Calderdale and Huddersfield NHS
NHS Foundation Trust

Meeting of the CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST MEMBERSHIP COUNCIL MEETING

Date: WEDNESDAY 9 NOVEMBER 2016 at 4.00 pm
Venue: Boardroom, Sub Basement, Huddersfield Royal Infirmary HD3 3EA

AGENDA

REF	ITEM	LEAD	PAPER	PURPOSE OF PAPER/ UPDATE
1	**Welcome and introductions:** Dr David Anderson, Non-Executive Director/SINED	Chair	**VERBAL**	**Note**
2	**Apologies for absence:** Dr Linda Patterson, Non-Executive Director Owen Williams, Chief Executive	Chair	**VERBAL**	**Note**
3	**Declaration of interests**	All	**VERBAL**	**Note**
4	**Minutes of the meeting held:** Wednesday 6 July 2016	Chair	**APP A**	**Approve**
5	**Matters Arising**	Chair	**VERBAL**	**Information**
6	**Clinical Audit representatives to present 'Results of the Audit on Clinical Audit'**		**APP B**	**Information**
CHAIRMAN'S REPORT				
7	**Information to be presented by the Chair**	Chair	**VERBAL**	**Information**
CONSTITUTION				
8	**Membership Council Register – Resignations/ Appointments**	Chair	**APP C**	**Approve**
9	**Register of Interests/Declaration of Interest**	AH	**APP D**	**Approve**
UPDATE FROM BOARD SUB COMMITTEES				
10	**Audit and Risk Committee**	**P Middleton/ B Richardson**	**VERBAL**	**Information**
11	**EPR**	**Brian Moore/ K Wileman**	**VERBAL**	**Information**
12	**Finance and Performance Committee**	**B Moore/ P Middleton/**	**VERBAL**	**Information**

13	**Quality Committee**	**L Moore**	**VERBAL**	**Information**
14	**Charitable Funds Committee – 22.8.16**	**A Haigh/ K Wileman**	**VERBAL**	**Information**
15	**Workforce Well-led Committee**	**R Hedges**	**VERBAL**	**Information**
16	**Nominations and Remuneration Committee Minutes – 21.7.16 & 18.10.16**	**A Haigh/P Middleton**	**APP E**	**Information**
OTHER ITEMS				
17	**ALLOCATION OF MEMBERSHIP COUNCILLORS TO SUB COMMITTEES/GROUPS**	RM	**APP F**	**Information**
18	**STRATEGIC PLAN & QUALITY PRIORITIES 2016-17 UPDATE** **a. Consultation Update** **b. CQC Inspection** **c. Update on Overall Plan** **d. WYAT/STP Update** **e. Quality Priorities Update**	VP/AH/BB	**VERBAL**	**Approve**
19	**TRUST PERFORMANCE** **a. INTEGRATED PERFORMANCE REPORT** **b. FINANCIAL POSITION AND FORECAST** **c. COMPLAINTS FOR Q1**	HB GB BB	**APP G** **APP H** **APP I**	**Information** **Information**
20	**CARE OF THE ACUTELY ILL PATIENT (CAIP) AND SAFER PATIENT PROGRAMME – presented by Helen Barker, Chief Operating Officer and Bev Walker, Associate Director for Urgent Care**	HB/BW	**APP J** **&** **PRESENTATION**	**Information**
21	**INFORMATION TO RECEIVE** **a. Updated Membership Council Calendar** **b. Draft MC/BOD Annual General Meeting Minutes – 15.9.16**	AH AH	**APP K** **APP L**	**Note** **Approve**
22	**ANY OTHER BUSINESS**	AH	**VERBAL**	**Receive**
DATE AND TIME OF NEXT MEETING: **Date:** **Tuesday 17 January 2017 commencing at 4.00 pm** **Venue:** **Boardroom, Sub Basement, Huddersfield Royal Infirmary HD3 3EA**				

APPENDIX A

Calderdale and Huddersfield NHS
NHS Foundation Trust

MINUTES OF THE FOUNDATION TRUST COUNCIL MEMBERS MEETING HELD ON WENESDAY 6 JULY 2016 IN THE BOARDROOM, SUB-BASEMENT, HUDDERSFIELD ROYAL INFIRMARY

PRESENT:

Andrew Haigh	Chair
Rosemary Hedges	Public elected – Constituency 1
Di Wharmby	Public elected – Constituency 1
Wayne Clarke	Public elected – Constituency 2
Peter Middleton	Public elected – Constituency 3
Dianne Hughes	Public elected – Constituency 3
Grenville Horsfall	Public elected – Constituency 5
Kate Wileman	Public elected – Constituency 7
Lynn Moore	Public elected – Constituency 7
Brian Moore	Public elected – Constituency 8
Eileen Hamer	Staff elected – Constituency 11
Chris Bentley	Staff-elected – Constituency 13 (Reserve Register)
Bob Metcalfe	Nominated Stakeholder - Calderdale Metropolitan Council
Cath O'Halloran	Nominated Stakeholder - University of Huddersfield

IN ATTENDANCE:

Dr David Anderson	Non-Executive Director/SINED
Helen Barker	Chief Operating Officer
Kathy Bray	Board Secretary
Brendan Brown	Executive Director of Nursing
Keith Griffiths	Executive Director of Finance
Ruth Mason	Associate Director of Engagement & Inclusion
Victoria Pickles	Company Secretary
Owen Williams	Chief Executive

40/16 APOLOGIES:

Apologies for absence were received from:

George Richardson	Public elected – Constituency 5
Annette Bell	Public elected – Constituency 6
Brian Richardson	Public elected – Constituency 6
Jennifer Beaumont	Public elected – Constituency 8
Mary Kiely	Staff-elected – Constituency 9
David Longstaff	Nominated Stakeholder – Clinical Commissioning Group
Dawn Stephenson	Nominated Stakeholder – SWYPFT
Naheed Mather	Nominated Stakeholder – Kirklees Metropolitan Council
Sharon Lowrie	Nominated Stakeholder – Locala

Anna Basford	Director of Transformation and Partnerships
David Birkenhead	Executive Medical Director
Mandy Griffin	Director of The Health Informatics Service
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities
Prof. Peter Roberts	Non-Executive Director

The Chair welcomed everyone to the meeting. The Chair introduced and welcomed Brendan Brown, newly appointed Executive Director of Nursing.

41/16 DECLARATION OF INTERESTS

There were no declarations of interest at the meeting.

42/16 MINUTES OF THE LAST MEETING – 7 APRIL 2016

The minutes of the last meeting held on 7 April 2016 were approved as an accurate record.

43/16 MATTERS ARISING

38/15a – Car Parking - The Chairman reminded the Membership Council of the discussions held at the last meeting and the subsequent amendments made to the proposal which had been circulated to the Membership Council and approved at the Board of Director's Meeting in May with specific comments from two Membership Councillors flagged. The feedback had been given to the Estates team to ensure that in future any proposed changes are discussed first at the Divisional Reference Group.

STATUS: Closed

All other matters arising were included within the agenda.

44/16 CHAIR'S REPORT

a. Consultation Process

It was noted that the Consultation period had now closed and this had been discussed in detail within the private Membership Council Meeting. Over 7,000 responses had been received by the Clinical Commissioning Group (CCG). It was confirmed that the comments from the Membership Council had been sent to the CCG for inclusion in the formal responses.

It was agreed that the Board of Directors would share the comments made to the CCG with the Membership Councillors.

ACTION: Chair/Board Secretary

The timeline for feedback following the close of the consultation was noted. The two clinical commissioning groups would meet in parallel on 20 October 2016 when the next steps would then be determined.

OUTCOME: The Membership council noted the progress with the Consultation

b. Board Appointment Updates

The Chairman reminded the Membership Council of the appointment of Brendan Brown, Executive Director of Nursing who had taken up post on the 13 June 2016.

c. Update from Chairs' Information Exchange

The Chair advised that the Chair's Information Exchange had been held on 1 July 2016. A number of actions had been agreed including investigation of utilisation of the Huddersfield Birthing Centre.

Thanks were given by the Membership Council to the Divisional staff for their input and enthusiasm at the DRG Meetings.

It was agreed that the minutes from this meeting would be circulated in due course.

ACTION: Membership Office

d. CQC Inspection Feedback

The Chief Executive reported that the feedback from the CQC inspection which had taken place over the period 8-11 March 2016 was expected at the end of July 2016.

The Executive Director of Nursing advised that following the verbal feedback received at the visit an action plan had been put in place and this would be reviewed on receipt of the full report.

Peter Middleton raised the recent media article regarding maternity compensation payments and asked whether there was any link with the CQC feedback. The Chief Executive assured the Membership Council there were no areas of risk identified from the CQC with regard to maternity claims. The Executive Director of Nursing advised that further work was underway to ensure any concerned existing or prospective service users could access an appropriate level of support within the Trust.

e. **HSJ Patient Safety Award**

It was noted that the Trust had received a Patient Safety Award from the Health Service Journal the previous day for the work undertaken in Dementia Care. It was noted that this work had been highlighted by the CQC as exemplar. Thanks were given to the team for their work.

f. **Organ Donation Committee**

The Chairman requested expressions of interest from any Membership Councillors interested in sitting on the Organ Donation Committee. It was noted that this Committee meets four times per annum. The focus of the Committee is in raising awareness about the importance of organ donation and overseeing the work that the team do in hospital. Any membership councillors interested should contact the Chairman.

Dianne Hughes expressed an interest in this role at the meeting if no other Membership Councillors express an interest.

CONSTITUTION

45/16 MEMBERSHIP COUNCIL REGISTER

The updated register of members was received for information. It was noted that the vacant positions had been included in the forthcoming elections.

46/16 REGISTER OF INTERESTS/DECLARATION OF INTERESTS

The updated Register of Interests/Declarations was received. Any amendments were requested to be notified to the Board Secretary as soon as possible. It was requested that the members with outstanding declarations listed at the end of the Register ensure that a response is forwarded to the Board Secretary as soon as possible.

47/16 CONSTITUTIONAL AMENDMENTS

Following comments received from Membership Councillors prior to the meeting it had been agreed that this item would be deferred and the document would be re-worked and circulated for comment. It was requested that any additional comments be forwarded to the Company or Board Secretaries as soon as possible.

ACTION: COMPANY/BOARD SECRETARY

OUTCOME: To be circulated to Membership Councillors for comment once amendments had been made.

48/16 TRUST PERFORMANCE

In order to allow the Chief Operating Officer to attend another meeting later that evening, the Chairman confirmed that this item would be moved up the agenda.

a. Integrated Performance Report

The Chief Operating Officer gave an overview of the key themes from the May IPR report. The areas of specific note were:

Safe

- Inpatient Falls with Serious Harm - there were 7 falls in May, which are currently being investigated. This is a further increase on what was already a peak in April. As part of the CQUIN on safety huddles implementation there is an action plan in place to address.
- Never Event - There was one Never Event reported in May relating to feeding by a dislodged Naso-gastric (NG) tube. This is in the process of being investigated with NHS England with a final submission date of 11 August to the CCG. The investigation will look at Trust compliance with NPSA alert 2011/PSA002 reducing the harm caused by misplaced NG feeding tubes.
- Maternity - % Post partum hemorrhage (PPH) 1500ml - An improvement in overall PPH rates has been recorded in May 2016, however, the Trust is still above the target. A reduction in overall PPH rates will lead to improved patient experience following delivery.
- Number of Trust Pressure Ulcers (Category 2) Acquired at CHFT - 22 against a monthly target of 17. Further cluster investigations into category 3 ulcers should see improvements in Quarters 2 and 3. Report is expected end of June.

Effective

- Total Number of Clostridium Difficile Cases - There were 3 cases in May. 2 were avoidable.
- Perinatal Deaths (0-7 days) - at 0.65% are above the 0.1% target. A New SOP for Perinatal deaths and quarterly reports has been produced. Perinatal mortality group meet monthly to review cases and feedback learning. All perinatal deaths are logged on Datix as an incident and fully investigated.
- Stillbirths Rate - at 0.65% is above expected levels for the second month running. New SOP in place for stillbirth reduction and action plan in place which is monitored on a weekly basis. Quarterly report produced and findings discussed at stillbirth reduction group and Audit meetings.
- Local SHMI - Relative Risk (1yr Rolling Data October 14 - September 15) 113.88 - The two diagnostic groups that are negative outliers are Acute Cerebrovascular Disease and Pneumonia. There is an improvement plan in place to address both of these.
- Split by site, in-hospital and 30-day post-discharge deaths show that SHMI for post discharge deaths from HRI is much higher than in-hospital HRI deaths or any in CRH. This is currently unexplained and is subject to investigation at present.
- Hospital Standardised Mortality Rate (1 yr Rolling Data April 15 - Mar 16) 111.6 - Trust predicts further modest reductions in the coming months.
- Mortality Reviews - The completion rate for Level 1 reviews has been declining and YTD was 34%. Recruitment of more reviewers has been discussed and a proposal to move towards a consultant delivered initial review process was agreed at the Mortality Surveillance Group and will be taken to the Divisional PSQB for implementation.
- Crude Mortality Rate - has peaked at 1.6% for May 16. This will be reviewed by the Mortality Surveillance Group.
- Average Diagnosis per Coded Episode - there has been an improvement in month and work continues with Surgery focusing on improving coding through the use of Bluespier. Similarly in Paediatrics work done on the Paediatric ward will be extended to the Paediatric Assessment Unit.
- Percentage Non-elective Fractured Neck of Femur (#NoF) Patients with Admission to Procedure of < 36 Hours - BPT based on discharge is 68.3% against 85% target. In

May 26 of 34 people received an operation within 36 hours. There were 3 clinical breaches and 5 organisational breaches. RCAs are carried on all breaches.

Caring

- Only 38% of complaints were closed within timeframe against a target of 100%. This is the lowest position in the last 12 months and is subject of specific discussions as part of the divisional performance agendas.
- Friends and Family Test Outpatients Survey - 90.8% against a target of 95% would recommend the Service against 95% target. Improvement plans are in place around car parking and clinic waiting times.
- Friends and Family Test Community Survey - 87% would recommend the Service against 96.2% target.
- Actions are in place to address concerns around the perception of poor staff attitudes, standards of communication and expected behaviours are discussed across the division at every meeting.

Responsive

- Emergency Care Standard 4 hours. May's position has fallen slightly to 93.47% with an increase in patients waiting over 8 hours and further corrective actions have been identified to correct the deterioration.
- If all actions are achieved the Trust aims to secure a quarter one position of 94 and are seeking to achieve 95% for June. The Trust is 2nd only to Harrogate in performance of surrounding Trusts for the quarter.
- % Daily Discharges - Pre 12pm. 17% against 40% target. 2 wards achieved 50% in May. A month on month improvement of 10% is expected from March to achieve 40% by the end of Q1.
- Green Cross Patients (Snapshot at month end) remains high at 90 patients, discharge coordinators now using a case management model to improve patient experience, discharge planning, continuity and integration with social care.
- 83.3% of patients spent 90% of their stay on a stroke ward similar to last month- action plan for stroke service improvement has been updated.
- Only 47.8% of Stroke patients were scanned within 1 hour of hospital arrival (where indicated) against 90% target - updated action plan.
- % Last Minute Cancellations to Elective Surgery - Continued pressure from Medical outliers on the Gynaecology bed base at CRH. Monthly performance of 1.35% against a target of 0.6%. Discussions taking
- place to set criteria for outlying into Gynaecology beds and management of patient flow (by July 16).
- RTT pathways over 26 weeks highest since July 2015 - need for further validation.
- 38 Day Referral to Tertiary has improved to 66.7% against 85% target. Action plans went to Divisional Performance reviews in May with a requirement to achieve by July reflecting changes to reporting rules from Q3.

Workforce

- Sickness Absence rate has fallen to 4.23% against 4% target the lowest position for over 12 months with improvements across all divisions. Within this long term sickness is 2.8% against 2.7% with the short term 1.47% against 1.3%. Surgery has improved particularly its short term sickness.
- Return to interviews are a key contributor to effective sickness management and are currently only running at 34.6% against 100% target. The Trust also has the highest Turnover rate when compared to surrounding Trusts.

- Mandatory Training and appraisal compliance remains a challenge. Appraisal training proposal paper to be received at the Education Learning Group meeting on 22 June 2016.

Efficiency / Finance

- Finance - referred to later in the meeting
- Theatre Utilisation has improved in month. However there is still room for further improvement due to insufficiently filled lists and large number of patient cancellations.

COUIN

- Sepsis - % of patients Screened (admission Units) - On plan to hit 3 out of 4 Q1 targets, risk in achieving 90% of patients screened in ED for Q1. Performance 43% against year end 70%. ED staff have identified a way to ensure that all staff have a trigger to 'think sepsis' during triage. From June 1st there is a prompt on
- the EDIS system which needs to be completed at triage to indicate whether patients are showing signs of sepsis. The pathway and triggers for those patients who present directly to MAU/SAU is next to be improved and engagement with colleagues in those areas has begun in June.

Activity

- Planned day case and elective activity performance is improved at 3.3% above the month 2 plan. This is driven by over-performance within day case activity, with elective activity remaining below plan. Non-elective activity overall is 3.2% below the month 2 plan which is a continued reduction from April. This continues to be mainly driven by emergency long-stay. A&E has seen activity 7.6% above the month 2 plan which is a significant increase from month 1. Outpatient activity has seen a significant increase across first and follow-ups and is 5.3% above the month 2 plan.

The Membership Council asked a number of questions around:-

- Community Services collaborative approach,
- Improvements in DNA rates due to texting system being in place,
- Domiciliary visits – impact on the Trust of patients not being at home when staff attended to give care,
- Green Cross Patients – new work being undertaken to reduce the number of green cross patients through the safer patient programme, developed with partner organisations.
- It was requested whether the Membership Council could see some granular breakdown of the A/E attendances/admissions and the Chief Operating Officer confirmed that internal metrics were available and she would arrange for this to be brought to the next meeting.

ACTION: Chief Operating Officer

Helen Barker, Chief Operating Officer and Owen Williams, Chief Executive left the meeting.

b. MONTH 2 – MAY 2016 FINANCE REPORT

The Executive Director of Finance presented the finance month 2 report as at the 31 May 2016.
The key issues included:-

Summary Year to Date:

The year to date financial position stands at a deficit of £5.87m, an adverse variance £0.06m from the planned £5.81m. In month, the Trust has seen a stronger performance against planned activity, catching up some of the shortfall seen in Month 1. However, to

deliver activity and maintain staffing ratios across the bed base the Trust continues to rely heavily upon agency staffing at premium rates to cover both medical and nursing vacancies driving a pay overspend in both of these areas. Total agency spend in month was just under £2.5m, an increase on an already high run rate and a significant draw on limited cash resources impacting the Trust's ability to pay for other goods and services in a timely way.

The impact of this operational position is as follows at headline level:
• A negative EBITDA of £1.82m, a £0.25m adverse variance from the plan.
• A bottom line deficit of £5.87m, a £0.06m adverse variance from plan.
• Delivery of CIP of £1.26m against the planned level of £1.24m.
• Contingency reserves of £0.66m have been released in line with the planned profile.
• Capital expenditure of £2.38m, this is below the planned level of £2.52m.
• A cash balance of £1.93m in line with the planned level of £1.94m.
• A Financial Sustainability Risk Rating (FSRR) of level 2, in line with the plan.

As was the case last month, the underlying trading position is masked by a number of one off financial benefits. Outpatient work has been high in the first two months as some specialties aim to get ahead in advance of anticipated capacity gaps later in the year and so this is not forecast to be maintained at the same level. Critical Care income has spiked by £0.46m as a result of the discharge in May of a particularly long staying patient. Finally, one off rebates totalling £0.20m have been received in relation to rates and utilities.

Forecast:
Whilst there have been one-off benefits in the year to date, the run rate on underlying expenditure is bringing ongoing pressure with a particular risk around ongoing high levels of agency expenditure. CIP has delivered as planned at Month 2 but it should be noted that the planned profile of CIP is heavily weighted into the latter part of the year and just under half of the £14m required is flagged as 'high risk'. In addition the £2m contingency reserves are planned across the first six months of the year and will therefore bring limited respite against these risks.

Whilst acknowledging these risks, the year end forecast position at this early stage continues to be to deliver the planned £16.1m deficit. Divisions are required to fully develop and deliver recovery plans to mitigate against the risks and pressures and offset any year to date shortfall. In addition, it is assumed that the Trust will achieve the necessary conditions to secure the £11.3m Sustainability and Transformation Funding which is intrinsic to delivery of the planned deficit.

OUTCOME: The Performance and Finance Reports were received and noted.

Discussion took place regarding the difficulties in being able to recruit to substantive posts and it was noted that further discussion would take place outside the meeting with the Medical Director and University of Huddersfield representatives.

ACTION: DB/CO'H

UPDATE FROM BOARD SUB COMMITTEES

49/16 Audit and Risk Committee

Peter Middleton reported that this was a focused Committee. The last meeting had been held on the 26 May 2016 to sign off the Annual Report and Accounts. He was pleased to advise that Clinical Audit was becoming visible to this Committee and at his request a paper had been submitted to the Membership Council, to be discussed later in the meeting.

50/16 Electronic Patient Record (EPR)

Rev Wayne Clarke confirmed that Kate Wileman and Brian Moore had both agreed to help as representatives of the Membership Council at future EPR meetings when Rev Clarke was not available. It was noted that the Membership Council had received an update on the implementation of the system which was due to go live in November in the private part of the meeting.

51/16 Finance and Performance Committee

Brian Moore confirmed that all issues had been raised by the Executive Director of Finance earlier in the meeting.

52/16 Quality Committee

Lynn Moore advised that all performance issues discussed at the Quality Committee had been included in the Integrated Performance Report presented by Helen Barker earlier in the meeting.

Other areas of focus by the Committee included:-

- Paediatric Cardiac Arrest Simulation
- Outpatient Appointment – Choose and Book system assurance received that the problems with the booking system did not jeopardise patient safety.

53/16 Charitable Funds Committee

Kate Wileman advised that fundraising activity had now commenced with:-

- Lottery system funds through Huddersfield Giants
- University of Huddersfield placements

54/16 Workforce Well-Led Committee

Rosemary Hedges advised that the main issues raised at the last meeting held on 14 June 2016 had been included within the Board of Directors papers at its meeting on the 30 June 2016. These included:-

- Sickness – work on-going to reduce sickness was noted.
- Mandatory Training – targets noted
- Breaches – in agency staff discussed and action plan noted.
- Medical and Nursing Workforce Strategy Group – arrangements made for this to feed into this Committee.
- Chair of WWLC – to be taken over by Karen Heaton, Non Executive Director
- Schedule of Meetings – Committee to meet monthly with effect from August 2016.

55/16 MC/BOD AGM Task and Finish Group

Ruth Mason reported that arrangements were in hand for the interactive healthfair part of the AGM on Thursday 15 September 2016 to focus on 'IT's vital to your health'.

The formal AGM would commence at 6.00 pm

Both the Healthfair and AGM would be held in the Learning Centre, Calderdale Royal Hospital.

OUTCOME: The Membership Council noted the arrangements were in hand for the AGM/Health Fair

56/16 MC Walkabout FSS HRI – Birth Centre, Radiology and Pharmacy

Kate Wileman updated the Membership Council on the excellent visit recently held and thanked staff for making the arrangements and for the support members of the Membership Council had received.

57/16 STRATEGIC PLAN AND QUALITY PRIORITIES 2016/17

The Company Secretary presented the Strategic Plan and Quality Priorities for 2016/17 which had been developed at the BOD/MC Workshop held on the 10 May 2016.

It was agreed that an update on each of the priority areas would be presented to the Membership Council as part of a rolling programme and would be built into the work plan for the meeting.

ACTION: Company Secretary

OUTCOME: The Membership Council approved the Strategic Plan and Quality priorities 2016/17

58/16 CLINICAL AUDIT AND INTERNAL AUDIT REPORTS

Peter Middleton had asked the Audit and Risk Committee for this information to be circulated to the Membership Councillors to raise the awareness of the Membership Council of the work of clinical audit and its links with both the internal and external auditors. It was noted that Martin DeBono would be attending the Membership Council Development event on 12 July to discuss clinical audit in more detail.

OUTCOME: The Membership Council received the information regarding the Internal Audit plans and its links with Clinical Audit.

59/16 ELECTION PROCESS FOR THE APPOINTMENT OF DEPUTY CHAIR/LEAD GOVERNOR-COUNCILLOR PROCESS

The process and timeline for the appointment of Deputy Chair/Lead Governor Councillor had been circulated for approval. All present noted the contents of the paper and supported the process which would commence on the 11 July and conclude with the formal announcement at the AGM pm the 15 September 2016.

Rev Wayne Clarke gave a brief overview of the role and confirmed that he would not be standing for re-election.

OUTCOME: The Membership Council approved the process for the election process for the appointment of Deputy Chair/Lead Governor-Councillor process.

60/16 CHAIR AND NON-EXECUTIVE DIRECTOR APPRAISAL

Andrew Haigh and Brendan Brown left the meeting

a. Chair Appraisal

Dr David Anderson presented the paper previously circulated to Membership Councillors which identified the appraisal process and confirmed the overall positive responses received from the Membership Council, Non-Executive Directors and Executive Directors.

Rev Wayne Clarke advised that 15 out of 21 questionnaires had been returned from the Membership Council and thanked everyone for the input. Unfortunately Membership Councillors' had not found the questionnaire easy to complete and it was suggested that for future years the Membership Council should have an informal meeting to share feedback with the Lead Governor-Councillor via the existing form which would then be shared with the SINED. All present agreed this arrangement, although it was noted that if there was no consensus of opinion it may be necessary to revert back to questionnaires being returned from individual Membership Councillors.

b. Non-Executive Appraisal

David Anderson left the meeting for this item.

The Chair returned to the meeting and presented the contents of the paper previously circulated and confirmed that he was in full supportive of the work and activities of the Non-Executive Directors during the year. It was noted that the Nominations and Remuneration Committee were due to meet on the 21 July 2016 to discuss the two Non-Executive tenures which were due to expire later in the year.

OUTCOME: The Membership Councillors received the Chair and Non-Executive Appraisal and confirmed their support.

61/16 FUTURE MC MEETINGS

The proposed meeting dates for 2016/17 were approved:-

DATE	TIME	VENUE
Thursday 15 September 2016 **Joint BOD/MC AGM**	6.00 pm	CRH - Lecture Theatre, Learning Centre, Calderdale Royal Hospital
Wednesday 9 November 2016	4.00 pm	HRI - Boardroom, Sub-basement, Huddersfield Royal Infirmary
2017		
Tuesday 17 January 2017	4.00 pm	HRI - Boardroom, Sub-basement, Huddersfield Royal Infirmary
Wednesday 5 April 2017	4.00 pm	CRH – Large Training Room, Learning Centre Calderdale Royal Hospital
Thursday 6 July 2017	4.00 pm	HRI – Discussion Room 1, Learning Centre, Huddersfield Royal Infirmary
Thursday 14 September 2017	TBC	TBC
Thursday 9 November 2017	4.00 pm	CRH – Large Training Room, Learning Centre Calderdale Royal Hospital

OUTCOME: The Membership Council meeting dates for 2016/17 were received and approved.

62/16 INFORMATION TO RECEIVE

The following information was received and noted:

a. Updated Membership Council Calendar – updated calendar received and contents noted.

63/15 ANY OTHER BUSINESS

a. S&A Walk About

Ruth Mason reported that arrangements were being made for a tour of HRI Day Surgery, Theatres and Ward 19 on either 3 or 10 August 2016 and requested preferred dates from interested Membership Councillors be notified to Vanessa Henderson in the Membership Office.

b. Community Nursing Homes – red bags

Lynn Moore brought to the attention of the Membership Council a recent article which promoted the use of red bags, packed by Community Nursing Homes in readiness for any patient requiring hospitalisation. It was agreed that this would be passed to Community Services to note.

c. Follow-up Letters to GPs and PLACE Inspection

Brian Moore highlighted the time delay in follow-up GP letters and thanked the PLACE Inspection team for their hard work.

d. Membership Council Elections

The Chair highlighted to the Membership Council that this meeting could be the last for some Membership Councillors whose tenure would cease at the Annual General Meeting. Although thanks would be given at the AGM, the Chairman wished to formally note thanks to all non-elected members for their help in supporting the Membership Council.

64/15 DATE AND TIME OF NEXT MEETING

Thursday 16 September 2016 – Joint MC/BOD Annual General Meeting **commencing at 6.00 pm in the Lecture Theatre, Learning Centre, Calderdale Royal Hospital.**

Wednesday 9 November 2016 – Public Membership Council Meeting **commencing at 4.00 pm in the Boardroom, Sub-basement, Huddersfield Royal Infirmary**

The Chair thanked everyone for their contribution and closed the meeting at 6.15 pm.

Calderdale and Huddersfield NHS
NHS Foundation Trust

MEMBERSHIP COUNCIL PUBLIC MEETING

MEETING TITLE AND TYPE: PUBLIC MEMBERSHIP COUNCIL MEETING	**REPORTING AUTHOR:** Terry Matthews
TITLE OF PAPER: Internal audit report of Clinical Audit at CHFT	
DATE OF MEETING: 09/11/16	**SPONSORING DIRECTOR:** Mr M DeBono
STRATEGIC DIRECTION – AREA: • Keeping the base safe • Transforming and improving patient care	**ACTIONS REQUESTED:** • To note
PREVIOUS FORUMS: Clinical Audit and Effectiveness Group Clinical Audit Group	

EXECUTIVE SUMMARY:

Clinical Audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against local and national standards and guidelines. Aspects of structure, processes and outcomes of care are selected and systematically evaluated against explicit criteria. It is a way to find out if healthcare is being provided in line with standards and ensures care providers and patients know where their service is doing well, and where there could be improvements.

