COMBINED PUBLIC BOD PAPERS - 28.5.15

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Meeting of the Board of Directors

To be held in public

Thursday 28 May 2015 from 1:30pm

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

AGENDA

1.	Welcome and introductions:- Mrs Liz Schofield, Publicly Elected Membership Councillor Mrs Chris Bentley, Staff Elected Membership Councillor	Chairman	
2.	Apologies for Absence: Ms Julie Hull, Executive Director of Workforce and OD	Chairman	
3.	Patient/Staff Story	Executive Director of Nursing & Operations	**PRESENTATION**
4.	Declaration of interests	All	**VERBAL**
5.	Minutes of the previous meeting ▪ Held on 23 April 2015	Chairman	**APP A**
6.	**Action Log and Matters arising:**	Chairman	**APP B**
7.	**Chairman's Report:-** a. Upcoming Chairs' Meetings b. Update on Monitor c. Registration of Nurses	Chairman	**VERBAL**
8.	**Chief Executive's Report:-** a. Update on EPR Event	Chief Executive	**VERBAL**
Keeping the base safe			
9.	**Integrated Board Report** - Responsive - Caring - Safety - Effectiveness - Well Led - CQUINs - Community - Monitor Indicators - Finance Month 1 – April 2015 Financial Narrative	Executive Director of PPEF Executive Director of Nursing Executive Director of Nursing Executive Medical Director Interim Director of Workforce and OD Executive Director of Nursing Executive Director of PPEF Executive Director of Finance Director of Finance "	**APP C** **APP C3**

10.	Review of Strategy/Strategy on a Page	Director of Commissioning & Partnerships/Company Secretary	**APP D**
11.	Risk Register	Executive Director of Nursing & Operations	**APP E**
12.	Annual Quality Report	Executive Director of Nursing & Operations	**APP F**
13.	Director of Infection Prevention and Control Report	Executive Medical Director	**APP G**
14.	Trust HCAI Annual Programme & Action Plan 2015-2016	Executive Medical Director	**APP H**
15.	Annual Reports:- a. Fire b. Health & Safety	Executive Director of Planning, Performance, Estates and Facilities	**APP I** **APP J**
16.	Care of the Acutely Ill Patient Report	Executive Medical Director	**APP K**
17.	Staff Survey and Action Plan	Executive Director of Workforce and Organisational Development	**APP L**
18.	Revalidation Report b. Nurses	Executive Director of Nursing & Operations	**APP M**
19.	Board of Directors Standing Orders	Company Secretary	**APP N**
Improvement and innovation through strategic alliance			
NO ITEMS			
Transforming Care			
NO ITEMS			
20.	**Update from sub-committees and receipt of minutes** ▪ Quality Committee (Minutes of 21.4.15 and verbal update from meeting held 26.5.15) ▪ Audit and Risk Committee (Minutes of 21.4.15 and verbal update from meeting held 28.5.15) ▪ Verbal update from Finance and Performance Committee (Minutes of 21.4.15 and verbal update from meeting held 28.5.15		**APP O** **APP P** **APP Q**
Date and time of next meeting Thursday 25 June 2015 at 1.30pm Venue: Boardroom, Sub-Basement, Huddersfield Royal Infirmary HD3 3EA.			

Resolution

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

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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, 28th May 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: PUBLIC BOARD OF DIRECTORS MEETING MINUTES - 23.4.15 - The Board is asked to approve the minutes of the last Public Board of Directors Meeting held on Thursday 23 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 minutes of the last Public Board of Directors Meeting held on Thursday 23 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 minutes of the last Public Board of Directors Meeting held on Thursday 23 April 2015.

Appendix

Attachment:

MINS - public bod minutes - 23.4.15.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Minutes of the Public Board Meeting held on Thursday 23 April 2015 in the Boardroom, Huddersfield Royal Infirmary

PRESENT

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

IN ATTENDANCE/OBSERVERS

Kathy Bray	Board Secretary
Rev Wayne Clarke	Membership Councillor
Dr Mark Davies	Consultant in A/E (for part of meeting)
Jackie Green	Interim Director of Workforce and Organisational Development
Nick Lavigueur	Huddersfield Examiner Reporter
Peter Middleton	Membership Councillor
Victoria Pickles	Company Secretary
Caroline Wright	Communications Manager

2 members of the public

Item

50/15 APOLOGIES FOR ABSENCE AND INTRODUCTIONS

Apologies were received from:

Anna Basford	Director of Commissioning and Partnerships
Julie Hull	Executive Director of Workforce and Organisational Development

The Chairman welcomed everyone to the meeting and introduced Jackie Green, Interim Director of Workforce and Organisational Development.

51/15 PATIENT STORY

Dr Mark Davies, Consultant in A/E attended the meeting to share with the Board a patient story which had occurred during the 'Perfect Week'. He outlined the journey of an 83 year old lady who had been admitted through A/E from a nursing home following a stroke. The lady had a number of complex conditions including dementia and a wound infection following a hip replacement and fitted the criteria for treatment under the sepsis bundle. The patient had a Do Not Resuscitate (DNACPR) in place. As the Trust was unable to contact the GP or family, the patient was admitted to a ward for review by the Tissue Viability Nurse and no intensive antibiotics were prescribed. The admission occurred on a Wednesday and following limited treatment the patient was discharged back to the nursing home on the following Tuesday.

The Board acknowledged that this was an unnecessary length of stay and an example of how things happen across the care pathway. They appreciated the issues being faced within the Trust.

Linda Patterson expressed her sadness that this was not a good experience for the patient with many moves and interventions taking place at the end of her life.

It was noted that a Green Cross Patient policy was in place to set out how the Trust would work with partners, including social care, to discharge medically fit patients as soon as possible. It was recognised that this remained an issue for the Trust and there was more to do. The benefits of new relationships in primary care were acknowledged.

The Board thanked Mark for sharing the patient story with the Board and asked about the current A/E pressures. It was noted that like other Trusts nationally, A/E remained under pressure and there were particular issues for the department related to the dual site working.

It was requested that Mark convey the Board's thanks for their continued help and support in meeting the workload.

52/15 DECLARATION OF INTERESTS

There were no declarations of interest to note.

53/15 MINUTES OF THE MEETING HELD ON THURSDAY 26 MARCH 2015

The minutes of the meeting were approved as a true record subject to the following amendments:-

e. 26/15 Community – "At the previous meeting" to be inserted at the beginning of the sentence.

43/15 Risk Register - THIS Modernisation Programme – At the last meeting 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. The Executive Director of Nursing requested that this item be reworded to clarify the proposal to separate out the risks related to THIS Modernisation including all the tactical programmes from the general risks around EPR and the benefits realisation of EPR.

46/15 NURSING AND MIDWIFERY STAFFING – HARD TRUTHS REQUIREMENT

It was requested that this item be amended to read "This paper was approved by the Board".

54/15 MATTERS ARISING FROM THE MINUTES

a. 183/14a Voluntary Redundancy Scheme

The Interim Director of Workforce & Organisational Development advised the Board that the Trust had received 534 expressions of interest in voluntary redundancy. The panel had approved 137 applications and made 110 offers. 14 applications were being revisited.

b. 42/15 Board Assurance Framework

It was noted that an updated version would be brought to the May meeting.

ACTION: BOD AGENDA ITEM – 28.5.15

55/15 ACTION LOG

There were no items outstanding on the Action Log.

56/15 CHAIRMAN'S REPORT

a. Annual General Meeting and Health Fair 17.9.15 - The Chairman reported that the AGM Planning Sub Group had met on the 14 April and due to the limited numbers of public attending previously and the pressures on staff time and finances, a decision had been made to slim down the Health Fair. In order to showcase the Acre Mill Outpatients Building, arrangements were being made for this to take place on that site (3rd Floor).
All present agreed with this decision.

57/15 CHIEF EXECUTIVE'S REPORT

a. NHS Confederation Trustees Board Meeting

The Chief Executive reported that he had recently attended the NHS Confederation Trustees Board Meeting and shared some of the themes.

There had been significant discussion on the NHS financial position, the 5 year forward view and the challenges that would be faced. Workforce challenges around recruitment and retention were a national as well as local problem. Discussion took place regarding social care, the need to work in partnership in the future and what the future architecture of the NHS might look like if real integration and transformation were to be achieved.

58/15 b. Divisional Restructure Progress

The Chief Executive advised the Board on the work undertaken to progress the architecture of the Trust. Since the last meeting a number of engagement events had been undertaken to change the divisional structure to three acute Divisions:- Surgery and Anaesthetics, Medicine (including A/E), CWF and DATs and the creation of a Community Division with a go-live date of the 1 May 2015.

It was noted that Fiona Alcorn, Interim Director of Operations would provide leadership in the creation of the Community Division and move this forward with other colleagues. Feedback from the Divisions and GP colleagues at Calderdale was that the creation of a Community Division was a positive move.

59/15 INTEGRATED BOARD REPORT

The Executive Director of Planning, Performance, Estates and Facilities introduced the Integrated Board report as at 31 March 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 the key issues from the executive summary commentary:-

- March had seen an over performance against the baseline activity in both elective and non-elective care. There has been a performance improvement in elective in-patient, day cases and outpatient appointments and treatments. This is welcomed, but still leaves issues across the year, that need to be resolved for 15/16.
- Non-electivity performance was 6.6% above baseline. There had been a further increase in delayed transfers of care to 6.7%. The increase in non-elective activity had resulted in increased outliers and ward moves.
- There had 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 the Trust missed the target for quarter

4. April was also busy but still challenging for the Department as reported earlier in the meeting by Mark Davies.

Discussion took place regarding the percentage of daily discharges undertaken before 11 am. The Executive Director of Nursing and Operations reported that the target was 30% and plans were in place to achieve this with a new launch of the discharge lounges and a focus on the expected date of discharge. It was appreciated that length of stay places a pressure on the 11 am discharge. In addition nursing staff were not using the the discharge lounges to their fullest potential as it appeared that they preferred to offer discharged patients room in day rooms. It was noted that this was not consistent across the Trust and varied between sites.

Dr Linda Patterson commented that it would be helpful for the report to track when red rated issues turn to green and green rated turn to red, along with identifying accountability leads. The Executive Director of Nursing and Operations agreed that this would be built into the next review of the document which was currently being worked on.

ACTION: JD/LH

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

- **Pressure Ulcers** - A review has been undertaken regarding the increase in pressure ulcers during November – February. A paper will be presented at the Quality Committee w/c 22 April 2015.
- **Falls** – There were 3 inpatient falls with serious harm during March 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 year's data.
- **Duty of Candour** – The Board were reminded of the statutory Duty of Candour which came into force on 27 November 2014. From December the Trust has been recording its compliance against this and have developed a monitoring tool to ensure this is captured. During March, 21 incidents were reported which fall within the requirements of Duty of Candour. Confirmation of compliance is awaited for 7 of these.

Effectiveness - The Medical Director reported:-

- **C.difficile** – There was one case in March, giving a year to date total 27 against a ceiling of 18. Of these, 10 were classified as avoidable and 17 classed as unavoidable. There were no common themes in terms of the reasons behind the cases. Key learning had been identified around isolation of patients with diarrhoea.
- **SHMI** - The most recently released information indicated a SHMI of 110 for the 12 months of July 13 to June 14. This has reduced from the 111 published for 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 information. Crude mortality is lower than the previous two months.

It was noted that a new coding proforma had been released and it was hope that increased use would improve the position.

Well Led – The Interim Director of Workforce and Organisational Development highlighted three key areas - Mandatory Training, Appraisal and Sickness and Absence.

- **Sickness** – Work was underway to look at the set of indicators that the Board of Directors receives.

- **Appraisal** – further work was being done to ensure that appraisals were undertaken on a rolling programme to try to prevent the end of year pressure in completing appraisals. There would also be a focus on the quality of appraisal.
- **Mandatory Training** - The problems with release of staff were noted. A piece of work was being undertaken to identify what is included in 'Mandatory Training' for different staff groups.

Community – The Executive Director of Planning, Performance, Estates and Facilities reported that work continues to improve the data within the report.

- **Smoking** - The number of pregnant women smoking was higher than the national figure and work with this group of patients was underway.
- **Home Delivery Equipment** - Issues of getting equipment from suppliers and access to patients homes were both causing problems.

CQUINS – The Trust had met most of the targets at year end. The 3 areas currently not achieving the targets:- A/E, Family and Friends and Safety Thermometer (pressure ulcers) and Asthma bundle re. A/E Department staffing availability – A plan was now in place to replace the asthma lead position.

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 year-end month 12:-

Summary Year end 2014/15

- Bed capacity pressures continue. Elective activity remains below planned levels.
- The level of income protection offered by the fixed value contract stands at £6.2m for the full year.
- The 2014/15 full year deficit is £1.61m including restructuring costs of £4.4m, against a planned surplus of £3.00m.
- Capital expenditure of £22.94m against revised planned £24.31m, an underspend of £1.37m (£6.26m below original plan).
- The cash balance was £13.70m, versus a planned £22.71m, £9.01m lower than planned. A level of loan funded borrowing has supported the cash required for capital investment.
- The Continuity of Service Risk Rating (CoSRR) stands at 2 against a planned level of 3.
- The regulator, Monitor has investigated the financial position and a Trust led turnaround process is now in operation.

It should be noted that:-

- Additional costs have been incurred as a result of staffing the additional bed capacity across the winter period supported by non-contracted staff. The greater use of agency staffing, particularly over the last 2 months, is a concern moving forwards into 2015/16.
- CIP schemes delivered £9.86m against the planned £19.53m. This is a shortfall of £9.67m which again brings extra pressure to 2015/16.
- £1.5m expenditure was recurrently committed in-year to extra substantive nurse staffing to strengthen nursing ratios across ward areas.
- £1.5m non-recurrent income was received from commissioners to support the Trust's investment in quality initiatives.

(the financial position presented is in advance of the finalisation and audit review of the year end accounts).

RESOLVED: The Board approved the Integrated Board Report

60/15 RISK REGISTER

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

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

No new risks had been added.
Risks with Increased score:-
Non-achievement of 100% Appraisal & Mandatory training target

Risks with reduced score:-
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.

Other issues arising from the debate included:-

- **CQC Risks** - It was noted that debate had taken place at the Quality Committee specifically around the CQC risks and a self-assessment report was due to be brought to the next Quality Committee.

- **Electronic Document Management System (EDMS)** – It was noted that work was underway to improve the time taken to retrieve information. The Chief Executive stated that it was important for the organisation to resolve this problem in order to ensure that this does not present any risks for the electronic patient record when it is implemented.

- **CIP** – It was agreed that it was too early to predict the future position and it was necessary to embed the current practices before we could confidently reduce the risk.

RESOLVED: The Board approved the Risk Register

61/15 DIRECTOR OF INFECTION, PREVENTION AND CONTROL (DIPC) REPORT

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

- **MRSA** – there was one case of hospital acquired MRSA identified in March, this was a surgical patient and had been allocated to the Trust. There were a total of 28 MRSA cases from April 2014 to March 2015.
- **C.Diff** - 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 had been investigated and there has been valuable learning for the majority of cases.
- **Pseudomonas** – As discussed at the last meeting control measures were now in place and no further cases had been reported.

RESOLVED: The Board received the report.

62/15 EMERGENCY PLANNING ANNUAL REPORT

The Executive Director of Planning, Performance, Estates and Facilities presented the annual report which updated the Board on the work over the year. Policies had been reviewed to ensure business continuity, along with specific partnership work on the Tour de France and Tour de Yorkshire bike races.

Jeremy Pease asked how this fitted with the Trust's escalation procedure. The Executive Director of Nursing and Operations explained that a triggering system for the escalation process was in place. The actions for individuals were being worked on and reviewed. It was noted that joined up work would be provided to the Quality Committee when this has been completed.

The Chief Executive identified that IT dependency was growing, particularly with the EPR project in the future. How the Board assures itself that IT business continuity is maintained once that paper-based systems are diminished was discussed. Prof. Peter Roberts suggested that the Trust might liaise with the Huddersfield University team in the future about overall business continuity planning and the Director of Planning, Performance, Estates and Facilities agreed to take this on board.

ACTION: LH

63/15 UPDATE FROM SUBCOMMITTEES AND RECEIPT OF MINUTES

The following information was received and noted:-

- **Quality Committee** – The Board received the minutes of the 24.3.15 and a verbal update from Jeremy Pease on the meeting held on 21.4.15 which included:
  - **Stroke Service Presentation** – Not meeting targets. A lot of good progress in delivering 3 day therapy services and it was expected to increase this to 5 days in the future.
  - **Coroners Rule 28 (record keeping)** – The Quality Committee reviewed the action plan to ensure that all actions go further than the department and division where the issue originated.
  - **CQC Preparation** – Action plan received by the Quality Committee. Still a lot of work to be done before the visit.
  - **Quality Accounts** – This document had been sent to stakeholders for comment. It was come to the Board in May 2015.
  - **Pressure Ulcers** – deep dive to be undertaken. The Action Plan will be monitored by the Quality Committee.
  - **Kirkup Report** – Action Plan to come to the May Quality Committee – no major areas of concern had been identifield.

- **Audit and Risk Committee** - The Board received a verbal update from Prof. Peter Roberts on the meeting held on 21.4.15 which included:-
  - **Staff Overpayments** – presentation received from Claire Wilson, Assistant Director Workforce and Organisational Development. Policy reviewed and approved. Progress report on staff over and under payments to be brought back to the Audit and Risk Committee in October 2015.
  - **Standing Orders** - Revised document approved subject to minor amendments. Updated version to be brought to the Board in May 2015.
  - **Audit Plan** – It was suggested that further audits should be undertaken to include:
    - Work on financial outcome of Acre Mill.
    - Close look at property partnership risks.

- Accuracy of information – source data.
- Staff training/appraisal – promote appraisals being undertake earlier in the financial year.
- Payroll – limited assurance received.
- Improved progress reporting request.

➢ **Local Counter Fraud** – Workplan, progress report and risk assessment 2015/16 received.
➢ **External Audit** – ISA/700/Audit plan 2014/15 received and discussed.

- **Finance and Performance Committee** - The Board received a verbal update from Phil Oldfield on the meeting held on 21.4.15 which included:-
  ➢ **End of Year position** – Details noted.
  ➢ **Activity discussions** – Learning points noted.
  ➢ **Contract Position** – Negotations continue. Inter-relationships and risks discussed.
  ➢ **Capital Drawdown** – Noted and supported £10m funding for EPR system.
  ➢ **Monitor Submission** – Discussed and supported.

- **Membership Council Standing Orders** – This document had been approved by the Membership Council at its meeting on the 8 April 2015. The Board agreed the revised document, subject to the following amendments:-
  - "NHS" fit and proper persons test
  - a revision of the terminology around Vice Chair and Deputy Chair
  - PCT being changed to CCG.

The Chairman thanked everyone for their attendance and asked the Membership Councillors present for any comments. Wayne Clarke commented that at the last Membership Council meeting, Alistair Morris, Consultant Paediatrician/Clinical Director for Modernisation had attended the meeting and suggested ways in which the Membership Council might be able to help with the Electronic Patient Record implementation. The Chairman advised that he would circulate a letter to Membership Councillors in due course.
ACTION: AH

Peter Middleton reported that he had attended an NHS Providers Workshop and wished to comment that compared with other Trusts nationally, the Membership Council were actively involved with the Board and felt that they were listened to in a culture of openness and engagement. The Workshop heard from Simon Stevens about the 5 year plan and the national agenda of 'getting serious about prevention' and 'encouraging a healthy staff'.

64/15 DATE AND TIME OF NEXT MEETING
Thursday 28 May 2015 at 1.30 pm in the Large Training Room, Learning Centre, Calderdale Royal Hospital.

The Chairman once again thanked everyone for their attendance and contributions and closed the meeting at approximately 3.30 pm.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 28th May 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: ACTION LOG - PUBLIC BOARD OF DIRECTORS - MAY 2015 - The Board is asked to approve the Action Log for the Public Board of Directors Meeting as at 1 May 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 May 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 May 2015

Appendix

Attachment:

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

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 May 2015 / APPENDIX B

Red	Amber	Green	Blue
Overdue	Due this month	Closed	Going Forward

Date discussed at BOD Meeting Date	AGENDA ITEM	LEAD	CURRENT STATUS / ACTION	DUE DATE	RAG RATING	DATE ACTIONED & CLOSED
30.10.14 140/14	**PATIENT/STAFF STORY** 30.10.14 - 'Carol's Story' extract video. 27.11.14 – 'Mr P' – Drug Error 18.12.14 – Dr Sarah Hoye 29.1.15 – Dr Mary Kiely – Care of the Dying 26.2.15 – Catherine Briggs, Matron – Green Cross Patient 26.3.15 – Diane Catlow – Families Senior Locality Manager 23.4.15 – Dr Mark Davies – Perfect Week	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 – Verbal update received			
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 –	28.5.15		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 May 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
			roll out of mortality review process from March 2014 24.4.14 – Update received. 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 May 2015.	28.5.15		
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		

ACTION LOG FOR BOARD OF DIRECTORS (PUBLIC)

Position as at: 1 May 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
26.3.15 26/15	**STAFF SURVEY** Item deferred until May 2015	Executive Director of W& OD		28.5.15		
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 following sign off of the Strategy on a page.	~~28.5.15~~ 25.6.15		

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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, 28th May 2015	**Sponsoring Director:** Lesley Hill, Director of Planning, Performance, Estates and Facilities
Title and brief summary: INTEGRATED BOARD 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: WEB - 21.5.15 Quality Committee - 26.5.15	
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:

IBR Report April 15.pdf

Board Of Directors Integrated Performance Report

Report For: April 2015

Calderdale and Huddersfield NHS
NHS Foundation Trust

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Executive Summary Commentary

April was a busy month for activity however, we were below the activity baseline for all inpatient activity. We have had particular issues in ophthalmology, orthopaedics, cardiology and rheumatology compared to baseline. The theatre utilisation project commenced at the end of April. On a weekly basis we are now checking that all theatres are scheduled appropriately. This should lead to increases in elective and day case activity, through better theatre utilisation. For non-elective activity, we did see a large number of medical outliers, and did have issues with discharging patients. We are working with our partners to try and reduce the number of delays due to external issues, and improving processes within the hospitals where there are issues with our own patient flow.

We did deliver additional outpatient activity. This is due to increased numbers of clinics to reduce the number of patients waiting for appointments who use Choose and Book, reduced levels of DNAs, and reduced patient cancellations.

We delivered the A&E 4 hour wait target in April. Thank you to all staff who have helped with this.

CHFT had a MRSA bacteraemia patient in April and an avoidable cdiff case. Both patients have had route cause analysis undertaken so that we can learn from these incidents.

Our SHMI is 109, a reduction on last month. Our HSMR is 108.53.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Responsive Executive Summary - Helen Barker Associate Director of Operations

	Report For: April 2015	Indicator Source	Report For: April 2015						Year To Date						Trend (Rolling 12 Month)	Year End Forecast	Data Quality
			Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community			
Activity	% Elective Variance against Plan	Local	0.00%	-4.24%	-7.15%	-11.31%	15.98%	-	0.00%	-4.24%	-7.15%	-11.31%	15.98%	-			
	% Day Case Variance against Plan	Local	0.00%	-3.30%	-2.58%	-5.29%	-2.92%	-	0.00%	-3.30%	-2.58%	-5.29%	-2.92%	-			
	% Non-elective Variance against Plan	Local	0.00%	-0.81%	-8.54%	7.49%	-5.88%	-	0.00%	-0.81%	-8.54%	7.49%	-5.88%	-			
	% Outpatient Variance against Plan	Local	0.00%	2.30%	0.32%	-1.69%	16.22%	-	0.00%	2.30%	0.32%	-1.69%	16.22%	-			
RESPONSIVE - Operational Targets	Theatre Utilisation (TT) - Main Theatre - CRH	Local	92.50%	87.57%	85.96%	-	100.44%	-	92.50%	87.57%	85.96%	-	100.44%	-			
	Theatre Utilisation (TT) - Main Theatre - HRI	Local	92.50%	91.46%	91.46%	-	-	-	92.50%	91.46%	91.46%	-	-	-			
	Theatre Utilisation (TT) - HRI DSU	Local	92.50%	75.69%	76.03%	-	85.84%	-	92.50%	75.69%	76.03%	-	85.84%	-			
	Theatre Utilisation (TT) - HRI SPU	Local	92.50%	80.30%	80.30%	-	-	-	92.50%	80.30%	80.30%	-	-	-			
	% Daily Discharges - Pre 11am	Local	28.00%	10.05%	12.36%	8.39%	10.10%	-	28.00%	10.05%	12.36%	8.39%	10.10%	-			
	Delayed Transfers of Care	Local	5.00%	7.30%	-	-	-	-	5.00%	7.30%	-	-	-	-			
	Green Cross Patients	Local	40	72	-	72	-	-	40	72	-	72	-	-			
	Number of Outliers (Bed Days)	Local	519	813	279	534	0	-	519	813	279	534	0	-			
	First DNA Rate	Local	7.00%	6.57%	6.25%	6.79%	7.25%	2.60%	7.00%	6.57%	6.25%	6.79%	7.25%	2.60%			
	% Hospital Initiated Outpatient Cancellations	Local	21.00%	18.00%	19.00%	21.00%	14.00%	-	21.00%	18.00%	19.00%	21.00%	14.00%	-			
	Appointment Slot Issues on Choose & Book	Local	5.00%	16.90%	13.00%	27.30%	9.60%	-	5.00%	16.90%	13.00%	27.30%	9.60%	-			
	No of Spells with > 2 Ward Movements	Local	-	153	23	99	31	-	-	153	23	99	31	-			
	% of Spells with > 2 ward movements (2% Target)	Local	2.00%	2.55%	1.59%	5.58%	1.12%	-	2.00%	2.55%	1.59%	5.58%	1.12%	-			
	No of Spells with > 5 Ward Movements	Local	-	5	0	5	0	-	-	5	0	5	0	-			
	% of spells with > 5 ward movements (No Target)	Local	-	0.08%	0.00%	0.28%	0.00%	-	-	0.08%	0.00%	0.28%	0.00%	-			
	Total Number of Spells	Local	-	5996	1443	1775	2778	-	-	-	-	-	-	-			
RESPONSIVE:18 Weeks and Other Access Indicators	% Non-admitted Closed Pathways under 18 weeks	National & Contract	95.00%	98.35%	98.39%	98.56%	97.77%	-	95.00%	98.35%	98.39%	98.56%	97.77%	-			
	% Admitted Closed Pathways Under 18 Weeks	National & Contract	90.00%	91.65%	90.92%	100.00%	94.27%	-	90.00%	91.65%	90.92%	100.00%	94.27%	-			
	% Incomplete Pathways <18 Weeks	National	92.00%	95.02%	93.40%	99.25%	97.84%	-	92.00%	95.02%	93.40%	99.25%	97.84%	-			
	18 weeks Pathways >=26 weeks open	Local	0	348	342	4	2	-	0	348	342	4	2	-			
	18 weeks Pathways >=40 weeks open	National	0	12	11	0	1	-	0	12	11	0	1	-			
	% Diagnostic Waiting List Within 6 Weeks	National & Contract	99.00%	99.85%	100.00%	100.00%	99.79%	-	99.00%	99.85%	100.00%	100.00%	99.79%	-			
	Community AHP - 18 Week RTT Activity	National	95.00%	91.30%	-	-	-	91.30%	95.00%	91.30%	-	-	-	91.30%			
	Paediatric Therapies - 18 Week RTT Speech Therapy	National	95.00%	97.92%	-	-	-	97.92%	95.00%	97.92%	-	-	-	97.92%			
	Paediatric Therapies - 18 Week RTT Occupational Therapy	National	95.00%	87.50%	-	-	-	87.50%	95.00%	87.50%	-	-	-	87.50%			
	Paediatric Therapies - 18 Week RTT Physiotherapy	National	95.00%	100.00%	-	-	-	100.00%	95.00%	100.00%	-	-	-	100.00%			
	% Last Minute Cancellations to Elective Surgery	National & Contract	0.60%	0.72%	0.92%	0.13%	1.89%	0.00%	0.60%	0.72%	0.92%	0.13%	1.89%	0.00%			
	28 Day Standard for all Last Minute Cancellations	National & Contract	0	0	0	0	0	-	0	0	0	0	0	-			
	No of Urgent Operations cancelled for a second time	National & Contract	0	0	0	0	0	-	0	0	0	0	0	-			

Calderdale and Huddersfield NHS
NHS Foundation Trust

Responsive Executive Summary - Helen Barker Associate Director of Operations

	Report For: April 2015	Indicator Source	Report For: April 2015 Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Year To Date Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Year End Forecast	Data Quality
RESPONSIVE: Cancer	62 Day Gp Referral to Treatment	National & Contract	85.00%	89.38%	92.22%	86.67%	75.00%	-	85.00%	89.38%	92.22%	86.67%	75.00%	-			
	62 Day Referral From Screening to Treatment	National & Contract	90.00%	85.71%	80.00%	-	100.00%	-	90.00%	85.71%	80.00%	-	100.00%	-			
	31 Day Subsequent Surgery Treatment	National & Contract	94.00%	100.00%	100.00%	100.00%	-	-	94.00%	100.00%	100.00%	100.00%	-	-			
	31 day wait for second or subsequent treatment drug treatments	National & Contract	98.00%	100.00%	100.00%	100.00%	-	-	98.00%	100.00%	100.00%	100.00%	100.00%	-			
	62 Day Aggregated Gp Urgent Referral To Treatment And Screening Referral To Treatment	National & Contract	86.00%	89.22%	91.58%	86.67%	80.00%	-	86.00%	89.22%	91.58%	86.67%	80.00%	-			
	31 Days From Diagnosis to First Treatment	National & Contract	96.00%	100.00%	100.00%	100.00%	100.00%	-	96.00%	100.00%	100.00%	100.00%	100.00%	-			
	Two Week Wait From Referral to Date First Seen	National & Contract	93.00%	96.45%	98.22%	89.50%	100.00%	-	93.00%	96.45%	98.22%	89.50%	100.00%	-			
	Two Week Wait From Referral to Date First Seen: Breast Symptoms	National & Contract	93.00%	93.33%	93.33%	-	-	-	93.00%	93.33%	93.33%	-	-	-			
RESPONSIVE: Accident & Emergency	A and E 4 hour target	National & Contract	95.00%	95.01%	-	95.01%	-	-	95.00%	95.01%	-	95.01%	-	-			
	Time to Initial Assessment (95th Percentile)	National	00:15:00	00:25:00	-	00:25:00	-	-	00:15:00	00:25:00	-	00:25:00	-	-			
	Time to Treatment (Median)	National	01:00:00	00:17:00	-	00:17:00	-	-	01:00:00	00:17:00	-	00:17:00	-	-			
	Unplanned Re-Attendance	National	5.00%	5.32%	-	5.32%	-	-	5.00%	5.32%	-	5.32%	-	-			
	Left without being seen	National	5.00%	3.65%	-	3.65%	-	-	5.00%	3.65%	-	3.65%	-	-			
	Improving management of patients attending A&E with Pneumonia (Reported quarterly)	CQUINS	-	-	-	-	-	-	-	-	-	-	-	-			
	Improving recording of diagnosis in A&E	CQUINS	80.00%	80.76%	-	80.76%	-	-	80.00%	80.76%	-	80.76%	-	-			

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Responsive/Operational Targets - Associate Director of Operations

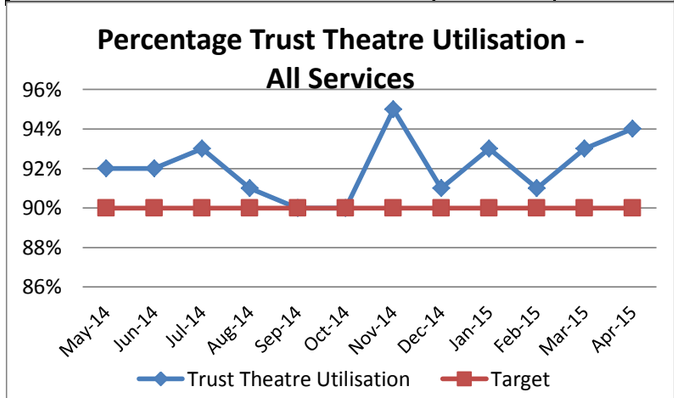
Report For: April 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Theatre Utilisation (TT) - Main Theatre - CRH	92.50%	87.57%	85.96%	-	100.44%	-
Theatre Utilisation (TT) - Main Theatre - HRI	92.50%	91.46%	91.46%	-	-	-
Theatre Utilisation (TT) - HRI DSU	92.50%	75.69%	76.03%	-	85.84%	-
Theatre Utilisation (TT) - HRI SPU	92.50%	80.30%	80.30%	-	-	-
% Daily Discharges - Pre 11am	28.00%	10.05%	12.36%	8.39%	10.10%	-
Delayed Transfers of Care	5.00%	7.30%	-	-	-	-
Green Cross Patients	40	72	-	72	-	-
Number of Outliers (Bed Days)	519	813	279	534	0	-
First DNA Rate	7.00%	6.57%	6.25%	6.79%	7.25%	2.60%
% Hospital Initiated Outpatient Cancellations	21.00%	18.00%	19.00%	21.00%	14.00%	-
Appointment Slot Issues on Choose & Book	5.00%	16.90%	13.00%	27.30%	9.60%	-
No of Spells with > 2 ward movements	-	153	23	99	31	-
% of Spells with > 2 ward movements (2% Target)	2.00%	2.55%	1.59%	5.58%	1.12%	-
No of Spells with > 5 Ward Movements	-	5	0	5	0	-
% of spells with > 5 ward movements (No Target)	-	0.08%	0.00%	0.28%	0.00%	-
Total Number of Spells	-	5996	1443	1775	2778	-

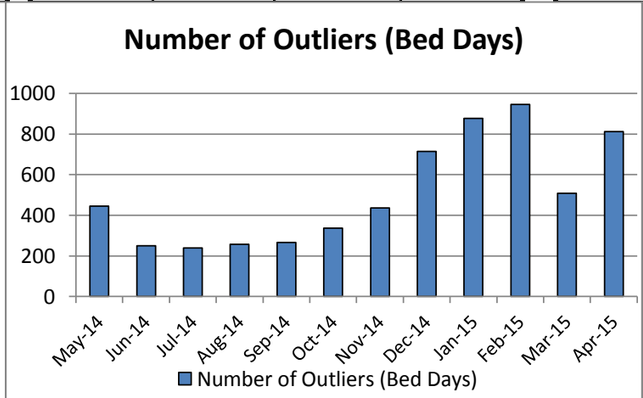
% Daily Discharges Pre 11am -
Why are we away from plan : The vehicle for making this possible is the detailed job planning and processes being designed around the Clinical Site Commanders. This design will incorporate existing systems such as Visual Hospital and will link with individual ward processes via Plan for Every Patient.
What are we doing to get back on Plan: This design is not yet complete. There are now time bound plans around this design.
When will this be achieved: An improvement in position is expected within the next month.

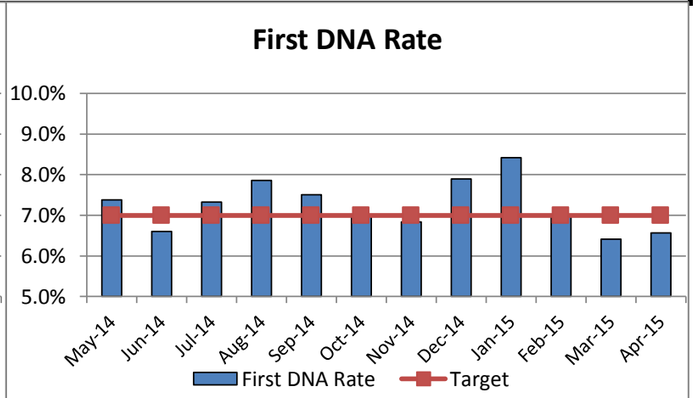
Appointment Slot Issues - **Why are we away from plan**: Target 5% performance 16.9%. ASIs relate to the following specialties: Dermatology (229 patients) majority of which are for services contracted to Locala for GPSI services. **What are we doing to get it back to plan**: Plans are place to reduce the backlog and Locala have been asked to push out the waiting time so it is in line with CHFT waiting times. GI/Liver (medicine and surgery) Additional Gastroenterology (124 patients awaiting appointment) - recruitment to vacancies and continued use of Locums is planned to address the shortfall. Orthopaedics (92 patients awaiting appointments) relating to paediatrics and shoulder/elbow, recruitment underway to vacant upper limb posts. WLI to continue as an interim. Cross Divisional weekly Access meeting established to review ASIs and agree timely actions in order to reduce ASIs moving forward. RAG rating: RED
First DNA Rate - **Why are we away from plan**: Target 7%, performance 6.57% - Performance has recovered and is within target levels with only one Division out of range. **What are we doing to get it back to plan:** 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. RAG rating GREEN .

Spells with >2 ward moves -
Why are we away from plan :The reported figure for this is 2.55% against a target of 2%, with the majority of occurrences within the Medical Division. This can be attributed to a high level of bed occupancy and pressure on bed stock, This has lead to patients being moved from wards, when clinically safe to do so, in order to free capacity on specialist wards for acute admissions. Another reason that has been identified for this level of movement is the likely need for the bed stock to reflect real demand by specialty.
What are we doing to get back on Plan : The LOS PMO is incorporating work to reduce occupancy, by LOS measures. Also this group are working on a parallel initiative to design capacity to match demand. Both these pieces of work should address the cause of the problem.
When will this be achieved : The Bed Stock planning work will be complete by June and discussed at EB. Other LOS enablers will effect by the end of June.

Theatre Utilisation - Why off plan : Unfortunately not all surgeons have been fully utilising their theatre time and this has been identified by the "four eyes" deep dive work that has taken place within the surgical division.
What are we doing to retrieve the position : There is a great deal of work taking place, through the theatre PMO scheme, initially this is with 10 surgeons spread over orthopaedics, ENT and general surgery. Areas that have been looked at are scheduling, patient flow to and from theatre, staff and skill mix, start and finish times of theatre lists. These have all been agreed with the CD's and the surgeons concerned and the "better week" did show some improvements in orthopaedics and ENT. This however needs to be rolled out to all specialities and all surgeons.
When will this be achieved : The full roll out should be complete by July 2015, therefore over the next 2 months we should see an improvement in the utilisation figures.







Calderdale and Huddersfield NHS
NHS Foundation Trust

Responsive - RTT - Associate Director of Operations

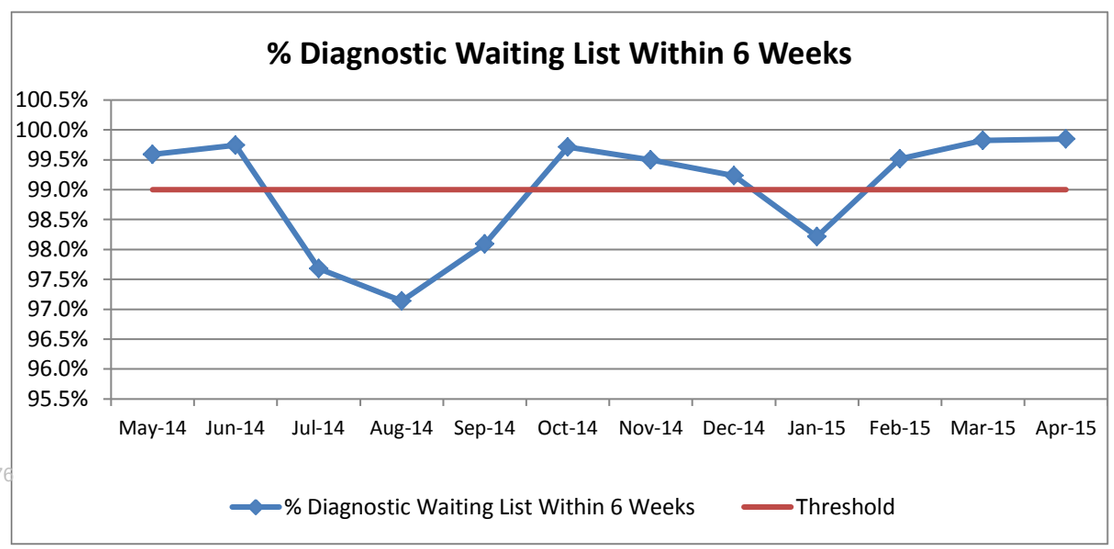
Report For: April 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Non-admitted closed Pathways under 18 weeks	95.00%	98.35%	98.39%	98.56%	97.77%	-
% Admitted Closed Pathways Under 18 Weeks	90.00%	91.65%	90.92%	100.00%	94.27%	-
% Incomplete Pathways <18 Weeks	92.00%	95.02%	93.40%	99.25%	97.84%	-
18 weeks Pathways >=26 weeks open	0	348	342	4	2	-
18 weeks Pathways >=40 weeks open	0	12	11	0	1	-
RTT Waits over 52 weeks Threshold > zero	0	0	0	0	0	-
Community AHP - 18 Week RTT Activity	95.00%	91.30%	-	-	-	91.30%
Paediatric Therapies - 18 Week RTT Speech Therapy	95.00%	97.92%	-	-	-	97.92%
Paediatric Therapies - 18 Week RTT Occupational Therapy	95.00%	87.50%	-	-	-	87.50%
Paediatric Therapies - 18 Week RTT Physiotherapy	95.00%	100.00%	-	-	-	100.00%
% Diagnostic Waiting List Within 6 Weeks	99.00%	99.85%	100.00%	100.00%	99.79%	-
% Last Minute Cancellations to Elective Surgery	0.60%	0.72%	0.92%	0.13%	1.89%	0.00%
28 Day Standard for all Last Minute Cancellations	0.00%	0.00%	0.00%	0.00%	0.00%	-
No of Urgent Operations cancelled for a second time	0.00%	0.00%	0.00%	0.00%	0.00%	-

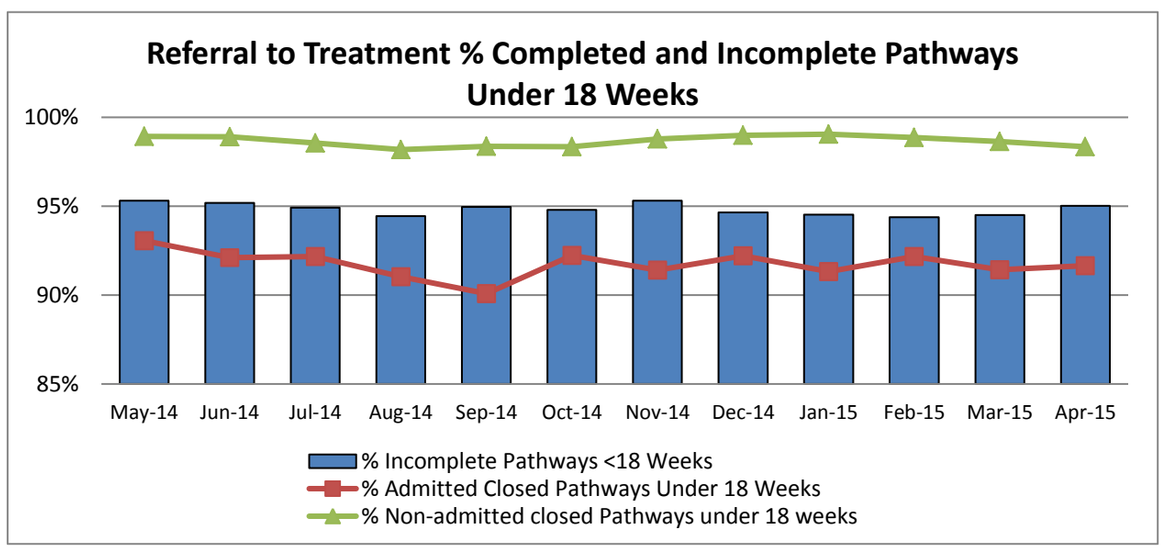
RTT Community : Why is the target away from Plan : Main services contributing to this are Physiotherapy Outpatients, Huddersfield Pulmonary Rehab and SALT Outpatients. Physio outpatients have seen an increase in referrals 14/15 and a reduction in capacity – adverts are currently out to recruit additional staff.
Huddersfield Pulmonary Rehab are receiving more referrals than they are commissioned to provide for – ongoing conversations with commissioners
SALT Outpatients is mainly due to a 9 month gap in the voice service.

What are we doing to get it back to plan: Post holder now in place and is working through the backlog of referrals with a view to breaking even in July/ August

When will this be achieved: Physio recruitment will take at least 3 months so that takes us to 1st September, hudds PRG is tied up in CC2H tender so 1st Oct and SALT approximately 1st August

Childrens Speech Therapy
Why is the target away from Plan : In March /April was a gap in staffing between leavers and new starters and then 4 new starters requiring induction etc reduced capacity in team
What are we doing to get it back to plan : New recruits now carrying a caseload
When will this be achieved : By end June
Childrens Physiotherapy and Occupational Therapy
Why is the target away from Plan : Significant vacancy factor in OT from March resulting in lack of capacity to fully meet the demands of new referrals
What are we doing to get it back to plan : Attempting to recruit to posts via advertising, difficult to recruit , agency, support from adult services- added to risk register
When will this be achieved : Will be reliant on ability to recruit





Calderdale and Huddersfield NHS
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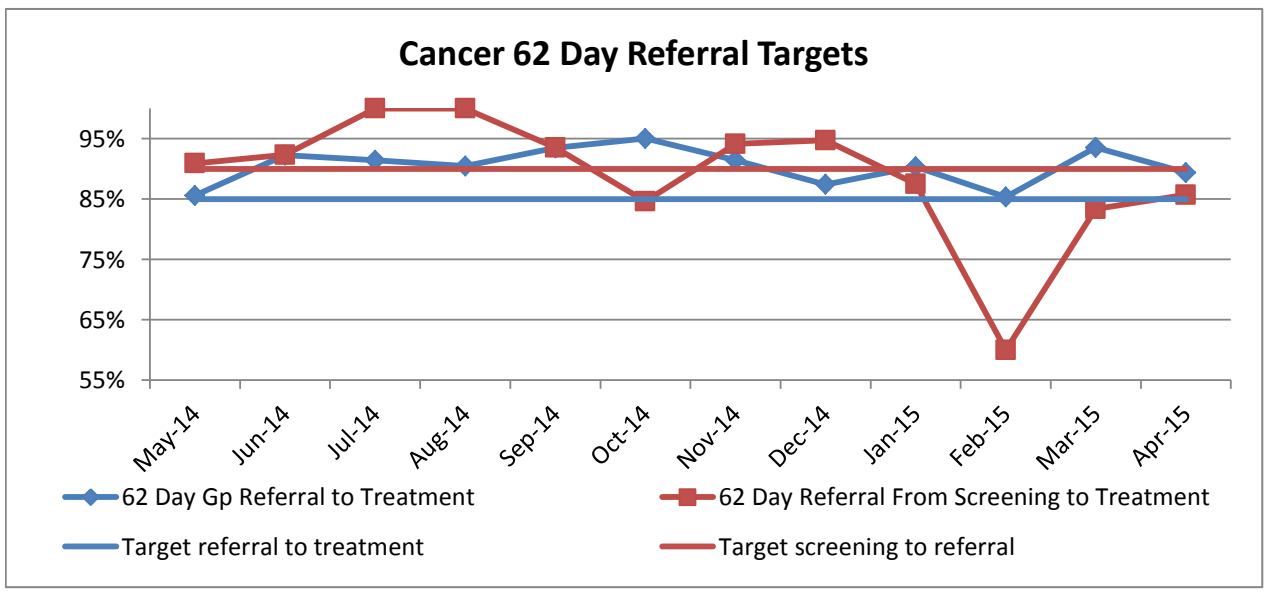
Responsive - Cancer - Associate Director of Operations

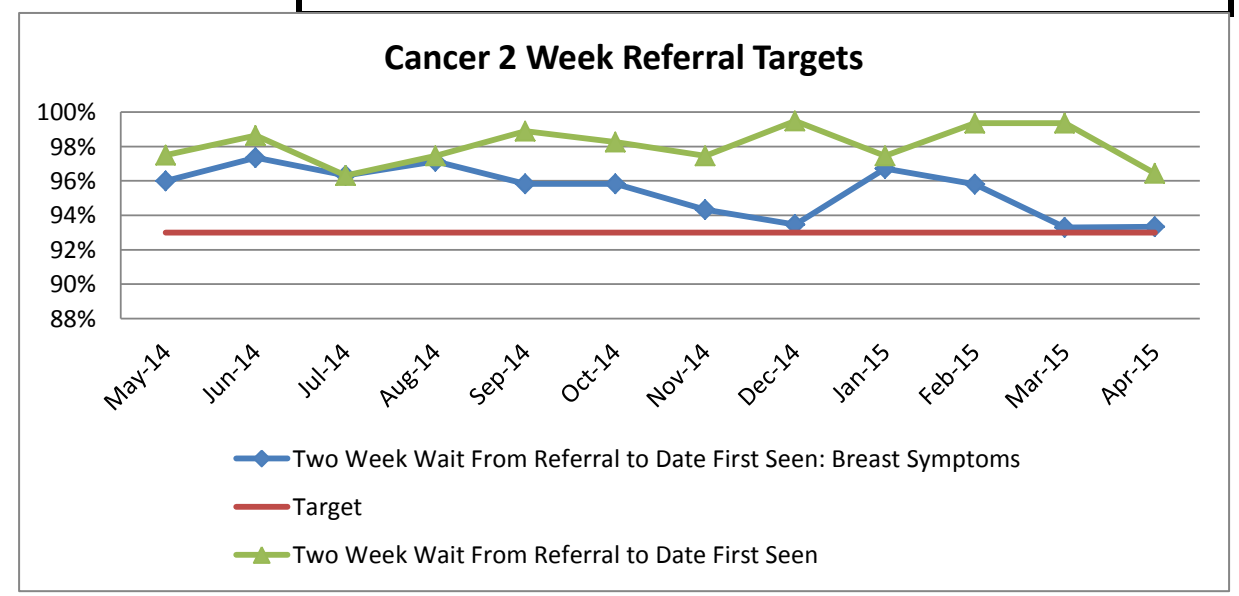
Report For: April 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Two Week Wait From Referral to Date First Seen	93.00%	96.45%	98.22%	89.50%	100.00%	-
Two Week Wait From Referral to Date First Seen: Breast Symptoms	93.00%	93.33%	93.33%	-	-	-
31 Days From Diagnosis to First Treatment	96.00%	100.00%	100.00%	100.00%	100.00%	-
31 Day Subsequent Surgery Treatment	94.00%	100.00%	100.00%	100.00%	-	-
31 day wait for second or subsequent treatment drug treatments	98.00%	100.00%	100.00%	100.00%	-	-
62 Day Aggregated Gp Urgent Referral To Treatment And Screening Referral To Treatment	86.00%	89.22%	91.58%	86.67%	80.00%	-
62 Day Gp Referral to Treatment	85.00%	89.38%	92.22%	86.67%	75.00%	-
62 Day Referral From Screening to Treatment	90.00%	85.71%	80.00%	-	100.00%	-

62 Day Aggregated GP Urgent Referral to Treatment and Screening Referral to treatment:
The breach In April for screening; was breast screening which originate in Bradford.
The screening service continues to have unusually low numbers of screening patients treated, which allows no scope for any breaches to occur in order to achieve the 90% target month on month. The 0.5 breach occurred because the 1st diagnostic test was inconclusive and bruising around the area of biopsy needed a minimum of 3 weeks to heal before further biopsies could be taken, causing a large delay in the pathway.
The 2ww in medicine was due to unforeseen clinic cancellation due to compassionate leave allowing no time to allocate patients to a further clinic OPA within target
The 62 day aggregate = Gynaecology had 1 full breach in April but numbers treated were low causing a failure to reach the 86% target. The breach occurred because the patient was found to have a cardiac problem and was unfit to go ahead with GA for diagnostics and needed a more thorough review prior to having procedure.

What are we doing to retrieve the position
The screening numbers have been low, this has been discussed at planned care board to see if public health can be involved.
2WW should not occur again
This is an unusual situation with treated numbers being low, ensure weekly monitoring to watch for any trends.

When will this be achieved
For the 2WW and 62 day aggregate it should be rectified within the month, unfortunately the low numbers in screening have been over the last 3 months but are being monitored closely.





Responsive/Accident & Emergency - Associate Director of Operations

Report For: April 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
A and E 4 hour target	95.00%	95.01%	-	95.01%	-	-
Time to Initial Assessment (95th Percentile)	00:15:00	00:25:00	-	00:25:00	-	-
Time to Treatment (Median)	01:00:00	00:17:00	-	00:17:00	-	-
Unplanned Re-Attendance	5.00%	5.32%	-	5.32%	-	-
Left without being seen	5.00%	3.65%	-	3.65%	-	-
A&E Ambulance 30-60 mins	0	29	-	29	-	-
A&E Trolley Waits	0	0	-	0	-	-
Improving management of patients attending A&E with Pneumonia (Reported quarterly)	-	-	-	-	-	-
Improving recording of diagnosis in A&E	80.00%	80.76%	-	80.76%	-	-

Time to Initial Assessment & Ambulance Turnaround

Why off plan

1 Increase in attendances – on occasions unprecedented numbers of attendances

2 'Exit block' – lack of flow out of the department for patients waiting for admission due to increase in green crosses causes lack of cubicle space

3 Lack of nursing staff – new workforce model being developed in line with NICE hard truths for emergency medicine

4 ED estate does not meet demand

Actions to get back on track

1 Increase in attendances:

- awareness of this issue to commissioners so that a review of capacity of services Local Care Direct streaming service review

Out of area attendances appear to be increasing

Appropriateness of ED presenting complaints

Workforce model to reflect the demand

2 'Exit block':

- daily meetings to review green cross patients
- increased focus and work ensuring EDD for all patients
- introduction of the discharge improvement meeting (all health economy partners involved)
- clinical commanders in post to take control of site and improve flow
- bed modelling to ensure correct capacity available
- discharge levelling

3 Lack of nursing staff

- new workforce model being developed in line with NICE hard truths for emergency medicine

Anticipated achieve by date

Time to Initial Assessment – HRI achieved the required standard over the last 3 weeks, site specific issues causing challenges at CRH. Expected anticipated date to achievement July 2015.

Ambulance Turnaround at present is running at 89-90% with a target of 95%, RAG – AMBER, risk to achieving the 95% as all actions need to be completed to make the trust compliant. To look at achieving a 1% increase month on month.

Unplanned re-attendance

Why off plan

Increase in attendances

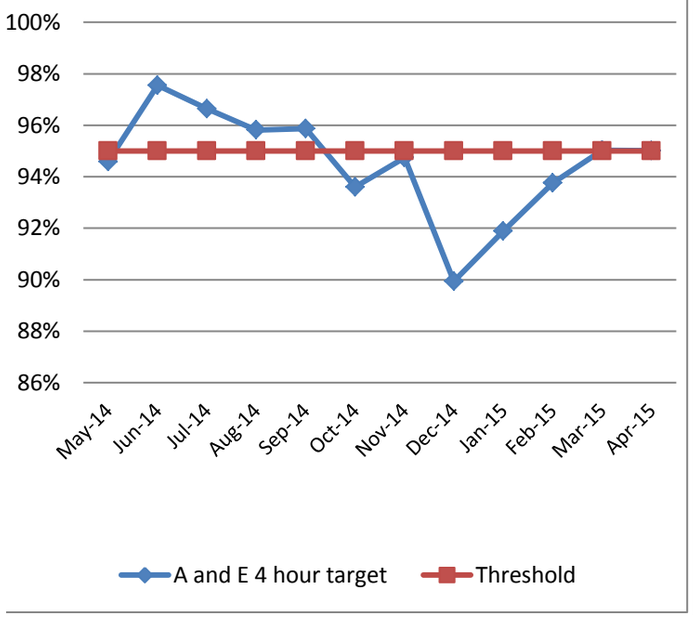
- patients decide not to wait and come back later
- patients move between sites when one department is busy
- exit block causes patients to have lengthy waits

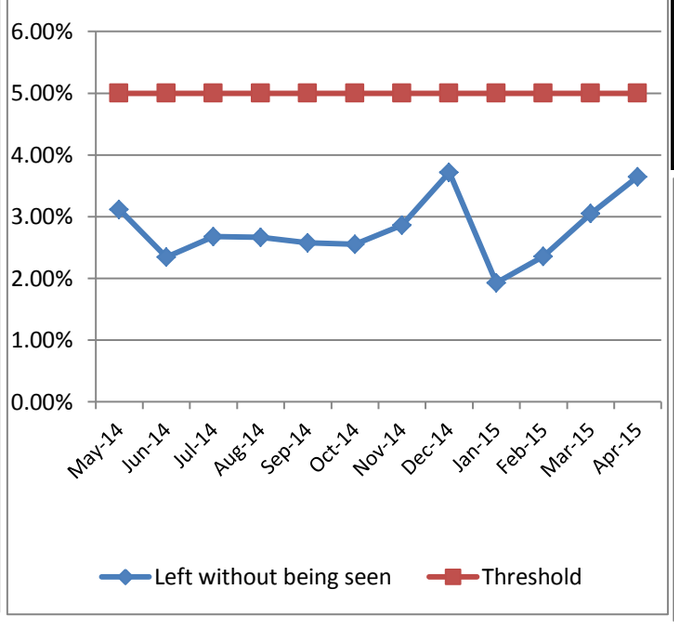
Actions to get back on track

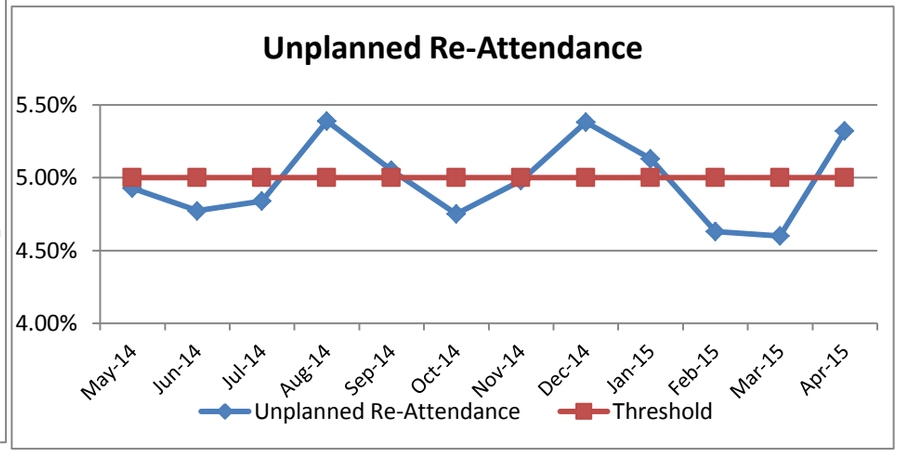
Further validation required, unlikely to be a month on month problem

Anticipated achieve by date

May 2015







Calderdale and Huddersfield NHS
NHS Foundation Trust

Caring Executive Summary - Julie Dawes Director of Nursing

	Report For: April 2015	Indicator Source	Target	Trust	Report For: April 2015 Surgical	Medical	Families and Specialist Services	Community	Year To Date Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Year End Forecast	Data Quality
Caring	Number of Mixed Sex Accommodation Breaches	National & Contract	0	0	0	0	0	-	-	-	-	-	-	-			
	% Complaints closed within target timeframe	Local	100.00%	30.00%	58.00%	14.00%	22.00%	-	-	-	-	-	-	-			
	Total Complaints received in the month	Monitor	-	58	15	21	14	-	-	-	-	-	-	-			
	Inpatient complaints per 1000 bed days	Monitor	-	1.1	1.3	0.8	-	-	-	-	-	-	-	-			
	Complaints acknowledged within 3 working days	Local	100.00%	96.00%	-	-	-	-	-	-	-	-	-	-			
	Total Concerns in the month	Monitor	-	46	14	16	-	-	-	-	-	-	-	-			
	Nutrition and Hydration - Patient Satisfaction (Reported quarterly)	CQUINS	75.00%	-	-	-			-	-	-	-					
	Nutrition and Hydration - Reducing Hospital Food Waste (reported quarterly)	CQUINS	75.00%	-	-	-			-	-	-	-					
	Nutrition and Hydration - Improving vending facilities (reported quarterly)	CQUINS	75.00%	-	-	-			-	-	-	-					
Caring - Friends & Family	Friends & Family Test (IP Survey) - Response Rate	Contract	25.00%	25.80%	25.10%	36.20%	11.80%	-	25.00%	25.80%	25.10%	36.20%	11.80%	-			
	Friends & Family Test (IP Survey) - % would recommend the Service	Contract	-	97.20%	98.10%	95.80%	95.83%	-	-	97.20%	98.10%	95.80%	95.83%	-			
	Friends & Family Test (IP Survey) - % would not recommend the Service	Contract	-	0.71%	0.60%	0.60%	2.08%		-	0.71%	0.60%	0.60%	2.08%				
	Friends & Family Test (Maternity Survey) - Response Rate	Contract	-	18.20%	-	-	18.20%	-	-	18.20%	-	-	18.20%	-			
	Friends & Family Test (Maternity) - % would recommend the Service	Contract	-	94.00%	-	-	94.00%	-	-	94.00%	-	-	94.00%	-			
	Friends & Family Test (Maternity) - % Would not recommend the Service	Contract	-	3.00%	-	-	3.00%		-	3.00%	-	-	3.00%				
	Friends and Family Test A & E Survey - Response Rate	Contract	15.00%	6.80%	-	6.80%	-	-	15.00%	6.80%	-	6.80%	-	-			
	Friends and Family Test A & E Survey - % would recommend the Service	Contract	-	90.70%	-	90.70%	-	-	-	90.70%	-	90.70%	-	-			
	Friends and Family Test A & E Survey - % would not recommend the Service	Contract	-	6.30%	-	6.30%	-		-	6.30%	-	6.30%	-				
	Friends and Family Test Community Survey - % would recommend the Service	Local	-	91.00%	-	-	-	91.00%	-	91.00%	-	-	-	91.00%			
	Friends and Family Test Community Survey - % would not recommend the Service	Local	-	6.00%	-	-	-	6.00%	-	6.00%	-	-	-	6.00%			
	Percentage of non-elective inpatients 75+ screened for dementia	CQUIN	90.00%	95.60%	-	-	-	-	90.00%	95.60%	-	-	-	-			

Calderdale and Huddersfield NHS Foundation Trust

Caring - Director of Nursing

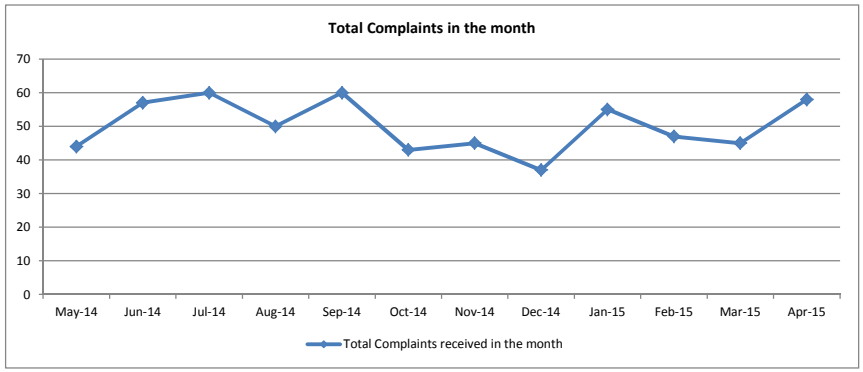
Report For: April 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Number of Mixed Sex Accommodation Breaches	0	0	0	0	0	-
% Complaints closed within target timeframe	100.00%	30.00%	58.00%	14.00%	22.00%	-
Total Complaints received in the month	-	58	15	21	14	-
Complaints acknowledged within 3 working days	100.00%	96.00%	-	-	-	-
Inpatient complaints per 1000 bed days	-	1.1	1.3	0.8	-	-
Total Concerns in the month	-	46	14	16	-	-
Nutrition and Hydration - Patient Satisfaction (reported quarterly)	75.00%	-	-	-		
Nutrition and Hydration - Reducing Hospital Food Waste (reported quarterly)	75.00%	-	-	-		
Nutrition and Hydration - Improving vending facilities (reported quarterly)	75.00%	-	-	-		

% Complaints closed within target time frame:

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.

