Calderdale and Huddersfield NHS
NHS Foundation Trust

Mr Andrew Haigh
Chairman
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The Royal Infirmary
Lindley
Huddersfield HD3 3EA

Ref: AH/KB

10 January 2014

To:- Membership Councillors

Dear Colleague

FORMAL AND INFORMAL MEMBERSHIP COUNCIL MEETING – MONDAY 20 JANUARY 2014 – BOARDROOM, SUB-BASEMENT, 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** to be held in the Boardroom, HRI.

I attach the agenda and associated papers for the formal meeting on 20 January 2014 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 Monday 20 January 2014 commencing at 4.00 pm in the Boardroom, Huddersfield Royal Infirmary, HD3 3EA

A G E N D A

1	**APOLOGIES FOR ABSENCE:-** Welcome to: Mrs Jan Wilson, Non Executive Director & Vice Chairman		
2	To receive a presentation from **Helyn Aris, Compliance Manager – Care Quality Commission (North East Region)**		
3	To approve the **MINUTES OF THE LAST MEETING** held on Wednesday 6 November 2013	**AH**	**APP A**
4	**MATTERS ARISING** a. Director of Nursing Appointment b. Company Secretary Appointment c. Care of the Acutely Ill Patient – Updated rag-rated report d. How do "we go and see" e. DRGs Agenda – Learning from Experience	**AH** **AH** **BAC/Juliette Cosgrove** **RM** **RM**	**VERBAL** **VERBAL** **APP B** **VERBAL** **VERBAL**
5	To receive details of the **TRUST FINANCIAL AND SERVICE PERFORMANCE**	**KG/LH**	**APP C**
6	To receive the **CHAIRMAN'S REPORT** **a. Chairs Information Exchange Meeting – 9.1.14** **b. Update on Streamlining Board Governance Task & Finish Group** **c. Strategic Review Update**	**RM/AH** **JRH/AH** **AH**	**APP D** **VERBAL** **VERBAL**

7	**CONSTITUTION:** **a.** To receive the **MEMBERSHIP COUNCIL REGISTER – RESIGNATIONS/ APPOINTMENTS** **b.** To receive the updated **REGISTER OF INTERESTS/DECLARATION OF INTEREST**	**AH** **AH**	**APP E** **APP F**
8	To approve the **MEMBERSHIP STRATEGY**	**RM**	**APP G**
9	To receive the **QUALITY ACCOUNTS – LONG LIST OF INDICATORS**	**BAC/JC**	**APP H**
10	To receive and action as appropriate the following **FAST-TRACK ITEMS:** **a. Updated Membership Council Calendar 2014** **b. MC/BOD Joint Annual General Meeting Minutes – 19.9.13** **c. MC News – January 2014**	**RM**	**APP I** **APP J** **APP K**
11	**Any Others Business**		
12	**Date and time of next meetings:** **Tuesday 8 April 2014 – commencing at 4.00 pm – Boardroom, Huddersfield Royal Infirmary**		

Calderdale and Huddersfield NHS
NHS Foundation Trust

MINUTES OF THE FOUNDATION TRUST COUNCIL MEMBERS MEETING HELD ON WEDNESDAY 6 NOVEMBER 2013 IN THE LARGE TRAINING ROOM, LEARNING CENTRE, CRH

PRESENT:

Andrew Haigh	-	Chair
Linda Wild	-	Public elected – Constituency 2
Wayne Clarke	-	Public elected – Constituency 2
Peter Middleton	-	Public elected – Constituency 3
Dianne Hughes	-	Public elected – Constituency 3
Christine Breare	-	Public elected – Constituency 4
Marlene Chambers	-	Public elected – Constituency 4
Bernard Pierce	-	Public elected – Reserve Constituency 5
Grenville Horsfall	-	Public elected – Constituency 5
Johanna Turner	-	Public elected – Constituency 6
Janette Roberts	-	Public elected – Reserve Constituency 6
Liz Schofield	-	Public elected – Constituency 7
Jennifer Beaumont	-	Public elected – Constituency 8
Avril Henson	-	Staff-elected – Constituency 10
Eileen Hamer	-	Staff-elected – Constituency 11
Liz Farnell	-	Staff-elected – Constituency 12
Chris Bentley	-	Staff-elected – Constituency 13
Bob Metcalfe	-	Nominated Stakeholder – Calderdale Metropolitan Council

IN ATTENDANCE:

Kathy Bray	-	Board Secretary
Jillian Burrows	-	Senior Manager, KPMG, External Auditors (for part of meeting)
Chris Benham	-	Deputy Director – Finance & Procurement (for part of meeting)
Barbara Crosse	-	Medical Director (for part of meeting)
Lesley Hill	-	Director of Planning, Performance, Estates & Facilities (for part of meeting)
Ruth Mason	-	Associate Director of Engagement & Inclusion
Jan Wilson	-	NED & Vice Chair

29/13 APOLOGIES:

Apologies for absence were received from:

Joan Taylor	-	Public elected – Constituency 1
Martin Urmston	-	Public elected – Constituency 1
Kate Wileman	-	Public elected – Constituency 7
Andrew Sykes	-	Public elected – Constituency 8
Mary Kiely	-	Staff elected – Constituency 9
Julie Mellor	-	Staff-elected – Constituency 13

Sue Cannon	-	Nominated Stakeholder, NHS Calderdale
Jan Giles	-	Nominated Stakeholder, Kirklees PCT
Dawn Stephenson	-	Nominated Stakeholder – SWYPFT
John Playle	-	Nominated Stakeholder – Uni. of Hudds.
Keith Griffiths	-	Director of Finance
Julie Hull	-	Director of Workforce & Organisational Development
Helen Thomson	-	Director of Nursing
Owen Williams	-	Chief Executive

The Chair welcomed all Membership Councillors, Jan Wilson, Non-Executive Director and Jillian Burrows to the meeting.

30/13 MINUTES OF THE LAST MEETING – 3 JULY 2013

The minutes of the last meeting held on 3 July 2013 were approved as a correct record.

31/13 ANNUAL AUDIT LETTER 2013/14

Jillian Burrows, Senior Manager, KPMG and External Auditor for the Trust attended the meeting to present the "CHFT Annual Audit Letter 2012/13". It was noted that due to the limited time available at the Annual General Meeting on 19 September 2013, the 'External Audit Opinion' had been included within the Members Pack which had been circulated at the event. For the future it had been requested that the Auditors are allocated time within the AGM agenda to present their Audit findings.

Jillian formally reported that an unqualified opinion had been issued with one unadjusted audit difference agreed and approved by the Audit & Risk Committee. She reported that the Annual Report was consistent with the financial statements and four recommendations raised had been addressed. The financial performance of the Trust was a Monitor overall risk rating of 3 for 2012/13 and a green rating for governance. The Trust had kept within the Prudential Borrowing Limit set by Monitor and reported compliance with the Prudential Borrowing Code. It had secured a surplus of £3.8 before exceptional items for the year.

In addition, the Audit covered key issues arising from:-
Use of Resources – no significant issues identified
Quality Report – achieved a limited assurance opinion on content with two mandated indicators

Areas for consideration in 2013/14 were highlighted:-

- Financial Statements – achievement of cost improvement plans and financial targets
- Use of Resources – Licensing conditions, risk assessment framework
- Quality Report – Quality Governance Framework, Care Quality Commission

Linda Wild asked for information on the unadjusted audit difference and it was noted that this was included within the Audit Opinion and referred to a technical adjustment recommendation regarding extra financial provisions/future costs for 2013/14.

It was noted that the Annual Audit Plan had been taken to the last Audit & Risk Committee.

Peter Middleton asked about the additional value added work undertaken by the Auditors. Chris Benham outlined that although a physical audit is undertaken, there is recognised change with computer aided audit tools available. This drives the intellectual questioning about risks and the Audit and Risk Committee receive regular updated on what is happening both within and outside the NHS in the field of audit and risk.

The Membership Council thanked Jillian for presenting the External Annual Audit opinion.

32/13 MATTERS ARISING

There were no matters arising.

33/13 TRUST FINANCIAL AND SERVICE PERFORMANCE REPORT

Lesley Hill presented the service performance report as at the end of September 2013. The key issues of concern were noted:-

HSMR (Hospital Standardised Mortality Rate) - The Trust's (HSMR) figure had recently been rebased and stood at 111 from a previous figure of 102. This rebased figure was due to national improvements showing results, faster than CHFT. Lesley Hill reported this was not a position that the Trust wanted to be at. It was noted that Dr Barbara Crosse, Medical Director would be presenting a detailed report about 'Care of the Acutely Ill Patient' later in the meeting.

Emergency Re-admissions within 30 days of discharge – The Greater Huddersfield CCG performance was now on target. The Calderdale CCG had dropped out of target. It was felt that this may be due to vacancies in the virtual ward team. The vacancies were being filled in November and hopefully this would improve the position.

Stroke % of Patients Spending at least 90% on Stroke Unit – The performance of 76.19%, against a year to date target of 80% in September was noted. This was due to the target not being met by one patient.

Fractured Neck of Femur – An improvement in the last two months had been noted but further work was underway to improve Theatres which will mean reduced capacity, therefore a reduction in lists may affect the target in the immediate future.

Patient Flow – A sub group of Urgent Care Board had been established to focus on delayed discharges. A/E targets were being achieved. Issues regarding

ambulance handovers were being discussed with the Yorkshire Ambulance Service to reduce potential penalties next year.

DNA Appointments – A new SMS reminder system had been launched. New booked appointments continue to be made 9-16 weeks in advance. Partial booking is to be introduced for follow-up appointments.

Sufficiency of Appointment Slots on Choose and Book – Position continues to improve. Focussed work in Ophthalmology, GI and Liver underway to improve performance.

It was noted that at the present time two wards were closed for refurbishment (Ward 7 and 8) and it was planned that these would open over the Xmas period and form part of the winter planning arrangements.

FINANCE

Chris Benham presented the finance report as at 30 September 2013, Month 6.

The main points highlighted from the report were:-

- The year to date Income and Expenditure position for Month 6 is a surplus of £0.28m, against a planned surplus of £0.25m.
- The cash position at the end of September 2013 is £16.74m (£0.93m below plan).
- Capital spend to date of £6.00m (£1.50m above plan).
- The current forecast year end position is to achieve a surplus of £2.97m, compared with a plan of £3.00m.
- The Financial Risk Rating (FRR) of 3 at the end of September 2013 (plan was 3), and the forecast is to end the year at level 3, as per the plan. It was noted that a separate presentation would be given later in the meeting regarding the Financial Risk Ratings.
- Increased activity within planned care and specialist commissioning together with slippage on some developments and delays in recruiting to vacancies had resulted in a marginally better than planning position at Month 6.
- Cash was below plan due to the need to pay suppliers slightly early prior to the upgrade of financial systems (Oracle).

  Key risks:
  - There is shortfall in identification of Cost Improvement Programme (CIP) of £4.7m at this early stage.
  - Achievement of CQUIN (Commissioning for Quality & Innovation) targets worth £7.1m will be critical.
  - Winter pressure plans are in place but additional costs of winter remain a risk.

34/13 FINANCIAL RISK RATING

Chris Benham presented slides detailing Monitor's current and proposed models for scoring financial risk ratings in the future. In summary this meant moving from a financial scorecard with ratings between 1-5, to a financial scorecard with ratings between 1-4. In addition this also meant a switch from the focus on Income & Expenditure and delivery of plan, to focus on continuity of service.

The impact for the Trust were discussed. This included:-

- Importance of cash strengthened
- Private Finance Initiative (PFI) costs recognised within the 'debt service' measurement
- Financial Risk Rating remains at level 3 but quarterly reporting moves to potential monthly reporting
- Annual working capital facility fee of £50k saved.

The Chairman reported that the Trust was working hard to identify recurrent savings and external consultants had been appointed to drive the work and identify further potential savings in specific areas within the Trust.

35/13 CHAIRMAN'S REPORT

a. **Director of Nursing Appointment** – The Chairman reported that 3 candidates had been interview for this post. An offer had been made to Julie Dawes, currently Director of Nursing at Portsmouth. A start date had yet to be confirmed.

b. **Company Secretary Appointment** – Six candidates had been interviewed on 4 November 2013. An offer was to be made but this had not yet been finalised.

c. **Chairs Information Exchange – 22.10.13** – The contents of the minutes circulated with the agenda were noted.

d. **Update on Streamlining Board Governance Task & Finish Group –** As part of the work identified by Foresight Partnership in reviewing the Board's effectiveness, a Task and Finish Group had been established consisting of Membership Councillors (Johanna Turner and Martin Urmston), Non-Executive Directors (Andrew Haigh and Peter Roberts), Executive Directors (Barbara Crosse and Julie Hull). A paper outlining the progress to date was due to be taken to the 21 November 2013 Board of Directors Meeting and would be brought back to the full Membership Council in due course.

ACTION: AH/JRH - Future MC Meeting

36/13 CONSTITUTION

a. **Constitutional Review Update**

The Chairman presented a tracked version of the Constitution. It was noted that the changes had been made following the implications of the Health & Social Care Act 2012 on the operation of the Constitution. In addition, the Constitution had

been updated to reflect the new NHS architecture. It was noted that other amendments may be required in the near future.

RESOLVED: **All present approved the tracked changes to the Constitution and noted that it would be submitted to Monitor for information.**
ACTION: **BOARD SECRETARY TO SUBMIT TO MONITOR**

b. Membership Council Register – Resignations/Appointments
The updated register of members was received for information.

c. 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.

37/13 CARE IF THE ACUTELY ILL PATIENT
The Medical Director gave a powerpoint presentation summarising the content of the paper circulated with the agenda. In summary the paper updated the Membership Council on the work undertaken within the Trust to improve mortality rates and the aim of improving this further through the care of our acutely ill patients.

It was noted that the Trust was not achieving the Hospital Standardised Mortality Rates (HSMR) figure it would like and the complicated issue of measurement was discussed.

The key themes from the work included:-
- Improving consistency across and within sites in the implementation of clinical pathways and bundles
- Improving quality with pace through clinical leadership
- Efficient and effective patient flow
- Optimise senior medical involvement in patient care out of hours
- CHFT as a learning organisation
- Staffing levels and skill mix to ensure safety and quality
- Ensuring coding is reflective of patient primary diagnosis and co-morbidities.

There were a number of key areas where further work would be focussed:-
- Sepsis
- Chronic Obstructive Pulmonary Disease
- Pneumonia
- Intracranial Injury
- Acute Kidney Injury
- Fractured Neck of Femur

Other supporting areas affecting the care of all patients across the Trust included:-
- Reducing harm from Venous Thromboembolyism
- Improving the care of the deteriorating patient
- End of life care

- Falls
- Medication safety
- Diabetes
- Pressure Ulcers

The Membership Council present welcomed and supported the work being undertaken within the Trust.

Liz Schofield asked about the learning and use of knowledge of staff on the role of the specialist nurses in the organisation, specifically around MS nurses, and Barbara Crosse agreed to ensure that awareness was circulated widely.

ACTION: BAC – Promote awareness of the role of Specialist Nurses

Rev Wayne Clarke agreed that this was good work being undertaken and asked that the Trust might also have an awareness of the non-medical/clinical factors and the benefits which can be brought about by support from family, friends and staff to promote emotional, spiritual factors to benefit patients. Dr Crosse agreed that this was critical for the wellbeing of patients, but sadly there were no measurable outcomes which could be attached to this.

It was agreed that the rag-rated (red, amber, green) report would be updated and brought to the next Membership Council Meeting on 20 January 2014

ACTION: BAC – MC AGENDA 20.1.14

38/13 FASTTRACK ITEMS

The following fast track items were received and noted:

a. Updated Membership Council Calendar 2013 and Allocation of MCs to Sub Groups/Committees.

b. Monitor publication – Your statutory duties – A reference guide for NHS Foundation Trust Governors – August 2013

39/13 ANY OTHER BUSINESS

a. BOARD/MC WORKSHOP AND XMAS BUFFET

The Chairman reported that the Xmas Buffet, previously scheduled for the 17 December 2013, had been cancelled and would be incorporated within the MC/BOD Joint Workshop on 3 December 2013. It was noted that this would be a morning only event, concluding with a buffet lunch, and would be held at the Blackley Centre.

b. DIVISIONAL REFERENCE GROUPS

Ruth Mason reported that the next round of DRG meetings would start next week and each group would be looking for new Chairs of each group to help. In the meantime Ruth Mason and Vanessa Henderson would meet with Divisional colleagues to set agendas.

c. CQC REPRESENTATIVE AT MC MEETING

The Chairman reported that Helyn Aris, Compliance Manager at the Care Quality Commission had been invited to attend the 20 January 2014 meeting to give a 20 minute presentation plus 20 minutes for questions and answers.

ACTION: AGENDA ITEM – 20.1.14

d. HOW DO WE 'GO AND SEE'

In relation to the presentation from Julie Hull at the last meeting "Delivering Your Care, Our Concern' – staff engagement strategy, Chris Breare asked how the Membership Council could deliver against the "We go see". It was noted that Membership Councillors are involved in annual visits to wards/departments but questioned whether this was sufficient. Ruth Mason agreed to add this subject to the agenda for the Ken Tooze Development session with the Membership Councillors on the 4 December 2013.

ACTION: RM – 4.12.13 MC Development Session Agenda.

e. OVERSEAS VISITORS

On behalf of Andrew Sykes, Janette Roberts wished to assure the Membership Councillors that the monies lost from Overseas Visitors affecting the CHFT were very low. Nationally a group had been established to monitor the position and retrieve lost monies. It was noted that this had been discussed at the Audit & Risk Committee.

f. CHFT VICE CHAIR AND SINED

The Chairman wished to draw the attention of the Membership Council to the agreement made at the September 2013 Board of Directors Meeting to appoint Mrs Jan Wilson as Vice Chair and Dr David Anderson as SINED.

There was no other business to note.

40/13 DATE AND TIME OF NEXT MEETING

Monday 20 January 2014
Members 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 6.30 pm.

…… ……

Mr Andrew Haigh, Chairman **Date**

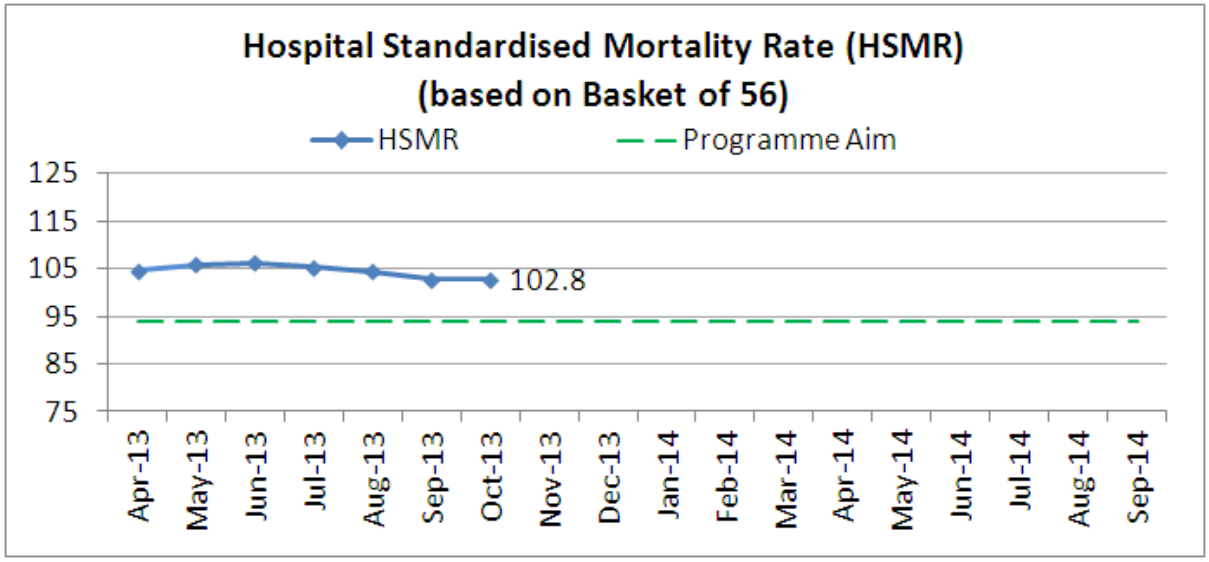
Subject	**Care of the Acutely Ill Patient**
Reporting Month	January 2014
Authors	Lisa Fox - Information Manager Mel Johnson - General Manager CGSU
Summary	Report to inform the membership council of progress against outcomes for the Care of the acutely Ill patient Programme
Contents	1 Hospital Standardised Mortality Rates: 2 Work stream Progress 3 High Performing Areas: - Sepsis - HSMR has fallen back in line with the national average. 4 Areas for further investigations: - Other Perinatal – HSMR score has recently alerted as an outlier 5 Overall Themes
Presented at	Membership Council Meeting – 20/01/2014
Highlights	The programme aims to see a 10 point drop in HSMR from the 12/13 position of 104. **What is HSMR?** HSMR is a national measure that is used to compare our death rates to those of other Trusts, it alerts us when we have more than the expected number of deaths for our population from certain clinical conditions, from this we re able to look in more depth at causes. A Score of 100 tells us we have a mortality rate which is as expected for our population. Below, is better. Above 100 is worse. ➢ Current data released by Dr Foster Intelligence (DFI) indicates that our HSMR is 102 for the period of Nov 12 – Oct 13. Against the 12-13 baseline of 104. ➢ We would expect to see noticeable improvements in the 12 month HSMR once the work streams of the Care of the Acutely Ill Patient Programme are in progress, HSMR has been chosen as a way of linking performance in a number of areas which will contribute to achieving the overall aim of a 10 point drop. Crude numbers have also been shown to be able to see the patients behind the HSMR score. ✓ **High Performing Areas:** **Sepsis** - HSMR has fallen back in line with the national average. × **Areas for further investigations:** **Other Perinatal** – HSMR score has recently alerted as an outlier

1. Hospital Standardised Mortality Rates:

Between April 2012 and March 2013 CHFTs published HSMR was 104. Whilst this was not statistically significantly different from other trusts in the country, it was of enough concern to develop the Care of the Acutely Ill Patient Programme.

