Calderdale and Huddersfield NHS
NHS Foundation Trust

The Royal Infirmary
Lindley
Huddersfield
HD3 3EA

Mr Andrew Haigh
Chairman
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Ref: AH/KB

28 October 2015

To:- Membership Councillors

Dear Colleague

FORMAL AND INFORMAL MEMBERSHIP COUNCIL MEETING – WEDNESDAY 4 NOVEMBER 2015 – BOARDROOM, HUDDERSFIELD ROYAL INFIRMARY

I am writing to remind Membership Councillors that I will be available for any informal discussion with interested Membership Councillors prior to the formal meeting at **3.00 pm** in the Boardroom, HRI. Please can we request that any business that is specific in nature, that a question is sent in advance to Rev Wayne Clarke prior to the 3.00 pm meeting. Wayne can be contacted on:- email: wayne:wayneclarke.org or mobile: 07725 834944.

I attach the agenda and associated papers for the formal meeting on the 4 November 2015 commencing at 4.00 pm in the Boardroom, HRI.

I hope that as many as possible will be able to join us.

Yours sincerely

Andrew Haigh
Chairman

Calderdale and Huddersfield NHS
NHS Foundation Trust

MEMBERSHIP COUNCIL MEETING

A meeting of the Calderdale & Huddersfield NHS Foundation Trust Membership Council will take place on Wednesday 4 November 2015 commencing at 4.00 pm in the Boardroom, Huddersfield Royal Infirmary, HD3 3EA

A G E N D A

1	**APOLOGIES FOR ABSENCE:- Ruth Mason, Chris Bentley, Lynn Moore** Welcome to: Mr Jeremy Pease, Non Executive Director Dr David Anderson, Non Executive Director/SINED		
2	**MINUTES OF THE LAST MEETING** held on Wednesday 9 July 2015	**AH**	**APP A**
3	**MATTERS ARISING** **27/15 EPR Update** **36/15a. Code of Conduct**	**AH**	**VERBAL**
4	**CHAIRMAN'S REPORT** **a. Development of the 5 Year Strategic Plan** **b. External Auditors Appointment**	**AH**	 **APP B1** **APP B2**
5	**CONSTITUTION:** **a. MEMBERSHIP COUNCIL REGISTER – RESIGNATIONS/ APPOINTMENTS** **b. REGISTER OF INTERESTS/DECLARATION OF INTEREST**	 **AH** **AH**	 **APP C** **APP D**
6	**UPDATE FROM BOARD SUB COMMITTEES:-** **a. Audit and Risk Committee** **b. EPR**	 **P Middleton/ B Richardson** **W Clarke**	 **VERBAL** **VERBAL**

	c. Finance and Performance Committee **d. Quality Committee** **e. Charitable Funds Committee**	**P Middleton/ B Richardson** **Julie Dawes for Lynn Moore** **K Wileman**	**VERBAL** **VERBAL** **VERBAL**
7	**ALLOCATION OF MEMBERSHIP COUNCILLORS TO SUB GROUPS/COMMITTEES**	**AH/JD**	**APP E**
8	**REVISED TERMS OF REFERENCE – NOMINATION AND REMUNERATION COMMITTEE (MEMBERSHIP COUNCIL)**	**VP**	**APP F**
9	**SCHEDULE OF MEMBERSHIP COUNCIL FUTURE MEETINGS 2016**	**AH**	**APP G**
10	**TRUST PERFORMANCE** a. **FINANCIAL POSITION AND FORECAST** **b. SERVICE PERFORMANCE**	**KG/ HB**	**APP H** **APP I**
11	To <u>receive and action</u> as appropriate the following information: **a. Updated Membership Council Calendar** **b. Draft Joint MC/BOD Formal AGM Minutes – 17.9.15** **c. Feedback from Food and Nutrition Event, HRI – 27.10.15**	**AH** **VP** **K Wileman/ G Richardson/ C Bentley**	**APP J** **APP K** **VERBAL**
12	**Any Others Business**		
13	**Date and time of next meeting** **Tuesday 19 January 2016 commencing at 4.00 pm in the Boardroom, Huddersfield Royal Infirmary**		

Calderdale and Huddersfield NHS
NHS Foundation Trust

MINUTES OF THE FOUNDATION TRUST COUNCIL MEMBERS MEETING HELD ON THURSDAY 9 JULY 2015 IN THE BOARDROOM, HUDDERSFIELD ROYAL INFIRMARY

PRESENT:

Andrew Haigh	Chair
Wayne Clarke	Public elected – Constituency 2
Dianne Hughes	Public elected – Constituency 3
Liz Schofield	Reserve Register – Constituency 4
George Richardson	Public elected – Constituency 5
Brian Richardson	Public elected – Constituency 6
Kate Wileman	Public elected – Constituency 7
Jennifer Beaumont	Public elected – Constituency 8
Avril Henson	Staff-elected – Constituency 10
Dawn Stephenson	Nominated Stakeholder – SWYPFT
Bob Metcalfe	Nominated Stakeholder - Calderdale Metropolitan Council
Naheed Mather	Nominated Stakeholder – Kirklees Metropolitan Council

IN ATTENDANCE:

Kirsty Archer	Assistant Director of Finance
Julie Dawes	Executive Director of Nursing
Lesley Hill	Executive Director of Planning, Performance, Estates & Facilities
Ruth Mason	Associate Director of Engagement & Inclusion
David Anderson	Non-Executive Director
Jan Wilson	Non-Executive Director

13/15 APOLOGIES:

Apologies for absence were received from:

Martin Urmston	Public elected – Constituency 1
Linda Wild	Reserve register – Constituency 2
Peter Middleton	Public elected – Constituency 3
Marlene Chambers	Public elected – Constituency 4
Grenville Horsfall	Public elected – Constituency 5
Johanna Turner	Public elected – Constituency 6
Lynn Moore	Public elected – Constituency 7
Andrew Sykes	Public elected – Constituency 8
Mary Kiely	Staff elected – Constituency 9
Eileen Hamer	Staff-elected – Constituency 11
Liz Farnell	Staff-elected – Constituency 12
Chris Bentley	Staff-elected – Constituency 13
David Longstaff	Nominated Stakeholder – Clinical Commissioning Group
John Playle	Nominated Stakeholder – Uni. of Hudds.
Kathy Bray	Board Secretary
Owen Williams	Chief Executive
David Birkenhead	Executive Medical Director

Julie Hull	Executive Director of Workforce & Organisational Development
Victoria Pickles	Company Secretary
Keith Griffiths	Executive Director of Finance - (for part of meeting)

The Chair welcomed all Membership Councillors including Cllr Naheed Mather, Stakeholder from Kirklees Metropolitan Council, David Anderson and Jan Wilson, Non Executive Directors.

26/15 MINUTES OF THE LAST MEETING – 8 APRIL 2015

The minutes of the last meeting held on 8 April 2015 were approved as an accurate record subject to the following amendments:-

- Kate Wileman and Jan Wilson had both sent their apologies for the last meeting.
- Wayne noted that the request was for an MC to input into the EPR project at both Project Board and Operational level.

27/15 MATTERS ARISING

a. EPR - The Chairman reported that a letter had not been issued to the Membership Councillors yet as final clarity was awaited around the actual role of the MC in this project.

Other matters arising were already included within the agenda.

28/15 TRUST PERFORMANCE
FINANCE REPORT

The Assistant Director of Finance presented the Finance report

The main points highlighted from the report as at the end of May 2015 were:-

Year to date

- The year to date Income & Expenditure position is a deficit of £5.05m, against a planned £5.22m deficit.
- CIP has delivered £1.70m against a plan of £1.27m.
- The cash position at the end of May 2015 was £11.13m against the planned level of £13.31m.
- Capital expenditure of £3.08m, slightly below the planned £3.33m.
- A Continuity of Risk Rating (CoSRR) of level 2, in-line with plan. This is falsely inflated by the receipt of £10m loan funding in April, the underlying trading position is represented at CoSRR 1.

Forecast and Risks

- Year end forecast to deliver £20m deficit (excluding exceptional restructuring costs) in line with plan.
- CIP of £17.24m forecast delivery against the planned level of £14.05m.
- Capital expenditure of £20.72m, in-line with the planned level and supported by the £10m capital loan drawdown in April.
- Forecast year end cash balance of £2.01m, in-line with the planned level, including external cash support of £14.9m.
- Year end CoSRR of 1.

- Balance of risks and opportunities remain.
- The Trust continues to be under scrutiny by Monitor due to the reliance on distressed cash funding. Longer term transformation plans are required.

PERFORMANCE REPORT
The Director of Planning, Performance, Estates and Facilities (PPEF) presented the Performance Report. The highlights of the report were noted:-

a. A/E ACTIVITY – Thanks were given to staff for achieving the A/E 95% target for Quarter 1. However, she confirmed that some 'winter beds' were still open and being used for patients.

b. THEATRES – The Trust was working hard on theatre productivity and on appointment slot issues. Some patients were waiting too long before receiving an appointment. The Trust was currently carrying a range of consultant vacancies.

c. PRESSURE SORES – The Trust was particularly targeting the incidence of pressure ulcers with a number of initiatives.

d. DUTY OF CANDOUR – Work continues to ensure open and timely exchange of information with patients/carers about complaints and incidence. The Trust was currently complying with the 10 day compliance.

e. HSMR & SHMI – A great deal of work had been undertaken on mortality issues to address these indicators. It was noted that the hospital had been particularly busy during the period January to March 2015 with a lot of frail patients. The Director of Nursing and Medical Director were working with colleagues from other Trusts to understand this better.

f. WELL LED REPORT – The Director of PPEF highlighted that a new report, The Well Led Report' was being developed. This indicated sickness levels, training and appraisals. Sickness had been looked at and there are currently no definite themes but work is on-going to monitor this. A discussion took place around productivity, stress and the Trust's approach to staff well-being.

g. DIVISIONAL RESTRUCTURING - It was noted that the internal restructuring of Divisions had meant that the FSS/CWF/DATs Divisional Reference Group had been cancelled and that Membership Councillors had missed this valuable opportunity to discuss important issues around finances and services.

h. RECRUITMENT – The Executive Director of Nursing confirmed that nursing recruitment was still on-going and remains a priority. There was still a national shortage of consultants and the Trust continued to use agency staff to cover vacant shifts.

29/15 CHAIRMAN'S REPORT

a. CHAIRS INFORMATION EXCHANGE – 25.6.15 – The minutes circulated with the agenda was taken as read. Any questions were welcomed to the Chair.

b. AGM Planning Sub Group - The Chairman reported that each Division would have one display to showcase their services and engage with the public at the AGM on the 17 September 2015. The venue would be Acre Mills, 3rd Floor, commencing at 5.00 pm and refreshments had been sponsored by ISS. It was suggested that display stands could be downstairs so that patients attending Outpatients appointments could participate.

ACTION: AGM Sub Committee to consider

30/15 CONSTITUTION

a. MEMBERSHIP COUNCIL REGISTER

The updated register of members was received for information.

b. REGISTER OF INTERESTS/DECLARATION OF INTERESTS

The updated Register of Interests/Declarations was received. Any amendments were requested to be notified to the Board Secretary as soon as possible.

c. PROCEDURE FOR APPOINTMENT OF DEPUTY CHAIR/LEAD GOVENOR APPOINTMENT

The procedure for appointment of Deputy Chair/Lead Governor Appointment in 2015 was received. Following amendments to the timeline to accommodate the dates for the elections, this was approved.

ACTION: Board Secretary

31/15 ANNUAL APPRAISAL FEEDBACK

a. **Chair**

At this point in the meeting David Anderson took over the chair and Andrew Haigh left the meeting. David Anderson reminded those present of the process undertaken to get feedback from the Membership Council, Executives and Non-Executive Directors within the Trust.

Overall feedback was very positive of Andrew's role in leading the Trust at a time when focus on financial, governance and quality challenges have never been more intense. Leading the Trust at a time of such a challenge and marshalling the Board and the Membership Council to work constructively and effectively reflected highly on his skills as a Chairman and was acknowledged by all. Future areas for development and objectives for next year, highlighted in the report, were noted.

Andrew Haigh returned to the meeting and outlined the roles of the Non-Executive Directors and the process for their appraisals. Objectives had been agreed. The Chairman had acknowledged that the joint workshop with the Membership Councillors and Non-Executive Directors had worked particularly well and that a format which included smaller groups of Membership Councillors and Non-Executive Directors in discussions with each other was very fruitful.

ACTION: Format for MC/NED Workshop to include small discussion groups and look towards having more workshops in the future.

32/15 MEMBER AND PUBLIC ENGAGEMENT – TASK AND FINISH GROUP WORK

Ruth Mason presented a paper prepared which included the feedback from the Task and Finish Group held on 29 June 2015 and all present agreed this approach.

George Richardson volunteered to attend Calderdale CCG Patient Reference Group Network Meeting on the 18 August 2015. The Membership Council agreed that if they used 'Streetlife', only official Membership Council messages should be shared e.g. 'Come to the AGM', 'Sign up as an FT Member', 'Did you know about the contact your MC inbox?'

Kate Wileman welcomed this in her capacity as member of the Women's Institute.

ACTIONS:

- **Ruth Mason to circulate the information on Patient Reference Group Network to MCs and request volunteers.**

- **Ruth mason to contact Brian Richardson about how to access other local patient groups.**

33/15 CHFT STRATEGIC OBJECTIVES

The Executive Director of Nursing updated the Membership Council on the enhancement that had been made to the Trust Strategy as a result of staff engagement. This was now available as a one-page diagram showing 1 year and 5 year versions.

A discussion took place around staff morale. It was a mixed picture depending on which staff group was questioned. It was acknowledged that things were particularly difficult for Huddersfield community staff in light of the recent decision around the Care Closer to Home Tender.

34/15 PROPOSED SCHEDULE OF MEMBERSHIP COUNCIL PUBLIC MEETING DATES 2016

The proposed dates circulated for 2016 were agreed.

35/15 INFORMATION TO RECEIVE

The following information was received and noted:

a. Updated Membership Council Calendar 2015

b. Notes from Annual Plan Presentation – MC Development Session – 13.4.15

36/15 ANY OTHER BUSINESS

a. CODE OF CONDUCT

A question was asked if the Trust had a policy around staff speaking English to other staff. The Executive Director of Nursing reminded the Membership Council that there is a formal Code of Conduct for staff.

ACTION: Chairman to pursue this with Workforce and OD colleagues

b. THANKS

The Chairman reminded the Membership Council of those Councillors who had completed their terms of office. He thanked them for their service to the Trust and presented Liz Schofield with a commemorative pen as a mark of thanks.

37/15 DATE AND TIME OF NEXT MEETING

Thursday 17 September 2015 – Joint BOD/MC Healthfair and Annual General Meeting commencing at 5.00 pm and 6.00 pm respectively in Acre Mill Outpatient Building, 3rd Floor.

Wednesday 4 November 2015 - **Membership Council Public Meeting commencing at 4.00 pm in the Boardroom, Huddersfield Royal Infirmary.**

The Chair thanked everyone for their contribution and closed the meeting at 6.00 pm.

Calderdale and Huddersfield NHS
NHS Foundation Trust

MEETING TITLE AND TYPE: PUBLIC MEMBERSHIP COUNCIL MEETING	**REPORTING AUTHOR:** Victoria Pickles, Company Secretary
TITLE OF PAPER: **DEVELOPMENT OF 5 YEAR STRATEGIC PLAN**	
DATE OF MEETING: Thursday 4 November 2015	**SPONSORING DIRECTOR:** Andrew Haigh
STRATEGIC DIRECTION – AREA: • Keeping the base safe • Transforming and improving patient care • A workforce for the future • Financial Sustainability	**ACTIONS REQUESTED:** • For comment • To approve • To note
PREVIOUS FORUMS: Discussed at Board of Directors Meeting – 24.9.15	
EXECUTIVE SUMMARY: As a Trust we need to transform the way our two hospitals work to make sure we provide safe, high quality, compassionate care for our patients. Building on the work we did to develop the Outline Business Case, we are working with the CCGs and Monitor, to develop a 5 Year Strategic Plan by the end of December 2015.	
RECOMMENDATION: The Membership Council are asked to note the progress on the development of the 5 Year Strategic Plan and consider if there are any other ways in which Membership Councillors would like to be engaged in this work.	
APPENDIX ATTACHED: YES ~~/ NO~~	

compassionate care

Briefing for Membership Councillors

Development of Calderdale and Huddersfield NHS Foundation Trust
5 Year Strategic Plan

1. Introduction

1.1. As a Trust we need to transform the way our two hospitals work to make sure we provide safe, high quality, compassionate care for our patients. Building on the work we did to develop the Outline Business Case, we are working with the CCGs and Monitor, to develop a 5 Year Strategic Plan by the end of December 2015.

1.2. Due to challenges identified in FY14/15, Monitor concluded that we were in breach of our licence. To rectify this we agreed a number of actions with Monitor to address ongoing clinical, operational and financial challenges. Since the start of 2015 we have made significant progress, particularly from a financial perspective and, as agreed with Monitor, are currently in the process of developing a 5 Year Strategic Plan to ensure sustainable services in the future.

2. Objectives of the 5 Year Strategic Plan

2.1. The plan will be developed with the aim of improving safety, service quality, experience and outcomes for our patients and the delivery of high quality care 24 hours a day, 7 days a week.

2.2. Both NHS Calderdale CCG and NHS Greater Huddersfield CCG are committed to working with us to develop the proposals for future services and have collectively agreed with us the objectives and work required to develop the 5 Year Strategic Plan by the end of this calendar year.

2.3. To support the plan's development we have agreed with Monitor to engage external contractor Ernst & Young ("EY") who will be working alongside our team to develop the plan.

2.4. Our clinicians have already agreed the clinical model, based on the Outline Business Case developed in 2014, with GP Commissioners. Over the next two months we will be working with EY to look at all options and to understand and analyse the impacts these options have on patients, staff and services. Primarily we will be considering:

- Which options would make the best use of our estate;
- The levels of patient activity we expect to see over the next 5 years;
- The number of beds we would then require; and
- The impact on travel for patients, staff and ambulance response times.

3. Next steps

3.1. Over the next two months you will receive monthly updates on the process and our progression towards agreeing a 5 Year Strategic Plan. In addition, we will

use established forums and planned meetings with you to discuss our 5 Year Strategic Plan throughout the period.

3.2. The governance table at appendix 1 sets out the sign off process which includes involvement with Membership Councillors and this will be an item for discussion at the workshop on 18 November. We are ensuring that our commissioners are fully engaged at different points along the development of the plan and a list of the milestones are attached at appendix 2 for your information. Both of these demonstrate the significant amount of work required to get to the point of having a plan ready for sign off by the end of December 2015 and the programme is being closely managed.

4. Recommendation

4.1. The Membership Council are asked to note the progress on the development of the 5 Year Strategic Plan and consider if there are any other ways in which Membership Councillors would like to be engaged in this work.

APPENDIX 1

GOVERNANCE TIMELINE TO SUPPORT DEVELOPMENT OF 5 YEAR STRATEGIC PLAN

Date	Meeting	Output
OCTOBER		
Wednesday 14th October	Board of Directors workshop	Review of assessment criteria /long list of options
Monday 19th October	Strategic Executive Board	Update on progress
Thursday 29th October	Board of Directors	Formal approval of assessment criteria / short list of options
NOVEMBER		
Wednesday 4th November	Membership Council	Broad overview of plan and update on progress
Monday 16th November	Strategic Executive Board	Activity modelling / bed numbers /workforce model
Wednesday 18th November	Board of Directors / Membership Council workshop	Progress update for membership councillors Activity modelling / bed numbers / workforce model
Thursday 26th November	Board of Directors	Final activity / financial model/workforce (excluding cap ex)
DECEMBER		
Monday 7th December	Membership Council Workshop	Update on progress
Wednesday 9th December	Board of Directors (additional workshop)	Preferred option - final activity/financial model/workforce (including cap ex)
Monday 14th December	Strategic Executive Board	Preferred option
Thursday 17th December	Board of Directors	Draft 5 Year Strategic Plan and draft implementation plan
TBC 29/30 December	Board of Directors	Final 5 Year Strategic Plan and implementation plan
JANUARY		
TBC w/c 18 January	CCG Joint Governing Body meeting	Decision of readiness to progress to public consultation – seeking confirmation of date. To be discussed at SR meeting
Tuesday 19 January	Membership Council	Final 5 Year Strategic Plan

APPENDIX 2

Calderdale and Huddersfield NHS Foundation Trust ("T") and Commissioners ("C"): Programme Milestones

Owner	Milestone	What will be shared	Date of Completion
T	1. Agree high level programme and milestones	Agreement of key milestones, overall project timeline and EY project plan • Agreement of progress and monitoring reporting processes and forums.	*9 October 2015*
T & C	2. **Joint** agreement on meeting schedule, and key milestones for each meeting. Financial forecast assumptions requested.	• Milestones for the meetings over the 12 weeks through to end 2015 • High level programme plan *Note: Request for baseline financial assumptions to be shared post meeting*	Meeting 1: Early October
T	3. Stakeholder engagement plan developed	• Agreed list of prioritised stakeholders • Agreed strategy for engaging with stakeholders	*16 October 2015*

T	4. Agree Terms of Reference with each division / Workstream	• Agree individual workstream ToR including:
		  ○ Named accountable lead
		  ○ Milestones and deliverables and target dates
			16 October 2015

T & C	5. **Joint** discussion on strategic commissioning intentions, 5 year plans and status, and joint review of commissioner requested services	• Commissioner strategic commissioning intentions • Commissioner requested services • Initial commissioner view (if available) on impact of strategic initiatives such as 'Care Closer to Home' and 'Right Care, Right Time, Right Place' – specifically on activity, capacity and income	Meeting 2: Mid October
T	6. **Trust** to share assessment criteria	• Criteria for assessing the estate configuration options developed by the CHFT Board, in light of the agreed clinical model	

T	7. **Trust** to share list of estate configuration options to be assessed	• Long list of estate configuration options for appraisal
		  ○ Estate options that can be discounted in advance of quantification based on the criteria
		  ○ Estate options to be taken forward for quantitative modelling	

T	8. CIP maturity assessment and governance review for FY16/17 CIPs	• Review of CIP governance and recommendations in relation to:
		  ○ Identification
		  ○ Planning
		  ○ Approval
			30 October 2015

		○ Monitoring • Maturity assessment of 2016/17 CIPs with recommendations for further development and identification of areas of shortfall.	
T	9. Agreed shortlist of clinical model options	• Trust leads for each option identified and further information gathered (including financial and activity impacts) • Options prioritised based on agreed assessment criteria • Identification of any further options for consideration • Trust agreement on which options and initiatives to take forward	*30 October 2015*
T	10. First cut view on saving opportunities	• Early indicative view on overall financial impact of the initiatives, productivity and CIPs – largely based on Trust work to date.	*30 October 2015*
T	11. Baseline agreed	• Agreement of financial and activity baseline to be used within the strategic plan and the development of the financial model • Reconciliation between the baseline and any reported positions to keep a clear audit trail of approval.	*30 October 2015*
T & C	12. **Joint** review of equality impact in light of estate options and travel analysis undertaken to date	• Travel time analysis previously undertaken • Narrative (as developed in the OBC) on equality impact of the options across the two main sites	Meeting 3: Early November
T & C	13. **Joint** comparison of financial assumptions and forward income baseline forecasts	Comparison between Trust and CCG assumptions on: • Commissioning intentions for 2016/17 • QIPP assumptions (% or value of income) • Growth forecasts over a 5 year period • Tariff deflator assumptions • Winter funding (and other non-recurrent funding) forecast spend over a 5 year period • Other income/activity adjustments over a 5 year period not covered in the above • Bridge from current year forecast outturn to position over 5 years incorporating the above *Note: This will be developed by the Trust based on the information received from the Commissioners*	
C	14. **Commissioners** to share detailed assumptions underpinning strategic plans	• Detailed QIPP plans – identifying activity type and impact for each (e.g. X% reduction in LTC patients in year Y), including capacity (beds) and income • Detailed plans underpinning any other significant changes to activity forecast or commissioning intentions within the 5 year period – specifically expected impact on CHFT in terms of required capacity (beds) and income	

T	15. **Trust** to share activity and patient flow modelling a. Impact of technology b. Implications for estate and workforce	For the base case and each shortlisted reconfiguration option: • Expected activity by site • Expected beds, theatres and outpatient clinic requirements by site • Workforce requirements by site This will be split into the impact of the reconfiguration itself, and the impact of other initiatives.	Meeting 4: Mid November
T	16. Reconfiguration Capital Expenditure quantified	The capital expenditure associated with the estate configuration quantified including: • New capital required • Backlog maintenance • Capital receipts or disposals • Risks (e.g. PFI timescales)	30 November 2015
T	17. Productivity opportunity / CIP opportunity agreed (including medical productivity, beds, theatres, medical admin and back office/estates) and income enhancement opportunities	• Final assessment of financial and activity impact of productivity, CIPs (including medical productivity, beds, theatres, medical admin and back office/estates) and income enhancement opportunities. • Identification of any interdependencies between productivity, CIP, income generation and other initiatives. • Trust to agree opportunities to include within the five year forecast and phasing for each	30 November 2015
T	18. Quantified clinical model and final savings opportunities	Trust review of quantified savings and activity impacts from CIPs, productivity and initiatives against the agreed baseline. • Further assessment of each against agreed assessment criteria and continuing refinement • Trust to review outputs from detailed activity and income modelling. This will include: o Future Trust income projections o Impact on other providers o Assumptions on income for activity that has changed setting (e.g. Activity that has moved from Acute to Community) o Impact by CCG/Commissioner • Trust to review financial forecasts over a 5 year period. This will include: o Surplus/Deficit position and key drivers for change in position o Capital requirements o Cash and working capital position o Funding requirement o Anticipated sources of funding	30 November 2015

T	19. **Trust** to share quality impact assessment	• Quality impact assessment for each of the shortlisted reconfiguration options	Meeting 5: Early December
C	20. **Commissioners** to share finalised equality impact assessment	• Equality impact assessment for each of the shortlisted reconfiguration options	
T	21. **Trust** to share financial forecast	Trust to share outputs from detailed activity and income modelling. This will include: o Future Trust income projections o Impact on other providers o Assumptions on income for activity that has changed setting (e.g. Activity that has moved from Acute to Community) o Impact by CCG/Commissioner • Trust financial forecasts over a 5 year period. This will include: o Surplus/Deficit position and key drivers for change in position o Capital requirements o Cash and working capital position o Funding requirement o Anticipated sources of funding • Commissioners to share updated assumptions (QIPP, Growth etc) to determine level of convergence	
T & C	22. **Joint** review of wider benefits	• Trust listing of benefits from the reconfiguration • Commissioner listing of benefits from the reconfiguration	
T	23. Preferred reconfiguration option agreed	Agreement of the preferred option including: o Agreed estate configuration o Initiatives to be taken forward o Timescales and phasing of impact on financial and activity o Scoring against approved assessment criteria	11 December 2015
T	24. Draft 5 year strategic plan	• Agreement of section owners from Trust with regular review meetings • Draft 5 year strategic plan for approval by the Trust Board	11 December 2015
	25. Draft implementation plan	• Agreement of section owners from Trust with regular review meetings • Input into implementation plans from each division and workstream • Draft implementation plan for approval by the Trust Board	11 December 2015
T & C	26. **Joint** confirmation of preferred option	• Any refinements to the modelling and financial forecasts • Description of the final configuration model	Meeting 6: Mid December

T	27. Final 5 year strategic plan	• Updates following review from Board and section owners • Final plan issued and approved by Trust Board	31 December 2015
T	28. Final implementation plan	• Updates following review from Board and section owners • Final plan issued and approved by Trust Board	31 December 2015

Calderdale and Huddersfield NHS
NHS Foundation Trust

MEETING TITLE: MEMBERSHIP COUNCIL PUBLIC MEETING	**REPORTING AUTHOR:** Company Secretary
TITLE OF PAPER: **APPOINTMENT OF EXTERNAL AUDITORS**	
DATE OF MEETING: **4 NOVEMBER 2015**	**SPONSORING DIRECTOR:** Andrew Haigh, Chairman
STRATEGIC DIRECTION – AREA: • Keeping the base safe • Transforming and improving patient care • A workforce for the future • Financial Sustainability	**ACTIONS REQUESTED:** • For comment • To approve • To note
PREVIOUS FORUMS: **Audit and Risk Committee – 20.10.15**	

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

Background

In July 2012, the Trust undertook a tendering exercise for the provision of external audit services commencing October 2012. This was a comprehensive exercise to ensure best fit and value for money carried out by a panel consisting of Membership Councillors, Non-Executive and Executive Directors using a "call off" contract previously arranged by Yorkshire and Humber Commercial Procurement Collaborative (CPC).

As a result the Membership Council formally appointed KPMG as the Trust's external auditors for a period of 3 years with the option to extend to 5 years if required.

Issue

The 3 year term of contract is due to finish. Given the current position in relation to the Trust's breach of licence and the development of the five year strategic plan, there is significant benefit of maintaining the current arrangement with KPMG as the external auditor and extending the contract for the next two annual accounts processes. This would enable some continuity to be maintained as we develop a plan for sustainability and deliver the significant transformational changes planned for 2016. A detailed process for re-tendering the contract would be brought to the Audit and Risk Committee and Membership Council in April 2017, to enable contract award in July 2017 for commencement October 2017.

Recommendation

The Audit and Risk Committee at its meeting held on the 20 October 2015 approved the extension of the contract for the External Auditors, subject to confirmation of value for money testing by the Executive Director of Finance. The Membership Council are asked to ratify this decision.

