Calderdale and Huddersfield NHS

NHS Foundation Trust

Annual Report and Accounts 2013/14

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4)
of the National Health Service Act 2006.

Calderdale and Huddersfield NHS Foundation Trust

Annual Report and Accounts

2013/14

Did you know...?
Student doctors from Leeds and midwives from Huddersfield join us every year.

Chairman's statement

It has been another year of significant change at our Trust and a year which I would define as seeing a major move from planning to action, particularly at the start of 2014.

We have begun a substantial estates maintenance programme. Huddersfield Royal Infirmary (HRI) is now nearly 50 years old and some aspects of the basic building maintenance and upkeep which a building of this age needs has been underway all year; this sort of expenditure will need to continue for some time to come and has been built into our future capital plans.

In addition, we have been continuing our estate improvement programme with a major refurbishment of Ward 8 at HRI and a revamp of the entrance to the hospital which has been long overdue. We also continue to move ahead with work on the Acre Mills site, across from HRI, to turn it into a state-of-the-art health centre which we hope to have fully operational in early 2015.

During the year there have been a number of changes at the top of the organisation including three of our non-executive directors and I would like to thank all of them for their dedication and insight. Our Medical Director, David Wise, stepped down and our Director of Nursing, Helen Thomson, retired this year. Both of them brought considerable skill and expertise to their roles and we have been fortunate in being able to replace them with Barbara Crosse and Julie Dawes respectively.

One year on from the publication of the Francis Inquiry review, as leaders of the Trust, our thinking has been shaped by a number of national reports on patient safety and quality: *Transforming urgent and emergency care service in England* following the review by Sir Bruce Keogh; the *Future Hospitals Report* from the Royal College of Physicians; the *Berwick Report* into patient safety and reducing harm; *A Review of the NHS Hospitals Complaints System* by MP Ann Clwyd. As a result, our Board agreed an updated vision for the Trust:

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

There is no better example of this than the Calderdale and Huddersfield Strategic Review which the Chief Executive refers to in his report. This is a real example of partner organisations coming together to focus on redesigning healthcare for our communities with a focus on putting the patient at the heart of the service and building the care round them. It also recognises the pressures the system is currently under and the desire to have care closer to home and hospital specialists available seven days a week. As part of this new way forward there is a real emphasis on individuals taking some responsibility for their own health and wellbeing.

A key aspect that will underpin achieving the changes we want to make is the effective use of information technology. It cannot be right that one of the first things we ask a new patient is what medication are they on as, at the moment, we cannot access a GP's records for that information. For the last two years we have been investing in updating our IT infrastructure and a procurement process is now underway for a new electronic patient record that will sit at the core of our systems and that will have the potential to be shared with all other healthcare providers involved in the patient's care.

Other examples of where we are now actively progressing our plans are:

- Our process redesign work under the banner of "Courage to put the Patient First" which is seeking to minimise wasted time for our patients whilst they are with us,
- Our work to minimise mortality rates within the hospital - the "Care of the Acutely ill Patient" programme,
- Modernising and prioritising our approach to patient engagement and complaints handling, and
- Working in collaboration with other health care providers to improve the delivery of our combined services.

Of, course, the beating heart of this Trust continues to be our amazing staff and yet again it has been a year of successes for them. For example, our emergency care specialist nurse, Heather McLelland, became the Trust's first Nightingale Scholar – a real honour reflecting Heather's commitment to improving care both here and abroad as she is a member of the global emergency response team and has also provided care in the Philippines in the wake of the devastating typhoon. I single Heather out but, of course, all our staff together make this Trust a special healthcare provider for the people of Calderdale and Kirklees.

As well as thanking all of them, I would also like to thank the Membership Council which has put in another year of sterling work in support of this Trust. Our membership and the Council are vital as we move forward and I am pleased that they continue to support our Medicine for Members Programme so well. These talks are proving to be increasingly popular and will undergo a format change for the up-coming year which I am sure will make them more popular still.

So, as always, I end with a big thank you to everyone who supports this Trust – staff, volunteers, League of Friends – as together we turn our plans into actions to face the considerable challenges of the future.

Andrew Haigh

The comments on the pages that follow were all sent in via the website from patients and their families after care at CHFT during 2013/14 ➤

Chief Executive's statement

It's been a year of big challenges and many highlights for the 6,000 of us who are a part of the Calderdale and Huddersfield NHS FT team. We have worked hard to provide 'Compassionate Care' by trying to put ourselves in our patients' shoes and we have notched up some notable achievements as the bar for quality, safe NHS care continues to rise.

We ended the year with a full compliance rating from the Care Quality Commission after a major unannounced visit in the late summer of 2013 and a follow-up check-up early in 2014. This is something we are proud of - but not complacent about - as it informs our patients that our care right across our community services, wards and clinics are up to standard.

This year we have also developed and committed ourselves to 'four pillars of behaviour' which we expect to be central to everyone's work here at the Trust. These are:

- We put the patient first – we stand in the patient's shoes and design services which eliminate unproductive time for the patient;
- We 'go see' – we test and challenge assumptions and make decisions based on real time data;
- We work together to get results – we co-create change with colleagues creating solutions which work across the full patient journey;
- We do the 'must-do's' – we consistently comply with a few rules that allow us to thrive.

We are working with colleagues to embed these behaviours so that our patients can be clear about what they should expect from us when they are in contact with us, whether that is in hospital, in a community facility or in their own homes, by telephone, email or in person.

Whether they are talking to a doctor, nurse, manager, non-executive or receptionist - none of this should make any difference, the expectation should be the same.

As I said in last year's report, we are continuing to work with health and social care partners and this has resulted in the development of the Calderdale and Greater Huddersfield Strategic Review.

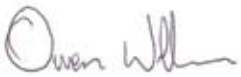
The review has included our doctors, nurses, therapists and managerial staff, working with our health and social care partners to look at how we need to transform care across our communities to ensure they are right for the future. This may mean making a number of changes which have the long term care and safety of our local people at their heart.

The Strategic Review programme aims to ensure that care is available within our communities or at home if that is best for our patients and their families. It also aims to ensure that both our hospitals remain able to provide patients with the right staff, equipment and facilities to ensure they get the best care possible at all times of any given week.

For the last couple of years, our local Clinical Commissioning Groups (CCGs) have been engaging our communities on how best this might be delivered and we expect there to be some options developed that will go to public consultation as agreed by Local Clinical Commissioning Groups. If we are to continue to deliver safe services into the future then change has to happen. However both our hospitals will continue to remain vital to healthcare in the future.

I would urge all staff and local people in our communities to take all opportunities to get involved in these discussions so that we can plan our future services together and ensure that the clinical care we are able to provide to our patients stays at the forefront of everyone's minds as we move ahead.

Finally, I would like to thank all staff who work for and behalf of the Trust. Your commitment to the cause is much appreciated and I know that you will continue to work hard to care for our patients and keep them safe whether they are in hospital or at home.



Owen Williams

Owen and colleagues when Kate Granger came to visit to talk about her "Hello, my name is…" better communications campaign.

Coronary care: "At every stage of my experience in A&E, the coronary and the cardiac wards all the nursing and dispensing staff, all the doctors and consultants listened, answered and waited with patience to check my understanding and whether there was anything else I wished to know. I found this most reassuring.. My thanks to all."


NEC
NOTEBOOK

Strategic Report

Strategic Report

The purpose of this report is to inform the users of our accounts and help them to assess how the directors have performed in promoting the success of our Trust.

This report is prepared in accordance with sections 414A, 414C and 414D of the Companies Act 2006, as interpreted by the Financial Reporting Manual (paragraphs 5.2.6 to 5.2.11). For this purpose we have treated ourselves as a quoted company.

Additional information on our future plans can be found in our Annual Plan which is on the Trust's website at www.cht.nhs.uk and in the Strategic Outline Case at www.rightcaretimeplace.nhs.uk. More information will become available following the publication of our Five-year Strategic Plan and the Outline Business case in July 2014.

Calderdale and Huddersfield NHS Foundation Trust – who we are and what we do

The Calderdale and Huddersfield NHS Foundation Trust is a statutory body, which became a public benefit corporation on 1 August 2006 following its approval as a NHS Foundation Trust by the Independent Regulator of the NHS Foundation Trusts (Independent Regulator) authorised under the Health and Social Care (Community Health and Standards) Act 2006 (the 2006 Act).

The principal location of business of the Trust is:
Trust Headquarters, Huddersfield Royal Infirmary, Acre Street, Lindley, Huddersfield, West Yorkshire HD3 3EA

In addition, the Trust has the following locations registered with the Care Quality Commission:

- Calderdale Royal Hospital, Salterhebble, Halifax, West Yorkshire, HX3 0PW
- St John's Health Centre, Lightowler Road, Halifax, West Yorkshire, HX1 5NB
- Todmorden Health Centre, Lower George Street, Todmorden, Todmorden, West Yorkshire, OL14 5RN
- Broad Street Plaza, 51 Northgate, Northgate, Halifax, West Yorkshire, HX1 1UB

The Trust is registered with the Care Quality Commission without conditions and provides the following regulated activities across the stated locations:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening services
- Management of supply of blood and blood derived products
- Maternity and midwifery services
- Nursing care
- Surgical procedures
- Termination of pregnancy
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

Our History

The Trust was formed in 2001 combining hospitals in Halifax and Huddersfield to deliver healthcare for the populations of Calderdale and Huddersfield.

Since those early days we have expanded beyond our hospital-based services and now provide a range of community services in Calderdale to meet the changing healthcare demands of our population.

As a Foundation Trust we have had the freedoms to develop and invest in our services to make sure they are tailored to the best needs of our local patients. This status has enabled us to develop Acre Mills in Lindley, Huddersfield with development partners Henry Boot. This former mill is due to be transformed into a new outpatients centre providing 120,000 appointments a year by early 2015.

Our vision and values

Calderdale and Huddersfield NHS Foundation Trust has recently refined its vision and values to ensure that the work it carries out always 'puts the patient first' and the Trust is working hard to improve the patient experience.

The Trust's vision is:
'We will work with partner organisations to understand the individual needs of patients and together, deliver outstanding compassionate care which transforms the welfare of the communities we serve.'

Backing this up are the Trust's values, the four pillars of behaviour that we expect all employees to follow. The four pillars have been introduced to the Trust over the past year and we are working hard to embed them into the organisation so that every member of staff understands their responsibilities.

Calderdale and Huddersfield NHS
NHS Foundation Trust

THE FOUR BEHAVIOURS EXPECTED OF ALL EMPLOYEES

COMPASSIONATE CARE

Strategic Report

What we do

We employ around 6000 staff who deliver care from our two main hospitals, Calderdale Royal Hospital and Huddersfield Royal Infirmary as well as in community sites, health centres and in patients' homes.

There are 435,000 people in the areas served by Calderdale and Kirklees councils and increasing numbers of patients travel to us for care from further afield

Last year more than 122,000 men, women and children were cared for as inpatients (stayed at least one night) or day cases and more than 434,000 people attended our outpatient clinics. Our A&E departments at both hospitals cared for more than 139,000 people.

From April 2013 to March 2014 some 202,000 adult service and 68,000 children service contacts were provided by our community teams.

Our services are divided into four divisions:

Division of Medicine

The Division of Medicine provides a comprehensive range of services through its three clinical directorates of Acute Medicine, Integrated Medical Specialities & Intermediate and Community Care. It provides its services across the two main hospital sites as well as through various community bases across the Calderdale and Greater Huddersfield geography.

The Acute Medicine directorate provides outpatient and inpatient services across the subspecialties of gastroenterology, diabetes, complex care, cardiology, respiratory and stroke sservice. The Acute Medical Unit and short stay wards are provided through a newly formed Emergency Care Network with our Surgical Division.

Integrated Medical Specialities provides oncology, haematology, dermatology, rheumatology, neurology, nephrology and medical daycase services.

The Intermediate and Community Care directorate provides all district nursing, community matrons, end of life, and intermediate care, crisis intervention and support and independence services across Calderdale. In addition it provides all of community therapy services across both Calderdale and Greater Huddersfield.

Division of Diagnostic and Therapeutic Services

The Division of Diagnostic and Therapeutic Services provides a full range of clinical support services including radiology, pathology, pharmacy, and medical records and appointments.

In addition Huddersfield Pharmacy Specials is hosted as a separate business unit which operates a commercial pharmacy manufacturing unit that supplies the West Yorkshire region and continues to attract new business from across the UK.

The radiology directorate provides a full complement of services, including interventional radiology. CHFT is a joint centre with Bradford Royal delivering vascular services. In the last year the service has retained its national accreditation and been designated an accredited AQP provider in MRI and non obstetric ultrasound. The service is continuing to develop its outreach and community provision of services. The directorate also hosts medical illustration and medical devices services.

The pathology directorate is a fully accredited service that provides a full complement of services including, Blood sciences, including transfusion, histopathology, microbiology and phlebotomy. The directorate manages the mortuary service and in partnership working with pharmacy it hosts the anticoagulation service. The next year will see a significant change to the delivery of services by adopting a much greater focus on near patient testing.

The pharmacy service includes a comprehensive clinical pharmacy service, inpatient dispensary and aseptic service on both hospital sites. Outpatient dispensing is now delivered through an outsource arrangement with the Co-operative. The service is currently implementing an e-medicines management system and exploring more automation to allow the clinical service to be closer to delivering direct patient care. It will progress to implementing e-prescribing as the trust delivers the Electronic Patient Record (EPR) modernisation programme in the next 12 months.

The medical records and appointments directorate supports the function of booking new and follow up appointment across outpatient services and ensuring clinical records are in the right place at the right time for our patients. We are embarking on a major transition in the next year to an electronic document management system which will be seen as a precursor to the forthcoming EPR as we move towards becoming paper light.

Division of Surgery and Anaesthetics

The division of Surgery and Anaesthetics provides a comprehensive range of service through its four clinical directorates of critical care and anaesthetics, emergency care, orthopaedics and trauma and general specialist surgical services.

The critical care and anaesthetic directorate provides inpatient and outpatient services, pre-assessment, pain services,intensive care and high dependency units, elective and acute theatre provision. The directorate of emergency care currently provides Accident and Emergency care at both sites and a surgical assessment unit at Huddersfield Royal Infirmary.

The orthopaedic and trauma directorate provides outpatient and inpatient services across the specialties of elective surgery, orthopaedic and trauma. The general specialist surgical services provides inpatient and outpatient services across the specialties of general surgery, breast surgery, colorectal surgery, upper-gastrointestinal surgery, including bariatric surgery, vascular surgery,

urology, maxillo-facial, ophthalmology, and ear, nose and throat surgery to the populations of Calderdale and Huddersfield.

The division also provides day case surgery in all specialties.

Division of Children's, Women's and Families (CWF)
The Children's Women's and Families services provide a comprehensive range of services within the two hospital sites and also the community. The women's directorate encompasses the services of maternity care, gynaecology, gynae-oncology, termination of pregnancy, sexual health and HIV services. The families directorate is community based and provides community midwifery services, health visiting, school nursing and family nurse partnership in the Calderdale locality through 4 locality hubs. The Directorate also has the community therapy service which provides a service across Calderdale and Huddersfield boundaries. The children's Directorate provides acute services including paediatric assessment and inpatient services as well as paediatric outpatients. The children's directorate is home to the neonatal intensive care unit providing for special care babies including high dependency unity (HDU) and intensive care unit (ICU) provision. The community home nursing team also support children and their families at home with their intensive care needs.

The Division's focus over the coming year is to develop its services into the community, to develop seven day working across its services and to test the ability to deploy technology to support the management and configuration of our services for the benefits of patients. We will continue to work with seven partner organisations across the 2 localities to redefine services for children's and families through the children's working group as part of the Strategic Review.

The four divisions are supported by a number of corporate functions such as finance, quality assurance, human resources, estates and health informatics.

How we are managed

The way in which foundation trusts are governed is set out in legislation, which is reflected in our Constitution and our Standing Orders. We have a Board of Directors and a Membership Council. The Membership Council is elected by the Trust members within each constituency to represent their interests and those of the wider public and staff and reflect these interests to the Board of Directors. The Membership Councillors also feedback information on the Trust, its vision and plans, to the public, staff and stakeholder organisations who have elected or appointed them.

The Board of Directors has the overall responsibility for decision-making but works closely with the Membership Council in formulating forward plans. More information on the responsibilities of the Board of Directors and the Membership Council and how they work together is provided in Our Governance and organisational arrangements section on page 102.

The Board of Directors has developed a schedule of matters reserved to the Board and a scheme of delegation to its sub-committees and executives. This is available on the Trust website at www.cht.nhs.uk.

Did you know...?
Our medics look after the next generation with "how to be a doctor" days for sixth-formers. Always a big hit.

Strategic Report

Principal risks and uncertainties

As part of good governance, the Trust continues to identify potential risks to achieving its strategic objectives. The Assurance Framework enables the identification, analysis and management of risk, described in the Annual Governance Statement on page 130 of this document. The issues below describe the risks that the Board of Directors consider to be of particular significance. There may be other risks or uncertainties not yet identified by the Trust that could impact on future performance. The main trends and factors likely to affect the Foundation Trust's future development, performance and position are described in the Annual Plan, submitted to Monitor. The three highest risks to quality are identified as:

Risk	Mitigating Actions	Outcome Measures
Lack of robust processes leads to failure to obtain approval for the implementation of the strategic review business case (SOC). Failure to obtain approval for the SOC leads to potential safety and sustainability issues for the Trust.	A robust engagement and public consultation process is being put in place by the Clinical Commissioning Groups (CCGs) to ensure that the correct process is followed in order to ensure that challenge cannot be made on process. The final decision on the strategic outline case topics will be made by the CCGs. Feedback during the engagement phase will be used to shape the Outline Business Case (OBC) which will develop the options for public consultation.	No challenge to the engagement and consultation processes. Approval of the final options that are taken to public consultation once the engagement is complete.
Failure to undertake robust commercial intelligence monitoring leads to a loss of services and missed opportunities, resulting in the loss of local services for patients and potential sustainability issues for the Trust.	The Trust is currently developing a commercial strategy that should be in place by May 2014. Horizon scanning continues to take place to ensure that all services at risk are identified and monitored and any appropriate opportunities are followed up.	The Trust will have a commercial strategy in place by May 2014.
Failure to implement the Trust's health and safety action plan leads to safety issues within the Trust for staff and patients.	The Trust has in place a robust health and safety action plan and has recently updated its health and safety policy and developed a health and safety operational group. This group adds more rigour to the Trust's health and safety monitoring. A whole organisation health and safety training programme has just begun.	The Trust does not have in place any warning or compliance notices relating to health and safety compliance.

Our staff

The Trust continues to prioritise staff welfare. Evidence of this includes work undertaken regarding sickness absence and regarding appraisal rates. As a result of this the overall staff sickness rate is now reduced to 4%. The appraisal rate for medical staff in non-training medical posts was 92%. The appraisal rate for non-medical staff was 92.6%.

The number of staff in post has increased by 113, from 5,924 in March 2013 to 6,037 in March 2014 broken down as follows:

- Female 4,964, Male 1,080. (Excluding non-executive directors)
- Total directors 6: Female 4, Male 2.
- Total non-executive directors 7: Female 2, Male 5.
- Total senior managers 134: Female 84, Male 50. (NB - the senior manager figure relates solely to those employed on local senior manager employment terms and conditions)

Every year we take part in the national NHS staff survey, where our staff have the chance to give us feedback on their job and workplace. We use this feedback to plan where we need to make improvements. Each year we produce a staff feedback action plan based on "what you said – what we've done and what we're doing". Between October and December 2013 a random sample of 850 members of staff were asked to fill in the survey and 493 responded (59%).

Further information on the Trust's approach to colleague engagement and staff survey, equality and diversity and remuneration is included in the Director's Report.

Accounting policies for pensions and other retirement policies and details of our senior employees' remuneration are set out in the Remuneration Report on page 121 and in note 5 to the accounts.

Health & safety

The Trust is committed to safeguarding the health and safety of its employees, patients, visitors and anyone who may be affected by its activities. The Trust has an active Health and Safety Committee which is made up of representatives from clinical and non-clinical groups, trade unions and staff. The Committee includes specialist advisors with expertise in key risks such as health and safety, fire safety and security.

During 2012/13 the health and safety focus has been:-

- Embedding health and safety observations within leadership walkabouts
- Nominating dedicated health and safety champions at Board level
- Providing focussed health and safety training from the Board to the front line
- Enhancing fire safety compliance by increasing the number of fire wardens and delivering mandatory fire safety training

- Confirming compliance with mandatory engineering standards

By implementing good risk management strategies, current knowledge and best practice, we ensure we provide a safe healthcare environment in accordance with the Health and Safety at Work Act and associated regulations.

Sustainability and climate change

Whilst continual efforts have been made to impact the Trust's carbon footprint CHFT saw a 0.5 tonne increase in CO2 emissions.

Improvements implemented during 2012/13 included:-

- Refurbishment of Ward 8 at HRI incorporating energy efficient LED lighting and replacement windows
- Refurbishment of HRI main entrance and main car-park with LED lighting
- Replacement macerators and bed-pan washers with new efficient equipment
- Replacement of aged boilers with efficient equipment
- Space utilisation monitoring to decrease energy consumption
- Programme of lagging and insulation in Trust retained areas

Acre Mill external refurbishment continued throughout the year with the commencement of internal fit out planned during the coming year.