The programme aims to reduce our HSMR score by 10 points to 94 by September 2014.

Current Position:



Programme Outcomes	Baseline - 12/13 HSMR	Aim - End Of Programme	Latest Month HSMR - Oct 13	Change from Previous period	HSMR Last 12 Months: Nov12-Oct13	Change from Previous period
HSMR	**104.09**	**94**	**91.2**	↑ +.02	102.8	→ 0

2. Work Stream Progress

One of the themes from the programme is to focus on number of areas of concern as well as some specific clinical conditions that are known to contribute to our inhospital mortality rate.

The aim for all these work streams is to improve clinical quality and track these improvements over time. Where applicable, improvements will be made through the adoption of a number of evidence based standards (often referred to as a care bundle) to standardise care to best practice.

For some of these work streams we will be tracking improvement through condition specific mortality rates and HSMR score. For other work streams different proxy outcome measures will be used.

Therefore the work streams can be broken down into two categories, those which focus on a clinical condition and those which focus more on a care process.

The table below reflects the HSMR scores for the condition specific work streams

Condition Specific	Baseline - 12/13 HSMR	Aim - End Of Programme	Latest Month HSMR - Oct 13	Change from Previous period	HSMR Last 12 Months: Nov12-Oct13	Change from Previous period
Reducing harm from sepsis	147.7	90	**0.0**	↓	**105.0**	↓
Reducing harm from VTE	68.4	90	**0.0**	→	**108.2**	↓
Reducing harm from COPD	105.8	100	**125.0**	↓	**119.0**	↑
Reducing harm from Pneumonia	110.2	100	**99.5**	↑	**109.0**	→
Reducing harm from Intracranial injury	120.0	100	**91.0**	↓	**129.3**	↑
Reducing harm from Acute & Unspec Renal Failure (AKI)	108..5	100	**79.1**	↓	**91.0**	↑
Reducing harm from # NOF	94.7	90	**52.0**	↓	**85.0**	↓
Reducing rates of Other Peri Natal (inc Still Birth)	160.0	100	**364.0**	↑	**179.0**	↑
Reducing Metabolic causes of Mortality	Not ammeanable to HSMR – Other measures being developed					

Care Process Measures:

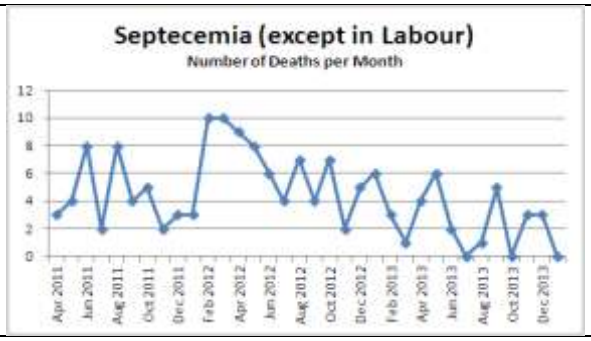
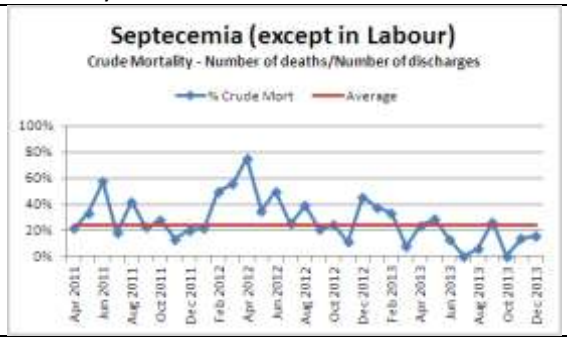
	Baseline - 12/13 HSMR	Aim - End Of Programme	Latest 12 month period	Pervious 12 month period	Last month	Previous month
Improving care of the Deteriorating Pt - Number of Cardiac Arrests	143	129	179	↑	17	↑
Reducing Missed Doses -	Measures being developed					
Reducing Falls (Harm Falls)	Measures being developed					
Reducing Pressure Ulcers (Pts 2-4)	Measures being developed					
Improving End of Life Care	Measures being developed					

3. High Performing Areas

A number of these areas are already showing significant improvement due to the ongoing improvement work within the trust. An example is highlighted below:

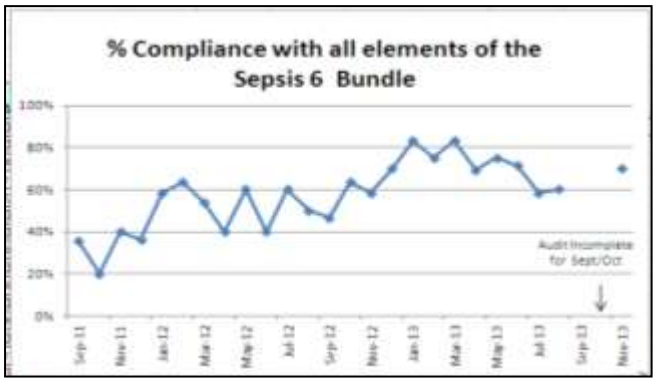
Area Where Improvement Noted - Sepsis:

Over the last 6 months we have seen an all time low in the number of patient dying form this condition.

Raw numbers	Mortality Rate
	

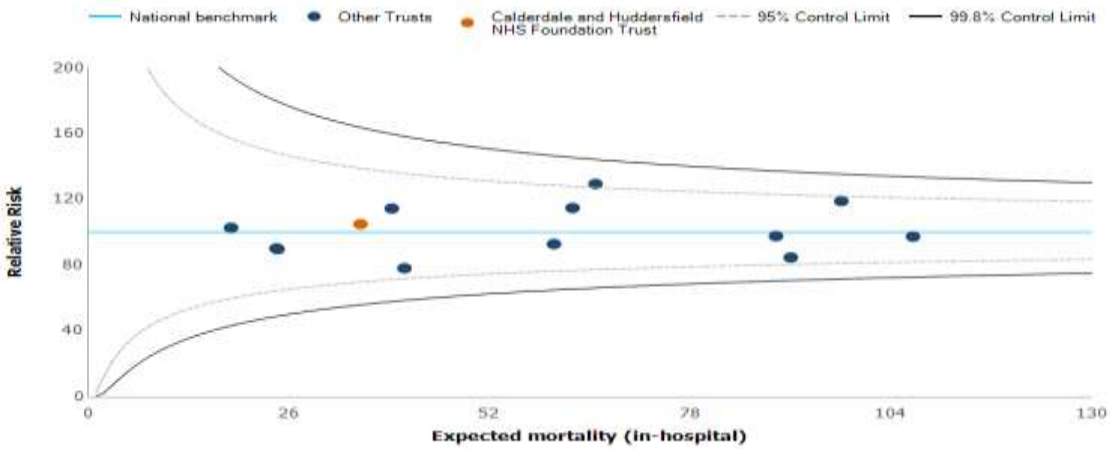
The data tells us that proportionately fewer patients are now dying from this condition, giving us confidence that this is related to improvements in care, as opposed to fewer patients being admitted.

Work has been ongoing since September 2011. There is now increased awareness following a number of engagement events, the introduction of the care bundle and sepsis screening tool on admission. The chart below shows increasing compliance with the sepsis 6 care bundle.
The trust continues to try and achieve its aim of 95% compliance.



How do we compare?

Using the Dr Foster Intelligence we can see that there is still the potential to improve further to be in line with best in the region. The planned further work will assist us in that aim.

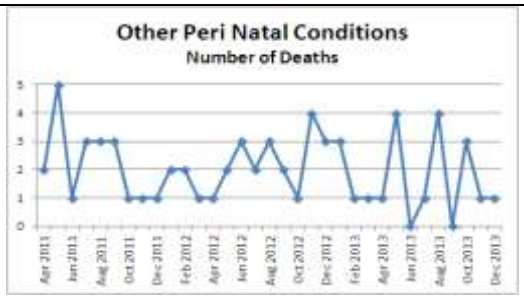
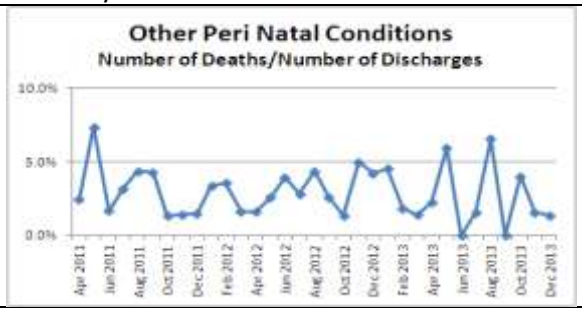


4. Areas for further investigations

We have also identified some areas in need for more intensive work and clarity.

Area of concern - Other Perinatal Conditions:

The trust would like to improve its position in relation to other perinatal deaths.

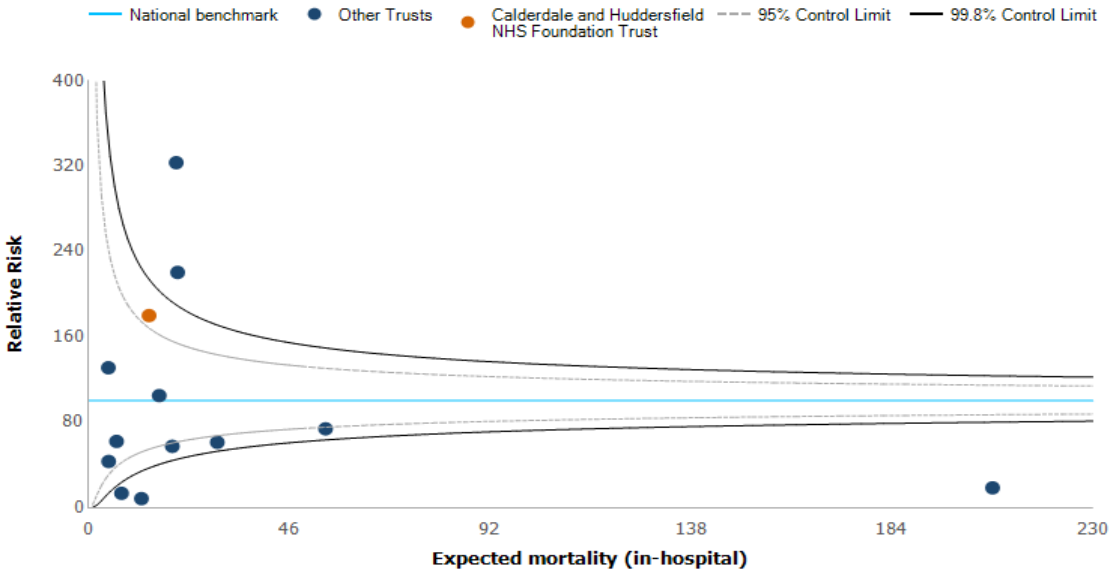
Raw Numbers	Mortality Rates
	

The workstream is seeking to understand contributing factors to the data and where appropriate will implement improvement processes.

The focus of which, are listed below:

- The rate of undetected Severe Growth Abnormalities (SGA)
- The incidence of women delaying reporting diminished Fetal Movement (FM)
- The rate of stillbirth associated with failure to identify and act on suboptimal fetal heart rate and pattern
- The rate of stillbirth associated with modifiable risk factors
- The rate of stillbirth associated with congenital abnormalities
- The experiences of women and families who experience stillbirth
- Data quality

How do we compare?



5. **Overall programme themes**

The programme contains a number of themes, pertaining to a wide number of actions, these are summarised below.

Care of the Acutely Ill Patient Overarching Themes:		
Theme 1	Improving consistency across and within sites in the implementation of clinical pathways and bundles.	As discussed above – This is the work around the 14 work streams which will contribute to a reduction HSMR
Theme 2	Improving quality with pace, through clinical leadership	Communication plan to engage staff at all levels with the need to maintain high standards of care delivery.
Theme 3	Efficient and Effective patient flow	There are a number of bespoke work stream in this area, including: Appropriate admissions, Safe transfers. Clinical intervention being given on time and in full; and Safe and timely discharge.
Theme 4	Optimise senior medical involvement in patient care, out of hours.	Modelling the 7 day hospital and how this will be structured and resourced
Theme 5	CHFT as a learning organisation	Forums for shared learning around delivering high quality of care.
Theme 6	Staffing levels and skill mix to ensure safety and quality	Ongoing recruitment for more nursing staff and E Rostering to help ensure good skill mix.
Theme 7	Ensuring coding is reflective of patient primary diagnosis and co morbidities.	Working groups to understand the underlying datasets and how they contribute to models of mortality reporting Improving the clinical documentation to ensure coding accurately reflects care delivered.

Calderdale and Huddersfield NHS
NHS Foundation Trust

Financial Position to Nov 2013

- The year to date Income & Expenditure position for Month 8 is a surplus of £2.26m, against a planned surplus of £2.65m.
- The cash position at the end of November 2013 is £16.21m (£0.67m above plan).
- Capital spend to date of £8.19m (£2.68m below plan).
- The current forecast year end position is to achieve a surplus of £1.93m, compared with a plan of £3.00m.
- The Monitor 'Continuity of Service Risk Rating' is 3 at the end of November 2013 (plan was 2), and the forecast is to end the year at level 3, as per the plan (on a scale of 1= poor to 4= good).

Financial Position to Nov 2013

Calderdale and Huddersfield NHS
NHS Foundation Trust

- Year to date expenditure is above planned levels due to undelivered Cost Improvement plans (CIP) and higher than planned levels of Agency spend.
- Cash is above plan as a result of slippage on Capital schemes.
- <u>Key Risks</u>
  - There is shortfall in identification of CIP of £5.2m and only £2.5m of Reserves available to offset any resulting cost pressure. This has increased the risk that the Trust will not achieve its planned surplus of £3m, which would in turn impact on investment opportunities in 2014/15.
  - Some CQUIN (Commissioning for Quality & Innovation) targets are currently rated red putting £0.9m on income at risk.

Your Care Our Concern

Calderdale and Huddersfield NHS
NHS Foundation Trust

Quality and Performance Report
November 2013 Highlights

The information provided to the Board within this paper comprises:

- The dashboard information across the 'Outcomes Framework domains'
- An exceptions report on the indicators which are off target
- The finance dashboard

There are a number of areas which should be brought to the attention of the Executive Board, as they currently present significant risk to the Trust.

Indicator	Update	Director Lead
Transfer of care Part B Discharge Medication as patients transfer from one provider to another (1)	Pharmacists are now routinely seeing ALL e-discharges during normal working hours on wards 2ab at CRH and Ward 6 at HRI. If this does not hold up discharges then there will be a further roll out to other wards early in the new year. The key indicator will be the percentage figure of e-discharges seen by Pharmacists at the end of December . Expecting between 25 to 30%. The Medical Division are on board.	Ashwin Verma
Crude mortality, SHMI, HSMR	Crude mortality for October this year was slightly higher than the equivalent month last year, but for November the rate is again slightly lower than last year's performance. The overall trend over the past few years remains downwards but the data does vary month on month.	Barbara Crosse

Indicator	Update	Director Lead
	There has been a data refresh at Dr Foster in the last few days. The result is that our 2013/14 year to September HSMR is now 98, with a rebased position of 106. This is a two point improvement from the August position. The next SHMI will be available in late January.	
ASTHMA - Improving management of patients presenting with Asthma in A&E	An A&E sister is now supporting this improvement work for 15 hours per week across site. This support and improvement work includes: 1. One to one 15 minute training session being delivered to all nurses, middle grades and junior doctors. 2. Regular feedback sessions/ focus board updates on recent results/good practice 3. Respiratory Nurse input for training package to increase validity. 4. Liaison with the self-management plans project leader 5. Training sessions delivered to all of the new Junior doctors The main area of improvement work has related to the three areas of the indicator where performance has not been met to date – nebuliser (first 20 minutes from attendance), steroids (30 minutes from attendance) and inhaler technique. Performance is now monitored weekly – recent weekly audit at HRI was 71% for the week suggesting a significant improvement (awaiting CRH audit). Further work is	Peter Holdsworth

Indicator	Update	Director Lead
	planned at CRH to continue improvement ahead of Q4 reporting requirement of 55%.	
Emergency readmissions within 30 days of discharge – Greater Huddersfield CCG and Calderdale CCG	At the end of September 16 discharge coordinators started work in new posts - one on each medical ward. Part of their job is to minimise the delays for patients who are ready to be discharged or to move to their next destination. This improved the situation in October but due to flow issues there has been a problem in November.	Mark Partington
Fractured Neck of Femur	Performance continues to be significantly below target. No update from last month.	Peter Holdsworth
Stroke - % of patients who spend at least 90% of time on a stroke unit	Extreme pressure on patient flow resulted in target missed by 3.5%. No update	Ashwin Verma
Stroke, % of TIA patients with a high risk of stroke treated in 24 hours.	In month target missed, continue to meet in year target.	Ashwin Verma
Patient Flow – Including delayed transfer bed days, A/E indicators,	Significant focus on this target both within and outside the organisation to Department of Health level. A sub group of Urgent Care Board has been set up specifically to focus on delayed discharges. Delayed transfer bed days is in target this month. Delays in handover times from ambulance to A/E continue. In A/E workforce modelling being reviewed and improving patient flow to release cubicles. Strengthen daily operational management in the A/E department.	Mark Partington
18 week RTT	This is being delivered at Trust level. All specialties achieved 18 weeks at Trust level in the three areas of Admitted RTT, Non-Admitted RTT and Incomplete Pathways in	Mark Partington

Indicator	Update	Director Lead
	November 2013.	
Provider cancellation of planned operations for non clinical reasons	We are in the process of reviewing reasons for list over-runs and the theatre utilisation process. A review of and changes to theatre pathways is already underway and implementation of some of the proposed changes will commence following appointment of the Theatre Project Manager	Mark Partington
DNA rate for first and follow up appointments	The new SMS reminder service has been launched. New booked appointments continue to be made 9-16 weeks in advance. Partial booking is now being rolled out for follow up appointments.	Mark Partington
Meeting the MRSA bacteraemia (post 48 hour) objective	Training of staff to ensure compliance.	David Birkenhead
Sufficiency of appointment slots on choose and book	The position continues to improve. GI and liver and Ophthalmology remain the outstanding problem areas, focusing on capacity to improve performance.	Anna Basford

The Board are asked to:

- Consider the information provided in the attached report
- Consider the risk areas described in this report and whether further support/action is required from Board

Integrated Board Report - November 2013

Calderdale and Huddersfield NHS
NHS Foundation Trust

Domain 1: Preventing People Dying Prematurely

Indicator	Month Agreed Target	Current Month Performance	YTD Agreed Target	YTD Performance	Lead Director	Activity Trend (activity trend April 12 - November 13)
Cancer: 31 day wait from diagnosis to first treatment	≥96%	100.00%	≥96%	99.72%	MP/AV	
Cancer: 31 day for second or subsequent treatment comprising surgery	≥98%	100.00%	≥98%	99.25%	MP/AV	
Cancer: 31 day for second or subsequent treatment comprising drugs	≥94%	100.00%	≤94%	100.00%	MP/AV	
Cancer: 62 day wait from urgent GP referral to first treatment	≥85%	91.00%	≥85%	91.88%	MP/AV	
Cancer: 62 day wait from screening service referral to first treatment	≥90%	100.00%	≥90%	98.71%	MP/AV	
Cancer: 62 day referral to treatment from hospital specialist	≥87.5%	90.91%	≥87.5%	97.14%	MP/AV	
Cancer: 62 day aggregated GP urgent Referral to treatment and screening Referral to treatment	≥86%	91.53%	≥86%	92.78%	MP/AV	
Access to Maternity services before 12 weeks and 6 days	≥90%	93.62%	≥90%	91.38%	MDB	
Transfer of care Part A Medicine reconciliation as patients transfer from one provider to another (1)	Q1&2 BaselineQ3>70%Q4>80%	84.00%	Q1&2 BaselineQ3>70%Q4>80%	79.40%	AV	
Transfer of care Part B Discharge Medication as patients transfer from one provider to another (1)	Q1-Q3 baseline Q4 >50%	23.40%	Q1-Q3 baseline Q4 >50%	22.00%	AV	

HRI - Crude Mortality Rate (hospital deaths per 1,000 discharges)	The most recent information available (Nov 2013) shows a rate of 16.0 (against 17.6 for the same calendar month last year).		
CRH - Crude Mortality Rate (hospital deaths per 1,000 discharges)	The most recent information available (Nov 2013) shows a rate of 9.2 (against 9.9 for the same calendar month last year).		
TRUST - Crude Mortality Rate (hospital deaths per 1,000 discharges)	The most recent information available (Nov 2013) shows a rate of 12.1 (against 13.0 for the same calendar month last year).		HSMR HRI
Standardised Hospital Mortality Indicator (SHMI) (Rolling 12 month relative indicator of mortality published by the Information Centre)	July 11 - June 12 102, Oct11-Sep12 103, Jan12-Dec12 101. The SHMI Apr 12 - Mar 13 is 102 with no particular trend in any direction at the moment.		
Hospital Standardised Mortality Ratio (HSMR) (year to date relative indicator of mortality published each month from June data onward, published by Dr Foster)	April to September HSMR was 98, rebased 106.		HSMR CRH

Referral to Tertiary Centre (Leeds)	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Patient Seen within 7 days	20%	20%	18%	28%	16%	21.5%	23%	28%				
Patients Referred to Tertiary with 38 Days	38%	67%	41%	53%	48%	35.3%	23%	53%				
Patients Treated within 54 Days	63%	79%	69%	69.4%	68.8%	77.9%	58%	62%				