The Trust conducts four different types of audit, National, HQIP, NICE and local. It is mandatory that the Trust comply with national audits set by HQIP, and the Trust has also chosen to regard other national audits as mandatory. If the Trust assesses that it is fully compliant with NICE guidance then they will undertake audit work to confirm.

Internal audit carried out a review of clinical audit in May/June 2016. The objective of the review was to provide assurance that the Foundation Trust has a robust and reliable approach to clinical audit. The wider governance arrangements that clinical audit sits within, were not included within the review.

Following the review the internal audit opinion was that the Trust's clinical audit approach can be relied on and the Trust has an effective system of undertaking clinical audits. The report highlighted some enhancements to the approach which would systematise aspects of the approach to increase the assurance that clinical audit activity, provides assurance in itself, is necessary and drives improvement.
An action plan has been produced to address the recommendations from the report and this is being monitored through the Clinical Audit Group.

RECOMMENDATION:
To note the contents of the report and action plan

APPENDIX ATTACHED: YES / NO

compassionate care

Internal Audit Report

for

Calderdale and Huddersfield NHS Foundation Trust

CLINICAL AUDIT

CHxx/2016

West Yorkshire Audit Consortium

ensuring quality and value

Section One

Executive Summary

Background

Clinical Audit is a quality improvement process that seeks to improve patient care and outcomes through a systematic review of care against local and national standards and guidelines. Aspects of structure, processes and outcomes of care are selected and systematically evaluated against explicit criteria.

It is a way to establish if healthcare is being provided in line with standards and ensures care providers and patients know where their service is doing well, and where there could be improvements.

The Trust conducts four different types of audit, National (includes NCAPOP and HQIP), NICE, Trust priorities and local. It is mandatory that the Trust undertake national audits set by HQIP, and the Trust have chosen to regard other national audits as mandatory. The Trust provides some specialist services which would be too small to be covered by HQIP so they are covered by national audit.

If the Trust asserts that it is compliant with NICE guidance then the audit work is undertaken to confirm this.

The central Clinical Governance Team meet with Divisional Clinical Audit Leads to identify local audits that are specifically called for within each Division. This local work is specified to meet local needs and can cover issues such as contributing to a business case for additional resource or investigating concerns arising from complaints.

Overall System Objective and Scope

The objective of the review was to provide assurance that the Foundation Trust has a robust and reliable approach to clinical audit. The wider governance arrangements that clinical audit sits within, will be included in the scope of later audits.

See Appendix A for detailed objectives and scope.

Audit Opinion

OVERALL AUDIT OPINION	
Significant Assurance	The Trust has an effective system of undertaking clinical audits. Mandatory audits are supported by the CGSU (Clinical Governance Support Unit) and are based on the requirements of national standards or guidance. In order to assist in the audit process, the CGSU produce audit tools, which are used in some cases, by clinicians in the relevant speciality to gather data. Internal Audit identified that the presentation of findings could be improved in order to provide a better foundation for change. Enhancements could be made to the current approach in respect of local audits. These are undertaken to meet the Trust' requirements and are generally planned and delivered by clinicians locally. This local approach means that the work should be based on a good understanding of local practice and priorities, however it would benefit from a more structured approach with audits as well as the overall local audit plan being reviewed and approved by local clinical leadership. In addition, formal quality assurance processes, guidance and training for those undertaking a clinical audit would give increased assurance over its reliability.

See Appendix B for definitions of audit assurance.

Key Findings

The following summarises the outcome of the review for each of the key objective areas considered as part of the audit:

Objective Area	Opinion	Comments
Quality Assurance Processes	Limited	Guidance is available for Facilitators showing how to conduct their work and aid the Clinical Audit Leads in carrying out the clinical audit activity. Guidance for those conducting the audit (project leads and junior doctors) is not available and would be useful. There is a job description in place for the Speciality Clinical Audit Lead, but not for the Project Audit Lead. Whilst the Project Lead may often be closely involved in the clinical audit, there is no systematic supervisory review of the output of clinical audit. The majority of national clinical audits performed require the first three to five cases examined for evidence to be double audited (by two separate individuals), this gives assurance over their accuracy. There is no such, similar practice for local audits. In addition, evidence supporting clinical audit work was generally not available during the course of the audit, such that queries about the data reviewed would be difficult to respond to.

Objective Area	Opinion	Comments
Continuing Professional Development and Training	Limited	The Clinical Audit Policy describes a package of training available at different levels, accessible via the CGSU (Clinical Governance Support Unit). However, training is currently not delivered at the Trust, instead reliance is placed on the coverage of this as part of the clinical auditor's, University education. There is no formal continuing professional development of clinical auditing skills. There is a monthly meeting where Clinical Audit Leads are encouraged to discuss the approach of audits. It is possible that this sort of event could be developed to share experience or alternatively more formal training could be offered.
Reporting	Significant	Internal Audit identified that the reporting faithfully represented the matters audited. However, their presentation could be enhanced. Procedures to proof read and sense check reports are in place. Internal Audit reviewed the reports from ten clinical audits. From the sample there were six cases where, in Internal Audit's view, insufficient reasoning or analysis of the data was included. Given the expert nature of the authors and their audience, there may be an assumption of a common understanding, however mutual understanding would be ensured if implicit matters were made explicit. Where action plans were formulated to address issues identified in the report, these were generally adequate. However, in two out of the five action plans reviewed, the actions were not "SMART". Whilst a presentation of the base facts may be appropriate in some cases, if the aim is to understand the root cause of the problem identified and to then address that matter, further analysis is advisable.
Planning & Methodology	Significant	Mandatory audits and other audits handled through the CGSU are well controlled, being established and approved formally, added to the Trust Clinical Audit programme. The methodology of these audits is reliable, with staff in the CGSU establishing an audit tool, where necessary, to demonstrate compliance with the national requirements being audited against. In terms of local audits a project plan or proposal is not routinely completed. Internal Audit was advised of instances whereby the CGSU was first aware of local audits when they are presented at the Audit Half-day. Nor is there always Divisional approval or awareness of the audits, which would enable consideration of the Trust's objectives and Board Assurance Framework. In addition, whilst CGSU confirm that important recommendations are implemented, there is not a

Objective Area	Opinion	Comments
		systematic re-audit of key areas to ensure that an improvement in performance has been made.
Clinical Audit Governance	Significant	The clinical audit programme should be based on the priorities of the Trust, consistent with the Trust's objectives, and considering the Trust's Board Assurance Framework. Whilst controls to achieve this are in place for mandatory audits and other audits handled through the CGSU, they are not applied to local audits. Local audits are not always approved in advance nor is there always awareness that some clinical audits are being undertaken. This can lead to the risk of work being undertaken which is not regarded as necessary or potentially duplicated. If a comprehensive local audit plan was produced and signed off by the Directorate's Clinical Director, with each audit proposal agreed by the Audit Lead, there would be greater assurance that the level of coverage was sufficient. The audit also considered the role of the Clinical Audit Leads. The nature of the role is clearly set out but the means by which the appointment is made can be opaque and would benefit from being handled in a more formal way. The role of the Clinical Audit Lead is a key one and their performance should be reviewed, like any role. This could be linked to a fixed term of appointment.

Added Value

Assurance can be given that the Trust's clinical audit approach can be relied on. This report highlights some enhancements to the approach which will systematise aspects of the approach to increase the assurance that clinical audit activity, both provides assurance in itself, is necessary and drives improvement

Section Two

Findings

2.1 Quality Assurance Processes

2.1.1 Audit Guidance

It is mandatory that the Trust comply with national audits set by The Healthcare Quality Improvement Partnership (HQIP), NCAPOP (national clinical audit patient outcome programme) audits and NHS Quality Accounts. The Trust has chosen to regard other national audits as mandatory to further best practice. In addition to these audits each speciality undertakes its own audits based on locally determined priorities.

The Trust's Clinical Audit Policy contains guidance for Facilitators in the CGSU, regarding their support role in the clinical audit process working to assist the Clinical Audit Leads. However, the policy guidance is not aimed at those, typically junior doctors or nurses, who actually undertake the work. Support for those doing a clinical audit is particularly important if the work is part of a local audit, where the content is not prescribed.

Guidance could be provided on matters such as:

- Sample size and selection methods;
- The independence of those undertaking the work of the activity being audited;
- Evidence retention; and
- Clinical audit report structure.

This could build on written guidance that the CGSU have written previously.

2.1.2 Supervisory Review

Clinical Audit work should be supported by a record of the evidence reviewed to enable re-performance of the tests undertaken, should it prove necessary.

The majority of audits utilise a Data Collection tool either taken from guidance, or developed by the audit Facilitators. The collected data may then be analysed by the Facilitators.

For many of the national audits the data collection tool is web based and data is submitted electronically, and in some of these cases or other audits undertaken, the data collection tool is populated with no record of which cases have been considered. Should there be a subsequent query, it would be difficult to explain how the end result was arrived at.

Each audit has a project lead, who oversees the work. From discussion with a number of project leads it appears that they do not always review the work that has been undertaken, nor is their role defined.

It was noted that some national audits require a proportion of the sample to be double audited (i.e. the first three to five cases), to ensure the reliability of the data collected.

If the Clinical Audit process included details of the sample selected it would facilitate a supervisory review of the output to ensure that the findings are well founded and to help quality assure the output.

Recommendation 1 A Clinical Audit Manual should be written to inform auditors how a clinical audit should be conducted.

Recommendation 2 **An Audit Project Lead job description should be introduced setting out the role of the Project Lead; this should include responsibility to undertake a quality review of each clinical audit. The review would assess its accuracy, including reviewing the audit documentation before the audit is presented.**

2.2 Training and Continuing Professional Development

Clinical Auditors should possess the knowledge, skills and other competencies needed to perform their individual responsibilities.

Clinical Audit Leads, Project Leads and/or junior doctors or nurses, who typically undertake the clinical audit work do not receive training in their role from the Trust. However doctors receive audit training as part of their University education and a doctor's continuing accreditation can be supported through undertaking clinical audits.

The Clinical Audit Policy describes a package of training available at different levels, accessible via the CGSU. However, training is not delivered at present. Internal Audit has been advised that this is because of insufficient resources in the CGSU and poor uptake in the past.

If there are insufficient resources to deliver training then other forms of sharing experience amongst those involved in clinical audit should be explored.

Recommendation 3 **The Trust should consider how it can support the training needs of those new to clinical audit and how to share best practice and to update the knowledge of those already involved in clinical audit.**

2.3 Clinical Audit Reporting

Reports should analyse the data collected and come to evidence based conclusions as to its meaning.

In six reports of the ten sampled, the report was not a concise representation of the audit, not including clear analysis of the data.

Of those sampled, five had action plans and of those one had an action to work as a team and one had been written by technical staff who had gathered the data, rather than clinical staff who might be better placed to judge what the data meant. The remaining 3 action plans were appropriately made and backed up by supporting information in the report.

If Clinical Audit is going to be an effective agent of improvement and change, as well as reliably assembling data, it needs to accurately determine what the data means. Therefore the root cause of the problem needs to be accurately ascertained. If this analysis has been undertaken it needs to be clearly set out in order to convince the reader and also ensure management actions are correctly directed.

Recommendation 4 **Training delivered to those undertaking clinical audit should include guidance on report writing. In addition the project review undertaken by the Project Lead should include a review of the findings to ensure that it sets out any reasoning in full and is based on work by the clinical auditor to understand the root cause of the problem.**

2.4 Re-Audit

A formal re-audit of key clinical audits should be established in order to establish improvement.

Currently the CGSU establish that the agreed actions have been implemented and some re-audit is undertaken. However, given that one of the purposes of clinical audit is to drive improvements in performance, a more systematic re-audit process should be considered for clinical audits where an improvement in performance is essential. A re-audit will give evidence that the changes in practice have occurred and that they have led to a change in the outcomes.

Recommendation 5 **Clinical Audit Leads should be encouraged to include a follow up re-audit of key clinical audits, where significant improvements are necessary. This should take place after a suitable period following the initial clinical audit. The CGSU review of the plans should identify where this takes place.**

2.5 Divisional Audit Governance

2.5.1 Unnecessary Clinical Audit Coverage

Clinical Audit activity should be aligned to the strategic objectives of the Trust and only be undertaken where it adds value. Whilst the audits driven centrally by the CGSU are clearly linked to Trust and wider NHS priorities, the concern was expressed that whilst important to the project lead, some audits lack wider legitimacy and some audits are undertaken unbeknownst to other clinicians in the speciality or Division.

This could mean that audit work may be duplicated or may be undertaken when unnecessary.

The Trust has a process to approve clinical audit work, by approving the project plan, but this process is not routinely applied to local audits. If this process was applied to all Clinical Audits, it could ensure that unnecessary audit work is not undertaken and that a comprehensive list of all clinical audit work can be put together and shared with CGSU and other people involved in clinical audit.

2.5.2 Insufficient Clinical Audit Coverage

From discussion with Clinical Audit Leads, it was apparent that they are not always able to exercise meaningful control over whether the local audit approach for some specialities is sufficient.

In addition, anecdotally, some Clinical Audit Leads are more active than others, possibly because of other commitments or priority given to other matters.

In order to assist with these matters, whilst the Clinical Audit Lead should approve each audit project, the overall local plan should be approved by the Directorate's Clinical Director. A more transparent clinical audit planning process could also involve input from the CGSU who could bring in comparisons to the practice in peers of the Trust.

Recommendation 6 **Clinical Audit Leads should approve all local audit work, and the speciality audit plan should have a final sign off from the Clinical Director. The value of proposed audit work can then be assessed and authorised if deemed appropriate and the comprehensiveness of the approach can be confirmed.**

2.6 Role of Clinical Audit Lead

The role of the Clinical Audit Lead is a key one to the effectiveness of clinical audit, in their area of responsibility.

The Clinical Audit Lead Job description states that post holders would ideally have:

- Awareness of the objectives of Clinical Audit and its place within the broader context of Clinical Effectiveness and Clinical Governance
- An understanding of Clinical Audit methodologies
- The ability to create an open and participative audit culture which encompasses colleagues from all relevant health professions
- A genuine interest in Clinical Audit – audit leads are the Trust's 'champions' of Clinical Audit
- Have the confidence and enthusiasm to introduce changes through the clinical audit process

They have an important role in shaping the clinical audit programme ensuring that it is based on the priorities of the Trust, with expectations of key stakeholders identified and considered.

Clinical Audit Leads are not appointed through a formal process, they are identified through networks in the Division. They serve as Clinical Audit Lead until they express a wish not to do so. One Clinical Audit Lead regarded it is part of the role he applied for when joining the Trust, whilst another was approached to take up the role. Nor is it defined who should make the appointment nor to whom the appointee should be accountable to.

An open application process would be more transparent and may encourage applications. Suitable applicants could still be encouraged to apply to ensure the post is filled.

The post holder could also be subject to an appraisal of their performance as clinical audit lead and consideration could also be given to the post holder holding the role for a term, to encourage wider involvement and give a specific point at which the effectiveness of the post holder can be reviewed and a determination be made whether they will continue or another appointment be made.

Recommendation 7 **The Trust should consider adopting a more formal recruitment process to appoint Clinical Audit Leads. The nature of the reporting line and who should make the appointment should also be defined. The role should be subject to performance appraisal, and this could be linked to a fixed term of office.**

Clinical Audit

Action Plan

Recommendation		Priority	Agreed	Comments	Responsibility	Action date
1	A Clinical Audit Manual should be available to inform auditors how the audit should be conducted.	High	Yes	To produce a clinical audit guide on how to undertake an audit project using existing documents and guidance on the intranet (Medical Division).	Clinical Governance Team	Jan 2017
2	An Audit Project Lead job description should be introduced setting out the role of the Project lead, this should include responsibility to undertake a quality review of each clinical audit. The review would assess its accuracy, including reviewing the audit documentation before the audit is presented.	High	Yes	To produce a job description for project leads setting out their role and responsibility. This will be developed using the existing Audit lead JD. This will be sent out to all project leads as an audit is commissioned.	Clinical Governance Team	Jan 2017
3	The Trust should consider how it can support the training needs of those new to clinical audit and how to share best practice and to update the knowledge of those already involved in clinical audit.	Low	Yes	Existing training package to be updated. Once completed to test out in one Directorate first. To enquire if we can present at the F1 training programme.	Clinical Governance Team Dr A Hardy	Jan 2017 Jan 2017
4	Training delivered to those undertaking clinical audit should include guidance on report writing. In addition the project review undertaken by the Project Lead should include a review of the findings to ensure that it sets out any reasoning in full and is based on work by the clinical auditor to understand the root cause of the problem.	Medium	Yes	Covered in actions 2&3	Clinical Governance Team	Jan 2017
5	Clinical Audit Leads should be encouraged to include a follow up re-audit of key clinical audits, where significant improvements are necessary. This should	Medium	Yes	To ensure that where audits have significant change that a re audit is carried out. This will be	Clinical Governance Team Leaders	Ongoing

Recommendation		Priority	Agreed	Comments	Responsibility	Action date
	take place after a suitable period following the initial clinical audit. The CGSU review of the plans should identify where this takes place.			identified by the team leaders and Monitored through the Clinical Audit Group.	Clinical Audit Group	
6	Clinical Audit Leads should approve all local audit work, and the speciality audit plan should have a final sign off from the Clinical Director. The value of proposed audit work can then be assessed and authorised if deemed appropriate and the comprehensiveness of the approach can be confirmed.	Medium		Each local audit project plan should be agreed by the clinical audit lead and the Clinical Director should sign off the annual programme prior to it going to PSQB.	Clinical Governance Team Clinical Audit Leads Clinical Directors	Ongoing April 2017
7	The Trust should consider adopting a more formal recruitment process to appoint Clinical Audit Leads. The nature of the reporting line and who should make the appointment should also be defined. The role should be subject to performance appraisal, and this could be linked to a fixed term of office.	Medium		Divisions to propose individuals for the role of Clinical Audit Lead through the appraisal process. An interview should then be arranged between Mr DeBono, the Governance Facilitator and the Audit Lead to describe the expectations of the role. The role should be a fixed term of office.	Divisions –Divisional Directors / Clinical Directors. Clinical Governance Facilitator	Ongoing

APPENDIX C

Calderdale and Huddersfield NHS
NHS Foundation Trust

MEMBERSHIP COUNCIL REGISTER
AS AT 22 SEPTEMBER 2016

CONSTITUENCY	NAME	DATE APPOINTED	TERM OF TENURE	ELECTION DUE
PUBLIC – ELECTED				
1	Mrs Rosemary Claire Hedges	17.9.15	3 years	2018
1	Mrs Di Wharmby	17.9.15	3 years	2018
2	Mrs Veronica Maher	15.9.16	3 years	2019
2	Mrs Katy Reiter	15.9.16	3 years	2019
3	Mr Peter John Middleton **(Deputy Chair from 15.9.16)**	22.9.11 18.9.14	3 years 3 years **1 year**	2014 2017 **2017**
3	Ms Dianne Hughes	19.9.13 15.9.16	3 years 3 years	2016 2019
4	Ms Nasim Banu Esmail	15.9.16	3 years	2019
4 (Reserve Register)	Mr Grenville Horsfall	19.9.13 15.9.16 (Reserve Register Cons. 4)	3 years 1 year	2016 2017
5	Mr Stephen Baines	15.9.16	3 years	2019
5	Mr George Edward Richardson	18.9.14	3 years	2017
6	Mrs Annette Bell	17.9.15	3 years	2018
6	Mr Brian Richardson	18.9.14	3 years	2017
7	Ms Kate Wileman	4.1.13 18.9.14	2 years (to Sept 2014) 3 years	2017
7	Mrs Lynn Moore	18.9.14	3 years	2017
8	Mr Brian Moore	17.9.15	3 years	2018
8	Mrs Michelle Rich	15.9.16	3 years	2019

CONSTITUENCY	NAME	DATE APPOINTED	TERM OF TENURE	ELECTION DUE
STAFF – ELECTED				
9 - Drs/Dentists	Dr Mary Kiely	22.9.11 18.9.14	3 years 3 years	2014 2017
10 - AHPs/HCS/Pharm's	Mrs Nicola Sheehan	15.9.16	3 years	2019
11 - Mgmt/Admin/Clerical	Mrs Eileen Hamer	20.9.12 17.9.15	3 years 3 years	2015 2018
12 - Ancilliary	Mrs Linda Dawn Salmons	15.9.16	3 years	2019
13 - Nurses/Midwives	Mrs Charlie Crabtree	15.9.16	3 years	2019
13 – Nurses/Midwives	VACANT POST			
NOMINATED STAKEHOLDER				
University of Huddersfield	Dr Cath O'Halloran (From 1.4.16)	1.4.16	3 years	2019
Calderdale Metropolitan Council	Cllr Bob Metcalfe	18.1.11	3 years 3 years	2014 2017
Kirklees Metropolitan Council	Cllr Carole Pattison	22.9.16	3 years	2019
Clinical Commissiong Group	Mr David Longstaff	18.9.14	3 years	2017
Locala	Mrs Sharon Lowrie	22.1.16	3 years	2019
South West Yorkshire Partnership NHS FT	Mrs Dawn Stephenson	23.2.10 15.8.13	3 years 3 years	2013 2016

MC-REGISTER MC – 22.9.16

Calderdale and Huddersfield NHS
NHS Foundation Trust

APPENDIX D

DECLARATION OF INTERESTS – MEMBERSHIP COUNCIL
AS AT 13 OCTOBER 2016

The following is the current register of the Membership Council of the Calderdale & Huddersfield NHS Foundation Trust and their declared interests. The register is maintained by the Foundation Trust Office, and holds the original signed declaration forms. These are available for inspection by contacting the office on 01484 355933.

DATE OF SIGNEDDECLARATION	NAME	MEMBERSHIP COUNCIL STATUS	DIRECTORSHIP	OWNERSHIP	CONTROLLING SHAREHOLDING	AUTHORITY IN A CHARITY /BODY	VOLUNTARY OR OTHER CONTRACTING FOR NHS SERVICES	OTHER EMPLOYMENT (PAID OR NON-PAID) & MEMBER OF PROFESSIONAL ORGAN'S
1.3.10	Dawn STEPHENSON	Nominated Stakeholder – South West Yorkshire Partnership Foundation Trust	Director of Corporate Development	-	-	Chair Trustee from 9.9.15 - Kirklees Active Leisure (KAL)	-	Fellow of the Association of Certified Accountants.
11.1.11	Bob METCALFE	Nominated Stakeholder – Calderdale Council	-	-	-	-	-	-
6.10.11	Mary KIELY	Staff-elected Constituency 9	-	-	-	Consultant in Palliative Medicine, Kirkwood Hospice	As before	- Medical Defence Union. - B.M.A. - Assoc. for Palliative Medicine of GB & Ireland
10.10.11	Peter John MIDDLETON	Public-elected Constituency 3	-	-	-	-	-	-
9.10.12	Eileen HAMER	Staff-elected Constituency 11	-	-	-	-	-	-

DATE OF SIGNED DECLARATION	NAME	MEMBERSHIP COUNCIL STATUS	DIRECTORSHIP	OWNERSHIP	CONTROLLING SHAREHOLDING	AUTHORITY IN A CHARITY /BODY	VOLUNTARY OR OTHER CONTRACTING FOR NHS SERVICES	OTHER EMPLOYMENT (PAID OR NON-PAID) & MEMBER OF PROFESSIONAL ORGAN'S
13.2.13	Kate WILEMAN	Public-elected Constituency 7	-	-	-	-	-	Member of Cancer Partnership Group at St James' Leeds
5.8.13	Grenville HORSFALL	Public-elected Constituency 5 (Reserve Register Cons. 4)	-	-	-	-	-	-
29.10.13	Dianne HUGHES	Public-elected Constituency 3	-	-	-	-	Civil Funeral Celebrant	Sheffield Teaching Hospitals NHS Trust RCN and Midwifery Council. Marie Curie Nursing Services.
8.9.14	George RICHARDSON	Public-elected Constituency 5	-	-	-	-	-	-
29.9.14	Lynn MOORE	Public-elected Constituency 7	-	-	-	-	-	-
1.11.14	Brian RICHARDSON	Public-elected Constituency 6	-	-	-	-	Locala Members' Council Healthwatch Calderdale Programme Board. Practice Health Champion PRG member at Beechwood Medical Centre	-

DATE OF SIGNED DECLARATION	NAME	MEMBERSHIP COUNCIL STATUS	DIRECTORSHIP	OWNERSHIP	CONTROLLING SHAREHOLDING	AUTHORITY IN A CHARITY/ BODY	VOLUNTARY OR OTHER CONTRACTING FOR NHS SERVICES	OTHER EMPLOYMENT (PAID OR NON-PAID) & MEMBER OF PROFESSIONAL ORGAN'S ETC.
29.9.15	Annette BELL	Public-elected Constituency 6	-	-	-	-	-	-
2.10.15	Brian MOORE	Public-elected Constituency 8	-	-	-	-	-	-
4.11.15	Di Wharmby	Public-elected Constituency 1	-	-	-	-	-	-
29.10.15	Rosemary HEDGES	Public-elected Constituency 1	-	-	-	-	-	Secretary – Calderdale 38 Degrees Group
21.4.16	Catherine O'HALLORAN	Nominated Stakeholder – University of Huddersfield	-	-	-	-		- University of Huddersfield - Registrant & Visitor of Health & Care Professions Council - Treasurer, Council of Deans of Health
14.9.16	Nasim Banu ESMAIL	Public-elected Constituency 4	-	-	-	-	-	-
12.10.16	Veronica MAHER	Public-elected Constituency 2	-	-	-	-	-	-
13.10.16	Michelle RICH	Public-elected Constituency 8	-	-	-	-	-	Kirklees College
10.10.16	Katy REITER	Public-elected Constituency 2	Managing Director Treefrog Communications	-	-	-	-	Mentoring via own business. Care Quality Commission
6.10.16	Stephen BAINES	Public-elected Constituency 5	-	-	-	Trustee – Halifax Opportunities Trust	-	Calderdale MBC

Please notify Kathy Bray, Board Secretary immediately of any changes to the above declaration:- 01484 355933 or Kathy.bray@cht.nhs.uk or return the attached with amendments.

Status:- AWAITING RETURNS FROM:– DAVID LONGSTAFF, SHARON LOWRIE, CLLR CAROLE PATTISON

Calderdale and Huddersfield NHS
NHS Foundation Trust

MEMBERSHIP COUNCIL PUBLIC MEETING

MEETING TITLE AND TYPE: PUBLIC MEMBERSHIP COUNCIL MEETING	**REPORTING AUTHOR:** Kathy Bray, Board Secretary
TITLE OF PAPER: **NOMINATION AND REMUNERATION COMMITTEE (MEMBERSHIP COUNCIL)**	
DATE OF MEETING: Thursday 4 November 2015	**SPONSORING DIRECTOR:** Andrew Haigh, Chair
STRATEGIC DIRECTION – AREA: • Keeping the base safe • Transforming and improving patient care • A workforce for the future • Financial Sustainability	**ACTIONS REQUESTED:** • For comment • To approve • To note
PREVIOUS FORUMS: Discussed at Board of Directors Meeting – 24.9.15 & 3.11.16	

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

At the Nomination and Remuneration Committee (Membership Council) meetings held on the 21 July and 18 October 2016 (minutes attached) the following issues were discussed and agreed, subject to ratification by the Membership Council at its meeting on the 9 November 2016:-

1. Following discussion by the Chair with Phil Oldfield and Dr Patterson regarding availability, the Committee approved the extension of both Non-Executive Director tenures to continue until 22 and 30 September 2018 respectively. At the meeting on the 18 October the Chair confirmed that both had confirmed their availability to continue their three-year tenures in the foreseeable future.
2. The Committee considered the tenure of the Chair and agreed that due to the challenges facing the Trust over the next 12 months that the offer of a further one-year tenure be made to Andrew Haigh, effective from July 2017.
3. The Committee agreed to defer the decision regarding the three Non-Executive Director tenures until the next meeting to be held in February 2017, but in order to maintain continuity and stability during a time of considerable challenge for the Trust it was agreed that a minimum of one Non- Executive Director would be recommended to roll over for a further 12 month period.

RECOMMENDATION:
The Membership Council is asked to RATIFY the decisions made by the Nomination and Remuneration Committee (Membership Council) on the 21 July and 18 October 2016.

APPENDIX ATTACHED: YES ~~/ NO~~

Calderdale and Huddersfield NHS
NHS Foundation Trust

MINUTES OF THE MEETING OF THE NOMINATION AND REMUNERATION COMMITTEE (MEMBERSHIP COUNCIL)

HELD ON THURSDAY 21 JULY 2016 AT 9.00 AM IN THE CHAIR'S OFFICE, TRUST OFFICES, HUDDERSFIELD ROYAL INFIRMARY

PRESENT: **Mr Andrew Haigh (Chairman)**
Mr Peter Middleton, Publicly Elected Member
Mr Brian Moore, Publicly Elected Member
Mrs Dawn Stephenson, Nominated Stakeholder
Mrs Di Wharmby, Publicly Elected Member

IN ATTENDANCE:
Miss Kathy Bray, Board Secretary

1. APOLOGIES

Apologies were received from:-
Rev. Wayne Clarke, Publicly Elected Member
Mrs Eileen Hamer, Staff Elected Member
Mr Brian Richardson, Publicly Elected Member
Mr Owen Williams, Chief Executive

2. MINUTES OF THE LAST MEETING

The minutes of the last Nomination and Remuneration Committee (Membership Council) meeting held on the 7 December 2015 were accepted as a correct record.

