Calderdale and Huddersfield NHS
NHS Foundation Trust

Forward Plan Strategy Document for 2012-13

Calderdale & Huddersfield NHS foundation trust

Forward Plan for y/e 31 March 2013 (and 2014, 2015)

This document completed by (and Monitor queries to be directed to):

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Date	**29 May 2012**

In signing below, the Trust is confirming that:

- **The Forward Plan and appendices are an accurate reflection of the current shared vision and strategy of the Trust Board having had regard to the views of the board of governors;**
- **The Forward Plan and appendices have been subject to at least the same level of Trust Board scrutiny as any of the Trust's other internal business and strategy plans;**
- **The Forward Plan and appendices are consistent with the Trust's internal business plans;**
- **All plans discussed and any numbers quoted in the Forward Plan and appendices directly relate to the Trust's financial template submission.**

Approved on behalf of the Board of Directors by:

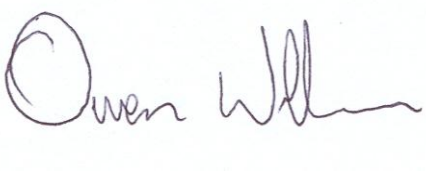
Name *(Chair)*	**Mr Andrew Haigh**

Signature

Approved on behalf of the Board of Directors by:

Name *(Chief Executive)*	**Mr Owen Williams**

Signature



Approved on behalf of the Board of Directors by:

Name	**Mr Keith Griffiths**

(Finance Director)	

Signature

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To be published

1. Section 1 – Forward Plan

Not intended for publication

2. Appendix 1 - Key risks
3. Appendix 2 - CIPs and efficiency
4. Appendix 3 - Financial commentary
    a) Income
    b) Service Developments
    c) Transactions
    d) Activity
    e) Workforce
    f) Capital expenditure
    g) Costs

Note: Although Monitor does not intend to publish Appendices 1-3, all information provided to Monitor is potentially subject to disclosure under the Freedom of Information Act 2000.

Section 1: Forward Plan

A. The Trust's vision is summarised as:

Current position

CHFT continues to deliver high quality services in a challenging environment. In 2011/12 we met all Care Quality Commission standards and delivered on all performance targets.

We have continued to deliver key service developments in line with our plan for 2011 / 12 and we have brought about real benefits for local people which include:

- 28% reduction in length of stay in medical beds, excluding rehabilitation beds. We have done this through work alongside the lean academy on techniques such as virtual ward (supporting patients in the early weeks of their discharge), visual hospital (tracking patients inpatient stay and maintaining momentum), plan for every patient and discharge planning. Length of stay for this cohort of patients has reduced from 6.1 days to 4.4 days and has contributed to the Trust having one of the shortest lengths of stay in the country.
- Compliance with all CQC standards.
- Continued reduction in the national standards in the number of MRSA bacteraemias and Clostridium Difficile cases. Cases of Clostridium difficile are at a record low at CHFT.
- Further development of tertiary services locally, including the accreditation from the British Cardiovascular Intervention Society (BCIS) to provide Percutaneous Coronary Intervention (PCI), moving services for local people from Leeds to Halifax.
- Upgrade MRI scanner at Calderdale Royal Hospital £0.5m
- Continued refurbishment of wards at Huddersfield Royal Infirmary £0.5m
- Extensive work at both our hospitals including the opening of the new £380,000 surgical outpatient unit at Huddersfield Royal Infirmary and the introduction of new electronic touch-screen check-in system at both CRH and HRI.
- In partnership with the tertiary service at Leeds, Huddersfield kidney dialysis patients are now receiving their treatment in a brand new £1.5 million unit at HRI. The facility will be run by Leeds Teaching Hospitals NHS Trust, which provides specialist renal services to patients across West Yorkshire.
- Successful participation in national programmes, including being one of only four Trusts nationally to be selected to take part in the People Powered Health Programme funded by NESTA (National endowment for Science, Technology and the Arts).

CHFT is geared towards delivering the key priorities for 2012/13 within the emerging operating environment. CHFT will work with all new and shadow organisations in 2012/13 to ensure a seamless transfer to the new ways of working.

The period covering this plan (2012-2015) will be one of the most challenging financial environments yet. CRES levels of 5-6% are expected to be necessary for the next 3-4 years at least. This will mean that the Trust has to achieve efficiency savings of c: £46m over the next three years. Joint working within the new structure will be critical to ensure continued provision of excellent health services. Plans will continue to be revised with stakeholders within the context of the current external environment, therefore the 3 year plan may change in the next year in partnership with all of our stakeholders. This may include maximising the benefit from any emerging opportunity, either in year or over the next three years.

The Trust's Vision

The Trust's vision for the next 3 years continues to be 'Your Care, Our Concern'. The vision and mission centre around the 4 Ps, Patients, People, Partnerships, Pride.

Vision:

- **Patients** – High quality, sustainable patient care
- **People** – The importance of our staff
- **Partnerships** – The value of our external relationships
- **Pride** – Our standards, achievements and aspirations

Mission:

- **Patients** – We will continuously transform care and improve patient experience
- **People** – We will attract, retain and develop the best staff
- **Partnerships** – We will create a sustainable future and develop effective external relationships
- **Pride** – We will be recognised for our achievements and aspirations as a highly successful organisation.

In the context of the vision and mission Calderdale and Huddersfield NHS Foundation Trust 'Way and Behaviours' have recently been reviewed and agreed by The Board. Together with our staff we have developed a set of core behaviours along with a number of principles that relate to our way of working in the Trust. These are:

Be respectful
We believe that everything we do should benefit the care and experience of our patients and service users

Be responsible
We expect people to solve problems at their own level

Be accountable
Everything is delivered by and through Divisions
We are clinically led and management supported

Be courageous
We aim to standardise work and reduce variation in all our processes to achieve reliability and excellence in all that we do
We understand the world we live in and deal with it

Be inspirational
We recognise and reward our staff for their outstanding contributions

Be positive
We expect our staff to be ambassadors for the Trust
We believe that the way we do things is as important as what we do

Be a team player
We see ourselves as part of the local community and work collaboratively with others to deliver the best outcomes for the population we serve.

The Trust's Strategic Goals

Through our vision and values we aim to deliver a number of strategic goals these include:

- to transform care
- improve the patient experience
- deliver the regulations
- develop the organisation for the future
- enable staff
- develop talent
- develop a business approach
- work with our communities

We will continue with our business strategy to protect turnover through a combination of increased patient numbers through some existing services, development of new services, and acquisitions and partnerships with other NHS and private sector organizations. We will work with our local commissioners and the local authorities with a view to delivering an integrated care organisation for the benefit of patients that use our services. In addition we will continue work in partnership with other NHS providers allowing us to ensure maximum efficiencies and learn and share from areas of good practice.