Complaints acknowledged within 3 working days:

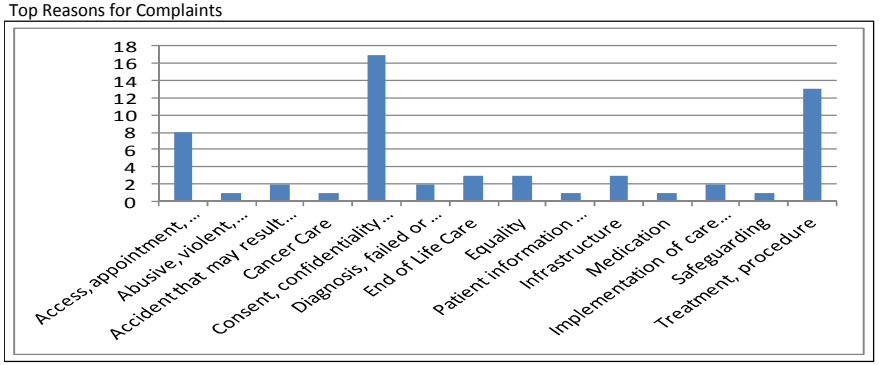
1. Why off plan: Performance slipped from 100% this month as the relocation of the department caused an exceptional delay in the process
2 .Actions to get back on plan: Resume normal processes
3. Achieved by date: May 2015



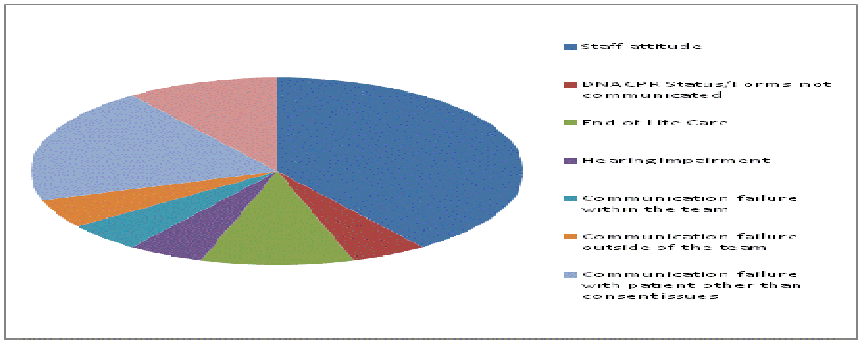
MONTH	Complaints Received		Variance	
	2013/14	2014/15	on year	on month
February	50	47	3	8
March	45	45	0	2
April	52	58	6	8

Complaints by Division and Severity	YELLOW	ORANGE	RED	Total
CORP	2	0	0	2
ESTATES	6	0	0	6
FSS	9	5	0	14
MEDICAL	11	8	2	21
SAS	8	4	3	15
Totals:	36	17	5	58

Top Reasons for Complaints



Distribution of Communication Issues



Caring - Director of Nursing

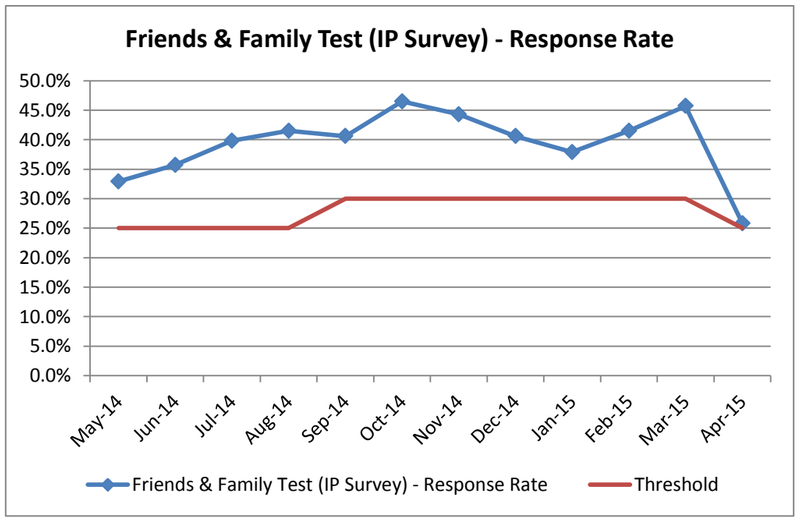
Report For: April 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Friends & Family Test (IP Survey) - Response Rate	25.00%	25.80%	25.10%	36.20%	11.80%	-
Friends & Family Test (IP Survey) - % would recommend the Service	-	97.20%	98.10%	95.80%	95.83%	-
Friends & Family Test (IP Survey) - % would not recommend the Service	-	0.71%	0.60%	0.60%	2.08%	
Friends & Family Test (Maternity Survey) - Response Rate	-	18.20%	-	-	18.20%	-
Friends & Family Test (Maternity) - % would recommend the Service	-	94.00%	-	-	94.00%	-
Friends & Family Test (Maternity) - % Would not recommend the Service	-	3.00%	-	-	3.00%	
Friends and Family Test A & E Survey - Response Rate	15.00%	6.80%	-	6.80%	-	-
Friends and Family Test A & E Survey - % would recommend the Service	-	90.70%	-	90.70%	-	-
Friends and Family Test A & E Survey - % would not recommend the Service	-	6.30%	-	6.30%	-	
Friends and Family Test Community Survey - % would recommend the Service	-	91.00%	-	-	-	91.00%
Friends and Family Test Community Survey - % would not recommend the Service	-	6.00%	-	-	-	6.00%
Percentage of non-elective inpatients 75+ screened for dementia	90.00%	95.60%	-	-	-	-

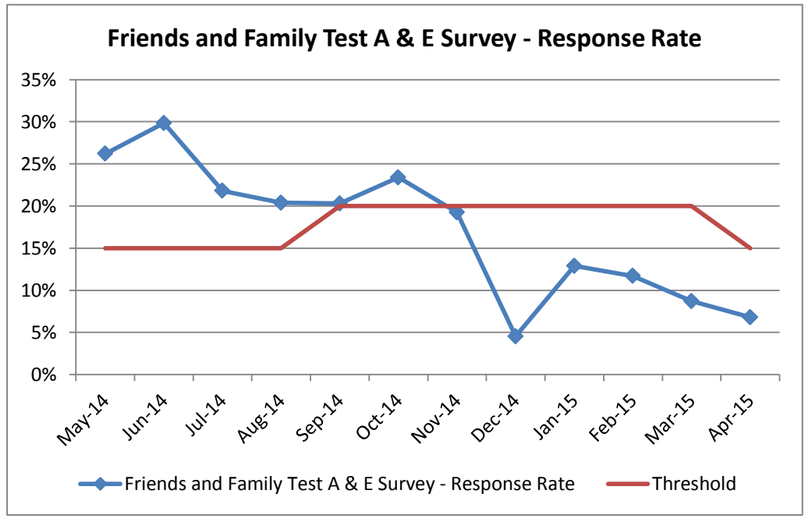
Friends and Family Test A & E Survey

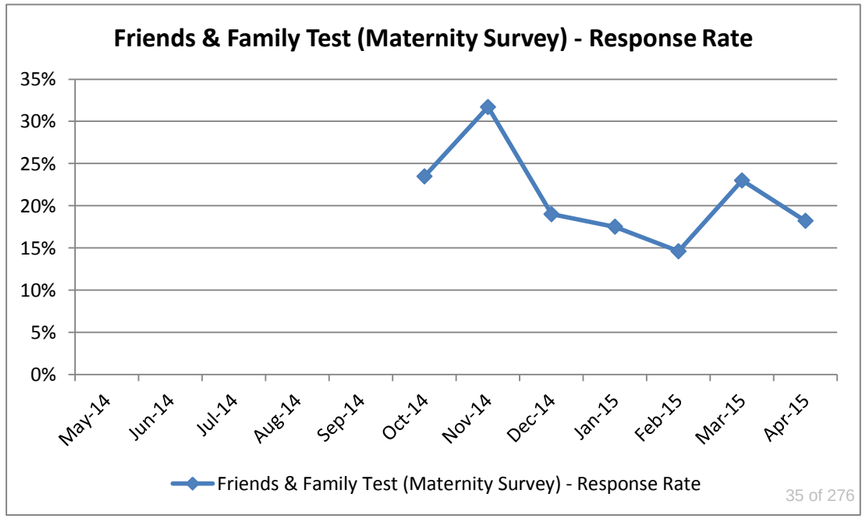
1. Why off plan: Ongoing work pressure in the A&E department appears to be making FFT difficult to deliver.

2 .Actions to get back on plan: Work continues to engage staff in the processes, from May 2015 key members of staff are given a quota of cards that they are to ensure are being a handed out and patient assisted with understanding the importance of completing the card. A new band 7 nurse has been given responsibility for patient experience on A&E and will be organising a visit to a local hospital to see how they are achieving higher response rates.

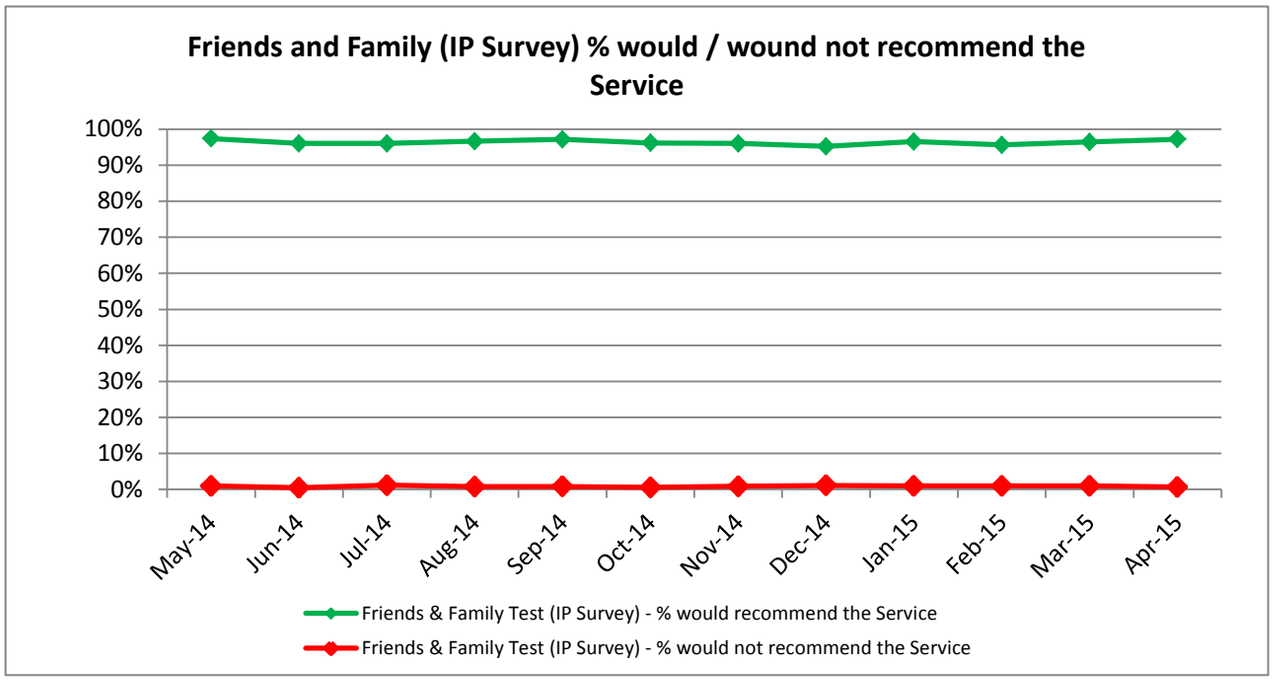
3. Achieved by date: Improvement in response rate expected to be seen next month. Visit to Stockport to take place in June 2015 to aid learning from others.

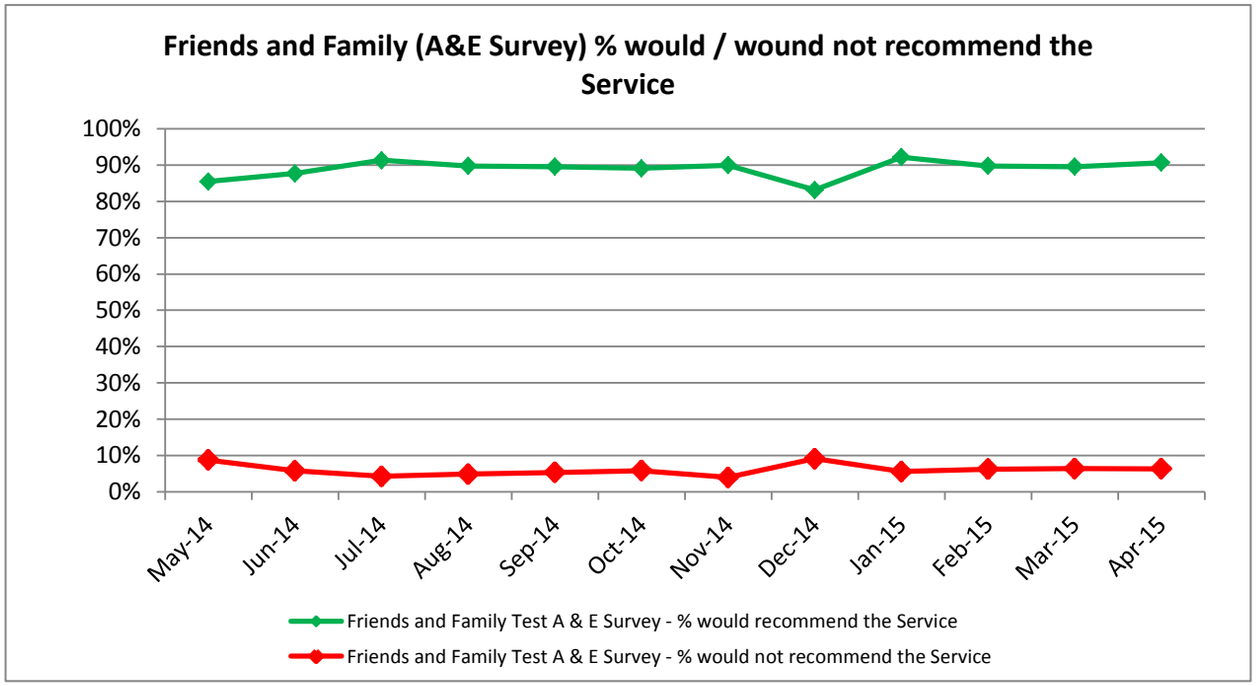


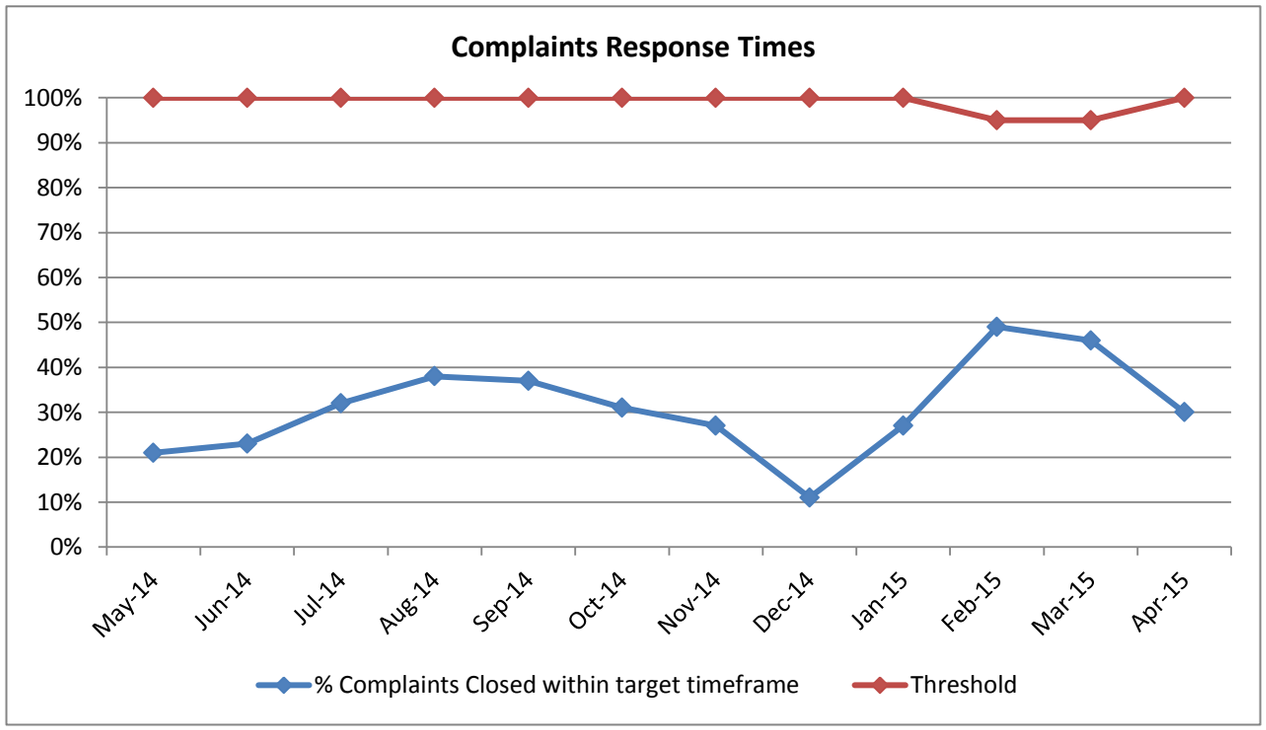


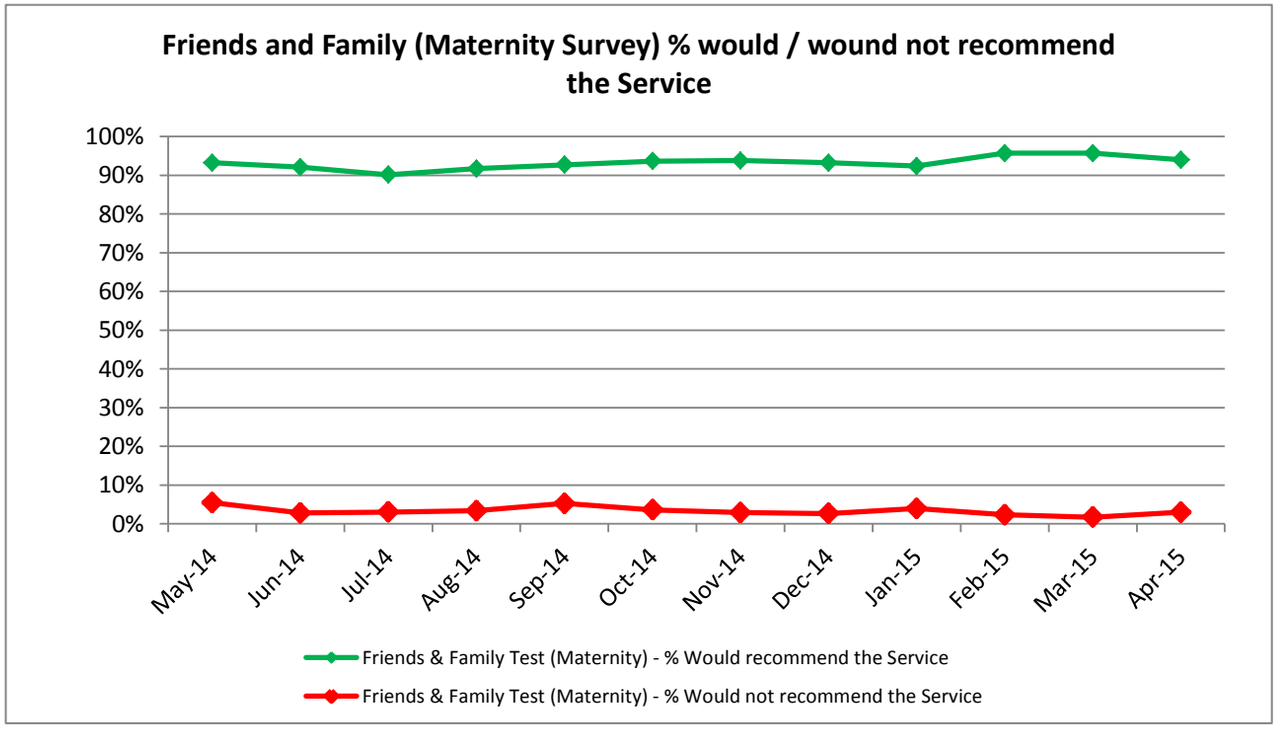


Caring - Director of Nursing









Calderdale and Huddersfield NHS
NHS Foundation Trust

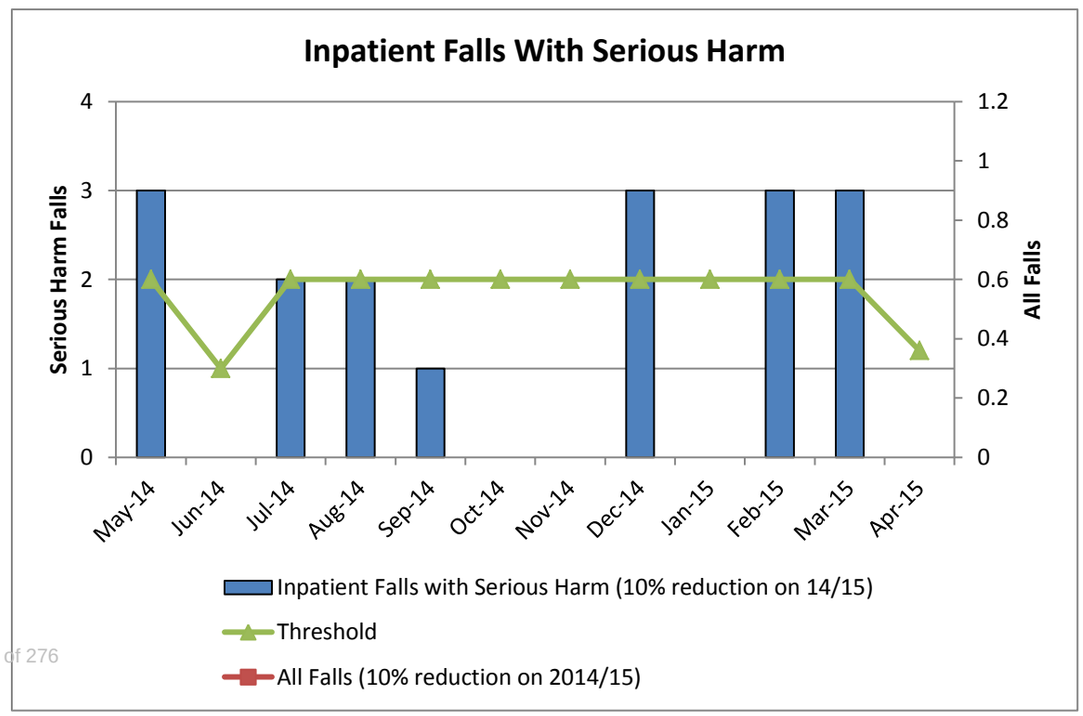
Safety Executive Summary - Julie Dawes Director of Nursing

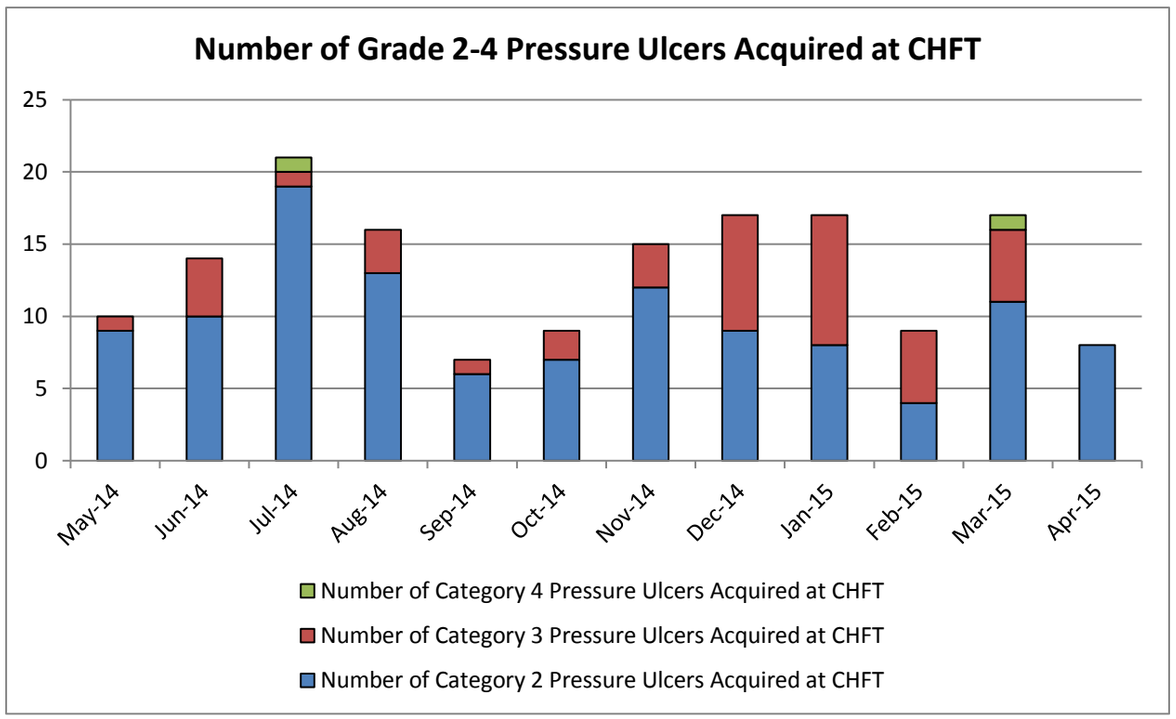
	Report For: April 2015	Indicator Source	Report For: April 2015 Target	Report For: April 2015 Trust	Report For: April 2015 Surgical	Report For: April 2015 Medical	Report For: April 2015 Families and Specialist Services	Report For: April 2015 Community	Year To Date Target	Year To Date Trust	Year To Date Surgical	Year To Date Medical	Year To Date Families and Specialist Services	Year To Date Community	Trend (Rolling 12 Month)	Year End Forecast	Data Quality
Safety	Inpatient Falls with Serious Harm (10% reduction on 14/15)	Local	1.2	0	0	0	0	-	14.4	0	0	0	0	-			
	All Falls	Local	-	194	35	155	4	-	-	194	35	155	4	-			
	Number of Trust Pressure Ulcers Acquired at CHFT	Local	16	11	3	8	0	-	189	11	3	8	0	-			
	Number of Category 2 Pressure Ulcers Acquired at CHFT	Local	11	8	0	8	0	-	127	8	0	8	0	-			
	Number of Category 3 Pressure Ulcers Acquired at CHFT	Local	0	0	0	0	0	-	0	0	0	0	0	-			
	Number of Category 4 Pressure Ulcers Acquired at CHFT	Local	0	0	0	0	0	-	0	0	0	0	0	-			
	Number of Category 3 & 4 Pressure Ulcers Acquired at CHFT	Local	0	0	0	0	0	-	0	0	0	0	0	-			
Safety 2	Percentage of Completed VTE Risk Assessments	National & Contract	95.00%	95.20%	94.70%	94.40%	97.60%	-	95.00%	95.20%	94.70%	94.40%	97.60%	-			
	Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	Local	100.00%	100.00%	100.00%	100.00%	100.00%	-	100.00%	100.00%	100.00%	100.00%	100.00%	-			
	% Harm Free Care	CQUIN	95.00%	93.87%	97.31%	89.47%	100.00%	94.81%	95.00%	93.87%	97.31%	89.47%	100.00%	94.81%			
	Safeguarding Alerts made by the Trust	Local	-	7	-	-	-	-	-	7	-	-	-	-			
	Safeguarding Alerts made against the Trust	Local	-	7	-	-	-	-	-	7	-	-	-	-			
	Improving Medicines Safety Discharge Accuracy Checks	CQUINS	55.00%	70.72%	-	-	-	-	55.00%	70.72%	-	-	-	-			
	Publication of Formulary	Contract	Yes or No	Yes	-	-	-	-	-	Yes	-	-	-	-			
	World Health Organisation Check List	National	100.00%	97.64%	-	-	-	-	100.00%	97.64%	-	-	-	-			
	Missed Doses (Reported quarterly)	National	10.00%	-	-	-	-	-	10.00%	-	-	-	-	-			
Safety 3	Number of Patient Incidents	Monitor	-	548	107	300	141	-	-	548	107	300	141	-			
	Number of SI's	Monitor	-	9	1	7	1	-	-	9	1	7	1	0			
	Number of Incidents with Harm	Monitor	-	159	26	102	31	0	-	159	26	102	31	0			
	Never Events	National	-	0	0	0	0	0	-	0	0	0	0	0			
	Percentage of SI's reported externally within timescale (2 days)	Local	100.00%	100.00%	100.00%	100.00%	100.00%	-	100.00%	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%	61.00%	100.00%	37.50%	100.00%	-	100.00%	61.00%	100.00%	37.50%	100.00%	-			
	Total Duty of Candour reported within the month	National & Contract	100%	87.50%	66.00%	100.00%	-	-	100%	87.50%	66.00%	100.00%	-	-			
	Total Duty of Candour outstanding at the end of the month	National & Contract	0	1	1	-	-	-	0	1	1	-	-	-			

Safety - Director of Nursing

Report For: April 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Inpatient Falls with Serious Harm (10% reduction on 14/15)	1	0	0	0	0	-
All Falls	-	194	35	155	4	-
Number of Trust Pressure Ulcers Acquired at CHFT	16	11	3	8	0	-
Number of Category 2 Pressure Ulcers Acquired at CHFT	11	8	0	8	0	-
Number of Category 3 Pressure Ulcers Acquired at CHFT	0	0	0	0	0	-
Number of Category 4 Pressure Ulcers Acquired at CHFT	0	0	0	0	0	-
Number of Category 3 & 4 Pressure Ulcers Acquired at CHFT	0	0	0	0	0	-

This month has seen us meet the target for both Pressure Ulcers and Falls. We believe this is a result of the actions that we have taken as described in previous reports.





Safety - Director of Nursing

Report For: April 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Percentage of Completed VTE Risk Assessments	95.00%	95.20%	94.70%	94.40%	97.60%	-
Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	100.00%	100.00%	100.00%	100.00%	100.00%	-
% Harm Free Care	95.00%	93.87%	97.31%	89.47%	100.00%	94.81%
Safeguarding Alerts made by the Trust	-	7	-	-	-	-
Safeguarding Alerts made against the Trust	-	7	-	-	-	-
Improving Medicines Safety Discharge Accuracy Checks	55.00%	70.72%	-	-	-	-
Publication of Formulary	Yes or No	Yes	-	-	-	-
World Health Organisation Check List	100.00%	97.64%	-	-	-	-
Missed Doses (Reported quarterly)	10.00%	-	-	-	-	-

VTE : **Why off plan :** The Trust target has been achieved. The Divisional failure to meet the target is likely to be related to the data collection method rather than a lack of compliance. **Actions to get it back to plan**: The introduction of the Nerve Centre Module will allow improved data collection. **Achieved by date**: This should be achieved by September 2015.

Harm Free Care:

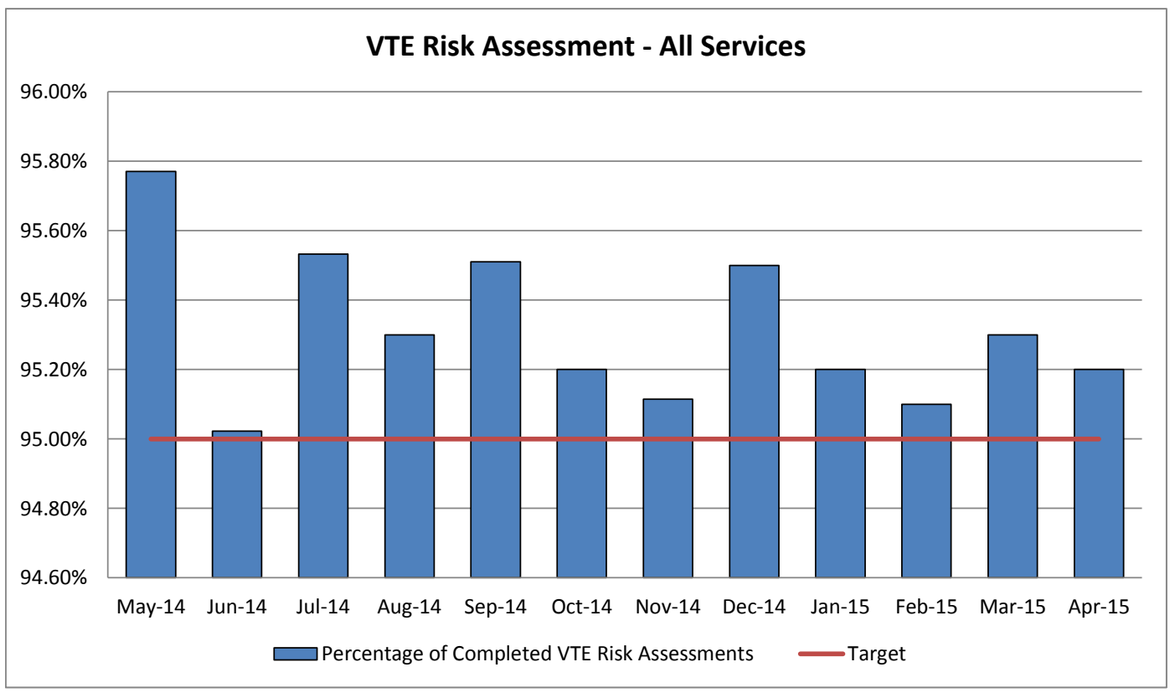
1. Why off plan? The target is based on a point prevalence audit completed every month, it is dependent on other improvement work in the Trust (Falls, Pressure Ulcers, Catheters and VTE) having the desired impact. As pressure ulcers make up the largest proportion of harm, reduction in ulcers will see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

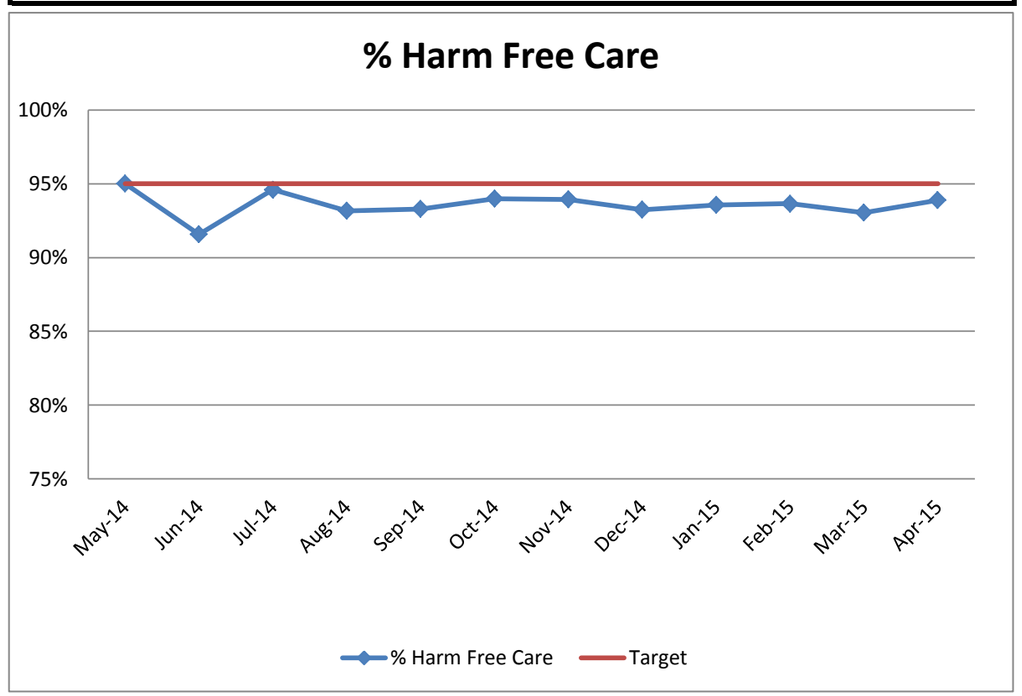
World Health Organisation Check List

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

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

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





Calderdale and Huddersfield NHS
NHS Foundation Trust

Safety - Director of Nursing

Report For: April 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Estates and Facilities	Corporate
Number of Patient Incidents	-	548	107	300	141	-	-	-
Number of SI's	-	9	1	7	1	-	-	-
Number of Incidents with Harm	-	159	26	102	31	0	-	-
Never Events	-	0	0	0	0	0	-	-
Percentage of SI's reported externally within timescale (2 days)	100.00%	100.00%	100.00%	100.00%	100.00%	-	-	-
Percentage of SI's investigations where reports submitted with timescale (45 days unless extension agreed)	100.00%	61.00%	100.00%	37.50%	100.00%	-	-	-
Total Duty of Candour reported within the month	100%	87.50%	66.00%	100.00%	-	-	-	-
Total Duty of Candour outstanding at the end of the month	0	1	1	-	-	-	-	-

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

1. Why off Plan: Of the 18 reports due for submission in April: CWF - 1 was submitted 1 day late. Medical - of the 16 due: 10 were submitted on time; 1 was 5 days late; 1 was 2 days late; 4 were 1 day late. SAS - 1 was submitted on time.

2. Action taken: The 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.

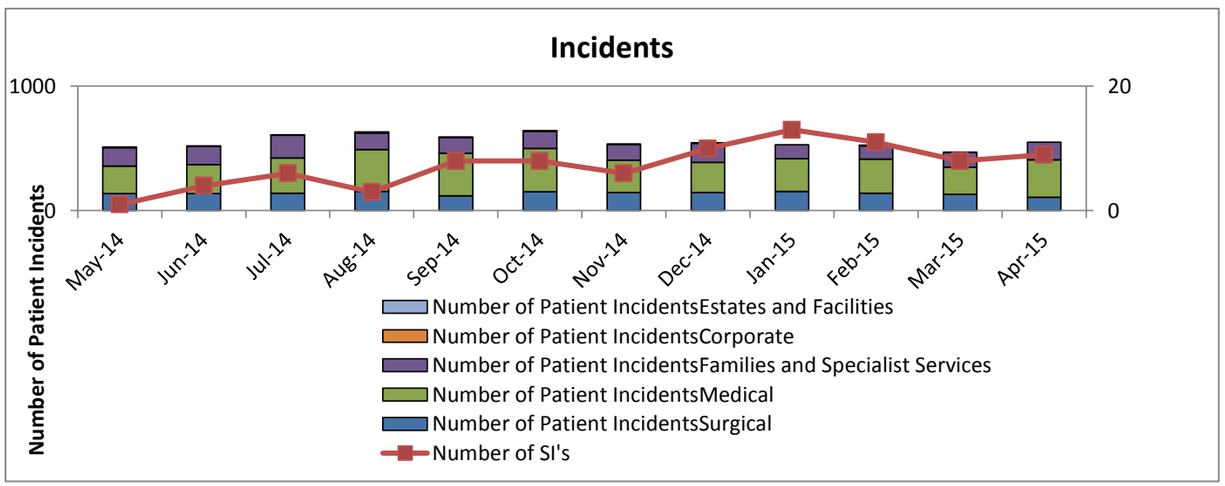
3.Achieved by: Ongoing

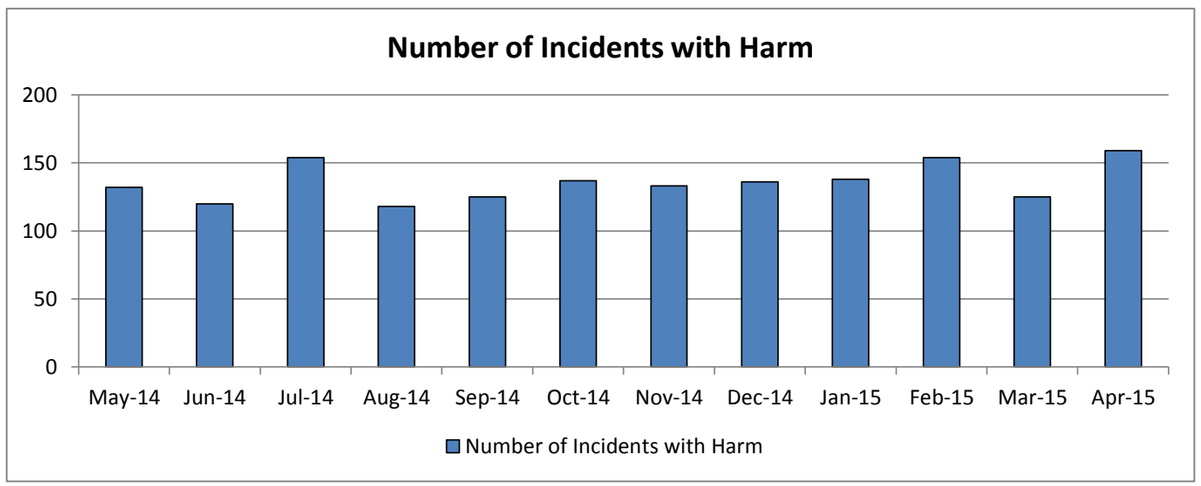
Total Duty of Candour reported within the month

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.
April data: There were 8 new incidents where Duty of Candour was required to be completed within April. Of these, we are still awaiting confirmation for 1 that the duty has been complied with.

2. Action taken: As at 8 April there were 29 incidents were Duty of Candour was outstanding, this has been reduced to 16. Introduction of a new DOC template letter in April has assisted with compliance. A meeting was held on 5 May 2015 with District Nursing staff to support them in understanding the requirements.

3. Achieved By: Ongoing - this will be monitored via the Serious Incident register.





Calderdale and Huddersfield NHS
NHS Foundation Trust

Effectiveness Executive Summary

	Report For: April 2015	Indicator Source	Report For: April 2015 Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Year To Date Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Monthl)	Year End Forecast	Data Quality
Effectiveness	Number of MRSA Bacteraemias – Trust assigned	National & Contract	0	1	0	1	0	-	0	1	0	1	0	-			
	Total Number of Clostridium Difficile Cases - Trust assigned	National & Contract	2	2	0	2	0	-	21	2	0	2	0	-			
	Avoidable number of Clostridium Difficile Cases	National & Contract	0	1	0	1	0	-	21	1	0	1	0	0			
	Unavoidable Number of Clostridium Difficile Cases	National & Contract	2	1	0	1	0	-	21	1	0	1	1	-			
	Number of MSSA Bacteraemias - Post 48 Hours	National	1	0	0	0	0	-	12	0	0	0	0	-			
	% Hand Hygiene Compliance	Local	95.00%	99.74%	99.49%	99.80%	100.00%	100.00%	95.00%	99.74%	99.49%	99.80%	100.00%	100.00%			
	MRSA Screening - Percentage of Inpatients Matched	Local	95.00%	96.73%	95.63%	99.17%	97.37%	-	95.00%	96.06%	94.72%	98.99%	97.91%	-			
	Number of E.Coli - Post 48 Hours	Local	2	1	0	1	0	-	29	1	0	1	0	-			
	Central Line Infection rate per 1000 Central Venous Catheter days	Local	1.50	1.37	2.75	0.00	0.00	-	1.50	1.37	2.75	0.00	0.00	-			
Effectiveness 2	Emergency Readmissions Within 30 Days (With PbR Exclusions)	National	8.00%	7.60%	4.50%	11.80%	7.60%	-	8.00%	7.60%	4.50%	11.80%	7.60%	-			
	Local SHMI - Relative Risk (1yr Rolling Data Oct 13- Sept 14)	National	100	109	-	-	-	-	100	109	-	-	-	-			
	Hospital Standardised Mortality Rate (1 yr Rolling Data Mar 14 - Feb 15)	National	100	108.53	-	-	-	-	100.00	106.78	-	-	-	-			
	Mortality Reviews	local	100.00%	69.80%	66.70%	70.10%	-	-	100.00%	69.80%	66.70%	70.10%	-	-			
	Crude Mortality Rate (Latest Month April 15)	National	1.00%	1.62%	0.64%	4.06%	0.13%	-	1.00%	1.62%	0.64%	4.06%	0.13%	-			
	Completion of NHS numbers within acute commissioning datasets submitted via SUS	Contract	99.00%	99.90%	99.90%	99.90%	99.90%	-	99.00%	99.90%	99.90%	99.90%	99.90%	-			
	Completion of NHS numbers within A&E commissioning datasets submitted via SUS	Contract	95.00%	99.10%	-	99.10%	-	-	95.00%	99.10%	-	99.10%	-	-			
	Average Diagnosis per Coded Episode	National	4.9	3.97	3.44	5.66	2.27	-	4.9	3.97	-	5.66	2.27	-			
	Acute Kidney Injury (Reported quarterly)	CQUINS	90.00%	-	-	-	-	-	90.00%	-	-	-	-	-			
	Sepsis Screening (Reported quarterly)	CQUINS	90.00%	-	-	-	-	-	90.00%	-	-	-	-	-			
	Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	National	85.00%	59.57%	59.57%	-	-	-	85.00%	59.57%	59.57%	-	-	-			

Effectiveness - Medical Director

Report For: April 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Number of MRSA Bacteraemias – Trust assigned	0	1	0	1	0	-
Total Number of Clostridium Difficile Cases - Trust assigned	2	2	0	2	0	-
Avoidable number of Clostridium Difficile Cases	0	1	0	1	0	-
Unavoidable Number of Clostridium Difficile Cases	2	1	0	1	0	-
Number of MSSA Bacteraemias - Post 48 Hours	1	0	0	0	0	-
% Hand Hygiene Compliance	95.00%	99.74%	99.49%	99.80%	100.00%	100.00%
MRSA Screening - Percentage of Inpatients Matched	95.00%	96.73%	95.63%	99.17%	97.37%	-
Number of E.Coli - Post 48 Hours	2	1	0	1	0	-
Central Line Infection rate per 1000 Central Venous Catheter days	1.50	1.37	2.75	0.00	0	-

MRSA Bacteraemia

1. Why off plan? Sepsis likely to have occurred from pneumonia acquired from endogenous flora, investigation concluded this there was no lapse in care that contributed to the case.

2. Actions to get back on plan: ANTT training and competency assessments need to be completed by all frontline staff in a timely manner
IC training (Beyond the Basics) for all ward staff

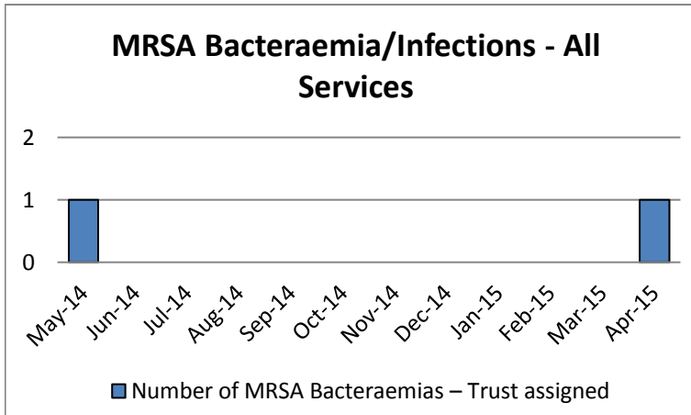
3. Achieved by: To be discussed within team on 14th May 2015 and monitored monthly via HCAI Dashboard

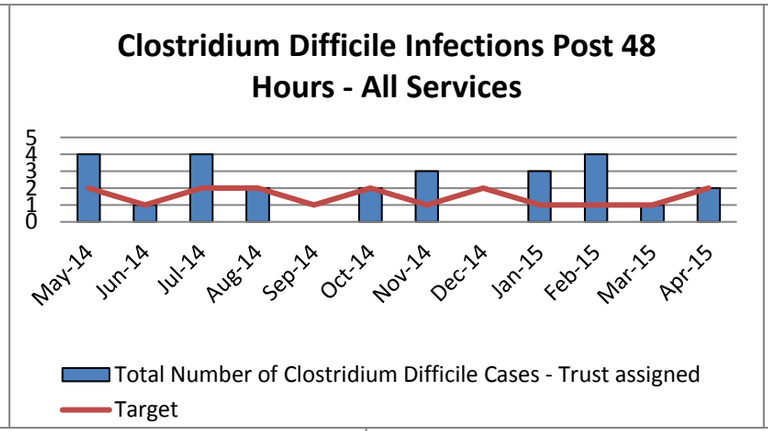
Avoidable number of Clostridium Difficile Cases

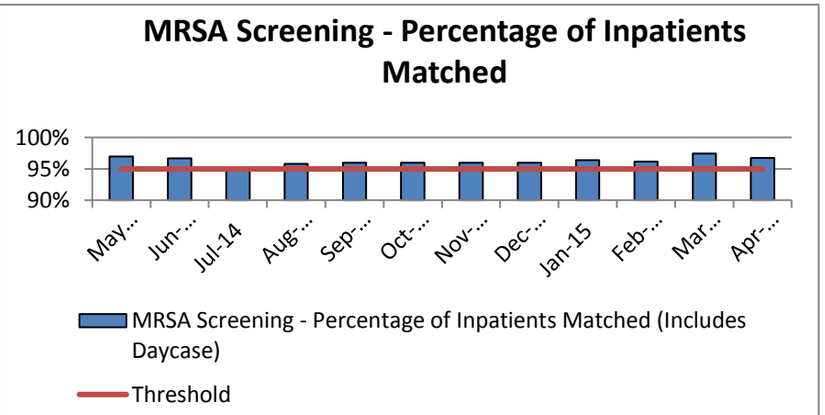
1. Why off plan? C.difficile – one cases agreed as avoidable due to likely contamination from cleaning issues

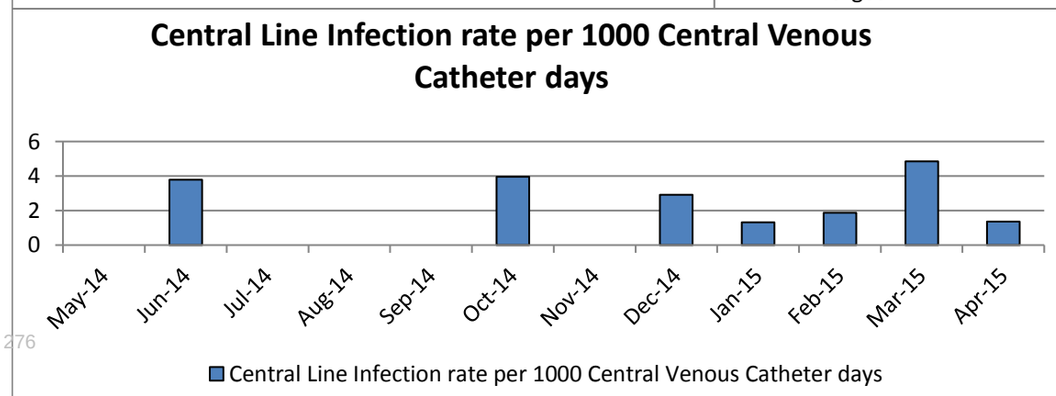
2. Actions to get back on plan: Additional training Infection prevention and control training has been provided for both the ward and the cleaning staff.

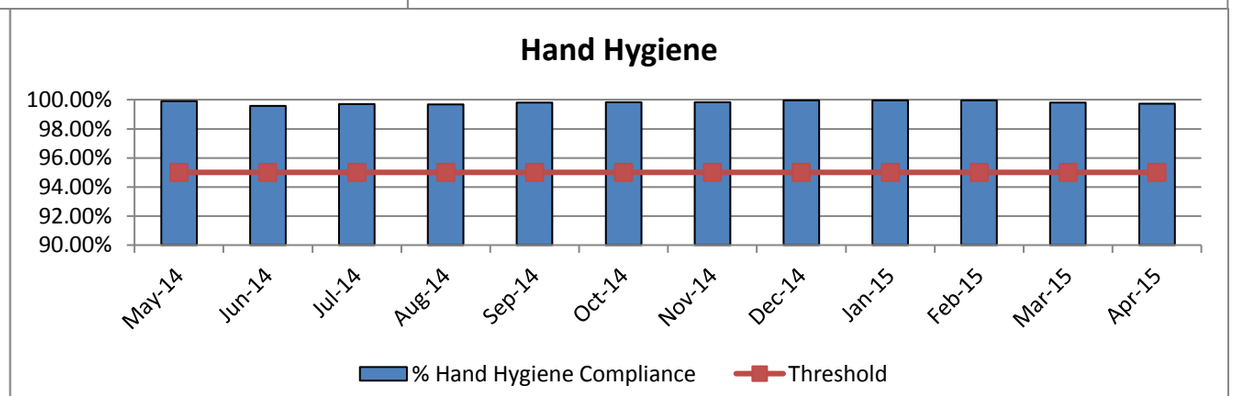
3. Achieved by: Completed.











Calderdale and Huddersfield NHS
NHS Foundation Trust

Effectiveness - Medical Director

Report For: April 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Emergency Readmissions Within 30 Days (With PbR Exclusions)	8.00%	7.60%	4.50%	11.80%	7.60%	-
Local SHMI - Relative Risk (1yr Rolling Data Oct 13- Sept 14)	100	109	-	-	-	-
Hospital Standardised Mortality Rate (1 yr Rolling Data Mar 14 - Feb 15)	100	108.53	-	-	-	-
Crude Mortality Rate (Latest Month April 15)	1.00%	1.62%	0.64%	4.06%	0.13%	-
Mortality Reviews	100.00%	69.80%	66.70%	70.10%	-	-
Completion of NHS numbers within acute commissioning datasets submitted via SUS	99.00%	99.90%	99.90%	99.90%	99.90%	-
Completion of NHS numbers within A&E commissioning datasets submitted via SUS	95.00%	99.10%	-	99.10%	-	-
Average Diagnosis per Coded Episode	4.9	3.97	3.44	5.66	2.27	-

SHMI/HSMR/Crude Mortality

1. Why it is off plan? The most recent release indicated a SHMI of 109 the 12 months of Oct 13 to Sept 14. This has reduced from the 110 published in June 13 - July 14 but is still higher than target. The most recent 12 months data for HSMR indicates a score of 108.53, which is a slight increase from previous release. April crude mortality was also higher than target. The number of mortlaity reviews carried out in February is under target.

2.Action to get back on plan: A review of the Care of the Acutely ill Patient (CAIP) programme will take place at the end of May 2015, one of the key intervention centres on the reliable implementation of care bundles and will be a feature of any future work given evidence suggests this will likley have a positive impact on improving patient outcomes. Works continues on the Mortlaity review process and lesson learnt are being fedback to the appropriate forums and clinical teams.

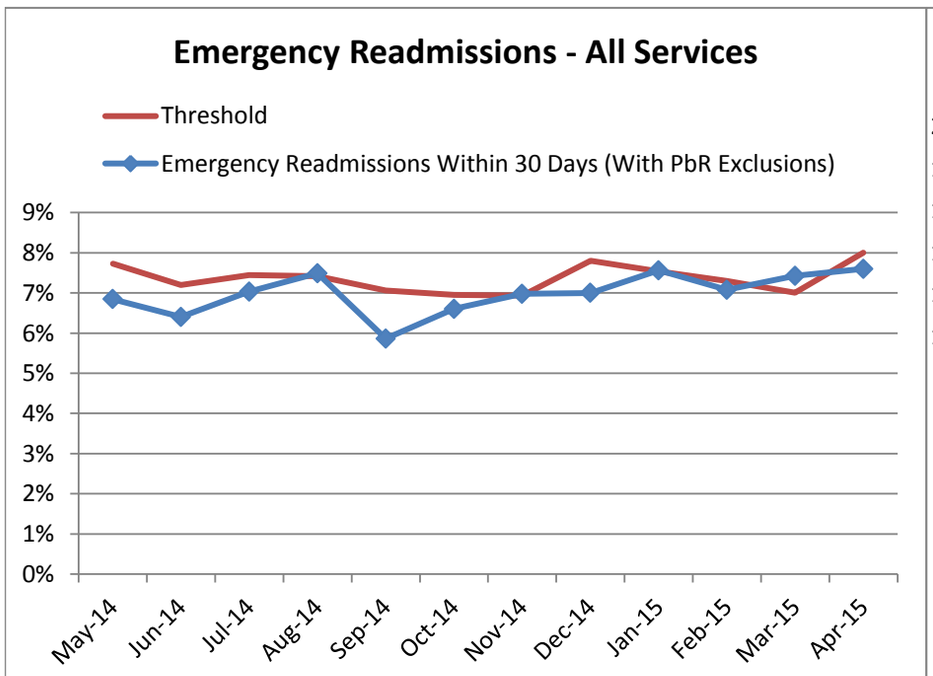
3.Achieved By: The Care of the Acutely Ill Patient programme is being reviewed at the end of May 2015

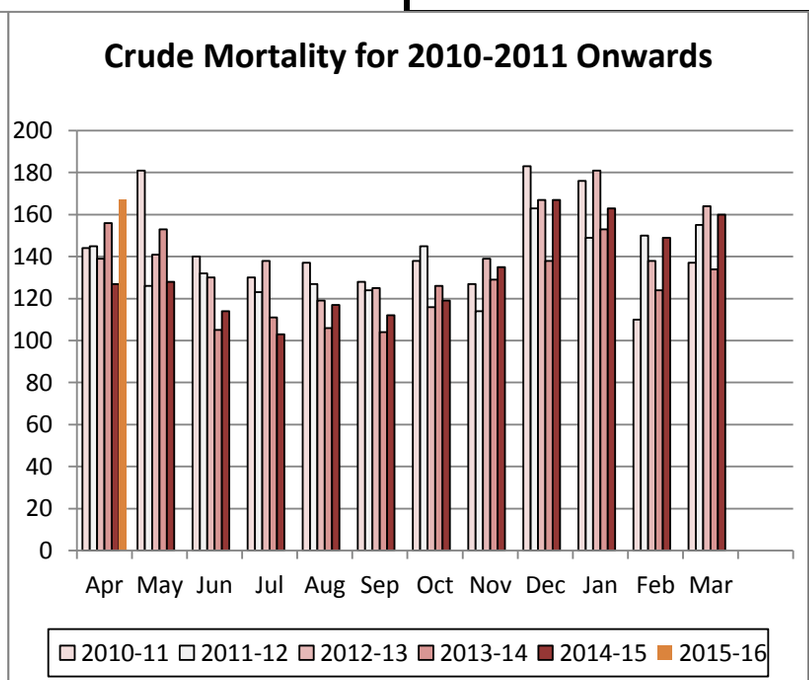
Average Diagnosis per Coded Episode

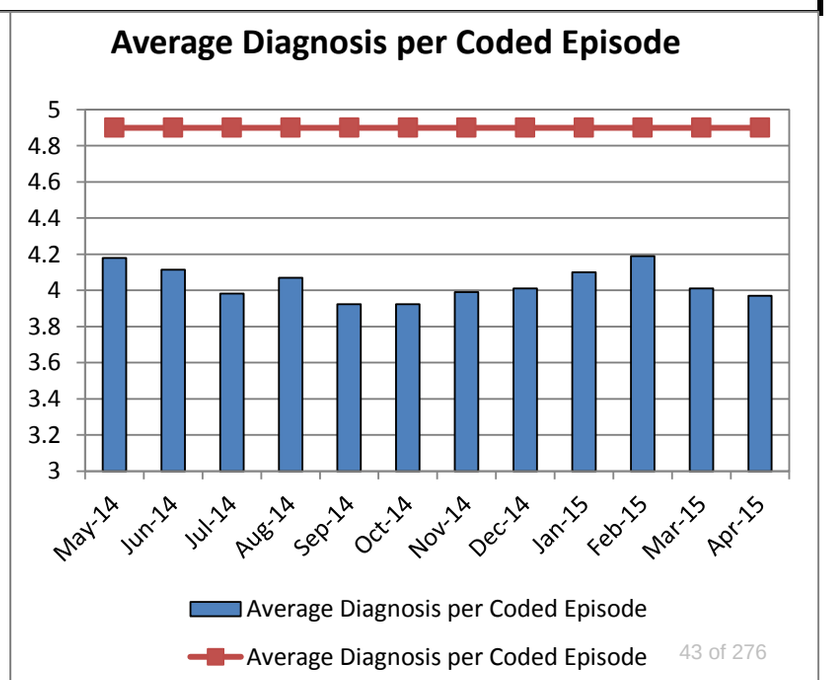
1. Why off plan? CHFT depth of coding is less than plan due to missed or undocumented relevant comorbidities within the coding source documentation. May also be due to incomplete coding documentation at the time of coding.

