Meeting of the Board of Directors

To be held in public

Thursday 23 April 2015 from 1:30pm

Venue: Boardroom, Sub-basement, Huddersfield Royal Infirmary HD3 3EA.

AGENDA

1.	Welcome and introductions:- Rev Wayne Clarke, Publicly Elected Membership Councillor Mr Peter Middleton, Publicly Elected Membership Councillor	Chairman	
2.	Apologies for Absence: Ms Julie Hull, Executive Director of Workforce and OD Anna Basford Director of Commissioning and Partnerships	Chairman	
3.	Patient/Staff Story "Perfect Week" presented by Dr Mark Davies, A/E Consultant	Executive Director of Nursing & Operations	**PRESENTATION**
4.	Declaration of interests	All	**VERBAL**
5.	Minutes of the previous meeting ▪ Held on 26 March 2015	Chairman	**APP A**
6.	**Action Log and Matters arising:** a. Voluntary Redundancy Scheme Update	Chairman Executive Director of Finance/ Interim Director of Workforce & OD	**APP B** **VERBAL**
7.	**Chairman's Report:-** a. Annual General Meeting – 17.9.15	Chairman	**VERBAL**
8.	**Chief Executive's Report:-** a. Divisional Restructure Progress	Chief Executive	**VERBAL**
Keeping the base safe			
9.	**Integrated Board Report** - Responsive - Caring - Safety - Effectiveness	Executive Director of PPEF Executive Director of Nursing Executive Director of Nursing Executive Medical Director	**APP C**

	- Well Led - CQUINs - Community - Monitor Indicators - Finance Financial Position Update – Month 12	Interim Director of Workforce and OD Executive Director of Nursing Executive Director of PPEF Executive Director of Finance Director of Finance Executive Director of Finance	**APP C2 TO FOLLOW**
10.	Risk Register	Executive Director of Nursing & Operations	**APP D**
11.	Director of Infection Prevention and Control Report	Executive Medical Director	**APP E**
12.	Emergency Planning Annual Report	Executive Director of Planning, Performance, Estates and Facilities	**APP F**
Improvement and innovation through strategic alliance			
NO ITEMS			
Transforming Care			
13.	**Update from sub-committees and receipt of minutes** ▪ Quality Committee (Minutes of 24.3.15 and verbal update from meeting held 21.4.15) ▪ Audit and Risk Committee – verbal update from meeting held 21.4.15 ▪ Verbal update from Finance and Performance Committee Meeting – 21.4.15 ▪ Membership Council Standing Orders		**APP G** **VERBAL** **VERBAL** **APP H**
Date and time of next meeting Thursday 28 May 2015 at 1.30pm Venue: Large Training Room, Learning Centre, Calderdale Royal Hospital, HX3 0PW.			

Resolution

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

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 23rd April 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 26.3.15 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 26 March 2015.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

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

Appendix

Attachment:

APP A - public bod minutes - 26.3.15.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 26 March 2015 in the Boardroom, Huddersfield Royal Infirmary

PRESENT

Andrew Haigh	Chairman
Dr David Birkenhead	Executive Medical Director
Julie Dawes	Executive Director of Nursing and Operations
Keith Griffiths	Executive Director of Finance
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities
Philip Oldfield	Non-Executive Director
Dr Linda Patterson	Non-Executive Director
Prof Peter Roberts	Non-Executive Director
Owen Williams	Chief Executive (for part of meeting)
Jan Wilson	Non-Executive Director

IN ATTENDANCE/OBSERVERS

Anna Basford	Director of Commissioning and Partnerships
Kathy Bray	Board Secretary
Diane Catlow	Lead Directorate Nurse (for part of meeting)
Eileen Hamer	Membership Councillor
Nick Lavigueur	Huddersfield Examiner Reporter
Joanne Machen	Project Manager – E-Rostering
Victoria Pickles	Company Secretary
Caroline Wright	Communications Manager

Item

33/15 APOLOGIES FOR ABSENCE AND INTRODUCTIONS

Apologies were received from:

Dr David Anderson	Non-Executive Director
Julie Hull	Executive Director of Workforce and Organisational Development
Jeremy Pease	Non-Executive Director
Linda Wild	Membership Councillor

The Chairman welcomed everyone to the meeting.

34/15 STAFF STORY

Diane Catlow, Lead Directorate Nurse – Families Senior Clinical Locality Manager attended the meeting to share with the Board her own experiences and that of the staff within the School Nursing Team during the recent transfer of the service in Calderdale to Locala. Diane gave an overview of the what it had been like for the staff to go through the procurement process from the initial notification the previous summer that the service would be put out to tender to the announcement that the Trust had been unsuccessful in its bid on 22 December 2015. She reflected that the team had worked hard to challenge their thinking about the service in the development of the bid and that the timing of the announcement had been difficult for staff.

During the three month prior to transfer of the servicestaff and management had worked with unions and commissioners. Diane advised the Board of the emotional support required to staff and their concern going into a social enterprise organisation. She confirmed that throughout this time the interests of the patients had been

paramount and that the team had ensured that the services continued to run effectively.
Diane shared the learning she had gained to date through this experience and hoped that this might help the Trust when other services are affected in this way. She confirmed that patients were aware of the new contact details and arrangements for the new service.

The Board thanked Diane for sharing her experiences and asked that in order to ensure the Trust learns from this she might prepare a summary of the learning points, together with her professional opinion on the reasons why the tender was unsuccessful.

35/15 DECLARATION OF INTERESTS

There were no declarations of interest to note.

36/15 MINUTES OF THE MEETING HELD ON THURSDAY 26 FEBRUARY 2015

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

37/15 MATTERS ARISING FROM THE MINUTES

a. 183/14a Voluntary Redundancy Scheme

In the absence of the Executive Director of Workforce & Organisational Development, the Executive Director of Finance advised that 111 offers had been made through the scheme. 9 applicants had withdrawn.The scheme would continue and late submissions would be considered. The staff leaving dates varied from April – May 2015. Savings at this stage had been identified as around £3m.

It was noted that an updated position would be brought to the next meeting.

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

b. 26/15 Rule 28

The Executive Director of Nursing and Operations reminded the Board that the Coroner had issued a Rule 28 due to the poor quality of the nursing and clinical documentation. She confirmed that this patient had died in March 2014 and therefore this was after the CQC review of documentation. The Quality Committee had discussed this issue and an action plan was being implemented to address the lessons learned around improvement in documentation including the re-establishment of the Documentation Group.

c. 26/15 Staff Survey

In the absence of the Executive Director of Workforce and Organisational Development, this item had been deferred until April 2015.

ACTION: BOD Agenda Item – May 2015 (JRH)

d. 26/15 Missed Doses

The Executive Director of Nursing and Operations advised that the work referred to in the previous minutes was being undertaken through the Audit Work.

e. 26/15 Community

Dr David Anderson's asked whether the figures for the number of patients who die within their preferred place of choice referred to inpatients. The Executive Director of Nursing and Operations confirmed that the figures related to community only.

f. 28/15 Draft Board Assurance Framework

Prof. Peter Roberts expressed concern that he had expected to be contacted to discuss this document outside the meeting but had not been approached. He was concerned that some comments agreed with the external advisers had not been taken on board which would give the document greater clarity and complexity. It was agreed that this would be discussed in detail later in the meeting.

38/15 ACTION LOG

Quarterly Quality Report

It was noted that an action date for an update of March 2015 had been noted on previous versions of the Action Log. The Executive Director of Nursing and Operations confirmed that the March date was for feedback on the document and that an update would be brought back to the Board at the May meeting.

ACTION: BOD Agenda Item – May 2015 (JD)

39/15 CHAIRMAN'S REPORT

a. West Yorkshire Chairs Meeting – 10.3.15 - The Chairman gave a brief overview of the issues discussed:-

i. Collaborative Working. A paper had been circulated to the Board. A further meeting with Chairs and Chief Executives was being planned for June.

ii. Emergency Care Programme. Feedback from NHS England had been provided at the Chairs meeting and further detail was expected later in the year.

iii. Structural Model. Dalton Review discussed.

vi. Winter Pressures. Challenges both locally and nationally discussed.

b. Update on Meeting with Local Chairs – The Chairman reported that he had met local commissioners and local authority representatives individually to discuss winter pressures. Calderdale Council's view was that there needs to be a push through the Health and Wellbeing Board to drive change in the health economy. It was noted that the People's Commission recommendations would be used to drive this forward.

ACTION: The Company Secretary agreed to produce a briefing note for the Board – April 2015

General discussion took place regarding the new commissioning arrangements in Greater Manchester and Prof. Peter Roberts suggested that himself and the Chairman might make arrangements in the future to attend one of their Board Meetings as observers.

ACTION: Prof. Peter Roberts

40/15 CHIEF EXECUTIVE'S REPORT

The Chief Executive advised that there were no matters to raise within the public part of the meeting.

41/15 INTEGRATED BOARD REPORT

The Executive Director of Planning, Performance, Estates and Facilities introduced the Integrated Board report as at 28 February 2014 and explained that each area would be presented in detail by the appropriate director.

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

- February saw a continuation of overperformance on non-elective workload reported in January. This had impact on patient flow resulting in:
  - Delayed discharges
  - Not achieving % of discharges before 11am
  - A further increase in outliers
  - It was noted that NHS England and requested a robust Easter Plan. This had been discussed at WEB.
- There had been an improvement in A/E 4 hour performance however it was unlikely that the 95% standard would be met for the month or the quarter,
- The DNA rate has recovered and is now within target.
- Capacity in Endoscopy has improved with the appointment of a locum consultant.
- Additional mobile MRI capacity has been procured between now and the end of the year.

- **Mixed Sex Breach** - The Trust had reported 1 mixed sex breach in Cardiology. A full route cause analysis was being undertaken.
- **Complaints** – Improvement had been made in the quality of the responses sent to complainants and further work done to reduce the backlog. A plan for every complaint was in place, particularly in Medicine and Surgery divisions to tighten processes.

Caring and Safety – the Executive Director of Nursing reported:-
- **Duty of Candour** – a process was now in place achieving 100% compliance.
- **Pressure Ulcers** - A slight rise in January/February was noted. A deep drive was being undertaken to investigate the reduction in grade 2 and the rise in grade 3 reports which would be discussed at the next Quality Committee.
  Family and Friends – Concern was expressed that although A/E staff were working hard to improve the response rates this had not been achieved. It was noted that a number of other Trusts were also reporting difficulty and work continued to look at good practice and how performance could be improved.
- **Effectiveness** – The Executive Medical Director reported**:-**
- **Fractured Neck of Femur** – The Trust had seen a much improved position from where it had been. Plans were in place to get this position back on track. It was noted that this position did not affect the trust financially under the current contract however it was important to improve this position as it impacts on the quality of care patients receive
- **Mortality** – It was agreed that this matter would be discussed under the Care of the Acutely Ill Patient report later in the meeting.

Well Led – on behalf of the Executive Director of Workforce and Organisational Development it was reported:-
- **Sickness** – Work was underway within the Divisions to reduce the levels of sickness particularly regarding long term sickness.
- **Mandatory Training** - There had been improved performance against the mandatory training across the Trust. Discussion took place regarding Appraisal of staff and it was noted that the position had changed since the report had been compiled. Work was in hand to improve the position for next year. Medical Appraisal was currently 82% and the expected target of 95% was expected to be achieved. Concern was expressed regarding the confusing data/ targets. It was noted that this had been discussed in detail at the Quality Committee.

Community – The Executive Director of Planning, Performance, Estates and Facilities reported that work continues to improve the data within the report. It was noted that reporting agreements with the Clinical Commissioning Group were not yet reflected within the new standards and this would be included in the future.

Commissioners had confirmed that they were happy with the services being provided.

CQUINS – The Trust were currently not achieving the targets in 3 areas:- A/E, Family and Friends and Safety Thermometer (ulcers). Further work was being done to agree the CQUINS for 2015/16.

The Board noted the contents of the report regarding:

- Monitor Indicators

Finance – the Executive Director of Finance reported on the content within the Integrated Board report and also presented the narrative of the financial position at month 11:-

Summary Year to Date

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

Summary Forecast

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

RESOLVED: The Board approved the Integrated Board Report

42/15 BOARD ASSURANCE FRAMEWORK (BAF)

The Company Secretary reminded the Board of the internal and external work undertaken to produce the Board Assurance Framework (BAF). It was acknowledged that this was an important document for the Board which described the way in which we managed the strategic objectives and drive the Board.

Links between the BAF and Risk Register were discussed and it was noted that both these documents were 'live' documents and constantly changing. Gaps were being identified and it was noted that once that work was finalised on the strategic objectives for 2015/16 these would be included within the revised BAF.

The Board discussed the contents of the BAF and overall it was felt that overall this was easier to follow than previous versions and the contents were a true reflection of the risks. Particular discussion took place regarding:-

- **Distinguishing Corporate from Operational Risks along with clinical and non-clinical risks.** Prof. Peter Roberts expressed concerns and was assured that the Audit and Risk Committee would have complete oversight of the BAF once it had been fully developed.
- **Transforming Care** – The Chairman asked whether there was duplication against the Care of the Acutely Ill Patient programme. Discussion took place regarding this programme and it was noted that this had been challenged at WEB and alignment to service improvement activity. It was noted that work continued to co-ordinate workstreams and achieve the targets set.
- **Workforce Plan** - Challenges in recruiting and reducing agency costs was discussed. The Chief Executive questioned whether the Board was comfortable with the lines of defence and at what stage should the Trust stop recruiting and do something else. There was no Workforce and OD representative at the meeting to respond.
- **Financial Risks** – The Executive Director of Finance expressed the need to work closer with divisions on a day to day basis. IT solutions were being reviewed and some management tools were being introduced.
- **E-Rostering** - The Chief Executive reported that this was a real learning curve for a number of colleagues in the Trust. An internal audit report had been undertaken and recommendations were expected to be reviewed by the Audit and Risk Committee at its next meeting in April.
- **Improvement and Innovation/Media Handling** - The Chief Executive suggested that media be invited to give an external view on the Trust's performance.

It was noted that this document would be brought to the Board on a regular basis and used as a management tool.

ACTION: Board Agenda Item – May 2015

43/15 RISK REGISTER

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

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

New risks which had been identified included:-

- Privacy & Dignity on Chemotherapy ward at HRI (16)

- THIS Modernisation programme, working with Bradford Teaching Hospitals Trust
- THIS Modernisation prog, tactical solutions to achieve Electronic Patient Record (EPR) project
- Completion of appraisal and mandatory training by 31.3.15
- Non-compliance with Information Commissioners Office Freedom of Information requirements
- Lack of Fire Wardens (predominantly Acre Mill)
- Failure to deliver expected benefits of EPR

The Board discussed the contents of the report and it was acknowledged that some timelines within it required updating. Other issues arising from the debate included:-

- **THIS Modernisation Programme** - The Chief Executive drew the Board's attention to the THIS Modernisation Programme and questioned whether it was appropriate to pull some of the risks together. Following discussion it was felt that EPR should stand alone and be kept as a separate risk for the organisation rather than combining it with E-Rostering.
- **Privacy and Dignity** - Jan Wilson, Non Executive Director reported that this was relevant to all wards. It was noted that an estates report on ward updates was being produced.
- **CQC Inspection** – Discussion took place about including the CQC Inspection in either the Risk Register or Board Assurance Framework. Following discussion it was agreed that this was required in both documents.

It was noted that work continued to embed risk identification, mitigation and management processes across the organisation, overseen by the Risk and Compliance Group

44/15 CARE OF THE ACUTELY ILL PATIENT

The Executive Medical Director presented the update on the Care of the Acutely Ill Patient and drew the Board's attention to the following:-

- **Mortality** – The Trust had recently purchased HED (Healthcare Evaluation Data) system licence. This new system would allow prediction of both Hospital Standardised Mortality Rates (HSMR) and SHMI only 1 month in arrears. There had been an increase seen in HSMR and mortality reviews had been undertaken for the 149 deaths in December. 18 of the 149 had gone through to the second stage of review In a very small number there were suggestions of some aspects of avoidability.
- **Deteriorating Patient** – Work was being rolled out within the organisation on the three key actions in this work stream:- the move to 'Nerve Centre' (the electronic observations and escalation system). Focus on ensuring escalation teams are correctly organised to respond to deteriorating patients and appropriate and timely end of life care decisions.
- **DNACPR** – More work was being undertaken on completion of forms and review date control. It was noted that this had been discussed in detail at the Quality Committee.
- **Care Bundles** – Actions over the next two months will include:
  ● Testing of admission signposting tool on admission areas
  ● Detailed gap analysis from current process to aid compliance with 2 new CQUINs - changes to be made over next 4 weeks so ready to capture data.
  ● Initial planning re work needed to improve compliance.
  ● Targets and improvement trajectories to be same as CQUINs for Sepsis and Acute Kidney Injury.

The Board noted that although the significant improvements had been made there needs to be continued focus on this work to complete some of the actions as the Trust performance remained a concern.

Specific discussion took place regarding:-

Coding – Phil Oldfield, Non Executive Director asked whether the Trust had considered utilising agency staff and software to support coding. This had been discussed at Quality Committee and coding remained an area of significant attention.

Care Bundles – It was suggested that the Quality Committee might invite clinicians/nurses to discuss the complexities of the care. This may include 'go and see' at other Trusts where care bundle compliance is good.

45/15 DIRECTOR OF INFECTION, PREVENTION AND CONTROL (DIPC) REPORT

The Board received the DIPC report and specific discussion took place regarding:-

- **C.Difficile cases** – 4 cases had been reported in February. The total number of cases was now 26 – 8 of which were classed as avoidable and 18 unavoidable.
- **Pseudomonas** HRI ICU - There have been 3 pseudomonas infections in patients linked to Huddersfield ICU and investigations were underway to review whether they were the same strain. It was felt that this was likely to be sporadic, however a meeting with Public Health England was planned to discuss these cases further.

RESOLVED: The Board received the report.

46/15 NURSING AND MIDWIFERY STAFFING – HARD TRUTHS REQUIREMENT

The Executive Director of Nursing and Operations presented the report which updated the Board on the work since the previous report in November 2014. It was noted that some areas required further investment and others need to reallocate resources.

Discussion took place regarding the methodology used and the fact that NICE guidance in A/E and NICU was awaited.

The report had been discussed within the Weekly Executive Board Meeting and it was agreed that funding would be obtained from other cost improvement plans.

The Board discussed the recruitment of overseas nurses. The Chief Executive asked if there was anything further the Trust could do in this regard. The Executive Director of Nursing and Operations advised that a supervision programme and induction/feedback was in place and felt confident that the required recruitment levels would be achieved subject to national shortages. Discussions were on-going around flexi-beds and the need to ensure a plan is in place in the future so that staffing could be arranged as appropriate.

47/15 GOVERNANCE REPORT

The Company Secretary presented the Governance Report which was taken as read. The report included:-

a. Use of Trust Seal during October 2014 to March 2015 - noted
b. Board Workplan 2015/16 – approved
c. Feedback from Monitor re Q3 Submission – information received and noted.

48/15 UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES

The following information was received and noted:-

- **Quality Committee** – The Board received the minutes of the 24.2.15 and a verbal update from the meeting on 24.3.15 which included:
    - **Kirkup Report** – report into failings of Morecambe Bay Maternity Unit. A gap analysis was being undertaken and reported back to the Quality Committee in May.
    - **Coroners Rule 28** – The Quality Committee reviewed the action plan and commented on the need to ensure that all actions go further than the department and division where the issue originated.
    - **DNA CPR** – Concern expressed by the Committee of the need to clearly define expectations in relation to DNA CPR with mechanisms being put in place.
    - **CQC Preparation** – The Board was assured that the Committee were assured that weekly executive CQC preparation meetings were working through actions which were being escalated and addressed.
    - **Performance** – The Committee acknowledged that although the Trust had seen a recent improvement in performance, it was likely to fail both the A/E target and the 62 day referral target for the year,. The Committee recognised the difficulties faced by the Trust in achieving the targets in the context of the recent significant pressures.

49/15 DATE AND TIME OF NEXT MEETING

Thursday 23 April 2015 at 1.30 pm in the Boardroom, Sub-basement, Huddersfield Royal Infirmary.

The Chairman thanked everyone for their attendance and contributions and closed the meeting at approximately 4.10 pm.

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 23rd April 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: ACTION LOG - PUBLIC BOARD OF DIRECTORS - APRIL 2015 - The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 April 2015	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

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

Appendix

Attachment:

DRAFT ACTION LOG - BOD - PUBLIC - As at 1 APRIL 2015.pdf

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 April 2015 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
30.10.14 140/14	**PATIENT/STAFF STORY** 30.10.14 - 'Carol's Story' extract video. 27.11.14 – 'Mr P' – Drug Error 18.12.14 – Dr Sarah Hoye 29.1.15 – Dr Mary Kiely – Care of the Dying 26.2.15 – Catherine Briggs, Matron – Green Cross Patient 26.3.15 – Diane Catlow – Families Senior Locality Manager	Executive Director of Nursing	Regular item on BOD Agenda going forward.	Monthly Reports		
18.12.14	**VOLUNTARY REDUNDANCY SCHEME – WORKFORCE PLAN** 27.11.14 – Draft proposal discussed in Private Board Meeting. Discussions to take place with Staff Representatives.	Executive Director of Workforce & OD	18.12.14 – Verbal update received 29.1.15 – Verbal update received 26.2.15 – Verbal update received 26.3.15 – Verbal update received	23.4.15		
25.7.13 113/13	**HSMR/MORTALITY/CARE OF THE ACUTELY ILL PATIENT** Presentation received from BC & HT. Action Plan discussed. Update on actions to be brought to BOD Meetings on a bi-monthly basis.	Executive Medical Director	Regular Updates to be brought back to BoD as plan progresses (bi- monthly). 26.9.13 – Update on worsened position received. Key themes and actions identified. Agreed that an updated plan would be brought back to the October 2013 BoD Meeting. 24.10.13 – Update and Action Plan received and note. Board endorsed plan and supported its implementation. Regular Updates to be brought back to BoD as plan progresses (bi- monthly). 19.12.13 – Update on progress received. Agreed that updated Action Plan would be brought to the Board in February 2014. 27.2.14 – Further work being undertaken by Divisions – roll out of mortality review process from March 2014 24.4.14 – Update received.	May 2015		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 April 2015 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
			26.6.14 – Update received 25.9.14 – Update received 27.11.14 – Update received 29.1.15 – Update received 26.3.15 – Update received			
29.1.15 14/15	**QUALITY REPORT** Report received. Feedback welcomed to the Executive Director of Nursing and Operations.	Executive Director of Nursing & Operations	Progress against actions to be reported to the Board in March 2015.	23.4.15		
24.11.11 134/11b.	**APPOINTMENT OF VICE CHAIR & SINED** Role of Vice Chair and SINED split into two. Alison Fisher – Vice Chair and Jane Hanson – SINED. Effective from 1.12.11. To be reviewed October 2012.	Chairman/ Director of Workforce & OD	18.10.12 – Agreed that current arrangements continue for a further 12 months 26.9.13 – Appointments made:- Jan Wilson and Vice Chair, David Anderson, SINED. To be reviewed 25.9.14 25.9.14 – Appointments extended for 12 months for Vice Chair, SINED and Audit & Risk Committee Chair – to be reviewed in September 2015	24.9.15		
29.1.15 13/15	**REVALIDATION REPORT** Update on progress within Trust on medical revalidations and appraisals was received. Revalidation for nurses to be introduced by end of financial year. Information on implementation awaited.	Executive Medical Director Executive Director of Nursing and Operations	1. Full year report to be brought to Board in May. 2. Revalidation for nurses report to be brought to the Board in May.	28.5.15 28.5.15		
26.3.15 26/15	**STAFF SURVEY** Item deferred until May 2015	Executive Director of		28.5.15		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 April 2015 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
		W& OD				
42/15 26.3.15	**BOARD ASSURANCE FRAMEWORK** Contents of the revised BAF discussed in detail. Amendments would be made and the document would be brought to the Board on a regular basis and used as a management tool		Next update to be brought to the Board in May 2015.	28.5.15		

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Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 23rd April 2015	**Sponsoring Director:** Lesley Hill, Director of Planning, Performance, Estates and Facilities
Title and brief summary: INTEGRATED BOARD REPORT - PERFORMANCE AND QUALITY REPORT - The Board is asked to note and approve the contents of the Integrated Board Report.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Quality Committee - 21.4.15	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

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

Appendix

Attachment:

Integrated Board Performance Report Mar 15.pdf

Board Of Directors Integrated Performance Report

Report For: March 2015

Calderdale and Huddersfield NHS
NHS Foundation Trust

Contents

Executive Summary Commentary

March has seen an over performance against the baseline activity in both elective and non-elective care. There has been a performance improvement in elective IP, DC and outpatient appointments and treatments. This is welcomed, but still leaves us with issues across the year, that need to be resolved for 15/16.

Non-electivity performance was 6.6% above baseline. There has been a further increase in delayed transfers of care to 6.7%. The increase in non-elective activity has resulted in increased outliers, ward moves, and may possibly be increasing the number of people who fall due to pressures on ward staff.

There has been another improvement in the number of complaints managed within timescales, and with the improvement plans in place, this should continue.

The March 4 hour A&E position was 95.03%. This is a good achievement when compared to activity levels. Unfortunately we have missed the target for quarter 4.

Calderdale and Huddersfield NHS Foundation Trust

Responsive Executive Summary - Mags Barnaby Director of Operations

THIS

Report For: March 2015		Indicator Source	Report For: March 2015 Target	Trust	Surgical	Medical	CWF	DATS	Year To Date Target	Trust	Surgical	Medical	CWF	DATS	Year End Forecast	Data Quality
Activity	% Elective Variance	Local	0.00%	6.74%	7.85%	8.33%	-7.89%	57.89%	0.00%	-7.09%	-7.59%	5.68%	-17.15%	9.12%		
	% Day Case Variance	Local	0.00%	6.67%	7.71%	11.93%	-24.55%	-56.10%	0.00%	1.46%	6.22%	-3.74%	-10.77%	-30.48%		
	% Non-elective Variance	Local	0.00%	8.00%	-5.13%	5.45%	16.66%	-	0.00%	1.54%	-6.29%	0.33%	6.32%	-		
	% Outpatient Variance	Local	0.00%	6.57%	9.65%	8.90%	2.70%	-47.44%	0.00%	0.19%	-1.06%	0.55%	5.34%	-10.17%		
RESPONSIVE - Operational Targets	Trust Theatre Utilisation	Local	90.00%	94.35%	93.32%	-	109.78%	-	90.00%	92.15%	91.98%	-	97.66%	-		
	% Daily Discharges - Pre 11am	Local	28.00%	10.86%	12.54%	9.83%	10.67%	-	28.00%	9.41%	11.43%	8.65%	8.82%	-		
	Delayed Transfers of Care	Local	5.00%	6.70%	-	-	-	-	5.00%	5.19%	-	-	-	-		
	Number of Outliers (Bed Days)	Local	0	508	92	416	0	0	0	6441	1210	5231	0	0		
	First DNA Rate	Local	7.00%	6.41%	6.28%	6.27%	6.94%	7.14%	7.00%	7.28%	7.29%	6.74%	7.81%	8.89%		
	Appointment Slot Issues on Choose & Book	Local	5.00%	12.59%	22.20%	15.59%	13.75%	-	5.00%	13.29%	15.64%	10.27%	5.99%	-		
RESPONSIVE: 18 Weeks and Other Access Indicators	% Non-admitted Closed Pathways under 18 weeks	National	95.00%	98.65%	98.49%	98.78%	99.03%	100.00%	95.00%	98.70%	98.70%	98.53%	99.14%	95.06%		
	% Admitted Closed Pathways Under 18 Weeks	National	90.00%	91.42%	91.21%	98.11%	93.58%	64.29%	90.00%	91.81%	91.00%	99.83%	96.02%	76.17%		
	% Incomplete Pathways <18 Weeks	National	92.00%	94.52%	92.50%	99.46%	98.72%	69.57%	92.00%	94.52%	92.50%	99.46%	98.72%	69.57%		
	18 weeks Pathways >=26 weeks open	Local	0	283	272	3	2	6	0	252	238	4	8	2		
	% Diagnostic Waiting List Within 6 Weeks	National	99.00%	99.82%	100.00%	99.82%	-	99.81%	99.00%	98.96%	98.92%	99.92%	-	98.87%		
	% Last Minute Cancellations to Elective Surgery	National	0.60%	0.21%	0.54%	0.00%	0.00%	0.00%	0.60%	0.23%	0.54%	0.00%	0.09%	0.00%		
RESPONSIVE: Cancer	62 Day Gp Referral to Treatment	National	85.00%	93.53%	92.23%	98.08%	100.00%	-	85.00%	91.02%	93.04%	87.41%	92.96%	-		
	62 Day Referral From Screening to Treatment	National	90.00%	83.33%	83.33%	-	-	-	90.00%	92.06%	91.79%	-	100.00%	-		
	31 Day Subsequent Surgery Treatment	National	94.00%	95.45%	94.44%	100.00%	-	-	94.00%	98.47%	98.97%	98.47%	-	-		
	62 Day Aggregated Gp Urgent Referral To Treatment And Screening Referral To Treatment	National	86.00%	98.37%	91.74%	98.08%	100.00%	-	86.00%	91.24%	92.85%	87.41%	93.85%	-		
	31 Days From Diagnosis to First Treatment	National	96.00%	100.00%	100.00%	100.00%	100.00%	-	96.00%	99.62%	99.60%	99.79%	98.18%	-		
	Two Week Wait From Referral to Date First Seen	National	93.00%	99.35%	99.69%	97.96%	100.00%	-	93.00%	98.23%	98.81%	95.90%	99.26%	-		
	Two Week Wait From Referral to Date First Seen: Breast Symptoms	National	93.00%	93.30%	93.30%	-	-	-	93.00%	95.63%	95.63%	-	-	-		
RESPONSIVE: Accident & Emergency	A and E 4 hour target	National	95.00%	95.03%	95.03%	-	-	-	95.00%	94.55%	94.55%	-	-	-		
	Time to Initial Assessment (95th Percentile)	National	00:15	00:25	00:25	-	-	-	00:15	00:21	00:21	-	-	-		
	Time to Treatment (Median)	National	01:00	00:17	00:17	-	-	-	01:00	00:19	00:19	-	-	-		
	Unplanned Re-Attendance	National	5.00%	4.60%	4.60%	-	-	-	5.00%	4.96%	4.96%	-	-	-		
	Left without being seen	National	5.00%	3.05%	3.05%	-	-	-	5.00%	2.73%	2.73%	-	-	-		

Calderdale and Huddersfield NHS
NHS Foundation Trust

Responsive/Operational Targets - Director of Operations

THIS

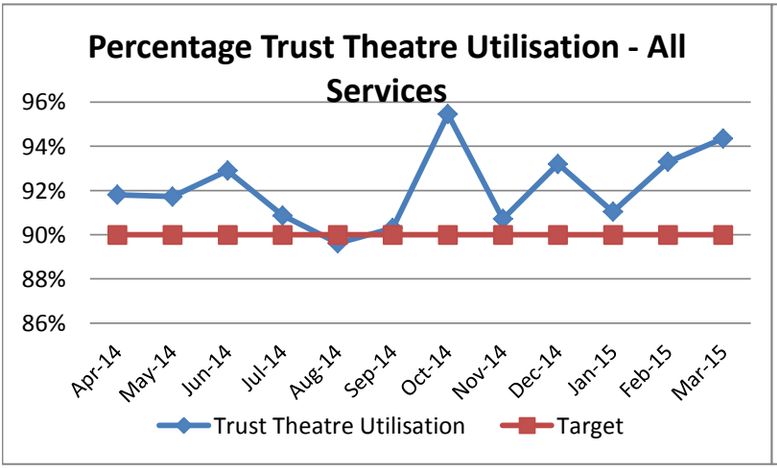
Report For: March 2015	Target	Trust	Surgical	Medical	CWF	DATS
Trust Theatre Utilisation	90.00%	94.35%	93.32%	-	109.78%	-
Outpatient Utilisation (Attendances Per Slot)	-	-	Indicator in Development			
% Daily Discharges - Pre 11am	28.00%	10.86%	12.54%	9.83%	10.67%	-
Delayed Transfers of Care	5.00%	6.70%	-	-	-	-
Number of Outliers (Bed Days)	0	508	92	416	0	0
Appointment Slot Issues on Choose & Book	5.00%	12.59%	22.20%	15.59%	13.75%	-
First DNA Rate	7.00%	6.41%	6.28%	6.27%	6.94%	7.14%

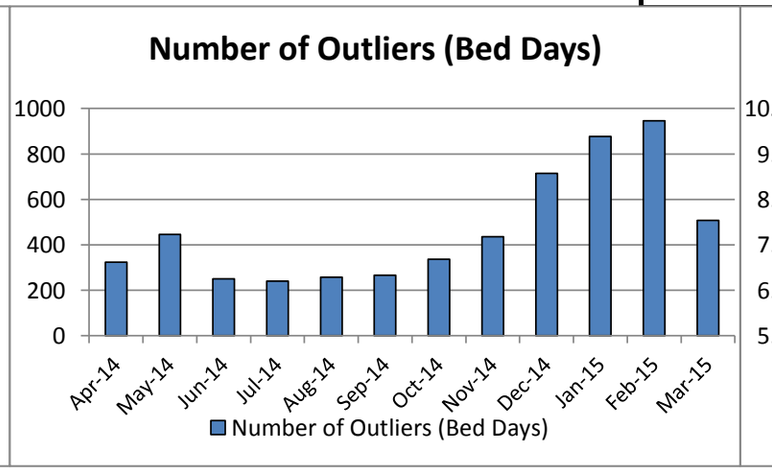
% Daily Discharges Pre 11am - discharge levelling targets require 28% of medical patients and 27% of surgical patients to be discharged before 11am, this released capacity allows us to admit patients who need a bed in the early part of the day. The vehicle for making this possible is Visual Hospital and Plan for Every Patient. A number of initiatives to improve performance have been implemented but not embedded consistently. Work is on-going to achieve this and this has now become part of the Reduced LOS work stream of the PMO. Clinical Site Commanders are now in post and detailed design work is ongoing to allow the Commanders to manage daily discharges, including facilitation of patients leaving hospital earlier in the day.