The Trust expects to see a reduction in CO2 emissions with further rationalisation of its estates buildings including the transfer of its laundry services to an external provider.

Endoscopy:
"I attended the HRI today for a Colonoscopy with some apprehension, but I needn't have been concerned at all because the nursing staff put me completely at ease. All the staff were completely professional and caring far beyond the call of duty and my grateful thanks go to you all."

Strategic Report

Looking forward

Innovation through strategic alliance - Our intention is to treat patients as individuals and deliver excellent and compassionate care to each and every one of them. We recognise that we cannot do this alone and we have been working closely with the six other health and social care organisations across the areas of Calderdale and Greater Huddersfield, to ensure that we work towards seamless joined-up care for our communities, whatever their health and social care needs. We are working together to develop and implement bold and transformative long-term strategies and plans for services that otherwise may become financially unsustainable and result in a decline in the safety and quality of patient care.

This approach is exemplified by the work the Trust is doing in partnership with South West Yorkshire Partnership NHS Foundation Trust and Locala Community Partnerships to develop an outline business case for system transformation across Calderdale and Huddersfield. This offers a proposal for a new way of working that will deliver more self-care, more integrated care closer to home, and a reconfiguration of hospital services. Changes in the configuration of services will be a key enabler for 7 day working.

Transforming care - The Trust has developed an ambitious transformational improvement programme designed to achieve the following key aims, with respect to quality of care for patients:

- Reduce mortality rates in hospital
- Improve patient experience and safety
- Provide better care for less cost
- Reduce the number of unnecessary emergency admissions
- Improve patient flow and reduce hospital unnecessary waits for care

This change will be delivered through a combination of working closely with partners and improving our internal systems and processes, adopting lean methodologies and learning from other organisations.

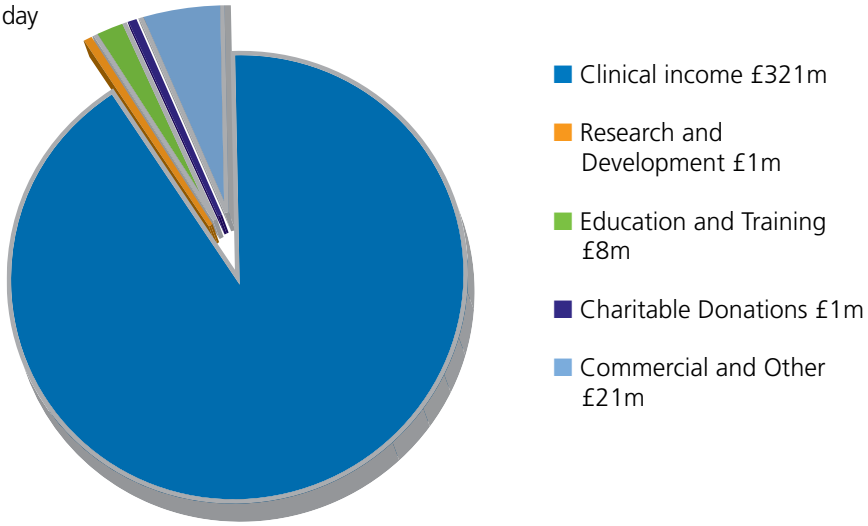
These improvements will be enabled through an IM&T modernisation programme, central to which is the need to put the patient at the heart of everything we do and one of the underpinning principles of the programme is that 'Real time patient information will always be at hand for us and our partners to provide the best seamless care'.

Keeping the Base Safe - In these times of rapid system change we need to ensure that we do not lose sight of the basics. We must keep the operational, quality and financial base safe and sustainable. Our aim is to improve access to care for patients and prioritise their safety, thereby also ensuring our regulatory compliance.

Our finances

At the end of 2013/14, we had met all of our statutory financial duties while achieving our planned Continuity of Service Risk Rating of 3 and a surplus of £2.7m. We received a total income of £352m of which £321m came from patient care and £31m came from research, education, car parking and non-clinical services to other organisations. Although there was a reduction in the national tariff of 1.1%, total patient care income increased by 1.0% primarily through funding of transformational schemes in the following key areas:

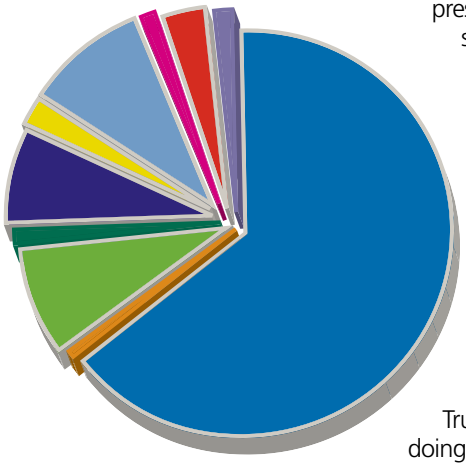
- Virtual Ward - Reducing avoidable admissions and readmissions through active management in the community.
- Outpatient antibiotic and parenteral therapy - Allowing patients who are medically stable to be treated in a community setting.
- Visual hospital - Developing a 'Plan for Every Patient' and utilising lean methodology to reduce hospital length of stay.



Our principal purpose is the provision of goods and services for the purpose of the health service in England. We do not fulfil this purpose unless, in each financial year, our total income from the provision of goods and services for the purposes of healthcare is greater than our total income from the provision of goods and services for any other purpose. During 2013/14 we achieved this requirement. The provision of other goods and services has not had an impact on our ability to provide services for our primary purpose. Information on any post balance sheet events is provided at note 24 to the accounts.

Operating expenditure (excluding impairments) was £336m and in line with the previous year. Our productivity and efficiency programme generated £16m savings through a number of initiatives that were driven through the Trust's clinical divisions and corporate strategic planning.

- Staff £218m
- Training and Consultancy £2m
- Clinical Supplies £29m
- General Supplies £3m
- Drugs £26m
- CNST Premium £7m
- Premises £32m
- Equipment Leases £4m
- Depreciation £11m
- Other £4m



During the year we invested in significant amounts of capital expenditure totalling £15.8m in the following areas:

- Medical equipment £1.9m
- Ward refurbishment at HRI £2.5m
- Information technology - infrastructure £3.9m
- Information technology - clinical systems £2.4m
- Operational and infrastructure schemes £5.1m

Financial risk rating

On 1 October 2013 Monitor replaced the compliance framework the risk assessment framework.

The principles behind the risk assessment framework are similar to those that Monitor has used so far in regulating NHS foundation trusts, and do not represent a significant change to the current regulatory approach under Monitor's compliance regime. The risk assessment framework introduces a new financial risk rating, known as the continuity of service risk rating. This is used to flag the risk of insolvency over the short to medium term (12-18 months), using a scale of one to four; with the lowest rating signifying the highest level of concern.

Our financial risk ratings over the last two years are outlined on page 29.

Financial risks and future plans

The Trust is operating in a challenging financial environment. This is shaped by the national financial picture with the ongoing need to reduce the public deficit and increasing challenge to maintain the NHS funding ring fence. A bigger test will come for the Trust in 2015/16 as resources are realigned across Health and Social Care into the Better Care Fund. These factors sit alongside the pressures of investing in clinical staffing ratios, providing services 7 days a week and responding to increasing demand.

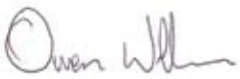
Our plan is to position ourselves well financially to deal flexibly with these challenges over the upcoming years. Our plan for 2014/15 is to achieve a £3m surplus, growing to a planned £4m surplus in 2015/16. These plans will continue to evolve throughout 2014/15 as longer term plans are finalised.

These are just the first two years of a ten year strategic financial plan which looks to reshape the Trust's delivery of services in line with the work we are doing in partnership with South West Yorkshire Partnership NHS Foundation Trust and Locala Community Partnerships to develop an outline business case for system transformation across Calderdale and Huddersfield.

We will invest in transformational capital IM&T and estate schemes in the immediate future which will release savings and enable the Trust to respond in an agile way to the outcome of the outline business case in the longer term.

Accounts preparation

Our accounts, which begin on page 137 of this document, have been prepared under a direction issued by Monitor under the NHS Act 2006. After making enquiries, the directors have a reasonable expectation that Calderdale and Huddersfield NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason we continue to adopt the going concern basis in preparing the accounts.



Owen Williams
Chief Executive

29 May 2014

Directors' Report
Including Quality Account

Directors' report

The directors' report provides a review of the main activities of Calderdale and Huddersfield NHS Foundation Trust over the year.

This directors' report is prepared in accordance with:
- sections 415, 416 and 418 Companies Act 2006 (section 415(4)-(5) and sections 418(5)-(6) do not apply to NHS foundation trusts)
- Regulation 10 and Schedule 7 to the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulations 2008
- additional disclosures required by the Treasury's Financial Reporting Manual
- additional disclosures required by Monitor in its Annual Reporting Manual 2013-14.

Additional information on quality is available in our quality account on page 31 and more information on quality governance is provided within our annual governance statement on page 130.

The Board of Directors

Calderdale and Huddersfield NHS Foundation Trust is led by a Board of Directors with responsibility for the exercise of the powers and the performance of the NHS Foundation Trust.

Chairman	**Mr Andrew Haigh**
Chief Executive	**Mr Owen Williams**
Executive Directors	**Mr Keith Griffiths** – Executive Director of Finance
	Dr Barbara Crosse – Executive Medical Director
	Mrs Julie Dawes – Executive Director of Nursing
	Miss Julie Hull – Executive Director of Workforce and Organisational Development
	Miss Lesley Hill – Executive Director of Planning, Performance, Estates and Facilities
Non-Executive Directors	**Mrs Jan Wilson** – Vice Chairman / Chair of the Quality Committee / Chair of the Health and Safety Committee
	Dr David Anderson – Senior Independent Director
	Prof Peter Roberts – Chair of the Audit and Risk Committee
	Mr Jeremy Pease
	Mr Phil Oldfield
	Dr Linda Patterson

The Board of Directors ensures that adequate systems and processes are maintained to deliver the Trust's Annual Business Plan, provide high quality compassionate healthcare, measure and monitor the Trust's effectiveness and efficiency as well as seeking continuous improvement and innovation.

The Board's Assurance Framework, corporate risk register and Integrated Performance Report enable an ongoing, comprehensive review of the performance of the Trust, against the agreed plans and objectives. Through transforming care, our aim is that our patients and staff will be able to positively describe what our vision means to them; we will treat our patients, staff and partners in a way that we would expect to be treated ourselves; and we will use our resources (financial, human and estate) as a driver for change rather than as a constraint. We will keep the base safe through improving access to care for patients and prioritise their safety; we will improve real time patient information being at hand for us and our partners to provide the best seamless care. We will seek improvement and innovation through strategic alliance which will improve patient outcomes and experience.

The Trust's Annual Business Plan is translated into individual objectives through the annual appraisal system. The key deliverables for 2014/15 are:

Transforming Care:
1. Rolling out the Courage to Put the Patient First lean action plan
2. Implementing the Colleague Engagement Plan
3. Developing state of the art outpatient services at Acre Mill
4. Working to deliver the Trust's efficiency plan of £20M
5. Modernising and prioritising the approach to patient engagement and complaints handling.

Keeping the Base Safe
6. Implementing action plans for both the Urgent Care Board and Care of the Acutely Ill patient
7. Actively seeking a partner to modernise our IM&T systems and install an electronic patient record
8. Reviewing and making changes to our governance arrangements
9. Implementing a health and safety action plan to make sure we have safe and suitable premises
10. Improving our commercial intelligence about future commissioning risks / opportunities

Improvement and innovation through strategic alliance
11. Working towards obtaining CCG / Health and Wellbeing Board / NHS England approval for implementation of the strategic outline case
12. Working in collaboration to improve
a. Bariatric surgery, assisted conception with Mid Yorkshire Hospitals Trust
b. Sexual health services with Mid Yorkshire Hospitals Trust and Locala
c. Psychiatric Liaison services with South West Yorkshire Partnerships FT

The Board monitors its progress against its quality improvement indicators which are detailed within the Quality Accounts section of this Report – please see pages 31 to 101.

Review of 2013/14

The delivery of our vision is within the context of the strategic environment in which we operate. This is shaped by the national financial picture with the ongoing need to reduce the public deficit and increasing challenge to maintain the NHS funding ring fence. A bigger challenge will come for the Trust in 2015/16 as resources are realigned across Health and Social Care into the Better Care Fund. These factors sit alongside the need to invest in clinical staffing ratios, provide services 7 days a week and respond to increasing demand.

In this challenging environment, the Trust delivered compassionate care meeting all its quality indicators, mandatory performance targets and its financial duties. A detailed analysis is included at page 40 of the Quality Account 2013/14 and in the regulatory report page 29.

A Quest for Quality

Transforming care

The Trust embarked upon a number of key service developments in 2013/14 to enhance the patient experience and provide both qualitative and system-wide efficiency, by ensuring that our patients are receiving the right service, in the right place at the right time.

The Trust built on existing service provision and introduced:

- A Quest for Quality, an exciting new model of care which will improve the level of support provided to care homes and their residents to improve health outcomes. The Quest team will work together with other health and social care providers to support and advise care home staff on the prevention and proactive management of the needs of older people. The Trust is working closely with a range of partners to deliver this service including Calderdale Council, and the tele-health provider Tunstall.

IV antibiotic therapy

- We were also selected to provide an enhanced Integrated End of Life service to the residents of Calderdale during 13/14. This service offers additional support to patients approaching their end of life, particularly out of hours and supports the promotion and education of end of life issues with local health and social care professionals. We are proud to be working with Overgate Hospice and Marie Curie Cancer Care to deliver this new service.

- The Trust is part of the Courage to Put the Patient First (CPPF) programme which builds on the Trust's association with the Lean Enterprise Academy (LEA) and will help to deliver all of our transformation aims. A key part of the programme is designed to establish an emergency intervention team where senior (consultant) decision makers improve clinical decision making in A&E to prevent unnecessary admissions and speed up clinical care to the acutely ill patient.

The Virtual Ward team

- The Virtual Ward team continues to build on its success since its launch in December 2011. The Virtual Ward is a dedicated multi-disciplinary team designed to identify and support

Review of 2013/14

those patients who are at high risk of readmission following a discharge from hospital. Since its launch the team has contributed to the local priority of preventing avoidable readmissions to secondary care by contacting patients within 48 hours of a discharge, with the aim of reducing the number of patients returning to hospital within seven and 30 days post-discharge following an acute spell. The service also plays an important role in decreasing the burden on primary care, improving the communication between the hospital and existing community service and where necessary supporting those patients who require further hospital treatment to receive this treatment in a planned manner (i.e. avoiding admissions to hospital through A&E)

- During 2013/14 the Trust launched a new model of care for individuals requiring intravenous antibiotics. This service ensures that the delivery of parental (intravenous - IV) antibiotics is done in a community setting as an alternative to inpatient care for those patients who are medically stable and whose only reason for admission or an extended length of stay in hospital is the requirement for IV antibiotic therapy. The service offers a highly clinically efficient, cost effective and safe alternative to inpatient care.

- We have introduced a specialist stroke rehabilitation service within Calderdale to patients recovering from a stroke for patients in Calderdale and Greater Huddersfield. The service supports patients to return home safely following a stroke and providing a quicker and improved recovery following a stroke. Patients receive a period of intensive rehabilitation support delivered prior to discharge from hospital and within the patient's own home following discharge. Our Trust's stroke care teams are amongst the first in West Yorkshire to receive stroke accreditation. The accreditation was granted following a peer review visit that examined several aspects of our new centralised stroke service. The external panel considered extensive evidence regarding the care pathway, training provided, and listening to patient feedback.

- An innovative model introduced within accident and emergency departments at the Trust means that a large number of patients who would have previously been admitted to hospital were safely supported to return home. This model involves a senior physician working closely with an experienced nurse and community matron to assess where it is safe and appropriate for a patient to be discharged home. Those who need a more thorough assessment do not then wait so long for their investigations and eventual diagnosis, and their decision to admit or discharge home is delivered more quickly. This service has significantly reduced the number of admissions to hospital and the waiting times within the department

Stroke rehabilitation service

A&E - an innovative model to allow for earlier discharge

- The Trust has collaborated with South West Yorkshire Partnership NHS Foundation Trust to develop a Rapid Assessment Interface and Discharge (RAID) psychiatric liaison service that improves outcomes for patients and makes more efficient use of acute beds. The service provides a 24 hour, seven day a week mental health liaison service for those being treated for physical health problems within the hospital. The model of service is based upon the evaluation and findings of the RAID service provided at City Hospital in Birmingham, and aims to reduce admissions, length of stay, psychological distress, and increase the number of people who can be discharged to their own homes with appropriate assessment and support.

- Improving communication is one of the Trust's ongoing priorities. Ward 3 at HRI have introduced "Dear Doctor" cards, where patients can write down any questions or concerns regarding their care before the start of their doctor's rounds so that they don't forget during the visit. The cards have already been trialled in other areas and are set to be rolled out across the Trust. Consultant Vascular Surgeon Neeraj Bhasin believes the cards have hugely empowered patients and very positive feedback has been received.

- The Trust's radiology department is the first in Yorkshire to be accredited. The departments at Calderdale and Huddersfield have become the 4th NHS facility in the country, and the only Trust in Yorkshire to be awarded the prestigious ISAS accreditation (Imaging Services Accreditation Service).

- Consultant Nurse Heather McClelland has been awarded the country's most prestigious award in nursing – a Florence Nightingale Scholarship. Heather is just one of seventeen nurses across the country to receive the award given to advance the study of nursing and to promote excellence in practice.

Radiology accreditation

Heather McClelland, awarded a Florence Nightingale Scholarship

Keeping the base safe

During 2013/14 there was a great deal of improvement work to clinical documentation, particularly nursing documentation to improve care and standardise the documentation. This work recognised the need to involve patients in the care-planning process and, as such, the care documentation is now kept at the patient bedside allowing the care planned to be agreed with the patient.

In addition, the nursing staff now provide the shift handover at the patient's bedside. The number of patient-held records is increasing, including a new patient-held urinary catheter record.

Guidance for doctors with regard to providing clear and understandable information to patients has been developed. The guidance is summarised in PLEASE posters displayed in patient

Review of 2013/14

areas, including behind the patient's bed, allowing the prompt for doctors. This also outlines what a patient can expect from their doctor.

The Trust provides an extensive range of patient information leaflets, predominantly in paper format. There is a robust system to ensure these are updated by the clinical teams to provide the best available information to our patients. We have started to investigate other methods of communication as we move towards the paper light era, using channels such as the internet and smart phone applications.

As part of our behaviour of putting the patient first we need to be open and honest with our patients. As a member of the 'Open and Honest Care: Driving Improvement' Programme we continue to work with patients and staff to provide open and honest care. By implementing quality improvements we can further reduce the harm that patients sometimes experience when they are in our care and this may include pressure ulcers, falls and hospital acquired infections.

We have made a commitment to publish a set of patient outcomes, patient experience and staff experience measures so that patients and the public can see how we are performing in these areas.

Each month we collaborate with other care providers to share what we have learned and to use this information to identify where changes can be made to improving the care we deliver. The Open and Honest Report is available each month on our Trust Website.

Handling complaints

Listening and responding to all feedback whether a compliment, comment, concern or complaint, remains an essential part of improving and advancing our services.

Through the year we have worked to provide investigations that are proportionate to the issues raised; provide an honest response and make changes where needed.

We also appreciate that these investigations can take a long time. The complaints management process is currently undergoing a further review to help ensure we are as responsive as possible to patients and their families.

Emergency planning

Under the Civil Contingencies Act 2004, the Trust is a category one responder to major incidents with specific responsibilities and we are required to be able to respond to emergency situations. We are a key member of a number of established committees to coordinate the local and regional response, including the Local Resilience Forum. We work closely with key partners, such as Calderdale and Kirklees Councils, Yorkshire Ambulance Service, West Yorkshire Police and the West Yorkshire Fire and Rescue Service to ensure that appropriate plans are in place to respond to emergencies rapidly and effectively. As part of this work, the Trust has in place business continuity plans so that, in the event of a major incident, we are able to continue to provide acute and community services as far as possible.

Locally, the Trust has participated in detailed planning for the Tour de France Grand Depart due to take place in July 2014. A significant part of the route will cross both Calderdale and Kirklees and will also impact on access to local major trauma centres. The Trust has been an active participant in both planning for the increase in population as well as the disruption to the local travel networks over the Tour de France weekend.

Our staff

Sickness Absence

For 2013/2014 the Trust's sickness absence rate was 4%. The Trust recognises that the health and wellbeing of its employees is a key determinant in safe and high quality services. High rates of absenteeism are costly, from an economic point of view as well as the impact on the morale of the workforce and the potential loss of continuity of patient care. The Trust has a policy which supports regular attendance at work that enables managers to manage attendance fairly, with a focus on rehabilitation and return to work wherever possible.