3. MATTERS ARISING

There no matters arising which had not been actioned.

4. TERMS OF REFERENCE

The Terms of Reference had been circulated to identify that the changes requested at the last meeting had been made. There were no further amendments to be made.

RESOLVED: **The Committee approved that there were no further changes required to the Terms of Reference**

5. DECLARATIONS OF INTEREST/ELIGIBILITY TO SERVE

There were no declarations of interest to note.

6.1 DISCUSSION PAPER

As outlined in the paper circulated, the Chairman reported that the tenure of two Non-Executive Directors was due to expire in September 2016 (Dr Linda Patterson and Mr Phil Oldfield). It was noted that under the Constitution both could be offered a further 3 year tenure. The Chairman reminded the Committee that the Membership Council had received feedback on the Non-Executive Directors appraisal at the Membership Council meeting held on 6 July 2016.

The Committee discussed the qualities which were brought to the Board by Dr Linda Patterson and Phil Oldfield but concern was expressed regarding their future availability.

The Chairman reported that Dr Patterson had indicated that she would be returning to the role following her return from Australia on the 1 September 2016. The Committee acknowledged the many skills and competencies which she brought to the Board, as outlined in the discussion paper. The Committee agreed that subject to the Chairman receiving assurance about her availability, a further tenure should be offered.

The Chairman reported that he had discussed with Phil Oldfield the possibility of extending his tenure and although he had recently taken on a new commercial post and his availability had been limited, he would like the opportunity to continue with the Trust. The Committee acknowledged the skills and competencies which he brought to the Board and again, subject to the Chairman confirming with him his availability, approved a further tenure being offered.

Discussion took place regarding the skills brought by the remaining Non-Executives and whether there would be any merit in reviewing their portfolios to ease difficulties in availability. The Chairman reported that this exercise would be undertaken if necessary.

OUTCOME: Following discussion by the Chair with Dr Patterson and Phil Oldfield regarding availability, the Committee approved the extension of tenures.

ACTION: Payroll to be notified.

The Chairman took the opportunity of raising the question of remuneration of the Finance and Performance Chair (currently Phil Oldfield). It was noted that the additional remuneration had been approved when this Committee was formed and was meeting twice a month. Since this had now reduced to monthly meetings and in line with other Trust remunerations to Non-Executive Directors it was agreed that the Chairman should have a discussion with Phil Oldfield regarding this remuneration ceasing.

ACTION: Chairman

6.2 NON EXECUTIVE TENURES

The Chairman referred to the paper contained within the papers which highlighted the Non-Executive tenures. It was noted that four Non Executives tenures were due to expire in 2017, including the position of Chair:-

Andrew Haigh – tenure expires 6.7.17
Dr David Anderson - " 22.9.17
Prof Peter Roberts - " 22.9.17
Jan Wilson - " 30.11.17

Discussion took place regarding the options available and the need to stagger replacements to these posts to ensure greater consistency on the Board in the future.

It was agreed that a further meeting would be arranged in September/October 2016 when the Chief Executive would be available to attend to discuss the tenures, particularly the position of Trust Chairman. This would allow sufficient time for the posts to be advertised as necessary. The Chairman nominated Peter Middleton to Chair this meeting during his absence. It was agreed that an options paper, including an outline of each Non-Executive Directors skills and expertise would be available for this meeting.

ACTION: Meeting to be arranged September/October 2016 – Board Secretary

7. ANY OTHER BUSINESS

There was no other business to note.

8. DATE AND TIME OF NEXT MEETING

To be confirmed - September/October 2016

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the meeting of the Nomination and Remuneration Committee (Membership Council)

Held on Tuesday 18 October 2016 in the Chair's Office, Trust Offices, Huddersfield Royal Infirmary at 2pm.

MEMBERS

Andrew Haigh	Chairman and Chair of the meeting (except for part of item 5)
Peter Middleton	Lead Membership Councillor and Chair of the meeting (for part of item 5)
Eileen Hamer	Staff Membership Councillor
Brian Moore	Publicly Elected Membership Councillor
Dawn Stephenson	Nominated Membership Councillor
Di Wharmby	Publicly Elected Membership Councillor

IN ATTENDANCE

Kathy Bray	Board Secretary (minutes)
Ian Warren	Executive Director of Workforce and OD

Item

01/16 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Brian Richardson, Publicly Elected Membership Councillor

02/16 DECLARATIONS OF INTEREST

There were no declarations of interest to note. All present had declared at the last meeting that they had no interest in applying for a Non-Executive post at the Trust before March 2017 and this position remained unchanged

03/16 MINUTES OF THE MEETING HELD ON 21 JULY 2016

The minutes of the last Nomination and Remuneration Committee (Membership Council) meeting held on the 21 July 2016 were accepted as a correct record.

04/16 MATTERS ARISING

The Chairman reported that since the last meeting he had spoken to both Phil Oldfield and Dr Linda Patterson and both had confirmed their availability to continue their three-year tenures in the foreseeable future. It was noted that the additional remuneration allowance for the Chair of Finance and Performance had ceased with effect from 1 October 2016**.**

05/16 DISCUSSION PAPER

The Chairman introduced the paper which set out that the tenures of three Non-Executive Directors and the Chairman were due to expire in 2017:-

- Andrew Haigh - 6 July 2017
- Dr David Anderson – 22 September 2017
- Prof Peter Roberts – 22 September 2017
- Jan Wilson – 30 November 2017

In line with the constitutional arrangements the Committee were asked to consider:

- Whether or not it wishes to consider an extension to any of the existing posts.
- If not, then permission is sought to go out to advertisement for the vacancies.
- If the Committee does wish to consider extension it should decide how many of the individuals should be given a contract extension (this would be for a maximum of a year).
- If the Committee does wish to consider extension it should consider which individuals should be retained based on required skills and knowledge, and whether further advice on a decision-making process needs to be sought from the Director of

Workforce and Organisational Development for consideration at a future meeting.

The Committee considered the need to stagger the appointment periods so as to maintain continuity and stability on the Board, particularly focusing on the challenges being faced by the Trust at the current time. The need to maintain a balance between new appointments and not disrupting the Board was important. The clause in the Constitution which stated that in "exceptional circumstances a Non-Executive Director may serve longer than six years (two three-year terms) and any subsequent appointment would be subject to annual re-appointment)" was discussed.

It was noted that all four colleagues had indicated that they would be interested in serving a further tenure, with the exception of Dr David Anderson who had indicated that he may wish to serve a further one-year term and this would be confirmed in early 2017.

The Committee agreed to initially consider the tenure of the Chair and then Andrew Haigh would be asked to return to the meeting in order to discuss the other three Non-Executive Director tenures.

At this point in the meeting Andrew Haigh left the meeting. As Lead Membership Councillor, Peter Middleton chaired the meeting.

It was noted that in July 2017 the Chair will complete 6 years' tenure and therefore under the Constitutional arrangements the Committee could offer a further 1 year tenure (subject to ratification by the Membership Council).

The Committee considered the qualities, skills and knowledge of Andrew Haigh, along with the satisfactory appraisal which had been received by the Membership Council at its meeting on 6 July 2016. Under the present challenges facing the Trust such as potential hospital reconfiguration, the impact of WYAAT / STP / Accelerator Zone work and the need for more collaborative working, together with the implementation of the Single Oversight Framework, it was felt that to maintain stability in the Board of Directors, the Trust should offer a further one-year tenure to Andrew Haigh to continue his role as Chair.

OUTCOME: The Committee considered the tenure of the Chair and agreed that due to the challenges facing the Trust over the next 12 months that the offer of a further one-year tenure be made to Andrew Haigh, effective from July 2017 (subject to ratification by the Membership Council at its meeting on the 9 November 2016).

At this point the Chair returned to the meeting and resumed the Chair role.

Discussion took place regarding the other three Non-Executive Director tenures and it was noted that under exceptional circumstances it was possible to offer a further one-year tenure to any of the Non-Executive Directors. The Committee agreed that now that the Chair tenure had been agreed there was no urgency in agreeing the other tenures and therefore this decision was deferred until the next meeting to be held in February 2017. All present agreed that in order to maintain continuity and stability, a minimum of one Non-Executive Director would be recommended to roll over for a further 12 month period.

OUTCOME: The Committee agreed to defer the decision regarding the three Non-Executive Director tenures until the next meeting to be held in February 2017, but in order to maintain continuity and stability during a time of considerable challenge for the Trust it was agreed that a minimum of one Non- Executive Director would be recommended to roll over for a further 12 month period.

ACTION: IW

The Director of Workforce and Organisational Development agreed to continue to offer advice and would establish a process for the Committee to enable them to make a decision at their next meeting in February 2017.

06/16 ANY OTHER BUSINESS

Executive Director of Finance – It was noted that Keith Griffiths, Executive Director of Finance had been successful in being appointed to the post of Director of Sustainability at East Lancashire Teaching Hospitals and would be leaving the Trust at the end of October 2016. Those present wished Keith all the best for the future and it was noted that in the interim Gary Boothby would be taking on the role of Executive Director of Finance for 6 months.

07/16 DATE AND TIME OF NEXT MEETING

To be confirmed February 2017.

The Chairman closed the meeting at 4pm.

Calderdale and Huddersfield NHS
NHS Foundation Trust

MEMBERSHIP COUNCIL PUBLIC MEETING

MEETING TITLE AND TYPE: PUBLIC MEMBERSHIP COUNCIL MEETING	**REPORTING AUTHOR:** RUTH MASON
TITLE OF PAPER: ALLOCATION OF MEMBERSHIP COUNCILLORS TO REFERENCE GROUPS AND SUB-COMMITTEES 2016-17	
DATE OF MEETING: Wednesday 9 November 2016	**SPONSORING DIRECTOR:** IAN WARREN
STRATEGIC DIRECTION – AREA: • Keeping the base safe • Transforming and improving patient care • A workforce for the future • Financial Sustainability	**ACTIONS REQUESTED:** • For comment • To approve • To note
PREVIOUS FORUMS: NONE	
EXECUTIVE SUMMARY: (inc. Purpose/Background/Overview/Issue/Next Steps) As part of the governance and holding to account responsibility of Membership Councillors our Staff and publicly elected Membership Councillors work with Trust colleagues through involvement on Divisional Reference Group and Sub-Committees of the Board and the Membership Council. Each year Membership Councillors are allocated to the various groups and committees in order to gain a good understanding of the range and nature of the work of the Trust. Allocations for these groups and committees effective from the 1 November 2016 are attached.	
RECOMMENDATION: Membership Councillors are asked to note and participate as shown.	
APPENDIX ATTACHED: YES	

compassionate care

MEMBERSHIP COUNCIL ALLOCATION TO GROUPS AND SUB COMMITTEES – EFFECTIVE FROM 1.11.16

DIVISIONAL REFERENCE GROUPS (Plus Divisional Reps)	QUORUM	MEETINGS (3 per annum)	ALLOCATION FROM NOVEMBER 2015
Families & Specialist Services (FSS) (Includes diagnostic services) Divisional Reference Group	1 Div rep 2 MC's 1 Membership Office rep		Annette Bell Peter Middleton Lynn Moore Michelle Rich Nicola Sheehan Kate Wileman
Surgical & Anaesthetics (S&A) Divisional Reference Group	"		Annette Bell Charlie Crabtree Grenville Horsfall Brian Richardson George Richardson Kate Wileman
Medicine Divisional (Med) Including A/E Reference Group	"		Rosemary Hedges Dianne Hughes Veronica Maher Brian Moore Katy Reiter Di Wharmby
Estates & Facilities (E&F) Divisional Reference Group	"		Stephen Baines Nasim Esmail Eileen Hamer Veronica Maher Brian Moore George Richardson
Community Services Division (Community) Divisional Reference Group	"		Annette Bell Grenville Horsfall Peter Middleton Lynn Moore George Richardson

MEMBERSHIP COUNCIL ALLOCATION TO GROUPS AND SUB COMMITTEES – EFFECTIVE FROM 1.11.16

STATUTORY SUB COMMITTEE TITLE	AGREED COMPOSITION AS PER TERMS OF REFERENCE	PROPOSED MEETINGS	ALLOCATION
Nomination and Remuneration Committee (MC) – Chair & Non Executive Directors	Declaration of Non-interest in NED post required A quorum shall be three members, two of whom must be public Membership Councillors.	**18.10.16** – 2.00 pm	Eileen Hamer Peter Middleton Brian Moore Dawn Stephenson Di Wharmby
Audit & Risk Committee	1 Membership Councillor to observe (+ Deputy)	**18.1.17** **19.4.17** **May** – tbc **19.7.17** **18.10.17** All commencing at 10.45 – Acre Mill OP Building	Peter Middleton Nasim Banu Esmail
Finance & Performance	1 Membership Councillor to observe (+ Deputy)	**29.11.16** **03.1.17** **31.1.17** **28.2.17** **04.4.17** **02.5.17** **30.5.17** **04.7.17** **01.8.17** **05.9.17** **03.10.17** **31.10.17** **05.12.17** All 9.00 – 12.00 noon	Brian Moore Katy Reiter (Reserve)
Quality Committee	1 Membership Councillor to observe (+ Deputy)	**29.11.16** **03.1.17**	Peter Middleton George Richardson (Reserve)

MEMBERSHIP COUNCIL ALLOCATION TO GROUPS AND SUB COMMITTEES – EFFECTIVE FROM 1.11.16

		30.1.17 **27.2.17** **03.4.17** **02.5.17** **29.5.17** **03.7.17** **31.7.17** **04.9.17** **02.10.17** **30.10.17** **04.12.17**	
Workforce (Well Led)	1 Membership Councillor to observe (+ Deputy)	TBC	Rosemary Hedges Brian Moore (Reserve)
EPR Group	1 Membership Councillor to observe (+ Deputy)	TBC	Brian Moore Kate Wileman (Reserve)
Charitable Funds Committee	1 Membership Councillor to observe	**09.11.16** **22.2.17**	Eileen Hamer
Organ Donation	1 Membership Councillor to observe	TBC	Dianne Hughes

KB/VH/MC SUB GROUPS 4.10.16(v3)

Calderdale and Huddersfield NHS
NHS Foundation Trust

MEMBERSHIP COUNCIL PUBLIC MEETING

MEETING TITLE AND TYPE: PUBLIC MEMBERSHIP COUNCIL MEETING	**REPORTING AUTHOR:** Sue Laycock, Personal Assistant
TITLE OF PAPER: Integrated Performance Report	
DATE OF MEETING: Wednesday 9th November 2016	**SPONSORING DIRECTOR:** Helen Barker, Chief Operating Officer
STRATEGIC DIRECTION – AREA: • Keeping the base safe • Transforming and improving patient care • A workforce for the future • Financial Sustainability	**ACTIONS REQUESTED:** • For comment • To approve • To note
PREVIOUS FORUMS: Finance and Performance Committee – Tuesday 1st November 2016 Board of Directors – Thursday 3rd November 2016	
EXECUTIVE SUMMARY: The Membership Council are asked to receive and note the contents of the Integrated Performance Report for September 2016 September's Performance Score has improved to 68% for the Trust. The Trust has now seen an improvement of 14 percentage points since April. Within the Safe Domain % Harm Free Care has gone below target hence domain has edged to an AMBER rating. 3 of the 6 domains improved in month with Safe, Caring and Responsive just short of Green ratings.	
RECOMMENDATION: The Membership Council are asked to receive and note the contents of the Integrated Performance Report for September 2016 and note the overall performance score.	
APPENDIX ATTACHED: YES / ~~NO~~	

compassionate care

Board Report

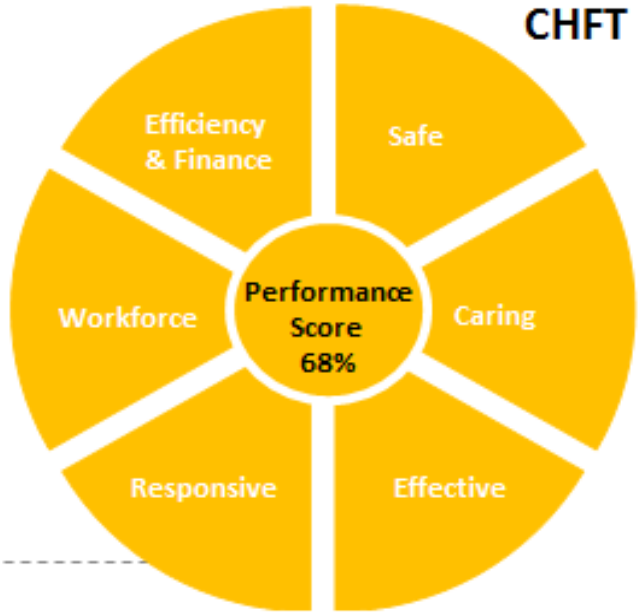
September 2016

Performance Summary

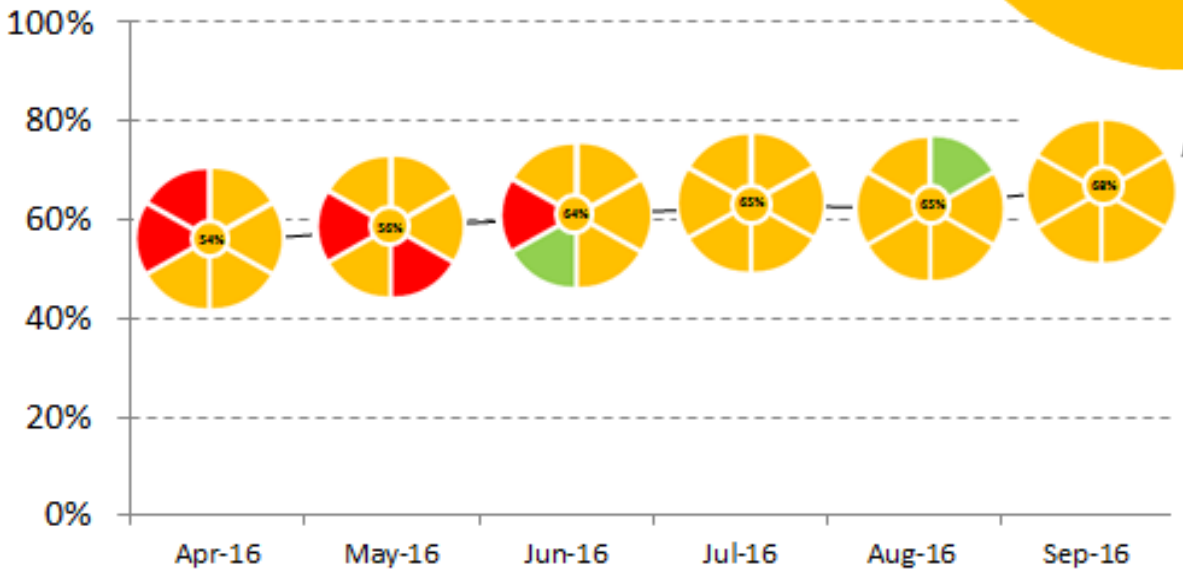
Most recent month's performance

RAG Movement

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



Total performance score by month



September Score by Domain

Safe	73%	↓
Caring	70%	↑
Effective	67%	↑
Responsive	72%	↓
Workforce	63%	↑
Efficiency & Finance	63%	↓
Performance Score	68%	↑

Regulatory Targets

CDiff Cases 3 (0)	Cancer 62 day Referral to Treatment
Avoidable Cdiff	Cancer 62 day Screening to Treatment
ECS 4 hours 94.38% (95%)	Cancer 31 day targets x3
RTT Incomplete Pathways	Cancer 2 Week Referral to Date first seen
Data Completeness Community Care x3	Cancer 2 week Breast Symptoms

Other Key Targets

VTE Assessments	FFT targets x6
Never events	FFT A&E x2 FFT OP 91.5% (95%)
MRSA	FFT Community 87% (96%)
SHMI 113.8 (100)	Stroke % admitted 4 hours 69.09% (90%)
HSMR 106 (100)	Diagnostics 6 weeks
Emergency Readmissions GHCCG 7.4% (7.05%)	Net surplus/ (deficit) £80k
% Complaints closed 42% (100%)	Sickness 4.43% (4%)

Carter Dashboard

		Current Month Score	Previous Month	Trend	Target
CARING	Friends & Family Test (IP Survey) - % would recommend the Service	97.4%	98.2%	↓	96%
	Inpatient Complaints per 1000 bed days	2.1	2.5	↑	TBC
EFFECTIVE	Average Length of Stay - Overall	5.0	5.4	↑	5.17
	Delayed Transfers of Care	2.21%	2.49%	↑	5%
	Green Cross Patients (Snapshot at month end)	109	104	↓	40
	Hospital Standardised Mortality Rate (12 months Rolling Data)	106.12	108.67	↑	100
	Theatre Utilisation (TT) - Trust	83.43%	84.13%	↓	92.5%
RESPONSIVE	% Last Minute Cancellations to Elective Surgery	0.65%	0.54%	↓	0.6%
	Emergency Care Standard 4 hours	94.38%	94.66%	↓	95%
	% Incomplete Pathways <18 Weeks	96.10%	95.49%	↑	92%
	62 Day GP Referral to Treatment	89.9%	89.6%	↑	85%
SAFE	% Harm Free Care	93.71%	95.14%	↓	95.0%
	Number of Outliers (Bed Days)	838	997	↑	495
	Number of Serious Incidents	7	4	↓	0
	Never Events	0	0	↔	0

MOST IMPROVED

Improved: There has been a significant improvement in month in % of patients with #NoF operated on in 36 hours. The month's performance is significantly above the national average.

Improved: Continued improvement in the RTT position meaning that the Trust is now performing better than all other benchmarked Trusts. Further work continues in validating patient pathways and improving the timeliness of patient treatment.

Improved: Still Birth Rate has reduced in month to 0.20%. Stillbirth Rate (excluding known abnormalities) is now 0.30% for the year.

MOST DETERIORATED

Deteriorated: % Harm Free Care - There has been a reduction in the % Harm Free Care, especially noticable in the Medicine division.

Deteriorated: 38 Day Referral to Tertiary. At 27.3% lowest position since August 2015.

Deteriorated: % Stroke patients scanned within 1 hour of hospital arrival. At 29.1% lowest position since March.

TREND ARROWS:
Red or Green depending on whether target is being achieved
Arrow upwards means improving month on month
Arrow downwards means deteriorating month on month.

ACTIONS

Action: ADN for Medicine has commissioned a deep dive into the Harm Free Care measure to look into ongoing trends and improvement plans.

Action: Action plans requested from all specialties to secure required improvement from October. A deep dive in Urology has highlighted potential areas to reduce the pathway, this speciality is a high contributor to breaches. No agreement on IPT has yet been reached across West Yorkshire.

Action: Pilot initially took delivery significantly beyond national guidance. Agreement has been reached that delivers compliance with national guidance and should show improvement in forthcoming months.

Arrow direction count	↔	↑	↓
	1	10	8

PEOPLE, MANAGEMENT & CULTURE: WELL-LED	Current Month Score	Previous Month	Trend	Target
Doctors Hours per Patient Day				
Care Hours per Patient Day	42,614	42,583	↓	
Sickness Absence Rate	4.1%	4.4%	↑	4.0%
Turnover rate (%) (Rolling 12m)	12.3%	13.7%	↑	12.3%
Vacancy	376.4	459.0	↑	NA
FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly) Q4	80.00%	Different division sampled each quarter. Comparisons not applicable		
FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly) Q4	61.00%	Different division samples each quarter. Comparisons not applicable		

OUR MONEY	Current Month Score	Previous Month	Trend
Income vs Plan var (£m)	£2.25	£1.94	●
Expenditure vs Plan var (£m)	-£2.68	-£2.28	●
Liquidity (Days)			
I&E: Surplus/(Deficit) var (£m)	£0.08	£0.12	●
CIP var (£m)	£2.08	£1.41	●
FSRR	2	2	●
Temporary Staffing as a % of Trust Pay Bill			

Executive Summary

The report covers the period from September 2015 to allow comparison with historic performance. However the key messages and targets relate to September 2016 for the financial year 2016/17.

Area	Domain
Safe	• **% Harm Free Care/All Falls -** There has been a reduction in the % Harm Free Care, especially noticable in the Medicine division. ADN for Medicine has commissioned a deep dive into the Harm Free Care measure to look into ongoing trends and improvement plans. The Lead Nurse for Falls is embedding the improvement work around Safety Huddles and education in relation to fall prevention equipment and this will continue over the next 6 months and is linked to the safety huddle CQUIN. The roll out of the falls five bundle has commenced across all medical wards focusing on 5 quality interventions to reduce the risk of falls . The Top ten wards with falls have been identified and there is a plan to roll out sleep hygiene (an initiative noted from a 'Go See' visit). • **Maternity - % PPH ≥ 1500ml/Major PPH - Greater than 1000mls** - In-month performance is stable and continues to be marginally above Trust target. • **Number of Category 4 Pressure Ulcers Acquired at CHFT -** There have been 3 Category 4s in the period to the end of August. A new weekly PU panel has been implemented to mirror the orange incident panel. This will result in PUs accurately validated weekly and learning captured and actioned.
Caring	• **Complaints closed within timeframe** - 71 complaints were closed in September, which is a 20% increase from August. Of the 71 complaints that were closed in September 42% were closed within target timeframe which is an 18 point decrease from August. • **Friends and Family Test Outpatients Survey** - % would recommend has improved in month to its highest position since December 2015 although at 91.5% is still below the target of 95%. Further work to continue as part of directorate action plan to achieve Q3 improvement trajectory (December 16). • **Friends and Family Test Community Survey** - FFT continues to report 2% of people would not recommend services. To provide alternative methods of responding to the FFT the Community division has included paper forms in Outpatient areas and has ensured that the webform is available to all staff using laptops. An options paper for FFT recording will be presented at October Board and will be shared at PRM with a recommendation.
Effective	• **Total Number of Clostridium Difficile Cases -** There have been three clostridium Difficille cases reported in month however all cases have shown as unavoidable following RCAs that have been undertaken. YTD 17 against an annual plan of 21. • **Number of E.Coli - Post 48 Hours** - There were 4 post 48 hours E-Coli Bacteraemias reported in September, 2 of these occurred on surgical wards (ward 15 and ICU). An analysis of both incidents was undertaken and there were no common themes or links between the 2 cases. • **Local SHMI - Relative Risk** (12 months Rolling Data April 15 - March 16) - Latest figures are still at 113. There is only one diagnostic group alerting in this release which is Acute Cerebrovascular Disease. • **Hospital Standardised Mortality Rate** (12 months Rolling Data August 15 - July 16) - has shown a further fall to 106. The weekday/weekend split shows a 7 point difference. 111.87 weekend against 104.34 weekday. • **Mortality Reviews** - The completion rate for Level 1 reviews stands at 23% of August deaths having had a corporate level one review. This reduction was anticipated as internal processes are adapted to capture more robust data from Q3 onwards. • **Emergency Readmissions Within 30 Days (With PbR Exclusions) - Greater Huddersfield CCG** - Further improvement in month. Community division has agreed, with Locala, to undertake an audit of readmissions.

Background Context

New compliance regime

Following the introduction of the Single Oversight Framework (SOF) additional indicators are now included in this report:
Emergency C-Section Rate
Executive Turnover (%)
Proportion of temporary Staff
Hospital Bed Days per 1000 population - Adults
Emergency Hospital Admissions per 1000 population - Adults

The Trust held a 2 day Planning Workshop in October to jointly develop Divisional plans for 17/18 with a view to 18/19 looking at the management of interdependencies within the revised planning timeline as set nationally.

Activity has seen growth in month 6 across all points of delivery, with the exception of planned daycase and elective where activity is below planned levels.

A&E has seen activity continue to over-perform in month 6 and has seen an increase from month 5. Activity is 6% above the month 6 plan and cumulatively 3.7% above plan.
Non-elective activity overall is 0.1% above the month 6 plan which is an increase from month 5 when activity was 2.2% below plan. The in-month over-performance is within non-elective long and paediatric short stay admissions. Cumulatively activity is 0.6% below planned levels due to emergency long stay activity. The impact is that the Trust has continued to rely on additional capacity in September with 14 beds open above plan and associated staffing challenges

CCGs are currently working on demand management strategies which will need to be considered alongside new capacity plans internally. Through recent planning workshops options to support Commisioners with demand reduction strategies have been explored; this is also being discussed across West Yorkshire providers where the picture locally is reflected with the aim of maximising consistency.

Planned day case and elective activity deteriorated against plan in month 6. This is driven by continued under-performance within inpatient elective activity. Some related to Q1 issues and some reflecting a transformation from inpatient to day case not yet reflected in plans.

The Safer programme continues with progress in ambulatory and Frailty via the collaboratives and our own internal teams enabling effective management of some of the increased demand and retaining a positive conversion rate from AED.

Executive Summary

The report covers the period from September 2015 to allow comparison with historic performance. However the key messages and targets relate to September 2016 for the financial year 2016/17.

