in May. Just once case in June to date. • SHMI and HSMR continue to cause concern especially HSMR which has slightly increased. HSMR looks sensitive to palliative care coding. • Crude mortality rates have been increasing which is a national trend. • Mortality reviews prove to be a challenge and put more pressure on staff. Looking at how we do can increase mortality reviews. Recent presentation given by Barnsley Trust as they perform better than we do. • Undertaking a lot of work on the Care of Acutely Ill Patient. • 30 day readmission rate off plan. LACE tool which identifies those most at risk of readmission has been implemented. **Well Led:** • Trust overall sickness for April 2015 was 4.48% - focus of activity is long term sickness absence. Using return to work interviews; focus on long terms cases – get people back to work as soon as possible. •Training indicators – programme went live from 1 June – catches elements from the mandatory programme. Need to pertain 8% per month and look at when this is not achieved how do we catch up? Debated at WEB last week. The Chief Executive gave a clear message that we must push this activity and compliance is imperative. Deputy Director of Workforce and OD said following the Staff Partnership meeting, staff side suggested not all staff are aware of what mandatory training they are required to do. Jason suggested we need a big push with managers on getting staff through their mandatory training. The Committee **RECEIVED** and **NOTED** the concern in relation to RTT and the backlog in the system and the big push for managers to ensure staff complete their appraisal and mandatory training. **ACTION: It was agreed that this would be reviewed in more detail following Q1 reporting.**
08/06/15	**SAFETY** 8.1 Serious Incident Register The Head of Risk and Governance, Andrea McCourt presented the Serious Incident Register for the week ending 12 June 2015. A cluster of serious incidents around late cancer diagnosis were noted. ACTION: Further

	details on these cases to be updated next month in more detail. The Committee **RECEIVED** and **NOTED** the content of the register. <u>8.2 Patient Safety Group Update</u> The Executive Director of Nursing & Operations presented an updated from the last meeting of the Patient Safety Group. The highlights from the meeting that were escalated to the Quality Committee were noted: • Falls: deep dive into falls collaborative – seen a reduction in harm falls by 10%. Set a 10% reduction for this year. • Big discussion from learning from inquest and claims – first report and regular reports will be received going forward. • Duty of candour: number of cases were outstanding, but a target was set to get letters out by the end of w/c 1 June 2015. • Patient Safety Pledges: 24 June 2015 marks the 1st anniversary of the 'Sign up to Safety' campaign to which the Trust has signed up. Members asked to submit their safety pledges to Stephanie Jones via email. Some of the pledges will appear in the Trust's patient safety newsletter. The chair queried how the Trust is sharing the leaning. Andrea McCourt referenced a sectioned in the Claims policy that refers to learning; however improvement is still required in this area. The Committee **RECEIVED** and **NOTED** the update and the items that had been escalated to the Committee by the Patients Safety Group.
09/06/15	**COMPLIANCE** <u>9.1 Corporate Risk Register</u> The Corporate Risk Register was presented by the Executive Director of Nursing and Operations. CHFTs four top risks were detailed. Since the publication of the register 2 other major risks are to be added and will be discussed at the next Risk & Compliance meeting in July 2015. These risk are 1) amount of transformation of big change project i.e. EPR, CQC readiness, Performance (A&E) and 2) progression of OBC and Care closer to Home. Both these areas carry big operational challenges and need to be reflected on the risk register to ensure we have got the right people and capacity in place to ensure these can go ahead. The risks around the increasing difficulties in recruiting medical staff were discussed. The chair queried whether feedback has been received on why people are leaving and vacant posts are not being filled. The Medical Director confirmed from feedback the reasons indicate concern in relation to high intensity workload, geographical challenges (cross site working). Oversees recruitment is currently being looked at as an option.