We are working with all local providers and commissioners to develop a health and social care vision for the whole community. Through this vision we have a programme over the next 18 months to review service delivery and to ensure a coordinated approach that empowers patients and the public and ensures services are safe and sustainable for the years to come.

We will continue to use our Organisational Development Strategy to integrate Calderdale Provider Services into our devolved, clinically led culture. Pathway transformation work is planned to continue to 2012/13.

Our clinical and quality vision is to continually improve the quality of care that we provide to our patients.

This is the responsibility of every part of our organisation. Our staff are fully dedicated to our Quality Improvement strategy aimed at boosting further the quality of care we deliver to our patients.

The Trust Quality Improvement Strategy makes explicit our commitment to patient safety, clinical effectiveness and patient experience, through the adoption of stretching goals which will demonstrate our ambition to be the premier provider of acute hospital care and community care.

The Trust has developed a Quality Account with its partners. Priorities within the Account agreed for 2012/13 are:

- reduction of numbers of pressure ulcers
- reducing the number of Hospital Acquired Infections MRSa bacteraemias
- reduce the numbers of readmissions
- improve communication, particularly between doctors and patients
- improve discharge processes.
- care of patients with dementia

Within the trust there is a program steering group for each of the three quality domains of patient safety, clinical effectiveness and experience. The steering groups report to the Quality Improvement Board (QIB) that has the overall lead for the trust's quality improvement strategy. QIB reports directly to the Executive Board and Board of Directors.

Equality and Diversity in the Trust

Equality and Diversity in the Trust is led by the Director of Nursing for service and patient issues and the Director of Personnel & Development for employment issues. A Non-Executive Director with a special interest in this area is closely involved in Trust monitoring and progress.

All equality issues have been reported to the Executive Board and Board of Directors on a regular basis.

Prior to the introduction of the Equality Act 2010 the Trust has taken a broad approach to equalities via Equality Impact Assessments and action via an Equality and Diversity steering group. In 2011 the Trust decided to change its approach to support the specifics within the act.

An Equality, Engagement and Experience Board was established, commissioned by and accountable to the Quality Assurance Board.

The Equality, Engagement and Experience Board sits above specific work streams related to service improvement for patients and staff with each of the protected characteristics. Age has been broken down to focus on the different needs of older and younger people and disability has been broken down to address the different needs of those with visual, hearing, physical, learning and mental impairment. This Board is chaired by the Director of Operations and includes representation from risk management, the Foundation Trust Membership Council and the membership and communications office.

The Trust has recognised where there are gaps in data, engagement and outcomes and is committed to rectifying these issues as part of its quality objectives for the individual work streams over the coming years.

In March 2012 the Board of Directors agreed the following high level corporate objectives:

- Access – the Trust will demonstrate improvements in access to services for people with protected characteristics.
- Information and communication – the Trust will demonstrate improvements in data collection, utilisation and analysis to inform service improvement for people with protected characteristics.
- Staff attitude, behaviour and training – the Trust will deliver training programmes that reflect the need for employees to respect equality, diversity and human rights.

Summary

In summary over the next three years CHFT will ensure we continue to drive up patient experience and clinical safety in partnership with colleagues across health and social care.

We will continue to do this by clearly understanding and making the links between our quality strategy, patient flows and pathways, activity levels, resource requirements and the need for our workforce to work differently, whilst being mindful of the risks and taking the opportunities created by contestability and the wider financial environment we work within.

CHFT strategic goals are translated into the following priorities

Key Priorities & Timescales	How this Priority underpins the strategy	Key milestones (2012-13)	Key milestones (2013-14)	Key milestones (2014-15)
To continue to improve patient satisfaction, particularly focusing on improving the areas of doctors communication with patients and information given to patients on discharge	We believe that by listening and taking on board our patients' views we will be able to enhance the services we offer and ensure timely interventions are put in place, which improve both quality and experience.	Achievement of CQUIN targets as agreed with commissioners. Successful outcome of Adult Inpatient Survey 2012/13	Achievement of CQUIN targets as agreed with commissioners Successful outcome of Adult Inpatient Survey 2013/14	Achievement of CQUIN targets as agreed with commissioners Successful outcome of Adult Inpatient Survey 2013/14
Avoid harm. Full delivery of safety standards including healthcare acquired infection To continually improve on our Hospital Standardised Mortality Ratios	Approximately 10% of patients admitted to NHS hospitals suffer some form of harm, much of which is avoidable. By reducing harm we will undoubtedly increase patient experience and improve job satisfaction for our staff. In addition it will help bring about a number of efficiencies such as reduced costs through getting things right, first time round.	MRSA 4 (2011/12 baseline 6) CDIF 33 (2011/12 baseline 33) Maintain existing care bundles. Introduce additional care bundles.	MRSA tbc CDIF tbc	MRSA tbc CDIF tbc
Delivery of core standards and targets	Delivery of all targets including cancer, 18 weeks and 4 hour A&E, 6 week diagnostic targets. This will ensure will deliver the regulations and continue to improve the patient experience.	Delivery of core standards and targets	Delivery of core standards and targets	Delivery of core standards and targets
Develop 5 year service strategy for health and social care in partnership with local commissioners and providers	Developing plans with local stakeholders including the public will ensure we can meet our identified drivers of:	Develop service strategy for the next 5 years Develop a business case for the strategy and undertake public	Respond to consultation and prepare plans for implementation. Begin implementation	Continue implementation.

Key Priorities & Timescales	How this Priority underpins the strategy	Key milestones (2012-13)	Key milestones (2013-14)	Key milestones (2014-15)
	•Keeping services local •Meeting the needs of the population demographic change •Meeting external standards •Addressing workforce challenges •Sustainable services in the challenging financial environment	consultation for any major service change		
Delivery of financial plans	This priority underpins the strategy of developing a business approach and delivering the regulations Delivery of financial plans ensures we remain a viable organisation able to deliver high quality care	Achievement of quarterly and annual surplus, cash balance and capital expenditure in line with plan. Achievement of planned risk rating.	Development of financial plans that deliver high quality safe care. Delivery of these plans.	Development of financial plans that deliver high quality safe care. Delivery of these plans
Workforce - Continue to develop our people to ensure that they are able to give of their best with their focus always being the care, dignity and respect of the patient and excellent relationships with their colleagues	Ensuring workforce is fit for purpose.	Implement strategies aimed at developing and improving our workforce. Implement CHFT 'Way and Behaviours' (see page 5)	Maintain deliver of strategies	Maintain delivery of strategies
Improve the patient experience through efficiency and effectiveness	Use lean principles to ensure effective utilisation creating efficiencies wherever possible	Maintain strategies aimed at improving los. These include virtual ward, visual hospital and plan for every patient.	Maintain delivery of strategies.	Maintain delivery of strategies.
To integrate	integration allows	Collaboration	Begin delivery	Ongoing service