Area	Domain
Responsive	• **Emergency Care Standard 4 hours -** September's position was the 95% target at 94.38% with 94.4% performance for Q2. An ED escalation SOP is in place and is being followed to ensure that any ED delays are addressed in a timely manner. • **A&E Ambulance 60+ mins** - 1 Patient with a YAS turnaround of over 60 minutes. An RCA is being completed. The Trust is exploring whether the ED can create a receiving area for YAS patients. • **Stroke -** Patients admitted to a stroke ward within 4 hours and scanned within 1 hour not being achieved. The division of Medicine will submit a business case to continue the pilot with Radiology as a permanent service. To ensure beds are available the Medical Division is running a pilot on 7B to look at reducing LOS. This involves all members of the MDT and will make beds available so that all patients have access to the unit. • **RTT pathways over 26weeks** - numbers are improving as divisions continue further validation. • **38 Day Referral to Tertiary** is now at its lowest position since August 2015 with a number of late referrals in September. A deep dive in Urology has highlighted potential areas to reduce the pathway. • **Appointment Slot Issues on Choose & Book** - The Trust's position stands at 16.6% which compares favourable with its peers. There has been a reduction of 656 referrals for patients awaiting appointment from the July position of 1824. The top 4 specialties for E-referral ASIs backlog are: Ophthalmology, Respiratory, General Surgery and Colorectal. Specialty action plans are in place to continue to reduce the ASIs over the forthcoming weeks and access meetings have restarted within the Surgical Divison.
Workforce	• **Sickness Absence rate** has improved in month and is now achieving its short term sickness target. • **Return to work Interviews have** improved again in month to 66% but are still some way short of 100% target. • **Mandatory Training and appraisal -** Information Governance, Fire Safety, Infection Control and Manual Handling. Currently just Manual Handling is off plan. Appraisal activity is now measured against planned activity. A more rigorous approach is being adopted at Divisional Performance Review Meetings to emphasise the need for improved appraisal coverage and quality.
Efficiency/ Finance	• **Finance:** Year to date: The financial position stands at a deficit of £9.67m, a favourable variance of £0.08m from the planned £9.74m. The in month, clinical contract activity position is above plan albeit at a slightly lower level that that seen last month. This drives an overall income position at Month 6 which is £2.25m above planned levels in the year to date. The in-month overperformance is seen across non electives, outpatients and A&E attendances. The non elective increase is due to success in discharging long stay patients. It continues to be the case that, in order to deliver activity and access standards across the Trust, there is a reliance upon agency staffing. However, operational actions that have been put in place to curb the use of agency have started to impact positively, total agency spend in month was £1.87m, compared with £2.17m last month. This improvement brings the agency expenditure close to a revised trajectory submitted to NHS Improvement. This trend will need to be continued in the remainder of the year to stay in line with the expectations of the regulator and secure the overall financial forecast. • **Theatre Utilisation** has stabilised around 84%. Having discussed the appropriateness of the 92.5% target it was agreed at Surgical Performance Review meeting to adopt more suitable targets for each theatre which will allow sufficient turnaround to clean theatres and prevent overrunning.
CQUIN	• **Staff Well Being Flu Vaccination** - The campaign is underway, the first two weeks have seen over 2,000 colleagues vaccinated. The Trust is projected to perform above the partial payment threshold. It is too early to state whether the full CQUIN will be achievable.
Activity	• **Activity** has seen growth in month 6 across all points of delivery, with the exception of planned daycase and elective where activity is below planned levels.

Background Context

The Trust has developed an improvement plan for agency spend 'Safer Staffing Workforce Utilisation and Efficiency Programme 2016/17'. The purpose of this plan is to define the overall improvements and a consistent model for medical, nursing, midwifery and AHP workforce utilisation, and efficiency. The plan links to the broader Workforce & Organisational Development work to improve recruitment, retention and staff engagement.

The Surgical Division has been struggling with Medical capacity where there has been difficulty in recruitment. In addition there has been limited capacity within the management team and a shortfall of key staff in critical areas such as theatres restricting the Division's ability to improve performance.

Within the Community Services division there has been a significant piece of work undertaken through September to support a collective understanding between CHFT and commissioning colleagues of the services that are within the block contract. This supports the contract agreement for the next two years. All services within the block contract arrangements have completed templates describing in detail the service that is delivered, the demand profile and the activity undertaken within the service. This information has been shared with commissioners and the division is awaiting feedback.
The scope of a service review within MSK has been agreed and is commencing in October.

Direct access and unbundled outpatient imaging has continued to see a large over-performance within MRI and Ultrasound with in-month performance 6.4% above plan. Diagnostic testing has seen a significant further increase in month 6 and is 4.4% above plan. This continues to be mainly driven by a large increase within Biochemistry and Haematology. Adult Critical Care is below plan in month 6 by 5.2% which is a decrease from the over-performance seen in month 5 which was driven by the discharge of 2 long-stay patients. NICU has seen an increase in activity in month 6 and is 22% above the month 6 plan. Rehabilitation is in line with planned levels for month 6. This is a small reduction in the over-performance seen in month 5 of 4.2%. Cumulatively activity is 6.7% above plan and continues to be driven by Calderdale activity.

Outpatient activity overall has continued to see an increase and is 1.8% above the month 6 plan. This is a reduction in the level of over-performance seen in month 5 when activity was 4.7% above plan. The over-performance in-month is across both first and follow-up attendances including procedures. The specialties with the more significant over-performance within first attendances are ENT, T&O, Paediatrics, Rheumatology, Dermatology and Gynaecology. General Surgery has continued to under-perform. Cumulatively outpatient activity is now 2.5% above plan however with demand continuing at high levels this is not resulting in a reduced waiting list size.

Calderdale and Huddersfield NHS
NHS Foundation Trust

MEMBERSHIP COUNCIL PUBLIC MEETING

MEETING TITLE AND TYPE: PUBLIC MEMBERSHIP COUNCIL MEETING	**REPORTING AUTHOR:** Kirsty Archer
TITLE OF PAPER: Financial overview at Month 6, September 2016	
DATE OF MEETING: 9/11/16	**SPONSORING DIRECTOR:** Keith Griffiths / Gary Boothby
STRATEGIC DIRECTION – AREA: • Keeping the base safe • Transforming and improving patient care • A workforce for the future • Financial Sustainability	**ACTIONS REQUESTED:** • For comment • To approve • To note
PREVIOUS FORUMS: Extracted from paper presented to Finance and Performance Committee 1/11/16	
EXECUTIVE SUMMARY: (inc. Purpose/Background/Overview/Issue/Next Steps) An overview of the year to date and forecast year end financial position at Month 6 – September 2016, incorporating Income & Expenditure, Capital, Cash and Financial Sustainability Risk Rating.	
RECOMMENDATION: To note the contents of the paper	
APPENDIX ATTACHED: YES	

compassionate care

EXECUTIVE SUMMARY: Trust Financial Overview as at 30th Sep 2016 - Month 6

YEAR TO DATE POSITION: M6

	M6 Plan	M6 Actual	Var
	£m	£m	£m
Total Income	**£185.11**	**£187.35**	**£2.25**
Total Expenditure	**(£182.09)**	**(£184.77)**	**(£2.68)**
EBITDA	**£3.02**	**£2.59**	**(£0.43)**
Non Operating Expenditure	(£12.77)	(£12.25)	£0.51
Deficit excl. Restructuring	**(£9.74)**	**(£9.67)**	**£0.08**
Restructuring Costs	£0.00	£0.00	£0.00
Surplus / (Deficit)	**(£9.74)**	**(£9.67)**	**£0.08**

YEAR END 2016/17

	Plan	Forecast	Var
	£m	£m	£m
Total Income	**£371.12**	**£375.38**	**£4.26**
Total Expenditure	**(£361.96)**	**(£366.94)**	**(£4.99)**
EBITDA	**£9.16**	**£8.43**	**(£0.73)**
Non Operating Expenditure	(£25.26)	(£24.48)	£0.78
Deficit excl. Restructuring	**(£16.10)**	**(£16.05)**	**£0.05**
Restructuring Costs	£0.00	£0.00	£0.00
Surplus / (Deficit)	**(£16.10)**	**(£16.05)**	**£0.05**

KEY METRICS

	Year To Date			Year End: Forecast		
	M6 Plan	M6 Actual	Var	Plan	Forecast	Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	(£9.74)	(£9.67)	£0.08	(£16.10)	(£16.05)	£0.05
Capital	£11.82	£7.98	£3.84	£28.22	£27.63	£0.58
Cash	£1.94	£2.95	£1.01	£1.95	£1.90	(£0.05)
Borrowing	£50.13	£57.93	£7.79	£67.87	£67.51	(£0.36)
CIP	£4.65	£6.73	£2.08	£14.00	£14.78	£0.78
Financial Sustainability Risk Rating	2	2		2	2	

Year to date: The year to date financial position stands at a deficit of £9.67m, a favourable variance of £0.08m from the planned £9.74m. The in month, clinical contract activity position is above plan albeit at a slightly lower level that that seen last month. This drives an overall income position at Month 6 which is £2.25m above planned levels in the year to date. The in-month over-performance is seen across non electives, outpatients and A&E attendances. The non elective increase is due to success in discharging long stay patients. It continues to be the case that, in order to deliver activity and access standards across the Trust, there is a reliance upon agency staffing. However, operational actions that have been put in place to curb the use of agency have started to impact positively, total agency spend in month was £1.87m, compared with £2.17m last month. This improvement brings the agency expenditure close to a revised trajectory submitted to NHS Improvement. This trend will need to be continued in the remainder of the year to stay in line with the expectations of the regulator and secure the overall financial forecast.

The impact of this operational position is as follows at headline level:

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

The year to date activity over performance sits alongside strong CIP delivery, achieving £2.08m in advance of the planned timescale. The combined benefit has not flowed through in full to the bottom line but has rather absorbed the activity related expenditure pressures and one off issues such as the Junior Doctors' strike action. However, of the £2m contingency reserves planned for in the year to date, £1m has not been released but rather has been held back to mitigate against pressures in the latter part of the year. This lesser reliance on contingency reserves in the year to date continues to be supported by the income over performance and CIP delivery.

Forecast: Whilst the year to date position remains favourable, the expenditure run rate brings ongoing pressure. The availability of contingency reserves which have not been called upon in full in the first 6 months will bring some respite and the forecast assumes the release of the full £2m across the year. However issues such as higher risk CIP schemes, commissioner affordability and Trust's response to the CQC recommendations bring further risk. Acknowledging these, the year end forecast position continues to be to deliver the planned £16.1m deficit. Divisions are required to deliver recovery plans and further savings schemes are being progressed. In addition, it is assumed that the Trust will achieve the financial and operational performance criteria to secure the £11.3m Sustainability and Transformation Funding which is intrinsic to delivery of plan.

Trust Financial Overview as at 30th Sep 2016 - Month 6

INCOME AND EXPENDITURE COMPARED TO PLAN

YEAR TO DATE POSITION: M6

CLINICAL ACTIVITY

	M6 Plan	M6 Actual	Var
Elective	4,443	3,874	(569)
Non-Elective	25,481	25,318	(163)
Daycase	18,675	19,220	545
Outpatient	171,361	175,688	4,327
A&E	74,137	76,858	2,721
Other NHS Non-Tariff	775,778	819,829	44,051
Other NHS Tariff	57,931	62,611	4,680
Total	1,127,806	1,183,398	55,592

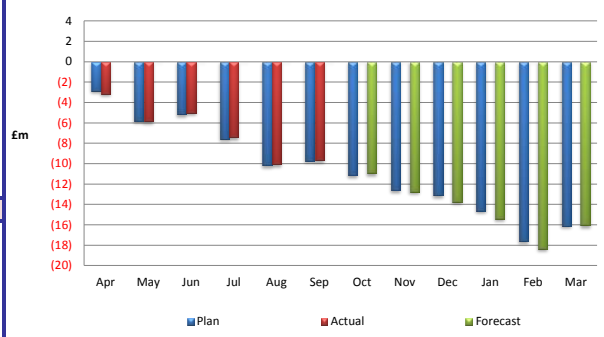
TRUST: INCOME AND EXPENDITURE

	M6 Plan	M6 Actual	Var
	£m	£m	£m
Elective	£11.36	£10.59	(£0.77)
Non Elective	£43.29	£44.63	£1.34
Daycase	£13.33	£13.74	£0.41
Outpatients	£21.94	£22.92	£0.98
A & E	£8.20	£8.62	£0.42
Other-NHS Clinical	£63.85	£64.43	£0.58
CQUIN	£3.40	£3.49	£0.10
Other Income	£19.75	£18.93	(£0.82)
Total Income	**£185.11**	**£187.35**	**£2.25**
Pay	(£119.81)	(£120.72)	(£0.91)
Drug Costs	(£17.37)	(£17.07)	£0.30
Clinical Support	(£15.29)	(£16.40)	(£1.12)
Other Costs	(£23.60)	(£24.55)	(£0.95)
PFI Costs	(£6.02)	(£6.02)	£0.00
Total Expenditure	**(£182.09)**	**(£184.77)**	**(£2.68)**
EBITDA	**£3.02**	**£2.59**	**(£0.43)**
Non Operating Expenditure	(£12.77)	(£12.25)	£0.51
Deficit excl. Restructuring	**(£9.74)**	**(£9.67)**	**£0.08**
Restructuring Costs			£0.00
Surplus / (Deficit)	**(£9.74)**	**(£9.67)**	**£0.08**

DIVISIONS: INCOME AND EXPENDITURE

	M6 Plan	M6 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	£9.43	£9.97	£0.54
Medical	£11.86	£12.03	£0.17
Families & Specialist Services	(£2.03)	(£2.45)	(£0.42)
Community	£2.13	£1.85	(£0.28)
Estates & Facilities	(£13.47)	(£12.92)	£0.56
Corporate	(£12.16)	(£12.11)	£0.05
THIS	£0.19	£0.29	£0.09
PMU	£1.18	£1.02	(£0.16)
Central Inc/Technical Accounts	(£4.85)	(£6.32)	(£1.47)
Reserves	(£2.02)	(£1.02)	£1.00
Surplus / (Deficit)	**(£9.74)**	**(£9.67)**	**£0.08**

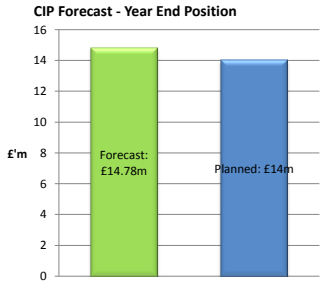
TRUST SURPLUS / (DEFICIT)

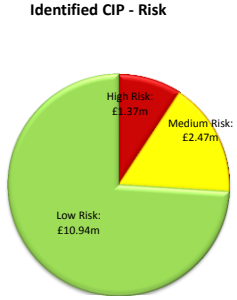


KEY METRICS

	Year To Date: M6 Plan £m	Year To Date: M6 Actual £m	Year To Date: Var £m	Year End: Forecast: Plan £m	Year End: Forecast: Forecast £m	Year End: Forecast: Var £m	
I&E: Surplus / (Deficit)	(£9.74)	(£9.67)	£0.08	(£16.10)	(£16.05)	£0.05	
Capital	£11.82	£7.98	£3.84	£28.22	£27.63	£0.58	
Cash	£1.94	£2.95	£1.01	£1.95	£1.90	(£0.05)	
Loans	£50.13	£57.93	£7.79	£67.87	£67.51	(£0.36)	
CIP	£4.65	£6.73	£2.08	£14.00	£14.78	£0.78	
	Plan	Actual		Plan	Forecast		
Risk Rating	2	2		2	2		

COST IMPROVEMENT PROGRAMME (CIP)





Total Planned: £14m **Total Forecast £14.78m**

YEAR END 2016/17

CLINICAL ACTIVITY

	Plan	Forecast	Var
Elective	8,787	7,979	(808)
Non-Elective	51,619	51,166	(453)
Daycase	36,895	37,978	1,083
Outpatient	338,922	341,837	2,915
A&E	148,571	149,692	1,121
Other NHS Non- Tariff	1,556,020	1,641,167	85,147
Other NHS Tariff	115,305	122,811	7,506
Total	2,256,117	2,352,629	96,511

TRUST: INCOME AND EXPENDITURE

	Plan	Forecast	Var
	£m	£m	£m
Elective	£22.48	£21.89	(£0.59)
Non Elective	£87.09	£89.15	£2.06
Daycase	£26.37	£27.31	£0.94
Outpatients	£43.43	£44.68	£1.25
A & E	£16.43	£16.82	£0.39
Other-NHS Clinical	£129.03	£130.80	£1.77
CQUIN	£6.79	£6.94	£0.15
Other Income	£39.50	£37.79	(£1.71)
Total Income	**£371.12**	**£375.38**	**£4.26**
Pay	(£237.12)	(£240.10)	(£2.99)
Drug Costs	(£35.59)	(£35.51)	£0.07
Clinical Support	(£30.16)	(£32.23)	(£2.08)
Other Costs	(£47.06)	(£47.07)	(£0.01)
PFI Costs	(£12.04)	(£12.02)	£0.02
Total Expenditure	**(£361.96)**	**(£366.94)**	**(£4.99)**
EBITDA	**£9.16**	**£8.43**	**(£0.73)**
Non Operating Expenditure	(£25.26)	(£24.48)	£0.78
Deficit excl. Restructuring	**(£16.10)**	**(£16.05)**	**£0.05**
Restructuring Costs			£0.00
Surplus / (Deficit)	**(£16.10)**	**(£16.05)**	**£0.05**

DIVISIONS: INCOME AND EXPENDITURE

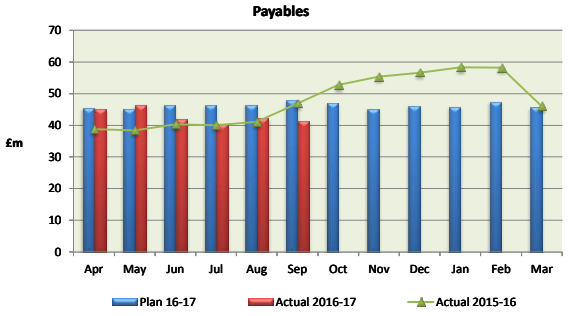
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	£19.52	£19.52	£0.00
Medical	£22.14	£22.16	£0.02
Families & Specialist Services	(£2.35)	(£2.35)	(£0.00)
Community	£4.30	£4.30	(£0.00)
Estates & Facilities	(£26.75)	(£26.38)	£0.37
Corporate	(£24.35)	(£24.34)	£0.00
THIS	£0.45	£0.53	£0.08
PMU	£2.62	£2.62	(£0.00)
Central Inc/Technical Accounts	(£9.63)	(£11.94)	(£2.30)
Reserves	(£2.03)	(£0.15)	£1.88
Surplus / (Deficit)	**(£16.10)**	**(£16.05)**	**£0.05**

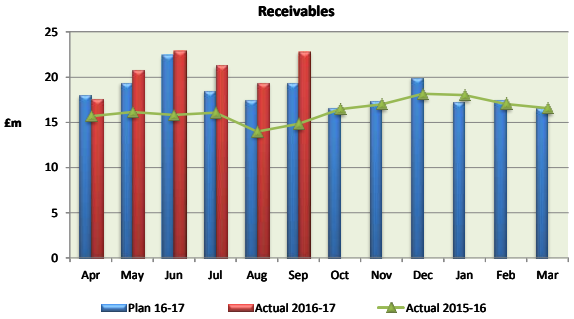
Trust Financial Overview as at 30th Sep 2016 - Month 6

CAPITAL AND CASH COMPARED TO PLAN

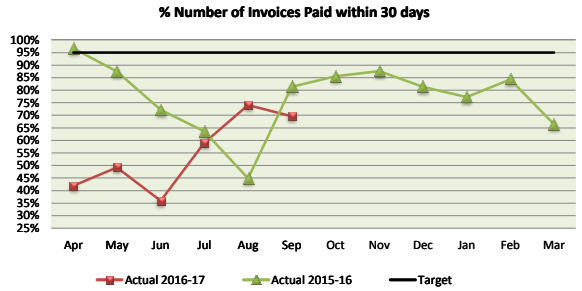
WORKING CAPITAL

	M6 Plan £m	M6 Actual £m	Var £m	M6
Payables	(£47.91)	(£41.32)	(£6.59)	
Receivables	£19.38	£22.83	(£3.45)	



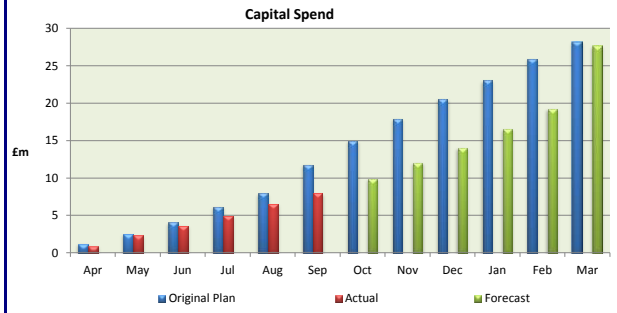


BETTER PAYMENT PRACTICE CODE



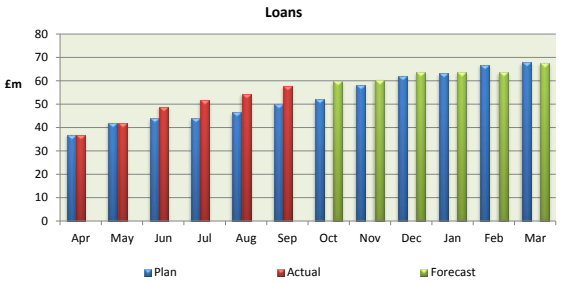
CAPITAL

	M6 Plan £m	M6 Actual £m	Var £m	M6
Capital	£11.82	£7.98	£3.84	

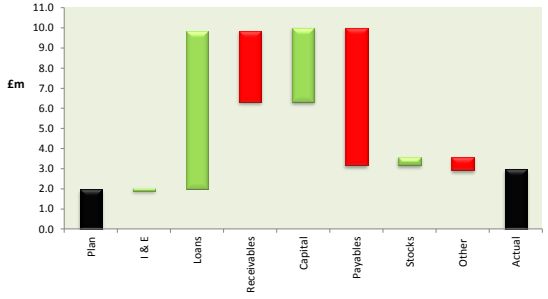


CASH

	M6 Plan £m	M6 Actual £m	Var £m	M6
Cash	£1.94	£2.95	£1.01	
Loans	£50.13	£57.93	£7.79	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The year to date deficit is £9.67m versus a planned deficit of £9.74m.
- Year to date Elective activity remains behind plan but is offset by higher than planned Outpatient, A&E and Daycase activity.
- Capital expenditure year to date is £7.98m against a planned £11.82m.
- Cash balance is above plan at £2.95m against a planned £1.94m.
- The Trust has drawn down loans earlier than planned. The total loan balance is £57.93m against a planned £50.13m.
- CIP schemes delivered £6.73m in the year to date against a planned target of £4.65m.
- The NHS Improvement performance measure Financial Sustainability Risk Rating (FSRR) stands at 2 against a planned level of 2.

SUMMARY FORECAST

- The forecast year end deficit is £16.05m, in line with the planned £16.10m.

This position assumes delivery of £14.8m CIP and recovery plans being put in place at Divisional level against ongoing pressures and risks.

- Cash forecast is in line with plan at £1.90m.
- The Trust cash position relies on the Trust borrowing £37.63m in this financial year to support both Capital and Revenue plans.
- Forecast capital expenditure is £0.58m below plan at £27.63m.
- The year end FSRR is forecast to be at level 2 as planned.

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 > £21.2m (20 working days cash)
- < £21.2m (unless planned) but > £10.6m (10 working days cash)
- < £10.6m (less than 10 working days cash)

Calderdale and Huddersfield NHS
NHS Foundation Trust

MEMBERSHIP COUNCIL PUBLIC MEETING

MEETING TITLE AND TYPE: PUBLIC MEMBERSHIP COUNCIL MEETING	**REPORTING AUTHOR:** Kathy Bray, Board Secretary
TITLE OF PAPER: COMPLAINTS UPDATE FROM QUARTER 1	
DATE OF MEETING: Wednesday 9th November 2016	**SPONSORING DIRECTOR:** Brendan Brown, Executive Director of Nursing
STRATEGIC DIRECTION – AREA: • Keeping the base safe • Transforming and improving patient care • A workforce for the future • Financial Sustainability	**ACTIONS REQUESTED:** • For comment • To approve • To note
PREVIOUS FORUMS: Board of Directors – Thursday 29 September 2016	
EXECUTIVE SUMMARY: The Membership Council are asked to receive and note the contents of the extract attached from the Quarter 1 Quality Report which was presented to the Board of Directors on 29 September 2016 regarding the update on Complaints.	
RECOMMENDATION: The Membership Council are asked to receive and note the contents of the extract from Quarter 1, Quality Report regarding the update on Complaints.	
APPENDIX ATTACHED: YES / ~~NO~~	

compassionate care

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

Indicator	Compliance
4.1 Learning from Incidents, Claims and Complaints	Reporting only
4.2 Appointment Slot Issues	Reporting only
4.3 Patient Flow and the SAFER programme	Reporting only

Highlights:

Incidents, complaints, claims – improvements in sharing of learning from adverse events via Patient Safety Quality Boards and Quality Committee and with divisions for claims

Appointment Slot Issues – improvement in the number of referrals awaiting appointment

4.1 Incidents, Complaints and Claims

Incidents

Key messages:

- 1.9% reduction in CHFT incidents recorded in Q12016/17 compared to Q1 2015/16
- Suspected falls is the top reported incident in Q1, as in the last quarter
- Medical Division is the highest reporter of incidents in Q1 (43.1% all incidents) by division
- Labour Delivery recovery Post Natal Unit is the highest reporting department (215 incidents)
- 13 Serious Incidents (Sis) Q1, 1 of which is a pressure ulcer
- 1 never event in Q1

1.1 Numbers of Incidents

For the period 1 April 2016 to 30 June 2016 a total of 2,593 incidents were reported by CHFT members of staff. Of these, 1120 43.1% were reported by the Medical Division.
The table below shows that the number of incidents report has decreased by 49 incidents (1.8%)

1.2 Incidents by Divisions:

The tables below show that the number of incidents reported in Quarter 1 per Division, with the Medical Division reporting 43.1% of total incidents

Incidents Reported by Division	Q4 2015-2016	Q1 2016-2017
Community Division	125	78
Corporate Division	8	5
Estates and Facilities	29	37
Families and Specialist Services	677	798
Huddersfield Pharmacy Specials	1	1
Medical Division	1203	1120
Surgical & Anaesthetics Services Division	599	554
Totals:	**2642**	**2593**

In Community the likely reason for a fall in the number of incidents reported is the transfer of a number of community services on the Huddersfield site being transferred , under contract transfer, to Locala Provider services . this will need to be monitored in future quarters to test this

A positive reporting culture remains in the Trust despite the reduction in the number of incidents reported. The incidents reported by the community division have reduced by 47 (37%). This is as a result of a change in the coding of incidents that occur in nursing homes which have previously been reported as CHT incidents and now are more accurately reported as non CHT incidents.

2 . CHFT Incidents

2.1Top Incident Categories

The top 20 reported incidents for Quarter 1 are given below with suspected fall being the top incident category reported, accounting for just under a third of incidents. This is consistent with quarter 4 of 20151/6.

There has been a change in the approach to coding during Q1, with staff coding incidents from mid May 2016. The incident team is currently reviewing what impact this is having on the reporting of incident categories.

Top 20 Incident categories Q1 2016/17

Top 20 Q4 15-16	
Slips, trips, falls and collisions	547
Administration or supply of a medicine from a clinical area	193
Patient's case notes or records	140
Lack of/delayed availability of facilities/equipment/supplies	128
Connected with the management of operations / treatment	125
Adverse events that affect staffing levels	123
Transfer	102
Pressure sore / decubitus ulcer	98
Discharge	96
Accident caused by some other means	73

Top 20 Q1 16-17	
Slips, trips, falls and collisions	523
Administration or supply of a medicine from a clinical area	161
Pressure sore / decubitus ulcer	132
Connected with the management of operations / treatment	103
Adverse events that affect staffing levels	96
Transfer	81
Accident caused by some other means	76
Lack of/delayed availability of facilities/equipment/supplies	75
Discharge	72
Patient's case notes or records	71

Abuse etc of Staff by patients	69		**Other**	66
Infection control	67		**Communication between staff, teams or departments**	61
Communication between staff, teams or departments	64		**Abuse etc of Staff by patients**	58
Medical device/equipment	61		**Transfusion of Blood related problem**	49
Administration of assessment	53		**Appointment**	48
Appointment	44		**Medical device/equipment**	45
Labour or delivery – other	43		**Labour or delivery – other**	44
Preparation of medicines / dispensing in pharmacy	37		**Security incident related to Personal property**	44
Admission	34		**Admission**	42
Possible delay or failure to Monitor	34		**Medication error during the prescription process**	41
Totals:	2131		**Totals:**	1888

FALLS

Falls remains the highest incident category reported, with 523 incidents reported in Q1 2016/17, a slight reduction from 541 falls in Q4 2015/16.

The above data shows an increase in the number of falls from height during the quarter, up from 23 in Q4 2015/16 to 67 in Q1 2016/17.

There have been 4 serious incidents relating to falls with harm and root cause analysis investigations are underway for each of these falls to identify learning and actions to prevent recurrence. Further details on falls is given in the Safe section of this report.

2.2 Incidents by Department:

The table below identifies the highest reporting ward/department (Top 10), with labour delivery recovery post-natal unit now being the highest department reporting incidents in Q1 2015/16. This is suggestive of an improved reporting culture in this area.