(1) Part A - Quarterly payment conditional on - Q1-Q2 baseline reporting. Q3 Target 70%. Q4 Target 80%.
(1) Part B - Quarterly payment based on quarterly reporting and 50% by Q4
NOTE: Referral to Tertiary activity for information only

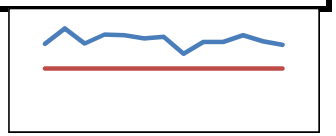
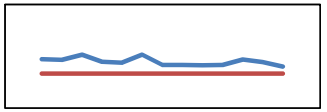
Financial penalties attached
Quarterly Submission

Activity Trend - Red line = Target/Blue line = monthly activity

Integrated Board Report - November 2013

Calderdale and Huddersfield NHS
NHS Foundation Trust

Domain 2: Enhancing quality of life for people with long term conditions

Indicator	Month Agreed Target	Current Month Performance	YTD Agreed Target	YTD Performance	Lead Director	Activity Trend (activity trend April 12 - November 13)
Dementia - use of dementia screening tool, risk assessment, referrals for emergency admissions aged 75 and over- NATIONAL	≥90%	97.1%	≥90%	96.4%	AV	
Dementia - identification of lead clinician and appropriate training for staff - NATIONAL	Quarterly action report	Quarterly reports required. Q1 submitted	Q4	Quarterly reports required. Q1 submitted	AV	
Dementia - ensuring carers feel supported - NATIONAL	≤90%	Quarterly reports required. Q1 submitted	≤90%	Quarterly reports required. Q1 submitted	AV	
Dementia - use of screening tool, risk assessments, referrals for emergency admissions aged 65 and over LOCAL MAU & SAU	Qly ≥90%	96.0%	≥90%	95.9%	AV	
COPD Discharged Care Bundle (reported quarterly)	≥95%	98.0%	≥95%	98.0%	AV	
ASTHMA - Improving management of patients presenting with Asthma in A&E	Action Plan	16.0%	55% Q4	8.0%	JB	
Diabetes - Part A Number of patients who are admitted who have a secondary care diagnosis of diabetes who are supported to self care	Baseline	12.5%	TBC	17.4%	AV	
Diabetes - Part B those attending A&E with diabetic hypoglycaemia who are referred to a specialist nurse and receive written educational support	Baseline	40.0%	TBC	11.1%	AV	

Financial penalties attached

Activity Trend - Red line = Target/Blue line = monthly activity

Integrated Board Report - November 2013

Calderdale and Huddersfield NHS
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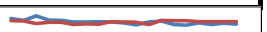
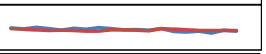
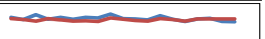
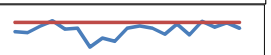
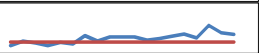
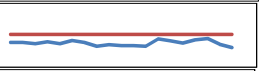
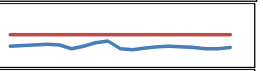
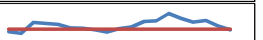
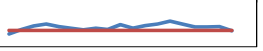
Domain 3: Helping people to recover from episodes of ill health or following injury

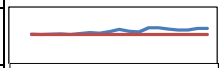
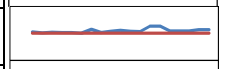
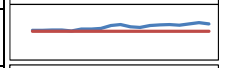
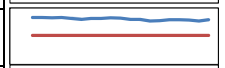
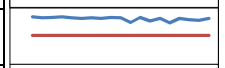
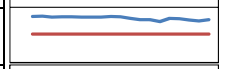
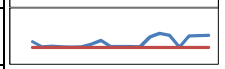
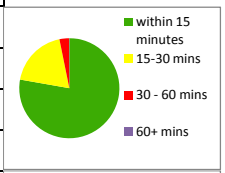
Indicator	Month Agreed Target	Current Month Performance	YTD Agreed Target	YTD Performance	Lead Director	Activity Trend (activity trend April 12 - November 13)
Emergency readmissions within 30 days of discharge from all admission	≤6.93%	6.85%	≤7.34%	7.38%	MP	
Emergency readmissions within 30 days of discharge from all admission - CALDERDALE CCG	≤7.4%	7.50%	≤7.97%	7.80%	MP	
Emergency readmissions within 30 days of discharge from all admission - GREATER HUDDERSFIELD CCG	≤6.70%	6.60%	≤7.00%	7.50%	MP	
Fractured neck of femur operations carried out within 36 hours of admission (linked to best practice tariff)	≥85%	60.00%	≥85%	62.50%	PH	
Stroke: % of patients who spend at least 90% of time on a stroke unit	≥80%	76.67%	≥80%	80.86%	AV	
Stroke: % of patients who spend at least 90% of time on a stroke unit - CALDERDALE CCG	≥80%	84.00%	≥80%	80.53%	AV	
Stroke: % of patients who spend at least 90% of time on a stroke unit - GREATER HUDDERSFIELD CCG	≥80%	69.70%	≥80%	80.52%	AV	
Stroke: % TIA cases with a higher risk of stroke who are treated within 24 hours	≥60%	50.00%	≥60%	65.06%	AV	
Stroke % of stroke patients thrombolysed	≥5%	20.00%	≥5%	14.16%	AV	
A&E Clinical Quality – Unplanned Re-attendance Rate - HRI	≤5%	4.49%	≤5%	4.62%	MP/PH	
A&E Clinical Quality – Unplanned Re-attendance Rate - CRH	≤5%	4.80%	≤5%	4.69%	MP/PH	
A&E Clinical Quality – Left Without Being Seen Rate - HRI	≤5%	3.34%	≤5%	3.38%	MP/PH	
A&E Clinical Quality – Left Without Being Seen Rate - CRH	≤5%	3.27%	≤5%	2.35%	MP/PH	
Delayed transfer bed days as a percentage of occupied bed days	≤5%	5.72%	≤5.0%	6.88%	MP	
Delayed transfer bed days as a percentage of occupied bed days - CALDERDALE CCG	≤5%	4.97%	≤5%	6.46%	MP	
Delayed transfer bed days as a percentage of occupied bed days - GREATER HUDDERSFIELD CCG	≤5%	6.88%	≤5%	7.47%	MP	
Delayed transfer bed days as a percentage of occupied bed days - COHORT patients with specific reasons	≤3.5%	4.92%	≤3.5%	4.39%	MP	

Activity Trend - Red line = Target/Blue line = monthly activity

Integrated Board Report - November 2013

Calderdale and Huddersfield NHS
NHS Foundation Trust

Domain 4: Ensuring that people have a positive experience of care

Indicator	Month Agreed Target	Current Month Performance	YTD Agreed Target	YTD Performance	Lead Director	Activity Trend (activity trend April 12 - November 13)
Patient Experience (RTPM) - Responses to a number of questions with Real Time Patient Monitoring. Focused specifically within MATERNITY and PAEDIATRICS. Q1 Action plan and specification of questions. Q2 implementation. Q3 Baseline report. Q4 improvement work (1)	Quarterly action plans				HT	
Maximum time of 18 weeks from Referral treatment for admitted patients	≥90%	93.12%	≥90%	92.80%	MP	
Maximum time of 18 weeks from Referral treatment for admitted patients - CALDERDALE CCG	≥90%	92.04%	≥90%	92.01%	MP	
Maximum time of 18 weeks from Referral treatment for admitted patients - GREATER HUDDERSFIELD CCG	≥90%	93.90%	≥90%	93.40%	MP	
Maximum time of 18 weeks from Referral treatment for non admitted patients	≥95%	98.69%	≥95%	98.72%	MP	
Maximum time of 18 weeks from Referral treatment for non admitted patients - CALDERDALE CCG	≥95%	98.70%	≥95%	98.75%	MP	
Maximum time of 18 weeks from Referral treatment for non admitted patients - GREATER HUDDERSFIELD CCG	≥95%	98.60%	≥95%	98.54%	MP	
Maximum time of 18 weeks from Referral treatment for direct access audiology	≥95%	100.00%	≥95%	100.00%	PH	
Patients on an "incomplete pathway" who have waited less then 18 weeks	≥92%	94.65%	≥92%	Not Applicable	MP	
Maximum time of 6 weeks from referral for diagnostics	≥99%	99.52%	≥99%	99.10%	DB	
Total time in A&E: Less than 4 hours - HRI	≥95%	94.10%	≥95%	93.94%	MP/PH	
Total time in A&E: Less than 4 hours - CRH	≥95%	94.04%	≥95%	96.22%	MP/PH	
Handovers between AMBULANCE and A&E within 15 minutes- HRI	100.0%	77.82%	100.0%	76.04%	MP	
Handovers between AMBULANCE and A&E % 15 to 30 mins - HRI	0.0%	19.03%	0.0%	20.30%	MP	
Handovers between AMBULANCE and A&E % 30 to 60 mins - HRI	0.0%	3.08%	0.0%	3.52%	MP	
Handovers between AMBULANCE and A&E % 60+ mins - HRI	0.0%	0.07%	0.0%	0.13%	MP	
Handovers between AMBULANCE and A&E within 15 minutes- CRH	100.0%	91.06%	100.0%	90.98%	MP	
Handovers between AMBULANCE and A&E % 15 to 30 mins - CRH	0.0%	8.61%	0.0%	8.36%	MP	
Handovers between AMBULANCE and A&E % 30 to 60 mins - CRH	0.0%	0.33%	0.0%	0.62%	MP	
Handovers between AMBULANCE and A&E % 60+ mins - CRH	0.0%	0.00%	0.0%	0.05%	MP	

NOTE: (1) RTPM - Quarterly payment based on - Q1 action plan and specification of questions. Q2 implementation. Q3 baseline report. Q4 improvement work
(2) Friends and Family Test - Monthly payment on achievement of 90% for all 3 elements of the tool (expection report can be submitted for single instance of performance 85%-90%

Financial penalties attached

Activity Trend - Red line = Target/Blue line = monthly activity

Integrated Board Report - November 2013

Calderdale and Huddersfield NHS
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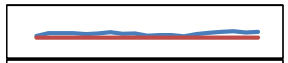
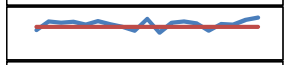
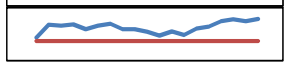
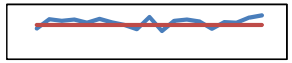
Domain 4: Ensuring that people have a positive experience of care

Indicator	Month Agreed Target	Current Month Performance	YTD Agreed Target	YTD Performance	Lead Director	Activity Trend (activity trend April 12 - November 13)
Zero tolerance trolley waits over 12 hours	0	0	0	2	MP	
A&E Clinical Quality – Time to Initial Assessment (95th percentile)-HRI	≤00:15:00	00:18:00	≤00:15:00	00:18:00	MP/PH	
A&E Clinical Quality – Time to Initial Assessment (95th percentile)-CRH	≤00:15:00	00:16:00	≤00:15:00	00:13:00	MP/PH	
A&E Clinical Quality – Time to Treatment Decision (median) - HRI	≤01:00:00	00:54:00	≤01:00:00	00:58:00	MP/PH	
A&E Clinical Quality – Time to Treatment Decision (median) - CRH	≤01:00:00	00:25:00	≤01:00:00	00:25:00	MP	
Cancer: 2 week wait from referral to date first seen for suspected cancer	≥93%	99.37%	≥93%	98.10%	MP/AV	
Cancer: 2 week from referral to date first seen for symtomatic breast	≥93%	96.88%	≥93%	95.29%	MP/AV	
Cancer: 2 week aggregated referrals seen and Breast symptomatic	≥93%	98.79%	≥93%	97.55%	MP/AV	
Mixed Sex Accommodation breaches	Zero	0	Zero	4	HT	
52 Weeks breaches (adjusted for patient choice or condition precludes treatment)	Zero	0	Zero	0	MP	
52 Weeks breaches (unadjusted)	10 per month	0	10 per month	0	MP	
Provider cancellation of planned operation for non clinical reasons	≤0.6%	0.82%	≤0.6%	0.64%	MP	
Number of urgent operations cancelled for a second time	0	0	0	0	MP	
Friends and Family Test - Part B Response rate to F&F test question - INPATIENT RESPONSE RATE	≥15%	31.60%	Successful rollout	25.9%	HT	
Friends and Family Test - Part B Response rate to F&F test question - INPATIENT Net Promoter Score Net Promoter Score (NPS)	No Set Target	74	0	74	HT	
Friends and Family Test - Part B Response rate to F&F test question - A&E Response Rate	≥15%	19.0%	Based on improvement	22.11%	HT	
Friends and Family Test - Part B Response rate to F&F test question - A&E Net Promoter Score Net Promoter Score (NPS)	No Set Target	39		37	HT	

NOTE: (1) RTPM - Quarterly payment based on - Q1 action plan and specification of questions. Q2 implementation. Q3 baseline report. Q4 improvement work
(2) Friends and Family Test - Monthly payment on achievement of 90% for all 3 elements of the tool (expection report can be submitted for single instance of performance 85%-90% Financial penalties attached

Activity Trend - Red line = Target/Blue line = monthly activity

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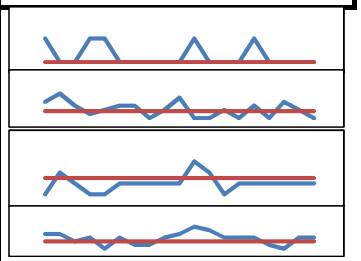
Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

Indicator	Month Agreed Target	Current Month Performance	YTD Agreed Target	YTD Performance	Lead Director	Activity Trend (activity trend April 12 - November 13)
Meeting the MRSA bacteraemia (Post 48 Hours) objective	Zero	1	Zero	2	DB	
Meeting the Clostridium difficile (Post 48 Hours) objective	7 per quarter	1	7 per quarter	12	DB	
MSSA Bacteraemias - (Post 48 hours) objective	6 per quarter	2	24 per year	8	DB	
E-Coli rates	8 per quarter	0	8 per quarter	16	DB	
Screening all elective in-patients for MRSA	95.0%	96.44%	95.0%	97.01%	DB	
Venous Thrombo Embolism - % risk assessed	≥95%	95.10%	≥95%	95.20%	BC	
Number of Root Cause Analyses carried out on cases of hospital associated Thrombolysis	≥95%	100.00%	≥95%	100.00%	BC	
NHS Safety Thermometer - reduction in the prevalence of Pressure Ulcers using thermometer	≤5.5%	5.00%	≤5.5%	5.01%	HT	
Use of Safety Thermometer	Completion of Data Set	Y	Completion of Data Set	Y	HT	
All Falls (1)	TBC	68	TBC	811	HT	
Harm Falls (2)	TBC	16	TBC	279	HT	
Medication Errors (3)	TBC	19	TBC	400	HT	
Duty of Candour: Number of patients notified in line with the duty of candour process	100.0%	No Patients	100.0%	82.0%	HT	

(1)-(3) The working groups are currently being established for falls and medications errors. Targets will be assigned by these groups

Activity - one month in arrears
Financial penalties attached

Activity Trend - Red line = Target/Blue line = monthly activity

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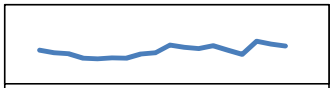
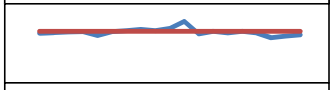
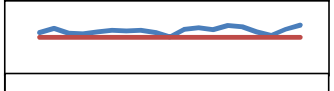
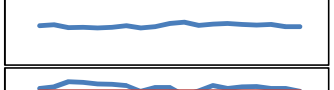
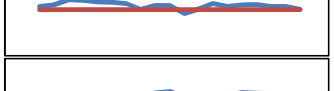
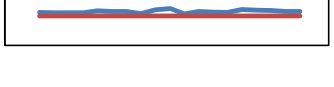
Domain 6: Resources

Indicator	Month Agreed Target	Current Month Performance	YTD Agreed Target	YTD Performance	Lead Director	Activity Trend (activity trend April 12 - November 13)
Operating Surplus/Deficit (£M - excluding exceptional items)	0.52	0.26	2.65	2.26	KG	
Cash (£M)	0.23	(2.00)	15.54	16.21	KG	
Monitor Risk Rating	3	4	2	3	KG	
Utility & Depreciation cost per sq metre, clinical and non-clinical space		Work in progress		Work in progress	KG	
Bed Capacity	No Target	779	No Target	779	MP	
Bed Occupancy (1)	TBC	87.3%	TBC	86.0%	MP	
Theatre Usage (%)	≥90%	94.2%	≥90%	93.2%	PH	
Standardised ALOS (excludes DC & Acute DC) (2)	TBC	5.15	TBC	5.29	MP	
DNA Rate - First Appointment	≤7%	7.0%	≤7%	7.7%	MP	
DNA Rate - Follow up Appointment	≤7.5%	8.6%	≤7.5%	9.3%	MP	

(1)-(2) These indicators are being reassessed hence the To Be Confirmed target status
Activity Trend - Red line = Target/Blue line = monthly activity

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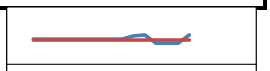
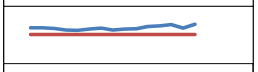
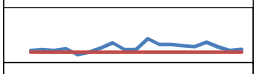
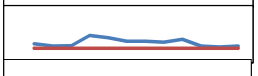
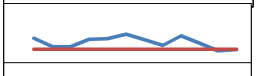
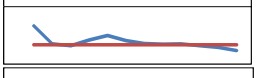
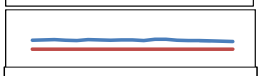
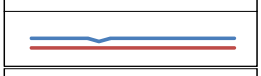
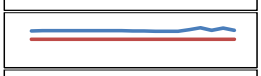
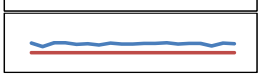
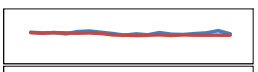
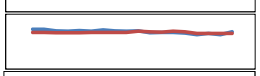
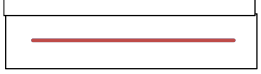
Domain 7: Reform/Information

Indicator	Month Agreed Target	Current Month Performance	YTD Agreed Target	YTD Performance	Lead Director	Activity Trend (activity trend April 12 - November 13)
Booking to services where named consultant led team was available (even if not selected) (1)	≥95%	100.00%	≥95%	98.00%	JW	
Proportion of GP referrals to first outpatient booked using C&B (2)	≥48.9%	72.00%	≥48.9%	71.28%	JW	
Sufficiency of appointments slots on choose and book (measured by appointment <5%) (3)	<5%	12.90%	<5%	11.74%	JW	
Sufficiency of appointments slots on choose and book (measured by appointment <5%) SURGERY	<5%	12.50%	<5%	12.75%	JW	
Sufficiency of appointments slots on choose and book (measured by appointment <5%) MEDICAL	<5%	11.50%	<5%	18.62%	JW	
Sufficiency of appointments slots on choose and book (measured by appointment <5%) CWF	<5%	7.80%	<5%	5.61%	JW	
Data Completeness in community services: Referral to Treatment information - CIDS	≥50%	85.61%	≥50%	88.91%	JR	
Data Completeness in community services: Referral Information - CIDS	≥50%	98.36%	≥50%	98.31%	JR	
Data Completeness in community services: Treatment activity information - CIDS	≥50%	98.76%	≥50%	98.59%	JR	
Data Completeness in community services: Patient Identifiers - CIDS	≥50%	73.07%	≥50%	72.90%	JR	
Data Completeness in community services: Patients dying at home/care homes - CIDS	≥50%	100.00%	≥50%	100.00%	JR	
Data Completeness in community services: Venous Ulcer treatments - CIDS	≥50%	94.83%	≥50%	92.11%	HT	
Data Quality on ethnic group - Inpatients/ Outpatients/Accident & Emergency	≥85%	98.19%	≥85%	98.40%	JR	
Clinical Coding - Signs & Symptoms	<10.0%	10.96%	<10.0%	11.1%	JR	
Clinical Coding - coded as unspecified	<13.4%	14.12%	<13.4%	13.8%	JR	
Clinical Coding - Average Diagnosis per coded Episode	>4.5	3.9	>4.5	4.04	JR	
Infant Health - data completeness, breastfeeding and smoking	100.0%	100.0%	100.0%	100.00%	JR	
Maternity hospital episode statistics	≤15%	0.21%	≤15%	0.26%	JR	
Information Governance Toolkit (4)	≥80%	80.00%	≥80%	80.00%	JR	
Time to approval for NIHR portfolio research studies (Median Days)	≤30	22		121	DB	
Participants recruited to NIHR portfolio research studies to time and target	≥85	44	≥473	557	DB	
Number of staff attending the Fire Warden Training	100.0%	12	100.0%	862 - 89% of staff trained. Complete by end Dec 13	LH	
Number of trained staff Vs Fire Safety Awareness Session	100.0%	339	100.0%	1222 - 25% of staff trained. Compete by end of Dec 13	LH	
Number of update fire risk assessments	100.0%	34	100.0%	76 ongoing. Complete by Apr 14	LH	

(1)-(2) Taken from Choose and Book Dashboard
Recruitment Targets based on Financial Year
(4) Based on achievement of 40 components at level 2 and above.