Key Priorities & Timescales	How this Priority underpins the strategy	Key milestones (2012-13)	Key milestones (2013-14)	Key milestones (2014-15)
provider services across the health and social care community	for efficiencies and improvements in the total patient pathways whilst ensuring we work with our key partners to create a sustainable future.	plans developed for local authority provider services	of collaboration plans for local authority provider services.	delivery
To work in partnership with other local providers to improve standards of dementia care for our population	Development of services transforms care for patients and their families.	A dementia strategy agreed across providers and commissioners. Development of the butterfly scheme and in-reach mental health services in the Trust	Continued implementation	Continued implementation
Ensure the most efficient use of the overall estate to ensure it is fit for purpose to support the delivery of modern health care services through the established property investment partnership	This will enable the securing of funding to develop the Acre Mill site in Huddersfield and ensure that the best value is gained from the closure of the St Luke's site to support and enhance the development of local health services for local people. The joint venture approach provides an innovative and flexible solution that will ensure the good use of public money, provide flexibility of funding arrangements and benefits from utilising the skills and expertise of both the public and private sector.	Development commences on Acre Mill site.	Development continues on Acre Mill site.	Development continues on Acre Mill site.
Becoming part of a Healthcare Group	Support the long term clinical, operational and financial	Develop strategic case for change Identify	Develop business case (outline business case	Implementation.

Key Priorities & Timescales	How this Priority underpins the strategy	Key milestones (2012-13)	Key milestones (2013-14)	Key milestones (2014-15)
	sustainability of CHFT through opportunities created through sharing a larger population base and operational turnover.	collaboration areas. Agree governance arrangements.	and full business case).	
Developing relationships with Clinical commissioning groups	Working with our key partners to develop a sustainable future for healthcare for the local population.	Work with the CCGs in shadow form. continue to meet formally in Local Medical Committees.	Work with the CCGs in both commissioning and contracting forums and health and well being boards. Continue to support organisational development as required.	Work with the CCGs in both commissioning and contracting forums and health and well being boards. Continue to support organisational development as required.
Developing role of membership council	The responsibility of NHS organisations to be transparent and accountable whilst developing their future plans is becoming increasingly more important. Developing the role of the Membership Council will help to ensure the transparency and accountability of CHFT.	In response to new legislation, review and develop the induction and training programme for Membership Councillors.	Refresh and develop the induction and training programme for Membership Councillors.	Refresh and develop the induction and training programme for Membership Councillors.
Use of CQUIN payments to identify priorities with commissioners and support service development	CQUIN measures around pressure ulcers, patient experience and care bundles (COPD) used to transform care across the health community and improve the patient's experience.	CQUIN measures, outcomes and accountability negotiated with commissioners and targeted at priority areas of development.	CQUIN measures, outcomes and accountability negotiated with commissioners and targeted at priority areas of development.	CQUIN measures, outcomes and accountability negotiated with commissioners and targeted at priority areas of development.
Delivery of the IM&T programme	The IM&T Programmes highlighted will act as an enabler to ensuring the domains of the NHS outcomes framework for	Year 1 Core IT Infrastructure Replacement Programme Core Network Refresh Programme	Year 2 continuation	Year 3 continuation

Key Priorities & Timescales	How this Priority underpins the strategy	Key milestones (2012-13)	Key milestones (2013-14)	Key milestones (2014-15)
	2012/13 are addressed appropriately by the Trust.	Laptop and PC Replacement Programme Wireless Infrastructure Enablement Programme E-Rostering Programme PAS Development Programme Digital Dictation Programme		

B. The Trust's strategic position is summarised as:

<u>The local health economy and the Trust's position within it</u>

In 2012/13 the change in the operating environment for CHFT will continue. By April 2013 PCTs and SHAs will be replaced by GP commissioning groups and a national commissioning board. Locally the Calderdale Commissioning Group and the Greater Huddersfield Commissioning Group have a chair and executive board in place and members are becoming increasingly involved in formal processes such as contracting, the development of large scale strategic plans across the health community and smaller initiatives for individual services. There will be a regional structure between GP groups and the national commissioning board. Local authorities will have responsibility for hosting a Health and

Wellbeing Board which is intended to lead on improving the strategic coordination of commissioning across NHS, social care and related children's and public health services. CHFT will work with all these organisations and new structures in 2012/13 to ensure a seamless transfer to the new ways of working. CHFT will work to ensure that the structural changes do not adversely impact on patient care. Monitor will continue its role as regulator of foundation trusts.

In 2012/13 CHFT will continue to work with partners in Calderdale Local Authority to strengthen the integration of community services between NHS and local authority in Calderdale. CHFT will work closely with Locala and Kirklees Local Authority to ensure all patients benefit from care pathways that are easy to navigate across organisational boundaries and to minimise any waste or inefficiency in the system.

In 2012/13 CHFT will work in partnership with other local health and social care providers in a programme led by local commissioners to review current service provision across the health and social care community. The objective of the review is to ensure service models are safe and sustainable for the future. The NHS Outcomes Framework (gateway ref 16886) will be used together with the Adult Social Care Outcomes Framework and the forthcoming Public Health Outcomes Framework to ensure we work in partnership in the context of national and local policy. Representatives from Calderdale and Huddersfield NHS Foundation Trust are together with representatives from both Local Authorities, both CCGs, the PCT Cluster and the local mental health provider taking part in a large scale change programme being supported by the NHS Institute for Innovation and Improvement.

The NHS Operating Framework for 2012/13 describes the introduction of clinical networks and senates. Work is ongoing to design the role and function of clinical senates. There will be a process of widespread engagement with stakeholders and it is expected that clinical networks and senates will be established in 2012/13. One of their key roles will be to contribute to engagement on clinical service redesign across wider health communities. This is anticipated to influence the trust significantly in year 2 and 3 of this plan.

In 2012/13 the choice of Any Qualified Provider (AQP) is being rolled out to give patients more choice and control. It will build on and extend the existing choice of provider for elective care introduced in 2007. This is an opportunity for CHFT to increase market share of elective treatments. It also presents service and financial risks as a result of increased competition from other NHS providers and the independent sector. In year 1 of this plan CHFT will evaluate opportunities under AQP.