	Non-Executive Director, Jan Wilson queried whether we have any paediatric nurse practitioners in post. The Deputy Director of Nursing confirmed we have had these for a number of years. The paediatric model of care was briefly discussed and it was noted that immediate action has been taken, following an incident, to ensure that every child has a paediatric review every day. The Committee **RECEIVED** and **NOTED** the content of the register.
10/06/15	**EFFECTIVENESS** <u>10.1 Clinical Effectiveness and Outcomes Group</u> The Medical Director presented the report from the Clinical Outcomes Group. It was noted as the meeting was on the 1st of the month the CAIP dashboard had not been updated. An update on this will be brought to the Committee in July 2015. As described as part of the Integrated Performance Report, there was a slight increase in HSMR in January 2015, which may have been influenced by the number of actual deaths. A workshop to review the Care of the Acutely Ill Programme (CAIP) will be arranged going forward and is likely to take place as part of SEB in August. The review will consider the 9 workstreams as there appears to be duplication. More focus needs to be on the main issues. Focus work for CAIP will be to look at top 10 areas of SHIMI. Some areas have triggered and then gone off. Detailed work to be done on why those patients die in top 10 areas of SHIMI. DNACPR compliance has seen some improvement and is now around 90%. Mary Keily, Consultant, continues to do lots of work in this area. Challenges around bundles compliance hovers around 50% to 60%. Further work is required to look at what good means and looks like. The quality of data is not great at this stage, but this should get better once EPR is implemented. Nerve centre: has been rolling out, is working well and has received positive feedback from users. It is hope it will allow a quicker response to the deteriorating patient. Leads for 7 day working will attend a meeting in Wakefield in July 2015 to discuss their 7 day working service. Frailty: The Associate Director of Nursing for Medicine has set up a task and finish group to define how we identify this group of patients. The Chair queried the model of care for frailty patients (i.e. when you can take frailty patient out of acute pathway). The Associate Director of Operations and Community Services confirmed she had had some discussions with Clinical Directors around this.

	The Committee **RECEIVED** and **NOTED** the content of the report and in particular the items that were asked to be brought to the attention of the Committee.
11/06/15	**WELL LED ORGANISATION** <u>11.1 Well Led Organisation Group</u> The Deputy Director for Workforce and Organisational Development gave an update report from the Well Led Organisation group. The well led metrics were discussed as part of Integrated Performance Report. The 2014 staff survey action plan was approved by the Board of Directors at its meeting on 28 May 2015. The Well Led group will oversee the implementation of the plan. The Board of Directors will receive a paper on the Work plan Race Equality Scheme in June 2015. A Well Led CQC inspection preparation sub group has been established which reports to the main Well Led group. This group will undertake a gap analysis of evidence using the CQCs Key Lines of Enquiry. The Committee **RECEIVED** and **NOTED** the content of the report.
12/06/15	**CARING** <u>12.1 Patient Experience and Caring Group</u> Alison Lodge, Clinical Governance Manager, presented the update report from the Patient Experience and caring group. The report detailed targets related to the sub-groups, key achievements, progress to date and key areas for improvement. The following points were highlighted to the Committee: • The June Patient Experience and Caring group meeting focussed on receiving update reports from the Divisions and on the 5 patient experience improvement projects. • The divisional reports dovetail the PSQB reports that come to the Committee. • The Lead Cancer Nurse gave an informative presentation to the group on the national cancer results and discussed the work she is doing with cancer leads. • The National inpatient survey results have been received through the CQC and the CHFT held a similar position to last year. The Committee **RECEIVED** and **NOTED** the content of the report.

13/06/15	**HEALTH AND SAFETY ISSUES RELATING TO QUALITY AND CARE** 13.1 Operational Health and Safety group minutes The Committee received the minutes from the Health and Safety Operational Group for information. The Director for PPE&F gave a verbal update: • The terms of reference have been agreed for the new Exec Committee and Operational group which has been pulled together. • Environment agency inspection at CRH took place last week. Initial feedback was positive with a couple of actions to address, specifically around training. Final report yet to be received. • Annual report went to Board last month. • Fire risk assessment now completed and the Division will work with departments. • Medical devices doing well with training but behind with checking on medical devices. This has been identified as a risk and is being looked at. The Committee **RECEIVED** and **NOTED** the verbal update.
14/06/15	**MATTERS TO BE ESCALATED TO THE BOARD OF DIRECTORS** The Committee agreed the following items would be highlighted to the Board of Directors meeting on 25 June 2015: • Verbal update received on Stepping Hill • QIAs for CIP • Two risks additional to the risk register • 2 regulation 28 letters • CQC action plan something to go to Board July / August • IPR Well led • Alert to follow up patients – those not seen on time – part of IPR.
15/06/15	**ITEMS TO NOTE** 15.1 Quality Committee Work Plan The Committee received the Quality Committee Work Plan for 2015/16 for information. The Committee **RECEIVED** and **NOTED** the updated work plan.
16/06/15	**ITEMS TO APPROVE** 16. 1 Claims Process Policy (draft) Andrea McCourt, Head of Governance and Risk, presented the Claims Process Policy which had been brought for consultation by the Committee prior to going to the Board of Director for final approval. One further policy remains outstanding that being the Management of Inquests. It was noted the policy is quite technical in places. Newly introduced this time is that the divisional lead is notified of a formal claim.