APPENDIX ATTACHED: NO

APPENDIX C

Calderdale and Huddersfield NHS
NHS Foundation Trust

MEMBERSHIP COUNCIL REGISTER
AS AT 27 October 2015

CONSTITUENCY	NAME	DATE APPOINTED	TERM OF TENURE	ELECTION DUE
PUBLIC – ELECTED				
1	Mrs Rosemary Claire Hedges	17.9.15	3 years	2018
1	Mrs Di Wharmby	17.9.15	3 years	2018
2	Mr Kenneth Malcolm Batten	17.9.15	3 years	2018
2	Rev Wayne Clarke	19.9.13	3 years	2016
3	Mr Peter John Middleton	22.9.11 18.9.14	3 years 3 years	2014 2017
3	Ms Dianne Hughes	19.9.13	3 years	2016
4	**VACANT POST**			
4	**VACANT POST**			
5	Mr Grenville Horsfall	19.9.13	3 years	2016
5	Mr George Edward Richardson	18.9.14	3 years	2017
6	Mrs Annette Bell	17.9.15	3 years	2018
6	Mr Brian Richardson	18.9.14	3 years	2017
7	Ms Kate Wileman	4.1.13 18.9.14	2 years (to Sept 2014) 3 years	2017
7	Mrs Lynn Moore	18.9.14	3 years	2017
8	Mr Brian Moore	17.9.15	3 years	2018
8	Mrs Jennifer Beaumont	19.9.13	3 years	2016

STAFF – ELECTED				
9 - Drs/Dentists	Dr Mary Kiely	22.9.11 18.9.14	3 years 3 years	2014 2017
10 - AHPs/HCS/Pharm's	**VACANT POST**			
11 - Mgmt/Admin/Clerical	Mrs Eileen Hamer	20.9.12 17.9.15	3 years 3 years	2015 2018
12 - Ancilliary	**VACANT POST**			
13 - Nurses/Midwives **(RESERVE REGISTER)**	Mrs Chris Bentley	6.10.09 20.9.12 17.9.15	3 years 3 years 1 year	2012 2015 2016
13 - Nurses/Midwives	Ms Julie Hoole	17.9.15	3 years	2018
NOMINATED STAKEHOLDER				
University of Huddersfield	Prof John Playle	1.9.12 17.9.15	3 years 3 years	2015 2018
Calderdale Metropolitan Council	Cllr Bob Metcalfe	18.1.11	3 years 3 years	2014 2017
Kirklees Metropolitan Council	Cllr Naheed Mather	22.5.15	3 years	2018
Clinical Commissiong Group	Mr David Longstaff	18.9.14	3 years	2017
Locala	**VACANT**			
South West Yorkshire Partnership NHS FT	Mrs Dawn Stephenson	23.2.10 15.8.13	3 years 3 years	2013 2016

Calderdale and Huddersfield NHS
NHS Foundation Trust

APPENDIX D

DECLARATION OF INTERESTS – MEMBERSHIP COUNCIL
AS AT 27 OCTOBER 2015

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

DATE OF SIGNEDDECLARATION	NAME	MEMBERSHIP COUNCIL STATUS	DIRECTORSHIP	OWNERSHIP	CONTROLLING SHAREHOLDING	AUTHORITY IN A CHARITY /BODY	VOLUNTARY OR OTHER CONTRACTING FOR NHS SERVICES	OTHER EMPLOYMENT (PAID OR NON-PAID) & MEMBER OF PROFESSIONAL ORGAN'S
6.10.09	Christine BENTLEY	Staff-elected Constituency 13	-	-	-	-	-	
1.3.10	Dawn STEPHENSON	Nominated Stakeholder – South West Yorkshire Partnership Foundation Trust	Director of Corporate Development	-	-	Voluntary Trustee - Kirklees Active Leisure (KAL)	-	Chair of MYHT Organ Donation Cttee/ Fellow of the Association of Certified Accountants.
11.1.11	Bob METCALFE	Nominated Stakeholder – Calderdale Council	-	-	-	-	-	-
6.10.11	Mary KIELY	Staff-elected Constituency 9	-	-	-	Consultant in Palliative Medicine, Kirkwood Hospice	As before	- Medical Defence Union. - B.M.A. - Assoc. for Palliative Medicine of GB & Ireland
10.10.11	Peter John MIDDLETON	Public-elected Constituency 3	-	-	-	-	-	-
10.9.12	Prof John PLAYLE	Nominated Stakeholder – Huddersfield University	-	-	-	-	-	Nursing Midwifery Council

DATE OF SIGNED DECLARATION	NAME	MEMBERSHIP COUNCIL STATUS	DIRECTORSHIP	OWNERSHIP	CONTROLLING SHAREHOLDING	AUTHORITY IN A CHARITY /BODY	VOLUNTARY OR OTHER CONTRACTING FOR NHS SERVICES	OTHER EMPLOYMENT (PAID OR NON-PAID) & MEMBER OF PROFESSIONAL ORGAN'S	
9.10.12	Eileen HAMER	Staff-elected Constituency 11	-	-	-	-	-	-	
13.2.13	Kate WILEMAN	Public-elected Constituency 7	-	-	-	-	-	Chair of Cancer Partnership Group at St James' Leeds	
5.8.13	Grenville HORSFALL	Public-elected Constituency 5	-	-	-	-	-	-	
28.9.13	Wayne CLARKE	Public-elected Constituency 2	-	-	-	-	-	Employed as Minister of New North Road Baptist Church	
11.10.13	Jennifer BEAUMONT	Public-elected Constituency 8	-	DATE OF SIGNED DECLARATION	NAME	MEMBERSHIP COUNCIL STATUS	DIRECTORSHIP	OWNERSHIP	C S
29.10.13	Dianne HUGHES	Public-elected Constituency 3	-	-	-	-	Civil Funeral Celebrant	Sheffield Teaching Hospitals NHS Trust RCN and Midwifery Council. Marie Curie Nursing Services.	

DATE OF SIGNED DECLARATION	NAME	MEMBERSHIP COUNCIL STATUS	DIRECTORSHIP	OWNERSHIP	CONTROLLING SHAREHOLDING	AUTHORITY IN A CHARITY/ BODY	VOLUNTARY OR OTHER CONTRACTING FOR NHS SERVICES	OTHER EMPLOYMENT (PAID OR NON-PAID) & MEMBER OF PROFESSIONAL ORGAN'S
8.9.14	George RICHARDSON	Public-elected Constituency 5	-	-	-	-	-	-
29.9.14	Lynn MOORE	Public-elected Constituency 7	-	-	-	-	-	-
1.11.14	Brian RICHARDSON	Public-elected Constituency 6	-	-	-	-	Locala Members' Council Healthwatch Calderdale Programme Board. Practice Health Champion PRG member at Beechwood Medical Centre	-
7.10.15	Ken BATTEN	Public-elected Constituency 2	-	-	-	-	-	-
29.9.15	Annette BELL	Public-elected Constituency 6	-	-	-	-	-	-
2.10.15	Brian MOORE	Public-elected Constituency 8	-	-	-	-	-	-

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

Status:- AWAITING RETURNS FROM:– DAVID LONGSTAFF, NAHEED MATHER, ROSEMARY HEDGES, DI WHARMBY, JULIE HOOLE

MEMBERSHIP COUNCIL PUBLIC MEETING

MEETING TITLE AND TYPE: PUBLIC MEMBERSHIP COUNCIL MEETING	**REPORTING AUTHOR:** RUTH MASON
TITLE OF PAPER: ALLOCATION OF MEMBERSHIP COUNCILLORS TO REFERENCE GROUPS AND SUB-COMMITTEES 2015	
DATE OF MEETING: 4.11.15	**SPONSORING DIRECTOR:** JULIE DAWES
STRATEGIC DIRECTION – AREA: • Keeping the base safe • Transforming and improving patient care • A workforce for the future • Financial Sustainability	**ACTIONS REQUESTED:** • For comment • To approve • To note
PREVIOUS FORUMS: NONE	

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

As part of the governance and holding to account responsibility of Membership Councillors our Staff and publicly elected Membership Councillors work with Trust colleagues through involvement on Divisional Reference Group and sub-committees of the Board and the Membership Council.

Each year Membership Councillors are allocated to the various groups and committees in order to gain a good understanding of the range and nature of the work of the Trust. Allocations for these groups and committees from the 2015 AGM are attached.

RECOMMENDATION:

Membership Councillors are asked to note and participate as shown.

APPENDIX ATTACHED: YES

MEMBERSHIP COUNCIL ALLOCATION TO GROUPS AND SUB COMMITTEES

DIVISIONAL REFERENCE GROUPS (Plus Divisional Reps)	QUORUM	MEETINGS (3 per annum)	ALLOCATION FROM NOVEMBER 2015
Families & Specialist Services (FSS) (Includes diagnostic services) Divisional Reference Group	1 Div rep 2 MC's 1 Membership Office rep	10 November 2015 12.00 – 2.00 Venue TBC 25 February 2016 1.00 – 1.00 Room F2, Acre House 27 June 2016 10.00 – 12.00 Room F2, Acre House 10 November 2016 11.00 – 1.00 Boardroom, HRI	Lynn Moore George Richardson Jennifer Beaumont Kate Wileman Annette Bell Mary Kiely
Surgical & Anaesthetics (S&A) Divisional Reference Group	"	30 November 2015 2.00 – 4.00 Discussion Room 3, Learning Centre, HRI 24 February 2016 2.00 – 4.00 Room F2, Acre House 29 June 2016 2.00 – 4.00 Room F2, Acre House 2 November 2016 2.00 – 4.00 Boardroom, HRI	Peter Middleton George Richardson Grenville Horsfall Dianne Hughes Chris Bentley Ken Batten
Medicine Divisional (Med) Including A/E Reference Group	"	19 November 2015 11.30 – 1.30 Boardroom, HRI 3 March 2016 11.30 – 1.30 Boardroom, CRH 30 June 2016 11.30 – 1.30 Medium Training Room, Learning Centre, CRH 7 November 2016 1.30 – 3.30 Large Training Room, Learning Centre, CRH	George Richardson Kate Wileman Brian Moore Di Wharmby Rosemary Hedges Wayne Clarke
Estates & Facilities (E&F) Divisional Reference Group	"	18 November 2015 2.00 – 4.00 Discussion Room 3, Learning Centre, HRI 29 February 2016 1.00 – 3.00 Room F2, Acre House 21 June 2016 2.00 – 4.00 Room F2, Acre House 9 November 2016 2.00 – 4.00 Room F2, Acre House	Brian Richardson Grenville Horsfall Ken Batten Brian Moore Annette Bell Eileen Hamer
Community Services Division (Community) Divisional Reference Group		To be confirmed	Annette Bell Lynn Moore Brian Richardson Wayne Clarke Peter Middleton Julie Hooles

MEMBERSHIP COUNCIL ALLOCATION TO GROUPS AND SUB COMMITTEES

STATUTORY SUB COMMITTEE TITLE	AGREED COMPOSITION AS PER TERMS OF REFERENCE	PROPOSED MEETINGS	ALLOCATION
Nomination and Remuneration Committee – Chair & Non Executive Directors (NEDs)	Declaration of Non-interest in NED post required A quorum shall be three members, two of whom must be public Membership Councillors.	Annually & As and when required	Brian Moore Eileen Hamer Peter Middleton Brian Richardson Di Wharmby Dawn Stephenson
AGM Planning Sub Group	Not specified	4 per annum:- 2.12.15 2016 DATES TBC	Grenville Horsfall Eileen Hamer **(Open for any MCs to attend)**
Audit & Risk Committee	1 Membership Councillor to observe	5 per annum:- 20 January 2016 19 April 2016 26 May 2016 19 July 2016 18 October 2016	Peter Middleton Brian Richardson (Reserve)
Finance & Performance	1 Membership Councillor to observe	Monthly: 17.11.15 15.12.15 2016 DATES TBC	Brian Moore Peter Middleton (Reserve)
Quality Committee	1 Membership Councillor to observe	Monthly: 26 January 2016 23 February 2016 29 March 2016 26 April 2016 24 May 2016 28 June 2016 26 July 2016	Lynn Moore Peter Middleton (Reserve)

MEMBERSHIP COUNCIL ALLOCATION TO GROUPS AND SUB COMMITTEES

		23 August 2016 27 September 2016 25 October 2016 22 November 2016 13 December 2016	

RM/KB/MC SUB GROUPS 19.10.15(v1)

MEMBERSHIP COUNCIL PUBLIC MEETING

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

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

The Trust currently has in place two Nominations Committees and two Remuneration Committees. In line with the Foundation Trust Good Governance Handbook, it is recommended that these Committees be brought together to form a Nominations and Remuneration Committee (Board of Directors) and a Nominations and Remuneration Committee (Membership Council). This will enable the streamlining of the consideration of new executive and non-executive appointments.

Following initial review by the Deputy Director of Workforce and OD and the Non-Executive Directors, the terms of reference for the Nominations and Remuneration Committee (Board of Directors) was approved at the Board of Directors Meeting held on the 24 September 2015.

In line with this format, the combined Terms of Reference for the Nominations and Remuneration Committee (Membership Council) are attached for the consideration and approval of the Membership Council.

RECOMMENDATION:

The Membership Council is asked to APPROVE the terms of reference for the Nominations and Remuneration Committee (Membership Council).

APPENDIX ATTACHED: YES ~~/ NO~~

NOMINATION AND REMUNERATION COMMITTEE (MEMBERSHIP COUNCIL)

TERMS OF REFERENCE

Version:	1.1 First draft circulated for review to Chair – 13.10.15 1.2 Draft submitted to Membership Council for approval – 4.11.15 1.3 Draft submitted to Board for approval – 26.11.15
Approved by:	Board of Directors & Membership Council
Date approved:	4.11.15 and 26.11.15
Date issued:	
Review date:	October 2016

NOMINATION AND REMUNERATION COMMITTEE TERMS OF REFERENCE (MEMBERSHIP COUNCIL)

1. Constitution

1.1 The Trust hereby resolves to establish a Committee to be known as the Nomination and Remuneration Committee (Membership Council). The Committee has no executive powers other than those specifically delegated in these terms of reference.

1.2 Please note that all references in these terms of reference to Non-Executive Directors are to be taken to include the Chair, unless specifically indicated otherwise.

2. Authority

2.1 The Membership Council Nomination and Remuneration Committee (the Committee) is constituted as a standing committee of the Membership Council. Its constitution and terms of reference shall be as set out below, subject to amendment at future Membership Council meetings.

2.2 The Nomination and Remuneration Committee is authorised by the Membership Council to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Nomination and Remuneration Committee.

2.3 The Nomination and Remuneration Committee is authorised by the Membership Council, subject to funding approval by the Board of Directors, to request professional advice and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

2.4 The Nomination and Remuneration Committee is also authorised to request such internal information as is necessary and expedient to the fulfilment of its functions.

3. Conflicts of Interest

3.1 The Chair of the Trust, or any Non-Executive director present at committee meetings, will withdraw from discussions concerning their own re-appointment, remuneration or terms of services.

3.2 In order to sit as a member of the committee participants must sign a declaration that they have no intention to apply for a Non-Exectuvie Director appointment in the 12 months following attendance at the meeting of the Nomination and Remuneration Committee.

4. Nominations role

The Committee will:

4.1 Periodically review the balance of skills, knowledge, experience and diversity of the Non-Executive Directors and, having regard to the view of the Board of Directors and relevant guidance on board composition, make recommendations to the Membership Council with regard to the outcome of the review.

4.2 Review the results of the Board of Directors' performance evaluation process that relates to the composition of the Board of Directors.

4.3 Review annually the time commitment requirement for Non-Executive Directors.

4.4 Give consideration to and succession planning for Non-Executive Directors, taking into account the challenges and opportunities facing the Trust and the skills and

expertise needed on the Board of Directors in the future.

4.5 Make recommendations to the Membership Council concerning plans for succession, particularly for the key role of Chair.

4.6 Keep the leadership needs of the Trust under review at Non-Executive level to ensure the continued ability of the trust to operate effectively in the health economy.

4.7 Keep up-to-date and fully informed about strategic issues and commercial changes affecting the Trust and the environment in which it operates.

4.8 Agree with the Membership Council a clear process for the nomination of a Non-Executive Director.

4.9 Take into account the views of the Board of Directors on the qualifications, skills and experience required for each position.

4.10 For each appointment of a Non-Executive Director, prepare a description of the role and capabilities and expected time commitment required.

4.11 Identify and nominate suitable candidates to fill vacant posts within the Committee's remit, for appointment by the Membership Council.

4.12 Ensure that a proposed Non-Executive Director's other significant commitments are disclosed to the Membership Council before appointment and that any changes to their commitments are reported to the Membership Council as they arise.

4.13 Ensure that proposed appointees disclose any business interests that may result in a conflict of interest prior to appointment and that any future business interests that could result in a conflict of interest as well as with compliance with 'Fit and Proper Person' requirements are reported.

4.14 Ensure that on appointment Non-Executive Directors receive a formal letter of appointment setting out clearly what is expected of them in terms of time commitment, committee service and involvement outside Board of Directors Meetings.

4.15 Advise the Membership Council in respect of the re-appointment of any Non-Executive Director. Any term beyond six years must be subject to a particularly rigorous review.

4.16 Advise the Membership Council in regard to any matters relating to the removal of office of a Non-Executive Director.

5. Remuneration role

The Committee will:

5.1 Recommend to the Membership Council a remuneration and terms of service policy for Non-Executive Directors, taking into account the views of the Chair (except in respect of his own remuneration and terms of service) and the Chief Executive and any external advisers.

5.2 In accordance with all relevant laws and regulations, recommend to the

Membership Council the remuneration and allowances, and the other terms and conditions of office, of the Non-Executive Directors.

5.3 Receive and evaluate reports about the performance of individual Non-Executive Directors and consider this evaluation output when reviewing remuneration levels.

5.4 In adhering to all relevant laws and regulations establish levels of remuneration which:

5.4.1 are sufficient to attract, retain and motivate Non-Executive Directors of the quality and with the skills and experience required to lead the Trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable to the Trust;

5.4.2 reflect the time commitment and responsibilities of the roles;

5.4.3 take into account appropriate benchmarking and market-testing, while ensuring that increases are not made where Trust or individual performance do not justify them; and

5.4.4 are sensitive to pay and employment conditions elsewhere in the Trust.

5.5 Oversee other related arrangements for Non-Executive Directors.

6. Membership and attendance

6.1 The membership of the committee shall consist of Membership Councillors appointed by the Membership Council.

6.2 The Committee will normally be chaired by the Trust Chair. Where the Trust Chair has a conflict of interest, for example when the Committee is considering the Chair's re-appointment or remuneration, the Committee will be chaired by the senior independent director or a Membership Councillor on the Committee.

6.3 A quorum shall be three members, two of whom must be public Membership Councillors.

7. Secretary

7.1 The Board Secretary shall be the secretary to the Committee

8. Attendance

8.1 Only members of the Committee have the right to attend Committee Meetings.

8.2 At the invitation of the Committee, meetings shall normally be attended by the Chief Executive and Director of Workforce.

8.3 Other persons may be invited by the Committee to attend a meeting so as to assist in deliberations.

9. Frequency of Meetings

9.1 Meetings shall be held as required, but at least twice in each financial year.

10. Minutes and Reporting

10.1 Formal minutes shall be taken of all Committee meetings and once approved by the Committee, circulated to all members of the Membership Council unless a conflict of interest, or matter of confidentiality exists.

10.2 The Committee will report to the Membership Council after each meeting.

10.3 The Committee shall receive and agree a description of the work of the Committee, its policies and all Non-Executive Director emoluments in order that these are accurately reported in the required format in the Trust's Annual Report.

11. Performance Evaluation

11.1 The Committee shall review annually its collective performance.

12. Review

12.1 The Terms of Reference of the Committee shall be reviewed by the Membership Council at least annually.

/KB/MC-NOMREM-TOR
OCTOBER 2015

APPENDIX G

Calderdale and Huddersfield NHS
NHS Foundation Trust

SCHEDULE OF MEMBERSHIP COUNCIL
FUTURE MEETINGS 2015-16

DAY/DATE	TIME	VENUE	PURPOSE OF MEETING
2015			
Wednesday 4 November 2015	4.00 pm	Boardroom Huddersfield Royal Infirmary HD3 3EA	Members Public Meeting
2016			
Tuesday 19 January 2016	4.00 pm	Boardroom, Sub-basement, Huddersfield Royal Infirmary HD3 3EA	Members Public Meeting
Thursday 7 April 2016	4.00 pm	Large Training Room, Learning Centre, Calderdale Royal Hospital HX3 0PW	Members Public Meeting
Wednesday 6 July 2016	4.00 pm	Boardroom, Sub-basement, Huddersfield Royal Infirmary HD3 3EA	Members Public Meeting
Thursday 15 September 2016	To be confirmed	To be confirmed	Joint BOD & MC Annual General Meeting for Members and Public Members Public Meeting
Wednesday 9 November 2016	4.00 pm	Boardroom, Sub-basement, Huddersfield Royal Infirmary HD3 3EA	Members Public Meeting

/KB/SCHEDULE OF MC MEETINGS 2015-16.mc

Calderdale and Huddersfield NHS
NHS Foundation Trust

Finance Position Sept 2015

Keith Griffiths,
Assistant Director of Finance

compassionate care

Financial Position to Sept 2015

Year to date

- The year to date Income & Expenditure position is a deficit (excluding restructuring costs) of £12.14m, against a planned £10.71m deficit.
- This reflects agency pay pressures and shortfall in elective and daycase activity.
- CIP has delivered £6.93m against a plan of £5.64m.
- The cash position at the end of September 2015 was £8.61m against the planned level of £1.92m. The main driver of this difference is early receipt of income from commissioners.
- Capital expenditure of £9.62m, versus £12.66m planned.
- A Financial Sustainability Risk Rating (FSRR)* of level 2, in-line with plan. FSRR is a new measure used by Monitor, replacing the previous Continuity of Service Risk Rating.

*FSRR works on a scale of 1 - 4, 1 = poor, 4 = good

Financial Forecast as at Sept 2015

Forecast and Risks

- Year end forecast to deliver £22.21m deficit (excluding exceptional restructuring costs) a £2.2m adverse variance from plan.
- CIP of £17.46m forecast delivery against the planned level of £14.05m.
- Capital expenditure of £20.53m, just slightly below the planned level and supported by the £10m capital loan drawdown in April.
- Forecast year end cash balance of £1.97m, in-line with the planned level, requiring external cash support of £18m.
- Year end FSRR of 2.
- Balance of risks and opportunities remain.
- The Trust continues to be under scrutiny by Monitor due to the reliance on distressed cash funding. Longer term transformation plans are in design.

Board of Directors Integrated Performance Report

Calderdale and Huddersfield NHS
NHS Foundation Trust

compassionate care

Contents

Report For: September 2015

Board of Directors

Integrated Performance Report

Executive Summary Commentary

The report on September performance remains good for the Monitor indicators and is showing more indicators improving on the previous month. The key areas to note are:

Responsiveness
The Trust delivered the Emergency Care Standard for the month and quarter
National cancer standards were met at Trust level and Day 38 performance is improving
Delayed transfer of care significantly improved in September
Diagnostics performance dipped with a fail for the month
Cancelled operations performance deteriorated with some high volume cancellations in Ophthalmology related to equipment failure
Elective activity continues to track below plan
Slight improvement of ASIs in month but sustainable improvement not yet in place.

Caring
Complaint acknowledged within 3 days remains at 100%
Friends and Family Test percentage was achieved in Maternity for September

Safety
Falls and Pressure ulcers remain a concern and are the focus of specific in depth reviews
Percentage of SI investigations completed within timescales has significantly improved
Maternity indicators show continued good performance

Effectiveness
A further MRSA reported in September
HSMR remains a key area of concern
Stillbirth rate was above tolerance for the month, all incidents related to known risk factors
Neck of Femur performance still not at required standard

Well led
Sickness has improved in 5 of the 7 service areas reported and 5 out of 8 staff categories with overall % sickness at its lowest point in current service year with a downward trend
Staff in post and fte is static
Over 85% of colleagues have now started their mandatory training programme.
Appraisal activity plans are in place with divisions now RAG rated against these plans.

A Performance Management and Accountability Framework is currently in production that will further increase the scrutiny, structure and delivery of effective performance across the Trust.

Monitor		Contract		Contract		NHSE		Quality		Quality		Other Internal	
Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator
↑	A and E 4 hour target	↑	% Stroke patients spending 90% of their stay on a stroke unit	→	28 Day Standard for all Last Minute Cancellations	↓	Friends & Family Test (IP Survey) - % would recommend the Service	n/a	End of Life Care Plan in place	↓	Unavoidable Number of Clostridium Difficile Cases	↓	% Elective Variance against Plan
↓	62 Day Gp Referral to Treatment		% Stroke patients scanned within 1 hour of hospital arrival (where indicated)	→	No of Urgent Operations cancelled for a second time	↑	Friends and Family Test A & E Survey - % would recommend the Service	→	Local SHMI - Relative Risk (1yr Rolling Data Jan14- Dec 14)	↓	MRSA Screening - Percentage of Inpatients Matched	↓	% Day Case Variance against Plan
→	62 Day Referral From Screening to Treatment	#N/A	% Stroke patients Thrombolysed within 1 hour	↑	% Harm Free Care	↑	Friends & Family Test (Maternity) - % would recommend the Service	→	Hospital Standardised Mortality Rate (1 yr Rolling Data Jul 14 - Jun 15)	↓	Number of E.Coli - Post 48 Hours	↑	% Non-elective Variance against Plan
→	31 Day Subsequent Surgery Treatment	↓	Percentage of Completed VTE Risk Assessments	↓	62 Day Aggregated Gp Urgent Referral To Treatment And Screening Referral To Treatment	↑	Friends and Family Test Community Survey - % would recommend the Service	↑	Crude Mortality Rate (Latest Month Sep 15)	↓	% Hand Hygiene Compliance	↑	% Outpatient Variance against Plan
→	31 day wait for second or subsequent treatment drug treatments	→	Completion of NHS numbers within acute commissioning datasets submitted via SUS	→	Number of Mixed Sex Accommodation Breaches	↓	Friends & Family Test (IP Survey) - Response Rate	↓	Mortality Reviews – August Deaths	↑	Avoidable number of Clostridium Difficile Cases	↑	Theatre Utilisation (TT) - Main Theatre - CRH
→	31 Days From Diagnosis to First Treatment	↓	Completion of NHS numbers within A&E commissioning datasets submitted via SUS	↑	Stillbirths Rate (including intrapartum & Other)	↑	Friends and Family Test A & E Survey - Response Rate	↑	Average Diagnosis per Coded Episode	↓	Number of MSSA Bacteraemias - Post 48 Hours	↑	Theatre Utilisation (TT) - Main Theatre -HRI
↑	Two Week Wait From Referral to Date First Seen	↑	Number of MRSA Bacteraemias – Trust assigned	→	Never Events	→	Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	↓	Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	↓	% Complaints closed within target timeframe	↑	Theatre Utilisation (TT) - HRI DSU
↓	Two Week Wait From Referral to Date First Seen: Breast Symptoms	↑	A&E Ambulance Handovers 30-60 mins (Validated)	↓	Percentage of SI's investigations where reports submitted within timescale (45 days unless extension agreed)	n/a	Percentage of non-elective inpatients 75+ screened for dementia	↓	Left without being seen	n/a	Total Complaints received in the month	↓	Theatre Utilisation (TT) - HRI SPU
→	Community care - referral to treatment information completeness	↓	Delayed Transfers of Care	→	A&E Trolley Waits	n/a	Acute Kidney Injury (Reported quarterly)	↑	Time to Initial Assessment (95th Percentile)	n/a	Total Concerns in the month	↓	World Health Organisation Check List
↓	Community care - referral information completeness	→	Percentage of Non-Compliant Duty of Candour informed within 10 days	↑	Perinatal Deaths (0-7 days)	n/a	Sepsis Screening (Reported quarterly)	↑	Time to Treatment (Median)	↑	Complaints acknowledged within 3 working days	↓	% Daily Discharges - Pre 11am
→	Community care - activity information completeness	↑	Total Duty of Candour informed within 10 days	↓	Neonatal Deaths (8-28 days)	n/a	Sepsis Antibiotic Administration (Reported Quarterly)	↓	Unplanned Re-Attendance	→	Percentage of SI's reported externally within timescale (2 days)	↑	Green Cross Patients (Snapshot at month end)
→	Total Number of Clostridium Difficile Cases - Trust assigned	n/a	Respiratory Care Bundle - Improving management of patients attending A&E with pneumonia (Reported quarterly)	n/a	Nutrition and Hydration - Reducing Hospital Food Waste (reported quarterly)			↑	Inpatient Falls with Serious Harm (10% reduction on 14/15)	n/a	Number of Patient Incidents	↓	Number of Outliers (Bed Days)

Table of Risk

Monitor		Contract		Contract		NHSE		Quality		Quality		Other Internal	
Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator	Outcome	Indicator
↑	7 Day Referral to First Seen	n/a	Respiratory Care Bundle - Improving management of patients presenting with Asthma in ED (Reported quarterly)	n/a	Nutrition and Hydration - Patient Satisfaction (Reported quarterly)			n/a	All Falls	n/a	Number of Incidents with Harm	↓	First DNA Rate
↑	38 Day Referral to Tertiary	↑	% Non-admitted Closed Pathways under 18 weeks	n/a	Improving Medicines Safety – Reconciliation (Effective Transfer of Medicines)			→	Missed Doses (Reported quarterly)	n/a	Number of SI's	→	% Hospital Initiated Outpatient Cancellations
↑	54 Referral to Treatment	↓	% Admitted Closed Pathways Under 18 Weeks	n/a	Improving Medicines Safety Discharge Accuracy Checks			n/a	% of diabetic patients supported to self-care	↑	Number of Trust Pressure Ulcers Acquired at CHFT	↓	CHFT Research Recruitment Target
		↑	% Incomplete Pathways <18 Weeks	→	% Diagnostic Waiting List Within 6 Weeks			n/a	Safeguarding Alerts made by the Trust	↑	Number of Category 2 Pressure Ulcers Acquired at CHFT	n/a	Total Number of Spells
		↓	Community - 18 Week RTT Activity	↓	18 weeks Pathways >=26 weeks open			n/a	Safeguarding Alerts made against the Trust	↑	Number of Category 3 Pressure Ulcers Acquired at CHFT	n/a	No of Spells with > 2 Ward Movements
			Appointment Slot Issues on Choose & Book	↓	18 weeks Pathways >=40 weeks open					↑	Number of Category 4 Pressure Ulcers Acquired at CHFT	↑	% of Spells with > 2 ward movements (2% Target)
		↑	% Last Minute Cancellations to Elective Surgery	→	RTT Waits over 52 weeks Threshold > zero					↑	Number of Category 3 & 4 Pressure Ulcers Acquired at CHFT	n/a	No of Spells with > 5 Ward Movements
												n/a	% of spells with > 5 ward movements (No Target)

↑ Improvement on last month ↓ deterioration on last month → No change on last month

RAG rating = GREEN Achieving Target / AMBER = missing target by a small margin / RED = Currently not Achieving Target

Achieving and Improving	Achieving No Change	Achieving but Deteriorating	Not Achieving No Change	Not achieving but improving	Not Achieving and Deteriorating
11	18	17	4	27	16

n/a - New indicators currently no trend /No RAG rating **24**

Overall Rating: Red reflecting enforcement action in place.