In 2012/13 the Trust Board has agreed specific objectives In accordance with our statutory responsibilities to comply with the Equality Act 2010. These objectives are focused on easy access to services, ensuring the Trust understands data to inform service improvement and training in staff attitude and behavior.

The challenges facing the health economy will only be achieved through successful partnership working with our colleagues in primary care, local authority and other provider organisations. Close working within the new structure outlined above will be critical to ensure we continue to provide excellent health services across the local community.

Threats and opportunities from competition, changes in commissioning intentions, service delivery changes

Key External Impact	Risk to/impact on the strategy	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
Overall healthcare funding and the wider economic environment including the impact of Local Authority funding on Social Services	The resources allocated nationally to the NHS reduce at a rate higher than currently anticipated. The impact of this may be via national tariff adjustments, efficiency targets, revisions to the standard national contract, financial allocations to commissioners. Potential impact on all aspects of Trust business and delivery of care.	The Trust is continually reviewing the national picture and developing its organisational response to the challenges ahead. There are a number of strategic opportunities that the Trust is pursuing; These include (but are not limited to) the potential formation of a hospital group, the development of an integrated care organisation, the use of benchmarking and efficiency indicators, and a sustained focus on financial management.	The Trust has an excellent track record of working in challenging times and would anticipate that its strategy and approach will enable it to meet the challenges ahead.	Progress is reported monthly through the Board. Overall accountability for this risk area sits with the Board of Directors.
Tariff changes	Efficiency requirements within the national tariff are set at levels over the levels currently forecast. Further changes are made to the tariff structure which reduces the Trust's income with no associated reduction in costs.	Downside scenario planning undertaken, the available options include generating additional efficiency savings, reducing the levels of surplus planned for and additional prioritisation of capital expenditure. Three-year financial plans are based on a realistic assessment of the likely financial challenges via national tariff changes. The potential	The Trust expects to be able to deliver the financial plan as outlined in this submission.	Accountability for the overall financial position sits with the Chief Executive, supported by the Board of Directors. The Board of Directors are fully informed of the impact of tariff changes and the Trust's proposed response.

Key External Impact	Risk to/impact on the strategy	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
		integration of community services provides opportunities to restructure activities and costs.		
Innovation and technology	Development of new technology that is high cost to Trust or Commissioners and impacts on financial balance of health community. Development of technology or service innovation that impacts significantly on pathway of care and location of service provision.	All technology service developments included in business plan and discussed in commissioning forums. Multi-organisational Transformational Board oversees pathway development and implementation of telemedicine	The Trust expects all innovation and technology to be included in the business plan and discussed and agreed with partner organisations prior to implementation	Developments discussed and approved through divisional and Executive Board structure.
Changes in national policy or law – changes to commissioning organisations	The move to PCT clusters, GP commissioning and creation of health and well being boards creates a risk that opportunities may be missed as the new organisations are developed, also a risk that new bodies may not sign up to existing strategic direction.	The Trust is working closely with partners to avoid these risks and ensure we understand key responsibilities and accountabilities in the new structure.	The Trust has a strong track record of working in partnership with commissioners and other healthcare providers and is confident it can support partner organisations as they go through significant change and maintain commitment to patients and the local population.	Accountability for partnership working sits with the CEO and Trust Board. The Trust works within existing multi organisational structures to ensure continued communication.
Loss of business through any qualified provider	Actual activity levels fall below plan adversely impacting on the organisation financially.	Review patient and GP satisfaction to maintain referral base. Identify new Commissioners where Trust can be any qualified provider.	High patient and GP satisfaction of our services. Patients choose and recommend CHFT as their provider of care. Increased range of services delivered from CHFT. Attract out of area referrals.	Monthly review of referral levels. Reported to Trust Board through divisional structure. Accountability through divisional structure.

Key External Impact	Risk to/impact on the strategy	Mitigating actions and residual risk	Overall expected outcome	Measures of progress and accountability
Demand management and commissioning behaviour;	Successful demand management strategies put in place by Commissioners, significantly reducing demand on service	Continued close working with Commissioners to ensure understanding of long term service strategy allowing for timely changes in capacity	Advanced notification of changes to commissioning strategy to allow Trust to make necessary service changes.	Delivered through multi-organisational meeting structure, Contracting Board and Contracting Committee.
PCTs financial position deteriorates	Contract values are set at levels which are affordable to the PCTs but do not allow the Trust to provide the required capacity to deliver the levels of activity anticipated under the contract. PCTs do not pay for clinical activity undertaken above contract value, whilst the Trust has committed resource to deliver that activity.	The Contract Management Board ensures that there is a shared understanding of financial issues and an agreed financial strategy, with clear risk management arrangements in place. The health economy response to the challenges include more efficient working, reducing capacity in certain areas and improving demand management through changes to care pathways.	Whilst this risk has the potential to emerge during the planning period, at this stage it is expected that the mitigating actions will be sufficient to deal with the risk.	This will be monitored with the PCTs via the Contract Management Board. The lead Directors for the Trust are the Director of Finance And Director of Service Development
Quality incentives / penalties(ap guidance) eg failure to meet CQUIN	Reduced financial incentive payment	Local agreement of thresholds received. Trajectories for achievement and monitoring mechanism in place.	Full achievement of CQUIN targets and subsequent incentive payment.	Clinical Quality Board.

Clinical and Quality Strategy

C. The Trust's Clinical and Quality strategy over the next three years is:

The Trust's Clinical and Quality Strategy over the next 3 years is to continue to progress towards the overarching goals identified in our Quality Improvement Strategy, ie:

To reduce our HSMR

- To reduce "harm" year on year as measured by the safety thermometer
- To improve patient satisfaction in line with our locally agreed CQUIN targets
- To continue to improve length of stay and readmission rate

These goals are monitored and measured through the Quality Improvement Board, with Executive leads for each of the supportive programmes of Safety, Effectiveness, Patient Experience and Exemplar Ward. The project groups, known as Collaboratives, within the Programmes each have goals and improvement measures which aim to deliver the strategic goals. These projects are consistent with our published Quality Account and with the CQUINs agreed with our commissioners. Progress is reported via the Quality Assurance Board, which is a sub committee of the Board of Directors.

The key changes that the trust is focusing on through all its improvement work are to improve reliability in the delivery of care, to reduce variation and minimise waste. The 2 primary strategies for achieving this are the introduction of evidence based bundles, for example, the skin bundle to reduce the incidence of preventable pressure ulcers and care bundles for common conditions such as Chronic Obstructive Pulmonary Disease. By ensuring that the right interventions happen at the right time and in the right order, avoidable harm and deaths can be prevented, as well as improving the overall patient experience.