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



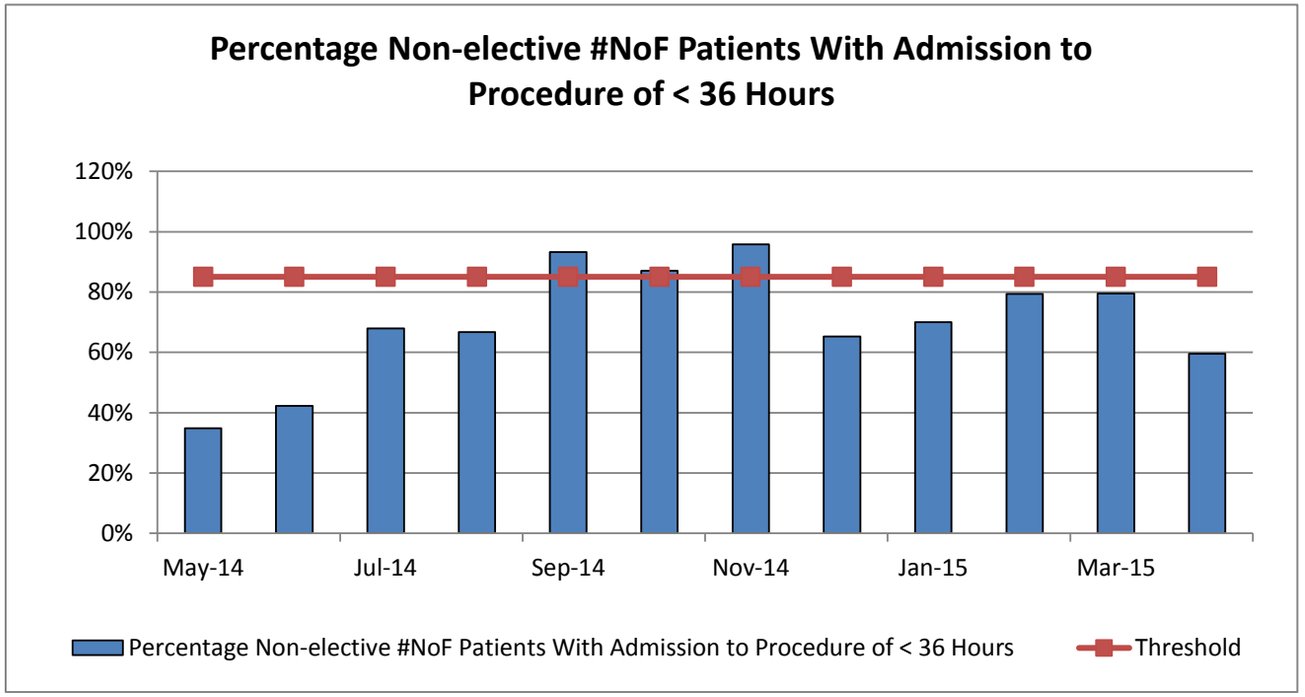




Calderdale and Huddersfield NHS
NHS Foundation Trust

Effectiveness - Medical Director

Report For: April 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Acute Kidney Injury (Reported quarterly)	90.00%	-	-	-	-	-
Sepsis Screening (Reported quarterly)	90.00%	-	-	-	-	-
Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	85.00%	59.57%	59.57%	-	-	-



Non-Elective #NOF

1.Why off plan? On April the 22nd we received 10 patients with #NOF within the space of 24 hours. This is unprecedented. This was on a backdrop of 53 admissions. It took the rest of the month to recover from the surge in admissions.

2. Actions to get back on plan: The Directorate made a decision to cancel elective activity in order to recover some control of the patients who were in need of trauma procedures. Dropped Theatres have been identified and where possible converted to Laminar Trauma Theatres, the rota team have been asked to ensure that the middle grade support is capable of running a theatre with consultant support.

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

Elective activity was cancelled. An extra theatre in alternate weeks has now been identified as far as August.

Well Led / Workforce - Director of Workforce and Organisational Development

Calderdale and Huddersfield NHS
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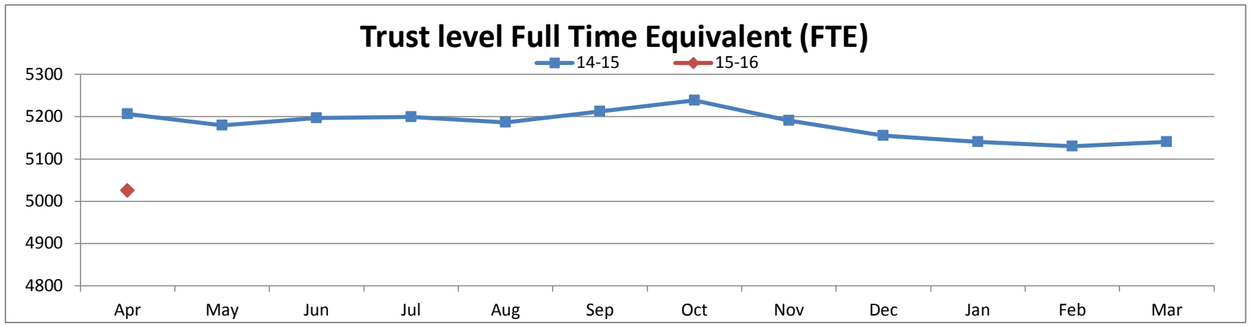
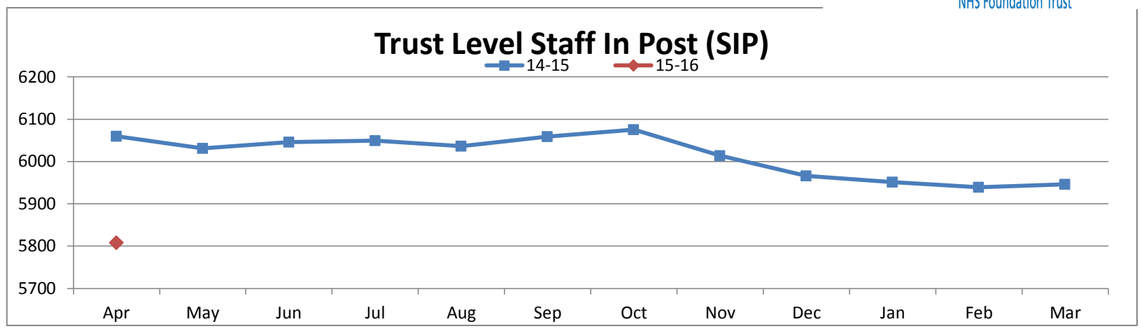
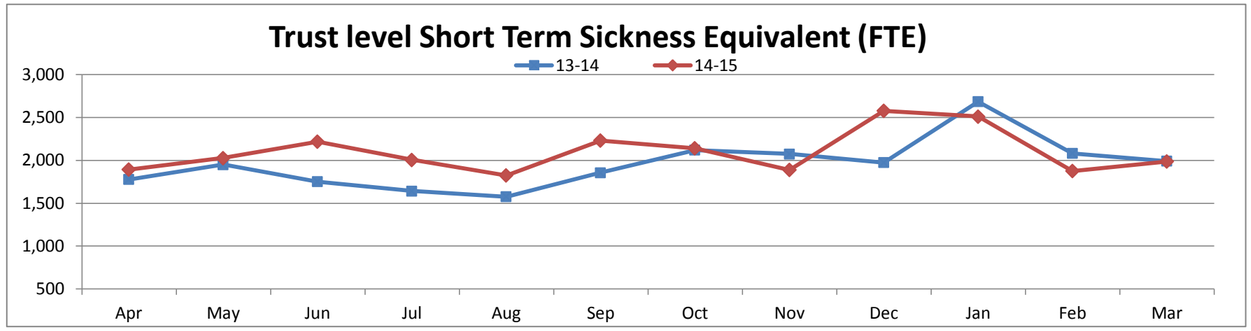
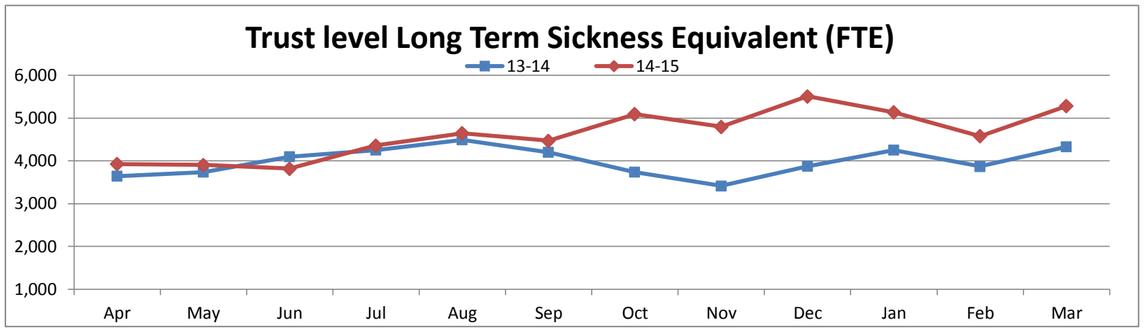








Director Lead	Report For: April 2015	Trust Threshold	Trust Actual	Surgery	Medical	CWF	DATS	Estates	Corporate	THIS
J.H	Sickness Absence rate (%) (1 Month Behind)	4.00%	4.56%	4.33%	5.00%	5.85%	2.66%	6.35%	1.72%	4.99%
J.H	Sickness Short Term Absence rate (%) (1 Month Behind)		1.25%	1.15%	1.46%	1.33%	1.18%	1.18%	0.77%	0.78%
J.H	Sickness Long Term Absence rate (%) (1 Month Behind)		3.31%	3.17%	3.54%	4.53%	1.48%	5.17%	0.94%	4.21%
J.H	Sickness Absence rate (FTE Lost) (1 Month Behind)		7267.97	1821.32	2498.09	1420.06	522.54	569.09	152.77	284.10
J.H	FTE Days Available (1 Month Behind)		159495.31	42106.96	49940.69	24265.72	19625.83	8959.33	8907.21	5689.57
J.H	Sickness Average FTE Lost per Episode		9.38	10.01	9.29	10.14	6.45	11.16	5.66	11.36
J.H	Sickness Absence rate (%) (YTD - Apr14-Mar15)	4.00%	4.26%	4.43%	4.85%	4.67%	3.20%	4.83%	1.61%	2.90%
J.H	Sickness Absence rate (FTE Lost) (YTD - Apr14-Mar15)		80633.76	21767.51	29017.70	13494.76	7355.71	5283.62	1647.23	2067.24
J.H	FTE Days Available (YTD - Apr14-Mar15)		1891113.54	490842.37	598626.59	288937.75	229712.82	109360.08	102471.21	71162.71
J.H	Sickness Average FTE Lost per Episode (YTD - Apr14-Mar15)		12.16	13.40	12.90	12.99	9.31	10.39	7.76	9.89
JH	Total Staff in Post (FTEs)		5,023.69	1,338.29	1,590.80	743.01	618.19	282.48	271.15	179.77
LH	Fire Safety Awareness	95.00%	87.60%	82.60%	82.70%	91.00%	97.80%	99.50%	88.60%	95.70%
LH	Fire Risk Assessments	95.00%	74% Audited							
MG	Information Governance - Rolling 12 Month	95.00%	75.90%	63.40%	75.90%	74.30%	88.20%	97.10%	76.60%	93.70%
JD	Risk Training - Rolling 12 Month	95.00%	75.50%	61.90%	78.30%	75.90%	81.50%	97.10%	75.60%	89.70%
JH	Appraisal Non Medical - YTD	100.00%	1.50%	4.30%	0.10%	0.70%	1.90%	0.00%	0.70%	2.30%
JH	Appraisal Non Medical - Rolling 12 Month (May14-Apr15)	100.00%	79.44%	65.03%	74.46%	91.52%	92.43%	96.41%	83.16%	78.45%
DB	Appraisal Medical - YTD	100.00%	1.62%	2.60%	1.20%	0.00%	0.00%	-	0.00%	-
DB	Appraisal Medical - Rolling 12 Month (May14-Apr15)	100.00%	80.13%	75.64%	85.71%	85.00%	86.21%	-	50.00%	-
DB	Medical devices training	95.00%	80.00%	74.00%	75.00%	80.00%	78.00%	-	92.00%	-
JD	Safeguarding - Level 1 - Staff compliant		75.50%	61.90%	78.30%	75.90%	81.50%	97.10%	75.60%	89.70%
JD	Safeguarding - Level 2 - Staff compliant		55.00%	58.00%	63.90%	27.10%	57.90%	97.20%	66.70%	0.00%
JD	Safeguarding - Level 3 - Staff Compliant		77.10%	55.40%	80.80%	79.50%	33.30%	-	100.00%	-
JH	FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly)		78.00%							
JH	FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly)		54.00%							
JD	Hard Truths Summary Day - Nurses/Midwives (1 Month Behind)	100.00%	83.1%	84.9%	79.4%	90.7%				
JD	Hard Truths Summary - Day Care Staff (1 Month Behind)	100.00%	101.3%	99.3%	104.2%	90.4%				
JD	Hard Truths Summary - Night Nurses/Midwives (1 Month Behind)	100.00%	88.5%	84.9%	90.3%	89.2%				
JD	Hard Truths Summary - Night Care Staff (1 Month Behind)	100.00%	118.3%	114.2%	128.0%	84.3%				

Please note the format of the Well Led slide and narrative will change with effect from 1 June 2015. Following the introduction of the revised approach to mandatory training, an overall measure will be provided of mandatory training compliance and compliance with each of the 10 elements will be identified.

Sickness Absence/Attendance Management at work
Why are we away from plan - Corporate and DATS are the only divisions with a % below the 4% threshold identified . Short term sickness absence for the Trust is at 1.25% long term absence at 3.31% . The March 2015 figure compares to a March 2014 figure of 1.32% short term absence and long term absence of 2.29%. The 2014-15 outturn sickness rate of 4.26% compares to a 2013-14 outturn sickness rate of 3.84%.
Action to get on Plan - Sickness absence deep dive May/June 2015, Attendance Management Policy update April/May 2015, enhanced line manager resource tool kit May/June 2015 , line manager break through sessions/ briefings from May 2015, ESR BI roll out from May 2015, Health and Wellbeing strategy development from April 2015, staff survey action plan May 2015

Appraisal
Why are we away from plan - low numbers of appraisal anniversary dates in early part of the year as a result of activity programmed in Q4 in previous years, absence of appraisal activity plans which spread activity across a 12-month period and / or non-delivery of appraisal activity plans
Action to get on Plan - The development of appraisal activity plans for 2015 / 2016 which ensure that activity is not concentrated in the last quarter or the last month of the year, maintenance of appraisal resources and continued month by month performance management of appraisal activity.
NB: ESR is the only accepted reporting tool for appraisal compliance. The deadline for inputting appraisal activity data each month is 1st working day of month for previous month's appraisals. Activity recorded after this data will only be included in compliance reports in the following month.

Medical Devices
Medical Devices Training is currently at 80% compliance across the Trust.
Action to get on Plan - (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

Information Governance
Action to get on Plan - (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 April 2015, seven ward areas had an average fill rate lower than 75% for Qualified nurses / Midwives in the day.
There were no areas with an average fill rate lower than 75% for Qualified nurses / Midwives at night.
The main reason for reduced fill rates in April 2015 are: vacancies, short term sickness and supporting additional capacity . We continue to transfer nurses within the trust to maintain safe staffing levels on additional capacity areas which has reduced the fill rate on their own ward which has been the case on Ward 21.
The overall average fill rates by site have been above 80% on both sites for qualified nurses / midwives on both days and nights.
Weekly staffing hotspot meetings have continued with the flexible workforce department prioritising staffing requests to the areas identified as being most in need.
Action to get on plan
Robust recruitment has continued. 60 students due to qualify in September have had substantive posts offered to them. The Nursing Workforce Team are tracking the recruitment process with the resourcing team to improve the time from recruitment to start date.
The Nursing Workforce Team are working with The Health Informatics Service to develop ward dashboards ,which will analyse key quality and outcome measures .
Contact time study is due to be completed on 4th June to identify direct and indirect patient contact time which will inform future staffing reviews.
Acuity and Dependency studies will also be repeated for 4 weeks from 18th May which inform future staffing reviews.
We are promoting the reporting of Red Flag safe staffing nursing and midwifery events and working with our colleagues in risk to ensure reporting is as efficient as possible utilising the DATIX system.
When
The Trust expect to see increased fill rates as additional capacity is reduced.

YTD Performance

		Trust Threshold	Trust Actual
Finance	Continuity of Service Risk Rating	2	2
	Operational Performance (Debt service cover)	1	1
	Cash & Balance Sheet Performance (Liquidity)	2	2
	Use of Capital	£1.13m	£1.13m
	Income and Expenditure	(£2.76m)	(£2.75m)
	Cost Improvement Programme (CIP)	£0.62m	£0.72m

Calderdale and Huddersfield NHS
NHS Foundation Trust

Contract income

		Year To Date Plan		Year To Date Actual		Year To Date Variance	
Division	**Monitor POD**	**Plan YTD - Spells**	**Plan YTD - Value (Inc MFF)**	**Actual 1415 - Spells**	**Actual 1516 -Value (Inc MFF)**	**Variance - Spells**	**Variance - Value (Inc MFF) with CQUIN**
CWF	DAYCASE	160	109,565	155	110,029	-5	463
	ELECTIVE	78	135,521	91	142,420	13	6,898
	NON-ELECTIVE	1,198	1,419,542	1,174	1,389,519	-24	-30,023
	OTHER NHS NON-TARIFF	3,645	1,661,981	3,663	1,702,602	18	40,621
	OTHER NHS TARIFF	1,267	880,589	1,204	895,215	-63	14,627
	OUTPATIENT	3,277	496,156	3,534	528,104	257	31,948
	CQUIN	0	104,097	0	107,117	0	3,020
CWF Total		9,625	4,807,451	9,821	4,875,005	196	67,555
DATs	DAYCASE	24	21,603	23	25,595	-1	3,992
	ELECTIVE	24	36,284	27	47,308	3	11,023
	NON-ELECTIVE	0	127	0	-5	-0	-132
	OTHER NHS NON-TARIFF	111,906	655,838	113,320	657,536	1,415	1,698
	OTHER NHS TARIFF	5,627	499,559	5,148	459,345	-479	-40,214
	OUTPATIENT	0	0	0	0	0	0
	CQUIN	0	29,091	0	28,481	0	-610
DATs Total		117,580	1,242,502	118,519	1,218,260	939	-24,241
Medicine	A&E	12,112	1,273,922	12,266	1,310,933	154	37,011
	DAYCASE	860	423,488	818	399,656	-42	-23,831
	ELECTIVE	82	174,513	74	144,431	-8	-30,081
	NON-ELECTIVE	2,086	3,423,034	2,223	3,887,056	137	464,021
	OTHER NHS NON-TARIFF	5,627	2,186,452	5,319	2,237,201	-308	50,749
	OTHER NHS TARIFF	1,005	249,618	1,159	289,038	154	39,420
	OUTPATIENT	7,405	979,151	7,785	1,010,799	380	31,648
	CQUIN	0	186,548	0	202,821	0	16,273
Medicine Total		29,177	8,896,726	29,643	9,481,936	466	585,210
Surgery	DAYCASE	2,306	1,633,575	2,249	1,608,210	-57	-25,365
	ELECTIVE	507	1,374,010	474	1,218,742	-33	-155,268
	NON-ELECTIVE	752	1,687,091	655	1,511,657	-97	-175,433
	OTHER NHS NON-TARIFF	2,409	927,211	2,446	1,073,822	37	146,611
	OTHER NHS TARIFF	1,417	145,988	1,476	145,505	59	-483
	OUTPATIENT	15,608	1,675,564	15,689	1,695,363	81	19,799
	CQUIN	0	180,827	0	174,215		-6,612
Surgery Total		22,998	7,624,266	22,989	7,427,515	-9	-196,751
Community	OTHER NHS NON-TARIFF	1,372	1,517,186	1,178	1,511,385	-194	-5,801
	CQUIN	0	41,181	0	37,785		-3,396
Community Total		1,372	1,558,367	1,178	1,549,170	-194	-9,197
Corporate	OTHER NHS NON-TARIFF	0	17,352	0	17,352	0	0
	CQUIN	0	423	0	434		11
Corporate Total		0	17,775	0	17,786	0	11
Ops & Facilities	OTHER NHS NON-TARIFF	0	42,452	0	42,452	0	0
	CQUIN	0	1,034	0	1,061		27
Ops & Facilities Total		0	43,487	0	43,514	0	27
Central	NON-ELECTIVE	0	0	0	0		
	OTHER NHS NON-TARIFF	4	44,564	76	25,752	72	-18,812
	OTHER NHS TARIFF	0	-11,277	0	-11,277		
	CQUIN	0	287	0	-47		-334
Central Total		4	33,575	76	14,429	72	-19,146
Grand Total		**180,756**	**24,224,148**	**182,226**	**24,627,614**	**1,469**	**403,466**

Trust Financial Overview as at 30th Apr 2015 - Month 1

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

YEAR TO DATE POSITION: M01

CLINICAL ACTIVITY

	M01 Plan	M01 Actual	Var
Elective	691	666	(25)
Non Elective	4,037	4,052	15
Daycase	3,349	3,245	(104)
Outpatients	26,290	27,008	718
A & E	12,112	12,266	154

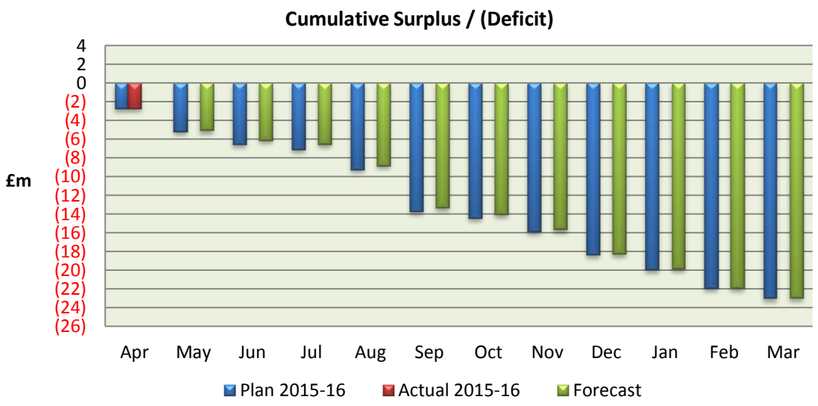
TRUST: INCOME AND EXPENDITURE

	M01 Plan	M01 Actual	Var
	£m	£m	£m
Elective	£1.72	£1.55	(£0.17)
Non Elective	£6.53	£6.79	£0.26
Daycase	£2.19	£2.14	(£0.04)
Outpatients	£3.15	£3.23	£0.08
A & E	£1.27	£1.31	£0.04
Other-NHS Clinical	£9.40	£9.66	£0.26
CQUIN	£0.54	£0.56	£0.02
Other Income	£2.98	£2.85	(£0.13)
Total Income	**£27.79**	**£28.10**	**£0.31**
Pay	(£18.64)	(£18.78)	(£0.14)
Drug Costs	(£2.45)	(£2.57)	(£0.12)
Clinical Support	(£2.52)	(£2.42)	£0.10
Other Costs	(£3.83)	(£3.98)	(£0.15)
PFI Costs	(£0.99)	(£0.98)	£0.01
Total Expenditure	**(£28.43)**	**(£28.73)**	**(£0.30)**
EBITDA	**(£0.64)**	**(£0.63)**	**£0.01**
Non Operating Expenditure	(£2.12)	(£2.11)	£0.00
Deficit excl. Restructuring	**(£2.76)**	**(£2.75)**	**£0.01**
Restructuring Costs	£0.00	£0.00	£0.00
Surplus / (Deficit)	**(£2.76)**	**(£2.75)**	**£0.01**

DIVISIONS: INCOME AND EXPENDITURE

	M01 Plan	M01 Actual	Var
	£m	£m	£m
Surg & Anaes	£1.31	£1.35	£0.03
Medical	£2.11	£2.05	(£0.06)
CWF & DATS	(£0.21)	(£0.22)	(£0.01)
Community	£0.18	£0.29	£0.11
Est & Fac	(£2.43)	(£2.11)	£0.33
Corporate	(£1.73)	(£1.86)	(£0.13)
THIS	£0.01	£0.06	£0.05
PMU	£0.17	£0.17	(£0.00)
Central Inc/Tech	(£1.90)	(£2.47)	(£0.57)
Reserves	(£0.26)	£0.00	£0.26
Surplus / (Deficit)	**(£2.76)**	**(£2.75)**	**£0.01**

TRUST SURPLUS / (DEFICIT)

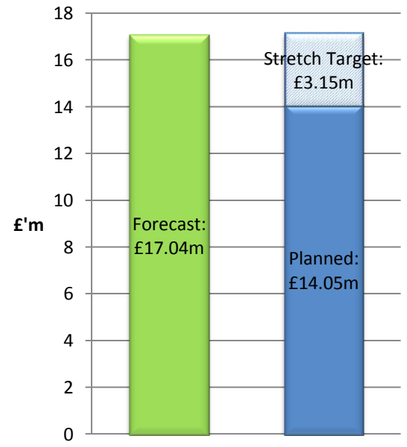


KEY METRICS

	Year To Date: M01 Plan	Year To Date: M01 Actual	Year To Date: Var	Year End: Forecast: Plan	Year End: Forecast: Forecast	Year End: Forecast: Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	(£2.76)	(£2.75)	£0.01	(£23.01)	(£23.01)	(£0.00)
Capital (forecast Plan)	£1.13	£1.13	£0.00	£20.72	£20.72	£0.00
Cash	£15.51	£15.51	£0.00	£1.92	£2.12	£0.20
	Plan	**Actual**		**Plan**	**Forecast**	
Continuity of Service Risk Rating	2	2		1	1	

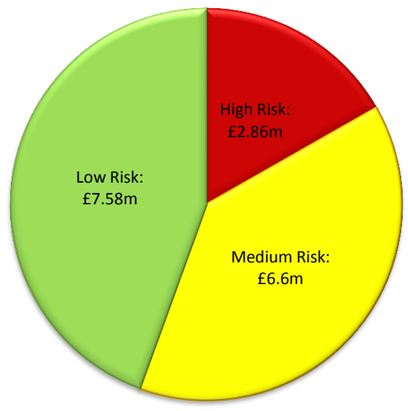
COST IMPROVEMENT PROGRAMME (CIP)

CIP Forecast Year End Position



Total Planned: £14.05m

Forecast CIP - Risk



Total Identified: £17.04m

YEAR END 2015/16

CLINICAL ACTIVITY

	Plan	Forecast	Var
Elective	8,577	8,619	42
Non Elective	49,263	48,703	(559)
Daycase	41,664	40,948	(716)
Outpatients	327,200	333,667	6,467
A & E	146,774	148,638	1,863

TRUST: INCOME AND EXPENDITURE

	Plan	Forecast	Var
	£m	£m	£m
Elective	£21.36	£20.81	(£0.55)
Non Elective	£79.89	£78.72	(£1.17)
Daycase	£27.23	£27.57	£0.34
Outpatients	£39.31	£39.82	£0.51
A & E	£15.44	£15.89	£0.45
Other-NHS Clinical	£119.93	£120.65	£0.72
CQUIN	£6.69	£6.80	£0.10
Other Income	£38.90	£38.71	(£0.19)
Total Income	**£348.75**	**£348.95**	**£0.20**
Pay	(£222.95)	(£223.80)	(£0.85)
Drug Costs	(£31.93)	(£32.15)	(£0.23)
Clinical Support	(£30.49)	(£30.28)	£0.21
Other Costs	(£45.94)	(£45.65)	£0.29
PFI Costs	(£11.92)	(£11.68)	£0.24
Total Expenditure	**(£343.23)**	**(£343.56)**	**(£0.33)**
EBITDA	**£5.52**	**£5.38**	**(£0.14)**
Non Operating Expenditure	(£25.53)	(£25.39)	£0.14
Deficit excl. Restructuring	**(£20.01)**	**(£20.01)**	**(£0.00)**
Restructuring Costs	(£3.00)	(£3.00)	£0.00
Surplus / (Deficit)	**(£23.01)**	**(£23.01)**	**(£0.00)**

DIVISIONS: INCOME AND EXPENDITURE

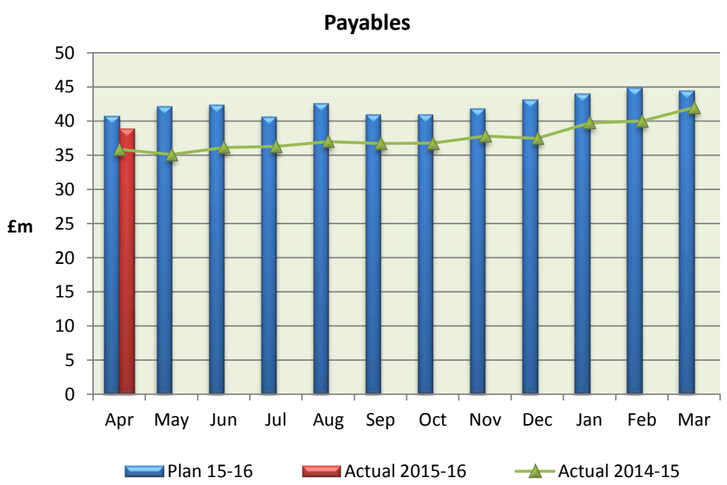
	Plan	Forecast	Var
	£m	£m	£m
Surg & Anaes	£21.67	£20.49	(£1.18)
Medical	£28.17	£27.90	(£0.27)
CWF & DATS	(£1.27)	(£1.56)	(£0.29)
Community	£2.20	£2.48	£0.28
Est & Fac	(£28.90)	(£28.67)	£0.23
Corporate	(£20.35)	(£20.32)	£0.03
THIS	£0.53	£0.53	(£0.00)
PMU	£3.16	£3.16	(£0.00)
Central Inc/Tech	(£25.23)	(£25.02)	£0.21
Reserves	(£3.00)	(£2.00)	£1.00
Surplus / (Deficit)	**(£23.01)**	**(£23.01)**	**£0.00**

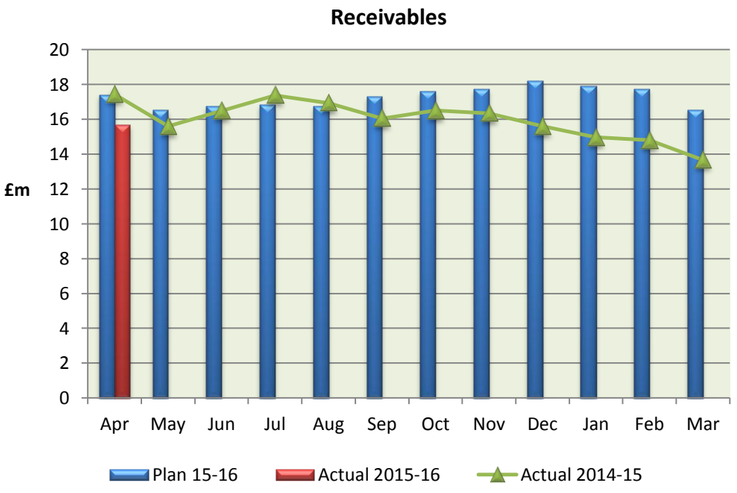
Trust Financial Overview as at 30th Apr 2015 - Month 1

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

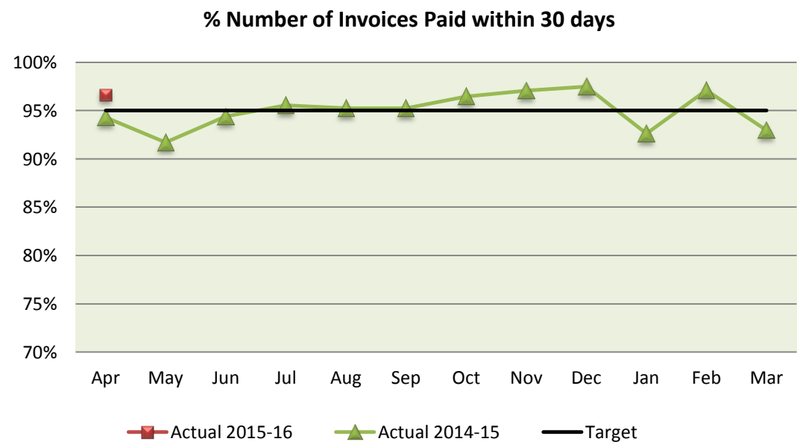
WORKING CAPITAL

	M01 Plan £m	M01 Actual £m	Var £m	M01
Payables	(£40.70)	(£38.82)	(£1.88)	
Receivables	£17.41	£15.68	£1.73	



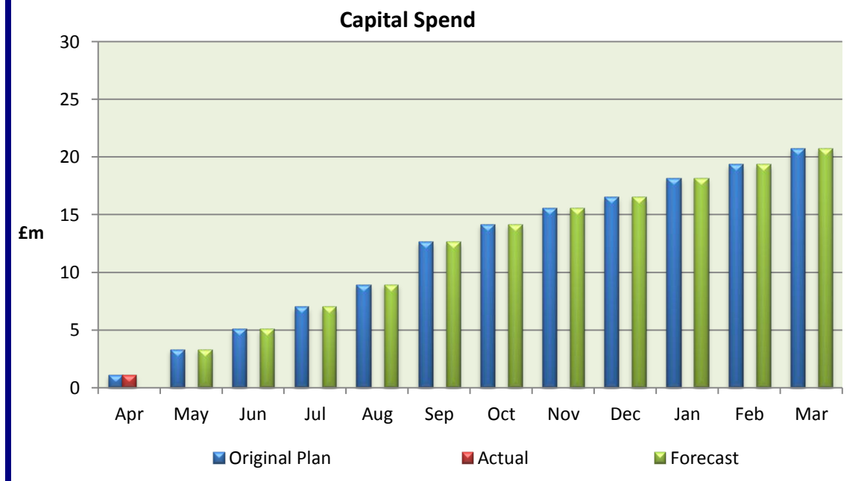


BETTER PAYMENT PRACTICE CODE



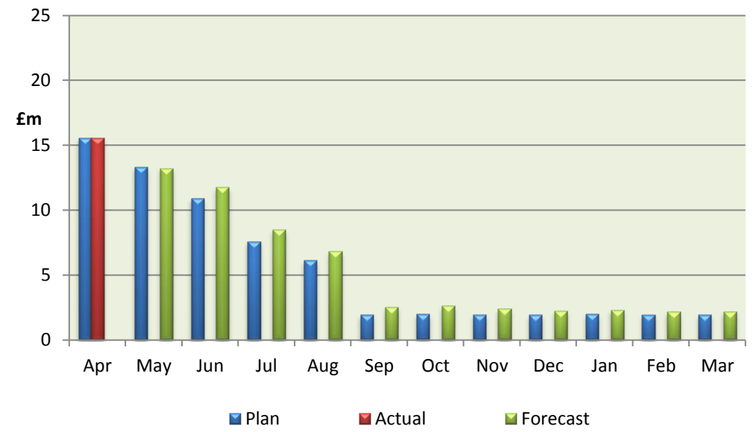
CAPITAL

	M01 Plan £m	M01 Actual £m	Var £m	M01
Capital	£1.13	£1.13	£0.00	

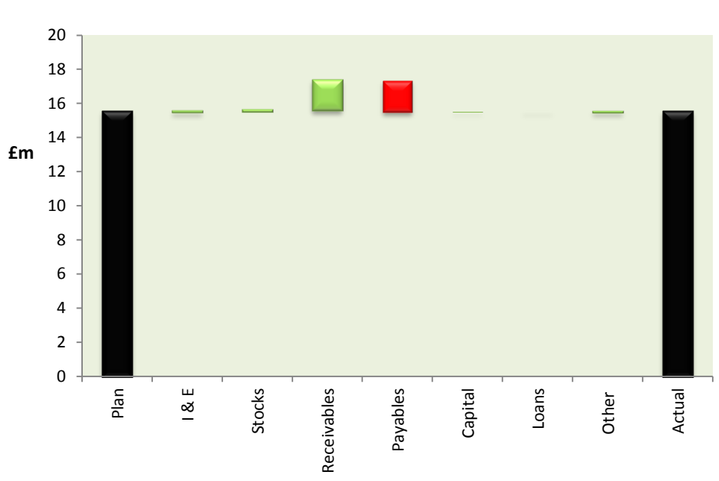


CASH

	M01 Plan £m	M01 Actual £m	Var £m	M01
Cash	£15.51	£15.51	£0.00	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The year to date deficit is £2.75m in line with the planned deficit of £2.76m, no contingency reserves were utilised.
- Non recurrent benefits have offset operating pressures to keep bed capacity open over the Easter period.
- Elective acivity and income is behind planned levels whilst non-elective stands above plan in the year to date.
- Capital expenditure year to date is £1.13m as planned.
- Cash balance is in line with plan at £15.51m. This includes £10m loan funded borrowing to support capital expenditure.
- CIP schemes delivered £0.72m in Month 1 against a planned target of £0.62m.
- The Continuity of Service Risk Rating (CoSRR) stands at 2 against a planned level of 2. The underlying trading position is at CoSRR level 1, this is falsely inflated in the short term by the cash receipt of loan funding.

SUMMARY FORECAST

- The forecast is to deliver the year end planned position, however at present this relies on use of £1m contingency reserves.
- The Trust must remain responsive to meet the capacity requirements between elective and non elective activity at Divisional level in a financially efficient way.
- The year end cash balance is predicated on external cash support being received from September onwards.
- The plans incorporate CIP devilvery at £14m, however the Trust is aiming to exceed this to deliver a stretch target, against which detailed schemes are in place to the value of £17.1m
- The year end CoSRR is forecast to be at level 1.

RAG KEY: (Excl: Cash)

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

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

RAG KEY - Cash:

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

Calderdale and Huddersfield NHS
NHS Foundation Trust

CQUINS Performance Report Month 1 2015-16

Performance is formally assessed quarterly

High Risk	
Moderate Risk	
No known Risk	

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

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

NHS England **421,193**

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

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

COMMUNITY DIVISIONAL PERFORMANCE REPORT & DASHBOARD

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

APRIL 2015

Key Points

April 2015
Performance Summary

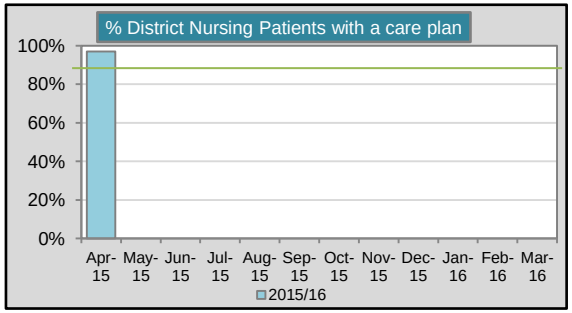
A - Why the target is away from plan
B - What are we doing to get it back to plan
C - When will this be achieved

% of patients with a LTC with a Calderdale Care Plan (1e)
A - Due to the transition period of new system functionality having been introduced to facilitate improved recording and reporting of this indicator
B - Fully train staff on the new process and ensure all eligible patients are included
C - 30th June

% of patients in receipt of community nursing services that have had a pressure ulcer screening and this is documented in their care plan (4a)
A - Reporting restrictions in patient caseload list used and screening report means some patients may be included but no pressure ulcer screening will show for them
B - Create manual checks to include all eligible
C - 31st July

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

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



COMMUNITY PERFORMANCE METRICS - CURRENT MONTHLY PERFORMANCE v YTD position (and TARGETS where applicable)

	1 Enhancing quality of life for people with a Long Term condition (LTC)	Target	Curr Month		YTD actual	
a	Home equipment delivery < 7 days	95%	98.1%		98.1%	
b	% Patient died in preferred place of death	95%	100.0%		100.0%	
c	% of people that died who were expected to die and had an advance care plan	Indicator suspended pending new pathway				
d	% District Nursing Patients with a care plan	90%	97.0%		97.0%	
e	% of patients with a LTC with a Calderdale Care Plan	90%	81.0%		81.0%	
f	% of patients under the care of the community specialist matron who have been readmitted to hospital with the same LTC in less than 30 days	<10%	0.7%		1.3%	

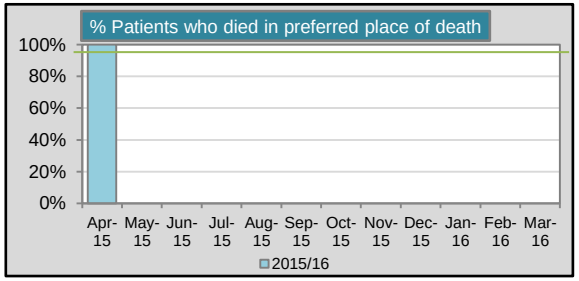
	2 Helping people to recover from episodes of ill health or following injury	Target	Curr Month		YTD actual	
a	% of leg ulcers healed within 12 weeks from diagnosis	75%	96.8%		96.8%	

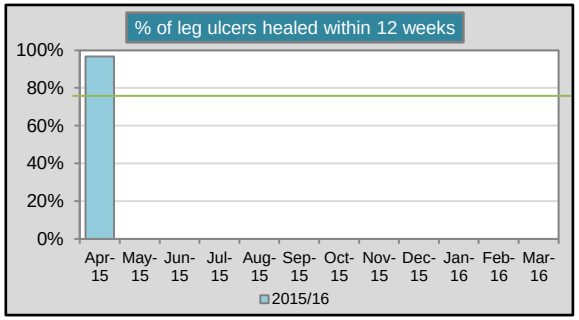
	3 Ensuring people have positive experience of care	Target	Curr Month		YTD actual	
a	Number of complaints	n/a	2		2	
b	Number of complaints about staff attitude	n/a	0		0	
c	Community AHP - 18 week RTT Snapshot at month end	95%	91.3%		91.3%	
d	Community Friends and Family Test	n/a	91.0%		91.0%	

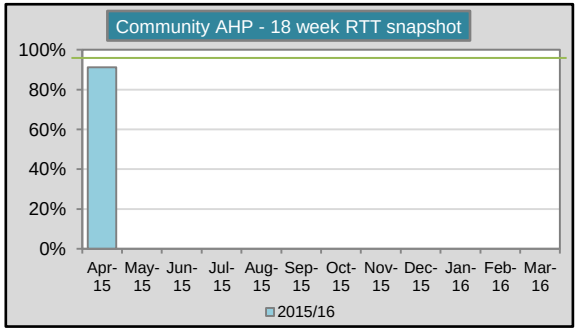
	4 Treating and caring for people in a safe environment; and protecting them from avoidable harm	Target	Curr Month		YTD actual	
a	% of patients in receipt of community nursing services that have had a pressure ulcer screening and this is documented in their care plan	90%	88.9%		88.9%	
b	Number of community acquired grade 3 or 4 pressure ulcers	<1.8	6		6	
c	Number of falls that caused harm whilst patient was in receipt of Comm Services	<1.1	4		4	
d	Patient safety thermometer - coverage - Harm free	>95%	94.8%		94.8%	
e	Patient safety thermometer - No of Harms Reported	<22.1	22		22	
f	% of staff that have undertaken safeguarding / mental capacity act training	95%	83.9%		84%	

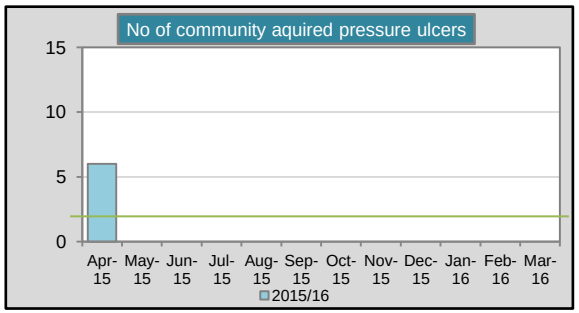
	5 Activity & Resource efficiency	Baseline	Curr Month		YTD actual	
a	Community DNA Rates	<1%	1.1%		1.1%	
b	Sickness Absence rate	<4%	0.0%		0.0%	

Target









SPECIALIST COMMUNITY MATRONS - PERFORMANCE REPORT & DASHBOARD

PROVIDING AN ASSESSMENT OF QUALITY

APRIL : 2015

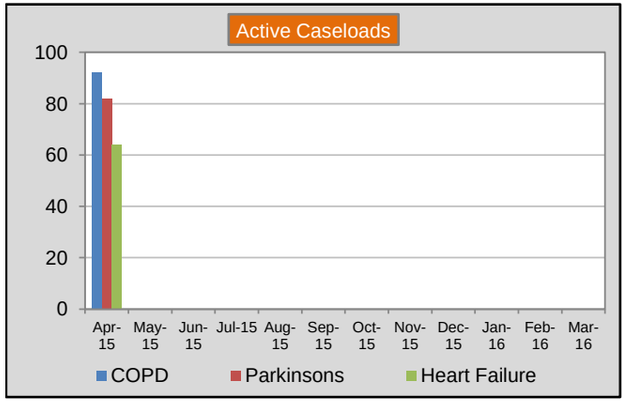
April 2015
Performance Summary

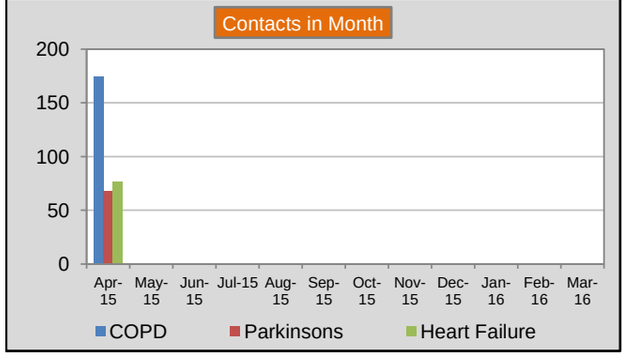
A - Why the target is away from plan
B - What are we doing to get it back to plan
C - When will this be achieved

Time to first contact (average) (1e,2e)
A - Methodology only includes Face to face contacts currently and this is not reflective in the way the service may contact patients initially
B - Investigate the impact of including other initial contacts methods such as Telephone
C - 31st July

% of patients attended A&E who are on a Community Matron Caseload (2a)
A - Parkinsons does not have any specific criteria therefore other non related reasons may be included
B - Investigate manual methods to identify excluded
C - 31st July

The COPD Respiratory Team is evolving & expanding and a



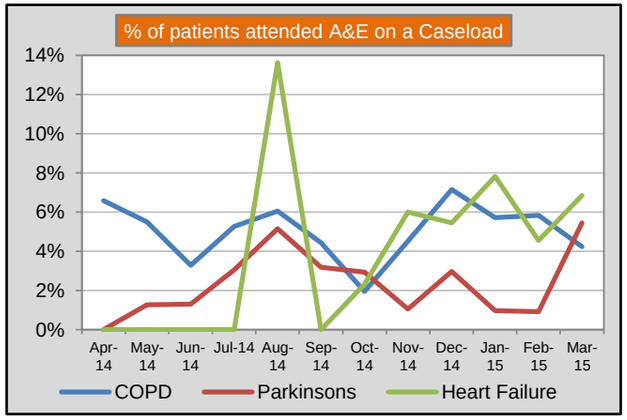


INDICATORS SPECIFIED

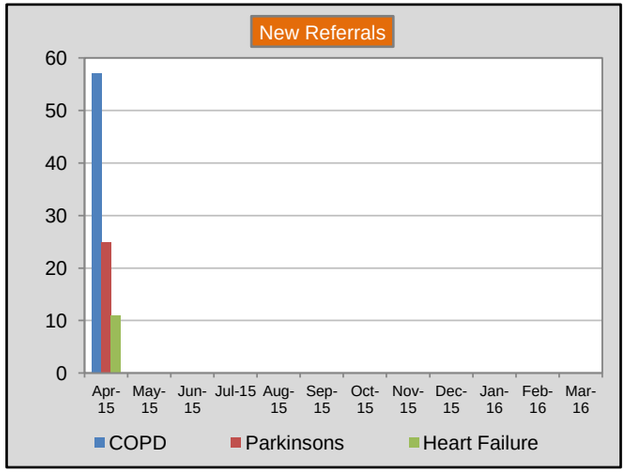
1	**COPD Respiratory** x3 WTE matrons	Annual Target	Curr Month		YTD actual	
a	% of patients attended A&E who are on a Community Matron Caseload	<5%	4.2%		5.0%	
b	COPD Related (Respiratory)		11		131	
c	% of patients attended A&E who are on a Community Matron Caseload readmitted within 30 days	<10%	1.2%		1.6%	
d	COPD Related (Respiratory)		3		43	
e	Time to first contact (average)	<7 days	33		33	
f	Active caseloads		92		92	
g	Average length of caseload		145		145	
h	Median length of caseload		90		90	
i	New Referrals in Month		57		57	
j	Contacts in Month		174		174	
k	Discharge in month		75		75	

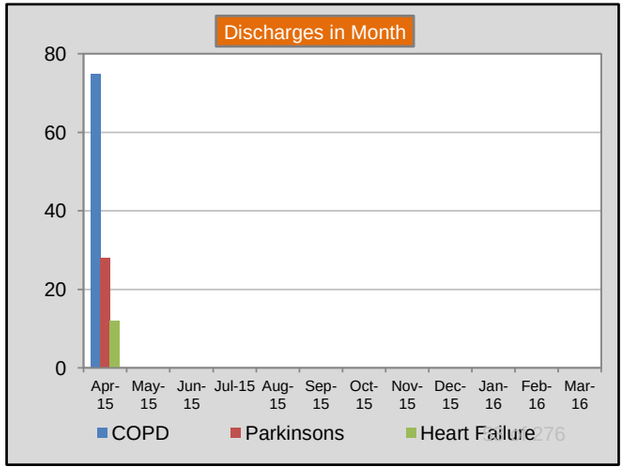
2	**Parkinson's** x1 WTE matron	Annual Target	Curr Month		YTD actual	
a	% of patients attended A&E who are on a Community Matron Caseload	<5%	5.5%		2.4%	
b	Parkinsons Related		6		28	
c	% of patients attended A&E who are on a Community Matron Caseload readmitted within 30 days	<10%	0.0%		0.8%	
d	Parkinsons Related		0		10	
e	Time to first contact (average)	<7 days	10		10	
f	Active caseloads		82		82	
g	Average length of caseload		126		126	
h	Median length of caseload		53		53	
i	New Referrals in Month		25		25	
j	Contacts in Month		68		68	
k	Discharge in month		28		28	

3	**Heart Failure** x1 WTE matron	Annual Target	Curr Month		YTD actual	
a	% of patients attended A&E who are on a Community Matron Caseload	<5%	6.8%		3.9%	
b	Heart Failure Related (Cardiac)		5		23	
c	% of patients attended A&E who are on a Community Matron Caseload readmitted within 30 days	<10%	0.0%		0.2%	
d	Heart Failure Related (Cardiac)		0		1	
e	Time to first contact (average)	<7 days	6		6	
f	Active caseloads		64		64	
g	Average length of caseload		128		128	
h	Median length of caseload		114		114	
i	New Referrals in Month		11		11	
j	Contacts in Month		76		76	
k	Discharge in month		12		12	



Showing upto Mar15 as figures reported one month in arrears





DISTRICT NURSING - PERFORMANCE REPORT & DASHBOARD

PROVIDING AN ASSESSMENT OF QUALITY

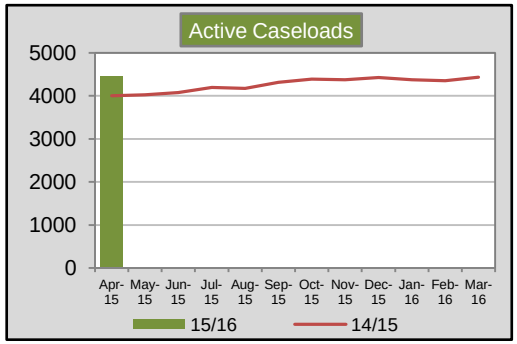
APRIL : 2015

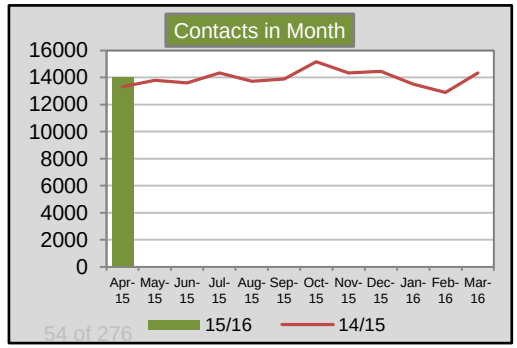
April 2015
Performance Summary

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

Time to first contact (1g,1h)
(urgent and non urgent)
A - The 2 urgencies specified are historical and do not represent the current practices used by the service
B - Consider new criteria & appropriate timescales
C - 31st July

No Access Visits (DNA) (1j)
A - Number of patients have multiple DNAs and therefore inflate the percentage
B - Investigate the use of proactive methods such as contacting the patient prior to the visit.
New 'Housebound policy' being developed.
C - 31st July



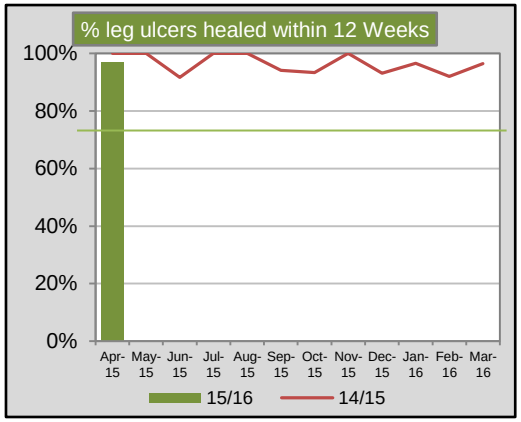


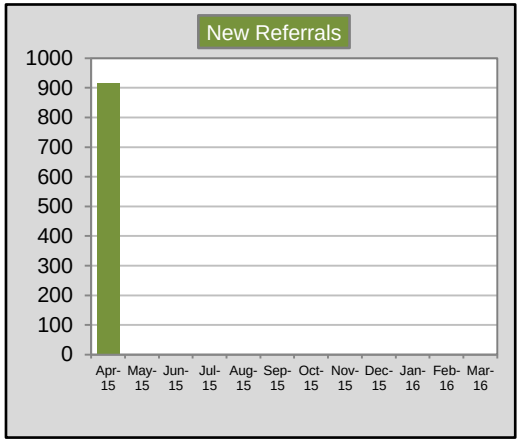
INDICATORS SPECIFIED

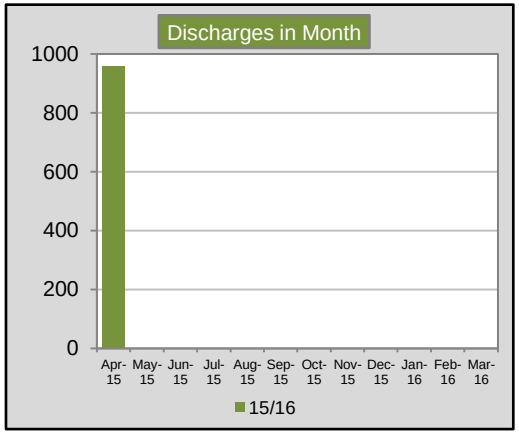
1	District Nursing xTBC WTE	Target	Curr Month		YTD actual	
a	Active caseloads	n/a	**4458**		4458	
b	Average length of caseload	n/a	**141**		141	
c	Median length of caseload	n/a	**19**		19	
d	New Referrals in Month*	n/a	**916**		916	
e	Contacts in Month	n/a	**14014**		14014	
f	Discharge in month	n/a	**957**		957	
g	Time to first contact (urgent referrals within 4 hours)	80%	**62.0%**		62.0%	
h	Time to first contact (Non urgent referrals within 2 days)	80%	**41.0%**		41.0%	
i	% of House Bound leg ulcers healed within 12 weeks from diagnosis (all grades)	75%	**96.8%**		96.8%	
		Numerator	**90**		90	
		Denominator	**93**		93	
j	No Access Visits (DNA)	<1%	**1.2%**		1.2%	
		No access visits	**176**		176	
		Total contacts	**14014**		14014	
k	% District Nursing Patients with a care plan	90%	**97.0%**		97.0%	
l	% of people that died who were expected to die and had an advance care plan	This indicator has been suspended pending a new End of Life pathway				
m	End of life - Patient died in preferred place of death	95%	**100.0%**		100.0%	
		Numerator	**9**		9	
		Denominator	**9**		9	

** Due to the changes introduced in July14 in how referrals are recorded in the system, the number of **New referrals** reported will show a reduction compared to 14/15, however this does not indicate a reduction of actual patient numbers through the service, caseload complexity, or a reduction in workload pressures **(1d)***

Target ----------







HEALTH VISITOR PERFORMANCE REPORT & DASHBOARD

PROVIDING AN ASSESSMENT OF QUALITY

APRIL 2015

Key Points

April 2015
Performance Summary

N/A Target not applicable

PERFORMANCE METRICS - CURRENT MONTHLY PERFORMANCE & YTD position (and TARGETS where applicable)

	1 Antenatal Visit	Target	Curr Month		YTD actual	
a	% of mothers who received a first face to face antenatal contact with a Health Visitor	95%	**77%**		77%	
b	Antenatal contacts		161		161	
c	Births in previous month		208		208	

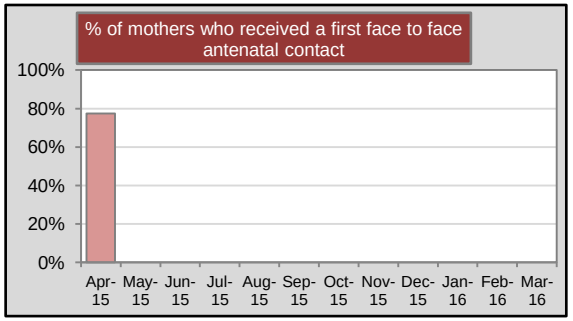
	2 New Birth Visit A	Target	Curr Month		YTD actual	
a	% of births that receive a face to face new birth visit within 14 days, by a Health Visitor	95%	**87%**		87%	
b	Birth visit between 7-14 days		180		180	
c	Births in previous month		208		208	

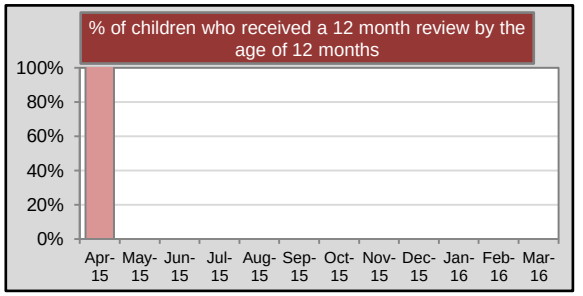
	3 New Birth Visit B	Target	Curr Month		YTD actual	
a	% of face to face new birth visits undertaken after 14 days, by a Health Visitor	N/A	**9%**		9%	
b	Birth visit between 15-30 days		18		18	
c	Births in previous month		208		208	

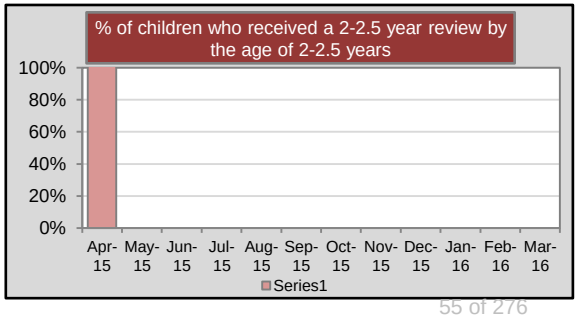
	4 12 Month Review A	Target	Curr Month		YTD actual	
a	% of children who turned 12 months in the quarter, who received a 12 month review, by the age of 12 months	95%	**116%**		116%	
b	12 month visit by 12 months		210		210	
c	Births in month prior year		181		181	

	5 12 Month Review B	Target	Curr Month		YTD actual	
a	% of children who turned 15 months in the quarter, who received a 12 month review, by the age of 15 months	95%	**119%**		119%	
b	12 month visit by 15 months		215		215	
c	Births in month prior year		181		181	

	6 2.5 Year Review	Target	Curr Month		YTD actual	
a	% of children due a review by the end of the quarter, who received a 2-2.5 year review, by the age of 2.5 years	95%	**104%**		104%	
b	2-2.5 year visit by 2-2.5 years		220		220	
c	Births in month relevant year		211		211	







CHILDRENS PERFORMANCE REPORT & DASHBOARD

PROVIDING AN ASSESSMENT OF QUALITY

APRIL 2015

Key Points

April 2015
Performance Summary

TBC Target not confirmed for 15/16

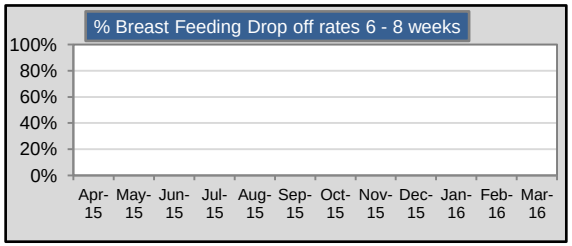
PERFORMANCE METRICS - CURRENT MONTHLY PERFORMANCE & YTD position (and TARGETS where applicable)

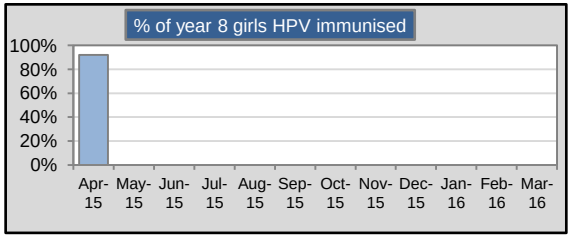
	1 Breast Feeding	Target	Curr Month		YTD actual	
a	Drop off Rates 6 – 8 weeks	TBC	**TBC**		TBC	

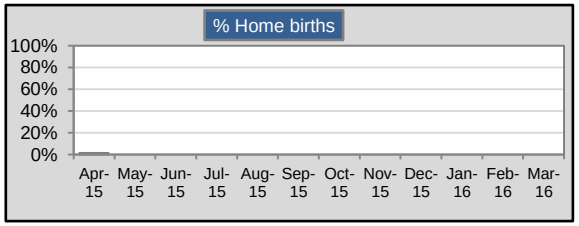
	2 Immunisations	Target	Curr Month		YTD actual	
a	% of year 8 girls HPV immunised	TBC	**92.1%**		92.1%	
b			1162		1162	
c			1262		1262	

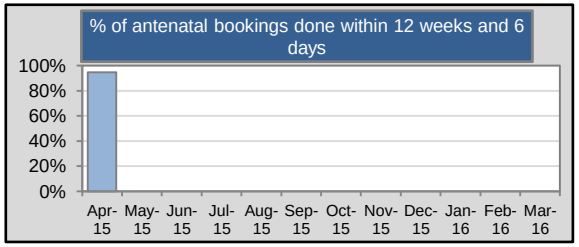
	3 Midwifery	Target	Curr Month		YTD actual	
a	% Home Births	TBC	**1.6%**		1.6%	
b			7		7	
c			440		440	
d	% of Antenatal Bookings done within 12 weeks and 6 days	TBC	**94.6%**		94.6%	
e			452		452	
f			478		478	
g	% women smoking at time of delivery	TBC	**10.6%**		10.6%	
h			46		46	
i			435		435	

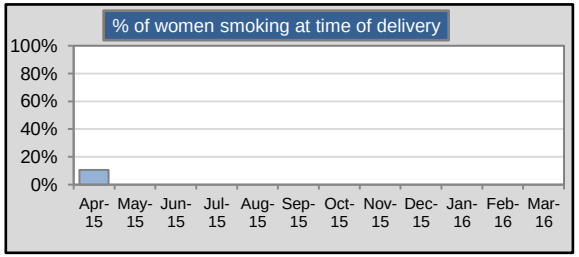
	4 Sexual Health	Target	Curr Month		YTD actual	
a	Referrals seen within 48 hrs	TBC	**96.2%**		96.2%	
b			1136		1136	
c			1181		1181	
d	Patients offered HIV test	TBC	**76.2%**		76.2%	
e			735		735	
f			964		964	

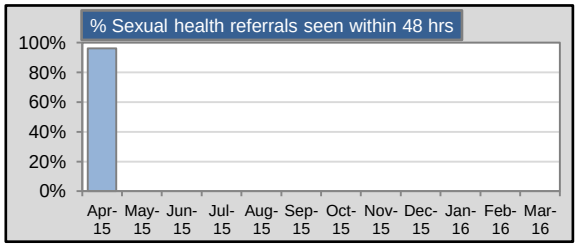


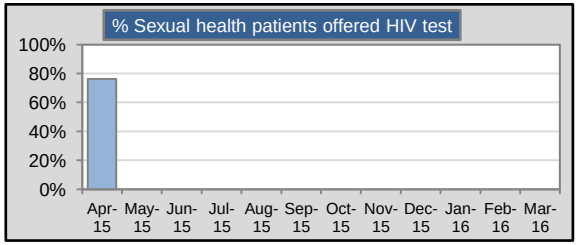












Calderdale and Huddersfield NHS
NHS Foundation Trust

Monitor Indicators

Indicators	Thresholds	Weighting	April 2015	Quarter 1	YTD
Incidence of MRSA Year to Date	0	1.0	1	1	1
Incidence of Clostridium Difficile Year to Date	3	1.0	2	2	2
Maximum Time of 18 Weeks From Point of Referral to Treatment - Admitted	90%	1.0	91.65%	91.65%	91.65%
Maximum Time of 18 Weeks From Point of Referral to Treatment - Non-Admitted	95%	1.0	98.35%	98.35%	98.35%
Maximum Time of 18 Weeks From Point of Referral to Treatment - Incomplete Pathways	92%	1.0	95.02%	95.02%	95.02%
62 Day Wait for First Treatment from Urgent GP Referral	85%	1.0	89.38%	89.38%	89.38%
62 Day Wait for First Treatment from Consultant Screening Service Referral	90%	1.0	85.71%	85.71%	85.71%
31 Day Wait for Second or Subsequent Treatment: Surgery	94%	1.0	100.00%	100.00%	100.00%
31 Day Wait for Second or Subsequent Treatment: Anti Cancer Drug Treatments	98%	1.0	100.00%	100.00%	100.00%
31 Day Wait from Diagnosis to First Treatment (All Cancers)	96%	0.5	100.00%	100.00%	100.00%
Two Week Wait From Referral to Date First Seen: All Cancers	93%	0.5	96.45%	96.45%	96.45%
Two Week Wait From Referral to Date First Seen: Symptomatic Breast Patients	93%	0.5	93.33%	93.33%	93.33%
A&E: Maximum Waiting Time of Four Hours from Arrival to Admission/Transfer/Discharge	95%	1.0	95.01%	95.01%	95.01%
Community care - referral to treatment information completeness	50%	0.5	100.00%	100.00%	100.00%
Community care - referral information completeness	50%	0.5	97.30%	97.30%	97.30%
Community care - activity information completeness	50%	0.5	100.00%	100.00%	100.00%
Overall Governance Rating			Amber-Red	Amber-Red	Amber-Red

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

Calderdale and Huddersfield NHS
NHS Foundation Trust

Data Quality Assessment

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

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

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

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

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

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

Month 1, April 2015 Financial Narrative

Purpose

This paper provides a narrative to accompany the monthly financial dashboard and will focus on the key messages within the month and year-end forecast and is presented in the following three sections

- Executive Summary;
- Month 1, April Performance;
- Forecast risk and opportunities.