Staff sickness absence	2013/14	2012/13
	Number	Number
Days Lost (Long Term)	**51,499**	51,020
Days Lost (Short Term)	**20,262**	18,682
Total Days Lost	**71,761**	69,702
Total Staff Years	**1,898,569**	1,870,014
Percentage Staff Sickness	**4%**	4%

Colleague engagement

We know that our employees (colleagues) play an important role in designing and delivering services that are of high quality and which meet the diverse needs of the people who use our services. We believe that colleagues are more likely to be motivated and experience higher levels of job satisfaction when the following factors exist in the workplace:

- Fair treatment
- Opportunity for skills development
- Involvement in the decision-making process
- Good management and support from effective leaders

Formal engagement with staff side representatives takes place through the Staff Management Partnership Forum which meets on a monthly basis and the Medical and Dental Pay and Conditions Committee.

We have six elected staff members on our Membership Council, all of whom are active in engaging with employees of the trust as Foundation Trust Members and ensuring that they are involved in developing the work of the trust. We also engage with our workforce directly through a variety of mechanisms including:

- Team Brief, which ensures all staff receive regular updates from Executive Board meetings as well as Divisional and Departmental updates
- Our monthly staff newsletter "Trust News", which provides a lively mixture of service, performance and financial information as well as items about individual, team and trust achievements
- Our staff intranet
- Team meetings, briefing sessions, workshops and meetings which involve the trust's Chief Executive and other members of the Executive Team
- Staff have access to the Chief Executive through his weekly "blog" communication, which allows for an exchange of views on specific issues. There is also an opportunity for staff to meet face-to-face with the Chief Executive through scheduled sessions to find about what is happening in the trust and its future direction. This also provides an opportunity for staff to question the Chief Executive about issues that are important to them
- Leadership and environmental "walkrounds", where staff have the opportunity to raise workplace issues with senior managers

The Trust has been recognised as an 'Investor in People' since 1999, one of only a few organisations in the country with so many years of recognition. We will continue to adopt the principles of the Standard to support its people management and development processes. The Investor in People Standard is a nationally recognised business continuous improvement tool.

The trust has in place a workforce health and wellbeing strategy, aiming to influence improvements which impact positively on the health and wellbeing of all of our staff. The wellbeing of our staff is important to ensure that we continue to provide high quality patient care, supported by good management practices and engage staff in key decisions which affect their health and wellbeing.

Staff survey

Every year we take part in the national NHS staff survey, where our staff have the chance to give us feedback on their job and workplace. We use this feedback to plan where we need to make improvements. Each year we produce a staff feedback and action plan based on "what you said – what we've done and what we're doing". Between October and December 2013 a random sample of 850 members of staff were asked to fill in the survey and 493 responded (59%).

Where we are improving

The results of the staff survey in 2013 have shown that there is a lower than average score for staff experiencing discrimination; we are better than the national average for team working; job satisfaction; and staff having opportunities to contribute to improvements at work. Our overall staff engagement score and staff recommending the Trust as a place to work or receive treatment is better than the national average.

Each division across the Trust is represented on our Workforce Wellbeing Strategy Group and each divisional lead is responsible for ensuring that the survey results are reported to their respective boards, shared with staff and actions are put in place to address their concerns.

Did you know...?

More than 434,000 out-patients appointments were booked last year.

Our staff

We have a range of approaches in place to deal with workplace conflict issues such as grievances, harassment and bullying, both formal and informal. The main focus is now on mediation as an alternative to formal processes. A number of key trust staff have been trained and are operating as accredited workplace mediators.

Summary of Performance

	2012/13		2013/14		Trust Position
Response rate	CHFT	National average for acute trusts	CHFT	National average for acute trusts	
	60%	50%	59%	49%	No change

	2012/13		2013/14		Trust Position
Top 4 Ranking Scores	Trust	National Average	Trust	National Average	Trust Position
KF28. Percentage of staff experiencing discrimination at work in last 12 months	9%	11%	8%	11%	Decrease of 1% - the Trust is performing better than the national average
KF22. Percentage of staff able to contribute towards improvements at work	71%	68%	71%	68%	No change - the Trust is performing better than the national average
KF15. Fairness and effectiveness of incident reporting procedures	3.50	3.50	3.57	3.51	Improvement of 0.07 - the Trust is performing better than the national average
KF6. Percentage of staff receiving job-relevant training, learning or development in last 12 months	86%	81%	82%	81%	Decrease of 4% - the Trust is performing at the national average

	2012/13		2013/14		Trust Position
Bottom 4 Ranking Scores	Trust	National Average	Trust	National Average	Trust Position
KF26. Percentage of staff having equality and diversity training in last 12 months	45%	55%	47%	60%	Increase of 2% - however the Trust is performing below the national average
KF11. Percentage of staff suffering work-related stress in last 12 months	31%	37%	39%	37%	Increase of 8% - the Trust is performing below the national average
KF18. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	27%	30%	31%	29%	Increase of 4% - the Trust is performing below the national average
KF2. Percentage of staff agreeing that their role makes a difference to patients	90%	89%	90%	91%	No change - the Trust is performing at the national average

Next Steps

In 2013/2014 the Trust launched its colleague engagement strategy which has at its core the four behaviours that we expect to see across the organisation.

The Trust is committed to introducing a consistent approach to how it manages change and in particular how we manage change that fully engages the potential and creativity of staff and allows colleagues to work across divisional and organisational boundaries.

A programme of activity has been initiated – the Work Together, Get Results (WTGR) programme explores simple and practical tools that helps leaders engage colleagues in a way that allows breakthroughs in their ability to lead transformational change in the organisation.

Properly applied the tools secure the commitment of colleagues to the organisation's results and values and ensure colleagues are motivated and contribute to delivering the Trust vision.

We delivered real improvement in our appraisal compliance during 2013/2014 achieving 92% for non-medical and medical colleagues. The result expected in 2014/2015 is 100%. Appraisals are seen by the Trust as a key contact with colleagues and an opportunity to engage them in what the organisation's goals are. Work now focuses on ensuring the appraisal interaction is of high quality and we will test colleagues' experience of the appraisal tool and the conversations that take place in the appraisal setting to improve our approach.

Our health and wellbeing strategy is being refreshed and we are exploring opportunities to work with a national charity, Public Concern at Work, to provide opportunities for colleagues to raise concerns about any matter that occurs in the workplace and for them to be appropriately managed and resolved. Additionally, a staff suggestion scheme is available to colleagues to submit ideas for improvement and as colleagues leave their employment with the Trust information about their experience is obtained through a leaver survey. A 'new starter' experience surveying tool is being developed to enhance the opportunities we offer to colleagues to feedback concerns and recommendations that enable us to improve what we do.

Following the reporting of the 2013 national staff survey results for the Trust commitments have been made to focus attention on workplace bullying (service user to colleagues as well as colleague to colleague), stress at work and the availability of equality and diversity training. Further, preparations are being made to deliver the colleague Family and Friends Test from June 2014.

Equality & Diversity

As a public sector body, the Trust has a statutory duty to comply with the Equality Act 2010. In line with the specific duties of the Act, the Trust is required to publish an annual report, detailing the ways in which the Trust meets the general duties of the Act to:

- Eliminate unfair discrimination, harassment and victimisation
- Advance equality of opportunity between different groups
- Foster good relationships between different groups

This annual report, known as the Public Sector Equality Duty (PSED) report is available to read in full on the Trust's website (www.cht.nhs.uk). The PSED report shows how effective the Trust is in collecting and utilising equality data to inform decision making; its arrangements for engagement and collaborative working; its activity towards meeting the general duties of the Act; and its outcomes for people with protected characteristics during 2013.

It contains separate sections relating to patients and staff. It also contains an update showing to what extent the Trust is meeting its published equality objectives

Consultation with communities of special interest in 2011 indicated that they wanted the Trust to focus on areas of improvement that fall broadly into three categories and in March 2012 the Board of Directors agreed the following high level corporate objectives:

1. Access
The Trust will demonstrate improvements in access to services for people with protected characteristics.

2. Information and communication
The Trust will demonstrate improvements in data collection, utilisation and analysis to inform service improvements for people with protected characteristics.

3. Staff attitude, behaviour and training
The Trust will deliver training programmes which reflect the need for employees to respect equality, diversity and human rights

Underneath these three over-arching objectives, workstream leads for each of the 9 protected characteristics identified in the Equality Act 2010 developed plans for action, with measurable deadlines and outcomes. This initially resulted in 102 individual objectives for completion during the 2012-2016 period. 90 of those original objectives (88%) have been completed to date.

Following annual reviews of the objectives in December 2012 and December 2013, the overall number of organisational objectives scheduled for completion before March 2016 has risen

Maxillofacial: "I came to see the emergency dentists at HRI yesterday with terrible toothache. The service was outstanding. The receptionist had a word with the dentist who slotted me in not only for an earlier assessment but also for a full tooth extraction. Well done Huddersfield Royal for providing an incredible service. Hopefully I won't be seeing you again but I'll be rest assured if I need to."

Our staff

to 158. Of these 126 (80%) have been completed as at the end of December 2013 were on track for completion by March 2014.

The Trust continually reviews its policy framework in order to ensure that it is meeting its legal obligations and providing a supportive workplace environment for all of its employees.

The Trust introduced an apprenticeship scheme on 1 October 2012 for all posts at Agenda for Change pay bands 1 and 2, and continues to recruit to posts through the scheme. The Trust has recruited to healthcare assistant roles, administrative and clerical and gardeners roles using the scheme. The apprenticeship scheme supports people with disabilities, those without qualifications, those from ethnic communities and from areas of significant deprivation in to the employment market. The Trust is an active player in the local job market and through employment it can make a significant difference to life opportunities for its local population as well as impacting health and wellbeing.

The Trust launched a colleague engagement strategy in June 2013. The strategy adopts a consistent approach to change management with colleague engagement at its core. The strategy focuses on four behaviours, based on agreed Trust values, which the Trust expects to be demonstrated by all employees.

The Trust's Occupational Health department received a Safe Effective Quality Occupational Health Standards full accreditation award for five years (SEQOHS) in December 2013. The Standards measure that the Occupational Health Department meets minimum requirements, reflecting existing ethical and professional guidance and consensus and helps them achieve uniform good practice. The Occupational Health Department has a strong focus on the health and well-being of staff and, as a focus for the future, will focus on initiatives such as becoming a smoke free Trust, and developing support for staff and managers on mental health pathways.

Regulatory ratings report

Financial risk rating

On 1 October 2013, Monitor introduced a new compliance framework for foundation trusts. The new risk assessment framework replaced the financial risk rating with the continuity of services risk rating. This did not represent a significant change in the way in which foundation trusts are assessed. The Trust achieved its target rating of 3 at the year end.

Governance risk rating

Under the previous compliance framework, a 'green' governance risk rating indicated that an NHS foundation trust's governance arrangements complied with their provider licence and that there were no material concerns; an 'amber-green' rating indicated that there were limited concerns surrounding the licence conditions; an 'amber-red' rating indicated there was a breach of the licence conditions; and a 'red' rating indicated that there was a likely or actual significant breach of licence conditions

Under the risk assessment framework, a "green" risk rating means that there are no evident concerns, and a "red" rating means that Monitor is taking enforcement action. Where Monitor has identified a concern within a foundation trust but not yet taken action, a narrative description is provided which states the issue at hand and the action it is considering.

At the start of the financial year our governance risk rating was amber-red as a result of a Care Quality Commission report on some of the Trust's premises. This changed to green once all actions had been implemented and the Care Quality Commission had confirmed that we met the standard.

	Annual Plan 2012/13	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13
Financial risk rating	**3**	**3**	**3**	**4**	**4**
Governance risk rating	**Green**	**Amber**	**Amber-Green**	**Green**	**Amber-Red**

	Annual Plan 2012/13	Q1 2012/13	Q2 2012/13	Q3 2012/13	Q4 2012/13
Financial risk rating	**3**	**3**	**3**		
Shadow continuity of services risk rating	**-**	**-**	**2***		
Continuity of service risk rating (CoSRR)				**2***	**3**
Governance risk rating	**Amber-Red**	**Amber-Red**	**Green**	**Green**	**Green**

Regulatory ratings report

Improvement and innovation through strategic alliance

In April 2013, following the Health and Social Care Act, the commissioning landscape changed significantly.

The Trust has worked closely with the Clinical Commissioning Groups for Calderdale and Kirklees to support the transition, and strengthen relationships to ensure the delivery of high quality care that meets the needs and expectations our community.

NHS England is now established in its role as a commissioner and the Trust has been working with them to review service specifications and services and to develop both operational and strategic networks across the region.

The Trust has also worked closely with both Calderdale and Kirklees local authorities following the transfer of commissioning responsibilities for some health services in year.

Over the past two years, seven health and social care organisations in Calderdale and Greater Huddersfield have been working together to encourage innovation and transformation to address the needs of an ageing population. Extensive partnership working has led to the development of a Strategic Outline Case (SOC) and proposals for change, which were shared with the public in January.

The proposals will ensure that we continue to deliver the right services, in the right place at the right time, into the future. The SOC has been developed in line with the strategic aims of both the Calderdale and Kirklees Health and Wellbeing Boards.

The Trust continues to build relationships to support key strategic alliances with the Mid Yorkshire Hospitals NHS Trust, South West Yorkshire Partnership Foundation Trust, Airedale NHS Foundation Trust, Locala Community Partnerships and other relevant providers. The developments and collaborations provide a framework for district general hospitals to work together to continue to deliver more services locally by sharing experience and learning to enhance the services across common pathways and geographical areas. This includes developing joint bids for the provision of services.

The Trust is now beginning a journey of IM&T Modernisation. The programme will transform the way clinical services are delivered to patients. Central to the Trust's IM&T Modernisation Programme is the need to put the patient at the heart of everything we do and one of the underpinning principles of the programme is that 'Real time patient information will always be at hand for us and our partners to provide the best seamless care'.

Directors' declaration

All directors have confirmed that, so far as they are aware, there is no relevant audit information of which the auditor is not aware and that they have taken all steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS foundation trust's auditor is aware of that information.

All directors understand that it is their responsibility to prepare the annual report and accounts, and that they consider the annual report and accounts, taken as a whole, to be fair, balanced and understandable, and to provide the information necessary for patients, regulators and other stakeholders to assess the performance of Calderdale and Huddersfield NHS Foundation Trust, including our business model and strategy

QUALITY ACCOUNT 2013/14

Quality Account: **Chief Executive's Statement**

Welcome to the 2013/14 Calderdale and Huddersfield NHS Foundation Trust Quality Account.

This report gives us the opportunity to let you know about the quality of services we deliver to our patients. It includes information on how we have performed against key priorities that were identified for further work last year and those areas that, together with our Membership Councillors, we have identified as priorities for the coming year.

This document by no means includes all the work that we are doing to constantly improve the quality of our services for our patients and their families but instead gives you a snapshot of the work being undertaken in our Trust.

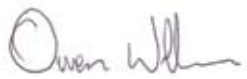
Providing 'Compassionate Care', and improving our patients' experiences of our services, continues to be a high priority for our staff and the Trust. We are determined to ensure that patients get the care they need, when they need it and from the right person.

There have been a number of national reports published over the past year, which focus on delivering better care to patients. We have considered these reports, together with listening to the views of local people, when looking at how we develop our services further and how we need to change them to meet the needs of our communities in the future.

Our Board of Directors continues to focus on quality and any improvements we look to make are assessed for their impact on quality before they are able to go ahead. We have some excellent examples of good quality services within our Trust but we know that there are also areas where we want to improve. Where the quality is already good, we strive to continue to improve that quality – we will not become complacent and know that there is always room for improvement.

I hope you will find the following pages informative and helpful in giving you an insight into the vast amount of improvement work we continue to do in the Trust.

To the best of my knowledge the information in this report is accurate.



Owen Williams
Chief Executive

Did you know...?
Around 2,500 nurses deliver care for our patients in hospitals and in the community in Calderdale.

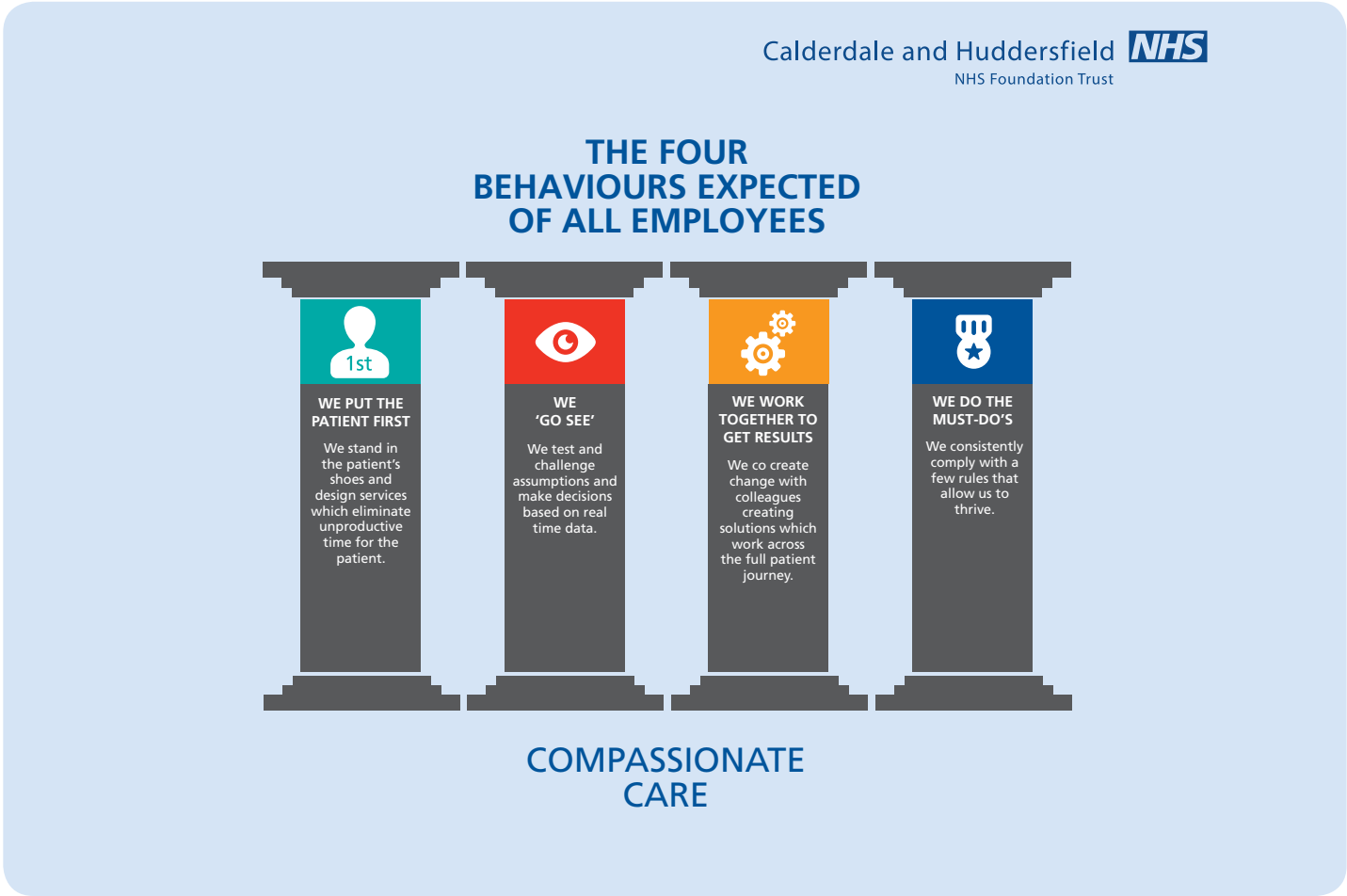
Quality Account: **The Vision for Calderdale and Huddersfield NHS Foundation Trust**

Calderdale and Huddersfield NHS Foundation Trust has recently refined its vision and values to ensure that the work it carries out always 'puts the patient first' and the Trust is working hard to improve the patient experience.

The Trust's vision is: 'We will work with partner organisations to understand the individual needs of patients and together, deliver outstanding compassionate care which transforms the welfare of the communities we serve.'

The Trust's vision is clear, that it will treat patients as individuals and deliver excellent and compassionate care to each and every one of them. However, the Trust recognises that it cannot do this alone and has been working closely with the six other health and social care organisations across the areas of Calderdale and Greater Huddersfield, to ensure that we work towards seamless joined-up care for our communities, whatever their health and social care needs.

Backing this up is the Trust's values, the four pillars of behaviour that it expects all employees to follow. The four pillars have been introduced to the Trust over the past year and we are working hard to embed them into the organisation so that every member of staff understands their responsibilities.