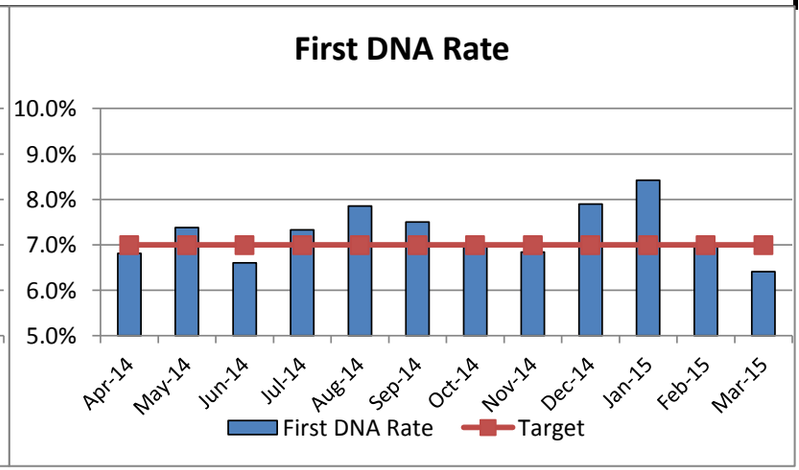
Appointment Slot Issues - Target 5% performance 13.75%. Gastroenterology (124 patients awaiting appointment) - In year, there have been short-term Locum contracts through resilience funding plus WLIs and additional goodwill sessions. In addition, the speciality has worked with the Newton team to review clinic templates and increase routine capacity by 686 attendances annually. The service has now reached a ceiling in terms of efficiency gains and capacity. The ongoing capacity gap is reflected in the ASI position and an advert has been placed for a second consultant. Maxillo-facial (184 patients awaiting appointments) - a recent increase in demand has resulted in ASIs. Additional clinics are planned to address the shortfall. Ophthalmology (173 patients waiting appointments) The ASIs relate to reduction in capacity due to consultant vacancies. Two new Consultants have now commenced, with one vacancy remaining. WLI clinics continue.

First DNA Rate - Target 7%, performance 6.41% - Performance has recovered and is within target levels with only one Division out of range. The SMS and Interactive Voice Messaging continues to deliver a reduction in missed appointments, and patients are now able to update contact numbers at the self checking kiosks. Evening staff have now been recruited to support the extended working in OP reception, the role includes telephoning potential DNAs as an added precaution - the work will focus on high DNA clinics and age ranges. Overall the DNA rate is in line with peer Trusts.

Outlier Rate (bed days) - target is no outliers. Decreasing numbers of patients have outlied in month from picture seen over last 3 months . The work going on within the reduced LOS PMO work stream aims to address the outlier situation further.







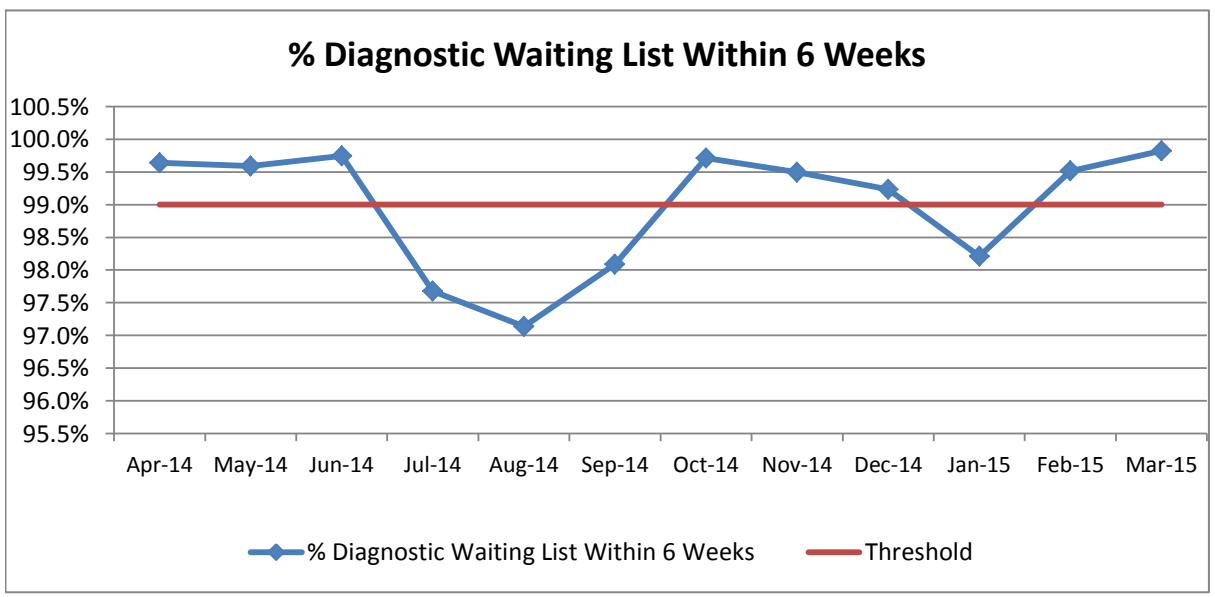
Calderdale and Huddersfield NHS
NHS Foundation Trust

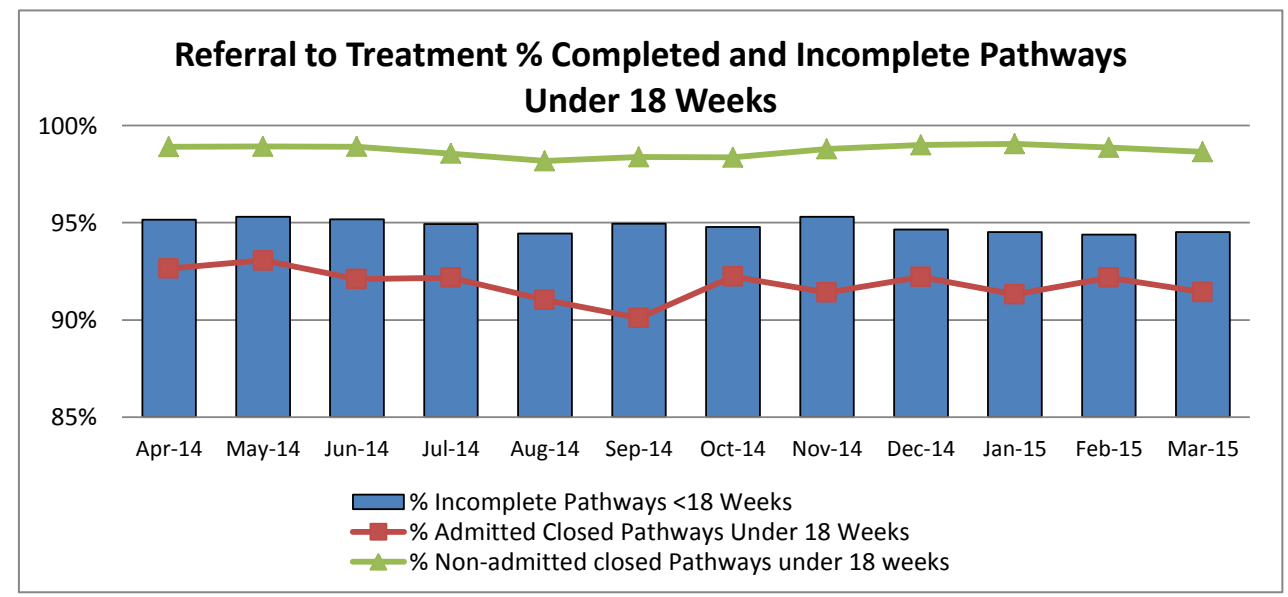
Responsive - RTT - Director of Operations

THIS

Report For: March 2015	Target	Trust	Surgical	Medical	CWF	DATS
% Non-admitted closed Pathways under 18 weeks	95.00%	98.65%	98.49%	98.78%	99.03%	100.00%
% Admitted Closed Pathways Under 18 Weeks	90.00%	91.42%	91.21%	98.11%	93.58%	64.29%
% Incomplete Pathways <18 Weeks	92.00%	94.52%	92.50%	99.46%	98.72%	69.57%
18 weeks Pathways >=26 weeks open	0	283	272	3	2	6
% Diagnostic Waiting List Within 6 Weeks	99.00%	99.82%	100.00%	99.82%	-	99.81%
% Last Minute Cancellations to Elective Surgery	0.60%	0.21%	0.54%	0.00%	0.00%	0.00%

RTT - Vascular time out 14th April - actions to reduce RTT of interventional radiology.
1. straight to intervention form MDT outcome in appropriate patient groups 2. Radiology expediting MRA reporting to Interventional consultant radiologists 3. Straight to test for further discussion - improvement in referrals form primary care would be required - we will actively monitor May/ June for improvement Diagnostic 6 week waits - continue with modality based capacity meetings. Business case for third MRI scanner being progressed. If approved implementation likely late 2015 Interim use of mobile scanners are in place and will continue.





Calderdale and Huddersfield NHS Foundation Trust

Responsive - Cancer - Director of Operations

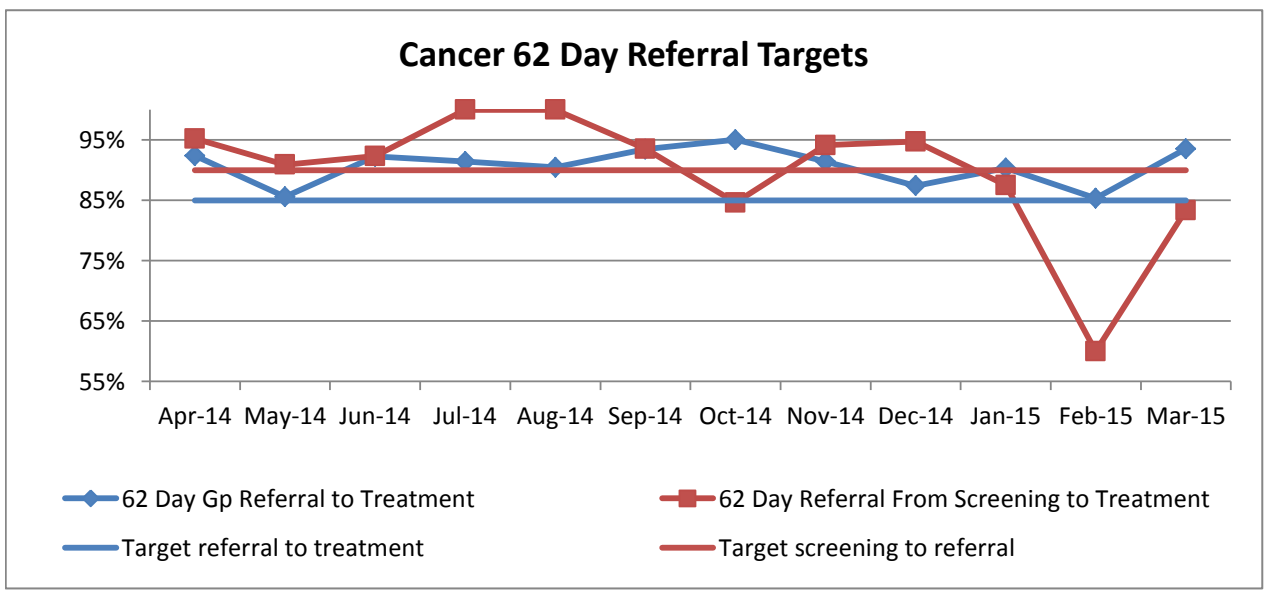
THIS

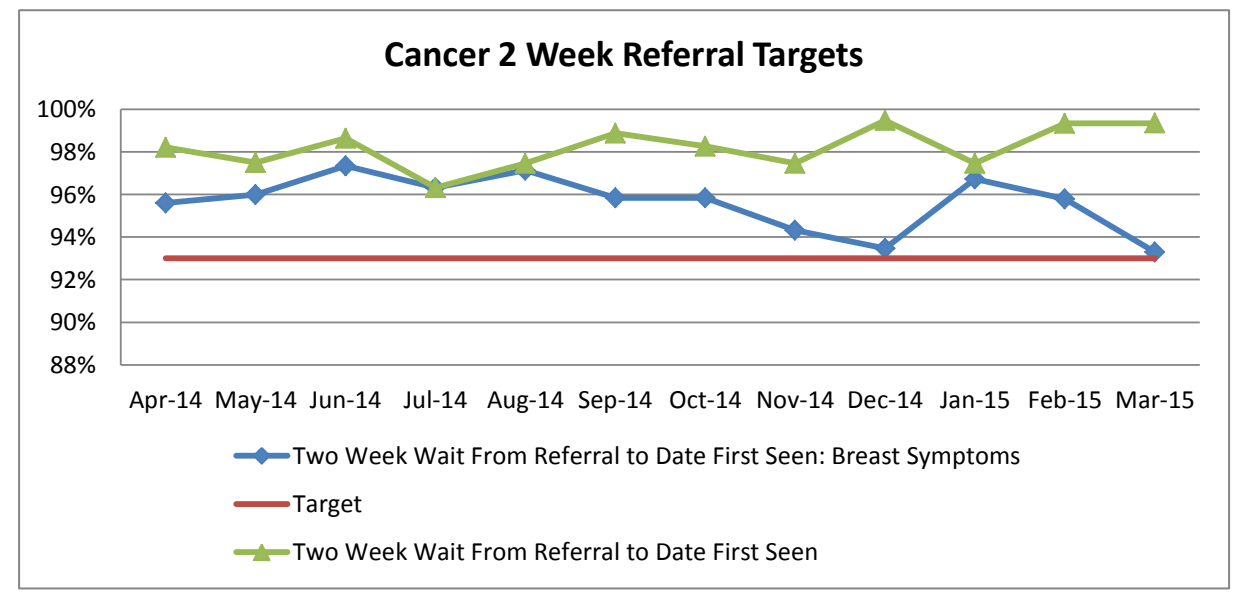
Report For: March 2015	Target	Trust	Surgical	Medical	CWF	DATS
Two Week Wait From Referral to Date First Seen	93.00%	99.35%	99.69%	97.96%	100.00%	-
Two Week Wait From Referral to Date First Seen: Breast Symptoms	93.00%	93.30%	93.30%	-	-	-
31 Days From Diagnosis to First Treatment	96.00%	100.00%	100.00%	100.00%	100.00%	-
31 Day Subsequent Surgery Treatment	94.00%	95.45%	94.44%	100.00%	-	-
31 day wait for second or subsequent treatment drug treatments	98.00%	100.00%	100.00%	100.00%	-	-
62 Day Aggregated Gp Urgent Referral To Treatment And Screening Referral To Treatment	86.00%	98.37%	91.74%	98.08%	100.00%	-
62 Day Gp Referral to Treatment	85.00%	93.53%	92.23%	98.08%	100.00%	-
62 Day Referral From Screening to Treatment	90.00%	83.33%	83.33%	-	-	-

The breach In March was breast screening which originate in Bradford.

Unfortunately in March the screening service had unusually low numbers of screening patients treated, allowing for no breaches to occur in order to achieve the 90% target. The 0.5 breach occurred due to the patient choosing to go on holiday for 6 weeks before attending the 1st OPA at BRI.

These issues are regularly discussed at Cancer Locality Board and Planned Care Board so that the GP's receive feedback along with ourselves and public Health; so that we can education patients in the importance of being treated early.





Calderdale and Huddersfield NHS
NHS Foundation Trust

Responsive/Accident & Emergency - Director of Operations

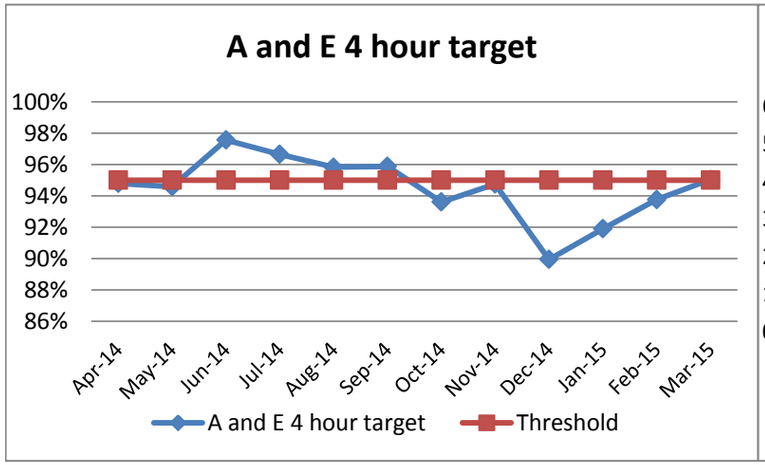
THIS

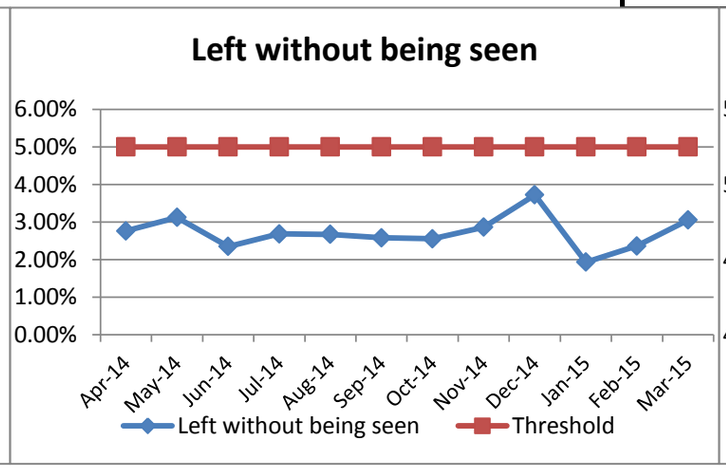
Report For: March 2015	Target	Trust	Surgical	Medical	CWF	DATS
A and E 4 hour target	95.00%	95.03%	95.03%	-	-	-
Time to Initial Assessment (95th Percentile)	00:15	00:25	00:25	-	-	-
Time to Treatment (Median)	01:00	00:17	00:17	-	-	-
Unplanned Re-Attendance	5.00%	4.60%	4.60%	-	-	-
Left without being seen	5.00%	3.05%	3.05%	-	-	-

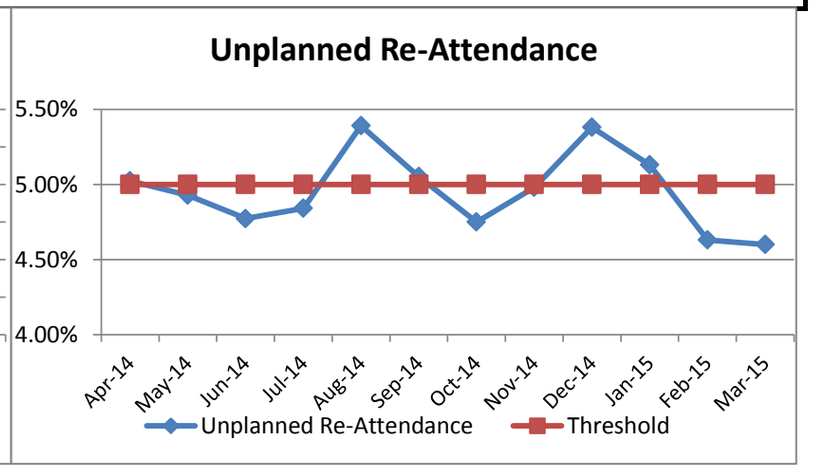
Continued increase in LOS and patients on the green cross pathway has shown a continued increase at both sites. Discharge levelling has generally not been achieved creating lengthy delays for patients and 'exit block' within A&E. A 'Must Do' attendance by Nurse in Charge of Wards at 1pm bed meeting has been introduced to discuss levelling and any potential delays. Clinical Site Commanders will be fully operational from 27th April 2015 and with improvements in the Operational Management this should have a significant impact on discharge levelling. March 2015 performance was over the 95% required performance target. The beginning of Q1 performance and April performance is at risk of delivering against the 95% target. Improvement plan in place to keep the focus on A&E indicators and improvement in patient experience.

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

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







			Report For: March 2015							Year To Date						
	Report For: March 2015	Indicator Source	Target	Trust	Surgical	Medical	CWF	DATS	Target	Trust	Surgical	Medical	CWF	DATS	Year End Forecast	Data Quality
Caring	Number of Mixed Sex Accommodation Breaches	National	0	0	0	0	0	0	0	15	0	15	0	0		
	% Complaints closed within target timeframe	Local	95.00%	46.00%	36.00%	37.00%	78.00%	100.00%	95.00%	32.00%	33.00%	27.00%	36.00%	35.00%		
	Total Complaints received in the month	Monitor	-	45	26	10	7	2	0	615	288	168	99	45		
	Inpatient complaints per 1000 bed days	Monitor	-	0.8	1.4	0.5	1.0	-	-	-	-	-	-	-		
	Total Concerns in the month	Monitor	-	71	32	22	9	7	-	865	373	321	76	64		
	Number of Patients Surveyed (RTM) - (Quarterly)	Local	-	606	230	336	40	-	-	2451	964	1337	150	-		
	Overall, How would you rate the care you received? (RTM)	Local	-	9.0	9	9	9	-	-	9.0	9.1	8.9	9.2	-		
	Have You Found Someone on the Hospital Staff to Talk to About Your Worries or Fears (RTM)	Local	-	8.9	9	9	9	-	-	8.9	8.9	8.8	9.5	-		
	% RTM Responses That are on or Above Target (Quarterly)	Local	-	59.30%	59.30%	59.30%	70.40%	-	-	55.60%	63.00%	65.40%	79.00%	-		
Caring - Friends & Family	Friends & Family Test (IP Survey) - Response Rate	CQUIN	30.00%	45.70%	46.50%	45.00%	49.40%	-	30.00%	40.40%	45.20%	36.20%	37.70%	-		
	Friends & Family Test (IP Survey) - % would recommend the Service	CQUIN	-	96.41%	95.60%	97.20%	97.50%	-	-	96.30%	96.80%	95.60%	98.60%	-		
	Friends & Family Test (IP Survey) - % would not recommend the Service	CQUIN	-	1.00%	1.30%	0.72%	1.28%		-	0.90%	0.80%	1.10%	0.60%			
	Friends & Family Test (Maternity Survey) - Response Rate	CQUIN	-	23.00%	-	-	23.00%	-	-	21.00%	-	-	21.00%	-		
	Friends & Family Test (Maternity) - % Would recommend the Service	CQUIN	-	95.70%	-	-	95.70%	-	-	93.00%	-	-	93.00%	-		
	Friends & Family Test (Maternity) - % Would not recommend the Service	CQUIN	-	1.70%	-	-	1.70%		-	3.30%	-	-	3.30%			
	Friends and Family Test A & E Survey - Response Rate	CQUIN	20.00%	8.70%	8.70%	-	-	-	20.00%	18.30%	18.30%	-	-	-		
	Friends and Family Test A & E Survey - % would recommend the Service	CQUIN	-	89.60%	89.60%	-	-	-	-	88.80%	88.80%	-	-	-		
	Friends and Family Test A & E Survey - % would not recommend the Service	CQUIN	-	6.36%	6.36%	-	-		-	6.00%	6.00%	-	-			
	Percentage of non-elective inpatients 75+ screened for dementia	CQUIN	90.00%	92.40%	-	-	-	-	90.00%	95.40%	-	-	-	-		

Caring - Director of Nursing

Report For: March 2015	Target	Trust	Surgical	Medical	CWF	DATS
Number of Mixed Sex Accommodation Breaches	0	0	0	0	0	0
% Complaints closed within target timeframe	95.00%	46.00%	36.00%	37.00%	78.00%	100.00%
Total Complaints received in the month	-	45	26	10	7	2
Inpatient complaints per 1000 bed days	-	0.8	1.4	0.5	1.0	-
Total Concerns in the month	-	71	32	22	9	7
Number of Patients Surveyed (RTM) - (Quarterly)	-	606	230	336	40	-
Overall, How would you rate the care you received? (RTM)	-	9.0	9.2	8.9	9.3	-
Have You Found Someone on the Hospital Staff to Talk to About Your Worries or Fears (RTM)	-	8.9	8.7	9.1	8.9	-
% RTM Responses That are on or Above Target (Quarterly)	-	59.30%	59.30%	59.30%	70.40%	-

Complaints:

1. Why off plan? There has been a drive to ensure all cases ongoing for more than 3 months over target were completed. This has increased the number of complaints closed within this month, many of which would have been out of time timeframe cases.

2. Actions to get on plan? The Medical and Surgical Divisions have developed detailed plans to complete all cases ongoing over target. All Divisions have established robust arrangements to respond to complaints in timescale.

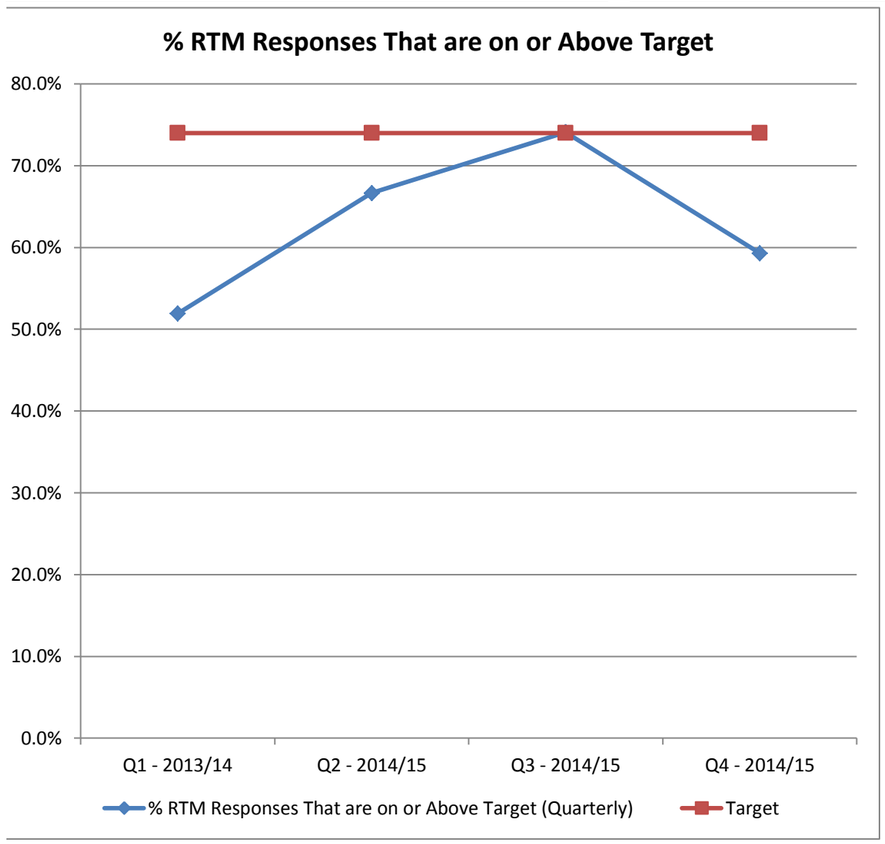
3.Achieved by date: All complaints that are over 3 months old to be complete by 17 April 2015. All cases ongoing over target to be complete by 31 May 2015. All cases to be managed in target from 1 June 2015.

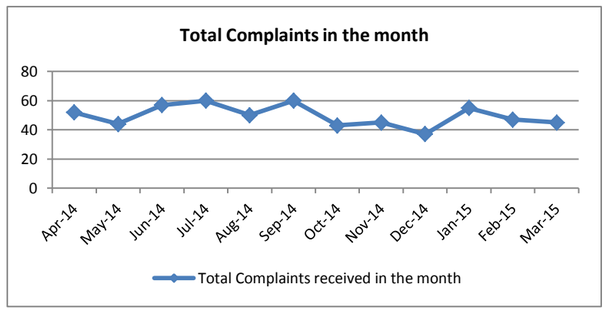
Real Time Patient Monitoring (RTPM)- NB - Quarterly process, data covers the period of Oct 14 - Dec 14

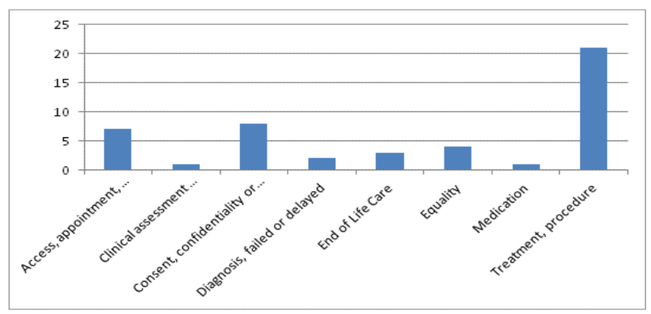
1. Why away from plan: All Divisions are scoring green (equivalent to top 20% of Trusts nationally) for the 2 questions listed. A local target has been set for 20 of the 27 questions asked to have a RAG rated 'green' score - this equates to 74%, this has not been achieved for quarter 3.

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

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

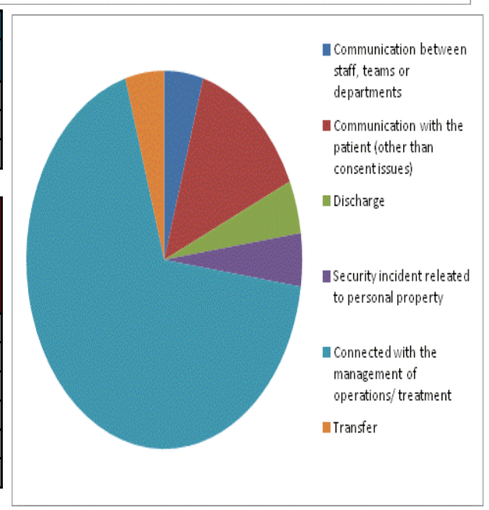






MONTH	Complaints Received		Variance	
	2013/14	2014/15	on year	on month
January	52	55	3	18
February	50	47	3	8
March	45	45	0	2

Complaints by Division and Severity	GREEN	YELLOW	ORANGE	RED
CWF	0	2	5	0
DaTS	0	1	1	0
Estates and Fa	0	0	0	0
Medical Divisi	0	5	4	1
SAS	0	22	3	1
Totals:	0	30	13	2



Caring - Director of Nursing

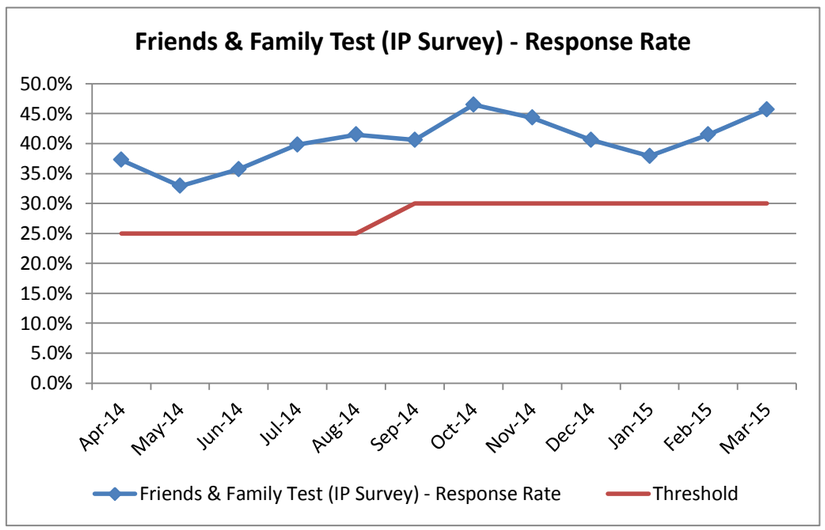
Report For: March 2015	Target	Trust	Surgical	Medical	CWF	DATS
Friends & Family Test (IP Survey) - Response Rate	30.00%	45.70%	46.50%	45.00%	49.40%	-
Friends & Family Test (IP Survey) - % would recommend the Service	-	96.41%	95.60%	97.20%	97.50%	-
Friends & Family Test (IP Survey) - % would not recommend the Service	-	1.00%	1.30%	0.72%	1.28%	
Friends & Family Test (Maternity Survey) - Response Rate	-	23.00%	-	-	23.00%	-
Friends & Family Test (Maternity) - % Would recommend the Service	-	95.70%	-	-	95.70%	-
Friends & Family Test (Maternity) - % Would not recommend the Service	-	1.70%	-	-	1.70%	
Friends and Family Test A & E Survey - Response Rate	20.00%	8.70%	8.70%	-	-	-
Friends and Family Test A & E Survey - % would recommend the Service	-	89.60%	89.60%	-	-	-
Friends and Family Test A & E Survey - % would not recommend the Service	-	6.36%	6.36%	-	-	
Percentage of non-elective inpatients 75+ screened for dementia	90.00%	92.40%	-	-	-	-

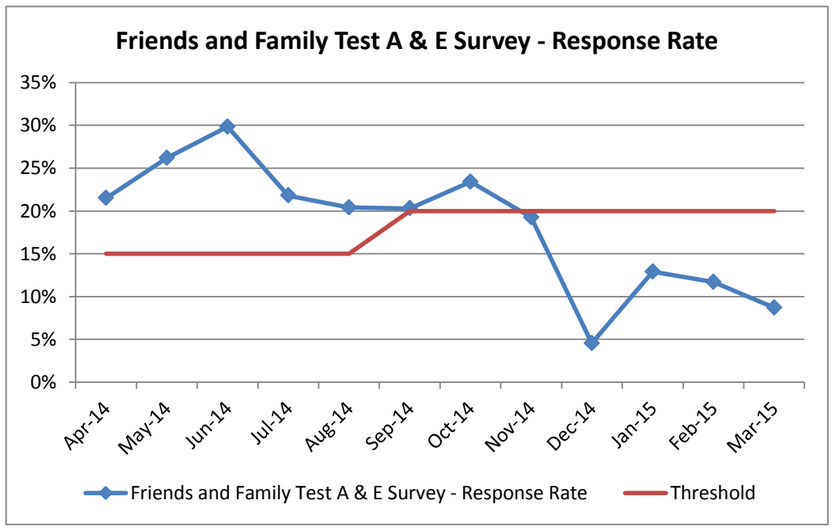
Friends and Family Test A & E Survey - Response Rate

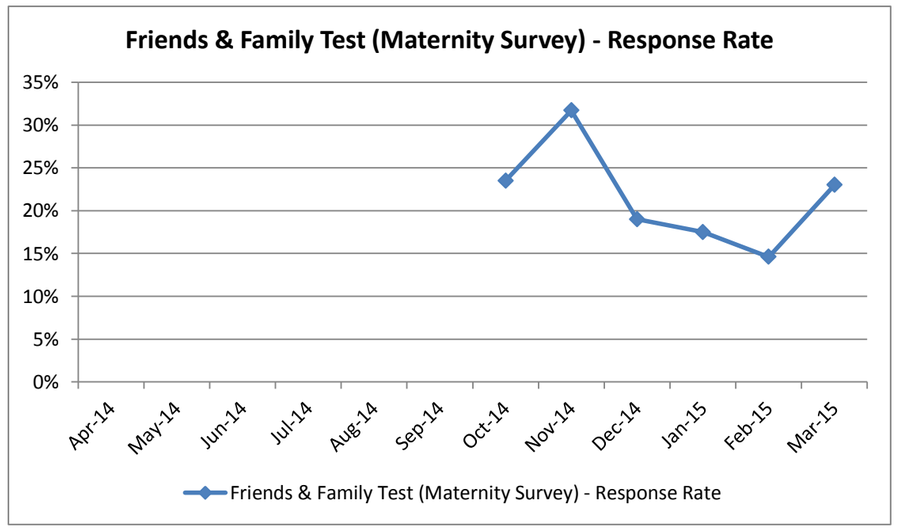
1. Why off plan: Ongoing work pressure in the A&E department appears to be making FFT difficult to deliver.