The comparisons and reference points within this paper are consistent with the dashboard highlighting actual performance against the plan as submitted to Monitor in May 2015.

This paper has previously been discussed at the Finance & Performance Committee on the 28 May 2015.

Executive Summary

The Trust has delivered the planned financial position for month 1 and is forecasting to deliver the planned position for the year-end 2015/16.

Month 1, April Position

Income and Expenditure Summary	Plan £m	Actual £m	Var £m
EBITDA	**(0.64)**	**(0.63)**	**0.01**
Deficit	**(2.76)**	**(2.75)**	**0.01**

- A negative EBITDA of £0.63m, in-line with the planned position.
- A deficit of £2.75m, in-line with the planned position.
- Delivery of CIP of £0.72m against the planned level of £0.62m.
- No release of reserves.
- Capital expenditure of £1.13m, in-line with the planned level.
- A cash balance of £15.51m, in-line with the planned level that includes a capital loan drawdown of £10m as planned.
- A Continuity of Risk Rating (CoSRR) of level 2, in-line with plan but is over-inflated by the drawdown of the capital loan. The underlying trading CoSRR is a 1 and is consistent with the planned level of 1.

Year-end Forecast Position

Income and Expenditure Summary	Plan £m	Actual £m	Var £m
EBITDA	**5.52**	**5.38**	**(0.14)**
Deficit excluding restructure costs	**(20.01)**	**(20.01)**	**0.00**
Restructure costs	(3.00)	(3.00)	0.00
Deficit including restructure costs	**(23.01)**	**(23.01)**	**0.00**

- An EBITDA of £5.38m, £0.14m under planned levels.
- A deficit before restructure costs of £20.01m, in-line with the planned position.
- Restructure costs forecast to be at planned levels of £3.00m.
- A deficit including restructure costs of £23.01m, in-line with the planned position.
- CIP of £14.05m delivering against the planned level of £14.05m.
- Requirement to protect £1m of reserves, retaining uncommitted reserves of £2m.
- Capital expenditure of £20.72m, in-line with the planned level and supported by the £10m capital loan drawdown in April.

- A cash balance of £2.12m, in-line with the planned level of £1.92m, including external cash support of £14.9m.
- A Continuity of Risk Rating (CoSRR) of level 1, in-line with plan.

Month 1, April Performance

Activity and Capacity

At an aggregated level, elective activity, which includes inpatient, daycase and outpatient activity, is over-performing within the month. However, the dis-aggregated position shows under-performance within day case and inpatient work offset by an over-performance within outpatients.

Non-elective activity including A&E attendances has seen an over-performance within the month. A&E attendances have seen a 1.3% increase against plan that is an increase of 4.8% against the same month of the prior year. The picture of non-elective admissions shows an aggregated performance in-line with planned levels but the split of short and long stay shows a significant increase within the long stay admissions, placing greater pressure upon the planned capacity.

Direct access diagnostic services are below plan in the month. The key driver for this underperformance is within ultrasound scanning. All other modalities, including MRI and CT are in line with plan.

The activity for specialist commissioned services has over-performed against the planned levels in all service areas: Adult Critical Care, NICU, Chemotherapy, High Cost Drugs and ICDs, with the latter two issues carrying direct pass through costs that result in a nil gain within the income and expenditure position.

Appointment Slot Issues (ASIs) are being monitored closely and remain challenging at Trust level driven by pressured specialties. The end of April performance is 16.9% and remains significantly above the Trusts target of 5%.

As referenced within previous Finance and Performance reports the unplanned bed capacity that remained open towards the end of March 2015 has stayed open within the month to assist in the provision of system resilience throughout the Easter period. As described within the Annual Plan for 2015/16 additional bed capacity had been planned for over and above the levels experienced within 2014/15. However, within the month, this additional planned capacity has been exceeded by an average of 40 beds recognising the on-going system resilience requirements and the significant increased levels of long stay non-elective emergency admissions as described above.

CQUIN performance has been assumed to deliver for April with the exception of the Asthma Care Bundle. As reported within previous reports, this scheme has failed to deliver against its performance standards for Q3 and Q4 within 2014/15. The forecast delivery for Q1 is not yet known but a financial provision of £0.02m has been made within the month for non-delivery of this standard.

Income

The 2015/16 contract value has not yet been agreed with the main commissioners and we are entering into an arbitration process to progress this. However, in the meantime, we are operating under a full Payment by Results (PbR) arrangement with the application of national rules and prices under the Enhanced Tariff Option (ETO).

Clinical income has over-performed by £0.18m across all points of delivery combined. Within this aggregate position, against the two main commissioners there is an underperformance in planned day case and elective activity which is offset by a large increase in emergency long stay admissions and critical care bed days.

The clinical income position recognises the impact of contract sanctions, CQUIN risk against the Asthma target and contract challenges anticipated under the operation of PbR of £0.14m in total.

Against the specialised commissioner contract with South Yorkshire & Bassetlaw there is an over performance driven by high cost drugs and devices, Chemotherapy and NICU.

Other income is beneath plan by £0.13m, this is across a range of small areas. The Trust's commercial income generation through The Health Informatics Service and Pharmacy Manufacturing Unit is slightly above plan at month 1 in both instances.

Expenditure

Pay

Pay costs have overspent in Month 1 by £0.14m. This includes, in continuation from the latter part of 2014/15, a high level of non-contracted pay which more than compensates for the level of substantive vacancies. The substantive whole time equivalents (wte) equates to 5,079 wte against a budgeted amount of 5,430 wte resulting in vacancies against budgeted levels of 351 wte.

Nursing workforce spend is overspending against plan by £0.18m across the clinical divisions, this includes £0.94m expenditure on non-contracted pay. To set this in context, this compares with a peak non-contracted pay spend in March 2015 of £1.2m for the month and an average spend across 2014/15 of £0.59m per month. The drivers for this are twofold, the need to staff additional bed capacity over and above the extra beds planned for and also the continued use of higher premium rated agencies outside of the Trusts preferred supplier arrangements.

Action has been taken in-month to curtail spend with the higher premium rate agencies, particularly in nursing, with director level approval now required prior to booking against these and their use being stopped completely outside of the Medical Division where the main staffing pressure sits.

Medical workforce has also overspent in April. Specialties that have medical workforce gaps are filling with locum/agency as appropriate recognising that significant variation in cost is being experienced.

Non Pay

Drug expenditure is over-spending against plan by £0.12m but this is in the context of the specialist commission activity over-performing and is supported by additional income within these areas.

The Trust continues to bear additional management consultancy and turnaround costs.

A one off benefit is included within non-pay as a result of a VAT rebate against utilities costs that the Trust has successfully pursued, coupled with a benefit upon closure of the 2014/15 utilities actual usage position versus earlier estimates. Without this non-recurrent benefit the expenditure pressures described above would have had a detrimental impact to the bottom line delivery of plan in month 1.

CIP

Achievement of the financial plan as submitted to Monitor relies upon delivery of £14.05m of CIP of which £0.62m was planned in Month 1. In addition, a further element of 'stretch' CIP is being planned for internally to bring the total plan to £18m against which £17.2m has been identified. The profile of planned CIP in these two tranches is shown at Appendix 1.

Against the £0.62m planned in month 1, £0.72m has been delivered.

As previously reported, the Turnaround Executive meet on a weekly basis to ensure progress and pace is maintained. Their focus has now moved to ensuring delivery of 2015/16 CIP schemes and the development of schemes for 2016/17 and beyond.

Capital

In month capital expenditure is in line with planned expenditure of £1.13m.

The main areas of spend relate to estates and IM&T schemes, with the key IM&T areas being within Electronic Patient Record (EPR), Nerve Centre (Ward based electronic observations) and Electronic Data Management System (EDMS).

The main areas of spend within Estates relates to the theatre refurbishment programme continued from 2014/15 and the start of the ward refurbishment scheme of Ward 7.

Within the month, there has been a £10m drawdown of the capital loan facility approved within 2014/15. The total amount drawn is £17m (£7m in October 2014) of the total £30m facility. There are no plans to draw further amounts of the capital loan within 2015/16.

Cash

The closing cash balance for month 1 was £15.51m, in line with the planned value.

Following the agreement of outstanding debtor balances through the agreement of balances exercise with intra-NHS organisations at year end, the Trust is actively pursuing cash payment of outstanding debts.

From a payables point of view, compliance with the Better Payment Practice Code stands above the 95% target at 96.6%.

As has been reported, the financial plans for 2015/16 rely on external cash support. In order to ensure the Trust is doing everything within its own ability to proactively manage cash and implement cash protection strategies the Trust has engaged with KPMG to complete a cash forecasting and cash management review. This piece of work has recently concluded with the first draft report having been received in the week commencing 18 May. This will be reviewed by the finance team in conjunction with KPMG in advance of future presentation to the Finance and Performance Committee.

CoSRR

The Continuity of Service Risk Rating (CoSRR) is a level 2 in line with the plan.

The CoSRR is falsely inflated in month 1 due to the timing of the drawdown of the capital loan which temporarily boosts the liquidity rating. The underlying trading performance would result in a CoSRR of level 1. The Trust has been explicit in describing this position to Monitor.

Forecast risk and opportunities

Activity and contract

Non elective activity was beneath plan in Surgery in April and early indications are that this is a continuing trend into May. Whilst the division are forecasting some recovery against this in future months, income in the full year position still remains below planned levels. Against this the division will need to release corresponding costs.

Simultaneously, non-elective activity is above plan in Medicine and the forward projection is for this to continue along with associated costs of delivery.

Elective activity was below plan in month 1 but this shortfall is forecast by the divisions to be recoverable by year end.

All activity is assumed to be priced under PbR rules, a risk remains whilst the clinical contract with commissioners remains unsigned but the forecast income position is inclusive of an anticipated level of penalties, contract challenges and CQUIN performance risk.

Reserves

Contingency reserves are held at £3m for the year. In mitigation of the activity pressures described above and forecast forward from Month 1, £1m of reserves need to be protected in the full year forecast. £2m of contingency reserves remain preserved in the full year position. There may be calls against this remaining contingency against the following potential risks:

- System wide capacity resilience – A number of intermediate care nursing beds have recently been removed from the Calderdale community system until further notice. This is in addition to ongoing pressure within nursing / residential care capacity across both Calderdale and Kirklees which is impacting significantly on the CHFT bed base. This has the potential to lead to further cost pressures over and above forecast levels.

- CQUIN – Under a live PbR contract there may be the need to invest in infrastructure to ensure delivery of these quality driven targets.

- CIP – Detailed plans are in place for the full £14m CIP included in the financial plans. Against this, £12.9m is ranked with a risk rating of low or medium, giving assurance on delivery, leaving £1.1m rated red. Until this is secured in full there remains a level of risk.

- Vacancy factor – Against the budget for the full establishment a £3.05m vacancy factor was planned for financially. This was never designed to be a barrier to recruitment to vacancies which exist in predominantly clinical roles and therefore there is a risk if vacancies are recruited to at a greater pace than anticipated that this will bring a financial pressure.

- A&E Nursing – Following on from the investment in nurse staffing ratios on the wards in 2014/15, nurse staffing levels in A&E are being reviewed. Any resultant recommendation for investment will be considered by the Trust's Commercial Investment and Strategy Committee. No specific development funding has been set aside for this and therefore a decision may be a call on reserves.

- 7 day services – Without support from commissioners, further internal investment would be required in order to facilitate extended working hours.

- Turnaround costs – There is a risk that the costs of external support to support the turnaround process exceed than planned commitment.

- Potential impact of CQC – The Trust anticipates a CQC inspection in 2015/16, the resultant recommendations may require expenditure commitment.

Cash

Restructuring costs are planned at £3m to support the delivery of the CIP programme, the forecast position assumes these costs in I&E and cash terms in line with plan.

External cash support will be required to sustain the plan. In line with the guidance received, the plans assume receipt of £14.9m cash support in year in order to maintain a minimum cash balance at £1.9m which represents two working days operating costs. The guidance states that cash should be managed to a minimum balance of £1m and a maximum balance of £3m.

Monitor will be visiting the Trust in week commencing 22 June, there will be the opportunity during this visit to further discuss the cash support requirements.

CIP

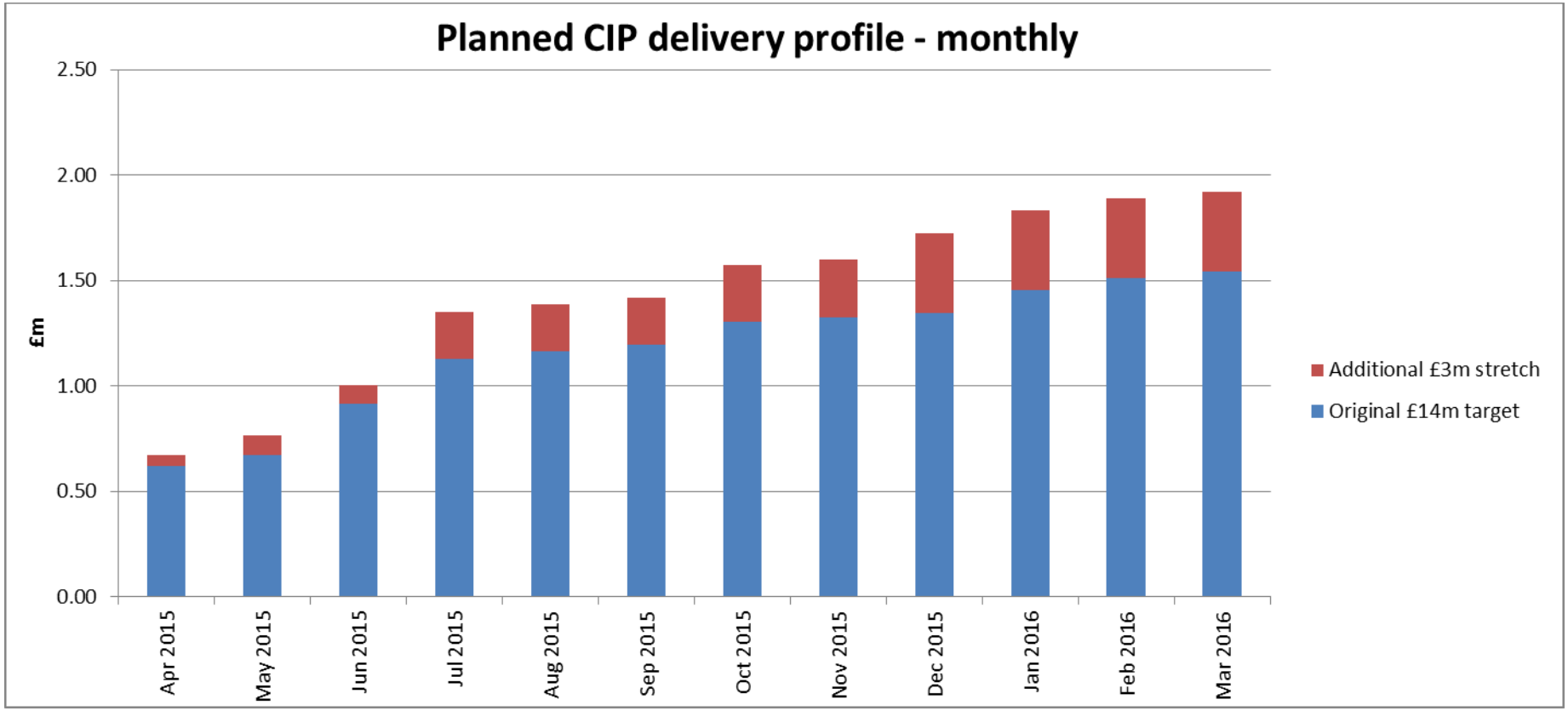
The forecast includes full delivery of the core £14m planned CIP. No benefit is currently assumed to the bottom line income and expenditure position upon delivery of the additional £3.2m identified of the 'stretch' target. At this early stage it has been assumed that this will be 'held back' to mitigate against any shortfall of core CIP schemes or other pressures.

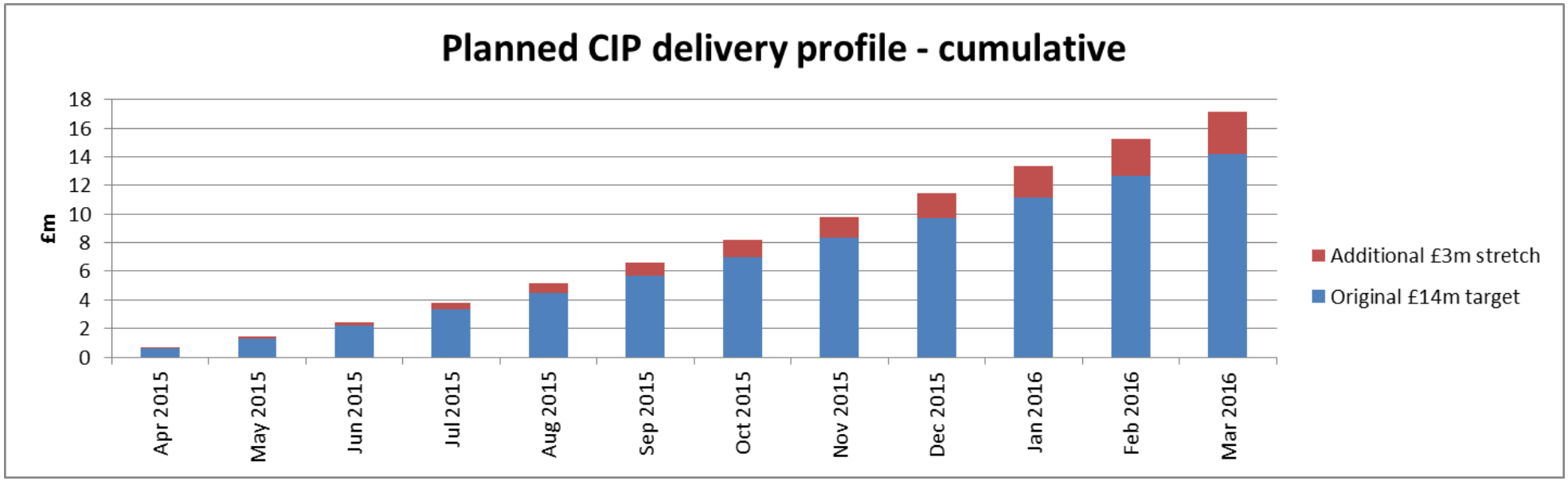
Care Closer to Home

The progression of the Care Closer to Home tender continues. The Trust is conscious that this will have one of two impacts within 2015/16 of a loss £5m income or a growth in income of £30m, both with associated costs. The Trust is currently forecasting the status quo in line with the plan submitted to Monitor but recognises that there is a risk or opportunity dependent upon the ultimate outcome of the process.

Keith Griffiths 28/5/2015

Appendix 1 CIP Profile




Planned CIP delivery profile - cumulative
£m
18
16
14
12
10
8
6
4
2
0
Apr 2015
May 2015
Jun 2015
Jul 2015
Aug 2015
Sep 2015
Oct 2015
Nov 2015
Dec 2015
Jan 2016
Feb 2016
Mar 2016
Additional £3m stretch
Original £14m target

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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, 28th May 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: REVIEW OF STRATEGY AND STRATEGY ON A PAGE GOING FORWARD - The Board is asked to note the progress on the strategy in 2015 and approve the Strategy on a Page going forward for 2015-16 and beyond.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Strategic Executive Board - 13.4.15 Board/Membership Council Workshop - 6.5.15	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

The Board is asked to note the progress on the strategy in 2015 and approve the Strategy on a Page going forward for 2015-16 and beyond.

Main Body

Purpose:

The purpose of this report is to inform the Board of the progress made against the objectives in the 2014/15 strategy and to present the 1 year and 5 year strategy and the quality priorities for 2015/16 for approval.

Background/Overview:

The Board has received a quarterly report on progress against the existing strategy throughout the previous year.

The Issue:

The paper sets out the up to date position on progress against each of these objectives and the outstanding items that will need to be taken forward into 2015/16.
The paper also describes the process of engagement and feedback that has been undertaken in the development of the 1 year and 5 year refreshed strategy

Next Steps:

The paper sets out the next steps to embed the strategy across the organisation and with stakeholders.

Recommendations:

The Board is asked to note the progress on the existing 2014/15 strategy; to approve the 1 year and 5 year strategy and quality priorities; and to comment on the next steps to ensure that the strategy and objectives are embedded in the Trust.

Appendix

Attachment:

Trust Strategy.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

1 and 5 Year strategy and the quality priorities

compassionate care

Development of the 2015/16 Strategy

Agreed that the Trust's strategy on a page required a refresh.

Undertook an engagement process to consider:

- What had been completed from the existing strategy
- What was still outstanding to be achieved from the 2014/15 strategy
- Any gaps not addressed by the existing strategy

Engagement process included:

- Initial discussion at Board to agree a way forward
- Workshop with Executive, Non-Executive and divisional colleagues
  - Revised the vision statement
  - Included goal on finance and workforce
  - Merged Transforming Care and Improvement and Innovation
- Workshop with Board members and Membership Councillors

compassionate care

Development of the 2015/16 Strategy

Feedback from the workshop with Membership Councillors

Positive

- Overall it was a good, clear and helpful document
- Good balance of national and local priorities and influences
- Showed commitment to community services and to staff
- Captured the challenges faced by the Trust

To consider for further development

- How will it be defined further for objectives
- Ensure that it reflects Vanguard and the Five Year Forward View
- Could reflect further that we are not an 'island'
- Wording in relation to colleagues / staff
- Consider the affordability of future plans
- Consider how we get real time data to support measurement of delivery
- Be clear who is responsible for each and consider capacity to deliver
- Need to ensure it reflects any political changes

The Strategy was updated to reflect these comments and to develop the wording in relation to workforce.

Development of the 2015/16 Strategy

The workshop also asked for feedback on what should happen next:

- Get on delivering it and make sure there are mechanisms for monitoring
- Engage staff throughout the organisation and make sure it is real for every member of staff
- Develop measures of success and milestones for delivery
- Stick with it
- Engage the public and makes sure that everything we do links back to the strategy.
- Align data with the strategy

The next steps are therefore proposed as:

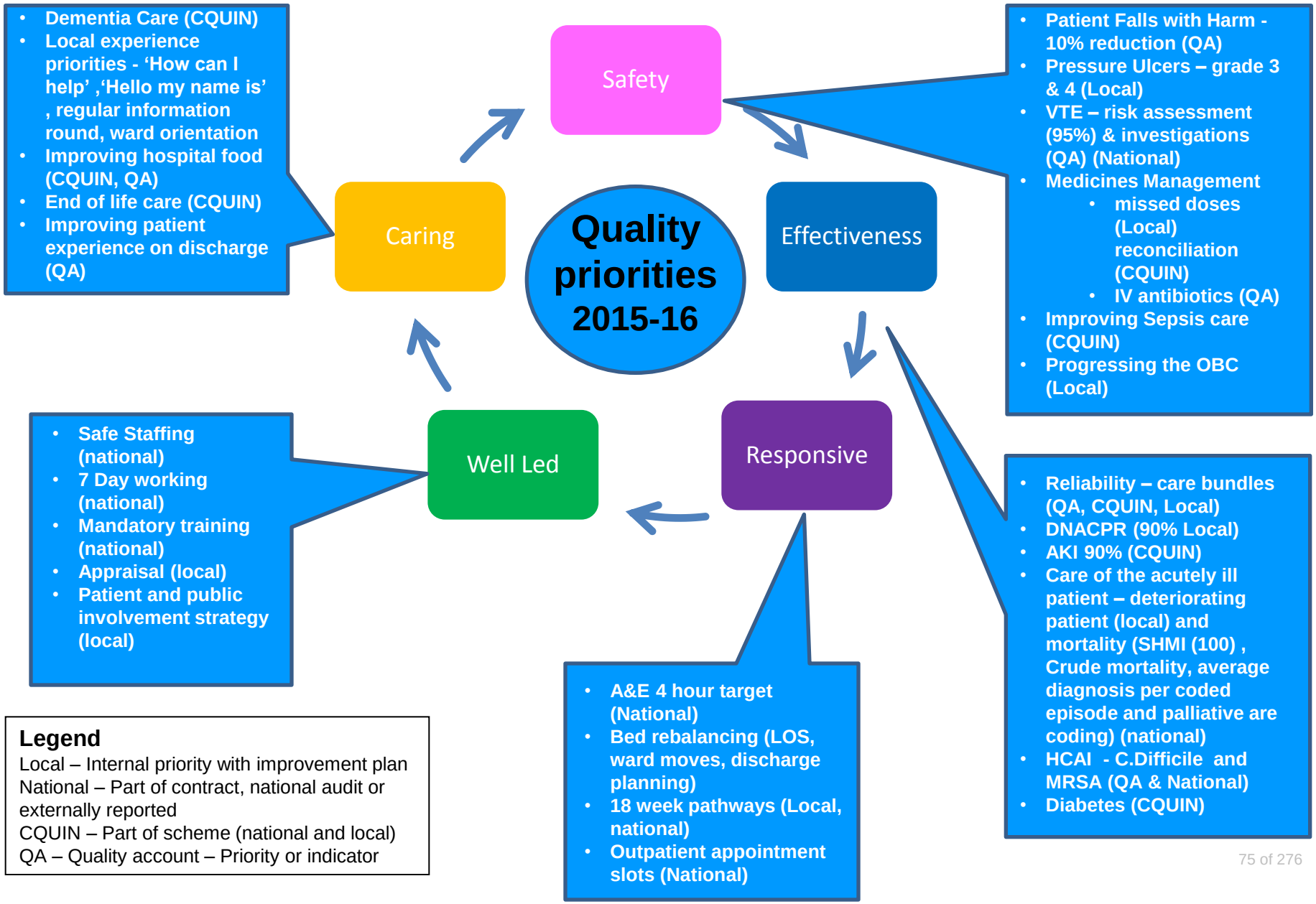
- Identify a lead director for each objective and link these in to the appraisal – end May 15
- Update the appraisal documentation to reflect these – end May 15
- Ensure the strategy is built into staff engagement – June 15
- Develop milestones and measurements for each of the objectives along with a reporting cycle to the Board and other parts of the governance to provide assurance on progress – June 15
- Develop the Board Assurance Framework for 2015/16 to reflect these objectives – June 15
- Develop the leadership visibility arrangements for both colleagues and the public - June 15

compassionate care

Our Vision	***Together we will deliver outstanding compassionate care to the communities we serve***			
Our behaviours	We put the patient first / We go see / We do the must dos / We work together to get results			
Our goals	Transforming and improving patient care	Keeping the base safe	A workforce for the future	Financial sustainability
By this we mean	Our SHMI will be 100 or less	We will have achieved a CQC rating of outstanding	We will have a workforce of the right shape & size with the capability & capacity to deliver safe, high quality servicesi in our hospitals & wider community ; maintaining safe staffing levels 24/7.	We will have implemented the five year plan
	We will have fully implemented an agreed re-configuration of integrated hospital and community services	We will be compliant with all Monitor requirements	We will be widely recognised as an Employer of Choice, attracting talented & committed people to join our team.	We will be financially sustainable with the ability to invest for the future
	We will meet all 7 day working standards	We will consistently achieve all national and local targets	We will actively engage with our people involving them in decisions that affect the Trust, teams and individuals.	We will understand our markets and have a clear plan of how we grow our business
	We will have a robust electronic patient record	We will be fully compliant with health and safety standards	We will invest in the health and well-being of our people, improving attendance and availability to ensure safe services 24/7	
	Our patients and the public will be involved in their treatment and we will use their feedback on services	Our estate will be fit for the future	We will embed a fully integrated approach to the development of our people, building a community of value driven senior leaders and promoting visible and supportive leadership at all levels of the organisation.	

Our Vision	*Together we will deliver outstanding compassionate care to the communities we serve*			
Our behaviours	We put the patient first / We go see / We do the must dos / We work together to get results			
Our goals	Transforming and improving patient care	Keeping the base safe	A workforce for the future	Financial sustainability
By this we mean	Design and implement the community division while continuing to work on CC2H	Implement the local quality priorities (see separate page)	Plan and implement workforce change to ensure that our people and resources actively support the reconfiguration of integrated hospital and community services..	Deliver a robust financial plan including CIP for 2015/16 and 2016/17
	Develop and roll out the first wave of 7 day working standards	Ensure readiness to achieve CQC rating of good	Design an innovative Trust-wide internal communications strategy and implementation plan.	Refresh the Commercial Strategy
	Roll out of the first year of programmes to support implementation of EPR	Strengthen our performance framework at corporate and divisional level	Secure safe staffing levels and have clear mitigation plans ready to be deployed if required.	Strengthen our financial control procedures
	Work with commissioners and providers locally and across WY to develop plans for the future configuration of integrated services	Ensure robust plans are in place to monitor and deliver A&E and C Diff	Launch a campaign to actively support improvements in health and well-being and reduce absence	Develop the 5 year turnaround plan with agreement across the local and regional health economy
	Continue the implementation of the Care of the Acutely Ill Patient action plan	Respond to Monitor in relation to breach of licence and undertake Well Led Governance Review	Design a strategic framework to articulate and govern a value driven people focussed approach.	
	Develop and implement a Public and Patient Involvement Plan	Implement the health and safety action plan	Create a Trust-wide, multi-disciplinary approach to Learning delivered via a fully integrated education and training function	

A Framework for Quality Improvement 2015-16



Legend
Local – Internal priority with improvement plan
National – Part of contract, national audit or externally reported
CQUIN – Part of scheme (national and local)
QA – Quality account – Priority or indicator

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Calderdale and Huddersfield NHS Foundation Trust
Strategic Plan – Progress Report March 2015

Introduction

Calderdale and Huddersfield NHS Foundation Trust vision is that:

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

The Trust Board has agreed actions and approaches to make progress towards this that are described in a 'plan on a page' that is shown below. The plan includes 14 strategic responses that are to be delivered during the period 2014 to 2016. Delivery against the plan is underpinned by the four key approaches of:

- We put the patient first
- We go see
- We work together to get results
- We do the must dos

The risks of not delivering the responses described in the plan are included in the Board Assurance Framework, which is currently being reviewed through the Trust's governance processes. The risks associated with the delivery of the responses have also been assessed and are included in the corporate risk register. The identified risks are reviewed and escalated as appropriate in line with the Trust's risk management arrangements.

We will work with partner organisations to understand the individual needs of patients and together, deliver outstanding compassionate care which transforms the welfare of the communities we serve.		
Our patients and our staff will be able to positively describe what our ''vision" means to them. We will treat our patients, staff and partners in a way that we would expect to be treated ourselves. We will use our resources (financial, human and estate) as a driver for change, rather than as a constraint.	We will improve access to care for patients and prioritise their safety, thereby also ensuring our regulatory compliance. We will improve real time patient information being at hand for us and our partners to provide the best and seamless care.	We will improve patient outcomes and experience through active and strategic collaboration within and outside CHFT.
TRANSFORMING CARE 1. We're rolling out the Courage to Put the Patient First lean action plan. 2. We're implementing the Colleague engagement plan. 3. We're developing state-of-the-art outpatient services at Acre Mill. 4. We're working to deliver the Trust's Efficiency Programme Board (EPB) activity for 2013 - 2015. 5. We're modernising and prioritising our approach to patient engagement and complaints handing.	**KEEPING THE BASE SAFE** 6. We're implementing action plans for both the Urgent Care Board and Care of the acutely ill patient. 7. We're actively seeking a partner to modernise our IM&T systems and install an Electronic Patient Record. 8. We're reviewing and making changes to our Governance arrangements. 9. We're implementing a Health & Safety action plan to make sure we have safe and suitable premises 10. We're improving our commercial intelligence about future commissioning risks/opportunities.	**IMPROVEMENT & INNOVATION THROUGH STRATEGIC ALLIANCE** 11. We're working towards obtaining CCG/HWB/NHS England approval for implementation of the strategic review business case. We're working in collaboration to improve :- 12. Bariatric surgery; Assisted conception with Mid Yorks. 13. Sexual health services with Locala and Mid Yorks. 14. Psychiatric liaison services with South West Yorkshire Partnerships.

Purpose of Report

The purpose of this report is to provide an update for Trust Board members of progress that is being made against the fourteen strategic responses described in the Trust's 2014/15 Strategic Plan.

Structure of Report

The report is structured to provide an overview assessment of progress against all fourteen strategic responses and this is rated in terms of delivery using the following categories:

1. On track – delivered (green)
2. On track - not yet delivered (amber / green)
3. Off track – with plan (amber / red)
4. Off track – no plan in place

For each strategic response there is also a summary narrative of the scope of the response and progress.

Summary

This report highlights that of the 14 strategic responses:

- One response is rated red i.e. off track with no plan in place.
- Six responses are rated amber / red i.e. off track with a plan in place.
- Six responses are rated amber / green i.e. on track but not yet delivered.
- One response is rated green i.e. on track and delivered.

Recommendation

Trust Board Members are requested to:

- Note the assessment of progress against the 2014/16 strategic responses.
- Discuss and agree the future action and assurance that may be required

Overview of Progress Against 2014/15 Responses

	Response	Assessment 1.On track – delivered (green) 2. On track - not yet delivered (amber / green) 3. Off track – with plan (amber / red) 4. Off track – no plan in place (red)
1.	We're rolling out the courage to Put the Patient First lean action plan. (Lead Director (s) : Lesley Hill, Director of Performance and Estates; Mags Barnaby, Director of Operations)	3. Off track – with plan (amber / red) Included in 2015/16 strategy
2.	We're Implementing the Colleague Engagement Plan Lead Director: Julie Hull, Director of Workforce and Organisational Development	2. On track – but not yet delivered (amber / green) Include in 2015/16 strategy
3.	We're Developing the State of the Art Outpatient Services at Acre Mill (Lead Director: Lesley Hill, Director of Performance and Estates)	1. On track – delivered (green)
4.	We're working to deliver the Trust's Efficiency Programme Board activity for 2014/15. Lead Director (s) : Mags Barnaby, Director of Operations; Ashwin Verma, Julie O'Riordan, Sal Uka, Martin DeBono, Divisional Directors	4. Off track – with no plan (red) Included in 2015/16 strategy under finance
5.	We're Modernising and Prioritising Our Approach to Patient engagement and Complaints Handling Lead Director: Julie Dawes, Director of Nursing	2. On track – but not yet delivered (amber / green) Included in 2015/16 strategy with PPI
6.	We're implementing action plans for both the urgent care board and care of the acutely ill patient Lead Director (s) : Mags Barnaby, Director of Operations and David Birkenhead, Medical Director	3. Off track – with plan (amber / red) Included in 2015/16 strategy
7.	We're actively seeking a partner to modernise our IM&T systems and install an Electronic Patient Record Lead Director: Mandy Griffiths, Acting Director of IM&T	2. On track – but not yet delivered (amber / green) Amended to broader goal in 2015/16 strategy
8.	We're reviewing and making changes to our governance arrangements Lead: Victoria Pickles, Company Secretary	2. On track – but not yet delivered (amber / green) Will be included in Well Led Governance review action plan Included in 2015/16 strategy
9.	We're implementing a Health and safety action plan to make sure we have safe and suitable premises. Lead Director: Lesley Hill, Director of Estates and Performance	2. On track – but not yet delivered (amber / green) Included in 2015/16 strategy
10.	We're improving our commercial intelligence about future commissioning risk and opportunities. Lead Director: Anna Basford, Director of Commissioning and Partnerships	2. On track – but not yet delivered (amber / green) Included in 2015/16 strategy
11.	We're working towards obtaining CCG/ HWB/ NHS England approval for implementation of the strategic review business case. Lead Director: Anna Basford, Director of Commissioning and Partnerships	3. Off track – with plan (amber / red) Included in 2015/16 strategy
12.	We're working in collaboration to improve Bariatric surgery and Assisted conception Services with Mid Yorkshire NHS Trust Lead Director: Anna Basford, Director of Commissioning and Partnerships	3. Off track – with plan (amber / red) Superceded
13.	We're working in collaboration to improve Sexual Health Services with Locala Community Partnerships and Mid Yorkshire NHS Trust Lead Director: Anna Basford, Director of Commissioning and Partnerships	3. Off track – with plan (amber / red) Superceded
14.	We're working in collaboration to improve Psychiatric Liaison Services with South West Yorkshire NHS Partnership Foundation Trust. Lead Director: Anna Basford, Director of Commissioning and Partnerships	3. Off track – with plan (amber / red) superceded

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Claire Gruszka, Patient Safety Risk Manager - LSMS
Date: Thursday, 28th May 2015	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: Risk Register - The attached papers provide details of the organisation risks scoring 15 or higher as at 20 May 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 the 19 May 2015 Risk & Compliance Group.	
Governance Requirements: .	
Sustainability Implications: None	

Executive Summary

Summary:

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Main Body

Purpose:

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Background/Overview:

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The Issue:

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Next Steps:

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Recommendations:

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Appendix

Attachment:

combined risk register - May 2015.pdf

RISK REGISTER REPORT

Risks as at 20 May 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
4783 (20): HSMR & SHMI
5792 (20): Lack of Opthalmology capacity due to Consultant gaps and impact of EDMS

RISKS WITH INCREASED SCORE

5792: Lack of Opthalmology capacity due to Consultant gaps and impact of EDMS – increased from 16 to 20

RISKS WITH REDUCED SCORE

2828: Risk of poor patient outcomes and experience caused by blocks in patient flow – 20 to 16
4706: Failure to meet CIP – 20 to 15
6136: Overarching risk for Infection Control – 20 to 15
6150: Finance: breach of licence - 20 to 10
6270: Completion of Appraisal and Mandatory Training – 16 – 12
6027: Failure to meet Capital programme – 15 – 10

NEW RISKS

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

6300: Compliance with CQC Standards

CLOSED RISKS

6161: Lack of availablity of bronchoscope due to age and frequent damage
6132: Reduction in elective surgery market shared – closed as risk not realised.

RISKS TO BE DISCUSSED AT NEXT RISK & COMPLIANCE COMMITTEE:

- Paediatrics in A&E and Paediatric model of care
- Safeguarding/Deprivation of Liberty
- Medical Devices
- Nursing staffing
- Impact of reduced Capital programme

Trust Risk Profile as at 20 May 2015

LIKELIHOOD (frequency)	CONSEQUENCE (impact/severity)				
	Insignificant (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
Rare (1)					
Unlikely (2)					
Possible (3)					< 4706 – Failure to meet CIP < 6136 – Infection Control = 6230 – Failure to deliver expected benefits of EPR
Likely (4)				< 2828 – Blocks in patient flow in A&E = 5806 – Privacy & Dignity issues on Ward 3, Chemo ward = 6130 - Loss of income/reduction in profit related to competitive procedures ! 6300 – CQC Compliance	= 2827 – Dependence on middle grade locums in A&E > 5792 – Shortage of Consultants in Opthalmology
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)

	Risk No	Div	Dir	Dep	Opened	Status	Srategic Objective/Goal	Risk Description plus Impact	Existing Controls	Gaps In Controls	Initail	Current	Target	Further Actions	Review	Target	RC	Exec Dir	Lead
Extreme	6131	Corporate	Commissioning & Partnerships	Commissioning & Partnerships	Oct-2014	Active	Objective 1 - Transforming & Improving Patient Care	There is a risk that the Trust will not be able to quickly progress service reconfiguration due to the requirements of a consultation process initiated by local CCG's resulting in delays to important clinical quality and safety issues e.g: Compliance with A&E National Guidance Compliance with Paediatric Standards Compliance with Critical Care Standards Speciality level review in Medicine Unable to meeting 7 day standards Difficulties in recruiting a medical workforce (increased reliance on Middle Grades and Locums) Increased gaps in Middle Grade Doctors	The continued funding of medical staff on both sites Nurse led service managing Paediatrics Critical care still being managed on both sites High usage of locum doctors Frequent hospital to hospital transfers to ensure access to correct specialties	Financial plans of associated reconfiguration not completed or agreed with CCG's Estate limitations inhibit the present way of working Consultant rotas cannot always be filled to sustain services on both sites	25 5 x 5	25 5 x 5	15 5 x 3	Working in partnership with CCG's to agree final configuration of services Hospital Services Board run by CCG's has been established from end of May 15 to agree models of care by end of Sept 15 CCG's continue to action services closer to home plan prior to hospital reconfiguration. Plan to be produced by end of Sept 15 MONITOR assisting in service review by end of Sept 15 Financial plans will be agreed following agreement of service model Continue to ensure compliance with current estate pending a decision Medical Workforce Plan to be developed by end of June 15 examining overseas recruitment	Jun-2015	Sep-2015	WEB	Anna Basford	Catherine Riley
Major	2827	Medical	Emergency Network	Accident & Emergency	Apr-2011	Active	Objective 2 - Keeping the Base Safe	There is a risk of poor clinical decision making in A/E due to a dependence on locum Middle Grade Doctors at weekends and on nights resulting in possible harm to patients, extended length of stay and increased complaints	Associated Specialist and Regular locums for continuity appointed Middle Grade Doctors moved within sites to respond to pressures Where necessary other medical staff re-located to ED Consultants act down into middle grade roles to fill gaps temporarily	Difficulty in recruiting Consultants, Middle Grade and longer term locums Relatively high sickness levels amongst locum staff	20 4 x 5	20 5 x 4	12 4 x 3	Expedite Outline Business case for reconfiguration of services across sites to afford better deployment of medical staff Explore use of ANP to fill vacant doctor posts 4 Consultant posts advertised currently. Closing date end of June 15 Business Continuity Plan awaiting approval of Urgent care Board covering ability to provide safe services for varying periods of time	Jun-2015	Oct-2015	WEB	Julie Dawes	Dr Mark Davies/Mrs Bev Walker
Major	4783	Corporate	All Directorates Corporate	All Departments/Wards Corporate	Aug-2011	Active	Objective 1 - Transforming & Improving Patient Care	There is a risk that the Trust falls below national standards for mortality levels due to not delivering appropriate standards of care for acutely ill patients/frail elderly patients and possible incorrect clinical coding resulting in inaccurate reporting of preventable deaths, increased external scrutiny and a possible increase in complaints and claims	Outlier areas are monitored (e.g. Stroke, Sepsis and COPD) Outliers are investigated in depth to identify the cause. Improvement work is implemented via an action plan Mortality dashboard analyses data to specific areas Monitoring key coding indicators and actions in place to track coding issues	Mortality reviews to assess preventable deaths which is indicating there isn't a problem but not yet performed for long enough or to sufficient depth to determine causes Coding improvement work not yet complete Improvement to standardized clinical care not yet consistent. To be completed by Dec 15	20 4 x 5	20 4 x 5	16 4 x 4	To complete the work in progress CQUINS to be monitored by the Trust	Jun-2015	Jun-2015	COB	David Birkenhead	Juliette Cosgrove

Major	5792	Surgery & Anaesthetics	Head and Neck	Ophthalmology	Apr-2013	Active	Objective 2 - Keeping the Base Safe	There is a risk of Glaucoma/Macular patients missing Ophthalmology Outpatient follow up appointments due to insufficient capacity caused by Consultant shortages and the impact of the EDMS, resulting in potential harm to patients (deterioration of sight)	Locum staffing cover and waiting list initiatives provide temporary extra capacity Orthoptist job roles redefined to be able to manage glaucoma patients from Aprpril2015 Number of patients booked into clinics reduced as a safety measure Additional support provided by I/T team to train staff in use of EDMS which will ultimately lead to greater skills and ability to book more patients in clinics from May 2015	Difficulty in recruiting to Consultant and Middle Grade posts EDMS system issues with implementation (e.g. repeated slowness, difficulty in tracking patient progress on system for Ophthalmic patients) Scanning patients notes onto the system makes them hard to interpret (e.g. Field tests)	25 5 x 5	20 5 x 4	12 4 x 3	Interviews for 2 Consultant posts to be held on 20 May 2015 Trust is considering how to reduce the number of notes to be scanned can be reduced. Work to commence on 1 June 2015 During 2016/17 the Trust will move onto a full Electronic Patient Record	Jun-2015	Sep-2015	WEB	Julie Dawes	Melanie Addy
Major	2828	Medical	Emergency Network	Accident & Emergency	Apr-2011	Active	Objective 2 - Keeping the Base Safe	There is a risk of too slow patient flow and breaches of national targets in A/E due to bed blockages across the Trust, resulting in harm to patients through delayed treatment and increased external scrutiny for the Trust.	Escalation protocol in place which requires ED Co-ordinator to link with Patient Flow/Clinical Site Commander to ensure patients are moved from ED to a bed within national guidelines Site Commander can authorize additional beds by using flexible capacity Level discharges (required discharges at certain points of the day) plan in place. Site Commander to work with Ward Managers at 2 hourly meetings to ensure these happen All patients have a personal plan established by their Ward which includes discharge arrangements Medically stable patients are reviewed daily by the Discharge Team and Local Authority Surge and escalation plan in place to escalate to higher levels of authority (e.g. cancel next day surgery)	Despite the controls, the bed base in still insufficient at certain times The night period is particularly vulnerable. There is a reliance on locum middle grade doctors due to vacancies	20 4 x 5	16 4 x 4	12 4 x 3	Bed modeling review underway as part of the ED Action Plan. To be completed by mid-June 15 Capacity and demand modeling being undertaken (matching resources to peak activity periods). To be complete by mid-June 15 Urgent Care Board is accessible to consider new initiatives and act as an escalation decision making body in the case of very urgent situations. The Board has reserve resources	Jun-2015	Jul-2015	CG	Julie Dawes	Sajid Azeb
Major	5806	Medical	Integrated Medical Specialities	Ward 3 HRI	May-2015	Active	Objective 2 - Keeping the Base Safe	There is a risk that the following urgent Estates schemes cannot be undertaken due to insufficient resources, resulting in a poor patient experience, possible ward closures and harm caused by slips, trips and falls • Failure to maintain privacy and dignity on the Chemotherapy Unit at HRI • Poor/unsafe flooring in ICU at HRI • Environmental/safety standards on Ward 18 at HRI • Temperature control in winter on Ward 4 at HRI • Poor environmental conditions on Ward 5 at HRI • Uneven floor surface on Ward 19 • Poor fitting windows on Ward 6 at HRI	Chemo unit- currently still on ward 3 but will be moving to new facilities on ward 7 in September. ICU- currently still issues Ward 18- decorated the discharge lounge and put in patient entertainment Ward 4- heaters available for cold rooms Ward 5- now moved to ward 11 whilst the ward has works done and a minor upgrade Ward 6- temporary solutions in place with the windows and heaters for cold rooms		16 4 x 4	16 4 x 4	8 4 x 2	Chemo- full upgrade available from Sept Ward 18- putting in place a plan for a new discharge lounge, and seeking a solution for a new paed ward Ward 4, 5, 6- upgrades in place over the next 5 years as part of the estate strategy, subject to funding.	Jun-2015	Oct-2015	QC	Lesley Hill	Maureen Overton

Major	6130	Corporate	Commissioning & Partnerships	Commissioning & Partnerships	Oct-2014	Active	Objective 4 - Financial Sustainability	There is a risk of a significant loss of income to the Trust due to Greater Huddersfield CCG and the Kirklees and Calderdale Local Authorities undertaking competitive procurement for a range of services (e.g.Care Closer to Home; Security Health; School Nursing; Anti Coag) resulting in threatened financial stability and increased scrutiny by MONITOR	There is a robust system in place to identify when services are to be tendered both within and beyond the catchment area e.g. anti-coagulation service/sexual health New models of care have been developed in response to the requirements of tenders A commercial strategy is in place which identifies core/non-core services by division and by immediacy of commercial risk (Clinical Services Model Wagon Wheel)	Need to anticipate weaknesses and gaps in services through risk assessments prior to tender processes to make service model changes rather than wait for pressure of a tender to force changes Service Line Reporting not yet concluded to identify profitability of services and whether to bid against tenders	16 4 x 4	16 4 x 4	8 4 x 2	Complete the Service Line Reporting work Develop new models of care in advance of Commissioner tendering processes with advance notice of services likely to be tendered in the future	Jun-2015	Jun-2015	CISC	Anna Basford	Rob Aitchison & Lisa Williams
Major	6300	Trustwide	All Divisions	All Departments/Wards	May-2015	Active	Objective 2 - Keeping the Base Safe	A number of clinical, operational and estates risks causing increased risks to patients and non-regulatory compliance which may result in CHFT not achieving a CQC rating of good or outstanding (e.g. Estates risks; Paediatric Standard compliance; A&E National Standards compliance).	- System for regular assessment of Divisional and Corporate compliance - Routine policies and procedures - Quality Governance Assurance structure - CQC compliance reported in Quarterly Quality and Divisional Board reports	- Full Divisional and Corporate self-assessment still to be completed - Some out of date policies and procedures	16 4 x 4	16 4 x 4	8 4 x 2	- CQC compliance Steering Group - Implementation CQC Compliance action plan - CQC Operational Group - Further embedding of CQC assurance into the Divisions and Corporate Governance structures	Jun-2015	Aug-2015	WEB	Julie Dawes	Juliette Cosgrove
Major	4706	Corporate	Finance	Corporate Finance	Jun-2011	Active	Objective 4 - Financial Sustainability	There is a risk that the Trust fails to achieve it's financial plans for 2015/16 thereby breaching it's MONITOR licence due to failure to deliver cost improvement plans, resulting in compromised patient safety and increased external scrutiny	Standing Financial Instructions set spending limits Turnaround structure in place which has created a more robust Project Management Office and the rigorous administration of cost improvement schemes Implementation of Turnaround Governance procedures (i.e. accurately reporting and projecting financial performance) Divisions can respond to activity targets ona specialty basis (e.g. additional theatre sessions/outsourcing if necessary) Formal Finance Our Future training Board to Budget Holders in place Budget reviews hold budget holders to account Accurate Income and Expenditure forecasting CIP target greater than actual savings required and contingency reserve established by the Director of Finance	Signed contracts not yet in place with main Commissioners for 2015/16 The unpredictability of Commissioners tendering process and possible decommissioning of services Financial plans for 2015/16 not yet formally accepted by MONITOR in line with the enforcement undertaking following the breach in 2014/15	15 5 x 3	15 5 x 3	10 5 x 2	Contracts to be agreed and signed following arbitration (date not yet fixed) Plans to be agreed to manage gains or losses following tendering process MONITOR reviews of Trust financial Plans to take place on 22/23 June 15	Jun-2015	Mar-2016	FPC	Keith Griffiths	Chris Benham

Major	6136	Diagnostics & Therapeutic Services	All Directorates Diagnostics	All Departments/Wards Diagnostics	Oct-2014	Active	Objective 2 - Keeping the Base Safe	There is a risk that the Trust will exceed its post 48 hours C Difficile target for 2015/16 due to non-compliance with Trust policies and procedures resulting in avoidable patient harm or death, increased external scrutiny and a reduced Governance Rating	Hand hygiene visual audits challenge non-compliance Hand hygiene is part of mandatory training requirements Anti-Biotic policy in place Standard Isolation policy in place Precautions to prevent the spread of C-difficile policy in place Major ward refurbishment always includes increases in the numbers of side rooms for isolation (over the last 5-6 years) PPM risk assessments cover defects which could harbor c-diff e.g. cracks Standards of cleaning agreed and in place High level decontamination with hydrogen peroxide following the identification of a case Learning from Root Cause Analysis is routinely applied	The relatively low numbers of Medical and Nursing staff on duty particularly out of hours The duration of anti-biotic usage by certain patients gives rise to increased vulnerability Availability of side rooms causes delays in the isolation of patients	25	5 x 5	15	5 x 3	10	5 x 2	Numbers of side rooms gradually increases following refurbishments to wards. This will improve further following the site re-configuration plans Hospital at Night and 7 day working plans are being produced by Autumn 2015 Compliance audits continue all year The Anti-Microbial Steering Group meets to endorse policies and agree an audit plan	Jun-2015	Mar-2016	ICPB	David Birkenhead	Jean Robinson
Major	6230	Corporate	Finance	Corporate Finance	Feb-2015	Active	Objective 1 - Transforming & Improving Patient Care	There is a risk that the Trust will not be able to deliver the expected financial benefits of the Electronic Patient Record (EPR) system due to the implementation being impeded by financial and operational constraints (eg additional costs incurred due to time delays or lack of appropriate resource being made available) resulting in a failure to demonstrate return on investment or value for money. There are two elements to this risk: Implementation of tactical solutions (e.g. e-rostering; nerve centre; maternity; voice recognition; EMS); and Project management delays, changes to specification and lack of capacity; clinical engagement and complexities with working jointly with Bradford Teaching Hospitals.	• Agreed loan from Independent Trust Financing Facility (ITFF) received in April 15 to support capital programme, specifically Electronic Patient Record (EPR). • Financial appraisal and selection of preferred supplier that included full benefits realisation and implementation plan. • Modernisation Programme Management and Governance structure to manage the implementation and roll-out of the EPR system within the Trust-wide IT Modernisation Programme.	None identified	15	5 x 3	15	5 x 3	5	5 x 1	EDMS being clinically assessed by end May 2015.	Jun-2015	Apr-2016	FC	Keith Griffiths	Kirsty Archer
Moderate	6270	Corporate	Workforce, OD & Training	Personnel & Development	Apr-2015	Active	Objective 2 - Keeping the Base Safe	There is a risk that all colleagues do not undergo an annual appraisal or complete mandatory training due to an inability to release them from other duties/insufficient training sessions, resulting in staff with some limited personal development and others who may cause harm to patients or colleagues through out of date or unrefreshed knowledge	E-learning packages in place for most elements of mandatory training (exceptions are Prevention, Dementia Care and Conflict Resolution) Data capture and reporting mechanisms standardized Divisional/Corporate Function leads have to produce an annual plan for Appraisal and Mandatory training by end of June 15 There is a section of the appraisal documentation which requires mandatory training to have been completed otherwise the user cannot continue to complete the sections There are policies in place for Appraisal and Mandatory Training	Scheduling is not yet in place for the production of annual plans by Divisional/Corporate leads The process of notifying staff/managers through ESR that mandatory training or appraisal is due is not in place Clinical priorities take precedence over appraisal or training	16	4 x 4	12	4 x 3	8	4 x 2	There will be improved staffing levels in place from September 15 following new intake from Universities Divisional managers to plan training for known quieter clinical demand periods	Jun-2015	Apr-2016	WEB	Director of Workforce and OD	Deputy Director of Workforce and OD

Moderate	6150	Corporate	Finance	Trustwide	Nov-2014	Active	Objective 4 - Financial Sustainability	There is a risk that the Trust will not be able to pay suppliers, staff and PDC loans due to cash flow timing or an overall shortfall of cash resulting in external scrutiny, significant reputational damage and possible inability to function as a going concern	Agreed loan from Independent Trust Financing Facility received in April 15 Agreement with main Commissioners to maintain their matching cash flow payments prior to agreement of contracts for 2015/16 Capital Programme restricted by risk assessing and prioritising schemes Cash forecasting processes enhanced through 13 week rolling forecasts Discussed and planned for Distress Funding cash support from MONITOR Trust's Standards Operating Procedures for Treasury Management and Accounts Payable give authority to withhold payments to suppliers	Cash support from Distress Fund not yet approved by MONITOR	15	5 x 3	10	5 x 2	5	5 x 1	KPMG are reviewing the Trust's cash management and forecasting. To be complete w/c 11 May Distress Fund support to be agreed when MONITOR visit the Trust 22/23 June 15	Jun-2015	Jun-2015	FPC	Keith Griffiths	Chris Benham

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Juliette Cosgrove, Assistant Director
Date: Thursday, 28th May 2015	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: Annual Quality Report - This annual quality report covers contractual, quality account, national and local quality priority requirements to provide a comprehensive overview of quality performance for 2014-2015 within Calderdale and Huddersfield NHS Foundation Trust (the Trust) and will identify key quality priorities for 2015-2016.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: None	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

This Annual Quality Report covers contractual, quality account, national and local quality priority requirements to provide a comprehensive overview of quality performance for 2014-2015 within Calderdale and Huddersfield NHS Foundation Trust (the Trust) and will identify key quality priorities for 2015-2016.

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

The Quality Goals are published in the Trust's Quality Account alongside key mandatory and local indicators. Each year the Trust works with the membership to agree the Quality Goals for the following performance year.

In 2014/15 the Trust also had two key Quality Improvement programmes;

1) Reducing avoidable mortality
2) Improving patient experience.

To deliver our mortality aim we have a comprehensive improvement programme designed to improve the care of acutely ill patients. Key priorities are to conduct mortality reviews and implement reliable care across acute pathways.

To deliver the aims of the patient experience programme a 12 month development plan was agreed that covers four main themes:

- Setting clear expectations- (Doing the Must Do's)
- Creating the means for hearing what patients tell us- (Go See)
- Making sure we respond to feedback- (Work Together to Get Results)
- Sharing the messages and learning (We Put the Patient First)

Another significant area of work is improving the way we respond to and learn from complaints. This is a key area in helping to improve the experience that patients have of our service and a number of improvement projects are arising as a result of feedback from patients.

The Care Quality Commission (CQC) Intelligent Monitoring reports also provide a framework for determining quality priorities, a full inspection within 2015/16 is expected under the new regulations. In preparation for that we worked with Price Waterhouse Cooper to conduct a self-assessment. As a result of that we have identified a number of areas where we will focus our improvement effort.

Main Body

Purpose:

Please see attached.

Background/Overview:

Please see attached.

The Issue:

Please see attached.

Next Steps:

Please see attached.

Recommendations:

Please see attached.

Appendix

Attachment:

2014 15 Annual Quality Report FINAL.pdf

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Juliette Cosgrove, Assistant Director
Date: Thursday, 28th May 2015	**Sponsoring Director:** Julie Dawes, Director of Nursing
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Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: None	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

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Recommendations:

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Appendix

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2014 15 Annual Quality Report FINAL.pdf

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Carole Hallam, Assistant Director of Infection Prevention Control
Date: Thursday, 28th May 2015	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Monthly DIPC Report - Monthly DIPC report provides an update on the position of HCAI	
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 HCAI	
Sustainability Implications: None	

Executive Summary

Summary:

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

Main Body

Purpose:

For information

Background/Overview:

Monthly update of the state of HCAI in the trust

The Issue:

Monthly update of the state of HCAI in the trust

Next Steps:

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

Recommendations:

For the Board to note the content

Appendix

Attachment:

Monthly DIPC Report May 2015.pdf

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

Performance targets

Indicator	Month agreed target	Current month (April)	YTD agreed target	YTD performance	Actions/Comments
MRSA bacteraemia (trust assigned)	0	**1**	0	**1**	Agreed as an unavoidable case
C.difficile (trust assigned)	2	**2**	21	**2**	1 avoidable 1 unavoidable
MSSA bacteraemia (post admission)	1	**0**	12	**0**	Target set with 2014-15 outturn
E.coli bacteraemia (post admission)	2	**1**	29	**1**	Target set with 2014-15 outturn
MRSA screening (electives)	95%	**96.73%**	95%	**96.45%**	March validated data
Central line associated blood stream infections (Rate per 1000 cvc days)	1.5	**1.4**	1.5	**1.37**	
ANTT Competency assessments (doctors)			95%	**60.4%**	Key trainer sessions are been held monthly and well attended. Assessments being performed at ward level. Clinical directors informed of the names where assessments remain outstanding
ANTT Competency assessments (nursing and AHP)			95%	**71.3%**	
Hand hygiene	95%	**99.74%**	95%	**99.83%**	

Quality Indicators

Indicator	Current month (April)	YTD performance	Comments
MRSA screening (emergency)	**91%**	**89.4%**	March validated data
Isolation breaches	**32**	**32**	Task and finish group to be set up to seek opportunities for improvement
Blood cultures Competency assessments		**54%**	Data only available for RN
Cleanliness	**97.18%**	**97.2%**	
Frontline Ownership Audits (% performed)	**67%**		Audit tool has been adjusted with recommendations to complete the audit by the 15th of each month; the cut off period for the data to be on the database is the last day of the month. ADNs will be informed of gaps by 21st of each month.