Building reliability into the system requires significant culture change: strategies to achieve this include communication, training and development plans and performance management systems. Measuring the indicators that matter from ward/department level to the Board of Directors and ensuring consistency of approach from ward to board is key to embedding a focus on quality. The Board begin their meetings with a patient story and members of the Board routinely visit all wards and departments using the IHI's Leadership Walk round approach.

In addition to the use of evidence based bundles, the Trust has formed a successful partnership with the Lean Enterprise Academy and is part of their "door to door" club to facilitate joint learning. Tactics such as the introduction of the Visual Hospital, Plan for Every Patient, Discharge Levelling and proactive flow management through the patient journey have been key to reducing our length of stay and efficiency to that of some of the best in the country.

Over the next 3 years the Trust will continue to build on these firm foundations, centralising quality in the performance framework and including further indicators from the 5 domains of the NHS Outcomes Framework. The quality improvement work will increasingly become more systems focused, maximising our potential for improving care through our position as an integrated Trust. Our experience with patient self management through the Health Foundation's Co-Creating health programme provides a third stream of work to prevent avoidable admissions and to maintain people's health and independence in our local community.

Clinical and Quality priorities and milestones

D. Clinical and Quality priorities and milestones over the next three years are:

The Trusts Quality priorities for 2012/13 are consistent with those included in the Quality Account and with those of our commissioners through the CQUIN Scheme.

Safety

Reducing the number of pressure ulcers

This priority has been carried forward to ensure we maintain our focus and pace of improvement to reduce the number of patients who develop hospital acquired pressure ulcers. Work is ongoing to implement the evidenced based SKIN care bundle across all wards. The number of pressure ulcers remains an important measure of quality.

Improvement work

- We will continue to embed the SKIN bundle reliably across all wards and review as part of monthly exemplar ward safe care audits
- We will continue to implement intentional nurse care rounds across wards
- We will continue to ensure all patients receive risk assessments on admission to hospital in line with the Trust policy and ongoing risk assessment and appropriate care.
- We will continue to learn from root cause analysis of our most serious pressure ulcers
- We will participate in the national Safety thermometer

Reporting

We will measure performance using the following indicator – number of patients with a hospital acquired pressure ulcer. Progress will be reported on a monthly basis to the Exemplar Ward Board, chaired by the Director of Nursing, and this information is then reported to the Quality Improvement Board.

Key Milestones

- 2012/13: intentional rounding in place in all adult medical and surgical wards
- 2013/14: increase reliability of the use of the SKIN bundle
- 2014/15: all wards and relevant services to be using safety thermometer

Reducing the number of healthcare associated infections – MRSA bacteraemias

We continue to seek ways to reduce healthcare associated infections by improving the reliability of our processes, learning from other Trusts' successes and gaining new knowledge. As our understanding increases we learn of more interventions to put in place and further drive down the incidence of infections in our Trust.

Improvement Work

- We will continue to be vigilant and maintain and improve upon standards of cleanliness on wards and departments.
- We will continue to monitor, challenge and improve upon standards of Hand Hygiene
- The work on invasive devices continues, improving their insertion and care using adapted and tested national care bundles and plans. Competency training in aseptic technique will continue to ensure we have an appropriately skilled workforce.
- A focus for us this coming year will be on Sepsis recognition and management. Work has already begun and we are currently rolling out a screening tool and Care Bundle into all wards and admission areas. Along with this we are working to improve the management of established sepsis to ensure patients are cared for in the most appropriate clinical environment.
- The correct use of antibiotics is another priority for us. For antibiotics to be most effective it is important guidance is followed regarding selection, route and course length. Initially we are working with the admission areas testing and developing a care bundle to help with this.

Reporting

We will continue to measure our performance using the number of patients who develop a post 48 Hour MRSA Bacteremias, MSSA Bacteremias, Clostridium Difficile and rates of E-Coli.

Each of our projects have their own measures of reliability around the changes we are making e.g. effective use of the care bundles. The Infection Control Performance Board closely monitor our performance feeding into Executive Board.

Key Milestones

Over the next 3 years we will:

- Continue to closely monitor the quality of hand hygiene
- Continue to roll out ANTT training to all relevant clinical staff and to ensure staff remain compliant with this technique
- To achieve and maintain 100% MRSA screening for all relevant patients

Effectiveness

Reducing hospital readmissions

Readmissions to hospital following a recent discharge from hospital can be distressing for patients and add a significant cost to healthcare. Eliminating unnecessary readmissions can free up resources which can be redirected in providing care closer to people's homes or in their homes. This work includes looking at patient discharges and providing support for patients after they leave hospital. Patient discharge is most successful when it is well planned by the hospital in partnership with patients, relatives and other agencies, such as social services.

Improvement work

There will be several strands to this work which will include:

- Working with primary and social service and mental health providers to create more effective pathways of care
- Partner with local health & social care providers to provide targeted effective follow up support for patients following a stay in hospital
- The development of discharge process and information flow
- Influencing reinvestment of support services to prevent readmissions
- Agreeing local exemptions (i.e. those cases where it might be expected that there may be a readmission) where appropriate due to the nature and reason for the second attendance
- Establishing alert systems to identify readmissions within 30 days and linking with primary care workers to ensure support mechanisms are in place for more effective discharge planning.
- Making sure that we are coding and counting readmissions properly and accurately.

Reporting

We will measure performance using the following indicator - emergency readmission within 30 days of discharge. Progress will be managed and monitored via the project steering group and divisional boards.

Key Milestones

- 2012/13: to reduce the number of avoidable readmissions by a third (compared to the previous year) year on year over the next 3 years

Improving the care of patients with dementia

Why we chose this

There are currently around 750,000 people living with dementia in the United Kingdom. This is predicted to rise to in excess of 1 million in the next 10 years. The National Dementia Strategy highlighted that healthcare costs for dementia nationally was £1.97 billion and that 44% of this cost was spent on hospital care. The National Dementia Audit found that dementia and the complex care needs associated with it are often overlooked or untreated on admission to hospital. In line with National Strategy it is important we boost early diagnosis of Dementia to improve patient and carer support.

Improvement work

- Work is taking place to ensure we assess all patients 75 and over for dementia. For patients who assess positively it is essential that a more detailed diagnosis takes place to ensure patients receive the appropriate care.
- The pathway for dementia is being developed through a trust wide collaborative group. It is then delivered through the dementia champions and clinical teams. The champion network will be extended to include safeguarding, dignity, dementia and learning disability and should reach all clinical areas by the summer.
- A care bundle is being developed which will support the pathway of care. The care bundle will address the risk assessments for reduced mobility and falls, malnutrition, pressure sores, pain, dehydration, constipation, incontinence, sensory impairment, sleep deprivation, complex medication issues, hypoxia, impaired cognition and mental health, and infection.
- The Trust is a National Pilot site for the Butterfly scheme and it is being used across all collaborative wards to highlight and support patients with dementia and their carers.