CQC status – Formal announced inspection date confirmed as commencing on the 8th March 2016

		Threshold	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Access and Outcome Metrics	% Admitted Closed Pathways Under 18 Weeks	>=90%	91.65%	92.41%	92.67%	92.79%	92.03%	91.64%							92.21%
	% Non-admitted closed Pathways under 18 weeks	>=95%	98.35%	98.89%	98.63%	98.23%	98.55%	98.67%							98.55%
	% Incomplete Pathways <18 Weeks	>=92%	95.02%	95.85%	95.44%	95.55%	95.44%	96.07%							96.07%
	A and E 4 hour target	>=95%	95.01%	94.80%	95.44%	95.44%	95.36%	95.37%							95.23%
	Total Number of Clostridium Difficile Cases - Trust assigned	21	2	0	1	1	3	3							10
	62 Day Gp Referral to Treatment	>=86%	89.38%	92.31%	90.00%	88.95%	93.94%	88.24%							90.09%
	62 Day Referral From Screening to Treatment	>=90%	85.71%	100.00%	100.00%	100.00%	100.00%	100.00%							98.48%
	31 Day Subsequent Surgery Treatment	>=94%	95.45%	100.00%	100.00%	100.00%	100.00%	100.00%							99.08%
	31 day wait for second or subsequent treatment drug treatments	>=98%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%							100.00%
	31 Days From Diagnosis to First Treatment	>=93%	100.00%	100.00%	99.24%	100.00%	100.00%	100.00%							99.86%
	Two Week Wait From Referral to Date First Seen	>=93%	96.45%	98.43%	96.55%	95.64%	93.78%	97.82%							96.43%
	Two Week Wait From Referral to Date First Seen: Breast Symptoms	>=93%	93.33%	93.75%	94.92%	94.87%	98.60%	98.47%							95.80%
	Community care - referral to treatment information completeness	>=50%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%							100.00%
	Community care - referral information completeness	>=50%	98.10%	98.10%	97.94%	97.54%	98.06%	97.56%							97.89%
	Community care - activity information completeness	>=50%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%							100.00%

Third Party Reports	Lung Cancer Peer review completed, awaiting written report. 1 Immediate concern relating to Pathology input to MDT which has been resolved. 1 serious concern relating to lack of Psychology provision but reviewers noted the Trust attempts to resolve and the commissioning decision in relation to this. The team were commended for their preparation, documentation and overall team dynamics reflecting a higher number of areas of good practice than many Trusts.
Quality Governance Indicators	**Patient Metrics -Narrative on Friends and Family included within Exception reports.**
	Staff Metrics : Reported quarterly – no further update from previous report

Finance	Financial Sustainability Risk Rating	2	2
	Operational Performance (Capital Service Cover)	1	1
	Cash & Balance Sheet Performance (Liquidity)	1	1
	Income & Expenditure Margin	1	1
	Income & Expenditure Margin - Variance from Plan	3	3
	Use of Capital	£12.66m	£9.62m
	Income and Expenditure (excluding Restructuring)	(£10.71m)	(£12.14m)
	Cost Improvement Programme (CIP)	£5.64m	£6.93m

	Report For: September 2015	Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Directon of travel (past 4 months)	Financial Penalities/Non Financial Impact	Year End Forecast	Data Quality
									Year To Date										
Activity	% Elective Variance against Plan	Local	0.00%	-6.77%	-8.96%	-0.60%	-0.81%	-	0.00%	-3.56%	-4.86%	-7.94%	6.48%	-		↓			
	% Day Case Variance against Plan	Local	0.00%	-8.67%	-8.25%	-9.46%	-10.26%	-	0.00%	-4.78%	-4.85%	-6.15%	2.53%	-		↑			
	% Non-elective Variance against Plan	Local	0.00%	6.68%	0.11%	6.99%	10.54%	-	0.00%	2.95%	-2.53%	4.37%	3.98%	-		↑			
	% Outpatient Variance against Plan	Local	0.00%	-3.30%	-3.75%	-2.13%	-4.00%	-	0.00%	-2.76%	-2.81%	-3.84%	-0.55%	-		↓			
RESPONSIVE - Theatre Utilisation	Theatre Utilisation (TT) - Main Theatre - CRH	Local	92.50%	89.70%	88.82%	-	96.42%	-	92.50%	87.27%	85.80%	-	97.95%	-		↑			
	Theatre Utilisation (TT) - Main Theatre -HRI	Local	92.50%	93.13%	93.13%	-	-	-	92.50%	94.44%	94.44%	-	-	-		↓			
	Theatre Utilisation (TT) - HRI DSU	Local	92.50%	79.83%	78.48%	-	89.56%	-	92.50%	76.85%	75.52%	-	87.38%	-		↑			
	Theatre Utilisation (TT) - HRI SPU	Local	92.50%	81.97%	81.97%	-	-	-	92.50%	83.23%	83.23%	-	-	-		↓			
Exception Report - Patient Flow	% Daily Discharges - Pre 11am	Local	28.00%	9.84%	12.57%	7.57%	10.19%	-	28.00%	10.43%	13.44%	8.50%	10.22%	-		↓			
	Delayed Transfers of Care	Local	5.00%	5.30%	-	-	-	-	5.00%	6.60%	-	-	-	-		↓			
	Green Cross Patients (Snapshot at month end)	Local	40	71	-	71	-	-	40	71	-	71	-	-		↓			
	Number of Outliers (Bed Days)	Local	267	598	40	558	0	-	1782	3735	362	3373	0	-		↓			
	No of Spells with > 2 Ward Movements	Local	-	129	24	80	25	-	-	823	131	523	169	-		→			
	% of Spells with > 2 ward movements (2% Target)	Local	2.00%	2.37%	1.60%	4.56%	1.14%	-	2.00%	2.28%	1.41%	4.96%	1.04%	-		↑			
	No of Spells with > 5 Ward Movements	Local	-	5	0	5	0	-	-	22	1	21	0	-		↑			
	% of spells with > 5 ward movements (No Target)	Local	-	0.09%	0.00%	0.28%	0.00%	-	-	0.06%	0.01%	0.28%	0.00%	-		↑			
	Total Number of Spells	Local	-	5444	1501	1756	2187	-	-	36040	9309	10540	16191	-		↓			

Calderdale and Huddersfield NHS
NHS Foundation Trust

Responsive Executive Summary - Helen Barker Associate Director of Operations

compassionate care

Report For: September 2015

Year To Date

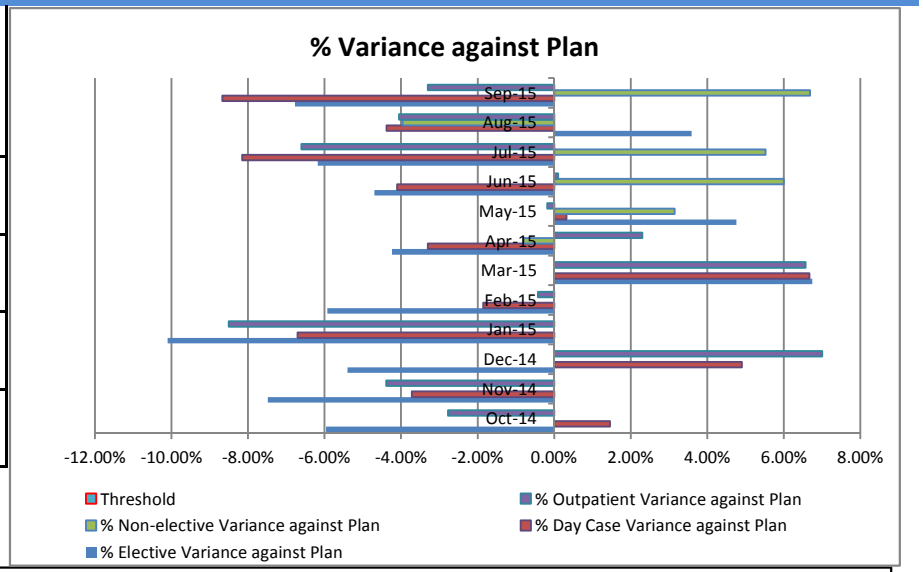
		Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Direction of travel (past 4 months)	Financial Penalities /Non Financial	Year End Forecast	Data Quality
Exception Report - Patient Flow 2	A and E 4 hour target	National & Contract	95.00%	95.37%	-	95.37%	-	-	95.00%	95.23%	-	95.23%	-	-		↓			
	Time to Initial Assessment (95th Percentile)	National	00:15:00	00:19:00	-	00:19:00	-	-	00:15:00	00:20:00	-	00:20:00	-	-		↑			
	Time to Treatment (Median)	National	01:00:00	01:00:00	-	01:00:00	-	-	01:00:00	00:58:00	-	00:58:00	-	-		↑			
	Unplanned Re-Attendance	National	5.00%	4.73%	-	4.73%	-	-	5.00%	5.04%	-	5.04%	-	-		↓			
	Left without being seen	National	5.00%	3.21%	-	3.21%	-	-	5.00%	3.29%	-	3.29%	-	-		↓			
	A&E Ambulance Handovers 30-60 mins (Validated)	National	0	3	-	3	-	-	0	44	-	44	-	-		→			
	A&E Trolley Waits	National	0	0	-	0	-	-	0	0	-	0	-	-		→			
Exception Report - Elective Access	First DNA Rate	Local	7.00%	6.07%	6.17%	6.56%	5.18%	4.10%	7.00%	6.72%	6.72%	6.63%	6.81%	3.80%		↓			
	% Hospital Initiated Outpatient Cancellations	Local	17.6%	13.40%	13.50%	15.30%	10.10%	-	17.6%	14.20%	14.60%	15.10%	11.80%	-		↓			
	Appointment Slot Issues on Choose & Book	Local	-	-	-	-	-	-	5.00%	15.00%	12.25%	8.33%	7.38%	-					
	CHFT Research Recruitment Target	Local	92	68	-	-	-	-	552	315	-	-	-	-		↑			
Exception Report - Elective Access 2	% Non-admitted Closed Pathways under 18 weeks	National & Contract	95.00%	98.67%	98.56%	98.79%	98.86%	-	95.00%	98.55%	98.55%	98.42%	98.86%	-		↑			
	% Admitted Closed Pathways Under 18 Weeks	National & Contract	90.00%	91.64%	90.90%	100.00%	94.50%	-	90.00%	92.21%	91.51%	100.00%	94.92%	-		↓			
	% Incomplete Pathways <18 Weeks	National	92.00%	96.07%	94.78%	99.16%	98.78%	-	92.00%	96.07%	94.78%	99.16%	98.78%	-		↑			
	18 weeks Pathways >=26 weeks open	Local	0	137	130	6	1	-	0	137	130	6	1	-		↓			
	18 weeks Pathways >=40 weeks open	National	0	1	1	0	0	-	0	1	1	0	0	-		↓			
	RTT Waits over 52 weeks Threshold > zero	National & Contract	0	0	0	0	0	0	0	0	0	0	0	0					
	% Diagnostic Waiting List Within 6 Weeks	National & Contract	99.00%	98.56%	100.00%	100.00%	98.13%	-	99.00%	99.56%	99.89%	100.00%	99.41%	-		↓			
	Community - 18 Week RTT Activity	National	95.00%	92.70%	-	-	-	92.70%	95.00%	96.70%	-	-	-	96.70%		→			
	% Last Minute Cancellations to Elective Surgery	National & Contract	0.60%	0.76%	1.15%	0.00%	0.76%	-	0.60%	0.64%	0.92%	0.03%	1.04%	-		↑			
	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	-		→			

Responsive Executive Summary - Helen Barker Associate Director of Operations

Year To Date

	Report For: September 2015	Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Direction of travel (past 4 months)	Financial Penalities/ Non Financial Impact	Year End Forecast	Data Quality
Exception Report - Access Stroke	% Stroke patients spending 90% of their stay on a stroke unit	National	83.20%	74.60%	-	74.60%	-	-	83.20%	78.60%	-	78.60%	-	-		↓			
	% Stroke patients Thrombolysed within 1 hour	National & Contract	56.10%	-	-	-	-	-	56.10%	-	-	-	-	-					
	% Stroke patients scanned within 1 hour of hospital arrival (where indicated)	National & Contract	80.00%	-	-	-	-	-	80.00%	-	-	-	-	-					
Exception Report - Elective Access 3	62 Day Gp Referral to Treatment	National & Contract	85.00%	88.24%	90.32%	89.09%	86.67%	-	85.00%	90.09%	91.09%	89.09%	93.67%	-		↓			
	62 Day Referral From Screening to Treatment	National & Contract	90.00%	100.00%	100.00%	-	-	-	90.00%	98.48%	98.44%	-	100.00%	-		→			
	31 Day Subsequent Surgery Treatment	National & Contract	94.00%	100.00%	100.00%	100.00%	-	-	94.00%	99.08%	100.00%	96.67%	-	-		→			
	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%	89.09%	91.43%	89.09%	86.67%	-	86.00%	90.73%	91.85%	89.09%	94.44%	-		↓			
	31 Days From Diagnosis to First Treatment	National & Contract	96.00%	100.00%	100.00%	100.00%	100.00%	-	96.00%	99.86%	99.78%	100.00%	100.00%	-		↑			
	Two Week Wait From Referral to Date First Seen	National & Contract	93.00%	97.82%	98.40%	96.38%	97.70%	-	93.00%	96.43%	97.92%	92.50%	96.95%	-		↑			
	Two Week Wait From Referral to Date First Seen: Breast Symptoms	National & Contract	93.00%	98.47%	98.47%	-	-	-	93.00%	95.80%	95.80%	-	-	-		↑			
	7 Day Referral to First Seen	National & Contract	50.00%	33.45%	30.30%	35.75%	47.13%	-	50.00%	36.70%	39.57%	29.26%	37.20%	-		↑			
	38 Day Referral to Tertiary	National & Contract	85.00%	60.87%	75.00%	16.67%	-	-	85.00%	51.11%	51.85%	51.16%	44.44%	-		↑			
	54 Referral to Treatment	National & Contract	85.00%	77.48%	79.57%	77.36%	50.00%	-	85.00%	73.73%	76.33%	70.33%	70.73%	-		↑			
Exception Report - Maternity	Antenatal Assessments < 13 weeks		90.00%	90.40%	-	-	90.40%	-	90.00%	92.00%	-	-	92.00%	-		↓			
	Maternal smoking at delivery		11.90%	9.80%	-	-	9.80%	-	11.90%	10.90%	-	-	10.90%	-		↓			

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Elective Variance against Plan	0.00%	-6.77%	-8.96%	-0.60%	-0.81%	-
% Day Case Variance against Plan	0.00%	-8.67%	-8.25%	-9.46%	-10.26%	-
% Non-elective Variance against Plan	0.00%	6.68%	0.11%	6.99%	10.54%	-
% Outpatient Variance against Plan	0.00%	-3.30%	-3.75%	-2.13%	-4.00%	-



% Variance against Plan

The main specialties leading to the under-performance against the elective and day case plan are Trauma and Orthopaedics (T&O), Ophthalmology, General Surgery and Rheumatology. The majority of the under-performance is within Day Case.

Why off Plan:

- The 2015-16 T&O plan includes a productivity CIP through the FourEyes work which continues to be under-delivered. The consultant body also has 1 less member since 2014-15 and there has been a reduction in the surgeons providing Waiting List Initiative (WLI) activity. Month 6 has seen a reduction in Spinal work.
- Ophthalmology WETMAC is behind plan due to capacity constraints in September in relation to the OCT (Optical Coherence Tomography) machines. The service also continues to have consultant vacancies.
- General Surgery has consultant and middle-grade vacancies with a consultant replacement starting mid-month. A reduction in casemix has also been seen in September.
- Rheumatology has seen a shift of day case subcutaneous injections now delivered within the community setting leading to activity below plan.

Actions to get back on plan:

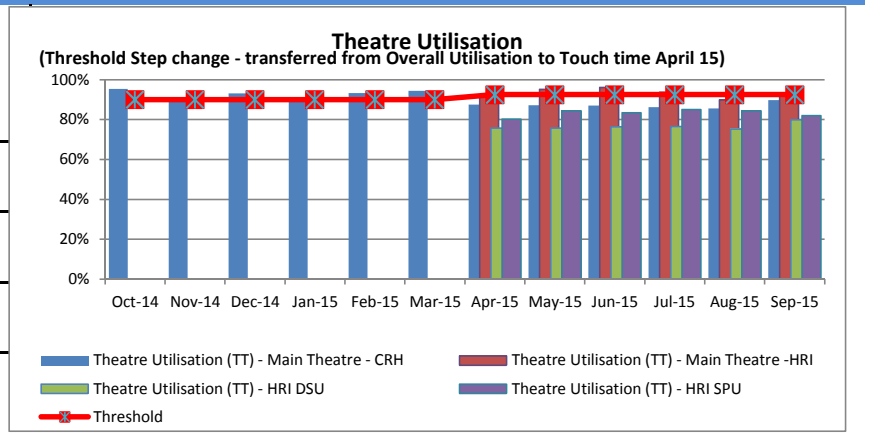
- The T&O recovery includes the appointment of an Upper Limb consultant from January onwards, the use of CHOP and ad-hoc lists where appropriate and changes made to the theatre timetable to improve allocation of Trauma lists. The recovery plans do not however bring activity back to plan levels and further work continues to consider other options.
- Ophthalmology WETMAC recovery includes the new OCT machine becoming available in October plus the recent recruitment of additional nursing posts. Ophthalmology day case activity recovery is due to recruitment to vacant consultant posts with interim locum capacity where available.
- The General Surgery recovery plan includes the recruitment of the 3rd Colorectal Surgeon post and Vascular Post.
- There is no plan to recover the Rheumatology activity as this will now continue to be delivered within the Community.

When will we be back on track

The current forecast reflects a level of recovery but does not anticipate that day case and elective activity will recover back to planned levels.

Accountable : Surgical and Medical Divisional teams

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Theatre Utilisation (TT) - Main Theatre - CRH	92.50%	89.70%	88.82%	-	96.42%	-
Theatre Utilisation (TT) - HRI DSU	92.50%	79.83%	78.48%	-	89.56%	-
Theatre Utilisation (TT) - HRI SPU	92.50%	81.97%	81.97%	-	-	-



Theatre Utilisation:

Why off plan:

We know from our Theatre action week that there are a number of causes for our performance on theatre utilisation:
We have lists that start late due to staffing, on call commitments, patients being available, and last minute changes to lists
Theatre cancellations cause a reduction in utilisation and are due to clinical reasons, patient requests or operational issues
The higher volume of patients on our day cases lists means there is inevitably more down time on the list associated with turning the theatre round between cases.
Stock and equipment availability
Communication errors, including consent forms, Bluespeir data entry, handover, case notes or electronic notes not being complete / available
Staffing levels within our admissions processes to get patients ready for theatre and there on time

Actions to get back to plan:

We have identified recommendations following the theatre action week that will improve the following factors:

- List start time
- Communication
- Upstream processes (e.g. admissions, pre-op etc.)
- Scheduling processes

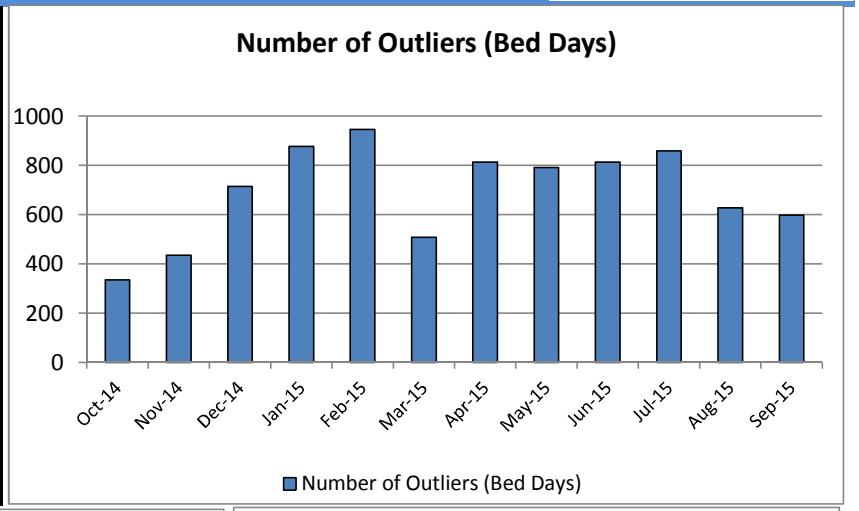
We are assessing the target utilisation against the four eyes data, and other evidence sources for DSU and SPU where high patient turnaround is a feature of the list.
We have assessed our workforce requirements for the admissions process and are implementing a revised workforce model to address this

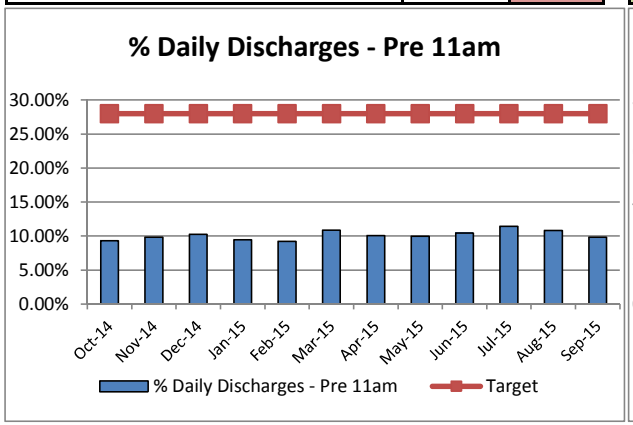
When will we be back on track?

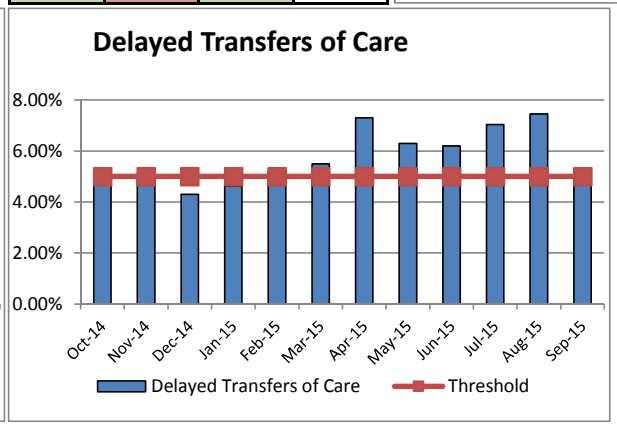
Due to the multifaceted nature of this problem it is difficult to assess when we will be back on track. However we would anticipate a month on month improvement as we implement the actions above in the coming months.

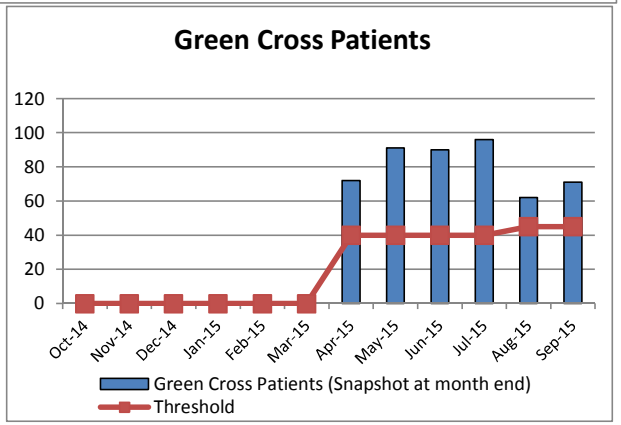
If colleagues wish to know more about the detail of our findings and our proposed actions please contact the Surgical Division for our detailed theatre action week report.

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Daily Discharges - Pre 11am	28.00%	9.84%	12.57%	7.57%	10.19%	-
Delayed Transfers of Care	5.00%	5.30%	-	-	-	-
Green Cross Patients (Snapshot at month end)	45	71	-	71	-	-
Number of Outliers (Bed Days)	267	598	40	558	0	-
% of Spells with > 2 ward movements (2% Target)	2.00%	2.37%	1.60%	4.56%	1.14%	-









Why off Plan:
A number of the patient flow metrics remain below target levels. Outlier bed days of 558 represents an average of 18 patients outlying across both our sites. Ward 14 (extra capacity) is currently open accommodating 14 surgical patients (due to location) to then free capacity in surgery to allow for the medical patients to outlie in a planned manner. Number of patients > than 2 moves has increased in month as patients are transferred to create capacity and is partly due to increasing non-elective admissions which were 7% above planned levels during September and 4.4% YTD.

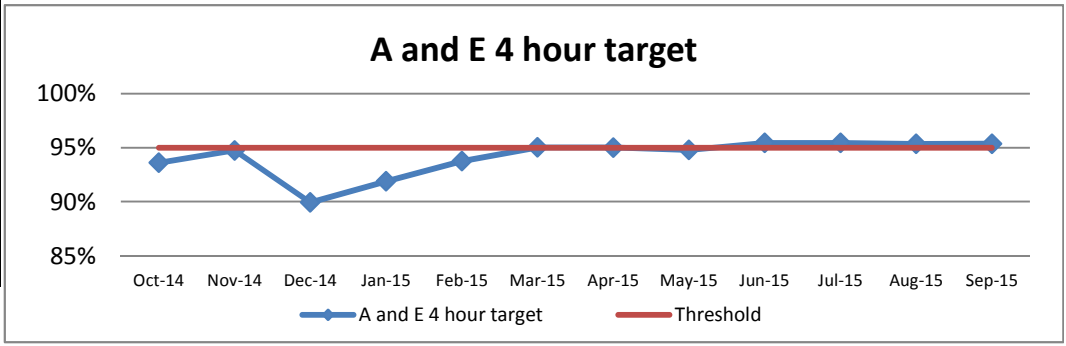
Actions to get back to plan:
Ward 5 at HRI (flex ward) will be handed back by estates on the 15th October allowing this area to come on line for medicine. Antenatal and post natal , C- Section ward have now relocated back to base wards therefore freeing up ward 4D to be used as extra capacity area. Clinical realignment of bed base taking place within Medicine during October to help minimise the number of non-clinical moves for patients. This action should help minimise disruption to patients and ensure improved compliance with other key standards such as stroke 90% stay. Four eyes continue to work on 3 test wards with a key expected output of improving morning discharges. The SRG have been working on a winter plan to ensure improved resilience. They have been asked to consider re-establishing the 12 beds at Oakmoor which were in place and managed by Locala during winter 14/15.

When will we be back on track:

When back on track:
Its expected the above actions will have taken place within the next 6 weeks and therefore should demonstrate improvements against a number of metrics.

Accountable : Helen Barker and Sajid Azeb

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Time to Initial Assessment (95th Percentile)	00:15:00	00:19:00	-	00:19:00	-	-
A&E Ambulance Handovers 30-60 mins (Validated)	0	3	-	3	-	-



Emergency care standard Time to initial assessment

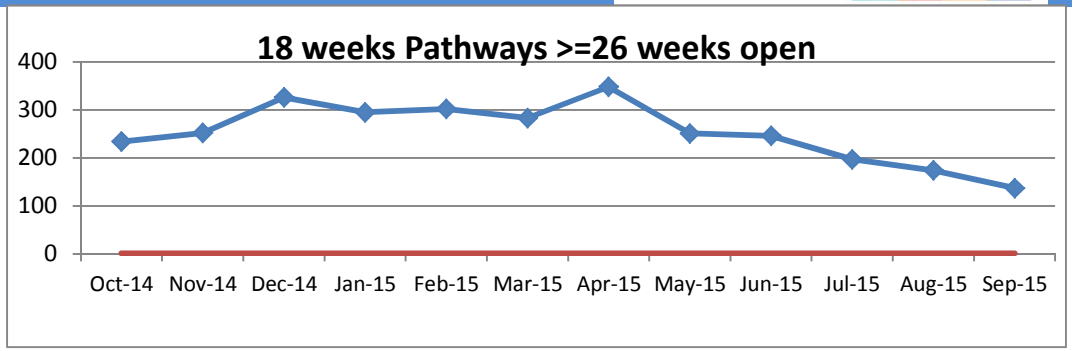
Why off Plan: The lack of cubicle capacity and exit block are the key reasons. A & E turnaround action plan in place. No standardised operational policy for co-ordination within the Emergency Department. Specific days analysis ongoing by Matron and GM where demand is high and performance down to explore further.

A**ctions to get back on plan:** Daily monitoring put in place which has identified specific days when there has been high demand and exit block a particular problem. New SOP for co-ordinator. Ongoing discussions with estates re department capacity fit for purpose whilst exit block an issue.

When will we be back on track: December 2015

Accountable : Bev Walker

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Last Minute Cancellations to Elective Surgery	0.60%	0.76%	1.15%	0.00%	0.76%	-
% Diagnostic Waiting List Within 6 Weeks	99.00%	98.56%	100.00%	100.00%	98.13%	-



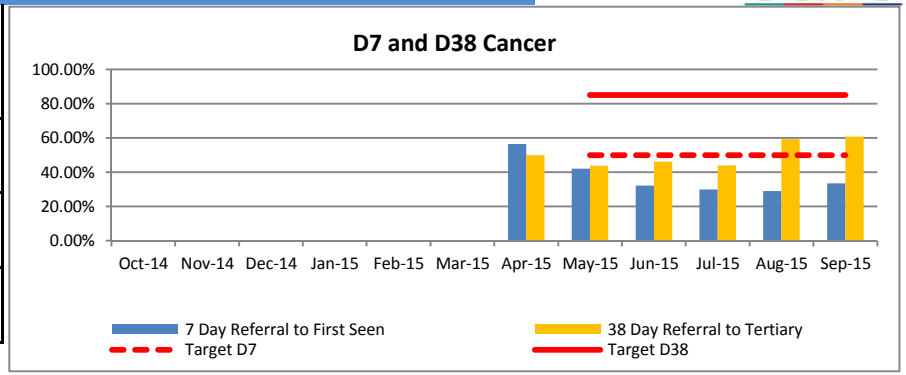
Diagnostics

Why off track : The Trust has failed the 6week diagnostic target in September with the breach volumes in Radiology – MRI & Ultrasound (90 patients)
This is a Symptom of increasing demand via Direct access however ultimately due to process error in booking patients. The increased demand and requirement for additional capacity had not been escalated with patients booked into capacity outside of the 6 week window.

What are we doing to get back on track A Root Cause Analysis is being undertaken in parallel to the immediate implementation of corrective actions which include a revised booking protocol and additional Capacity.
Work had already commenced on the introduction of performance reports for radiology that look forward at booking pressures and referral trends. This work has being expedited with some manual reports and an automated solution is progressing. This is now included in the weekly Performance review meeting
The corrective actions have ensured all breach patients have received their diagnostic and there are no known risks for October
Longer term the 3rd MRI scanner will provide additional physical scanning capacity

Accountable officer: CD via GM in Radiology

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
7 Day Referral to First Seen	50.00%	33.45%	30.30%	35.75%	47.13%	-
38 Day Referral to Tertiary	85.00%	60.87%	75.00%	16.67%	-	-
54 Referral to Treatment	85.00%	77.48%	79.57%	77.36%	50.00%	-



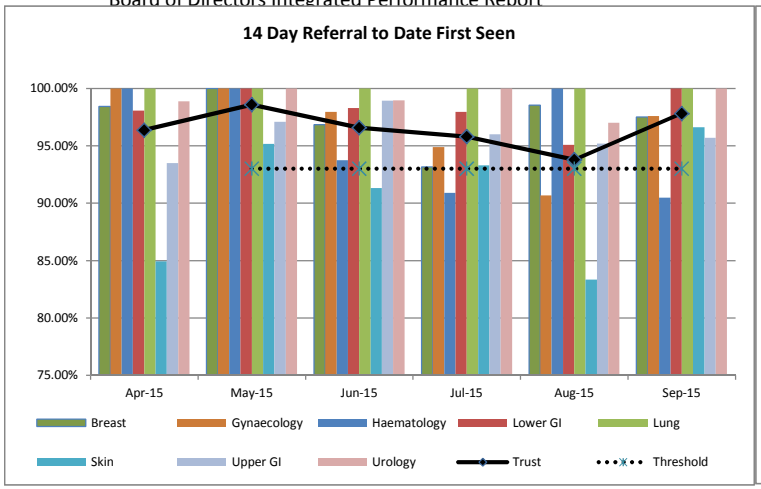
Cancer D7, D38 :

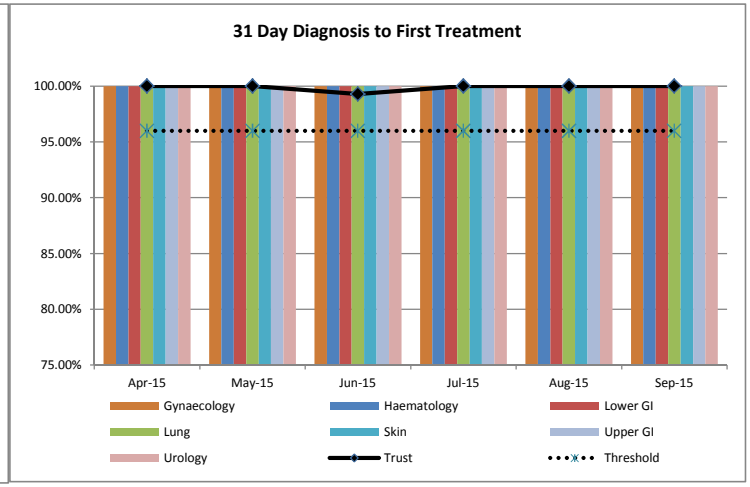
Why off Plan: Day 7 – During September 35.7% of all fast track referrals were seen within 7 days, 96.4% were seen within 14 days of referral. The specialities below the 50% target for 7 days in the Medical division are Skin, Lung and Haematology. The skin cancer performance is variable and is largely due to a significant increase in referrals from GPs and availability of locum consultants. The lung pathway has been changed, however it has come to light that the initial contact that has been made with the patients have not been recorded on PPM which has caused the 7 day breaches. The Haematology service has seen a 56% increase in fast track referral from 11/12 – 15/16 as well as a growth in general new patient referrals of 14% over the same time period. Clinics are often overbooked to try and accommodate patients within target time.