MRSA bacteraemia

Case details	Summary of case	Key issues identified from PIR (post infection review)
H6 MESS No 408348 Datix 117954	Patient admitted to ward 6 on 10th April with vomiting and reduced appetite and recently discharged from ward 17. History of MRSA since 2010 and screening and suppression treatment all performed as per policy. Developed signs of sepsis on 13th April; sepsis likely to have occurred from pneumonia acquired from endogenous flora.	• PIR meeting concluded this was an unavoidable case • ANTT training and competency assessments need to be completed by all frontline staff in a timely manner • IC training (Beyond the Basics) for all ward staff • Previous knowledge of MRSA should be taken into consideration when prescribing antibiotics • Assurance should be sought when giving MRSA information to patients in whom English is not well spoken

Clostridium difficile

There were 2 cases in April and summarised in the table below.

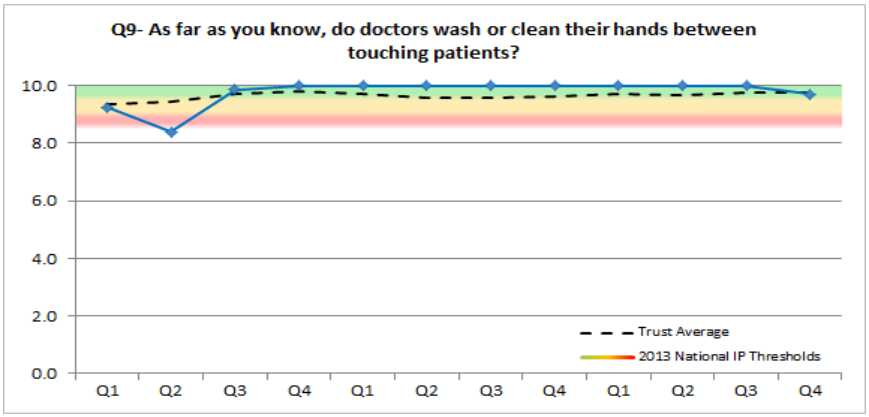
Case details	Summary of case	Key issues identified from RCA
04.04.15 **C7B** RCA meeting MESS no 406595 Datix 117756	Patient was admitted from on the 19th March with a CVA to ASU and then transferred to 7B on 22nd April. Regular laxatives prescribed for constipation and treated with antibiotics for a chest infection	• Agreed as an avoidable case • Suboptimal cleaning of the patient environment • Lack of knowledge on C.difficile with some staff • Delay in isolation • Delay in obtaining stool specimen
17.04.15 **C6D** RCA meeting MESS no 408661 Datix 118036	Patient was admitted to the ASU on the 10th April with a history of a sudden onset of right sided weakness. She was treated with antibiotics for LRTI and laxatives for constipation	• Agreed as an unavoidable case • Delay in isolation • Delay in obtaining stool specimen

HCAIs/Areas of Concern/Outbreaks

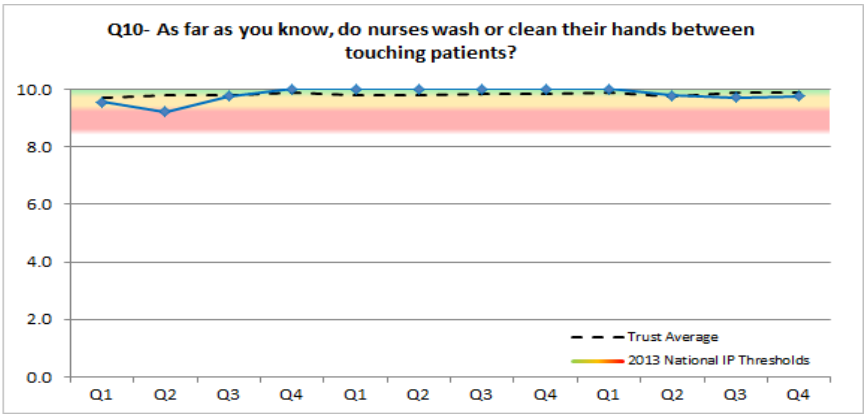
- **Isolation breaches** recorded by the Infection Control Team during April were 32. Of these 32 isolation breaches,
    - 14 were at CRH and 18 were at HRI
    - All but one of the breaches were on medical wards
    - 16 of the breaches occurred in the medical assessment areas, 12 at HRI and 4 at CRH
- **MRSA** – there were two cases of hospital acquired MRSA identified in April, one was a medical patient and one was an orthopaedic patient.

- **Viral gastroenteritis** – Ward 4 at HRI was closed for 2 days due to suspected viral gastroenteritis resulting in 3 lost bed days
- **Real Time Patient Monitoring** showed the following results for hand hygiene and cleanliness. The charts show the trust monthly scores for the last 12 months.

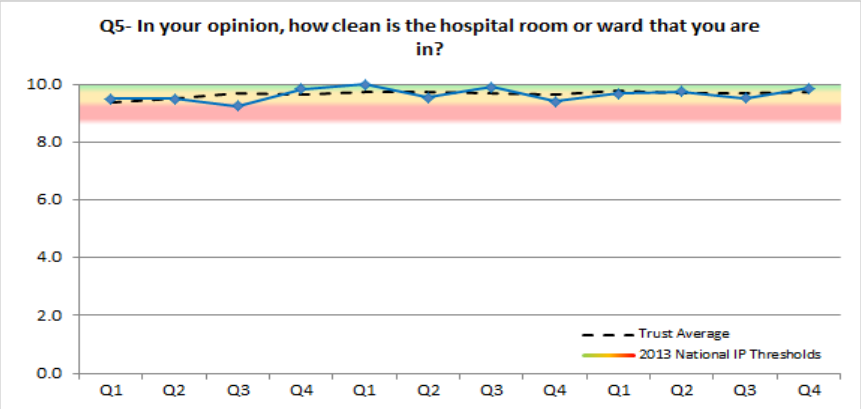
Q9, 'As far as you know, do doctors wash or clean their hands between touching patients?'



Q10, 'As far as you know, do nurses wash or clean their hands between touching patients?'



Q5, 'In your opinion, how clean is the room you are in?'



Quality Improvement Audits

- Two Quality Improvement Audits were performed in April

- HRI ward 12 – Scored Green (95%)
- HRI Chemotherapy OPD – Scored Amber (86%)
    - Dust observed on the curtain rails
    - Damage to catheter stands
    - Hand hygiene data out of date
    - Hand washbasin unclean
    - Not all equipment labelled when cleaned
    - Microwave unclean
    - Fridge temperature monitoring incomplete

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, 28th May 2015	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Trust HCAI Annual Programme and Action Plan 2015-16 - The Trust HCAI Annual Programme and Action Plan outlines the activity within the trust to reduce HCAI	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: The Trust HCAI Annual Programme has been presented to the ICC, HCAI Operations Group and the IC Performance Board	
Governance Requirements: Improving patient experience - reducing healthcare associated infections	
Sustainability Implications: None	

Executive Summary

Summary:

The Trust is committed to providing a safe environment for patients including preventing healthcare associated infections. Although the Trust has made significant reductions in healthcare associated infections over the last 5 years it also recognises that continued focus and effort is required to sustain the changes and meet the targets set for Healthcare Associated Infections (HCAI) in 2015/2016.

The objectives set for 2015/2016 are, a zero tolerance of avoidable post admission cases of MRSA bacteraemias and a ceiling of 21 post admission cases of Clostridium difficile infection.

Main Body

Purpose:

This HCAI Annual Programme must be read in conjunction with the Trust HCAI Action Plan (appendix 1). This programme lays out the routine and ongoing work in the trust to prevent HCAI, whereas the Action Plan sets out the specific actions with tight time frame to ensure changes occur rapidly. The Action Plan will continue to be updated as actions are identified through Root Cause Analysis (RCA) and other investigations.

Background/Overview:

The Trust develops an HCAI annual programme each year and has shown success in delivering a number of actions to reduce HCAI.

The Issue:

The trust continues to monitor HCAI and compliance to policy. This is reported monthly in the DIPC report

Next Steps:

The Annual programme is monitored by the ICC on a quarterly basis and the action plan is monitored by the ICPB

Recommendations:

The Board is requested to approve the HCAI Annual Programme and Action Plan 2015-16

Appendix

Attachment:

Trust HCAI Annual Programme 2015-16 V0.4.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

PREVENTION OF HEALTHCARE ASSOCIATED INFECTIONS

Trust Annual Programme and HCAI Action Plan 2015/16

Contents

Introduction

The Trust is committed to providing a safe environment for patients including preventing healthcare associated infections. Although the Trust has made significant reductions in healthcare associated infection it also recognises that continued focus and effort is required to sustain the changes and meet the targets set for Healthcare Associated Infections (HCAI) in 2015/2016.

The objectives set for 2015/2016 are, a zero tolerance of avoidable post admission cases of MRSA bacteraemias and a ceiling of 21 post admission cases of *Clostridium difficile* infection.

This programme must be read in conjunction with the Trust HCAI Action Plan (appendix 1). This programme lays out the routine and ongoing work in the trust to prevent HCAI, whereas the Action Plan sets out the specific actions with tight time frame to ensure changes occur rapidly. The Action Plan will continue to be updated as actions are identified through Root Cause Analysis (RCA) investigations.

Objectives

1. Ensure compliance with the Health and Social Care Act (2012) is both maintained and strengthened.
2. To achieve the objectives associated with the reduction of healthcare associated infections, including MRSA bacteraemia and *Clostridium difficile* infections.
3. To achieve standards outlined by the NHS Litigation Authority to prevent HCAIs.
4. To satisfy the Care Quality Commission that there are robust systems and processes within the trust to prevent HCAIs
5. To reduce the healthcare associated infections as part of the Trusts patient safety programme
6. To recognise the link between infection and mortality to prevent healthcare associated infections and reduce the risk of infection associated deaths providing a positive approach to the reduction of HSMR (Hospital Standardised Mortality Ratio)

Key Priorities for Actions 2015/2016

1. Strengthen the governance and assurance processes for preventing HCAI
2. Increase compliance with effective hand hygiene
3. Continue improvements in the safety of insertion and management of invasive devices
4. Improve the cleanliness and the environment
5. Development of specific strategies for reducing MRSA and MSSA bacteraemias
6. Development of specific strategies for reducing C.difficile
7. Development of specific strategies for reducing E.coli bacteraemia
8. Development of specific strategies for the prevention and control of antibiotic resistant organisms
9. Ensuring compliance with the Trust Antibiotic Policy
10. Delivery of the staff flu vaccine programme

Monitoring of the Programme and Action Plan

The Infection Control Committee members will monitor the progress of the Annual HCAI Programme quarterly at each meeting. The Assistant Director of Infection Prevention and Control or the Lead Nurse in her absence will provide a progress report to the Infection Control Committee.

The HCAI Action Plan will be monitored by the members of the Infection Control Performance Board. The Director of Infection Prevention and Control or the Assistant Director of Infection Prevention and Control in his absence will provide a progress report to the Infection Control Performance Board.

Exceptions to the progress of both the HCAI Annual Programme and the HCAI Action Plan will be reported to the Quality Assurance Board.

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The Health and Social Care Act 2012 – Maintenance and Strengthening of Compliance with the Code of Practice

	Current state	Future state	Executive Lead	Operational Lead	Frequency	Measure of Success
Criterion 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them						
	The trust's Governance Strategy outlines the collective responsibility for preventing HCAI	To update the Governance Strategy as appropriate	Medical Director/Director of Infection Prevention and Control	Associate Director of Risk	Annually	Governance Strategy
	There is an Infection Prevention and Control Arrangements policy that outlines the systems and processes in place to manage and prevent infection	To update and review the IP&C arrangement policy every two years or in light of new information and/or guidance	Medical Director/Director of Infection Prevention and Control	Lead Infection Prevention and Control Nurse	Two yearly	Infection Prevention and Control Arrangements policy
	There is an HCAI annual programme that includes an audit programme to ensure key policies and practices are implemented appropriately	The HCAI Annual programme needs to be monitored quarterly by the Infection Control Committee	Medical Director/Director of Infection Prevention and Control	Assistant Director of Infection Prevention and Control	Quarterly	Completed Annual Programme and minutes of the ICC
	The DIPC provides a monthly report to the Board	The DIPC report should keep the Board informed regarding the state of HCAI in the Trust	Medical Director/Director of Infection Prevention and Control	Assistant Director of Infection Prevention and Control	Monthly	Monthly DIPC reports
	The DIPC produces an annual report on HCAIs as outlined in 'Winning Ways'	The DIPC will produce an annual report outlining the state of HCAIs as outlined in	Medical Director/Director of Infection	Assistant Director of Infection Prevention and	May	Annual HCAI report

		'Winning Ways'	Prevention and Control	Control		
	All cases of MRSA bacteraemia and Clostridium difficile are reported to the PHE and the commissioner in a timely manner	All cases of MRSA bacteraemia and Clostridium difficile will be reported to the PHE and the commissioner in a timely manner as per the RCA/PIR pathways	Medical Director/Director of Infection Prevention and Control	Lead Infection Prevention and Control Nurse	Ongoing	PHE Data Capture System
	All cases of MRSA bacteraemia and Clostridium difficile are investigated using PIR/RCA in a timely manner	All cases of MRSA bacteraemia and Clostridium difficile will be investigated using RCA in a timely manner as per the RCA/PIR pathways	Divisional Director	Divisional Associate Director of Nursing	Ongoing	RCA/PIR reports and completed action plans
	There is a water safety group established	The WSG meets at regular intervals and monitors the water safety plan	Director of Planning, Performance, Estates and Facilities	Infection Prevention and Control Doctor	On-going	Water testing results
Criterion 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections						
	There is a Strategic Cleaning Policy	The Strategic Cleaning Policy is reviewed, monitored and updated by the members of the Estates and Facilities Board	Director of Planning, Performance, Estates and Facilities	Facilities General Manager	Bi-monthly	Cleaning Strategy
	Monthly cleaning scores are reported to the Board	Monthly cleaning scores continue to be reported to the Board	Director of Planning, Performance, Estates and Facilities	Facilities Matron, Estates & Facilities	Monthly	Monthly cleaning scores
	There is a schedule of	The schedule of PPM is	Director of	Head of Estates	Monthly	PPM schedule and

	Planned Preventative Maintenance (PPM) to ensure the environment is safe	reviewed, monitored and updated by the Estates and Facilities Divisional Board and appropriate actions taken where required, the PPM schedule mirrors the Estates Management Plans	Planning, Performance, Estates and Facilities	Operations		completed action plans, Service Performance, Monthly Audit, Authorising Engineer Audit (for HTM related activities)
	Planned Infection Control Environmental Quality audits are performed by a Multidisciplinary team to include Matrons, Infection Control, Cleaning Managers and Estates staff.	Planned Infection Control Environmental Quality audits involving the Multidisciplinary team will continue to performed according to the arranged schedule and the results shared with the appropriate Division for action where required	Director of Infection Prevention & Control	Lead Infection Prevention and Control Nurse and Facilities Matron	Monthly	Audit reports and completed action plans
	Frontline Ownership tool (FLO) has been developed to gain assurance around key infection control areas	The FLO tool will be used weekly by ward/department managers in all clinical areas, monthly by matrons and 3 monthly by Peer review	Director of Infection Prevention and Control	Matrons	Monthly	HCAI dashboard
	Cleaning Schedules are clearly displayed in each ward and clinical department	Cleaning Schedules are reviewed, updated and continue to be displayed	Director of Estates and Facilities	Matrons	Annually	Cleaning schedules
Criterion 3: Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance						
	The Trust has an Antimicrobial Management team (AMT) that meets monthly and membership includes microbiologists, pharmacist and senior clinicians	The AMT reviews and measures compliance with Antimicrobial policies, antimicrobial training and the results of audits.	Medical Director/Director of Infection Prevention and Control	Antibiotic pharmacists and Trust Antimicrobial Lead	Monthly	Minutes of the AMT

Criterion 4: Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion						
	Information is provided to other healthcare professionals regarding the infection status as outlined in the following IP&C Policies, section T – Multi-resistant Organisms, section W – IP&C for bed management and section Y – Clostridium difficile management	The IP&C policies will be reviewed and updated, training provided and their implementation measured through the audit programme.	Medical Director/Director of Infection Prevention and Control	Lead Infection Prevention and Control Nurse	Annually	IP&C Policies, sections T, W and Y and audit reports
	The electronic discharge summary (EDS) has been set up to include MRSA details	Medical staff need to include MRSA in patients EDS	Medical Director/Director of Infection Prevention and Control	Divisional Directors	As required	EDS
	A range of Patient Information leaflets are provided to patients and their visitors	Patient information leaflets are reviewed and updated regularly with the support from the FT Membership Council Members and at least 2 yearly	Director of Nursing	Lead Infection Prevention and Control Nurse	2 yearly	Patient information leaflets
	Information regarding hand hygiene, isolation precautions and outbreak precautions are communicated to the public by appropriate signage	Signage is reviewed and updated as required involving views of the FT Membership and these continue to be displayed as appropriate	Director of Nursing	Lead Infection Prevention and Control Nurse	2 yearly	Isolation door, ward outbreak and hand hygiene signage
	The Annual DIPC Report is published on the Trust website	The Annual DIPC Report is published in a timely manner	Medical Director/Director of Infection Prevention and	Assistant Director of Infection Prevention and Control	Annually	Annual DIPC report

			Control ion and Control			
Criterion 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people						
	The ICNet surveillance system provides information of alert organisms 3 times daily to the IP&C nurses, which is then passed onto the ward staff with appropriate advice on preventing spread to other patients	The IP&C nurses will continue to monitor the ICNet system and act accordingly as per standard operating procedures (SOPs)	Director of Infection Prevention and Control	Lead Infection Prevention and Control Nurse	As required	ICNet system and SOPs
	Patient with Multi-resistant organisms including MRSA, are flagged on both the PAS & EDIS system to alert users of PAS to the infection risks	The IP&C nurses will update the PAS & EDIS system with new cases of MRSA and other multi-resistant organisms.	Medical Director/Director of Infection Prevention and Control	Lead Infection Prevention and Control Nurse	As required	PAS & EDIS system
	Microbiology data is available to clinical staff on the ICE system	Clinical staff continue to access microbiology data on the ICE system	Director of Infection Prevention and Control	Microbiology Manager	As required	
	Universal MRSA screening is performed in line with DH guidance to inform appropriate actions and treatment if required	Universal MRSA screening should be continued to be performed in line with DH guidance and compliance monitored	Director of Infection Prevention and Control	Lead Infection Prevention and Control Nurse	Monthly	Screening compliance data
Criterion 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.						
	The prevention of HCAI is included in everyone's job description	The prevention of HCAI continues to be included in everyone's job description and is include in the appraisal process of clinical staff	Director of Personnel and Development	Divisional Human Resources Managers	Annually	Job Descriptions and appraisal documentation

	There is an infection control training strategy that ensures staff are adequately trained and competent in infection prevention and control procedures	The strategy needs to be implemented and its effectiveness reviewed	Medical Director/Director of Infection Prevention and Control	Lead Infection Prevention and Control Nurse	Annually	Training Strategy
	There is both a link practitioner and clinical champions model used to support and promote compliance with good infection prevention practice at a local level	Provide regular updates to the infection prevention link practitioners and clinical champions empowering them to challenge poor practice and to promote good infection prevention practice	Medical Director/Director of Infection Prevention and Control	Lead Infection Prevention and Control Nurse	Bi-annually	Update programme
Criterion 7 Provide or secure adequate isolation facilities						
	Patients requiring isolation are isolated promptly. On the occasions when patients cannot be isolated, these incidents are reported via the trust incident reporting process	Continue to isolate patients requiring isolation promptly, reporting the occasions when patients cannot be isolated, and using the isolation breach data to inform future isolation requirements.	Medical Director/Director of Infection Prevention and Control	Lead Infection Prevention and Control Nurse and Patient Flow Site Commander	As required	Datix reports
	Isolation facilities are increased within the ward refurbishment programme	Isolation facilities continue to be increased using the surveillance data, outbreak data and isolation breech data to inform the capacity required	Director of Estates and Facilities	Lead Infection Prevention and Control Nurse	As required	Ward Upgrade Risk Prioritisation Tool and minutes of the Space Utilisation Board
Criterion 8 Secure adequate access to laboratory support as appropriate						
	The laboratory has Clinical Pathology Accreditation (CPA), last assessed in January 2010	CPA standards are maintained.	Divisional Director of DaTs	Microbiology Manager	2 yearly	CPA certificate

	Microbiology specimens are processed using approved Standard Operating Procedures (SOP)	SOPs are reviewed and maintained using best available guidance	Divisional Director of DaTs	Microbiology Manager	Annually	SOPs
Criterion 9: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections						
	Infection Control Policies are developed using best available evidence and are available on the staff intranet	Infection Control Policies are reviewed and updated as required and as a minimum 2 yearly and meet the standard required by NHS LA.	Medical Director/Director of Infection Prevention and Control	Lead Infection Prevention and Control Nurse	2 yearly	IP&C Policies
	There is an audit programme to measure compliance with the standard infection prevention and control policies and reported to the Infection Control Committee	The audit programme should be reviewed annually and any actions arising from none compliance should prompt an effective action plan	Medical Director/Director of Infection Prevention and Control	Lead Infection Prevention and Control Nurse	Annually	Audit reports and action plans
Criterion 10: Providers have a system in place to manage the occupational health needs of staff in relation to infection						
	Pre-employment procedures ensure that new starters are asked relevant questions around infectious disease, and all clinical placements are asked to attend an immunisation check appointment with an OH Nurse on commencement.	Continue to check all new starters and ensure all staff are immunised as per recommendations in the 'green book' and this is reflected in the policies within the Occupation Health Department	Director of Personnel and Development	Lead Occupational Health Nurse	As and when required	Occupational Health policies.
	Frontline staff are immunised against season influenza as per DH guidelines	70% of frontline staff are immunised against season influenza as per the NHS North of England recommendation	Director of Personnel and Development	Lead Occupational Health Nurse	Annually	Occupational Health records and ImmForm

Infection Prevention and Control policies and other HCAI related policies

Infection Control and Prevention Policies				
Title of the policy	**Responsible team/author**	**Date of issue**	**Issue no.**	**Date of review**
Section A – Infection Control Arrangements	Lead Infection Prevention and Control Nurse	Dec 14	8	Dec 16
Section B – Notifiable Disease		Oct 13	7	Oct 15
Section C – Standard Precautions		Apr 13	5	Apr 15
Section D – Meningococcal Disease		Jan 13	5	Jan 15
Section E – Major Outbreak of Infection		Sept 14	5	Sept 16
Section F – Decontamination & Disinfection		Jul 13	5	Jul 15
Section G – Aseptic Technique		Mar 13	4	May 15
Section H – Hand Hygiene		May 13	5	May 15
Section J - Management of Patients with Multi Resistant Organisms inc. CPE, VRE, PRP and ESBL		Jun 14	15	Jun 16
Section K – Isolation		Mar 14	5	Mar 16
Section M – Management of Contamination Injuries		Mar 14	6	Mar 16
Section N – Viral Haemorrhagic Fever Policy		Sept 14	1	Sept 16
Section O – Transmissible Spongiform Encephalopathies		Apr 14	6	Apr 16
Section P – Care of the Deceased Body		Mar 14	6	Mar 16
Section R – Specimen Collection and Handling		Jan 15	6	Jan 17
Section S – Tuberculosis		Jun 13	4	Jun 15
Section T – MRSA and PVL Policy		Mar 14	8	Mar 16
Estates and Facilities Policies				
Title of the policy	**Responsible team/author**	**Date of issue**	**Issue no.**	**Date of review**
Strategic Cleaning Policy	Director of Estates and Facilities	Aug 14	02	August 16
Safe Management and Control of Estates policy		Jan 15	02	January 17
Laundry operational policy		Jan 15	01	November 16
Pest Control		Aug 12	01	August 2014

Waste Management Policy		Oct 13	02	July 16
Food hygiene		Jan 15	03	December 16
Invasive Devices Policies				
Title of the policy	**Responsible team/author**	**Date of issue**	**Issue no.**	**Date of review**
Venepuncture guidelines	IV Strategy Group members	Jan 15	02	January 2017
Extravasation guidelines		March 15	02	March 2017
Peripheral Venous Cannulation		March 14	03	March 2016
Central Venous Access Devices		*May 15*	02	*May 2017*
Urinary Catheter Policy	Urinary Catheter Steering Group	March 15	03	March 2017
Antibiotic guidelines				
Antibiotic Guidelines	Trust Antimicrobial Lead	Sept 2009		Each section 2 yearly
OPAT pathways			01	

Infection Prevention and Control Audits to provide assurance of compliance with policies and guidance

Audit	Frequency	Responsibility	Reports to
Infection Prevention Quality Improvement (combined Environmental) Audits	12-18 monthly	Lead Infection Prevention and Control Nurse/Matron, Estates & Facilities	HCAI Dashboard and IC Performance Boards
Cleaning audits	Weekly	Head of Cleaning Services	HCAI Dashboard and IC Performance Boards
Isolation compliance	Monthly	Lead Infection Prevention and Control Nurse	HCAI Dashboard and IC Performance Boards
CJD Risk assessment	Annual	Lead Infection Prevention and Control Nurse	Infection Control Committee & highlights to Divisional Boards
Sharps handling and disposal	Annual	Lead Infection Prevention and Control Nurse	Infection Control Committee & highlights to Divisional Boards
MRSA colonisation suppression	Annual	Antibiotic Pharmacist	Infection Control Committee & highlights to Divisional Boards
Urinary Catheter audit	Annual	Lead Infection Prevention and Control Nurse	Infection Control Committee, Urinary Catheter Steering Group & highlights to Divisional Boards
Peripheral Venous Cannula audit	Annual	Lead Infection Prevention and Control Nurse	Infection Control Committee, IV Strategy Group & highlights to Divisional Boards
Antibiotic prescribing	Monthly	Antibiotic Pharmacist	Infection Control Committee & highlights to Divisional Boards
Management of Contamination Injuries	Annual	Occupational Health Lead Nurse	Infection Control Committee
Frontline Ownership audits – 10 key infection control areas	Weekly	Ward/Department Audits	Matrons
Frontline Ownership audits – 10 key infection control areas	Monthly	Matrons	HCAI Dashboard
Frontline Ownership audits – 10 key	quarterly	Peer review	Associate Directors of Nursing

infection control areas			
Waste Audit	Monthly	Waste Manager	Ward/department manager
Aseptic non-touch technique (ANTT) audit	Annual	Assistant Director of Infection Prevention and Control	Infection Control Performance Board and HCAI Operations Group

Healthcare Associated Infections Surveillance

Surveillance	Frequency	Responsibility	Reports to
MRSA and MSSA bacteraemia	Continuous	DIPC	Executive, Trust and Divisional Boards
Clostridium difficile	Continuous	DIPC	Executive, Trust and Divisional Boards
Escherichia coli bacteraemia	Continuous	DIPC	Executive, Trust and Divisional Boards
MRSA colonisation and infection (hospital acquired cases)	Continuous	Lead Infection Prevention and Control Nurse	Executive, Trust and Divisional Boards
Extended Spectrum Beta-lactamase Producing organisms	Continuous	Lead Infection Prevention and Control Nurse	Infection Control Committee
Surgical Site Surveillance (hips and knee surgery)	July to Sept annually	Lead Infection Prevention and Control Nurse	Infection Control Committee & Orthopaedic Surgeons
Catheter (CVAD) related infections	Continuous	Lead Nurse Invasive Devices/ Lead Infection Prevention and Control	CVAD Steering Group and Executive, Trust and Divisional Boards

Training Programme

Training Title	Specific Infection Control Time	Who Attends	Frequency	Key Learning Objectives	Relate To Policy Section
Induction Training	30 minutes	All new starters	Monthly	Introduction to the IPC and the IPC team. National, regional and local perspective Infective Agents The chain of infection Standard Precautions Hand Hygiene Decontamination of equipment Sharps Handling & Safe Disposal	A T, Y D,N,O,S C H F M
Mandatory Risk Management (DVD)	Part of the 20 minute training DVD	All staff every year	Weekly	Standard Precautions Hand Hygiene Sharps Handling & Safe Disposal Isolation Practice Segregation of Laundry Waste management	C H M L V
Right from the Start	2 hours	New starters	Monthly	Overview of IPC. Hand hygiene Decontamination of equipment Waste management Laundry management Sharps management Personal protective equipment Isolation precautions Alert organisms – MRSA & C difficile.	A H F V L M C K T, Y
Beyond the Basics	2 hours	Clinical staff	Weekly	Update re IPC Healthcare associated infections Legal requirements	A C, H, S, T, B, C,

				Good practice / poor practice MRSA – outbreak Personal protective equipment Chain of Infection Decontamination Hand hygiene Sharps / contamination injury Learning from Root Cause Analyses Key (alert) micro-organisms	C, H, J, T, Y E, T C C, H, F F H M T,Y T, Y
Back to Basic	45 minutes	Ward based clinical staff	Specific period for support	Update re IPC Healthcare associated infections Legal requirements Good practice / poor practice MRSA – outbreak Personal protective equipment Chain of Infection Decontamination Hand hygiene Sharps / contamination injury Learning from Root Cause Analyses Key (alert) micro-organisms	A C, H, S, T, B, C, C, H, J, T, Y E, T C C, H, F F H M T,Y T, Y
Domestic Services Induction Training & Ongoing refresher update	30 minutes	All cleaning staff	As and when required	Isolation Practice Hand Hygiene Standard Precautions Disinfection Policy	J H C F
Estates staff Induction Training & Ongoing refresher update	30 minutes	All staff	As and when required	Isolation Practice Hand Hygiene Standard Precautions Disinfection Policy	J H C F
Venepuncture & Cannulation (infection control issues)	30 minutes	Nurses & AHP who perform venepuncture & cannulation	monthly	Risk of Infection in Venepuncture & Cannulation Hand Hygiene Aseptic Non-touch Technique	 H G

Link Infection Prevention & Control Practitioner Workshops	Half day	LIPCPs	3 monthly	Feedback of Audit Data Update on New/Changed Policy Risk Assessment Principles of Audit MRSA Screening & Colonisation Suppression	S, N, P,R
Hand Hygiene Training with Light Box	Unlimited (light boxes to be rotated to all clinical areas)	All clinical staff	Annual	Raise Awareness of Hand Hygiene Improve Hand Hygiene Technique	H H
Aseptic Non-touch Technique	DVD on intranet	Clinical staff performing aseptic procedures	As and when required.	Principles of Asepsis Use of Trolley for ANTT procedures Will be audited at time of reassessment	G
Aseptic Non-touch Technique updates	2 hour	Key trainers	Two yearly	Principles of Asepsis Use of Trolley for ANTT procedures Will be audited at time of reassessment	G
Preventing MRSA – Learning through RCA	1 hour	Matrons, clinical teams, link practitioners	As & when required	Clinical Audit Meetings Matrons Divisional Meetings	T
Waste Management	Session delivered by estates & facilities staff	All staff		Segregation of Waste Safe Handling & Disposal of Waste	W
Junior Doctors Induction – Skills Workshop	30 minutes (repeated throughout an afternoon)	All new junior doctors	6 monthly	Hand Hygiene Decontamination of Equipment Care of Invasive Devices Communication Antibiotic Policy Challenging Poor Practice	H F T & W
Antibiotic Policy Training	Flexible - to be delivered by microbiologists & antibiotic pharmacist	All doctors	As and when required	Principles of Antibiotic Prescribing Introduction to the antibiotic care bundle	
Masterclass training	Proposed 1 hour	All staff that need	As and	CJD risk assessment	O

for CJD risk assessment and management		to perform CJD risk assessments	when required	Understanding of CJD Management of a patient with CJD	
Specific infectious disease training	As required	Key clinical staff	As and when required	TB CJD Clostridium difficile Meningococcal disease Ebola	S O Y D
Urinary Catheterisation (infection control risks)	30 minutes	Clinical staff that perform catheterisation	2 monthly	Hand hygiene Infection risks of catheterisation Prevention of infection Aseptic technique	H
Infection Prevention & Control for Medical Students	1 hour	3rd and 5th year medical students	As required	Hand hygiene Aseptic technique Sharps handling and disposal Standard Precautions Isolation precautions	H
Generic skills day for regional foundation trainees	Yearly lecture by microbiologists	regional foundation trainees	Yearly	IC and appropriate antibiotic prescribing	
International Nurses induction, plus 1-2-1 workplace sessions.	1 hour	Spanish nurses	When required	Introduction to the IPC and the IPC team. National, regional and local perspective Infective Agents The chain of infection Standard Precautions Hand Hygiene Decontamination of equipment Sharps Handling & Safe Disposal	A T, Y D,N,O,S C H F M

Appendix 1 TRUST HEALTHCARE ASSOCIATED INFECTION PREVENTION ACTION PLAN 2014/15

1.0 Key Priority Area: Strengthen the governance and assurances processes for preventing HCAI									
No	**Current state**	**Future state**	**Actions**	**Date to Complete**	**Executive Lead**	**Operational Lead**	**Measure of success**	**RAG**	**Progress**
1.1	Infection Prevention & Control structure reviewed in 2014	IP&C Governance structure should be effective to ensure accurate information is received in a timely manner by those that need to take action	Monitoring and performance management of IP&C key indicators by the IC Performance Board	Immediate	Director of Infection Prevention and Control	Assistant Director of Infection Prevention and Control	HCAI dashboard, Intergrated Board report and minutes of the IC Performance Board		
1.2	HCAI information provided via monthly Dashboard, DIPC report and Intergrated Board report	Regular reporting of IP&C key indicators providing recommendations for action	a) HCAI Ops Group to agreed actions as required and add to HCAI action plan		Director of Infection Prevention and Control	Assistant Director of Infection Prevention and Control	Minutes of the HCAI Ops Group		
			b) review progress and evaluate effectiveness	Mar-16			Minutes of the HCAI Ops Group and HCAI Dashboard		
1.3	The training strategy identifies all staff that	Not all staff access infection prevention and	a) Review training to be accessible and effective	Jul-15	Director of Infection Prevention and	Lead Infection Prevention and Control	Training strategy		

	require infection and prevention training	control training in a timely manner	b) develop the best method of measuring training of frontline staff in 'beyond the basics infection and prevention' training	Dec-15	Control	Nurse	Training report		
2.0 Key Priority Area: Hand hygiene should be performed effectively and appropriately									
2.1	Current data suggests hand hygiene could be improved	Continue with initiatives to improve hand hygiene	a) work with one test ward to implement improvement methodology and process measures	Immediate	Director of Infection Prevention and Control	Lead Infection Prevention and Control Nurse	Improvement in hand hygiene compliance		
			b) evaluate progress and develop a programme to spread	Sep-15			Implementation programme		
3.0 Key Priority Area: Invasive Devices are inserted and managed safety									
3.1	78% of staff were compliant with all elements of ANTT in the audit perfomed in December 2014	Staff should be compliant with in element of ANTT >95%	a) Ensure each clinical area has access to an ANTT key trainers	Jul-15	Director of Nursing		List of ANTT key trainers		
			b) Performance manage competency assessment through regular sharing of competency matrix and reporting via HCAI Dashboard	May-15	Medical Director		HCAI Dashboard		
			c) re-audit of ANTT to be performed and appropriate actions taken	Jan-16	Director of Nursing		Audit report (2015)		

			a) Inform junior medical staff and matrons that staff perfoming blood cultures are aware of the competency requirements. Training DVD and self-declaration are avialable on the intranet	Apr-15			Intranet page with DVD and self-declaration		
3.2	Blood culture training and competency assessments are in place	Staff performing blood culture should be competent	b) Performance manage competency assessment through regular sharing of competency matrix and reporting via HCAI Dashboard	May-15	Director of Infection Prevention and Control	Assistant Director of Infection Prevention and Control	HCAI Dashboard		
			a) all CVAD related bacteraemias to be reported on Datix and investigated	Apr-15			Datix reports		
			b) Commence monitoring CVAD infection rates in community lines	Apr-15			CVAD dashboard		
3.3	Process for identifying and investigating catheter related blood stream infections (CRBSI) is in place	Review process for identifing and investigating CRBSI to ensure robustness and shared learning	c) key learning to be presented at the CVAD Steering Group and appropriate actions agreed.	Jun-15			Minutes of the CVAD Steering Group		

3.4	Currently RCA investigation is only performed on CRBSI	Investigation of bacteraemia cases to include device related cases to assure shared learning	a) a drop down box on the APEX system to add the option of 'device related' on positive blood cultures b) commence investigation of device related bacteraemias	Jun-14 Jul-15	Director of Infection Prevention and Control	Assistant Director of Infection Prevention and Control	RCA reports		
4.0 Key Priority Area: Improve the cleanliness and environment									
4.1	Inconsistent cleaning audit results	Robust and auditable approach for monitoring performance of cleaning	Development of an effective audit process and monitor its effectiveness	Mar-16	Director of Estates and Facilities/Planning and Performance	ADD Estates and Facilities	Audit reports		
4.2	Ward 7 at HRI is in need of refurbishment	Refurbishment of ward 7	Provision of a unit which meets requirements in line with healthcare/infection control guidance for haematology/oncology outpatients	Jan-16	ADD Estates anfd Facilities	Estates Manager	Per review of services		
4.3	External report has highlighted inconsistent systems, processes and cleaning methods on the HRI site	Consistent systems, processes and cleaning methods to provide effective cleaning	Provision of an Operational Manual for the delivery of effective cleaning services, including revised cleaning methods/risk assessments	Mar-16	Director of Estates and Facilities/Planning and Performance	ADD Estates and Facilities	Operational Manual and audit reports		

5.0 Key Priority Area: development of specific strategies for reduction of MRSA and MSSA bacteraemia									
5.1	Surgical site surveillance infection (SSI) is performed in orthopaedic joint surgery as per mandatory requirements	Increase surveillence of surgical site infections to include a wider level of incisional surgical procedures			Director of Infection Prevention and Control	Divisional Director of Surgery			
5.2	MRSA screening is performed on all patients undergoing surgery	Consider the introduction of MSSA screening for high risk surgery	a) commence MSSA screening for high risk surgery	Jun-15	Director of Infection Prevention and Control	Lead Infection Prevention and Control Nurse			
			b) evaluate the process and assess the benefits	Mar-16					
5.3	MSSA bacteraemia is externally reported but no national target set	Set internal target for reduction of MSSA bacteraemia	Monitor key themes to highlight areas requiring action	Mar-16	Director of Infection Prevention and Control	Lead Infection Prevention and Control Nurse	HCAI Dashboard		
6.0 Key Priority Area: development of specific strategies for reduction of Clostridium difficile									
6.1	The timing of isolation in patient with diarrhoea is variable	Isolation of patients with acute diarrhoea must be timely	a) set up a task and finish working group to understand the issue with delayed isolation and agree actions	May-15	Director of Infection Prevention and Control	Associate Director of Nursing (Medicine)	Isolation working group Terms of Reference/minutes		
			b) continue to monitor isolation breaches and report monthly	Apr-15		Lead Infection Prevention and Control Nurse	HCAI Dashboard		

6.2	RCA highlight delays in obtaining stool specimens for testing in patients with acute diarrhoea	Timely testing for Clostridium difficile in patients with acute diarrhoea	a) plan and implement an awareness campaign to educated and empower frontline staff on the appropriate time to send stool specimens for testing						
7.0 Key Priority Area: development of specific strategies for reduction of E.coli bacteraemia									
7.1	Urinary catheters are often implicated in E.coli sepsis	Reductions in the use of urinary catheters, length of time insitu and improvements in insertion and care are required	a) Meet with Health Informatics regarding collection of data to measure improvement	May-15	Director of Infection Prevention and Control	Assistant Director of Infection Prevention and Control	Notes of the meeting		
			b) Focus work on collaborative wards until improvements achieved	Apr-15			Quarterly evaluation reports		
			c) monitor outcome data	Sep-15			outcome data		
			d) monitor and evaluate intermittent catheter project	Mar-16			Quarterly evaluation reports		
7.2	Catheters are not being removed in a timely manner	Catheters should be removed as soon as they are	a) plan and implement an awareness campaign to educated and empower frontline staff on the appropriate time to send stool specimens for testing						
8.0 Key Priority Area: development of specific strategies for the prevention and control of antibiotic resistant organisms									

8.1	The UK has seen a rapid increase in cases of Carbapenamase-producing enterbacteriaceae (CPE)	Public Health England has produced new guidelines on prevention and control of CPE	Monitor compliance with the CPE policy	Jun-15	Director of Infection Prevention and Control	Lead Infection Prevention and Control Nurse	Policy		
9.0 Key Priority Area: Antibiotics are prescribed using best available evidence									
9.1	Recent clinical incident highlighted that antibiotic guidelines on Trust intranet are out of date versions	Antibiotic guidelines are up to date and easily accessible	Antibiotic guidelines reviewed, approved by Medicines Management Committee May 2015 and updated versions on Trust intranet by end of May 2015	May-15	Director of Infection Prevention and Control	Lead Microbiologist for Antibiotics and Antibiotic Pharmacists	Minutes of Antimicrobial Management Team meetings (monthly), Minutes of MMC Meetings		
9.2	Recent clinical incident showed poor adherence to Antibiotic Surgical Prophylaxis guidelines	Antibiotics prescribed for surgical prophylaxis are prescribed according to local guidelines	Review the use of IV Gentamicin as part of antibiotic surgical prophylaxis – to discuss potential use of alternatives. Provide assurance of compliance by re-auditing antibiotic surgical prophylaxis	Sep-15 Dec-15	Director of Infection Prevention and Control	Lead Microbiologist for Antibiotics and Antibiotic Pharmacists	Audit results show good compliance with prescribing according to guidelines. Minutes of Antimicrobial Management Team (AMT) meetings (monthly)		

9.3	6 monthly bacterial resistance and antibiotic consumption data provided to AMT and disseminated via antibiotic dashboard to Trust Exec, Directorates and Pharmacy	Data regarding bacterial resistance patterns and antimicrobial consumption, incorporating Define software, is provided Annually for ARHAI. This will allow benchmarking against other Trusts	Antibiotic pharmacist to undertake training on Define software to enable reports to be produced. This will allow compliance with ARHAI/ESPAUR and enable National benchmarking	Jun-15	Director of Infection Prevention and Control	Lead Microbiologist for Antibiotics and Antibiotic Pharmacists	Report produced and compliant with ARHAI/ESPAUR requirement. Minutes of Antimicrobial Management Team (AMT) meetings (monthly)		
9.4	Step down from IV to oral antibiotics could be made sooner for appropriate patients	Enable earlier switch from IV to oral antibiotics, as per CHFT Antimicrobial Management policy	Update CHFT Antimicrobial Management policy, incorporating enhanced guidance re: suitable criteria to facilitate IV to oral switch. For MMC May 2015. Briefing sessions for Pharmacy staff re: use of policy and yellow “review antibiotic stickers”	May 2015	Director of Infection Prevention and Control	Lead Microbiologist for Antibiotics and Antibiotic Pharmacists	Reduced expenditure for IV Piperacillin/Tazobactam by 10%		

9.5	Carbapenem usage has increased and Fidaxomicin costs for 2014-15 were £80,000	Carbapenem usage reduced by 20% and Fidaxomicin usage reduced by 25%	Review of patients prescribed meropenem on weekly antibiotic ward rounds (weekly usage data produced from Pharmacy Ascribe system). Agreement of place in therapy for C.Diff for Fidaxomicin. Pharmacy staff to supply smaller quantities of oral fidaxomicin when dispensing	Jun-15	Director of Infection Prevention and Control	Lead Microbiologist for Antibiotics and Antibiotic Pharmacists	Carbapenem and Fidaxomicin usage monitored from Pharmacy Ascribe data monthly. Minutes of Antimicrobial Management Team (AMT) meetings (monthly)		
9.6	Results from November 2014 Antibiotic Point Prevalence audit showed 90% prescriptions had indication specified on inpatient prescription chart and 69% stop/review date specified	Antibiotics prescribed at CHFT are in accordance with Antibiotic guidelines and principles of Antimicrobial Stewardship (Start Smart-then focus)	Ensure antibiotic audits being undertaken as part of Annual Programme. Increase % antibiotic prescriptions with indication specified on prescription chart to 95% and 80% stop/review date	Dec-15	Director of Infection Prevention and Control	Lead Microbiologist for Antibiotics and Antibiotic Pharmacists	Minutes of Antimicrobial Management Team (AMT) meetings (monthly)		

9.7	Education and Training strategy for staff who prescribe, administer and dispense antibiotics 2012-13. Needs to be formally updated and approved. Education currently still be provided to staff at CHFT	2015-16 Strategy for Education and Training for staff who prescribe, administer and dispense antibiotics approved. Training delivered in accordance with strategy	Strategy to be updated and approved by AMT and MMC	Sep-15	Director of Infection Prevention and Control	Lead Microbiologist for Antibiotics and Antibiotic Pharmacists	Minutes of Clinical Audit meetings. Antibiotic Awareness Campaign, to coincide with European Antibiotic Awareness Day 18th November. Minutes of Antimicrobial Management Team (AMT) meetings (monthly)		
9.8	Recent incident where patient with documented allergy to penicillin prescribed a penicillin. (No harm reported but should be a "never" event)	Reduce the incidence of penicillins prescribed to patients with a documented allergy to penicillin	Awareness campaign for staff eg posters on wards with penicillin-type antibiotics and article in Trust Patient safety newsletter	Jul-15	Director of Infection Prevention and Control	Lead Microbiologist for Antibiotics and Antibiotic Pharmacists	Fewer incidents reported on Datix. Minutes of Antimicrobial Management Team (AMT) meetings (monthly)		
9.9	EPR being developed	Future inpatient prescribing will be electronic. Other Trusts with electronic prescribing have built in mechanisms to support antimicrobial stewardship when	Ensure input from AMT members on EPR project	Jan-16	Director of Infection Prevention and Control	Lead Microbiologist for Antibiotics and Antibiotic Pharmacists	When antimicrobials are prescribed, there are in built prompts to support antimicrobial stewardship. Also to have the ability to download information to support review of antimicrobials by AMT by identifying patients.		

		antimicrobials are prescribed							
10.0 Key Priority Area: reduce risk of influenza in patients and staff									
10.1	Staff are given flu vaccine at the beginning of the flu season	Last year 64% of frontline staff were given flu vaccine	Ensure the uptake of flu vaccine for frontline staff to >75% (with a stretch internal target of 80%)	Jan-16	Director of workforce and OD	Lead Occupational Health Nurse	Weekly flu vaccine reports		

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Alison Wilson, Head of Estates Operations and Compliance
Date: Thursday, 28th May 2015	**Sponsoring Director:** Lesley Hill, Director of Planning, Performance, Estates and Facilities
Title and brief summary: CHFT Annual Fire Safety Report - Annual Fire Safety Report	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: The annual report has been reviewed by CHFT's External Authorising Engineering, at the Health & Safety Committee and at Weekly Exec Board.	
Governance Requirements: CHFT must comply with the Regulatory Reform (Fire Safety) Order 2005 and Health Tehcnical Memorandum 05 - Fire Safety in Healthcare. The annual plan provides assurance how the Trust comply with the requirements and identifies an action plan to make improvements in areas.	
Sustainability Implications: None	

Executive Summary

Summary:

The annual report provides a progress report on CHFT's fire safety arrangements and monitors performance throughout 2014/2015. A workplan is incorporated focussing on improvements for 2015/16.

Main Body

Purpose:

To provide assurance to Trust Board on the progress made throughout 2014/2015 and the workplace for 2015/2016.

Background/Overview:

The report is provided to Trust board on an annual basis.

The Issue:

The 2015/16 workplan focusses on implementing fire risk assessments, delivering suitable and sufficient training, progressing with fire related capital works and reducing the number of unwanted fire calls.

Next Steps:

To monitor the 2015/16 work plan at monthly Health and Safety Committee meetings.

Recommendations:

Trust Board are requested to approve the annual report.

Appendix

Attachment:

CHFT Annual BOD Fire Report2015.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

CHFT Annual Fire Safety Report
1st April 2014 – 31st March 2015

1. INTRODUCTION

This report describes the fire safety arrangements and activities of Calderdale and Huddersfield NHS Foundation Trust during 2014/2015 in order to meet the requirements of the Regulatory Reform (Fire Safety) Order 2005 (FSO), Health and Social Care Act 2008 - Regulation 15 Safety and Suitability of Premises and the Department of Health's Health Technical Memorandum (HTM) 05 – Managing Healthcare Fire Safety.

2. BACKGROUND

The Fire Safety Order places responsibilities on the Trust to carry out risk assessments to identify, manage and reduce the risk of fire. Regulation 15 places responsibilities on the Trust to provide safe and suitable premises to service users. HTM 05 framework sets out recommendations and guidance for the management of fire safety in healthcare buildings including protective measures, precautionary measures and the need for an independent authorising engineer.

There has been a significant amount of activity within this small department to move forward with a number of shortcomings that have been identified. The improvements necessary will require ongoing substantial capital funding to ensure our building(s) are fully compliant. The current financial constraints the Trust are under will impact further on the journey towards a safer and compliant building however, capital funding available is being prioritised in this area.

3. REPORT

3.1 Policies

The Trust Fire Safety Strategy is due for review and will be ratified by Executive Board in May 2015.

West Yorkshire Fire & Rescue Service and the Trust in addition to the joint working protocol in August 2013 are also working with the Trust to support the reduction in the number of unwanted fire signals.

3.2 Risk Assessments

Risk assessments are a requirement of the FSO and these have been carried out within CHFT's premises. It has become apparent the difficulty in providing assurance the fire risk assessment's have been implemented throughout the Trust and actions are complete. To address this, an audit of the Fire Risk Assessments is being carried out and databases are being explored to ensure information is managed appropriately.

Whilst Fire Risk Assessment have been issued to Divisions there appears to be a lack of dissemination down so that those staff in the working environment. All staff should be able to see the fire risk assessment in the area where they work.

Common findings include inadequate fire compartmentation, poor housekeeping and storage.

It is a legal requirement that fire risk assessments are reviewed on an annual basis or, when there has been a change within the area. Changes may include the physical environment or change of patient group. The review process also shows that there is a lot of departmental movement internally within the Trust resulting in a requirement to re-assess the area.

3.3 Fire Calls

3.3.1 False Alarms

West Yorkshire Fire and Rescue Authority began a pilot scheme on 1st April 2014 for charging organisations £350 + Vat for each unwanted fire signal (UFS). Their objective is to reduce the number of UFS thus ensuring fire tenders are available for actual fire calls. CHFT's Fire Officer and Authorising Engineer are working closely with the Authority and Estates and Cofely to ensure where possible we are not charged. CRH has received the first charge for an unwanted fire signal which cost £420

Fire alarms activations fall into 3 categories as per the HTM, these are:

Fires (F)	A fire can be regarded as an incident resulting in the uncontrolled emission of heat and/or smoke;
False Alarms (FA)	A false alarm is an activation of the fire detection and alarm system resulting from a cause (other than fire) and the fire & rescue service **were not called** to attend site.
Unwanted Fire Signals (UFS)	A false alarm is an activation of the fire detection and alarm system resulting from a cause (other than fire) and the fire & rescue service **were called** to attend site. These will be chargeable in future, if there are more than 3.

Whilst there are still high numbers of false alarms on both sites and efforts are being made to reduce this through training and upgrading of the fire alarm system at HRI. The number of calls has reduced but more work is required.

The number of calls at CRH is high but the life cycle upgrades are now helping to reduce these activations. The Trust is required to monitor fire alarm activations to ensure they are kept to a reasonable level and determine the reason for the activation and actions to prevent a reoccurrence.

2014/15	Actuations	Fires	False Alarms	Unwanted Fire Signals
Huddersfield	**53**	**4**	**51**	**4**
Calderdale	**100**	**0**	**100**	**5**

2013/14	Actuations	Fires	False Alarms	Unwanted Fire Signals
Huddersfield	**67**	**5**	**40**	**5**
Calderdale	**95**	**2**	**93**	**6**

Fires at HRI relate to:-

- A contractor ignited the roof whilst repairing a leak.
- A member of staff over cooked a jacket potato in a microwave oven causing it to set on fire.
- An old light fitting gave off smoke causing an evacuation of the Physiotherapy department.
- A motor on an air handling unit overheated and gave off smoke.

No Fires at CRH

3.4 Training

3.4.1 Fire Safety Training

During the year Fire Safety Training was stabilised and standardised resulting in a significant increase in attendance. The role of Fire Warden has now become established and works extremely well; staff undertake weekly fire safety checks to ensure passive fire protection measures are being maintained. The number of fire safety issues raised by staff has increased significantly since the fire safety training and fire safety checks.

		2013/14	2014/15
Fire Safety Training	-	**2460**	**4976**
Fire Warden Training	-	**826**	**1042**

Training figures are provided to EB on a weekly basis and these are now shown by division. A number of staff require fire warden training and a significant number of staff are required to attend fire safety. Various delivery methods have been successfully used but Trust wide training only achieved 87.1% which still leaves 740 members of staff untrained.

A fire safety training needs analysis has been developed and has led to a fire safety booklet being published for 2015, this reinforces last year's training, but also free up time to carry out Fire Extinguisher training for key staff.

3.4.2 Evacuation training

Due to the risk to patients there are limited options to undertake live fire evacuation training on wards. However in 2014 numerous staff evacuations with staff practicing for the event occurred. Further evacuation exercises are planned for 2015 but this will depend on the availability of suitable facilities and staff being available.

Acre Mill

Specific training in this building has been carried out and approximately 250 staff received fire training along with a full evacuation of the building.

There have also been numerous Fire Safety issues which are being resolved which have taken a significant amount of time. There are fire safety points learnt from the Acre Mill project which must be taken forward on future projects.

3.5 Governance

3.5.1 Reporting Arrangements

Fire safety is reported on a monthly basis to the health and safety committee. Fire safety monitoring arrangements, progress and issues are discussed in detail on a monthly basis at the Estates and Facilities Quality and Safety Board. Issues of concern are escalated appropriately.

3.5.2 Audits

CHFT's authorising engineer has started his audit of the Trust's premises during 2015 and measure compliance against the FSO, Health and Social Care Act 2008 Outcome 10 and HTM 05. A compliance report will be provided to the Health and Safety Committee.

3.6 Capital Works (HRI)

3.6.1 Fire Compartmentation

The Trusts buildings are made up of a number of fire resisting compartments to reduce the spread of fire from one location to another. This fire compartmentation allows the Trust to use progressive horizontal evacuation as its primary evacuation method.

The fire compartmentation at HRI has deteriorated due to works been carried out by Contractors over a many years and the fire compartmentation has not been reinstated following the completion of the work. A fire survey identified works necessary to reinstate the compartmentation back to its original design; a plan is in place to ensure all high risk areas are reinstated, but this a massive task and comes with a large financial cost. There is no option but to do this work, as it is a legal requirement.

Contractor safe systems of work have been reviewed by Estates and improvements implemented ensuring tasks are sufficiently completed and the premises are handed back in a safe state.

Over the period 1st April 31st March 2015 there have been a number of capital schemes that have improved the fire precautions within the Trust these are:

- Ward 11
- Penthouse Plant rooms (on going)
- Theatres and plant room (on going)
- Haematology

The Trust would benefit from a life cycle replacement programme ensuring ageing items are funded for replacement at annual intervals. This approach would reduce the likelihood of failing items and also allow the Trust to prioritise and plan funding.

3.6.2 Fire Detection

Improved fire detection has been installed in the majority of areas where there was detection at HRI. However there are numerous areas that do not have fire detection which needs resolving. There is still work required to update and improve coverage at HRI bringing the system up to the required standard. The new type of smoke detector (Squad) that is being installed can distinguish better between smoke and other products (eg: air freshener / steam etc) so a further reduction of calls is anticipated.

CRH fire detection is being upgraded with the lifecycle programme that is in place; so a further reduction of calls is anticipated and needed.

3.7 West Yorkshire Fire and Rescue Service

Fire Strike

Strike activity took place across England during 2014/2015. Fire safety patrols were carried out across CHFT premises and extra vigilance from staff was requested. No fire calls were made during the fire strike period and the patrols were managed effectively. There is no indication that further strike activity will stop, however should further events be planned the same controls will be implemented to manage fire safety.

Operational Visits

There has been a marked increase in the number of both operational and familiarisation visits by local Fire Crews. This partnership working is important and ensures the fire crews have a better understanding of the problems they may face in the event of an incident and enables them to deal better with the situation. There have been (to both hospital sites) 22 visits by Fire Service personnel, plus two attendances at Safety Central (Fire Safety HQ for WYF&RS).

Fire Safety

Advice and assistance from West Yorkshire Fire & Rescue Service has been sought on some issues regarding the Acre Mill project and Compartmentation at HRI.

Following any fire incident on premises occupied by the Trust; a dialogue is established to ensure no enforcement is required.

4. DRAFT WORKPLAN FOR 2015/2016

	Actions	Who	When
	FIRE RISK ASSESSMENT		
1	Audit Fire Risk Assessments for HRI & CRH	Authorising Engineer	Sept 15
2	Audit Fire Risk Assessments for community Premises	Authorising Engineer	Sept 15
3	Annual Review of Fire Risk Assessments	Authorising Engineer	Sept 15
4	Database fire risk assessments	A Wilson	June 15
	FIRE SAFETY TRAINING		
5	Provide Fire Warden Training	K Rawnsley	March 16
6	Provide Site Co Fire Training	K Rawnsley	March 16
7	Roll out fire Safety Awareness (booklet)	K Rawnsley	March 16
8	Provide fire extinguisher training for key staff	K Rawnsley	March 16
9	Deliver evacuation training for high risk areas	K Rawnsley	March 16
	FIRE SAFETY CAPITAL WORKS		
10	Progress fire compartmentation works	P Gilling	March 16
11	Progress installation of fire detection	P Gilling / W Dean	March 16
	FIRE CALLS		
12	Reduce further the number of fire alarm activations across CHFT	K Rawnsley / W Dean / J Stainton	June 15

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.

25th April 2015
Estates & Facilities

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Alison Wilson, Head of Estates Operations and Compliance
Date: Thursday, 28th May 2015	**Sponsoring Director:** Lesley Hill, Director of Planning, Performance, Estates and Facilities
Title and brief summary: Annual Health & Safety Report - Overview of CHFT's health and safety performance.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Trust Health & Safety Committee Weekly Executive Board	
Governance Requirements: The Trust are required to comply with the Health and Safety at Work Act 1974 and its supporting regulations. T15/16.he report provides an overview of progress made during the last 12 months and details the improvements required during	
Sustainability Implications: None	

Executive Summary

Summary:

The annual health and safety report for BoD to review and approve 2015/16 workplan.

Main Body

Purpose:

The report provides assurance how CHFT are managing health and safety risks and identifiies improvements for 2015/16.

Background/Overview:

The report is provided to BoD on an annual basis and provides an update on progress made during the previous 12 months. Actions are identified in a work plan which BoD as requested to approve.

The Issue:

Improvements are detailed in 2015/16 workplan.

Next Steps:

BoD are requested to approve the report and 2015/16 work plan. The workplan will be monitored by the Health and Safety Committee to ensure sufficient resource is focussed on the plan.

Recommendations:

The Board is asked to approve the annual health and safety report.

Appendix

Attachment:

CHFT Annual Health and Safety Report May 2015.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

CHFT Annual Health & Safety Report
1st April 2014 – 31st March 2015

1. INTRODUCTION

This report describes the health and safety arrangements and activities of Calderdale and Huddersfield NHS Foundation Trust (CHFT) during 2014/2015 in order to meet the requirements of the Health and Safety at Work etc. Act 1974 (H&SAWA) and it supporting regulations.

2. BACKGROUND

The H&SAWA provides the legal framework for health and safety and aims to protect employees and the public from its work activities. The Act, and its underpinning regulations, places responsibilities on the Trust and its employees to identify manage and reduce the health and safety related risks.

Health and safety support and advice is provided through the following departments:-

- **Estates and Facilities** - competent health and safety advice
- **Risk Management** – moving and handling training, management of public and employees liability claims and management of the Trusts incident reporting system
- **Pharmacy** – support and advice for the Control of Substances Hazardous to Health (COSHH)
- **Medical Engineering** – management of medical devices, including advice on safety, support and training

The Trust's Health and Safety Committee consult with management and staff side on a monthly basis. Incident data, legislative changes and issues are discussed and areas of concern escalated appropriately.

3. REPORT

3.1 Policies

The Trust's Health and Safety Policy was approved by Trust Board in December 2014 and provides an overarching health and safety framework for CHFT. Specific health and safety related policies were consulted during the year which is detailed in appendix 1.

3.2 Risk Assessments

The Management of Health and Safety at Work Regulations 1999 place a requirement on organisations to undertake suitable and sufficient risk assessments to identify significant risks to the health, safety and welfare of employees and anyone that may be affected by their activities. Specific risk assessments are completed for fire safety, moving and handling, estates engineering tasks and COSHH.

The Trust's risk register approach embraces a risk assessment methodology using a 5 x 5 scoring matrix and mitigation. Whilst staff have an understanding of the methodology further training is required to embed this in the organisation. A Trust generic risk assessment tool has been developed which is based on HSE guidance however, further work is necessary to

embed this organisation. It is recommended this is incorporated into the health and safety training currently being rolled out.

3.3 Incidents Reported Under the Reporting of Incidents Injuries and Dangerous Occurrence Regulations (RIDDOR) 2013

RIDDOR is the law that requires employers and others in control of work premises, to report and keep records of:-

- work-related accidents which cause death,
- work-related accidents which cause certain serious injuries (reportable injuries)
- diagnosis of certain industrial diseases
- certain 'dangerous occurrences' (incidents with the potential to cause harm)

During the reporting period a total of 21 RIDDOR injuries were reported to the Health and Safety Executive (HSE). A total of 19 were staff injuries, 1 related to a member of the public and 1 to a contractor working on Trust premises. A breakdown of incidents is illustrated in table 1.