	It was suggested the report should go to the Audit and Risk Committee for information. Any further amendments to be emailed to Andrea McCourt. The Committee **RECEIVED, NOTED** and **APPROVED** the policy.
17/06/15	**ANY OTHER BUSINESS** <u>17.1 CCG Quality and Safety Case for Change (draft)</u> Helen Barker, Associate Director of Operations and Community Services presented to the Committee a document from the Calderdale and Greater Huddersfield Clinical Commissioning Groups (CCGs) that is currently in working progress. It was noted this document forms one chapter of a larger document and will compliment CHFTs Outlines Business Case (OBC). Helen has made comments on the paper which have been accepted by the CCGs. This paper will now be submitted to the CCGs Quality Board going forward. Key issues for the Trust will be: - workforce - college standards - availability and access to workforce - Variation across the organisation The Chair queried the final audience for the document. Helen confirmed it will form part of the CCGs final consultation. The Committee **RECEIVED** and **NOTED** the document for information.
18/06/15	**DATE AND TIME OF NEXT MEETING** Tuesday 28 July 2015 2pm – 5pm Discussion Room 1, L&D Centre, HRI **<u>DATE MINUTES APPROVED:</u>**

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 30th July 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: FINANCE AND PERFORMANCE COMMITTEE - UPDATE - The Board is asked to receive a verbal update from the Finance and Performance Committee held on 21.7.15 and the minutes held on 24.6.15.	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive a verbal update from the Finance and Performance Committee held on 21.7.15 and the minutes held on 24.6.15.

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 Finance and Performance Committee held on 21.7.15 and the minutes held on 24.6.15.

Appendix

Attachment:

FINANCE AND PERFORMANCE CTTEE MINS - 24.6.15.pdf

Minutes of the Finance & Performance Committee held on Wednesday 24 June 2015 in Meeting Room, 3rd Floor, Acre Mill, Huddersfield Royal Infirmary commencing at 3.00pm

PRESENT

Peter Roberts	Non-Executive Director (Chair)
Anna Basford	Director of Commissioning and Partnerships
David Birkenhead	Executive Medical Director
Keith Griffiths	Executive Director of Finance
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities
Jan Wilson	Non Executive Director

IN ATTENDANCE

Kirsty Archer	Assistant Director of Finance
Helen Barker	Associate Director of Community Services & Operations (for Julie Dawes)
Mandy Griffin	Acting Director of the Health Informatics Service
Andrew Haigh	Chair
Victoria Pickles	Company Secretary
Betty Sewell	PA (minutes)

ITEM

151/06/15 WELCOME AND INTRODUCTIONS

Peter Roberts Chaired the Committee in the absence of Phil Oldfield and welcomed attendees.

152/06/15 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Owen Williams, Chief Executive
Julie Dawes, Executive Director of Nursing
Phil Oldfield, Non-Executive Director
Jeremy Pease, Non-Executive Director
Julie Hull, Executive Director of Workforce & OD
Jackie Green, Interim Director of Workforce & OD
Peter Middleton, Membership Councillor

153/06/15 DECLARATIONS OF INTEREST

There were no declarations of interest.

154/06/15 MINUTES OF THE MEETINGS HELD 28 MAY 2015

The minutes were approved as a correct record, subject to the addition of Jeremy Pease to the attendance list.

155/06/15 MATTERS ARISING AND ACTION LOG

20/01/15 - Clinical Coding Update Report: The Acting Director of THIS stated that since the issuing of the papers there has been further progress, namely the deployment of K2 into maternity and a business case is being put together for the software required for the 3M Coder. Depth of coding is working well and improvements are being made which should

be acknowledged, but recruitment is still an issue. The options regarding recruitment were outlined with an initial preference for Option 2, however, following discussions it was recommended that a 'hybrid' between Option 2 to re-grade Clinical Coders and Option 4, to look at the possibility of recruiting a senior clinician who currently cannot practice. David Birkenhead agreed to have a conversation with Jackie Green to explore any internal interest with a clinician with the relevant expertise.

On behalf of the Committee, Mandy Griffin was asked to pass on thanks to the team for their hard work.