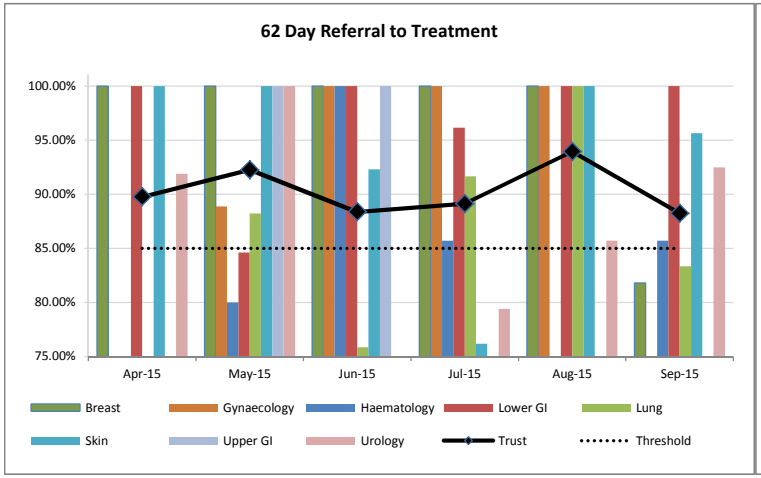
Day 38 – The division had 5 breaches in month against the 38 day standard. All were within the Lung cancer pathway and an analysis of the individual patient pathways has found that this is of the due to diagnostics not being undertaken within 7 days (as per trust agreement), which then leads to a delay in the management plan being formulated.

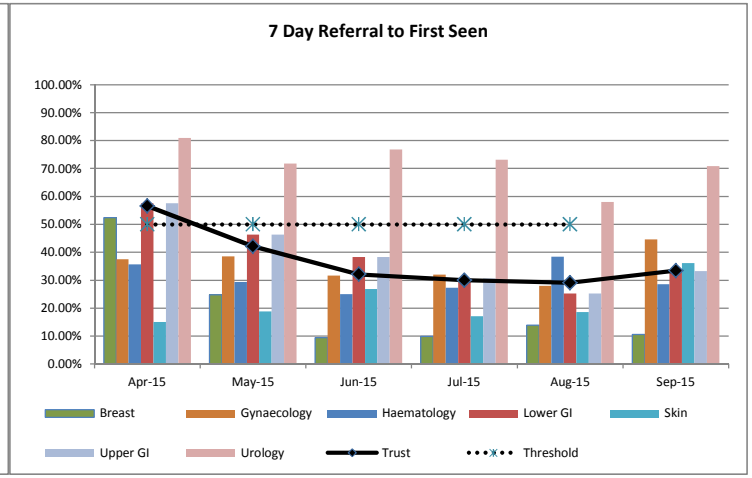
Actions to get back to plan: Day 7 – A number of actions have been taken in order to get back to plan these include:
Respiratory consultants have been asked to ensure all patient interactions are accurately reflected on to the PPM system.
Dermatology remains vulnerable due to its reliance upon locum workforce we have however contacted GP practice to offer specific training and guidance to high referring practices. In addition Locala have been asked to establish a community lesion clinic which should help to reduce the number of fast track referrals we receive within the trust (Locala have struggled with capacity to set this up)
Haematology – a business case for a 5th consultant for the service has been written and presented at the last Divisional Business meeting this is currently with the other divisions for approval of support.

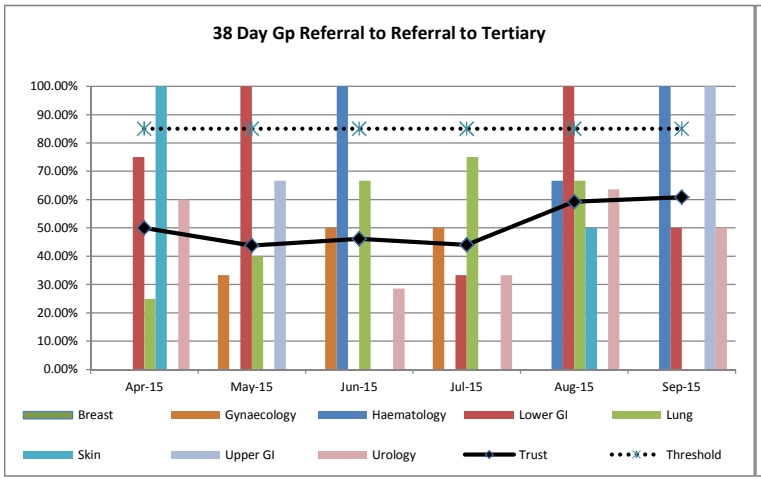
Day 38
Operational policy for 7 day diagnostics being written by Maureen Overton and will be sent through for ratification.
Lung pathway tracker to escalate any pathway delays to GM
Performance monitored on a weekly basis

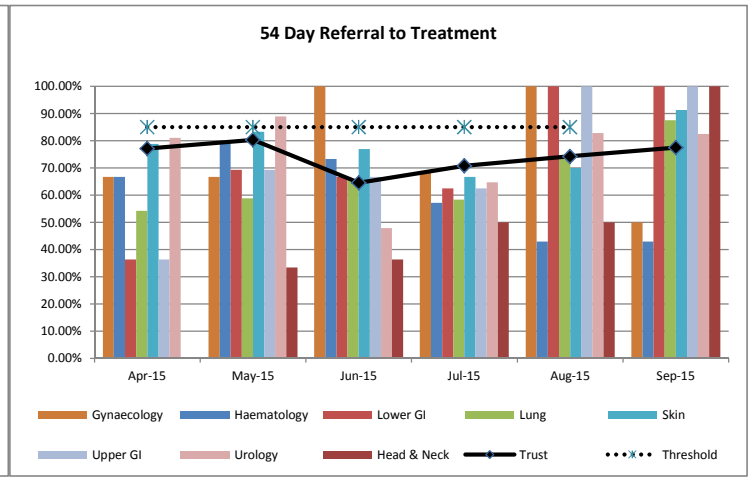

14 Day Referral to Date First Seen
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Breast
Gynaecology
Haematology
Lower GI
Lung
Skin
Upper GI
Urology
Trust
Threshold


31 Day Diagnosis to First Treatment
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Gynaecology
Haematology
Lower GI
Lung
Skin
Upper GI
Urology
Trust
Threshold


62 Day Referral to Treatment
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Breast
Gynaecology
Haematology
Lower GI
Lung
Skin
Upper GI
Urology
Trust
Threshold

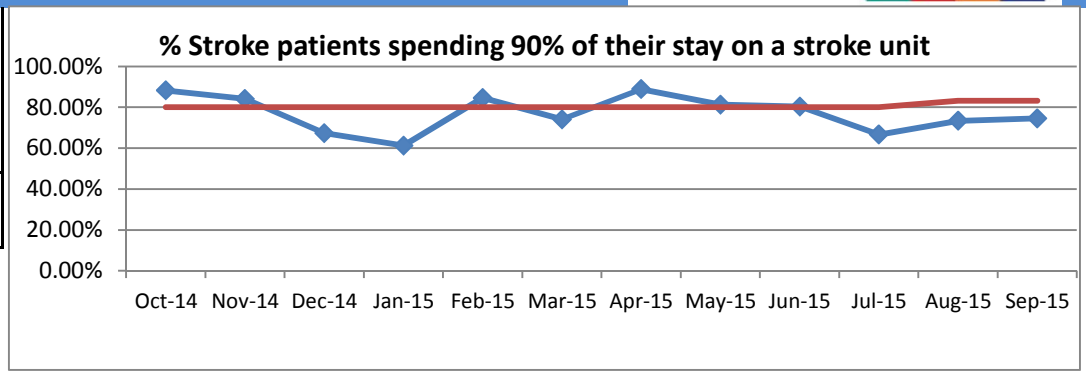

7 Day Referral to First Seen
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Breast
Gynaecology
Haematology
Lower GI
Skin
Upper GI
Urology
Trust
Threshold


38 Day Gp Referral to Referral to Tertiary
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Breast
Gynaecology
Haematology
Lower GI
Lung
Skin
Upper GI
Urology
Trust
Threshold


54 Day Referral to Treatment
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
Apr-15
May-15
Jun-15
Jul-15
Aug-15
Sep-15
Gynaecology
Haematology
Lower GI
Lung
Skin
Upper GI
Urology
Head & Neck
Trust
Threshold

Report For: September 2015

	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Stroke patients spending 90% of their stay on a stroke unit	83.20%	74.60%	-	74.60%	-	-



Stroke Activity:

Why off Plan: In month, there were 15 patients who breached this target, with 7 of these due to bed pressures - 4 were initially admitted elsewhere and 3 were moved off the stroke unit to create room for new admissions pending discharge arrangements e.g. POC and patient moved to step down unit. 5 patients were appropriately managed on other clinical wards due to other medical reasons. There were 4 patients who had a delayed diagnosis of stroke and therefore also breached this target.
Actions to get back on plan: Medical revised bed modelling plan and stroke admission SOP now in place. Daily escalation to site commanders for medical outliers on the stroke unit to be moved off.

When will we be back on track: October

Accountable : Dr Rob Moisey

Caring Executive Summary - Julie Dawes Director of Nursing

	Report For: September 2015	Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Direcion of travel (past 4 months)	Financial Penalities/Non Financial Impact	Year End Forecast	Data Quality
									Year To Date										
Complaints	Number of Mixed Sex Accommodation Breaches	National & Contract	0	0	0	0	0	n/a	0	0	0	0	0	n/a		→			
	% Complaints closed within target timeframe	Local	100.00%	51.85%	40.00%	64.29%	73.33%	0.00%	100.00%	51.27%	45.60%	47.24%	70.83%	73.33%		↓			
	Total Complaints received in the month	Monitor	-	48	17	13	14	2	-	311	105	100	71	15		↓			
	Complaints acknowledged within 3 working days	Local	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	83.59%	83.02%	89.90%	87.32%	73.33%		↑			
	Total Concerns in the month	Monitor	-	60	15	27	16	0	-	335	104	116	70	17		↓			
Friends & Family Test	Friends & Family Test (IP Survey) - Response Rate	Contract	40.00%	24.40%	26.20%	21.90%	24.80%	-	40.00%	24.60%	27.10%	24.50%	24.90%	-		↓			
	Friends & Family Test (IP Survey) - % would recommend the Service	Contract	95.00%	96.50%	97.00%	95.00%	98.80%	-	95.00%	96.90%	97.30%	95.70%	98.00%	-		↓			
	Friends and Family Test A & E Survey - Response Rate	Contract	30.00%	9.50%	-	9.50%	-	-	30.00%	7.20%	-	7.20%	-	-		↑			
	Friends and Family Test A & E Survey - % would recommend the Service	Contract	95.00%	86.20%	-	86.20%	-	-	95.00%	89.40%	-	89.40%	-	-		↓			
	Friends & Family Test (Maternity) - % would recommend the Service	Contract	95.00%	98.80%	-	-	98.80%	-	95.00%	95.70%	-	-	95.70%	-		↑			
	Friends and Family Test Community Survey - % would recommend the Service	Local	95.00%	92.00%	-	-	-	92.00%	95.00%	90.80%	-	-	-	90.80%		↑			
Caring Maternity	Proportion of Women with a concern about safety during labour and birth not taken seriously		6.50%	0.00%	-	-	0.00%	-	6.50%	1.70%	-	-	1.70%	-		↓			
	Proportion of women who were left alone at a time that worried them during labour		4.50%	4.10%	-	-	4.10%	-	4.50%	3.50%	-	-	3.50%	-		↑			
	Proportion of Women who received Physical 'Harm Free' Care		70.00%	73.50%	-	-	73.50%	-	70.00%	72.40%	-	-	72.40%	-		↑			
	Proportion of Women with a perception of safety		90.40%	95.90%	-	-	95.90%	-	90.40%	95.40%	-	-	95.40%	-		↓			
	Proportion of Women who received Combined 'Harm Free' Care		70.90%	73.50%	-	-	73.50%	-	70.90%	69.00%	-	-	69.00%	-		↑			

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Complaints closed within target timeframe	100.00%	51.85%	40.00%	64.29%	73.33%	0.00%

% Complaints closed within target timeframe

Why off Plan: 52% complaints were closed within time frame, reduction of 4 % compared to August 2015. Responses from Divisions overdue at the end of September were: 33 overdue (up to 1 month), 9 (up to 2 months), 6 (up to 3 months), 2 (up to 4 months) . An increased focus on quality assurance by the complaints team has resulted in a number of responses being returned to the divisions for additional details which has added some delay into the process., however this should reduce the number of cases re-opened; 25 complaints were re-opened in quarter 2 of this year.

Actions to get back on plan: There is continued focus on closing overdue cases and managing new cases within timescales through use of weekly performance report on complaints to divisions to highlight overdue complaints and complete these as soon as possible. Weekly meetings with Medical Division to progress overdue cases.

When will we be back on track All cases ongoing over target to be completed by divisions as a matter of urgency, with new cases managed in target.

Accountable: Head of Governance and Risk

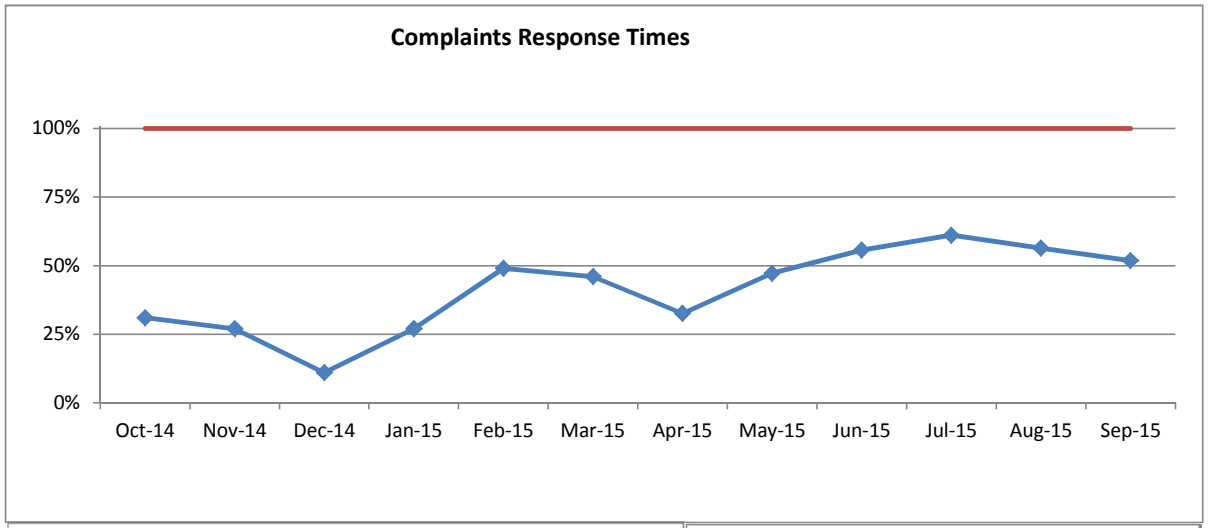
Complaints Overview:

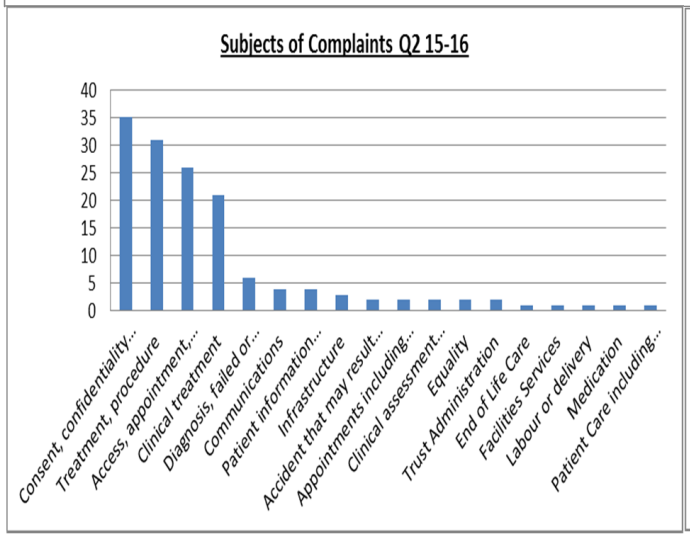
As shown on the chart to the right, during Q2, the top 3 complaint subjects, were consistent with previous quarters . These were:

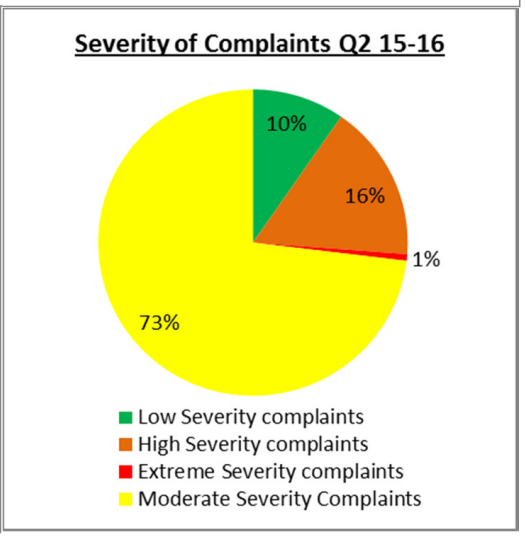
1) Clinical Treatment/Treatment Procedure , 2) Consent, confidentiality, communication – majority relate to communication issues with patients , 3) Access, Appointment, Admission, Transfer and discharge.

Ombudsman (PHSO)

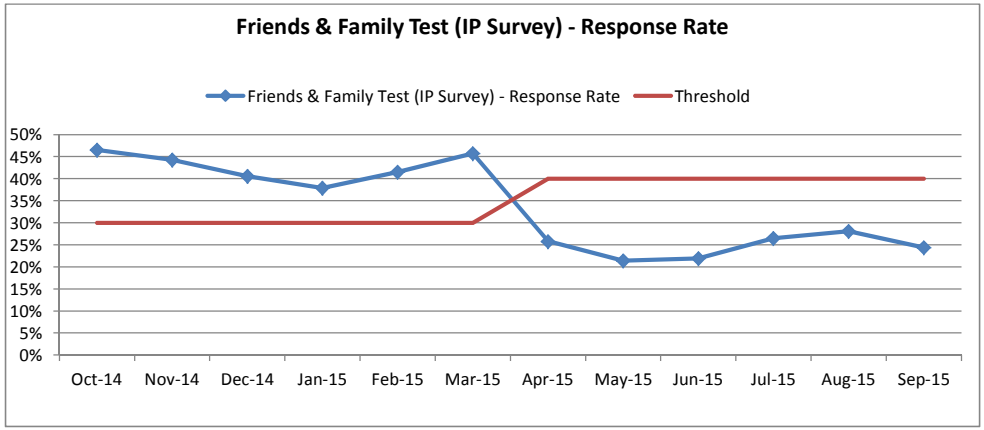
There were no new cases referred to the Trust for investigation by the Ombudsman (PHSO) in September 2015. There are 13 active Ombudsman cases, 7 of which were received from the Ombudsman for investigation in this financial year. 6 Ombudsman cases have been closed within this financial year to date. Between 2 -3 % of all Trust complaints are investigated by the Ombudsman.







Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Friends & Family Test (IP Survey) - Response Rate	40.00%	24.40%	26.20%	21.90%	24.80%	-
Friends and Family Test A & E Survey - Response Rate	30.00%	9.50%	-	9.50%	-	-
Friends and Family Test A & E Survey - % would recommend the Service	95.00%	86.20%	-	86.20%	-	-
Friends and Family Test Community Survey - % would recommend the Service	95.00%	92.00%	-	-	-	92.00%



Community FFT - Would Recommend:

1. Why off plan? Performance remains below target. but an improvement has been seen on the previous month
As planned, a review is currently taking place of all the negative comments. It appears that most of these refer to the long waiting times for out-patient Physio . There is a lack of availability of suitable candidates to fill current vacancies.

2. Actions to get back on plan: In the short term 2 locums are due to start in the coming months. There are longer term plans working closely with Calderdale CCG , specifically on a task and finish group for Physio. This will include reviewing referral criteria, clinical pathways etc.

3. Achieved by date: Improvements are expected in the waiting times once the Locums are in place and as such patient should have a more favourable experience.

Accountable: Deputy Director of Nursing

A&E FFT - Would recommend:

1. Why off plan: there has been a slight improvement in month, however not yet back at the Q1 position of 90%. Recent results have been analysed which show that there are 3 specific themes in the patients feedback 1) Delays in waiting time 2) Poor Communication 3) Staff attitude/professionalism.
2. Actions to get back on plan: Father analysis of the comments is being undertaken to better understand the reasons for the slip in performance and any cross site differences. this will enable more targeted action planning.
3. When will we be on track: In is anticipated that any improvements identified will take some time to embed and will use a 90 day plan approach.

A&E FFT - Reponses Rate :
1. Why off plan: As expected the changes in process has resulted in a much improved positions 2.7% to 9.5% however it is acknowledged that this is still short of the target of 30%.
2. Actions to get back on plan: Work has already begun to understand how we can better encourage people to respond to the text message when they receive it. this will be discussed at the Task and finish group.
3. When will we be on track: Now that the baseline is known a trajectory for further improvement and achievement of the response rate target will be set

Accountable: Deputy Director of Nursing

Inpatient FFT Response Rate:

1.Why off plan: As discussed last month the Trust is aware
that this low response rate is associated with the spread to all 'day case' areas in April 2015. Using the pre April 15 criteria for inpatients FFT, the Trust would continue to score above 40%.

2.Actions to get back on plan: Throughout September there has been further engagement with the individual department leads to resolve any process issues that are contributing to poor response rates. It is clear from the September data that some areas are seeing much improved response rates, however these are masked by poor performing areas which are yet to fully engaged with the process. There has been a 'go see' exercise in order to better understand the process issues which highlighted a step in the process which is causing a technological barrier to staff issuing the cards to patients. The aim is to resolve this issue during October.

3. Achieved by date: The level of improvement required will require some time to embed the changes and ensure all potential areas have been identified, there is a trajectory in place to achieve this by Quarter

Accountable: Deputy Director of Nursing

Calderdale and Huddersfield NHS Foundation Trust

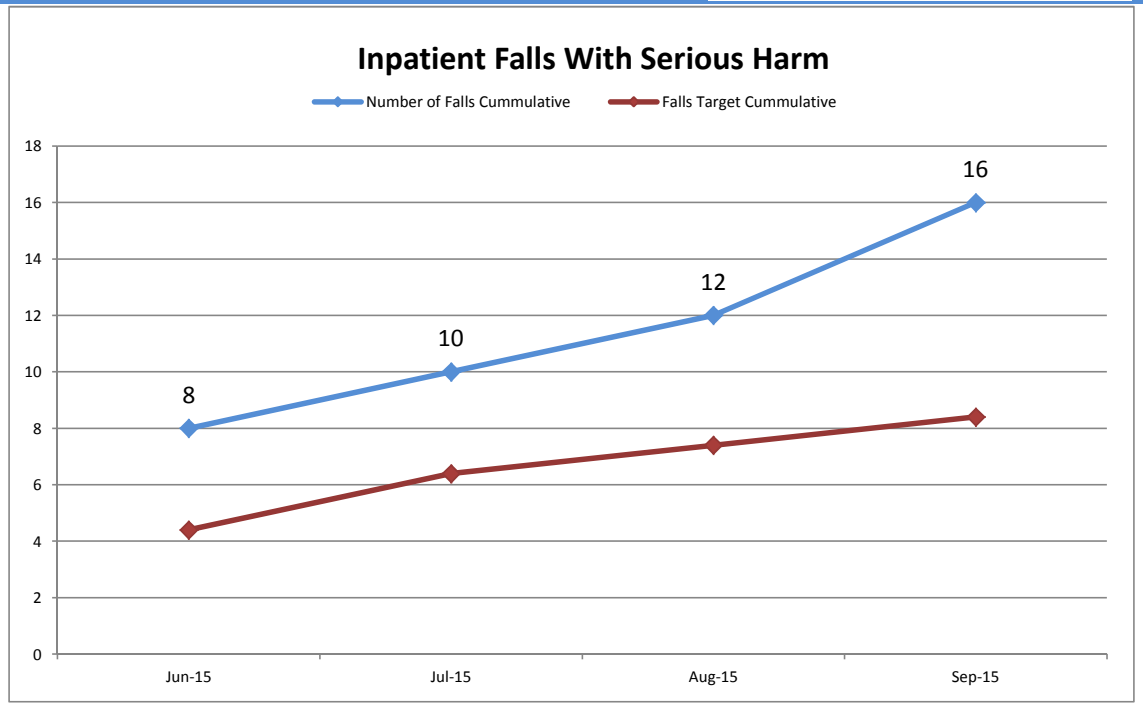
Safety Executive Summary - Julie Dawes Director of Nursing

compassionate care

Report For: September 2015

		Indicator Source	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Direcon of travel (past 4 months)	Financial Penalties/Non Financial Impact	Year End Forecast	Data Quality
									Year To Date										
Safety	Inpatient Falls with Serious Harm (10% reduction on 14/15)	Local	1	4	0	3	1	0	6	16	1	14	1	0		→			
	All Falls	Local	-	175	35	133	2	5	-	1005	164	791	22	28		↑			
	Number of Trust Pressure Ulcers Acquired at CHFT	Local	25	33	6	14	0	13	150	331	40	86	2	203		↓			
	Number of Category 2 Pressure Ulcers Acquired at CHFT	Local	17	24	5	10	0	9	102	248	29	63	2	154		↓			
	Number of Category 3 Pressure Ulcers Acquired at CHFT	Local	7	8	1	4	0	3	42	74	10	21	0	43		↓			
	Number of Category 4 Pressure Ulcers Acquired at CHFT	Local	1	1	0	0	0	1	6	9	1	2	0	6		↓			
	Number of Category 3 & 4 Pressure Ulcers Acquired at CHFT	Local	8	9	1	4	0	4	48	83	11	23	0	49		↓			
Safety 2	Percentage of Completed VTE Risk Assessments	National & Contract	95.00%	95.20%	95.30%	96.30%	92.70%	-	95.00%	95.40%	95.00%	95.20%	96.80%	-		→			
	Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	Local	100.00%	100.00%	100.00%	100.00%	n/a	-	100.00%	100.00%	100.00%	100.00%	100.00%	-		→			
	% Harm Free Care	CQUIN	95.00%	93.46%	92.44%	90.58%	100.00%	95.51%	95.00%	93.31%	94.42%	90.68%	99.73%	93.79%		↓			
	Safeguarding Alerts made by the Trust	Local	-	8	-	-	-	-	-	97	-	-	-	-		↓			
	Safeguarding Alerts made against the Trust	Local	-	4	-	-	-	-	-	44	-	-	-	-		↓			
	World Health Organisation Check List	National	100.00%	97.76%	-	-	-	-	100.00%	98.02%	-	-	-	-		↑			
	Missed Doses (Reported quarterly)	National	10.00%	8.68%	7.30%	8.49%	18.36%	-	10.00%	8.24%	8.47%	7.80%	12.46%	-					
Safety 3	Number of Patient Incidents	Monitor	-	626	143	327	126	29	-	4026	744	1889	1064	355		↑			
	Number of SI's	Monitor	-	7	2	3	0	2	-	83	13	24	4	42		↓			
	Number of Incidents with Harm	Monitor	-	176	29	106	27	14	-	1143	141	521	251	229		↓			
	Never Events	National	0	0	0	0	0	0	0	0	0	0	0	0		→			
	Percentage of SI's reported externally within timescale (2 days)	Local	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	-	-	-	-	-	-		↑			
	Percentage of SI's investigations where reports submitted within timescale (45 days unless extension agreed)	Local	100.00%	90.00%	100.00%	100.00%	100.00%	50.00%	100.00%	45.45%	100.00%	46.15%	100.00%	50.00%		↑			
	Percentage of Non-Compliant Duty of Candour informed within 10 days	National & Contract	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	-	-	-	-	-	-		→			
	Total Duty of Candour informed within 10 days	National & Contract	0	0	0	0	0	0	0	5	3	4	0	0		↑			
Safety - Maternity	Elective C-Section Rate		10.00%	9.60%	-	-	9.60%	-	10.00%	8.70%	-	-	8.70%	-		↑			
	Total C-Section Rate		22.50%	20.40%	-	-	20.40%	-	22.50%	23.40%	-	-	23.40%	-		↓			
	No. of Babies over 37 weeks with APGAR5<7		8.00%	0.60%	-	-	0.60%	-	8.00%	0.60%	-	-	0.60%	-		↓			
	Full Term to SCBU (NNU)		4.00%	1.70%	-	-	1.70%	-	4.00%	2.70%	-	-	2.70%	-		↓			
	Major PPH - Greater than 1000mls		8.00%	7.60%	-	-	7.60%	-	8.00%	9.80%	-	-	9.80%	-		↓			
	3rd or 4th Degree tear from ANY delivery		3.00%	2.80%	-	-	2.80%	-	3.00%	2.40%	-	-	2.40%	-		↑			
	Planned Home Births	National	2.30%	1.70%	-	-	1.70%	-	2.30%	1.60%	-	-	1.60%	-		↑			

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Inpatient Falls with Serious Harm (10% reduction on 14/15)	1	4	0	3	1	0
Number of Trust Pressure Ulcers Acquired at CHFT	25	33	6	14	0	13
Number of Category 2 Pressure Ulcers Acquired at CHFT	17	24	5	10	0	9
Number of Category 3 Pressure Ulcers Acquired at CHFT	7	8	1	4	0	3
Number of Category 4 Pressure Ulcers Acquired at CHFT	1	1	0	0	0	1
Number of Category 3 & 4 Pressure Ulcers Acquired at CHFT	8	9	1	4	0	4



Falls with Serious Harm

Why off Plan: During the first six months of 2015/16 the Trust has had 16 falls with harm, which is 10 above the trajectory target of 6, and results in the trust breaching its annual threshold of 14. There have been 10 falls with harm at the CRH site with 6 falls with harm at the HRI site.

Actions to get back on plan: An internal harm summit has been instigated by the Trust on the 10th November. This summit will focus on key patient harm areas, such as falls, pressure ulcers and medication safety and will result in action learning for these areas

When will we be back on track: As the 10% reduction target has already been passed future work focuses on reversing the current trends. This reserval will be expected to be seen as a result of outcomes of the safety sumit and as such impact not likely to be seen until Q4.

Accountable: Deputy Director of Nursing

Pressure Ulcers:

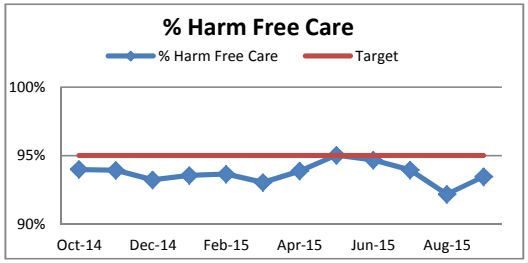
Why off Plan: The improvement target has been readjusted for community which has impacted on overall performance as the community directorate is significantly off trajectory and has already exceeded annual target. Hospital performance is also above target & if performance continues to match the existing pattern the target will be exceeded by year end. An increased awareness of pressure ulcer incident reporting, unplanned capacity/ use of agency staff and increased demand on TV team (in relation to referrals) has impacted on performance.

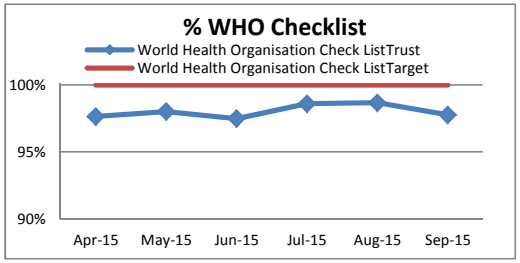
Actions to get back on plan: An internal harm summit has been instigated by the Trust on the 10th November. This will include a focus on pressure ulcers amongst other harm topics. Wards that are off their own trajectory have been asked to develop improvement plans in preparation. The community directorate will also hold a multi-professional forum in November to launch initiatives to improve communication between community agencies & share learning from RCAs. Community are planning to test the safety huddle approach with a community nursing team with input from other professionals in the coming months.