Table 1 – RIDDOR INCIDENTS

Slips, trips, falls and collisions	10
Infection control	1
Lifting accidents	3
Abuse etc of Staff by patients	1
Accident caused by some other means	4
Injury caused by physical or mental strain	2
	21

The above figures show 57% increase in the number of reportable injuries which is a concern for the Trust. Further work is necessary to determine why staff are receiving serious injuries at work and having long periods of sickness as a result.

3.4 Staff Related Incidents

A total of 962 staff incidents occurred in 2014/15 with the main incidents relating to:-

- Abuse of staff by patients
- Slips, trips & falls
- Needle-stick / sharp injury
- Lifting incidents

Incidents relating to patient abuse to staff are monitored by the Trust's Violence and Aggression Group and reported separately to Trust Board on an annual basis.

Slips, trips and fall incidents show an increase on the previous year and contribute to the majority of RIDDOR incidents. Detailed analysis indicates a number of incidents occurred in Theatres, grounds and gardens which will be interrogated further by the Health and Safety Committee.

The number of needle-stick/sharp's injuries has reduced as a result of the introduction of safer sharps needles. However, the Trust has seen an increase in the number of near miss splash related incidents which the Health and Safety Committee are reviewing and aiming to introduce alternative personal protective equipment.

Moving and handing incidents have reduced over a 12 month period which is detailed in section 3.8.5.

3.5 Employee Injury Claims

Risk Management provide a quarterly Employers and Public Liability claims to the Health and Safety Committee. During the reporting period a total 16 employers liability and 8 public liability claims were made against the Trust which is an increase of 3 over the previous year.

During the reporting period 8 claims were settled and 12 claims were successfully repudiated.

3.6 Training

The Trust commenced a program of health and safety training in 2013 covering 4 tiers of management within the Trust as follows:-

Tier 1 - IOSH for Senior Executives
Tier 2 - Bespoke Health and Safety; Senior Managers
Tier 3 - IOSH Managing Safely; Departmental & Supervisory Staff
Tier 4 – Health and Safety Awareness; Remaining Trust Staff

Following delegate feedback a corporate decision was made to combine tier 2 and 3 into a healthcare specific training programme with clear health and safety outcomes. This will commence during 2015/16.

Divisional attendance is illustrated below in Table 2.

Table 2 – Trust Tier 2 Health and Safety Training by Division

Division	Staff Requiring Training	Staff Trained	Percentage Complete
Children, Women's & Families	28	17	60.71%
Corporate Division	34	19	55.88%
Diagnostic & Therapeutic Services Division	28	9	32.14%
Medical Division	113	36	31.86%
Surgery & Anaesthetics Division	61	4	6.56%
Estates & Facilities Division	30	18	60%
Health Informatics Division	13	0	0.00%

3.7 Governance

3.7.1 Reporting Arrangements

The Health and Safety Committee meet on a monthly basis and originally reported into the Strategic Health and Safety Committee (a sub-committee of Board). Following a review of meetings the Strategic Committee was disbanded and the Committee now report into Risk and Compliance.

3.7.2 Health and Safety Committee

The committee is well attended by topic specialists however Divisional and Staff Side attendance is sporadic. To ensure that health and safety is being effectively consulted and managed there is a requirement for relevant representation. Appendix 2 provides attendance figures over the reporting period.

3.7.3 Audits

a) West Yorkshire Audit Team reviewed progress of Health and Safety Audit (CH08/2015) and provided assurance to the Risk and Audit Committee that suitable and sufficient processes were in place to further develop Health and Safety arrangements. The findings were reported to the Health and Safety Committee and final actions closed out Feb 15.

b) Front line ownership (FLO) audits are carried out by Ward Managers covering various ward related risks. Actions are underway to ensure health and safety risks are incorporated into the FLO audit ensuring hazards are managed locally.

c) Programmes of health and safety inspections are carried out in non-clinical areas with involvement from the staff side and the Trust Health and Safety Advisor. Further dates are planned for 2015.

d) Leadership walk rounds are carried out by the Senior Executive team which are patient and staff focussed. They aim to improve patient experience, safety and promote staff engagement. Action plans are generated following each tour and progressed via the relevant division.

e) A monthly conditional survey (Risk Analysis Tour) is undertaken by PFI and Trust partners at Calderdale Royal Hospital. The purpose of the tours is to examine the physical condition and general environment ensuring remedial actions are implemented.

3.8 Specific Risks

3.8.2 Control of Substances Hazardous to Health (COSHH)

An audit during 2013 identified that improvements were required to ensure the Trust had a robust COSHH management system in place. Subsequently, the Trust is implementing a COSHH management system which will provide an on-line library of hazardous substance and task specific risk assessments.

A COSHH Strategy Group is chaired by the Clinical Director of Pharmacy and ensures the management system is implemented. Divisional COSHH leads / assessors will assist with the local management of COSHH locally.

3.8.3 Safe Management of Contractors

The Safe Management of Contractors Policy was reviewed during 2014 and ratified in May 2015. The policy provides guidance for the management of ALL contractors on CHFT sites and makes clear that Trust induction is a requirement for ALL contractors and is available from both HRI Estates Team and CRH Cofely Estates Team.

3.8.4 Asbestos management

The Trust has a formal structure in place for the management of asbestos containing materials (ACMs) which includes the provision of competent specialist advice from PCS Asbestos Consultants Ltd ((PCS). PCS hold the Trusts asbestos register which identifies the location of existing ACMs and areas where ACM's have been removed. An annual visual inspection is carried out to provide assurance that ACMs remain in good condition and do not pose a risk.

The Asbestos Management Group is attended by key stakeholders and meets on a quarterly basis to ensure compliance and governance arrangements are robust. Reports are communicated to the Estates and Facilities Quality and Safety Board.

The Trust have continued with planned asbestos removal in redevelopment areas which included Ward 7, Ward 8, Ward block 1 & 2 penthouses, Ward block 2 plant room and the ongoing theatre upgrades including strip out of the theatre plant room. This extensive removal programme will continue throughout next financial year.

3.8.5 Manual Handling

The Manual Handling Department is based at the Calderdale Royal Hospital and serves both main acute sites, Community Services in Calderdale and Calderdale Social Services Adult Services.

The Department consists of a Senior Moving and Handling Advisor, a Moving and Handling Advisor and a part-time Moving and Handling Trainer. Training provided over the reporting period is illustrated in table 3 below:-

Table 3 – Manual Handling Team - February 2014 - January 2015

Training Course	Attendees
4 x 4 Day Facilitator Training Courses (Feb, May, Sept & Nov)	24 places available; 11 attendees (46%)
59 x 1 day Practical Patient Handling for new starters.	354 places available; 275 attendees (78%)
26 x ½ day sessions for Facilitator updates	156 places available; 66 attendees (42%) (*11 x ½ day sessions cancelled due to lack of participants)*
4 x 1 day Apprentice HCAS training.	24 places available; 24 attendees (100%)

Divisional Manual Handling Facilitators provided training to 470 staff in 2013/14 which is detailed in appendix 3.

A Moving and Handling Training programme is planned for 2015 which is detailed below in table 4.

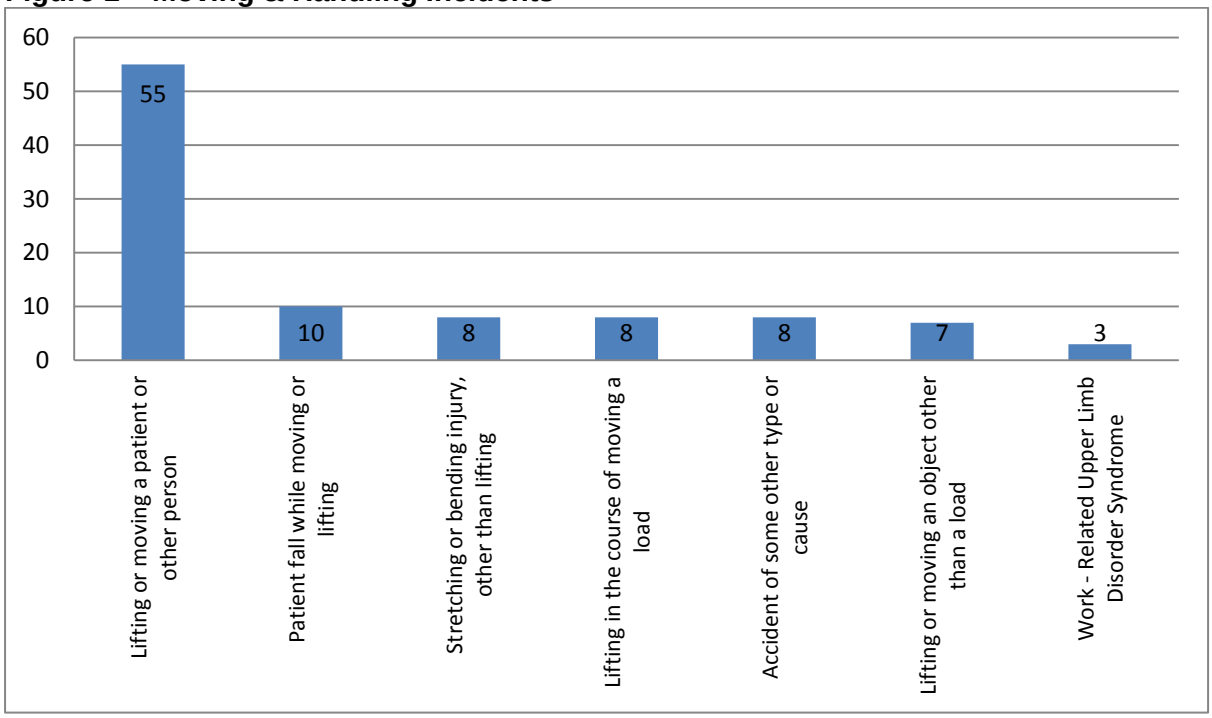
Table 4 – Training scheduled and Resourced for 2015 Jan-Dec

Training Courses	Number of Places Available (Total)
51 x Practical Patient Handling courses	306 places
20 x half day Facilitator update	120 places
10 x Trust induction sessions	
4 x 4 Day Facilitator courses	24 places
2 x Work Base Assessors training day	12 places
4 x Work based updates	36 places

Additional work based assessors training and updates can be provided where necessary.

There were a total of 99 manual handling incidents reported during the 12 month reporting period; an overview of the incidents is detailed in figure 1:-

Figure 1 – Moving & Handling Incidents



The main cause of incident relates to the lifting of a patient or other persons with the main areas of prevalence being:-

- Acute Medicine (41%)
- Orthopaedics (15%)
- Intermediate & Community Services (13%)

A detailed breakdown of divisional moving and handling incidents is provided in Appendix 4.

Learning from moving and handling incidents have been put in place to reduce the likelihood of reoccurrences and / or harm to staff and patients. This includes “Back to basic” update training delivered to facilitators in patient handling areas includes the importance of a manual handling risk assessment that is current and up to date before transferring a patient, and the techniques used within the Trust to best assist a patient from seat to seat.

The Moving & Handling Advisors are supporting both managers and facilitators in all areas with cascading training and importance of completing manual handling risk assessments.

3.8.6 Medical Engineering

The Medical Devices Regulations 2002(11) require all medical devices to carry the CE marking which is captured within the Medical Devices Management Policy. The Medical Engineering department provide an important service to the Trust and follow the MHRA document “Managing Medical Devices-Guidance for healthcare & social services organisations – April 2014” which includes:

- checking equipment for compliance with appropriate regulations
- managing the provision of appropriate maintenance and repair for medical devices

- providing proactive advice on the procurement of suitable medical devices ensuring that devices are of good quality, comply with appropriate standards and are cost efficient resulting in safe and appropriate equipment for healthcare use
- coordination & provision of medical devices training
- monitoring and recording of training on the 'Medical Devices Training Database'

The efficient management of medical devices is a vital factor in keeping CHFTs base safe and it is important to have accurate, safe working equipment and the staff who are trained to use it. Medical devices play an increasingly important role in the diagnosis and treatment of our patient's health and from a patient's point of view the availability of functioning equipment and authorised competent staff must be re-assuring.

The Medicines and Healthcare Regulatory Agency (MHRA) have recommended changes to the management of medical devices principally to the roles and responsibilities of the Trust board and the introduction of the Medical Devices Safety Officer MDSO. The Chief Engineer/Head of Medical Engineering now undertakes this responsibility.

During 2014/2015 there were 163 incidents involving medical equipment reported via Datix; a breakdown is provided in table 5.

Table 5 – Breakdown of Medical Device Incidents Reported on Datix

Classification	Organisational	Patient	Member of the public	Staff	Voluntary worker	Total
GREEN	27	112	0	3	0	142
YELLOW	0	19	1	1	0	21
ORANGE	0	0	0	0	0	0
RED	0	0	0	0	0	0
Total	**27**	**131**	**1**	**4**	**0**	**163**

Of these 3 were reported to the MHRA a summary of these are provided in Table 6.

Table 6 – Summary of Incidents Reported to the MHRA

Speciality	Number of reports	Investigations completed
General Ward based equipment	0	0
Theatre Instrumentation	1	0
X-ray Ancillary	0	0
Life support	2	1
Total	**3**	**1**

The 2 incomplete investigations have been investigated by Medical engineering who are awaiting a response from MHRA to enable the investigations to be closed / completed.

The MHRA issued 48 Medical Device Alerts (MDAs) in 2014 relating to medical devices, all of which were applicable to the Trust, and were dealt with in accordance with Trust policy. In addition to MDAs the Trust also dealt with a number of manufacturers Field Safety Notices in the same manner which were applicable to the Trust.

Availability of equipment has improved since the introduction of the Medical Equipment library at both sites. This method of asset control means that the equipment can be checked and made ready for the next use with greater assurance and maximises the use of limited resource. The introduction of wireless technology at each site may lead to a further step change in asset management enabling widely used but scarce equipment to be located quickly.

Since 2010, Medical Device training has been standardised and promoted across the Trust, this methodology has now been extended to the community services. A review of training has resulted in reporting streams to Divisional Quality and Safety Boards, Operational Health

& Safety committee, The Audit Committee and Trust Board, a new training database, training strategy (including delivery methods and materials) being developed as well as a link community training.

The Trust has set targets of 70% of staff being trained prior to clinical use of a new device and a 95% target of permanent authorised staff sufficiently trained on current devices. Although the Trust has moved towards its 95% target, it currently achieves an average of 82% (A breakdown of training by Division is provided in Table 7); however, it should be noted the enormity of this task, given that in 12 months ending March 2015 there were over 16500 separate recorded training instances. Work is underway to increase the number of training instances with more Medical device training events being organised for 2015. Nonetheless, continuing progress is being maintained towards achieving the Trust's targets.

Table 7 - Medical Device Training by Divisions

Division	Percentage of staff trained in March 2014	Percentage of staff trained in March 2015
CWF	72%	83%
DATS	98%	87%
Surgery	75%	75%
Medical	75%	75%
Corporate	N/A	91%

3.9 WORKPLAN (2014/2015) PROGRESS

CHFT's previous health and safety work plan, along with actions, is illustrated below:-

	WHAT	Progress
1	Additional NED to support H&S process	Completed June 2014. NEDs J Wilson and D Anderson involved in H&S meetings. ***This action is closed***
2	Establish strategic & operational H&S committees	The Strategic & Operational H&S committees were established June 2014. However, a rationalisation of meetings has resulted in one effective health and safety committee. ***This action is closed.***
3.	Provide quarterly EL & 3rd party claims to H&S Committee.	Quarterly reports are now provided to the Health & Safety Committee. ***This action is closed***
	Implement COSHH framework	A COSHH Strategy Group has been established & database populated with risk assessments. Training required for COSHH Assessors / Leads ***Training action carried forward into 2015/16 health and safety work plan.***
5	Implemented health & safety policy	Health & Safety policy ratified at Trust Board December 2014. ***This action is closed.***
6	Develop & monitor health and safety training for all staff	Health and Safety Awareness Training being progressed via Workforce Organisation Development with other mandatory training. ***Training action carried forward into the 2015/16 health and safety work plan.***.
7	Develop risk assessment training	Risk assessment tool now developed and included within the Health and Safety Policy Ratified Dec 2014 ***This action is closed***
8	Improve RIDDOR & incident reporting	Improvements in RIDDOR reporting; action closed. Further work is required to improve incident reporting via the Datix system. ***Improve incident reporting to remain on the 2015/16 health and safety work plan***.

	WHAT	Progress
9	Improve attendance at Manual Handling Training	This is currently monitored by Risk Management however, further progress is necessary. ***Moving & Handling training to remain on the 2015/16 health and safety work plan.***
10	Improve attendance at Medical Device Training & received regular reports at H&S Committee	The report indicates progress that has been made toward complying with the training requirements with regards to medical devices; it has also highlighted enormity of the task. This will be monitored and managed through the Medical Devices Committee. ***This action is transferred to the Medical Devices Committee for monitoring during 2015/16.***
11	Audit health & safety arrangements	This has been completed and the report presented to the health and safety committee in Feb 15. ***This action is closed***.
12	Provide monthly performance reports to EB	Monthly reports provided to the Health and Safety Committee and any areas of concern are escalated accordingly. ***This action is closed.***

4. RECOMMENDATIONS

Based on the information provided and the actions carried forward the Trust Board are requested to accept the following health and safety work plan for 2015 / 16.

	WHAT	WHO	WHEN
1.	Incorporate Risk Assessment methodology into health and safety training.	A Wilson	July 15
2.	Carry out analysis of RIDDOR incidents.	A Wilson / Risk Management	July 15
3.	Provide healthcare specific health and safety training for Managers / Supervisors.	A Wilson / Training Provider	Aug 15
4.	Provide generic health and safety awareness training via Workforce Organisation and Development.	A Wilson / B France	July 15
5	Include health and safety monitoring within FLO Audit.	A Wilson / J Robinson	May 15
6	Support Risk Management to promote the use of Datix (Incident Reporting System)	Risk Management Dept / A Wilson	Sept 15
7	Improve attendance at Manual Handling Training	Risk Management Dept & Divisions	Sept 15
8.	Implement COSHH Framework	M Culshaw	June 15
9.	Improve divisional representation at Health & Safety Committee	L Hill / Exec Directors	June 15
10.	Improve staff side representation at Health & Safety Committee	L Hill / J Eddleston	June 15

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.

6th May 2015

Estates & Facilities

Appendix 1 - Register of Policies Consulted on at the Health & Safety Committee

May 2014
Slips, Trips & Falls
Environmental Policy

July 2014
Safe Management of Contractors Policy Statement (Part 1)

August 2014
Health & Safety Policy Development (Phase 2)
Slips, Trips & Falls
Smoking Policy
Heatwave Policy
Medical Device Policy
Process for Management of Central Alerting System (CAS)

September 2014
Health & Safety Policy (Part 1)
Safe Management of Contractors – Roles & Responsibilities (Part 2)

October 2014
Health & Safety Policy (Part 1 Policy Statement & 2 Roles & Responsibilities)
Manual Handling Policy

November 2014
Safe Management of Contractors – Roles & Responsibilities (Part 2)
Process for the Management of the Central Alerting System ("CAS")
Medical Device Management

December 2014
Health & Safety Policy

January 2015
Security Policy
COSHH Policy

February 2015
Safe Management of Contractors

March 2015
Safe Control of Contractors Policy

Appendix 2 - Overview of Attendance Health and Safety Attendance

Committee delegate	Possible Attendance	Attendance	Percentage Attendance
Lesley Hill (Chair)	12	12	100.00%
General Manager, Compliance & Facilities	12	8	66.67%
Trust Health & Safety Officer	12	9	75.00%
Security Manager	12	10	83.33%
Fire Officer	12	11	91.67%
Trust Waste Manager	12	1	8.33%
Medical Engineering	12	11	91.67%
Manual Handling	12	8	66.67%
Occupational Health Rep / HR Rep	12	2	16.67%
Local Security Management Specialist (joint with Risk)	12	6	50.00%
ISS Representative (PFI Partner Soft FM Services)	12	7	58.33%
Catalyst SPC Representative	12	1	8.33%
COSHH Advisor DATS	12	0	0.00%
Divisional Representative THIS	12	9	75.00%
Divisional Representative DATS	12	5	41.67%
Divisional Representative Medical Division	12	0	0.00%
Divisional Representative Corporate Division	12	0	0.00%
Divisional Representative CWF Division	12	2	16.67%
Divisional Representative Surgery Division	12	1	8.33%
Union Lead Convener	12	7	58.33%
CWF H&S Rep	12	5	41.67%
S&A H&S Rep	12	2	16.67%
DATs H&S Rep	12	5	41.67%
THIS H&S Rep	12	4	33.33%

Appendix 3 - Training Provided by Trained Facilitators – April 2014 – March 2015

DIVISION	Ward/Department	Number of Staff Trained				TOTAL
		Q1	Q2	Q3	Q4	
MEDICAL	Cardiology CRH	16				16
	Ward 17	22	12			34
	Community nurses		50	37	3	90
	Ward 5		4			4
	Ward 21	1	6			7
	Macmillan unit			4		4
	Ward 6			12		12
	Ward 12				13	13
	Therapists	8	30	6	6	50
	Community Podiatrists	6				6
	Medical OPD	4	5			9
	SIT					
	Loan Stores				2	2
	Wheelchair Services					
	Physio OPD					
	Tissue Viability					
SAS	A&E	21		6		27
	Ward 3 HRI	4				4
	Ward 19/20					
	Eye Clininc			48	2	50
	ICU	9				9
	Theatre CRH					
	Theatre HRI		3			3
	DSU HRI					
	Ward 22			25		25
	Orthopaedic OPD	1		29		30
	AAA				5	5
	Endoscopy CRH			18		18
	Pain clinic			4		4
CWF	Ward 1D/9					
	Community Maternity					
	Community Paediatrics					
Estates & Facs	Porters/ISS	2	2	1	2	7
DaTS	Radiology	6		10		16
	Ultra sound		17			17
	Pharmacy				8	8
	TOTAL					470

Appendix 4 - Manual Handling incidents reported by Division & Type

DIVISION	DIRECTORATE	Stretching or bending injury, other than lifting	Lifting in the course of moving a load	Lifting or moving an object other than a load	Accident of some other type or cause	Lifting or moving a patient or other person	Patient fall while moving or lifting	Work - Related Upper Limb Disorder Syndrome	Total
CORPORATE	Service Development & Health Informatics	0	0	1	0	0	0	0	1
CWF	Childrens Services	0	0	0	0	1	0	0	1
	Families Directorate	0	0	1	0	0	1	0	2
	Womens Services	3	0	0	0	1	0	0	4
DaTS	Appointments and Health Records	0	1	0	0	0	0	0	1
	Pathology	0	0	1	0	0	0	0	1
	Pharmacy Manufacturing Unit	0	1	0	1	0	0	0	2
	Radiology	0	0	0	0	2	0	2	4
ESTATES	Facilities	0	0	0	0	1	0	0	1
	Estates Maintenance	0	1	0	0	0	0	0	1
MEDICAL	Acute Medical	2	0	0	3	22	2	0	29
	Emergency Network	1	0	1	2	2	2	0	8
	Intermediate and Community	1	1	0	2	7	3	0	14
	Integrated Medical	0	1	0	0	0	1	0	2
SAS	General & Specialist Surgery	2	1	1	0	2	0	1	7
	Head & Neck	0	1	1	0	1	0	0	3
	Operating Services	0	1	1	0	7	0	0	9
	Orthopaedic	0	0	0	0	8	1	0	9
Totals:		9	8	7	8	54	10	3	99

Injuries sustained

Abrasion/graze/scratch	4
Bruise/swelling	8
No visible injury but swelling	2
Dislocation	1
Exposure/irritation	1
Fracture	1
Laceration/cut	7
Other injury	13
Sprain/strain	43
Totals:	80

The fracture was a patient who bent her knee following a knee replacement and caused a fracture.

Most prevalent injuries:

Type of incident	Activity untaken
Patient Injury	Standing transfer, Hoisting, Log Rolling, lateral transfer, falling. Unexplained bruising, poor manual handling techniques, shearing of skin, skin tear
Staff Injury	Standing Transfer, Walking, Hoist Log Roll,
Load Handling	Lifting and lowering loads, pulling and pushing loads, trips
Postural	Prolonged holding of limbs in theatre, endoscopy dept prolonged positions held and equipment e.g. chairs not in full working order
Involving falling patients	10 patients mainly walking and standing transfer
Involving bariatric patients	2

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Juliette Cosgrove, Assistant Director
Date: Thursday, 28th May 2015	**Sponsoring Director:** David Birkenhead, Medical Director
Title and brief summary: Care of the Acutely Ill Patient - This paper provides the Board with an update on the Care of the Acutely Ill Patient Programme which is aiming to reduce avoidable mortality for our patients.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Quality Committe April 2014	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

This paper provides the Board with an update on the Care of the Acutely Ill Patient Programme which is aiming to reduce avoidable mortality for our patients.

Main Body

Purpose:

Please see attached

Background/Overview:

Please see attached

The Issue:

Please see attached

Next Steps:

Please see attached

Recommendations:

Please see attached

Appendix

Attachment:

Care of the Acutely Ill Patient May 2015.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

Care of the Acutely Ill Patient (CAIP) Programme Board of Directors

Update: May 2015

Subject	**Care of the Acutely Ill Patient Programme**
Reporting Month	May 2015
Authors	Juliette Cosgrove – Assistant Director
Summary	Report to inform the Board on the progress against outcomes for the Care of the Acutely Ill Patient (CAIP) Programme.

Contents

Care of the Acutely Ill Patient Programme

The Care of the Acutely Ill Patient (CAIP) programme is arranged into 8 themes:

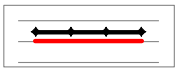
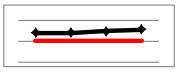
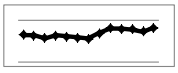
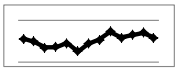
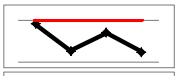
1) Reducing Mortality (overall outcome measures)
2) Ensuring the recognition and prompt treatment of our deteriorating patients.
3) Delivering high standard of care through reliable delivery of care bundles.
4) Frailty
5) Effective (focus on the Courage to Put Patient First programme).
6) Focus on SHMI Conditions of Interest
7) Well Led Organisation
8) Coding

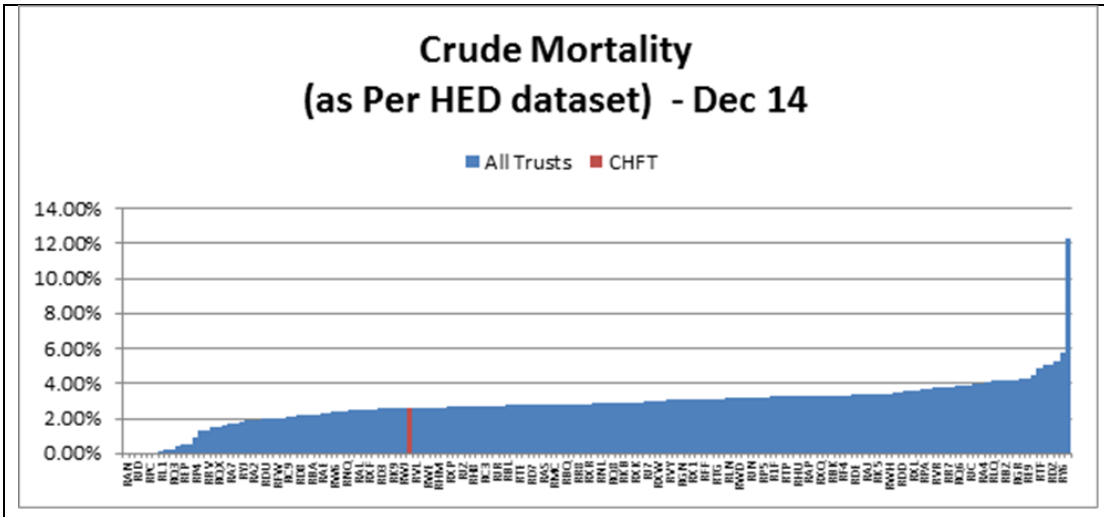
Key Aim is:

The primary aim of the CAIP programme is to reach and maintain a Standardised Hospital Mortality Index (SHMI) below 100.

Overview of Progress

The first reports are being pulled from the new HED system, December's score is 105.66. There has been variance month on month therefore work has been commissioned to look at the data across a range of months and compare them.

	Mortality Indicator	SHMI Latest =	Oct 13 - Sep 14	HSMR Latest =	Feb 14 - Jan1 5	
Theme 1: Reducing Mortality Rates	SHMI	100	109.03	100	-	
	HSMR	100	105.34	100	106.78	
	% Crude Mortality - All Admissions	-	1.62%	-	1.62%	
	% Crude Mortality - Weekend Admissions	-	2.86%	-	2.86%	
	% Mortality Reviews	100%	70%	100%	53%	
	% of deaths which started with a Nursing home admission	-	17%	-	17%	



The latest data obtained via HED for December 2014 actually shows the Trust to be a in a relatively good position for crude mortality when compared to other Trusts.

Mortality Reviews:

Decembers review data has been further analysed, a report was presented to WEB in April.

Key findings:

- The high number of ward moves (not able to get by clinical vs organisational need)
- 14% of cases where reviewers felt the admission could have been avoided with better community support
- High numbers of patients in this cohort being admitted from nursing homes and dying – this is in line with other months in 2014.
- Only half the patients were reviewed by a consultant within 12 hours of admission
- DNACPR performance measures were in line with other audit data
- 2% deaths likely to be preventable – lower than national research which suggests a 5% figure.

The plan is for a detailed 3 monthly report from mortality reviews to be produced along with monthly report for COG and divisional reports. In addition the Qlik View portal has a model in development for mortality review information – available to all staff if requested. When completed awareness sessions will be presented at appropriate meetings.

Weekly performance reports are being circulated both corporately and to divisional leads to help ensure reviewers carry out the 4 reviews per month as agreed; this is improving month on month and is around the 60% mark currently.

The Clinical Effectiveness, Audit and Mortality Group has been established and has met for the first time. This is a sub group of the COG with a responsibility for assuring the process for mortality reviews is being followed and to look in depth at the findings to make recommendations for further work. It is also responsible for the oversight of national and local audits and NICE compliance.

A review of the Care of the Acutely Ill Patient Programme will be undertaken in June to ensure the plan is fit to deliver the aim, the review will be led by the Medical Director.

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

'Nerve Centre' (an electronic Observations and Escalation system) is being refined currently post the pilot phase, detailed scoping has been agreed regarding the changes required.

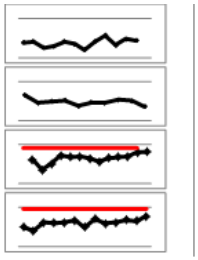
Roll out to the next wards is ongoing, with a plan in place for all wards in the Trust; the implementation team are training wards prior to the going live.

An outline business case with requirements for full Hospital at night and weekends was presented at COG. It was agreed that further work needs to be undertaken to link with existing clinical teams, however the requirement for significant investment was identified.

This is no anticipated investment in medical staff to support this model at this stage. Evidence suggests the task management system enables better use of available resources and greater transparency of workload. A plan to deliver 7 day working and workforce plan is being developed and led by Dr S. Uka.

It has been agreed that cardiac arrest will be reported as incidents so they can be investigated at the appropriate level – a detailed plan will be worked out and presented for comment in May.

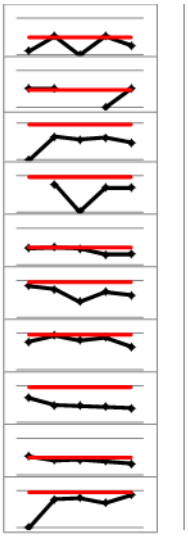
	Indicator	Month Agreed Target	Current Month Performance	Rolling 12 Month Target/YTD	YTD Performance
Theme 2: Ensuring earlier recognition & prompt treatment of deteriorating patients	Number of Cardiac Arrests per 1000 bed days	-	0.89	-	0.75
	Unplanned Admission to ICU	-	36	-	482
	DNACPR % Discussion completion	95%	90%	95.0%	90%
	DNACPR Review date completion %	95%	76%	95.0%	76%



The other focus of the work is around DNACPR – compliance is improving but further work is still required.

3. Delivering high standards of care through reliable delivery of care bundles:

	Indicator	Month Agreed Target	Current Month Performance	Rolling 12 Month Target/YTD	YTD Performance
Theme 3: High standards of care through reliable delivery of care bundles	Asthma - Bundle Started	95%	50%	95%	50%
	Asthma - Bundle Completed	95%	100%	95%	100%
	AKI - Bundle Started	95%	47%	95%	47%
	AKI - Bundle Completed	95%	67%	95%	67%
	Sepsis - Bundle Started	95%	59%	95%	59%
	Sepsis - Bundle Completed	95%	60%	95%	60%
	COPD - Bundle Started	95%	62%	95%	62%
	COPD - Bundle Completed	95%	38%	95%	38%
	Pneumonia - Bundle Started	95%	62%	95%	62%
	Pneumonia - Bundle Completed	95%	88%	95%	88%
	Heart Failure	Design Phase			



Data for this theme around initiation of bundles is included as below by ward for:

- Community acquired Pneumonia
- Acute Kidney Injury
- Asthma
- COPD
- Sepsis

This data is collected by the clinical audit team and focuses on uptake and whether the stickers that are placed in the clinical record are being completed. Leads conduct a more detailed audit of compliance with the individual elements. The data still shows poor reliability of bundle implementation.

There has been a delay in agreeing content of the screening document to point junior staff to use the care bundles, this has been partly down to waiting for the CQUIN guidance to be released and some difficulty getting agreement on the heart failure elements. Both have now been agreed and testing will take place over the next month. It was noted by the COG that work in this area was not progressing at the required pace therefore the leads are being asked to meet to establish barriers to implementation, this meeting will happen in June.

4. Frailty

	Indicator	Month Agreed Target	Current Month Performance	Rolling 12 Month Target/YTD	YTD Performance
Theme 4: Frailty	% frailty Deaths (as a proportion of all deaths)	-	10.8%	-	10.8%

A review of frailty has been undertaken and a Frailty Improvement Group has been established chaired by the ADN for Medical Division and a Consultant Physician who is an Improvement Fellow with the Academic Health Science Network.

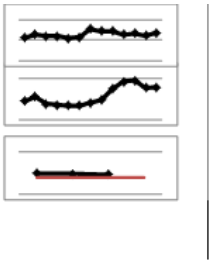
A system wide driver diagram has been developed, the initial focus will be on areas we can improve internally and then work with external stakeholders to deliver system wide improvements. The plan will be overseen by the COG.

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

These aims are all being delivered through the Courage to Put the Patient First Programme who have their own measures dashboard.

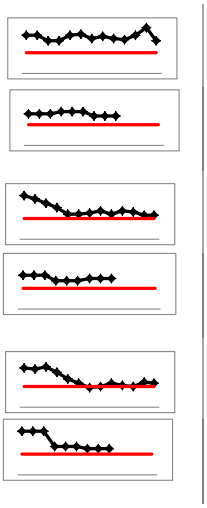
Work has been focussed on length of stay enablers, specifically management of green cross patients and resolution of issues/delays raised through plan for every patient. Work continues on the design of Clinical Site Commander role and associated Pacemaker loop staff. Plan from every review has been tested but is felt by those clinicians that it is not suitable for our use.

	Indicator	Month Agreed Target	Current Month Performance	Rolling 12 Month Target/YTD	YTD Performance
Theme 5: Effective	Bed Occupancy %	-	87.0%	-	87.0%
	Number of Outlying Bed Days	-	780	-	780
	% of spells with > 2 ward movements (2% Target)	2%	2.4%	2%	2.3%
	Average Length of Stay (ALoS)	-	3.54	-	3.54



6. Focus on SHMI Conditions of Interest

	Mortality Indicators	SHMI Latest =	Oct 13 - Sep 14	HSMR Latest =	Feb 14 - Jan1 5
Theme 7: Conditions of Interest	COPD - HSMR	100	117.11	100	115.21
	COPD - SHMI (75)	100	111.29	100	-
	Heart Failure - HSMR	100	105	100	103.78
	Heart Failure - SHMI (65)	100	111.98	100	-
	ACD (inc Stoke) - HSMR	100	104	100	103.68
	ACD (inc Stoke) - SHMI (66)	100	107.13	100	-

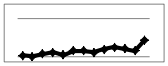
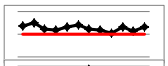
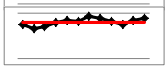
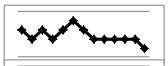
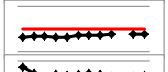


In order to drive down the trusts SHMI a sensible approach is to maintain a focus on those conditions that either alert or have a higher rate than expected.

The latest analysis on the HED system indicates that stroke and heart failure will not be showing as of concern in the next release, however COPD will still flag. A deep dive into COPD causes for outlying will be conducted in June 2015.

Further analysis will be undertaken in June to identify any areas where additional scrutiny is required.

7. Well Led Organisation

	Indicator	Month Agreed Target	Current Month Performance	Rolling 12 Month Target/YTD	YTD Performance	
Theme 6: Well led organisation - improving quality with pace	Number of Handover Incidents	-	3	-	3	
	Number of Serious Incidents	-	22	-	22	
	Inpatient FFT Score (% Would Recommend)	95%	97.0%	95%	96.3%	
	Inpatient FFT Response Rate	40%	44.4%	40%	40.3%	
	Number of Walk Rounds	-	1	-	1	
	Nurse Fill Rates - Day	100%	83.1%	100%	-	
	HCA Fill Rates - Day	100%	101.3%	100%	-	
	Nurse Fill Rates - Nights	100%	88.5%	100%	-	
	HCA Fill Rates - Nights	100%	118.3%	100%	-	

Acuity and Dependency Audits. Nurse Staffing Levels meeting the acuity of patients – Work is ongoing to determine the most updated metrics to measure performance. The Acuity and Dependancy Audit will be repeated in May.

Update to Communications plan – The plan is to be revisited and will be integrated into the CQC communications plan.

Leadership walk round process – The action is making good progress and is being monitored as part of the CQC action plan.

- NED walk rounds – as current announced walk round process, these will need to include community areas and OOH.
- Executive Directors -Monthly walk rounds in dedicated geographic area – to cover estate as well as clinical issues.
- Senior Management team – Back to the floor Fridays 1/2 day once a month.
- Matrons – Weekly back to the floor. Peer reviews are to be included.
- Other – e.g. Chairman's surgeries, focus groups etc.

Handover module on Nerve Centre – Part of scoping for roll out, 2 ward teams that used as pilot were very positive about the tools usefulness. Part of the scoping is to have 3 key teams, nursing, therapy and medical handover, all data is live and can be viewed when away from the patient.

% of reporting against national mark. (NRLS) –The effective investigations group was presented to COG in February. In brief the work is in 3 key groups of interventions ;

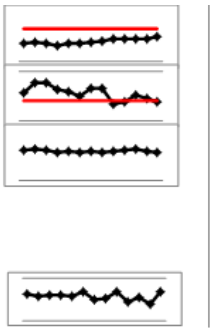
- Tools for investigations (Standardise with core investigation and RCA principles)
- Training for investigations
- Improving the investigations process to simplify reporting and improve feedback, ensuring learning and changes of practice.

Sessions have been booked for serious investigations skills training – being delivered by a national expert. The toolkit is in daft and being refined and work has commenced on updating DATIX to improve the ease of reporting with capture of cause of incident/compliant to remain a focus.

Human Factors – As above – the focus for this action will be around improving the investigations process.

8. Coding

	Indicator	Month Agreed Target	Current Month Performance	Rolling 12 Month Target/YTD	YTD Performance
Theme 8: Coding	Average Charlson Score	4	3.52	4	3.52
	% Sign and Symptom	9.5%	9.40%	9.5%	9.40%
	Average Diagnosis	5	3.98	5	3.98
	Co-morbidity capture	90%	28%	90%	28%
	% Coded with Specialist Pall Care	-	0.67%	-	0.67%



The engagement work has started to show some improvement to depth of coding and also required reduction to % signs and symptoms.

Plans are in place in each division to continue to engage with clinicians so impact and expectations are clearly understood. Audit of compliance with the co morbidity capture proforma remains low at only 21% for March.

9. The Board is asked to note the following risk to delivery:

- Improvements in the mortality review process including key findings from the December review.
- Nerve centre is due to commence roll out across the Trust from May 5th.
- The significant resources required to fully implement the H@N and H@weekends modules.
- Agreement to report all cardiac arrests as incidents.
- Improvements in DNACPR compliance.
- Improved mortality reporting that is starting to be available from the HED system.
- Continued poor compliance against the co morbidity capture proforma.
- Resource impact of the extra national requirements mandated as part of the hard truths work.

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Linda Cordingley, Executive Assistant to Chief Executive
Date: Thursday, 28th May 2015	**Sponsoring Director:** Jackie Green, Interim Director of Workforce and OD
Title and brief summary: NHS Staff Survey 2014 - The purpose of this paper is to brief the Board of Directors on the results of the 2014 National Staff Survey	
Action required: Note	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Executive Board	
Governance Requirements: Keeping the Base Safe	
Sustainability Implications: None	

Executive Summary

Summary:

The purpose of this paper is to brief the Board of Directors on the results of the 2014 National Staff Survey.

The Trust participated in the 2014 NHS Staff Survey (1th national annual survey). A total of 850 staff were included in the sample, of which 822 were eligible to complete the survey. 370 staff completed the survey giving a response rate of 45% compared to the national average of 42%. Despite pressures on the Trust, we have maintained our staff engagement score at 3.77 out of 5, which is above the national average. This report includes the key findings, where the Trust compares most favourably and least favourably with other acute trusts. A number of local questions were included in the survey to canvas staff opinion on key issues. The results are included in the report.

An action plan addressing the worst performing areas from the survey has been shared widely and will be enhanced through further testing with colleagues as the survey results are communicated in the Trust. The actions will be monitored by the Well-Led Organisation Group.

Main Body

Purpose:

The purpose of this paper is to brief the Board of Directors on the results of the 2014 National Staff Survey.

Background/Overview:

The Trust participated in the 2014 NHS Staff Survey (the 11th national annual survey). A total of 850 staff were included in the sample, of which 822 were eligible to complete the survey. Our Survey Contractor was Picker Institute Europe. 370 staff completed the survey giving us a response rate of 45% compared to the national average of 42%. This year, for the first time, staff on maternity leave were eligible to take part in the survey.

There were minor changes to some survey questions, including the question around hot water, soap and paper towels and a change to the question about malpractice and wrongdoing, this is now being referred to as ‘unsafe clinical practice’.

This year a number of additional questions were included in the survey to canvas staff opinion on patient experience (using the national module of questions) and how the Trust communicates its key issues. The 2014 results are attached in the appendix.

The Issue:

1. The National Picture

The national results show growing pressure on those working in the NHS, but also that the vast majority of staff remain positive about their work and the service they provide.

Of the 29 key findings, 11 have shown improvement since 2013, one has remained the same, 15 have deteriorated and two cannot be compared due to changes in the questions.

There are some positive improvements in the perception of quality of care. For example, 67% of staff said they thought patient care was the top priority for their organisation compared to 66% in 2013. More than three quarters of staff reported that patient experience measures are collected in their organisation and 50% said such feedback is used to improve patient care.

A new question on raising concerns shows that 68% of staff would feel safe to raise a concern about unsafe clinical practice and 93% would know how to do so.

2. The Local Picture

The national staff survey questionnaire, patient experience module, local questions, comparator report for staff groups and neighbouring organisations and action plan are attached.

Despite pressures on the Trust, we have maintained our staff engagement score at 3.77 out of 5, which is above the national average.

2.1 Improvement/Deterioration since 2013

Scores that show improvement since the 2013 survey are:

• Staff receiving an appraisal review in last 12 months

There has been no change in all other scores although by national comparison we have scored “worse than average” in the following areas:

• Work pressure felt by staff
• Staff receiving health and safety and equality and diversity training
• Fairness and effectiveness of incident reporting procedures
• Staff experiencing physical violence from staff/patients and relatives
• Staff reporting that communication between senior management and staff is not effective

2.2 Top Five Ranking Scores

The five key findings where the Trust compares most favourably with other acute trusts are:

KF13 Percentage of staff reporting errors, near misses or incidents witnessed in the last month - 95% (national average 90%)
KF7 Percentage of staff appraised in last 12 months - 91% (national average 85%)
KF27 Percentage of staff believing the trust provides equal opportunities for career progression or promotion - 91% (national average 87%)
KF22 Percentage of staff able to contribute towards improvements at work - 72% (national average 68%)
KF28 Percentage of staff experiencing discrimination at work in last 12 months (lower score better) - 9% (national average 11%)

The five key findings where the Trust compares least favourably with other acute trusts are:

KF17 Percentage of staff experiencing physical violence from staff in last 12 months (lower score better) - 4% (national average 3%)
KF26 Percentage of staff having equality and diversity training in last 12 months - 45% (national average 63%)
KF16 Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months (lower score better) - 17% (national average 14%)
KF14 Fairness and effectiveness of incident reporting procedures - 3.50/5 (national average 3.54/5)
KF10 Percentage of staff receiving health and safety training in last 12 months - 74% (national average 77%)

2.3 Local Questions

The national patient experience module was used to gather additional information to support our mission of "compassionate care". A number of local questions were also included to identify awareness of our "four pillars" of behaviour, our financial position and raising concerns (whistleblowing). The results are included in the appendix.

Next Steps:

The attached action plan has been developed to address the worst performing areas from the survey. The action plan has been shared widely and will be enhanced through further testing with colleagues as the survey results are communicated in the Trust. The actions will be monitored by the Well-Led Organisation Group.

Recommendations:

The Board of Directors is asked to note the contents of this paper and support next steps for the Staff Survey.

Appendix

Attachment:

Appendix - Staff Survey.pdf

National NHS Staff Survey 2014

What is this survey and why are we asking you to complete it?

This is an independent survey of your experience of working in your organisation. The overall aim is to gather information that will help to improve the working lives of staff in the NHS and so help to provide better care for patients.

Your organisation will be able to use the results of the survey to improve local working conditions and practices and to increase involvement and engagement with staff. Other organisations, including NHS commissioners, the Care Quality Commission, the Department of Health, and NHS England, will make use of the results.

Please complete the survey for your current job, or the job you do most of the time. If you work across two or more employers in the NHS, please answer in relation to the organisation that pays your salary. Please read each question carefully, but give your immediate response by ticking the box which best matches your personal view.

Who will see my answers?

The survey is being conducted by Contractor Name and the NHS Staff Survey Co-ordination Centre on behalf of your organisation and NHS England.

Your answers will be treated in confidence. No one in your organisation will be able to identify individual responses. The bar code / number below is only used by Contractor Name to identify which staff should be sent a reminder and will not be available to staff in your organisation.

The survey findings will be analysed by Contractor Name and the NHS Staff Survey Co-ordination Centre and the results will be presented in a summary report in which no individual, or their responses, can be identified.

Please return this questionnaire, in the envelope provided, to:

Contractor Name
Address 1
Address 2
Address 3
Postcode

If you have any queries about this questionnaire please contact the NHS Staff Survey Co-ordination Centre based at Picker Institute Europe on 01865 208141 or go to www.nhsstaffsurveys.com

NHS

YOUR PERSONAL DEVELOPMENT

1. Have you had any training, learning or development (paid for or provided by your organisation) in the following areas?

Please include any taught courses or more informal ways of learning such as supervised on-the-job training, e-learning, shadowing, reading journals / manuals etc.

	Yes, in the last 12 months	Yes, more than 12 months ago	No	Not applicable to me
a. Health and safety training	☐ 1	☐ 2	☐ 3	☐ 9
b. Equality and diversity training	☐ 1	☐ 2	☐ 3	☐ 9
c. How to prevent or handle violence and aggression to staff, patients / service users	☐ 1	☐ 2	☐ 3	☐ 9
d. Infection control (e.g. guidance on hand-washing, MRSA, waste management, disposal of sharps / needles)	☐ 1	☐ 2	☐ 3	☐ 9
e. How to handle confidential information about patients / service users	☐ 1	☐ 2	☐ 3	☐ 9
f. How to deliver a good patient / service user experience	☐ 1	☐ 2	☐ 3	☐ 9
g. Any other job-relevant training, learning or development	☐ 1	☐ 2	☐ 3	☐ 9

2. To what extent do you agree or disagree with the following statements?

My training, learning and development has helped me to...

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
a. ...do my job more effectively.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. ...stay up-to-date with professional requirements.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. ...deliver a better patient / service user experience.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

3a. In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?

☐ 1 Yes ☐ 2 No ☐ 3 Can't remember

If YES, please answer parts b to f below; if NO, go to Question 4

b. Did it help you to improve how you do your job? ☐ 1 Yes ☐ 2 No

c. Did it help you agree clear objectives for your work? ☐ 1 Yes ☐ 2 No

d. Did it leave you feeling that your work is valued by your organisation? ☐ 1 Yes ☐ 2 No

e. Were any training, learning or development needs identified? ☐ 1 Yes ☐ 2 No

If YES to Question 3e, please answer part f below; if NO, go to Question 4

f. Did your manager support you to receive this training, learning or development? ☐ 1 Yes ☐ 2 No

YOUR JOB

4. The following questions are about team working and relate to the group of people that you work with most closely.

a. Do you work in a team? ☐ 1 Yes ☐ 2 No

If NO, go to Question 5; if YES, please answer the following questions about the main team or group you work in:

Team members...

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
b. ...have a set of shared objectives.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. ...often meet to discuss the team's effectiveness.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d. ...have to communicate closely with each other to achieve the team's objectives.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

5. For each of the statements below, how often do you feel this way about your job?	Never	Rarely	Sometimes	Often	Always
a. I look forward to going to work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. I am enthusiastic about my job.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. Time passes quickly when I am working.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

6. To what extent do you agree or disagree with the following statements about your job?	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
a. I have clear, planned goals and objectives for my job.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. I always know what my work responsibilities are.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. I am trusted to do my job.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d. I am able to do my job to a standard I am personally pleased with.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

7. To what extent do you agree or disagree with the following statements about your work?	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
a. There are frequent opportunities for me to show initiative in my role.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. I am able to make suggestions to improve the work of my team / department.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. I am involved in deciding on changes introduced that affect my work area / team / department.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d. I am able to make improvements happen in my area of work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
e. I am unable to meet all the conflicting demands on my time at work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
f. I have adequate materials, supplies and equipment to do my work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
g. There are enough staff at this organisation for me to do my job properly.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

8. How satisfied are you with each of the following aspects of your job?	Very dissatisfied	Dissatisfied	Neither satis. nor dissatisfied	Satisfied	Very satisfied
a. The recognition I get for good work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. The support I get from my immediate manager.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. The freedom I have to choose my own method of working.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d. The support I get from my work colleagues.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
e. The amount of responsibility I am given.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
f. The opportunities I have to use my skills.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
g. The extent to which my organisation values my work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
h. My level of pay.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

9. Do the following statements apply to you and your job?	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Not applicable to me
a. I am satisfied with the quality of care I give to patients / service users.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
b. I feel that my role makes a difference to patients / service users.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
c. I am able to deliver the patient care I aspire to.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9

YOUR MANAGERS

10. To what extent do you agree or disagree with the following statements about your immediate manager?	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
My immediate manager...					
a. ...encourages those who work for her/him to work as a team.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. ...can be counted on to help me with a difficult task at work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. ...gives me clear feedback on my work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d. ...asks for my opinion before making decisions that affect my work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
e. ...is supportive in a personal crisis.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

11. To what extent do you agree or disagree with the following statements about senior managers where you work?	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
a. I know who the senior managers are here.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. Communication between senior management and staff is effective.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. Senior managers here try to involve staff in important decisions.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d. Senior managers act on staff feedback.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
e. Senior managers are committed to patient care.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

YOUR ORGANISATION

12. To what extent do these statements reflect your view of your organisation as a whole?	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
a. Care of patients / service users is my organisation's top priority.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. My organisation acts on concerns raised by patients / service users.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. I would recommend my organisation as a place to work.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d. If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

13. Patient / service user experience measures	Yes	No	Don't know	Not applicable to me
a. Is patient / service user experience feedback collected within your directorate / department? (e.g. Friends and Family Test, patient surveys etc.)	☐ 1	☐ 2	☐ 3	☐ 9

If YES, please answer parts b and c below; if NO, go to Question 14

To what extent do you agree with the following statements about feedback from patients / service users?	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Don't know
b. I receive regular updates on patient / service user experience feedback in my directorate / department (e.g. via line managers or communications teams).	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
c. Feedback from patients / service users is used to make informed decisions within my directorate / department.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9

YOUR HEALTH, WELL-BEING AND SAFETY AT WORK

14. To what extent do you agree or disagree with the following statements?	**Strongly disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly agree**
a. In general, my job is good for my health.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. My immediate manager takes a positive interest in my health and well-being.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. My organisation takes positive action on health and well-being.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

15a. In the last three months have you ever come to work despite not feeling well enough to perform your duties?

1 ☐ Yes 2 ☐ No

If YES, please answer parts b to d below; if NO, go to Question 16

b. Have you felt pressure from **your manager** to come to work? 1 ☐ Yes 2 ☐ No

c. Have you felt pressure from **colleagues** to come to work? 1 ☐ Yes 2 ☐ No

d. Have you put **yourself** under pressure to come to work? 1 ☐ Yes 2 ☐ No

16. During the last 12 months have you felt unwell as a result of work related stress?

1 ☐ Yes 2 ☐ No

17. In the last month have you seen any errors, near misses, or incidents that could have hurt...

a. Staff 1 ☐ Yes 2 ☐ No

b. Patients / service users 1 ☐ Yes 2 ☐ No

If YES to either a or b above, please answer part c below; if NO, go to Question 18

c. The **last** time you saw an error, near miss or incident that could have hurt **staff** or **patients / service users**, did you or a colleague report it?

1 ☐ Yes, I reported it 2 ☐ Yes, a colleague reported it 3 ☐ No 4 ☐ Don't know

18. To what extent do you agree or disagree with the following?	**Strongly disagree**	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly agree**
a. My organisation treats staff who are involved in an error, near miss or incident fairly.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
b. My organisation encourages us to report errors, near misses or incidents.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. My organisation treats reports of errors, near misses or incidents confidentially.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
d. My organisation blames or punishes people who are involved in errors, near misses or incidents.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
e. When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
f. We are informed about errors, near misses and incidents that happen in the organisation.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
g. We are given feedback about changes made in response to reported errors, near misses and incidents.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

19. Raising concerns about unsafe clinical practice

	Yes	No	Don't know
a. If you were concerned about unsafe clinical practice, would you know how to report it?	☐ 1	☐ 2	☐ 9

To what extent do you agree with the following statements about unsafe clinical practice?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
b. I would feel secure raising concerns about unsafe clinical practice.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
c. I am confident that my organisation would address my concern.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

20. In the last 12 months how many times have you personally experienced physical violence at work from...?

a. Patients / service users, their relatives or other members of the public

☐ 1 Never ☐ 2 1-2 ☐ 3 3-5 ☐ 4 6-10 ☐ 5 More than 10

b. Managers / team leader or other colleagues

☐ 1 Never ☐ 2 1-2 ☐ 3 3-5 ☐ 4 6-10 ☐ 5 More than 10

c. The last time you experienced physical violence at work, did you or a colleague report it?

☐ 1 Yes, I reported it ☐ 2 Yes, a colleague reported it ☐ 3 No ☐ 4 Don't know ☐ 9 Not applicable

21. In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from...?

a. Patients / service users, their relatives or other members of the public

☐ 1 Never ☐ 2 1-2 ☐ 3 3-5 ☐ 4 6-10 ☐ 5 More than 10

b. Managers / team leader or other colleagues

☐ 1 Never ☐ 2 1-2 ☐ 3 3-5 ☐ 4 6-10 ☐ 5 More than 10

c. The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?

☐ 1 Yes, I reported it ☐ 2 Yes, a colleague reported it ☐ 3 No ☐ 4 Don't know ☐ 9 Not applicable

22. Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?

☐ 1 Yes ☐ 2 No ☐ 9 Don't know

23. In the last 12 months have you personally experienced discrimination at work from any of the following?

a. Patients / service users, their relatives or other members of the public ☐ 1 Yes ☐ 2 No

b. Manager / team leader or other colleagues ☐ 1 Yes ☐ 2 No

If YES to either a or b above, please answer part c below; if NO, go to Question 24

c. On what grounds have you experienced discrimination? *Please tick all that apply*

☐ 1 Ethnic background ☐ 3 Religion ☐ 5 Disability ☐ 7 Other *(please specify)*

☐ 2 Gender ☐ 4 Sexual orientation ☐ 6 Age

BACKGROUND INFORMATION

We would like to know a bit more about you so that we can compare the experiences of different types of staff.

24. About you

a. Gender: ☐ 1 Male ☐ 2 Female

b. Age: ☐ 1 16-20 ☐ 2 21-30 ☐ 3 31-40 ☐ 4 41-50 ☐ 5 51-65 ☐ 6 66+

25. Working hours

a. How many hours a week are you contracted to work?

1 ☐ Up to 29 hours 2 ☐ 30 or more hours

b. On average, how many *additional* PAID hours do you work per week for this organisation, over and above your contracted hours? *Please include paid overtime, bank shifts, and additional paid hours on-call.*

1 ☐ 0 hours 2 ☐ Up to 5 hours 3 ☐ 6-10 hours 4 ☐ 11 or more hours

c. On average, how many *additional* UNPAID hours do you work per week for this organisation, over and above your contracted hours? *Please include unpaid overtime and additional unpaid hours on-call.*

1 ☐ 0 hours 2 ☐ Up to 5 hours 3 ☐ 6-10 hours 4 ☐ 11 or more hours

26. What is your ethnic background?

White

01 ☐ British
02 ☐ Irish
03 ☐ Any other White background

Mixed

04 ☐ White and Black Caribbean
05 ☐ White and Black African
06 ☐ White and Asian
07 ☐ Any other mixed background

Asian/Asian British

08 ☐ Indian
09 ☐ Pakistani
10 ☐ Bangladeshi
11 ☐ Any other Asian background

Black/Black British

12 ☐ Caribbean
13 ☐ African
14 ☐ Any other Black background

Chinese and other ethnic background

15 ☐ Chinese
16 ☐ Any other ethnic background *(please specify)*

27. Which of the following best describes how you think of yourself?

1 ☐ Heterosexual (straight) 2 ☐ Gay Man 3 ☐ Gay Woman (lesbian)
4 ☐ Bisexual 5 ☐ Other 6 ☐ I would prefer not to say

28. What is your religion?

1 ☐ No religion
2 ☐ Christian
3 ☐ Buddhist
4 ☐ Hindu
5 ☐ Jewish
6 ☐ Muslim
7 ☐ Sikh
8 ☐ Any other religion *(please specify)*
9 ☐ I would prefer not to say

29. Disability

a. Do you have a long-standing illness, health problem or disability? 1 ☐ Yes 2 ☐ No

By long-standing, we mean that it has lasted, or will last, for at least 12 months
If YES, please answer part b below; if NO, go to Question 30

b. Has your employer made adequate adjustment(s) to enable you to carry out your work?

1 ☐ Yes 2 ☐ No 3 ☐ No adjustment required

30. Do you have face-to-face contact with patients / service users as part of your job?

1 ☐ Yes, frequently 2 ☐ Yes, occasionally 3 ☐ No

31. How many years have you worked for this organisation?

If your organisation has merged with another or changed its name, please include in your answer all the time you have worked with this organisation and its predecessors

1 ☐ Less than 1 year
2 ☐ 1-2 years
3 ☐ 3-5 years
4 ☐ 6-10 years
5 ☐ 11-15 years
6 ☐ More than 15 years

32. What is your occupational group?

Please tick one box only

Allied Health Professionals / Healthcare Scientists / Scientific and Technical

01 ☐ Occupational Therapy
02 ☐ Physiotherapy
03 ☐ Radiography
04 ☐ Pharmacy
05 ☐ Clinical Psychology
06 ☐ Psychotherapy
07 ☐ Arts therapy *(e.g. art, music, drama therapy)*
08 ☐ Other qualified Allied Health Professionals *(e.g. dietetics, speech and language therapy, complementary therapy)*
09 ☐ Support to Allied Health Professionals *(e.g. support worker, therapy helper, therapy assistant or student)*
10 ☐ Other qualified Scientific and Technical or Healthcare Scientists *(e.g. haematology, clinical biochemistry, microbiology)*
11 ☐ Support to healthcare scientists *(e.g. technicians, assistants or students)*

Medical and Dental

12 ☐ Medical / Dental - Consultant
13 ☐ Medical / Dental - In Training *(e.g. Foundation Y1 & Y2, StRs (incl FTSTAs & LATs), SHOs, SpRs / SpTs / GPRs)*
14 ☐ Medical / Dental - Other *(e.g. Staff and Associate Specialists / Non-consultant career grade)*

Ambulance (operational)

15 ☐ Emergency Care Practitioner
16 ☐ Paramedic
17 ☐ Emergency Care Assistant
18 ☐ Ambulance Technician
19 ☐ Ambulance Control Staff *(e.g. call handler, dispatchers, PTS controllers)*
20 ☐ Patient Transport Service *(e.g. ambulance drivers, support staff)*

Public Health

21 ☐ Public Health / Health Improvement

Commissioning

22 ☐ Commissioning managers / support staff

Registered Nurses and Midwives

23 ☐ Adult / General
24 ☐ Mental health
25 ☐ Learning disabilities
26 ☐ Children
27 ☐ Midwives
28 ☐ Health Visitors
29 ☐ District / Community
30 ☐ Other Registered Nurses

Nursing or Healthcare Assistants

31 ☐ Nursing auxiliary / Nursing assistant / Healthcare assistant *(including Health / Clinical / Nursing Support Worker)*

Social Care

32 ☐ Approved social workers / Social workers / Residential social workers
33 ☐ Social care managers
34 ☐ Social care support staff

Wider Healthcare Team

35 ☐ Admin & Clerical *(including Medical Secretary)*
36 ☐ Central Functions / Corporate Services *(e.g. HR, Finance, Information Systems, Information Technology)*
37 ☐ Maintenance / Ancillary *(e.g. housekeeping, domestic staff, maintenance, facilities, estates)*

General Management

38 ☐ General Management *(N.B. If you are a manager and can choose a group from elsewhere in the list, please select that other occupational group)*
39 ☐ Other occupational group *(please specify)*

PATIENT EXPERIENCE

33. To what extent do you agree or disagree with the following statements about the emotional and physical well-being of patients?	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Not applicable to me
In my experience...						
a. Patients / service users have confidence and trust in the **nurses** working in this organisation.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
b. Patients / service users have confidence and trust in the **doctors** that are treating them.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
c. Patients / service users have confidence and trust in the **allied health professionals** that are treating them.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
d. Staff involve patients / service users in decisions about their care and treatment.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
e. Overall, patients / service users are treated with respect and dignity by staff in my organisation.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
f. Patients / service users receive enough emotional support from staff in my organisation.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
g. Patients / service users are given enough privacy when being examined or treated by staff in this organisation.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
h. In this organisation, patients / service users always have access to clean toilets and bathrooms.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
i. Patient / service user safety is a priority for staff in my organisation.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9

34. To what extent do you agree or disagree with the following statements about information and staff co-ordination?	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Not applicable to me
In my experience...						
a. When patients / service users ask a **nurse** an important question, they get answers that can be clearly understood.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
b. When patients / service users ask a **doctor** an important question, they get answers that can be clearly understood.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
c. When patients / service users ask an **allied health professional** an important question, they get answers that can be clearly understood.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
d. Patients / service users are given enough information about their condition/treatment by staff.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
e. Patients / service users receive consistent information about their treatment from different staff members.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9
f. In this organisation there are enough staff available to meet patient / service user needs.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 9

If you have any additional comments about working in this organisation, please write these on a separate sheet and attach them to this questionnaire

CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST **APPENDIX 2**

NATIONAL NHS STAFF SURVEY 2014 - RESULTS OVERVIEW

The Trust's national NHS survey outcomes have been summarised by NHS England and are presented in the form of 29 Key Findings (KFs). There are two types of KFs:-

(i) percentage scores - the percentage of staff giving a particular response to one, or a series of, survey questions; and
(ii) scale summary scores - calculated by converting staff responses to particular questions into scores. For each score the minimum is 1 and the maximum is 5.