Quality Account: **How we performed against the five priorities we set for 2013/14**

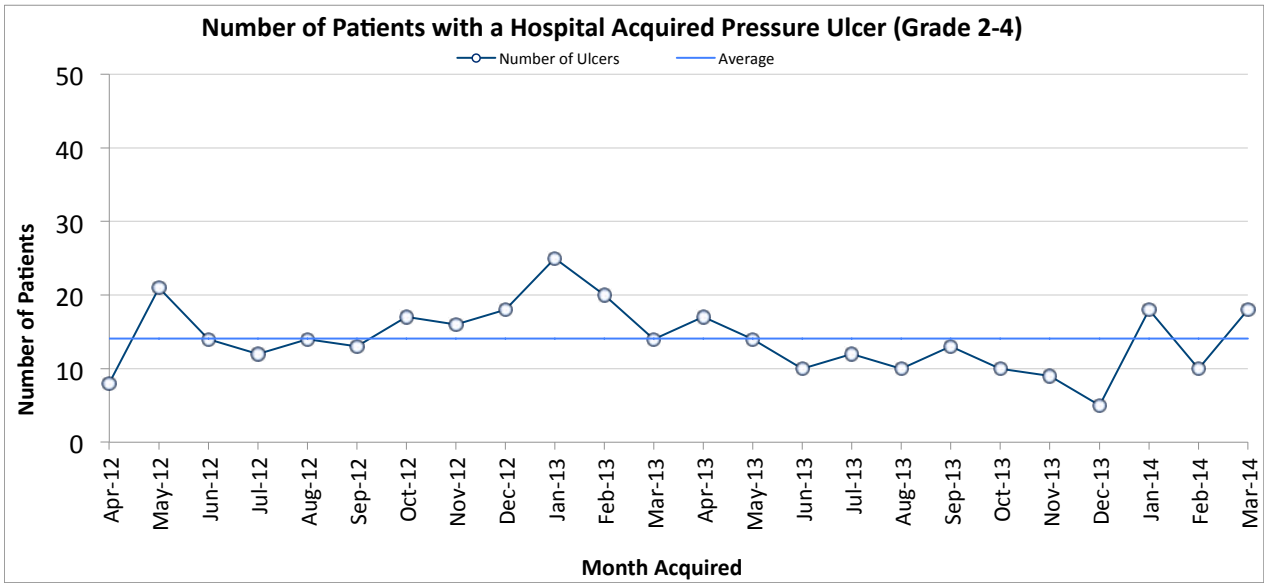
Last year the Trust identified five quality improvement priorities for 2013/14. This section of the Quality Account shows how the Trust has performed against each of these priorities.

Improvement priority	Were we successful in 2013/14?
Reducing the number of pressure ulcers	**Yes**
Reducing the number(s) of healthcare associated infections - Methicillin -resistant Staphylococcus aureus (MRSA) Bacteraemia	**Yes**
Appropriate and safe discharge	**Yes**
Improving the care of patients with dementia	**Yes**
Helping people to manage their long-term conditions	**Yes**

Priority one: Reducing the numbers of pressure ulcers

Pressure ulcers, also sometimes known as bed sores or pressure sores, are injuries that affect areas of the skin and underlying tissue. They are caused when an area of skin is placed under too much continuous pressure.

The number of pressure ulcers remains an important measure of the quality of care we provide.



The above chart shows the improvement made in the prevention of pressure ulcers. The increase in incidents in January 2014 and March 2014 is related to changes to the data validation process from the Trust changing the incident reporting system. This process is being improved and the Trust expects the data will stabilise.

Improvement has been achieved through
- Bespoke training to individual wards
- Train the trainer approach regarding pressure ulcer prevention
- Development of pressure ulcer prevention competencies for registered nurses.
- Online training continued
- A new investigation template was implemented in February 2014 to understand causes better.

It is recognised that further improvement can be made. Moving forward the Pressure Ulcer Collaborative will use a more focused approach ensuring that on wards the following basic tools are reliably implemented:
- Documentation
- Competencies
- Dressing stock
- Medical device training
- Bespoke training
- Review of the Surface, Keep moving, Nutrition (SKIN bundle)

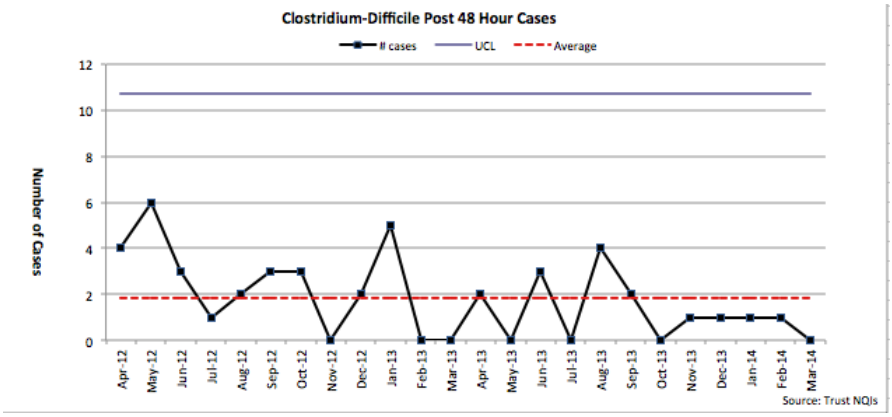
For our community nursing teams the following changes are planned:
- Training to be planned for team leaders – focus on learning from incidents and conducting Serious Incidents (SI) investigations
- General training and check of competencies for Staff Nurses and Health Care Assistants
- Developing an early warning trigger for residential homes
- Developing a SKIN bundle

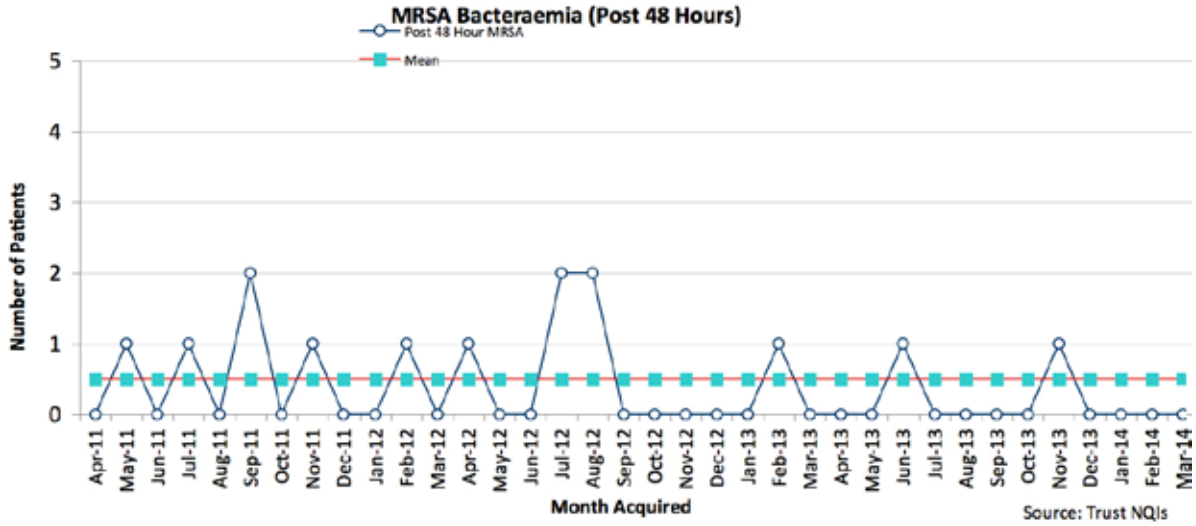
Day Surgery Unit HRI
"Every member of staff treated me with exemplary care. Any nervousness I felt about the procedure was effectively dispelled, and I was treated with respect, care, and professional efficiency. My late father was an active promoter of the NHS after the war and would have been pleased to know that the principles of the Health Service initiated by Mr Bevin persist today."

Quality Account: **How we performed against the five priorities we set for 2013/14**

Priority two: Reducing the number(s) of healthcare associated infections

Healthcare associated infections (HCAIs) remain a priority area both within the Trust and nationally. MRSA bacteraemia and clostridium difficile have an associated mortality risk and interventions over the last few years have seen levels of HCAI significantly reduce in the Trust. As the hard work to combat the HCAI continues it is expected to see the incidence of HCAI reduce further, increasing patient safety as well as improving the patient experience.





There has been continued reductions in healthcare associated infection in the Trust with last year seeing our lowest numbers of MRSA and Clostridium difficile. The Trusts' frontline staff have taken real ownership in ensuring hygiene standards are at their best, including hand hygiene and keeping the wards clean. All cases of MRSA and clostridium difficile are investigated by the clinical team so that the Trust can learn from these cases to prevent further cases.

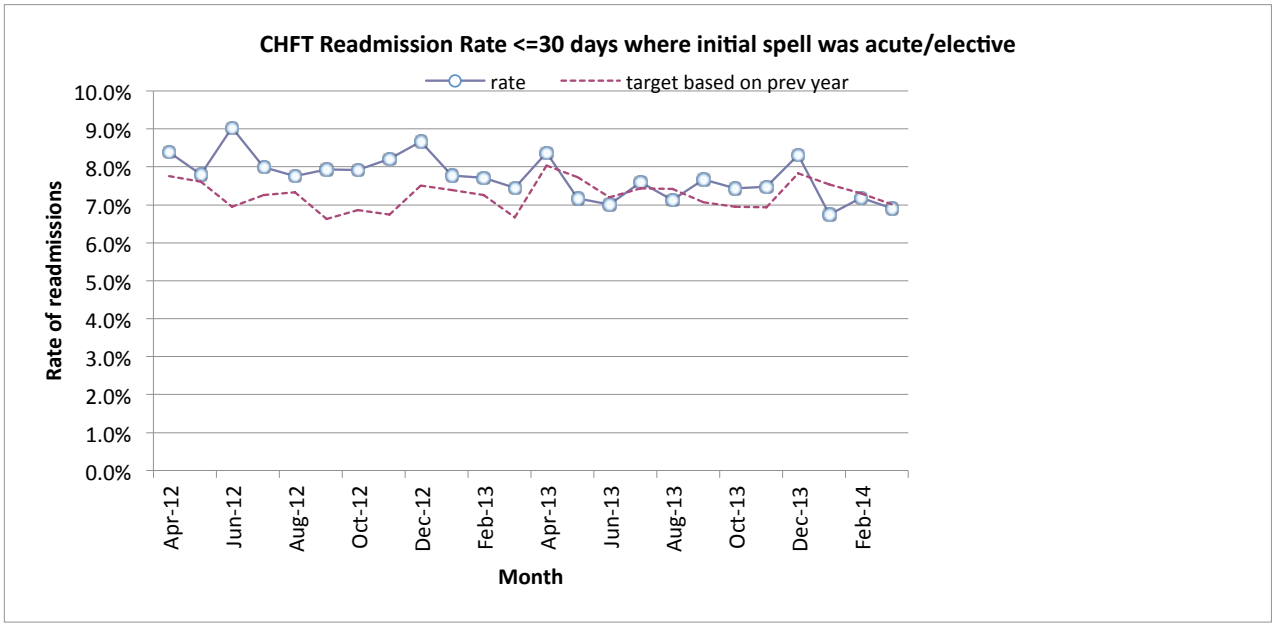
Future focus will include expanding work with all the Trusts' health and social care partners to proactively assess risks and investigate cases of HCAI. Working together we will be able to minimise risks and provide safer care for the Trusts' patients.

Priority three: Appropriate and safe discharge

The Trust measures readmissions as a way of demonstrating possible failures in discharge planning.

Causes of readmission are complex; they can be due to care post discharge from hospital or changes to a patient's condition as well as poor discharge planning.

Requiring readmission following a recent stay in hospital can be a very distressing experience for patients and their families. By reducing the number of unplanned and avoidable readmissions the Trust can not only provide better and safer care but also use its resources more efficiently.



The above chart shows some improvement in the rate of readmission in the Trust.

The improvement is largely due to the introduction of discharge coordinators on the medical wards. This is a key role and helps ensure patients and their carers are adequately supported when planning for discharge and coordination of all the other agencies involved.

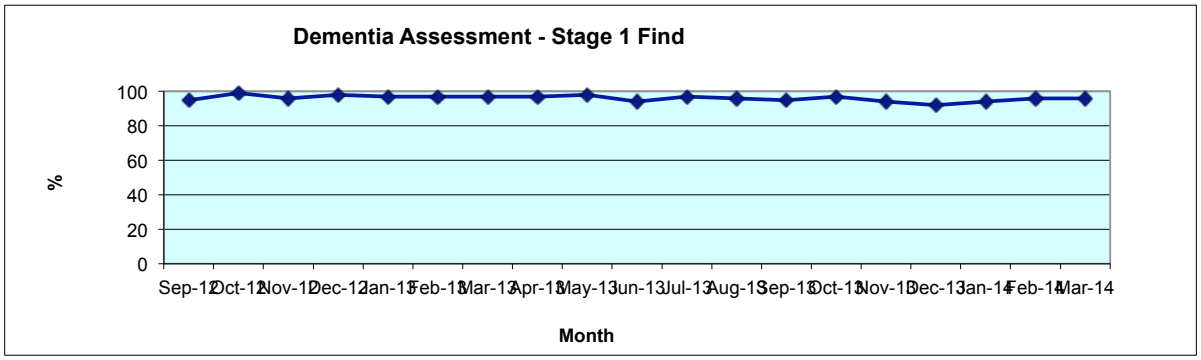
In addition 'Plan for Every Patient' boards ensure the whole ward team are aware of progress towards discharge and ensure that supporting clinical care is delivered 'on time and in full' helping to make sure there are no gaps or delays.

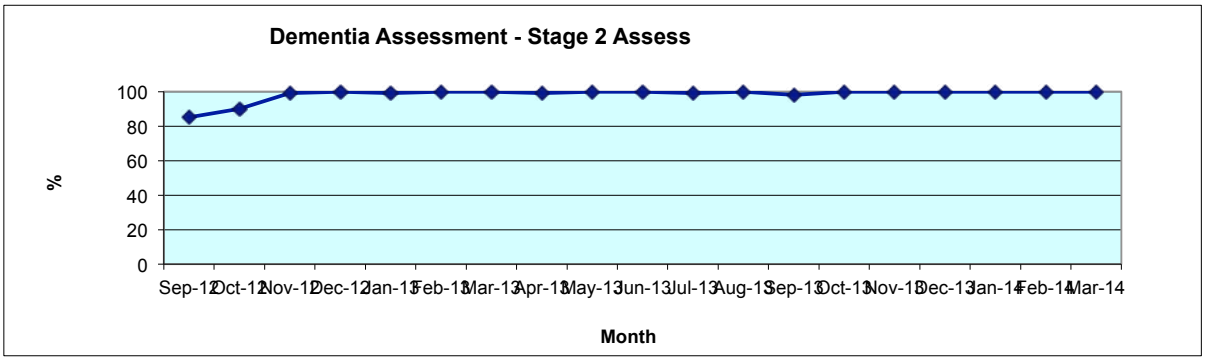
On the Medical Admission Units (MAUs) there is a pilot project running called 'ticket home'. This is to ensure patients have the right level of information whilst in hospital and on discharge.

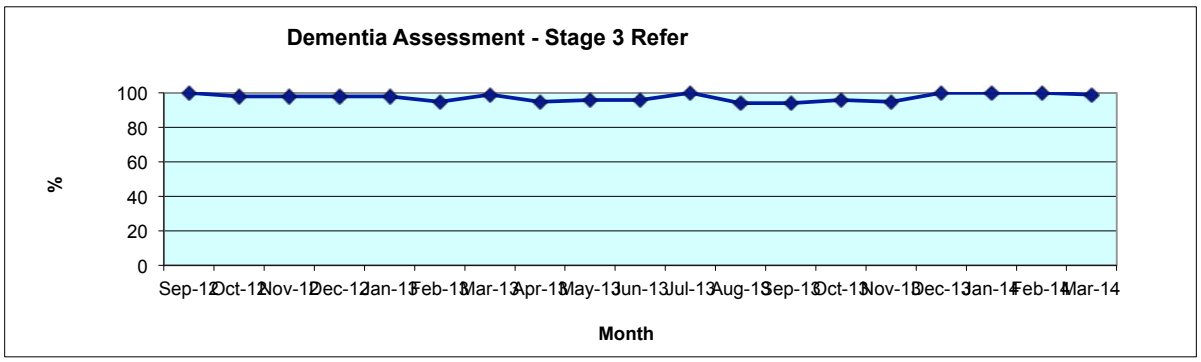
Quality Account: **How we performed against the five priorities we set for 2013/14**

Priority four: Improving the care of patients with dementia

The incidence of dementia is rising and the Trust has been working to make sure the complex needs of these patients are met when they are in our care delivering the most positive experience possible. The Trust has been working to ensure patients with dementia can be diagnosed sooner so patients and carers get the support they need as soon as possible.







The above charts show compliance with the three stages of the process for assessment and referral for possible dementia.

Stage 1 Find – refers to a key question being asked.

'Have you been more forgetful in the last 12 months and that has significantly affected your daily life?'

Stage 2 assess – assessment using the 10 question abbreviated mental test score.

Stage 3, refer – referral to GP for further investigation is completed when patients score 8 and below on Stage 2.

As you can see the Trust has remained compliant with all 3 stages meeting the target of 90% for 2013/14 (all acute admissions over 65 years of age).

The Trust will continue to achieve compliance with the above process, ensuring all new doctors and nurses are aware and able to carry out the assessment.

Upgraded ward environments continue to be made dementia friendly where appropriate. This is to help improve the safety and experience for patients with dementia and their carers.

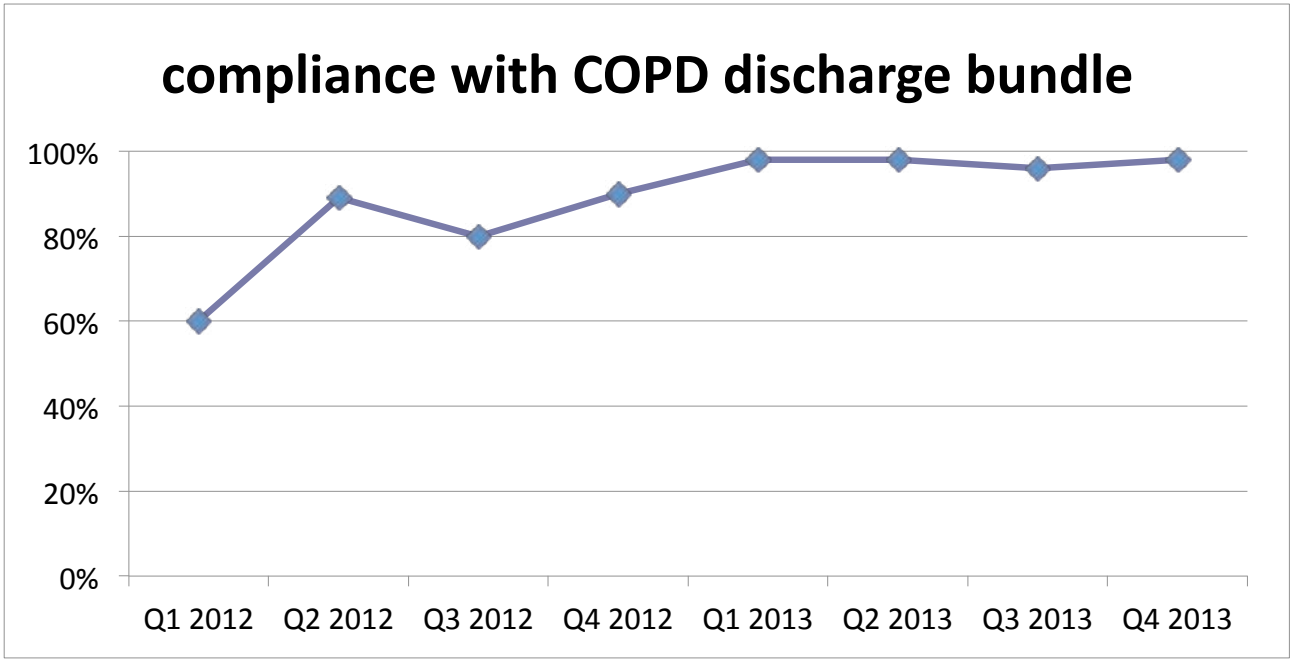
Throughout this year there has been a training programme running on the care of vulnerable adults for senior nursing staff. Staff attending this training have a responsibility to disseminate learning to the rest of their teams. All adult hospital wards have been represented on this course. Plans are in place to extend and maintain this level of training.

The Trust continues to use the 'Butterfly Scheme', an opt-in scheme for patients and carers identifying the patients with either delirium or confirmed dementia so all staff are aware of the extra help and care that may be needed. In addition carers are regularly asked for feedback and suggested improvements to dementia care.

Quality Account: **How we performed against the five priorities we set for 2013/14**

Priority five: Helping people to manage their long-term conditions

Last year it was decided to focus on Chronic Obstructive Pulmonary Disease (COPD) in the quality account due to the numbers of patients affected and the improvement work ongoing, particularly the implementation of two care bundles. One is delivered on admission to ensure the correct treatments are given quickly and in full to aid quick recovery. The second is designed to ensure these patients have a safe discharge from hospital to minimise the risk of readmission, ensure appropriate follow up and a good experience of care.



The above chart shows compliance with the second care bundle for COPD. The target of 95% has been met and maintained throughout the last year. Continued delivery has been met through increased presence on the wards from the respiratory teams and work to ensure, wherever possible, patients are educated on the wards to better self-manage their condition. Where appropriate the community based respiratory team support patients to be discharged earlier. This helps to reduce the need for further admissions by adopting a supportive role in community and referring patients onto pulmonary rehabilitation where appropriate.