Q4 15-16 **Top 10 by dept/ward**	
Operating Theatre	163
Labour Delivery Recovery Post-natal Unit	146
Accident and Emergency	129
Intensive Care Unit/High Dependency Unit	91
Outpatient Department	81

HWD5	68
HWD19 Trauma	60
HWD8	60
HRI MAU	59
Health Centre/Clinic	56
Totals:	913

Q 1 16-17 Top 10 by dept/ward	
Labour Delivery Recovery Post-natal Unit	215
Accident and Emergency	137
Calderdale birth Centre WD1A	96
Operating Theatre	96
HWD19 Trauma	86
Outpatient Department	77
HRI MAU	76
HWD5	73
HWD8	64
Intensive Care Unit/High Dependency Unit	62
Total	982

Incidents by Severity:

The numbers of incidents by severity are:

by severity	**Q4** 2015/16	**Q1** 2016/17
GREEN	**2065** (78.1%)	**1966** (75.8%)
YELLOW	**530** (20.1%)	**551** (21%)
ORANGE	**39** (1.5%)	**60** (2.3%)
RED	**8** (0.3%)	**16** (0.6%)
Totals:	2643	2593

There is a 2.3% decrease in the number of incidents reported. However, the incidents with harm have increased for all *harm* incidents. It is worth noting that incidents are now coded and categorised by the reporters and incident managers/handlers.

In Quarter 1, 13 incidents were identified as being “serious” and required reporting to the CCG/NHS England via STEIS. The types of incidents were:

Serious Incidents reported to CCG/NHS England via STEIS.	**2016/17 Q1**
HCAI/Infection control incident meeting SI criteria	1
Screening issues meeting SI criteria	1
Sub-optimal care of the deteriorating patient meeting SI criteria	1
Surgical invasive procedure incident meeting SI criteria	1
Treatment delay meeting SI criteria	1
Accident e.g. collision/scald (not slip/trip/fall) meeting SI criteria	1
Maternity/Obstetric incident meeting SI criteria: (mother and baby)	1
Slips/tips/falls meeting SI criteria	4
Medication incident meeting SI criteria	1
Diagnostic Incident meeting SI criteria (including failure to act on test results)	1
Grade 3 Pressure Ulcer	1
Totals:	14

All incidents were reported on STEIS within the 48hr timescale.

Learning from Incidents
Information on learning from incidents is shared within divisional Patient Safety Groups and for serious incidents via the Quality Committee.

Learning from Incidents

Information on learning from incidents is shared within divisional Patient Safety Groups and for serious incidents via the Quality Committee. Learning identified from incidents during the quarter is given below.

Learning the Lessons - Medicine	
Issue:	Learning:
Pressure Ulcer On washing patient discovered category 3/4 in sacral cleft. looks deep approximately 1cm possibly secondary to moisture. Surrounding tissue looks macerated. Barrier spray applied. Observed pressure ulcer prevention care plan and no evidence of the sore on admission. Sister informed. Pressure mattress ordered but patient may not be stable enough to transferred onto it.	Found to be moisture linear skin damage secondary to faecal and urinary incontinence. Waterlow calculated wrong (too low) on 3 occasions. Skin inspections carried out x 2 daily no detection of pressure damage to natal cleft until March 27. but moisture damage found. Intentional rounding should have been 2 hourly and not 4 hourly as completed. Moving and handling careplan should have been in situ. Urine incontinence careplan should have been in use also. Closer inspection of all patient pressure areas should be
Observation Called to bed 8 a side by nurse call bell from bed 7 to tell us that the patient was out of bed and disorientated when we then realised she had dislodged her chest drain. on further questioning the lady in bed 7 Thought she had seen patient take a pair of scissors to her actual chest drain, on inspection this looked the case. The drain was found on floor in two parts with a piece of suture connected to one part of it with the possibility of the tip being embedded into the tissue. This was not visible on inspection. EWS 2 O2 in place.	Patients with chest drains need very close observations during the day and night. This patient was in a three bedded room off the main ward area. In the future we should be considering these patient being in a high visibility bed for safety. To discuss in the ward meeting.
Blood Products Member of clinical team brought 3 bottles of 20%HAS that had been sitting on the ward (in sunlight) for 3 weeks. The Blood Transfusion Department had followed the traceability protocol and a letter regarding the fate of these units had been used to the ward. The ward had returned this legal document and had stated that the returned units were transfused to the named patient.	To ensure that all qualified nursing staff sign for all blood products when they have administered them and ensure that unused blood products are returned immediately to the transfusion department. Stress to nursing staff the cost of wasted units.
Equipment training HCA informed me that on transferring patient with samhall turner, she was unable to take her own weight on her legs and hca lowered her to	Member of staff tried to transfer patient using equipment. This type of equipment needs X 2 members of staff. Training need identified. Staff member in question has been spoken to. The

the floor and came for assistance.	moving and handling co-ordinator on the ward is ensuring that all relevant competencies are up to date.
Discharge Medication Discharged home with buprenorphine patches. one 20mcg box with one patch in and one 5mcg box with one patch in. Neither box had a patients name on but specified the ward. Date on 20mcg box was 5.5.16 and date on 5mcg box was 12.5.16 Patient normally takes fentanyl patches 25mcg every 72 hours.	Adherence to the CHFT Medicine Code and RGN accountability for their actions. Discharge medications to be prepared in advance to promote a smooth discharge for the patient. Clear communication between departments post angio procedure to ensure ward is fully aware of discharge plans.
Lack of handover The patient was brought up to the ward post having a peg put in place without a handover from Medical Assessment Unit (MAU). The patient had been on MAU that day but was transferred to ward 6 without a handover. Only a name was given. Endoscopy also phoned us asking to collect the patient who had been sedated however we did not as we knew nothing about the patient. She was eventually brought to the ward unexpectedy where the nurses from endoscopy gave a handover from their point of view.	It is imperative that we communicate effectively when transferring patients to other specialist areas. To ensure a safe patient experience.

Learning the Lessons - Surgical Division

Issue:	Learning:
Underlying condition - An orthopaedic inpatient had an undiagnosed heart block - The fall the patient suffered could have been as a result of this	- The need for a holistic approach to all patients who have underlying and known conditions - Information must be followed up at the time of test result so as not to 'get lost in the system' - The need to complete documentation fully in particular in this case the falls bundle
Pressure Ulcer - Patient had a hospital acquired grade 3 pressure ulcer - Poor documentation led to not being able to evidence where this pressure damage occurred	- Documentation has to be completed at time of admission and transfer - Collaborative working between Divisions where there is discrepancy as to where incident occurred - All staff should be able to assess pressure damage categories and arrange for suitable equipment where necessary. Need for more staff training - Share learning regarding incident with all ward staff (Surgical and Medical Divisions)

- Failure to escalate a deteriorating patient with NEWS between 12 and 14. Patient died - Delay in certifying the death	• instances where escalation should have occurred but did not – Nerve Centre now in place to highlight elevated NEWS and to reduce risk of occurrence. • Death certificate training is now included in the Junior Doctor's training pack • Need for holistic approach to all patients
Insulin / handover - Insufficient insulin checks - Empty fluid bag - Poor handover of diabetic patient	- All staff on ward received up to date training on managing patients who are insulin dependent - Staff training regarding handover of all patients and in particular those who are insulin dependent - Continuous monitoring of record keeping standards - All staff have received training and have signed off competencies in new blood sugar monitoring
Learning the Lessons - FSS	
Issue:	Learning:
Labour / Delivery - Emergency caesarian section for failure to progress at 5cm. Epidural top up ineffective, Remifent given. - Unable to deliver baby - delivered as breech in poor condition, no respiratory effort, full resuscitation given and transferred to Special Care Baby Unit.	- Escalation to Consultant where necessary for all surgical procedures in a timely manner. - Importance of keeping the anesthetist informed of progress and complications - Learning from experience newsletter to remind staff about timely summoning of consultant paediatrician in a timely manner. - Findings to be presented at Perinatal Mortality Meeting
Labour Delivery - Delay in admission for undiagnosed breech presentation. - Baby born in poor condition.	- It is crucially important to listen to what the woman is telling us - Health care staff should keep the woman the focus of care - If a woman is unhappy with the clinical advice she is given this should be escalated and dealt with immediately. -
Stillbirth Unexpected stillbirth at Emergency Caesarean Section in maternity theatre	- CTG interpretation was incorrect in the last hour - The category of Caesarean section declared and documented was incorrect reflecting the lack of urgency - Misinterpretation of the fetal growth based on the last scan as well as incorrect SFH - Measurement after the scan which would contribute to the compromise in

	reserves - This was an IVF pregnancy which has an increasing risk of small babies and a two to four fold risk of stillbirth
Intra Uterine Death (IUD) - high risk pregnancy, uterine fibroids. - Attended for augmentation in view of spontaneous rupture of membranes (SROM). Prostin administered at 01 50, CTG following classified as reassuring, therefore discontinued at 02:59. - Reports to have been contracting frequently. Care taken over on day shift, history noted, planned for CTG monitoring, unable to locate fetal heart rate, escalated this to shift coordinator and registrar. Portable scanner used by registrar, still unable to locate fetal heart. Transferred to main scan room to be scanned by sonographer. IUD confirmed on scan.	- This woman had a large uterine fibroid but growth scans were discontinued at 36 weeks. - Fundal height palpation (which plotted on the 90th centile) was inappropriate in this case. i. Fetal growth scan should have been continued until delivery. ii. Offer immediate augmentation for term SROM as per NICE and our guidelines.

Improvements:

An update against improvement areas for 2016/17 is given below:

- Changes have been made to the incident reporting and investigation process. Incidents are now categorised (coded) by the reporter and quality checked by the investigating managers. This process gives the incident administrators the opportunity to check and assure the quality of the information provided as well as to follow up on actions. The change was introduced mid May 2016. It is proving a challenge to ensure that coding, and therefore incident analysis , information is accurate and important that incident reporters and investigating managers check coding accuracy. Individual feedback is being given to reporters and Datix drop in sessions are in place to support staff. The incident team and system super users have held sessions and been out to wards to train staff in the coding process.

- Ensuring that duty of candour is undertaken in a timely way for incidents with harm and evidencing this within the incident reporting system is also proving a challenge. This is being monitored closely and a toolit is to be developed for staff, as well as a more prominent area within the recording system to record duty of candour discussion dates.

Complaints

Complaints are a vital source of information for the Trust, helping to identify where the quality and safety of services and care require improvement for service users.

This section provides a quarterly summary of Patient Advice and Complaints contacts using information collected from the data held on the Trust's Patient Advice and Complaints database. This section includes information on:

- Performance re: complaints management in 2016/17

- Information on complaints by Division
- Learning from complaints
- Improving complaints management in 2016/17
- Areas for improvement

Key points detailed in the section below are:

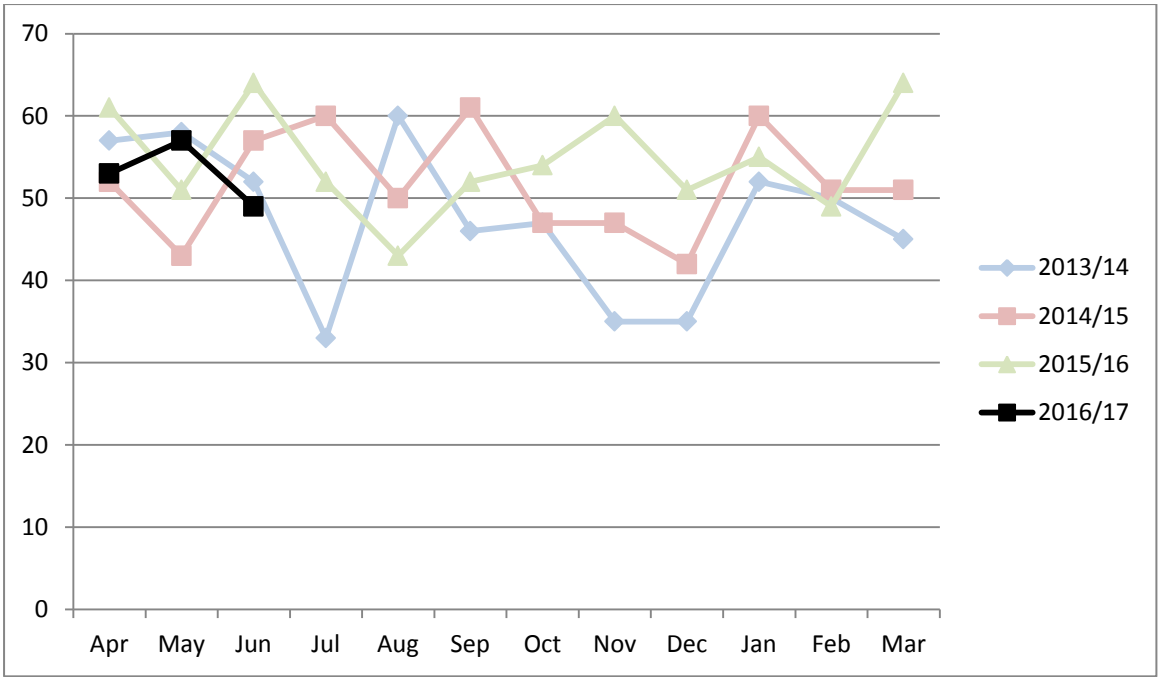
- A small decrease of 6% in the number of complaints received in this quarter, compared to the same quarter in 2015/16; however, there has been an increase 15% from the last quarter of 2015/16.
- The majority of complaints (70%) were graded as yellow or green, ie no lasting harm / minimal impact on care
- Clinical treatment and communications are the main subjects of complaints; this was the same as the financial year.
- Appointments and access to appointments are the main areas of concern
- Medicine is the Division with the highest number of complaints; however, it is also the largest Division and the number of complaints reflects its size.

Key Performance Indicators

Complaints 2016/17	**2016/17 Q1**
Number of new complaints received	159
% increase / decrease on 2015/16	↓ 6% (169)
Number of complaints closed	177
% complaints upheld	45%
% complaints partially upheld	34%
% complaints not upheld	18%
Number of complaints re-opened following final response	19
Number of complaints received from Ombudsman for investigation	10
Number of complaints upheld by Ombudsman (includes partially upheld)	2
Number of complaints not upheld by Ombudsman in quarter	0

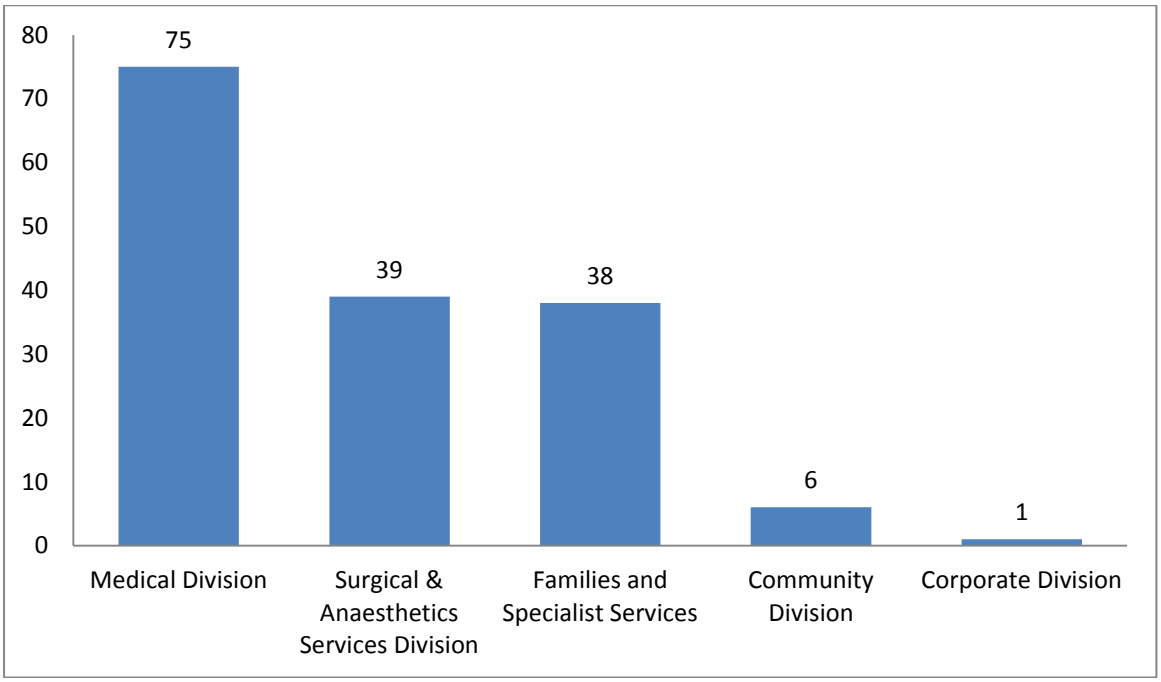
Complaints Performance 2016/17

Comparison of complaints from 2013/14 to present:
Complaints data reflecting the trends in the number of complaints for the past three years – including numbers for this quarter



Complaints Received:
At the end of quarter 1 of 2016/17 the Trust received a total number 159. This is an decrease of 10% from the same quarter last year and a decrease of 5% from the same quarter in 2013/14. National complaints data for quarter 1 of 2016/17 has not yet been released from the HSCIC.

Quarterly Complaint Numbers by Directorate:



Of the 159 Complaints received in 2015/16:

- 47% of complaints received related to the Division of Medicine, which is the largest division with Accident and Emergency Services. The Emergency Network was the Directorate within Medicine with the highest number of complaints, a total of 39. Acute Medical received a total of 19 complaints and Integrated Medical received a total of 17.

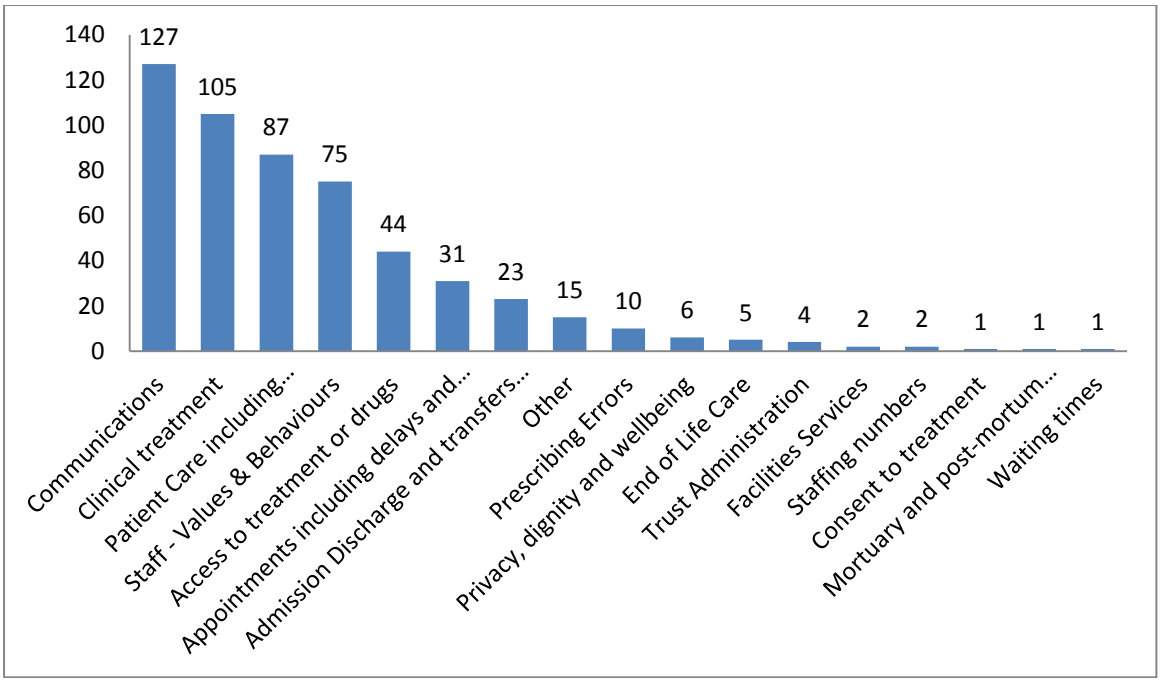
- 25% complaints received related to the Division of Surgery and Anaesthetic Services (SAS). General and Specialist Surgery was Directorate within SAS with the highest number of complaints, a total of 22. Head & Neck received a total of 12 complaints, Orthopaedic a total of 12, and Critical Care received a total of 2.

- 24% complaints received related to the Division of Family and Support Services (FSS). Woman's Services was the Directorate within FSS with the highest number of complaints, a total of 20. Radiology received a total of 7 complaints, Outpatient and Records a total of 5, Children's Services a total of 4, and Pathology and Pharmacy both received a total of 1.

- 3% complaints received related to the Division of Community. Intermediate and Community was the Directorate within Community with the highest number of complaints, a total of 5. Families Directorate received 1 complaint.

Analysis of Complaints by Theme

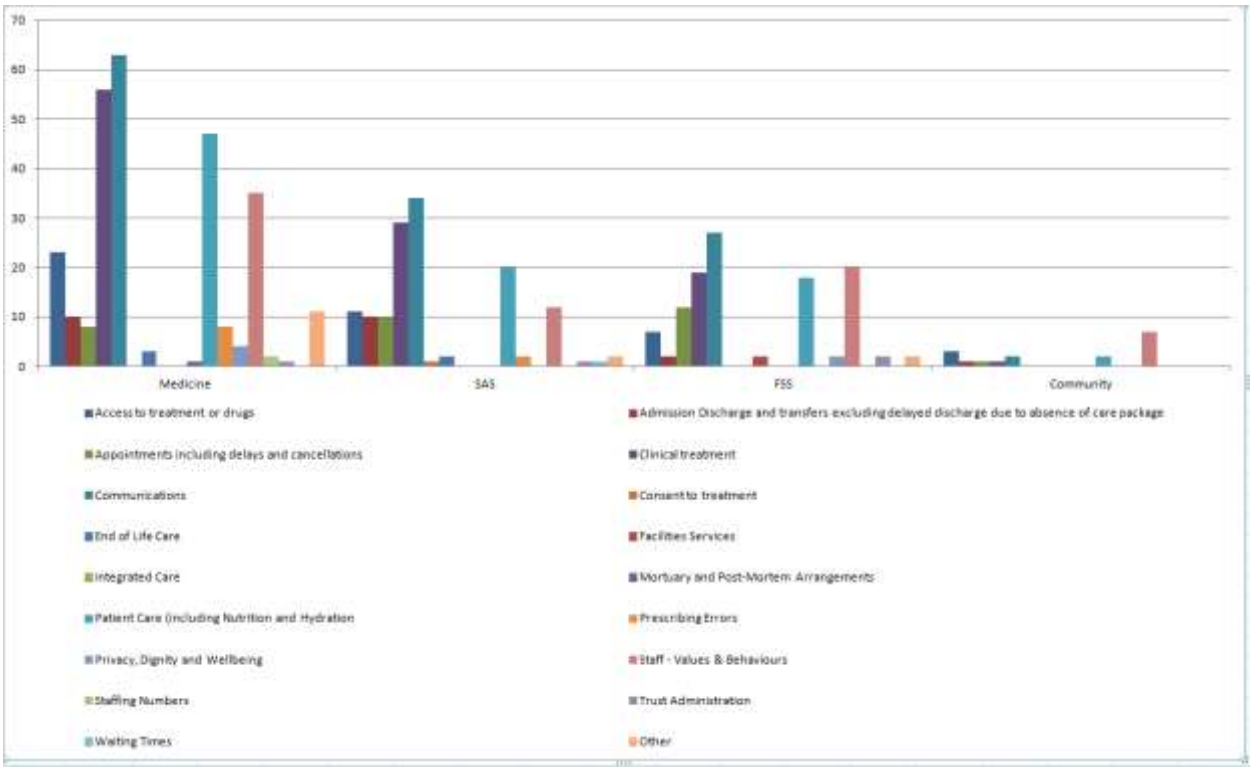
Complaints are analysed below by Primary Subjects, within each complaint subject there will be a number of different sub categories with more detail relating to the complaint. There are often a number of issues logged for a single complaint, which is way the number of Primary Subjects differs from the total number of complaints received.



The top three subjects of Complaints for the Trust are as follows:

Subject	Percentage
Communication	24%
Clinical Treatment	19%
Patient Care (including Nutrition and Hydration)	16%

Quarter 1 Complaints received by Division and Primary Subject



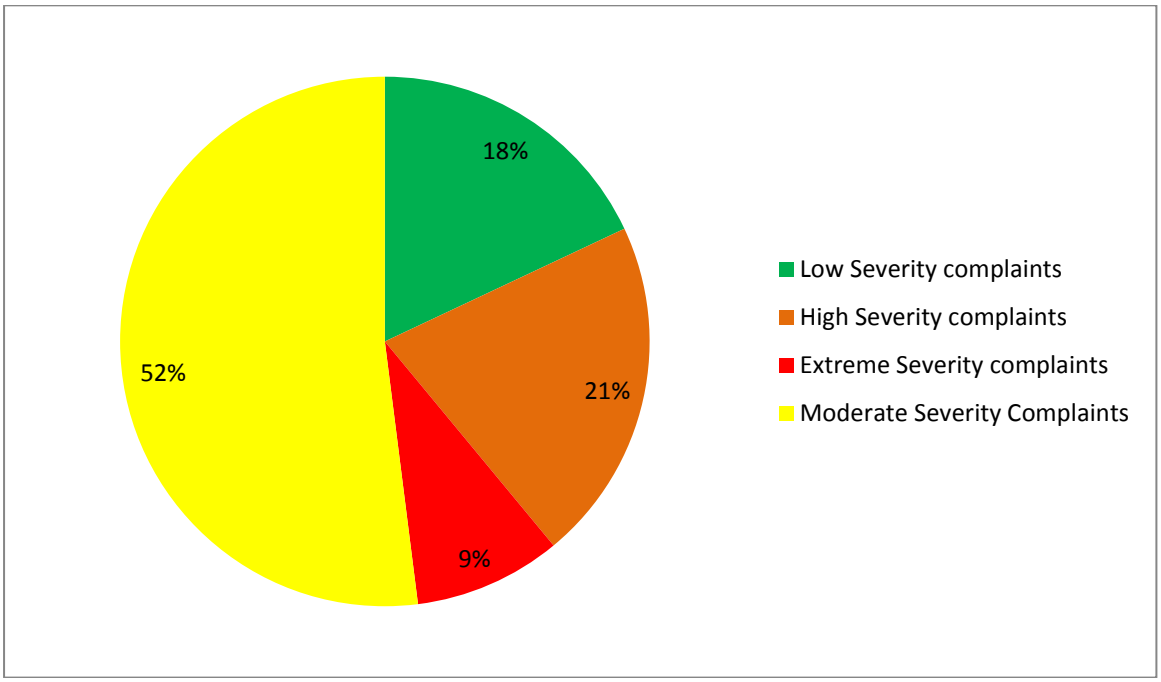
- The top subject of complaint for Medicine was Communication, representing 23% of all complaint subjects received for Medicine within Quarter 1. Clinical Treatment represented 21% and Patient Care (including Nutrition and Hydration) 17%.

- The top subject of complaint for SAS was Communication, representing 25% of all complaint subjects received for SAS within Quarter 1. Clinical Treatment represented 21% and Patient Care (including Nutrition and Hydration) 15%.

- The top subject of complaint for FSS was Communication, representing 24% of all complaint subjects received for FFS within Quarter 1. Staff – Values & Behaviours represented 18% and Clinical Treatment 17%.

- The top subject of complaint for Community was Staff - Values & Behaviours representing 41% of all complaint subjects received for Community with Quarter 1. Access to Treatment or Drugs represented 18% and Communication 12%.

Severity of Complaints Received
The majority of complaints received in are graded as yellow severity; no lasting harm (52%) in Quarter 1. 9% complaint received were graded Red.



Key: Green – no / minimal impact on care, Yellow – no lasting harm,
Amber – quality care issues/ harm, Red – long term harm, death, substandard care

Red Complaints Data

A red complaint is a case where the patient, or their family, feels the action or inaction of the Trust have caused the death or significant and non-reversible harm to the patient. A complaint may also be graded Red, although the Trust has not caused the death or significant and non-reversible harm to the patient, if the complaint has had a significant impact on patient experience or Trust reputation.

For Quarter 1 of 2016/2017 the Trust received a total of 14 Red complaints, this is a 50% increase from the same quarter last year. Of these 14 complaints 3 are linked to an incident and 1 is linked to a claim.

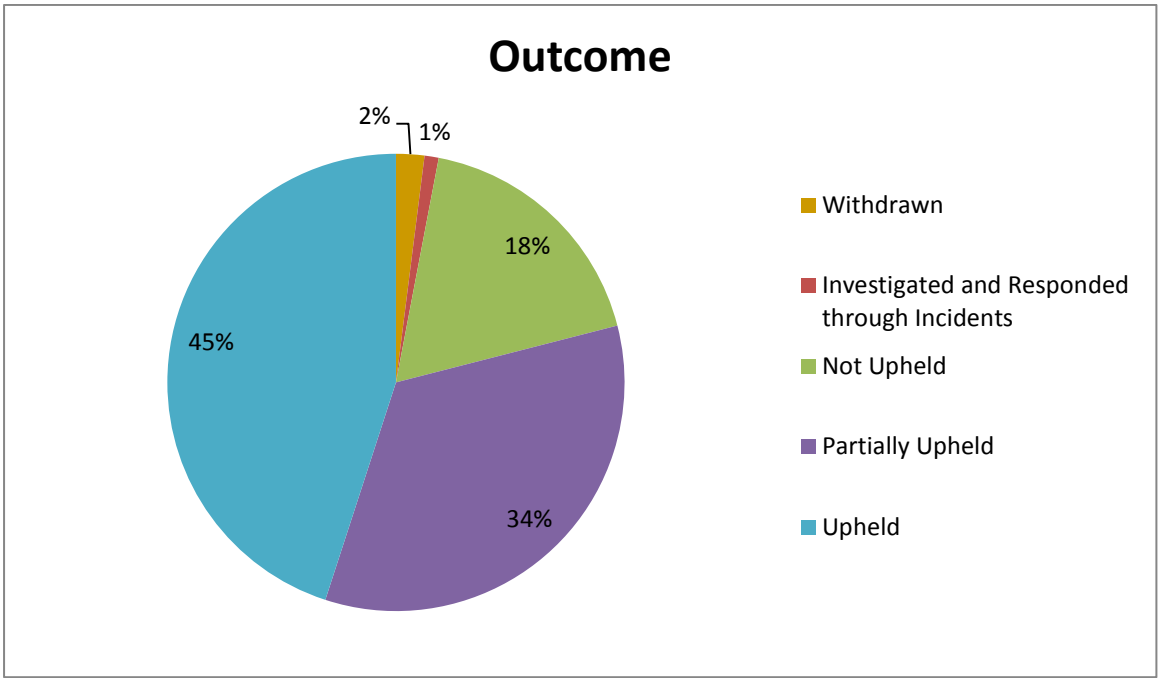
Acknowledgement Time

1 out the 159 complaints received within Quarter 1 of 2016/17 was not acknowledge within three working days, this represents less than 1% of all complaints received. The complaint was not acknowledge within time as complaints staff needed to find the details for the Next of Kin, to complete the complete the consent form that would that accompanies the acknowledgment.