When we will be back on track: Following the safety summit and associated changes a trajectory for improvement will be devised and adhered to.

Accountable: Deputy Director of Nursing

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
% Harm Free Care	95.00%	93.46%	92.44%	90.58%	100.00%	95.51%
World Health Organisation Check List	100.00%	97.76%	-	-	-	-





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. For the exempt patients a theatre system upgrade has been requested to have a N/A option included, this was originally planned for September 2015 but has been delayed by the system supplier.

3.Achieved by date: Awaiting confirmation of system upgrade date from supplier.

4. Accountable: GM for Theatres

Harm Free Care:

1. Why off plan? Harm free care for the trust is at 93.46%. With all divisions, bar Medical, seeing a better position that the previous month. The harm events contributing to this are primarily old pressure ulcers, of which there were 35, this is a decrease from the 55 in August. These are ulcers which are present on admission or developed within the first 72 hours of admission. Alongside this there were also 9 new Pressure Ulcers, 12 harm falls 12 UTIs in patients with a catheter and 2 VTEs.

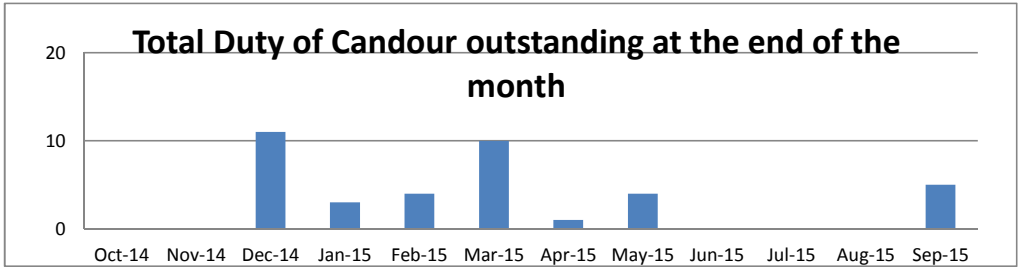
2. Actions to get back to plan: Work is ongoing to improve the trust position in relation to the number of Ulcers and Falls occurring in the trust (Please see detail p22) In relation to the UTIs, phase two of the indwelling improvement work continues and an associated drop in infection rates is anticipated when the work in more wide spread at the end of the year.

3. Achieved by date: See individual subject areas for Ulcers and Falls (page 22)

4. Accountable: Deputy Director of Nursing

Exception Report - Safety - Director of Nursing

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Percentage of SI's investigations where reports submitted within timescale (45 days unless extension agreed)	100.00%	90.00%	100.00%	100.00%	100.00%	50.00%



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

Why off Plan: 10 reports were due for submission in September. Of these: 1 were submitted late by one day due to an error in the administrative scheduling .

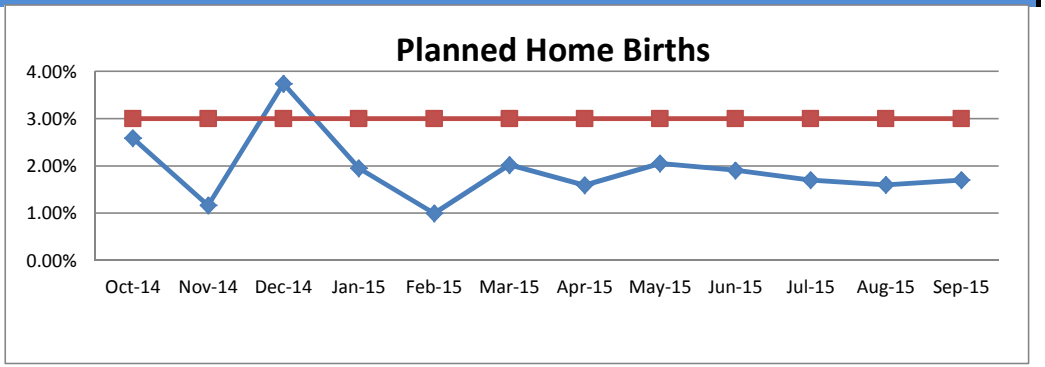
Actions to get back on plan: Administrative Scheduling has been reviewed, and corrective action in place.

When will we be back on track: October 2015

Accountable : Head of Risk and Governance

Exception Report - Safety - Director of Nursing

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Planned Home Births	2.30%	1.70%	-	-	1.70%	-



Planned Home Births:

Why off plan: The % of home births consistently performs around 1.7%, which despite being above the north of England average, is still below the national average of 2.3% and CHFTs internal target. The Community Midwifery Manager, Home Birth Team midwives and midwives do champion and promote home birth however there is little movement in the % of mother opting for a home birth.

Actions to get back on plan: The Community Midwifery Manager, Home Birth Team midwives and midwives will continue to champion and promote home birth. A review of regional performance is taking place in November which will enable the trust to better understand relative performance.

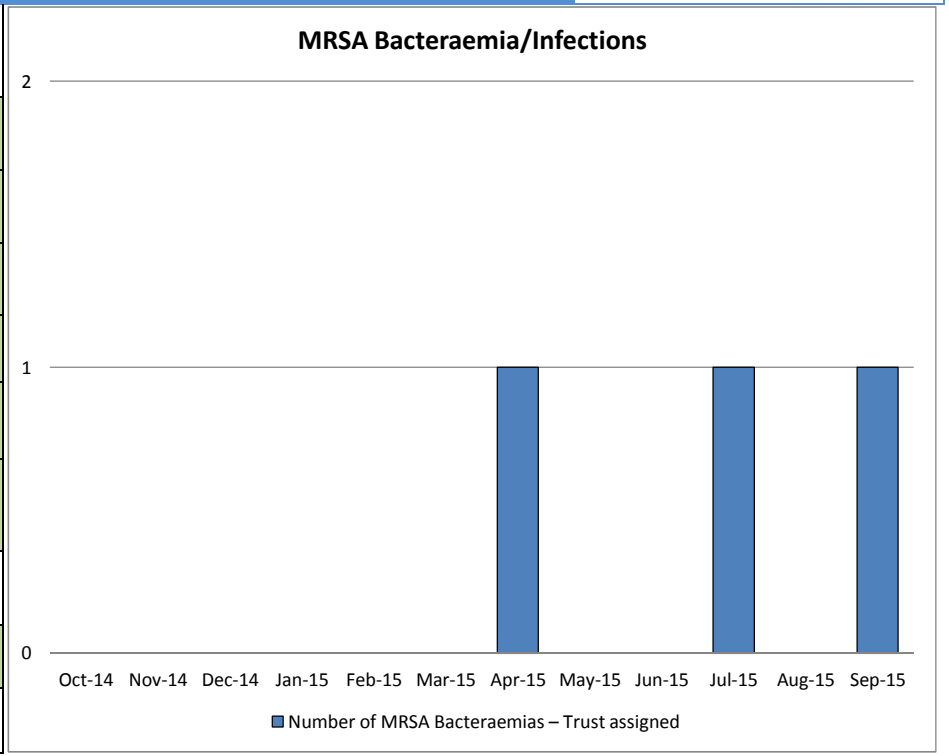
When will we be back to target? End Q4 2015-2016

Accountable: Midwifery Senior Clinical Manager

Effectiveness Executive Summary

	Report For: September 2015	Indicator Source	Target	Trust	Year To Date: Surgical	Medical	Families and Specialist Services	Community	Target	Trust	Surgical	Medical	Families and Specialist Services	Community	Trend (Rolling 12 Month)	Direction of travel (past 4 months)	Financial Penalties/Non Financial Impact	Year End Forecast	Data Quality
Effectiveness	Number of MRSA Bacteraemias – Trust assigned	National & Contract	0	1	0	1	0	0	0	3	0	2	0	1		↑			
	Total Number of Clostridium Difficile Cases - Trust assigned	National & Contract	2	3	1	2	0	0	13	10	2	8	0	-		↑			
	Avoidable number of Clostridium Difficile Cases	National & Contract	0	1	0	1	0	0	0	3	1	2	0	0		→			
	Unavoidable Number of Clostridium Difficile Cases	National & Contract	2	2	0	2	0	0	13	7	0	7	0	0		↑			
	Number of MSSA Bacteraemias - Post 48 Hours	National	1	0	0	0	0	0	6	5	1	4	0	-		↓			
	% Hand Hygiene Compliance	Local	95.00%	99.51%	98.92%	99.86%	99.57%	100.00%	95.00%	99.66%	99.08%	99.82%	99.94%	100.00%		↑			
	MRSA Screening - Percentage of Inpatients Matched	Local	95.00%	95.29%	92.30%	100.00%	91.67%	n/a	95.00%	95.06%	92.00%	99.00%	95.00%	-		↓			
	Number of E.Coli - Post 48 Hours	Local	3	0	0	0	0	0	16	15	4	11	0	-		↓			
	Central Line Infection rate per 1000 Central Venous Catheter days	Local	1.50	1.43	-	-	-	-	1.50	0.77	-	-	-	-					
Effectiveness 2	Stillbirths Rate (including intrapartum & Other)	National	0.50%	0.64%	-	-	0.64%	-	0.50%	0.36%	-	-	0.36%	-		↓			
	Perinatal Deaths (0-7 days)	Local	0.10%	0.00%	-	-	0.00%	-	0.10%	0.10%	-	-	0.10%	-		↓			
	Neonatal Deaths (8-28 days)	Local	0.10%	0.00%	-	-	0.00%	-	0.10%	0.00%	-	-	0.00%	-		↓			
	Local SHMI - Relative Risk (1yr Rolling Data Jan14- Dec 14)	National	100	109.3	-	-	-	-	100	109.1	-	-	-	-		↑			
	Hospital Standardised Mortality Rate (1 yr Rolling Data Jul 14 - Jun 15)	National	100.00	113.00	-	-	-	-	100.00	113.00	-	-	-	-		↑			
	Mortality Reviews – August Deaths	local	100.00%	50.80%	60.00%	49.50%	n/a	n/a	100.00%	40.80%	47.30%	40.00%	n/a	-		↑			
	Crude Mortality Rate (Latest Month Sep 15)	National	1.21%	1.22%	0.37%	2.72%	0.17%	n/a	1.17%	1.28%	0.39%	3.07%	0.07%	-		↑			
	Completion of NHS numbers within acute commissioning datasets submitted via SUS	Contract	99.00%	99.90%	99.90%	100.00%	99.90%	n/a	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%	-	n/a	95.00%	99.10%	-	99.10%	-	-		→			
	Average Diagnosis per Coded Episode	National	4.90	4.35	3.58	5.91	2.53	n/a	4.90	4.05	3.45	5.63	2.30	-		↑			
Effectiveness3	Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	National	85.00%	55.56%	55.56%	-	-	-	85.00%	65.23%	65.23%	-	-	-		↓			
	IPMR - Breastfeeding Initiated rates		70.00%	80.20%	-	-	80.20%	-	70.00%	79.30%	-	-	79.30%	-					
	Emergency Readmissions Within 30 Days (With PbR Exclusions)		7.40%	6.57%	4.32%	11.99%	4.89%	-	7.53%	8.03%	4.59%	12.71%	6.27%	-					
	Emergency Readmissions Within 30 Days (With PbR Exclusions) - Calderdale CCG		7.67%	7.13%	-	-	-	-	8.15%	8.25%	-	-	-	-					
	Emergency Readmissions Within 30 Days (With PbR Exclusions) - Greater Huddersfield CCG		6.77%	6.45%	-	-	-	-	7.11%	8.41%	-	-	-	-					
	CHFT Research Recruitment Target		92	68	-	-	-	-	552	315	-	-	-	-					

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Number of MRSA Bacteraemias – Trust assigned	0	1	0	1	0	0
Total Number of Clostridium Difficile Cases - Trust assigned	2	3	1	2	0	0
Avoidable number of Clostridium Difficile Cases	0	1	0	1	0	0
Unavoidable Number of Clostridium Difficile Cases	2	2	0	2	0	0
Number of MSSA Bacteraemias - Post 48 Hours	1	0	0	0	0	0
% Hand Hygiene Compliance	95.00%	99.51%	98.92%	99.86%	99.57%	100.00%
MRSA Screening - Percentage of Inpatients Matched	95.00%	95.29%	92.30%	100.00%	91.67%	-
Number of E.Coli - Post 48 Hours	3	0	0	0	0	0
Central Line Infection rate per 1000 Central Venous Catheter days	1.50	1.43	-	-	-	-



MRSA Bacteraemia - Trust assigned

Why off Plan: Patient developed an MRSA bacteraemia one week after hospital admission, having been found to be MRSA screen negative at the time of admission. The patient was initially treated for a chest infection, prior to a clinical deterioration when MRSA was isolated from blood cultures. The MRSA bacteraemia was deemed to be avoidable as assurance was felt to be lacking around ANTT practice, given the patient had undergone several cannulations, it is felt at the post infection review there was scope for this to have been prevented through better ANTT practice.

Actions to get back on plan: The Infection Prevention and Control Team have taken over responsibility for delivering ANTT from the Surgical Division. An action plan to restore the training infrastructure has been developed. Divisions will support ensuring that each clinical area has enough assessors, and that all those who need to be assessed are assessed.

When will we be back on track: Robust reports will be in place from November 15, resulting in relevant staff being identified for training and booked into assessment.

Accountable: Lead Consultant for Infection Control

Total Number of Clostridium Difficile Cases - Trust assigned

Why off Plan: Of the three cases, only 1 was deemed avoidable at post infection review. The patient was known to carry C. difficile and had a unnecessary sample taken . The patient should have been treated on the basis of the initial positive result. however in light of the second positive result, The C.diff was deemed an avoidable case due to there not being evidence of an appropriate medication review.

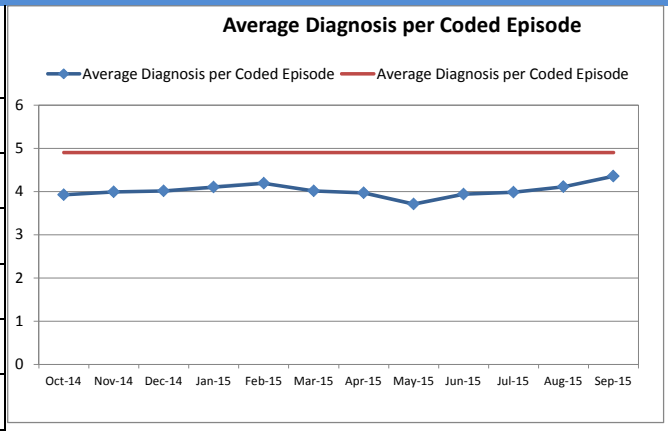
Actions to get back on plan: Recognising that we must only sample when clinically indicated to do so it is important the medical division share the learning around repeat sampling. The microbiology laboratory will ensure there is a more robust process to prevent repeat, unnecessary testing.

When will we be back on track: in relation to removing unnecessary repeat sampling, processes in place from next month.

65

Accountable: Lead Consultant for Infection Control

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Stillbirths Rate (including intrapartum & Other)	0.50%	0.64%	-	-	0.64%	-
Local SHMI - Relative Risk (1yr Rolling Data Jan14- Dec 14)	100	109.3	-	-	-	-
Hospital Standardised Mortality Rate (1 yr. Rolling Data Jul 14 - Jun 15)						
Crude Mortality Rate (Latest Month Sep 15)	1.21%	1.22%	0.37%	2.72%	0.17%	n/a
Mortality Reviews – August Deaths	100.00%	50.80%	60.00%	49.50%	n/a	n/a
Average Diagnosis per Coded Episode	4.90	4.35	3.58	5.91	2.53	n/a



Average Diagnosis per Coded Episode

1. Why off plan? CHFT depth of coding is less than plan due to missed or undocumented relevant secondary diagnoses/complexities/comorbidities within the coding source documentation. This may also be due to incomplete coding documentation at the time of coding. Clinical Coding depth fell initially at the start of 2015-16 due to changes to coding rules. Since May coding depth has gradually improved although not to national average levels there is variable improvement across specialties.

2. Action to get it back on plan: Clinical engagement and presentations continue around importance of complete and accurate documentation – this included presentations to junior doctors and registrars. Work continues to develop existing documentation to assist coding process e.g. inclusion of co-morbidity pro-forma in Surgical and Medical assessment clerking in documentation and in pre-operative assessment documentation. Co-morbidity form compliance continues to be monitored on a fortnightly basis. Recruitment process is ongoing and a clinical coding trainer will start with the team in mid-October and 2 ACC qualified coders in November. A pilot is to commence in October 15 of 3 coders attending the ward round with 3 Upper GI clinicians in order to gain better mutual understanding.

3.Achieved By: Expect to see continued improvement month on month, with a trajectory to hit target by March 2016

4. Accountable: Head of Clinical Coding

SHMI/HSMR/Crude Mortality

1. Why it is off plan? The most recent release indicated a SHMI which was maintained at 109 the 12 months of Jan 14 to Dec14. It remains in the "as expected" category, indicating that there are not significantly more deaths than would be expected for the trust's patient population. The most recent 12 months data for HSMR indicates a score of 113, which is an increase from previous release and continues to be an outlying position. The September 2015 crude mortality is however in line with the same point in the previous year

2.Action to get back on plan: A draft of the revised Acutely ill Patient (CAIP) plan was finalised in September 2015, although it remains a working document. It focuses on six areas: mortality reviews and learning; reliability; deteriorating patients; end of life care; frailty; and coding.

External support in further understanding our HSMR position has been sought from Professor Mohammed Mohammed of Bradford University. There are regular meetings as he begins to look for patterns in the data that allow the formulation of hypotheses to be tested.

The latest figure of the number of mortality reviews carried out in September (August's deaths) is 50.8%. This is a slight setback from last month, but close performance management of the process will be greatly aided by the development of an electronic data collection process which is now possible after testing of redesigned review tools. Thematic reports from the reviews are now being received at the CEAM group.

Additionally, The need for a number of focused reviews has been identified: a review of all patients who died in HRI in March is being undertaken as a result of a sharp rise in the HSMR in March. This is still underway. In terms of reliability of care, a PMO work stream is redesigning a number of care bundles, revamping the process for measurement of reliability of delivery, and planning their integration with routine documentation. The Nervecentre rollout is progressing well, and there is project work underway on frailty.

3.Achieved By: Progressive improvement in mortality review completion is expected month on month.

4. Accountability: Medical Director

Still Birth Rates:

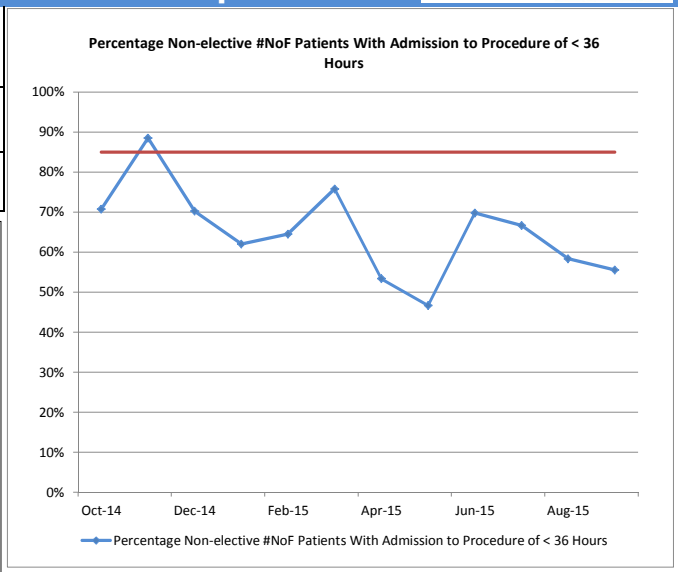
Why off plan – Two babies had known congenital abnormalities, parents chose to continue with their pregnancies rather than terminate. One baby was stillborn at 25 weeks gestation to a woman with risk factors for stillbirth.

Action to get back on plan – Continue with focused stillbirth reduction work (including participation in NHS England SABiNE project and roll out of NHSLA funded patient safety improvement work around intrapartum fetal surveillance.

Achieved by – Year end continued reduction of stillbirth (14 cases YTD 2015-2016 vs 27 cases YTD 2014-2015)

Accountability: head of Midwifery Clinical Senior Manager

Report For: September 2015	Target	Trust	Surgical	Medical	Families and Specialist Services	Community
Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	85.00%	55.56%	55.56%	-	-	-
CHFT Research Recruitment Target	92	68	-	-	-	-



Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours

Why off plan?
There were 2 weekends in September where large numbers of #NOF patients were admitted. There were a number who were delayed for clinical reasons.
Of 58 patients in September 16 were not done within 36 hours. Of those 5 were not operated on and 5 more were delayed for clinical reasons so there were 6 patients who were delayed for organisational reasons. 42 patients had their operation within 36 hours.

Actions to get back on plan:
Additional trauma lists identified through the theatre scheduling meeting to leave the main trauma list free for #NOF patients. This is still being worked on as there is some difficulty aligning available fallow lists and surgeons. During October we are also trialling moving appropriate trauma patients to CRH to fit onto elective lists.

When we be on track?
We anticipate an improvement trajectory over the next 2 months although the target of 85% will be a significant challenge .

CHFT Research Recruitment Target

Why off plan: The Trust has entered a partnership agreement with the Y&H Clinical Research Network (CRN) to accept research funding in return for contribution to deliver research. The target of 1,100 for 2015-16 was set by the CRN. As funding is performance related, the current position of achieving much less than 50% of its recruitment target at month 6 is of concern. This has resulted from a number of factors including having studies which are of a small recruiting nature –specialised studies which wouldn't expect a large number of applicable participants. There is a lack of large recruiting studies to balance this out. Alongside this the service pressures are resulting in clinical teams being unable to commit to opening new studies. Should the Trust not achieve target then research support funding for 2016-17 will decrease, adding further pressure for 2016-17.
Actions to get back on plan: A new research nurse structure has been implemented from the 1st of October in order to generate more capacity by enabling more flexible working across a range of studies. A review of non-recruiting studies has also taken place and closure of studies where appropriate. A number of high recruiting studies are being set up, this will increase the number of participants however it is not yet known the full impact these will have.
When will we be back on plan? The actions above will enable us to bring together a recovery plan with divisional engagement to encourage greater participation to meet our target and put trajectories in place for modelling predicted performance at year end

Accountable: Head of R&D

Fracture Neck of Femur	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	YTD
Number of fragility hip fracture discharges recorded on the National Hip Fracture Database	45	46	43	39	38	43							**256**
% achieving Best Practice Tariff	53.33%	45.65%	69.77%	66.67%	57.89%	55.56%							**57.81%**
a) time to surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an admitted patient, to the start of anaesthesia.	73.33%	56.52%	76.74%	66.67%	63.16%	55.56%							**65.23%**
(b) admitted under the joint care of a consultant geriatrician and a consultant orthopaedic surgeon.	97.78%	91.30%	100.00%	100.00%	100.00%	97.78%							**97.66%**
(c) admitted using an assessment protocol agreed by geriatric medicine, orthopaedic surgery and anaesthesia.	100.00%	100.00%	97.67%	100.00%	100.00%	100.00%							**99.61%**
(d) assessed by a geriatrician in the perioperative period (within 72 hours of admission).	93.33%	82.61%	95.35%	100.00%	97.37%	86.67%							**92.19%**
(e) postoperative geriatrician-directed multi-professional rehabilitation team	82.22%	91.30%	93.02%	97.44%	92.11%	94.74%							**87.72%**
(f i) fracture prevention assessments (Falls)	82.22%	80.43%	88.37%	92.31%	84.21%	92.11%							**85.38%**
(f ii) fracture prevention assessments (Bone health)	100.00%	93.48%	100.00%	94.87%	94.74%	94.74%							**97.08%**
(g i) two Abbreviated Mental Tests (AMT) performed and all the scores recorded in NHFD with the first test carried out prior to surgery and the second post-surgery but within the same spell - Pre-Op	93.33%	91.30%	97.67%	100.00%	94.74%	100.00%							**95.32%**
(g ii) two Abbreviated Mental Tests (AMT) performed and all the scores recorded in NHFD with the first test carried out prior to surgery and the second post-surgery but within the same spell - Post-Op	91.11%	84.78%	90.70%	97.44%	94.74%	97.37%							**91.23%**

Workforce indicators

The first row of tables look at the year to date performance of CHFT and the divisions against the 4% target. The second looks at performance by staff group against the 4% threshold.
The Second row of tables below show sickness absence rates for CHFT during July and August 2015, broken down by division, identifying movement from the previous month, performance against the 4% threshold, the average length of a sickness episode, identifying movement from the previous month.
The final table looks at staff in post by headcount and full time equivalent (FTE).

FTE Days Lost is calculated by taking the FTE of the employee and multiplying by the length of sickness (in days). For example an employee on 0.5 FTE who is sick for 4 days would equate to an FTE Days Lost of 2.0
FTE Days Available is calculated by taking the FTE of the employee and multiplying by the number of days in the reporting period. For example during May an employee on 0.5 FTE would have 15.5 FTE Days Available.

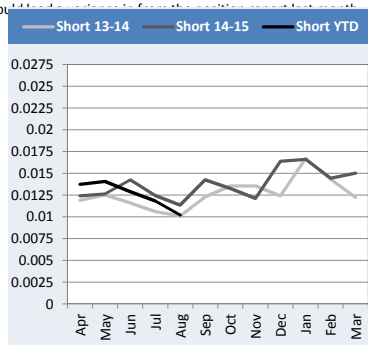
NB: Each month the month end sickness absence figures are adjusted to take account of all sickness absence returns. This could lead to variances in figures from the position reported last month.

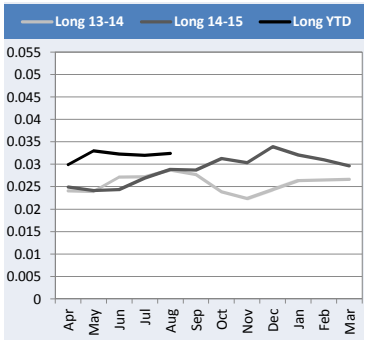
Sickness Absence full time equivalent (FTE) breakdown Year to Date

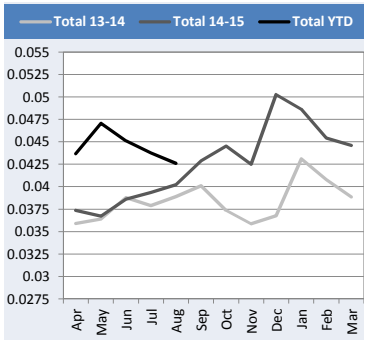
Division	Available FTE	FTE Days Lost	YTD Sickness %	RAG
Surgery	396660.09	17325.87	4.37%	
Medical	469447.33	25351.58	5.40%	
Community	228494.94	8554.82	3.74%	
FSS	490914.93	22970.57	4.68%	
Estates	104719.11	5311.66	5.07%	
Corporate	100904.71	1751.91	1.74%	
THIS	67665.87	2557.12	3.78%	
Trust	**1858806.98**	**83823.52**	**4.51%**	

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

Division	Available FTE	FTE Days Lost	YTD Sickness %	RAG
Add Sci & Tech	23162.40	552.53	2.39%	
ACS	161423.73	10916.72	6.76%	
Admin & Clerical	151120.25	5468.45	3.62%	
AHP	58507.30	1400.39	2.39%	
Estates & Ancil.	21907.47	1206.80	5.51%	
Healthcare Scientists	17586.45	401.93	2.29%	
Medical and Dental	77411.54	774.27	1.00%	
Nursing & Midwifery	250548.66	13190.13	5.26%	







In month Sickness Absence rate (%) (1 Month Behind)

Division	Short Term	Long Term	Overall %	RAG
Surgery	1.35%	3.12%	4.47%	
Medical	1.39%	4.20%	5.59%	
Community	0.95%	2.92%	3.87%	
FSS	0.80%	3.12%	3.92%	
Estates	0.22%	2.97%	3.19%	
Corporate	0.30%	1.85%	2.15%	
THIS	0.46%	1.62%	2.08%	
Trust	**1.02%**	**3.24%**	**4.26%**	

In month Sickness Absence rate (%) (1 Month Behind)

Division	Jul-15	Aug-15	Movement
Surgery	4.25%	4.47%	↑
Medical	5.00%	5.59%	↑
Community	4.01%	3.87%	↓
FSS	4.73%	3.92%	↓
Estates	3.76%	3.19%	↓
Corporate	2.10%	2.15%	↑
THIS	3.77%	2.08%	↓
Trust	**4.38%**	**4.26%**	**↓**

In month Sickness Average FTE Lost per Episode

Division	Jul-15	Aug-15	Movement
Surgery	9.32	10.44	↑
Medical	9.13	9.29	↑
Community	9.92	10.33	↑
FSS	9.07	11.67	↑
Estates	8.94	16.38	↑
Corporate	7.42	13.85	↑
THIS	10.68	10.85	↑
Trust	**9.21**	**10.48**	**↑**

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

Division	Available FTE	Short Term FTE	Long Term FTE	FTE Days Lost
Surgery	33131.53	447.80	1034.43	1482.23
Medical	39342.89	548.36	1652.73	2201.09
Community	18665.96	177.75	545.28	723.03
FSS	39903.73	317.73	1245.46	1563.19
Estates	8217.50	18.00	244.00	262.00
Corporate	8385.98	25.00	155.00	180.00
THIS	5736.65	26.40	93.00	119.40
Trust	**153384.24**	**1561.04**	**4969.90**	6530.94

In month Sickness Absence rate (%) (1 Month Behind)

Staff Group	Jul-15	Aug-15	Movement
Add Sci & Tech	2.51%	2.58%	↑
ACS	6.63%	6.50%	↓
Admin & Clerical	3.68%	3.17%	↓
AHP	1.93%	2.35%	↑
Estates & Ancil.	4.30%	3.79%	↓
Healthcare Scientists	2.05%	1.75%	↓
Medical and Dental	1.46%	0.96%	↓
Nursing & Midwifery	5.13%	5.28%	↑

Staff in Post (FTE)

Division	Aug-15	Sep-15	Movement
Surgery	1069.98	1079.68	↑
Medical	1267.54	1285.79	↑
Community	605.58	605.01	↓
FSS	1282.93	1280.10	↓
Estates	264.04	263.86	↓
Corporate	274.25	284.11	↑
THIS	187.45	188.49	↑
Trust	**4951.77**	**4987.03**	↑

Staff in Post (Headcount)

Division	Aug-15	Sep-15	Movement
Surgery	1193	1204	↑
Medical	1413	1430	↑
Community	745	744	↓
FSS	1501	1498	↓
Estates	348	347	↓
Corporate	314	325	↑
THIS	194	196	↑
Trust	**5708**	**5744**	↑

Sickness Absence/Attendance Management at work

Why are we away from plan -

The 2015-16 year to date sickness rate of 4.51% compares to a 2014-15 outturn sickness rate of 4.26%. The Aug 2015 year to date figure of 4.51% compares to the year to date at Aug 2014 figure of 3.85%. Community ,THIS and Corporate have a YTD % below the 4% threshold identified. Community , Families & Specialist Services, Estates and Facilities, THIS and Corporate have a % below the 4% threshold identified . Short term sickness absence for the Trust is at 1.02% long term absence at 3.24% . The Aug 2015 figure compares to a Aug 2014 figure of 1.08% short term absence and long term absence of 2.93 %.