Activity - one month in arrears

Activity Trend - Red line = Target/Blue line = monthly activity

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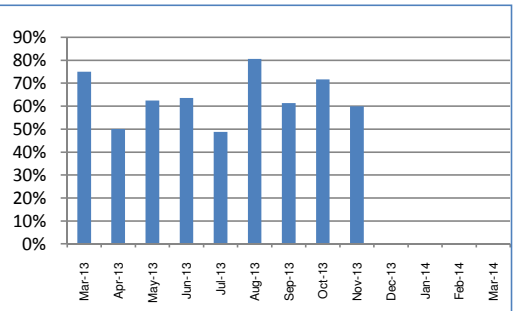
Helping	Indicator	Target	Nov-13	YTD
Fractured neck of femur operations carried out within 36 hours of admission		**85.0%**	**60.00%**	**62.50%**

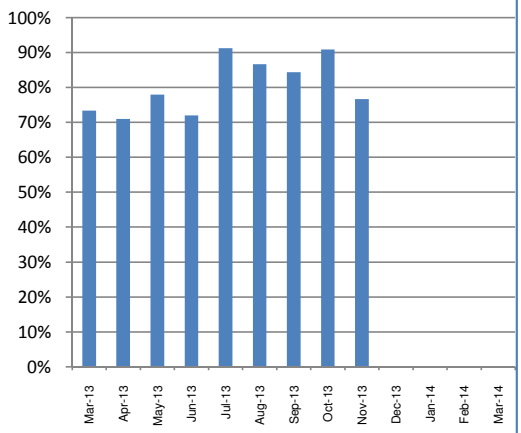
What is driving the reported underperformance ?	What actions have we taken to improve performance ?	
Uneven demand. On the weekend of the 16th we had other trauma patients who were more clinically urgent. Also we lost some time at the beginning of the list due to equipment that was required being in other theatres. On the 25th we had 5 #NOF admitted, one of which was carried out through the night. The remaining 4 were treated over the 26th and 27th, one conservatively. Another #NOF was a clinical delay, in that the MRI was inconclusive, so needed a CT as well, which delayed us past 36 hours.	The surgoens are continuing to deliver extended theatre lists at weekends. The on-call system and trauma theatre following on-call does not lend itself to carrying on into the evening with the existing surgery team. A theatre project team has been set up, work is not expected to start until April, and estimated completion of the first Theatre is 12 weeks beyond that. Any procedure where we are implanting metalwork requires a laminar theatre. recent experience would suggest that 1 laminar theatre working 7 unextended days does not deliver sufficient capacity to deliver normal trauma capacity. **This score may not be an exception for the forseeable future.**	



Completed By	Andrew Bottomley
Lead Director	Peter Holdsworth

Helping	Indicator	Target	Nov-13	YTD
Stroke: % of patients who spend at least 90% of time on a stroke unit		80.0%	76.67%	80.86%
Stroke: % of patients who spend at least 90% of time on a stroke unit - Greater Huddersfield CCG		80.0%	69.7	80.50%

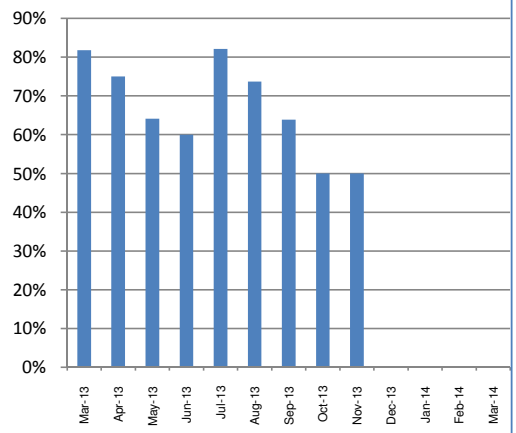
What is driving the reported underperformance ?	What actions have we taken to improve performance ?
In month, there were 60 patients discharged with a diagnosis of stroke, of which 14 patients did not spend 90% of their stay on a stroke ward. 4 of the 14 patients were brought to HRI by YAS as stroke was not initially suspected and were admitted to MAU HRI before onward referral to the stroke team. A further two GP referrals attended HRI in the first instance and then were transferred to CRH. The remaining patients that breached this target were either due to a delay in diagnosis as other conditions were suspected in the first instance, or an ASU bed wasn't immediately available, leading to an overnight stay on MAU CRH. The majority of this cohort of patients had a length of stay of less than 10 days meaning that one day not on a stroke unit results in a breach of the 90% target.	Feedback to be given to YAS and GPs regarding patients directed to HRI in the first instance. Additional winter capacity beds have been opened to relieve pressure on ASU beds. The monthly stroke clinical governance group led by Dr Rana are monitoring and acting upon this key performance indicator along with others to continuously improve stroke services.



Completed By	Ellie Sheehan
Lead Director	Dr Verma

Helping	Indicator	Target	Nov-13	YTD
Stroke: % TIA cases with a higher risk of stroke who are treated within 24 hours		**60.0%**	**50.00%**	**65.06%**

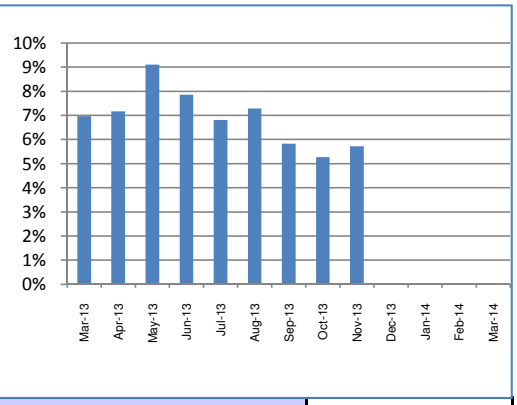
What is driving the reported underperformance ?	What actions have we taken to improve performance ?
The YTD performance against this target has been consistently above target until last month, however in this month only 12 of the 24 patients were seen within 24 hours. The YTD figure remains within target. Upon review of the patient pathways, two cases were unavoidable (patient refused to come the next day and late referral by GP (next day). However, the remaining cases have highlighted an issue with overbooking of the TIA clinic resulting in a lack of capacity and issues regarding current processes i.e. a high proportion of patients attending who are not TIAs causing capacity issues.	The pathway for TIA patients is currently being reviewed by the MDT in order to reduce waiting times for referrals, investigations and access to the TIA clinic. In addition, the capacity required for the TIA clinic is also being reviewed, alongside the appropriateness of referrals into this clinic to reduce unnecessary attendances and therefore release capacity for high risk clinics.



Completed By	Ellie Sheehan
Lead Director	Dr Verma

Helping	Indicator	Target	Nov-13	YTD
Delayed transfer bed days as a percentage of occupied bed days		5.0%	5.72%	7.07%
Delayed transfer bed days as a percentage of occupied bed days - GREATER HUDDERSFIELD CCG		5.0%	6.88%	7.73%

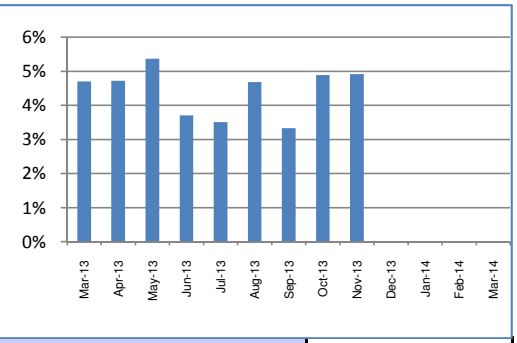
What is driving the reported underperformance ?	What actions have we taken to improve performance ?
Our underperformance against this target is due in part to the fact that we have, via Visual Hospital and Plan for Every Green Cross Patient very comprehensive information about patients experiencing delays and so are in a position to capture all this information when other Trusts may not have such detail available. That is not to say that we don't need to be seeking to reduce the numbers.	At the end of September 16 discharge coordinators started work in new posts - one on each medical ward. Part of their job is to minimise the delays for patients who are ready to be discharged or to move to their next destination.



Completed By	Tania king
Lead Director	Mark Partington

Helping	Indicator	Target	Nov-13	YTD
Delayed transfer bed days as a percentage of occupied bed days - COHORT with Identified patients with specific reasons		3.5%	4.92%	4.32%

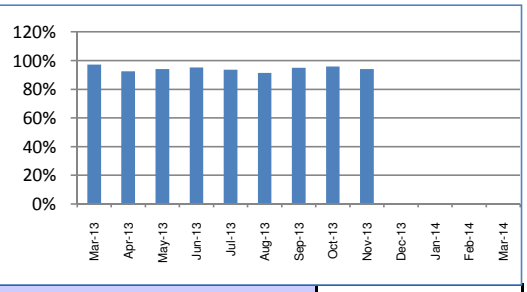
What is driving the reported underperformance ?	What actions have we taken to improve performance ?
Our underperformance against this target is due in part to the fact that we have, via Visual Hospital and Plan for Every Green Cross Patient very comprehensive information about patients experiencing delays and so are in a position to capture all this information when other Trusts may not have such detail available. That is not to say that we don't need to be seeking to reduce the numbers.	At the end of September 16 discharge coordinators started work in new posts - one on each medical ward. Part of their job is to minimise the delays for patients who are ready to be discharged or to move to their next destination.



Completed By	Tania king
Lead Director	Mark Partington

Ensuring	Indicator	Target	Nov-13	YTD
Total time in A&E: Less than 4 hours - HRI		95.0%	94.10%	93.94%
Total time in A&E: Less than 4 hours - CRH		95.0%	94.04%	96.22%

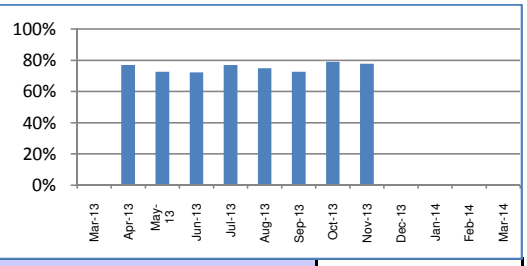
What is driving the reported underperformance ?	What actions have we taken to improve performance ?
Demand for in patient capacity does not meet the demand	Winter Planning- Phase 1- Additional inpatient capcity opened at CRH up to 27 beds. 8 additional transitional step down beds opened in Kirklees. 10 additional transitional beds opened in Calderdale. Intensive support/containment of patients on a green cross pathway. Extension of discharge lounge hours at HRI. Increase Consultant on site presence until 8pm Mon- Sun in medicine. Additional junior medical staff to support additional capacity. Phase 2- additional in patient capacity opening on the 16th December at HRI.



Completed By	Bev Walker
Lead Director	Mark Partington

Ensuring	Indicator	Target	Nov-13	YTD
Handovers between AMBULANCE and A&E within 15 minutes - HRI		100.0%	77.82%	76.04%
Handovers between AMBULANCE and A&E % 15 to 30 mins - HRI		0.0%	19.03%	20.30%
Handovers between AMBULANCE and A&E % 30 to 60 mins - HRI		0.0%	30.80%	3.52%
Handovers between AMBULANCE and A&E% 60+ mins- HRI		0.0%	0.07%	0.13%
Handovers between AMBULANCE and A&E within 15 minutes - CRH		100.0%	91.06%	90.98%
Handovers between AMBULANCE and A&E % 15 to 30 mins - CRH		0.0%	8.61%	8.36%
Handovers between AMBULANCE and A&E % 30 to 60 mins - CRH		0.0%	0.33%	0.62%

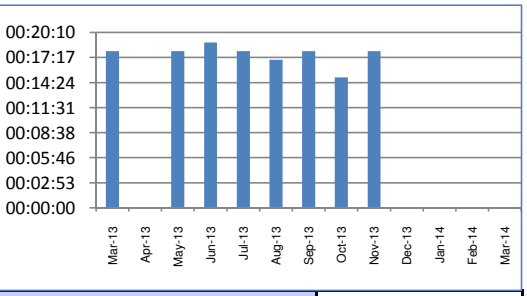
What is driving the reported underperformance ?	What actions have we taken to improve performance ?
Lack of capacity within the in patient bed base to enable timely patient flow.	Clear handover process between YAS and A&E staff. Improve Operational Management in A&E. Introduce EDIT. Introduce levelling discharges to ensure capacity matches demand. Working with Commissioners to review targets.



Completed By	Bev Walker
Lead Director	Mark Partington

Ensuring	Indicator	Target	Nov-13	YTD
A&E Clinical Quality – Time to Initial Assessment for ambulance patients (95th percentile)- HRI		00:15:00	00:18:00	0:18:00

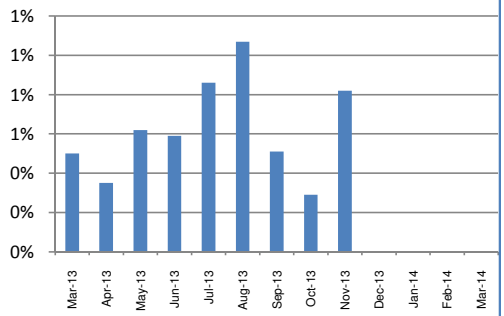
What is driving the reported underperformance ?	What actions have we taken to improve performance ?
Lack of timely patient flow out of the department into in patient capacity/lack of timely electronic recording of initial assessmnet.	Focused work to deliver level discharges. Additional inpatient capacity opened.Transitional beds opened in Kirklees and Calderdale. Intensive support/containment of patients on a green cross pathway.Additional operational support given to A&E to ensure documentation of the initial assessment is timely.



Completed By	Bev Walker
Lead Director	Mark Partington

Ensuring	Indicator	Target	Nov-13	YTD
Provider cancellation of planned operation for non clinical reasons		**0.6%**	**0.82%**	**0.64%**

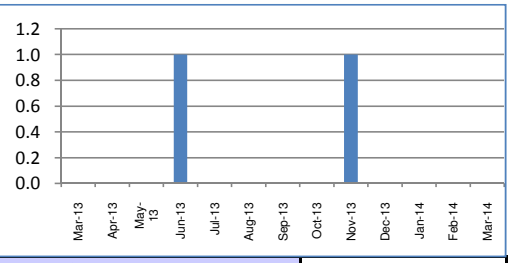
What is driving the reported underperformance ?	What actions have we taken to improve performance ?
40 patients were cancelled for sit rep reportable reasons, the reasons were as follows: 1 - Admin Error 11 - Emergency/Trauma 18 - List overrun 2 - Surgeon/Anaesthetist unavailable 3 - Ward beds unavailable 5 - Equipment failure/unavailable	Performance was 0.82% against a target of 0.6%, YTD 0.64%. We are in the process of reviewing reasons for list over-runs and the theatre utilisation process. A review of and changes to theatre pathways is already underway and implementation of some of the proposed changes will commence following appointment of the Theatre Project Manager. Work is required with support of CD's to review how patients are listed for theatre. We have introduced an Escalation Policy to alert General Managers of potential cancellations before they occur .



Completed By	Kathryn Aldous
Lead Director	Mark Partington

Treating	Indicator	Target	Nov-13	YTD
Meeting the MRSA bacteraemia (Post 48 Hours) objective		0	1	2

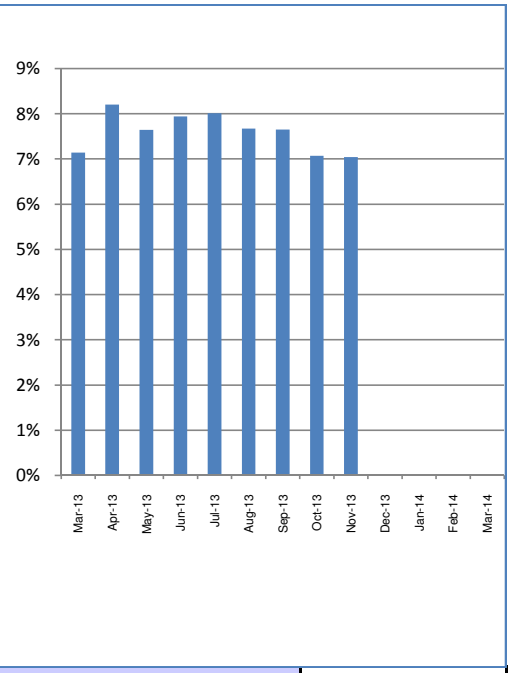
What is driving the reported underperformance ?	What actions have we taken to improve performance ?
The performance has continued to rise due to improvement in validaiton checking.	Continue with validationof data and messages passed on via ADD's, Leads and Matrons to ensure all areas understand the mandatory requirement to comply.



Completed By	Jean Robinson
Lead Director	David Birkenhead

Resources	Indicator	Target	Nov-13	YTD
DNA Rate - First Appointment		7.0%	7.04%	7.71%

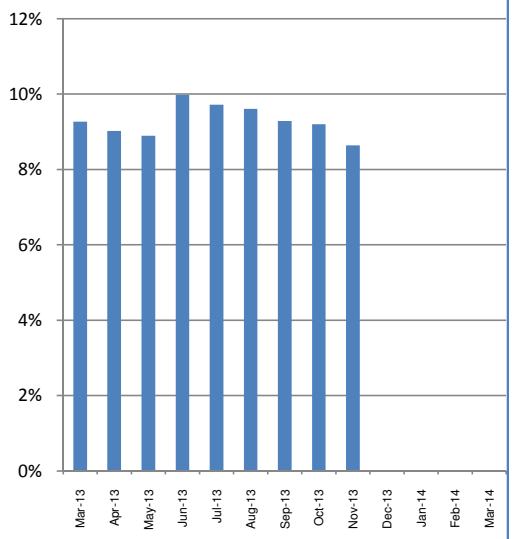
What is driving the reported underperformance ?	What actions have we taken to improve performance ?
Due to capacity and demand pressures, wait times in most specialties for first appointment have been pushed out which means that some first appointments are now booked 9-16 weeks in advance of the appointment date. By extending the waiting time the risk of the patient failing to attend increases.	Two SMS reminders now go to **all** patients where we hold a mobile phone number unless they have chosen to opt of the service. A 2-way SMS reminder is sent 7 days prior to the appointment and a further reminder is then sent to the patient the day before the appointmentInteractive voice messages (IVM) has also been implemented, this will enable contact with those patients where we do not have a valid mobile number. The IVM service includes a verification process, and ability to be put through to the Appt Centre if the appt is to be changed/cancelled. Following patient feedback the IVM script has been changed. It is anticipated that improved communications with the patient will reduce the number of missed appointments. Divisional business plans are underway and include capacity and demand plans to reduce maximum waiting times.



Completed By	Katharine Fletcher
Lead Director	Mark Partington

Resources	Indicator	Target	Nov-13	YTD
DNA Rate - Follow up Appointment		7.5%	8.64%	9.32%

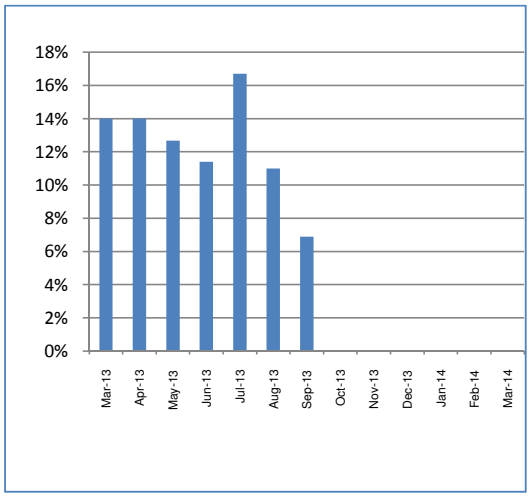
What is driving the reported underperformance ?	What actions have we taken to improve performance ?	
Follow up appointments are booked months in advance which increases the risk of patients forgetting the appointment and failing to attend.	Reduction of follow-up DNAs is evident albeit slow. Two SMS reminders now go to all patients where we hold a mobile phone number unless they have chosen to opt of the service. Interactive voice messages (IVM)has now been implemented this will enable contact with those patients where we do not have a valid mobile number. The IVM service includes a verification process, and ability to be put through to the Appt Centre if the appt is to be changed/cancelled. Following patient feedback the IVM script has been amended and is now shorter. It is anticipated that improved communications with the patient will reduce the number of missed appointments and there is already evidence of increased patient cancellations. In addition partial booking for follow ups is being rolled out with appointments for 6weeks or more added to a pending list and patients invited to contact the appointment centre to negotiate an appointment of convenience. Plastics, Upper GI, Maxillofacial and Breast services have moved onto Partial Booking, with plans to add other specialties over the forthcoming weeks.	



Completed By	Katharine Fletcher
Lead Director	Mark Partington

Reform_information	Indicator	Target	Nov-13	YTD
Sufficiency of appointments slots on choose and book (measured by appointment <5%) Total		5.0%	12.90%	11.74%
Sufficiency of appointments slots on choose and book (measured by appointment <5%) SURGERY		5.0%	12.50%	12.75%
Sufficiency of appointments slots on choose and book (measured by appointment <5%) MEDICAL		5.0%	11.50%	18.62%
Sufficiency of appointments slots on choose and book (measured by appointment <5%) CWF		5.0%	7.80%	5.61%

What is driving the reported underperformance ?	What actions have we taken to improve performance ?
ASIs have increased by 4.6% in comparison to October this is due to Insufficient capacity to meet appointment demand, particularly in the specialties shown in the table below:	**Cardiology-** Additional capacity agreed for January - currently being arranged. **Ophthalmology** - A number of issues are impacting on performance. Vacant Consultant post, plus resignation of a second consultant. Considering recruitment of macular fellow, and NHS Locum rather than agency locum. Waiting list initiative clinics planned in interim. **Pain Management** - additional capacity and advanced practitioner sessions identified**. GI/Liver** - Additional clinics/slots continue to manage demand. Considering recruitment of additional Consultant for Upper GI.