Reporting

There is to be a national CQUIN for dementia assessment from April 2012 that includes the identification of all patients with existing dementia enabling them to be placed on the dementia pathway, screening for delirium and the identification of early signs of dementia leading to referral for diagnosis.

A Dementia Board is to be set up with an executive lead for dementia. The board will oversee the pathway, the CQUIN and will report through the Quality Improvement Board.

Butterfly scheme The butterfly scheme is a way of identifying patients with dementia so they are given the best possible care.

Key Milestones

- 2012/13: To achieve compliance with all elements of the Dementia CQUIN
- 2013/14: To ensure all Dementia patients are on the correct pathway of care and reliably receive all the care bundle elements and to sustain improvement made in the previous year.
- 2014/15: To maintain improvements to date and where possible implement further beneficial interventions.

Experience

Improving doctor's communication

This is a priority that has been carried forward from the previous year as the National surveys for both inpatient and outpatient care still shows opportunities for improvement.

It is recognised that poor communication causes unnecessary anxiety and can affect the quality of patient care.

Improvement work

- A collaborative group is now established to focus on improving the quality of Doctors' communication covering both inpatient and outpatient areas. Some interventions are being tested which aim to act as a prompt to the doctors involved in the patient consultation.

Reporting

We will measure and monitor performance using Real Time Patient Monitoring along with a questionnaire focused on Doctor specific questions.

Our aim is to continue to increase the number of Doctors who attend communication training and testing further interventions that improve doctors' communication and when appropriate spread them to other wards/departments. Reporting on this will be through the Trusts Patient Experience Steering Group, which reports to the Quality Improvement Board.

Key Milestones

- 2012/13: Test, refine and spread current and further interventions, measuring impact via the doctor specific questionnaires
- 2013/14: Spread and sustain Doctors communication interventions
- 2014/15: Continue to monitor scores for doctors communication

Improving patient information on discharge

It is essential that all patients have the correct information about their ongoing treatment and care when they leave hospital to ensure an uneventful recovery, unnecessary readmission to hospital and, very importantly, that they maintain confidence in the care they receive.

Improvement work

- Over the last year a generic discharge sheet was introduced to improve the level of information that patients are discharged with. Data from the real time monitoring demonstrates that scores have significantly increased.
- The following questions from the National Inpatient survey will be used to measure improvement via the monthly Real Time Monitoring report: Improving information on discharge:
    - Were you told about medication side effects to watch out for when you went home?
    - Were you told who to contact if you were worried about your condition after you left hospital?

Reporting

Our aim is to sustain the improvement already achieved and focus on areas that still require improvement. We will measure performance using Real Time Patient Monitoring. Reporting on this will be through the Trusts Patient Experience Steering Group, which reports to the Quality Improvement Board.

Key Milestones

- 2012/13: Monitor data at individual ward level to ensure improvements are sustained and take remedial action as required
- 2013/14: Ensure all elements of the discharge process score as high as each other
- 2014/15: Continue to monitor scores for discharge questions

Financial Strategy

E. The Trust's financial strategy and goals over the next three years:

The strategic context and operational response to the challenges faced by the Trust over the coming years has formed a key part of the financial discussions held at Board of Directors, Executive Management Board and the Membership Council (Board of Governors) and can be summarised under the banners of the Trust's strategic goals as follows:

Developing a business approach

The Trust is operating in a changing environment with the forthcoming replacement of PCTs and SHAs with GP commissioning groups and a national commissioning board. There is also a risk to the Trust maintaining its current market share of healthcare provision through the expansion of contestability offered through the Any Qualified Provider (AQP) programme. The Trust is also entering the first of three years of national economic constraint.

Our plan is to position ourselves well financially to deal flexibly with these environmental challenges. The plan for 2012/13 – 2014/15 is to achieve a £3m annual surplus, approximately 1% of turnover (excluding items which are exceptional in nature such as impairments and impairment reversals which do not have a cash impact).

We are also focussing on developing a business approach at every level of the organisation, ensuring that there are clear links between income generation and expenditure. This will ensure that future decisions, for example relating to AQP support the financial stability of the Trust.

Developing the organisation for the future

The three year planning period sees the Trust taking partnership and collaboration to a new level. This is the case across primary, secondary and social care as we work together with organisations across the local health economy.

The financial programme needs to support this work and this is exemplified by the capital programme where investment is being made in information technology which will strengthen our ability to support future integration of systems across organisational boundaries. At the same time, there is a level of restraint in the estate investment in the capital programme. This will ensure that we address backlog maintenance and maintain a safe patient environment whilst allowing flexibility in the future shape of our physical infrastructure pending work on clinical service redesign with our partners over the next year.

Improving the patient experience

The Trusts strategic goal to improve the patient experience is supported through investments in key developments including the following;

- Significant investment to increase midwifery staffing ratios and health visitor number in 2012/13 to support delivery of safe, quality care;
- Investment in the Stroke service to ensure that the best clinical practice is delivered 24 hours a day, 7 days a week;
- New investment in leasing diagnostic equipment including an MRI and CT scanner as well as other equipment to aid delivery of waiting time targets;
- Commencement of service delivery from the Trust's new facility at Broad Street in Halifax, delivering care closer to home for patients.

Income and expenditure assumptions underpinning the plan

The three year financial plan assumes minimal growth in elective activity through demographic growth, offset by demand management initiatives. There is assumed to be some reduction in non elective activity through the moves to deliver more care in the community supported by re-ablement schemes and readmission avoidance programmes that the Trust is working on in partnership with other agencies.

The impact of any non elective activity reduction on income is tempered by the tariff structures around non payment of readmissions and the 30% marginal rate for emergency activity over and above the 2008/09 threshold. The PbR tariff has been assumed to deflate year on year over the planning period in line with the 'assessor case' contained within the letter from Monitor to Foundation Trusts. Price inflation is expected to remain high over the planning period, with the assumptions for years two and three being in line with the current levels.

Actions required

As a result of the activity, income and expenditure assumptions described above and in order to deliver the planned level of surplus, the Trust will have to deliver challenging CIP targets over the next three years. Responsibility for designing and delivering these efficiency programmes is devolved through the Trust's divisional structure to ensure clinical and operational engagement.

The financial structures that the Trust operates within will need to adapt to support a new shape of service delivery, for example through agreeing tariffs for community activities to ensure financial stability as more activity is delivered by the Trust outside of traditional secondary care. New service models will also have to be considered in the capital expenditure programme for years two and three of the capital plan.