Notes:

Note 1 - The occupational group scores are compared to the Trust's score (green is better, red is worse, black is the same)
Note 2 - Fewer than 11 people answered the survey question therefore no score reported
Note 3 - Scores are colour coded according to national rankings (green is best 20%/better than average, red is worse than average/worst 20%, average is black
Note 4 - New questions for 2014

Key Findings	Trust 2014 (n = 370)	Trust 2013 (n = 493)	Change since 2013 survey	All nurses (n = 111) Please see Note 1	Medical & Dental (n = 25) Please see Note 1	All Allied Healthcare Professionals (n = 24) Please see Note 1	Scientific & Technical (n = 29) Please see Note 1	Admin & Clerical (n = 56) Please see Note 1	Central Functions/ Corporate Services (n = 30) Please see Note 1	Maintenance/ Ancillary (n = 12) Please see Note 1	National Average 2014	National threshold for best 20% of acute Trusts	National theshold for worst 20% of acute Trusts	Airedale NHS Foundation Trust (n = 387) Please see Note 3	Bradford Teaching Hospitals NHS Foundation Trust (n= 312) Please see Note 3	Harrogate & District NHS Foundation Trust (n= 482) Please see Note 3	Leeds Teaching Hospitals NHS Trust (n = 477) Please see Note 3	Mid Yorkshire Hospitals NHS Trust (n = 352) Please see Note 3	York Teaching Hospital NHS Foundation Trust (n = 517) Please see Note 3	Salford Royal NHS Foundation Trust Please see Note 3	Comments
Response Rate	45% BTA	59% B20%	▼								42%	50%	35%	42%	36% W20%	56% B20%	50% BTA	46% BTA	47% BTA	56% B20%	
BEST 20%																					
KF7 staff appraised in last 12 months	91%	82%	▲	90%	100%	80%	93%	91%	87%	92%	85%	89%	80%	B20%	Average	BTA	B20%	Average	WTA	BTA	Please refer to Question 3a in the national staff survey questionnaire
KF13 reporting errors, near misses or incidents witnessed in the last month	94%	91%	▲	100%	100%	- (Please see Note 2)	- (Please see Note 2)	- (Please see Note 2)	- (Please see Note 2)	- (Please see Note 2)	90%	93%	88%	Average	W20%	B20%	BTA	WTA	Average	BTA	**Lower score better.** Please refer to Questions 17a-b, 17c in the national staff survey questionnaire
KF22 able to contribute towards improvements at work	72%	71%	▲	78%	72%	75%	79%	68%	73%	50%	68%	72%	65%	Average	BTA	B20%	W20%	W20%	WTA	B20%	Please refer to Questions 7a-b, 7d in the national staff survey questionnaire
KF27 belief that the trust provides equal opportunities for career progression or promotion	91%	90%	▲	93%	95%	91%	89%	95%	85%	- (Please see Note 2)	87%	90%	83%	B20%	WTA	B20%	WTA	BTA	B20%	Average	Please refer to Question 22 in the national staff survey questionnaire
KF28 experiencing discrimination at work in last 12 months	9%	8%	▼	10%	16%	16%	0%	7%	7%	0%	11%	9%	14%	BTA	WTA	B20%	Average	Average	B20%	Average	**Lower score better**. Please refer to Questions 23a-b in the national staff survey questionnaire
ABOVE (BETTER THAN) AVERAGE																					
KF2 agreeing their role makes a difference to patients	91%	90%	▲	95%	88%	100%	93%	88%	71%	- (Please see Note 2)	91%	92%	88%	WTA	Average	BTA	WTA	W20%	Average	B20%	Please refer to Question 9b in the national staff survey questionnaire
KF6 receiving job-relevant training, learning or development in last 12 months	82%	82%	↔	86%	74%	85%	90%	71%	82%	- (Please see Note 2)	81%	83%	78%	Average	B20%	Average	Average	WTA	BTA	Average	Please refer to Questions 1a-g, 2a-c in the national staff survey questionnaire
KF18 experiencing harassment, bullying or abuse from patients/relatives/public in last 12 months	25%	30%	▲	36%	28%	27%	19%	20%	3%	17%	28%	25%	31%	BTA	B20%	BTA	WTA	BTA	BTA	B20%	**Lower score better.** Please refer to Question 21a in the national staff survey questionnaire
KF19 experiencing harassment, bullying or abuse from staff in last 12 months	23%	22%	▼	22%	16%	20%	23%	35%	17%	33%	23%	21%	27%	BTA	WTA	BTA	WTA	WTA	BTA	B20%	**Lower score better.** Please refer to Question 21b in the national staff survey questionnaire
KF23 staff satisfaction	3.63	3.63	↔	3.61	3.67	3.79	3.89	3.58	3.68	3.46	3.60	3.67	3.53	Average	Average	BTA	WTA	W20%	Average	B20%	Please refer to Questions 8a-g in the national staff survey questionnaire
KF25 staff motivation	3.89	3.86	▲	3.89	4.07	3.91	3.99	3.82	3.79	3.89	3.86	3.93	3.77	WTA	BTA	B20%	WTA	W20%	WTA	B20%	Please refer to Questions 5a-c in the national staff survey questionnaire
AVERAGE																					
KF1 feeling satisfied with quality of work and patient care	77%	77%	↔	75%	79%	86%	82%	81%	86%	- (Please see Note 2)	77%	82%	75%	W20%	WTA	Average	WTA	WTA	WTA	B20%	**Key patient care indicator.** Please refer to Questions 6d, 9a, 9c in the national staff survey questionnaire
KF4 Effective team working	3.73	3.76	▼	3.82	3.77	3.83	4.04	3.69	3.63	- (Please see Note 2)	3.74	3.80	3.68	Average	Average	BTA	WTA	W20%	Average	Average	Please refer to Questions 4a-d in the national staff survey questionnaire
KF5 working extra hours	69%	68%	▼	81%	88%	75%	63%	48%	63%	67%	71%	68%	74%	Average	WTA	WTA	BTA	B20%	BTA	Average	**Lower score better.** Please refer to Questions 25b-c in the national staff survey questionnaire
KF8 having a well-structured appraisal in last 12 months	39%	37%	▲	34%	32%	26%	62%	40%	34%	45%	38%	42%	33%	Average	Average	BTA	WTA	W20%	WTA	B20%	Please refer to Questions 3a-d in national staff survey questionnaire
KF9 support from immediate managers	3.67	3.62	▲	3.68	3.35	3.74	3.90	3.70	3.98	3.00	3.65	3.73	3.57	WTA	WTA	BTA	W20%	W20%	Average	B20%	Please refer to Questions 10a-e in the national staff survey questionnaire
KF11 suffering work-related stress in last 12 months	37%	39%	▲	38%	40%	45%	25%	31%	33%	42%	37%	34%	41%	BTA	W20%	B20%	WTA	WTA	BTA	BTA	**Lower score better.** Please refer to Question 16 in the national staff survey questionnaire
KF12 witnessing potentially harmful errors, near misses or incidents in last month	31%	33%	▲	43%	48%	41%	31%	13%	3%	0%	34%	30%	37%	B20%	BTA	B20%	W20%	BTA	B20%	BTA	Please refer to Questions 17a-b in the national staff survey questionnaire
KF15 agreeing that they would feel secure raising concerns about unsafe clinical practice	66%	(Please see Note 4)	(Please see Note 4)	71%	79%	56%	68%	49%	57%	75%	67%	73%	64%	WTA	B20%	BTA	Average	WTA	WTA	B20%	Please refer to Question 19b in the national staff survey questionnaire
KF24 recommending trust as a place to work or receive treatment	3.67	3.75	▼	3.60	3.59	3.60	3.63	3.79	3.92	3.69	3.67	3.84	3.47	Average	Average	BTA	WTA	W20%	WTA	B20%	Please refer to Questions 12a, 12c-d in the national staff survey questionnaire
KF29 agreeing feedback from patients/service users is used to make informed decisions in their directorate/department	55%	(Please see Note 4)	(Please see Note 4)	54%	50%	55%	40%	46%	- (Please see Note 2)	- (Please see Note 2)	56%	61%	49%	WTA	BTA	BTA	WTA	W20%	W20%	B20%	Please refer to Questions 13a, 13c in the national staff survey questionnaire
BELOW (WORSE THAN) AVERAGE																					

Key Findings	Trust 2014 (n = 370)	Trust 2013 (n = 493)	Change since 2013 survey	All nurses (n = 111) Please see Note 1	Medical & Dental (n = 25) Please see Note 1	All Allied Healthcare Professionals (n = 24) Please see Note 1	Scientific & Technical (n = 29) Please see Note 1	Admin & Clerical (n = 56) Please see Note 1	Central Functions/ Corporate Services (n = 30) Please see Note 1	Maintenance/ Ancillary (n = 12) Please see Note 1	National Average 2014	National threshold for best 20% of acute Trusts	National theshold for worst 20% of acute Trusts	Airedale NHS Foundation Trust (n = 387) Please see Note 3	Bradford Teaching Hospitals NHS Foundation Trust (n= 312) Please see Note 3	Harrogate & District NHS Foundation Trust (n= 482) Please see Note 3	Leeds Teaching Hospitals NHS Trust (n = 477) Please see Note 3	Mid Yorkshire Hospitals NHS Trust (n = 352) Please see Note 3	York Teaching Hospital NHS Foundation Trust (n = 517) Please see Note 3	Salford Royal NHS Foundation Trust Please see Note 3	Comments
KF3 work pressure felt by staff	3.12	3.10	↔	3.18	3.20	3.39	3.09	2.74	3.27	2.97	3.07	3.01	3.17	W20%	Average	BTA	WTA	WTA	Average	B20%	**Lower score better.** Please refer to Questions 7e-g in the national staff survey questionnaire
KF10 receiving health and safety training in last 12 months	74%	77%	▼	77%	56%	86%	79%	68%	67%	- (Please see Note 2)	77%	83%	70%	Average	WTA	Average	WTA	WTA	W20%	B20%	Please refer to Question 1a in the national staff survey questionnaire
KF14 fairness and effectiveness of incident reporting procedures	3.50	3.57	▼	3.51	3.51	3.54	3.71	3.42	3.39	3.50	3.54	3.60	3.46	BTA	B20%	WTA	Average	Average	W20%	B20%	Please refer to Questions 18a-g in the national staff survey questionnaire
KF16 experiencing physical violence from patients/relatives/public in last 12 months	16%	15%	▼	27%	12%	23%	4%	2%	0%	17%	14%	12%	17%	B20%	B20%	B20%	Average	B20%	Average	B20%	**Lower score better.** Please refer to Question 20a in the national staff survey questionnaire
KF20 feeling pressure in last 3 months to attend work when feeling unwell	28%	28%	↔	28%	14%	32%	32%	18%	28%	64%	26%	24%	29%	WTA	W20%	B20%	W20%	Average	BTA	B20%	**Lower score better.** Please refer to Questions 15a-c in the national staff survey questionnaire
KF21 reporting good communication between senior management and staff	28%	29%	▼	33%	21%	30%	38%	30%	27%	17%	30%	34%	25%	WTA	WTA	BTA	BTA	W20%	WTA	B20%	Please refer to Question 11a-d in the national staff survey questionnaire
WORST 20%																					
KF17 experiencing physical violence from staff in last 12 months	4%	2%	▼	4%	0%	8%	0%	6%	3%	0%	3%	2%	3%	BTA	WTA	Average	Average	B20%	B20%	Average	**Lower score better.** Please refer to Question 20b in the national staff survey questionnaire
KF26 having equality and diversity training in last 12 months	45%	47%	▼	36%	52%	40%	38%	55%	47%	- (Please see Note 2)	63%	74%	51%	BTA	Average	B20%	Average	W20%	W20%	B20%	Please refer to Question 1b in the national staff survey questionnaire

OVERALL STAFF ENGAGEMENT SCORE - KF22, KF24 & KF25	**3.77 BTA**	**3.77 BTA**	↔	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3.74	N/A	N/A	**3.72 Average**	**3.75 Average**	**3.83 B20%**	**3.65 WTA**	**3.43 W20%**	**3.70 WTA**	**3.97 B20%**	Please refer to Questions 7a-b, 7d, 12a, 12c-d, 5a-c in the national staff survey questionnaire

Base	314
Q33a. Patients / service users have confidence and trust in the nurses working in this organisation.	
Strongly disagree	2 0.6%
Disagree	8 2.5%
Neither agree nor disagree	41 13.1%
Agree	157 50.0%
Strongly agree	51 16.2%
Not applicable to me	55 17.5%

Base	315
Q33b. Patients / service users have confidence and trust in the doctors that are treating them.	
Strongly disagree	2 0.6%
Disagree	12 3.8%
Neither agree nor disagree	51 16.2%
Agree	150 47.6%
Strongly agree	43 13.7%
Not applicable to me	57 18.1%

Base	316
Q33c. Patients / service users have confidence and trust in the allied health professionals that are treating them.	
Strongly disagree	1 0.3%
Disagree	4 1.3%
Neither agree nor disagree	62 19.6%
Agree	147 46.5%
Strongly agree	46 14.6%
Not applicable to me	56 17.7%

Base	313
Q33d. Staff involve patients / service users in decisions about their care and treatment.	
Strongly disagree	2 0.6%
Disagree	17 5.4%
Neither agree nor disagree	44 14.1%
Agree	138 44.1%
Strongly agree	60 19.2%
Not applicable to me	52 16.6%

Base	313
Q33e. Overall, patients / service users are treated with respect and dignity by staff in my organisation.	
Strongly disagree	4 1.3%
Disagree	8 2.6%
Neither agree nor disagree	20 6.4%
Agree	139 44.4%
Strongly agree	103 32.9%
Not applicable to me	39 12.5%

Base	313
Q33f. Patients / service users receive enough emotional support from staff in my organisation.	
Strongly disagree	3 1.0%
Disagree	32 10.2%
Neither agree nor disagree	71 22.7%
Agree	106 33.9%
Strongly agree	54 17.3%
Not applicable to me	47 15.0%

Base	314
Q33g. Patients / service users are given enough privacy when being examined or treated by staff in this organisation.	
Strongly disagree	1 0.3%
Disagree	24 7.6%
Neither agree nor disagree	32 10.2%
Agree	136 43.3%
Strongly agree	70 22.3%
Not applicable to me	51 16.2%

Base	315
Q33h. In this organisation, patients / service users always have access to clean toilets and bathrooms.	
Strongly disagree	1 0.3%
Disagree	16 5.1%
Neither agree nor disagree	33 10.5%
Agree	146 46.3%
Strongly agree	67 21.3%
Not applicable to me	52 16.5%

Base	315
Q33i. Patient / service user safety is a priority for staff in my organisation.	
Strongly disagree	3 1.0%
Disagree	9 2.9%
Neither agree nor disagree	23 7.3%
Agree	145 46.0%
Strongly agree	93 29.5%
Not applicable to me	42 13.3%

Base	311
Q34a. When patients / service users ask a nurse an important question, they get answers that can be clearly understood.	
Strongly disagree	2 0.6%
Disagree	11 3.5%
Neither agree nor disagree	48 15.4%
Agree	140 45.0%
Strongly Agree	41 13.2%
Not applicable to me	69 22.2%

Base	312
Q34b. When patients / service users ask a doctor an important question, they get answers that can be clearly understood.	
Strongly disagree	1 0.3%
Disagree	18 5.8%
Neither agree nor disagree	68 21.8%
Agree	126 40.4%
Strongly Agree	29 9.3%
Not applicable to me	70 22.4%

Base	312
Q34c. When patients / service users ask an allied health professional an important question, they get answers that can be clearly understood.	
Strongly disagree	1 0.3%
Disagree	10 3.2%
Neither agree nor disagree	55 17.6%
Agree	147 47.1%
Strongly Agree	39 12.5%
Not applicable to me	60 19.2%

Base	310
Q34d. Patients / service users are given enough information about their condition/treatment by staff.	
Strongly disagree	2 0.6%
Disagree	23 7.4%
Neither agree nor disagree	59 19.0%
Agree	133 42.9%
Strongly Agree	42 13.5%
Not applicable to me	51 16.5%

Base	311
Q34e. Patients / service users receive consistent information about their treatment from different staff members.	
Strongly disagree	5 1.6%
Disagree	41 13.2%
Neither agree nor disagree	67 21.5%
Agree	121 38.9%
Strongly Agree	24 7.7%
Not applicable to me	53 17.0%

Base	313
Q34f. In this organisation there are enough staff available to meet patient / service user needs.	
Strongly disagree	57 18.2%
Disagree	105 33.5%
Neither agree nor disagree	65 20.8%
Agree	39 12.5%
Strongly Agree	8 2.6%
Not applicable to me	39 12.5%

Base	310
Q35. The trust has four pillars of behaviour which are 1) We put the patient first; 2) We go see; 3) We work together to get results and 4) We do the must dos. To what extent are you aware of these four pillars of behaviour?	
Not at all aware	21 6.8%
Somewhat aware	102 32.9%
Very aware	187 60.3%

Base	309
Q36. Have these four pillars of behaviour been discussed with you as a part of your most recent annual appraisal?	
Yes	138 44.7%
No	113 36.6%
Haven't had my appraisal yet	58 18.8%

Base	268
Q37. What would be your preferred route to find out more about the four pillars of behaviour?	
Line manager	66 24.6%
Team brief	66 24.6%
Trust News	65 24.3%
Colleagues	12 4.5%
Appraisal	45 16.8%
Other, please specify below	14 5.2%

Base	306
Q38. How would you rate your understanding of the budget position for your ward, department or team?	
Don't understand at all	55 18.0%
Understand a little	155 50.7%
Understand well	96 31.4%

Base	305
Q39. Do you feel that there are things that you could personally do differently to improve the budget position for your ward, department or team?	
Yes	129 42.3%
No	176 57.7%

Base	306
Q40. How would you rate your understanding of the budget position for the Trust as a whole?	
Don't understand at all	51 16.7%
Understand a little	174 56.9%
Understand well	81 26.5%

Base	251
Q41. What would be your preferred route to find out more about the Trust's budget position now and into the future?	
Line manager	86 34.3%
Team brief	97 38.6%
Trust News	49 19.5%
Colleagues	4 1.6%
Appraisal	8 3.2%
Other, please specify below	7 2.8%

Base	309
Q42. In the past 3 years have you been aware of an incident at work which was not addressed through the normal management process and which led you to consider being a whistleblower?	
Yes	37 12.0%
No	272 88.0%

Base	304
Q43. Are you aware of the Trust's whistleblowing arrangements?	
Yes	168 55.3%
No	136 44.7%

Base	207
Q44. Did you raise your concerns?	
Yes	35 16.9%
No	172 83.1%

Base	47
Q45. If yes, who did you raise your concerns with?	
Line manager	33 70.2%
Supervisor	4 8.5%
Trade union	1 2.1%
HR	2 4.3%
Other, please specify below	7 14.9%

Base	54
Q46. How do you think your concerns were handled?	
Not at all	11 20.4%
Not very well	21 38.9%
Well	22 40.7%

Base	60
Q47. Did you suffer any negative repercussions?	
Yes	14 23.3%
No	46 76.7%

Base	141
Q48. Going forward how confident are you that your concerns will be addressed properly by the Trust?	
Unsure	17 12.1%
Not confident	43 30.5%
Reasonably confident	68 48.2%
Very confident	13 9.2%

Calderdale and Huddersfield NHS
NHS Foundation Trust

Staff Survey Action Plan

the Trust's response to the feedback provided by survey respondents with a focus on specific areas for improvement

May 2015

NB: the content of this action plan has been informed by colleague comment and recommendation

Survey Measure	National Score	Trust Score	Action	Lead	Timescale
1. Survey communication			Report survey findings and action plan to Quality Committee	Deputy Director of Workforce and OD	26 May 2015
			Report survey findings and action plan to Executive Board and Board of Directors	Director of Workforce and OD	28 May 2015
			Survey findings and action plan to be cascaded through Team Brief. To include reference to what we are doing well and to make commitment to continue supporting these areas	Company Secretary	June 2015
			Confirm support from staff side for the action plan	Director of Workforce and OD	June 2015
			Colleague panel participants to continually test ideas and suggestions for improvement	Staff Survey Lead	June 2015
			Run briefing sessions in the Trust for colleagues to hear about the survey findings and to contribute to action plan. Use the survey administrator, Picker in briefing sessions.	Staff Survey Lead	June 2015
			Survey findings and action plan to be made available on Trust intranet with opportunity to comment and contribute provided to colleagues	Staff Survey Lead	June 2015
			Email account to be created for colleagues to contribute to survey action plan	Staff Survey Lead	June 2015

Survey Measure	National Score	Trust Score	Action	Lead	Timescale
			Well Led group to provide a monthly 'you said, we did' update using Trust News, CHFT weekly and the intranet	Staff Survey Lead	By end of each month
			Progress report to Executive Board and Board of Directors	Director of Workforce and OD	September 2015
			'You said, we did' briefing as part of build-up to 2015 staff survey	Staff Survey Lead	October 2015
2. KF3 Work pressure felt by staff (low score better)	3.07/5	3.11/5	Publicly report nursing safer staffing levels information and associated actions	Deputy Director of Nursing	Monthly
			Develop safer staffing models for AHP staff group	Deputy Director of Nursing	tbc
			Develop a safer staffing model for medical staff	Medical Director	tbc
			Design and agree the key elements of the Trust's recruitment and retention strategy	Director of Workforce and OD	July 2015
			Develop a comprehensive recruitment programme for difficult to recruit to posts	Director Nursing/Medical Director/Director of Workforce and OD	July 2015
			Make a real difference to staff health and well-being through the development of a comprehensive health and well-being strategy	Director of Workforce and OD	August 2015

Survey Measure	National Score	Trust Score	Action	Lead	Timescale
			Launch a comprehensive health and well-being programme of activities and events	Workforce Wellbeing Lead	June 2015
			Centre the Work Together, Get Results approach into existing leadership and management development programmes	Head of Workforce Development	June 2015
			Develop, promote and monitor the Trust's new mindfulness programme	Workforce Wellbeing Lead	from June 2015
			Promote the Work Together, Get Results toolkit, progress roll out in the organisation and support colleagues with the application of the tools and techniques in the workplace	Head of Workforce Development	From May 2015
3. KF10 Received health and safety training in last 12 months	77%	74%	Launch new mandatory training approach, incorporating health, safety and well-being, moving and handling, fire and conflict resolution training	Head of Workforce Development	May 2015
			Mandatory training refresh 'go live'		1 June 2015
			Electronic Staff Record (ESR) used as the data capture system and through its Business Intelligence (BI) tool for compliance reporting within divisional structures and through the Integrated Board report (IBR) monthly to Executive Board and Board of Directors	Head of Workforce Development	Monthly

Survey Measure	National Score	Trust Score	Action	Lead	Timescale
			Well Led group to oversee mandatory training compliance rates and to highlight 'hot spot' areas where compliance is of concern	Well Led Chair/Assistant Divisional Directors and corporate equivalents	Monthly
			Manage appraisal activity on a 12 month rolling and in-year basis checking that mandatory training compliance for individual colleagues is maintained	All Managers	Monthly
KF14 Fairness and effectiveness of incident reporting procedures	3.54/5	3.50/5	Review and refresh incident reporting procedures and ensure colleagues understand their responsibilities for reporting incidents and raising concerns	Assistant Director, Office of the Medical and Nurse Director	June/July 2015
			Design a formal, trackable feedback mechanism into incident reporting procedures that ensures colleagues raising the issues are informed of the response/actions	Assistant Director, Office of the Medical and Nurse Director	July 2015
KF16 Experienced physical violence from patients/ relatives or public in last 12 months (low score better)	14%	17%	Identify necessary actions jointly with colleagues working in service areas with high reports of physical violence incidents	Health and Safety Committee	June/July 2015
			Redesign conflict resolution training as part of Trust mandatory training package	Risk Manager	May 2015
			'Go see' good practice sites	Risk Manager	July 2015

Survey Measure	National Score	Trust Score	Action	Lead	Timescale
			Explore approaches to refreshing and restating a zero tolerance approach to abuse and violence towards Trust employees	Risk Manager	August 2015
KF17 Experienced physical violence from staff in last 12 months (low score better)	3%	4%	Conduct a robust in- depth assessment of the survey data and test responses with colleagues to identify areas of concern and develop actions to tackle issues that are found.	Well Led Group	May/June 2015
KF20 Felt pressure in last 3 months to attend work when feeling unwell (low score better)	26%	27%	Review Attendance Management policy and ensure line managers understand their responsibilities in managing attendance including annual leave	Assistant Director of Human Resources (Equality and Diversity Lead)	June 2015
			Enhance resources for line managers to assist in the management of colleague health and well-being	Assistant Director of Human Resources (Equality and Diversity Lead)	June 2015
			Make a real difference to staff health and well-being through the development of a comprehensive health and well-being strategy	Director of Workforce and OD	July 2015
			Launch a comprehensive health and well-being programme of activities and events	Workforce Wellbeing Lead	May 2015
			Continued roll out of Work Together, Get Results toolkit and support colleagues with the application of the tools and techniques in the workplace	Head of Workforce Development	from June 2015

Survey Measure	National Score	Trust Score	Action	Lead	Timescale
			Develop, promote and monitor the Trust's new mindfulness programme	Workforce Wellbeing Lead	from June 2015
4. KF21 Reported good communications between senior management and staff	30%	28%	Design an integrated engagement/communication approach to support the refresh of the Trust's vision, goals and values with colleagues	Company Secretary/Director of Workforce and OD	June 2015
			Run a visible leaders programme through 'go see' Leadership Walk Rounds and a Back to the Floor programme	Executive Board/Board of Directors/Divisional Leads	in-place
			Senior leaders to role model and act as champions for the Work Together, Get Results toolkit	Executive Board/Board of Directors/Divisional Leads	from May 2015
			Team brief programme to be re-launched	Company Secretary	June 2015
			Enhance the coverage of leadership and management development programmes and ensure the incorporation of the Work Together, Get Results toolkit. Support colleagues with the application of the Work Together, Get Results tools and techniques in the workplace	Head of Workforce Development	July 2015
			Refresh and formally re-launch the staff suggestion scheme	Company Secretary	June 2015

Survey Measure	National Score	Trust Score	Action	Lead	Timescale
			Design a social media engagement plan in support of communication with colleagues	Company Secretary	July 2015
KF26 Had equality and diversity training in last 12 months	63%	45%	Launch new mandatory training approach, incorporating equality, diversity and human rights training. Explore opportunities to invite external organisations to run seminars, promotional roadshows to raise awareness in identified 'hotspots'. Promote on screensaver and intranet	Head of Workforce Development Associate Director of Engagement and Inclusion	May 2015 July 2015
			Mandatory training refresh 'go live'		1 June 2015
			Electronic Staff Record (ESR) used as the data capture system and through its Business Intelligence (BI) tool for compliance reporting within divisional structures and through the Integrated Board report (IBR) monthly to Executive Board and Board of Directors	Head of Workforce Development	Monthly
			Well Led group to oversee mandatory training compliance rates and to highlight 'hot spot' areas where compliance is of concern	Well Led Chair/Assistant Divisional Directors	Monthly
			Manage appraisal activity on a 12 month rolling and in-year basis checking that mandatory training compliance for individual colleagues is maintained	All managers	Monthly

Survey Measure	National Score	Trust Score	Action	Lead	Timescale
5. Raising concerns (Whistleblowing)			A partnership with Public Concern at Work (PCaW) has been created to assist the Trust in creating an environment where colleagues are encouraged to raise concerns at work	Senior Human Resources Adviser	From November 2014
			The Trust is committed to PCaW's 'First 100' campaign and is working towards compliance with a national whistleblowing code of conduct	Senior Human Resources Adviser	June 2015
			Whistleblowing helpline established	Senior Human Resources Adviser	from January 2015
			Refresh the Trust's Freedom of Speech policy and rename it Raising Concerns (Whistleblowing) policy	Senior Human Resources Adviser	June 2015
			Create intranet sourced resources for line managers and colleagues generally (guides, checklists, reference material, posters)	Senior Human Resources Adviser	January through June 2015
			Complete an assessment of progress against NHS Employers 'Draw the Line' checklist	Senior Human Resources Adviser	May 2015
			Complete an assessment against the Francis 'Speak Up Review' recommendations	Senior Human Resources Adviser	May 2015
			Establish a network of Guardians	Senior Human Resources Adviser	June 2015

Survey Measure	National Score	Trust Score	Action	Lead	Timescale
			Create a network of raising concerns champions to sign post colleagues to appropriate resources and processes	Senior Human Resources Adviser	August 2015
			Design a communication strategy that promotes and publicises the Trust's commitment to supporting colleagues with concerns and the mechanisms available to do so	Senior Human Resources Adviser	July 2015
			Design and deliver awareness sessions for line manager colleagues on how to handle concerns raised by team members and awareness sessions for all other colleagues on how to raise concerns	Senior Human Resources Adviser	August 2015
6. Values			Design an integrated engagement/communication approach to support the refresh of the Trust's vision, goals and values with colleagues	Company Secretary/Director of Workforce and OD	June 2015
			Extend the Trust's values based recruitment approach to all staff groups	Assistant Director of Human Resources (Resourcing Lead)	August 2015
			Strengthen the visibility of the Trust values in induction and probationary periods tools	Head of Workforce Development/Senior Human Resources Adviser	June 2015
			Make the Trust values visible in all policy documents (clinical and non-clinical)	Policy Leads	

Survey Measure	National Score	Trust Score	Action	Lead	Timescale
			Reference the values in all Trust publications including the Trust internet web pages	Company Secretary	
			Refresh appraisal documentation to incorporate the revised vision and goals	Head of Workforce Development	May 2015
			Promote the use of the Work Together, Get Results toolkit	Head of Workforce Development	
7. Financial position			Design an integrated engagement/communication approach to support the refresh of the Trust's vision, goals and values with colleagues	Company Secretary/Director of Workforce and OD	June 2015
			Design a finance training/briefing tool for inclusion in the Trust's essential skills training programme	Director of Finance	May 2015
			Colleague turnaround/CIP briefings to be scheduled as part of financial engagement/communication strategy	Director of Finance	May 2015
			Team brief programme to be re-launched	Company Secretary	June 2015

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Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Jackie Murphy, Deputy Director of Nursing
Date: Thursday, 28th May 2015	**Sponsoring Director:** Julie Dawes, Director of Nursing
Title and brief summary: NURSE REVALIDATION - From 2016 nurses and midwives in the UK will be legally expected to undertake a process of revalidation every 3 years in order to remain on the nursing register. This paper describes the purpose and expected process that is currently being piloted across a number a health care settings. It describes the implications to the Trust including the significant risks for consideration by the Board.	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: This report has previously been received by the Nursing and Midwifery Committee and the Associate Nurse Directors meeting.	
Governance Requirements: See report	
Sustainability Implications: None	

Executive Summary

Summary:

This paper describes the Nursing and Midwifery Council requirement for all registered nurses and midwives to undertake a process of revalidation every 3 years.

Nurses and Midwives will need to revalidate at the point of the renewal of their registration in order to remain on the NMC register.

This is a legal requirement for all nurses and midwives who work in the UK and is a key recommendation following the Francis Inquiry.

The new system of revalidation replaces the current process of post registration education and practice (PREP) and comes into effect on 31 December 2015. This means that by December 2018 all nurses and midwives on the register will have undergone revalidation.

Main Body

Purpose:

The purpose of revalidation is to improve public protection by making sure that nurses and midwives continue to be fit to practise throughout their career. Furthermore it ensures that employers can be assured that the nurses and midwives are deemed fit to practise.

Background/Overview:

See report

The Issue:

See report

Next Steps:

As detailed below in recommendation

Recommendations:

The Board is asked to support the revalidation process ensuring there is a robust system for continuing professional development and a performance management system for appraisal, mandatory and essential training in order to be assured that nurses and midwives remain fit for practise.

The Board is also asked to be aware of the additional time commitment to give and receive third party feedback.

Appendix

Attachment:

Nurse Revalidation - MAY 2015.pdf

Calderdale and Huddersfield NHS
NHS Foundation Trust

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

Report to: **Subject:** **Sponsored by:**	Board of Directors – May 2015 **NURSE REVALIDATION** Julie Dawes, Director of Nursing
Prepared by:	Jackie Murphy, Deputy Director of Nursing
Purpose of the Report:	From 2016 nurses and midwives in the UK will be legally expected to undertake a process of revalidation every 3 years in order to remain on the nursing register. This paper describes the purpose and expected process that is currently being piloted across a number a health care settings. It describes the implications to the Trust including the significant risks for consideration by the Board.
Key Points for Trust Board Members:	• All nurses will have to revalidate every 3 years • A performance management system for appraisal, mandatory and essential skills will be essential • Registered nurses will be expected to undertake and evidence 450 hours of nursing practice over 3 years which will have implications for colleagues who are registered but are not employed in a nursing role • All nurses will be expected to undertake 40 hours of professional development over 3 years 20 hours of which has to be interactive – this will have implications on the allocated absence assumption in ward/ dept. budgets • Nurses will be expected to keep an electronic portfolio in order to submit evidence if requested
Next Steps Future action:	The Board is asked to support the revalidation process ensuring there is a robust system for continuing professional development and a performance management system for appraisal, mandatory and essential training in order to be assured that nurses and midwives remain fit for practise. The Board is also asked to be aware of the additional time commitment to give and receive third party feedback.
Strategic Aim	Keeping the Base Safe
Risk Register	
CQC Reference	

NURSE REVALIDATION

1.0 INTRODUCTION

This paper describes the Nursing and Midwifery Council requirement for all registered nurses and midwives to undertake a process of revalidation every 3 years.

Nurses and Midwives will need to revalidate at the point of the renewal of their registration in order to remain on the NMC register.

This is a legal requirement for all nurses and midwives who work in the UK and is a key recommendation following the Francis Inquiry**.**

The new system of revalidation replaces the current process of post registration education and practice (PREP) and comes into effect on 31 December 2015. This means that by December 2018 all nurses and midwives on the register will have undergone revalidation.

2.0 PURPOSE

The purpose of revalidation is to improve public protection by making sure that nurses and midwives continue to be fit to practise throughout their career. Furthermore it ensures that employers can be assured that the nurses and midwives are deemed fit to practise.

It aims to prevent scandals such as Mid Staffordshire by improving patient safety and ensuring all nurses and midwives are providing care that is an acceptable standard.

This means that nurses and midwives need to do more to remain on the Nursing and Midwifery Council Register.

Registrants need to stay up to date in their professional practice, develop new skills, keep up to date on standards and understand the changing needs of the public they serve and fellow healthcare professionals with whom they work.

It is not about addressing bad practice amongst a small number of nurses and midwives. It is about promoting good practice across the whole population of nurses and midwives.

3.0 PROCESS

Revalidation is a process that all nurses and midwives will need to comply with to demonstrate that they are fit to practise throughout their career.

All nurses and midwives will have ownership of, and will be held accountable for their own revalidation process.

All nurses and midwives are currently required to renew their registration every three years, however revalidation will strengthen the renewal process by increasing

professionalism and introducing new requirements. Nurses and midwives will be required to

- Declare they have practised for 450 hours during the three years.
- Demonstrate up-to-date practice and professional development. The number of hours required is increasing from 35 hours to 40 hours
- Produce five reflective pieces on the professional standards of practice and behaviour as set out in the Code. **http://www.nmc-uk.org/Publications/Standards/The-code/Introduction/**
- Ensure the reflection is discussed with another registrant.
- Demonstrate engagement in professional discussions with other registered nurses or midwives.
- Obtain feedback based on practice (this can be formal or informal, written or verbal and for peers, professional's or patients
  .

The revised system requires an additional level of monitoring as every nurse and midwife will need to be signed off by their manager or someone in a similar position.

The NMC requires confirmation is received from someone well placed to comment on a nurse or midwife practice. This will confirm that a nurse or midwife is performing to the standard set out in the Code and it will be based on information available at the time.

If a nurse or midwives fail revalidation they will not be registered to work legally in the UK.

4.0 PROGRESS IN CALDEREDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

A task and finish approach led by the Deputy Director of Nursing has been adopted to ensure the Trust is ready to revalidate nurses and midwives commencing December 2015.

The initial work plan includes

- Go see
- Work in partnership with colleagues in Workforce and Development to ensure there is an effective process to alert individuals and line managers when a nurse or midwife is due to revalidate.
- Establish a process to verify nurse and midwives have been revalidated when commencing employment at CHFT
- Ensure the Trust appraisal tool supports the requirements for revalidation including feedback and reflection.
- Ensure the trusts electronic system the performance management of appraisal, mandatory and essential skills training
- Ensure nurses and midwives understand reflection and reflective practice
- Ensure training and education has CPD points attached
- Ensure nurse and midwives understand the implications of CPD
- Commence testing, E portfolio in order to make a recommendation for the Trust to use (RCN I currently being tested http://rcni.com/?gclid=CPKE-uz0ucQCFfQatAodKVUAP
- Shadow revalidation for the senior nurse team and registrants who will be due to revalidate

Develop a communication strategy with regard to revalidation**.**

5.0 RISKS

- Acquiring robust systems to alert nurses to revalidate every three years
- Currently not achieving 100% compliance with appraisal
- Many nurses in the Trust do not work in nursing roles
- Additional time expected for CPD
- Additional time expected for reflection and supervision
- All nurses keeping e portfolio

6.0 SUMMARY

The Board is asked to support the revalidation process ensuring there is a robust system for continuing professional development and a performance management system for appraisal and mandatory and essential training in order to be assured that nurses and midwives remain fit for practise.

The Board is also asked to be aware of the additional time commitment to give and receive third party feedback.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 28th May 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: REVIEW OF STANDING ORDERS - BOARD OF DIRECTORS - The Board is asked to approve the amendments made to the Board of Directors Standing Orders	
Action required: Approve	
Strategic Direction area supported by this paper: Keeping the Base Safe	
Forums where this paper has previously been considered: Audit and Risk Committee - 21.4.15	
Governance Requirements: Keeping the base safe	
Sustainability Implications: None	

Executive Summary

Summary:

A review of the Trust's Standing Orders has been undertaken to ensure that they remain fit for purpose and are updated to include any changes in requirements. Following the minor amendments made to the document last April, a full review has been undertaken and amendments made throughout the document to ensure that they remain up to date and in line with best practice. In particular reference to what action would be taken should standing orders not be followed has been included and reference made to the appropriate Bribery and Fraud Acts.

Two further amendments were made following review by the Audit and Risk Committee - the inclusion of some missing wording at 2.21 and the addition of the Finance and Performance Committee to the Committees of the Board.

Following the Board's decision in April to re-form the Health and Safety Committee as a sub-group rather than a committee of the Board, this amendment has also been included in the list of Committees of the Board.

The Board is asked to approve the amendments made to the Board of Directors Standing Orders

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 amendments made to the Board of Directors Standing Orders

Appendix

Attachment:

APP N Standing Orders.pdf

STANDING ORDERS

BOARD OF DIRECTORS

Directorate responsible for policy:	Chief Executive's Office
Version:	V1.2
Policy author:	Company Secretary
Responsible Committee:	Audit and Risk Committee
Date written:	31 March 2015
Date approved:	
Date issued:	
Review date:	

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Declaration of Interest
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Custody of Seal
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Register of Sealing

SIGNATURE OF DOCUMENTS

MISCELLANEOUS

Standing Orders to be given to Directors and Officers
Documents having the Standing of Standing Orders
Review of Standing Orders
Non-availability of Chair / Deputy Chair / Chief Executive / Director of Finance

FOREWORD

Within the terms of authorization issued by Monitor, the Independent Regulator, NHS Foundation Trusts are required to demonstrate appropriate arrangements to provide comprehensive governance arrangements in accordance with the need to agree Standing Orders (SOs) and schedules of Reservations of Powers to the Trust and Scheme of Delegation in accordance with their constitutions, their Terms of Authorisation and the requirements of the National Health Service Act 2006 ("the 2006 Act").

This Standing Order document, together with Standing Financial Instructions and the Reservation of Powers to the Board (Scheme of Delegation), provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

These documents provide a comprehensive business framework. All Directors and all members of staff should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions.

INTERPRETATION

These Standing Orders are subject to continuous review (and formally reviewed and approved by the Audit Committee and Board of Directors every 2 years) to ensure that they reflect the obligations to which the Foundation Trust is subject under the Health and Social Care (Community Health and Standards) Act 2003, the Terms of Authorisation and the provisions of its Constitution.

For the avoidance of doubt nothing contained within these standing orders shall be construed in contravention of the Terms of Authorisation and in the event that there is such a contravention, the Terms of Authorisation, the 2006 Act and the Constitution shall take precedence.

Whilst the nature of these Standing Orders is that they are subject to variation, no such variation shall contravene the Terms of Authorisation, the 2006 Act and the Constitution.

INTRODUCTION

Statutory Framework

The Calderdale & Huddersfield NHS Foundation Trust (the Trust) is a public benefit corporation which was established under the National Health Service Act 2006 ("the 2006 Act").

The principal place of business of the Trust is:
Trust Offices, Huddersfield Royal Infirmary, Acre Street, Lindley, Huddersfield, HD3 3EA

The statutory functions conferred on the Trust are set out in the 2006 Act. The Trust also has a constitution ("the Constitution") as required under the 2006 Act, which includes further provisions consistent with Schedule 7 in support of the governance arrangements within the Trust.
It should be noted that the Trust also has in place Standing Orders (SOs) which deal with the Membership Council which may need to be referred to.

The purpose of the Trust (as required by the 2006 Act) is to serve the community by the provision of goods and services for purposes related to the provision of health care in accordance with its statutory duties and the Terms of the Independent Regulator's Authorisation (the "Terms of Authorisation"). The Trust is to have all the powers of an NHS Foundation Trust as set out in the 2006 Act, subject to the Terms of Authorisation.

As a statutory body, the Trust has specified powers to contract in its own name.

The Trust also has powers under section 28A of the NHS Act 1977 as amended by the 2006 Act to fund projects jointly planned with local authorities, voluntary organisations and other bodies.

Regulatory Framework

Under its regulatory framework the Trust must adopt Standing Orders for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions as an integral part of Standing Orders setting out the responsibilities of individuals.

The Trust's Constitution also requires that the Board of Directors draw up a schedule of decisions reserved to that Board and a scheme of delegation to enable responsibility to be clearly delegated to committees of the board and individual directors.

The Constitution also requires the establishment of an Audit Committee and a Remuneration Committee with formally agreed terms of reference. The Constitution requires a register of possible conflicts of interest of members of both the Board of Directors and the Membership Council and how those possible conflicts are addressed.

In addition to the statutory requirements the Independent Regulator (the office known as Monitor) will issue further requirements and guidance. Many of these are contained within the 2006 Act and on Monitor's website http://www.regulator-nhsft.gov.uk or the Department of Health website http://www.dh.gsi.gov.uk . Information is accessible locally via the Board Secretary.

Arrangements for public access to information are set out in the Code of Practice on Openness in the NHS and in the Trust's publication scheme under the Freedom of Information Act 2000.

Delegation of Powers

Under the Standing Orders relating to the Arrangements for the Exercise of Functions (SO 4) the Board exercises its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of SO 5 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit or as the Independent Regulator may direct. Delegated Powers are covered in a separate document (Scheme of Delegation). That document has effect as if incorporated into the Standing Orders.

INTERPRETATION

Save as permitted by law, at any meeting the Chair of the Trust shall be the final authority on the interpretation of Standing Orders (on which he/she should be advised by the Chief Executive).

Any expression to which a meaning is given in the 2006 Act or in the Regulations or Orders made under the Act shall have the same meaning in this interpretation and in addition:

"Accounting Officer" means the Officer responsible and accountable for funds entrusted to the Trust. He/she shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive.

"Trust" means the Calderdale & Huddersfield NHS Foundation Trust.

"**Board of Directors**" means the Board of Directors as constituted in accordance with the Constitution;

"Budget" shall mean a resource, expressed in financial terms, proposed by the Board anauthorised by the Independent Regulator for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

"Chair" is the person appointed in accordance with schedule 7 of the 2006 Act and under the terms of the Constitution to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression "the Chair of the Trust" shall be deemed to include the Deputy Chair of the Trust if the Chair is absent from the meeting or is otherwise unavailable or is unable to act as Chair due to a conflict of interest.

"Chief Executive" shall mean the chief officer of the Trust.

"Committee" shall mean a committee appointed by the Board of Directors.

"Committee members" shall be persons formally appointed by the Board of Directors to sit on or to chair specific committees.

"Director" means a member of the Board of Directors

"Director of Finance" shall mean the chief finance officer of the Trust.

"Elected council member" means those Council Members elected by the public constituency and the staff constituency.

"Funds held on Trust" (Charitable Funds) shall mean those funds that the Trust as Corporate Trustee holds at the date of authorisation, or receives on distribution by statutory instrument or chooses subsequently to accept. Such funds will be charitable.

"Monitor" is the name of the Independent Regulator for NHS Foundation Trusts

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

"Nominated officer" means an officer charged with the responsibility for discharging specific tasks within the Constitution and the SOs and SFIs.

"Officer" means an employee of the Trust.

"SFIs" means Standing Financial Instructions.

"SINED" means Senior Independent Non-Executive Director.

"SOs" means Standing Orders.

"Deputy Chair" means the non-executive director appointed by the Trust to take on the Chair's duties if the Chair is absent for any reason or is unable to act due to a conflict of interest.

1 THE TRUST

All business shall be conducted in the name of the Trust.

The roles and responsibilities of the Board of Directors are set out in Appendix X of the Trust's Constitution.

The Trust has the functions conferred on it by the 2003 Act and by its Terms of Authorisation.

All funds or property received in trust under section 22 of the 2003 Act shall be in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees under Chapter 5, section 51 of the 2006 Act. Accountability for charitable funds held on trust is in accordance with the relevant arrangements made by the Charity Commission and such other statutory requirements or direction by Monitor as may apply.

The Trust has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in "Reservation of Powers to the Board" and have effect as if incorporated into the Standing Orders.

1.2 Composition of the Board of Directors

In accordance with the 2006 Act, Terms of Authorisation and the Constitution, the Board of Directors of the Trust shall comprise both Executive and Non-Executive Directors as follows:

A Non-Executive Chair
Up to 5 other Non-Executive directors (one of who shall act as the SINED)
Up to 6 Executive directors including:
- *the Chief Executive (the Chief Officer)*
- *the Director of Finance (the Chief Finance Officer)*
- *a medical or dental practitioner*
- *a registered nurse or midwife*

The Non-Executive Directors and Chair together shall be greater than the total number of Executive Directors.

Other Directors may be appointed to the Board of Directors from time to time but shall have no voting rights.

1.3 Appointment and removal of the Chair and Non-Executive Directors

The Chair and Non-Executive Directors are appointed and may be removed by the Membership Council in accordance with Schedule 7 of the 2006 Act and under Paragraph 13 of the Constitution.

1.4 Terms of Office of the Chair and Non-Executive Directors

The Chair and Non-Executive Directors are appointed for a period of office in accordance with Schedule 7 of the 2006 Act and under Paragraph 13 of the Constitution. The terms and conditions of the office are decided by the Membership Council.

1.5 Appointment of Deputy Chair

For the purpose of enabling the proceedings of the board of directors to be conducted in the absence of the Chair, the directors of the Trust will appoint a non-executive director from amongst them to be Deputy Chair. This individual may, through agreement with the Chair take on the role of Senior Independent Non-Executive Director (SINED), as contained in 12.11 of the Constitution.

Any Non-Executive Director so elected may at any time resign from the office of Deputy Chair by giving notice in writing to the Chair and the Directors of the Trust may thereupon appoint another Non-Executive director as Deputy Chair in accordance with these Standing Orders.

1.6 Powers of Deputy Chair

Where the Chair has ceased to hold office or where he has been unable to perform his/her duties as Chair owing to illness, absence or any other cause, references to the Chair shall, so long as there is no Chair able to perform those duties, be taken to include references to the Deputy Chair.

1.7 Appointment of Senior Independent Director

The Board of Directors shall, following consultation with the Membership Council, appoint one of the Non-Executive Directors to be their Senior Independent Director using the procedure set out in the Constitution.

1.8 Joint Directors

Where more than one person is appointed jointly to a post in the Trust which qualifies the holder for Executive Directorship or in relation to which an Executive Director is to be appointed, those persons shall become appointed as an Executive Director jointly, and shall count for the purpose of Standing Orders as one person.

1.9 Secretary

The Board of Directors shall appoint the Secretary of the Trust and subject to following good employment practice, may also remove that person. The Secretary may not be a Membership Councillor, or the Chief Executive or the Finance Director. The Secretary shall be accountable to the Chief Executive and their functions shall be as listed in Paragraph 14 of the Constitution.

2. MEETINGS OF THE BOARD OF DIRECTORS

2.1 Admission of the Public and the Press

The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Board but shall be required to withdraw upon the Board 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" (Section 1 (2) Public Bodies (Admission to Meetings) Act 1960).

The Chair 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 Board's business shall be conducted without interruption and disruption and without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted. The public will be required to withdraw upon the Board resolving as follows:

"That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public (Section 1 (8) Public Bodies (Admission to Meetings) Act 1960).

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

2.2 Observers at Board meetings

The Board of Directors will decide what arrangements and terms and conditions it feels are appropriate to offer in extending an invitation to observers to attend and address any of the Trust Board meetings and will change, alter or vary these terms and conditions as it deems fit.

2.3 Public questions

Members of the public wishing to submit questions to the Board of Directors meeting will be required to submit these in writing by close of play the day before the meeting. The Chair will have the discretion to accept questions at the meeting if appropriate. Questions / statements must not relate to any defined as confidential under Section 1 (2) of the Public Bodies (Admissions to Meetings) Act 1960, unless the matter relates to a person's personal circumstances where that person has given their consent to is being raised at a public meeting. The Chair's ruling on the appropriateness of the question / statement is final. The Chair will reserve the right to respond to questions in writing if time does not permit these questions to be answered in the meeting.

2.4 Calling Meetings

Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine.

Meetings of the Board of Directors may be called by the Secretary or by the Chair at any time. Meetings may also be called by at least one-third of the directors who given written notice to the Secretary specifying the business to be carried out. The Secretary should send a written notice to all directors within seven days of receiving such a request. If the Chair or Secretary refuses to call a meeting after such a request one-third or more directors may forthwith call a meeting.

2.5 Notice of Meetings

Before each meeting of the Board of Directors of the Trust, a notice of the meeting, specifying the business proposed to be transacted at it, shall be delivered to every director, or sent electronically or by post to the usual place of residence of such director, so as to be available at least three clear days before the meeting.

A notice shall be presumed to have been served one day after posting. Lack of service of the notice on any director shall not affect the validity of the meeting.

In the case of a meeting called by directors in default of the Chair, the notice shall be signed by those directors and no business shall be transacted at the meeting other than that specified in the notice.

Before each meeting of the NHS Foundation Trust a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's offices at least three clear days before the meeting. (required by the Public Bodies (Admission to Meetings) Act 1960 S.I. (4) (a)

The Board of Directors 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

2.6 Chair of the Meeting

At any meeting of the Board of Directors the Chair, if present, shall preside. If the Chair is absent, the Deputy Chair shall preside. If the Chair and Deputy Chair are absent one of the other Non-Executive Directors in attendance, as chosen by the Board of Directors shall preside.

If the Chair is absent from a meeting temporarily on the grounds of a declared conflict of interest, the Deputy Chair, if present, shall preside. If the Chair and Deputy Chair are absent, or are disqualified from participating, such Non-Executive director as the directors present shall choose shall preside.

2.7 Setting the Agenda

The Board of Directors may determine that certain matters shall appear on every agenda for a meeting of the Trust and shall be addressed prior to any other business being conducted.

A director who requires a matter to be included on an agenda should advise the Secretary to the Board prior to the agenda being agreed with the Chair and no less than 7 days before a meeting.

Where a petition has been received by the Trust, the Chair shall include the petition as an item for the agenda of the next Board of Directors meeting.

2.8 Annual Members Meeting

The Trust will publicise and hold an annual members meeting in accordance with its Constitution.

2.9 Notices of Motion

A director of the Trust wishing to move or amend a motion should advise the Secretary to the Board prior to the agenda being agreed with the Chair and no less than 7 days before a meeting. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda.

2.10 Emergency Motion

Subject to the agreement of the Chair, and subject to the provision of SO 3.8, a director may give written notice of an emergency motion after the issue of the notice of the meeting and agenda up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chair's decision is final.

2.11 Withdrawal of Motion or Amendments

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 Chair.

2.12 Motion to Rescind a Resolution

Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding **six (6)** calendar months shall bear the signature of the director who gives it and also the signature of the majority of the other directors. When any such motion has been disposed of by the Trust, it shall not be competent for any director other than the Chair to propose a motion to the same effect within **six (6)** months, however the Chair may do so if he/she considers it appropriate.

2.13 Motions - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

When a motion is under discussion or immediately prior to discussion it shall be open to a director 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. (*)
(f) A motion under Section 1 (2) of the Public Bodies (Admission to Meetings) Act 1960 resolving to exclude the public (including the press).

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

No amendment to the motion shall be admitted if, in the opinion of the Chair of the meeting, advised by the Secretary, the amendment negates the substance of the motion.

2.14 Chair's Ruling

Statements of directors made at meetings of the Board of Directors shall be relevant to the matter under discussion at the material time and the decision of the Chair of the meeting, on questions of order, relevancy, regularity and any other matters shall be observed at the meeting.

2.15 Voting

Every question put to a vote at a meeting shall be determined by a majority of the votes of the Chair of the meeting and the directors present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote. No resolution of the Board of Directors shall be passed by a majority composed only of Executive Directors or Non-Executive Directors.

All questions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the directors present so request.

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

If a director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

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

An officer who has been appointed formally by the Board to act up for an executive director during a period of incapacity or temporarily to fill an executive director vacancy, shall be entitled to exercise the voting rights of the executive director. An officer attending the Board of Directors to represent an executive director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the executive director. An officer's status when attending a meeting shall be recorded in the minutes.

2.16 Minutes

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.

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

Minutes shall be circulated in accordance with directors' 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 on Openness in the NHS). A record of items discussed in private will be maintained and approved by the Board of Directors.

2.17 Joint Directors

Where a post of executive director is shared by more than one person

a) Both persons shall be entitled to attend meetings of the Trust
b) If both are present at a meeting they should cast one vote if they agree
c) In the case of disagreement between them no vote should be cast
d) The presence of either or both of those persons shall count as one person for the purposes of SO 3.20 Quorum

2.18 Suspension of Standing Orders

Except where this would contravene any statutory provision or any direction made by Monitor, any one or more of the Standing Orders may be suspended at any meeting, provided that at least two-thirds of the Board of Directors are present, including two Executive directors and two Non-Executive directors, and that a majority of those present vote in favour of suspension.

A decision to suspend SOs shall be recorded in the minutes of the meeting.

A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the directors.

The Audit and Risk Committee shall review every decision to suspend SOs.

2.19 Variation and Amendment of Standing Orders

These Standing Orders shall be amended only if:

(a) a notice of motion under Standing Order 3.8 has been given; and
(b) no fewer than half the total of the Trust's total Non-Executive directors vote in favour of amendment; and
(c) at least two-thirds of the Directors are present; and
(d) the variation proposed does not contravene a statutory provision or provision of authorization or of the Constitution

2.20 Record of Attendance

The names of the Chair and directors present at the meeting shall be recorded in the minutes. The Secretary shall maintain a record of the number of meetings of the Board of Directors and the attendance of individual directors. This will include those who participate by telephone, video or computer link in accordance with these SOs.

2.21 Quorum

No business shall be transacted unless one-third of the whole number of the Directors are present (including two Executives and two Non-Executives are present), one of whom is the Chair or Deputy Chair and as such has a casting vote.

Any officer in attendance for an executive director but without formal acting up status may not count towards the quorum.

If the Chair or a director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SOs 6 and7) he/she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business. The above requirement for at least two Executive Directors to form part of the quorum shall not apply where the Executive Directors are excluded from a meeting.

3. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

Subject to a provision in the authorization or the Constitution, the Board of Directors may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO 4.2 below, or by a director or an officer of the Trust in each case subject to such restrictions and conditions as the Board of Directors thinks fit.

3.1 Urgent Decisions

The powers which the Board of Directors has retained to itself within these Standing Orders (SO 2.5) may in emergency be exercised by the Chief Executive and the Chair after having consulted at least two non-executive directors. The exercise of such powers by the Chief Executive and the Chair shall be reported to the next formal meeting of the Board of Directors for ratification.

3.2 Delegation to Committees

The Board of Directors shall agree from time to time to the delegation of executive powers to be exercised by committees or sub-committees, which it has formally constituted. The constitution and terms of reference of these committees, or sub-committees, and their specific executive powers shall be approved by the Board of Directors.

3.3 Delegation to Officers

Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate officers to undertake the remaining functions for which he/she will still retain accountability to the Board of Directors.

The Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board of Directors as indicated above.

Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of Directors of the Director of Finance or other executive director to provide information and advice to the Board of Directors in accordance with any statutory requirements and the Terms of Authorisation.

The arrangements made by the Board of Directors as set out in the “Scheme of Delegation” shall have effect as if incorporated in these Standing Orders.

3.4 Overriding Standing Orders

If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around non-compliance shall be reported to the next formal meeting of the Board of Directors for action or ratification. All members of the Board of Directors, Membership Council and staff have a duty to disclose any non-compliance with these Standing Orders to the Chief Executive as soon as possible.

4. COMMITTEES

4.1 Appointment of Committees

Subject to the authorisation and the Constitution, the Board of Directors may appoint committees of the Trust consisting wholly or partly of the Chair and director of the Trust or wholly of persons who are not directors of the Trust.

A committee appointed under this SO may, subject to such directions as may be given by Monitor or the Board of Directors, appoint sub-committees consisting wholly or partly of members of the committee (whether or not they include directors of the Trust) or wholly of persons who are not members of the Trust committee (whether or not they include directors of the Trust).

The Standing Orders of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees or sub-committee established by the Trust. In which case the term 'Chair' is to be read as a reference to the Chair of the Committee as the context permits, and the term "director" is to be read as a reference to a member of the committee also as the context permits. There is no requirement to hold meetings of committees established by the Trust in public.

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 Board of Directors), as the Board of Directors shall decide. Such terms of reference shall have effect as if incorporated into the Standing Orders.

Committees may not delegate their executive powers to a sub-committee unless expressly authorised by the Board of Directors.

The Board of Directors shall approve the appointments to each of the committees which it has formally constituted. Where the Board of Directors determines that persons, who are neither directors nor officers, shall be appointed to a committee, the terms of such appointment shall be determined by the Board of Directors. The Board of Directors shall define the powers of such appointees and shall agree the terms of their remuneration and/or reimbursement for loss of earnings and/or expenses subject to approval by the Membership Council.

Where the Trust is required to appoint persons to a committee and/or to undertake statutory functions as required by Monitor, and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with the regulations laid down by Monitor.

The Committees and sub-committees established by the Trust are:

- Audit and Risk Committee
- Finance and Performance Committee
- Remuneration and Terms of Service Committee
- Charitable Funds Committee
- Quality Committee

Such other committees may be established as required to discharge the Board's responsibilities.

4.2 Confidentiality

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 Board of Directors or shall otherwise have concluded on that matter.

A Director of the Trust or a member of a committee shall not disclose any matter reported to the Board of Directors or otherwise dealt with by the committee, notwithstanding that the

matter has been reported or action has been concluded, if the Board of Directors or committee shall resolve that it is confidential.

5. DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

Schedule 7 of the 2006 Act and Section 13.20 of the Constitution requires all Board directors (including Non-Executive Directors) and any other officers nominated by the Trust to declare interests which are relevant and material to the Board of Directors. A register of these interests must be kept by the Trust.

5.1 Declaration of Interests

All existing Directors should declare such interests. Any board directors/officers appointed subsequently should do so on appointment.

Interests may be financial or non-financial (i.e. political or belief-based). Interests which should be regarded as relevant and material and which, for the avoidance of doubt should be included in the register are:

- Any directorship of a company;
- Any interest (excluding holding of shares in a company whose shares are listed on any public exchange where the holding does not exceed 2% of the total issued share capital or the value of such shareholding does not exceed £25,000) or position in any firm of company 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 including private healthcare organisations and other foundation trusts;
- Any interest in an organization providing health and social care services to the NHS;
- Position of authority in a charity or voluntary organization in the field of health or social care;
- Any affiliation to a special interest group campaigning on health or social care issues.

To the extent not covered above, any connection with an organization, entity or company considering entering in to or having entered in to financial arrangement with the NHS Foundation Trust, including but not limited to lenders or banks.

Reference should also be made to the Monitor *NHS Foundation Trust Code of Governance* and the Trust's Constitution and Declaration of Interests Policy in determining whether other circumstances or relationship are likely to affect, or could appear to affect the director's judgement.