Complaints Closed

The Trust closed a total of 177 within Quarter 1 of 2016/17. This is a decrease of

12% from the same quarter last year. Of these 177 complaints closed 45% were upheld, 34% were partially upheld (The HSCIC counts partially upheld complaints as upheld complaints so if looked at in this way the figure is 80%), 18% were not upheld, 2% were withdrawn, and 1% of complaints were closed, investigated and responded to through incidents.



Re-Opened Complaints

The Trust re-opened a total of 19 complaints in Quarter 1 of 2016/17. This is 24% decrease from the same quarter last year. The Trust will re-open a complaint for 1 of the following three reasons.

i. Response failed to address all issues and concerns
ii. New issue and concern
iii. Parliamentary and Health Service Ombudsman Investigation

In 2015/16 the Trust undertook a piece of work to improve the overall quality of its responses to complaints so that people received a full and detailed response to the issues they had raised. We introduced a robust quality checking process; the decrease in re-opened complaints would suggest an increase in the quality of complaints responses.
The Trust has developed a Patient Satisfaction questionnaire which will be sent out to complaints responded to in 2016/17. Responses from these will be used in conjunction with the continued monitoring of the re-opened complains to assess the quality of the responses provided by the Trust.

Overdue Complaints

Closing overdue complaints remains a primary focus for the Trust in 2016/17. The

total number of overdue complaints at the end of Quarter 1 2016/17 was 44. The number of overdue complaints for the same quarter last year has not been recorded; however, at the end of Quarter 1 2016/17 there has been an increase of 52% from the number overdue from the end of the last financial year.

The breakdown of overdue complaints at year end is as follows:

0 – 1 month overdue: 21 complaints
1 – 2 months overdue: 15 complaints
2-3 months overdue: 7 complaints
3-4 months overdue: 1 complaint

Weekly monitoring reports continue to be provided to divisions to ensure that all cases overdue are clearly identified and timescales for completion of complaints that are due are clear.

Parliamentary and Health Service Ombudsman Complaints (PHSO)

The Trust received a total of 9 complaints in Quarter 1 of 2016/17 for investigation from the PHSO.

By the end of Quarter 1 of 2016/17 the Trust had 17 active cases which the Ombudsman is investigating.

The breakdown of these are as follows:

Division	Directorate	Received	Description
Community	Intermediate and Community	01/04/2016	Failure to provide a Lymphoedema Clinic
SAS	Head and Neck	14/04/2016	Complaint regarding lack of treatment/diagnosis dating back to December 2007
Medicine	Integrated Medical	20/04/2016	Delay in diagnosing brain tumour and communication regarding Lymohoma.
Medicine	Emergency Network	20/04/2016	Care and treatment of patient leading up to their death
Medicine	Acute Medical	16/05/2016	Complainant claimed incorrect medication prescribed which caused Atrial Fibrillation. Inappropriate discharge.
Medicine	Acute Medical	16/05/2016	Dates back to 2013; ambulance failed to arrive to transport patient to x-ray appointment. Patient admitted and died a few days later.
Medicine	Acute Medical	19/05/2016	Daughter concerned her late mother was put on care of dying pathway. Daughter does not feel it was the correct decision and is concerned this was not communicated with her in detail.
Medicine	Acute Medical	24/05/2016	Soup given when nil by mouth so procedure couldn't go ahead. Daughter complains that this affected her mother's medical care
Medicine	Emergency	14/06/2016	Sub standard care in A&E. Errors in documentation

	network		and treatment provided and in discharge information

The red line indicates a complaint graded and managed as a red complaint, i.e. where Trust actions / inactions caused death or significant and non-reversible harm.

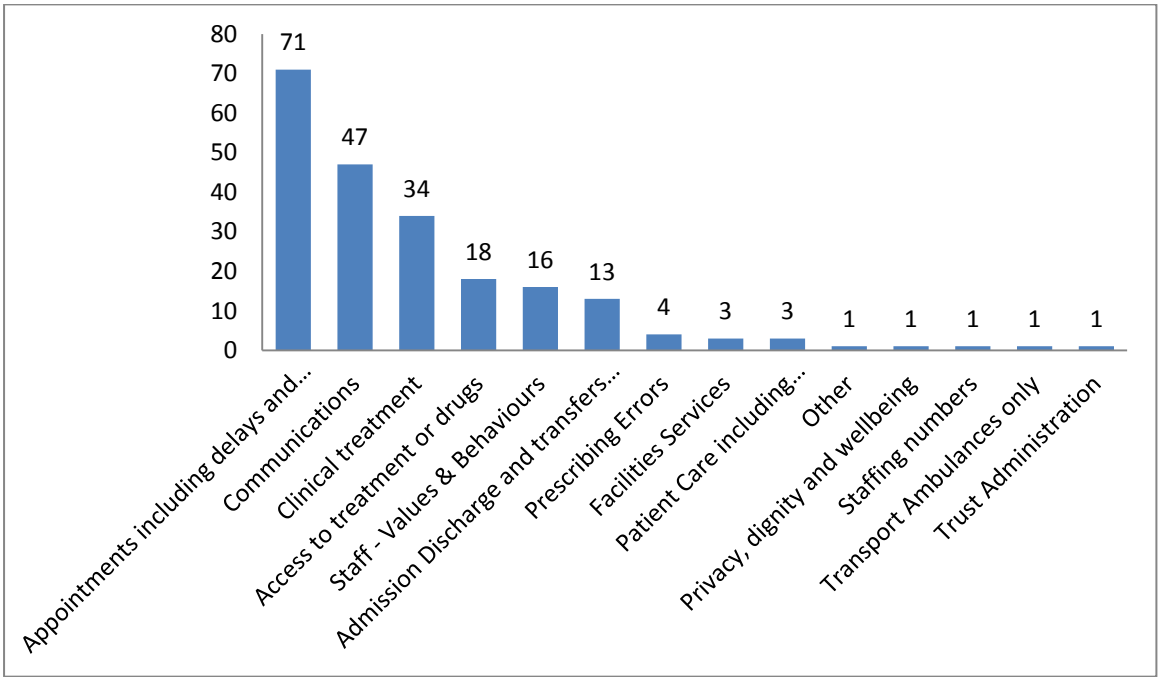
3 PHSO complaints were closed in Quarter 1 of 2016/17; of these 2 were part upheld and 1 was withdrawn. Learning from PHSO cases is given at the end of this section.

Patient Feedback from Other Sources: Concerns, Patient Opinion and Compliments

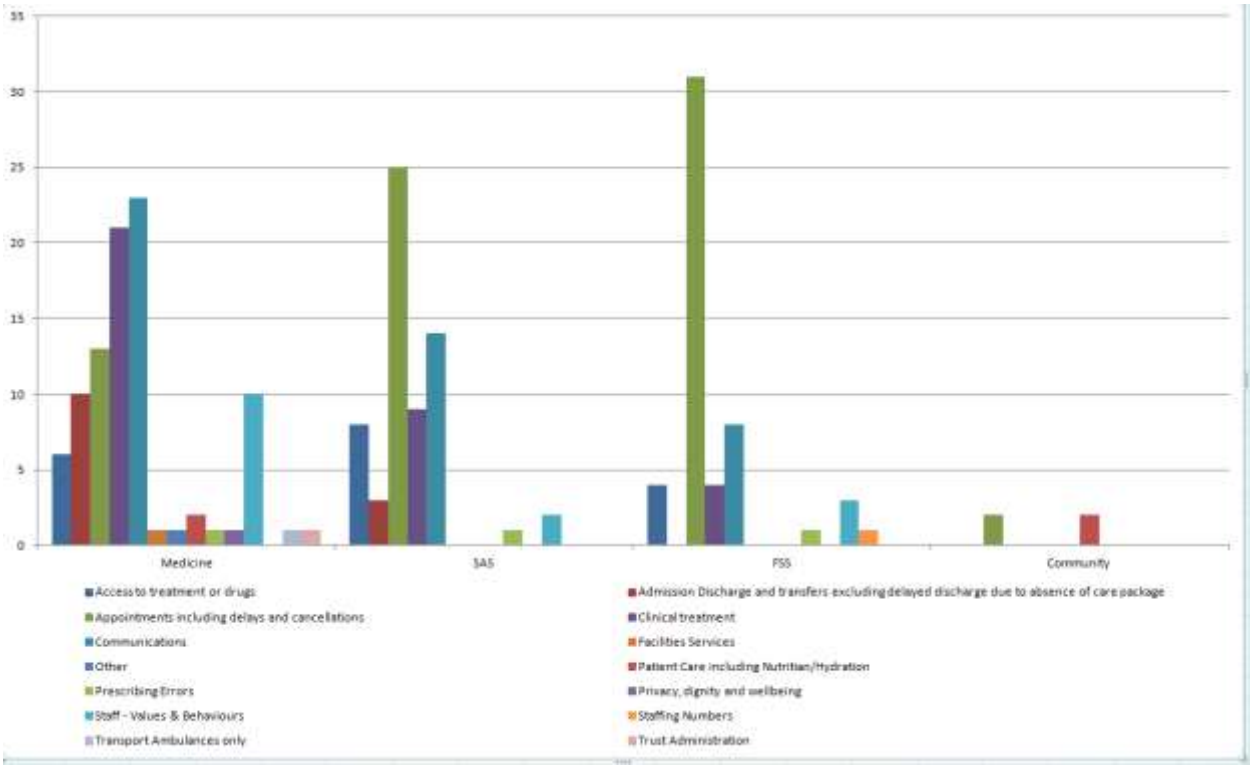
Concerns

The Trust received a total number of 210 concerns in Quarter 1 of 2016/17. Concerns are issues raised by patients or relatives via the Patient Advice Team. There has been a 29% increase in the number of concerns received in Quarter 1 of 2016/17 compared to the same quarter last year.

Analysis of Concerns by Theme



Appointments and Appointments including Delays and Cancellations has dominated the concerns received in Quarter 1 of 2016/17 representing 33% of all subjects. Communication represented 21% and clinical treatment represented 16%.



- The top subject of concern for Medicine was Communication, representing 25% of all concern subjects received for Medicine within Quarter 1; this was also the top complaint subject received for Medicine within Quarter 1. Clinical Treatment represented 22%, again similar to the second largest complaint subject for Medicine with Quarter 1, and Appointments including Delays and Cancellations 17%.

- The top subject of concern for SAS was Appointments including Delays and Cancellations, representing 40% of all concerns subjects received for SAS within Quarter 1, unlike complaints subjects where Communication was the largest complaint subject received for SAS within Quarter 1. Communication represented 23% and Clinical Treatment) 15%.

- The top subject of concern for FSS Appointments including Delays and Cancellations, representing 61% of all concerns subjects received for FSS within Quarter 1, unlike complaints subjects where Communication was the largest complaint subject received for FSS within Quarter 1. Communication represented 13% and Access to Treatment or Drugs 8%.

- The top subject of concern for Community was Appointments including Delays and Cancellations, representing 66% of all concerns subjects received for FSS within Quarter 1, unlike complaints subjects where Staff - Values & Behaviours was the largest complaint subject received for Community within Quarter 1. Patient Care (including Nutrition and Hydration) 33%.

Whilst Appointments including Delays and Cancellations was top subject of concern in Quarter 1 and the top subject for SAS, FSS and Community, it was not in the top

three subjects of complaint, nor was it with the top three for any Division. This would suggest that the majority of these issues are resolved through Patient Advice.

Patient Opinion Feedback 2015/16

Patient Opinion is an independent website about patient's experiences of health services, good and bad. The Patient Advice Team review comments receive and advise people leaving negative feedback to contact the service if they wish to take their concerns further.

Compliments 2015/16
12 compliments were recorded on the Datix risk management system by staff. The numbers below under estimate the number of compliments received by staff, as many compliments are made direct to teams and wards and are not captured in a central system.

The Trust is currently developing a user manual, which will guide ward staff through upload a compliment onto Datix step by step. Once this has been developed and roll out we hope to have a truer reflection of compliments received by the Trust, and use these to prompt learning from good practices.

Division	Number of Compliments recorded on Datix Q3 2015/16 by directorate
Medicine	4
Surgical and Anaesthetics	1
Family and Specialist Services	7

Learning from Complaints
The feedback we receive from complaints gives the Trust a wealth of information that can be used to improve services as an individual complaint provides detailed insight into a patient's experience.

As an organisation we aim to ensure that we learn from complaints so that we can:

- Share good practice
- Increase patient safety
- Improve the patient experience
- Reduce the number of complaints

Our complaints process includes identifying learning from each complaint and sharing this and each service and division is required to be clear:

- How the services records learning from complaints
- How this learning is disseminated within the service / directorate / division
- How it can point to changes arising from learning from complaints

Information on learning from complaints for each division is given below.

Learning:

Medicine	
- Giving the patient incorrect technical information.	- Small errors in wording can lead to confusion and stress for the patient. - Response letters to be over read by specialist in that area to ensure technical information is correct and to review how it will sound to the patient.
- Inadequate level of support and follow-up instructions given in Emergency department	- Staff are ill prepared/trained to do adequate discharges in an area where they usually do not discharge patients. - Training regarding the discharge process for all staff in the area.
- Family felt that the wrong information/ diagnosis was given about their loved one. Doctor stated stroke, nurse stated TIA.	- Patients and their families can be confused by different definitions given for one condition. - Explained both definitions, which without correct assessment, present in exactly the same way in the majority of cases and assured that both definitions were correct.
- Investigations were not performed and a diagnosis was missed as a result.	- Patient stated that they had already had an investigation however this was not followed up. - To repeat investigations if results cannot be verified.
- Lack of perceived input from the clinical team with regards to changes in patient's skin condition	- Improved communication between clinical staff and families following examinations and reviews to ensure the family and patient are aware that that their concerns have been acknowledged and addressed. Comprehensive clinical documentation in patient's clinical records regarding changes in patient's skin condition's needed.
- Delay in prescribing medications	- This would have ensured that the patient received the appropriate treatment for recent eye surgery. - Medical staff need to be more vigilant when taking drug history and nursing staff need to be more proactive in ensuring medications are transcribed once alerted that they have been

	omitted.
- Patient did not have a bath or shower while on ward	- In this instance the patient had the capacity to be able to make this decision however documenting clearly will evidence the offers made to patients and also include alterative options for hygiene needs to be met. - To ensure that staff are aware to inform family if needed they can support with this.
- No follow up appointment made with the appropriate consultant	- This would have ensured that the patient received the follow up care that was required. All staff are having clear training on leaving the correct information to the ward clerks to ensure they can send copies of discharge letters on that are needed
- Patient was found off the ward causing distress for patient and family	- Staff to be more vigilant with checking on patients if needed. - If the patient is confused may need to consider DOLs. Will help support staff to ensure patient who are confused and lack capacity may require 1:1 care or increased visual checks
- Confidentiality policy not adhered to as patient diagnosis was discussed at a handover within the hearing of patients and visitors to the department	- To ensure that all handovers are completed using nervecentre technology and that diagnoses are not verbally referred to at patient's bedside.
FSS	
Emergency LSCS for failure to progress at 5cm. Epidural top up ineffective, Remifent given. - Unable to deliver baby - delivered as breech in poor condition, no respiratory effort, full resuscitation given and transferred to SCBU.	- Escalation to Consultant where necessary for all surgical procedures in a timely manner. - Importance of keeping the anesthetist informed of progress and complications - Learning from experience newsletter to remind staff about timely summoning of consultant paediatrician in a timely manner. - Findings to be presented at Perinatal Mortality Meeting
- Delay in admission for undiagnosed breech presentation. - Baby born in poor condition.	- It is crucially important to listen to what the woman is telling us - Health care staff should keep the woman the focus of care - If a woman is unhappy with the clinical advice she is given this should be escalated and dealt with immediately
Following up an anomaly with final rinse water results from the Nasendoscope washer disinfector; it was discovered that there was a series of process failures associated with the decontamination of the scopes	Prior to implementation of new equipment that require decontamination: a. An operational policy should have been in place b. Clear, user friendly Standard Operating Procedures for the various elements of the task should be in place

	c. Staff should be trained to follow these SOP's and have documentary evidence of training and competence in them d. Documentation to support traceability at each critical point of the process should be in place with a planned audit schedule prior to implementation of the new equipment.
- high risk pregnancy, uterine fibroids. - Attended for augmentation in view of spontaneous rupture of membranes Prostin administered at 01 50, CTG following classified as reassuring, therefore discontinued at 02:59. - Reports to have been contracting frequently. Care taken over on day shift, history noted, planned for CTG monitoring, unable to locate fetal heart rate, escalated this to shift coordinator and registrar. Portable scanner used by registrar, still unable to locate fetal heart. Transferred to main scan room to be scanned by sonographer. IUD confirmed on scan.	- This woman had a large uterine fibroid but growth scans were discontinued at 36 weeks. - Fundal height palpation (which plotted on the 90th centile) was inappropriate in this case. i. Fetal growth scan should have been continued until delivery. ii. Offer immediate augmentation for term SROM as per NICE and our guidelines.
Unexpected stillbirth at Emergency Caesarean Section in maternity theatre	- CTG interpretation was incorrect in the last hour - The category of Caesarean section declared and documented was incorrect reflecting - the lack of urgency - Misinterpretation of the fetal growth based on the last scan as well as incorrect SFH - Measurement after the scan which would contribute to the compromise in reserves - This was an IVF pregnancy which has an increasing risk of Small babies and a two to four fold risk of stillbirth

Key National Publications

Parliamentary and Health Service Ombudsman - A Report of Investigations into Unsafe Discharge from Hospital, May 2016

The report focuses on nine experiences drawn from recent complaints the Parliamentary and Health Service Ombudsman investigated, which best illustrate the problems they are seeing.

People told the Parliamentary and Health Service Ombudsman how their loved one's traumatic experience of leaving hospital, including repeated emergency readmissions, added to their pain and grief. One woman captured the sentiment of many, saying she would be 'haunted for the rest of her life' by her mother's avoidable suffering before her death.

The Parliamentary and Health Service Ombudsman identified four areas of concerns which were:

1. Patients being discharged before they are clinically ready to leave hospital
2. Patients not being assessed or consulted properly before their discharge
3. Relatives and carers not being told that their loved one has been discharged
4. Patients being discharged with no home-care plan in place or being kept in hospital due to poor co-ordination across services

The Trust is doing a piece of work to look into these issues, which will be present at the Patient experience group.

Claims

CLINICAL CLAIMS

During the last 5 financial years up to 30 June 2016, CHFT has opened 874 new clinical negligence claims. Nationally NHS Trusts have seen a sharp increase in the number of clinical negligence claims brought.

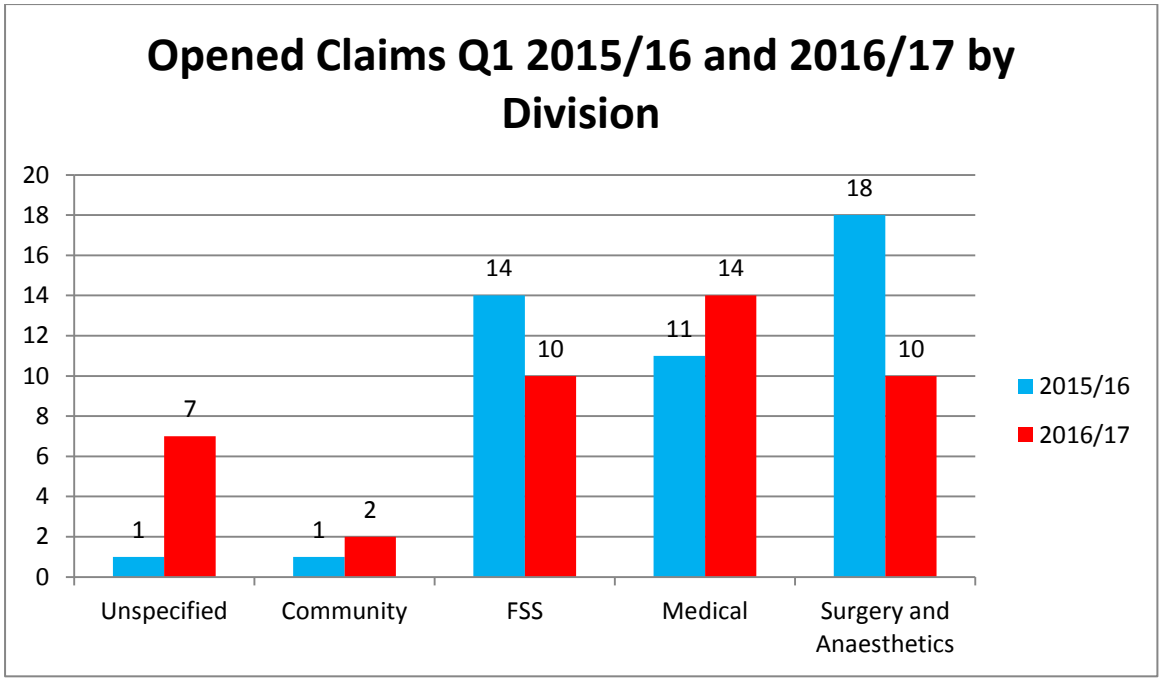
Opened Claims

In Q1 2016/17 43 new clinical claims were opened. In the same quarter of 2015/16 45 new claims were opened. This represents a small decrease of 4.4%.

Opened Claims by Division

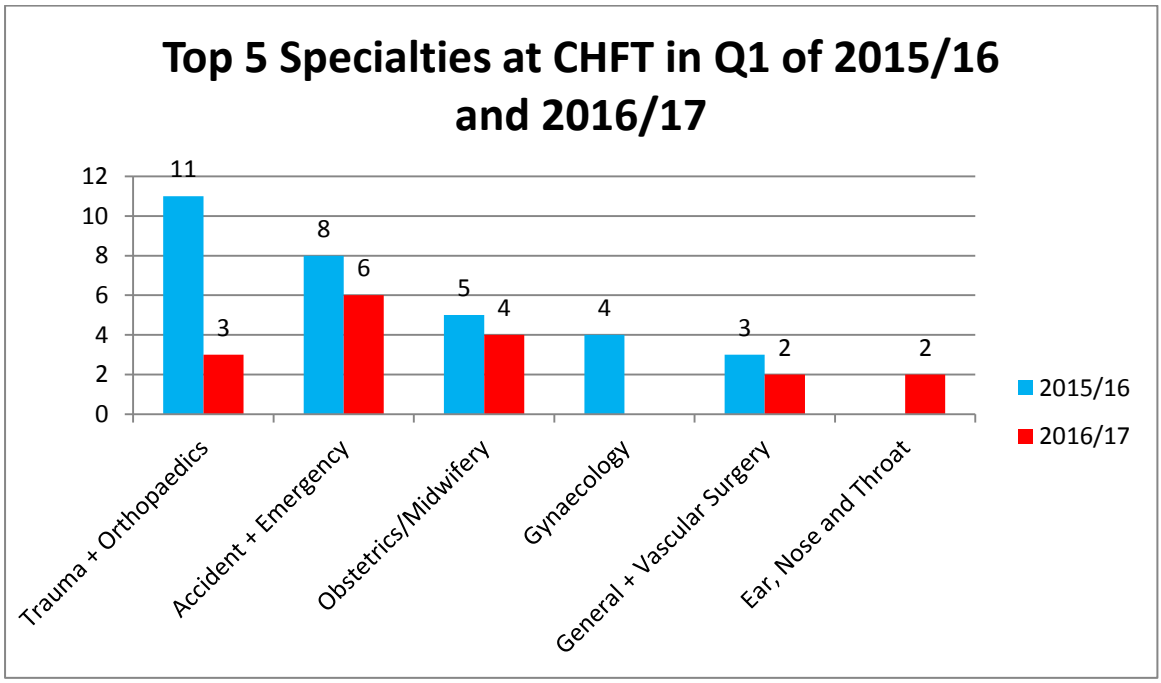
The graph below shows the number of opened claims over the comparable quarters by Division during Q1 of 15/16 and 16/17. Notable trends show a decrease in FSS from 14 to 10 claims (28.5%) and a large decrease in Surgery and Anaesthetics from 18 to 10 claims (44.4%).

Of note is the large number of claims in Q1 of 2016/17 which are unallocated to a division. It is not uncommon for claimant solicitors not to specify the nature of the claim despite the Legal Services Team asking them to specify the nature of the intended claim in line with the Clinical Negligence Protocol.



Claims Opened by Specialty

The Top 5 specialties at CHFT for Q1 of 2016/17 and 2015/16 are detailed below.



Trauma and Orthopaedics have seen a marked decrease from 11 to 3 claims (266%) in the last year. A+E, Obstetrics and Midwifery and General and Vascular Surgery have seen small decreases in the number of claims whilst still remaining in the top 5 specialty claim types for both quarters.

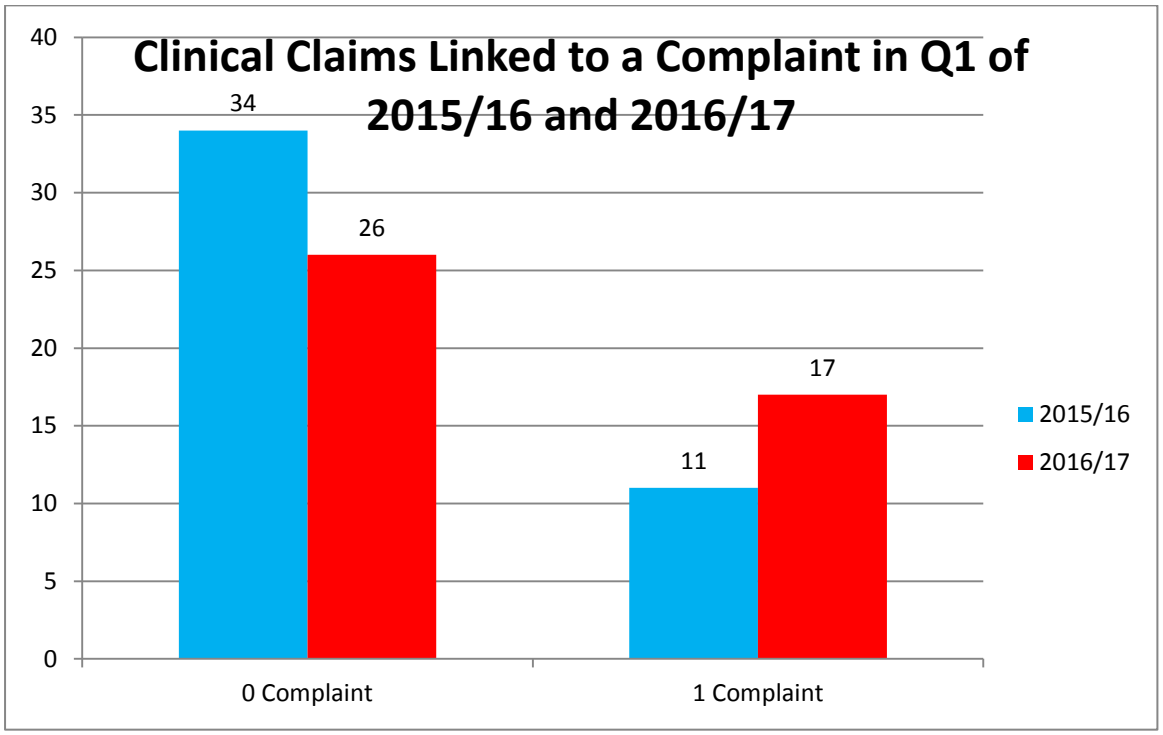
Ear, Nose and Throat have newly entered in to the top 5 of claim specialty in 2016/17 with 2 claims. Looking at these claims in more detail they relate to:

a) One claim relates to an alleged delay in diagnosis of throat cancer. The case is at the disclosure of medical records stage and comments will be obtained by our staff;

b) One claim relates to the alleged negligent fitting of a hearing aid. The medical records have been disclosed on this matter.