Risks to delivery

The key risks to delivery of the financial plan are considered in Appendix 1.

Summary

Based on the Compliance Framework for 2012/13, the Trust's self-assessment based on the financial projections within the plan results in a risk rating of level 3 across 2012/13 and each of the forthcoming two financial years. The planned year end surplus in 2012/13 is £3m before impairments and reversals of previous impairments. Similarly, in 2012/13 and 2013/14 the planned surplus is £3m prior to impairment and reversals.

Leadership and Organisational Development

F. The Trust's approach to ensuring effective leadership and adequate management processes and structures over the next three years is:

To ensure effective leadership and adequate management processes and structures are in place to address the challenges of the period of this plan, 2012-15 the Trust:
Reviews factors in the forward plan that may require a changed or enhanced leadership approach

- Regularly reviews the effectiveness of the board, and all levels of management, to address the challenges of this period
- Reviews the organisational development plans, and ensures they are fit for the purpose of supporting the delivery of the organisations key priorities
- Develops training and development programmes for key groups of staff.

The table below outlines the key challenges for leadership and organisational development identified as a result of this review, and the actions taken to address these challenges.

Key leadership and governance priorities	Key risks (and gaps)	Actions to rectify / mitigate	Milestones 2012/13 2013/14 2014/15
Delivery of Trust vision and strategic goals 'Your Care Our Concern'	An agreed contract that enables delivery of the vision is vital. Activity and capacity requirement to deliver the vision to be agreed. At the core of the vision is the organisation's quality strategy. The strategy puts quality at the centre of the Board of Directors agenda. Strategy to be built on firm foundations of strong clinical leadership and engagement, firm board leadership and a proactive membership council.	Fully established Contract Management Board with director level representation ensuring our overall NHS contract with the local Commissioners reflects and meets our needs in order to deliver our vision. Contracting Committee with informatics and divisional management representation from CHFT and local PCTs to ensure activity and demand analysis and contract monitoring throughout the year.	Contract sign off April 2012. Delivery against quality improvement strategy

Key leadership and governance priorities	Key risks (and gaps)	Actions to rectify / mitigate	Milestones 2012/13 2013/14 2014/15
		Maintain Quality Improvement Board with director leads against each work stream and clear parameters of work	
Clinical services review in partnership with all other local providers, led by the commissioners; focused on long term provision of safe and sustainable services.	Change agreed is not evidence based. Process does not meet SCAP (Service Change Assurance Process) criteria set down by the SHA. Change is not agreed in a timely way, prior to next election. Public is not sufficiently engaged and consulted in the process The programme outcome does not address the 5 drivers identified by the trust Change in service results in change of funding streams, which potentially destabilises one or more organisations in the health and social care economy.	Governance structure put in place, led by commissioners, including a board, steering group and care stream groups to work up case for change. External project director appointed to manage the programme to specific criteria and timescales. Monthly reporting to trust board to ensure they are sighted on the progress of the programme. Clinical leadership and management support, of all sections of the programme. Steering group attend large scale change training programme developed by the NHS Institute for Innovation and Improvement External independent advice provided on engagement and consultation Discussion and	2012/13 – Governance structure in place including the critical path . Shared vision signed off. Period of public and staff engagement to develop service options. Consultation if necessary. Independent external evaluation of any consultation. 2013/14 Decisions made jointly by all organisation boards based on the outcome of any consultation. Review of governance framework at this stage for implementation. Begin implementation 2014/15 Continue implementation

Key leadership and governance priorities	Key risks (and gaps)	Actions to rectify / mitigate	Milestones 2012/13 2013/14 2014/15
		advice from other public sector organisations that have undertaken similar models, and from those staff involved in the reconfiguration 5 years ago, to learn from these experiences. Appointments made in the trust of people with experience of multi-organisational change Board addresses unintended consequences, such as changes to funding, and patients and services are protected by ensuring funding changes take place on a phased basis	
Leadership succession planning	Successful induction of new CEO and NEDs. Any unplanned changes of senior management	The Board of Directors on an annual basis reviews the skills and expertise required of the Board and individual Directors. Ongoing Board development programme.	Selection and appointment process successful. All performance, quality and regulatory requirements met.
Ensuring a financial surplus in line with annual plan	Allocation of NHS resources may reduce at a rate higher than currently expected impacting on our ability to maintain service provision and overall organisational financial stability.	The Trust is continually reviewing the national picture and developing its organisational response to the challenges ahead. There are a number of strategic	End of year financial surplus and delivery of all CRES programmes.

Key leadership and governance priorities	Key risks (and gaps)	Actions to rectify / mitigate	Milestones 2012/13 2013/14 2014/15
	Clinical divisions to be fully engaged from the outset to help deliver efficiency plans.	opportunities that the Trust is pursuing that will assist the Trust in meeting the challenges ahead. These include (but are not limited to) the potential formation of a hospital group, the development of an integrated care organisation, the property development Joint Venture, the continued assessment of benchmarking and efficiency indicators, the establishment of quality and efficiency programmes across key areas of service in the Trust, and a sustained focus on financial management. In addition, the organisation continually works to ensure full clinical engagement through the divisional structure.	
Property investment partnership	Delivery of Foundation Trust aims and objectives by Joint Venture to timescales agreed	Full governance structure in place including Joint Venture Board with membership from the Trust and private sector partner. Business plans reviewed quarterly. Development	Development and delivery of Trust accommodation in support of Service Strategy 2012/13 Delivery of further efficiency and effectiveness through estate rationalisation 2013/14

Key leadership and governance priorities	Key risks (and gaps)	Actions to rectify / mitigate	Milestones 2012/13 2013/14 2014/15
		management team in place to deliver operational objectives. Regular reporting to Trust Board of Directors on progress and key decision points.	
Becoming a provider of integrated care	Understand the demands of providing integrated care across multiple providers, and in the context of AQP. Decision making across multiple organisations Changes in funding acting as a disincentive to service change	Set up shared governance structures, such as the intermediate tier board, to ensure joint planning of services Understand impact of changes and develop strategies to ensure service continuity	Shared structures in place 2013/14 Agree shared objectives for the year Implement services changes
Achieving MRSA Cdiff and HSMR targets	Key risk associated with achievement of targets given a reduced trajectory for MRSA and Cdiff in 2012/13 as compared to 2011/12, making it more difficult to achieve compliance. Despite a programme of work based on reducing HSMR there is a risk that we will not meet our aspiration to be in the top 20% of Trusts, due to unknowns about re-basing HSMR. The rebasing is	Well established Infection Control Strategy and Infection Control Board to performance manage rates of infections. Annual programmes of work for infection and HSMR developed to ensure continued compliance. Quality improvement strategy for CHFT focused on these priority areas. Lead Directors identified and performance reported to Executive and	MRSA 4 CDIFF 33.