Although the Trust has made and sustained improvements there are further plans in place to continue with this important work.

- Increased presence of the respiratory teams on the wards to focus on admission avoidance.
- Working together with patients to better plan long term care and creating advance care plans stating preferred place of death.
- In Huddersfield working with those identified as end of life to attend the 'Breathe Better' course at the hospice.
- Across both sites improving the utilisation of the pulmonary rehabilitation groups to better support patients to self manage

Quality Account:
Looking ahead to 2014/15

A 'long list' of potential priorities for 2014/15 was developed from regulator reports, incidents and complaints, ongoing internal quality improvement priorities, national reports and areas of concern and evaluating the Trust's performance against its priorities for 2013/14.

This long list was discussed with the Trusts' Membership Council in a special meeting; it was circulated to key stakeholders for comment and also presented to the Trust membership at an event in February 2014. This was an opportunity to vote for the potential priorities felt to be most important. This opportunity to vote was also given via the Trusts' internet site and advertised in the local press and through Foundation News.

This work has helped identify the quality improvement priorities for 2014/15 because they are important to the Trust's stakeholders.

Because significant improvement has been seen in all the priorities from last year's quality account it was agreed that new projects should be selected this year that better reflected the current quality priorities for the Trust. All previous priorities will continue to be monitored as part of the Trust's ongoing improvement programme.

The Four Priorities for 2014/15 are:

Domain	Priority
Safety	To improve the quality of the care we provide as measured by the Hospital Standardised Mortality Rate (HSMR)
Effectiveness	To ensure Intravenous antibiotics are given correctly and on time
Effectiveness	Improving the care of patients with diabetes so they do not develop complications and have to spend longer in hospital
Experience	To help patients with long term pain develop the skills needed to manage their conditions through supported self-management courses

Quality Account: **Looking ahead to 2014/15**

Priority One - to improve the quality of the care we provide as measured by the HSMR

Why we chose this
HSMR is a high level outcome measure that can be used for tracking the quality of care provided. For this reason the Trust's Care of the Acutely Ill Patient (CAIP) Programme uses this measure to track progress.

HSMR - What is it?
Hospital Standardised Mortality Rate (HSMR) is a standardised measure of mortality. The rate is the number of actual deaths divided by the number of predicted deaths for the Trust's patients treated.

A rate of 100 means expected number of deaths matched actual number of deaths. Above 100 means we had more than expected, less than 100 means we had less than expected.

Improvement work
To deliver the desired reduction in HSMR and improve the quality of care provided, the Trust is working to deliver the CAIP programme.

Target
The target is to reduce the Trust's rolling HSMR by 10 points by October 2014 in the first instance.

This programme consists of seven domains:

Theme 1	Improve consistency (Implement Care Bundles and Pathways)
Theme 2	Improving quality with pace, through clinical leadership
Theme 3	Efficient and effective patient flow
Theme 4	Optimise senior medical involvement in patient care out of hours.
Theme 5	Calderdale and Huddersfield NHS Foundation Trust as a learning organisation
Theme 6	Staffing levels and skill mix to ensure safety and quality
Theme 7	Coding reflective of patient primary diagnosis and co morbidities.

Reporting
The CAIP programme reports into the Clinical Outcome Committee (chaired by the Medical Director), through this to the Quality Committee, Executive Board and finally Board of Directors.

Priority 2 - to ensure Intravenous (IV) antibiotics are given correctly and on time

Why we chose this
When infections are diagnosed it is essential antibiotics are given correctly and on time to aid recovery and ensure that the patient's condition does not deteriorate.

Work has been ongoing in the Trust for a number of years and changes have occurred but this priority was chosen as it is recognised that further improvements need to be made.

Improvement work
The focus of the improvement work this year is to ensure we have tested and designed a robust process for the prescribing and administration for antibiotics in readiness for introduction of the new e-prescribing system.

Ongoing audit work allows improvements to be targeted where they are most needed.

Antibiotic ward rounds continue on a twice weekly basis. This is a ward round involving a consultant microbiologist, specialist antibiotic pharmacist and infection control nurse. The focus of these is education, challenge, advice and monitoring of antibiotic use.

In addition work is ongoing with junior doctors around implementation of an antibiotics care bundle. The aim is to involve junior front line staff in implementing change to their areas.

Target
- The Trust aim is to reduce by 50% unintentional missed doses of IV antibiotics.
- To ensure that antibiotics are prescribed according to Trust Guidelines.

Reporting
This work is part of the Missed Doses workstream which is part of the Care of the Acutely Ill Patient programme. This reports to the Clinical Outcomes Committee and Quality Committee and then by exception to Executive Board and Board of Directors.

Priority 3 - improving the care of patients with diabetes so they do not develop complications and have to spend longer in hospital

Why we chose this
At any one time 20% of all adult patients in hospital have diabetes. Patients with diabetes stay on average two days longer than patients without diabetes. The Trust wants 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.

Improvement work
Work has taken place on four collaborative wards to support patients to self care with their medications including Insulin.

From the robust testing that has already taken place the Trust plans to spread the process to at least two further wards.

This improvement work means that if patients are able they are encouraged to administer their own Insulin, test their own blood sugars, adjust the dose and have access to snacks should they need them to manage their blood sugars.

To support this work there will be ongoing training of frontline nurses in the self administering of medication.

Target
The overall outcome and aim of the work is to reduce harm and length of stay for diabetic patients.

As a way of measuring success the Trust will be tracking length of stay and measuring the number of patients self administering their Insulin.

Reporting
Reporting is via the Diabetes workstream which reports into the 'Care of the Acutely Ill Patient' programme, monitored by Clinical Outcome Committee and reported to the Executive Board and Board of Directors.

Priority 4 - to help patients with long term pain develop the skills needed to manage their conditions through supported self-management courses

Why we chose this
This course is one part of an overall programme that aims to further embed self- management into the care given to patients.

To support self- management you need:

- Service redesign to build in opportunities for staff to support patients to self manage.
- Trained staff so that they can develop effective communication skills and tools to support their patients.
- Opportunities for patients to gain some control back over their health. Self management training courses are one way of doing this.

By developing self-management skills, patients become more confident to manage their condition better and to work in a more collaborative way with health professionals. The outcome is more activated patients who want to maintain more control of the management of their lives and their health.

Improvement work
- To continue to deliver supported self-management courses and improve the quality of these courses.
- To improve the quality and usefulness of materials provided to patients.
- To continue to utilise the experience of the advocates for self-management (patients who have attended the course before).

Target
Throughout this year the Trust will increase the number of patients attending self-management courses.

The Trust will also increase the mean improvement score in the motivation of attendees to 'take control' of their conditions.

Reporting
The supported self-management team reports monthly to the supported self-management operations group and bi-monthly to the clinical leads group.

In addition regular reports on progress are submitted to the Health Foundation who currently fund the work.

Did you know...?
Colleagues from more than 200 different professions work at CHFT.
One team – many players.

Quality Account:
Statements of assurance from the board

Review of services

During 2013/14 the Calderdale and Huddersfield NHS Foundation Trust provided and/or sub-contracted 41 relevant health services.

The Calderdale and Huddersfield NHS Foundation Trust has reviewed all the data available to it on the quality of care in 34 of these relevant health services.

The income generated by the relevant health services reviewed in 2013/14 represents 62.55% of the total income generated from the provision of relevant health services by the Calderdale and Huddersfield NHS Foundation Trust for 2013/14.

Participation in Clinical Audits

During 2013/14, thirty two of the national clinical audits and four national confidential enquiries covered relevant NHS services provided by Calderdale and Huddersfield NHS Foundation Trust.

During that period Calderdale and Huddersfield NHS Foundation Trust participated in 100% of national clinical audits and 100% national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries that Calderdale and Huddersfield NHS Foundation Trust was eligible to participate in during 2013/14 are contained in **Appendix A**.

Participation in clinical research

The Calderdale and Huddersfield NHS Foundation Trust is committed to research as a driver for improving the quality of care and patient experience.

The number of patients receiving relevant health services provided or sub-contracted by Calderdale and Huddersfield NHS Foundation Trust in 2013/14 that were recruited during that period to participate in research approved by a research ethics committee was 967.

Participation in clinical research demonstrates Calderdale and Huddersfield NHS Foundation Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatments and active participation in research leads to successful patient outcomes.

Calderdale and Huddersfield NHS Foundation Trust was involved in conducting 154 clinical research studies of which 67 were actively recruiting, 72 were closed to recruitment (but participants were still involved) and 15 studies were 'in set up' (either waiting for initiation or local approval).

During 2013/14 actively recruiting research studies were being conducted across all five divisions in eighteen specialties:

Corporate	3 studies
Women, Children and Family Services	15 studies, 4 specialties
Diagnostic and Therapeutic Services	5 infection studies
Medical Services	66 studies, 8 specialties
Surgical and Anaesthetic Services	7 studies, 5 specialties

An improvement in patient health outcomes in Calderdale and Huddersfield NHS Foundation Trust demonstrates that a commitment to clinical research leads to better treatments for patients.

There were 64 clinical staff participating in research approved by a research ethics committee at Calderdale and Huddersfield NHS Foundation Trust during 2013/14, of which 44 were local principal investigators and one was chief investigator on an international multicentre clinical trial. There were two clinicians commencing, and a further five continuing their studies at doctoral level.

Also, in the last three years, six publications have resulted from our involvement in National Institute for Health Research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

Goals agreed with commissioners

A proportion of Calderdale and Huddersfield NHS Foundation Trust's income in 2013/14 was conditional upon achieving quality improvement and innovation goals agreed between Calderdale and Huddersfield NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with, for the provision of relevant health services, through the Commissioning for Quality and Innovation (CQUIN) payment framework. The figure for CQUINs allocated for 2013/14 was £7.125m and for 2014/15 is £6.8 million. The Trust successfully achieved all requirements for the 2013/14 CQUIN programme.

The CQUIN identified for 2013/14 covered a broad range of areas and reflected those priorities specified at a national level and supported by local priorities identified in partnership between commissioners and the Trust.

Four National CQUIN areas were identified for 2013/14:
– Venous Thromboembolism (VTE) screening;
– Dementia screening and referral;
– Friends and Family Test;
– NHS Safety Thermometer Harm Measurement Indicator.

These national areas were complemented by further locally agreed CQUIN indicators in the following areas:
– Chronic Obstructive Pulmonary Disease (COPD) care bundle;
– Maternity services and Paediatric patient experience;
– Diabetes: supporting the treatment of patients presenting acutely with hypoglycaemia and the promotion of self-care;
– Transfer of care

In planning for 2014/15 the Trust has continued to work closely with local commissioners to develop a programme of CQUIN quality indicators which are consistent with the key challenges faced locally. The development of these areas of focus has had strong clinical involvement in identifying areas for possible inclusion.

A number of 2013/14 CQUIN indicators have been retained and will enter a further year of targeted improvement work during 2014/15:
– Dementia (National);
– NHS Safety Thermometer (National)
– Friends and Family Test (National)
– Improving the management of patients presenting in A&E with Asthma
– Diabetes: supporting the treatment of patients presenting acutely with hypoglycaemia and the promotion of self-care;
– Improving medicine safety (previously transfer of care)

The other locally agreed CQUIN areas for 2014/15 are:
– Improving the management of patients attending A&E with pneumonia
– Improving care for those approaching End of Life
– Improving hospital food

Further details of the nationally agreed goals for 2013-14 and for the following 12 month period are available electronically at: http://www.england.nhs.uk/nhs-standard-contract/

Dermatology: "Having visited dermatology and having had a skin growth removed this morning in the same clinic I would like to say how impressed I am by the service provided. The speed of referral to both clinics was excellent, there were no waiting times and the staff were all first class in their care and treatment. Thank you"

Quality Account:
Statements of assurance from the board

Care Quality Commission registration

Calderdale and Huddersfield NHS Foundation Trust is required to register with the Care Quality Commission and has full registration without conditions. The Care Quality Commission has not taken enforcement action against Calderdale and Huddersfield NHS Foundation Trust during 2013/14.

Calderdale and Huddersfield NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

In August 2013 the Trust was required to take action to improve compliance with Outcome 10, Safety & Suitability of Premises. An action plan was developed and implemented and was subject to close oversight by the Board of Directors. The Trust had further unannounced inspections by the CQC in February 2014, and was assessed as being compliant with Outcome 10.

• CQC Intelligent Monitoring Report

The CQC plans to publish a quarterly intelligent monitoring report for each NHS Trust from this year forward. To date two reports have been published for the Trust.

Each report contains a priority band for inspection for the Trust, 1 being the highest priority for inspection (i.e. where the data indicates greatest concern for care quality) and 6 being the lowest priority.

The indicators cover:

- Incidents
- Infections
- Mortality
- Maternity and women's health
- Readmissions
- Patient Reported Outcome Measures (PROM's)
- Audit
- Compassionate care
- Meeting physical needs
- Overall experience
- Treatment with dignity and respect
- Trusting relationships
- Maternity survey
- Access to treatment measures
- Discharge and integration
- Reporting culture
- Partners
- Staff survey
- Staffing levels
- Qualitative intelligence

In the October 2013 report the Trust was banded as a 3. Elevated risks were reported for in-hospital mortality (vascular conditions), data from the national hip fracture database, delays in transfer from hospital, whistle blowing alerts and a risk reported in the rating of the electronic staff records in relation to staff registration.

In the March 2014 report the Trust was banded as a 4 (an improvement from October 2013). There were two elevated risks reported, data from the national hip fracture database and whistle blowing alerts. Risks were reported from the maternity survey, delays in transfer and staff support and supervision.

Information has been included in this report around ongoing work to improve the treatment of patients with a hip fracture, delays in transfers and actions from the maternity survey. An investigation was conducted into the standard of care for patients recorded as dying

from a vascular condition and an action plan has now been completed.

Risks were also highlighted in professional registration and staff support and supervision. For professional registration a considerable amount of work has been put in place to rectify issues highlighted in the July 2013 report. New processes and protocols have been put into place around capturing information for all employees including bank (the Trusts flexible staff register) which was previously missing and steps put in place to monitor information capture.

For staff support and supervision, the Trust is currently recruiting to a number of band 5 vacancies, as a result the current ratios around charge nurses to staff nurses and the proportion of all ward staff who are registered nurses are showing as a risk. The Trust is working to actively recruit to all essential staff nurse vacancies to rectify this situation.

Data quality

Calderdale and Huddersfield NHS Foundation Trust's Information Governance and Records Strategy Committee has approved a Data Quality Improvement Plan for 2014/15 which includes the following actions:

- Implementation of automated real time check of patient demographic and GP data from the national spine for key inpatient and outpatient events;
- Continuation of development of data dictionary and system documentation to support key management data users;
- Review and update of data quality guidance notes for data collectors;
- Ensuring pre-planned cycle of data quality audits meeting Information Governance Toolkit standards;
- Provision of data quality advice and input to roll out of ward whiteboards to support timely and accurate collection of inpatient activity data;
- Provision of targeted data collection and training for key areas of concern;
- Support for process and system review to ensure RTT (referral to treatment time) data can be included in the Trust's central data submission
- Data Quality input to implementation of new Maternity, Theatre and Vital Signs monitoring systems;
- Development of Data Quality Knowledge Portal;

NHS Number and general medical practice code validity

Calderdale and Huddersfield NHS Foundation Trust submitted records during 2013/14 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- Which included the patient's valid NHS Number was:

  Admitted Patient Care = 99.8%
  Outpatient care = 99.9%
  Accident & Emergency Care = 98.8%

- Which included the patient's valid General Practitioner's Registration Code was:

  Admitted Patient Care = 100%
  Outpatient Care = 100%
  Accident & Emergency Care = 99.9%

These figures are based on April 2012 to January 2013, which are the most recent figures in the Data Quality Dashboard.

Quality Account:
Statements of assurance from the board

Information Governance

Calderdale and Huddersfield NHS Foundation Trust Information Governance Assessment Report overall score for 2013/14 was 80% and was graded as 'Satisfactory' with all scores at a level 2 or 3.

In the submission of the Information Governance Toolkit for March 2014 the Trust scored 80% and was marked as 'Satisfactory'. All scores were either at a level 2 or a level 3. A substantial programme of work is under way for 2014/15 to promote the use of technology within the Trust. This will lead to an improvement in information security and much more awareness of staff of the Information Governance Agenda. There will be leaflets, road show events and visits to wards and departments across the Trust to interact with staff and ensure that all Information Governance standards are being adhered to.

Clinical Coding Error Rate

The Trust was not subject to the Payment by Results clinical coding audit 2013/14 by the Audit Commission.

Quality Account: **Review of quality performance – how we compare with others**

In this section you will find more information about the quality of services that the Trust provides by looking at performance over the last year and how the Trust compares with other Trusts.

This year the Department of Health (DH) has published a core set of indicators to be included in the Quality Accounts of all NHS Foundation Trusts. These changes support the Mandate commitment that the NHS should measure and publish outcome data for all major services by 2015.

Summary table of performance against mandatory indicators

Indicators	Previous 2 Periods		Most Recent Period
12. Summary Hospital-Level Mortality Indicator (SHMI).	**April 2012 – March 2013**	**July 2012 – June 2013**	**Oct 2012 – Sept 2013**
(i) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the Trust for the reporting period: National Average: 100 Lowest: 63 Highest: 118.6	102.06	105.71	106.13
(ii) the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period. National Average: 21.3 Lowest: 0 Highest: 44.9	16.8%	17.8%	17.9%
18. PROMS; patient reported outcome measures.	**2010/11**	**2011/12**	**2012/13**
(i) groin hernia surgery*,	0.10	0.10	0.07
(ii) varicose vein surgery*,	0.09	0.09	0.10
(iii) hip replacement surgery,* and	0.42	0.45	0.43
(iv) knee replacement surgery*.	0.38	0.32	0.37
19. Patients readmitted to a hospital within 28 days of being discharged.	**2009/10**	**2010/11**	**2011/12**
(i) 0 to 15; and	11.7%	11.1%	10.4%
(ii) 16 or over.	11.3%	12.4%	12.0%
20. Responsiveness to the personal needs of patients.	**2010/11**	**2011/12**	**2012/13**
	65.9	66.8	76.7

• More date on these figures is contained on pages 52 and 53.