Claims Linked to Complaints

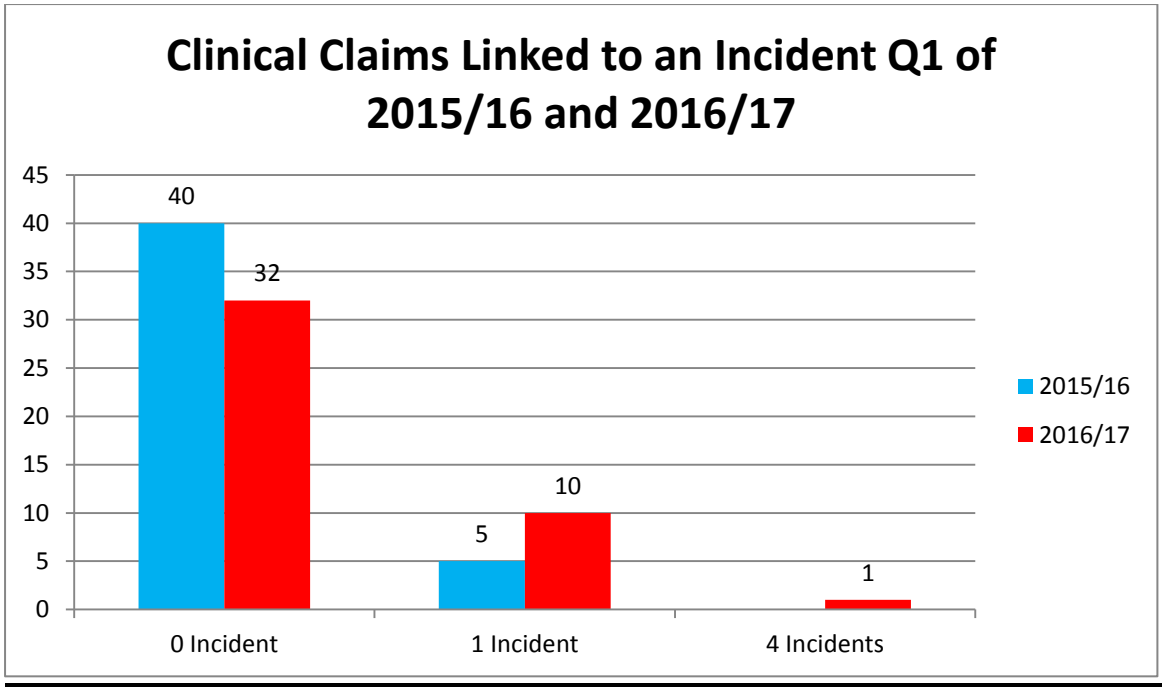
The bar graph below shows that in2016/17 17/43 (39.5%) claims were linked to a complaint. In the same quarter of 2015/16 11/45 (24.4%) claims were linked to a complaint. This shows a marked increase over the last two quarters. One reason for this is that pursuing a complaint is a cost effective way of establishing if there is merit in a claim.



Claims Linked to Incidents

The bar graph below shows the number of claims linked to an incident. In Q1 of 2016/17 11/43 (25.5%) of claims were linked to at least 1 incident. In Q1 of 2015/16 5/45 (11.1%) of claims were linked to an incident.

The claim linked to 4 incidents relates to treatment from 2 June to October 2015 during which the claimant allegedly suffered from a fall, skin tears and an on-going pressure ulcer.



Closed Claims

In Q1 of 2016/17, 14 claims were closed. Of the 14 claims that were closed 7 claims (50%) closed without any payments being made. Of the 7 claims that closed with payments, the highest payment was from Medicine Division for £148,380 (comprising of £40,000 damages, £95,000 claimant costs and £13,380 of defence costs) for a failure to diagnose a left hand scaphoid fracture.

In Q1 of 2015/16, 20 claims were closed. 10/20 (50%) closed without any payments being made. The remaining 10 closed with a payment being incurred.

Learning from Claims

Claims that closed between 1 January 2016 and 1 June 2016 resulting in a payment of damages to patients and staff have been circulated to the divisions for them to action and evidence what has and will be done to prevent or minimise a recurrence. A summary is provided below.

CWS	Management of breech delivery
CWS	Alleged failure of adequate obstetric care resulting in a still birth
DATS	Failure to diagnose Quadriceps muscle damage
DATS	Failure to diagnose fracture of Ankle
Medical	Failure to diagnose severed tendon in hand
Surgical & Anaesthetics	Failure to implement gall bladder pathway resulting in death
Medical	Slip on floor in hydrotherapy pool area
Medical	Patient assault injury to hand

EMPLOYEE AND PUBLIC LIABILITY CLAMS

During the last 5 financial years up to 30 June 2016, CHFT has opened 110 new employee and public liability claims.

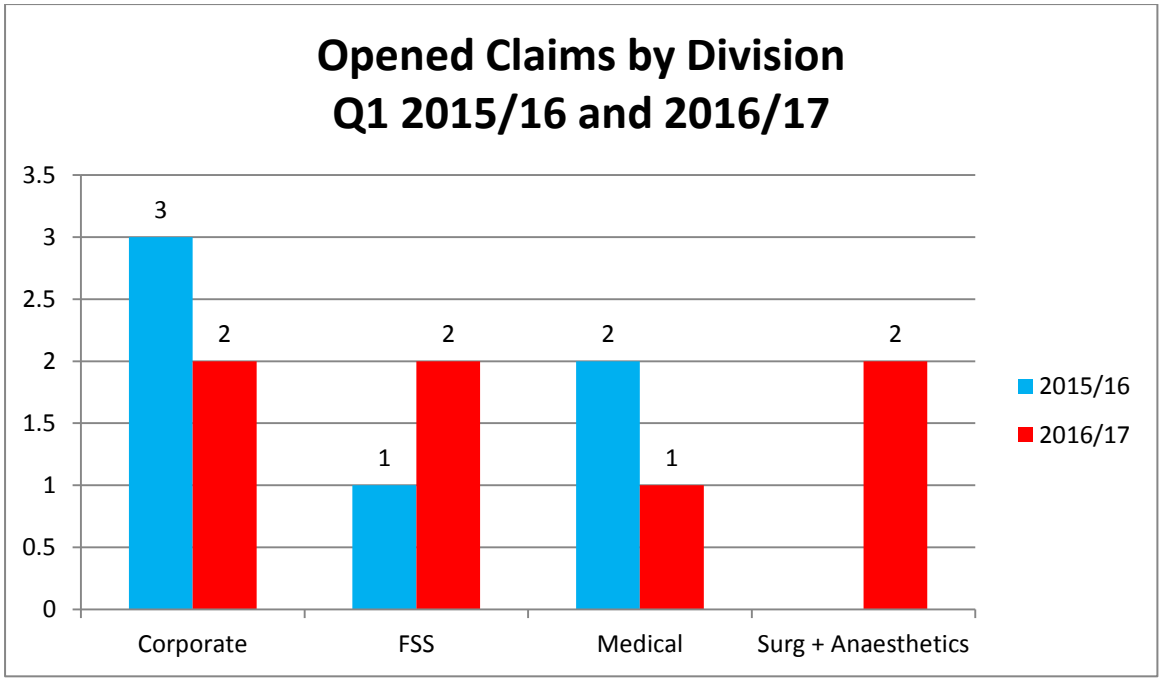
Opened Claims

In Q1 of 2016/17 7 new claims were instigated against CHFT. In Q1 of 2015/16 6 claims were brought.
An extract of the claims descriptions brought in Q1 of 2016/17 is provided below.

Ref	Description (Policies)
PL CLAIM	Incident occurred on 1st floor of Acre Mill of Female Public Toilet in disabled toilet cubicle Patient used it between 16.10-16.15 hrs Apparently no witnesses she was using toilet and wanted to exit and pulled the door open and door fell off its hinges and hit her left Arm ? also shoulder as she tried to push it off herself and pushed the door back and lent it against wall so that she could exit Toilet. She then went to Nurse in ENT who she first met to tell her also what had happened.
PL1	Claimant's fingers trapped by an electrical recliner chair in the WEEE compound CRH
2989	Claimant walked into theatre 2 and she went to get a phone base and the boom that the gases come down through had been left down and not pushed back up to the ceiling and the Claimant walked into the boom and banged her head and was knocked to the floor as a result of this incident.
2946	The Claimant is a driver. He was making a delivery on behalf of his Employer, Polar Speed Distribution Ltd, when he slipped on pieces of broken black plastic that were littered on the floor of the parking area to the loading bay. He fell heavily to the ground.
2967	Slipped on wet floor in scrub room. Tried to prevent myself from falling but went down on my left knee and on my right hand.
2948	Claimant's statement verbatim on EL1 Form: "Due to the way the ward was on the day i had no choice but to move a demanding patient onto a slipper pan by myself...as i turned the patient i felt my left elbow give way.... thinking that it was a pulled muscle i continued to work after reporting the incident to the qualified member of staff that was on duty with me....i know i shouldn't off moved him but the patient declared that he would defecate the bed if i didn't.....and that would of taken three members off staff to deal with said patient... And at the time off the incident they were not available...."
2999	Whilst getting trolley cleaned down in wash up area near waste food bin slipped on the floor and fell down on left hand side of body left buttock, Shoulder, arm and elbow. Slipped on custard that had been spilt on the floor. Area had been signed with a slippery floor sign.

Claims by Division

The graph below shows the number of opened claims over the comparable quarters by Division during Q1 of 16/17 and 2015/16. The claims relating to Corporate Division come from the Estates and Facilities specialty. In 2016/17 3/7 (42.8%) of these claims related to a slip and 1/7 (14.2%) claim related to allegedly sustaining a severe injury as a result of manual handling.



Claims Linked to Incidents

In Q1 of 2016/17, 5/7 (71.4%) claims were linked to an incident. In Q1 of 2015/16, 4/6 claims were linked to an incident. If a claim is not linked to an incident the Trust has the possibility of a reasonable defence.

Closed Claims

In Q1 of 2016/17 4 claims were closed. ¼ claims closed with a payment of damages to the claimant (a staff member). The claim relates to a failure to provide extra staff for a known aggressive patient who subsequently assaulted the staff member. The damages payment was £7,500, defence costs £9,300 and defence costs were £480. The remaining 3 closed without any payment of damages or costs.
In Q1 of 2015/16, 3 claims were closed. 1/3 claims closed with a payment of damages to a staff member which was lodged against Surgery and Anaesthetics. This was for a needlestick injury. The damages were £1,500, claimant's costs were £1,080 and defence costs were nil. 1 claim closed without any payments and 1 claim closed with defence costs only.

INQUESTS

As at 30 June 2016 the Trust opened 54 inquest cases. An inquest by HM Coroner is held where here is a concern that the patient suffered a violent or unnatural death, or if the cause of death cannot be ascertained, and by a post mortem.

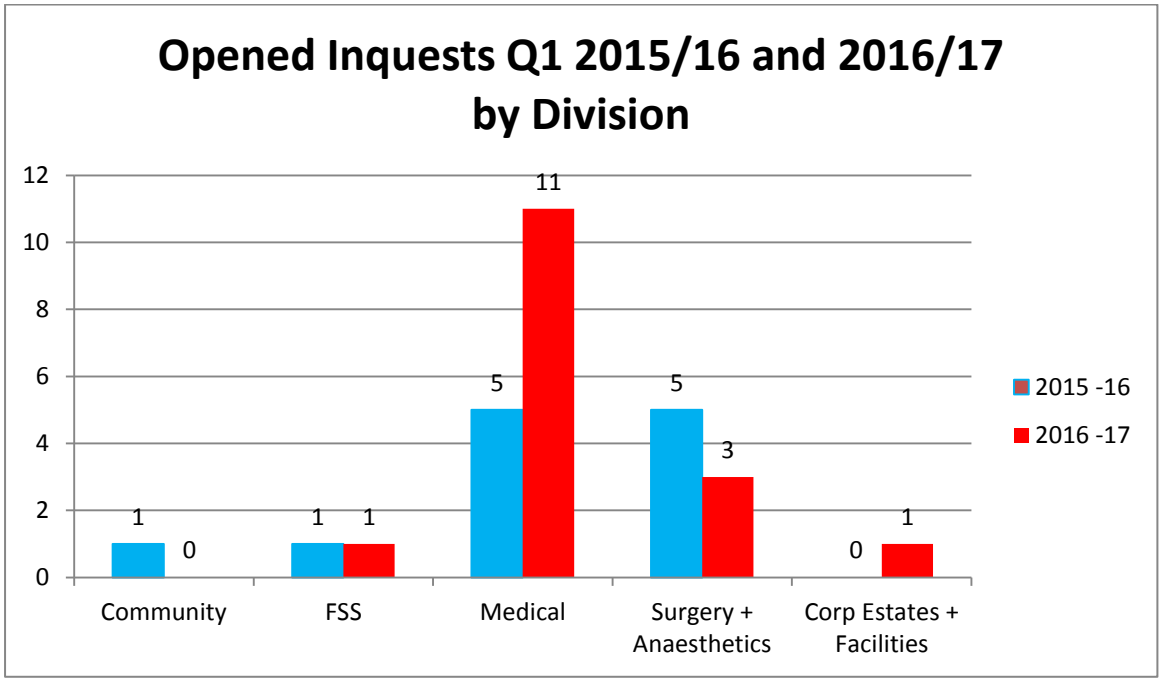
Opened Inquests

In Q1 of 2015/16 12 new inquests were opened. In Q1 of 2016/17 16 new inquests were opened. This represents an increase of 33.3% in the corresponding quarters.

Opened Inquests by Division

The graph below shows the number of inquests opened by each division in Q1 over the last two financial years. Notable trends are that Medicine has seen a 120%

increase in the number of inquests from 5 to 11 inquests over the corresponding quarters.



Looking at the 11 opened inquests for Q1 of 2016/17:
4/11 (36.3%) relates to A&E but of note is that 2 of these 3 relates to fatalities pre-dating admission to CHFT.
3/11 (27.2%) inquests relate to Acute Medicine.
1/11 (9%) relate to Cardiology; 1/11 relate to elderly care; 1/11 relate to Rheumatology; 1/11 relate to Short Stay.
Of particular note is that 5/11 (45.4%) of the above inquests are related to a fall sustained whilst being treated at CHFT hospitals.

Closed Inquests and Learning

In Q1 of 2015/16 7 inquests were closed. In the same quarter of 2016/17 5 inquests were closed. They are detailed below.
Where there is a robust investigation with evidenced actions on how the incident (giving rise to the death) can be prevented HM Coroner is less minded to issue a Regulation 28 report.

ID	Description	Determination (at Inquest) and Learning
2740	Died on Ward 5d CRH following admission. Patient admitted due to self-neglect and burns. DoL in place and Safeguarding Alert raised at time of death.	INQUEST OUTCOME: NATURAL CAUSES Actions from investigation on-going. HM Coroner applauded CHFT for thorough incident investigation.
2772	Died following reaction to cement	Narrative verdict reached.

	inserted to repair hip fracture. Reported to HMC as died within 24 hours of procedure. Statements obtained from 2 x staff plus investigation report sent to HM Coroner.	Paper Inquest held on 26/2/16. No witnesses called as there were no issues to resolve.
2690	Male was admitted to Calderdale Royal Hospital on the 3rd June following a collapse at home. He remained overnight. Examination showed air under the diaphragm in keeping with spontaneous bowel perforation. High mortality rate discussed and agreed with the patient prior to consent. He was transferred to Huddersfield Royal Infirmary on 06/06/15 and taken to theatre on 07.06.15. At operation, two perforations in the small bowel were identified and a 20cm segment of bowel was removed. There was no evidence of necrosis. The operation was successful and he was taken to the ICU for the following two days. On the 12th June he developed diarrhoea possibly thought to be due to antibiotics but then rapidly deteriorated. It is unclear whether there was an anastomotic leak or bowel ischaemia. He died on 13.06.15.	Misadventure. No further learning for CHFT. CHFT staff commended by HM Coroner and the family.
2667	Safeguarding concern raised by Nursing Home re decision to discharge in early hours of morning readmitted same day 3.5.15 with chest symptoms, subsequently died 11.5.15. A Safeguarding and incident investigation took place. Issues regarding loss of IV access and aggressive behaviour were investigated.	INQUEST OUTCOME: The verdict was a narrative verdict which essentially sets out the circumstances. The Trust is required to write to the Coroner to set out the lessons learned regarding their involvement with the patient arrangements to make to avoid future miscommunications with the home and other similar care homes Response provided to HM Coroner on 16 June 2016 setting out the integration

		process Pose a Risk Documentation that is to be incorporated before December 2016.
2784	Preliminary cause of death is sepsis. Safeguarding Referral to Police led to Forensic PM. Inquest is not listed and case is closed. Awaiting formal notification from HM Coroner as at 16/3/16 and 29/03/16.	No inquest hearing.

One inquest that was concluded in the Quarter 4 of 2015/16 but from which the actions were ongoing in to Q1 of 2016/17 and concluded was the inquest of a patient who had had a GI bleed and died after transfer from CRH to HRI, following which CHFT received a Prevention of Future Death (PFD) letter from HM Coroner.

A PFD letter is issued by HM Coroner who is now under a duty (no longer discretion) to issue the same where they consider that a future death can be prevented.

The detail is provided below:

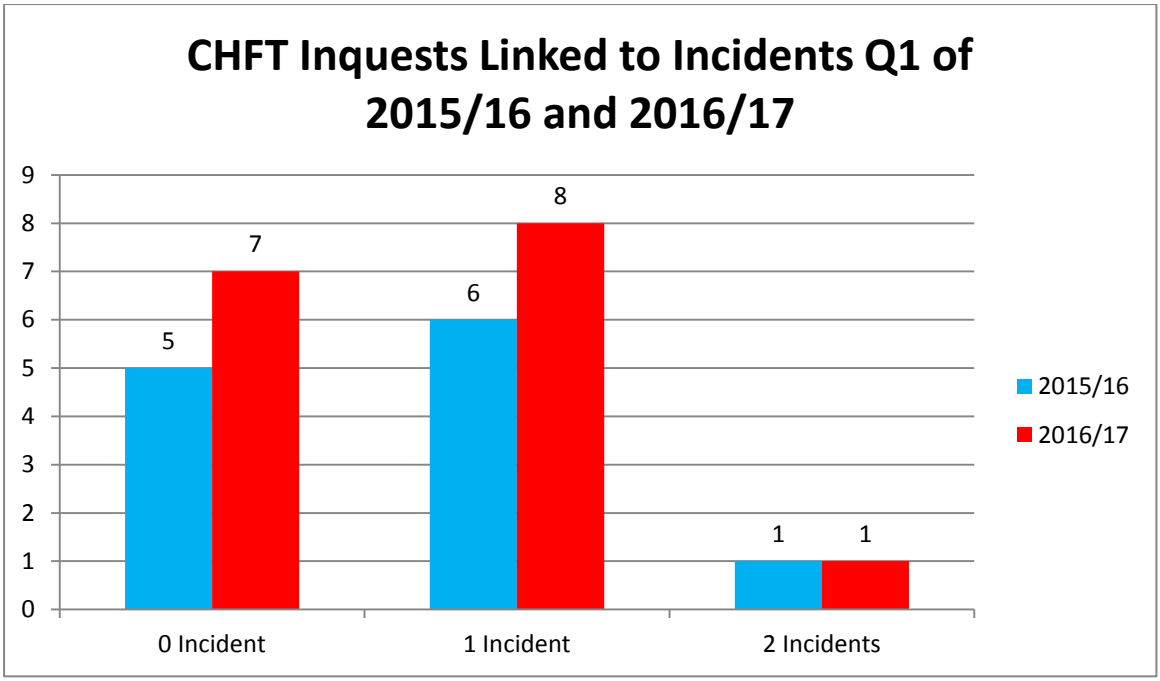
ID	**Description**	**Determination (at Inquest) and Learning**
2542	Patient under GI bleed protocol bled prior to transfer to CRH and was unstable - patient deteriorated and died on arrival. The Trust was criticised for its management of the suspected GI bleed that she presented with and the transfer arrangements. Had the patient been transferred before the afternoon of 16 December 2014, she would in all probability have survived the GI bleed she suffered from.	PFD response received with 7 specific points for CHFT to address. Detailed action plan (with evidence) including the roll out of the new GI Bleed Protocol Trust wide and documentation process for all staff submitted to HM Coroner.

Inquests Linked to Incidents and Complaints

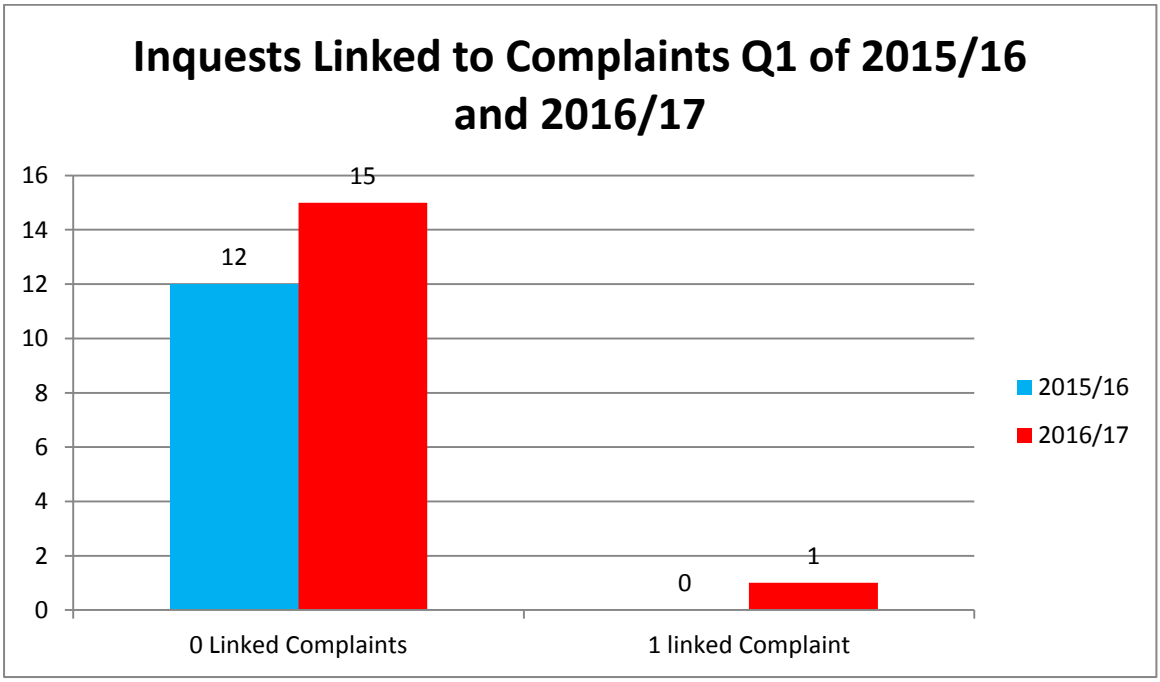
The Legal, Complaints and Investigations teams are triangulating data from their respective areas to highlight and action where inquests are related to incidents and complaints so that better family, Trust and coronial engagement can take place.

Often families will use the inquest process as a vehicle to air their concerns where a complaint could have resolved the issues that they have. Relationships are being forged to assist HM Coroner where our Trust can dispense with issues that relate to a complaint.

The graph below shows that in Q1 of 2015/16 7/12 (58.3%) inquests were linked to at least 1 incident. In the same quarter of 2016/17 9/16 (56.25) of inquests were linked to an incident.



In Q1 of 2015/16 no inquests were linked to a complaint.
In Q1 of 2016/17 1/16 (6.25%) inquests were linked to a complaint.



SAFER – update on progress

November 2016

Paper Title: SAFER – Progress Update	Report Author: Bev Walker
Date: 9th November 2016	Sponsoring Director: Helen Barker

Title and Brief Summary:

SAFER – Progress Update
November 2016

The purpose of this paper is to provide the Membership Council with a report on the progress of the SAFER Patient Flow Transformation Programme (Year 1) and its impact in sustainable delivery of quality benefits, performance benefits and financial efficiencies. The paper describes the governance structure, the transformational work being developed and implemented and how they are being measured.

Action required by the Executive Board:

The Membership Council is asked to note the contents of the report.

Strategic Direction area supported by this paper:

Keep the base safe- Safe today, safer tomorrow

Forums were this paper has been previously considered:

None

Governance requirements:

Sustainability implications:

Executive Summary

The SAFER Transformational Programme has a combination of committed and courageous leadership, workforce engagement and motivation, accountability and insights from data; all elements that are important for an ambitious transformation programme to succeed. In addition, we are part of 2 national collaborative and a supportive health and social care system both of which are significant enablers for impact.

Our organisational SAFER transformational programme is now aligned with our commissioner and primary care partner QIPP programmes; we have collaborative partners in all elements of the transformation work from Social Care to Locala Community Partnership and the voluntary sector.
We are engaging with staff, patients and the membership council through a continuously developing communication strategy.

The programme is in its second formal quarter and is managed through a formal programme governance structure with a monthly SAFER Board where the three main work streams are held to account for progress and improvement.

The Programme is structured in three work streams:-

1. Bed Avoidance
2. Bed Efficiencies
3. Bed Alternatives

In addition the 7 day programme and Hospital Out of Hours (HOOP) programmes are managed through the Safer structure reflecting the interdependencies of each transformation.

Each work stream has two key themes identified from the 5 year plan and are those which are felt will deliver both the financial element and as importantly quality and safety and above all improved patient outcomes and experience in year one (16/17).

One of the key deliverables in 16/17 is the opening of fewer beds in quarter 3 & 4 than planned therefore releasing cash. This approach has been received well in clinical teams.

The patient flow dashboard measures:-

- Number of beds open
- Occupied bed days
- LOS (unplanned)
- 4 Hour Emergency Care Standard
- Patients with 4 or more ward moves

Each key theme within the work streams have specific KPI's that they are measured against but all are also measured against the overarching organisational KPI's.

The Effect Dashboard and Theme Dashboard have been developed to provide clarity on the Effect each work stream's theme has on the overarching organisational KPI's.

Effect Dashboard

Work stream	**Theme**	**Simple Theme Specific Measure**	**Impact on Organisational Dashboard Measures**				
			Occupied Bed Days	Number of Beds Open	4hr ED Target	LOS	Impact on quality and safety Measures
Bed Avoidance	Ambulatory Care Units	Number of patients seen in AEC	Yes	Yes	Partly	Partly	Yes
	Frailty	Reduction in LOS for Patients over 75yrs	Yes	Yes	Partly	Yes	Yes
Bed Efficiency	SAFER Bundle	% of patients discharged in the morning		Partly	Yes		Yes
		Diagnostics done on day	Yes	Yes	Partly	Yes	Yes
		Number of Patients staying over 50 days	Yes	Yes	Partly	Yes	Yes
		LOS on Speciality Wards	Yes	Yes	Partly	Yes	Yes
Bed Alternatives	Rehab	Number of Patients taken into the community ward from bed base weekly	Yes	Yes	Partly	Yes	Yes
		LOS Stroke	Yes	Partly		Partly	Yes
	EOL	Length of stay after 'fast track'	Yes	Partly		Partly	Yes
7 day Services		Number of discharges at weekends	Partly	Yes	Yes	Yes	Yes

Theme specific Effect Dashboard

Theme	Aim	Theme Specific Measures	Effect	Visibility on High Level KPIs
Ambulatory	To Introduce 10 Pathways before October 2017 (Medical and Surgical)	Number of patients seen in Units	300 Occupied Bed Days = 10 beds	Occupied Bed Days Beds Open
Frailty	To prevent five patients admission to speciality bed base weekly. Reducing these patients LOS by 5 days. To be achieved by October 2017	LOS for patients over 75 yrs.'	100 Occupied Bed Days 3 beds	Occupied Bed Days Beds Open
Bed Efficiency and 7 day Services	To reduce LOS in speciality areas by 0.3 days by October 2017	% discharges before noon Diagnostics IPS Pts on Discharge pathways (GXs) LOS Specialty Wards Discharges at weekends	210 bed days 7 beds	Occupied Bed Days Beds Open 4 Hour Target
Community Ward	To admit 5 patients weekly from inpatient bed base from October 2017 onwards	Number admitted from bed base	600 bed days 20 inpatient beds (with 15 community ward beds)	Occupied Bed Days Inpatient Beds Open
Rehab /Stroke Pathway transformation	To reduce stroke LOS (early predictions will be available in September)	LOS Stroke patients		Beds open Occupied bed days

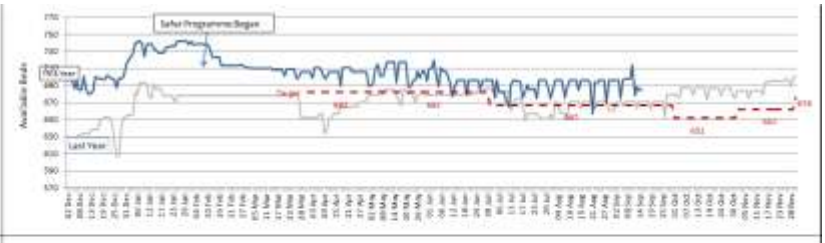
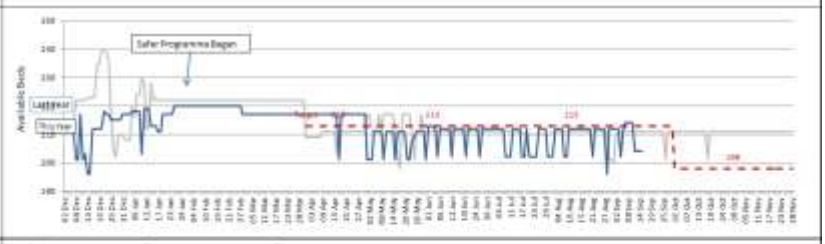
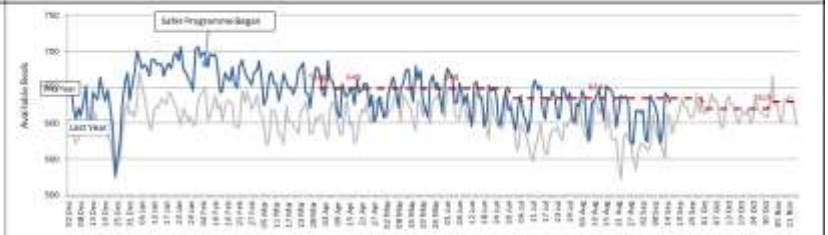
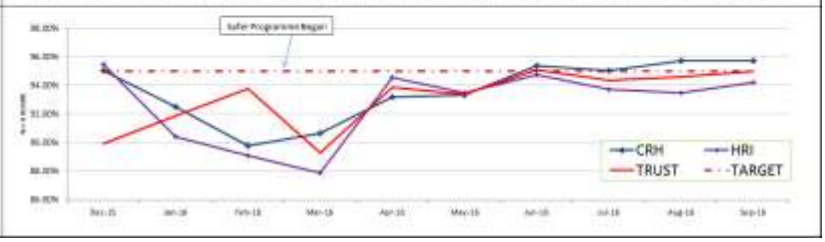
Update on progress;

- LOS had stabilised at around 5.5 days, the mean from December 2015 being 5.9. There could be an increase in LOS as a consequence of increasing ambulatory care patients. The patients with a LOS at present of 0-1 who will now go through AAU will be now 0 day LOS which will impact on the denominator. Work has commenced to ensure we can map this change effectively and ensure system agreement on the outcome.
- Increased collaborative working between CHFT discharge teams and Local Authority teams who are now co-located have contributed to a reduction in patients with a LOS over 100 days.
- At present the Trust has 688 adult beds open (excluding Obstetrics). This is a significant reduction from a high point of 749 at the onset of the programme and despite non elective demand, Green X patients and Excess bed days running higher than plan. The target is 680 in October. The Winter Plan for the Medical Division was to open an additional 39 beds. The introduction of work within each SAFER work stream enabled a revised plan to be developed of only 24 beds. However a continued reduction in the need for these beds is predicted with the planned increase in Ambulatory Care and the operationalising of an Acute Frailty model's, bed efficiency initiatives and improvements expected through new rehab processes.