2 .Actions to get back on plan: Extensive engagement continues with the A&E team led by the matrons and senior sisters. There has been an increase in publicity, with large posters displayed in the clinic rooms and additional post-boxes located in the department to submit returns. In addition the team are considering text messages and a 'go see' to another A&E unit with better response rates.

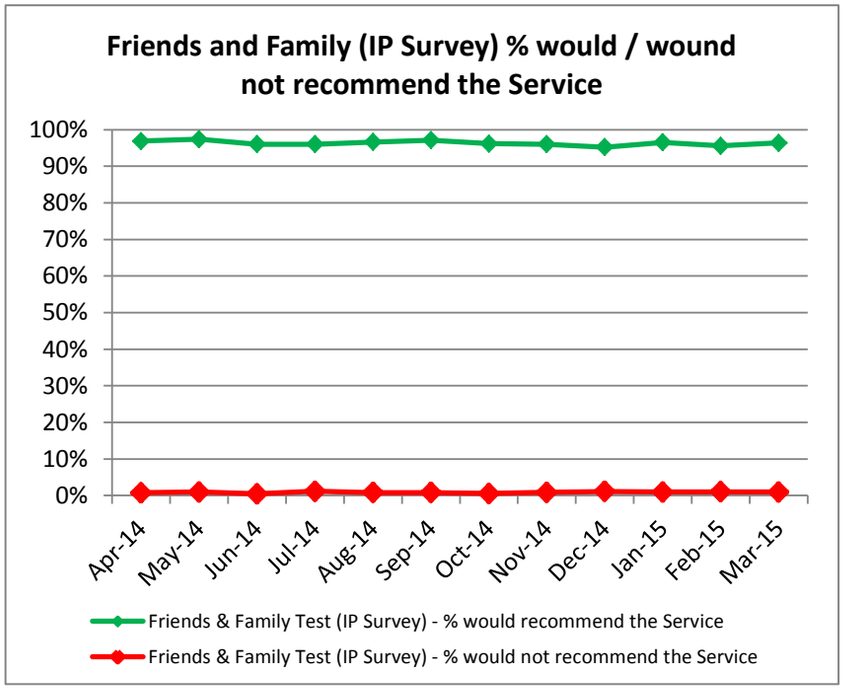
3. Achieved by date: Further discussion of low response rate takes place 12/04/2015 - actions to be be considered following this.

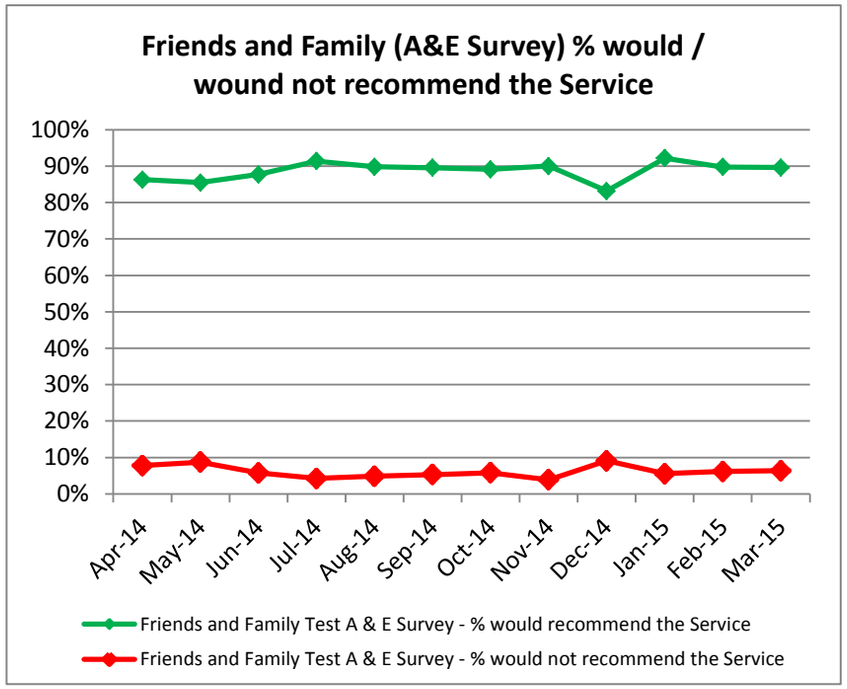


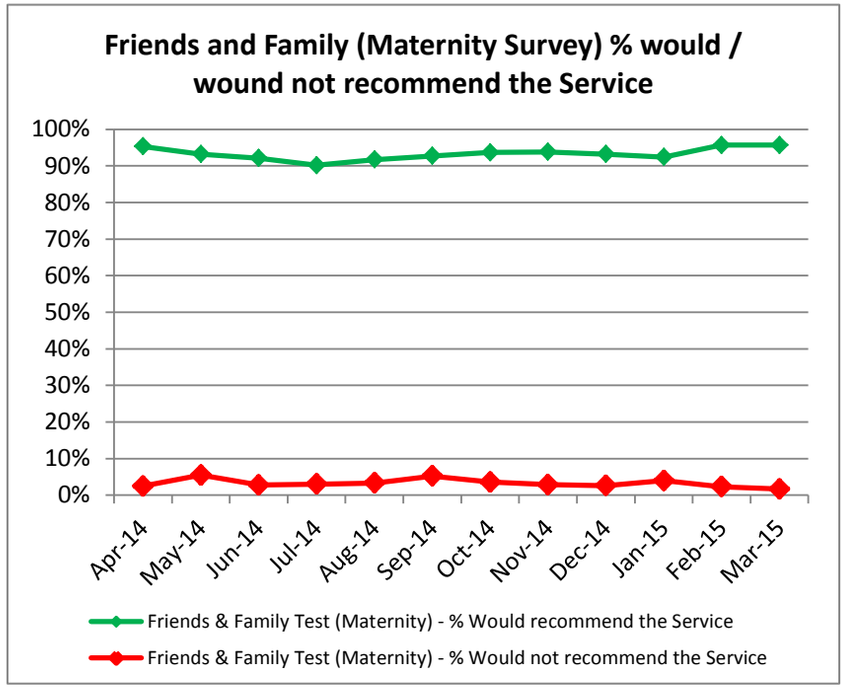


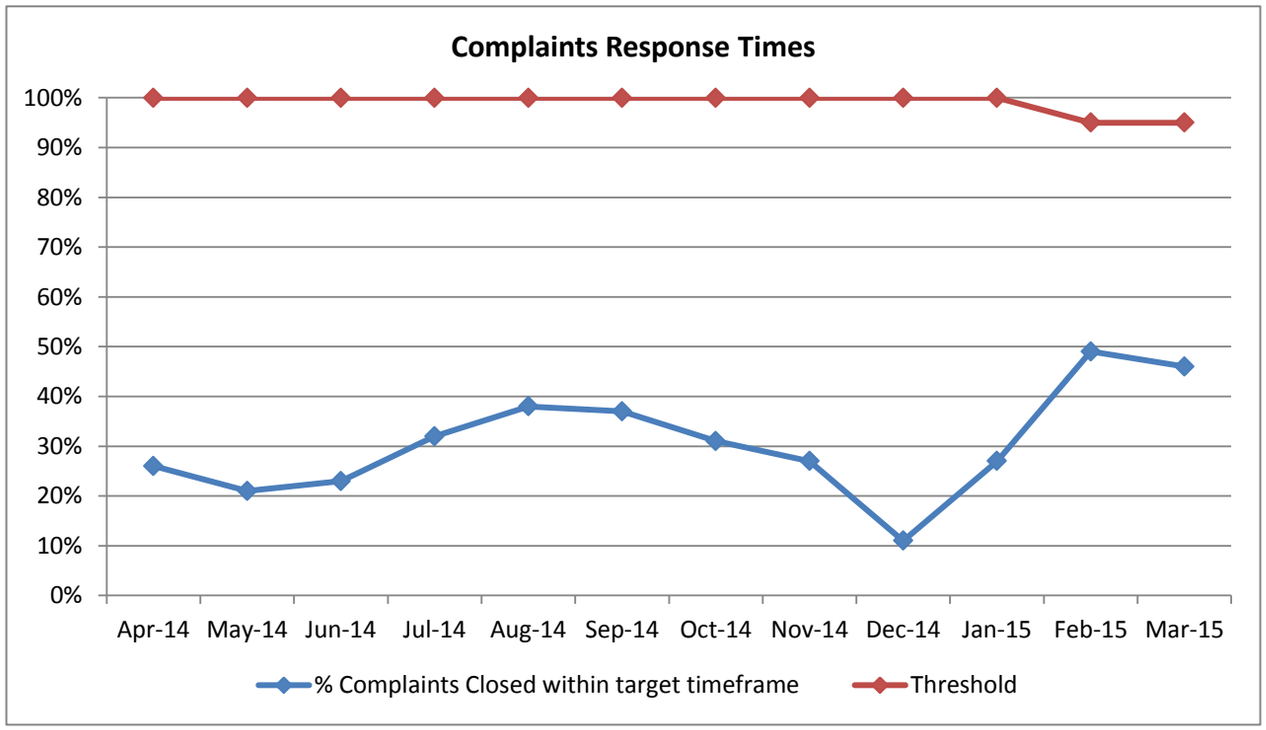


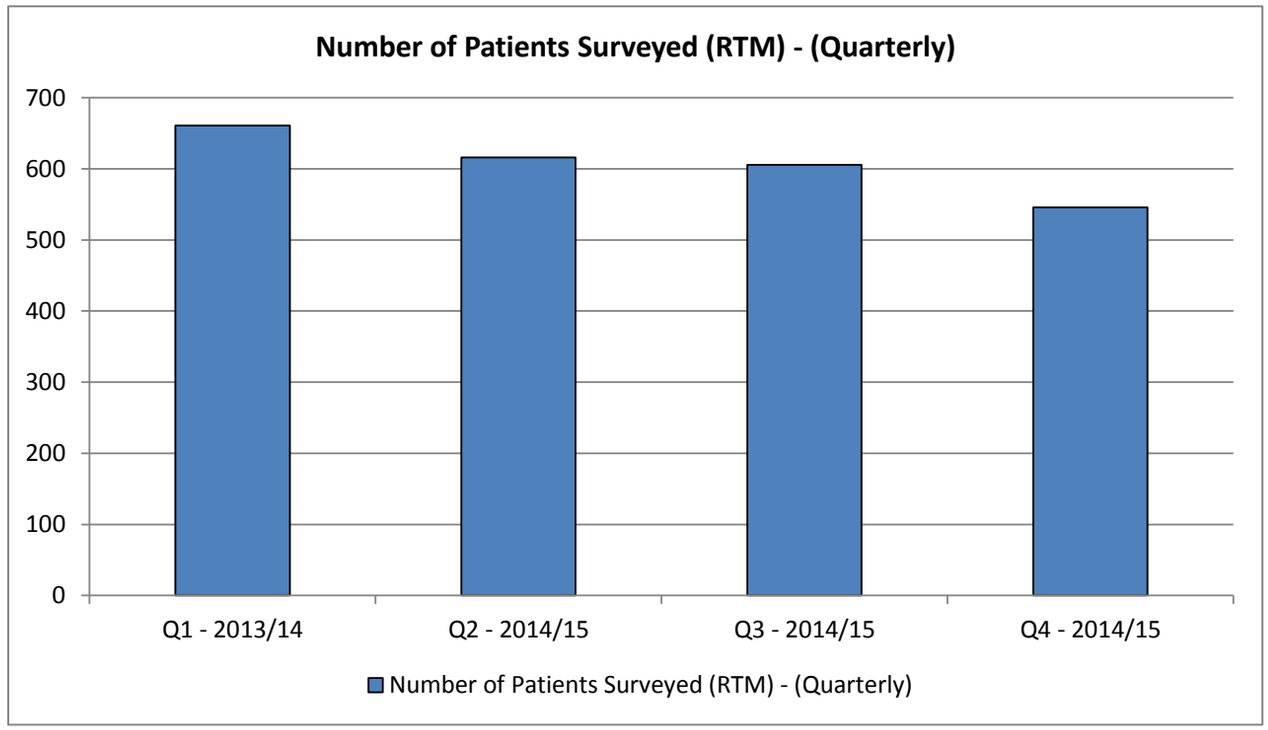
Caring - Director of Nursing











Safety Executive Summary - Julie Dawes Director of Nursing

	Report For: March 2015	Indicator Source	Report For: March 2015 Target	Trust	Surgical	Medical	CWF	DATS	Year To Date Target	Trust	Surgical	Medical	CWF	DATS	Year End Forecast	Data Quality
Safety	Inpatient Falls with Serious Harm (10% reduction on 13/14)	Local	2	3	0	3	0	-	22	16	6	12	0	-		
	All Falls (10% reduction on 2013/14)	Local	112	133	30	101	2	-	1343	1782	385	1361	36	-		
	Number of Trust Pressure Ulcers Acquired at CHFT	Local	11	17	7	10	0	-	130	206	76	129	1	-		
	Number of Grade 2 Pressure Ulcers Acquired at CHFT	Local	7	11	4	7	0	-	88	139	57	81	1	-		
	Number of Grade 3 Pressure Ulcers Acquired at CHFT	Local	0	5	3	2	0	-	0	63	19	44	0	-		
	Number of Grade 4 Pressure Ulcers Acquired at CHFT	Local	0	1	0	1	0	-	0	4	0	4	0	-		
Safety 2	Percentage of Completed VTE Risk Assessments	National	95.00%	95.30%	94.55%	94.84%	97.88%	100.00%	95.00%	95.30%	94.10%	95.30%	98.30%	100.00%		
	Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	National	100.00%	100.00%	100.00%	100.00%	-	-	100.00%	100.00%	100.00%	100.00%	100.00%	-		
	% Harm Free Care	CQUIN	95.00%	93.04%	91.98%	90.00%	100.00%	-	95.00%	93.60%	94.55%	90.75%	99.78%	-		
	Improving Medicines Safety Discharge Accuracy Checks		70.00%	72.60%	-	-	-	-	70.00%	68.00%	-	-	-	-		
Safety 3	Number of Patient Incidents	Monitor	-	468	130	220	89	27	0	6773	1767	3303	1273	377		
	Number of SI's	Monitor	-	8	3	5	0	0	0	107	19	83	4	0		
	Number of Incidents with Harm	Monitor	-	125	33	64	22	5	0	1640	395	891	287	58		
	Never Events	National	0	0	0	0	0	0	0	0	0	0	0	0		
	Serious hazards of transfusion	Local	-	-	-	-	-	-	0	0	0	0	0	0		
	Percentage of SI's reported externally within timescale (2 days)	Local	100.00%	100.00%	100.00%	100.00%	-	-	-	-	-	-	-	-		
	Percentage of SI's investigations where reports submitted with timescale (45 days unless extension agreed)	Local	100.00%	50.00%	0.00%	75.00%	-	-	-	-	-	-	-	-		
	Total Duty of Candour reported within the month		-	21	6	14	0	0	-	79	22	46	8	1		
	Total Duty of Candour outstanding at the end of the month		-	10	3	6	0	0	-	28	10	14	0	1		

Safety - Director of Nursing

Report For: March 2015	Target	Trust	Surgical	Medical	CWF	DATS
Inpatient Falls with Serious Harm (10% reduction on 13/14)	2	3	0	3	0	-
All Falls (10% reduction on 2013/14)	112	133	30	101	2	-
Number of Trust Pressure Ulcers Acquired at CHFT	11	17	7	10	0	-
Number of Grade 2 Pressure Ulcers Acquired at CHFT	7	11	4	7	0	-
Number of Grade 3 Pressure Ulcers Acquired at CHFT	0	5	3	2	0	-
Number of Grade 4 Pressure Ulcers Acquired at CHFT	0	1	0	1	0	-

Pressure Ulcers:

1. Why off plan? A review has been undertaken regarding the increase in pressure ulcers November – February. A paper will be presented at the Quality Committee w/c 22/4/15

2. Actions to get back on plan: Wards with the highest reported incidence for this period to review ward action plans or develop plans to support improvement (End May 2015). TV support will be provided regarding training and clinical expertise. There is key work as a direct result of investigations is that nursing competencies that relate to pressure ulcer prevention are being reviewed as part of the development of a competency portfolio for band 5 nurses.

3. Achieved by When? End of May 2015

Falls:

1. Why off plan? Inpatient falls with serious harm – Mar 15 the Trust had 3 against a monthly target of 2; however when viewed over the whole year 16 serious harm falls were recorded against a target of 22. This is a significant improvement from the previous full years data, the target for the year moving forward is in the process of being agreed. For all falls however the yearly target has been missed.

2. Action to get back on plan: the falls lead is seeking to recruit another 2 interested clinicians to spread the work achieved on ward 5 HRI and MAU at CRH around using safety briefings. In addition the Trust is taking part in its first national falls audit in May this year, the team collecting data for this is being recruited and the detail worked out. This audit will help with understand the true level of compliance around the falls prevention process on wards.

3. Achieved by (a specific date): During April, planning work will be completed for the national falls audit this will take place in May and be reported in June. By the end of May another 2 clinicians will be signed up and prepared to implement safety briefings in their areas.
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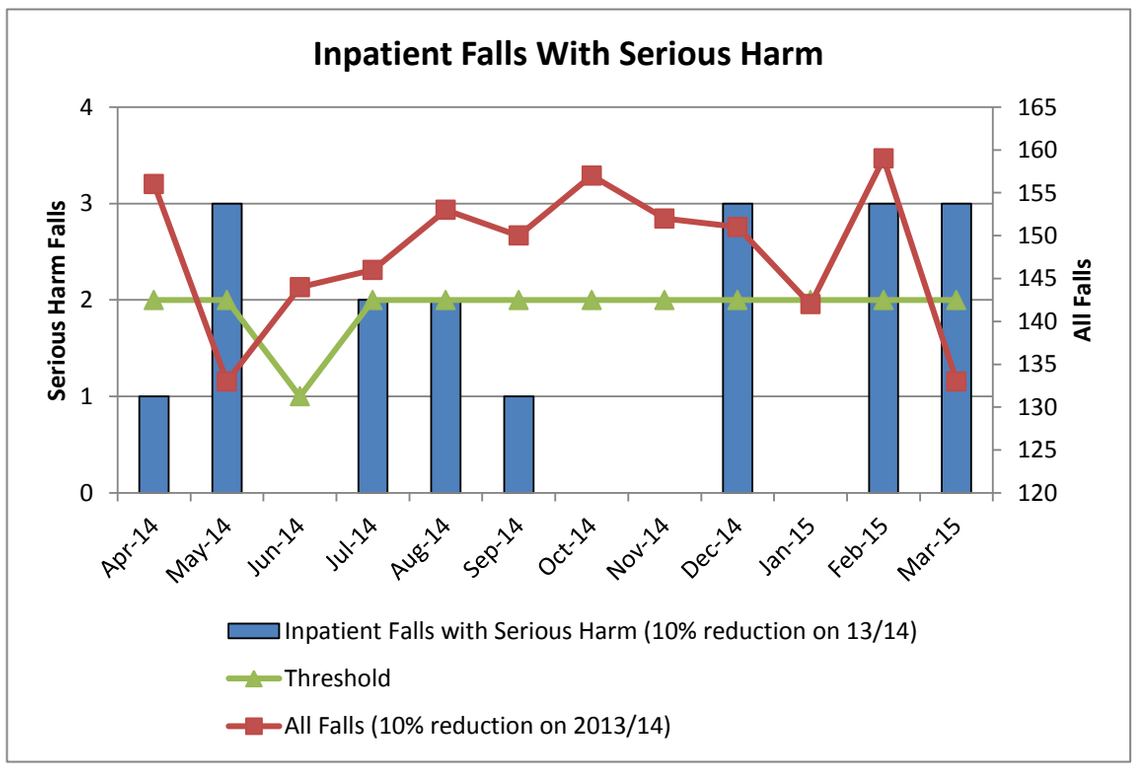
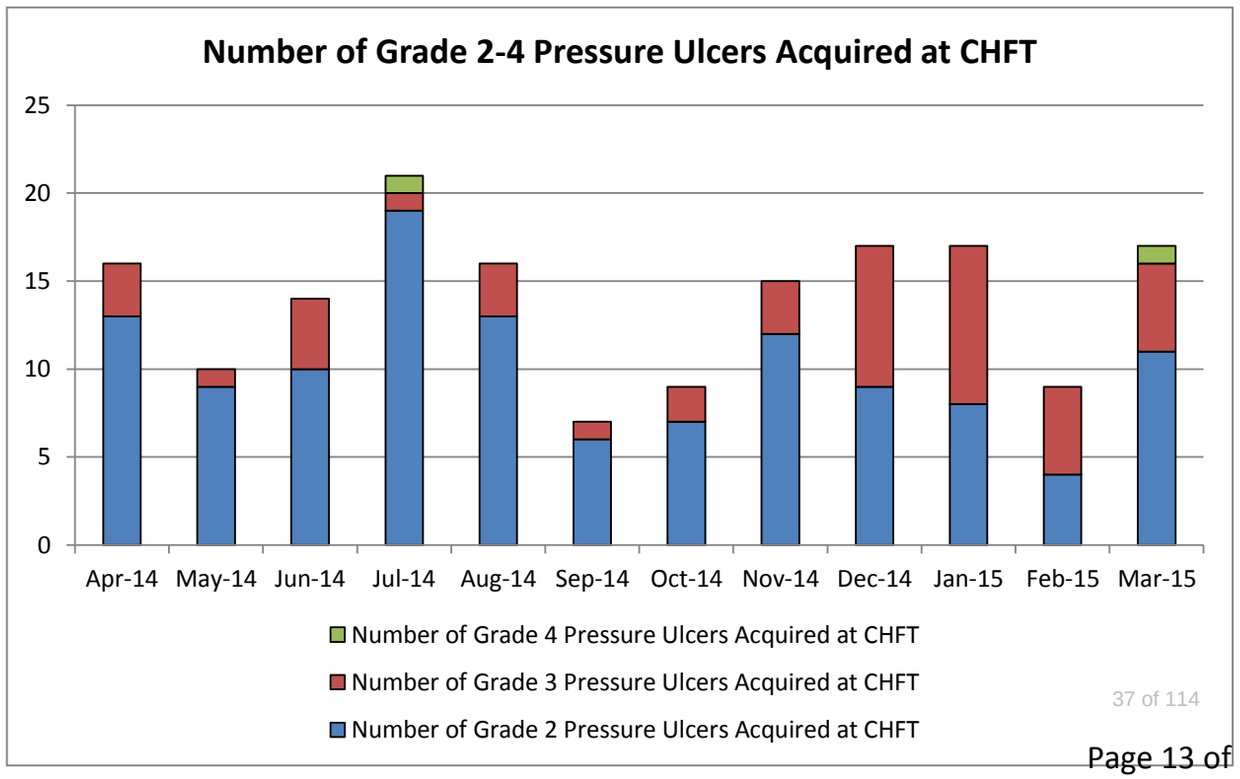




Safety - Director of Nursing

Report For: March 2015	Target	Trust	Surgical	Medical	CWF	DATS
Percentage of Completed VTE Risk Assessments	95.00%	95.30%	94.55%	94.84%	97.88%	100.00%
Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	100.00%	100.00%	100.00%	100.00%	-	-
% Harm Free Care	95.00%	93.04%	91.98%	90.00%	100.00%	-
Safeguarding Alerts made by the Trust	-	11	-	-	-	-
Safeguarding Alerts made against the Trust	-	7	-	-	-	-
Improving Medicines Safety Discharge Accuracy Checks	70.00%	72.60%	-	-	-	-

VTE: Both VTE risk assessment and RCA process are on plan. In March 2015 there were 6 hospital acquired thrombosis none of which were preventable. Following a recent audit an amended prescription chart is currently being trailed which has a specific prophylaxis section. If this is successful it will be introduced throughout the trust with the exception of Maternity and paediatric services and will be in place by August 15.

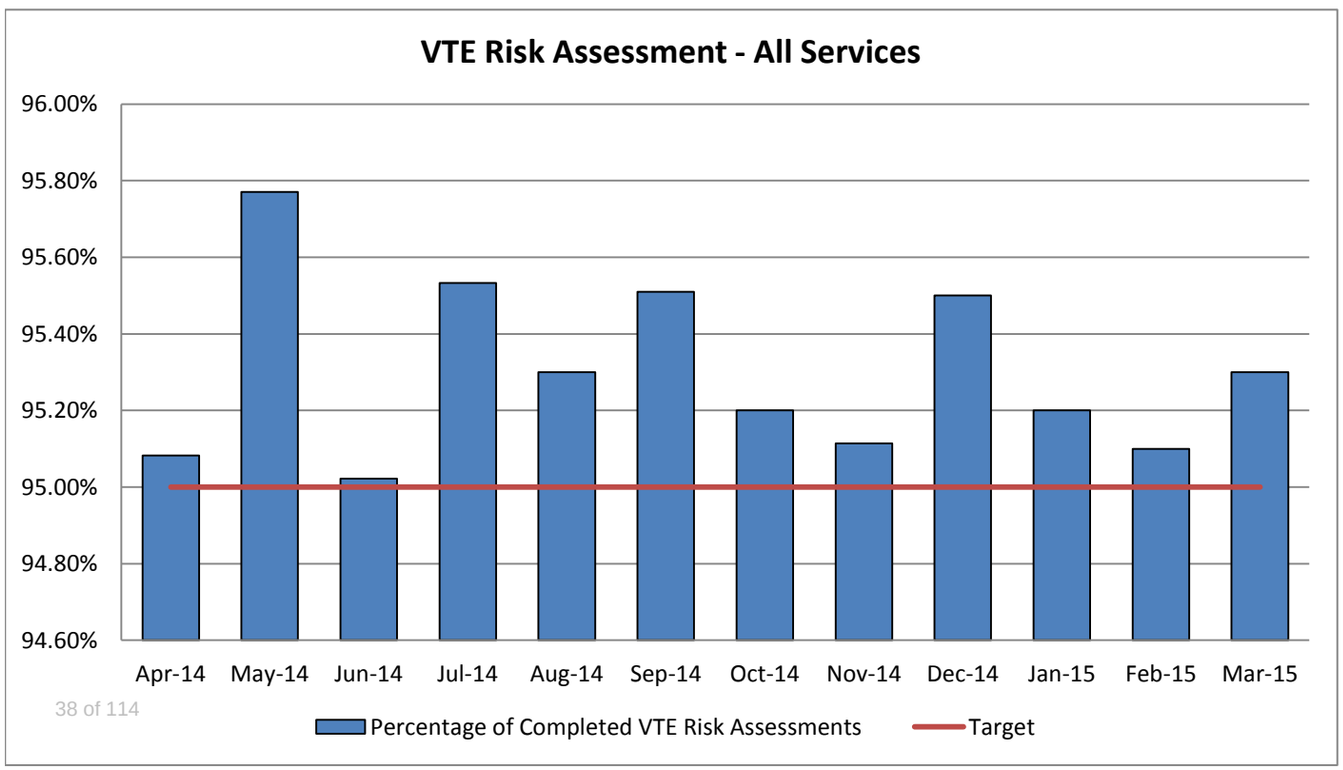
Harm Free Care:

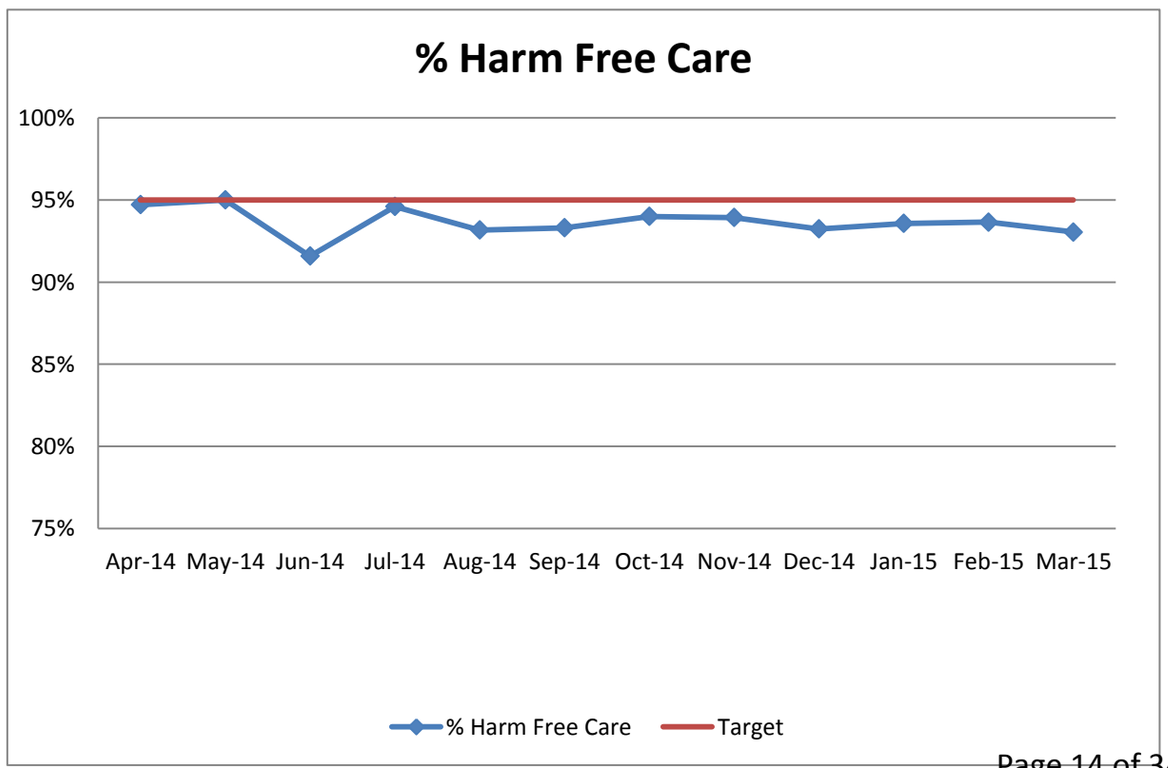
1. Why off plan? The target is based on a point prevalence audit completed every month, it is dependent on other improvement work in the Trust (Falls, Pressure Ulcers, Catheters and VTE) having the desired impact. As pressure ulcers make up the largest proportion of harm, reduction in ulcers will see a positive impact on harm free care.

2. Actions to get it back to plan: Please see updates on Falls and pressure ulcers.

3. Achieved by date: Continue to be monitor as part the Trust contact for 15/16.

Safeguarding Current Work: The vulnerable adult operational group established in Feb 2015, is bringing together safeguarding adults, dementia, mental health, learning disability and falls. It's remit will be to ensure the Trust is working towards protecting vulnerable adults. Currently producing a work plan to look at key themes with actions, timescales and improvement targets.





Calderdale and Huddersfield NHS
NHS Foundation Trust

Safety - Director of Nursing

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Report For: March 2015	Target	Trust	Surgical	Medical	CWF	DATS	Estates and Facilities	Corporate
Number of Patient Incidents	-	468	130	220	89	27	2	0
Number of SI's	-	8	3	5	0	0	0	0
Number of Incidents with Harm	-	125	33	64	22	5	1	0
Never Events	0	0	0	0	0	0	0	0
Serious hazards of transfusion	-	-	-	-	-	-	-	-
Percentage of SI's reported externally within timescale (2 days)	100.00%	100.00%	100.00%	100.00%	-	-	-	-
Percentage of SI's investigations where reports submitted with timescale (45 days unless extension agreed)	100.00%	50.00%	0.00%	75.00%	-	-	-	-
Total Duty of Candour reported within the month	-	21	3	4	0	1	0	0
Total Duty of Candour outstanding at the end of the month	-	10	3	4	0	1	0	0

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

1. Why off Plan: Of the 4 reports due for submission in March: Medical - of the 3 due: 2 were submitted on time, 1 was 18 days late. SAS - 1 was submitted 1 day late.