Any director 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 directors.

At the time board directors' interests are declared, they should be recorded in the board minutes. Any changes in interests should be declared at the next board meeting following the change occurring.

Board directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the board's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

During the course of a meeting of the Board of Directors, if a conflict of interest is established the director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. For the avoidance of doubt this includes voting on such an issue where a conflict is established. If there is a dispute as to where a conflict does exist a majority vote will resolve the issue with the Chair having the casting vote. If by inadvertence they do remain and vote, their vote shall not be counted.

There is no requirement in the Code of Accountability for the interest of directors' spouses or partners to be declared. However, in accordance with the Nolan Principles of integrity, accountability and openness, good practice suggests that such declarations are strongly

advisable (as are declaring the interests of other immediate family members and co-business partners). SO 6, which is based on these regulations requires that the interests of spouses or partners (if living together) in contracts should be declared. Therefore the interests of spouses or cohabiting partners should also be regarded as relevant.

If Board directors/officers have any doubt about the relevance of an interest, this should be discussed with the Chair or Trust Secretary. Financial reporting standard 8 (issued by the Accounting Standards Board) specifies that influence rather than the immediacy of the relationship is more important in assessing the relevance of in interest. The interests of partner in professional partnerships including general medical practitioners should also be considered.

5.2 Register of Interests

The Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Board directors and officers. In particular the Register will include details of all directorships and other relevant and material interests which have been declared by both board directors and officers, as defined in SO 5.1. The Register shall also contain the names of all members of the Board of Directors including those who have no interests.

These details will be kept up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated.

The Register will be available to the public and the Secretary 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.

6. EXCLUSION OF THE CHAIR AND DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

Subject to the following provisions of this Standing Order, if the Chair or a director of the Trust has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he/she shall at the meeting and as soon as practicable after its commencement disclose the fact and should withdraw so as not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

Monitor may, subject to such conditions as he/she may think fit to impose, remove any disability imposed by this Standing Order in any case in which it appears to him/her in the interests of the National Health Service that the disability shall be removed.

The Board of Directors may exclude the Chair or a director from a meeting of the Trust while any contract, proposed contract or other matter in which he/she has a pecuniary interest, is under consideration.

Any remuneration, compensation or allowances payable to the Chair or director by virtue of the 2006 Act shall not be treated as a pecuniary interest for the purpose of this Standing Order.

For the purpose of this Standing Order the Chair or a director shall be treated, subject to SO 6, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

(a) he/she, or a nominee of his/hers, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration;

or

(b) he/she is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration; and in the case of persons living together the interest of one person shall, if known to the other, be deemed for the purposes of this Standing Order to be also an interest of the other.

The Chair or director shall not be treated as having a pecuniary interest in any contract proposed contract or other matter by reason only:

(a) of his/her membership of a company or other body, if he/she has no beneficial interest in any securities of that company or other body;

(b) of an interest in any company, body or person with which he/she is connected as mentioned in SO 7.5 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

Where the Chair or director:

(a) has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

(b) the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

(c) if the share capital is of more than one class, the total nominal value of shares of any one class in which he/she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

This Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it without prejudice however to his/her duty to disclose his/her interest.

This Standing Order applies to a committee or sub-committee of the Trust as it applies to the Board of Directors and applies to any member of any such committee or sub-committee (whether or not he/she is also a director of the Trust) as it applies to a director of the Trust.

7. STANDARDS OF BUSINESS CONDUCT

7.1 Policy

Staff must comply with the national guidance contained in HSG(93)5 "Standards of Business Conduct for NHS Staff and contained in the Trust's "Policy of Standards of Business Conduct for NHS Staff". The following provisions should be read in conjunction with this document.

7.2 Interest of Officers in Contracts

If it comes to the knowledge of a Board director or an officer of the Trust that a contract in which he/she has any pecuniary interest not being a contract to which he/she is him/herself 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 Chief Executive of the fact that he/she is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

An officer must also declare to the Chief Executive any other employment or business or other relationship of his/hers, or of a cohabiting spouse or partner, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

7.3 Canvassing of, and Recommendations by, Directors in Relation to Appointments

Canvassing of Board directors or officers of the Trust or members of any committee of the Trust directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this paragraph of the Standing Order shall be included in application forms or otherwise brought to the attention of candidates.

A Board director or officer of the Trust shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this paragraph of this Standing Order shall not preclude a director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

Informal discussions outside appointments panels or committees, whether solicited or unsolicited, should be declared to the panel or committee.

Failure to declare any interest which may conflict itwh, or compromise, any employee's Trust duties and obligations in respect of the award, operation or administration of a Trust / NHS contract may result in a potential breach of the Bribery Act 2010 and necessitate further investigation by the Trust's counter fraud specialist.

7.4 Relatives of Directors or Officers

Candidates for any staff appointment shall when making application disclose in writing whether they are related to any director or the holder of any office under the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.

The Directors and every officer of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that director or officer is aware. It shall be the duty of the Chief Executive to report to the Foundation Trust any such disclosure made.

Any allaged false representation contained on any application to the Trust, or failure to disclose any information when required to do so, may also result in investigation by the Trust's counter fraud specialist and / or NHS Prtect and possible prosecution under the Fraud Act 2006.

On appointment, Directors or officers (and prior to acceptance of an appointment in the case of executive directors) should disclose to the Foundation Trust whether they are related to any other director or holder of any office under the Trust.

Where the relationship of an officer or another director to a Board director of the Trust is disclosed, the Standing Order headed `Disability of directors in proceedings on account of pecuniary interest' shall apply.

The key elements of the Trust's Standards of Business Conduct with which directors and officers are required to comply are:

a. refuse gifts and hospitality above the value of £20
b. declaration of Business interests
c. decline offers of preferential treatment
d. permission to undertake outside employment
e. declaration of offers of commercial sponsorship
f. declaration of rewards
g. respect confidentiality of information.

The principles set out in this Standing Order 8.11 may be expanded by the Trust's Code of Business Conduct as from time to time approved by the Board of Directors.

8. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

8.1 Custody of Seal

It is the responsibility of the Chief Executive to ensure that the Common Seal of the Trust is kept in a secure place.

8.2 Sealing of Documents

The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by a resolution of the Board of Directors or of a committee thereof or in accordance with any delegation by the Board of its power. The affixing of the Seal shall be attested and signed for by two Executive Directors (not from the originating department) or one Executive Director and the Company Secretary.

Before any building, engineering, property or capital document is sealed the scheme must be approved and authorised and countersigned by the Chief Executive (or an officer nominated by him/her who shall not be within the originating department.)

Contracts for the purchase of goods and services shall be under seal where the aggregate contract value may be reasonably expected to exceed £500,000.

8.3 Register of Sealing

An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealings shall be made to the Board of Directors at least quarterly. The report shall contain details of the seal number, the description of the document and the date of sealing. The book will be held by the Chief Executive or nominated officer.

9. SIGNATURE OF DOCUMENTS

Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

The Chief Executive or nominated officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or committee or sub-committee to which the Board has delegated appropriate authority.

10. MISCELLANEOUS

10.1 Standing Orders to be given to Directors and Officers

It is the duty of the Chief Executive to ensure that existing directors and officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions. Updated email copies shall be issued to staff designated by the Chief Executive. New designated officers shall be informed in writing and shall receive e-copies where appropriate of SOs.

10.2 Documents having the standing of Standing Orders

Standing Financial Instructions and Scheme of Delegation shall have the effect as if incorporated into SOs.

10.3 Review of Standing Orders

Standing Orders and all documents having effect as if incorporated in Standing Orders shall normally be reviewed regularly by the Audit and Risk Committee on behalf of the Board of Directors.

10.4 Non-availability of the Chair / Deputy Chair and Chief Executive / Director of Finance.

Save as expressly provided in these standing orders if the Chair of the Trust is not available for whatever reason to transact the business of the trust expressly or by implication delegated to him/her, then the Deputy Chair shall be empowered to act in his/her place and to exercise all the powers and duties of the Chair until the Chair is again available.

If the Deputy Chair is not available for whatever reason to transact the business of the Trust expressly or by implication delegated to him/her, then any two Non-Executive Directors shall be empowered to act in his/her place and to exercise all the powers and duties of the Deputy Chair in relation to that matter.

If the Chief Executive is not available for whatever reason then any of the Chief Executive's powers and duties expressly or by implication under these Standing Orders may be exercised on his/her behalf by some other Officer duly authorised by the Chief Executive in writing so to act.

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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, 28th May 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 26.5.15 and the minutes held on 21.4.15.	
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 26.5.15 and the minutes held on 21.4.15.

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 26.5.15 and the minutes held on 21.4.15.

Appendix

Attachment:

QC Minutes 21 04 15 - draft.pdf

Minutes of the QUALITY COMMITTEE MEETING held on

PRESENT	David Birkenhead, Medical Director Jackie Murphy, Deputy Director of Nursing / Associate Nurse Director, Surgery & Anaesthetics Division Jeremy Pease, Non-Executive Director (Chair) Julie Dawes, Executive Director of Nursing & Operations Julie O'Riordan, Divisional Director, Surgery & Anaesthetics Division Juliette Cosgrove, Assistant Director to Medical and Nursing Directors Lesley Hill, Executive Director of Planning, Performance, Estate & Facilities Lynn Moore, Membership Councillor Lynsey Rudge, Associate Nurse Director, Medical Division Sajid Azeb, Assistant Divisional Director, Medical Division Sal Uka, Divisional Director, DATS/CWF Division Victoria Pickles, Company Secretary
IN ATTENDANCE	Stephanie Jones, PA (Minutes) Helen Fearnley, Tissue Viability Lead (full meeting) Joanne Machon, Project Manager for E-Rostering (Item 5.1) Lynsey Whitelam, Senior Sister (Item 5.1) Rob Moisey, Consultant (Item 5.2) Owen Williams, Chief Executive (Observer – full meeting)

Item

1/04/15 WELCOME AND INTRODUCTIONS

The chair welcomed members to the meeting. The meeting was confirmed as quorate.

2/04/15 APOLOGIES FOR ABSENCE AND ATTENDANCE REGISTER

Apologies for absence were received from:

Anne-Marie Henshaw, Associate Nurse Director/Head of Midwifery, DATS/CWF Division
Claire Gruszka, Risk Manager
Jan Wilson, Non-Executive Director

Jason Eddleston, Assistant Director, Workforce and OD
Kristina Arnold, Assistant Divisional Director, Surgery & Anaesthetic Division
Linda Patterson, Non-Executive Director
Martin DeBono, Divisional Director, DATS/CWF Division

3/04/15 MINUTES OF THE MEETING HELD ON 24 MARCH 2015

The minutes of the meeting held on 24 March 2015 were approved as a true record.

4/04/15 ACTION LOG (Items due this month)

All items on the Action Log due this month were discussed under the main agenda.

5/04/15 MATTERS ARISING

5.1 Update and Presentation on E-Rostering

Joanne Machon, Project Manager for E-rostering and Lynsey Whitelam, Senior Sister MAU gave an informative presentation on e-rostering and, in particular, how it has been received by staff on the Medical Assessment Unit. The e-rostering package, supplied by SMART Kronos, offers staff the ability to book annual and study leave electronically and produces 70% to 80% of rosters, producing a 4 week roster.

Implementation of the system has been phased and to date 39 wards/areas are up and running, with one thousand staff being paid directly from the roster. During implementation each ward/area has been supported by and worked closely with the e-rostering team to ensure a smooth transition onto the electronic system. There have been some challenges during the process, such as creating rotas as it take times and IT skills are required, alignment of Trust processes, vacancies in ward areas. However, all these are being addressed by looking at KPIs, headroom, annual leave and agreeing a forward plan for 2015/16.

Lynsey Whitelam, Senior Sister on MAU, discussed how e-rostering has been introduced onto the Medical Assessment Unit and her experience. Lynsey explained how the ward prepared for the transition of moving from paper to an electronic system, the challenges faced and how these challenges were overcome. Lynsey highlighted the benefits of the new electronic system and the work that is ongoing to ensure efficient running of the system.

In conclusion, it was felt the new system is fair, standardised and a consistent approach to roster creation. A 4 week roster can be created in around 3 hours and gives the ability to see shortfalls in staffing from any level in the Divisional structure.

The following questions were raised by members:

1. How do we learn from this exercise in future? (Julie Dawes)

Lindsay Rudge explained there were issues around having the right IT skills and correct equipment and this could be learnt from in future.

Jackie Murphy said we should give consideration to how we work round and through policies, such as annual leave and flexible working.

2. How do staff on the ward feel about the new system? (Julie Dawes)

Lynsey confirmed staff like the new system now they are used to it and it saves administrative time now it is up and running.

3. If a Trade Union representative was present now, what would they say? (Owen Williams)

Lindsay Rudge confirmed that there had been some organisational noise, however throughout the process there has been engagement with the Staff Side and Joanne has worked with them to address any concerns raised. The Royal College of Midwives (RCN) have been to review and have approved the system and it was felt that although the Royal College of Nurses (RCN) have not visited, they would be happy with the new electronic system as we are not the first Trust to introduce an electronic rostering system.

4. How is the challenge of drop in performance due to annual leave addressed? (Owen Williams)

Lindsay Rudge confirmed a calendar can be created in draft and will be reviewed. E-rostering can be used to balance out annual leave and can produce data on what annual leave has been taken and what is planned going forward.

5. Will therapists and pharmacist be transferred onto e-rostering? (Sal Uka)

Lindsay Rudge confirmed this is being looked at going forward.

The Chair thanks Joanne and Lynsey for their informative presentation.

5.2 Update on the Stroke Service

Rob Moisey, Consultant Endocrinology & Diabetes and Acute Medicine was in attendance to give an update on the Stroke Service. Stroke had been identified as a condition with a higher than expected mortality rate at CHFT. The Medical Division have worked collaboratively with Greengage Consulting to develop new ways of working and delivering actions. Supported by Greengages, the Divisional Stroke Team developed the Stroke

Strategy and the 8 “must do’s” identified by the Team to deliver this.

Following implementation of the Stroke Strategy, improvement with SHMI and HSMR has been seen and all the rag rated “must do’s” are green.

The following questions were raised by members:

1. Are we reaching all targets in relation to stroke? (Julie Dawes)

Lindsay Rudge confirmed we are not reaching all National targets, however the “must do’s” are related to the targets which are enablers to reaching the overall targets.

2. Are stroke beds being ring-fenced? (Jeremy Pease)

Sajid Azeb confirmed 1 stroke bed is ring fenced so there is always one bed available.

3. What actions are in place if the CT scanner goes down? (Sal Uka)

The Division have an action plan in place to address this should it occur.

4. What made the biggest difference? (David Birkenhead)

The Divisional approach and support from Greengages has been hugely beneficial. It has allowed the Stroke Team to focus on the Strategy. The Stroke Team have felt well supported and have been able to recognise where they are succeeding and recognise areas that require more attention.

5. SHMI is drifting up a little? (David Birkenhead)

Further work is to be done around the metrics. This will include audit work with Yorkshire Ambulance Service (YAS)

The Medical Director congratulated the Division for the work and progress made to date.

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

ACTION: A further update report on Stroke will be received by the Quality Committee in August 2015.

5.3 Emergency Services Departments update

Sajid Azeb, Assistant Divisional Director for Medicine, presented an update report in relation to the Emergency Departments (EDs) key performance indicators for Q4 2014/15. In addition, the report highlighted the key areas of focus to ensure improved performance into 2015/16. It was noted the EDs had transferred from the Surgical & Anaesthetic Services Division to the Medical Division with effect from the 1 April 2015.

The report had been structured under the 3R's to articulate future direction (**R**esult), current performance and key issues faced (**R**eality) and key areas going forward (**R**esponse).

The EDs have faced significant challenge during Q4 of 2014/15 and the pressures experience had not been unique to CHFT, but a national reporting issue. The A&E 4 hour target of 95% was not achieved for Q4, resulting in the target not being achieved overall for 2014/15. Time to initial assessment had not been achieved in the last quarter, also resulting in the target not being achieved overall for 2014/15. The remaining 3 targets; unplanned re-attendance, time to treatment and left without being seen were all achieved for Q4 and overall for 2014/15.

In response to the two failed targets, a number of internal and external key areas of focus were detailed to ensure the Trust are best placed to meet the challenges being faced. These key areas of focus will be converted into an action plan and presented back to the Committee as part of the end of Q1 2015/16 report.

The Quality Committee **received** and **noted** the report and **supported** the key areas of focus.

ACTION: Update report on the Emergency Services Departments to be received by the Committee in July 2015.

5.4 Multi-disciplinary Education Group

The Deputy Director of Nursing presented a report from the Multi-disciplinary Education Group. The report described the intention to develop a multi-disciplinary education and training function and some of the work being undertaken within the Trust to ensure the workforce is competent and capable to deliver compassionate care.

Following a 'go see' visit to Portsmouth and Southampton NHS Trust's by the medical and nurse education leads, a proposal is being developed to ensure there is leadership and oversight of all areas of education delivery within the Trust.

Although the multi-disciplinary group has temporarily stood down, the work is being delivered through the current groups; *Practice Placement Quality, Core Skills, Clinical Skills and Apprentices*. The current work of each group was described within the report.

ACTION: A report to the Weekly Executive Board at the end of April will describe the future approach to mandatory training, essential skills training and induction will be received by the Committee in May 2015.

The Committee **received** and **reviewed** the proposal in development regarding the structure, function, framework and leadership of the multi-disciplinary approach to education and training. The Committee **noted** the ongoing work to ensure high quality training and education is being delivered according to organisational need and in accordance with the Strategy.

5.5 Regulation 28 Letter from HM Coroner

The Deputy Director of Nursing presented the action plan drawn up following receipt of a Regulation 28 letter from H M Coroner. It was noted the Director of Nursing is to chair a group to look at all areas of learning and ensure learning is shared across the Trust.

The action plan presented focusses on clinical records and the majority of the work will be put through the Clinical Records Group. The second part of the action plan relates to medicines management. Missed doses audits will be monitored to ensure they are undertaken, which will be overseen by the Patient Safety Committee.

ACTION: The full action plan report will be received by the Committee going forward.

The Committee **received** and **noted** the content of the action plan. The Chair queried how the lessons learnt will be disseminated to staff. The Director of Nursing confirm this will be done via a future edition of the safety newsletter; *So What Happened Next…*

5.6 Feedback from the Trauma Peer Review

The Divisional Director for Surgery and Anaesthetics Services reported that a Trauma Peer Review had taken place in March 2015, where all Trusts locally were reviewed. Overall, the feedback from the visit was positive, despite the challenge of patient flow. The initial letter received from the National Peer Review Team in response to their visit highlighted 2 serious concerns;

1. There are no agreed network trauma management guidelines and in their absence there is no evidence of local guidelines. The reviewers were significantly concerned that in the absence of network or local guidelines there may be a variation of clinical practice that could compromise the quality of patient care and outcomes.

2. There is no overall trauma co-ordinator service to ensure that all major trauma patients in the Trust have their multiple needs managed throughout the care pathway, including current and future rehabilitation. This includes the transfer and repatriation of patients to and from the MTC and associated specialist services. This could affect the treatment and outcomes for patients.

In relation to the first concern, the Trust will work with the Network to develop the trauma management guidelines. In relation to the second concern, the current Trauma co-ordinator's role will be developed to include rehabilitation.

It was noted the Division have responded to the letter received from the National Peer Review Team and the final report from them is expected shortly.

The Committee **noted** the content of the letter from the National Peer Review Team and the **action** being taken to address the two serious concerns.

06/04/15 **CQC PREPARATION AND ACTION PLAN**

6.1 Update on CQC Action Plan

The Assistant Director to the Nursing and Medical Directors' presented the action plan in preparation for the impending inspection from the Care Quality Committee (CQC).

Since the last Committee meeting, the action plan had been revised and the position in relation to the Key Lines of Enquiry had been addressed in Appendix 2 of the paper.

The Executive CQC Preparation Committee is meeting weekly to identify key priorities that help support the delivery of the overall plan. Any issues that are causing a concern are escalated to the Committee. The CQC group continue to meet monthly to review the action plan.

The communication campaign is up and running and there will be an article in the next Trust News.

The Chair requested that we utilise the knowledge of Linda Patterson, Non-Executive Director and requested that the action plan be rag rated.

The Committee **received** and **noted** the update on the action plan. A further update will be received by the Committee next month.

7/04/15 **RESPONSIVE**

7.1 Integrated Performance Report

The Integrated Performance Report (IPR) was presented to the Committee, by the Executive Director for Planning, Performance, Estates and Facilities. The report included data for March 2015 and the following was noted:

Responsive: March had seen an increase in activity against the baseline in both elective and non-elective care. The March 4 hours A&E target position was 95.03%. This was a good achievement when compared to activity. Unfortunately, the target for Q4 was not achieved.

Caring: There has been a drive on complaints to ensure all cases ongoing for more than 3 months over target were completed. Improvement in the number of complaints managed within the timescale was also noted.

Safety: A review of the increase in pressure ulcers has been completed and presented to the Committee this month. Increase in inpatient falls with serious harm was noted, with 3 noted for the month of March against a target of 2. The falls lead is seeking another 2 interested clinicians to spread the work achieved on ward 5, HRI and MAU at CRH.

Effectiveness: C.diff – one case in March, YTD total 27 against a ceiling of 18. Of these 10 are classified as avoidable and 17 classed as unavoidable. No common themes noted in terms of reasons behind the cases.
Central line infection rate currently quite high and is being investigated.
SHMI fallen to 109.
MRSA bacteraemia: 1 case noted for April 2015.

Well Led: 80.13% of non-medical appraisals completed against 95% and 87.37% of medical appraisals completed against 95%. Concern was noted that data with regards to divisional appraisals may not be real time. The chair agreed to discuss this with the Interim Director of Personnel outside the meeting.

The Committee **received** and **noted** the content of the Integrated Performance Report.

7.2 Draft Quality Account 2014/15

The Committee received the draft Quality Account for 2014/15, which is produced on a yearly basis and forms part of the Annual Plan for the Trust. The report will go through rigorous consultation with key stakeholders between 20 April to 11 May 2015 and KPMG will provide an external audit opinion.

The choice of the priorities is a mandated process with extensive consultation with the Membership Council and the general public. The Board of Directors will sign off the Account at its meeting on 28 May 2015.

Three out of the four priorities for 2014/15 were achieved. The Chair requested that the priority in relation to *intravenous antibiotics are given correctly on time* be referenced as partially completed rather than not completed. It was felt that for this the Trust will be able to make some measurable improvements on this priority for 2015/16.

The Committee **received** and **noted** the draft Quality Account for 2014/15.

7.3 CQUIN Quality Priorities for 2015/16

The Assistant Director to the Medical and Nursing Directors' presented a paper which gave an overview of the proposed CQUIN scheme for the Trust for 2015/16.

It was noted that there are two new national CQUINs and all the local ones are building on those agreed for 2014/15.

The National CQUINs are:
Acute Kidney injury (AKI)
Sepsis
Dementia
Urgent Care

The local CQUINs are:
Respiratory
Diabetes
Medicines reconciliation and discharge accuracy
End of life care
Nutrition

The new national CQUINs should have an impact in improving the clinical outcome of patients within our care and will build upon the work that has been done as part of the Trust's work on Caring for the Acutely Ill Patient programme. There will be challenges in meeting the targets and, as such, the Trust may incur a financial penalty.

The local schemes are a good mixture of improving clinical outcomes and patient experience and if achieved will bring measurable benefit.

The Committee **received** the report and **noted** the financial penalty that would be applied should the national targets not be achieved.

SAFETY

8/04/15

8.1 Serious Untoward Incident Report and Register

The Director of Nursing and Operations presented the Serious Incident Register for the week ending 10 April 2015. The items that required escalation to the Committee were highlighted in red, the majority of which related to outstanding Duty of Candour compliance.

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

8.2 Patient Safety Group Update

The Director of Nursing and Operations presented an update report following the last meeting of the Patient Safety Group held on 9 April 2015.

At this meeting, the Group had considered the new Never Events and Serious Incident Framework, received the safety section of the Integrated Performance Report and Safeguarding six-monthly report and discussed items for the safety newsletter.

A number of items were escalated to the Committee, which were detailed in the report.

The Committee **received** and **noted** the content of the report and action being taken to address the issues that were escalated to the Committee.

8.3 Update report on increase in Pressure Ulcers (Grade 3&4)

The lead nurse for Tissue Viability presented a report in relation to the increase in grade 3 and 4 pressure ulcers, which detailed the action to be taken to address the increase.

CHFT acquired pressure ulcer incidents have increased from an average of 20 per month (April to October 2014) to 30.75 per month (November 2014 to February 2015). This increase has occurred across the hospital and community services, but is more notable for the hospital acquired category 3 incidents. A review of pressure ulcer incidents revealed issues related to the accuracy of pressure ulcer reporting and timeliness of pressure ulcer validation. The themes that have emerged from the investigation of category 3 and 4 pressure ulcers revealed that the heel and sacrum/buttocks are the most frequent location of pressure ulcers.

It was recommended that the validation process for pressure ulcer incidents be reviewed and changes made to ensure it is more robust. Development /review of ward action plans for the highest reporting areas to support improvement and ensure actions are measurable are also required to provide assurance.

The Committee **received** and **noted** the content of the report and supported the action plan developed.

ACTION: Pressure ulcers will continue to be monitored via the Integrated Performance Report, which will be monitored by the Patient Safety Group.

8.4 Report on Quality / CIP / Performance

The Director of Nursing and Operations presented an update report in relation to Quality/CIP/ Performance. The heat map detailed risks above 15. It was noted that each PMO scheme looks at the risk of the QIA. Future quarterly Quality Reports will include CIP impacts.

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

9/04/15 COMPLIANCE

9.1 Corporate Risk Register

The Corporate Risk Register was presented by the Executive Director of Nursing.

The Committee **noted** the content of the report and the **action** to be taken.

ACTION:
- Set narrative of where this is being monitored, which will be brought back to the Committee at the end of Q1.
- Committee members confirmed they are happy that plans are in place to mitigate the Estate risks in order to reduce the rating from 16 to 8. Director of Nursing and Operations to discuss with the Director for Planning, Performance, Estates and Facilities, outside the meeting, to see how the risks can be individually reflected.

10/04/15

EFFECTIVENESS

10.1 Clinical Effectiveness and Outcomes Group

The Medical Director presented the report from the Clinical Outcomes Group.

The Committee were asked to note the following:

- Improvements in the mortality review process. Work on reporting and Qlik View modelling.
- Key findings from the December review.
- Nerve centre is due to commence roll out across the Trust from May 5th.
- The significant resources required to fully implement the H@N and H@ weekends modules.
- Agreement to report all cardiac arrests as incidents.
- DNACPR compliance is failing to show significant improvements.
- Improved mortality reporting that is staring to be available from the HED system.
- Continued poor compliance against the co morbidity capture proforma.
- Resource impact of the extra national requirements mandated as part of the hard truths work.

The Committee **received** and **report** and noted the above.

11/04/15 WELL LED ORGANISATION

11.1 Well Led Organisation Group

An update report from the Well Led Organisation Group was received by the Committee. It was noted the Group are restructuring its agenda to focus on the CQC Key Lines of Enquiry for the Well Led Domain and preparing to develop a portfolio of activity that supports evidence of an 'outstanding' well led organisation. The well led dashboard is to refocus on 'hotspots' and link to evidence of actions.

At its meeting in April, the group gave consideration to:

- 2014 staff survey action plan
- Activity to progress Public Sector Equality Duty objectives
- Compliance with Fit and Proper persons tests
- The Francis 'Speak up Review' recommendations
- A revised approach for the delivery of mandatory training

The Committee **noted** the content of the update report.

11.2 Colleagues Engagement Strategy

A paper was received by the Committee in order to give an update on the Colleagues Engagement Strategy. The engagement approach adopted by the Trust was detailed in the report along with key milestones.

The Director of Nursing and Operations queried whether there is a clear plan of what is going to be achieved and by when. As there was no HR representation at the meeting to confirm the position it was agreed this would be picked up outside the meeting.

12/04/15 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 report detailed an update on the Patient Experience CQUIN targets (FFT, Dementia & End of Life Care).

The following key achievements were noted:

- All Q3 CQUIN targets delivered (FFT, End of Life, Dementia)
- Some of the Q4 CQUIN targets already delivered (FFT, End of Life, Dementia)
- Dementia key achievements have been recognition, butterfly scheme and training

The progress of the group to date was noted, along with the key areas for action/improvement.

The following actual / potential issues were noted:

A&E CQUIN target: Q4 20% response rate has not been achieved, with a rate of 11.7% rate for February 2015.

Open complaints trajectory: As at 13.3.15, the Trust was not meeting its complaints trajectory with an actual figure of 134 against a planned target of 60. The only Division

currently on target is CWF
To note:
RTPM in its current for will change from April 2015. This has been running since April 2010, questions will be refocused to measure performance against improvement priorities.

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

13/04/15 **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 Committee **noted** the content of the minutes.

14/04/15 **MATTERS TO BE ESCALATED TO THE BOARD OF DIRECTORS**

The Committee agreed the following items would be highlighted to the Board of Directors:

- Stroke Services
- Coroner's Rule 28 (Record Keeping)
- CQC Preparation
- Quality Account
- Pressure Ulcer report (increase in grade 3 & 4 incidents)
- Kirkup Report

15/03/15 **ITEMS TO NOTE**

15.1 Quality Committee Work Plan
The Committee received the draft Quality Committee Work Plan for 2015/16 for information.

16/03/15 **ITEMS TO APPROVE**

The following policies were received and approved by the Committee:

- Incident Reporting and Management Policy
- Being Open/Duty of Candour Policy
- Claims process
- Complaints Policy

17/03/15 **ANY OTHER BUSINESS**

No further items of business were discussed.

18/03/15 DATE AND TIME OF NEXT MEETING

Tuesday 26 May 2015
3pm – 5pm
Boardroom, 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, 28th May 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: AUDIT AND RISK COMMITTEE - DRAFT MINUTES - 21.4.15 - The Board is asked to receive and note the contents of the Draft Audit and Risk Committee Minutes from the meeting held on 21.4.15 and receive a verbal update on the meeting held on 28.5.15.	
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 and note the contents of the Draft Audit and Risk Committee Minutes from the meeting held on 21.4.15 and receive a verbal update on the meeting held on 28.5.15.

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 and note the contents of the Draft Audit and Risk Committee Minutes from the meeting held on 21.4.15 and receive a verbal update on the meeting held on 28.5.15.

Appendix

Attachment:

ARC - MINS ARC public minutes 21.4.15.pdf

Minutes of the Audit and Risk Committee Meeting held on Tuesday 21 April 2015 in Acre Mill, 3rd Floor commencing at 10:45pm

PRESENT

Peter Roberts	Chair, Non-Executive
Phil Oldfield	Non-Executive Director
Jeremy Pease	Non-Executive Director

IN ATTENDANCE

Chris Benham	Deputy Director of Finance
Chris Boyne	Internal Audit Manager
Jillian Burrows	Senior Manager, KPMG
Julie Dawes	Executive Director of Nursing and Operations
Keith Griffiths	Executive Director of Finance
Adele Jowett	Local Counterfraud Specialist
Peter Middleton	Membership Councillor
Victoria Pickles	Company Secretary
Trevor Rees	External Audit
Kathy Bray	Board Secretary (minutes)
Claire Wilson	Assistant Director of Workforce & OD (for item 5)

OBSERVERS

Jan Wilson	Non-Executive Director
Andrew Haigh	CHFT Chair
Helen Wells	Assistant Director of Finance

Item

17/15 APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Nigel Bell, Head of Internal Audit

18/15 MINUTES OF THE MEETING HELD ON 20 JANUARY 2015

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

19/15 DECLARATIONS OF INTEREST

There were no conflicts of interest declared at the meeting.

20/15 MATTERS ARISING FROM THE MINUTES AND ACTION LOG

It was noted that the matters arising would be addressed later in the meeting.

21/15 OVERPAYMENTS BRIEFING PAPER

Claire Wilson attended the meeting to present a briefing paper outlining the Trust's current position in relation to overpayments made to staff. It was noted that the Trust has a responsibility, as a public body, to ensure public funds are not inappropriately spent and therefore has a duty to recover overpayments made to employees.

The statistics regarding overpayments were noted. A draft Salary Overpayments policy was shared with the Committee for information and Claire reported that this would be submitted to the Executive Board for approval later that month. The Policy outlined the processes and procedures around the recovery of salary overpayments and what steps would be taken. Employees would be reminded that as part of the signed Contract Of Employment with the Trust they had agreed to permit the Trust to make deductions from their pay in accordance with Part II of the Employment Rights Act 1996 in respect of any monies owed by employees to the Trust. It was noted that

any recovery plan would be agreed with individual employees and the Trust would take all necessary action to recover salary overpayments.

Phil Oldfield raised the fact that many of the overpayments were as a result of late terminations of staff. It was agreed that there was an awareness issue which needed to be raised with managers to ensure timely reporting of terminations, completion of exit interviews and recovery of loaned equipment. All present agreed that further work was required to tighten the termination of employment process and ensure it became a clear part of the management role.

It was agreed that an update on the action plan, together with underpayment trends would be brought back to the Audit and Risk Committee in 6 months' time (20 October 2015).
ACTION: ARC AGENDA ITEM 20.10.15 - CW

GOVERNANCE REPORT
The Company Secretary presented the report which brought together a number of governance items for discussion by the Committee.

22/15 **a. Update on the development of the Board Assurance Framework and Risk Register -** It was noted that work continued to update the Board Assurance Framework and Risk Register in line with the revised Strategic review update.

b. Assurance on Trust Quality Accounts - The Company Ssecretary gave a verbal update on the progress of the Quality Accounts which was due to go in first draft form to the Quality Committee later that day. The draft document had also been circulated for Stakeholder consultation which would close on the 11 May 2015.

The indicator chosen this year this year by the Membership was:-

- Length of stay in Medicine.

The Trust had been successful in 3 out of the 4 indicators for 2014/15:-
- To improve the quality of care we provide as measured by the Hospital Standardised Mortality Rate (HSMR)
- Improving the care of patients with diabetes so they do not develop complications and have to spend longer in hospital
- To help patients with long term pain develop the skills needed to manage their conditions through supported self-management course.

The one not fully achieved:-
- To ensure Intravenous antibiotics are given correctly on time – data would be reviewed again this year.

The priorities put forward for 2015-16 included:-
- Improving Sepsis Care
- To ensure intravenous antibiotics are given correctly and on time
- Improving the discharge process
- Better Food

c. Review Standing Orders – The Company Secretary reported that this document had been reviewed and updated in line with current guidance on standing orders.

The policy was approved subject to the addition of 'shall be transacted" at point 2.21 and the inclusion of the Finance and Performance Committee on page 16. This would be updated and taken to the Board of Directors for approval in May 2015.

ACTION: BOD AGENDA ITEM – MAY 2015 - VP

d. Audit and Risk Committee Work Plan/Business Cycle – 2015/16 - The Company Secretary presented the updated work plan which incorporated identified leads for each item.

Discussion took place regarding any amendments and subject to three amendments this document was approved:-

- External Audit – plan and fees moving to July
- Internal Audit Annual Report moving to July
- Internal Audit Consortium Annual Report included in January

The Executive Director of Finance asked the Committee to consider whether CIP scrutiny and risks, particularly with regard to the quality impact assessment process was sufficiently covered. The Executive Director of Nursing and Operations assured those present that this had been mapped and was due to be discussed at the Quality Committee later that day. Following discussion it was agreed that co-reporting through the Audit and Risk Committee and Quality Committee should give assurance to the Audit and Risk Committee on this issue.

External Audit commented that it was usual practice in Trusts that the Audit and Risk Committee would hold the ring on this through the Board Assurance Framework.

e. Whistleblowing and other expressions of concern – The Company Secretary reported that she was not aware of any issues being raised.

23/15 REVIEW OF WAVING OF STANDING ORDERS

The Deputy Director of Finance presented a report detailing the waving of Standing Orders for the period 1 January to 31 March 2015. During the quarter there had been three instances requiring a waiver of Standing Orders, at a total cost of £78,863.67 There were 6 tenders over the fourth quarter, the value of spend was £8,998,184. There were no areas of concern to escalate to the Board.

The Deputy Director of Finance advised that the PWC engagement work would be included once the work had been completed. It was agreed that information provided would be commercially sensitive if this was to be shared with External Audit.

The Committee **received and approved** the report.
ACTION: CB

24/15 REVIEW OF LOSSES AND SPECIAL PAYMENTS

In accordance with the Standing Financial Instructions, the Deputy Director of Finance presented the losses and special payments for the period 1 January to 31 March 2015. There were no areas of concern to escalate to the Board.

The Chair asked for comparable information to last year and Deputy Director of Finance agreed to provide this outside the meeting.

The Committee **received** the report.
ACTION: CB

25/15 REPORT ON CURRENT REGULATORY COMPLIANCE ISSUES

The Executive Director of Nursing and Operations advised that preparation work for the pending Care Quality Commission (CQC) visit during June to December 2015 continued. Delays to the whole CQC inspection process were noted.

A further meeting was scheduled with Monitor on the 7 May 2015. The morning meeting would be a whole health economy meeting and the afternoon would focus on the Trust's review of progress made. All issues were on track to be addressed.

The Executive Director of Finance reported that the Scrutiny Committee was attended by Monitor and they confirmed in public that there was no suggestion of financial mis-management at the Trust and that we had been diligently managing our cash over a number of years.

26/15 REFERENCE COST AND CODING AUDIT

As briefly reported at the last meeting, the Deputy Director of Finance advised that the Trust had been invited to take part in the annual Reference Cost and Coding Audit being undertaken nationally to help inform the Payment by Results Tariff.

It was noted that this was due to be undertaken during the first and last week in May 2015 and interviews with key Trust personnel would be arranged.

27/15 PUBLIC WORKS CONTRACTS (PROCUREMENT)

The Deputy Director of Finance reported that this paper had been brought to the Audit and Risk Committee for completeness.

The Cabinet Office had published the Public Contracts Regulations 2015 on 26 February 2015, replacing the Public Contracts Regulations 2006. The key changes and themes within the new regulations affected timelines and transparency

It was noted that all relevant policies and procedures within the Trust would be reviewed accordingly.

REVIEW OF TREASURY MANAGEMENT POLICY

28/15 The Deputy Director of Finance presented an updated policy. It was noted the concept of prudential borrowing had been removed. It was agreed that this policy would be updated within the Trust Policies.

ACTION: Update on Trust Policies Section - KB

INTERNAL AUDIT

29/15 a. DRAFT AUDIT NEEDS ASSESSMENT AND AUDIT PLAN

The Internal Audit Manager advised that the Draft Audit Needs Assessment and Audit Plan had been discussed with the Director of Finance and circulated to the Executive Directors. The plan would be flexible to allow for any further work required by the Trust to be accommodated as it develops during the coming year.

The Committee suggested that further audits may be included on:-

- work on financial outcome of Acre Mill
- close look at property partnership risks
- accuracy of information – source data
- staff training/appraisal – promote appraisals being undertake earlier in the financial year.

The document was approved by those present and it was agreed that it would be brought back and amended at a future date.

b. PROGRESS REPORT

The Internal Audit Manager reported that since the last Audit & Risk Committee in January 2015 the following reports had been issued to and discussed with management.

Report No	Report	Opinion
CH16/2015	Debtors	Full
CH18/2015	Payroll	Limited
CH19/2015	Infection Control	Significant
CH20/2015	Capital Assets and Charges	Significant
CH21/2015	Friends and Family Test	Full
CH23/2015	Purchasing and Creditor Payments	Significant
CH24/2015	Tendering Processes	Significant

The report with a limited assurance was discussed in detail:-

CH18/2015 Payroll
This report concluded with an overall limited opinion.

The review found that documentation selected for audit testing could not always be located as a result of filing issues. Due to this, assurance could not always be provided on the completion and proper approval of forms which result in changes to payroll. This issue was also reported in the last year's audit report.

Payroll had intended to have in place a fully electronic web based self-serve system for submitting key payroll documentation and full electronic filing by the end of 2014/2015 – the indications are that this will be achieved by October 2015. Once implemented this system should help resolve many of the issues identified in the report.

Testing identified the need for the Authorised Signatory List to be updated, to fully reflect the specific elements which each officer can authorise. The review noted a number of instances where documentation had been authorised by officers who did not appear to have the authority to authorise the particular payroll change being applied.

The recommendations from the Audit were discussed in detail and the Executive Director of Nursing and Operations asked how this risk be reflected in the Risk Register. It was agreed that this should be scored and included in the risk register and remain there until all risks have been eliminated.

All other issues within the report were received and noted.

c. INTERNAL AUDIT REPORTS AND SUMMARY ACTION PLAN LOG
The contents of the report was received and noted. Members emphasised the importance of tracking the progress of recommendations and identifying any under performance.

d. REVIEW OF EFFECTIVESS OF INTERNAL AUDIT
The Internal Audit Manager was unsure why this item had been placed on the agenda and pointed out that the progress report included outstanding issues and these could be tracked back through subsequent meetings.

Discussion took place regarding how executive directors are notified of actions and recommendations and concerns regarding out of date action/information in follow-up audits.

External Audit recommended that at other Trusts Internal Audit recommendations are made following follow-up by someone within the executive team who acts as a lead prior to the follow-up audits coming to Audit and Risk Committee. This ensures that

accurate information is included within the recommendations.

ACTION: All present agreed with this recommendation and this would be taken forward by the Company Secretary

30/15 LOCAL COUNTER FRAUD UPDATE

a. LCF WORK PLAN 2015/16
The Local Counter Fraud Specialist (LCFS) presented the Workplan for 2015/16 and the contents were noted.

The Committee **received** the report.

b. LOCAL COUNTER FRAUD SPECIALIST PROGRESS REPORT
The Local Counter Fraud Specialist (LCFS) presented the progress report and highlighted the work undertaken by the counter fraud service over the previous quarter. She reported on a government initiative planned by the Home Office looking at agency staff and testing that individuals have the right to work. The appetite of the Committee was sought on whether the Trust should get involved in this. It was felt that the Trust had robust processes in place for the recruitment of agency staff where contracts are held, but in exceptional cases the Trust might have to utilise off-line agencies and this could present a risk.

It was agreed that this could affect the Trust from a risk, safety and reputation stance and therefore all present agreed that the Trust should take part in this exercise.

The Committee **received** the report.

c. FRAUD RISK ASSESSMENT 2015-16
The Local Counter Fraud Specialist (LCFS) presented a paper which considers current and emerging fraud risks for the Trust in 2015/2016, and assesses the direction anti-fraud work will take during the forthcoming financial year. The assessment is undertaken to ensure that a risk-based approach is taken to counter fraud activity during 2015/2016 for both local and national concerns. This will also help to inform and direct LCFS resources to where they may be most needed.

The Committee received and noted the content of the report and noted that the LCFS would work with Trust staff to ensure systems and processes are being followed.

The Committee **received** the report.

d. REVIEW OF EFFECTIVENESS OF LCFS
It was noted that a number of documents are reviewed within the Committee, resulting in the Annual Report which is brought to the Audit and Risk Committee in July.

31/15 EXTERNAL AUDIT

a. TECHNICAL UPDATE
The External Auditors presented the Technical Update and highlighted that a KPMG event to be held in Manchester on the 24 June from 6.00 – 7.30 to which all members of the Board of Directors were welcome to attend. The speaker at this event was to be Stephen Dorrell, MP. It was expected that in the context of the general election and the devolution of health and social care budgets in Greater Manchester he will discuss his views onthe links between health and social housing and the potential solutions that lie in greater partnership between these sectors.

The Committee **received** the report.

b. ISA700/AUDIT PLAN 2014-15
The Senior Manager, KPMG presented the ISA700. The purpose of this document was to outline the work to be completed for the Trust 2014/15 and how this will be undertaken. The key changes to previous years were noted.

The document outlined the areas which were assessed as significant audit risks in terms of their impact on the financial statements opinion which would be produced as part of this process. These issues in the audit approach were:-

- Tangible Assets – Property, plant and equipment
- Joint Venture – Accounting arrangements
- Revenue Recognition and Associated Fraud Risks - NHS Income, Non-NHS Income, Debtor provisions
- Management Override of Controls

The format of the template which would be used for the report was noted.

32/15 ITEMS TO RECEIVE AND NOTE

a. Quality Committee minutes
The Audit and Risk Committee received the minutes of the Quality Committee meetings held on 27.1.15. 24.2.15 and 24.3.15.

Jan Wilson, Non-Executive Director advised that a decision had been made that due to duplication and to ensure quoracy the Operations and Strategic Health and Safety Groups had been merged. It was noted that the Board would discuss the reporting arrangements for this group.
ACTION: Board of Directors

b. Risk & Compliance Group Minutes
The Audit and Risk Committee received the minutes of the Risk and Compliance Group meeting held on 13.1.15, 10.2.15 and 10.3.15. It was noted that this group would now report directly to the Audit and Risk Committee rather than Quality Committee.

c. THIS Management Board
The Audit and Risk Committee received the minutes of the THIS Management Board meeting held on 23.2.15.

d. MC – Remuneration Committee – Non-Executive Directors – Minutes 27.1.15
The Audit and Risk Committee received the minutes of the MC – Remuneration Committee – Non-Executive Directors – Minutes meeting held on 27.1.15.

e. Strategic Health & Safety Committee Minutes – 2.4.15
The Audit and Risk Committee received the minutes of the Strategic Health & Safety Committee Minutes meeting held on 2.4.15.

33/15 ANY OTHER BUSINESS
There were no other items of business.

34/15 MATTERS TO BE REPORTED TO THE BOARD OR OTHER COMMITTEES
It was agreed that the following items would be highlighted to the Board:
- Internal Audit – Payroll – Limited Assurance
- Review of Standing Orders

- Workplan for Audit and Risk Committee
- LCFS – Progress Report
- External Audit – ISA700/Audit Plan

35/15 DATE AND TIME OF NEXT MEETING

Thursday 28 May 2015, at 10.45 am, in Acre Mill, 3rd Floor Meeting Room.

/KB/ARC-21.4.15

SUMMARY ON A PAGE

MEETING OF: AUDIT AND RISK COMMITTEE

DATE OF MEETING: 21 APRIL 2015

FREQUENCY OF MEETINGS: 5 PER ANNUM

CHAIR OF MEETING: Prof. Peter Roberts

WAS MEETING QUORATE? Yes

SUMMARY OF KEY BUSINESS/ACTIONS AT THE MEETING:

1. **Matters Arising – Action Log**
2. **Overpayments Briefing Paper** **Action:** Agreed that an action plan, together with underpayment trends would be brought back to the ARC in October 2015.
3. **Governance Report** - **Update on the development of the Board Assurance Framework and Risk Register** - **Receive assurance on Trust Quality Accounts** – progress noted - **Review of Standing Orders** **Action: Agreed subject to Board approval at May BOD** - **Audit and Risk Committee Work plan/Business Cycle – 2015/16** – received and approved subject to BOD approval. - **Whistleblowing and other expressions of concern** – None to note
3. **Review Waiving of Standing Orders** **Action:** Received and approved
4. **Review of Losses and Special Payments** **Action:** Received **CB to provide comparable information to the Chair**
5. **Report on current Regulatory Compliance Issues** – Noted. CQC Assessment preparation work continues. Next meeting with Monitor scheduled for 7.5.15.
6. **Reference Cost and Coding Audit** - Audit to be undertaken first and last week in May 2015.
7. **Public Works Contracts (Procurement)** – New regulations received and noted
8. **Review of Treasury Management Policy (G-87-2012)** – Approved **Action:** To be uploaded to Trust Policies.
9. **Internal Audit:** a. **Draft Audit Needs Assessment and Audit Plan** – Document agreed. b. **Progress Report** – 7 audits received. 2 with full Opinion, 4 with Significant and 1 with Limited Opinion “Payroll”. **Action:** To be cascaded to BOD 23.4.15

c. **Internal Audit Reports and Summary Action Plan Log** – received and noted d. **Review of Effectiveness of Internal Audit** – Recommendation by EA for Internal Audit Reports be reviewed by Trust lead prior to follow-up Audits coming to ARC. **Action:** Executive Director of Nursing & Operations
10. **Local Counter Fraud:** a. **LCF Work Plan 2015/16** - received b. **LCF Progress Report** - received c. **Fraud Risk Assessment 2015-16** - received d. **Review of Effectiveness of LCF** – Annual report to be received in July 2015.
11. **External Audit:** a. **Technical Update** – received – Event 24.6.15 – Manchester – Stephen Dorrell – Board invited to attend. b. **Audit Plan 2014-15** – Report received and noted. To be cascaded to Board.
12. **FASTTRACK ITEM:** a. **Quality Committee Minutes** – 27.1.15, 24.2.15, 24.3.15 b. **Risk & Compliance Group Minutes** – 13.1.15, 10.2.15, 10.3.15 - Risk & Compliance Group to report to ARC. c. **THIS Management Board Minutes** 23.2.15 d. **MC Remuneration Committee – Non-Executive Directors Minutes** 27.1.15. e. **Strategic Health & Safety Committee Minutes** – 2.4.15 – It was not that the Operations and Strategic H&S Groups had merged.
13. Any Other Business
14. Date and time of the next meeting: **Thursday 28 May 2015 at 10.45 am**

ITEMS TO CASCADE TO BOARD OF DIRECTORS:

a. Internal Audit – Payroll – Limited Assurance
b. Review of Standing Orders
c. Workplan for Audit
d. LCFS – Progress Report
e. External Audit – ISA700/Audit Plan

AUTHOR OF THIS REPORT
NAME: Kathy Bray
POSITION: Board Secretary

Calderdale and Huddersfield NHS
NHS Foundation Trust

Approved Minute

Cover Sheet

Meeting: Board of Directors	**Report Author:** Kathy Bray, Board Secretary
Date: Thursday, 28th May 2015	**Sponsoring Director:** Victoria Pickles, Company Secretary
Title and brief summary: FINANCE AND PERFORMANCE COMMITTEE - UPDATE - The Board is asked to receive and note the contents of the Finance and Performance Committee Minutes from the meeting held on 21.4.15 and receive a verbal update from the meeting held on the 28.5.15.	
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 and note the contents of the Finance and Performance Committee Minutes from the meeting held on 21.4.15 and receive a verbal update from the meeting held on the 28.5.15.

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 and note the contents of the Finance and Performance Committee Minutes from the meeting held on 21.4.15 and receive a verbal update from the meeting held on the 28.5.15.

Appendix

Attachment:

F&P - Draft Minutes of the meeting held on 21 April 2015.pdf

Minutes of the Finance & Performance Committee held on Tuesday 21 April 2015 in Meeting Room, 3rd Floor, Acre Mill, Huddersfield Royal Infirmary commencing at 08:30

PRESENT

Philip Oldfield	Non-Executive Director (Chair)
Anna Basford	Director of Commissioning and Partnerships
Julie Dawes	Executive Director of Nursing
Keith Griffiths	Executive Director of Finance
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities
Peter Roberts	Non-Executive Director
Owen Williams	Chief Executive
Jan Wilson	Non Executive Director (in part)

IN ATTENDANCE

Chris Benham	Deputy Director of Finance
Mandy Griffin	Acting Director of the Health Informatics Service
Peter Middleton	Membership Councillor
Linda Patterson	Non Executive Director (in part)
Victoria Pickles	Company Secretary
Betty Sewell	PA (minutes)
Helen Well	Assistant Director of Finance – CWF & DaTS (observer)

ITEM

83/04/15 WELCOME AND INTRODUCTIONS

The Chair of the Committee welcomed attendees.

84/04/15 APOLOGIES FOR ABSENCE AND DECLARATIONS OF INTEREST

Apologies for absence were received from:
David Birkenhead, Executive Medical Director
Andrew Haigh, Chair
Julie Hull, Executive Director of Workforce & OD

There were no declarations of interest.

85/04/15 MINUTES OF THE MEETINGS HELD 17 MARCH 2015

The minutes were approved as a correct record.

86/04/15 MATTERS ARISING AND ACTION LOG

6/12/14 – Monitor, carried forward to the next meeting – 28 May 2015
19/02/14 – Capital Schemes with associated Risks to be shared again – subsequently recirculated after the meeting – action closed.
19/02/14 – Recruitment and retention strategy moved forward to 28 May 2015. In Julie Hull's absence for the next two months, Jackie Green, Interim Director of Workforce, would be asked to attend future meetings.

87/04/15 FINANCE AND FINANCIAL UPDATE

Month 12, 14/15
Performance Summary Report – The Deputy Director of Finance presented the Month 12 position.

The key messages are still similar to previous months, with a slight improvement in our overall referral position but the same sub-specialties causing issues. In terms of in month improvement the same sub-specialties are driving this position. The Chief Executive commented that 13/14 may have been a high performing year and what we are seeing for 15/16 may be the level of what we can achieve. He also observed that 2011 was the final year of the waiting list initiative which raised concerns as we go into contract negotiations as we may be at our productivity levels and this is what we would normally be. The Chair commented that it is important to understand what the right position is.

It was noted that Ophthalmology is causing concern in relation to a long term sickness issue and the impact of EDMS.

Theatre capacity was discussed and the Executive Director of Planning, Performance, Estates & Facilities confirmed that the Trust would be running the better week with surgeons from all three divisions to test what can actually be delivered, touch time is also being maximised.

The Chief Executive requested that rather than a retrospective view a forward view in terms of the reports received for this item on the agenda should be available for the next meeting. All Divisions have strengthened their reporting systems which need to translate into a report which could provide this information.

ACTION: To consolidate a report to provide a forward view in terms of figures for the next meeting. JD/KG/AB/LH

Discussions turned to demographic growth and how this information is being used for contract negotiations. It was acknowledged that the Commissioners are not recognising demographic growth but we do know that we have increased our market share from out of area NHS providers. It was agreed that demographic growth requires correlation with our actual pattern of referrals and procedures.

<u>Contract Activity Summary</u>

The Deputy Director of Finance presented the summary report, the key messages were noted as follows:

- Increased protection from under-trade of just under £6.5m primarily driven by the elective work which increases the difficulty with the contract negotiations.
- Significant reduction in our elective work of 9% but increased throughput through A&E.

The Chair asked if there had been a switch between elective and day case, it was confirmed that there had but not significantly. The impact of the theatre refurbishment with regard to elective activity was discussed, it was noted that theatre refurbishment would continue but that there had been learnings from last year which will be taken into account. It was also noted that we should be aware that as we move away from a fixed term contract, penalties relating to A&E waiting times and ambulance handovers may have an impact.

Month 12 Financial Narrative

The Deputy Director of Finance presented the narrative which accompanies the monthly financial dashboard. It was noted that the contents are still subject to the year-end external audit process and that the financial representation of the year-end fixed asset revaluation are excluded from this report and dashboard. Technical adjustments for impairments and revaluations are exceptional in nature and have no bearing on cash, CoSRR or the underlying trading position.

It was reported that Trust has successfully delivered the year-end financial position in line with the Monitor reforecast plan of a deficit of £4.30m in real terms. However, since submitting the reforecast plan a number of planned actions have concluded which have influenced the shape of the I&E position at year end, although not the underlying position. These are summarised as follows:

- Receipt of £1.5m funding from the local commissioners in support of the Trust's investments in clinical quality. This brings an improvement to EBITDA versus reforecast plan.
- A benefit of £0.4m to the I&E position against the reforecast plan from receipt of additional donated asset income to support capital investment.
- A benefit of £0.7m as a result of lower than anticipated depreciation charges.
- Restructuring costs reflecting a combination of 'MARS' severance costs and voluntary redundancy costs which total £4.4m

It was also reported that EBIDA had been delivered.

As reported in previous months, an elective outsourcing programme for Calderdale patients using CCG non-recurrent funding has been implemented. The cases identified for outsourcing were: 47 Orthopaedic cases and 20 General Surgery cases and have an associated income and expenditure stream of £300k. We will maintain 18 week performance at aggregate CCG level however as we are targeting treatment for a higher proportion of longer waiters we have agreement from Commissioners that we may breach 18 weeks at speciality level. This will not have any negative impact on external 18 week performance.

Additional bed capacity continued in March and this will continue into April, the Executive Director of Nursing explained that several things contributed to this. Over the winter we had 95 beds open and we used premium staff, the bed base was not correct with a high number of green cross patients. Temporary workforce move between agencies when they become aware that we are using high cost agencies. We have to stop using high cost agencies but this is hard when we have so many additional beds open. At the moment, in the first instance, we go to bank, then to agency and then high cost agency however, we can change the gateway at which we move from bank to agency to high cost agency. There are tight controls around additional staffing but we need to ensure that shifts are being put out early enough and that annual leave is being managed appropriately. At the highest point we had 97 additional beds open now have around 47 open.

Activity seems also to be affected by annual leave management and there is some work to do to ensure rosters are managed appropriately, it was acknowledged that we need to find a way of looking forward to manage staffing levels.

Linda Patterson commented that in effect we have three wards full of patients who do not necessarily need to be there. Some are within our gift to discharge but some are impacted further down the line by waiting for packages of care in local authority. Discussions took place around the difficulties in social care and the lack of capacity in the nursing and care home market. The Trust may consider with Commissioners whether or not there is opportunity to open a nurse-led ward to build in capacity but we need to be better at doing the straightforward discharges.

ACTION: A dedicated WEB session to have a specific deep dive on less complex discharge and the improvement of the current baseline – JD

Peter Roberts suggested a 'go see' in Scotland where there is a statutory obligation from health and social care.

ACTION: To look at what we can do ourselves within the short-term and also to look at the wider picture and 'go see'.

In relation to the staffing model, it was confirmed that the surgical and medical bed modelling workstreams will conclude at the end of this week. Medical have not been in the bed base for 3 years and the starting point is to review week on week what the medical bed model will be and put a plan in place which will include plan for every patient; procedures for patients over 14 days to try to get back into the funded bed base, we will then be able to describe the substantive workforce. Surgical shows that we run at 85% and we have more beds than we need but there is a large variance from one day to the next. The plan is to Identify medical and surgical beds and align to theatre productivity workstream which may seem simple but operationally it is more complicated. Both FourEyes and PWC are to challenge the modelling this week.

ACTION: To pick up this at future F&P – June

<u>Monitor Commentary on the Financial Return</u>
The Deputy Director of Finance presented the narrative and confirmed that we had delivered what we said in Month 12 and discussions will take place later today with Monitor.

88/04/15 MONTH 1 FY 15/16
The Director of Finance confirmed that as already discussed Medicine already have £200K cost pressure resulting from additional beds and staffing which support these. He also asked the Committee to note that CQUINS etc., will impact on the contract if we move to a PBR arrangement. This information is being feed into WEB to ensure spend is being controlled as far as possible.

We need to find a way to address this going forward and will have to drive actions to get us back on track. We are working through how we can get closer to the divisional information but it is unlikely we will see the impact of this until the summer.

It was noted that the CCGs do not believe that we can do the productivity and that we have overstated the impact of demographics, presenting this should change behaviour but it will

be challenging to drive this through the Trust. When we set the plans there was a vacancy factor built in which will require to be monitored as we move through the year.

89/04/15 CONTRACT UPDATE

The Director of Finance presented a briefing sheet and in summary reported that in order to have the potential to realise the level of income the Trust recognises it can attain through baseline activity and CIP initiatives, the current position of the CCG is inadequate. Equally this position makes no financial provision for systems/quality/ access issues which are the CCG's responsibility to a at least recognise. There is a final attempt to agree a suitable settlement on Thursday 23 April, which if unsuccessful, will result in the Trust asking formal arbitrators to affect a resolution. The Director of Finance asked the Committee to note the position and the resulting risks and opportunities associated with a full PbR contract.

Discussions took place with regard to the Trust's position in the absence of an agreement and what a PbR contract would mean in terms of this year's plan. It was confirmed that PbR exposes us to risks in relation to CQUIN penalties etc., to a potential value of £6m. It was noted that PbR introduces risks but a 'floor/ceiling' contract will not enable us to fund what we need to deliver turnaround. It was noted that arbitration will enable us to flesh out these issues.

90/04/15 CIP

The Director of Finance introduced a briefing paper to provide an update to members regarding the current position with CIP for 2015/16. It was noted that firm plans to deliver £14m have been identified and are on track to have designed £18m by 30 April as planned. The risks around delivery remain and are being assessed alongside 'normal' divisional I&E run rates to ensure the financial commitments the Board has signed off will be delivered.

ACTION: F&P Committee to get sight of the plans for the £18m as at 30 April – KG

91/04/15 STRATGIC REVIEW

The Chief Executive confirmed that he and the Turnaround Director had spoken to our lead at Monitor. The high level looks like:

- CIP £14M & £4M slippage for FY16 & 17
- Year 3&4 would be EPR and then dual site running
- Assumes PFI not changed
- CIP modelling for years 3&4 needs to be profiled
- Year 4&5 EPR and dual site would get us to a position of sustainability

The message from Monitor is clear we should do what we can, what we are in control of. The Chief Executive, Director of Finance and Director of Commissioning and Partnership will contribute in relation to the strategic narrative to support this, Ed Grimshaw from FourEyes will carry out some specific work on dual site running.

ACTION: First draft back to F&P June and July.

92/04/15 MONITOR MEETING

It was confirmed that the meeting had been rescheduled to the 7th May and that

information requested prior to Easter was still required. A request has been made to CCGs for a presentation for the broader strategic meeting with Monitor.

93/04/15 CASH FLOW FORECAST

The Committee were advised that KPMG have been retained to completely review cash flow from ward to corporate finance. This report will be shared with WEB prior to it coming to F&P.

94/04/15 EPR

The Director of THIS presented a highlight report and confirmed that they are looking at external assurance. Risks described are being reviewed and a paper will go to WEB. Progress is being made on tactical solutions and a 2-day workshop with as many senior people as possible will take place 12/13 May. The appointment of the initial resource requirements has been completed.

Internal audit have already looked at some of the risks and are reviewing the assurance around the project. There is a joint piece of work between the Trust and Bradford looking at what will be the gateway review process for the programme.

ACTION: To provide collaboration documents for circulation - MG

04/15 WORK PLAN

The updated work plan was received and approved.

04/15 CAPITAL LOAN FACILITY

The Committee were provided with an update of the capital loan drawdown plan for 2015/16 in line with the Trust's annual plan. The Committee were asked for approval for the Director of Finance to complete the drawdown of the capital loan facility in line with the annual plan. **APPROVED**

It was agreed that any additional draw down would come to this Committee for approval.

04/15 MATTERS FOR THE BOARD AND OTHER COMMITTEES

Contract negotiations

April's position in relation to CIP and activity.

04/15 ANY OTHER BUSINESS

There were no other items of business.

DATE AND TIME OF NEXT MEETINGS

Thursday 28 May 2015, 08:30 – 10:30, 3rd Floor, Acre Mill Outpatients