- Targeted partnership collaboration is focusing on expediting the patient's with a LOS over 50 days, alongside a clinical review of patients with a LOS over 6 days reflecting one of the high impact initiatives recommended by NHSI.

Organisation Dashboard Measures

Organisation Dashboard Measures

Number of beds open Trust (Including FSS, Excluding CDU)	Adult beds excluding maternity, both sites. Snapshot taken midnight every day. Chart runs from Dec 2015	682	
Number of beds open Medicine only	Adult beds excluding maternity, both sites. Snapshot taken midnight every day. Chart runs from Dec 2015	465	
Number of beds open Surgical only	Adult beds excluding maternity, both sites. Snapshot taken midnight every day. Chart runs from Dec 2015	204	
Occupied Bed Days Trust	Adult beds excluding maternity, both sites. Snapshot taken midnight every day. Chart runs from Dec 2015. Target is 95% of beds open target	631	
Average Length of Stay (unplanned activity)	Weekly figure, each Sunday. Emergency / Unplanned admissions excluding maternity. Adults over 18. Chart runs from Dec 2015 Methodology is total bed nights in week for patients, divided by total admissions in week	5.9	
Accident & Emergency 4 Hour Target	% of patients in A&E seen in under 4 hours	TRUST 95.00% CRH 95.73% HRI 94.22%	

Work Streams

1. Bed Avoidance

Theme 1: Ambulatory Emergency Care (AEC)

Work to date:

The AEC team, who are from across health and adult social care have joined the National AEC network and have completed various current state exercises that highlighted opportunities for further pathways and changes so that patients can be treated in AEC rather than to have full inpatient admission. This work is being undertaken across medicine and surgery. These pathways are being phased in with full clinical engagement and associated KPIs that are captured in a specific dashboard for the AEC Units. The first pathways were launched in medicine on the 22nd August. Support from senior clinical staff from each directorate has been essential to ensure pathways are progressed, for example, the new chest pain pathway will allow patients who historically stayed overnight due to the need for a blood test at 12 hours. These patients will now have the test completed at 6 hours together with a risk assessment. Urology have launched 3 ambulatory pathways in September and work with the orthopaedic team has commenced.

The National AEC Team visited CHFT on the 3rd August where they had a tour of the Ambulatory Areas and met with the COO and have provided a report on our progress to date and recommendations for further work.

Their Recommendations are:

- Stop overnight bedding of medical and surgical AEC as a matter of urgency
- Consider co locating both surgical and medical AEC services near ED
- Develop consultant delivered services
- Work with primary care to improve volume and quality of referrals
- Instigate twice daily board rounds with ED from medical and surgical AEC and develop a poster campaign to reinforce the 'message'
- Develop 'simple rules' to ensure appropriate patient selection
- Work with ACPs to extend their skills
- Undertake an EBD study

These recommendations will from part of the project plan for AEC.

Finance Update:

The aim of both the AEC and acute Frailty is to prevent the need to open 15 beds over the winter period releasing the funding that had been allocated. The total savings identified £402k.

Theme 2: Development and delivery of a Frailty model

Work to date:

A core team from across health and adult social care have attended the launch of the national collaborative event to support and help develop acute frailty and community frailty care. In both

acute hospitals senior community nursing are working with social care, therapy and on the HRI site with an Elderly Care consultant to scope out through PDSA's a model of care that will allow frail, predominantly elderly patients to return home rather than be absorbed into the speciality bed base with the associated danger of a loss of function and independence. This scoping is phase one of introduction of the model and data is being collated to identify the opportunity. This is in conjunction with testing out a Discharge to Assess Model using the same team. The Medical Division facilitated a care of the elderly consultant to join the MDT from the 12th September. This work continues to link to the Bed Alternatives work and rehabilitation model redesign.
This has also been identified as a priority in both the ECIST report and the Invite Service Review of Complex Care.

2. Bed Efficiencies

Theme 1: Discharge systems and process, the clinical flow team, hospital at night and the discharge lounge

Work to date:
The mapping of the existing state has been completed. Significant work has been undertaken to develop our intelligence around reasons for delays in the discharge pathway. The matrons, discharge teams, social care and therapy staff are working collaboratively to take every opportunity to prevent delays, improve communication and the patient's experience.
Discharge to Assess- is being safely tested using PDSA cycles with full review of each patient's case managed through this process.
HOOP was launched on the Calderdale site in September 2016. Early indications are that it is progressing well.
Discharge lounge was closed on the Calderdale site and a new proposal to work with voluntary services to support patients in ED and the wards on the day of discharge is being developed.

Finance Update:
In relation to discharge planning, clinical flow team, hospital at night and the discharge lounge. Mapping of current process is being carried out with a view to re-profile the teams reflecting duplication and opportunities following the introduction of the EPR. The first release of CIP was achieved in September of £142K.

Theme 2: Safer Bundles

This is the implementation across all wards and then clinical areas of the flow bundle. The acronym describes:

S	Senior review daily
A	All patients will have an EDD with 24 hours of admission
F	Flow of patients to begin early to enable capacity in the assessment areas

E	Early discharge on base wards before 10am to allow for movement from assessment areas
R	Review as a team daily by enabling MDT board rounds and safety huddles

Work to date:
This theme is seeing a high level of clinical engagement. The ADN for medicine is providing strong leadership to the matrons and ward managers who are engaging readily in the work. An compliance audit has been completed to understand next steps for implementation. The aim is to stabilise LOS and minimise any waits from admission, in their clinical care, by improved discharge planning and review of plans. One of the key drivers of this Theme is to reduce medical outliers in surgery in order for the necessary reconfiguration of surgical beds to take place before winter but the SAFER bundle is to be rolled out in full across the organisation and evidence shows that this is a key facilitator for improved patient flow, efficiency, safety, patient quality and experience.
Improvements in partnership working with Calderdale Adult Social Care will also support this as the majority or patients in outlying areas are from that district.

A weekly review meeting has also been introduced with Senior Managers from CHFT and both Calderdale & Kirklees Adult Social Care to review and expedite patients with the longest LOS who have a discharge plan that is challenging to deliver.

Theme 3: Planned Care: Reduction in surgical and gynaecology bed base and overall review of beds Trust-wide

Work to date:
The plan from Surgery was a reduction of beds which aligned with the previous modelling from four eyes, this currently being re-validated through work with Simul8. This work will align to the SAFER ward improvements and ensure the speciality bed base is an accurate reflection of the needs of the patients that use our services however this has not yet progressed and has resulted in programme slippage.

Financial Update:
CIP planned for this scheme has slipped by one month and the timeline for recovery has yet to be confirmed by the Surgical Division

3) Bed Alternatives

Theme 1: End of Life care

Work to date:
This work has identified that there are multiple agencies and individuals looking to improve EOL care. Previously these were not always sighted on each other, leading to a slightly disjointed process that often duplicated effort. A priority for the leads of this theme was to bring all interested groups together to plan the work. This is the current focus before any large redesign takes place.

Theme 2: Rehabilitation

Work to date:
The Director of Operations for Community Services has led this work and is designing a 'community place' within the existing structure. This area would be initially within the hospital building but outside of the organisational structure, being managed by community and medically supported by GPs. The patients would receive functional reablement and this should reduce the level of social care support needed on discharge. This area is now largely designed and with a date to operationalise of the 1st December 2016.
In addition to the 'community place' some work is also being undertaken by a senior community therapist to transform stroke rehabilitation practices in the hospital to provide more functional, focused pathways with the aim of reducing the LOS for this group of patients.

Finance Update:
Enabling scheme reviewing intermediate care, rehab, packages of care and timing of availability. High level opportunities included in previous Safer paper presented in March 16. Ongoing development required to understand operational impact and financial benefits achievable.

4) 7 DS & HOOP

Work to date:
These two complimentary themes are now a part of the SAFER programme and will be monitored at Programme Board.
After feedback from the national survey/audit each directorate has been asked for a view of possible seven day models for their areas. These have started to return, and when they have been received will be pulled into a single document by the Trust lead. This document will describe a future state. Trust representatives have also attended a whole health economy meeting that allowed for discussion around what 7DS meant for partner organisations, and forged links between CHFT lead and CCG colleagues.

The Trust have recently been offered external support to accelerate implementation of the 4 key standards; whilst this has initially been accepted the scope of this is still to be determined reflecting the standards can only be achieved within existing resources.

The Hospital at Night work has been progressed, with the COO and Trust Lead meeting relevant colleagues. After this a subsequent breakthrough meeting was held to understand an organisational vision. Whilst his theme has no direct KPIs, it is an enabler for a reduction in LOS and bed occupancy, as well as a national requirement. The Task Management System was launched in September on the Calderdale site.

The next 7DS survey to gauge position against standard is due in September 2017. The financial plan for 16/17 assumes delivery of 7 day within existing resources

Summary

The multi-faceted nature of the SAFER Programme has made it challenging to initiate and it has taken time to fully engage with the wider teams in the organisation.

However, we are now starting to see recognition of the value of this work and a willingness to commit throughout the Trust, this is true of both managerial and clinical teams. This commitment is now becoming evident at operational level and the individual work themes within the programme are starting to deliver small but definite improvements that can be developed and grown to ultimately bring about the desired transformation.

Reliable and relevant metrics have now been established to monitor the continued effectiveness of the Programme and will be reviewed through a monthly reporting structure.

Recommendations/Next Steps

To hold a ‘market place’ style event to showcase work and foster broader interest in the SAFER Programme for those not already involved.

Engagement with the membership council is one of the key ways in ensuring the SAFER programme has patient/carer involvement. An event will be held in November where the membership council, leads from each work stream and operational staff delivering transformational change through the programme will share and discuss the progress and impact.

The SAFER Programme asks for continued support of the Executive Board to develop a culture of transformation and to deliver the quality and efficiency improvements necessary for the organisation to deliver the 5 year clinical strategy.

MEMBERSHIP COUNCIL CALENDAR OF ACTIVITY 2016

NOVEMBER 2016

DATE	MEETING	TIME	LOCATION	PLEASE ATTEND
1 Nov	Estates & Facilities DRG meeting	10.00 – 12.00	Room F2, First Floor, Acre House	SB, EH, GH, VM, BM, GR
1 Nov	Community DRG meeting	3.30 – 5.30	Room F2, First Floor, Acre House	AB, NE, PM, LM, GR
9 Nov	MCs/Chair Informal meeting	3.00 – 4.00	Boardroom, HRI	All
9 Nov	Members Public meeting (MCs Formal meeting)	4.00 – 6.00	Boardroom, HRI	All
10 Nov	FSS DRG meeting	11.00 – 1.00	Boardroom, HRI	AB, PM, LM, MR, NS, KW
10 Nov	Staff MCs' meeting	2.00 – 4.00	Room F2, Acre House	EH, MK, CC, NS, LS
16 Nov	BOD/MC Workshop (MCs morning only)	9.00 – 5.00	Boardroom, HRI	Any
25 Nov	MC Training Session: Understanding Quality in the NHS	10.30 – 12.30	Room F2, Acre House	Any

DECEMBER 2016

14 Dec	MC Development Session	12.30 – 4.30	Large Training Room, Learning Centre, CRH	Any

Calderdale and Huddersfield NHS

NHS Foundation Trust

Minutes of the Calderdale & Huddersfield NHS Trust Board of Directors and Membership Council Members Annual General Meeting held on Thursday 15 September 2016 at 6.00 pm in the Lecture Theatre, Learning Centre, Calderdale Royal Hospital

PRESENT

Speakers
Mr Andrew Haigh, Chairman
Mr Wayne Clarke, Publicly Elected Member-Deputy Chair/Lead MC
Mr Keith Griffiths, Director of Finance
Mrs Clare Partridge, Engagement Lead – KPMG External Auditors
Mrs Lindsay Rudge, Deputy Director of Nursing
Mr Owen Williams, Chief Executive

Others present:
Board of Directors
Dr David Anderson, Non-Executive Director
Mrs Helen Barker, Chief Operating Officer
Dr David Birkenhead, Executive Medical Director
Mr Richard Hopkin, Non-Executive Director (part)
Dr Linda Patterson, Non-Executive Director
Mr Ian Warren, Executive Director of Workforce and OD
Mrs Jan Wilson, Non-Executive Director
Mrs Victoria Pickles, Company Secretary

Membership Council
Mr Stephen Baines
Mrs Nasim Banu Esmail
Mrs Rosemary Hedges
Mrs Dianne Hughes
Mrs Katy Reiter
Mrs Veronica Maher
Mr Peter Middleton
Mr Brian Moore
Mrs Lynn Moore
Mrs Jennifer Beaumont
Mr Brian Richardson
Mr George Richardson (part)
Mrs Di Wharmby
Mr Bob Metcalfe

1. CHAIR'S OPENING STATEMENT AND INTRODUCTIONS

The Chairman opened the meeting by welcoming people to Calderdale Royal Hospital. He introduced the speakers and noted that other members of the Board of

Directors and Membership Councillors were also present in the audience. The Chairman highlighted the Information Technology Developments showcase given by the Health Informatics team both and, on behalf of the Board and Members thanked staff for their support.

2. APOLOGIES

Apologies were received from:

Board of Directors

Mr Brendan Brown, Executive Director of Nursing
Mrs Karen Heaton, Non-Executive Director
Mrs Lesley Hill, Director of Planning, Performance, Estates & Facilities
Mr Philip Oldfield, Non-Executive Director
Prof. Peter Roberts, Non-Executive Director

Membership Council Members

Mrs Annette Bell
Mrs Charlie Crabtree
Mr Grenville Horsfall
Mrs Michelle Rich
Ms Kate Wileman
Mr David Longstaff
Mrs Sharon Lowrie
Dr Cath O'Halloran
Mrs Dawn Stephenson
Mrs Chris Bentley
Mrs Eileen Hamer
Dr Mary Kiely
Mrs Linda Salmons

3. ANNUAL REPORT 2015/16

The Chairman reported that 2015/16 was a challenging year for the Trust. The national deficit was £2.45 billion and the Trust deficit stood at £20 million. He explained that the Trust had worked hard, in liaison with the regulators, to deliver high quality services both in hospital and the community with targets being maintained in the majority of areas.

The Chairman reported some of the key things that had happened during the year including the launch of a monthly Star Award to recognise and celebrate the achievement of Trust staff. He also highlighted the Care Quality Commission inspection in March which had shown some good care across both acute and community settings yet also highlighted areas for improvements and this work has been underway since their visit in March.

The Chairman commented that the NHS financial position is challenging and will continue to be in the future. NHS organisations will face difficult choices and that locally this has been seen in the Right Care, Right Time, Right Place (RCTP) consultation. Colleagues from the Trust had spent a lot of time with CCG colleagues talking to the public, patients and service users about the proposed changes and that the CQC inspection report findings supported the case for change.

The Chairman reported that this was the ninth year when the Board of Directors and Membership Council had come together at a joint Annual General Meeting, alternating sites between Huddersfield and Halifax each year to present the Annual Report and Accounts, to report on the work of the Membership Council and to present the results of the recent Membership Council elections.

4. ANNUAL ACCOUNTS – APRIL 2015 TO MARCH 2016

Keith Griffiths, Executive Director of Finance presented the Annual Accounts, full details of which were available in the Annual Report. It was noted that the details of these had been discussed at the Board of Directors Meeting and these were approved as a correct record.

The key areas were noted:

Financial Context

The Executive Director of Finance explained that over the year the Trust had seen:

- 122,000 inpatients – elective, non-elective and day cases
- 441,000 outpatients
- 147,000 A&E attendances

In addition the Trust has a turnover of £350m, the majority of which is spent on staffing with 5,909 colleagues employed by the Trust. There is property and equipment over two hospital sites with a combined value of £218m. The Trust is required to make efficiency savings, driven by tariff against a challenging financial and operational landscape.

The Trust's Performance in 2015/16 compared to 2014/15:

- 5% more non elective inpatients were treated
- 3.5% more activity was seen in A&E
- This put pressure on the Trust's capacity to deliver planned elective activity
- Savings/efficiency gains worth £18m were delivered.

2015/16 Financial Performance

	Plan	**Actual**
Income and Expenditure (excl. exceptional items)	(23.0)	(21.0)
Capital Expenditure	20.7	20.2
Cash Balance	1.9	1.9
Continuity of Service Risk Rating	2	2
Unqualified Audit Opinion	√	√

Key Financial Pressures

- Bed capacity linked to system resilience issues and the closure of capacity in community
- High levels of clinical staffing vacancies and national recruitment pressures driving high levels of agency staffing costs

Efficiency Savings Achieved

Procurement	£1.4m
Administrative and management	£2.2m

Clinical productivity	£2.5m
Clinical workforce	£3.2m
Non clinical and clinical income	£5.6m
Estates & facilities systems	£1.2m
Divisional budgetary control	£1.9m
Total savings achieved	£18m

The Future
The Executive Director of Finance explained that the NHS faces unprecedented financial challenges both locally and nationally. Locally the Trust has an increased demand for services which will require closer joint working with other organisations across West Yorkshire and modernisation of both technology and the estate. He concluded that there were no short term solutions to CHFT's financial deficit.

5. QUALITY REPORT
Lindsay Rudge, Deputy Director of Nursing presented the Quality Report. The presentation highlighted the quality priorities for 2015/16 and their progress:-

- Improving Sepsis – partially achieved
- Ensuring intravenous antibiotics are given on time – partially achieved
- Improving the discharge process - complete
- Better food – complete

She reported that work which had been undertaken throughout the year included:-

- Safety Huddles - a multi-disciplinary programme aimed at reducing falls.
- Technology supporting care – 'Nervecentre' roll-out to detect when a patient's condition is deteriorating
- Hospital Out of Hours Programme
- Visit by CQC Inspectors – overall rating "Requires Improvement"
- Development of a new Community Division

Joint work with the Membership Council to address patient experience feedback included:-

- Reduce Noise at Night – introduction of soft closing bin lids. Research study commenced on Ward 1, HRI
- Community – Time arranged to meet the midwife – increased number of community drop in clinics
- Not many menu choices – updated menus reviewed every 4 weeks. Additional options and special diet menus available
- Care and residential homes required more information around falls prevention and mental health guidance – The QUEST multi-disciplinary team have developed advice sheets for homes.

The Trust had also been successful in receiving a patient safety award for the Dementia team's work and this was being further developed within the Trust. It was noted that the CQC had commented on this work and acknowledged it as an example of good practice.

Finally, she highlighted that 'Compassionate Care' was a key motivator for all Trust colleagues and that the legacy of the late Dr Kate Granger who introduced "Hello my name is …" would be continued throughout all departments.

6. EXTERNAL AUDIT OPINION ON ANNUAL REPORT/QUALITY ACCOUNTS

Clare Partridge, Engagement Lead from KPMG gave a presentation outlining the work undertaken by the external auditors on the Annual Report and Accounts and the Quality Accounts. She explained the three areas focussed on within the Audit were:-

- Use of resources
- Financial Statements Audit
- Quality Accounts

Use of Resources

The Engagement Lead explained that the audit had concluded that the Trust had adequate arrangements to secure economy, efficiency and effectiveness in its use of resources with the following exceptions:-

- The Trust provided evidence that progress has been made against the enforcement undertakings issued in January 2015, and therefore arrangements were in place to secure value for money through responding to the enforcement undertakings. However the undertakings and modifications of the licence remained in place at the date of the report.
- Additionally, the Trust's strategic and turnaround plan still forecasts the Trust to be in deficit and reliant on Secretary of State external financial assistance beyond 2016/17.

Financial Statements and Annual Report

It was noted that within the financial accounts there had been one unadjusted audit difference and a number of minor presentational changes had been made but no recommendations were raised. There were no adjusted audit differences.

No inconsistencies had been found between the content of the Annual Report and Accounts. The Annual Governance Statement was found to be consistent with the financial statements and complied with relevant guidance.

Quality Accounts

A clean limited assurance opinion had been issued on the content of the Quality Report which could be referenced to supporting information and evidence provided. This represented an unmodified audit opinion on the Quality Report. It was noted that feedback from Calderdale Council Overview and Scrutiny Committee had been requested but not received.

Two mandated indicators had been tested:

- % of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the report period; and
- % of patients with a total time in A/E for 4 hours or less from arrival to admission, transfer or discharge.

A clean limited assurance opinion was given on the presentation and recording of the A&E Indicator data. It had not been possible to provide a limited assurance

opinion on the incomplete pathways indicator due to issues with accuracy of data, specifically in relation to the validation checks undertaken.

No issues were identified in the testing of the local indicator 'complaints closed within target time', as selected by the Membership Council.

Two recommendations were made in relation to improvement of processes in place.

7. FORWARD PLAN

Owen Williams welcomed everyone and thanked staff, volunteers and Membership Councillors for their work and commitment in caring for patients. He also wished to thank the Board of Directors for their commitment and challenge over the past year throughout the reconfiguration of services consultation.

Looking ahead the Chief Executive reported that the Trust would continue to use the 4 pillars of behaviour to achieve compassionate care:

- we put the patient first
- we work together to get results
- we do the must do's
- we go see

The Chief Executive set out the key areas of work for the Trust over the next year:

- Reconfiguration – he explained that commissioners would be make a decision on whether or not to progress to the next stage with proposals around the future configuration of hospital services in October.
- West Yorkshire – the Trust is a key participant in the work across West Yorkshire to develop a Sustainability and Transformation Plan. These were also being impacted upon by national discussions around the financial challenges in the NHS.
- Electronic Patient Record (EPR) – the Trust would implement a whole new EPR which would be key to ensuring better patient care and help to provide efficient services in the future.
- Care Quality Commission – The Trust's ambition was to keep improving services and to deliver the actions which had been developed following the inspection.

The Chief Executive shared a patient story which highlighted the care of a suicidal patient visiting the area who had been inappropriately admitted to the Trust. He highlighted the need to ensure that patients are treated in the right place, at the right time, by the right person to ensure complete compassionate care.

The Chairman thanked everyone for their contributions and reinforced that it was clear that this current year was going to be just as challenging as 2015/16.

8. ELECTION RESULTS AND APPOINTMENTS

The Chair reported that the second half of the meeting would concentrate on the Membership Council AGM.

a. Council Members

The Chairman reported the results of the elections run by the Electoral Reform Services on behalf of the Trust over the period 7 June to 22 August 2016. This had resulted in six public membership council appointments (Veronica Maher, Katy Reiter, Dianne Hughes, Nasim Esmail, Stephen Baines and Michelle Rich) and three staff membership council appointments (Nicola Sheehan, Linda Salmons, Charlie Crabtree).

It was noted that Peter Middleton had been appointed as Deputy Chair/Lead Governor to take over from Rev Wayne Clarke. The Chair thanked Wayne for his support as Membership Councillor for the past three years and latterly as Deputy Chair/Lead Governor for the Membership Council since 2015.

The Chairman extended a welcome to the newly elected and re-elected members along with Grenville Horsfall who had agreed to stay on for another year on the Reserve Register.

All these appointments could be seen on the Register of Members which was available within the packs. The ballot turnout rates this year was around 15% which was comparable to other trusts.

The Chairman wished to thank the other retiring members who included:- Mrs Jennifer Beaumont, Avril Henson, Julie Hoole, Kenneth Batten in addition to Chris Bentley who had been on the Reserve List. Two Stakeholder representatives had also ended their tenures – Prof John Playle and Cllr Naheed Mather.

b. Board of Directors – Non Executive Directors

The Chairman reported that the Nomination and Remuneration Sub Committee (Membership Council) had met on the 21 July 2016 to consider the two Non-Executive Directors whose tenures were due to expire this year. The Committee had agreed that the tenures of Dr Linda Patterson and Mr Phil Oldfield should be extended for a further three year period.

Those present formally ratified the aforesaid appointments and the Chairman introduced and welcomed the new members of the Membership Council.

9. MEMBERSHIP COUNCIL UPDATE – OVERVIEW OF THE MEMBERSHIP COUNCIL CONTRIBUTION DURING 2015/16

Rev Wayne Clarke, Deputy Chair gave an overview of the work of the Membership Council during 2015/16. This included:-

- Development of plans for the Trust, particularly through the Divisional Reference Groups
- Participation in training and development opportunities including Induction, individual training and development days.
- Oversight and holding to account of the Board of Directors through:
  - Chairman's One to One Meetings
  - Attendance at full Membership Council meetings and AGM
  - Attendance at Board of Directors Meetings.
  - Attendance of Council members on a wide range of sub committees such as Nomination and Remuneration, Organ Donation, Quality, Finance and Audit, Workforce, EPR and Charitable Funds.

- Joint workshops with the Membership Council and Board of Directors
- Involvement in interview panels
- Development of Patient Information Leaflets
- Awards panels for the Trust's Celebrating Success.
- Selection of indicators and oversight of the Quality Accounts.

Additional work undertaken by the Membership Council in 2015/16 included:-

- Participation in Theatre Action Week to improve theatre use and increase efficiency
- Involvement in the Integrated Transport Review to assess the efficiency of hospital and community resources
- Views on designing the best possible signage and way-finding techniques for patients through our hospitals
- Participation in the Trust's sustainability strategy
- Participation in familiarisation tours around specific areas of the Trust
- Work with Clinical Commissioning Groups to help design the Right Care, Right Time, Right Place public consultations
- Being a focus group for the Care Quality Commission inspection to the Trust
- Attending sessions on the Future State Validation on how EPR would affect the patient experience.

In conclusion Rev Wayne Clarke wished to thank the Membership Office for their help and support throughout the year.

10. QUESTIONS AND ANSWERS

The Chairman gave opportunity for those present to raise any general questions of the Board or Membership Council.

Question 1

Could the Trust be described as having a "good" year when HSMR and complaints rates were up?

The Chairman responded that the Trust's mortality rates were considered at each Board meeting as it remains a concern. He highlighted that a lot of work had been done to understand the reason behind the figures and that this would continue. This had included an independent review of mortality. In relation to complaints he commented that it was important people that people felt able to raise issues about services and make a complaint so that the Trust could learn from any case where a patient and their family had not been totally happy with their care. He said expectations are very high and that all complaints were investigated and responded to.

Question 2

Whether one of the testimonials in the consultation document was valid and that it had been submitted by the Trust to the CCG without consent.

The Chairman responded that this issue would be investigated as a complaint and formal response provided.

Question 3
What is the impact of the Government's decision to cease nurses' training grants?

The Deputy Director of Nursing Lindsay Rudge said that the Trust works closely with the University and that there would be plans in place for when the new system comes in in 2017/18. She said there are strong recruitment and retention policies in place and we would be trying to ensure the change was not detrimental to how we operate.

Question 4
Is the Trust affected by expensive drug costs?

The Executive Director of Finance and Chief Executive said that like all other Trusts, CHFT is affected by expensive drug costs but the more we use the cheaper they become.

Question 5
What is the impact of rising clinical negligence costs?

The Executive Director of Finance said that the pay outs often relate to historical cases and that he expected pay outs to rise again. The Chief Executive said it was important we try to support families so they do not feel as though litigation is their only route of action.

Question 6
If the CCG plans to reduce A&E attendances will that mean a reduction in income for the Trust?

The Chief Executive responded that as the Trust is also a community provider, there would be an opportunity to increase community income as more care is provided outside of hospital. The Trust is also working closely with GP Federations to provide joined up care in community. He said nationally there is the desire to reduce the number of patients.

Membership councillor Peter Middleton commented that over the last 20 years, life expectancy has increased by up to four years and that is due to excellent NHS care. He wanted to thank everyone working in the Trust.

11. DATE AND TIME OF NEXT MEETING
It was noted that a provisional date had been set for the next Annual General Meeting - Thursday 14 September 2017. The time and venue would be confirmed nearer the date.

The Chairman closed the formal meeting at approximately 7.15 pm.

/KB/AGM2016-MINS