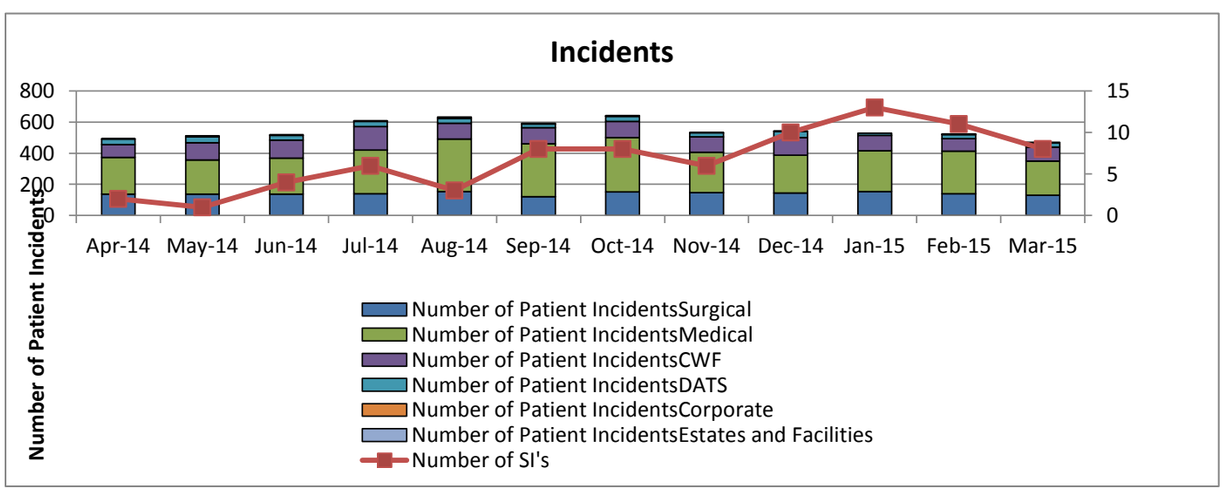
2. Action taken: corporate team working closely with the divisional managers to ensure investigators are aware of submission deadlines, extensions to be authorised by the assistant director for quality in exceptional circumstances only.

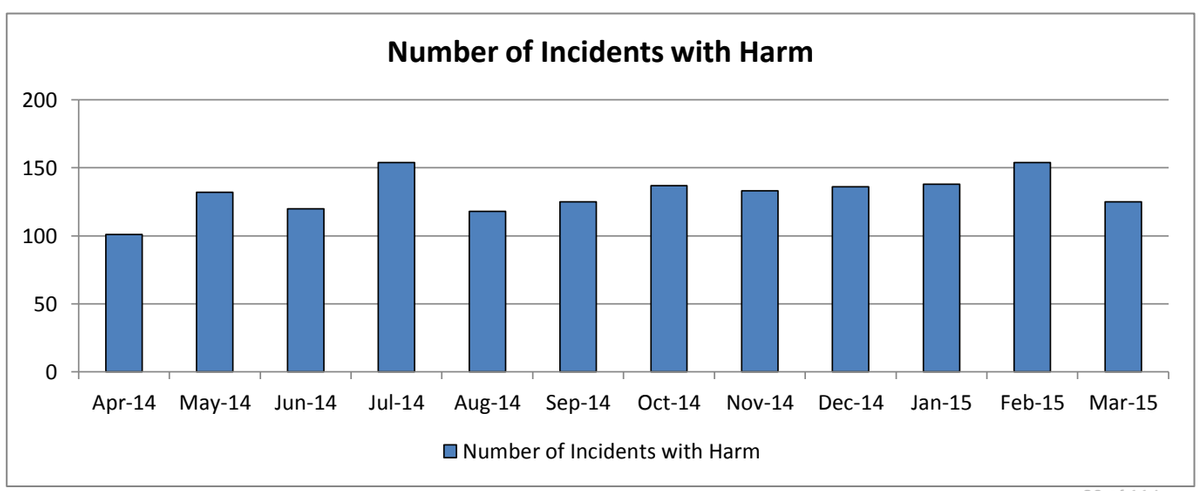
3.Achieved by: This will be achieved within the next month.

1. Why off Plan? On 27 November the Statutory Duty of Candour came into effect. From December we have been recording our compliance against this and have developed a monitoring tool to ensure this is captured.
March data: During March, 21 incidents were reported which fall within the requirements of Duty of Candour. Of these, we are still awaiting confirmation for 7 that the duty has been complied with.

2. Action taken: In March it was recognised that there were a number of incidents to which the Duty of Candour applied (i.e. pressure ulcer incidents) which had not previously been accounted for within this report. As a result, in order to provide an assurance that these incidents are not missed, work has been undertaken within each Division to go back to those incidents and undertake the Duty retrospectively. At the time of reporting, there are a number of cases where the Duty is outstanding, however, an assurance has been provided that these will be completed.

3. Achieved By: This will be monitored via the Serious Incident register.





Calderdale and Huddersfield NHS Foundation Trust

Effectiveness Executive Summary

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Report For: March 2015		Indicator Source	Report For: March 2015						Year To Date						Year End Forecast	Data Quality
			Target	Trust	Surgical	Medical	CWF	DATS	Target	Trust	Surgical	Medical	CWF	DATS		
Effectiveness	Number of MRSA Bacteraemias – Trust assigned	National	0	0	0	0	0	0	0	1	0	0	0	0		
	Total Number of Clostridium Difficile Cases	National	1	1	1	0	0	0	18	27	9	16	2	0		
	Total Number of Clostridium Difficile Cases – Trust assigned	National	0	1	1	0	0	0	0	10	7	3	0	0		
	Unavoidable Number of Clostridium Difficile Cases	National	1	0	0	0	0	0	18	17	4	12	1	0		
	Number of MSSA Bacteraemias - Post 48 Hours	National	1	3	3	0	0	0	15	12	5	6	1	0		
	% Hand Hygiene Compliance	Local	95.00%	99.81%	99.91%	99.96%	100.00%	100.00%	95.00%	99.82%	99.57%	99.99%	100.00%	99.94%		
	MRSA Screening - Percentage of Inpatients Matched	Local	95.00%	97.42%	96.00%	99.00%	100.00%	-	95.00%	96.00%	99.00%	95.00%	98.00%	-		
	Number of E.Coli - Post 48 Hours	Local	1	2	1	1	0	0	23	29	9	20	0	0		
	Central Line Infection rate per 1000 Central Venous Catheter days	Local	1.50	4.85	0.00	16.39	0.00	-	1.50	1.35	-	-	-	-		
Effectiveness 2	Emergency Readmissions Within 30 Days (With PbR Exclusions)	National	7.00%	7.42%	4.28%	12.25%	8.41%	2.63%	7.36%	7.42%	4.69%	12.02%	6.21%	5.28%		
	Local SHMI - Relative Risk (1yr Rolling Data Jul 13- Jun14)	National	100	110	-	-	-	-	100	111	-	-	-	-		
	Hospital Standardised Mortality Rate (1 yr Rolling Data Jan 14 - Dec 14)	National	100.00	106.98	-	-	-	-	-	-	-	-	-	-		
	Rebased HSMR	National	-	-	-	-	-	-	-	-	-	-	-	-		
	Crude Mortality Rate (Latest Month - March 15)	National	1.00%	1.46%	0.48%	3.88%	0.07%	0.00%	1.14%	1.30%	0.46%	3.41%	0.10%	0.00%		
	Average Diagnosis per Coded Episode	National	4.9	4.01	3.46	5.74	2.36	2.91	4.9	4.07	3.61	5.75	2.39	3.34		
Effectiveness 3	Number of Unplanned Adult Admissions to ITU		-	34	-	-	-	-	-	567	0	0	0	0		
	No of Spells with > 2 Ward Movements	local	-	148	23	91	34	-	2	1636	242	1034	360	-		
	% of spells with > 2 ward movements (2% Target)	local	2.00%	2.37%	1.41%	5.10%	1.20%	-	2.00%	2.31%	1.28%	5.15%	1.14%	-		
	No of Spells with > 3 Ward Movements	local	-	50	6	39	5	-	-	452	55	339	58	-		
	% of spells with > 3 ward movements (No Target)	local	-	0.80%	0.37%	2.18%	0.18%	-	-	0.64%	0.29%	1.69%	0.18%	-		
	No of Spells with > 4 Ward Movements	local	-	17	2	15	0	-	-	158	17	129	12	-		
	% of spells with > 4 ward movements (No Target)	local	-	0.27%	0.12%	0.84%	0.00%	-	-	0.22%	0.09%	0.64%	0.04%	-		
	No of Spells with > 5 Ward Movements	local	-	4	0	4	0	-	-	47	4	38	5	-		
	% of spells with > 5 ward movements (No Target)	local	-	0.06%	0.00%	0.22%	0.00%	-	-	0.07%	0.02%	0.19%	0.02%	-		
	Total Number of Spells	local	-	6250	1626	1785	2839	-	-	70695	18927	20092	31676	-		
	Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	National	85.00%	79.50%	79.50%	-	-	-	85.00%	65.89%	65.89%	-	-	-		

Effectiveness - Medical Director

Report For: March 2015	Target	Trust	Surgical	Medical	CWF	DATS
Number of MRSA Bacteraemias – Trust assigned	0	0	0	0	0	0
Total Number of Clostridium Difficile Cases	1	1	1	0	0	0
Total Number of Clostridium Difficile Cases – Trust assigned	0	1	1	0	0	0
Unavoidable Number of Clostridium Difficile Cases	1	0	0	0	0	0
Number of MSSA Bacteraemias - Post 48 Hours	1	3	3	0	0	0
% Hand Hygiene Compliance	95.00%	99.81%	99.91%	99.96%	100.00%	100.00%
MRSA Screening - Percentage of Inpatients Matched	95.00%	97.42%	96.00%	99.00%	100.00%	-
Number of E.Coli - Post 48 Hours	1	2	1	1	0	0
Central Line Infection rate per 1000 Central Venous Catheter days	1.50	4.85	0	16.39	0	-

1. Why off plan?

C.difficile – One case in March, YTD total 27 against a ceiling of 18. Of these, 10 classified as avoidable and 17 classed as unavoidable. There are no common themes in terms of the reasons behind the cases. Key learning identified around isolation of patients with Diarrhoea

E.Coli – A review of cases highlighted that almost half of the cases were associated UTI and around 25% of these had a urinary catheter.

MSSA - Three cases in March, one was due to hospital acquired pneumonia, one was community acquired cellulitis and one was a line infection (also reported below)

Line infections - There were three line infections identified in March and currently being investigated, these cases are not related. YTD performance remains under the ceiling target

2. Actions to get back on plan

C Difficile - A task and finish group is being set up to improve isolation breaches to include a Matron from each Division, an IPCT member, a member of patient flow and a Ward manager.

E. Coli – Urinary Catheter audit to be formed to investigate compliance with best practice and review of laxative policy to prevent constipation. Catheter project to reduce number of catheters is underway

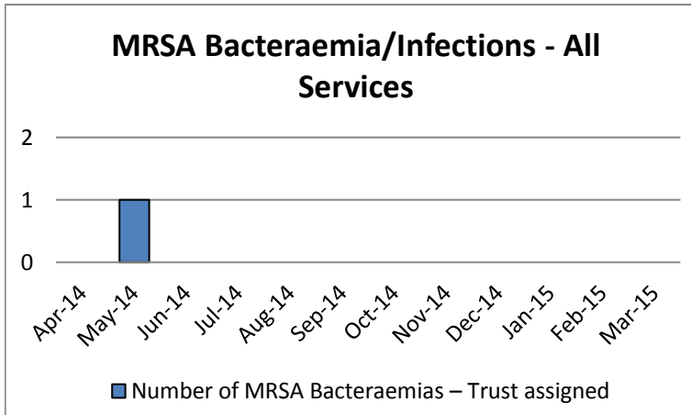
Line Infections - Actions include refresher training and development of patient held record (CVAD Passport).

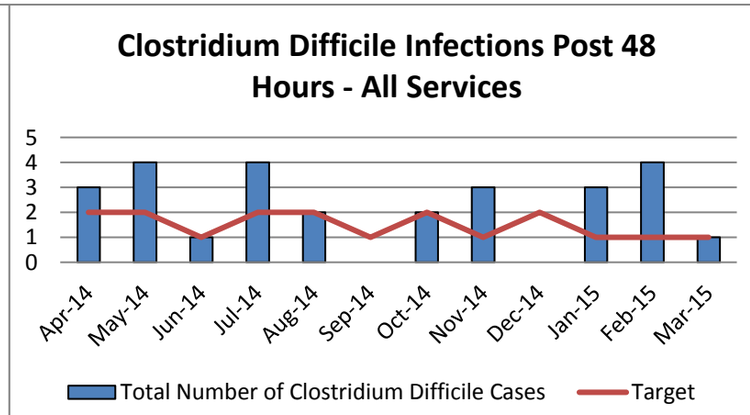
3. Achieved by:

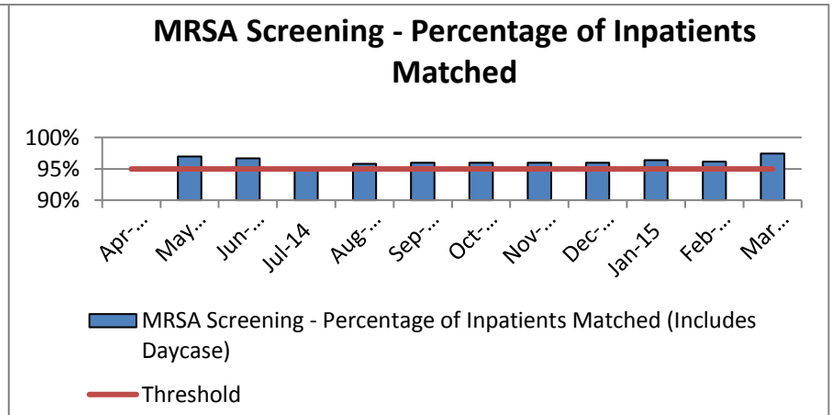
C Difficile – Task and finish group set up by the end of April.

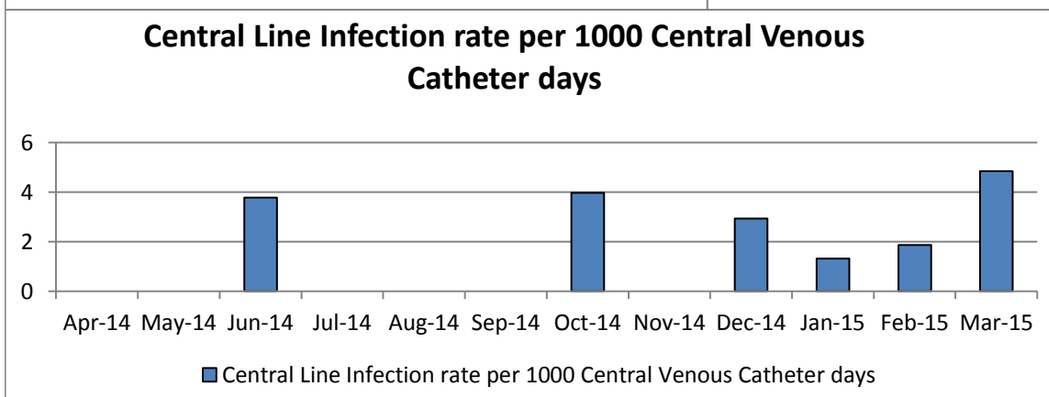
E. Coli – Constipation guidelines reviewed by May 15 and catheter audit results analysed by May

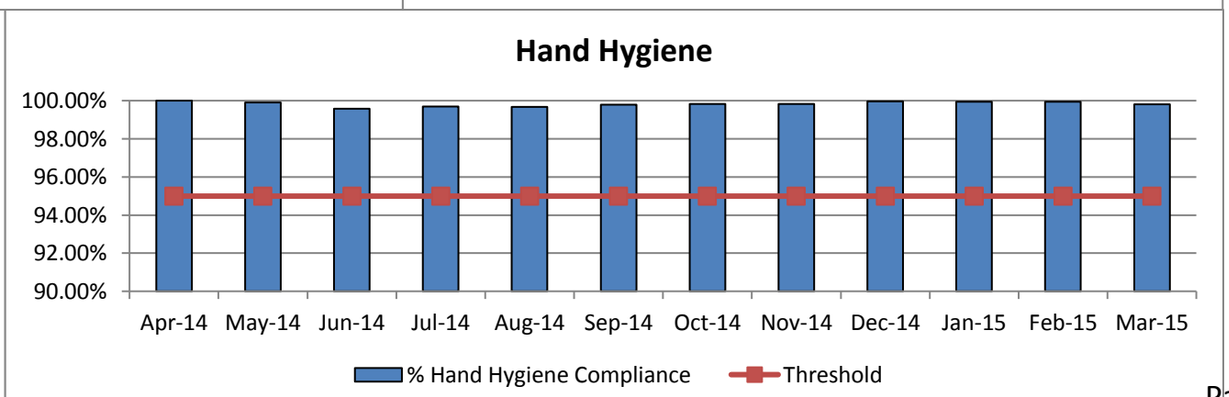
Line Infections – RCA investigations to be completed by the end of the month











Effectiveness - Medical Director

Report For: March 2015	Target	Trust	Surgical	Medical	CWF	DATS
Emergency Readmissions Within 30 Days (With PbR Exclusions)	7.00%	7.42%	4.28%	12.25%	8.41%	2.63%
Local SHMI - Relative Risk (1yr Rolling Data Jul 13- Jun14)	100	110	-	-	-	-
Hospital Standardised Mortality Rate (1 yr Rolling Data Jan 14 - Dec 14)	100	106.98	-	-	-	-
Crude Mortality Rate (Latest Month - March 15)	1.00%	1.46%	0.48%	3.88%	0.07%	0.00%
Average Diagnosis per Coded Episode	4.9	4.01	3.46	5.74	2.36	2.91

SHMI/HSMR/Crude Mortality

1. Why it is off plan? The most recent released indicated a SHMI of 110 the 12 months of July 13 to June 14. This has reduced from the 111 published in April 13 - March 14 but is still higher than target. HSMR is measured against a national average of 100. The most recent 12 months data indicates a score of 107.17, which is a slight increase from previous release. Crude mortality is lower than the previous two months.

2.Action to get back on plan: The mortality review process is now established, with a large proportion of deaths being reviewed each month - A report on Dec 14 deaths was submitted to Clinical Outcomes Group and Quality Committee in March 15, assurance was gained as to the quality of care delivered. Work continues in the Care of the Acutely Ill Patient programme, including reliable implementation of care bundles, focus on frail patients, coding and condition specific work where mortality rates appear to be outlying.

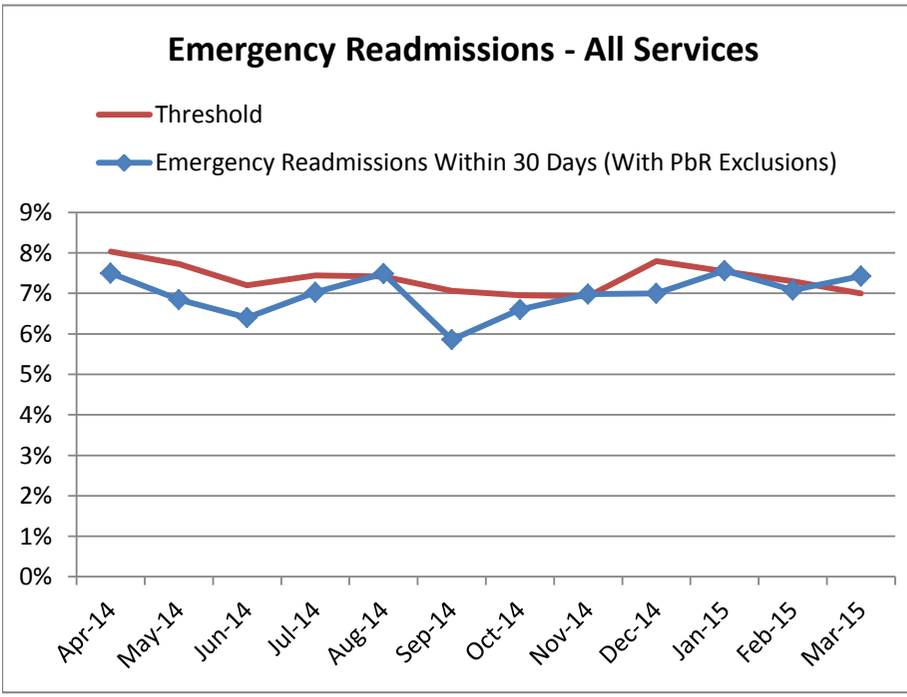
3.Achieved By: There is a target to review over 80% of February deaths by the end of April to identify additional trends and themes

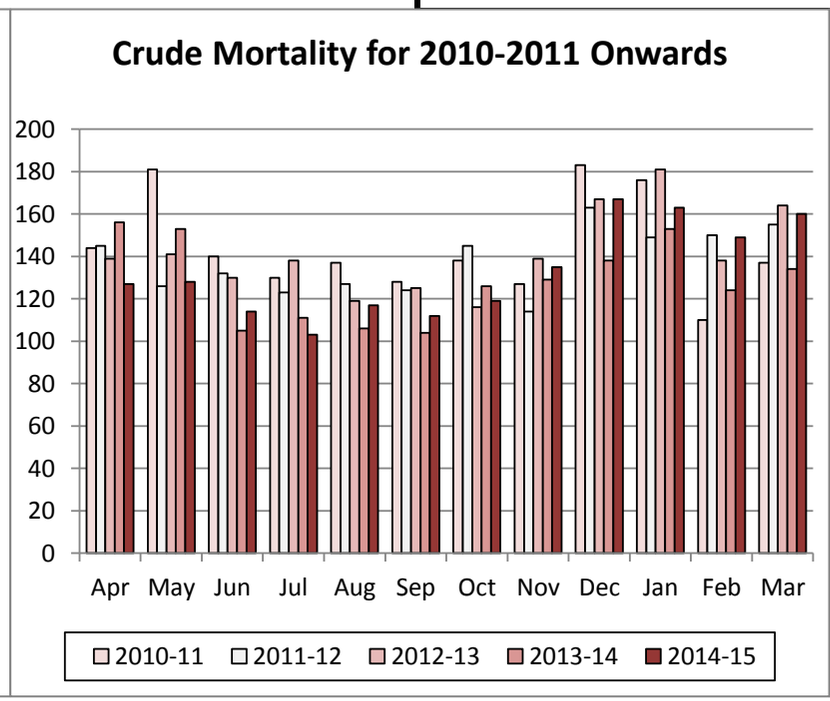
Average Diagnosis per Coded Episode

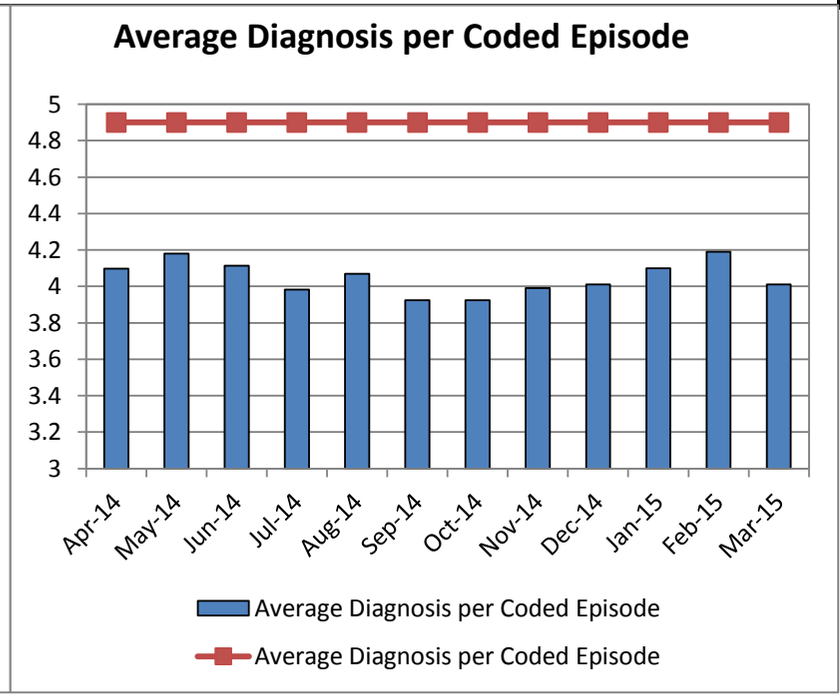
1. Why off plan? CHFT depth of coding is less than plan due to missed or undocumented relevant comorbidities within the coding source documentation. May also be due to incomplete coding documentation at the time of coding.

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

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







Report For: March 2015	Target	Trust	Surgical	Medical	CWF	DATS
Number of Unplanned Adult Admissions to ITU	-	34	-	-	-	-
No of Spells with > 2 Ward Movements	-	148	23	91	34	-
% of spells with > 2 ward movements (2% Target)	2.00%	2.37%	1.41%	5.10%	1.20%	-
No of Spells with > 3 Ward Movements	-	50	6	39	5	-
% of spells with > 3 ward movements (No Target)	-	0.80%	0.37%	2.18%	0.18%	-
No of Spells with > 4 Ward Movements	-	17	2	15	0	-
% of spells with > 4 ward movements (No Target)	-	0.27%	0.12%	0.84%	0.00%	-
No of Spells with > 5 Ward Movements	-	4	0	4	0	-
% of spells with > 5 ward movements (No Target)	-	0.06%	0.00%	0.22%	0.00%	-
Total Number of Spells	-	6250	1626	1785	2839	-
Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	85.00%	79.50%	79.50%	-	-	-

% of spells with > 2 ward movements

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

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

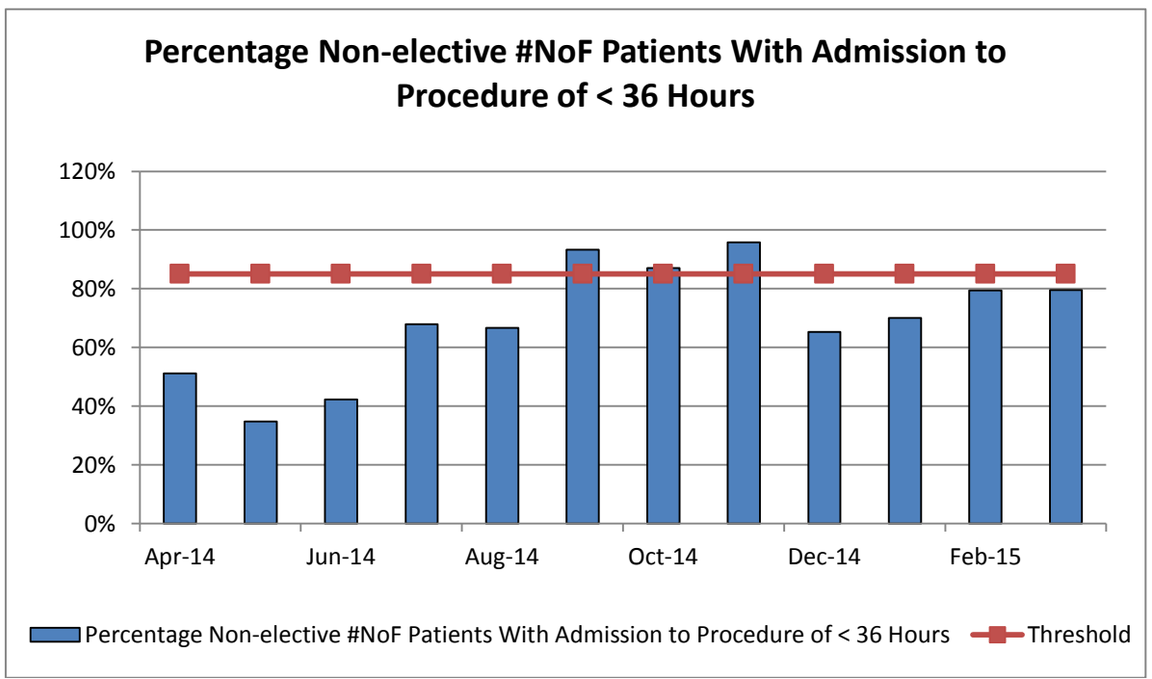
3. Achieved by date: Ongoing 2015

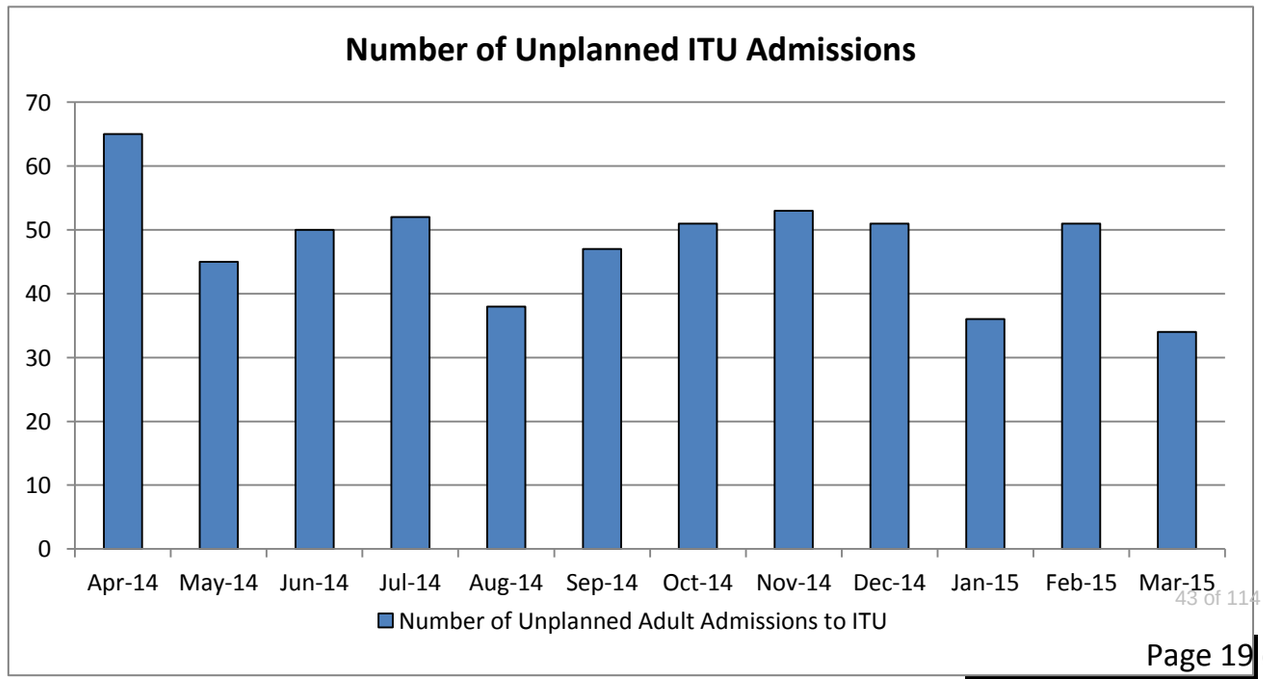
"Non-Elective #NOF

1.Why off plan? In March there were a high number of admissions, 55 in total. 7 were under the age of 60 which is an unusually large number, for the purposes of the data they are not included (not externally reportable on the hip # database) so are excluded from the denominator – making a total of 49. Of these 4 were delayed due to clinical reasons and 5 for operational reasons, 3 of the operational failures 5 only just missed the target – getting to Theatre in under 38 hours.