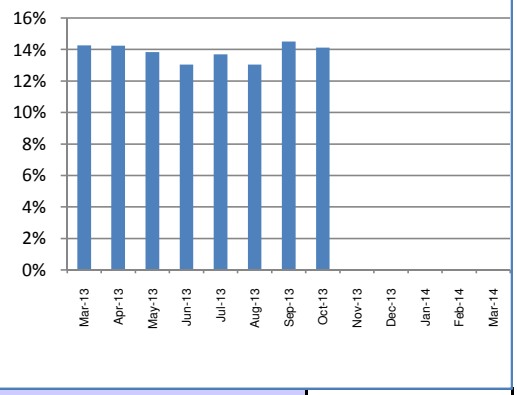
Completed By	Katharine Fletcher
Lead Director	Anna Basford/Graham Brown

Total ASIs	DBS Bookings	ASIs
733	5664	13%

Specialty Name	Total referrals	Total ASIs	%
Cardiology	129	104	80.6%
Ophthalmology	495	123	24.8%
Pain Management	89	20	22.5%
GI & Liver (med/surg)	580	123	21.2%

Reform_information	Indicator	Target	Oct-13	YTD
Clinical Coding - Signs & Symptoms		**10.0%**	**11.0%**	**11.1%**

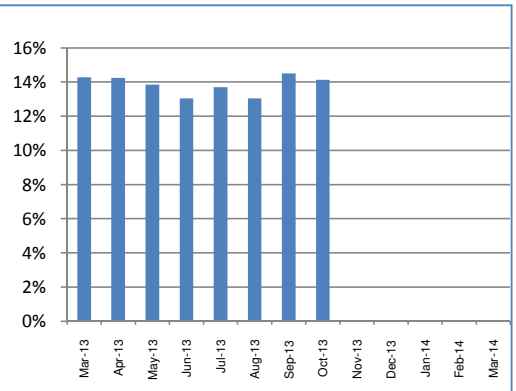
What is driving the reported underperformance ?	What actions have we taken to improve performance ?
CHFT sign and symptom coding is slightly higher than the peer group meaning it has slightly more patients coded symptomatically rather than with a definitive diagnosis eg shortness of breath rather than asthma. This may be as a result of the terminology, content and quality of what is written within the case notes.	Regular meetings with some clinicians have been established. Clinicians are asked to validate the coding of all deceased patients. Clinical Coders attended a Medical Division Audit Meeting early in December and were well received. A regular coding meeting between divisions and coders is in the process of being established with aim being to further improve the quality of clinical coding. Work is also being undertaken to establish if any differences between Divisions/Specialties. There is coder attendance at the regular mortality meetings.



Completed By	Sharan Boothroyd
Lead Director	John Rayner

Reform_information	Indicator	Target	Oct-13	YTD
Clinical Coding - coded as unspecified		**13.4%**	**14.1%**	**13.8%**

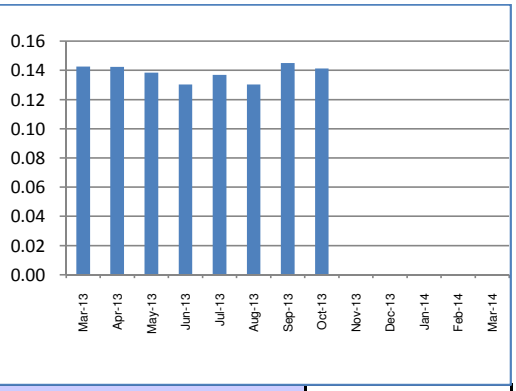
What is driving the reported underperformance ?	What actions have we taken to improve performance ?
CHFT unspecified coding is slightly higher than the peer group meaning it has slightly more patients who are coded to a non specific diagnosis code (for example C509 Malignant neoplasm: Breast Unspecified versus C501 Malignant neoplasm: Central portion of breast) than the peer group. This may be as a result of lack of clarity/information within the case notes in order for the coder to assign a more specific code. The quality of the case note may also play a part - incorrectly filed sheets or case notes that aren't complete with all documentation at the time of coding.	Regular meetings with some clinicians have been established. Clinicians are asked to validate the coding of all deceased patients. Clinical Coders attended a Medical Division Audit Meeting early in December and were well received. A regular coding meeting between divisions and coders is in the process of being established with aim being to further improve the quality of clinical coding. Work is also being undertaken to establish if any differences between Divisions/Specialties. There is coder attendance at the regular mortality meetings.



Completed By	Sharan Boothroyd
Lead Director	John Rayner

Reform_information	Indicator	Target	Oct-13	YTD
Clinical Coding - Average Diagnosis per coded Episode - Depth of Coding		4.48	3.89	4.04

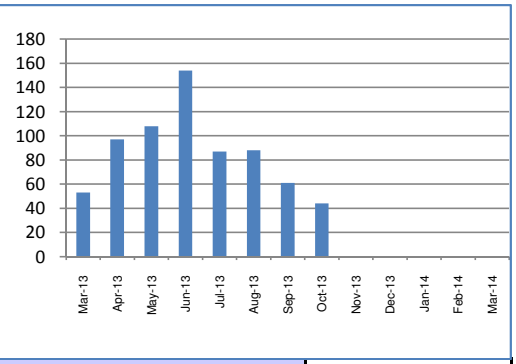
What is driving the reported underperformance ?	What actions have we taken to improve performance ?
CHFT depth of coding is slightly lower than the peer group meaning it has slightly more patients with fewer diagnostic clinical codes than the peer group. This may be as a result of missed relevant comorbidities identified within the stay in the case notes. The quality of the case note may also play a part - incorrectly filed sheets or case notes that aren't complete with all documentation at the time of coding.	Regular meetings with some clinicians have been established. Clinicians are asked to validate the coding of all deceased patients. Clinical Coders attended a Medical Division Audit Meeting early in December and were well received. A regular coding meeting between divisions and coders is in the process of being established with aim being to further improve the quality of clinical coding. Work is also being undertaken to establish if any differences between Divisions/Specialties. There is coder attendance at the regular mortality meetings.



Completed By	Sharan Boothroyd
Lead Director	John Rayner

Reform_information	Indicator	Target	Oct-13	YTD
Participants recruited to NIHR portfolio research studies to time and target		108	44	557

What is driving the reported underperformance ?	What actions have we taken to improve performance ?
There is a lag in the data from national office. The final figure is likely to be higher.	performance is dependant upon patient recruitment eligibility. All study teams are aware of their study targets.



Completed By	Asifa Ali
Lead Director	David Birkenhead

Trust Financial Overview as at 30th November 2013 - Month 8

YEAR TO DATE POSITION: M8

CLINICAL ACTIVITY

	M8 Plan	M8 Actual	Var
Elective	6,775	6,309	(466)
Non Elective	34,537	32,984	(1,553)
Daycase	24,979	26,534	1,555
Outpatients	215,849	221,075	5,226
A & E	95,487	94,284	(1,203)

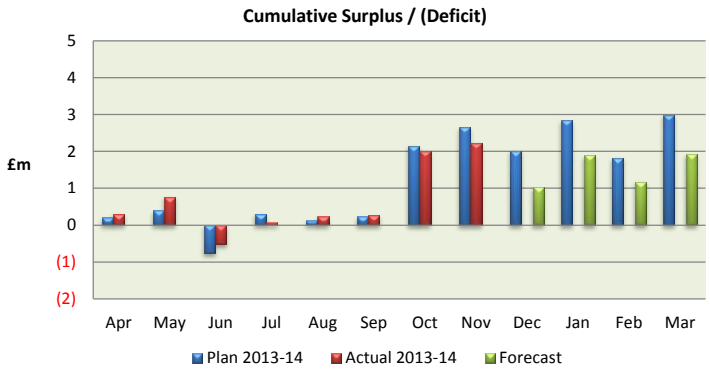
TRUST: INCOME AND EXPENDITURE

	M8 Plan	M8 Actual	Var
	£m	£m	£m
Elective	£17.12	£17.42	£0.30
Non Elective	£56.83	£56.28	(£0.55)
Daycase	£17.99	£18.10	£0.11
Outpatients	£26.08	£26.38	£0.30
A & E	£9.37	£9.41	£0.04
Other-NHS Clinical	£79.11	£80.50	£1.39
Other Income	£23.16	£24.13	£0.97
Total Income	**£229.66**	**£232.23**	**£2.57**
Pay	(£142.01)	(£144.11)	(£2.10)
Drug Costs	(£16.23)	(£16.93)	(£0.70)
Clinical Support	(£19.76)	(£20.59)	(£0.83)
Other Costs	(£25.03)	(£24.37)	£0.66
PFI Costs	(£7.45)	(£7.48)	(£0.03)
Total Expenditure	**(£210.48)**	**(£213.48)**	**(£3.00)**
EBITDA	**£19.18**	**£18.75**	**(£0.43)**
Restructuring Costs	£0.00	£0.00	£0.00
Non Operating Expenditure	(£16.53)	(£16.49)	£0.04
Surplus / (Deficit)	**£2.65**	**£2.26**	**(£0.39)**

DIVISIONS: INCOME AND EXPENDITURE

	M8 Plan	M8 Actual	Var
	£m	£m	£m
Surg & Anaes	£21.38	£20.72	(£0.66)
Medical	£18.13	£17.23	(£0.90)
CWF	£14.63	£16.14	£1.51
DATS	(£8.79)	(£8.32)	£0.47
Est & Fac	(£15.89)	(£16.27)	(£0.38)
Corporate	(£12.29)	(£12.51)	(£0.22)
Central Inc/Tech	(£13.88)	(£14.73)	(£0.85)
Reserves	(£0.64)	£0.00	£0.64
Surplus / (Deficit)	**£2.65**	**£2.26**	**(£0.39)**

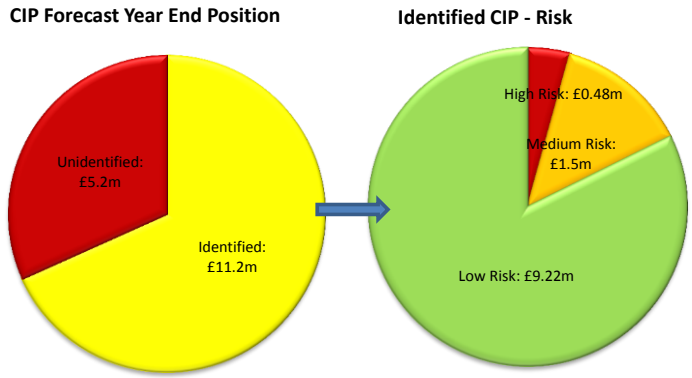
TRUST SURPLUS / (DEFICIT)



KEY METRICS

	Year To Date			Year End: Forecast		
	M8 Plan	M8 Actual	Var	Plan	Forecast	Var
	£m	£m	£m	£m	£m	£m
I&E: Surplus / (Deficit)	£2.65	£2.26	(£0.39)	£2.97	£1.93	(£1.04)
Capital	£10.87	£8.19	£2.68	£14.83	£14.97	(£0.13)
Cash	£15.54	£16.21	£0.67	£17.79	£20.37	£2.57
	Plan	**Actual**		**Plan**	**Forecast**	
Financial Risk Rating	3	3		3	3	
Continuity of Service Risk Rating	2	3		3	3	

COST IMPROVEMENT PROGRAMME (CIP)



Total Planned: **£16.40m** **Total Identified:** **£11.2m**

FORECAST 2013/14

CLINICAL ACTIVITY FORECAST

	Plan	Forecast	Var
Elective	10,021	9,333	(689)
Non Elective	52,319	50,016	(2,303)
Daycase	36,827	39,011	2,184
Outpatients	318,716	326,632	7,916
A & E	142,369	140,576	(1,794)

TRUST: INCOME AND EXPENDITURE FORECAST

	Plan	Forecast	Var
	£m	£m	£m
Elective	£25.35	£25.78	£0.43
Non Elective	£85.80	£84.83	(£0.97)
Daycase	£26.50	£26.66	£0.16
Outpatients	£38.52	£38.99	£0.47
A & E	£13.97	£14.04	£0.07
Other-NHS Clinical	£119.25	£124.00	£4.75
Other Income	£34.47	£36.30	£1.83
Total Income	**£343.86**	**£350.60**	**£6.74**
Pay	(£213.71)	(£219.39)	(£5.68)
Drug Costs	(£24.52)	(£25.08)	(£0.56)
Clinical Support	(£29.11)	(£31.46)	(£2.35)
Other Costs	(£37.59)	(£36.71)	£0.88
PFI Costs	(£11.18)	(£11.21)	(£0.03)
Total Expenditure	**(£316.11)**	**(£323.85)**	**(£7.74)**
EBITDA	**£27.75**	**£26.75**	**(£1.00)**
Restructuring Costs	£0.00	£0.00	£0.00
Non Operating Expenditure	(£24.78)	(£24.82)	(£0.04)
Surplus / (Deficit)	**£2.97**	**£1.93**	**(£1.04)**

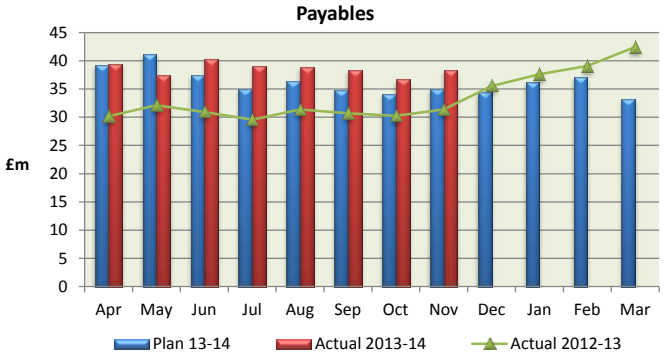
DIVISIONS: INCOME AND EXPENDITURE FORECAST

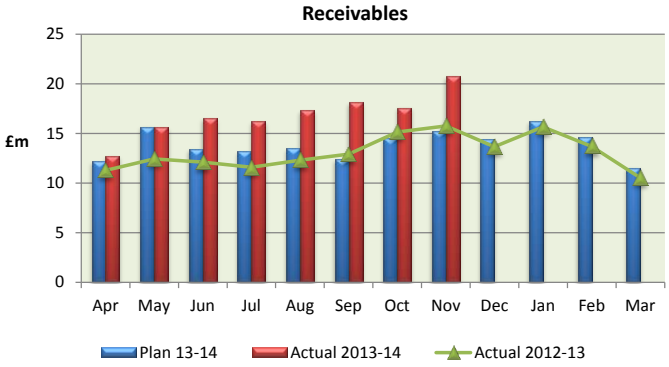
	Plan	Forecast	Var
	£m	£m	£m
Surg & Anaes	£32.00	£31.29	(£0.71)
Medical	£27.35	£26.46	(£0.89)
CWF	£22.02	£22.89	£0.87
DATS	(£13.20)	(£12.88)	£0.32
Est & Fac	(£23.81)	(£24.37)	(£0.56)
Corporate	(£17.83)	(£17.99)	(£0.16)
Central Inc/Tech	(£20.22)	(£20.77)	(£0.55)
Reserves	(£3.34)	(£2.70)	£0.64
Surplus / (Deficit)	**£2.97**	**£1.93**	**(£1.04)**

Trust Financial Overview as at 30th November 2013 - Month 8

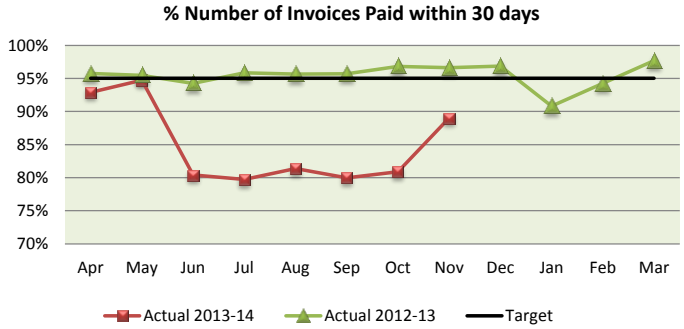
WORKING CAPITAL

	M8 Plan £m	M8 Actual £m	Var £m	M8
Payables	(£34.91)	(£38.25)	£3.34	
Receivables	£15.26	£20.73	(£5.47)	



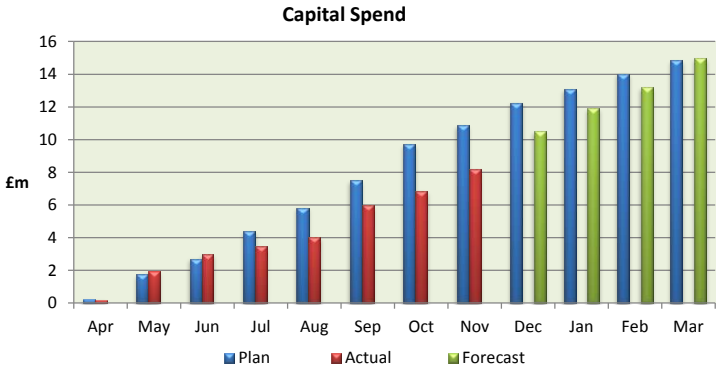


BETTER PAYMENT PRACTICE CODE



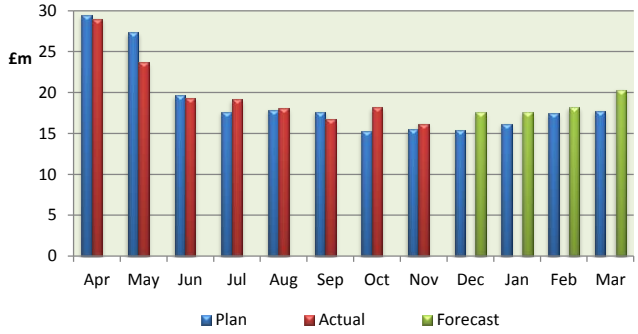
CAPITAL

	M8 Plan £m	M8 Actual £m	Var £m	M8
Capital	£10.87	£8.19	£2.68	

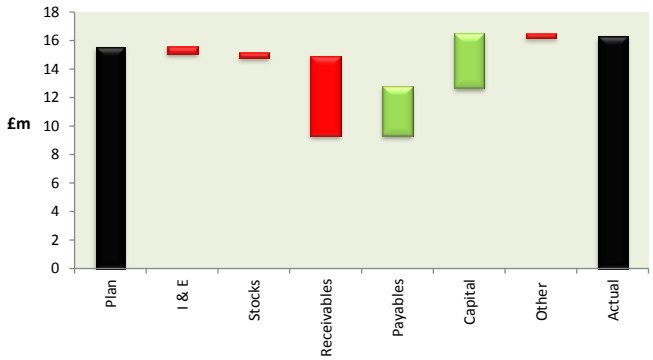


CASH

	M8 Plan £m	M8 Actual £m	Var £m	M8
Cash	£15.54	£16.21	£0.67	



CASH BRIDGE



SUMMARY

The main points highlighted in this paper are:

- a year to date surplus of £2.26m against a planned surplus of £2.65m, giving a Monitor Continuity of Service Risk Rating (COSRR) of 3 (against a planned level of 2).
- a forecast full year surplus of £1.93m, compared with a planned £2.97m, giving an COSRR of 3 (planned at a 3).
- capital expenditure of £8.19m against a plan of £10.87m and a forecast of £14.97m versus a plan of £14.83m;
- a cash balance of £16.21m, versus a planned £15.54m; driven largely by slippage in Capital spend.
- Whilst some winter capacity opened in late November, activity levels remained largely on trend in Month 8. Divisional Expenditure was above planned levels in the month reflecting increasing levels of undelivered CIP, (£0.65m in Month 8), and some unexpected cost pressures.

It should be noted that :

- In total there is a shortfall of £5.20m in identification of CIP schemes at this stage, and of the schemes identified a further £0.48m is considered to be at high risk of not being achieved. The forecast assumes that unidentified CIP will be delivered.
- It is assumed that Trust Reserves of £2.69m will be spent by year end, with £2.54m remaining uncommitted. Reserves budget of £0.64m was left unspent in Month 8 and is offsetting unachieved CIP.
- Achievment of CQUIN targets is also off track: £0.74m is now rated red and £0.65m rated amber out of a total £7.1m available. The increased risk of not achieving CQUIN has led to a change in the forecast, with £0.87m CQUIN income removed from the forecast.
- Failure to achieve CIP and no reduction in the level of unidentified CIP since Month 6, has greatly increased the risk that the planned surplus will not be achieved. Failure to achieve a £3m surplus will affect investment opportunities in 14/15 and increase future CIP targets.

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 > £17.2m (20 working days cash)
- < £17.2m (unless planned) but > £8.6m (10 working days cash)
- < £8.6m (less than 10 working days cash)

Calderdale and Huddersfield NHS

NHS Foundation Trust

CHAIRS' INFORMATION EXCHANGE MEETING

Minutes of the meeting held on Thursday 9 January 2014 at 9.30am in the Board Room, Trust Offices, CRH

PRESENT:	Andrew Haigh	Chairman
	Ruth Mason	Associate Director of Engagement & Inclusion
	Vanessa Henderson	Business Manager, Membership & Inclusion
	Liz Schofield	Chair, Estates & Facilities DRG & Medical DRG
	Peter Middleton	Chair, DaTS DRG
	Martin Urmston	Chair, Surgical DRG
	Eileen Hamer	Chair, Staff Membership Councillors' Group

1 Apologies

Janette Roberts — Deputy Chair

2 Minutes of the meeting held on 22 October 2013

The minutes of the meeting held on 22 October 2013 were approved as a correct record. In response to a question from Peter, Andrew clarified the involvement of NCAT (National Clinical Advisory Team) with the Trust.

3 Matters arising from the minutes

4 j) Mortality Rates

Andrew reported that it was felt that it was not appropriate for Linda to be involved in the work around mortality rates as this was a very operational piece of work.

5 Membership Strategy

Membership Councillors had been invited to comment on the draft Membership Strategy, following which it was approved at the Board meeting in December 2013. The strategy was to be ratified at the MCs' meeting on 20 January 2014.

4 Update from the Chair

a) Appointment of Company Secretary

Andrew advised that the Trust had appointed a Company Secretary, Vicky Pickles, who was to take up her post in February 2014. Vicky is well known to the Trust, having previously worked at the Calderdale PCT. She is currently employed at Leeds Community Partnership Trust.