Action to get on plan -

There are a number of key interventions planned to address the current rate of sickness absence:-
dedicated absence management resource to support divisional activity/line managers (Establishment of a dedicated Attendance Management team is progressing. A team leader has been appointed and a recruitment plan is in place and being actioned for the remaining posts in the team.)
increasing awareness of health and lifestyle choices(a comprehensive colleague health and wellbeing strategy is in development and will be available at the end of November 2015)
Evidence based data driven – target action (BI)
Clear and simple attendance management policy (The Attendance Management policy has been updated to include a case management approach, early intervention, fast access to Occupational Health and Physiotherapy, robust return to work process, meetings and action plans, revised triggers for short term episodes and active management. The policy has been approved by staff side representatives of the Staff Management Partnership Forum and Local Negotiating Committee and will now progress to Executive Board for ratification)
Joined up approach – line manager/HR/Occupational Health/Staff Side
Fast access to Occupational Health and Physiotherapy
Robust return to work process – meetings and plans
Training for managers – " how to ….."
Realistic improvement targets
Case management approach
Early intervention Active management.
A 'go see' activity planned with Leeds Teaching Hospitals NHS Trust takes place on 14 October 2015.

Training indicators

Mandatory Training Indicators compliance from April 2015

Division	Prevent	Equality & Diversity	Information Governance	Infection Control	Health & Safety	Manual Handling	Safeguarding	Fire Safety	Overall Compliance*
Surgery	22.50%	61.30%	64.30%	35.70%	35.10%	35.60%	24.0%	27.90%	18.11%
Medical	31.70%	70.30%	69.20%	37.80%	36.90%	37.70%	24.7%	28.00%	18.91%
FSS	39.40%	78.00%	77.30%	47.00%	46.80%	46.80%	27.9%	41.30%	7.72%
Community	78.50%	73.40%	75.00%	36.80%	36.20%	38.70%	22.6%	34.20%	9.82%
Estates	16.80%	81.00%	82.60%	19.30%	18.20%	18.50%	15.5%	47.90%	8.29%
Corporate	47.20%	78.20%	79.80%	30.30%	30.70%	31.00%	24.7%	40.30%	9.69%
THIS	28.40%	83.40%	81.50%	62.80%	56.30%	62.80%	28.8%	26.20%	6.99%
Trust	**37.5%**	**72.10%**	**70.90%**	**39.20%**	**38.50%**	**39.30%**	**25.2%**	**34.40%**	**10.33%**

Medical Devices Training

Division	Compliance	100% Target
Surgery	71.00%	●
Medical	63.00%	●
FSS	75.00%	●
Community	81.00%	●
Estates	98.00%	●
Corporate	79.00%	●
THIS	-	-
Trust	**78.00%**	●

Mandatory Training Indicators completed in last 12 Months

Division	Prevent	Equality & Diversity	Information Governance	Infection Control	Health & Safety	Manual Handling	Safeguarding	Fire Safety	Overall Compliance*
Surgery	22.50%	61.30%	64.30%	62.90%	62.90%	61.50%	58.30%	51.20%	10.90%
Medical	31.70%	70.30%	69.20%	66.70%	67.30%	67.70%	64.30%	57.10%	16.30%
FSS	39.40%	78.00%	77.30%	73.40%	73.20%	71.90%	68.80%	70.10%	23.10%
Community	78.50%	73.40%	75.00%	74.30%	72.50%	74.30%	71.30%	67.70%	46.30%
Estates	16.80%	81.00%	82.60%	83.10%	81.50%	81.40%	80.10%	67.90%	11.70%
Corporate	47.20%	78.20%	79.80%	71.50%	74.20%	73.20%	68.50%	65.20%	19.90%
THIS	28.40%	83.40%	81.50%	80.20%	79.20%	79.20%	74.70%	65.50%	17.20%
Trust	**37.5%**	**72.10%**	**70.90%**	**71.10%**	**72.10%**	**70.90%**	**68.3%**	**63.70%**	**20.40%**

Mandatory Training

Why are we away from plan?

The new mandatory training approach (the Core Skills Training Framework or CSTF) has been in operation since 1st June 2015. Colleagues are still becoming familiar with the new approach and this will factor into the compliance data reported through the IBR. Steady progress has been made. 88% of colleagues have commenced completion of the new programme of mandatory training since 1st June 2015, this is an increase of 28% from last month. However, increased participation and completion across all of the 8 available programme elements is low.

Action to get on plan including timescales

An intranet portal has been established giving access into the Electronic Staff Record (ESR) to complete the mandatory training elements. The web pages contain comprehensive support materials including videos and scripts which are to be used by colleagues enabling them to access the training and complete it satisfactory. A help facility has been established as well as an FAQ which sets out issues colleagues have raised in using the system and the solutions to them. Extra PREVENT classroom sessions have now been scheduled to increase availability for colleagues. Information about home access for colleagues who wish to complete training outside of the workplace has been strengthened on the mandatory training web page and the possibility of loan devices to increase home accessibility is being explored. Work to ascertain which of the mandatory subjects might have alternate, higher level qualifications which might satisfy the learning outcomes for the mandatory subjects and therefore prevent the need for colleagues to complete the awareness level mandatory packages has also commenced.

Medical Devices

Medical Devices Training is currently at 79% compliance across the Trust.

Action to get on Plan - (1) Regular reminders to all staff re Medical Devices training requirements via newsletter, intranet 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 (4) Contact all areas below 75% compliance (in the red) to develop an action plan to improve training compliance

By Who- (1) Director of Planning, Performance, Estates & Facilities, ADN's, Matrons, General Managers, Department Heads, Line Managers and link nurses (2) Medical Devices Training Coordinator and Medical Devices Training support on-going throughout the year

Appraisal Activity

The first table shows the Number of non medical and medical Appraisal activity completed this has been RAG rated against divisional activity plans. The second table shows the number of appraisals completed in the last 12 months against the 100% target.

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 months appraisals. Activity recorded after this data will only be included in compliance reports in the following months.

Appraisal-Completed Since April 2015

Division	Compliance	Projected activity as of 30.09.2015	RAG
Surgery	7.20%	30.00%	
Medical	28.70%	**	
FSS	32.20%	33.00%	
Community	29.90%	27.00%	
Estates	23.70%	54.00%	
Corporate	26.00%	32.00%	
THIS	40.40%	38.00%	
Trust	**25.17%**	-	

Key

Compliance	RAG
Equal or Above Plan	
less than 2% off plan	
More than 2% off plan	

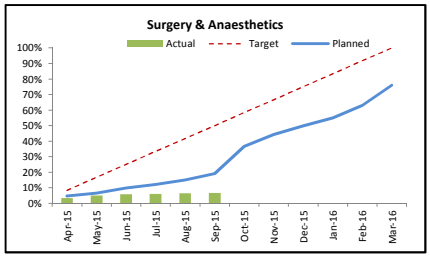
Appraisal- Completed in last 12 Months

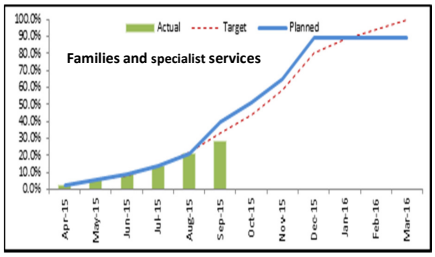
Division	Compliance	100% Target
Surgery	58.80%	
Medical	66.50%	
FSS	82.50%	
Community	71.80%	
Estates	77.60%	
Corporate	74.90%	
THIS	80.20%	

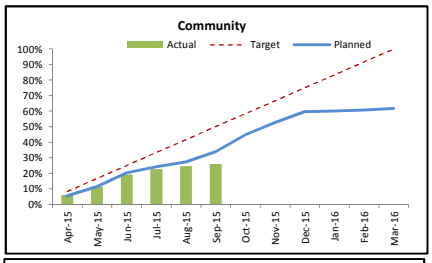
** Medical division has not returned their appraisal profiler

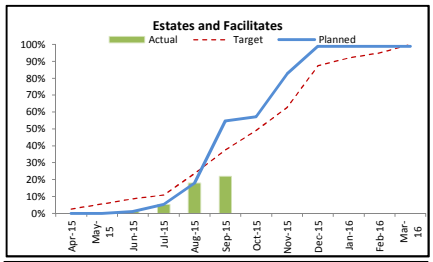
Appraisal Activity

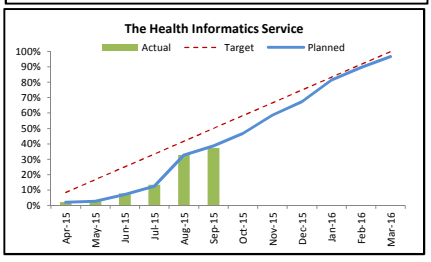
The graphs below showed planned activity to reach the 100% target by 31st March 2015.

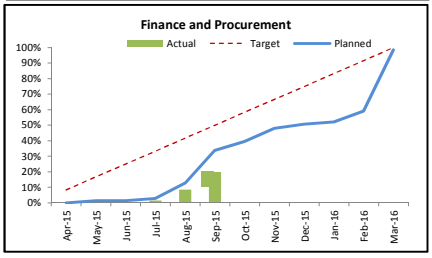


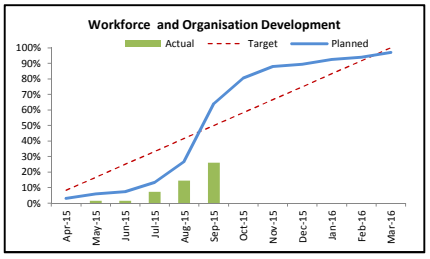


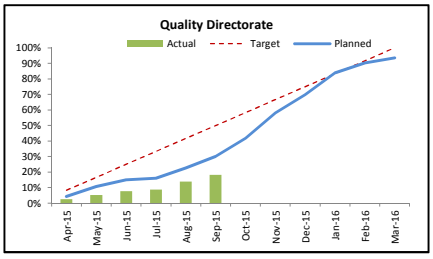












Mandatory Training and Appraisal commentary

The narrative below is provided by divisional leads to about the current position for Mandatory Training and Appraisal for their area.

Medical

Why are we away from plan?

September figures for medicine show a significant improvement in the numbers of completed appraisals having improved from 13% up to 28% this month. Current vacancy levels and additional capacity areas are placing pressure on staff.

Action to get on Plan including timescales

The new appraisal profile tool is currently being implemented within the division. All ward / department managers are being asked to populate the booked appraisal dates so that we can track our progress to achieving 100% by the end of the year. This is currently work in progress and it is expected a further improvement against both the actual appraisals undertaken and booked will be noted.

A directorate, ward and departmental level breakdown showing compliance is now available and areas below expected performance are being asked to put in place corrective action. Matrons and GMs are proactively managing under performance.

Surgery

Why are we away from plan?

Appraisal – Current performance April to September suggests 7.2% based on the available information within ESR. The Division has now trained two members of the Divisional workforce to ensure that the ESR system is the key data source for this information and over the coming month appraisals completed will now be captured in the ESR system. Based on a manual completion of the Appraisal Profiler it would suggest that the performance April to September is in the region of 18%.

Mandatory training, Prevent and Safeguarding remain key areas of performance.

Action to get on Plan including timescales

Appraisal – Administration support training completed as referenced above. Appraisal Profiler now 87% completed for monthly monitoring. Gap relates medical staffing data to be collated as well a recognition of a level of staff on maternity leave, long term sickness and within the probationary period. Dates will be confirmed for these staff as they return to work etc

Continued focus on Mandatory training across the Board with key reference to Prevent and Safeguarding

Structured performance management at Directorate level established via Divisional Board. Directorate Objectives clearly set incorporating Appraisal and Mandatory Training

Community

Why are we away from plan?

Appraisal

Detailed review of appraisal position undertaken and identified a lack of understanding of operational teams on the requirements for appraisal within the financial year. Requirement clarified and all staff in work have an appraisal date agreed which will be monitored and will bring the Division into compliance

Mandatory Training

Several elements of Mandatory training are only required to be updated bi-annually or every three years. The Division had been under the misinterpretation that this did not have to be undertaken until due rather than understanding April 2015 was a new clock start for all training. This has now been communicated and dates for all staff will be aligned with appraisal dates; the Division is now looking at how to recover lost performance from April to September and will update at a future performance meeting

FSS

Why are we away from plan?

Mandatory training - broadly meeting plan in a number of areas including E&D, IG, Infection control, Health & Safety and Manual Handling.

Prevent- lack of availability of sessions has proved challenging but additional capacity now planned. Fire training (marginally below plan) and Safeguarding trajectory not currently being met.

Appraisal – performance at 30.9% against set trajectory of 33%. Teams now all using planning tool to promote with teams

Action to get on Plan including timescales

Continued monitoring and support via weekly team meetings

Closely working with ward teams to identify limiting factors and support completion. Focused work being undertaken during October to ensure safeguarding training sessions and PREVENT booked for all staff

Estates

Why are we away from plan?

Mandatory Training

1) A significant number of staff do not have access to PC's during their normal working day.

2) A number of challenges have been made in relation to specific training (eg: Health & Safety 2 day training should negate the need to do H&S Awareness training). This is being addresses with the topic expert and Bev France to ensure subjects are not duplicated

3) Some staff do not have time available during the day due to other pressures.

Appraisals

1) The Division has been through a Business Redesign Programme (BRP) and management restructure. Staff were given new Job Description and revised responsibilities. The Division felt it important to complete the BRP, give staff the opportunity to understand their new roles and be clear about the revised services model and divisional objectives so that this could be used to form the basis of the appraisal programme, in particular for the new senior management team. This resulted in a delay in starting the appraisal programme.

Action to get on Plan

Mandatory Training

training events planned for staff unable to access PC's (use of IT training rooms on a weekly basis). Sessions to be completed by end Dec 15.

ACTION: C Gorman to organise with IT (for training rooms) and L&D (for facilitation) and Heads of Services to release staff for training

2) Knowledge experts working with B France to map key learning outcomes to awareness training (eg: Health & Safety) to reduce duplication of effort. Exercise for Health & Safety completed 10th Oct 15.

ACTION: A Wilson & B France (complete)

3) Staff are reminded they can access mandatory training "remotely". This is being cascaded again via to all Managers with a view that all Managers can access the database and Managers training is complete by end Nov 15. (http://nww.cht.nhs.uk/divisions/corporate/workforce-and-organisational-development/mandatory-training/accessing-esr-from-home/)

ACTION: D McGarrigan & Heads of Services to lead by example and have all mandatory training complete.

Appraisals

1) The BRP is now complete and the appraisal programme has started. A number of staff have received an appraisal, mainly the senior/middle management teams, with all other staff, apart from those on long term sick, having dates in the diary when their appraisal will take place. The objective is to complete all appraisals by the end of December 2015.

Corporate

Appraisal

Why are we away from plan?

Significant progress has made for all corporate function in completing appraisal profiler. dates for majority of appraisal for corporate function have been scheduled . Activity recorded in ESR does not match planned activity.

Action to get on plan

Review of the reasons appraisal are not being completed as identified within the plan, immediate action to be taken to set revised dates for appraisals not done. Appraisal profiler to be refreshed at end of quarter 3.Th emphasis of appraisals to be reinforced across the corporate function grouping.

Mandatory Training

Why are we away from plan?

There remains an element of the workforce in corporate function that has not commenced any element of the mandatory training programme. Additional, whilst there is a significant number of colleagues that have commenced one or more of the elements there remains low completion of the full 8 elements .

Action to get on plan

The actions detailed in the Quality committee update report in September are been actioned. an emphasis on mandatory training completion specifically across corporate functions is to be progressed.

THIS

Why are we away from plan?

Appraisals – The profile tracker has been submitted showing THIS just off plan at the half year point but with a clear profile to track just below target, meeting it before year end. THIS has seen a good increase across the board between August and September stats. Whilst this is still not 'on-plan', it does show that the steps been taken (outlined in the actions below) are working and if it were not for the slow start progress would be as expected. The change to a monthly plan is taking time to be acknowledged/understood by all staff who are used to completing training and appraisals once within each financial year. Appraisals have been taking place but those involved (either the manager or staff), were not informing the divisional training co-ordinator that they were complete, this has been addressed.

Mandatory Training: - THIS are now above 50% at the half year point on some of the modules. The attendance modules have staff booked on over the next couple of months to bring those in line. Access to some training modules was difficult at the start of the financial year again contributing to a slow start, still difficulties with Safeguarding which is one of THISs lowest compliances.

Action to get on Plan including timescales

THIS has seen good progress towards plan in the first half of the year after a slow start in both Mandatory Training and Appraisals. The actions below are in place to track the profile submitted for Appraisals and to meet training targets by the end of the financial year. Reports and the reasons for delivering against the targets are discussed in divisional communications as well as departmental team meetings. Each head of department has a responsibility to monitor activity against plan and manage it accordingly. Meeting trust targets for mandatory training and appraisals will form part of the personal appraisal objectives of Heads of Departments and Managers within THIS. Communications have been sent out (and will continue every month) by the divisional training co-ordinator reminding staff to inform them of when an appraisal has taken place. The managers have been informed that this is part of their responsibility. The relevant slide from IBR (as well as the HR report) is discussed at the THIS monthly board to ensure the senior team are clear on progress and activity against plan. THIS holds division wide staff briefing sessions at least twice a year and Training/Appraisals is on the agenda for both. THIS understands that this is a transitional year and is working with departmental managers to pull together a clearer process around when Training/appraisals are completed by each department giving a more balanced spread throughout the year.

Well Led indicators

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

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

FFTStaff - Would you recommend us to your friends and family as a place to receive treatment? (Quarterly)			
Division	Quarter 4	Quarter 1	Movement
Surgery	79.00%	79.00%	→
Medical	80.00%	76.00%	↓
FSS	74.00%	76.00%	↑
Community	-	77.00%	
Estates	89.00%	83.00%	↓
Corporate	79.00%	82.00%	↑
THIS	75.00%	72.00%	↓
Trust	81.00%	77.00%	↓

FFT Staff - Would you recommend us to your friends and family as a place to work? (Quarterly)			
Division	Quarter 4	Quarter 1	Movement
Surgery	55.00%	55.00%	→
Medical	54.00%	49.00%	↓
FSS	49.00%	47.00%	↓
Community	-	49.00%	
Estates	53.00%	45.00%	↓
Corporate	57.00%	52.00%	↓
THIS	66.00%	72.00%	↑
Trust	59.00%	51.00%	↓

Hard Truths Summary Day - Nurses/Midwives		
Division	Sep-15	95% Target
Surgery	93.71%	
Medical	83.33%	
FSS	89.66%	
Trust	87.47%	

Hard Truths Summary - Day Care Staff		
Division	Sep-15	95% Target
Surgery	94.06%	
Medical	97.28%	
FSS	79.52%	
Trust	94.31%	

Hard Truths Summary - Night Nurses/Midwives		
Division	Sep-15	95% Target
Surgery	91.08%	
Medical	90.44%	
FSS	85.58%	
Trust	89.37%	

Hard Truths Summary - Night Care Staff		
Division	Sep-15	95% Target
Surgery	112.27%	
Medical	118.34%	
FSS	69.85%	
Trust	110.06%	

Hard Truths Staffing Levels

Why we are away from plan

The overall average fill rate for qualified nurses (day and night) has increased in September on both sites in comparison to August 2015. On the HRI site the average fill rate for qualified nurses was 92 % (day and night) in comparison to 88.85% in August 2015. At CRH the average fill rate for qualified nurses was 85.49% in comparison to 83.3% in August 2015.
For unqualified staff the average fill rate (day and night) has remained largely static from the August position on the HRI site to 104.6% and reduced on the CRH site to 100.5%

	Day		Night		
	Qualified	Unqualified	Qualified	Unqualified	Combined
Red (less than 75% fill rate)	6	7	1	3	17
Amber (75 – 89% fill rate)	11	6	13	1	31
Green (90-100% fill rate)	16	10	18	5	49
Blue (greater than 100%)	2	12	2	16	32

The number of areas rag rated red in September increased in comparison to August 2015.
At present the nursing workforce continues to have a number of vacancies and a sickness rate for colleagues above the threshold built into the workforce model which has impacted upon fill rates. Increased demand on additional capacity areas has also contributed to reduced fill rates.
An increase in areas with an average fill rate of above 100% has been reported in comparison to August, but this remains less than the June and July position.
Five areas reported an average fill rate of over 100% for qualified nurses. Ward 3 (119.5%) has been attributed to newly qualified nurses starting who have yet to receive their NMC registration. The remaining 4 areas reporting an overfill had fill rates of less than 102% attributed to a combination of achieving an element of supervisory status and newly qualified nurses arriving, but awaiting their NMC registration.

Table 2: Analysis of areas with unqualified average fill rates above 105%

Area	Day	Night	Reason
MAU (HRI)		113.3%	• Supporting reduced fill rate of 86% for qualified nurses • Additional 6 shifts required to support 1-1 care
2AB		115.5%	• Supporting reduced fill rate of 89% for qualified nurses • Additional 8 shifts required to support 1-1 care
4	124%		• Supporting reduced fill rate of 93% for qualified nurses
5 (11)		180%	• Trial of increased HCA on nights resulting in overfill. Associate Director of Nursing monitoring.
5AD	126.2%	130%	• Supporting reduced fill rate for qualified nurses on days of 67.9%. • Clarification on planned hours against workforce required • 21 Additional shifts required for 1-1 support and specialist care
5B	143.4%	134.9%	• Supporting additional capacity requirement • Additional 22 shifts required to support 1-1 care
6	112%	112%	• Supporting Qualified nurse fill rate of 93.6 – 98.4%
6A	113%	120%	• Supporting additional capacity requirement • Additional 15 shifts required to support 1-1 care
6BC		116%	• Supporting Qualified nurse fill rate of 92.5%
6D	108%		• Supporting reduced Qualified nurse fill rate of 74% • Additional 12 shifts required to support 1-1 care
7AD		141.2%	• Supporting reduced qualified nurse fill rate of 80.8%
7BC		136.1%	• Supporting reduced qualified nurse fill rate of 93.6%
8		111.1%	• Supporting reduced qualified nurse fill rate of 81.7%
12		170%	• Supporting reduced qualified nurse fill rate of 76.7%
17		144.8%	• Supporting reduced qualified nurse fill rate of 87.9%
21	119.2%		• Supporting reduced qualified nurse fill rate of 68.8%
8AB		117.3%	• Supporting reduced qualified nurse fill rate of 81.7% • Additional 6 shifts required to support 1-1 care
10	136.7%		• Supporting reduced qualified nurse fill rate of 90.6% • Additional 6 shifts required to support 1-1 care
SAU		155.5%	• Supporting reduced qualified nurse fill rate of 92.4%

Table 3: Analysis of reduced fill rate for Qualified Planned Hours

Area	Day	Night	Reason
MAU CRH	71.4%		Vacancies, Sickness
5AD	67.8%		Vacancies; Increased number of long shifts worked against planned resulting in decreased fill rate.
6D	74%		Vacancies; Sickness
21	68.8%		Supporting additional capacity areas; Sickness
8D	51.7%		Vacancies; Supported by additional unqualified nurses risk assessed by matron of the day.
4C	74.6%		Vacancies;
9	69.6%		Sickness; vacancies

Matron of the day role commenced in September 2015 to provide increased support in achieving safe staffing levels across the Trust.
Action Plan
Review of agency spend on qualified nurses on a weekly basis to monitor position against agency ceiling cap received in September 2015.
Focused recruitment for unqualified nurse vacancies both planned, and completed within September 2015. Future unqualified nurse recruitment events planned to ensure continuation of pipeline workforce.
Focused recruitment both UK based and International to recruit to vacancies.
Winter planning for safe staffing across the nursing workforce to be completed.
Reduction in higher cost agency use, with Director level approval for any tier 3 (high cost) agency required.
Induction and increased support for both newly qualified and newly recruited nurses (both qualified and unqualified).
Review of additional roles to support 1-1 requirements.
Daily review of staffing across site by matron to ensure the most effective use of resources.

Achieved by Date
The Trust has started to realise the increased fill rate and decreased vacancy position expected through the recruitment of qualified nurses and midwives.
Increased fill rates will be monitored by the Associate Directors of Nursing.
Winter planning for the nursing workforce will be completed and monitored through the Nursing Workforce Strategy Group.

Calderdale and Huddersfield NHS Foundation Trust

INTERMEDIATE CARE AND COMMUNITY DIRECTORATE

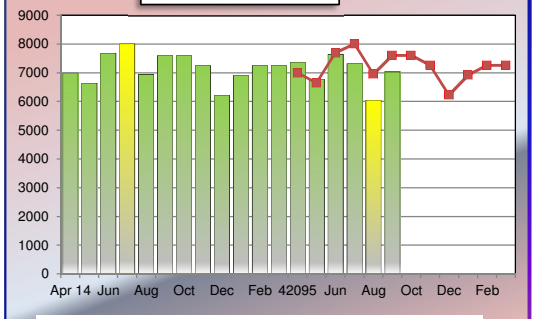
DIRECTORATE PERFORMANCE DASHBOARD

MONTH : SEPTEMBER 2015

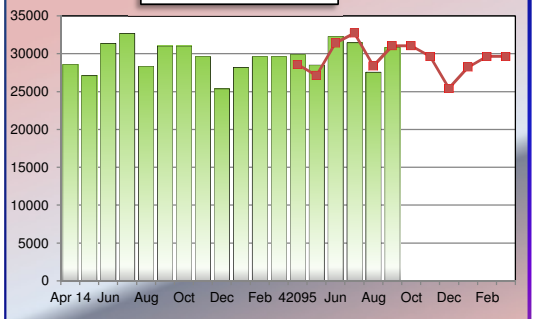
compassionate care

CLINICAL THERAPY SERVICES

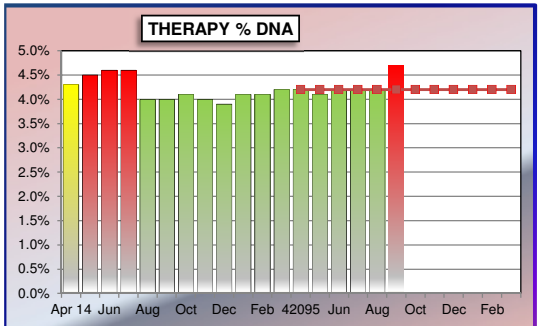
THERAPY all Referrals



THERAPY all Contacts



THERAPY % DNA



ACTIVITY EFFICIENCIES - PERFORMANCE v PLAN

ALL THERAPY CONTACTS (includes Inpatients & All Commissioners)

CLINICAL THERAPIES : Activity Metric	Curr Month	YTD actual	YTD PROFILE	Actual 14/15	POSITION
Referral Demand	7,036	42,544	43,877	86,372	-3.0%
Initial Contacts	5,523	32,276	34,604	68,118	-6.7%
Follow Up Contacts	24,354	143,417	139,839	275,273	2.6%
Telephone Contacts	966	5,204	4,842	9,531	7.5%
THERAPY CONTACTS - including Inpatients	**30,843**	**180,897**	**179,284**	**352,922**	**0.9%**
CTR Podiatry	6,346	35,199	37,409	73,640	-5.9%
CTR Therapies Outpatients	5,657	34,090	35,094	69,082	-2.9%
CTR Inpatient Therapies	9,460	55,902	47,926	94,342	16.6%
CTR Long Term Conditions and Rehab	4,995	31,124	32,521	64,018	-4.3%
CTR Acute & Planned Care is 'Other Outpatients'	1,605	9,655	10,431	20,534	-7.4%
CTR Childrens Therapies	1,814	9,723	11,062	21,775	-12.1%
Telephone Contacts	966	5,204	4,842	9,531	7.5%
THERAPY CONTACTS - including Inpatients	**30,843**	**180,897**	**179,284**	**352,922**	**0.9%**

First DNAs	303	1515
First DNAs % Rate	5.2%	4.5%
Total DNAs	1506	8159
Total DNA % Rate	4.7%	4.3%

Snapshot : Waiting List - Waiting for First Appt	8324

COMMUNITY ADULT : Activity Metric	Curr Month	YTD actual	YTD COMM	COMM PLAN	POSITION
Referral Demand	3,898	24,260	23,987	47,219	1.1%
Initial Contacts*	2,615	15,636	17,589	34,624	-11.1%
Follow Up Contacts	22,059	136,872	131,817	259,482	3.8%
Telephone Contacts	3,248	18,161	16,629	32,735	9.2%
ALL Clinical Contacts - Face to Face & Telephone	27,922	170,669	166,035	326,841	2.8%

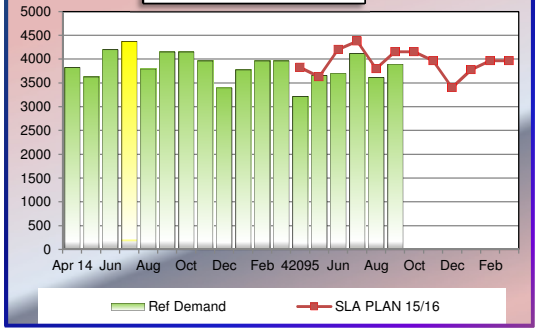
* From changes to recording of referrals introduced this financial year - this will reduce the number of initial contacts

Total DNAs - No Access Visits + DNAs	817	4764
Total DNA (No Access) % Rate	2.84%	2.72%

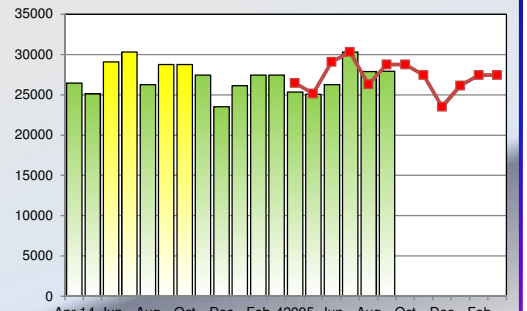
DIRECTORATE SUMMARY KPIs	Curr Month	YTD actual	YTD COMM	Actual 14/15	POSITION
Referral Demand	10,934	66,804	67,864	133,591	-1.6%
Total Contacts	54,551	328,201	323,848	637,497	1.3%
Telephone Contacts	4,214	23,365	21,471	42,266	8.8%
TOTAL CONTACTS - ALL SERVICES	**58,765**	**351,566**	**345,320**	**679,763**	**1.8%**
Total DNAs	2323	12923			
Total DNA % Rate	4.1%	3.8%			
Snapshot : Waiting List - Waiting for First Appt	8,324				

CALDERDALE COMMUNITY ADULT

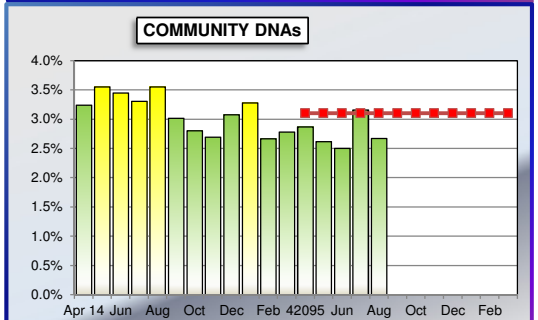
COMMUNITY all Referrals



ADULT CMR COMMUNITY CONTACTS



COMMUNITY DNAs



Calderdale and Huddersfield NHS
NHS Foundation Trust

COMMUNITY DIVISIONAL PERFORMANCE REPORT & DASHBOARD

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

SEPTEMBER 2015

compassionate care

Key Points

September 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

(1c) Advance care plan
Individualised Care of the Dying (ICOD) training being rolled out across teams. First trial has been evaluated and changes are being mad eto the document

(1e) % with Calderdale Care Plan

Improvement seen in this area as all care plans completed in full within 2 weeks of arrival onto caseload as expected

(4a) Pressure ulcer screening
A - Work to do around how we report this as the screening is reflected in the holistic assessment in all cases and in the care plans where there is an issue.
B - Developed outcome measures for completion when a pressure ulcer care plan has been performed and there is targeted work ongoing to improve data capture
C - November

(4b) Community acquired pressure ulcers
A- Thematic review of RCAs has been performed and used to develop community wide action plan. Need to have a more joined dup approach across all professionals and agencies to pressure ulcer prevention
B - Multi professional forum planned for 13th November with plans to launch 2 trials aimed at working with care staff and care agencies
C- Unlikely to meet 10% reduction target as planned need to set revised target to monitor improvement work month on month