2. Actions to get back on plan: The Directorate is investigating increasing capacity of the trauma theatres, and backfilling with elective day case procedures, (a short call list is now operational) when there is low trauma demand (supported by the Director of Director of Planning, Performance, Estates and Facilities). There is a new Trauma coordinator in post, the role is being moulded to include more performance management duties

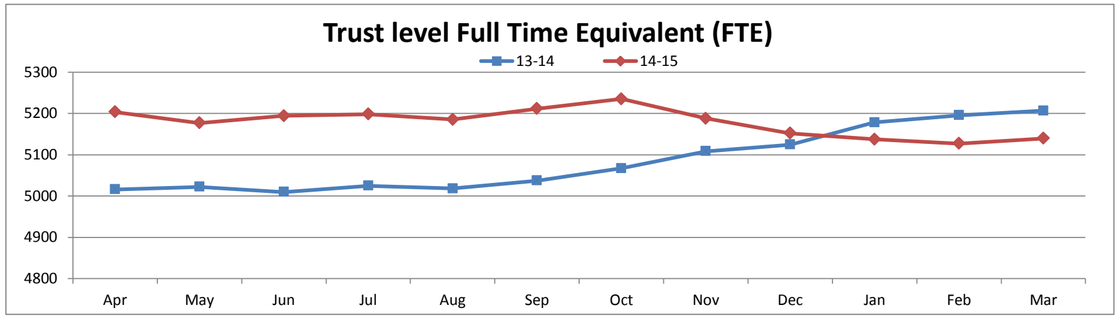
3. Achieved by date: Trauma coordinator already doing task management, will refine role further over next 4 weeks as part of her induction

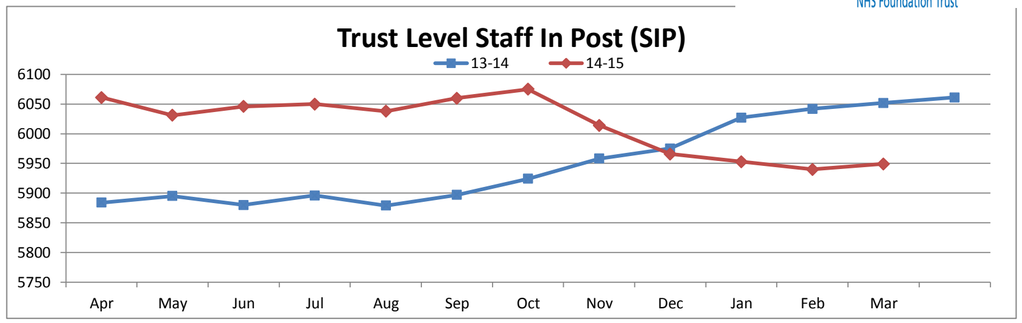


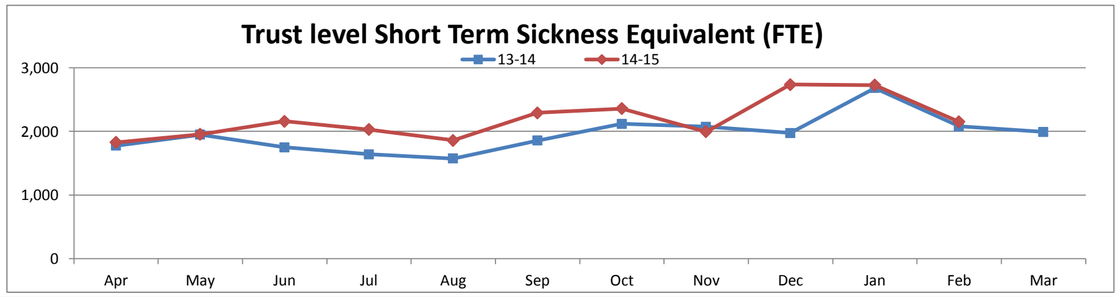


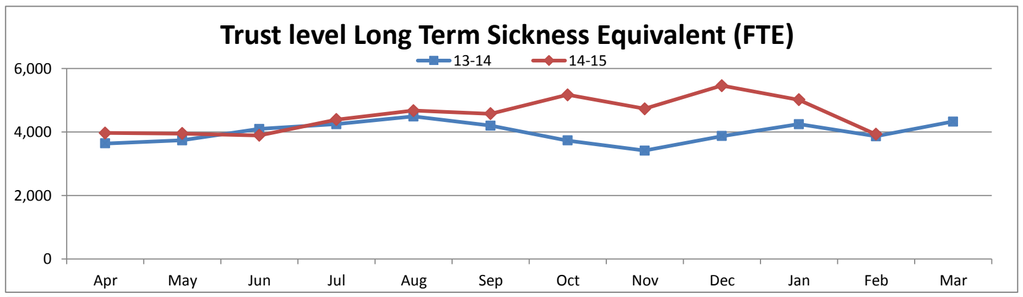
Well Led / Workforce - Director of Workforce and Organisational Development

Calderdale and Huddersfield NHS
NHS Foundation Trust









Director Lead	Report For: March 2015	Trust Threshold	Trust Actual	Surgery	Medical	CWF	DATS	Estates	Corporate	THIS
J.H	Sickness Absence rate (%) (1 Month Behind)	4.00%	4.24%	4.45%	4.40%	4.97%	2.29%	6.49%	2.04%	4.68%
J.H	Sickness Absence rate (FTE Lost) (1 Month Behind)		6082.18	1675.38	1988.31	1083.54	405.21	526.39	162.84	240.51
J.H	FTE Days Available (1 Month Behind)		143559.64	37611.05	45233.33	21793.22	17701.51	8114.09	7966.57	5690.57
J.H	Sickness Absence rate (%) - Year to date	4.00%	4.24%	4.47%	4.78%	4.66%	3.22%	4.82%	1.56%	2.72%
JH	Total Staff in Post (FTEs)		5,139.45	1,351.28	1,615.38	785.29	631.05	287.43	285.45	183.57
LH	Fire Safety Awareness	95.00%	87.10%	81.40%	82.60%	90.80%	97.00%	99.50%	87.10%	94.70%
LH	Fire Risk Assessments	95.00%	74% Audited							
MG	Information Governance - Rolling 12 Month	95.00%	72.40%	63.70%	66.90%	71.30%	89.70%	92.30%	72.90%	92.80%
JD	Risk Training - Rolling 12 Month	95.00%	69.70%	61.30%	58.30%	76.80%	80.40%	100.00%	76.10%	96.10%
JH	Appraisal Non Medical- YTD	95.00%	80.13%	62.20%	76.80%	94.60%	94.70%	100.00%	63.60%	97.20%
DB	Appraisal Medical- YTD	95.00%	87.37%	80.80%	92.80%	100.00%	89.70%	-	100.00%	-
DB	Medical devices training	95.00%	82.00%	75.00%	75.00%	83.00%	87.00%	-	91.00%	-
JD	Safeguarding - Level 1 - Staff compliant		69.70%	61.30%	58.30%	76.80%	80.40%	100.00%	76.10%	96.10%
JD	Safeguarding - Level 2 - Staff compliant		52.80%	55.40%	61.60%	26.40%	57.60%	81.10%	67.20%	0.00%
JD	Safeguarding - Level 3 - Staff Compliant		82.90%	71.30%	90.50%	82.80%	83.30%	-	100.00%	-
JH	FFTStaff - Would you recommend us to your friends and family as a place to receive		78.00%							
JH	FFT Staff - Would you recommend us to your friends and family as a place to work?		54.00%							
JD	Hard Truths Summary Day - Nurses/Midwives (1 Month Behind)	100.00%	81.42%	82.45%	79.09%	85.52%				
JD	Hard Truths Summary - Day Care Staff (1 Month Behind)	100.00%	91.03%	89.91%	96.01%	73.13%				
JD	Hard Truths Summary - Night Nurses/Midwives (1 Month Behind)	100.00%	88.70%	86.15%	88.39%	92.11%				
JD	Hard Truths Summary - Night Care Staff (1 Month Behind)	100.00%	117.05%	112.78%	129.00%	80.84%				

Sickness Absence/Attendance Management at work

Action – Senior managers within Divisions and Directorates are taking a proactive approach to managing short-term and long-term sickness absence by task focused sickness absence meetings where individual cases are reviewed, taking advice and support from Human Resources Leads as required. This approach is supported by intensive briefing of colleagues with regard to how attendance impacts on our ability to deliver safe services and high quality patient care.
The Attendance Management policy is currently under review.

By Who- A line manager toolkit developed by NHS Employers has been made available on the intranet. The Human Resources Team are currently developing enhanced tools to support managers on a day-to-day basis. This will be tested in the near future with line managers within the Trust. Further developments will take place in the form of a programme of line manager breakthrough events. The breakthrough events will focus on what improvements can be made on how the Trust manages sickness absence/attendance at work and what good practice tools/resources are needed in order to deliver excellent attendance at work.
Quality sickness absence data is a critical part of an effective approach to management attendance and information on individual service areas is available routinely. Increased attention to data quality and to the availability/timeliness of absence reports is key to the performance management of sickness absence. Significant improvements in access to data as well as the quality of data capture, reporting and monitoring will be delivered with the full implementation of ESR manager self-service, which is currently available on a pilot basis.

Fire Safety Awareness -Fire Alarm Activations for March 2015
CRH 9 Activations - 3 for A&E, 2 using a grill, 1 using a microwav. 0 activations for SWYFT (Mental Health Villas)
HRI 3 Activations - 2 Activations for Ward 20 and 1 for Ward 21, all toaster incidents
Fire Safety Awareness Training Handbooks are being issued in a phased approach, with a target date 30th April to be issued. Staff are reminded to submit the training declaration. Fire Risk Assessments issued have not been devolved to Departments which as slowed the implementation. Plan in place to re-issue end of May 2015.

Appraisal YTD
Action - The monthly compliance target for appraisals is 8% in all Divisions and Directorates .
By who - Resources provided by the Workforce Development Team are still being added to the intranet available toolkit. For example, appraisal planning and appraisal preparation videos are new additions.
When - All areas forecast compliance of 100% at 31 March 2015. There is strong evidence that appraisal activity is concentrated in last 3 months of performance year and this should be addressed by managers to manage appraisal activity.

Medical Devices
Medical Devices Training is currently at 82% compliance across the Trust.
Action - (1) Regular reminders to all staff re Medical Devices training requirements via newsletter, intranet notices, link nurse, matrons and department managers group emails (2)Discuss and remind Medical Devices training group and link nurse meeting members to cascade Medical Devices Training requirements throughout divisions. (3) Organise and promote medical devices training events
By Who- (1) Matrons, General Managers, Department Heads, Line Managers and link nurses (2) Medical Devices Training Coordinator and Medical devices Training support .
When- (1) On-going throughout the year,

YTD Information Governance
IG Training is currently at 74% compliance across the Trust.
Action - (1) Regular reminders to all staff re Mandatory training requirements, (2)Discuss and remind Information Governance Group members to cascade IG Training requirements throughout divisions.
By Who- (1) Department Heads, Line Managers, (2) IG Group Members.
When- (1) On-going throughout the year, (2)May 2015.

Hard Truths Staffing Levels
Why are we away from plan
In March 2015, eight ward areas had an average fill rate lower than 75% for Qualified nurses / Midwives in the day.
There were no areas will an average fill rate lower than 75% for Qualified nurses / Midwives at night.
The main reason for reduced fill rates in March 2015 are: vacancies, short term sickness and supporting additional capacity .Some nurses were transferred within the trust to maintain safe staffing levels, reducing there fill rate within their own ward area at times
The reduced fill rates are a result of workforce models not been aligned to staffing hours . The planned hours been calculated on 2 nurses working 2 short shifts resulting in 15 hours of nursing care, where a significant number of shifts have been completed with 1 nurse working a 11.5 hour shift. Whilst the planned number of nurses have been on the ward, the actual hours worked are reduced through this and affect the fill rate.
Action taken to address any gaps between planned and actual staffing hours
From April 2015 each workforce model has been updated following the results of the latest acuity and dependency studies, and planned hours aligned to include and reflect the use of 11.5 hour shifts.
Weekly staffing hotspot meetings have continued with the flexible workforce department prioritising staffing requests to the areas identified as being most in need. Staffing has been reviewed regularly each day by the site co-ordinator and senior nursing team to ensure all areas are staffed safely.
Action plan
Robust recruitment has continued with 50 candidates attending the band 5 assessment day on 23 March 2015. 75% of candidates attending this month were students who have been recruited and offered “keep in touch” contact from experienced nurses to maintain engagement between now and the completion of their studies . The recruitment of students will reduce our vacancies further and align to agreed establishment levels.
By implementing a proportion of 11.5 hour days into the workforce models within the divisions of Medical and Surgery and Anaesthetics, the trust has reduced vacancies .
The Nursing Workforce Team are working with The Health Informatics Service to develop ward dashboards ,which will analyse key quality and outcome measures .
Achieved by date
The Trust anticipates that fill rates will increase with aligned planned hours incorporating some 11.5 hr / long days and will be evident in April 2015.
The Trust also expect to see increased fill rates as additional capacity is reduced.
The continued focus will be on recruitment and reduction in vacancies . It is expected that fill rates will continue to improve . The data will be reported on a monthly. basis.

Calderdale and Huddersfield NHS Foundation Trust

Community Executive Summary

THIS

	Report For: March 2015	Indicator Source	Report For: March 2015 Target	Trust	Surgical	Medical	CWF	DATS	Year To Date Target	Trust	Surgical	Medical	CWF	DATS	Year End Forecast	Data Quality
Community -CWF	Antenatal Health Visiting Contact by 32 Weeks	National	80.00%	82.00%	-	-	82.00%	-	80.00%	80.00%	-	-	80.00%	-		
	Health Visiting - Post Birth Visits within 14 days	National	95.00%	97.00%	-	-	97.00%	-	95.00%	87.00%	-	-	87.00%	-		
	Health Visiting - Breast Feeding drop off rates-initiation to GP 6-8 week check	National	-	45.90%	-	-	45.90%	-	-	44.50%	-	-	44.50%	-		
	Immunisations - % of year 8 girls HPV immunised	National	90.00%	91.40%	-	-	91.60%	-	90.00%	91.40%	-	-	91.40%	-		
	Paediatric Therapies - 18 week RTT in SLT	National	95.00%	100.00%	-	-	100.00%	-	95.00%	100.00%	-	-	100.00%	-		
	Paediatric Therapies - 18 week RTT in Physiotherapy	National	95.00%	100.00%	-	-	100.00%	-	95.00%	100.00%	-	-	100.00%	-		
	Paediatric Therapies - 18 week RTT in Occupational Therapy	National	95.00%	100.00%	-	-	100.00%	-	95.00%	100.00%	-	-	100.00%	-		
	Family Nurse Partnership	Local	TBC	TBC	-	-	TBC	-	TBC	TBC	-	-	TBC	-		
Community - CWF 2	Midwifery - % Home Births	National	-	2.50%	-	-	2.50%	-	-	1.80%	-	-	1.80%	-		
	Midwifery - % of Antenatal Bookings done with 12 weeks and 6 days	National	90.00%	91.00%	-	-	91.00%	-	90.00%	92.00%	-	-	92.00%	-		
	Midwifery - % women smoking at time of delivery	National	11.90%	13.70%	-	-	13.70%	-	11.90%	11.90%	-	-	11.90%	-		
	Sexual Health - % Referrals seen within 48 Hours	Local	-	95.90%	-	-	95.90%	-	-	96.80%	-	-	96.80%	-		
	Sexual Health - % Patients offered a HIV Test	Local	-	100.00%	-	-	100.00%	-	-	100.00%	-	-	100.00%	-		
	CDU	Local	TBC	TBC	-	-	TBC	-	TBC	TBC	-	-	TBC	-		
	Communituy - Children's Nurses		TBC	TBC	-	-	TBC	-	TBC	TBC	-	-	TBC	-		
Community	Home equipment delivery < 7 days	National	95.00%	85.00%	-	-	-	-	95.00%	94.90%	-	94.90%	-	-		
	% of patients under the care of the community specialist matron who have been readmitted to hospital with the same LTC in less than 30 days (one month behind)	Local	10.00%	1.20%	-	1.20%	-	-	10.00%	1.40%	-	1.40%	-	-		
	% of leg ulcers healed within 12 weeks from diagnosis	Local	75.00%	96.40%	-	96.40%	-	-	75.00%	96.20%	-	96.20%	-	-		
	Number of community acquired grade 3 or 4 pressure ulcers	National	6.3	2	-	2	-	-	To be agreed	20	-	20	-	-		
	Community AHP - 18 week RTT Snapshot at month end	National	95.00%	92.60%	-	92.60%	-	-	95.00%	95.30%	-	95.30%	-	-		
	Percentage of Community Staff equipped with mobile device	Local	-	-	-	-	-	-	-	77.00%	-	77.00%	-	-		
	% district nursing patients with a care plan	Local	90.00%	95.00%	-	-	-	-	90.00%	95.00%	-	95.00%	-	-		
	Number of patients with a Calderdale care plan - (this is a self management plan incorporates the emergency care plan)	Local	50.00%	49.00%	-	49.00%	-	-	50.00%	43.00%	-	43.00%	-	-		
	District Nursing Performance Active caseload	Local	-	4433	-	4433	-	-	-	4260	-	4260	-	-		
	District Nursing Performance New referrals in month	Local	-	1052	-	1052	-	-	-	16467	-	16467	-	-		
	District Nursing Performance Urgent referrals seen within 4 hours	Local	80.00%	68.00%	-	68.00%	-	-	80.00%	70.00%	-	70.00%	-	-		
	District Nursing Performance Non urgent referrals seen within 2 days	Local	80.00%	60.00%	-	60.00%	-	-	80.00%	60.00%	-	60.00%	-	-		
	Community Friends & Family Test - % Would recommend the Service	CQUIN	-	89.00%	-	89.00%	-	-	-	90.00%	-	90.00%	-	-		
	Community Friends & Family Test - % Would NOT recommend the Service	CQUIN	-	6.00%	-	6.00%	-	-	-	5.33%	-	5.33%	-	-		
	Patients who died at their preferred place of choice	Local	95.00%	100.00%	-	100.00%	-	-	95.00%	91.00%	-	91.00%	-	-		

Community - Children's, Women's and Families Division

Report For: March 2015	Target	Trust	Surgical	Medical	CWF	DATS
Antenatal Health Visiting Contact by 32 Weeks	80.00%	82.00%	-	-	82.00%	-
Health Visiting - Post Birth Visits within 14 days	95.00%	97.00%	-	-	97.00%	-
Health Visiting - Breast Feeding drop off rates-initiation to GP 6-8 week check	-	45.90%	-	-	45.90%	-
Immunisations - % of year 8 girls HPV immunised	90.00%	91.40%	-	-	91.60%	-
Paediatric Therapies - 18 week RTT in SLT	95.00%	100.00%	-	-	100.00%	-
Paediatric Therapies - 18 week RTT in Physiotherapy	95.00%	100.00%	-	-	100.00%	-
Paediatric Therapies - 18 week RTT in Occupational Therapy	95.00%	100.00%	-	-	100.00%	-
Family Nurse Partnership	TBC	TBC		-	TBC	-

Family Nurse Partnership (FNP)

Family Nurse Partnership indicator to be confirmed as the service reports on multiple indicators to NHS England. NHS England raised no concerns at the recent advisory board.

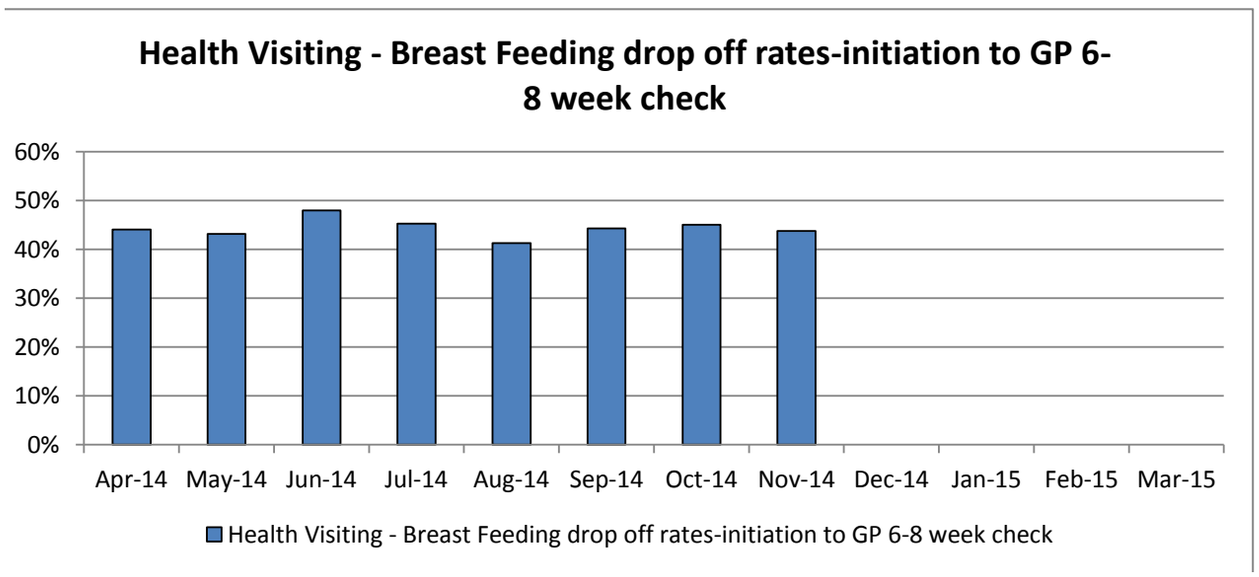
Antenatal Health Visiting Contact by 32 Weeks - The target increased to 80% for quarter 4. Work is currently being done within teams to ensure this will be achieved. Individual practitioners are also being monitored.

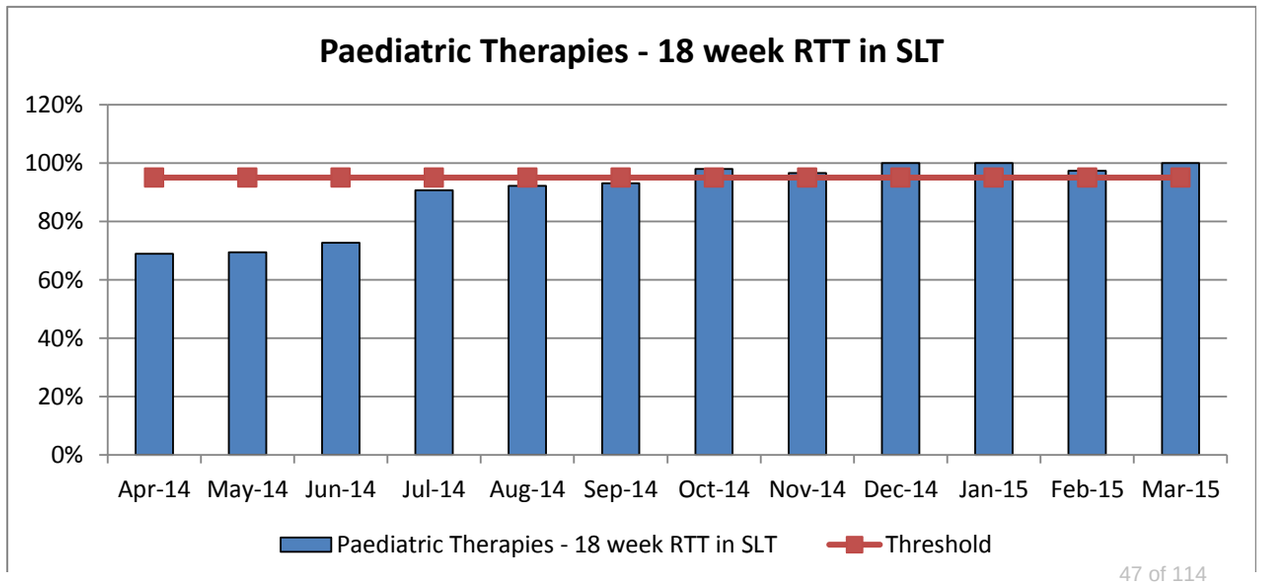
Health Visiting - Post Birth Visits within 14 days - The target increased to 95% for quarter 4. Work is currently being done with teams to review compliance against the target. Data validations and exception reports to be added by NHS England so show where patients were offered an appointment, but this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

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

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

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





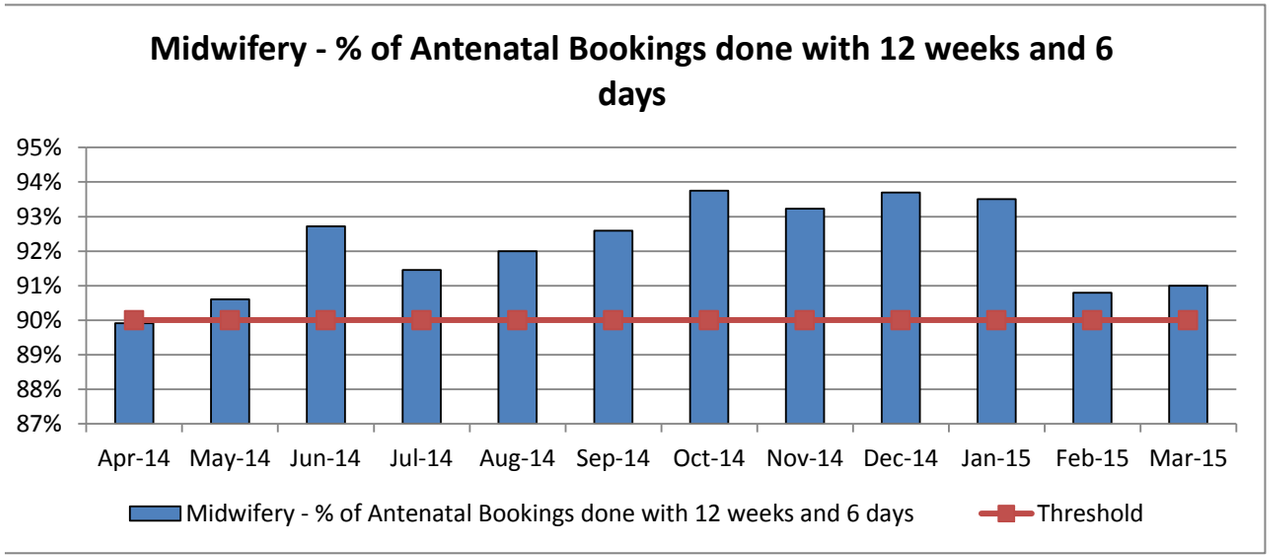
Community - Children's, Women's and Families Division

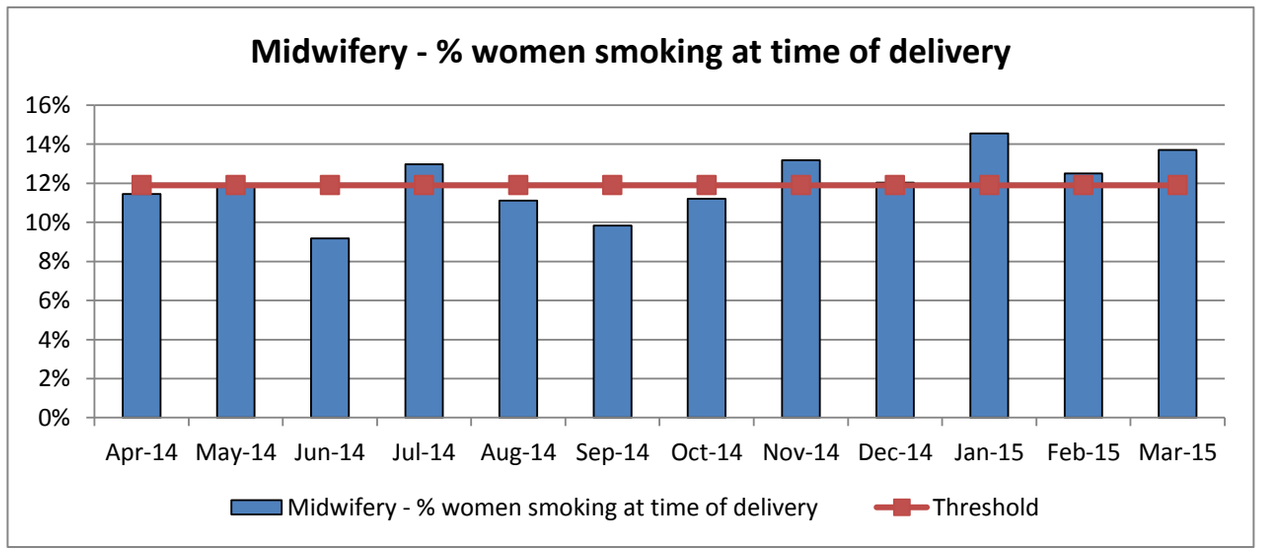
Report For: March 2015	Target	Trust	Surgical	Medical	CWF	DATS
Midwifery - % Home Births		2.50%	-	-	2.50%	-
Midwifery - % of Antenatal Bookings done with 12 weeks and 6 days	90.00%	91.00%	-	-	91.00%	-
Midwifery - % women smoking at time of delivery	11.90%	13.70%	-	-	13.70%	-
Sexual Health - % Referrals seen within 48 Hours	95.00%	95.90%	-	-	95.90%	-
Sexual Health - % Patients offered a HIV Test	100.00%	100.00%	-	-	100.00%	-
CDU	TBC	TBC	-	-	TBC	-
Community - Children's Nurses	TBC	TBC	-	-	TBC	-

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

CDU - Indicator to be devised for the next report

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



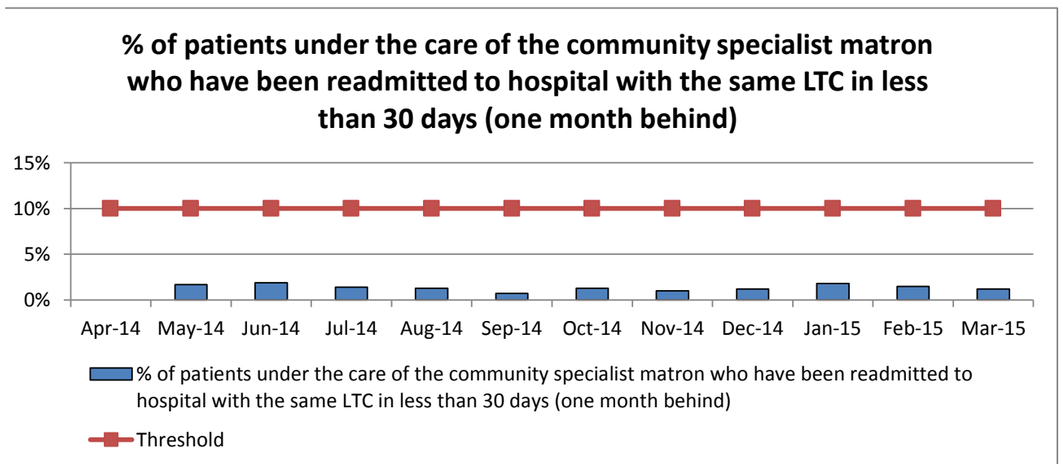


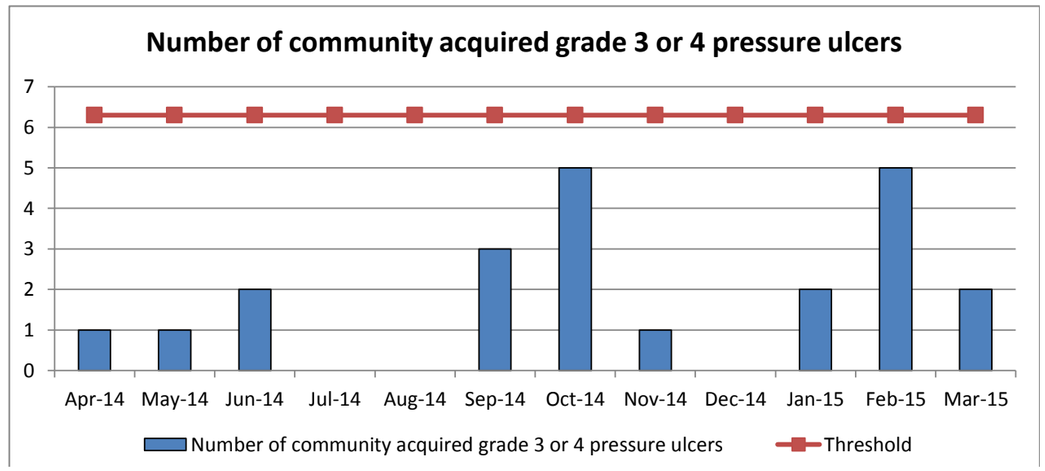
Report For: March 2015	Target	Trust	Surgical	Medical	CWF	DATS
Home equipment delivery < 7 days	95.00%	85.00%	-	85.00%	-	-
% of patients under the care of the community specialist matron who have been readmitted to hospital with the same LTC in less than 30 days (one month behind)	10.00%	1.20%	-	1.20%	-	-
% of leg ulcers healed within 12 weeks from diagnosis	75.00%	96.40%	-	96.40%	-	-
Number of community acquired grade 3 or 4 pressure ulcers	6.3	2.0	-	2.0	-	-
Community AHP - 18 week RTT Snapshot at month end	95.00%	92.60%	-	92.60%	-	-
Percentage of Community Staff equipped with mobile device	100.00%	-	-	-	-	-
% district nursing patients with a care plan	90.00%	95.00%	-	-	-	-
Number of patients with a Calderdale care plan - (this is a self management plan	50.00%	49.00%	-	49.00%	-	-
District Nursing Performance Active caseload	-	4433	-	4433	-	-
District Nursing Performance New referrals in month	-	1052	-	1052	-	-
District Nursing Performance Urgent referrals seen within 4 hours	80.00%	68.00%	-	68.00%	-	-
District Nursing Performance Non urgent referrals seen within 2 days	80.00%	60.00%	-	60.00%	-	-
Community Friends & Family Test - % Would recommend the Service	-	89.00%	-	89.00%	-	-
Community Friends & Family Test - % Would NOT recommend the Service	-	6.00%	-	6.00%	-	-
Patients who died at their preferred place of choice	95.00%	100.00%	-	100.00%	-	-

% Leg ulcers healed with 12 weeks from Diagnosis - YTD 225/234 of leg ulcers diagnosed by the team were supported to heal within 12 weeks. There has been extensive work in the healing of leg ulcers and only 9 patients out of 234 did not have their leg ulcer healed within 12 weeks.

LTC Patients with a Calderdale Care Plan - The target around LTC patients and Calderdale Care plan is linked to the self -management plan and is only recorded on the community matrons caseload.
Several new workstreams are in place to identify the priority areas to improve the recording and reporting of this indicator.

Community Friends and Family Test – The results for the first 3 month are positive with an average of 90% of patients pleased with their care received and would recommend the service.