Andrew said Vicky's job description is fairly flexible as it will cut across a number of areas and one of the early pieces of work is to firm this up. Vicky would take overall responsibility for governance following the departure of Helen Thomson, and her role would cover all issues connected with the Board, including legal issues and company secretarial issues.

Andrew advised that the role had been created as a result of the Foresight review and it was noted that other Trusts had Company Secretaries.

b) Strategic Review

The full review with all 7 partner organisations was not making progress and there were a number of imperatives coming into play which meant that the 3 providers felt it necessary to take the review forward and come up with a blueprint for how they felt care could be provided.

The imperatives in question were:

(i) The Keogh review into emergency care which would result in a reduction in the number of major emergency care providers. Andrew suggested that, depending on the final number of centres agreed nationally, the number of major centres in West Yorkshire might reduce to 3 or 4, or even to 2;
(ii) The 7-day working requirement which will have implications on numbers of staff required and how services are structured;
(iii) The report from the Future Hospitals Commission which might result in changes to how the hospitals are structured to cope with the type of patients (more elderly and complex) that we are now seeing;
(iv) The Integrated Care Fund, now the Better Care Fund, which will result in a significant amount of money (£1 billion this year and £3.8 billion next year) being transferred from the health budget to Local Authorities in an attempt to drive integrated care.

Work has been ongoing by the 3 organisations and a Strategic Outline Case document was submitted to the CCGs (Clinical Commissioning Groups) for consideration on 8 January.

Andrew said that at the Trust, one of the hospitals would focus on emergency care and one on planned care. At a special meeting of the Board to approve the Strategic Outline Case document, there was much debate around whether a decision should be taken to go public with which hospital would take on which role, but it was felt that there was not sufficient information available to make a decision at this stage. The intent was to have the information available for the Board at its January meeting.

With regards to the timeline, it was hoped that the CCGs would adopt the document as a blueprint, then take it to the Local Authority Overview and Scrutiny Committees and Health and Wellbeing Boards. If the proposals were accepted an engagement and consultation period would then run between March and September.

Andrew confirmed that outpatient services would remain on both sites and there would be minor injury units on both sites. Discussions were ongoing around the possibility of also having minor injury units in the community.

Discussion then took place around the need to communicate more effectively with the public at this early stage in order to avoid confusion and misunderstandings. Ruth assured the MCs that this would form part of the engagement strategy but it was felt that communications with the public should be strengthened at this stage.

Andrew outlined the local MPs' stance on the issue, which varied from party to party and it was noted that he and Owen meet regularly with the MPs about this issue.

Peter suggested that the Trust could investigate the possibility of communicating the Trust's position via the Council Tax flyer that is sent out to all homes. Andrew agreed to pursue this.
Action: AH

Martin suggested that the MPs could be invited to meet with the NEDs and MCs at their forthcoming joint workshop. It was agreed that this could be an effective way of questioning the MPs on their stance, and communicating the Trust's position.
Action: AH/RM

5 DRG SOAPs and Action Logs

The DRG SOAPs and Action Logs were received:

a) Children, Women's & Families

It was noted that at the last meeting, although the meeting was quorate, it was felt that there was not a sufficient number of publically elected MCs in attendance to be able to nominate and elect a Chair and this had therefore been deferred to the next meeting.

The divisional dashboard was to be brought to future meetings. With regard to the maternity PAS (patient administration system) Andrew said this formed part of the Trust's overall IT strategy but that in 2 areas (maternity and theatres) it had been decided to implement new systems in advance of other areas.

With regard to collaborative working with Mid Yorkshire, Andrew said engagement continued to prove difficult.

b) DaTS

Peter said it had become clear from discussions at the meeting that there was a national issue around how DaTS services would be made up in the future, influenced heavily by advances in technology.

With regard to the PACE project, Andrew advised that since the DaTS DRG meeting, a paper had been submitted to the December 2013 Board suggesting that the collaboration did not go ahead but that discussion should continue with Pennine Acute about collaborative working in some areas.

The pressure on Medical Records was noted as a result of the size of the digitising exercise to be carried out. Andrew said if the exercise was not complete in time for the opening of Acre Mill, the Trust would continue with paper records in the short term.

c) Estates & Facilities

Liz said she was very pleased to have heard that the welfare of current staff had been paramount during the retail and catering tendering exercise. Andrew advised that staff have been made aware of the plan to enter into partnership with Compass Group.

With regard to the flu jab uptake, discussion took place around the difficulties of enforcing inoculation.

It was confirmed that the laundry service is currently under review.

d) Medical Division

It was noted that the division was very committed to dealing with complaints and learning from them.

Andrew advised that work around the Future Hospitals commission report was being led by Ashwin Verma. It was agreed that the MCs would benefit from a presentation on the report, and Andrew agreed to ask Linda Patterson (who was the author of part of the report) to present at the joint NED/MC workshop on 12 February.
Action: AH

Andrew said it was not possible to give a timescale for the introduction of 7-day working for senior medical staff as this was linked to the national agreement for consultants.

e) Surgical Division

It was noted that there was a heavy focus in the division around the specialised commissioning of services.

Martin suggested that the MCs might find it useful to see a storyboard of complaints, rather than numbers. This would give the MCs an understanding of how complaints were handled in the division, and how lessons were learned. Ruth suggested this could be requested at the agenda setting meeting for the next DRG meeting.
Action: MU/RM

Liz stressed the importance of also being aware of themes that arise from complaints.

f) Staff Membership Group

The notes of the meeting held on 31 October 2013 were received.

g) Membership Office

It was noted that the Membership Office were to undertake recruitment activities to target under-represented groups, which included members of the Asian population.

Andrew asked for the Action Log to be shortened in line with those from the DRGs.

6 Quality Accounts Event – 20.02.14

It was noted that an event was to be held on 20 February in order to determine the Trust's quality priorities for the forthcoming year. Members of the public would be asked to vote for their preferred options and those not able to attend the event would be able to vote on-line. The event would also be used as an opportunity to present the division's business plans and key personnel would be in attendance.

Ruth asked for as many MCs to attend as possible.

7 Agenda items for the MC Meeting – 20.01.14

Agenda items for the forthcoming MC meeting to include:

- Helyn Aris, our CQC local manager, in attendance
- Juliette Cosgrove in attendance to brief MCs on Quality Accounts
- Membership Strategy
- MC Calendar of events
- Financial position
- Quality indicators

It was felt that it would be beneficial for the MCs to have an indication of the proposals within the Strategic Outline Case document prior to the public meeting. Andrew agreed to brief the MCs at the informal meeting beforehand.
Action: AH

8 Date and time of next meeting

PLEASE NOTE CHANGE OF DATE SINCE THE MEETING:

Next meeting to be held on **Monday 31 March between 10 am and 12 noon in Discussion Room 2, Learning Centre, HRI.**

Calderdale and Huddersfield NHS
NHS Foundation Trust

MEMBERSHIP COUNCIL REGISTER
AS AT 10 JANUARY 2014

CONSTITUENCY	NAME	DATE APPOINTED	TERM OF TENURE	ELECTION DUE
PUBLIC – ELECTED				
1	Mrs Joan Doreen Taylor	19.9.13	3 years	2016
1	Mr Martin Urmston	20.9.12	3 years	2015
2	Mrs Linda Wild	1.10.08 22.9.11	3 years 3 years	2014
2	Rev Wayne Clarke	19.9.13	3 years	2016
3	Mr Peter John Middleton	22.9.11	3 years	2014
3	Ms Dianne Hughes	19.9.13	3 years	2016
4	Mrs Marlene Chambers	20.9.12	3 years	2015
4	Mrs Christine Breare	1.10.08 22.9.11	3 years 3 years	2014
5	Mr Grenville Horsfall	19.9.13	3 years	2016
5 **(RESERVE REGISTER)**	Mr Bernard Pierce	20.9.13	1 year	2014
6	Mrs Johanna Turner	4.1.13	3 years (to Sept 2015)	2015
6 **(RESERVE REGISTER)**	Mrs Janette Roberts	20.9.13	1 year	2014
7	Ms Kate Wileman	4.1.13	2 years (to Sept 2014)	2014
7	Mrs Liz Schofield	22.9.11	3 years	2014
8	Mr Andrew Sykes	20.9.12	3 years	2015
8	Mrs Jennifer Beaumont	19.9.13	3 years	2016
STAFF – ELECTED				
9 - Drs/Dentists	Dr Mary Kiely	22.9.11	3 years	2014
10 - AHPs/HCS/Pharm's	Miss Avril Henson	4.1.13	3 years (to Sept 2015)	2015

11 - Mgmt/Admin/Clerical	Mrs Eileen Hamer	20.9.12	3 years	2015
12 - Ancilliary	Miss Liz Farnell	6.10.09 20.9.12	3 years 3 years	2012 2015
13 - Nurses/Midwives	Mrs Chris Bentley	6.10.09 20.9.12	3 years 3 years	2012 2015
13 - Nurses/Midwives	Mrs Julie Mellor	22.9.11 RESIGNED 5.11.13	3 years	2014
NOMINATED STAKEHOLDER				
University of Huddersfield	Prof John Playle	1.9.12	3 years	2015
Calderdale Metropolitan Council	Cllr R Metcalfe	18.1.11	3 years	2014
Kirklees Metropolitan Council	**VACANT POST**			
NHS Kirklees CCG	Mrs Jan Giles	6.7.11	3 years	2014
NHS Calderdale CCG	Mrs Sue Cannon	16.4.08 23.9.11	3 years 3 years	2011 2014
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

F

DECLARATION OF INTERESTS – MEMBERSHIP COUNCIL
AS AT 10 JANUARY 2014

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 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
10.10.07	Janette A ROBERTS	From 20.9.13 Reserve Register Constituency 6	-	-	-	-	- Patient Rep of Yorkshire Cancer Network. - Patient Rep on Cancer Local Implementation Team. - Patient Rep for Clinical Audit. - Patient Rep for PEAT Inspection. - Co-Chair of Cancer Connections. - Patient Rep for Gynae. Forum. - Member – CHFT Organ Donation Cttee	
29.10.07	Bernard PIERCE	From 20.9.13 Reserve Register Constituency 5	-	-	-	-	- Patient Rep for PEAT Information to Patient Steering Group - Patient Rep for local GP Practice's Groups	
12.6.08	Sue CANNON	Nominated Stakeholder – Calderdale PCT	Executive Director of Quality & Engagement	-	-	-	-	

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
18.9.08	Linda WILD	Public-elected Constituency 2	-	-	-	-	Employed by BMI Hospitals	
6.10.08	Christine BREARE	Public-elected Constituency 4	-	-	-	-	-	
6.10.09	Christine BENTLEY	Staff-elected Constituency 13	-	-	-	-	-	
6.10.09	Liz FARNELL	Staff-elected Constituency 12	-	-	-	-	-	
1.3.10	Dawn STEPHENSON	Nominated Stakeholder – South West Yorkshire Partnership Foundation Trust	Director of Corporate Development	-	-	Voluntary Trustee - Dr Jackson Cancer Fund	Voluntary Trustee - Kirklees Active Leisure (KAL)	
11.1.11	Bob METCALFE	Nominated Stakeholder – Calderdale Council	-	-	-	-	-	-
22.6.11	Jan GILES	Nominated Stakeholder, NHS Kirklees	-	-	-	-	-	University of Huddersfield Sessional Lecturer. Member of Managers in Partnership. Member of AVMA
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

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
10.10.11	Elizabeth SCHOFIELD	Public-elected Constituency 7	-	-	-	Support Officer for Halifax & Calder Valley M.S. Society	-	- MS Society - Patients Group, King Cross Surgery, Halifax
10.10.11	Peter John MIDDLETON	Public-elected Constituency 3	-	-	-	-	-	-
10.9.12	Prof John PLAYLE	Nominated Stakeholder – Huddersfield University	-	-	-	-	-	Nursing Midwifery Council
16.10.12	Marlene CHAMBERS	Public-elected Constituency 4	-	-	-	-	-	-
15.10.12	Andrew SYKES	Public-elected Constituency 8	-	-	-	-	-	- School Governor Hinchliffe Mill J&I - Employee (Internal Audit) RSM Tenon Group plc - Secretary of the Holme Valley Hospital League of Friends
9.10.12	Eileen HAMER	Staff-elected Constituency 11	-	-	-	-	-	-
10.10.12	Martin URMSTON	Public-elected Constituency 1	-	-	-	-	-	- Department of Justice Tribunal Service - Chartered Society of Physio
13.2.13	Kate WILEMAN	Public-elected Constituency 7	-	-	-	-	-	Chair of Cancer Partnership Group at St James' Leeds

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
15.1.13	Johanna TURNER	Public-elected Constituency 6	-	-	-	-	-	Retired member of Royal College of Nurses (RCN)
13.2.13	Avril HENSON	Staff-elected Constituency 10	-	-	-	-	-	HPC CSP
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
1.10.13	Joan Doreen TAYLOR	Public-elected Constituency 1	Director of The White Ribbon Campaign	-	-	-	-	-
11.10.13	Jennifer BEAUMONT	Public-elected Constituency 8	-	Lindley Park Associates – provider of Occupational Therapy, Case management & Intermediary Services	-	-	Civic Trust Accessible Design Assessor	CQC – Specialist Advisor and Compliance Inspector. Registrant member HCPC Council. British Association of Occupational Therapists. College of Occupational Therapists. Health & Care Professions 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
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.

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:- COMPLETE

Calderdale and Huddersfield NHS

NHS Foundation Trust

MEMBERSHIP STRATEGY

November 2013

Your Care Our Concern

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1 INTRODUCTION

1.1 Background

In 2006 the Calderdale and Huddersfield NHS Trust became a NHS Foundation Trust. A fundamental part of being a NHS Foundation Trust is the particular way the organisation is structured: it is based upon the involvement of local people, patients, carers and staff employed within the Trust, collectively known as the Trust's membership.

Foundation trusts endeavour to give greater ownership to service users and carers, local people, communities and key stakeholders through the democratic process of elected governors (at this Trust, called "Membership Councillors) forming a governing body (at this Trust, called the "Membership Council"). It is the role of the Membership Council to hold the Trust to account for its performance and to make sure that it always acts in the best interests of the people it serves.

We already seek to involve patients and members of the public in how we deliver and develop our services, but our membership arrangements as a NHS Foundation Trust help us to build this more directly into the Governance and corporate decision-making of the Trust to ensure our services continue to meet the needs and wishes of local people.

In accordance with the Trust's constitution, these arrangements are documented in a Membership Strategy which is approved and periodically reviewed by the Membership Council.

1.2 Purpose of this strategy

This strategy outlines our vision for membership and the methods we intend to use to maintain a representative membership and strengthen engagement and communication with members. It also outlines our future plans for recruitment and retention of members and how we will measure the success of our membership.

The strategy sets out plans to ensure that our membership is representative and meaningful and offers individuals every opportunity to become as actively involved as they would wish to be. In addition, Membership Councillors have a duty to represent not only the interests of the members, but of the public too. This strategy highlights opportunities for Membership Councillor engagement with members and with the public.

Objectives for the next 2 years are set out in the final section, and these are expanded on in the annual work plan shown at Appendix 1, which includes defined responsibilities and timescales for delivery.

1.3 The Trust's Engagement Strategy (the People Management Framework)

The approaches outlined in this strategy fit directly with the Trust's Engagement Strategy and the 4 key pillars of engagement approach. These are shown below, together with a brief explanation of how this strategy aligns with them:

- We put the patient first – the strategy ensures we have a diverse and active membership representing the interests of patients and local people, and a Membership Council that holds the Trust to account for its performance;
- We 'go see' – the strategy ensures that we triangulate information by gathering different views, from our members and Membership Councillors, to challenge assumptions, including direct conversations at engagement events and orientation walkabouts into clinical areas;
- We work together to get results – the strategy ensures we have an involved and informed membership, and Membership Council, who work collaboratively and effectively with both clinical and non-clinical staff to inform decision-making and future plans;
- We do the must-dos – the strategy ensures that the Trust complies with its constitution and with the requirements of Monitor.

2 DEFINING OUR MEMBERSHIP

2.1 Public membership

Individuals can become a public member of the Trust providing they are aged 16 or over and fulfil one or more of the following criteria:

- *They are or have been a patient or carer at the Trust;*
- *They live within our "defined membership area"*

The Trust actively encourages all eligible people to become members of the Trust to develop as broad a membership as possible, thus fully reflecting the diversity of the communities served. We would like our membership to reflect the age, gender, ethnicity and socio-economic groups of our local population.

Any member is eligible to stand for election to the Membership Council. There are 16 public Membership Councillors elected from within the public membership. Councillors are elected to one of eight constituencies broadly representing one eighth of the population served by the Trust and the term of office is for 3 years with the possibility of re-election for a further 3 years.

Membership Councillors who have previously held and completed their elected terms of office or who are not re-elected following the first term of their elected office with the Foundation Trust can apply to be on the "reserve register", which exists to ensure that the statutory sub-committees of the Board of Directors can run effectively and that the role of Deputy Chair of the Membership Council can continue. A reserve Membership Councillor may only serve one term of office on the Membership Council for a 12 month period.

There are also nominated stakeholder Membership Councillors from partner organisations.

2.2 Staff membership

All staff are members unless they choose to opt out. This means that there will be greater emphasis on front line staff having more say on local decisions.

Staff are eligible for membership provided they fulfil one of the following criteria:

- *They are employed by the Trust on a permanent basis;*
- *They have been employed by the Trust on a temporary contract of 12 months or more;*
- *They have continually worked for the Trust or one of its partners for 12 months or more*

There are 6 elected staff Membership Councillors. To ensure that the composition of the Membership Council is representative of our workforce, there are 5 staff constituencies encompassing all disciplines, as shown in the following table:

Constituency	Staff group	No of elected members
9	Doctors/dentists	1
10	Allied Health Professionals/Healthcare Scientists/Pharmacists	1
11	Management/Admin/Clerical	1
12	Ancilliary	1
13	Nurses/Midwives	2

3 BENEFITS OF MEMBERSHIP

3.1 Benefits to the organisation

One of the greatest benefits of being a NHS Foundation Trust is that the structure helps us to work much more closely with local people and service users to help us respond to the needs of our communities.

Membership makes us more accountable to the people we serve, and provides better opportunities for the Trust to take advantage of the contributions people wish to make.

3.2 Benefits to members

Being a member of the Trust provides a number of benefits/opportunities. Members can:

- feed back to the Trust their views and experiences;
- increase their knowledge about the broad range of services provided by the Trust and how to access them;
- contribute to and influence the Trust's annual plans, making sure that members' priorities are understood and heard;
- contribute their views and opinions about specific issues that have been identified for development;
- attend membership events on topics of interest;
- receive information about our services and how we are progressing;
- provide practical support and volunteer their services in support of events;
- vote for a representative on the Membership Council through democratic elections;
- stand to be a Membership Councillor.

4 ENGAGING OUR MEMBERSHIP

4.1 Engagement with public members

There are many reasons why people would choose to become a member of our Trust and we recognise that different people will want to be involved in different ways, from simply being able to express their support by being a member to being actively involved in influencing our on-going plans. In response to this, we will provide and continue to develop a range of methods and opportunities for involvement that are well communicated and flexible.

Some members will choose to have a very active membership and some will even choose to go on to become a Membership Councillor or NED. Others will choose to only receive a newsletter. The level of involvement is the choice of the individual and with this in mind the strategy outlines plans that enable members to be as actively engaged as they feel is appropriate to them.

As part of the application process members are asked to specify how involved they wish to be with regard to various activities, such as reviewing patient information leaflets, sharing views through surveys or being involved in staff interviews. This allows us to ensure membership is a worthwhile experience for individuals as we engage with them in ways that they have said will suit them.

The Trust currently engages with its public members through the following mediums:

'Foundation News' Magazine

The bi-annual membership magazine is the primary channel of communication with members. Its purpose is to inform members about developments at the Trust, and to convey to members the work that the Membership Councillors are doing on their behalf.

Trust Website

The Trust's external website has a membership portal providing information about the Trust, its membership and the Membership Council. A function within the portal allows members of the community to apply to become a member of the Trust on line. However, presently only approximately 11% of all applications received originate from the portal and a review of it is required in order to ensure that this medium, which has the potential to reach a wide and diverse audience, is utilised at the optimum level and our membership grows in line with our objectives.

It is acknowledged that if developed and properly used the Membership Portal could be a place where membership is promoted and could also provide opportunities for online engagement with our members and our wider community.

Membership Inbox

The Trust has a dedicated Membership Inbox to facilitate engagement with its members via e-mail. The inbox is monitored by the Membership Office, and allows

members and the public to contact the Membership Office with queries and bookings for meetings and events.

Membership Council Elections

The election process of a Membership Councillor to a vacant seat in a constituency is an important part of the democratic process for members. It is their opportunity to engage with the Trust and appoint the people who they feel will be able to best serve their interests.

Members' Public Meetings

The Trust is committed to holding at least 3 public membership meetings in each financial year. The public meetings are an important mechanism for Membership Councillors, enabling them to meet Trust members and members of the public and listen to their views. Consideration needs to be given to how widely the public meetings are publicised, in order to ensure that the opportunity to attend is given not only to members, but also the general public. This will assist the Membership Councillors in fulfilling the requirement on them to seek the views of and feed back to the public as well as to members.

Medicine for Members Events

Medicine for Members events are held throughout the year, and are open to both members and the public. The lectures are hosted by a Membership Councillor and generate debate and discussion with clinical and other senior staff.

Health Fair & Annual General Meeting

The Health Fair held each year gives the Trust both a platform on which to engage directly with its members, and also an opportunity to showcase its services, developments and initiatives in an interactive way. Attendees are encouraged to give feedback at the event, on any of the Trust's services, and the feedback is then disseminated to the Trust's senior managers for action as appropriate.