Key leadership and governance priorities	Key risks (and gaps)	Actions to rectify / mitigate	Milestones 2012/13 2013/14 2014/15
	due to the relative pace of improvement in other organisation. CHFT have therefore based its assumptions on improving from the current base-line.	Board of Directors.	
Ongoing clinical leadership, particularly in the context of a challenging financial environment	Existing clinical leaders reach the end of their term and do not want to continue The current environment makes it difficult for leaders to deliver the improvement they want to see. Unable to recruit and support sufficient clinical leaders to influence the level of change the health community wants to see.	Leadership training programme in place for all clinical leaders of the future. Support and development in place for existing clinical leaders, including a clear description of their role and how they fit into the overall process. Sufficient management support in place to support clinical leaders to undertake their role.	2012/13-15 All formal Clinical leadership roles filled and supported be management roles All new consultants trained in leadership. Horizon scanning for potential new issues and leaders.
Improve the patient experience through improvement and efficiency	That we do not have sufficient depth of knowledge across the organisation of lean. The service change is seen as a 'nice to do' rather than a 'must do'. Lean changes in the hospital create unintended consequences, either in the	Continue our association with the Lean enterprise academy. Continue to use tactics include Visual hospital, Plan for every Patient, Discharge Levelling and proactive floor management through the patient journey in partnership with	Shared structures in place. The work of the lean programmes report through the system wide Quality Improvement Board

Key leadership and governance priorities	Key risks (and gaps)	Actions to rectify / mitigate	Milestones 2012/13 2013/14 2014/15
	hospital or outside it.	other providers and commissioners within a project management framework as part of the Quality strategy.	

Other Strategic and Operational plans

G. The Trust's other strategic and operational plans over the next three years:

Throughout this document CHFT has described:

- The current position
- The vision
- Strategic goals
- Key priorities and timescales
- Strategic position
- External threats and opportunities
- Clinical quality and strategy
- Clinical quality priorities and milestones
- Financial strategy and goals
- Leadership and management processes and structures
- Regard to the views of trust governors
- Key risks (financial and non-financial)
- Risks to quality
- Use of external assurance

Other strategic and operational plans over the next three years not referenced in great detail include:

- Workforce plan
- IM&T plan – Maintaining the delivery of safe service through a reliable and future forward IM&T strategy
- Estates plan – Supporting delivery of the clinical service and maximising use of the estate
- Communications plan – Ensuring the public, patients, partners and staff understand our business and future direction
- Divisional business plans – detailed planning aimed at ensuring delivery of the Trust's vision

All these are set to address the key priorities and timescales identified in section A, and the Trust's overall vision.

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Regard to the views of Trust Governors

H. The Trust has had regard to the views of Trust Governors by:

The Membership Council (MC) of Calderdale and Huddersfield NHS Foundation Trust comprises 16 publically elected, 6 staff elected and 6 nominated stakeholder Councillors. Councillors listen to and gather the views and ideas of the Trust's membership. In turn, the Trust offers a range of events and opportunities for the Membership Councillors to share those views and engage with the board of directors in order to help produce and finalise the annual plan. These opportunities include:

- **Membership Council Induction**

Newly elected Membership Councillors learn about the structure, priorities and services of CHFT. Induction is a comprehensive programme of information and Trust guest speakers where Councillors start to become familiar with and engage in the development of Trust plans and services.

- **Divisional Reference Groups (DRG)**

The Trust operates through a devolved divisional structure. Each division has a divisional reference group which is chaired by a Membership Councillor. Meetings are attended by fellow Membership Councillors along with senior staff from the respective division. Each divisional reference group meeting discusses divisional business planning, divisional priorities and any service developments.

- **Chair's Information Exchange**

Views and discussions on the divisions' future plans are taken by each DRG chair to the 'Information Exchange' meeting. This is hosted by the Trust chairman who in turn feeds back to the board of directors.

- **MC Development Sessions**

The Trust has devised a programme of four development sessions for Membership Councillors. These sessions are attended by Membership Councillors, the Trust chairman and respective board directors. An 'open space' discussion is always included where Membership Councillors debate current key challenges and opportunities. These debates and discussions help to shape future Trust plans.

- **Engagement events**

Membership Councillors host Trust wide membership engagement events. These events are designed to share the Trust's business planning process and to highlight priorities in the quality of patient care. Importantly they're also an opportunity for Membership Councillors to talk directly to both members and Trust staff. The views generated at these events are captured and reported back to the DRGs.

- **Engagement activities**

Membership Councillors and members are often directly involved with helping to improve the patient experience. Examples of this are involvement in hospital food tasting sessions; the conducting of audits concerned with patient privacy and dignity; and involvement in the Trust's 'Real Time Patient Monitoring' programme. The results of these activities are fed back directly to ward staff and managers for action, and again via the DRGs to the Trust board, to help to inform future Trust plans.

- **Divisional Walkabouts**

Each division organises and facilitates an orientation 'walkabout'. These walkabouts are attended by Membership Councillors and Trust staff and are designed to familiarise Membership Councillors with the clinical areas and the patient services that they provide. They are also an opportunity for Membership Councillors to talk directly to patients and Trust staff. Issues and ideas from these walkabouts are reported back to directors via the DRGs.

- **Membership Council meetings**

The full Membership Council meets formally four times a year, including the AGM. The meetings are attended by respective board directors and attendees discuss business planning along with standing agenda items such as service developments and the Trust's financial position.

- **Board of Director's meetings**

Membership Councillors are invited to attend and observe board of director's meetings, which are held monthly.

- **AGM and Health Fair**

The annual Membership Council/Board of Director's general meeting and health fair is an important opportunity for members and Membership Councillors to question and engage with Trust directors.

- **Joint board of director and Membership Councillor workshop**

This is an annual event where Trust directors and Membership Councillors meet to discuss and agree key priorities and the future direction of the organisation

- **Ad hoc working groups**

When Membership Councillors' views are sought for a particular issue, an ad hoc working group is created. An example this year is the creation of a small working group of Membership Councillors, Trust executive directors, and Trust non-executive directors to look at the implications of the recent Health and Social Care Act.

- **Extraordinary Membership Council meeting**

Prior to this meeting a draft version of the Trust's annual plan is shared with Membership Councillors. This provides the opportunity for Membership Councillors to review and comment upon the culmination of the year's engagement activities and feedback. At the meeting, the Membership Councillors are asked to give their agreement to the finalisation of the annual plan.