Calderdale and Huddersfield NHS
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CQUINS SCHEMES / INDICATORS - CHFT
FINANCIAL YEAR 2014/15
TRUST WIDE

Indicator Name	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3	Quarter 4			Q4	YTD
	Apr	May	Jun	Total	Jul	Aug	Sep	Total	Oct	Nov	Dec	Total	Jan	Feb	Mar	Total	
1.1 - Friends and Family Test - Implementation of the staff FFT across the provider from April 2014 - reporting by end of Q1 One payment at end of Q1 (£319k total)																	
Indicator 1.1 Reporting by end of Q1			YES														
1.1.1 - Friends and Family Test - Implementation of FFT across outpatient and day case department across the Trust - establish by end of Q2 and report from Q3 onwards One payment at end of Q2 (£319k total)																	
Indicator 1.2 Reporting from Q3 - Daycase (including endoscopy, day surgery and day procedures).							YES		26.3%	26.0%	25.2%						
Indicator 1.2 Reporting from Q3 - Outpatient							YES		16.7%	16.3%	11.5%						
1.1.2 - Friends and Family Test - Implementation of FFT across Community services - establish by end of Q3 and report from Q4 onwards One payment at end of Q3 (£319k total)																	
Indicator 1.1.2 Reporting from Q4											YES						
1.2 - Friends and Family - Response rate to F&F test question **Inpatient - Q1 25%, Q4 30%** **A&E - Q1 15%, Q4 20%** Two payments, end of Q1 and Q4 (£159k total)																	
Indicator 1.2 Inpatient response rate to F&F test question	37.3%	32.9%	35.7%		39.8%	41.5%	40.6%		46.5%	44.3%	40.6%		37.9%	41.5%	45.7%		
Indicator 1.2 A&E response rate to F&F test question	21.5%	26.2%	29.8%		21.8%	20.40%	20.3%		23.4%	19.2%	4.5%		12.9%	11.7%	8.7%		
1.3 - Friends and Family - Response rate to F&F test question **Inpatient - further improvement requirement to achive 40% in any month during Q4.** One payment, end of Q4 (£159k total)																	
Indicator 1.3 Inpatient response rate to F&F test question	37.3%	32.9%	35.7%		39.8%	41.5%	40.6%		46.5%	44.3%	40.6%		37.9%	41.5%	45.7%		40.4%

Calderdale and Huddersfield NHS
NHS Foundation Trust

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

Indicator Name	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3	Quarter 4			Q4	YTD
	Apr	May	Jun	Total	Jul	Aug	Sep	Total	Oct	Nov	Dec	Total	Jan	Feb	Mar	Total	
2.1 - Safety Thermometer (Quarterly payment conditional on use of thermometer in each of 3 months) Quarterly payment (£159k total)																	
The collection of data on Patient Harm using the NHS Safety Thermometer Harm Measurement Instrument. Collects Falls, Pressure Ulcers, Catheter Infection & VTE																	
Indicator. Continued use of thermometer for monthly data collection	Y	Y	Y		Y	Y	Y		Y	Y	Y		Y	Y	Y		
2.2 - Safety Thermometer - Reduction in the prevalence of pressure ulcers One payment based on achievement of three consecutive months at or below required level One payment (£478k total)																	
(100% payment <4.1%, 75% payment < 4.6%, 50% payment < 5%, 0% payment if >5%)																	
Numerator: Reduction in the prevalence of pressure ulcers using thermometer	47	39	57		39	47	49		43	48	53		44	59	58		**583**
Denominator: Reduction in the prevalence of pressure ulcers using thermometer	1135	1119	1056		1091	1097	1059		1032	1048	1093		1087	1067	1093		**12977**
Indicator. Reduction in the prevalence of pressure ulcers using thermometer	**4.14%**	**3.49%**	**5.40%**		**3.57%**	**4.28%**	**4.63%**		**4.17%**	**4.58%**	**4.85%**		**4.05%**	**5.53%**	**5.31%**		**4.49%**

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NHS Foundation Trust

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

Indicator Name	Quarter 1 Apr	May	Jun	Q1 Total	Quarter 2 Jul	Aug	Sep	Q2 Total	Quarter 3 Oct	Nov	Dec	Q3 Total	Quarter 4 Jan	Feb	Mar	Q4 Total	YTD
3.1- Dementia - Use of dementia screening tool, risk assessments, referrals for emergency admissions aged 75 and over (Target - 90% aggregate) Quarterly payment based on achievement of all three elements (£478k total)																	
Dementia Screen - Emergency Admission 75 Years & Above (Target - 90% aggregate per quarter)																	
Numerator 1: No of Non Elec admissions of patients aged 75 and over reported as having been asked the SQUID question for case finding	461	469	456		457	441	436		468	396	396		530	414			**4924**
Demoninator 1. No. of Non Elec admissions of patients aged 75 and over, who were admitted as inpatients in an emergency minus the exclusions	494	491	472		463	457	439		503	412	412		572	448			**5163**
Indicator 1. Percentage of patients aged 75 and over admitted as inpatients who were screened for dementia	**93.3%**	**95.5%**	**96.6%**		**98.7%**	**96.5%**	**99.3%**		**93.0%**	**96.1%**	**96.1%**		**92.7%**	**92.4%**			**95.4%**
Dementia AMTS - Emergency Admission 75 Years & Above (Target - 90% aggregate per quarter)																	
Numerator 2: No of Non Elec patients admitted aged 75 and above, who have scored positively on the SQUID and reported as having had a dementia diagnostic assessment. (AMTS)	76	87	65		57	81	87		70	57	80		90	70			**660**
Demoninator 2. No of Non Elective patients aged 75 and above admitted as inpatients, who have scored positively on the SQUID case finding question (figures should balance to Numerator 1)	76	87	65		57	81	87		71	58	82		92	72			**664**
Indicator 2. Percentage of patients aged 75 and over admitted as inpatients who were appropriately risk assessed	**100%**	**100%**	**100%**		**100.0%**	**100.0%**	**100.0%**		**98.6%**	**98.3%**	**97.6&%**		**97.8%**	**97.2%**			**99.4%**
Dementia Referral - Emergency Admission 75 Years & Above (Target - 90% aggregate per quarter)																	
Numerator 3:No of Non Elec Patients admitted aged 75 and above, who have had a positive diagnostic assessment, who are referred on for further diagnostic advice.	71	78	64		55	74	74		68	55	71		52	39			**610**
Denoninator 3. No of Non Elec patients aged 75 and above admitted as inpatients, who underwent a diagnostic assessment (in whom the outcome is either "positive" or "inconclusive")	71	78	64		55	74	74		68	55	71		52	39			**610**
Indicator 3. Percentage of patients aged 75 and over admitted as inpatients who were appropriately referred on to GP	**100%**	**100%**	**100%**		**100.0%**	**100.0%**	**100.0%**		**100.0%**	**100.0%**	**100.0%**		**100.0%**	**100.0%**			**100.0%**

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

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

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

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

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FINANCIAL YEAR 2014/15
TRUST WIDE

Indicator Name	Quarter 1			Q1	Quarter 2			Q2	Quarter 3			Q3	Quarter 4			Q4	YTD
	Apr	May	Jun	Total	Jul	Aug	Sep	Total	Oct	Nov	Dec	Total	Jan	Feb	Mar	Total	

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

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

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

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

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CQUINS SCHEMES / INDICATORS - CHFT
FINANCIAL YEAR 2014/15
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Indicator Name	Quarter 1 Apr	May	Jun	Q1 Total	Quarter 2 Jul	Aug	Sep	Q2 Total	Quarter 3 Oct	Nov	Dec	Q3 Total	Quarter 4 Jan	Feb	Mar	Q4 Total	YTD
5.1 - Diabetes Self Care (Q1 achieve 50% on 4 wards, Q2 achieve 50% on 6 wards, Q3+Q4 achieve 50% on 8 wards) 2 payments - end of Q2 and Q4 Two payments, end of Q2 and Q4 (£319k total)																	
Diabetes Self care																	
Target RAG Rating					Report							Q4 Complete					
Numerator. Number of patients supported to self care (fully compliant with bundle)	16				15				16				28				**75**
Denominator. Number of patients admitted to cohort wards who have insulin dependant diabetes and are competent to self-administer	20				25				20				41				**106**
Number of patients sampled who are admitted to cohort wards and have insulin dependant diabetes	31				37				46				60				**174**
Assessed to self care	31	31	100.0%		32	37	86.5%		40	46	87.0%		45	60	75.0%		**148**
Care plan in place	29	31	93.5%		33	37	89.2%		40	46	87.0%		47	60	78.3%		**149**
Giving own Insulin	20	31	64.5%		30	37	81.1%		38	46	82.6%		50	60	83.3%		**138**
Adjusting the dose of insulin	20	31	64.5%		30	37	81.1%		37	46	80.4%		50	60	83.3%		**137**
Testing own blood sugars	18	31	58.1%		22	37	59.5%		35	46	76.1%		46	60	76.7%		**121**
Access to food and snacks	31	31	100.0%		37	37	100.0%		46	46	100.0%		59	60	98.3%		**173**
% Diabetes patients supported to self care (fully compliant with bundle)	**80.0%**				**60.0%**				**80.0%**				**68.3%**				**70.8%**

5.2 - Diabetes (Q1 - 60% achievement, Q2-Q4 90% achievement) Two payments, end of Q2 and Q4 (£159k total)																	
Diabetes - Management of hypoglycaemia patients in A&E, CDU and MAU																	
Target RAG Rating																	
Numerator. Patients attending A&E, CDU or MAU with diabetic hypoglycaemia who are referred to a specialist nurse and receive written educational support	3	8	12		6	12	7		7	20	18		19	13	11		136
Denominator. Patients attending A&E, CDU or MAU with diabetic hypoglycaemia	4	8	12		6	12	7		7	20	18		19	13	11		137
% Diabetes attending A&E, CDU or MAU referred to specialist nurse	**75.0%**	**100.0%**	**100.0%**		**100.0%**	**100.0%**	**100.0%**		**100.0%**	**100.0%**	**100.0%**		**100.0%**	**100.0%**	**100.0%**		**99.3%**

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

Indicator Name	Quarter 1 Apr	May	Jun	Q1 Total	Quarter 2 Jul	Aug	Sep	Q2 Total	Quarter 3 Oct	Nov	Dec	Q3 Total	Quarter 4 Jan	Feb	Mar	Q4 Total	YTD
6 - Improving Medicines Safety																	
Support the effective transfer of information about medicines when patients are being transferred from one provider to another following an unplanned admission to hospital																	
Part 6.1 - Reconciliation (Quarterly payment conditional on: Q1-3 70% target. Q4 - 80% Quarterly payment (£319k total)																	
Part A: Number of e-discharges checked by Pharmacy with medicines reconciled - numerator	1060	698	639		679	676	650		730	642	645		590	609	688		8306
Part A: The number of patients (admitted for longer than 24 hours) on acute medical wards - denominator	1185	753	733		778	744	736		832	747	759		694	707	857		9525
Part A: Reconcilliation of medicines on admission - total	**89.5%**	**92.7%**	**87.2%**		**87.3%**	**90.9%**	**88.3%**		**87.7%**	**85.9%**	**85.0%**		**85.0%**	**86.1%**	**80.3%**		**87.2%**
Part 6.2 - Discharge Accuracy Checks (Quarterly payment conditional on: Q1 - 55%, Q2- 60%, Q3 - 65%, Q4 - 70% Quarterly payment (£319k total)																	
Part B: The number of patients (admitted for longer than 24 hours) on acute medical wards having their e-discharge prescription approved and reconciled against the inpatient prescription chart by a pharmacist - numerator	1185	753	733	2671	778	744	736	2258	832	747	759	2338	694	707	857	2258	
Part B: The number of patients (admitted for longer than 24 hours) on acute medical wards - denominator	1826	1200	1106	4132	1141	1104	1073	3318	1179	1057	1093	3329	1035	1009	1180	3224	
Part B: Discharge Medication - total				**64.6%**				**68.1%**				**70.2%**				**70.0%**	
7 - End of Life																	
Part A - introduction of care bundle on two respiratory wards Q2 - 30% of staff to have received training, Q4 - 90% Single payment end of Q4 (£478k total)																	
Implementation of care bundle in two respiratory wards					**Report completed**								Reporting Due				
Part B - Join the TRANSFORM programme Quarter 2 - Production of driver diagram to include key measures. Quarter 4 - Demonstration of programme achievements as evidenced by a dashboard and key measures Two payments, end of Q2 and Q4 (£478k total)																	
					Report completed								Report due				
8 - Nutrition																	
Establish a collaborative task and finish group to scope patient, staff and visitor food provision in order to understand the current catering services across the hospital setting with a view to achievement of the Food For Life Catering Mark and Government Buying Standards where feasible. Q2 - Baseline Report on progress YTD, including Real Time Patient Monitoring (RTPM) baseline results Q4 - Report including RTPM demonstrating improvement work carried out Two payments, end of Q2 and Q4 (£319k total)																	
Reports due highlighting progress	Report Complete				Action Plan Implemented								Report due				

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Monitor Indicators

THIS

Indicators	Thresholds	Weighting	March 2015	Quarter 4	Comments
Incidence of MRSA Year to Date	0	1.0	0	1	
Incidence of Clostridium Difficile Year to Date	3	1.0	1	27	
Maximum Time of 18 Weeks From Point of Referral to Treatment - Admitted	90%	1.0	91.42%	91.63%	
Maximum Time of 18 Weeks From Point of Referral to Treatment - Non-Admitted	95%	1.0	98.65%	98.86%	
Maximum Time of 18 Weeks From Point of Referral to Treatment - Incomplete Pathways	92%	1.0	94.52%	94.52%	
62 Day Wait for First Treatment from Urgent GP Referral	85%	1.0	93.53%	91.03%	
62 Day Wait for First Treatment from Consultant Screening Service Referral	90%	1.0	83.33%	77.78%	
31 Day Wait for Second or Subsequent Treatment: Surgery	94%	1.0	95.45%	97.70%	
31 Day Wait for Second or Subsequent Treatment: Anti Cancer Drug Treatments	98%	1.0	100.00%	100.00%	
31 Day Wait from Diagnosis to First Treatment (All Cancers)	96%	0.5	100.00%	100.00%	
Two Week Wait From Referral to Date First Seen: All Cancers	93%	0.5	99.35%	98.85%	
Two Week Wait From Referral to Date First Seen: Symptomatic Breast Patients	93%	0.5	93.30%	94.80%	
A&E: Maximum Waiting Time of Four Hours from Arrival to Admission/Transfer/Discharge	95%	1.0	95.03%	93.62%	
Community care - referral to treatment information completeness	50%	0.5	100.00%	100.00%	
Community care - referral information completeness	50%	0.5	97.30%	98.20%	
Community care - activity information completeness	50%	0.5	100.00%	100.00%	
Overall Governance Rating			Amber-Green	Amber-Red	

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

Calderdale and Huddersfield NHS
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Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Claire Gruszka, Patient Safety Risk Manager - LSMS
Date: Thursday, 23rd April 2015	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: Risk Register - Organisational Risks scoring 15+ - The attached papers provide details of the highest risk areas as at 14 April 2015.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Papers presented at 7 April 2015 Risk & Compliance Group.	
Governance Requirements: .	
Sustainability Implications: None	

Executive Summary

Summary:

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Main Body

Purpose:

.

Background/Overview:

.

The Issue:

.

Next Steps:

.

Recommendations:

.

Appendix

Attachment:

COMBINED RISK REGISTER - APRIL 2015.pdf

RISK REGISTER REPORT

Risks as at 14 April 2015

TOP RISKS

6131 (25): Progression of service reconfiguration impact on quality and safety

2827 (20): Risk of poor patient outcomes due to dependence on middle grades
2828 (20): Risk of poor patient outcomes and experience caused by blocks in patient flow
4783 (20): HSMR & SHMI
6136 (20): Overarching risk for Infection Control
4706 (20): Failure to meet CIP
6150 (20): Finance: breach of licence

RISKS WITH INCREASED SCORE

6270 (16) – Non-achievement of 100% Appraisal & Mandatory training target

RISKS WITH REDUCED SCORE

4706 (25): Failure to meet CIP
6150 (25): Finance: breach of licence
6232 (15): Lack of Fire Wardens*

*The above risk now sits on their local risk register.

NEW RISKS

No new risks have been added.

CLOSED RISKS

No risks were closed.

RISKS TO BE DISCUSSED AT NEXT RISK & COMPLIANCE COMMITTEE:

- 6175 – EDMS impact
- Paediatrics in A&E*
- Safeguarding/Deprivation of Liberty*
- 6152 – Anaesthetic cover*
- Other new risks identified on risk register

*Carried over as either no information provided or lack of information provided at Risk & Compliance Group on 7 April 2015.

Trust Risk Profile as at 14 April 2015

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Rare (1)					
Unlikely (2)					
Possible (3)					= 6027 – Failure to meet Capital programme = 6230 – Failure to deliver expected benefits of EPR = 6143 – THIS Modernisation prog, working with BTHT
Likely (4)				= 5792 – Shortage of Consultants in Opthalmology = 6130 = Loss of income/reduction in profit related to competitive procedures = 6132 = Reduction in elective surgery market share and volume of work = 5806 – Estates risks ! 6270 – Non-achievement of 100% Appraisal & Mandatory training target	= 2828 – Blocks in patient flow in A&E = 2827 – Dependence on middle grade locums in A&E = 6136 – Infection Control < 4706 – Failure to meet CIP < 6150 – Breach of Monitor licence
Highly Likely (5)				= 4783 – HSMR & SHMI	= 6131 – Progression of service reconfiguration impact on quality and safety

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

Extreme and Major Risks (15 or over)

The Health Informatics Service
Informing Healthcare

	Risk No	Div	Dir	Dep	Opened	Status	SO	Risk Description plus Impact	Existing Controls	Initail	Current	Target	Further Actions	Review	Target	RC	Exec Dir	Lead
Extreme	6131	Corporate	Commissioning & Partnerships	Commissioning & Partnerships	Oct-2014	Active	Objective 2 - Keeping the Base Safe	Risk: The delay in being able to progress service reconfiguration creates the risk that the Trust will not be able to address important clinical quality and safety issues Background: The Outline Business Case identified service reconfiguration proposals that would mitigate and address significant clinical and quality safety issues associated with the current configuration of services across two sites. Clinical Commissioning Groups have decided that consultation on changes in configuration of hospital services will not commence in 2014 and will be delayed. Impact: The delay in being able to progress service reconfiguration creates the risk that the Trust will not be able to address important clinical quality and safety issues identified by NCAT such as: • Non-compliance with many of the standards for Children and Young People in Emergency Care settings; • Paediatric medicine and surgery are not co-located on the same hospital site; • The two hospitals in Halifax and Huddersfield do not provide the same acute services and this leads to a frequent need for inter-hospital transfers • Non-compliance with the prescribed NHS England standards such as: □ All admissions seen by a suitable consultant within 14 hours of admission, or within 6 hours between 0800-2000, except patients who are very ill, where it should be 1 hour; □ Hospital inpatients must have scheduled seven-day access to diagnostic services; □ Support services, both in the hospital and in primary,	To address this the Trust is reviewing and assessing possible actions and critical service changes that could be progressed in the interim period, and as quickly as possible, within the required statutory and regulatory processes so as to improve the clinical, quality, safety and sustainability of services. This review has been completed and the report and recommendations approved by the Trust Board in October 2014. The recommendations are now being implemented however in the absence of major reconfiguration the impact they will have on mitigating clinical and financial risk is limited.	25 5 x 5	25 5 x 5	15 3 x 5	Clinical Commissioning Groups have established a Hospital Board to review the OBC and consider the risks related to current model of provision. CCGs are looking at options for consultation building on the OBC proposals and are likely to include scope for West Yorkshire collaboration and also the new models of care described the NHS Five Year Future Forward. Hospital future model care workshop being held on 16 April 2015.	Mar-2015	Sep-2015	WEB	Anna Basford	Catherine Riley

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

Major	4706	Corporate	Finance	Corporate Finance	Jun-2011	Active	Objective 2 - Keeping the Base Safe	The Trust's current expenditure exceeds planned levels through failure to deliver Cost Improvement Programme (CIP) or budgetary overspend. The expenditure levels in 2014/15 carry forward into 2015/16 to give rise to an income an expenditure gap that is insurmountable through achievable savings levels. This will result in the Trust not generating a sufficient I&E surplus and cash to meet on-going commitments and cannot remain a viable and sustainable organisation.	- Appointment of PWC to assist in the creation of a more robust PMO to develop, control and monitor the 14/15 CIP schemes. - A revised PMO approach which includes external and internal support and has been built on the ideas and schemes that were previously managed within the Efficiency Programme Board. - Appointment of a Turnaround Director to provide further direction and support to the PMO process under the overall leadership of the Turnaround Executive. - Weekly meetings with Turnaround Executive to review, challenge and escalate progression within the necessary workstreams. Remaining Trust reserves to mitigate against shortfall in part in 2014/15. Monthly financial reporting and forecasting to allow remedial action. Business planning for 2015/16 indicates that due to the size of the initial income and expenditure deficit position this cannot be met through CIP delivery. Therefore, cash support will be required within 2015/16 with discussions being held with Monitor and the Independent Trust Financing Facility (ITFF).	15 5 x 3	20 5 x 4	5 5 x 1	- Additional external resource will be considered based on need and specialist input identified within each workstream. - CIP schemes and delivery for 2015/16 will be monitored and progressed through the PMO driven disciplines under the guidance of the Turnaround Executive. - The Trust have committed to Monitor that we will deliver the national tariff (4%) savings.	Apr-2015	Mar-2016	FPC	Keith Griffiths	Chris Benham
Major	6150	Corporate	Finance	Trustwide	Nov-2014	Proposed for Acceptance	Objective 2 - Keeping the Base Safe	The Trust will be unsustainable as a result of a challenging financial position resulting in regulatory special measures. The Trust is currently in breach of it's Monitor licence.	£14M CIP identified Further £2M identified and in pipeline Monthly report to Board, Finance and Performance Committee and WEB. Regular reporting to the Membership Council. Divisional Business meeting reporting. Workstream programme arrangements in place. QIA assessments undertaken. Independent review of financial position and CIP. Full review of budgets taking place. Appointment of Turnaround Director Turnaround processes in place Strengthened programme arrangements Strengthened QIA process	15 5 x 3	20 5 x 4	5 5 x 1	- Action plan resulting from Independent report - Increased frequency of budget monitoring with all divisions / departments - Compliance with the terms of it's breach of licence as agreed with Monitor - WLGR self assessment - WLGR by PWC	Apr-2015	Jun-2015	FPC	Keith Griffiths	Chris Benham
Major	6027	Corporate	Finance	Corporate Finance	May-2014	Active	Objective 2 - Keeping the Base Safe	A failure to secure sufficient cash to pay for the planned Capital programme or meet ongoing commitments. The potential impact is: The Trust is unable to develop infrastructure in support of a sustainable future for the organisation.	Loan and drawdown profile agreed with the Independent Trust Financing Facility to support capital investment. Capital forecast revised further downwards in September to protect liquidity. Robust management of working capital ongoing. 2015/16 capital plans have been risk assessed and reduced. Further modelling is being undertaken as part of the 15/16 business planning process. The Trust is holding discussions with Monitor and the Independent Trust Financing Facility (ITFF) to secure cash support as a forecast requirement within 2015/16 exists.	16 4 x 4	15 5 x 3	12 4 x 3	Opportunities under review to increase CIP delivery and improve I&E position will improve cash availability. 2015/16 capital plans have been risk assessed and reduced. Further modelling is being undertaken as part of the 2015/16 business planning process. Completion of discussions with Monitor and the ITFF to secure forecast cash support for 2015/16.	Mar-2015	Mar-2016	WEB	Keith Griffiths	Chris Benham

Major	4783	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Aug-2011	Active	Objective 2 - Keeping the Base Safe	The HSMR and SHMI are higher than the national average, which may indicate that there are more deaths than expected, according to these methodologies. This may lead us to believe that more patients are dying in our services however we cannot assume that despite these statistics. The mitigating actions will ensure that we discover whether there are preventable deaths and what actions need to be taken to prevent any avoidable harm.	-- Care of the acutely ill patient programme underway underpinned by a number of workstreams, reporting to Clinical Outcomes Board, key outcomes are- comprehensive mortality review programme to establish whether any death was avoidable and whether there are areas where care can be improved introduction of Nerve Centre, this will improve the recording of patients vital signs and improve the response to deterioration implementing improved standards of care in high risk areas such as stroke, COPD, sepsis and others - A mortality dashboard down to ward level has been developed to improve monitoring. - The Medical Division has plans for 3 diagnostic outliers: COPD, Stroke and heart failure. - Improved understanding of proxy HSMR and SHMI measures are allowing us to map closer to real time the impact of the programme including monitoring of crude mortality rate.	20 4 x 5	20 4 x 5	8 4 x 2	Implement action plan by: - Implementation of Outline Business Case - Reducing mortality rates - Early recognition of our deteriorating patients including the roll out of Nerve Centre - Reliable delivery of care bundles - Improving care for frail patients- plan being developed within the Medicine Division - Investigating the cause of outlying SHMI conditions - Improving coding, this is now a CIP work-stream - Reducing patient transfers and outlying - Improved staffing and improved handover. - Clinical commissioning Groups have established a Hospital Board to review the OBC and consider the risks related to current model of provision. The Trust will be working with CCGs to support development of possible risk mitigation strategies by the commissioner.	May-2015	Jun-2015	COB	David Birkenhead	Juliette Cosgrove
Major	6136	Diagnostics & Therapeutic Services	All Directorates Diagnostics	All Departments/Wards Diagnostics	Oct-2014	Active	Objective 2 - Keeping the Base Safe	The number of cases of post 48 hr C Difficile creates a risk to patient safety & experience, and could impact upon CHFT's governance rating. The target for 2015/16 is 21 cases. As at 13.4.2015 there has been one case reported, if there are a no further cases reported in month we will achieve the target.	Hand hygiene compliance audits Antibiotic prescribing & monitor according to Trust policy FLO audits completed Replacement of commodes to ensure that they can be effectively cleaned 24/7 cleaning available CCGs involved in C Diff RCAs to ensure learning across the health economy Standard isolation procedures, with any breaches incident reported C Difficile care plan to ensure best practice, with daily ICPN review External Review of Infection Control practice & procedures	25 5 x 5	20 5 x 4	15 5 x 3	- Share the learning from RCAs effectively - Implement the recommendations of the External Review - HPV of wards - Antibiotic ward rounds - Prompt isolation of patients	May-2015	Mar-2016	ICPB	David Birkenhead	Jean Robinson

Major	5792	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Apr-2013	Active	Objective 1 - Transforming Patient Care	The shortage of Consultants has lead to difficulties in maintaining capacity, rsulting in the risk of glaucoma/macular patients missing follow up s as CHFT are unable to provide an appointment at the correct interval. This could result in harm (i.e. deterioration of sight). Additional risks identified in April 2015 having an impct on this risk: Another Consultant leaving, placing reliance upon locum cover; performance issues with EDMS (adding additional time to clinic appointments): 1.Increased time required to review previous records on EDMS compared to paper records, especially for review of returning patients will reduce the number of patients that can be seen in a clinic significantly, even once staff have become used to the format. Estimate a long-term 20% reduction in capacity with consequential impact on contract delivery 2. Staff new to the Department will need to be trained in the system on their first day of work, otherwise they will be unable to do clinical work. Training must be available instantly; it cannot be left to other clinical staff to do this. 3.Much of the Ophthalmology record for certain groups of patients is recorded in the Medisoft EPR, and this will increase. Confirmation has been sought, but not received, that Medisoft records will be downloaded into EDMS, to avoid duplication of record-keeping. 4. Access to EDMS at Westwood Park Diagnostic and Treatment Centre is necessary and needs to be a fast connection. At present, there is no access to the Intra-net or Internet there, except for Bradford Teaching Hospitals and Medisoft. It will not be possible to continue clinics there without this access.	- Partial Booking introduced to assist with planning of follow up appointments - Some Consultants helping by undertaking WLI and allowing their clinics to be overbooked to see the urgent cases -- Actioned Newton revised clinic templates - Pathway work ongoing with CCGs to ensure that Primary Care initiatives are supported and utilised (PEARS scheme, Cataract Refinement, Ocular Hypertension follow ups) - Explored different ways of working to assist currently (employed additional Optometrists on bank) and in the future looking to employ additional Orthoptists and Optometrists and expand their practice so that can undertake reviews of Glaucoma patients(within agreed protocols) and undertake non medical prescribing and intra-occular injections. - reviewed clinical portfolio of existing Consultants and the Cornea Specialists now taking responsibility for the patients that are most vulnerable from their chronic condition - Specialty removed on C&B for out of area referrals to reduce impact on already stretched capacity	25 5 x 5	16 4 x 4	4 2 x 2 x 4	- continue to explore opportunities to involve AHPs and expand their roles with protocols and pathways and additional training for non-medical prescribing to enable the Consultants to deal with the more complex cases The risk rating will be reduced once we are assured that all the pending appointments have been actioned and no patients are waiting (other than for their own choice) 12.11.14 Consultant Appointments Committee set for December 2014, with one Consultant appointed but further pending Consultant vacancy 13.04.15 - Interviews scheduled for 20 May 2015. Advice is being sought via IT team (Steve Coady) as to whether Westwood Park solution can be found. All other issues will need to be mitigated against - IT will need to provide training for EDMS either online or on first day for new starters (needs consideration) 27 Feb - solution in place for WWP - tried and tested April 13 2015 EDMS impacting on running of clinics - adding up to 30 minutes per Consultation.	May-2015	Sep-2015	WEB	Julie Dawes	Melanie Addy
Major	5806	Medical	Integrated Medical	Ward 3 HRI	Jan-2015	Active	Objective 1 - Transforming Patient Care	**ESTATES RISKS: There are a number of estates risks which include:** A failure to maintain privacy and dignity of patients on the Chemotherapy Unit at HRI, caused by the poor environment on Ward 3 (which is shared with the vascular surgical ward). This could result in the ward area being closed down by peer review and poor patient experience.	Staff on the Unit are taking whatever action they can to maintain privacy and dignity for all the patients in this cramped environment, pending the longer term solution.	16 4 x 4	16 4 x 4	8 2 x 4	Ward 7, HRI is to be upgraded to accommodate Chemotherapy Day Unit and Oncology Outpatients, this will commence in April 2015 and be completed in October 2015. In the interim accept current risk	May-2015	May-16	QC	Lesley Hill	Maureen Overton
	5801			Haematology	May-2013	Active		There is a risk of a poor patient experience & complaints due to the poor state of the general environment in Haematology. This will result in complaints, concerns and negative feedback for the service and the Trust.	The general corridor area has seen some improvements during 2014 however, the remaining area remains in a poor state of repair Cleaning is carried out daily in the area and general repairs are carried out as and when reported.				Discussed at Feb 15 Divisional Quality & Safety Board. 1) Estates to re-visit the area to ascertain what further work can be carried out to improve the areas.					J Stainton
	2846			HRI, ICU	Apr-2011	Active		Floor throughout the unit is generally becoming poor – it is cracked around the edges all around the unit making cleaning difficult. Floor also has a lot of marks which cannot be removed – makes it look dirty. 14/7/2014 condition of the floor continues to deteriorate . Some patching up done in areas	Continue with cleaning programme – report any deterioration to estates				Monitor condition ICU requires full refurbishment and flooring will be addressed at this point due to requirement of moving the unit to alternative accommodation in order to replace the floor, On the capital programme for refurbishment but not imminent. Reviewed 6/12/13 no change to previous comments					J Carter

5024			PAOU	Jan-2014	Active		Failure to maintain adequate environmental and safety standards on Ward 18 HRI leading to a failure to meet the requirements of the Infection control and Prevention Quality Improvement Audit due to lack of appropriate alternative accommodation. Resulting in potential harm to children through issues of privacy and dignity, exposure to infection and fire hazards	Control of infection in place with actions in place eg Estates action plan in place rectifying issues of cracked tiles, painting- completed Ward 18 remains on the capital programme for upgrade however, there is no confirmation as to when this work will take place.				Commitment by the trust/division to review of paediatric inpatient services being undertaken with a view to defining level of investment required. initial scoping session Feb 2015. Colleagues continue to make possible improvements, with weekly environmental monitoring by Lead PNP undertaken.					Gill Harries/Jemmy Taylor
5947			Ward 4 HRI	Jan-2014	Active		Risk to patient experience and quality of care due to issues with temperature control, particularly during winter period on Ward 4 at HRI.	Estates informed and managed as required with portable heaters and temporary repair of windows.				To continue to liaise with estates on highlighting temperature issues as and when required. Form part of normal ward upgrade works					JULIE HEPWORTH
5686			Ward 5, HRI	Feb-2013	Active		There is a risk of poor environmental conditions on Ward 5 at HRI due to windows which cause draughts in cold weather but fail to open in warmer weather, resulting in poor patient experience and possible extensions to length of stay.	Windows have been temporarily sealed. Temporary radiators in place during windy, winter weather. Gap in control - measures taken do not fully resolve the issue and the windows need to be replaced.				Windows need to be replaced/repaired - escalated to estates and to form part of ward upgrade programme					Dave MCGarragan
5832			Ward 19	Jun-2013	Active		Failure to consider the risks caused by the floor being uneven and slippery after buffing may result in patients with balance, delirium problems being less safe when mobilising on Ward 19.	Escalated to estates and interserve increased awareness of falls risk increased requirement of 1:1 nurses				Awaiting review by estates and interserve.					Helen Falconio
5847			Ward 6 HRI	Aug-2013	Active		issue of poor fitting windows in B6,7,8,9, 10, 11, A1,2 Reccurring issue each winter with cold weather causing room temperatures to drop, patients complain. This winter will be the 5th year repairs not made Secondary glazing installed on B side but nothing on A side.	heaters obtained however are not sufficient when temperatures drop. Have met with estates each year to repair windows however no further steps taken				risk logged at this stage so work can be considered in the summer and minimum disruption to patient care and services Update 18.07.13 Estates Risk register reviewed. Not present on their Risk register. Further action - to raise with Estates. Scoring reviewed and altered. Contact estates to see why it is on the upgrading schemes Work to 2 windows completed by B7/8, one window has not been secondary glazed.					paula mcdonagh
6034			Ward 3 - Vascular	Jun-2014	Active		The floor under beds 4 and 5 in the main ward have holes in covered with sticky tape. All the windowsills on the ward have lifted and are gathering dirt underneath them.	Estates have been aware since 2013 and delayed re flooring and replacing the windowsills because they thought we were relocating.				Estates have been contacted again and are aware that this work need carrying out as a matter of urgency. Floors under beds 4 and 5 have now been repaired. Windowsills need replacing still and Estates are aware. AS AT 02/03/2015 the floor under beds 4 and 5 has been repaired but we are still awaiting the repair of the window sills .					Alex Henderson