FINANCE AND PERFORMANCE

156/06/15 MONTH 2 PERFORMANCE SUMMARY REPORT

The Director of Commissioning & Partnerships presented the key headline messages which are emerging from the first 2 months compared to the same period last year. Firstly, there is positive news in that we are recovering more clinical income, however, the full picture needs to be assessed and looking at the activity we are undertaking approximately 12% less activity this year for the same period last year. In terms of the plan, we have less referrals largely in the area of orthopaedics, urology, general surgery and ophthalmology. We are also seeing a reduction in waiting lists with 700 fewer people waiting for surgery and 300 people fewer on the incomplete pathways compared to last year.

With regard to the actual performance for Month 2, we are slightly above plan for outpatients but 8% less than the previous year. For day case and electives we are 1% above plan in month but YTD 1% below plan, with particular concerns in day case which relate to ENT and ophthalmology. An improved picture against plan has been seen in relation to general surgery, urology and orthopaedics in terms of income recovery. A&E is slightly below plan in month. Non-elective activity is significantly above plan and significantly higher than previous years and this is driving additional income recovery.

In conclusion, we have more income and we are closer to plan delivery but the aggregate picture could be high risk with regard to sustainability and with further risks later in the year associated to known retirements within medical specialties. The headline message is that we need to continue to drive elective and day case/elective recovery and reduce length of stay.

The Executive Director of Planning, Performance, Estates & Facilities commented that the work being carried out within theatres is making an impact on specialties, other than ENT and Ophthalmology which still requires work with FourEyes.

It was recognised that recruitment is a real challenge for the Trust and we seem to struggle more than most with regard to the recruitment of medical workforce but that this is both a national and regional issue. In addition to recruitment we are losing staff, which in turn makes it more difficult with colleagues and we should try to make positions as attractive as possible within the constraints we have as a Trust

It was agreed that the recovery plans for ENT and Ophthalmology are critical and continued focus on the specialties where we have started to see improvements in productivity needs to continue to be driven forward.

It was also noted that as we are on a live tariff this year we have some specialties that are up but activity is down, this could be due to a richer case mix and further analysis is required.

157/06/15 MONTH 2 CONTRACT ACTIVITY AND INCOME PERFORMANCE

The Executive Director of Finance stated that Anna Basford had already covered the headline income position. In relation to Adult Critical Care and NICU we are underperforming, there is no guarantee that the income we are generating at the moment will be available at the year-end and there is some fragility to the I&E projection. The CIP element continues to be ahead of expectations, £1.7m over 2 months which is £0.5m more than where we expected to be, with no major concern at the moment we are still on track to deliver £17m CIP.

It was noted that there will be a deep-dive into the Medicine Division which will take place next week as the risks of non-elective sits with the Division. It will allow us to have an understanding of where we need to be in the next 9/10 months with the Division so that mitigation can be put in place to cover risks.

With regard to the cash position, at the end of May the Trust was £2m behind our planned position, this is mainly due to local authorities and NHS colleagues delaying payment. This is not due to any disputes and the Trust is actively pursuing those organisations for swift payment.

The year-end forecast is still on track to deliver what was reported to Monitor, however, £700k of reserves has been committed to cover pressures and we may need to call against the remaining balance of £2.3m against potential risks which were outline in the report.

The Care Closer to Home tender continues. The Trust is currently forecasting the status quo in line with the plan submitted to Monitor but recognises that there is a risk or opportunity dependent upon the outcome of the process.

The Chair asked about the situation with regard to the pressure on non-elective work and PbR contract, the Executive Director of Finance explained the sticking point with the CCGs revolves around the extra cost of keeping extra beds open for longer.

The Associate Director of Community Services & Operations commented that the challenge this year is the availability of the workforce and to plan for system resilience and that there is no direct coloration between green cross patients and the delayed discharge and work is being carried out internally. It was also noted that a series of 'moving on' letters which are more specific have been agreed for communicating to patients and/or their families, a communication plan is being worked up.

Jan Wilson asked for clarification of the need to invest in infrastructure it was explained that this relates to specific drugs for stroke.

Director of Commissioning and Partnerships suggested that we need analysis of the step change and to be mindful of the contract arbitration negotiations, Helen Barker also

suggested linking into some of the evidence of the recording of acuity which could underpin our argument.

158/05/15 MONTH 2 FINANCIAL NARRATIVE AND MONTHLY DASHBOARD

It was agreed that this has been covered and there was nothing more to add to discussions which have already taken place.

159/05/15 MONTH 2 COMMENTARY ON MONITOR FINANCIAL RETURN

The paper provides confirmation that what we report to Monitor is consistent with what we report to the Board.

The Company Secretary also informed the Committee that there would be changes to the Monitor Risk Assurance Framework and an update on this would be brought to the next Finance and Performance Committee.