(4f) Safeguarding training
A - Recording is over a 36 month period therefore the target for the year is not in line with the current calculation methodology. clarification has been requested around whether this training has to be repeated to allow data capture on ESR - informed that this is currently not shown for staff who have completed within a 3 year period prior to launch of ESR
B - Investigations around how best to represent this indicator with information available is ongoing
C - December

(5a) Community DNA rates
A - Number of patients have multiple DNAs and therefore inflate the percentage
B - .
The housebound policy second draft has gone to CCG and primary care for comments. Need to scope estates in terms of clinic space and understand the percentage of DV that can be converted to clinic setting. Managed through PMO as part of efficiency stream
C - March 2016

75

	1 Enhancing quality of life for people with a Long Term condition (LTC)	Target	Current Month		YTD		YTD 14/15
a	Home equipment delivery < 7 days	95%	99.2%		99.4%		96.3%
b	% Patient died in preferred place of death	95%	100.0%		100.0%		95.6%
c	% of people that died who were expected to die and had an advance care plan	Indicator suspended pending new 'ICOD' pathway					
d	% District Nursing Patients with a care plan	90%	98.0%		98.2%		94.6%
e	% of patients with a LTC with a Calderdale Care Plan	90%	100.0%		87.7%		59.5%
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%	3.3%		3.9%		1.4%

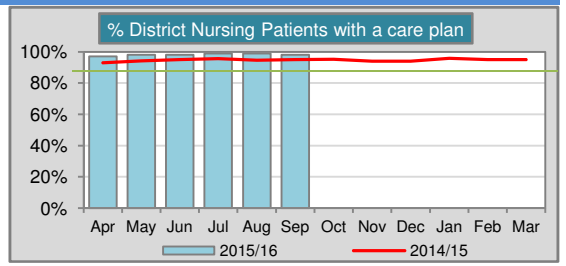
	2 Helping people to recover from episodes of ill health or following injury	Target	Current Month		YTD		YTD 14/15
a	% of leg ulcers healed within 12 weeks from diagnosis	75%	83.7%		93.0%		97.6%

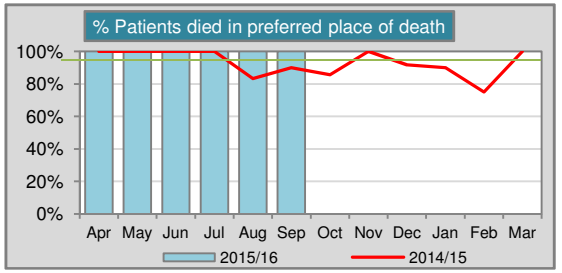
	3 Ensuring people have positive experience of care	Target	Current Month		YTD		YTD 14/15
a	Number of complaints	n/a	TBC		13		13
b	Number of complaints about staff attitude	n/a	TBC		0		0
c	Community AHP - 18 week RTT Snapshot at month end	95%	TBC		92.8%		89.7%
d	Community Friends and Family Test	n/a	92.0%		90.8%		N/A

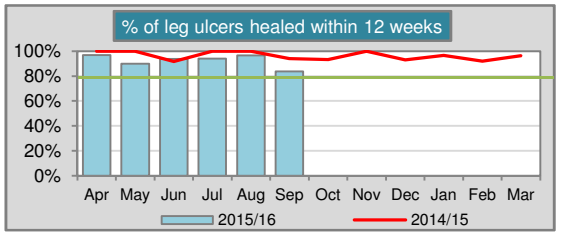
	4 Treating and caring for people in a safe environment; and protecting them from avoidable harm	Target	Current Month		YTD		YTD 14/15
a	% of patients in receipt of community nursing services that have had a pressure ulcer screening and this is documented in their care plan	90%	84.0%		84.8%		89.6%
b	Number of community acquired grade 3 or 4 pressure ulcers	<1.8	TBC		14		7
c	Number of falls that caused harm whilst patient was in receipt of Comm Services	<1.1	TBC		12		9
d	Patient safety thermometer - coverage - Harm free	>95%	95.5%		94.8%		94.1%
e	Patient safety thermometer - No of Harms Reported	<22.1	18		120		151
f	% of staff that have undertaken safeguarding / mental capacity act training	95%	46.7%		64.1%		67.8%

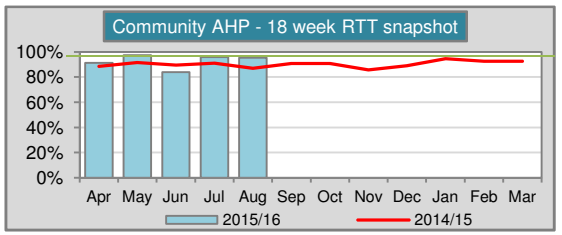
	5 Activity & Resource efficiency	Baseline	Current Month		YTD		YTD 14/15
a	Community DNA Rates	<1%	1.4%		1.2%		1.1%
b	Sickness Absence rate	<4%	TBC		3.0%		4%

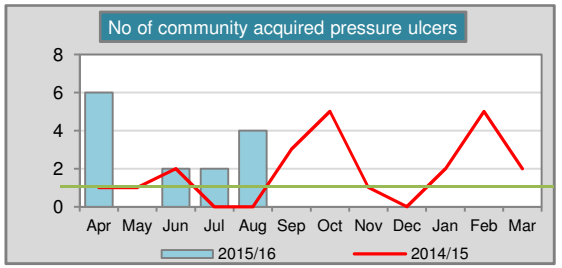
Target











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

YEAR TO DATE POSITION: M06

CLINICAL ACTIVITY

	M06 Plan	M06 Actual	Var	
Elective	4,532	4,180	(352)	
Non Elective	24,216	24,939	723	
Daycase	21,757	20,065	(1,692)	
Outpatients	164,663	160,951	(3,712)	
A & E	75,173	73,652	(1,521)	

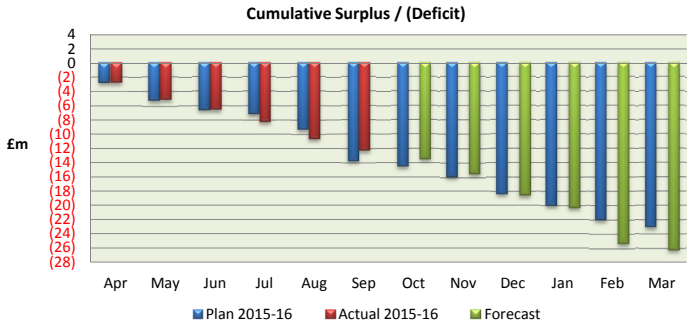
TRUST: INCOME AND EXPENDITURE

	M06 Plan	M06 Actual	Var	
	£m	£m	£m	
Elective	£11.41	£10.68	(£0.74)	
Non Elective	£39.55	£41.07	£1.52	
Daycase	£14.78	£12.92	(£1.87)	
Outpatients	£19.82	£19.62	(£0.20)	
A & E	£7.91	£7.97	£0.06	
Other-NHS Clinical	£58.10	£58.34	£0.24	
CQUIN	£3.35	£3.36	£0.01	
Other Income	£18.70	£18.09	(£0.62)	
Total Income	**£173.63**	**£172.04**	**(£1.59)**	
Pay	(£111.59)	(£112.02)	(£0.43)	
Drug Costs	(£15.66)	(£15.46)	£0.20	
Clinical Support	(£15.53)	(£15.06)	£0.47	
Other Costs	(£22.88)	(£23.18)	(£0.30)	
PFI Costs	(£5.96)	(£5.91)	£0.05	
Total Expenditure	**(£171.62)**	**(£171.63)**	**(£0.01)**	
EBITDA	**£2.01**	**£0.41**	**(£1.60)**	
Non Operating Expenditure	(£12.72)	(£12.55)	£0.16	
Deficit excl. Restructuring	**(£10.71)**	**(£12.14)**	**(£1.43)**	
Restructuring Costs	(£3.00)	(£0.10)	£2.90	
Surplus / (Deficit)	**(£13.71)**	**(£12.24)**	**£1.47**	

DIVISIONS: INCOME AND EXPENDITURE

	M06 Plan	M06 Actual	Var
	£m	£m	£m
Surgery & Anaesthetics	£10.36	£9.20	(£1.16)
Medical	£13.40	£11.53	(£1.88)
Families & Specialist Services	(£1.25)	(£1.43)	(£0.19)
Community	£2.95	£3.19	£0.25
Estates & Facilities	(£14.18)	(£13.03)	£1.15
Corporate	(£10.20)	(£10.68)	(£0.49)
THIS	£0.19	£0.14	(£0.05)
PMU	£1.41	£0.82	(£0.59)
Central Inc/Technical Accounts	(£14.96)	(£11.42)	£3.54
Reserves	(£1.44)	(£0.56)	£0.88
Surplus / (Deficit)	**(£13.71)**	**(£12.24)**	**£1.47**

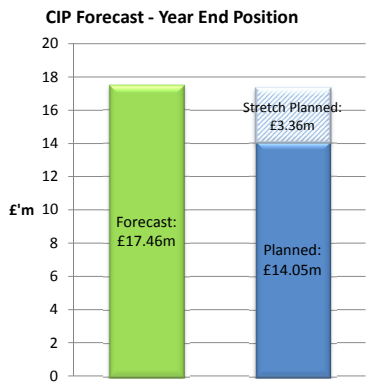
TRUST SURPLUS / (DEFICIT)



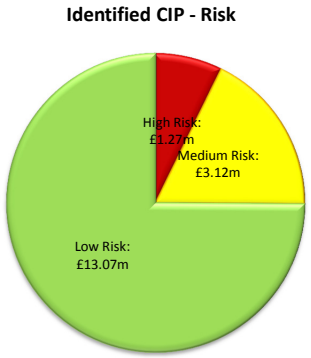
KEY METRICS

	Year To Date M06 Plan	Year To Date M06 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)	(£13.71)	(£12.24)	£1.47	(£23.01)	(£26.21)	(£3.20)	
Capital (forecast Plan)	£12.66	£9.62	£3.04	£20.72	£20.53	£0.19	
Cash	£1.92	£8.61	£6.69	£1.92	£1.97	£0.05	
CIP	£5.64	£6.93	£1.29	£14.05	£17.46	£3.41	
	Plan	**Actual**		**Plan**	**Forecast**		
Financial Sustainability Risk Rating	2	2		2	2		

COST IMPROVEMENT PROGRAMME (CIP)



Total Planned: £14.05m



Total Forecast £17.46m

YEAR END 2015/16

CLINICAL ACTIVITY

	Plan	Forecast	Var	
Elective	9,185	8,446	(739)	
Non Elective	49,263	50,908	1,645	
Daycase	43,731	40,950	(2,781)	
Outpatients	327,200	322,051	(5,149)	
A & E	146,774	143,804	(2,970)	

TRUST: INCOME AND EXPENDITURE

	Plan	Forecast	Var	
	£m	£m	£m	
Elective	£23.39	£21.75	(£1.64)	
Non Elective	£79.89	£83.45	£3.56	
Daycase	£30.25	£26.52	(£3.73)	
Outpatients	£39.45	£39.95	£0.50	
A & E	£15.49	£15.57	£0.08	
Other-NHS Clinical	£117.49	£115.17	(£2.32)	
CQUIN	£6.69	£6.75	£0.06	
Other Income	£38.90	£38.44	(£0.46)	
Total Income	**£351.55**	**£347.60**	**(£3.95)**	
Pay	(£224.98)	(£226.80)	(£1.82)	
Drug Costs	(£32.05)	(£30.83)	£1.21	
Clinical Support	(£31.15)	(£29.60)	£1.55	
Other Costs	(£45.94)	(£45.60)	£0.34	
PFI Costs	(£11.92)	(£11.87)	£0.05	
Total Expenditure	**(£346.04)**	**(£344.70)**	**£1.34**	
EBITDA	**£5.51**	**£2.90**	**(£2.61)**	
Non Operating Expenditure	(£25.52)	(£25.11)	£0.41	
Deficit excl. Restructuring	**(£20.01)**	**(£22.21)**	**(£2.20)**	
Restructuring Costs	(£3.00)	(£4.00)	(£1.00)	
Surplus / (Deficit)	**(£23.01)**	**(£26.21)**	**(£3.20)**	

DIVISIONS: INCOME AND EXPENDITURE

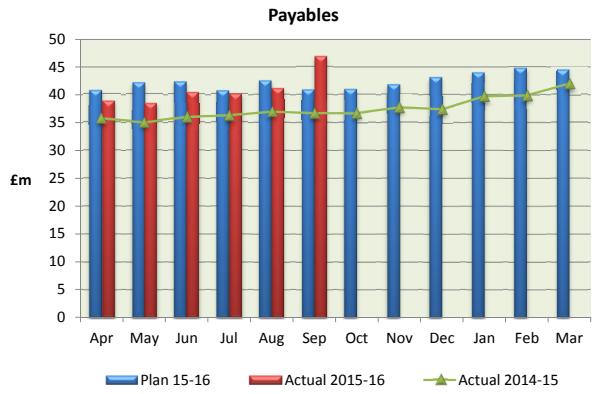
	Plan	Forecast	Var
	£m	£m	£m
Surgery & Anaesthetics	£21.30	£19.35	(£1.95)
Medical	£26.18	£21.88	(£4.30)
Families & Specialist Services	(£1.56)	(£1.69)	(£0.13)
Community	£5.77	£5.75	(£0.01)
Estates & Facilities	(£28.64)	(£27.52)	£1.12
Corporate	(£20.18)	(£22.35)	(£2.18)
THIS	£0.53	£0.42	(£0.11)
PMU	£3.16	£2.96	(£0.20)
Central Inc/Technical Accounts	(£25.20)	(£25.01)	£0.19
Reserves	(£4.38)	£0.00	£4.38
Surplus / (Deficit)	**(£23.01)**	**(£26.21)**	**(£3.20)**

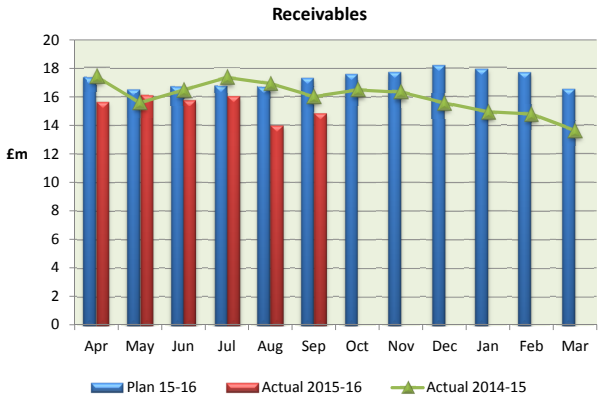
Board of Directors Integrated Performance Report

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

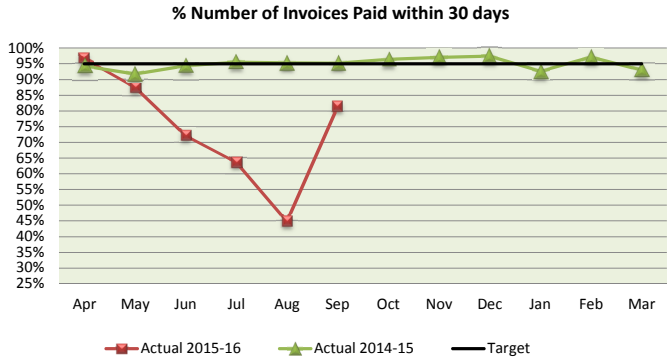
WORKING CAPITAL

	M06 Plan £m	M06 Actual £m	Var £m	M06
Payables	(£40.91)	(£46.93)	£6.02	
Receivables	£17.31	£14.84	£2.47	



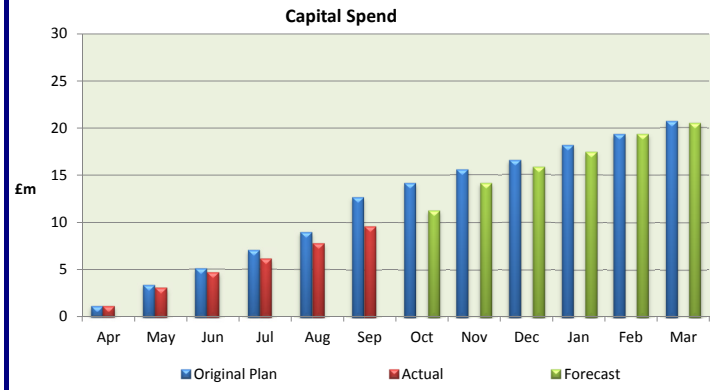


BETTER PAYMENT PRACTICE CODE



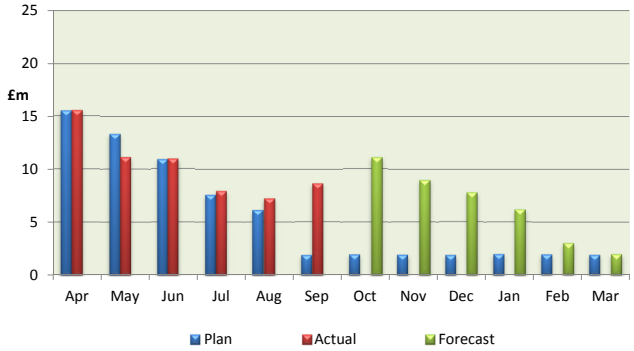
CAPITAL

	M06 Plan £m	M06 Actual £m	Var £m	M06
Capital	£12.66	£9.62	£3.04	

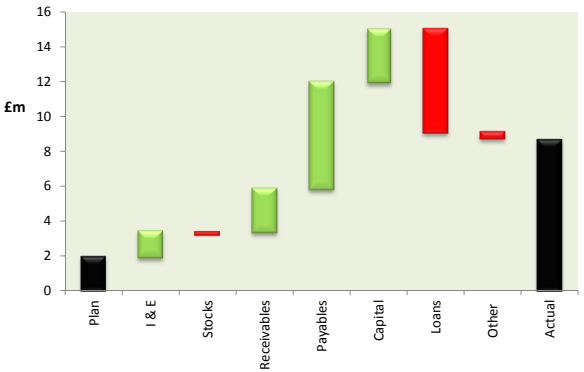


CASH

	M06 Plan £m	M06 Actual £m	Var £m	M06
Cash	£1.92	£8.61	£6.69	



CASH FLOW VARIANCE



SUMMARY YEAR TO DATE

- The year to date deficit (excluding restructuring costs) is £12.14m versus a planned deficit of £10.71m.
- The overall deficit is £12.24m less than the planned £13.71m, due to restructuring costs not being incurred in the year to date
- Elective and daycase activity have fallen further behind planned levels in month with an adverse impact on income.
- Pay expenditure remains high including significant levels of agency staffing expenditure.
- Capital expenditure year to date is £9.62m against the planned £12.66m with due to timing differences mainly on IT spend.
- Cash balance is £8.61m against a planed £1.92m, due predominantly to securing cash payments in advance for clinical activity
- CIP schemes delivered £6.93m in the year to date against a planned target of £5.64m.
- The new Monitor performance measure Financial Sustainability Risk Rating (FSRR) stands at 2 against a planned level of 2.

SUMMARY FORECAST

- The forecast year end deficit (excluding restructuring costs) is £22.21m against a planned £20.01m, an adverse variance of £2.20m. This position includes full release of remaining contingency reserves and delivery of £17.46m CIP against the original planned £14m.
- This is a slight worsening on the forecast at Month 5. This adverse position is driven by the ongoing impact of the activity, income and pay expenditure pressures seen in the year to date and costs associated with additional bed capacity.
- No further contingency reserves remain to cover other pressures and risks.
- Efforts must continue to be focussed on delivering planned activity by increasing productivity and containing pay spend particularly agency costs.
- The year end cash balance relies on external cash support of £18m, this is higher than originally planned due to the forecast increased deficit.
- Year end capital expenditure is forecast to be £20.53m against the planned planned £20.72m. The year end FSRR is forecast to be at level 2.

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 2015-16

compassionate care

Goal Number	Goal Name	Current Target	Q1	Q2	Q3	Q4	Q4 Target	Commentary
1	Acute Kidney Injury	21%	22%	32%			90%	Improvement Work Required
2a	Sepsis	Baseline	88%	40%			90%	Improvement Work Required
2b	Sepsis	Baseline	41%	63%			90%	Improvement Work Required
3	Urgent care	85%	86%	88%			85%	On Plan
4.1	Dementia	90%/90%/90%	91%/99%/100%	91%/99%/100%			90%/90%/90%	On Plan
4.2	Dementia	Written Report	n/a	Y			Written Report	On Plan
4.3	Dementia	Written Report	n/a	Y			Written Report	On Plan
5.1	Respiratory - Asthma	Q2 = 70%	66%	80%			75%	On Plan
5.2	Respiratory - Pneumonia	Q2 = 65%	70%	78%			75%	On Plan
6	Diabetes	50%	74%	64%			50%	On Plan
7.1	Improving Medicines Safety	80%/70%	80%/73%	82%/88%			80%/70%	On Plan
7.2	Improving Medicines Safety	Development	Y	Y			TBC	Target to be set after Q2
8	End of Life Care	Monitoring	36%	44%			Monitoring	On Plan
9.1	Hospital Food	Baselining	78%	76%			TBC	Target to be set after Q2
9.2	Hospital Food	Baselining	5.48%	0.0%			TBC	Target to be set after Q2
9.3	Hospital Food	Written Report	Y	Y			Written Report	On Plan

Acute Kidney Injury - Q4 Achievement Plan

A step change in performance is expected d once the changes to the Electronic Discharge summary take effect. This was implemented it the end of September 2015 and early results are promising.
In additional the to the changes on technology, the CQUIN concept and components were introduced to new junior doctors through Trust induction in August 2015

Divisional directors have been contacted regarding the CQUIN elements and importance of delivery via e-mail in August 2015

A procedure for informing non-complying clinical team for auctioning in Q3 has been agreed
Weekly monitoring of the CQUIN to commence in Q3 to allow a more proactive management of the CQUIN delivery programme

Weekly Monitoring of performance sine October 2015

Sepsis - Q4 Achievement Plan

Intensive improvement work is needed throughout the trust to ensure robust processes for screening applicable patients on admission, and ensuring that when indicated those patient get antibiotics within an 1hour.

There is some way to go to achieve the Q4 position, as such a safety and improvement nurse has been deployed to work with the ward and Sepsis Nurse Consultant to implement sustainable and high quality processes.

There has been additional education rolled out to junior ED and medical teams on induction.
Improvement is expected gradually over the next 6 months and a trajectory will be in place to ensure we are on track. Weekly monitoring programme agreed with the audit team and results will be fed back to the clinical teams.

Financial CQUINS Performance Report as at month 6

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**

High risk
Moderate risk
No known risk

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**

Calderdale and Huddersfield NHS
NHS Foundation Trust

Best Practice Tariff

compassionate care

BPT No.	INDICATOR	METRIC	Q1 Apr	Q1 May	Q1 Jun	Q2 Jul	Q2 Aug	Q2 Sep	Q3 Oct	Q3 Nov	Q3 Dec	Q4 Jan	Q4 Feb	Q4 Mar	YTD	Q1	Q2	Q3	Q4
BP01	BPT STROKE DIRECT ADMISSION AND 90% STAY	No. of stroke patients directly admitted to ASU, who also spent 90% of their spell on ASU	26	28	30	22	25								131	84	47		
		% Achieved BPT	59.1%	66.7%	68.2%	48.9%	46.3%								57.2%	64.6%	48.9%		
		Additional Income Available	£45,144	£43,092	£45,144	£46,170	£55,404								£234,954	£133,380	£101,574		
	TARIFF PER SPELL £1,026	Income Achieved	£26,676	£28,728	£30,780	£22,572	£25,650								£134,406	£86,184	£48,222		
		Income Lost	£18,468	£14,364	£14,364	£23,598	£29,754								£100,548	£47,196	£53,352		
BP01	RAPID BRAIN IMAGING	No. of stroke patients who had their initial brain imaging delivered in accordance with best practice guidelines**	32	33	33	35	48								181	98	83		
		% Achieved BPT	72.7%	78.6%	75.0%	77.8%	88.9%								79.0%	75.4%	77.8%		
		Additional Income Available	£17,556	£16,758	£17,556	£17,955	£21,546								£91,371	£51,870	£39,501		
	TARIFF PER SPELL £399	Income Achieved	£12,768	£13,167	£13,167	£13,965	£19,152								£72,219	£39,102	£33,117		
		Income Lost	£4,788	£3,591	£4,389	£3,990	£2,394								£19,152	£12,768	£6,384		
BP17	DIAGNOSIS AND TREATMENT WITHIN 24 HOURS	No. of high risk TIA patients diagnosed and treated within 24 hours	22	35	31	23	32								143	88	55		
		% Achieved BPT	68.8%	85.4%	86.1%	69.7%	86.5%								79.9%	80.7%	69.7%		
		Additional Income Available	£3,232	£4,141	£3,636	£3,333	£3,737								£18,079	£11,009	£7,070		
	TARIFF PER ATTENDANCE £101	Income Achieved	£2,222	£3,535	£3,131	£2,323	£3,232								£14,443	£8,888	£5,555		
		Income Lost	£1,010	£606	£505	£1,010	£505								£3,636	£2,121	£1,515		
BP02		Adult Renal Dialysis	Not applicable to CHFT																
BP03	Daycase	No. of Daycase	140	131	154	155	116	135							831	425	406		
		% Achieved BPT	53.6%	58.0%	57.8%	63.2%	50.0%	64.4%							58.1%	56.5%	59.9%		
		Additional Income Available																	
	TARIFF PER SPELL	Income Achieved																	
		Income Lost																	

Calderdale and Huddersfield NHS
NHS Foundation Trust

Best Practice Tariff

compassionate care

BPT No.	INDICATOR	METRIC	Q1 Apr	May	Jun	Q2 Jul	Aug	Sep	Q3 Oct	Nov	Dec	Q4 Jan	Feb	Mar	YTD	Q1	Q2	Q3	Q4
BP04	Diabetic Ketoacidosis Hypoglycaemia	No of patients diagnosed with Diabetic Ketoacidosis Hypoglycaemia	8	6	6	4	13	7							44	20	24		
		No of patients who met all criteria of the BPT	5	4	1	2	4	4							20	10	10		
		% Achieved BPT	62.5%	66.7%	16.7%	50.0%	30.8%	57.1%							45.5%	50.0%	41.7%		
	TARIFF PER SPELL	Additional Income Available	£1,348	£1,011	£1,011	£1,072	£2,376	£1,147							£7,964	£3,369	£4,595		
		Income Achieved	£842	£674	£168	£252	£742	£742							£3,421	£1,685	£1,736		
		Income Lost	£505	£337	£842	£820	£1,634	£405							£4,544	£1,685	£2,859		
BP05		Early Inflammatory Arthritis	currently not being captured by the Service																
BP06	Endoscopy	No. of Endoscopy																	
		% Achieved BPT																	
	TARIFF PER SPELL	Additional Income Available																	
		Income Achieved																	
		Income Lost																	
BP07	Fragility Hip Fracture (inc #NOF)	No. of Fragility Hip Fracture (inc #NOF)	45	45	43	39	36								208	133	75		
		No of patients who met all criteria of the BPT	24	21	30	26	21								122	75	47		
		% Achieved BPT	53.3%	46.7%	69.8%	66.7%	58.3%	0.0%							58.7%	56.4%	62.7%		
	TARIFF PER SPELL	Additional Income Available	-	-	-	-	-								-	-	-	-	-
		Income Achieved	£32,040	£28,035	£40,050	£34,710	£28,035									£100,125	£62,745		
		Income Lost	£28,035	£32,040	£17,355	£17,355	£20,025									£77,430	£37,380		
BP08	Interventional Radiology	No. of Interventional Radiology																	
		% Achieved BPT																	
	TARIFF PER SPELL	Additional Income Available																	
		Income Achieved																	
		Income Lost																	
		No. of Major Trauma																	

Calderdale and Huddersfield NHS
NHS Foundation Trust

Best Practice Tariff

compassionate care

			Q1			Q2			Q3			Q4							
BPT No.	INDICATOR	METRIC	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Q1	Q2	Q3	Q4
BP09	Major Trauma	% Achieved BPT		0.0%	0.0%	0.0%	0.0%												
		Additional Income Available																	
	TARIFF PER SPELL	Income Achieved																	
		Income Lost																	
BP10	Outpatient Procedures	No. of Outpatient Procedures																	
		% Achieved BPT																	
		Additional Income Available																	
	TARIFF PER SPELL	Income Achieved																	
		Income Lost																	
BP11	Paediatric Diabetes	No. of Paediatric Diabetes	14	14	16	20	16	19							99	44	55		
		% Achieving BPT	94.4%	94.4%	94.4%	93.2%	93.2%	93.2%							93.8%	94.4%	93.2%		
		Additional Income Available	-	-	-	-	-	-											
	TARIFF PER SPELL	Income Achieved	£42,803	£42,803	£49,918	£61,147	£48,918	£58,090							£303,679	£135,524	£168,155		
		Income Lost	£0	£0	£0	£0	£0	£0							£0	£0	£0		
BP12	Paediatric Epilepsy	No. of Paediatric Epilepsy	50	33	35	32	53	30							233	118	115		
		% Achieved BPT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%							100.0%	100.0%	100.0%		
		Additional Income Available	-	-	-	-	-	-							-				
	TARIFF PER SPELL	Income Achieved	£1,800	£1,188	£1,260	£1,152	£1,908	£1,080							£8,388	£4,248	£4,140		
		Income Lost	£0	£0	£0	£0	£0	£0							£0	£0	£0		
BP13		Parkinsons	currently not being captured by the Service																

Best Practice Tariff

BPT No.	INDICATOR	METRIC	Q1 Apr	Q1 May	Q1 Jun	Q2 Jul	Q2 Aug	Q2 Sep	Q3 Oct	Q3 Nov	Q3 Dec	Q4 Jan	Q4 Feb	Q4 Mar	YTD	Q1	Q2	Q3	Q4
BP14	Pleural Effusion	No of Pleural Effusion HRG Spells - DZ06Z, DZ16B, DZ16C	4	7	5	3	3	9							31	16	15		
		No of Planned Day Case Spells		1	4	1		1							7	5	2		
		% Achieving BPT as a D/C	0.0%	14.3%	80.0%	33.3%	0.0%	11.1%							22.6%	31.3%	13.3%		
		Income Achieved		£1,361	£5,444	£1,361		£1,361							£9,527	£6,805	£2,722		
BP15	Primary Total Hip and Knee Replacement	No. of Primary Total Hip and Knee Replacement																	
		% Achieved BPT																	
		Additional Income Available																	
	TARIFF PER SPELL	Income Achieved																	
		Income Lost																	
BP16	Same day Emergency Care	No. of Same day Emergency Care	613	711	713	731	681	736							4185	2037	2148		
		Zero Length of Stay	254	299	284	316	288	324							1765	837	928		
		% Achieved BPT	41.4%	42.1%	39.8%	43.2%	42.3%	44.0%							42.2%	41.1%	43.2%		
		Additional Income Available																	
	TARIFF PER SPELL	Income Achieved																	
		Income Lost																	
BP18	Heart Failure	No. of Non Elective Inpatient Spells with HRG EB03H or EB03I who had a primary diagnosis of Heart Failure	72	62	50	48	38								270	184	86		
		No. of HF patients who have had a face-to-face review with a specialist member of the HF team.	32	25	18	21	25								121	75	46		
		% Achieved BPT	44.4%	40.3%	36.0%	43.8%	65.8%								44.8%	40.8%	53.5%		
		Additional Income Available	£23,157	£20,837	£16,509	£15,393	£13,788								£89,684	£60,503	£29,181		
	TARIFF PER SPELL	Income Achieved	£0	£0	£0	£0	£13,788								£13,788		£13,788		
		Income Lost	£23,157	£20,837	£16,509	£15,393	£0								£75,896	£60,503	£15,393		

Board of Directors Integrated Performance Report

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.