Major	6130	Corporate	Commissioning & Partnerships	Commissioning & Partnerships	Oct-2014	Active	Objective 2 - Keeping the Base Safe	Risk: Loss of income or reduction in profit related to competitive procurements There is a significant risk of the Trust losing income and market share of service provision through competitive procurements. This is caused by Greater Huddersfield CCG and Kirklees and Calderdale Local Authority decisions to undertake competitive procurement for services. The aggregate value of the risk of services currently exposed to competitive procurement is circa £12m. Even if the Trust is able to win tenders and secure continued service provision the bidding financial envelope defined by commissioners may mean a reduction in the existing profit margin on service delivery. Impact: The immediate impact of this risk is a potential loss of circa £12m service income, or the potential reduction in profitability of services. This could impact in 15/16 and have negative impact on Trust financial viability. Strategically the loss of a number of community based services creates risk to the Trust's reputation and credibility as an integrated provider of community and hospital based services. This could potentially generate further risk regarding continued provision of other services that are appropriate for	There are proactive systems in place to ensure that we are aware of risk and opportunities related to competitive procurement. We are responding and submitting tenders to secure continued service delivery. We are working collaboratively with partners such as GP Federations, Mid Yorks, and Forget Me Not Hospice and other voluntary sector providers. We are redesigning services to meet the specifications and offer value for money. We have used bid writers to assist us in presenting tenders.	16 4 x 4	16 4 x 4	8 2 x 4	To improve our ability to offer competitive service offers we are undertaking detailed Service Line Review using a toolkit we have developed to understand how we can improve our offer of quality and efficiency. This is now one of the PMO work streams and is being regularly reviewed and monitored. Contracts lost: School Nursing services Contracts won: Sexual Health services	Mar-2015	May-2015	CISC	Anna Basford	Rob Aitchison & Lisa Williams
Major	6132	Corporate	Finance	Corporate Finance	Oct-2014	Active	Objective 2 - Keeping the Base Safe	Risk: Reduction in elective surgery market share and volume of work undertaken by the Trust. Impact: Reduction in income that will impact on overall Trust viability. The current value of under performance against the block contract for elective surgery is £3m.	A recovery plan to increase the volume of procedures undertaken within existing capacity has been developed and is being implemented. The NHS England Elective Intensive Support Team has provided support to develop capacity models for elective surgery specialities. Four Eyes Insight are working with the Trust to identify opportunities for increased productivity.	20 5 x 4	16 4 x 4	8 2 x 4	The trust will develop GP and patient information to support the offer of choice and promote the services provided by the Trust.	May-2015	May-2015	WEB	Anna Basford/Julie	Kristina Arnold
Major	6270	Corporate	Personnel and Development	Workforce & OD	Apr-2015	Active	Objective 2 - Keeping the Base Safe	Risk:- Failure to ensure all colleagues are appraised and complete mandatory training requirements in the last 12 months thereby missing 100% appraisal and mandatory training compliance target. Impact:- Colleagues practice without the necessary understanding of how their role contributes to the achievement of strategic direction/objectives and without the knowledge/competence to deliver compassionate care.	WEB IBR monitoring of compliance data Quality Committee assurance check Well Led oversight of compliance data identifying 'hotspot' areas for action Divisional Business meetings focus on performance and compliance Real time compliance data available through local data collation/recording (through ESR)	16 4 x 4	16 4 x 4	12 4 x 3	Position key compliance messages on front page of intranet with banner Check operational use by divisions of ESR data entry, capture and reporting Refresh intranet accessible appraisal tools Design e-learning appraisal tool Develop and approve divisional appraisal and mandatory activity action plans for 2015/2016 Design mandatory and essential skills training programme and delivery methodology Obtain approval from WEB for approach to mandatory training Monitor compliance month by month	Jul-2011	Apr-2015	WEB	Director of Workforce and OD	Deputy Director of Workforce and OD

Major	6143	Corporate	THIS	Modernisation Programme	Nov-2014	Active	Objective 1 - Transforming Patient Care	There is added complexity in working with Bradford Teaching Hospitals who are being named as a beneficiary of the procurement. This may affect the deployment timescale and delay any associated benefit. There could also be increased costs as a result of the delays.	- Regular discussions with senior management at Bradford Trust; - Inclusion of the implications of working with Bradford (during procurement; during implementation and post implementation) in all negotiations with potential suppliers.	16 4 x 4	15 5 x 3	4 4 x 1	1) The legal team are formulating an MOU between the two Trusts which will form the basis of a contract. 2) There is an option to receive a managed service with off site hosting which may be considered post contract award. 3) Update Feb 2015: A Back to Back Contract will be in place pre-contract signature that will clearly identify both organisations responsibilities and liabilities regarding the delivery of a jointly agreed implementation plan. This will supplemented via a joint governance structure that will include executives and none executives from both organisations. 4) Update March 2015: Collaboration agreement in place and draft governance structure agreed by the two CEO's. First meeting of the Transformation Board scheduled to take place in April. Risk score changed to Impact 5, Likelihood	Jun-2015	Apr-2015	WEB	Mandy Griffin	Dave Lang & Cindy Fedell
Major	6230	Corporate	Finance	Corporate Finance	Feb-2015	Active	Objective 2 - Keeping the Base Safe	A failure to deliver the expected benefits of Electronic Patient Record system through financial and/or operational challenge impeding implementation (e.g., need to release staff/instigate major service change and support capital and revenue consequences prior to release of financial benefit) may result in the Trust being unable to develop an infrastructure in support of a sustainable future for the organisation.	- Loan and draw-down profile agreed with the Independent Trust Financing Facility to support capital investment, including EPR investment. - Financial appraisal and selection of preferred supplier. - Modernisation Programme management and governance structure.	15 5 x 3	15 5 x 3	10 5 x 2	- Costs and funding options to be fully worked through and implementation plan agreed. - Benefits realisation and overall affordability plan to be finalised as part of contract award negotiations.	May-2015	Apr-2016	FC	Keith Griffiths	Kirsty Archer

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Carole Hallam, Assistant Director of Infection Prevention Control
Date: Thursday, 23rd April 2015	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Monthly DIPC Report - Report of the position of Healthcare Associated Infections	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: WEB	
Governance Requirements: Improving patient experience - reducing healthcare associated infections	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

For information

Background/Overview:

Monthly update on HCAI in the Trust

The Issue:

Current position of HCAI outlined in the report

Next Steps:

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

Recommendations:

For the Board to note the content

Appendix

Attachment:

Monthly DIPC Report April 2015.pdf

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

Performance targets

Indicator	Month agreed target	Current month (March)	YTD agreed target	YTD performance	Actions/Comments
MRSA bacteraemia (trust assigned)	0	**0**	0	**1**	One case has been assigned the trust
C.difficile (trust assigned)	2	**1**	18	**27**	10 avoidable 17 unavoidable
MSSA bacteraemia (post admission)	1	**3**	15	**12**	Of the three cases, one was due to hospital acquired pneumonia, one was community acquired cellulitis and one was a line infection (see actions below regarding line infections)
E.coli bacteraemia (post admission)	2	**2**	23	**29**	A review of cases highlighted that almost half of the cases were associated UTI and around 25% of these had a urinary catheter. Full report attached as appendix 1
MRSA screening (electives)	95%	**97%**	95%	**96.45%**	February validated data

Quality Indicators

Indicator	Month agreed target	Current month (March)	YTD agreed target	YTD performance	Comments
MRSA screening (emergency)		**91%**		**89.4%**	February validated data
Central line associated blood stream infections (Rate per 1000 cvc days)	1.5	**4.85**	1.5	**1.35**	There were three line infections identified in March and currently being investigated, these cases are not related. Actions include refresher training and development of patient held record (CVAD Passport). YTD performance remains under the ceiling target
Isolation breaches		**8**		**243**	
ANTT Competency assessments (doctors)			95%	**60.7%**	Key trainer sessions are been held monthly and well attended. Assessments being performed at ward level. Clinical directors to be informed of the names
ANTT Competency assessments (nursing and AHP)			95%	**71.3%**	

					where assessments remain outstanding
Blood cultures Competency assessments (Drs)				**8.4%**	Nursing matrix is currently being updated. All junior doctors have been notified to complete the self-declaration of competency
Blood cultures Competency assessments (RN)				**53.4%**	
Cleanliness		**95%**		**97%**	
Hand hygiene	95%	**99.81%**	95%	**99.83%**	
Frontline Ownership Audits (% performed)		**58%**			Divisional leads have agreed a process at the ICPB for these to be completed on same day each month to increase performance

Clostridium difficile

There were a total of 27 cases from April 2014 to March 2015. Of these 10 were agreed as avoidable and 17 agreed as unavoidable. All cases have been investigated and there has been valuable learning for the majority of cases. The commonest issues were delay in obtaining and sending specimens for testing and delay in isolating patients with loose stools.
A task and finish group is being set up to improve isolation breaches to include a Matron from each Division, an IPCT member, a member of patient flow and a Ward manager and to report back to ICPB

The table below provides a summary of the C. difficile case in March

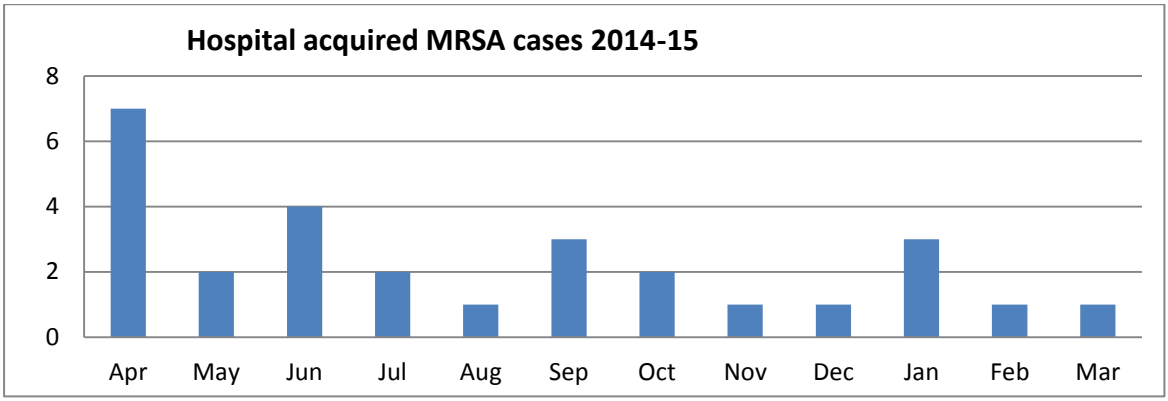
Case details	**Summary of case**	**Key issues identified from RCA**
20.03.15 **H22** MESS No 404117 Datix 117243	Patient admitted to CRH on 27th February following a fall. On the 6th March was transferred to ward 22 for urology review. Treated with antibiotics for chest infection. Had several episodes of diarrhoea as well as constipation. Stool specimen was negative when first tested and became positive for C.difficile on 20th March.	• RCA meeting concluded this was an avoidable case • Constipation not treated appropriately • Incomplete documentation on the stool chart • Delay in sending stool specimen for testing

HCAIs/Areas of Concern/Outbreaks

- **Isolation breaches** recorded by the Infection Control Team during March were 8 compared to 33 in February. Of the 8 isolation breaches in,
    - 7 were at CRH and 1 was at HRI
    - All breaches were on medical wards
- **Pseudomonas** - A meeting was held on 27th March to discuss a small cluster of *Pseudomonas aeruginosa* cases related to Huddersfield ICU from late January to mid-February. There were 3 linked cases by VNTR typing. Assurance was received around the water management processes. The process around tap/basin cleaning was scrutinised and some re-training is already underway. There will be regular observations of the cleaning process itself to ensure this training is embedded into practice. On-going surveillance of new cases/acquisitions will continue. To date, we have had a 5 week

period with no new acquisitions. Any new acquisitions over the next 3 months will be sent for typing. There is no plan to convene another meeting unless we see further cases. The cause/source of this small cluster has not been identified.

- **MRSA** – there was one case of hospital acquired MRSA identified in March, this was a surgical patient. There were a total of 28 cases from April 2014 to March 2015. The chart below shows the number of cases per month.



Quality Improvement Audits

- Four Quality Improvement Audits were performed in March
  - CRH Endoscopy – Scored Green (94%)
    - Dusty shelves in the store room
    - Boxes of clean equipment stored on the floor
  - CRH Orthopaedic OPD – Scored Green (92%)
    - Dusty shelves in the store room
    - Boxes of clean equipment stored on the floor
  - HRI Orthopaedic OPD – Scored Amber (90%)
    - PPE not available in the consulting rooms
    - Damaged noted to a foot stool
    - Dusty fans
    - Damaged covering to one of the couches
  - HRI 4 – Scored Amber (89%)
    - Dust observed on the crash trolley
    - Damage to foot stools
    - Inappropriate items stored in the sluice
    - Dust noted on one of the bed frames
    - Corridor cluttered with equipment due to lack of storage space

Carbapenemase Producing Enterobacteriaceae (CPE) Audit

A CPE audit was carried out by the IPCT during March 2015. 6 wards who take direct admissions were audited to ascertain whether the CPE questions were being asked when a patient was admitted. CHFT policy states: 'All emergency and elective admissions to CHFT should have a risk assessment carried out in order to determine CPE status as part of the admission process.'

CPE questions:

- In the last 12 months, has the patient been an inpatient in a hospital abroad or been dialysed abroad?

- In the last 12 months, has the patient been an in-patient in a UK hospital known to have had problems with the spread of CPE? (For an up-to-date list please refer to the CPE link within the IPC section of the intranet)
- Has the patient ever been colonised with or had an infection caused by CPE or been a close contact with a person who has.

A separate sheet containing the questions was initially used within CHFT but these have now been incorporated into the Nursing Assessment Tool. It was found during the audit that there are still a number of areas who are not yet using the updated Nursing Assessment Tool but are still using the separate question sheet (see table below).

The table below illustrates the numbers and percentages of wards were compliant with the Trust CPE policy at the time of the audit. As CPE is an emerging micro-organism that is extremely resistant to most known antibiotics, it is of the utmost importance that patients are screened on admission to the hospital in order to determine whether they are at risk of CPE colonisation / infection and that appropriate precautions are taken in order to minimise the risk of cross transmission of such micro-organisms to other patients, visitors or health-care workers.

HRI				**CRH**			
WARD	**Number audited**	**Percentage compliance**	**Using new/old tool**	**WARD**	**Number audited**	**Percentage compliance**	**Using new/old tool**
MAU	20/20	100%	Mixture	MAU	0/22	0%	Old
SAU	16/17	92%	Mixture	8A	7/9	78%	Mixture
H03	12/14	86%	New	8C	12/14	86%	Mixture

Appendix 1

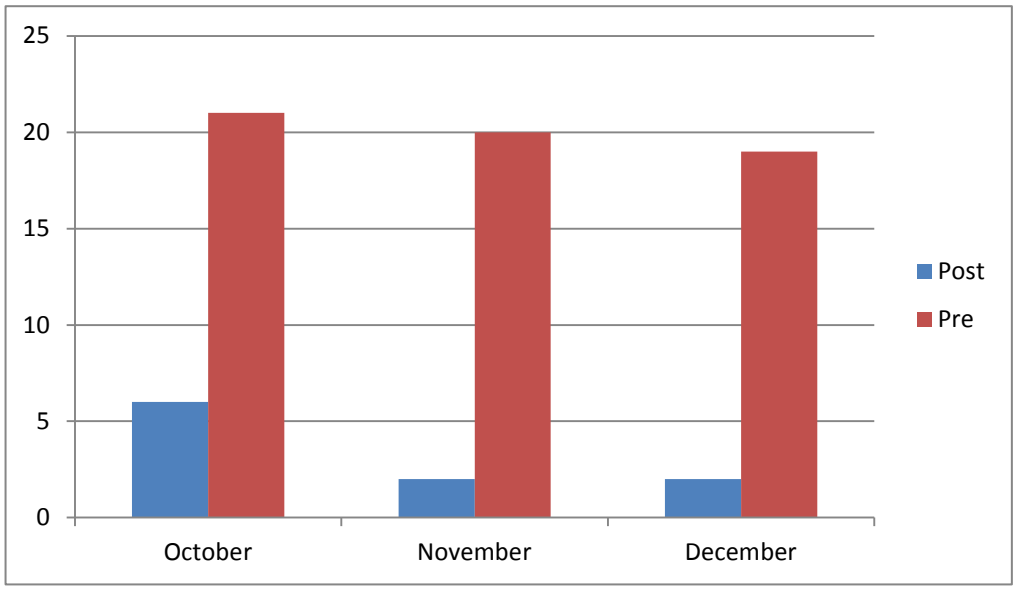
Review of *E. coli* bacteraemia cases October to December 2014

Background

Mandatory reporting of *E. coli* bacteraemia cases commenced in June 2011. Surveillance data are collected by the microbiologists and reported on the HPA Data Capture System. This reports looks at a three month period from October to December 2014 compared to the same time period in 2013.

The chart below shows the monthly cases since the start of mandatory reporting.

E- Coli Bacteraemia cases October 2014 - December 2014



Findings

There were at total of 70 cases compared to 57 the previous year; which equates to an increase of 18%. Of these, 10 were post-48 hour cases and 60 were pre-48 hour cases. 39 cases were Kirklees patients, 30 cases were Calderdale patients and 1 cases were from out of the area. There was a 59/41% split between female and male cases.

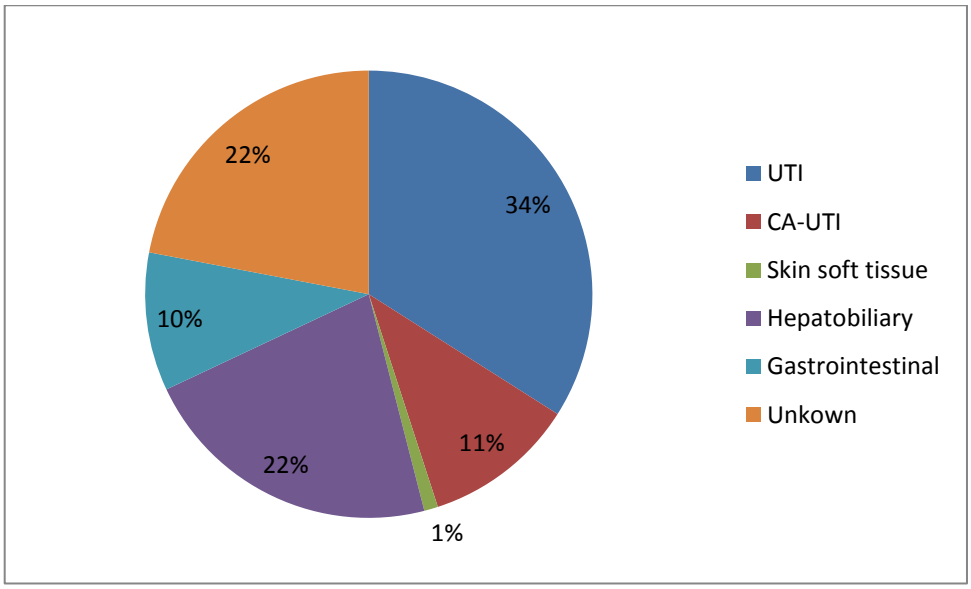
The average age of the cases was 71 years (range 18 to 94 years). 6 patients were from Nursing or Residential cares, 5 of these were pre-48 hour cases. Of the 10 post-48 hour cases the median length of stay for 9 these patients was 37 days (range 7 – 70 days) compared to 17 days during the same time period 2013. One patient has been an inpatient for over 240 days so I have excluded him from the figures. Of these E.coli bacteraemia cases, 4 (5%) died within 7 days of the septic episode.

Most likely primary source

The chart below shows the most likely primary source following assessment of the patient with the microbiologist and the doctor in charge of the patient. The urinary tract accounted for the greatest number of cases, totalling 45% (30) of all cases. Of these, 11% (8) were attributed to urinary catheters.

Of the 2 CA-UTI cases, both of the catheters had been in longer than 28 days and therefore classes as long term catheters; both of these were pre 48 hour cases.

The chart below shows the most likely primary source for these cases.



Conclusion

The majority of the E. coli bacteraemas were not thought to be healthcare related, however 10 (14%) of cases were classed as healthcare associated. Of the 10 HCAI cases, 6 were catheter associated UTI (CA-UTI) ; 2 were UTIs; 1 were gastrointerstinal and 1 unknown source.

The mortality rate is 5% compared to the same period last year which was 10%, and 17% in 2012/13. The length of stay has significantly increased compared to last year within this patient group.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** HEATHER KIRK, Emergency Planning Officer
Date: Thursday, 23rd April 2015	**Sponsoring Director:** Lesley Hill, Director of Planning, Performance, Estates and Facilities
Title and brief summary: CHFT Emergency Planning and Business Continuity Annual Report 2014-2015 - 2014-2015 annual report fro Emergency Planning and Business Continuity	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Approved by Health and Safety Committee 14th April 2015	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

A summary of Emergency Planning and Business Continuity activity between 1st April 2014 and 31st March 2015 and a draft work plan for 2015/2016

Main Body

Purpose:

A summary of Emergency Planning and Business Continuity activity between 1st April 2014 and 31st March 2015 and a draft work plan for 2015/2016. To be noted by the BOD.

Background/Overview:

Required to be produced and be presented to the BOD annually.

The Issue:

No issue - Annual Report

Next Steps:

Subsequent annual report to be produced in 2016

Recommendations:

The Board of Directors are requested to receive and note the contents of the annual report and agree the draft work plan for 2015 / 2016.

Appendix

Attachment:

CHFT Annual BOD Emergency Planning and BC 2014-2015 Final.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

CHFT Annual Emergency Planning and Business Continuity Report 1st April 2014 – 31st March 2015

1. INTRODUCTION

This report describes the emergency planning activities of Calderdale & Huddersfield Foundation Trust (CHFT) during 2014/15 in order to meet the requirements of the Civil Contingencies Act 2004 (CCA) and the NHS England Emergency Preparedness Framework 2013.

The role of Accountable Emergency Officer (AEO), a statutory requirement under the CCA, remains with the Executive Director of Planning, Performance, Estates and Facilities. The trust's Emergency Planning Officer (EPO) sits within this division and is supported by the AEO in Emergency Preparedness, Resilience and Response (EPRR) matters.

2. BACKGROUND

The CCA outlines a single framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparation and response at local level. The Act divides local responders into two categories, imposing a set of duties on each. Category 1 responders are those organisations at the core of the response to most emergencies, and are subject to the full set of civil protection duties. Category 2 responders have a lesser set of duties and are required to co-operate and share relevant information with other Category 1 and 2 responders.

CHFT is a category 1 responder and is subject to the following civil protection duties:

- assess the risk of emergencies occurring and use this to inform contingency planning
- put in place emergency plans
- put in place business continuity management arrangements
- put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- share information with other local responders to enhance co-ordination
- Cooperate with other local responders to enhance co-ordination and efficiency.

In alignment with the NHS Commissioning Board Emergency Preparedness Framework, NHS England published the Emergency Preparedness, Resilience and Response (EPRR) core standards in April 2013. These were subsequently revised in April 2014. Each provider of NHS funded care is required to be compliant against these core standards. CHFT submitted a statement of compliance and improvement plans to the Local Health Resilience Partnership (LHRP) in January 2015 based upon the revised standards.

3. REPORT

3.1 Policies

The 2013/2014 annual report detailed the action to be taken that would result in the amendment and merger of the trust *Preparing for Emergencies Policy* and *the Emergency Management Arrangements* into more effective, concise and friendly user documents. The trust now has an approved Business Continuity Policy *(as at 16.04.15)* and an EPRR policy currently being written.

The following subsidiary plans to the above policies were written and reviewed during 2014/15:

- Heat Wave Plan
- Flood Plan
- Major Incident Plan
- Pandemic Flu Plan – Ongoing review in conjunction with the regional plan.

3.2 Business Continuity (BC)

As a result of risks identified in the 2013/2014 Business Continuity audit, the Trust Emergency Planning Officer (EPO) explored the possibility of working in collaboration with an external organisation with a mature Business Continuity Management System (BCMS) in place. The provision of evidence and a presentation to the Executive Board resulted in the board's approval to work in partnership with the Business Continuity Manager from Yorkshire Ambulance Service, which has recently been given accreditation against ISO 22301, to build and embed a robust BCMS within CHFT.

As previously stated, the trust now has a Business Continuity Policy and the trust strategy is being agreed. Guidance documentation has been produced to be used in conjunction with the policy.

Business Continuity Leads have attended a two day business continuity training course and individual one to one appointments have taken place to support them. Many of them have now completed Business Impact Analysis' and are making good progress with writing their business continuity plans.

In 2015/2016 it is expected that all of the trust's identified critical activities plans will have robust business continuity plans written and approved and the cycle of testing these plans will be underway.

There do remain some gaps in the departments that have nominated business continuity leads and plans being written which will be addressed directly with the appropriate divisional senior management teams.

All embedding of the BCMS is aligned to ISO 22301 meaning, should the trust wish to, accreditation may be sought in the future.

3.3 The Tour De France (TDF)

In July 2014 the Tour De France 'Grand Depart' took place and, as part of stage 2, the race travelled through the Huddersfield and Calderdale areas. The health economy had been working collaboratively for 12 months leading up to the event and, as a result, it was a huge success. CHFT had all necessary plans in place to ensure that the trust was fully prepared. Trust staff showed flexibility and commitment to ensure the maintenance of services. Other than the cost implications, which were expected but the amount could not be estimated before the event, there was very little impact on the day. Multi-agency debriefs highlighted and praised the preparation and performance of health organisations whose areas the route passed through.

3.4 Training and Exercises

As detailed in the business continuity section, training has been provided to nominated colleagues on the development of business continuity plans. This will culminate in a trust-wide, table top business continuity exercise to be held in June 2015.

A discussion based exercise took place at CRH in February 2015 to test elements of the JERP (Joint Emergency Response Plan). Colleagues from trust departments attended alongside representatives from Catalyst, Cofely and ISS. Lessons were identified and actions taken forward. Greater awareness of the JERP among on call staff will be addressed during 2015/2016.

Major incident training and the exercising of plans is an important part of the emergency preparedness cycle and following on from the trust wide Emergo exercise that CHFT participated in in 2013 the Yorkshire and Humber Major Incident Practitioners group are planning a multi-site Emergo exercise to take place in 2015/16.

The trust has taken part in regional communication exercises carried out by NHS England and have been compliant each time.

Two further members of the on call team have attended the Emergency Planning College to undertake the Strategic Leadership in a Crisis course. There has also been an EPRR awareness session delivered to colleagues on the director on call rota.

Commander on call training has been highlighted as an issue in other local acute trusts and the EPO is working collaboratively with partner organisations to address this with a consistent approach.

3.5 Governance

3.5.1 Internal Reporting Arrangements

The CHFT Resilience forum convened in February 2015 to facilitate the approval of the reviewed Major Incident Plan prior to its presentation at EB. However, it does not meet on a regular basis. The matter of whether the Resilience Forum should be a formal, regular committee or not is intended to be discussed during 2015.

Emergency Planning and BC are reported on a monthly basis to the Operational Health and Safety committee which is a sub-committee of the Board. Progress and issues are also discussed at the Estates and Facilities Quality and Safety Board.

Regular updates are provided to the Trust Executive Board through the AEO.

3.5.2 Partnership Working

The Trust works in collaboration with a range of partner agencies through formal standing meetings and ad hoc arrangements. Formal committees of which the Trust was a member include the Local Health Resilience Partnership (LHRP), West Yorkshire Resilience Forum Health Subgroup, Kirklees Emergency Planning Forum, Calderdale Civil Contingencies Group and the Yorkshire and Humber Major Incident Practitioners Group. The purpose of these groups is to ensure that effective and coordinated arrangements are in place for NHS Emergency Preparedness, Resilience and Response in accordance with national policy and direction from NHS England and Public Health England.

4. DRAFT WORKPLAN FOR 2015/2016

4.1 Policies

Emergency Planning and Business Continuity related policies will be reviewed and updated. (Throughout 2015/2016) including;

- Fuel Supply Emergency Plan
- Decontamination (CBRN) Plan
- Heat Wave Plan
- Flood Plan

4.2 Business Continuity

Continue to work collaboratively with the YAS Business Continuity Manager and embed the BCMS across the trust throughout 2015/2016.

4.3 Audit

Explore the option of part of the trust being audited against ISO 22301 (Business Continuity).

Be compliant in the audit to be conducted on the trust's CBRN capabilities (2015).

4.4 TDY

The TDY professional cycle race event travels through Yorkshire during the weekend of 1st – 3rd May 2015. This coincides with the May day bank holiday weekend. The TDY has been organised on the back of the huge success of the Tour De France (TDF) that was held in July 2014. The race will travel through both the Huddersfield and Calderdale areas on Sunday 3rd May but using a different route, particularly in the Huddersfield area. In this case the route is confined to the periphery of Huddersfield and does not come near the town centre or the HRI site.

The event is not expected to be as large or have as high impact. There are likely to be around 1/5 – 1/3 of the number of spectators at the TDF. There will be no official spectator hubs or events planned. Road closures will be for a relatively short period of time.

However, this does not eliminate the need for planning and the trust EPO is attending various multi-agency planning meetings and chairs the CHFT TDY internal working group. All divisions are represented at the working group and it is planning to ensure robust BC plans are in place to enable the trust to be able to provide reassurance to the appropriate bodies and organisations that CHFT is fully prepared to maintain service delivery whilst the event takes place. (May 2015)

4.5 Training

On call staff who will take on a commander role in the event of an incident will be given training to enable to them to carry out the role effectively. (September 2015)
JERP awareness to be rolled out to on call staff.
Explore the option of an overview of Emergency Planning and BC being integrated into the induction package. (September 2015)

4.6 On Call Packs

Work with THIS and the executive administrators to put together electronic on call packages enabling on call managers and directors to access all relevant information, policies and plans electronically. (May 2015)

5. RECOMMENDATIONS

The Board of Directors are requested to receive and note the contents of the annual report and agree the draft work plan for 2015 / 2016.

10th April 2015
Heather Kirk – Emergency Planning Officer

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 23rd April 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: QUALITY COMMITTEE MINUTES - UPDATE - The Board is asked to receive a verbal update from the Quality Committee held on 21.4.15 and the minutes held on 24.3.15.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: N/A	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to receive a verbal update from the Quality Committee held on 21.4.15 and the minutes held on 24.3.15.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

The Board is asked to receive a verbal update from the Quality Committee held on 21.4.15 and the minutes held on 24.3.15.

Appendix

Attachment:

Minutes QC 24.03.15 - draft.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the QUALITY COMMITTEE MEETING held on Tuesday 24 March 2015 in the Boardroom, Huddersfield Royal Infirmary, commencing at 3pm

PRESENT	Anne-Marie Henshaw, Associate Director of Nursing, CWF/Head of Midwifery Jeremy Pease, Non-Executive Director (Chair) David Birkenhead, Medical Director Claire Gruszka, Risk Manager Jan Wilson, Non-Executive Director Julie Dawes, Executive Director of Nursing & Operations Victoria Pickles, Company Secretary Julie O'Riordan, Divisional Director, Surgery & Anaesthetics Juliette Cosgrove, Assistant Director to Medical and Nursing Directors' Lesley Hill, Executive Director of Estate, Facilities, Planning & Performance Linda Patterson, Non-Executive Director Lynn Moore, Membership Councillor Sal Uka, Divisional Director, DATS
IN ATTENDANCE	Stephanie Jones, PA (Minutes) Jason Eddleston, Assistant Director of Workforce and OD *(on behalf of Julie Hull)* Melanie Johnson, General Manager, CGSU (for item 5.1) Gemma Berriman, Matron, Surgical & Anaesthetic Division *(on behalf of Jackie Murphy)* Jo Middleton, Matron, Medical Division *(on behalf of Lindsay Rudge)*

Item

1/03/15 WELCOME AND INTRODUCTIONS

The chair welcomed members to the meeting.

2/03/15 APOLOGIES FOR ABSENCE AND ATTENDANCE REGISTER

Apologies for absence were received from:

Julie Hull, Executive Director of Workforce and Development
Keith Griffiths, Executive Director of Finance
Kristina Arnold, Assistant Divisional Director, CWF Division
Martin DeBono, Divisional Director, CWF Division
Ashwin Verma, Divisional Director, Medical Division

Lindsay Rudge, Associate Director of Nursing, Medical Division
Ashwin Verma, Divisional Director, Medical Division
Sajid Azeb, Assistant Divisional Director, Medical Division
Mags Barnaby, Interim Director of Operations

3/03/15 MINUTES OF THE MEETING HELD ON TUESDAY 16 DECEMBER 2014

The minutes of the meeting from the 27 January 2015 and the informal meeting on 24 February 2015 were approved as a true record.

4/03/15 ACTION LOG (Items due this month)

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

• DNACPR: update received as part of item 10.1 on the agenda.

• Quality Impact Assessments (QIAs): The Executive Director of Nursing informed members that the QIAs proforma had been revised to ensure it is stronger and more robust. Key Performance Indicators (KPIs) are now on one dashboard, which will be received by the Quality Committee on a regular basis going forward.

The closed items on the action log as 25 February 2015 would be removed.

5/03/15 MATTERS ARISING

5.1 Update on the Quality Account Priorities for 2014/15
The Committee received a report, presented by Melanie Johnson, General Manager, CGSU, which gave an update on the Quality Account Priorities for 2014/15. The report outlined the four priorities for 2014/15 and the progress achieved to date for each priority.