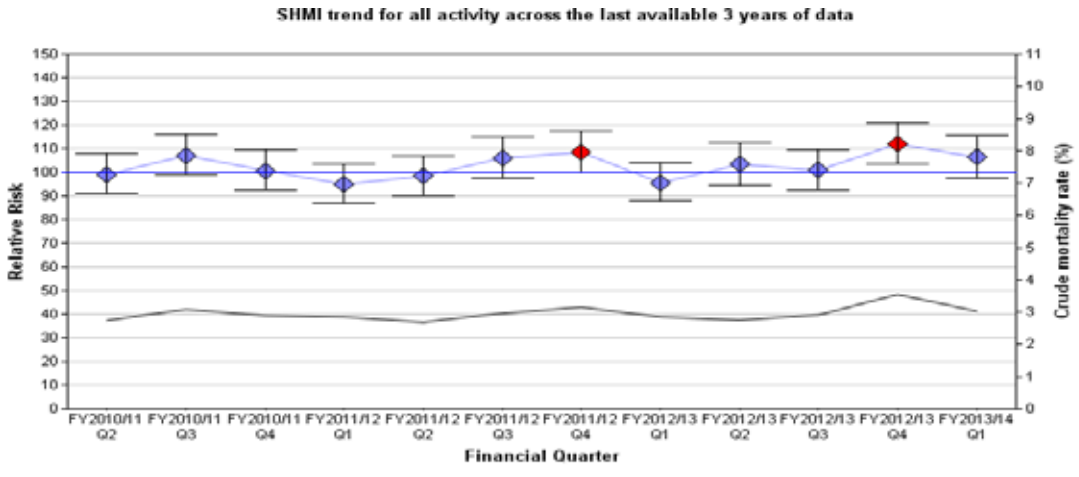
Quality Account: **Review of quality performance – how we compare with others**

Indicators	Previous 2 Periods		Most Recent Period
21. Staff who would recommend the Trust to their family or friends.	**2011**	**2012**	**2013**
	66%	69%	68%
New Indicator - Patients who would recommend the Trust to family or friends.	**Nov 2013**	**Dec 2013**	**Jan 2014**
	Response rates only	74	75
23. Patients admitted to hospital who were risk assessed for venous thromboembolism.	**FY2013/14 Q1**	**FY2013/14 Q2**	**FY2013/14 Q3**
	95.16%	95.27%	95.1%
24. Rate of C.difficile infection.	**2010/11**	**2011/12**	**2012/13**
	25.5	14.3	12
25. Patient safety incidents and the percentage that resulted in severe harm or death.	Oct 11 - Mar 12	Apr 12 - Sep 12	Oct 12 – March 13
(i) Rate of Patient Safety incidents per 100 Admissions	5.77	5.43	6
(ii) % of Above Patient Safety Incidents = Severe/Death	1.8%	2.5%	2.4%

12 Preventing People from dying prematurely
(i) Summary Hospital-Level Mortality Indicator (SHMI).

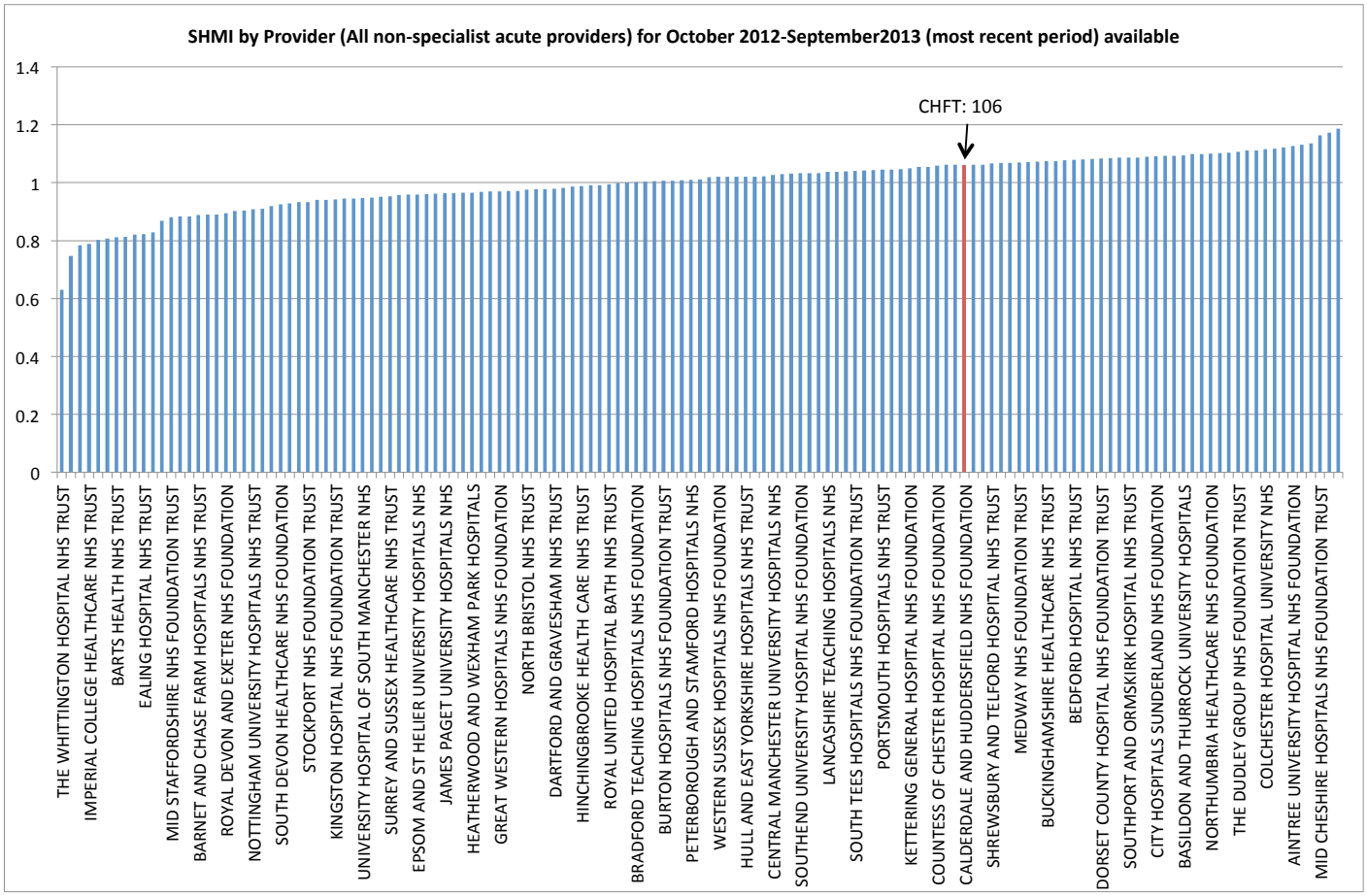
Summary hospital-level mortality indicator (SHMI) measures deaths that happen both in an NHS hospital and that occur within 30 days of discharge from a hospital stay. It is the ratio between the actual number of patients who die following a treatment at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

The chart below shows the value and banding of the SHMI for the Trust for the reporting period from July 2010 to July 2013.



100 is the expected score based on data submitted from all NHS trusts.

The red diamonds represent a statistically significant relative risk (i.e. the lower 95% confidence limit and the upper 95% confidence limit are both above 100). This tells us that for Calderdale and Huddersfield NHS Foundation Trust our relative risk was higher than expected for that quarter.



The Calderdale and Huddersfield NHS Foundation Trust considers that this data is as described for the following reason:

- The SHMI data shows the Trust's performance against the expected mortality rate of 100. Data available for the past three years is relatively stable against expected with two periods (red diamonds) of concern.

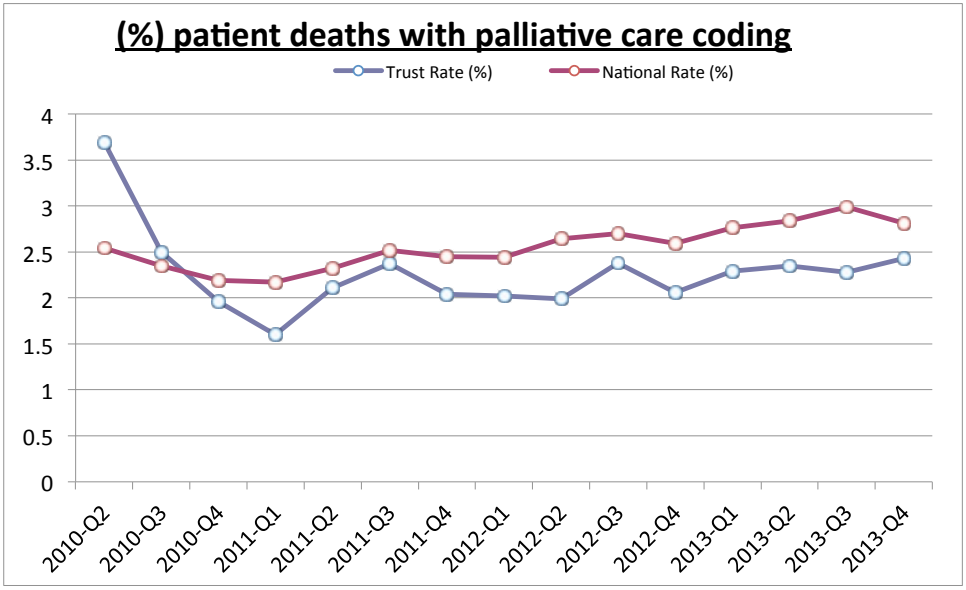
The Calderdale and Huddersfield NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by:

- Like HSMR, SHMI is a high level measure of the quality of care provided. As well as the Trust's overall strategies to improve care quality such as the 'Care of the acutely ill patient' programme, the Trust also investigates alerts from both HSMR and SHMI to understand the causes of these and where necessary deliver some targeted improvement work.

Quality Account: **Review of quality performance – how we compare with others**

12 (ii) Percentage of patient deaths with palliative care coded

The chart shows the percentage of Calderdale and Huddersfield NHS Foundation Trust hospital deaths that have a palliative care code against the national rate.



The Calderdale and Huddersfield NHS Foundation Trust considers that this data is as described for the following reason:

- The Trust's performance against the national rate since 2010 has been lower for this indicator. There are differences in the way palliative care advice is captured in different Trusts and work is ongoing to try to improve the capture rates at CHFT.

The Calderdale and Huddersfield NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by:

- Through regular audit, both by the Trust's clinical coding and palliative care teams, the Trust ensures the accuracy of both palliative care codes and the quality of end of life care. There is an end of life care collaborative that targets improvements where issues are identified.

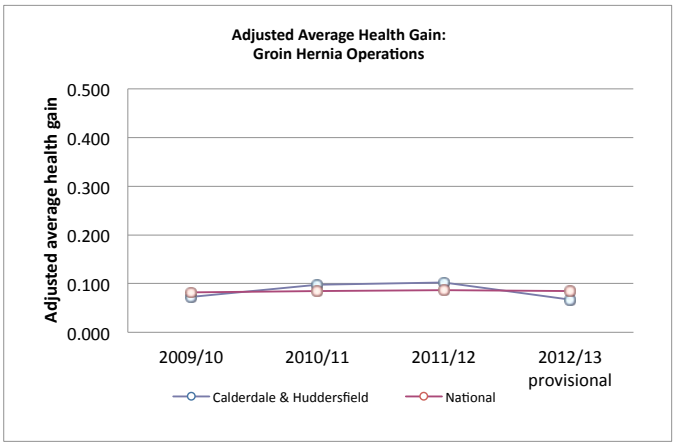
18. Helping people recover from episodes of ill health or following injury

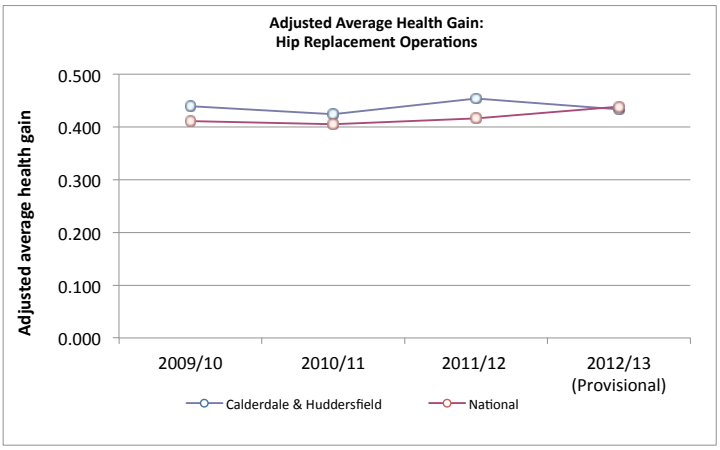
Patient reported Outcome Measures (PROMS) are a way of collecting information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves.

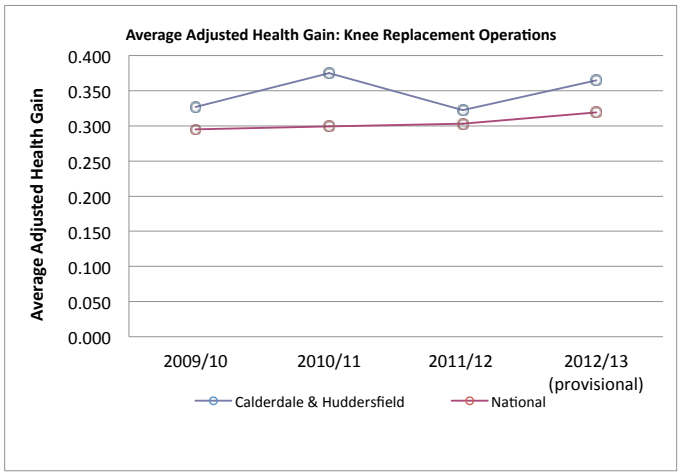
Data on PROMS has been collected since April 2009 (four years) on four different procedures:

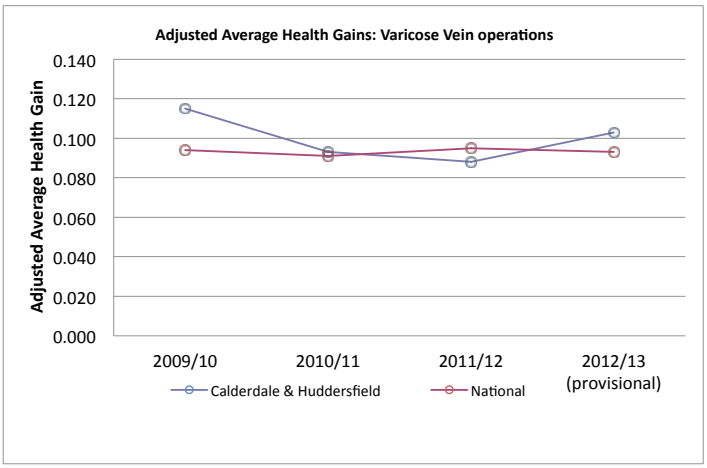
- Groin Hernia;
- Hip replacements;
- Knee replacements;
- Varicose Veins.

Questionnaires are completed by patients before and after the surgery to evaluate how effective the procedure has been. From the findings of these questionnaires, pre and post operative scores and health gains are calculated. (Example of pre questions – answering questions on five different areas of the individuals own health state, Mobility, Self Care, Usual Activities, Pain/Discomfort and Anxiety/Depression).









Please note: there is no data available showing the Trust compared to best and worst performers

The Calderdale and Huddersfield NHS Foundation Trust considers that this data is as described for the following reasons:

- Participation:

  Overall the participation rate for completing the questionnaire before the operation is lower for 2012/13 compared with 2011/12 across all four procedures' data. Calderdale and Huddersfield NHS Foundation Trust is at 77.1%. This does however compare favourably to the national average for participation across all four procedures at 74.9%

  Participation rate after the operation is 70.1% for England with Calderdale and Huddersfield NHS Foundation Trust at 68.4%; however, this has still time to improve when all the remaining questionnaires from patients are completed.

Did you know...?

We are delivering more care than ever before at weekends and in the evenings to fit our care with our patients' lives. We see 5,434 patient on Saturdays and 3,472 patients on a Sunday.

Quality Account: **Review of quality performance – how we compare with others**

- Health Gain compared to national data:

  Groin Hernia – Calderdale and Huddersfield NHS Foundation Trust, 47.2% improved, England 50.2%.

  Hip Replacement – Calderdale and Huddersfield NHS Foundation Trust, 88.3% improved, England 89.7%.

  Knee Replacement – Calderdale and Huddersfield NHS Foundation Trust, 87.0% improved, England 81.7%. The Trust is a positive outlier for knee replacement health gains when compared to national data.

  Varicose Veins – Calderdale and Huddersfield NHS Foundation Trust, 50.8% improved, England 52.7%.

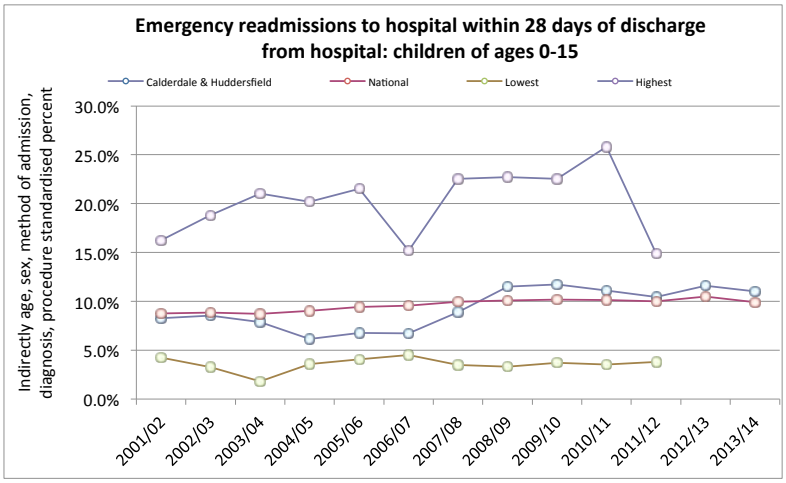
  The reported health gains for Groin Hernia and Varicose Veins are lower than for Hip and Knee replacements; this could be due to patients not actually experiencing problems such as pain or reduced mobility prior to the procedure.

The Calderdale and Huddersfield NHS Foundation Trust has taken the following actions to improve this score and so the quality of its services, by:

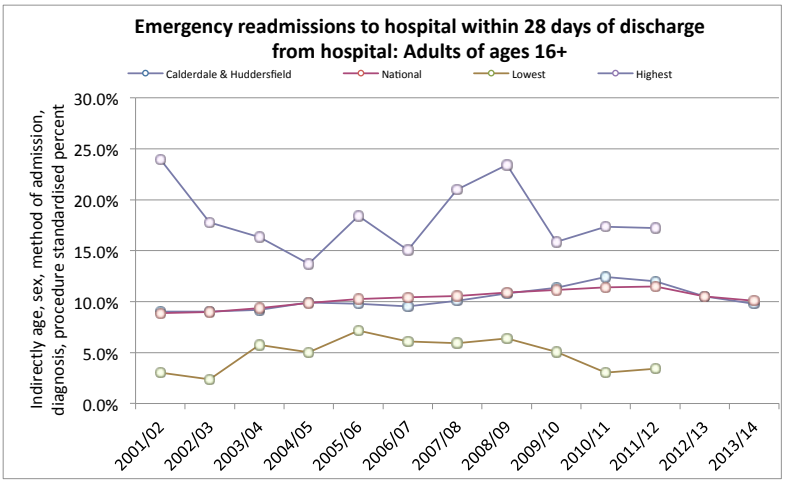
- Ensuring the data is accessible at consultant level so it can be used for clinical revalidation and to help drive improvements in practice.

19. Readmissions

The charts show the percentage of patients aged:
1. 0 to 15; and
2. 16 and over;
readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.



	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14
CHFT	7.9%	6.1%	6.8%	6.7%	8.9%	11.5%	11.7%	11.1%	10.4%	11.6%	11.0%
National	8.7%	9.0%	9.4%	9.5%	9.9%	10.1%	10.2%	10.2%	10.0%	10.5%	9.9%



	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14
CHFT	9.2%	9.9%	9.8%	9.5%	10.1%	10.8%	11.3%	12.4%	12.0%	10.5%	9.8%
National	9.4%	9.9%	10.3%	10.4%	10.6%	10.9%	11.2%	11.4%	11.5%	10.5%	10.1%

Community (Physiotherapy): "Our community physiotherapist has been coming to our home for the last couple of months and her tips regarding getting into bed, using the bed board properly and showing me how to exercise to improve my mobility have been invaluable. She is a pleasant lady and I feel she represents your team wonderfully."

Quality Account: **Review of quality performance – how we compare with others**

The Calderdale and Huddersfield NHS Foundation Trust considers that this data is as described for the following reason:
- The above data shows that for both age groups the Trusts readmission rate is in line with the national average.
- The charts show comparator data against national and highest and lowest rates provided by the health and social care information centre. This data is not yet available for the last two years so data has been included from the Trusts own data sources.
- The data included in these charts differs from the Trust board performance report as the parameters used are slightly different. This variance makes the internal report more meaningful to the Trust.

The Calderdale and Huddersfield NHS Foundation Trust intends to take the following actions to improve this score and so the quality of its services, by:
- The introduction of the discharge coordinator role on medical wads during this year has already led to reductions in readmissions, this role continues to be improved upon and the staff to gain better skills.

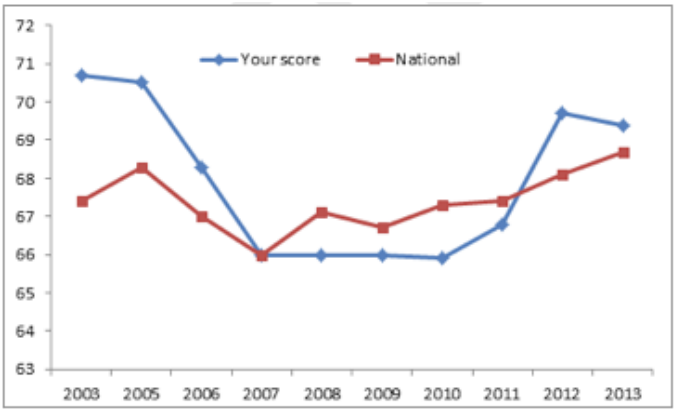
Better ward organisation has also had a positive impact and continues to be improved through ongoing training of ward teams in the use of Plan for Every Patient boards.

20. Responsiveness to the personal needs of patients.

This is the Trust's Commissioning for Quality and Innovation indicator (CQUIN) score with regard to its responsiveness to the personal needs of its patients during the reporting period.

The Calderdale and Huddersfield NHS Foundation Trust considers that this data is as described for the following reason:

Question		2012		2013	
		Your score	National	Your score	National
Q32	Were you involved as much as you wanted to be in decisions about your care and treatment?	73.5	72.7	73.4	73.2
Q34	Did you find someone on the hospital staff to talk about your worries and fears?	60.5	58.1	63.0	58.8
Q36	Were you given enough privacy when discussing your condition or treatment?	83.9	84.1	84.9	84.5
Q56	Did a member of staff tell you about medication side effects to watch for when you went home?	50.8	48.2	43.7	49.3
Q62	Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	79.9	77.6	82.0	77.7
	OVERALL	69.7	68.1	69.4	68.7



The Calderdale and Huddersfield NHS Foundation Trust intends to take the following actions to improve this score and so the quality of its services by:

- Continued monitoring of individual ward-based scores on a quarterly basis by ward sisters and matrons as part of the real time patient monitoring reports.
- Continued use of bedside handover to promote patients being involved in their care and treatment. This has been rolled out to all wards since the time of the 2013 survey (July discharges).
- Recently appointed Discharge Co-ordinators on all medical wards will work with the ward teams and patients and carers to pull together discharge plans and ensure these are delivered.
- Further work will be focused on identifying opportunities to inform patients of any side effects of their medication. The aim is to increase pharmacy presence on the wards to allow more opportunities for pharmacists to explain the role and possible side effects of medications to patients prior to discharge from hospital.