ACTION : Vicky Pickles to bring update on the new RAF – July 2015

160/06/15 CONTRACTUAL MEDIATION RELATING TO THE 2015/16 CONTRACT

The Director of Commissioning and Partnerships presented a paper to provide additional information with regard to the mediation resolution process. We have made contact with Centre for Effective Dispute Resolution (CEDAR) and they have appointed a mediator and we have confirmed with the Commissioners that the mediation day will be 24 July. A briefing pack will be provided a week in advance of this meeting. The paper also outlined the summary of the dispute and discussions took place with regard to the possible outcome. Monitor are providing intelligence with regard to the documents required to support our case which will be worked up and brought back to the next Committee.

161/06/15 MARKET SHARE

Director of Commissioning and Partnerships explained that we are struggling to obtain data and the information outlined in the paper has been provided through the HED system collated by the University of Birmingham. It confirms that the healthcare market share has increased by 13% across the board and within that CHFT has seen a growth of 3.4% over a full 3 year period. Some of this new demand as gone to other providers namely BMI and Spire other trust have also seen a growth of 1% but there has been a reduction in market share at Leeds.

The overall view of the data confirms what we already know, looking at the 3 years it's a sign our market share has reduced but it's not the strongest data which brings us back to our activity and elective work.

STRATEGIC ITEMS

162/06/15 CIP 15/16 £14m/£18m PROGRESS AND PLANNING

The Director of Finance reported that we are seeing a slow down at the rate of which schemes are moving through Gateway 2. It was also reported that work has started on 16/17 schemes and this will continue to develop. The paper was received and noted by the Committee.

163/06/15 EPR UPDATE

The Acting Director of Health Informatics Service informed the Committee that a Programme Manager has been identified with EPR deployment experience. It was noted that delays have been experienced regarding recruitment and vacancies will be going out to NHS Jobs next week. Discussions have taken place with regard to the sharing of our plans with CHFT colleagues to share engagement and a presentation will be given to WEB and shared with this Committee to give reassurance of the robustness of the business case.

164/06/15 CARTER REVIEW

The Director of Finance explained that following the Carter Review the need to be transparent with regard to agency spend and the reporting to Monitor. A deeper-dive is being done to highlight agency and consulting spend, which will need to be sent to Monitor.

165/06/15 PMU 5 YEAR BUSINESS PLAN

The Assistant Divisional Director of FSS, Emma Livesley introduced the senior management team from PMU. Emma gave recognition to the team for their hard work in producing the business plan. A high level summary of the presentation was given to the Committee highlighting the significant contribution made by PMU since its establishment in 2012. Looking at the future potential four distinct options were outlined in detailed namely, growth, business as usual, do nothing and divest.

Within the Directorate there is a strong belief that a growth strategy is in the best interests of both HPS and the wider Trust. In order to achieve the preferred strategy growth, HPS has identified the following 5 interlinked strategic initiatives it intends to develop:

1. Licence products
2. New product development
3. Opportunity led sales
4. Maximise profit of existing portfolio of products
5. Contract manufacture

Each of the strategic initiatives was summarised highlighting the benefits and risks.

Following the presentation in-depth discussions followed with regard to each of the strategic initiatives. It was recognised that further work was required and the next piece of this work would be to engage commercial expertise from within the industry to translate the strategic vision into an operational plan.

The presentation and clarity of the report was well received by the Committee and the PMU Team were thanked once again for their achievements. The Director of Finance suggested that half a day should be spent going through the business plan to give it justice and several Committee members expressed their interest to attend.

The Committee gave approval for the team to proceed to the next stage of development and that this would be reported to the Board.

ACTION: To arrange a half-day session to go through the Business Plan in more detail.

166/06/15 CASH MANAGEMENT REPORT

The Director of Finance is still awaiting the report from KPMG and this will be circulate to the Committee once finalised.

167/06/15 MONITOR INTERVENTIONS IN MEETING THE WIDER NHS CHALLENGE

The paper was received and noted by the Committee.

168/06/15 WORKPLAN

There were no items added to the Workplan.

169/06/15 MATTERS FOR THE BOARD AND OTHER COMMITTEES

- ENT Recovery Plan will be discussed at PMO and presented to WEB.
- PMU Business Plan to be discussed at Board.

170/06/15 ANY OTHER BUSINESS

There were no items raised.

DATE AND TIME OF NEXT MEETINGS

Wednesday 18 August 8.30am – 10.30am, 3rd Floor, Acre Mill Outpatients