Planning for the 2015/16 Quality Account is ongoing. Six priorities were put out for public vote, which included; *Safer medication, Improving sepsis care, Better food, Reducing noise at night, Improving the discharge process, Improving responsiveness to complaints.*

Following consultant on the proposed priorities, the Trust received a good response, with a 187 votes received. The most popular from each category are: **Safety;** *safer medication & improving sepsis care*, **Experience**; *better food and reducing noise at night*, **Effectiveness;** *improving the discharge progress and responses to complaints.* These will be developed into priorities for 2015/16 for inclusion into the Quality Account. It was noted Food and Sepsis are also CQUINs for 2015/16.

The Executive Director of Nursing and Operations suggested a report to tie in the KPIs would be required and she would work with Juliette Cosgrove and Melanie Johnson to develop this.

The Committee **noted** the content of the report and supported the priorities chosen for 2015/16.

5.2 Briefing paper on Kirkup Inquiry (Morecombe Bay Investigation)
The Committee received a report from the Associate Nurse Director for CWF, which detailed the Trust's response to the findings of the Kirkup Report into Morecombe Bay. The report was the findings of an Independent investigation which had taken place after a series of

other regulatory body investigations.

The Kirkup report made 44 recommendations – 19 of which were relevant to Trusts. The remaining 25 recommendations were for regulatory and other centralised bodies.

The report sets out to provide assurance to the Quality Committee that a CWF multidisciplinary team have evaluated the recommendations made for UHMB, completed a self-audit against the recommendations and devised an action plan. Completion of the action plan would be monitored by the CWF PSQB. All actions will be implemented by the end of September 2015. A more detailed gap analysis is being undertaken and a detailed plan developed, which will come back to the Committee in May 2015.

ACTION: Interim report on progress to be received by the Committee in May 2015, with the final report due September/October 2015.

The Committee **noted** the content of the report and **highlighted** the need to ensure that the learning is not only captured in maternity, but is shared more widely across the Trust. It was also requested all Divisional Directors and Associate Nurse Directors read the Report and its recommendations in detail.

5.3 Summary recommendations from the Health Select Committee: Complaints and Raising Concerns

The Committee received a summary of a report produced by the House of Commons Health Select Committee following an inquiry concerning how NHS complaints are managed and how staff that raise concerns are treated. The report 'Complaints and Raising Concerns' was published in January 2015.

The report recognised that most people who complain about the NHS services do so to understand what happened during their experience of care and to ensure that, where harm has occurred, others do not suffer the same harm. There were a number of recommendations from the report to support the achievement of that aim.

The Assistant Director to the Medical and Nursing Directors' explained the action the Trust will take to address the recommendations detailed within the report. These include;
- Quarterly Quality Report to the Board of Directors detailing complaints made, how they have been handled and lessons learnt.
- Data on complaints to be more visible on the Trust website to ensure greater transparency (by April 2015).
- Branding: Improve the awareness that patients have about how to raise a concern or make a complaint and where they can assess independent advice (by April 2015).
- Whistle-blowers who have suffered serious harm to be provided with apology: it is understood by the Trust that no staff or ex-employees have suffered serious harm as a result of whistle-blowing. The Trust has being doing a lot of work around its whistle-blowing procedures and has signed up, as one of the first 100, committing the Trust to the Whistle-blowing Commission's Code of Practice, which includes 15 recommendations. Whistle-blowing is reported to the Well Led Group.

The Committee Chair asked the Divisional Leads how learning is shared within their respective Divisions. The Divisional Director, Surgery & Anaesthetics confirmed they have made improvement in this area with the use of patient stories; however there is still work to be done to ensure further improvements are made.

The Executive Director of Nursing and Operations said the Quarterly Quality Report that will be received by the Committee will detail the Trust's learning and can be used as evidence

for the CQC.

The Committee **noted** the content of the report and **received assurance** that plans are in place to ensure the Trust is compliant with the recommendations outlined in the report by the end of April 2015.

5.4 Regulation 28 Letter from H M Coroner

The Committee received a briefing report from the Divisional Director, Surgery & Anaesthetics detailing the action the Trust has taken following the receipt of a Regulation 28 letter issued by H M Coroner in January 2015, following the inquest of a patient cared for at HRI in March 2014.

The regulation was ordered to ensure the Trust demonstrates leaning from this tragic event is acted upon in order to prevent future deaths. H M Coroner requested the Trust submit a detailed action plan by 18 March 2015.

The letter highlighted concern regarding poor practice around the completion of documentation.

The Committee reviewed the action plan, developed by the Surgical & Anaesthetic Division, and confirmed the need to ensure actions go further than the department and Division where the issue originated. There was also discussion around the need to ensure that staff involved are clear on the implications of their actions.

ACTION: Work on the Action Plan to be progressed and brought back to the Committee in April 2015.

5.5 Self-Assessment of Quality Committee's effectiveness

The Company Secretary informed members that they will shortly receive a questionnaire in order to self-assess how well they feel the Committee is working. An Annual Report will then be developed and received by the Committee in June 2015.

It was noted that Pricewaterhouse Coopers will observe at the Committee meeting in May 2015.

06/03/15 CQC PREPARATION AND ACTION PLAN

6.1 Update on CQC Action Plan

The Assistant Director to the Medical and Nursing Directors presented the CQC Visit action plan, which detailed an updated position for March 2015. The plan focuses on significant actions identified following the mock CQC inspection in September 2014 and intelligence gathered from other organisations regarding commonly identified areas for improvement. It was noted the plan is being revised and a new plan will be present to the Committee in April.

A weekly meeting of the Executive Directors has commenced, which will expedite any delays to implementing the plan. The first meeting looked in details at Divisional complaints and addressing the back-log and the meeting on the 1 April will focus on Mental Capacity Act and Deprivation of Liberty.

Divisions continue to progress their action plans following the self-assessment exercise and will update the Committee in May on the progress made. It was reported significant pieces of work underlying the action plan are progressing.

The Chair asked that the Key Lines of Enquiry (KLE) need to reflect more accurately our

current position.

Progress is being made on the comms engagement plan and a detailed discussed had taken place on how the communication with staff is taken forward.

The Committee **received** assurance from the content of the report that progress was being made in preparation for the CQC inspection.

7/03/15 RESPONSIVE

7.1 Integrated Performance Report
The Integrated Performance Report (IPR) was presented to the Committee which included data for February 2015 and the following was noted:

Responsive:
February saw a continuous over-performance on non-elective workload, which impacted on the A&E target. Despite A&E improved 4 hour performance, the Trust were unable to achieve the 95% standard. In light of this, it is anticipated the target for Q4 will not be achieved.

Issues with delayed discharges/outliers were noted, which were understood to be for a variety of reasons. Interim Director of Operations, Mags Barnaby, is undertaking a specific piece of work around discharge/outliers and it is hoped going forward that improvement will be seen.

The 62 day referral from screening to treatment (monitor target) was amber/red. This was noted to be a concern and should be brought to the attention of the Board of Directors.

Caring:
The complaints position continued to be off plan, however progress had been made in February with more complaints being closed down.

Safety:
Good compliance on Duty of Candour for February was acknowledged.

Effectiveness:
- 4 cases of c.difficile noted for February (3 medical and 1 surgery)
  9 c.difficile avoidable in total against a total of 26
- Central line infection rates have seen a dip. RCAs that have been completed highlight no common themes.
- Ward moves >2 higher than we would like, but this is being managed.
- Bed modelling shows there are not enough medical beds with surgical bed modelling showing a surplus. Work on-going to look at the bed requirement at specialty level in order to have a plan for the right capacity.

Well Led:
• Sickness/absence rates improved in-month. Deep dive on sickness to focus on management response.
• Appraisals: under reporting is a concern and a request was made for all areas to focus their attention on this. It is anticipated the current figure will increase for

March. Strong assurance has been received from Divisions and Corporate functions that they have plans in place to ensure appraisals are carried out.
• Staff survey 2014: no evidence to see high levels of sickness are stress related.

The Committee **received** and **noted** the content of the Integrated Performance Report and asked that the A&E performance and 62 day referral to treatment data be brought to the attention of the Board of Directors meeting in March 2015.

8/03/15 **SAFETY**

8.1 Serious Untoward Incident Report and Register
The Risk Manager presented to the Committee the Serious Incident Register as at the 13 March 2015 detailing all open serious incidents and their current position. It was noted the timescale of 48 hours for reporting incidents was being achieved, which was acknowledged to be a significant improvement.

18 new incidents were noted, with 16 of these being Trust acquired pressure ulcers. The increase in grade 3 and 4 pressure ulcers was noted to be a concern and the Executive Director of Nursing confirmed she had commissioned a piece of work to investigation this further, which will be reported back to the Committee in April 2015.

ACTION: Report on increase in Grade 3 and 4 Pressure Ulcers to be received by the Committee in April 2015.

The Committee **received** and **noted** the content of the report.

8.2 Patient Safety Group Update
The report from the Patient Safety Group was received and the contents noted by the Committee. No further discussion took place.

9/03/15 **COMPLIANCE**

9.1 Corporate Risk Register
The Corporate Risk Register was presented by the Executive Director of Nursing. It was noted a couple of the risks need to change to become the responsibility of the Committee. This would be looked at by the Risk Manager and Executive Director of Nursing and amended accordingly.

The Committee **received** and **noted** the content of the report.

10/03/15 **EFFECTIVENESS**

10.1 Clinical Effectiveness and Outcomes Group
The Medical Director presented the report from the Clinical Outcomes Group. The following was noted:

• SHMI: The Trust has commenced a new contract with the Healthcare Evaluation Data System (HED) which will allow better prediction for both HSMR and SHMI much closer to

real time.
• Crude mortality: concern was noted on the increasing crude mortality rate. It is unclear what effect this will have on SHMI/HSMR.
• Mortality reviews: 160 deaths in December 2014; 87% had had mortality reviews, 12% required a more detailed review. Learning from level 1 reviews is limited; however it does give assurance that the care the patient received was acceptable. The 9 outstanding mortality reviews will be completed shortly. The number of mortality reviews undertaken in December was noted to be a challenge for staff.
• DNACPR: The results from the DNACPR completion rate per ward point prevalence audit in January 2015 were presented. DNACPR compliance rate is still a concern and is not where it needs to be. Work is going to triangulate all the data sets available. A series of presentations have been planned for April 2015 at Clinical Audit half days. The points prevalence audit will be repeated in March.

The Committee discussed compliance with the completion of the DNACPR forms and the need to see some significant improvement. It was agreed the Trust should clearly define its expectations in relation to DNACPR and then put in place mechanisms to hold people to account of complying with the Trust's expectations.

ACTION: It was agreed that the Medical Director would lead a piece of work to look at this alongside the wider issue of good documentation.

Coding: Improvement on coding compliance noted. Currently out to recruit new coders, but no success at present. Looking to purchase new coding software.

Nerve Centre: has gone live on a number of wards and will be rolled out across the Trust going forward.

The Committee **received** and **noted** the content of the report and the risks to delivery that were highlighted.

11/03/15 **WELL LED ORGANISATION**

11.1 Well Led Organisation Group
The Assistant Director of Workforce and OD presented the Committee with an update report from the Well Led Organisation Group.

It was noted the Group are restructuring the agenda to focus on the CQC Key Lines of Enquiry for the Well Led domain.

The 2014 Staff Survey action plan will be sign off shortly, but due to time constraints this may not be actioned until after it has been to the Executive Board and the Board of Directors.

The Health and Well Being Strategy will go to WEB and the Board of Directors in April 2015.

12/03/15 CARING

12.1 Patient Experience and Caring Group
The Assistant Director to the Medical and Nursing Directors' presented the Committee with an update report from the Patient Experience and Caring Group.

The draft results (in house analysis) of the National Patient Survey 2014 are now available and the Group are reviewing the report and will build in any key areas for improvement into their work programme.

A request was made for Committee members to report back following walkrounds on whether good patient experience is being observed.

The Committee **noted** the content of the report and **received assurance** that progress was being made by the group.

13/03/15 HEALTH AND SAFETY ISSUES RELATING TO QUALITY AND CARE

13.1 Operational Health and Safety group minutes
The Committee received the minutes from the Health and Safety Operational Group for information.

The Executive Director for Estates, Facilities, Planning and Performance requested the following be noted:

• International nurses: concern regarding poor English of the nurses. Medical equipment translator has been sourced and received.
• Manual handling equipment: a number of slings have been condemned, but no replacement had been sourced. The Executive Director of Nursing understood this issue had now been addressed.
• Fire Wardens at Acre Mill OP: fire wardens now in place and training complete.
• Safe management of contractors' policy: policy being revised.

14/03/15 MATTERS TO BE ESCALATED TO THE BOARD OF DIRECTORS

The Committee agreed the following items would be highlighted to the Board of Directors:
• Kirkup Report (Morecambe Bay)
• Regulation 28 Letter from HM Coroner
• DNACPR – concern around compliance
• CQC preparation
• A&E Performance and 62 day referral target

15/03/15 ITEMS TO NOTE

15.1 Quality Committee Work Plan
The Committee received the draft Quality Committee Work Plan for 2015/16. Members were asked to forward any amendments to the plan to Steph Jones prior to the next Committee meeting in April 2015.

16/03/15 ANY OTHER BUSINESS

No further items of business were discussed.

17/03/15 DATE AND TIME OF NEXT MEETING

Tuesday 21 April 2015
3pm – 5pm
Discussion Room 2, L&D Centre, HRI

DATE MINUTES APPROVED:

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 23rd April 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: DRAFT MEMBERSHIP COUNCIL STANDING ORDERS - The Board is asked to approve the Membership Council Standing Orders.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Membership Council Meeting - 8 April 2015	
Governance Requirements: Keeping the base safe.	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to approve the Membership Council Standing Orders which were approved by the Membership Council at its last meeting held on 8 April 2015.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

If approved by the Board of Directors this will be loaded onto the Trust Policies website.

Recommendations:

The Board is asked to approve the Membership Council Standing Orders which were reviewed and approved by the Membership Council at its last meeting held on the 8 April 2015.

Appendix

Attachment:

G-1-2015 - DRAFT Standing Orders - MC and BOD.pdf

UNIQUE IDENTIFIER NO: G/1/2015~~1~~
Review Date: ~~December 2012~~March 2017
Review Lead: ~~Finance Director~~Company Secretary

Calderdale and Huddersfield NHS
NHS Foundation Trust

a public benefit corporation

STANDING ORDERS

MEMBERSHIP COUNCIL

(Reviewed March 2015~~December 2010~~)

UNIQUE IDENTIFIER NO: G/1/2015~~1~~
Review Date: ~~December 2012~~March 2017
Review Lead: ~~Finance Director~~Company Secretary

CONTENTS **2**

UNIQUE IDENTIFIER NO: G/1/2015~~1~~
Review Date: ~~December 2012~~March 2017
Review Lead: ~~Finance Director~~Company Secretary

INTERPRETATION

In these Standing Orders, the provisions relating to interpretation in the Constitution shall apply and the words and expressions defined in the Constitution shall have the same meaning and, in addition:

"THE ACT" shall mean the National Health Service Act 2012~~06~~.

"TERMS OF AUTHORISATION" shall mean the Authorisation of the Trust issued by the Monitor with any amendments for the time being in force.

"CORPORATION " means Calderdale & Huddersfield NHS Foundation Trust, which is a public benefit corporation.

"BOARD OF DIRECTORS" shall mean the Board of Directors as constituted in accordance with the Trust's constitution.

"CHAIRMAN" means the person appointed to be Chairman of the Trust under the terms of the constitution.

"CHIEF EXECUTIVE" shall mean the chief officer of the Trust.

"CONSTITUTION" shall mean the constitution attached to the Authorisation with any variations from time to time approved by Monitor.

"COUNCIL MEMBER" shall mean a member of the Membership Council as defined in section 12 of the constitution.

"DIRECTOR" shall mean a member of the Board of Directors as defined in section 13 of the constitution.

"MEMBERSHIP COUNCIL" shall mean the Council of Members as constituted in accordance with the corporation's constitution.

"MONITOR" shall mean the Independent Regulator for NHS Foundation Trusts – known as 'Monitor'.

"MOTION" means a formal proposition to be discussed and voted on during the course of a meeting.

"OFFICER" means an employee of the TRUST.

"VICE-CHAIRMAN" means the Vice-Chairman of the TRUST pursuant to the terms of the constitution who will preside at meetings of the Membership Council in the Chairman's absence.

"SECRETARY" means the secretary to the corporation or any other person appointed to perform the duties of the secretary to the corporation.

UNIQUE IDENTIFIER NO: G/1/2015~~1~~
Review Date: ~~December 2012~~March 2017
Review Lead: ~~Finance Director~~Company Secretary

SECTION A: CONDUCT OF MEETINGS

Admission of the Public and the Press

1. The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Membership Council but shall be required to withdraw upon the Membership Council resolving as follows:

   "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest in accordance with 12.24 of this constitution~~.~~".

2. The Chairman (or Vice-Chairman) shall give such directions as he/she thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Membership Council's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on the grounds of the confidential nature of the business to be transacted, the Membership Council may resolve as follows:

   "That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Membership Council to complete business without the presence of the public in accordance with 12.24 of this constitution."

3. Nothing in these Standing Orders shall require the Membership Council to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than in writing, or to make any oral report of proceedings as they take place without prior agreement of the Membership Council.

Calling and notice of meetings

4. The Membership Council is to meet at least three times in each financial year. Meetings shall be determined at the first meeting of the Membership Council or at such other times as the Membership Council may determine and at such places as they may from time to time appoint.

5. Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least **fourteen (14)** days written notice (including Saturday and Sunday and any bank holiday) of the date and place of every meeting of the Membership Council to all Council Members. Notice will also be published in local media and on the Trust's website.

6. Meetings of the Membership Council may be called by the Secretary, by the Chairman, by the Board of Directors or by eight Council members including two appointed Council Members who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Council Members as soon as possible after receipt of such a request. The

Secretary shall call a meeting on at least fourteen but not more than twenty-eight days notice to discuss the specified business. If the Secretary fails to call such a meeting then the Chairman or four Council Members, whichever is the case, shall call such a meeting.

7. In the case of a meeting called by Council Members in default of the Chairman, the notice shall be signed by those Council Members and no business shall be transacted at the meeting other than that specified on the notice.

8. All meetings of the Membership Council are to be general meetings open to members of the public unless the Membership Council decides otherwise in relation to all or part of the meeting for reasons of commercial confidentiality or on other proper grounds. The Chairman may exclude any member of the public from a meeting of the Membership Council if they are interfering with or preventing the proper conduct of the meeting

9. The Membership Council may invite the Chief Executive or through the Chief Executive any other member or members of the Board of Directors, or a representative of the Trust's auditors or other advisors to attend a meeting of the Membership Council. The Chief Executive and any Executive of the Trust nominated by the Chief Executive shall have the right to attend any meeting of the Membership Council provided that they shall not be present for any discussion of their individual relationship with the Trust

10. The Membership Council may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

11. All decisions taken in good faith at a meeting of the Membership Council or of any committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the Council Members attending the meeting.

12. Following notice of the meeting per paragraph 6, an agenda for the meeting, specifying the business proposed to be transacted at it and signed by the Chairman or by the Secretary, shall be delivered to every Council Member, or sent by post to the usual place of residence of such persons, so as to be available to him/her at least **seven (7)** clear days (including Saturday and Sunday and any bank holiday) before the meeting.

13. The agendas will include all supporting papers available at the time of posting. Further supporting papers will be received no later than **three (3)** clear days (including Saturday and Sunday and any bank holiday) before the meeting.

14. Lack of service of the notice on any one person above shall not affect the validity of the meeting, but failure to serve such a notice on more than six governors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

Quorum

15. Sixteen Membership Council members (including not less than nine Public Council Members, not less than three Staff Council Members and not less than two Appointed Council Members – in line with the Constitution) present in person or by proxy under arrangements approved by the Membership Council shall form a quorum

Setting the agenda

16. A Council Member desiring a matter to be included on an agenda shall make the request in writing to the Chairman at least **fourteen (14)** clear days (including Saturday and Sunday and any bank holiday) before the meeting. Requests made less than fourteen clear days before a meeting may be included on the agenda at the discretion of the Chairman or the Secretary.

Chairmanship of meeting

17. The Chairman of the Trust or, in his/her absence, the Vice-Chairman, or in his/her absence a Deputy Chairman will chair meetings of the Membership Council.

18. The Deputy Chairman/Lead Governor will be appointed from the Public Membership at a general meeting. He/she will act as Chairman of the meeting should the Chairman and the Vice-Chairman be in conflict. The Deputy Chairman will hold the casting vote when he/she is acting as Chairman.

Notices of motion

19. A Council Member desiring to move or amend a motion shall send a written notice thereof at least **fourteen (14)** clear days (including Saturday and Sunday and any bank holiday) before the meeting to the Chairman, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to preceding provisions.

Withdrawal of motion or amendments

20. A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairman.

Motion to rescind a resolution

21. Notice of motion to amend or rescind any resolution (or general substance of any resolution) which has been passed within the preceding six calendar months shall

bear the signature of the Council Members who give it and also the signature of four other Council Members, of whom at least two shall be Public Council Members. When any such motion has been disposed of by the Trust, it shall not be competent for any Council Member other than the Chairman to propose a motion to the same effect within six months, although the Chairman may do so if he/she considers it appropriate.

Motions

22. The mover of a motion shall have the right of reply at the close of any discussions on the motion or any amendment thereto.

23. When a motion is under discussion or immediately prior to discussion it shall be open to a Council Member to move:

    a) An amendment to the motion.

    b) The adjournment of the discussion or the meeting.

    c) That the meeting proceed to the next business. (*)

    d) The appointment of an ad hoc committee to deal with a specific item of business.

    e) That the motion be now put. (*)

    [* In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Council Member who has not previously taken part in the debate.]

24. No amendment to the motion shall be admitted if, in the opinion of the Chairman of the meeting, the amendment negates the substance of the motion.

Chairman's ruling

25. The decision of the Chairman of the meeting on the question of order, relevancy and regularity shall be final. The Chairman, advised by the Secretary, shall be the final authority in the interpretation of this.

Voting

26. Questions arising at a meeting of the Membership council requiring a formal decision shall be decided by a majority of votes. In case of an equality of votes the Chairman shall decide the outcome. No resolution of the Membership Council shall be passed if it is unanimously opposed by all of the Public Council Members.

27. All questions put to the vote shall, at the discretion of the Chairman, be determined by oral expression or by a show of hands. A paper ballot may also be

used if a majority of the Council Members present so request, or the Secretary deems it advisable or necessary.

28. If at least one third of the Council Members present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Council Member present voted or abstained.

29. If a Council member so requests his vote shall be recorded by name upon any vote (other than by paper ballot).

30. In no circumstances may an absent Council Member vote by proxy. Absence is defined as being absent at the time of the vote.

Minutes

31. The minutes of the proceedings of a meeting shall be drawn up and submitted for agreement at the next ensuing meeting where they will be signed by the person presiding at it.

31.

32. No discussion shall take place upon the minutes, except upon their accuracy, or where the Chairman considers discussion appropriate. Any amendments to the minutes shall be agreed and recorded at the next meeting.

33. Minutes shall be circulated in accordance with Council Members' wishes. Where providing a record of a public meeting the minutes shall be made available to the public via the Trust Website. (required by Code of Practice of Openness in the NHS)

SECTION B: COMMITTEES

Appointment of Committees

34. Subject to paragraph 40 below and such directions as may be given by Monitor, the Membership Council may and, if directed by him, shall appoint committees of the Membership Council, consisting wholly or partly of Council Members. In all cases, each committee shall have a majority of Public Council Members.

35. A committee appointed under paragraph 34 may, subject to such directions as may be given by Monitor or the Membership Council, appoint sub-committees consisting wholly or partly of members of the committee.

36. These Standing Orders, as far as it is applicable, shall apply with appropriate alteration to meetings of any committees or sub-committee established by the Membership Council.

37. Each such committee or sub-committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Membership Council), as the Membership Council shall decide. Such terms of reference shall have effect as if incorporated into these Standing Orders.

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38. Committees may not delegate their powers to a sub-committee unless expressly authorised by the Membership Council.

39. The Membership Council shall approve the appointments to each of the committees which it has formally constituted. Where the Membership Council determines that persons who are neither Council Members, nor directors or officers, shall be appointed to a committee, the terms of such an appointment shall be determined by the Membership Council subject to the payment of travelling and other allowances being in accordance with such sum as may be determined by the Board of Directors or Monitor.

40. Where the Membership Council is required to appoint persons to a committee or to undertake statutory functions as required by Monitor, and where such appointments are to operate independently of the Membership Council or the Board of Directors, such appointment shall be made in accordance with the any regulations laid down by the Chief Executive or his nominated officer or any directions or guidance issued by the Monitor from time to time.

Confidentiality

41. A member of a committee shall not disclose a matter dealt with by, or brought before, the committee without its permission until the committee shall have reported to the Membership Council or shall otherwise have concluded on that matter.

42. A Council Member or a member of a committee shall not disclose any matter reported to the Membership Council or otherwise dealt with by the committee, notwithstanding that the matter has been reported or action has been concluded, if the Membership Council or committee shall resolve that it is confidential.

43. In relation to patient confidentiality, the provisions at paragraphs 42 and 43 above for disclosure of information by Council Members or members of committees established by the Membership Council shall not apply, and such information shall not be disclosed under any circumstances.

Appointment of the Chairman, Vice-Chairman and Non-Executive directors

44. The membership council shall appoint a Chairman of the Trust. The Board of Directors will appoint one Non-Executive Director to be Vice-Chairman of the trust. This individual may, through agreement with the Chair take on the role of SINED (Senior Independent Non-Executive Director). The Membership Council shall ratify the appointment of the Vice Chairman at a general meeting.

45. Non-Executive Directors are to be appointed by a sub-committee (not exceeding four persons) of the Membership Council using the procedures set out under paragraph 13 of the constitution.

SECTION C: REGISTER AND DISCLOSURE OF INTERESTS

46. If Council Members have any doubt about the relevance or materiality of an interest, this should be discussed with the Chairman or the Secretary.

47. Any Council Member who has a material interest in a matter as defined below and in the constitution shall declare such an interest to the Membership Council and it shall be recorded in a register of interests and the Council Member in question:
    a) Shall not be present except with the permission of the Membership Council in any discussion of the matter, and

    b) Shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

48. Any Council Member who fails to disclose any interest required to be disclosed under the preceding paragraph must permanently vacate their office if required to do so by a majority of the remaining Council Members.

49. At the time the interests are declared, they should be recorded in the minutes of the Membership Council. Any changes in interests should be officially declared at the next meeting as appropriate following the change occurring.

50. It is the obligation of a Council Member to inform the Secretary in writing within seven days of becoming aware of the existence of a relevant or material interest. The Secretary will amend the register upon receipt within three working days.

51. The details of Council Members' interests recorded in the register will be kept up to date by means of a monthly review of the register carried out by the Secretary, during which any changes of interests declared during the preceding month will be incorporated.

52. Subject to the requirements of the Public Benefit Corporation (Register of Members) Regulations 2006 and the Data Protection Act 1998, the register will be available for inspection by the public free of charge. The Chairman will take reasonable steps to bring the existence of the register to the attention of the local population and to publicise arrangements for viewing it.

53. Copies or extracts of the register must be provided to members of the Trust free of charge and within a reasonable time period of the request. A reasonable charge may be imposed on non-members for copies or extracts of the register.

54. A material interest in a matter is any interest (save for the exceptions referred to below) held by a Council Member, or their spouse or partner, in any firm or business which, in connection with the matter, is trading with the trust, or is likely to be considered as a potential trading partner with the trust. The exceptions which shall not be treated as material interests are as follows:

a) Shares not exceeding 2% of the total shares in issue held in any company whose shares are listed on any public exchange;

b) An employment contract held by staff Council Members;

c) A contract with their PCT held by a PCT Council Member;

d) An employment contract with a Local Authority held by a Local Authority Council Member;

e) An employment contract with any organisation listed at paragraph 12.3.5 of the constitution.

55. If, in relation to 47, the Chairman has a conflict of interest, the Vice-Chairman will exercise the casting vote. If the Vice-Chairman has a conflict of interest, the Deputy Chairman will preside and exercise the casting vote, the nomination to be approved by a majority vote of those present at the meeting.

56. An elected Council Member may not vote at a meeting of the Membership Council unless, before attending the meeting, they have made a declaration in the form of specified by the Membership Council as to the basis upon which they are entitled to vote as a member. The Constitution provides guidance. An elected Council Member shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Membership Council, and every agenda for meetings of the Membership Council will draw this to the attention of elected Council members.

57. Members of the Membership Council must meet the requirements of the Fit and Proper persons test.

SECTION D: TERMINATION OF OFFICE AND REMOVAL OF COUNCIL MEMBER

57. A person holding office as a Council member shall immediately cease to do so if:

a) They resign by notice in writing to the Secretary;

b) They fail to attend two meetings in any Financial Year, unless the other Council Members are satisfied that the absences were due to reasonable causes, and they will be able to start attending meetings of the trust again within such a period as they consider reasonable;

c) In the case of an elected Council Member, they cease to be a Member of the constituency by whom they were elected;

d) In the case of an appointed Council Member, the Appointing Organisation terminates the appointment;

e) They have failed to undertake any training which the Membership Council requires all Council Members to undertake;

f) They have failed to sign and deliver to the Secretary a statement in the form required by the Membership Council confirming acceptance of the Code of Conduct for Council Members/Membership Council Charter;

g) They refuse to sign a declaration in the form specified by the Membership Council that they are a Member of a specific public constituency and are not prevented from being a Member of the Membership Council. This does not apply to Staff Members;

h) They are removed from the Membership Council under the following provisions.

58. A Council Member may be removed from the Membership Council by a resolution approved by not less than three-quarters of the remaining Council Members present and voting at a general meeting of the Membership Council on the grounds that:

a) They have committed a serious breach of the Code of Conduct; or

b) They have acted in a manner detrimental to the interests of the Trust; and

c) The Membership Council considers that it is not in the best interests of the Trust for them to continue as a Council Member.

59. Where a person has been elected or appointed to be a Council Member and he/she becomes disqualified for appointment, under paragraph 57 above, he/she shall notify the Secretary in writing of such disqualification.

60. If it comes to the notice of the Secretary that a person elected or appointed to be a Council Member may be disqualified, under paragraph 57 above, from holding that office and the Secretary has not received a notice, under paragraph 59, from that person, the Secretary will make such inquiries as he/she thinks fit and, if satisfied that the person may be so disqualified, the Secretary will advise the Chairman so that the Chairman can make a recommendation for disqualification to the Membership Council. The recommendation will either be made to a general meeting or to a meeting called specifically for the purpose.

61. The Secretary shall give notice in writing to the person concerned that the Trust proposes to declare the person disqualified as a Council Member. In this notice, the Secretary shall specify the grounds on which it appears to him/her that the person is disqualified and give that person a period of fourteen days in which to make representations, orally or in writing, on the proposed disqualification.

62. The Chairman's recommendations and any representations by the Council Member concerned shall be made to the Membership Council. If no representations are received within the specified time, or the Membership Council upholds the proposal to disqualify, the Secretary shall immediately declare that the person in question is disqualified and notify him/her in writing to that effect. On such declaration the person's tenure of office shall be terminated and he/she shall cease to act as a Council Member.

SECTION E: REMUNERATION AND PAYMENT OF EXPENSES

Remuneration

63. Council Members are not to receive remuneration.

Payment of expenses

64. The Trust may pay travelling expenses and other expenses to Council Members at such rates as it decides.

65. Expenses will be authorised through the Secretary's office and reimbursed on receipt of a completed and signed expenses form, evidenced by receipts.

SECTION F: STANDARDS OF CONDUCT OF COUNCIL MEMBERS

Policy

66. In relation to their conduct as a member of the Membership Council, each Council Member must comply with the same standards of business conduct as for NHS staff. In particular, the Trust must be impartial and honest in the conduct of its business and its office holders and staff must remain beyond suspicion. Council Members are expected to be impartial and honest in the conduct of official business.

Interest of Council Members in contracts

67. If it comes to the knowledge of a Council Member that a contract in which he/she has any pecuniary interest not being a contract to which he is himself a party, has been, or is proposed to be, entered into by the Trust, he/she shall, at once, give notice in writing to the Secretary of the fact that he/she has such an interest.

68. A Council Member shall not solicit for any person any appointment in the Trust.

69. Informal discussions outside appointment committees, whether solicited or unsolicited, should be declared to the committee.

SECTION G: MISCELLANEOUS PROVISIONS

Suspension of Standing Orders

70. Standing Orders may be suspended at any general meeting provided that:

    a) at least two-thirds of the Membership Council are present, including at least six elected Council Members and one appointed Council Member, and

    b) the Secretary does not advise against it, and

    c) a majority of those present vote in favour.

71. But Standing Orders cannot be suspended if to do so would contravene any statutory provision, or the Trust's Terms of Authorisation, or the Trust's constitution.

72. A decision to suspend Standing Orders shall be recorded in the minutes of the meeting and any matters discussed during the suspension of Standing Orders shall be recorded separately and made available to all members of the Membership Council.

73. No formal business may be transacted while Standing Orders are suspended.

Variation and amendment of Standing Orders

74. Standing Orders may only be varied or amended if:

    a) the proposed variation does not contravene any statutory provision, or the Trust's Terms of Authorisation, or the Trust's constitution;

    b) unless proposed by the Chairman or the Chief Executive or the Secretary, a notice of motion under paragraph 19 has been given;

    c) at least two-thirds of the Membership Council are present, including at least six elected Council Members and one appointed Council Member, and at least half of the Council Members present vote in favour of amendment.

Review of Standing Orders

75. Standing Orders shall be reviewed bi-annually by the Membership Council. The requirement for review shall extend to all and any documents having effect as if incorporated in Standing Orders.