Patient Surveys

The above was a subsection of the Adult in Patient survey; the following is an overview of the results the Trust received from the whole survey.

In addition included is a section on results from another National patient survey for the Trust's Midwifery service.

- **National Survey of Adult In-patients 2013**

This report details the key messages from the 2013 survey of adult inpatient services. There was a national response rate of 49%. Locally the survey was sent out to 850 patients who had been discharged from an inpatient ward in July 2013. The Trusts response rate was 51% which is slightly higher than last year's of 50%.

The questionnaire asks people about their experiences from hospital admission to discharge.

Survey section scores	2012	2013	Change in score
The A&E Department	8.5	8.7	+ 0.2
Waiting list and Planned Admission	8.9	9.0	+ 0.1
Wait for bed	7.4	7.2	- 0.2
The Hospital And Ward	8.3	8.3	No change
Doctors	8.4	8.5	+ 0.1
Nurses	8.4	8.4	No change
Your Care and Treatment	7.6	7.8	+ 0.2
Operations & procedures	8.1	8.3	+ 0.2
Leaving Hospital	7.2	7.3	+ 0.1
Overall	**5.0**	**5.2**	**+ 0.2**

The CQC reported the Trust as scoring 'about the same' for all but one question.
The Trust scored 'better' than most other Trusts for the question about the length of a delayed discharge. This was asked of a sub group of patients who indicated their discharge had been delayed and assesses the length of a delay for reasons attributable to the hospital.

There were no questions where the Trust scored 'worse' than other Trusts.

Quality Account: **Review of quality performance – how we compare with others**

There was one question that was noted to have achieved a statistically significant improvement from the previous year; - Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?

It was disappointing to see that the question regarding medication side effects, (Did a member of staff tell you about medication side effects to watch out for when you went home?), has dropped to a score of 4.4 (previously 5.1). This doesn't correlate with the quarterly RTPM data, and as such will be investigated further.

Next Steps:
The Trust is looking at how the results of the National Survey and RTPM correlate with the data available from the Friends and Family Test.

The Trust will be looking at what makes a difference between the patients who say they would definitely recommend our service and those giving one of the alternative responses.

The results of this survey will be taken into account as part of the Trust's Patient Engagement and Experience Plan which is currently being developed, looking in more detail at the individual question scores to identify areas where specific interventions can be implemented.

- **Maternity Patient Surveys 2013**

During 2013-14 the Trust took part in the national maternity survey; the following is a summary of the results and actions arising:

Antenatal Care – The Trusts scored better than most other Trusts on one of the two sections included in this survey. This related to the start of your care in pregnancy. For the other section antenatal check ups the Trusts scored Amber – about the same as other trusts.

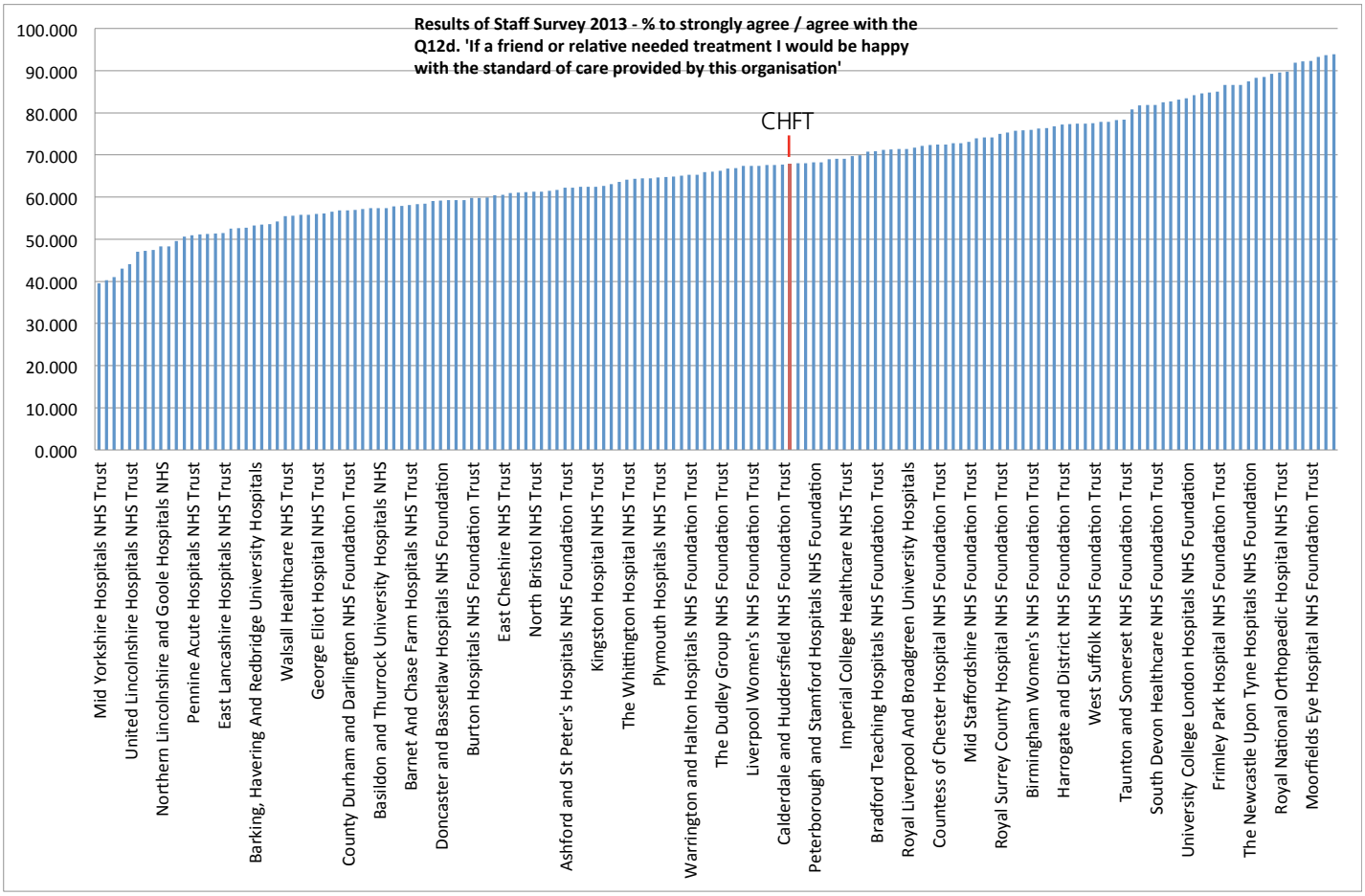
In Patient Care – There were three sections included in this survey, for two the Trusts scored better than most other Trusts, these were for Labour & birth and care in hospital after birth. Out of the twenty indicators included there was only one for which the Trust scored worse than other Trusts, this was 'did staff treating and examining you introduce themselves?'.

Postnatal Care – The Trust scored better for the two sections of this survey, feeding and care at home after the birth. Of the twenty indicators included the Trust scored Better for two, there were no worse scores.

Action following this survey has been included in the inpatient maternity feedback plan, this includes information from these surveys as well as information gleaned from Real Time Patient Monitoring conducted in house. For the indicator where the Trust scored worse than others the action includes: work with ward managers to ensure all staff introduce themselves properly (including medical staff), to be audited by 'secret shopping' phone calls, there will also be a display board that explains to patients and their families staff roles.

21. Staff who would recommend the Trust to their family or friends

The charts shows the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family and friends.



The Calderdale and Huddersfield NHS Foundation Trust considers that this data is as described for the following reason:

- The Trust's staff survey is based on a sample of 850 staff. The response rate was 59% - making a total of 493 staff who participated in the survey. The sample was drawn from a total of 5877 eligible staff employed at the time of the survey (September 2013).

- The staff survey score for KF24 - Staff recommendation of the Trust as a place to work or receive treatment is 3.75 out of 5. The score in the 2012 survey was 3.70 out of 5. This is a summary scale score calculated from the scores of the following questions:

  The extent to which staff think care of patients/service users is the Trust's top priority, would recommend their Trust to others as a place to work and would be happy with the standard of care provided by the Trust if a friend or relative needed treatment.

Quality Account: **Review of quality performance – how we compare with others**

The Trust's sample frequency scores indicate that:

1 72% agree that care of patients/service users is the Trust's top priority

2 62% would recommend the Trust to others as a place to work

3 68% would be happy with the standard of care provided by the Trust if a friend or relative needed treatment

From the survey as a whole the following table shows where the Trust performed better and worse than the national average.

Indicator	CHFT	National	Better/Worse
% of staff experiencing discrimination at work in the last 12 months	8%	11%	↑
% of staff able to contribute towards improvements at work	71%	68%	↑
Fairness and effectiveness if incidents reporting procedures	3.57	3.51	↑
% of staff receiving job-relevant training, learning or development ion the last 12 months	82%	81%	↑
% of staff experiencing harassment, bullying or abuse from staff in the last 12 months	22%	24%	↑
% staff having equality and diversity training in the last 12 months	47%	60%	↓
% staff suffering from work related stress in the last 12 months	39%	37%	↓
% staff suffering harassment, bullying or abuse from patients, relatives or the public in the last 12 months	31%	29%	↓
% staff agreeing that their role makes a difference to patients	90%	91%	↓
% staff feeling satisfied with the quality of work and patient care they are able to deliver	77%	79%	↓

The Calderdale and Huddersfield NHS Foundation Trust intends to take the following actions to improve this score and so the quality of its services, by:

- In 2013/2014 the Trust launched its colleague engagement strategy which has at its core four behaviours that the Trust expects to see across the organisation.

The behaviours are:-

- We put the patient first – we stand in the patient's shoes and design services which eliminate unproductive time for the patient.

- We 'go see' - we test and challenge assumptions and make decisions based on real time data.

- We work together to get results - we co-create change with colleagues creating solutions which work across the full patient journey

- We do the must-do's - we consistently comply with a few rules that allow us to thrive.

- The Trust is committed to introducing a consistent approach to how it manages change and in particular how it manages change that fully engages the potential and creativity of staff and allows colleagues to work across divisional and organisational boundaries. A programme of activity has been initiated in support. The Work Together, Get Results (WTGR) programme explores simple and practical tools that help leaders engage colleagues in a way that allows breakthroughs in their ability to lead transformational change in the organisation. Properly applied the tools secure the commitment of colleagues to the organisation's results and values and ensure colleagues are motivated and contribute to delivering the Trust vision.

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

- The Trust delivered real improvement in its our appraisal compliance during 2013/2014 achieving 92% for non-medical colleagues and 92% for medical colleagues. The result expected in 2014/2015 is 100%. Appraisals are seen by the Trust as a key contact with colleagues and an opportunity to engage them in what the organisation's goals are. Work now focuses on ensuring the appraisal interaction is of high quality and the Trust will test colleagues' experience of the appraisal tool and the conversations that take place in the appraisal setting to improve its approach.

- The Trust's health and wellbeing strategy is being refreshed and the Trust is exploring opportunities to work with a national charity, Public Concern at Work, to provide opportunities for colleagues to raise concerns about any matter that occurs in the workplace and for them to be appropriately managed and resolved.

- Additionally, a staff suggestion scheme is available to colleagues to submit ideas for improvement and as colleagues leave their employment with the Trust information about their experience is obtained through a leaver survey. A 'new starter' experience surveying tool is being developed to enhance the opportunities offered to colleagues to feedback concerns and recommendations that enable the Trust to improve what it does.

- Following the reporting of the 2013 national staff survey results for the Trust commitments have been made to focus attention on workplace bullying (service user to colleagues as well as colleague to colleague), stress at work and the availability of equality and diversity training. Further, preparations are being made to deliver the colleague Family and Friends Test from June this year.

Quality Account: **Review of quality performance – how we compare with others**

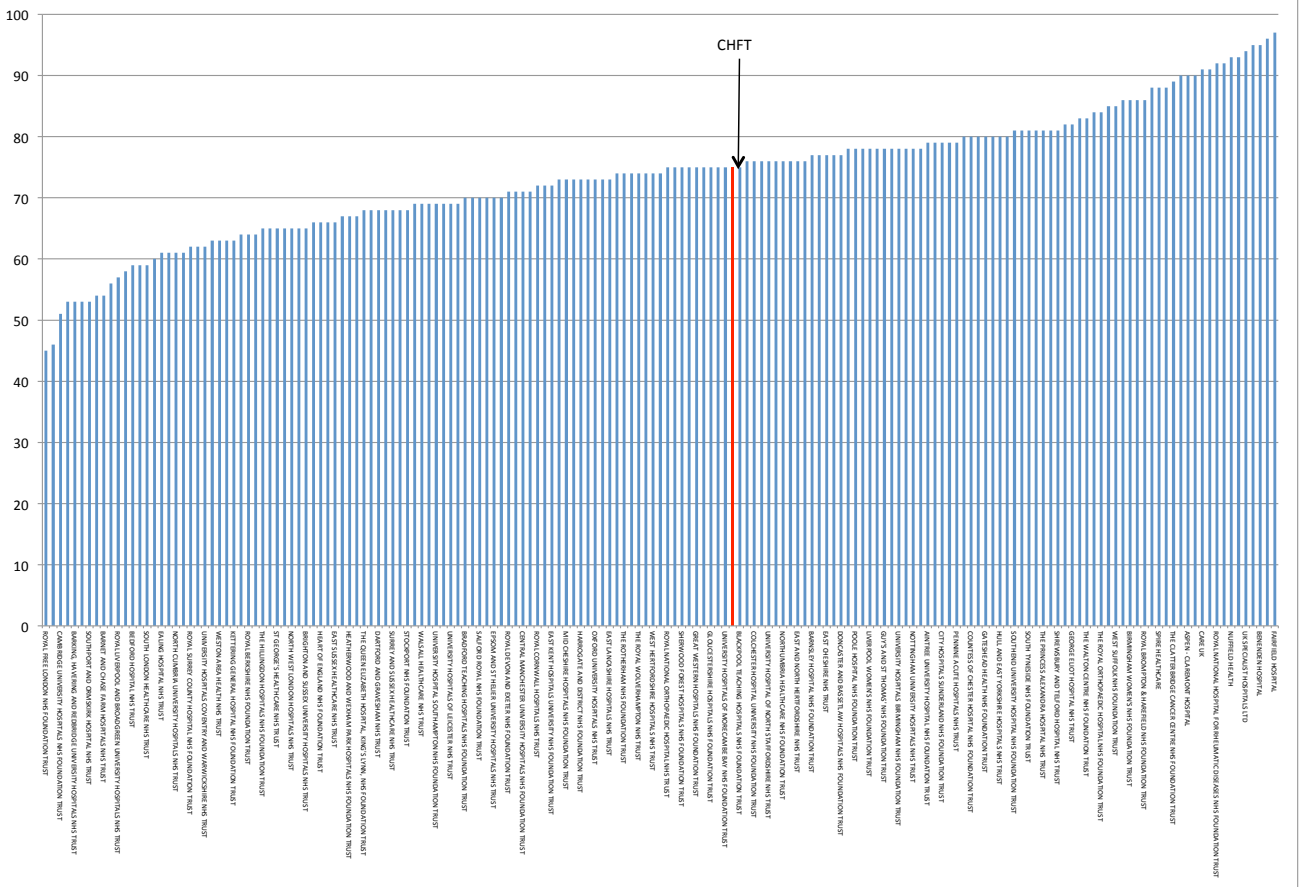
Extra Indicator 2014 - Patient element of friends and family test
From this year the Trust has elected to include an extra indicator.

The Friends and Family Test is a question that has been asked to all inpatients over 16 in NHS hospital trusts since April 2013. The question asks "How likely are you to recommend our ward to friends & family if they needed similar care or treatment?" From this a Net Promoter Score (NPS) is calculated on a scale of -100 to 100

The Calderdale and Huddersfield NHS Foundation Trust considers that this data is as described for the following reason:

- The chart shows the Net Promoter score achieved by each trust between April 2013 and February 2014 with the Trust highlighted in red.

Friends and Family Net Promoter Score

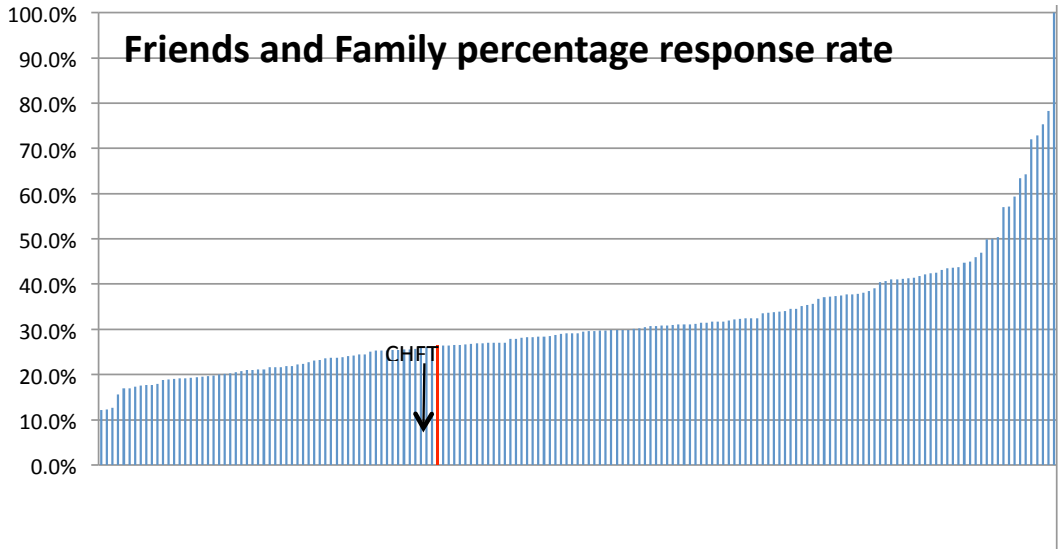


- In the Trust between April 2013 and February 2014, 27,517 patients were given the opportunity to answer the question. Of these 7,241 responded giving a response rate of 26.3% and a ranking of 111th out of 171 trusts (65th percentile).
- The Trust achieved an NPS of 75. This ranks at 75th out of 171 trusts (44th percentile).

Note: In order to protect patient confidentiality a breakdown of responses for four trusts were not provided for some months. These trusts have still been included in the above figures and chart but their scores have been calculated without the data for the redacted months.

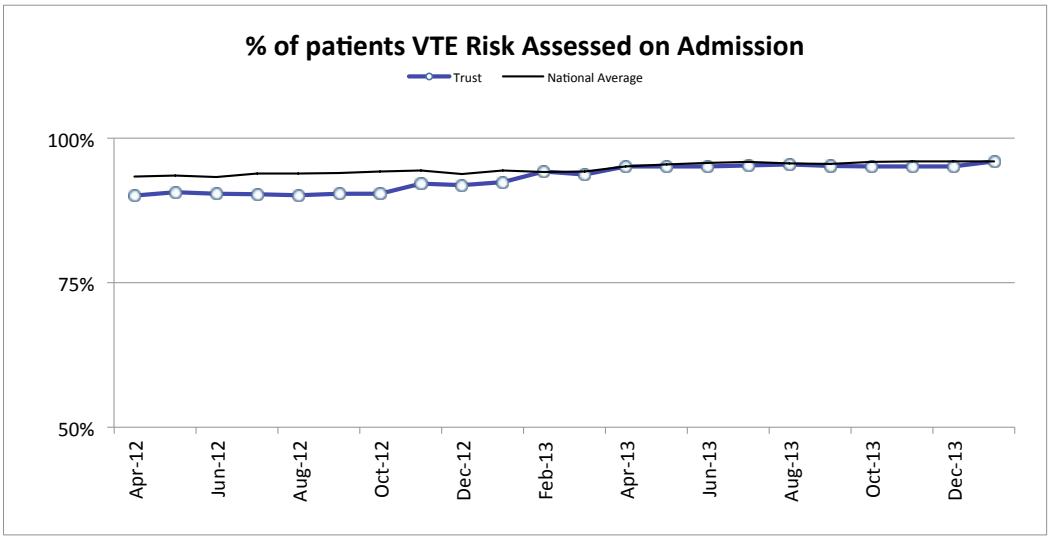
The Calderdale and Huddersfield NHS Foundation Trust has taken the following actions to improve this percentage and so the quality of its services:

- In order to promote improvement, scores are provided monthly at ward level. In addition, comments collected through the Friends and Family Test process are also made available to allow the Trust to gain a better understanding of patient perception and plan interventions when necessary around these comments.