Indicator	Board of Directors Integrated Performance Report	Source	Target/Threshold
% Variance against Plan	The actual activity levels against the planned activity levels. (Plan based on previous activity, financial / clinical constraints)	Trust reporting tool - Knowledge Portal.	Internally set target of 0% RED – More than 2% below plan GREEN – above plan AMBER – less than 2% below plan
Theatre Utilisation (TT)	The utilisation of theatre capacity, indicating how much time in theatre is lost due to lack of utilisation. TT stands for Touch Time and this utilisation is assessing the proportion of patient facing time against the time available.	Bluespier	Target Local of 92.5%. RED <90% AMBER between 90% and 92.5% GREEN >= 92.5%
% Daily Discharges - Pre 11am	% patients discharged from hospital prior to 11 am	Sophia database - admitted data sets (PAS)	Target Local of 40% RED <35% AMBER between 35% and 92.5% GREEN >= 92.5%.
Delayed Transfers of Care	% patients who discharge from hospital has been delayed (Delayed nights divided by Total Occupied nights in month (KH03))	Bed Nights - Sophia database (PAS feed) Delayed Bed Nights - Spreadsheet looked after by patient flow.	Target Local of 5% RED >5.5% AMBER between 5% and 5.5% GREEN < 5%
Green Cross Patients (Snapshot at month end)	Count of patients on wards who are recorded on the Visual Hospital as medically stable for discharge.	Visual Hospital (HRI and CRH)	Target Local of 40 RED >44 AMBER between 40 and 44 GREEN <= 40
Number of Outliers (Bed Days)	The sum of bed-days within the month under the clinical care of one division (eg. a medical divisional consultant) but actually located in a ward that is managed by another division (eg. an orthopaedic ward) at midnight. If a patient is in the wrong divisions bed for more than one night, then each night is counted. Please note paediatrics wards, Intensive care wards and surgical patients on the Gynaecology ward are excluded from this indicator.	Bed Occupancy Cube from Sophia warehouse. Patients with a Treatment Function Code other than the Ward Divisions are classed as an outlier.	Target Local. Currently comparing to previous years actual figures. RED >= last year AMBER between 90% and 100% of last year GREEN < 90% of last year.
First DNA Rate	Patients that did not attend their first outpatient appointment, the threshold is less than or equal to 10% of all first appointments	Sophia database - outpatient data sets (PAS)	Target Local of 7% RED > 7.7% AMBER between 7% and 7.7% GREEN <= 7%
% Hospital Initiated Outpatient Cancellations	% outpatient appointments cancelled by the Trust	Trust reporting tool - Knowledge Portal. Target 17.6% based on previous years outturn.	Target Local RED > 18% AMBER between 17.60% and 18% GREEN <= 17.60%
Appointment Slot Issues on Choose & Book	% of patients who experience an appointment slot issue when attempting to use Choose and book to book an appointment	Choose & Book Website	Target Local. 5% RED > 18% AMBER between 17.60% and 18% GREEN <= 17.60%

Indicator	Board of Directors Integrated Performance Report	Source	Target/Threshold
No of Spells with Ward Movements	Patients on all wards who have moved from one ward to another more than twice in their stay. Excludes specific wards to account for diagnostic tests etc.	Sophia data warehouse (APCEncounter, WardStay, LastWardStayInSpell and WardStay)	Target Local. 2% RED > 2.2% AMBER between 2.0% and 2.2% GREEN <= 2.0%
% Non-admitted closed Pathways under 18 weeks	Patients that are referred for treatment that doesn't involve an admission receive their first definitive treatment within 18 weeks of referral. The threshold is 95%.	Sophia database	Nationally set target of 95%. RED – below 94% GREEN – 95% or above AMBER – 94% to 95%
% Admitted Closed Pathways Under 18 Weeks	Patients that have a decision to treat should be admitted within 18 weeks of the start of their referral to treatment pathway. The threshold is 90%.	Sophia database	Nationally set target of 90%. RED – below 89% GREEN – 90% or above AMBER – 89% to 90%
% Incomplete Pathways <18 Weeks	Incomplete pathways are waiting times for patients still waiting to start treatment. The threshold is 92%	Sophia database	Nationally set target of 92%. RED – below 91% GREEN – 92% or above AMBER – 91% to 92%
18 weeks Pathways >=26 weeks open		Sophia database	Locally set target of zero patients. .RED – greater than 10 patients GREEN – zero patients AMBER – 1 - 9 patients Not available at divisional level
18 weeks Pathways >=40 weeks open		Sophia database	Locally set target of zero patients. RED – greater than 10 patients GREEN – zero patients AMBER – 1 - 9 patients Not available at divisional level
% Diagnostic Waiting List Within 6 Weeks	Patients referred into the hospital for a diagnostic test will wait no longer than 6 weeks for that test as the percentage of the total volume waiting. Target 99%	Sophia database	Nationally set target of 99%. RED – below 98% GREEN – 99% or above AMBER – 98% to 99%
Community AHP - 18 Week RTT Activity	% Patients who have completed an 18 weeks pathway for community services	SystmOne reporting tool	Internally set target of 95%. RED – below 91% GREEN – 95% or above AMBER – 92 to 94% to 99%
Cancellations to Elective Surgery	Patients who are listed for a surgical procedure who are cancelled by the Hospital with less than 24 hours' notice. The threshold is less than or equal to 0.6% of elective admissions.	Elective admissions - Sophia database (PAS admitted dataset) Cancellations - Theatres Manual SitRep process spreadsheet	Target Local. 0.6% RED > 0.66% AMBER between 0.60% and 0.66% GREEN <= 0.60%
Two Week Wait From Referral to Date First Seen	Patients that have a suspected cancer diagnosis and sent on a 2 week wait faxed proforma should receive an appointment within 2 weeks of the date of the referral. The threshold is 93%	PPM	Target National. 93% RED < 92% AMBER between 92% and 93% GREEN >= 93%

Indicator	Board of Directors Integrated Performance Report	Source	Target/Threshold
Two Week Wait From Referral to Date First Seen: Breast Symptoms	Patients that have a suspected breast cancer diagnosis and sent on a 2 week wait faxed proforma should receive an appointment within 2 weeks of the date of the referral. The threshold is 93%	PPM	Target National. 93% RED < 92% AMBER between 92% and 93% GREEN >= 93%
31 Days From Diagnosis to First Treatment	Patients that have a cancer diagnosis should have a date for treatment within 31 days of the decision to treat them. The threshold is 96%	PPM	Target National. 96% RED < 95% AMBER between 95% and 96% GREEN >= 96%
31 Day Subsequent Surgery Treatment	Patients that have a decision to treat them surgically for a cancer diagnosis should have a date for their treatment within 31 days of the decision to treat them. The threshold is greater than or equal to 94%.	PPM	Target National. 94% RED < 93% AMBER between 93% and 94% GREEN >= 94%
31 day wait for second or subsequent treatment drug treatments	Patients that have a decision to treat with medication for a diagnosis of cancer should receive their first definitive treatment of drugs within 31 days of the decision to treat them. The threshold is greater than or equal to 98%	PPM	Target National. 98% RED < 96% AMBER between 96% and 98% GREEN >= 98%
62 Day Aggregated Gp Urgent Referral To Treatment And Screening Referral To Treatment	Patients that are referred via the screening service with a suspected cancer diagnosis should receive their first definitive treatment within 62 days of the date of the referral. The threshold is 86%	PPM	Target National. 86% RED < 85% AMBER between 85% and 86% GREEN >= 86%
62 Day Gp Referral to Treatment	Patients that are referred to the hospital with a suspected diagnosis of cancer should be treated within 62 days of the date of the referral. The threshold is 85%	PPM	Target National. 85% RED < 84% AMBER between 84% and 85% GREEN >= 85%
62 Day Referral From Screening to Treatment	Patients that are referred via the screening service with a suspected cancer diagnosis should receive their first definitive treatment within 62 days of the date of the referral. The threshold is 90%	PPM	Target National. 90% RED < 89% AMBER between 89% and 90% GREEN >= 90%
A & E Targets	Measures the length of time the patients wait to be seen, have a decision to treat and spend in the department prior to either being discharged or admitted.	EDIS	Target National/Monitor. 95% RED < 94% AMBER between 94% and 95% GREEN >= 95%
Number of Mixed Sex Accommodation Breaches	Patients should be accommodated in single sex accommodation unless clinically indicated. Target is zero breaches of this indicator	Sophia database	Target National. 0 RED 1 and above GREEN 0
Complaints	All complaints received by the hospital from a patient or relative	Datix	
Total Concerns in the month	The number of patient concerns that have been raised	Datix	

Indicator	Board of Directors Integrated Performance Report	Source	Target/Threshold
CQUINS - % of diabetic patients supported to self-care	Commissioning for Quality innovation	Various sources	
CQUINS - Nutrition and Hydration			
CQUINS - Improving Medicines Safety			
CQUINS - Acute Kidney Injury (Reported quarterly)			
CQUINS - Sepsis Screening			
CQUINS - Respiratory Care Bundle			
CQUINS - End of Life Care Plan in place			
Percentage of non-elective inpatients 75+ screened for dementia	Assesses the proportion of patients aged 75+ who are at risk of dementia and ensures they are referred onward appropriately	Sophia Database	
Friends & Family Test	% of patients who complete a friends and family questionnaire following an inpatient admission	Ward Audits	
Falls	The number of patients who have fallen during their stay in hospital	Datix	
Pressure Ulcers Acquired at CHFT	The number of pressure ulcers reported as developed during a patients stay in hospital	Datix	
Percentage of Completed VTE Risk Assessments	% of Admissions in month that have had a VTE Risk Assessment on Admission.	PAS / K2 Maternity System / Manual Validations. (Future data source to include nerve centre forms)	Target National. 95% RED < 93% AMBER between 93% and 95% GREEN >= 95%
Percentage of Stage 1 RCAs completed for all Hospital Acquired Thrombosis	The stage 1 process for RCA's is to identify any Hospital Acquired Thrombosis (HAT) and investigate the episode of care to ensure the trusts VTE prevention policy has been followed correctly.	Episodes are identified from the certification database and reports from Radiology on positive PE's and DVT's	
% Harm Free Care	A tool which is used by clinician to monitor and record the presence and absence of pressure ulcers, falls, Urinary tract infections and New venous thromboembolisms (VTEs)		
Safeguarding Alerts	An alert is the formal raising with Social Services of a concern, suspicion or allegation of potential abuse or harm or neglect which may have arisen	Alerts recorded on Datix whether received by the Trust from Social Services or made by the Trust to Social Services	
World Health Organisation Check List	The WHO Surgical Safety Checklist was developed after extensive consultation aiming to decrease errors and adverse events, and increase teamwork and communication in surgery. The 19-item checklist is now used by a majority of surgical providers around the world.		

Indicator	Board of Directors Integrated Performance Report	Source	Target/Threshold
Missed Doses	Where medicine doses have been omitted, delayed or missed during shifts.	Ward Audits	
Patient Incidents	A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients	Datix	
Never Events	An event that should never happen, for example wrong site surgery or an instrument left in the patient post-surgery. The threshold is zero cases per year.	Datix	Target National. 0 RED 1 and above GREEN = 0
Duty of Candour	To ensure that providers are open and transparent with people who use their services and that Trusts act lawfully on their behalf when things go wrong with care and treatment	Datix and Risk Management incident register.	
Number of MRSA Bacteraemias – Trust assigned	Methicillin-resistant Staphylococcus aureus, This is no longer a monitor requirement however continuing to work to a de minimus of 6 cases after which contract penalties apply.	Infection Control Net (IC Net)	
Total Number of Clostridium Difficile Cases	The Foundation Trust has a target of no more than 21 cases per year attributable to the organisation.	Infection Control Net (IC Net)	
Number of MSSA Bacteraemias - Post 48 Hours	The number of MSSA infections acquired after 48 hours of a hospital stay	Infection Control Net (IC Net)	
% Hand Hygiene Compliance	The percentage of monthly hand hygiene observations which have been done to the required standard.	Hand Hygiene System	
MRSA Screening - Percentage of Inpatients Matched		Infection Control Net (IC Net)	
Number of E.Coli - Post 48 Hours	The number of E.Coli infections acquired after 48 hours of a hospital stay	Infection Control Net (IC Net)	
Central Line Infection rate per 1000 Central Venous Catheter days	The number of infection acquired in patient with a CVC line in situ. Each day a line is in is counted as one calendar day. This is scaled up to the number of patients with a line present	Departmental Audits	
Emergency Readmissions Within 30 Days	% patients readmitted (unplanned) back into hospital within 30 days of their discharge	Sophia database	Target Local (varies month on month for seasonality) 7.40% RED above 7.6% AMBER between 7.4% and 7.6% GREEN below 7.4%

Indicator	Board of Directors Integrated Performance Report	Source	Target/Threshold
Local SHMI - Relative Risk (1yr Rolling Data Oct 13- Sept 14)	The SHMI (Summary Hospital Mortality Index) is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It includes deaths which occur in hospital and deaths which occur outside of hospital within 30 days (inclusive) of discharge	HSCIC and summary analysis via HED (www.hed.nhs.uk)	
Hospital Standardised Mortality Rate (1 yr. Rolling Data Apr 14 - Mar 15)	The HSMR (Hospital Standardised Mortality Rate) is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 diagnosis groups in a specified patient group. The expected deaths are calculated from logistic regression models with a case-mix of: age band, sex, deprivation, interaction between age band and co-morbidities, month of admission, admission method, source of admission, the presence of palliative care, number of previous emergency admissions and financial year of discharge.	HED (www.hed.nhs.uk)	
Mortality Reviews – Month Deaths	The number of in hospital adult deaths which have been reviewed using the local mortality proforma	Mortality Knowledge Portal	Target Local. 100% RED below 95% AMBER between 95% and 100% GREEN = 100%
Crude Mortality Rate (Latest Month June 15)	Crude mortality is the number of inpatient and Daycase deaths as a proportion of all discharges	Knowledge Portal	Target Local. 1.21% RED above 1.23% AMBER between 1.21% and 1.23% GREEN below 1.21%
Average Diagnosis per Coded Episode	The average number of clinical diagnostic codes that each admitted finished consultant episode attracts based on the information that can be coded from the clinical record	Knowledge Portal	Target Local. 4.9 RED < 4.7 AMBER between 4.7 and 4.9 GREEN >= 4.9
Completion of NHS numbers within commissioning datasets submitted via SUS	The activity submitted to the Secondary Care User Service is fully complete with the patient NHS number	Knowledge Portal	Target Contract 99% RED < 98.8% AMBER between 98.8% and 99% GREEN >= 99%

Indicator	Board of Directors Integrated Performance Report	Source	Target/Threshold
Percentage Non-elective #NoF Patients With Admission to Procedure of < 36 Hours	% of hip fracture patients who are receive surgery within 36 hours as a percentage of those receiving surgery.	The National Hip Fracture Database	Internally set target at 85% to allow for patients who are too ill and will not be operated on as this is in their best interest.
↑ ↓ →	Flow of direction of activity		
RAG Rating (Also called Traffic light rating)	RED – Not achieving the set target GREEN – Achieving the set target AMBER – Not achieving the target by 10%	-	-

MEMBERSHIP COUNCIL CALENDAR OF ACTIVITY 2015

NOVEMBER 2015

DATE	MEETING	TIME	LOCATION	PLEASE ATTEND
4 Nov	MCs/Chair Informal Meeting	3.00 – 4.00	Board Room, HRI	All
4 Nov	Members Public Meeting (MCs Formal meeting)	4.00 – 6.00	Board Room, HRI	All
10 Nov	Families & Specialist Services DRG meeting	12.00 – 2.00	TBC	LM/GR/JB/KW/AB/MK
11 Nov	MC Development Session: Leading for Change at CHFT	1.00 – 3.00	Syndicate Room 2, LC, CRH	Any
18 Nov	MC/BOD Workshop	9.00 – 5.00	Boardroom, HRI	All
18 Nov	Estates and Facilities DRG meeting	2.00 – 4.00	Discussion Room 3, LC, HRI	BR/GH/KB/BM/AB/EH
19 Nov	Medical DRG meeting	11.30 – 1.30	Boardroom, HRI	GR/KW/BM/DW/RH/WC
30 Nov	Surgical DRG meeting	2.00 – 4.00	Discussion Room 3, LC,HRI	PM/GR/GH/DH/KB/CB

DECEMBER 2015

DATE	MEETING	TIME	LOCATION	PLEASE ATTEND
2 Dec	Equality and Diversity Awareness Session	9.00 – 12.00	Discussion Room 2, LC, HRI	Any (book through Workforce Development)
2 Dec	AGM Planning Sub-group	11.00 – 12.00	Chair's Office, HRI	GH/EH
7 Dec	MC Development Day (inc Festive Buffet)	12.00 – 4.30	Large Training Room, Learning Centre, CRH	Any
17 Dec	Chairs' Information Exchange	9.00 – 11.00	Syndicate Room 1, Learning Centre, CRH	

Calderdale and Huddersfield NHS

NHS Foundation Trust

Minutes of the Calderdale & Huddersfield NHS Trust Board of Directors and Membership Council Members Annual General Meeting held on Thursday 17 September 2015 at 6.00 pm in Acre Mills Outpatient Building, 3rd Floor HD3 3EB

PRESENT:-

Speakers present on the stage were:-
Mr Andrew Haigh, Chairman
Mr Owen Williams, Chief Executive
Mr Keith Griffiths, Director of Finance
Mr Trevor Rees, Partner – KPMG External Auditors
Mr Wayne Clarke, Publicly Elected Member-Deputy Chair/Lead MC

Others present were:-
Board of Directors
Dr David Birkenhead, Executive Medical Director
Mrs Julie Dawes, Executive Director of Nursing & Operations
Mrs Lesley Hill, Executive Director of Planning, Performance, Estates & Facilities
Mr Jeremy Pease, Non Executive Director
Prof. Peter Roberts, Non Executive Director
Dr Linda Patterson, Non Executive Director
Mrs Jan Wilson, Non Executive Director

Membership Council

Mrs Rosemary Hedges	Miss Liz Farnell	Mr Bob Metcalfe
Mrs Dianne Hughes	Mrs Eileen Hamer	
Mr Ken Batton	Ms Julie Hoole	
Mrs Annette Bell		
Mr Grenville Horsfall		
Mr Brian Moore		
Mrs Liz Schofield		
Mr Andrew Sykes		
Mrs Jennifer Beaumont		
Mr Brian Richardson		
Mr George Richardson		
Mrs Lynn Moore		

1. CHAIR'S OPENING STATEMENT AND INTRODUCTIONS

The Chairman opened the meeting by thanking everyone for attending and introduced the speakers. It was noted that other members of the Board of Directors and Membership Councillors were also present in the audience. The Chairman reported that it gave him great pleasure to welcome everyone to the new Acre Mills Outpatients Building which was a mixture of old and new and a real investment for patient care for the future. Just that week the Trust had learned that it had been

shortlisted in the Building Better Healthcare national awards and the outcome was awaited.

The Chairman reported that 2015-16 will see the Trust continue to focus on delivering care with compassion for our patients and their families. He explained that the Trust is here to deliver the best patient care and that we want patients to leave us and spread the word about the quality of care at CHFT. He pointed out that a large number of Trusts, like CHFT, are struggling financially. To this end the Trust was constantly working to improve efficiency and reorganise the care we deliver at both hospitals. If we wish to retain services locally, collaboration across the system and providers is going to be key. Locally this would involve more work with partners including local commissioners and the Health and Wellbeing Board to discuss the changes we have to make.

The Chairman highlighted that safeguarding has also been a focus this year in the wake of the Jimmy Savile Inquire. CHFT had reviewed all appropriate policies and guidelines to ensure our patients and staff are protected.

He reported that for the first time, the Trust ended 2014/15 with a financial deficit and that a deficit position was also forecast for the end of March 2016. The Trust is working hard to rectify the position and has the full support of Monitor, our regulator. It was emphasised that we will not achieve this through compromising on care.

Thanks were given to the staff for their dedicated pursuit of delivering healthcare excellence, innovation and above all being caring. Two examples of this included a colleague in Costa winning the national Customer Service award and a colleague who delivers support to patients with deteriorating eye sight achieving the Mascular Society's Health Professional of the Year. Thanks were also given to the Membership Council for their support as well as the Board of Directors, Executive Team and League of Friends.

The Chairman reported that this was the eighth year when the Board of Directors and Membership Council had come together at a joint Annual General Meeting, alternating sites between Huddersfield and Halifax each year. It was noted that the Health Fair held from 5.00 to 6.00 pm that evening had been very successful and thanks were given to all staff involved.

It was noted that the packs which had been circulated contained:-

- Agenda
- Membership Council Register of Members at 17 September 2014
- Summary Annual Report and Accounts
- Evaluation Form
- Annual Audit Letter from the external auditors
- Membership Forms

Paper copies of the full Annual Reports and Accounts were available at the meeting and electronically on the Trust website.

2 APOLOGIES

Apologies were received from:-

Board of Directors
Dr David Anderson, Non Executive Director
Miss Julie Hull, Executive Director of Workforce and Organisational Development
Mr Philip Oldfield, Non Executive Director

Membership Council Members
Mrs Linda Wild
Mr Martin Urmston
Mrs Di Wharmby
Mr Peter Middleton
Mrs Marlene Chambers
Mrs Johanna Turner
Mrs Linda Wild
Mrs Kate Wileman
Dr Mary Kiely
Miss Avril Henson
Mrs Chris Bentley
Prof John Playle
Cllr Naheed Mather
Mr David Longstaff
Mrs Dawn Stephenson

3 TRUST ANNUAL ACCOUNTS – APRIL 2014 TO MARCH 2015
Keith Griffiths presented the Annual Accounts, full details of which were available in the Annual Report. It was noted that the details of these had been discussed at the Board of Directors Meeting and these were approved as a correct record.

The key areas were noted:-

Financial Context
- Turnover £354m
- Patients
- *49,000 inpatients – elective and day cases*
- *50,000 inpatients – non elective*
- *385,000 outpatients*
- *142,000 A&E attendances*
- 5,479 colleagues
- Property and equipment over two hospital sites with a combined value of £222m
- 4% Efficiency challenge for the 5th year running
- Challenging financial landscape

The Trust's Performance in 2014/15
- Income was £354m in 2014/15
- Total expenditure was £360m

2014/15 Financial Performance

	Plan	Actual
Income and Expenditure	£3m	(£6m)
Income and Expenditure (excl. exceptional items)	£3m	(£4m)
Capital Expenditure	£24m	£23m
Cash Balance	£23m	£14m
Monitor Continuity of Service Risk Rating	3	2

Unqualified Audit Opinion	√	√

Key Financial Pressures

- Investment in nurse staffing ratios £1.5m
- Medical and Nursing agency spend £3.0m

Efficiency Savings Achieved

Procurement	£1m
Administrative and other staffing	£4m
Budgetary Control	£1m
Service Reconfiguration	£2m
Other schemes	£2m
Total savings achieved	£10m

External Assurance/Impact

PWC - Forecasting accurate
- No financial mismanagement

Monitor - Breach of Licence
- Monthly monitoring regime

Overview and Scrutiny Committee (Greater Huddersfield and Calderdale Local Authorities)

KPMG - Unqualified audit opinion

The Future

- Unprecedented financial challenges – locally and nationally
- Higher quality standards to be achieved – CQC compliance
- Even better levels of patient access – patient expectations
- Modernisation – technology and estate
- No short term solutions to CHFT's financial deficit.

4 ANNUAL REPORT 2014/15 and FORWARD PLAN

Owen Williams welcomed everyone and thanked staff and Membership Councillors for their work and commitment in caring for patients.

He made reference to the Summary Annual Report which contained the Trust's achievements and challenges for 2014/15. Looking ahead he outlined the Trust's engagement work using the four pillars and goals of the Trust:-

Four Pillars of Behaviour

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

Trust Goals

- Transforming and improving patient care
- Keeping the base safe
- A Workforce for the Future

- Financial Sustainability

He emphasised the need to work together both as a Trust and with commissioners in the challenging times ahead and the changing face of healthcare. He made reference to his personal reflection of his own experience of healthcare and the need to get to a place where the clinical commissioners are able to 'work together to get results' being a fundamental part of this. Advances in technology with the implementation of the electronic patient record would help this joint working as well as the financial position. He ended his presentation with a question "How can we help each other to work together to put patients first and provide quality clinical care?"

5 EXTERNAL AUDIT OPINION ON ANNUAL REPORT/QUALITY ACCOUNTS

Trevor Rees, Head of External Audit from KPMG gave a presentation outlining the scope and the work undertaken of the external auditors and assurances given. The three areas focussed on within the Audit included:-

- Finance Statements Audit
- Use of Resources
- Quality Report

He explained that as part of the finance statements audit, KPMG had given a clean, unqualified audit opinion with one unadjusted audit difference and a number of presentational changes. The Annual Report and Annual Governance Statement were consistent with financial statements and complied with Monitor's requirements. Four recommendations had been made in relation to payroll and the accounts production, together with recommendations on improving the accounts production in the future.

Trevor Rees then went on to explain that the Use of Resources work:-

- A modified (qualified) opinion was issued in relation to Use of Resources issued.
- As a result of the matters highlighted in the enforcement undertakings issued by Monitor on 29 January 2015, KPMG were not satisfied that the Trust made proper arrangements for security economy, efficiency and effectiveness in its use of resources.

The content of the Quality Report complied with the requirements of Monitor. Three indicators were tested:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period (mandated by Monitor)
- Emergency readmissions within 28 days of discharge from hospital (mandated by Monitor)
- Average length of stay (selected by the Membership Council)

The work resulted in achieving a 'clean opinion' for the Emergency Readmissions and Average Length of Stay with one recommendation and two recommendations being made respectively. Unfortunately, as consistent with the majority of Trusts nationally, KPMG were unable to provide an opinion on the 18 week wait due to issues with data.

Overall a recommendation was made in relation to locating patient records relevant to all indicators.

Trevor Rees announced that he would be retiring at the end of the year and a new Engagement Lead, Clare Partridge would be taking on the role. He wished the Trust all the best for the future.

6 ELECTION RESULTS AND APPOINTMENTS

The Chair reported that the second half of the meeting would be concentrating on the Membership Council AGM. There were a number of elections and appointments over the last 12 months which required formal ratification at the meeting.

a. Council Members

As members were aware, over the period 9 June to 21 August 2015, on behalf of the Trust, the Electoral Reform Services had held elections. This had resulted in 5 public and 3 staff seats being filled by Mrs Rosemary Hedges, Mrs Di Wharmby, Mr Kenneth Batten, Mrs Annette Bell, Mr Brian Moore, Mrs Avril Henson, Mrs Eileen Hamer and Ms Julie Hoole. Rev Wayne Clarke had been appointed as Deputy Chair/Lead Governor to take over from Martin Urmston. The Chair thanked Martin for his support as Membership Councillor for the past 3 years and latterly as Deputy Chair/Lead Governor for the Membership Council since 2014.

All these appointments could be seen on the Register of Members which was available within the packs. The ballot turnout rates this year was around 12.3% which was comparable to other trusts.

The Chairman wished to thank the retiring members who included:- Mrs Marlene Chambers, Johanna Turner, Andrew Sykes, Liz Farnell, Chris Bentley and Martin Urmston, together with Linda Wild and Liz Schofield who had been on the Reserve List. Two Stakeholder representatives had also ended their tenures – Cllr Hilary Richards and Mrs Janet Boucher.

b. Board of Directors – Non Executive Directors

The Chair reported that the Nominations Sub Committee had not had cause to meet in the past year due to there being no Non Executive Director tenures to consider on the Board of Directors.

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

7 MEMBERSHIP COUNCIL UPDATE – OVERVIEW OF THE MEMBERSHIP COUNCIL CONTRIBUTION DURING 2013/14

Rev Wayne Clarke, Deputy Chair gave an overview of the Membership Council Contribution during 2014/15. This included:-

- The role of the Membership Council and involvement via the Divisional Reference Groups with Service Users to develop the plans for the Trust.
- Training and Development opportunities including Induction, individual training and development days.
- Governance issues:-
    - Chairman's One to One Meetings

    - Attendance at full Membership Council meetings and AGM
    - Attendance at Board of Directors Meetings.
    - Attendance of Council members on a wide range of sub committees such as Nominations, Remuneration, Organ Donation, Quality, Finance and Audit and Charitable Funds.
    - Joint workshops with the Membership Council and Board of Directors
    - Council Members continue to be actively involved in Patient and User Interview Panels, Real Time Monitoring and Awards panels for the Trust's Celebrating Success.
    - Annual Report and Quality Accounts involvement in their compilation
    - Governance Task and Finish Group re member engagement
- Engagement and Involvement Opportunities including walkabouts, Real Time Patient Monitoring, Patient/User Interview Panels, Awards Panels, Staff Suggestion Scheme and Ad hoc involvement opportunities in partnership with the Patients Association.
- Opinion Seeking via surveys, strategic projects and Membership Email in-box

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

8 QUESTIONS AND ANSWERS

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

Q – Whether the capital and financial charges included the PFI and whether it would be possible to see the PFI Contract?

A – The Executive Director of Finance explained that the PFI is like a rent and therefore the charges did not apply. It was noted that the PFI Contract had some elements that would be commercially confidential and therefore it would need to be checked what could and couldn't be released.

Q – The Trust has described its development of robust plans for sustainability, could the Chief Executive provide a taster of what this might include?

A – The Chief Executive responded that over the next three months the Trust will be developing a 5 Year Strategic Plan. Some of the plan would be based on the work done to develop the outline business case but that the world had moved on since with new initiatives such as the West Yorkshire Vanguard and the changing relationship between health and local authorities into the future. He explained that the plan would be developed with partners in mind and would consider the best location of services. He pointed out that Calderdale Clinical Commissioning Group had made a decision to retain the Trust as the provider of community services until March 2017. The Chief Executive said that this work was in its early stages and so there was no more to share at this point but it would address the challenge faced by the Trust of providing care across two sites and would consider opportunities for delivery of care away from just the physical hospital locations. The Chair added that staying still was not an option for either delivery of high quality care or from a financial perspective.

Q – Why do you refer to Greater Huddersfield as most residents wouldn't recognise this?

A – The Chief Executive explained that it reflects how commissioning responsibilities are allocated whereby Kirklees is split into North Kirklees and then Greater Huddersfield which covers the area of Huddersfield and its valleys.

Q – What can be done to increase the staff friends and family test figures?

A – The Chief Executive responded that the way in which we currently provide care is a tremendous ask for people and impacts on their daily lives. We need to provide a better environment for staff and give them a platform to be able to make changes.

Q – What are the views about making the best use of technology and using innovative partnerships to do this?

A – The Chief Executive explained that he is passionate about using technology to get the best results for patients and that he feels aghast that in 2015 patients are unable to routinely be able to see their own clinical record. He gave hypertension as an example of a condition where technology could be used by patients in their own home to self-manage successfully. He commented that partners in the commercial and voluntary sectors are key to making a change and that the notion of competition was beginning to change as it was in the interests of patients to collaborate. The use of technology would be a way forward.

Q – Is there an opportunity to do more with the training suites and include an observation suite with a camera system?

A - The Chair commented that he recognised that the Trust did not have these facilities as it wasn't a teaching hospital. He added that the Trust did train a lot of students and that technology had been put in place such as the use of sophisticated manikins that responded like real patients to different care and treatment.

9 DATE AND TIME OF NEXT MEETING

It was noted that details of the next Annual General Meeting had yet to be confirmed but it was intended to be held on Thursday 15 September 2016. The time and venue would be confirmed nearer the date.

The Chairman closed the formal meeting at approximately 7.30 pm.

/KB/AGM2015-MINS