The Trust's formal AGM follows on from the Health Fair and this is an opportunity for the Trust and the Membership Councillors to feed back to members about the Trust's performance over the year.

Focus needs to be given to increasing the number of attendees at these events.

Recruitment Panels

As part of the Trust's recruitment process, 3 members are routinely asked to sit on interview panels for key appointments to provide feedback to the HR Department. This gives the Trust the opportunity to directly engage with its members and involve them in decision-making processes.

Real time patient monitoring

Members are invited to take part in real time patient monitoring, which gives them an insight into the services provided to patients and an opportunity to engage with front-line staff.

Review of patient leaflets

Groups of members are often asked to provide feedback on patient leaflets, giving the Trust the opportunity not only to engage with, but also seek views from, its members.

4.2 Engagement with staff members

The majority of staff are members who can stand as and vote for staff Membership Councillors. This ensures that the views of the workforce are reflected in the strategic direction and governance of the organisation. We aim to ensure that our staff members are engaged with the development of the Trust and its services by:

- Having a culture of open and transparent communication with the workforce;
- Encouraging involvement of staff members in our public membership engagement events

4.3 Engagement with Membership Councillors

The Trust strives to have regular and meaningful engagement with its Membership Councillors through various forums. These are:

- Informal meetings with the Chairman;
- Divisional Reference Group (DRG) meetings at which current divisional issues and future plans are debated. Each division's DRG is chaired by a Membership Councillor;
- Chairs' information exchange meetings, which are an information sharing exercise following on from the DRGs. These help to inform the agenda of the Trust Board meetings and of the Membership Council meetings;
- Membership Council sub-committees: the AGM planning sub-committee; the Remuneration & Terms of Services sub-committee and the Nominations sub-committee;
- The Trust's Audit & Risk Committee, the Charitable Funds Committee and the Organ Donation Committee, all of which have Membership Council representation;
- A series of 4 development days set up across the year to which all Membership Councillors are invited. These serve as opportunities to develop the knowledge base of our Membership Councillors;
- Bi-annual joint Board of Director and Membership Councillor workshops at which key priorities and the future direction of the organisation are discussed and agreed;
- Joint Membership Council and Non-executive Director workshops, held twice a year, at which the Councillors and Directors share insights into their respective roles and collaborate to ensure effective governance of the Trust;
- Board of Directors' meetings to which Membership Councillors are invited;
- Task & Finish groups to which Membership Councillors are often invited to bring their views and experience;
- A comprehensive training programme to help develop the skills and knowledge of Membership Councillors;
- A Trust induction process for newly elected Membership Councillors, held jointly with newly appointed NEDs;

- Divisional and Trust-wide 'walkabout' visits to help orientation and understanding of Trust services and facilities;
- Annual Membership Councillor questionnaire surveying the activities, involvement and effectiveness of the Membership Council.

5 MEMBERSHIP RECRUITMENT & RETENTION

5.1 Recruitment activities

Recruitment activity needs to be on-going in order to maintain adequate numbers of members and to ensure that our membership continues to reflect the diversity of the communities we serve.

Current recruitment activities are aimed mainly around student populations in local colleges and universities and the Trust recognises the need to broaden its current recruitment activities in order to capture other sectors of its communities, particularly those that are under-represented.

The Trust will aim to do this in conjunction with the Membership Councillors and current members through a large range of methods, such as:

- Specific focussed recruitment campaigns in appropriate locations, eg visitor areas and outpatient clinic areas, shopping centres, health clubs, community centres;
- Distribution of membership application leaflets across the hospital sites, in health centres and in GP surgeries;
- Use of public meetings, eg Health Fair & Annual General Meeting;
- Targeting new and existing volunteers;
- The Foundation Trust Members Newsletter;
- Trust News;
- Direct contact with established user and carer groups;
- Information campaigns;
- Use of the Trust's website (in particular the Membership Portal);
- Staff Induction events;
- Poster displays in public areas of the Trust (main entrances, cafeterias etc);
- Targeted use of local papers (advertising, inserts and editorials);
- Encouraging staff to recruit friends and family;
- Encouraging staff to make aware to service users/patients and carers the benefits of membership;

Although membership events such as Medicine for Members lectures are aimed primarily at existing members, they are also an excellent opportunity to recruit new members. By holding events about topics which are important to people, members of the public are likely to attend. At this point they can be signed up as new members.

Through monitoring of membership data, it can be ascertained when certain groups needs to be targeted, be it based on ethnicity, disability, gender, age, or geographical location. It is the responsibility of the Business Manager – Membership & Inclusion to evaluate membership information and determine action plans to address any

potential imbalances in membership. This may include targeted membership events or reaching out to particular voluntary community and faith sector groups.

5.2 Membership retention

Attention needs to be given to the retention of members once they have been recruited: this can be achieved in part by ensuring successful engagement takes place with members in order to maintain their interest in the Trust.

Some natural wastage of members is inevitable as they move away from the area and when this does occur, efforts should be made to recruit new members from the same sector using the methods described above. This is particularly relevant to student populations, highlighting the need to have a rolling programme of recruitment events at freshers' fairs at the Trust's local colleges and the university.

Staff members are a valuable resource as they have insight into how the Trust functions and are in a good position to help the Trust shape its services to meet the communities' needs. In view of this, any member of staff leaving the Trust will be offered the opportunity to join as a public member, except when the member of staff is relocating to an area outside the Trust's constituencies. Figures show that this is a worthwhile exercise: over a recent 9-month period there were 824 staff leavers who could potentially have been recruited as public members.

6 MANAGING MEMBERSHIP

6.1 The Membership Office

The Trust has an established Membership Office, responsible for all functions associated with membership. Overall responsibility for the Membership Office rests with the Associate Director of Engagement & Inclusion, whilst day-to-day activities are undertaken by the Business Manager – Membership & Inclusion and the Membership Office PA.

Members are able to communicate with the Membership Office by telephone or by e-mail using the Membership inbox. In addition members have the facility to send questions relating to the Trust direct to the Chairman or the Chief Executive via an inbox specifically set up for members' questions. Both inboxes are monitored by the Membership Office.

The Business Manager – Membership & Inclusion has responsibility for ensuring that systems are in place to facilitate the smooth running of the Membership Office and that all systems are audited on a regular basis.

The Membership Office supports the activities of the Membership Councillors to allow them to:

- Have the opportunity to share their views of the Trust's hospitals, and other hospitals where appropriate, with the Care Quality Commission, as part of its inspection of hospitals process;
- Seek the views of members and the public on material issues or changes being discussed by the Trust;

- Feed back to members and the public information, vision, performance and material strategic proposals;
- Represent not only the interests of members, but also the interests of the public in general, in accordance with the requirements of the Health & Social Care Act 2010.

6.2 The Membership Database

A database of members is maintained, in line with the Data Protection Act, by the Membership Office and this facilitates effective communication with members. It also enables the reporting of membership figures for the purposes of identifying, for example, areas of under-representation.

Reports can also be produced to identify those members who have expressed a wish to be more actively involved, for example to participate in surveys and help with staff interviews. In such cases, the Membership Office works closely with the operational services and other corporate functions to manage the engagement process.

The Trust's Register of Members is contained within the membership database.

7 MONITORING/EVALUATING SUCCESS

It is the responsibility of the Membership Council, through delegated responsibility to the Associate Director of Engagement & Inclusion, to develop and implement an action plan to implement this strategy.

The strategy will be reviewed every 3 years although the annual work plan (Appendix 1) will be reviewed each year by the Membership Office. Reviews of the strategy will be formally fed back to the Membership Council and the Board of Directors.

The review of the strategy will evaluate success of membership recruitment with specific reference to:

- Level of engagement and involvement of members;
- Diversity of membership;
- Geographical representation;
- Systems of communication

This will ensure compliance with Monitor's Code of Conduct for NHS Foundation Trusts which states that, "The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement. This information should be used to review the trust's membership strategy, taking into account any emerging best practice from the sector."

8 OUR DEVELOPMENT PLAN – OBJECTIVES FOR 2014 & 2015

To fulfil this strategy, over the next two years our objectives will be to:

1 Maintain and as appropriate build on our existing membership base and ensure that it reflects the diversity of our local communities;

2 Maintain and as appropriate build on a thriving and influential Membership Council which is embedded in the local community, is responsive to the aspirations and concerns of members and the public, and works effectively with the Board of Directors;
3 Review our current recruitment activities and broaden these where necessary, giving particular focus to under-represented sectors of the community;
4 Review the number and format of our engagement activities in an effort to ensure we are communicating and engaging with our members at the optimal level;
5 Deliver a range of engagement events and activities with particular emphasis on publicity and increasing attendance at these events;
6 Carry out a full review of (a) the Membership Office business systems & processes and (b) the Membership Portal and implement any changes necessary to enhance the membership function.

In order to achieve these objectives, we will undertake the specific actions outlined in the Annual Work Plan for 2014 shown at Appendix 1.

APPENDIX 1

Annual Work Plan for 2014

Objective 1:	Maintain and as appropriate build on our existing membership base and ensure that it reflects the diversity of our local communities.	
Action	Responsible	Timescale
Carry out a review of membership in terms of age, gender, ethnicity & socio-economic groups	Business Manager	31/01/2014
Implement system to e-mail members where mail returned to clarify whether member still in area	Business Manager	31/01/2014
Investigate possibility of inclusion in Staff Induction course to engage with staff	PA	31/01/2014
Reinstate process of offering staff members opportunity to join as public member as they leave	Business Manager	28/02/2014

Objective 2:	Maintain and as appropriate build on a thriving and influential Membership Council which is embedded in the local community, is responsive to the aspirations and concerns of members and the public, and works effectively with the Board of Directors.	
Action	Responsible	Timescale
Carry out a review of MC development days to ensure they remain relevant & informative	Associate Director	28/02/2014
Undertake a review of the MC induction pack	Business Manager	31/08/2014

Objective 3:	Review our current recruitment activities and broaden these where necessary, giving particular focus to under-represented sectors of the community.	
Action	Responsible	Timescale
Compile list of existing/past recruitment activities	PA	31/01/2014
Using review of membership data from Objective 1, identify and contact user groups etc in areas where sectors are under-represented	Business Manager	28/02/2014
Produce revised programme of recruitment activities focusing on under-represented groups	Business Manager	31/03/2014

Objective 4:	Review the number and format of our engagement activities in an effort to ensure we are communicating and engaging with our members at the optimal level.	
Action	Responsible	Timescale
Compile list of existing engagement activities	PA	31/01/2014
Produce revised programme of engagement activities for remainder of year	Business Manager	28/02/2014

Objective 5:	Deliver a range of engagement events and activities with particular emphasis on publicity and increasing attendance at these events.	
Action	Responsible	Timescale
Review current publicity methods for events & their success in terms of attendance levels at the events	Business Manager	31/01/2014
Investigate alternative methods of publicising events, eg the Trust's Twitter account	Business Manager	28/02/2014 and ongoing

Objective 6:	Carry out a full review of (a) the Membership Office business systems & processes, and (b) the Membership Portal and implement any changes necessary to enhance the membership function.	
Action	Responsible	Timescale
Compile register of business systems and processes	Business Manager/ PA	31/01/2014
Audit each system/process to test its efficacy and make amendments where necessary	Business Manager/ PA	31/03/2014
Investigate and advise on any potential developments to the membership portal to make it more effective in terms of attracting and engaging with members and the wider community	Business Manager	30/04/2014

Calderdale and Huddersfield NHS
NHS Foundation Trust

Quality Account –Long List of Priorities for 2014-15

1. Background

Each year a long list of possible priorities are generated to be selected for inclusion in the Trusts Quality account. These priorities are selected from a long list by patients, staff, Foundation Trust members, the general public, the local involvement networks (LINks) in Calderdale and Kirklees, local authority overview and scrutiny panels, the local mental health Trust, health and wellbeing boards and clinical commissioning groups.

As in previous years the priories for the long list included in this paper are determined by:

- Looking at national and local priorities agreed with our Clinical Commissioning Groups as part of Commissioning for Quality and Innovation (CQUIN);
- Considering the priorities in 'Everyone Counts: Planning for Patients 2013/14' and the 'NHS Outcomes Framework 2013/14' - both documents shape our approach;
- Listening to what our regulators had identified as a priority;
- Taking into account national reports and issues raised by organisations such as the Patients Association.
- What our patients have told us
- Considering learning from incidents and complaints

2. Current Priorities

Quality improvement priorities for 2013/14 were:

1. Healthcare associated infections
2. Appropriate and safe discharge
3. Care of patients with dementia
4. Reducing healthcare acquired pressure ulcers
5. Helping people to manage their long-term conditions

3. Process 2014/15

This long list of possible priorities will be made available along with supporting information on the Trusts website in advance of a membership event to be held on

the 20th February. Members will be informed of this event via Foundation News and the website. Members will be asked either to attend the event and vote in person or to vote electronically. In total they will be asked to select 3-4 priories for inclusion, as a minimum at least one priority must be selected from Patient Safety, Patient Experience and Effective care. Our local stakeholders will also be given an opportunity to comment.

4. Long List for Quality Account Priorities 2014-15

Category	Priority	Rationale for inclusion
Safety	Reducing serious harm from falls in Hospital .	Complaints/Incidents theme. Improvement work stream in place which is focussing on person centred care and individualised care planning to reduce the risks.
Safety	Reducing the numbers of patients being admitted with Clostridium Difficile	This work is linked to national drivers and targets around zero tolerance. We have seen an increase in the numbers of patients being admitted with Clostridium difficile. Working with our community partners we would like to raise awareness of clostridium difficile to help ensure early detection and treatment hopefully reducing harm and the need for hospital admission.
Safety	To reduce the number and improve management of indwelling urinary catheters in hospital and at home	This work is linked to national drivers and targets around zero tolerance. Use of indwelling urinary catheters is linked to an increased risk of E Coli and MRSA infections and thus to causing serious harm. Working both in the hospital and also in community the aim is to ensure urinary catheters are only used when needed and are managed as safety as possible.
Safety	To improve the Trusts relative position on mortality rates as measured by the Hospital Standardised Mortality Rate	This is the outcome aim for the Improving the care of the acutely ill patient programme and it is a major focus of our quality improvement work at the Trust.
Effectiveness	To ensure intravenous antibiotics are given correctly and on time.	Complaints/Incidents theme. Improvement work stream in place which is focussing on ensuring intravenous antibiotics are given in a timely manner. This is crucial for patient safety and to ensure delays to treatment are avoided. We know from ongoing improvement work delays occur due to a number of reasons such as cannula's

		not being in place or medications not being available. This work will focus on removing these barriers and thus ensuring IV antibiotics are given at the correct times.
Effectiveness	Reduce the increased length of stay for patients with diabetes	National driver and improvement workstream. At any one time 20% of all adult patients in hospital have diabetes. Patients with diabetes stay on average 2 days longer than patients without diabetes. We want to improve the care of patients with diabetes and encourage more patients to manage their own diabetes whilst on the ward to reduce the amount of time they need to spend in hospital.
Experience	Focus on implementing the prevention of Delirium pathway which is supported by volunteers.	There are national drivers for improvement in this area. This is new innovative work which will lead to a better experience for both patients with dementia and their carers whilst improving understanding around dementia and delirium with our wider community.
Experience	To help patients with long term pain develop the skills needed to manage their conditions through Supported Self Management courses.	Patients with long term pain are advised and encouraged to self refer to a course by community and hospital staff. The Supported Self Management course aims to give patients the support and skills needed to manage their pain better. These courses are part of a wider programme of work that also trains health professionals to support patients to self manage their conditions better. The aim is thus to give patients more control of their condition, build an equal partnership between patients and clinicians and improve the patients quality of life.

MEMBERSHIP COUNCIL CALENDAR OF ACTIVITY 2013 & ALLOCATION TO SUB COMMITTEES/GROUPS AS AT 9th JANUARY 2014

(Amendments to previous information provided are in red)

JANUARY 2014

DATE	MEETING	TIME	LOCATION	PLEASE ATTEND
Thurs 9	Chairs' Information Exchange	9.30-11.30	Board Room, Trust Offices, CRH	JR, MU, PM, LS, EH
Thurs 9	DaTS Divisional Walkabout	1.30-4.30	Pathology, Radiology CRH (meet at main entrance)	ANY
Mon 20	MCs/Chair Informal Meeting	3.00 – 4.00	Boardroom, Sub-basement, HRI	ALL
Mon 20	MCs formal Meeting	4.00 – 6.00	Boardroom, Sub-basement, HRI	ALL
Thu 23	S & A DRG Agenda setting	2.30-3.30	Julie Barlow's office, Surgical Offices, HRI	MU
Tues 28	Remuneration & Terms of Service – Chair & NEDs	9.00 – 11.00	Chair's Office, HRI	EH, CBentley, JR, JB, AS, WC

FEBRUARY 2014

DATE	MEETING	TIME	LOCATION	PLEASE ATTEND
Mon 03	CWF DRG Agenda setting	9.30–10.00	Kristina Arnold's office, CWF offices, CRH	*None (Chair to be appointed at DRG mtg)*
Tues 04	Medicine for Members 'Radiology from Cradle to Grave'	5.30 – 7.00	Boardroom/Lecture Theatre, HRI	Volunteers
Mon 10	Medicine for Members 'Radiology from Cradle to Grave'	5.30 – 7.00	Lecture Theatre, CRH	Volunteers
Tues 11	Members recruitment event	10.00 – 2.00	Kirklees College, Huddersfield	Volunteers
Wed 12	Joint MC/NED Informal Workshop	4.00 – 6.00	Boardroom, HRI	ALL
Thurs 13	CWF DRG meeting	12.00-2.00	Board Room, Trust offices, CRH	KW, CBreare, WC, LF, BP, MK, MC
Mon 17	DaTS DRG Agenda setting	11.30-12.30	Emma Livesley's office, DaTS Offices, North Drive, HRI	PM
Tues 18	Divn of Medicine agenda setting	10.00-11.00	Old Ward 10 meeting room, CRH	LS

Thurs 20	Estates & Facilities Directorate agenda setting	10.00-11.00	Lesley Hill's office, Trust Offices, HRI	LS
Thurs 20	S & A DRG meeting	2.00 – 4.00	Boardroom, HRI	MU, BP, JT, LW, GH, AH
Thur 20	Members recruitment event	4.00 – 6.00	Greenhead College, Huddersfield	Volunteers
Thurs 20	Quality Account Engagement Event	5.30 – 7.00	Learning Centre, HRI	ALL
Thu 27	Staff MC Meeting	10.00 –12.00	TBA, HRI	AH, CBentley, EH, LF, MK
Fri 28	Divn of Medicine DRG meeting	10.30-12.30	Boardroom, HRI	CB, JB, JT, PM, DH, LS

MARCH 2014

DATE	MEETING	TIME	LOCATION	PLEASE ATTEND
Tues 04	DaTS DRG Meeting	1.00 – 3.00	DaTS Meeting Room, DaTS offices, HRI	AH, PM, WC, JR, MC, LS
Thur 06	E & F DRG Meeting	2.00 – 4.00	Discussion Room 2, LC, HRI	LS, CBreare, GH, EH, JT, LF
Tues 11	Embracing Diversity	9.30 – 12.30	Large Training Room, CRH	ANY
Thur 20	Extra-ordinary MC Meeting re Annual Plan	1.00 am – 2.30 pm (approx.)	Boardroom, HRI	ALL
Mon 31	Chairs Information Exchange	10.00-12.00	Discussion Room 2, LC, HRI	JR, MU, PM, LS, EH

APRIL 2014

DATE	MEETING	TIME	LOCATION	PLEASE ATTEND
Wed 2	Medicine for Members 'A day in the life of an Anaesthetist and his role in ICU'	5.30 – 7.00	Boardroom/Lecture Theatre, HRI	Volunteers
Mon 7	Medicine for Members 'A day in the life of an Anaesthetist and his role in ICU'	5.30 – 7.00	Lecture Theatre, CRH	Volunteers
Tues 8	MC Informal Meeting	3.00 – 4.00	Boardroom, Sub-basement, HRI	ALL

Tues 8	Members Public Meeting	4.00 – 6.00	Boardroom, Sub-basement, HRI	All
Mon 28	Staff MC Meeting	1.00 – 3.00	Chairs office, Trust offices, HRI	AH, CBentley, EH, LF, MK

MAY 2014

DATE	MEETING	TIME	LOCATION	PLEASE ATTEND
Tues 6	MC/BOD Workshop	9.00 – 4.00	TBC	All
Tues 13	Embracing Diversity	9.30 – 12.30	Discussion Room 1, HRI	Any
Mon 19	DaTS agenda setting mtg	11.30-12.30	Emma Livesley's office, DaTS offices, HRI	PM
Wed 21	E & F agenda setting mtg	3.00 – 4.00	Discussion Room 1, LC, HRI	LS
Wed 28	CWF agenda setting mtg	4.00 – 5.00	Kristina Arnold's office, CWF offices, CRH	Chair of CWF DRG

JUNE 2014

DATE	MEETING	TIME	LOCATION	PLEASE ATTEND
Mon 2	DaTS DRG Meeting	10.00-12.00	DaTS Meeting room, DaTS offices, HRI	PM, AH, WC, JR, MC LS
Wed 4	E & F DRG Meeting	2.00 – 4.00	Hospital Boardroom, HRI	LS, CBreare, GH, EH, JT, LF
Thu 5	Med Divn agenda setting mtg	11.00-12.00	Old Ward 10 Meeting Room, CRH	LS
Thu 5	Medicine for Members 'A day in the life of a Junior Doctor'	5.30 – 7.00	Boardroom/Lecture Theatre, HRI	Volunteers
Mon 9	CWF DRG Meeting	9.00 – 11.00	Parentcraft Room, CWF offices, CRH	CBreare, WC, LF, BP, MK, KW, MC
Wed 11	S & A DRG Meeting	2.00 – 4.00	Discussion Room 3, LC, HRI	BP, MU, JT, LW, GH, AH
Wed 11	Medicine for Members 'A day in the life of a Junior Doctor'	5.30 – 7.00	Lecture Theatre, CRH	Volunteers
Thu 19	Medical Divn DRG meeting	3.00 – 5.00	Boardroom, CRH	LS, DBentley, JB, JT, PM, DH

Tues 24	Chairs Information Exchange	2.00 – 4.00	Discussion Room 2, LC, HRI	JR, MU, PM, LS, EH

JULY 2014

DATE	MEETING	TIME	LOCATION	PLEASE ATTEND
Wed 9	MC Informal Meeting	3.00 – 4.00	Boardroom, Sub-basement, HRI	All
Wed 9	Members Public Meeting	4.00 – 6.00	Boardroom, Sub-basement, HRI	All

AUGUST 2014

DATE	MEETING	TIME	LOCATION	PLEASE ATTEND
Thur 21	Staff MC Meeting	10.00-12.00	TBA, HRI	AH, CBentley, EH, LF, MK

SEPTEMBER 2014

DATE	MEETING	TIME	LOCATION	PLEASE ATTEND
Mon 8	MC/NED Informal Workshop	4.00 – 6.00	Large Training Room, CRH	ALL
Thur 18	Joint BOD & MC AGM & Health Fair	TBC	TBC	ALL
Tues 23	Embracing Diversity	9.30 – 12.30	Large Training Room, CRH	Any

OCTOBER 2014

DATE	MEETING	TIME	LOCATION	PLEASE ATTEND
Mon 20	Staff MC Meeting	1.00 – 3.00	TBA	AH, CBentley, EH, LF, MK
Wed 29	DaTS DRG agenda setting mtg	1.00 – 2.00	Emma Livesley's office, DaTS offices, HRI	PM

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NOVEMBER 2014

DATE	MEETING	TIME	LOCATION	PLEASE ATTEND
Mon 3	CWF DRG agenda setting mtg	4.00 – 5.00	Kristina Arnold's office, CWF offices, CRH	Chair of CWF DRG
Wed 5	Embracing Diversity	9.30 – 12.30	Discussion Room 1, HRI	Any
Tues 11	MC/BOD Workshop	9.00 – 4.00	TBC	ALL
Wed 12	DaTS DRG meeting	11.00 – 1.00	DaTS Meeting Room, DaTS offices, HRI	PM, AH, WC, JR, MC, LS
Mon 17	CWF DRG meeting	9.00 – 11.00	Parentcraft Room, CWF Offices, CRH	CBreare, WC, LF, BP, MK, KW, MC
Wed 26	S & A DRG meeting	1.00 – 3.00	Discussion Room 1, LC, HRI	MU, BP, JT, LW, GH, AH

DECEMBER 2014

DATE	MEETING	TIME	LOCATION	PLEASE ATTEND
Thur 4	Medical Divn DRG meeting	2.30 – 4.30	Small Training Room, LC, CRH	LS, CBentley, JB, JT, PM, DH
Mon 8	E & F DRG meeting	2.00 – 4.00	Hospital Boardroom, HRI	LS, CBreare, GH, EH, JT, LF

DIVISIONAL REFERENCE GROUPS (Plus Divisional Reps)	QUORUM	3 per annum	ALLOCATION FROM 1 NOVEMBER 2013 • Denotes chair of DRG
Children, Women & Families (CWF) Divisional Reference Group	- 1 Divisional representative - 2 Membership Councillors - 1 Membership Office representative	13.2.14, 12-2 pm Boardroom CRH 9.6.14 9 – 11 am Parentcraft Room, CWF offices, CRH 17.11.14, 9-11 am Parentcraft Room, CWF offices, CRH	Chris Breare Wayne Clarke Liz Farnell Bernard Pierce Mary Kiely Kate Wileman Marlene Chambers
Surgical & Anaesthetics (S&A) Divisional Reference Group	"	20.2.14, 2-4 pm Hospital Boardroom, HRI 11.6.14 2-4 pm Discussion Room 3, LC, HRI 26.11.14, 1 – 3 pm Discussion Room 1, LC, HRI	Bernard Pierce Martin Urmston* Johanna Turner Linda Wild Grenville Horsfall Avril Henson
Diagnostic & Therapeutic (DATs) Divisional Reference Group	"	4.3.14 1-3 pm 2.6.14 10am-12 noon 12.11.14, 11am –1pm All: DaTS Meeting Room, North Drive, HRI	Avril Henson Peter Middleton* Wayne Clarke Janette Roberts Marlene Chambers Liz Schofield
Medicine Divisional (Med) Reference Group	"	28.2.14, 10.30-12.30 pm Boardroom, HRI 19.6.14, 3-5 pm Boardroom, CRH 4.12.14, 2.30-4.30pm Small Training Room, LC, CRH	Chris Bentley Jennifer Beaumont Johanna Turner Peter Middleton Dianne Hughes Liz Schofield*
Estates & Facilities (E&F) Divisional Reference Group	"	6.3.14, 2-4 pm Discussion Room 2, HRI 4.6.14 2-4 pm Boardroom, HRI 8.12.14, 2 – 4 pm Boardroom, HRI	Liz Schofield* Chris Breare Grenville Horsfall Eileen Hamer Joan Taylor Liz Farnell

STATUTORY SUB COMMITTEE TITLE	AGREED COMPOSITION AS PER TERMS OF REFERENCE	PROPOSED MEETINGS	ALLOCATION
Remuneration & Terms of Services – Chair & Non Executive Directors (NEDs)	6 Members – including 1 staff (Declaration of Non-interest in NED post required)	28.1.14 9.00 am Chair's Office, HRI	Eileen Hamer Chris Bentley Janette Roberts Jennifer Beaumont Andrew Sykes (apols 28.1.14) Wayne Clarke
Nominations Sub Committee Chair & NEDs	Trust Chairman (or Vice/Acting Chair in relation to Chair appointments) Trust Chief Executive 1 Appointed Member 3 Elected Members (at least 2 publicly elected)	Annually & As and when required	Chris Breare Johanna Turner John Playle Linda Wild
AGM Planning Sub Group	Not specified	4 per annum	Chris Breare Chris Bentley Janette Roberts Grenville Horsfall
Audit & Risk Committee	1 Membership Councillor to observe	5 per annum	Andrew Sykes (Peter Middleton – reserve)

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 19 September 2013 at 7.00 pm in the Lecture Theatre, Huddersfield Royal Infirmary

PRESENT:-

Speakers present on the stage were:-
Mr Andrew Haigh, Chairman
Mr Owen Williams, Chief Executive
Mr Keith Griffiths, Director of Finance
Mrs Helen Thomson, Deputy Chief Executive/Director of Nursing
Mrs Janette Roberts, Publicly Elected Member-Deputy Chair/Lead MC

Others present were:-
Board of Directors
Dr David Anderson, Non Executive Director
Dr Barbara Crosse, Medical Director
Mrs Lesley Hill, Director of Planning, Performance, Estates & Facilities
Miss Julie Hull, Director of Personnel & Development
Mr Philip Oldfield, Non Executive Director
Mr Jeremy Pease, Non Executive Director
Prof. Peter Roberts, Non Executive Director
Mrs Jan Wilson, Non Executive Director

Membership Council
Mr Bernard Pierce
Mr Martin Urmston
Mrs Christine Breare
Mrs Liz Schofield
Mrs Marlene Chambers
Mr Andrew Sykes
Mrs Joan Taylor
Mrs Johanna Turner
Mrs Jennifer Beaumont
Mr Wayne Clarke
Mr Grenville Horsfall
Mrs Dianne Hughes
Mrs Christine Bentley
Miss Liz Farnell
Mrs Eileen Hamer
Mrs Dawn Stephenson
Prof J Playle

1. CHAIR'S OPENING STATEMENT AND INTRODUCTIONS

The Chairman opened the meeting by thanking everyone for attending and introduced the speakers. The change of venue from the John Smiths' Stadium to the Huddersfield Royal Infirmary was noted due to clashes with Super League rugby games planned this year. Thanks were given to everyone who was involved in reorganising the plans for the Healthfair and AGM at short notice.

It was noted that other members of the Board of Directors and Membership Councillors were also present in the audience.

The Chairman reported that this had been a year for the Trust and the whole NHS when it had held the mirror up to itself especially in light of the Francis Report, Keogh Review and Berwick Report. The CHFT had held the mirror up to itself in a number of ways during the last year and two slides were given as examples – showing the 4 core objectives and 6 underpinning principles. He reported on the work being undertaken in the Trust to address the recommendations made in each of the reports.

The Chairman reported that this was the sixth 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 5.30 to 7.00 pm that evening had been very successful and thanks were given to all staff involved in arranging the marketplace and visits. Particular thanks were also given to sponsors Henry Boot Developments for providing sponsorship for the event and the hard work and dedication of staff, volunteers and League of Friends.

It was noted that the packs which had been placed on seats contained:-

- Agenda
- Membership Council Register of Members at 19 September 2012
- Summary Annual Report and Accounts
- Evaluation Form
- Annual Audit Letter from the external auditors
- Medicine for Members Forthcoming Events
- Membership Forms
- Proposed changes to the Constitution

A number of paper copies of the full Annual Reports and Accounts were available at the front of the room and this was also available electronically on the Trust website.

It was aimed to keep the formal meeting as brief as possible with opportunity for questions at the end of the meeting.

2 APOLOGIES

Apologies were received from:-

Board of Directors

Mrs Alison Fisher, Non Executive Director
Mrs Jane Hanson, Non Executive Director
Dr Linda Patterson, Non Executive Director

Membership Council Members

Mrs Sue Cannon
Mr Peter Middleton
Mrs Wendy Wood
Mrs Linda Wild

Mrs Kate Wileman
Dr Mary Kiely
Mr Harjinder Singh Sandhu
Mrs Avril Henson
Mrs Jan Giles
Mrs Lisa Francis
Mrs Julie Mellor
I

3 TRUST ANNUAL ACCOUNTS – APRIL 2012 TO MARCH 2013

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 £351m
- Patients
- *119,000 inpatients/day cases*
- *414,000 outpatients*
- *185,000 adult service community contacts*
- *90,000 children service community contacts*
- 5260 colleagues
- 2 main hospital sites that have a combined value of £201m

Our Performance in 2012/13

Our Results were:-

- Income & Expenditure surplus of £3.8m, (1.1% of turnover £0.8m ahead of plan
- An investment of £10.6m in medical equipment, estates and IT
- The cash balance at year end was £33m
- Monitor risk rating of 4

Compared to 2011/12

- 3000 more patients were treated in our A&E department
- 5000 more patients received care in outpatients
- Savings/efficiency gains worth £14m were delivered

Specific Facts

- Income grew to £351m in 2012/13 – an increase of £10m from 2011/12
- 91% of our income continues to come from our 2 main health partners; NHS Kirklees and NHS Calderdale
- Total expenditure was £347m - £214m of our costs relate to pay, £119m non-pay expenditure
- Capital Financing charges £14m.

Summary

- All key financial targets met or exceeded
- Unqualified Audit opinion received

4 ANNUAL REPORT 2012/13 and FORWARD PLAN

Owen Williams welcomed everyone to the meeting and gave a presentation highlighting the achievements and challenges for 2012/13. He outlined the Trust's engagement work using the four pillars:-

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

As briefly mentioned by the Chairman, Owen Williams drew the attention of those present to the review into the quality of patient care and treatment brought to light by the Keogh Review. It was noted that there had been an increase in patients admitted to hospital over 65 years old, an increase in mortality of around 10% and 28% of consultant physicians rating their hospital's ability to deliver continuity of care for patients are very poor. Information regarding the partnerships for patients and future care and results were received. (Just need to make it clear that these are national figures and not relating to our Trust – although please check!)

5 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.

a. Council Members

As members were aware, over the period 11 June to 23 August 2013, on behalf of the Trust, the Electoral Reform Services had held elections. This had resulted in 5 public seats being filled.

All these appointments could be seen on the Register of Members which was available within the packs. The ballot turnout rates this year were between 12.9% and 20.3% which was comparable to other trusts.

The Chairman wished to thank the retiring members who included:- Harjinder Singh Sandhu, Wendy Wood, Vic Siswick and Lisa Francis.

b. Board of Directors – Non Executive Directors (NEDs)

The Chair reported that the Nominations Sub Committee had considered the forthcoming NED vacant positions this included Alison Fisher, Jane Hanson and Michael Savage. Members of the Nominations Committee were thanked for making the three appointments on the 31 July 2013, all of whom had been offered 3 year tenures:-

Mr Philip Oldfield
Mr Jeremy Pease
Dr Linda Patterson

Thanks were given to Alison Fisher and Jane Hanson for their support as Vice Chair and Senior Independent Non Executive Director respectively.

Those present formally ratified the aforesaid appointments and introductions to new members of the Membership Council and Board of Directors were made.

6 MEMBERSHIP COUNCIL UPDATE – OVERVIEW OF THE MEMBERSHIP COUNCIL CONTRIBUTION DURING 2011/12

Janette Roberts, Deputy Chair gave an overview of the Membership Council Contribution during 2012/13. This included:-

- The work of the Remuneration and Terms of Service Sub Committee.
- The role of the Membership Council and involvement via the Divisional Reference Groups with Service Users to develop the plans for the Trust.
- Training Programme for Membership Councillors continues
- Joint workshops with the Membership Council and Board of Directors
- Involvement in PEAT/PLACE visits to monitor the standards in both hospitals
- Continuing to engage with members through Medicine for Members Events and member engagement events.
- Participation in the Health and Social Care Strategy Review.
- Reviewing the role of the Membership Councillor in light of the new Health & Social Care Act 2012.

7 CONSTITUTIONAL CHANGES

Janette Roberts reported that two amendments to the Constitution had been approved by the Board and Membership Council. This included the provisions within the Health & Social Care Act 2012 for the Membership Council/Council of Governors to approve amendments to the Foundation Trust Constitution without reference to Monitor.

Secondly the Membership Council had agreed arrangements for a Constitutional change to allow for the establishment of a Reserve Register for Membership Councillors in the event of vacancies on the Membership Council. It was noted that the a list had been established and two Reserve Membership Councillors had been appointed to the Membership Council in accordance with the new clause and this was highlighted on the Membership Council Register contained within the Pack.

The Chairman thanked Janette for the summary. It was noted that these constitutional changes had been agreed at the Board of Directors and Membership Council Meetings held on 27 June and 3 July 2013 respectively. All presented voted via a show of hands in agreement of the proposed changes.

8 STANDING IN THE PATIENT'S SHOES

Helen Thomson shared a clip from Youtube.

9 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:-

Tony Gorton – Huddersfield Epilepsy Action – wanted to thank Helen Thomson for supporting his aims in getting a Neurological service up and running in the Trust. Thanked Helen for the Group's long relationship with the Trust.

Long waiting list for Pain Clinic for follow-up appointment. Complimentary about A&E services following a recent visit. Helen Thomson agreed to speak to the lady outside of the meeting.

Thank you to the Trust for dealing with the cubicles in X-ray department for people with a disability.

Black Ice Friday – had appointment to remove cataract at CRH. Dedicated staff in department, ran out of coffee. Had good treatment. Doctors had difficulty getting into work.

Q - Ophthalmology – saw GP last year, who could not guarantee they would be seen quickly by the hospital so went privately for treatment (cataract removal). What is the waiting list position? Is there a choice of where this can be done?
A – Helen Thomson said that if treatment is urgent you will be seen quickly. If GP does not think it is urgent there is a choice of where to go.

Q - A&E – had a 4½ hour wait. Can't GPs take on minor cases to relieve the pressure on doctors.
A – Trust agrees but difficult to put in place.

Q - Andrew Sykes, Membership Councillor – rate of change and how is Trust affected?
A – Owen Williams – this is part of the HSCR in partnership with SWYPFT, CCGs, 2 LAs and Locala. How do we move from care driven by an individual organisation's perspective to the patient's perspective. Door to door experience is about meeting patients' needs and not organisations' needs. We are working towards this in a genuine partnership way. There is commitment to do the right thing and a quickly as possible.

10 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 18 September 2014. The time and venue would be confirmed nearer the date.

There were no further matters of business. The Chairman closed the formal meeting at approximately 8.30 pm.

/KB/AGM2013-MINS

Calderale and Huddersfield NHS

NHS Foundation Trust

MC News

Issue 1: January 2014

Happy New Year! Welcome to the first ever edition of MC News!

We hope you all had a very merry Christmas, and a happy New Year! Hands up those who didn't over-indulge!

We want to keep our Membership Council informed and up-to-date with things that are happening across the Trust and to help us to do this, we have introduced "MC News".....we want to share with you news, information, and dates for your diary, tell you about success stories within the Membership Council and generally keep you informed of what is going on around the Trust and in the Membership Office.

If you have any news or stories that you would like to share with your fellow Membership Councillors, please let Kathy or Vanessa know.

As this is our first edition, please feel free to give us your feedback!

Membership Office: membership@cht.nhs.uk or 01484 347342

Key appointments:

- Assistant Divisional Director, CWF—Kristina Arnold—took up post in December 2013
- Company Secretary—Victoria Pickles—starts on 10 February 2014
- Director of Nursing—Julie Dawes—takes up her post on 1 April 2014

Key dates for your diary....*Please also see full calendar overleaf*

- MC formal meeting—20.1.14
- Feb/March—spring round of DRG meetings
- Quality Account event—20.2.14—to agree the Trust's quality priorities for the coming year
- MC Extraordinary meeting—20.3.14—to consider the Trust's Business Plan

Thank you.....

- To Dianne Hughes, who did a reading at St Stephen's Church Carol Service on Sunday 22 December 2013 on behalf of the MCs—Dianne said afterwards she was "very proud to do it".
- To all the MCs who have recently volunteered to carry out Real Time Patient Monitoring for us (and of course, to those who are old hands at it!). Hope you find it a worthwhile experience.
- To all the MCs who have helped us out at Medicine for Members Events and recruitment events over the last 12 months - very much appreciated.

Membership Strategy

The updated Membership Strategy was approved by the Board of Directors in December 2013 and will be submitted to the MC meeting on 20 January 2014. Thanks to those MCs who commented on the draft version.

And last but not least—it's Dryathlon time!

Some of you may have seen in Owen's recent message, reference to "Dryathlon", which is a well-intended attempt at encouraging people to go sober for the month of January....good luck if you are embarking on the programme—we would love to hear from any of you who make it to the end of the month (you may get a mention in next month's edition....!).

(Oh, and if it's any consolation to any of you, the 3 of us in the Membership Office have failed miserably already, and we're only a week in!!)

CONGRATULATIONS!

Many congratulations to Jan Roberts, who has been successfully selected to the pool of inspectors for the CQC.

Well done Jan—we're sure you will be kept busy!

MEMBERSHIP COUNCIL
Calendar of Activity for January & February 2014
(Amendments to previous information provided are in red)

January 2014

DATE	MEETING	TIME	LOCATION	PLEASE ATTEND
Thurs 9	Chairs' Information Exchange	9.30 – 11.30	Board Room, Trust Offices, CRH	JR, MU, PM, LS, EH
Thurs 9	DaTS Divisional Walkabout	1.30 – 4.30	Pathology, Radiology, CRH (meet at main entrance)	Any
Mon 20	MCs/Chair informal meeting	3.00 – 4.00	Board Room, HRI	ALL
Mon 20	MCs' formal meeting	4.00 – 6.00	Board Room, HRI	ALL
Thurs 23	S&A DRG Agenda setting	2.30 – 3.30	Julie Barlow's office, Surgical Offices, HRI	MU
Tue 28	Remuneration & Terms of Service – Chair & NEDs	9.00 – 11.00	Chair's Office, HRI	EH, CBentley, JR, JB, AS, WC

February 2014

DATE	MEETING	TIME	LOCATION	PLEASE ATTEND
Mon 3	CWF Agenda setting	9.30 – 10.00	Kristina Arnold's office, CWF offices, CRH	*None (Chair to be appointed at DRG mtg)*
Tues 4	Medicine for Members – 'Radiology from Cradle to Grave'	5.30 – 7.00	Board Room & Lecture Theatre, HRI	Volunteers
Mon 10	Medicine for Members – 'Radiology from Cradle to Grave'	5.30 – 7.00	Lecture Theatre, CRH	Volunteers
Tues 11	Members recruitment event	10.00 – 2.00	Kirkwood College, Huddersfield	Volunteers
Wed 12	Joint MC/NED Workshop	4.00 – 6.00	Board Room, HRI	ALL
Thurs 13	CWF DRG meeting	12.00 – 2.00	Board Room, Trust Offices, CRH	KW, CB, WC, LF, BP, MK, MC
Mon 17	DaTS DRG Agenda setting	11.30 – 12.30	Emma Livesley's office, DaTS Offices, North Drive, HRI	PM
Tues 18	Med DRG Agenda setting	10.00 – 11.00	Old Ward 10 meeting room, CRH	LS
Thurs 20	E&F DRG Agenda setting	10.00 – 11.00	Estates Meeting Room, HRI	LS
Thurs 20	S&A DRG meeting	2.00 – 4.00	Board Room, HRI	MU, BP, JT, LW, GH, AH
Thurs 20	Quality Accounts event	5.30 – 7.00	Learning Centre, HRI	ALL
Thurs 20	Members recruitment event	4.00 – 6.00	Greenhead College, Huddersfield	Volunteers
Fri 28	Med DRG meeting	10.30 – 12.30	Board Room, HRI	CB, JB, JT, PM, DH, LS