23. Patients admitted to hospital who were risk assessed for venous thromboembolism.

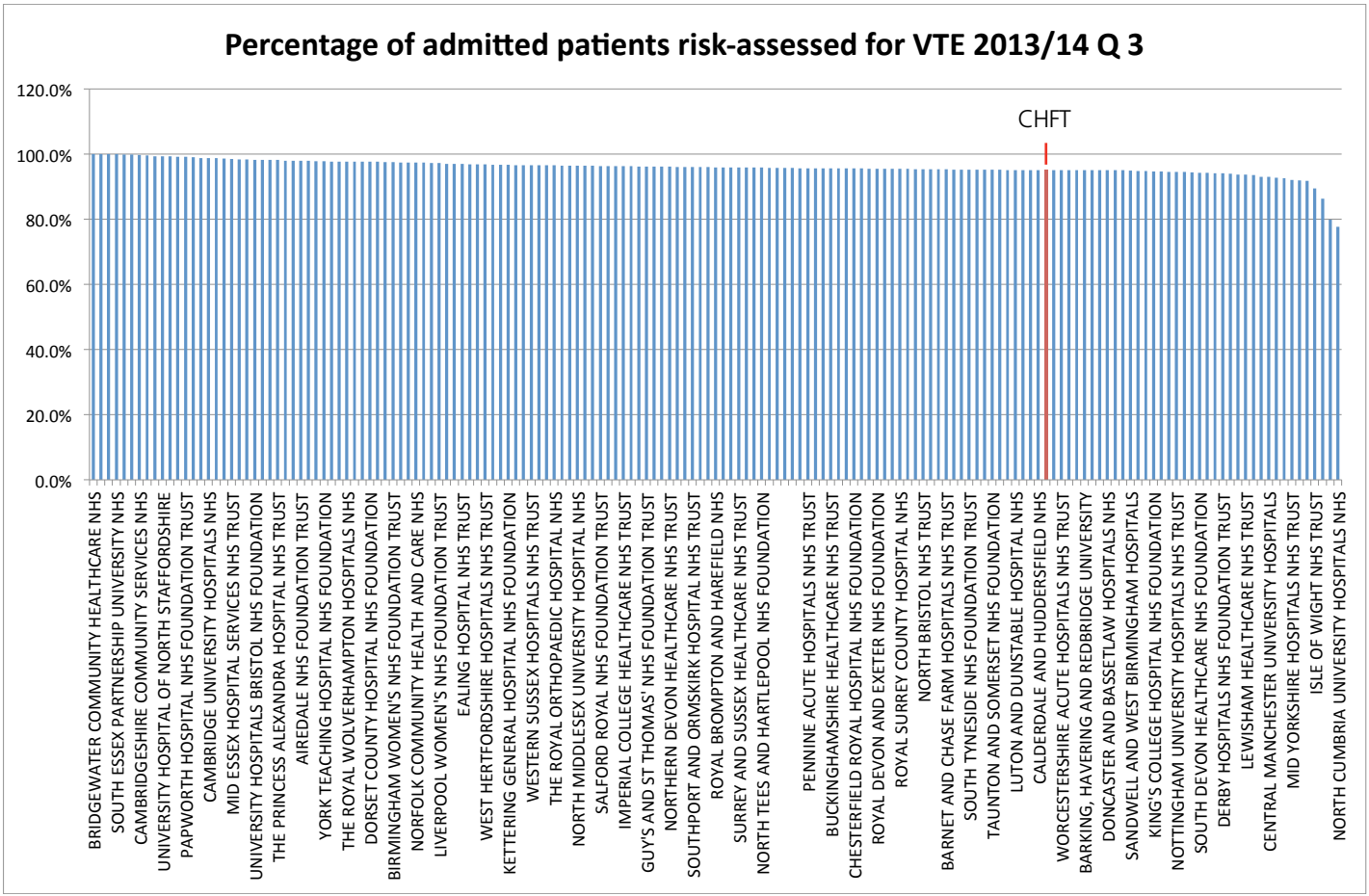
The charts show the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the report period from June 2011 to February 2014.



Did you know...?

Radio 2 is the most requested background in the MRI scanning suite.

Quality Account: **Review of quality performance – how we compare with others**



The Calderdale and Huddersfield NHS Foundation Trust considers that this data is as described for the following reason:

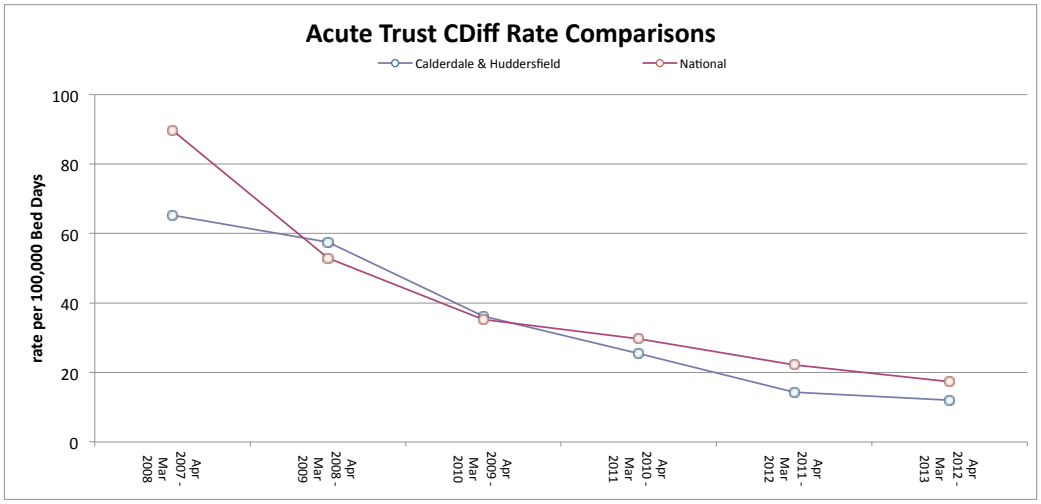
- The target from 1 January 2011 to 31 March 2013 was 90% and this was met for VTE risk assessment for all patients admitted. From December 2012 the number of inpatients risk assessed for VTE has continued to rise and been sustainable above 95% from April 2013. The benchmarking graph shows the Trust to be in the bottom 10% of Trusts however issues with data capture make it difficult to evidence performance above the 95% target.

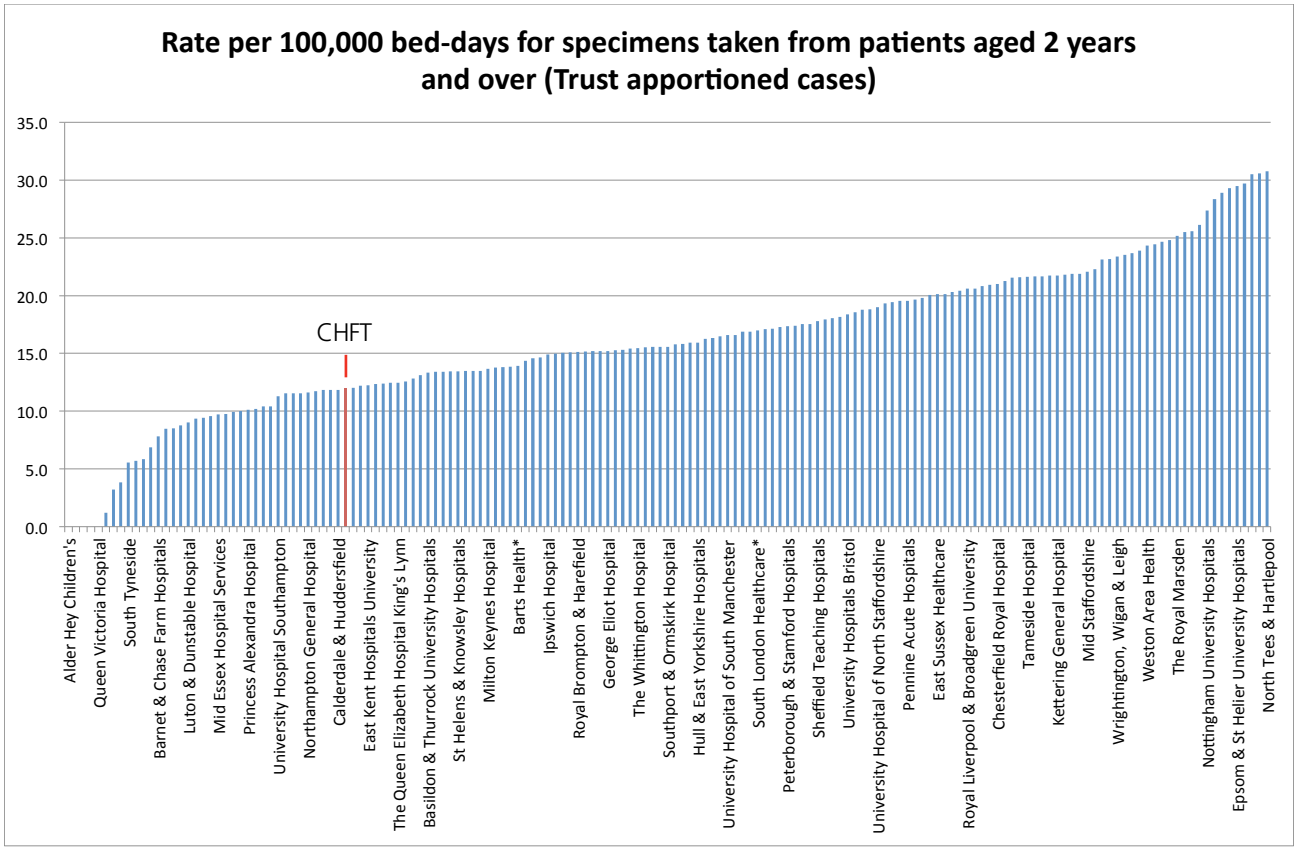
The Calderdale and Huddersfield NHS Foundation Trust has taken the following actions to improve this and so the quality of its services, by:

- Quality improvement nurses continued in their key role of educating doctors to complete the risk assessment and ensure appropriate prophylaxis is being prescribed. There is a reliable process in place to ensure when hospital associated VTE are identified the Trust is learning from any gaps in compliance and addressing these so it can increase the quality of care provided.

24. Rate of C.difficile infection

The charts shows the rate per 100,000 bed days of cases of C-difficile infection reported within the Trust amongst patients aged two or over during the reporting period from April 2007 to March 2013.





Labour Ward: "I had a difficult birth last week which was supported by a great midwife.She helped both me and my husband through a tough day which resulted in me having an emergency c-section. She then came into the theatre with us, calmed me down and made the process less scary All the midwifes and nurses I met were caring, helpful and supportive.""

Quality Account: **Review of quality performance – how we compare with others**

The Calderdale and Huddersfield NHS Foundation Trust considers that this data is as described for the following reason:

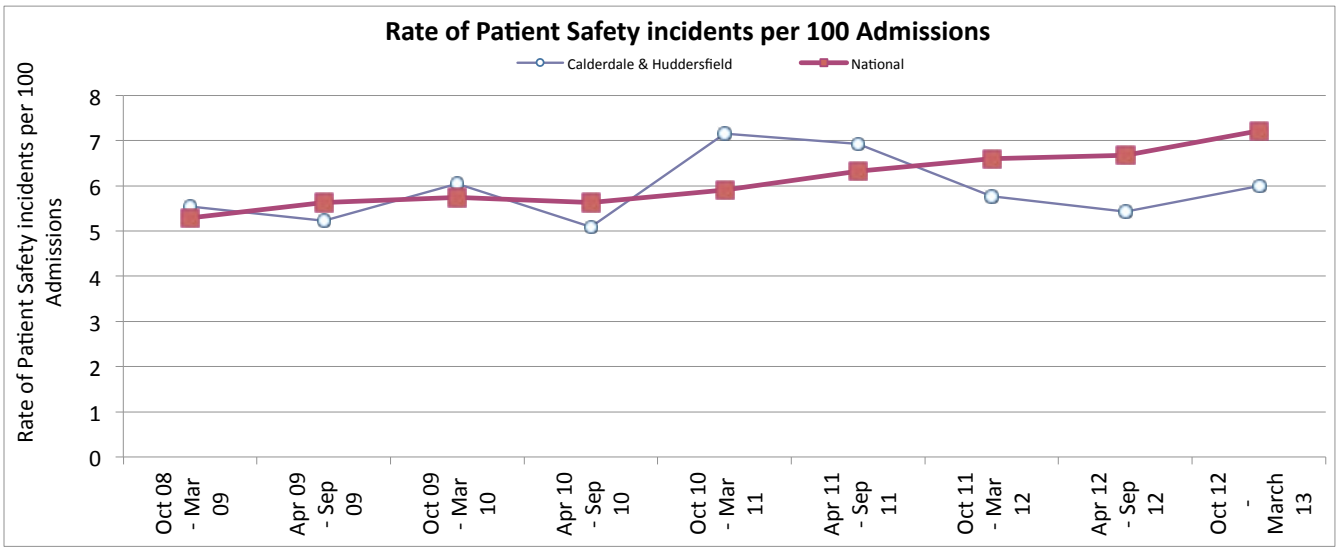
- The Trust continues to report all data externally via the Health Protection data capture system and internally to the Executive Board and Board of Directors monthly.
- Charts show continuous improvement over the past five years, Trust data has been maintained below national rates since 2010.
- The second chart shows that in 2012/13 the Trust performed very well when compared to other similar NHS organisations

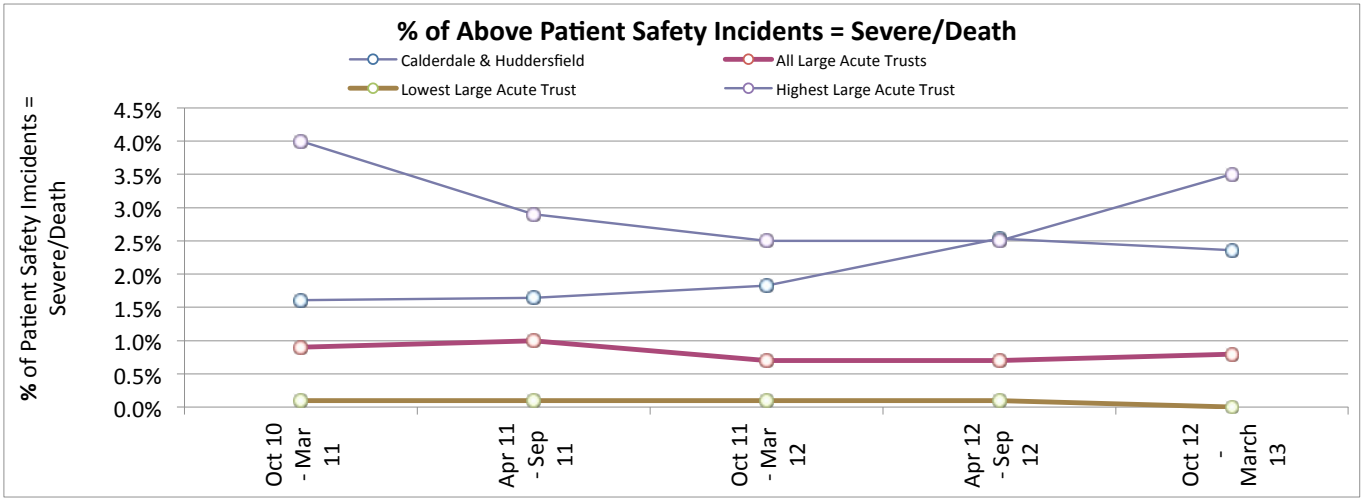
The Calderdale and Huddersfield NHS Foundation Trust intends to take the following actions to improve this rate and so the quality of its services, by:

- Continuing to implement a specific pathway for patients with C-difficile
- Daily review of all patients with C-difficile by a specialist Infection Prevention and Control Nurse using a checklist and escalating any issues immediately
- Routine use of Hydrogen Peroxide Vapour (HPV) decontamination of all rooms where patients with C-difficile have been treated after they are discharged
- Ongoing weekly infection control ward rounds with a microbiologist
- Ongoing weekly Antibiotic ward rounds
- Continued collaborative working with Matrons
- Additional cleaning
- Strict adherence to Personal Protective Equipment policies and protocols, additional signage and use of hand hygiene with soap and water
- Mandatory training for all clinical staff and new starters
- Root Cause Analyses of every single case of hospital acquired C.difficile to ensure that lessons are learned to prevent future infections

25. Patient safety incidents and the percentage that resulted in severe harm or death.

The charts show the rate of patient safety incidents reported within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.





The Calderdale and Huddersfield NHS Foundation Trust considers that this data is as described for the following reason:

- The Trust reports a higher rate of severe/death patient safety incidents than other large acute trusts. This is attributable to the type of incidents the Trust views as severe patient safety incidents compared with other large acute trusts, for example, all category 3 and 4 pressure ulcers are viewed by the Trust as severe harm and any patient who sustains a fractured neck of femur whilst in the care of the Trust is also reported as severe harm. This reflects the seriousness with which the Trust views these incidents and grading in this way ensures the correct level of investigation is carried out and appropriate actions taken to reduce their incidence in future. The Trust has aligned the severity rating of incidents with the severity rating from the transparency project framework which other trusts appear not to have done.

The Calderdale and Huddersfield NHS Foundation Trust has taken the following actions to improve this percentage and so the quality of its services:

- Through ongoing improving patient safety work. This includes falls and pressure ulcer collaboratives which aim to reduce the number of patient safety incidents in these areas. All severe patient safety incidents are formally investigated, learning is identified and actions implemented to help prevent reoccurrence of similar incidents.

There have been no Never Events in the Trust this year.

- **Type and Severity of Incidents**

6951 patient safety incidents were reported in 2013/14. Relating these to activity, 1% of patient episodes involved a reported incident. Of these 0.2% of patient episodes resulted in harm, mostly minor harm.

There has been a 20% reduction in the number of severe harm incidents reported with a total of 159 red severity incidents. All red severity incidents require a Root Cause Analysis ("RCA") to be completed. Over the year, 51% of red severity incidents related to category 3 and 4 Pressure Ulcers, compared to 53% last year.

Overall when analysing categories by level of harm, the top three issues for the year are pressure ulcers; medication and patient falls.

Quality Account: **Review of quality performance – how we compare with others**

Learning from Incidents

Pressure ulcers – The number of pressure ulcers reported during 2013/14 has reduced by 10%. Category 2 pressure ulcers are the highest category reported and 63% of these are reported in the patient's own home by district nursing teams.

As detailed previously, work has continued to further decrease the numbers of hospital associated pressure ulcers.

Medications – The number of medication incidents reported has increased this year by 30%. Over the year the need to recognise and report medication errors has been promoted and this will continue in line with the safety alert and quality measure effective for the year ahead.

Improvement work has been ongoing through the year and medication incident reports are presented to the medicines management committee on a regular basis highlighting and sharing the type of incidents that are occurring. Other improvement activities have included the following:

- A multi-disciplinary work stream is leading work on 'Missed Doses'.
- Allergies they have been coded differently (red near misses) and escalated for investigation and action within Divisions
- Newsletters brief staff on common themes and actions that they might take to minimise risk
- Health professionals use information on incidents to inform teaching sessions and timeouts for colleagues
- Developments and improvements on prescriptions are made which take into account incidents reported e.g. Warfarin prescription,
- Updates to clinical guidelines take into account incidents reported. E.g. anticoagulation guidelines.
- Updates to the Trust Medicine Code and incident reporting underway to improve reporting and learning.

Patient falls – falls account for the highest number of incidents reported in 2013/14, accounting for 1827 reported incidents. 67% of these incidents caused no harm, with a further 31% causing minor harm.

As previously detailed, work has continued to further decrease the numbers of patient falls.

Type and Severity of Complaints

The number of concerns and complaints received has decreased in 2013/14. The key subjects of complaint remain treatment, communication and access.

During 2013/14, 562 complaints were received representing a 12% decrease against the 638 received in 2012/13. This equates to the ratio of complaints to patient episodes has reduced from 0.09 % last year to 0.08% this year.

All complaints are assessed, upon receipt, in terms of severity. There has been a small increase in the total number of complaints given a Red severity.

Parliamentary Health Services Ombudsman (PHSO) Complaints

In the past 12 months, we are aware of 11 cases being raised with the Ombudsman, compared to 18 the previous year.

Of these 11: 2 required no further action; 4 were resolved following further action; 5 are currently under review

Information Commissioner

During the year, one complaint was referred to the Information Commissioner, who concluded that a breach of the Data Protection Act had occurred. No regulatory action was taken.

Outcomes of Complaints received

Of the complaints closed to date, 36% have been upheld; 34% partially upheld and 30% not upheld. Over the year 33% of complaint responses have been made within the agreed timescale.

Key themes and learning from Complaints

Communication is a large issue in complaints, and is raised as a specific issue of complaint in 50% of all complaints received. Themes raised in complaints regarding communication relate to patients feeling that they are not being treated as individuals; not being listened to and staff not being aware of their individual situations.

The following are examples where learning from complaints has helped lead to changes:

The role of Discharge Co-ordinator on wards is aimed to facilitate discharges and enhance all communication between patients, families and healthcare professionals.

The need for prompt communication with families regarding untoward incidents, including falls, was reinforced. As part of the learning shared with the staff, families are now made aware, within a two hour window, of a fall, and the doctor is contacted relaying the patient's present condition and the circumstances of the fall to determine the priority for review. To support this, the web based incident form is being changed to prompt contact.

Clear communication between nursing staff is provided verbally at handover and also in writing on the handover sheet and escalated to the shift co-ordinator. The team is being supported to provide bedside handovers. These are regular reviews undertaken at the bedside involving both the patient and carers in an update, discussion of progress and communication regarding care.°

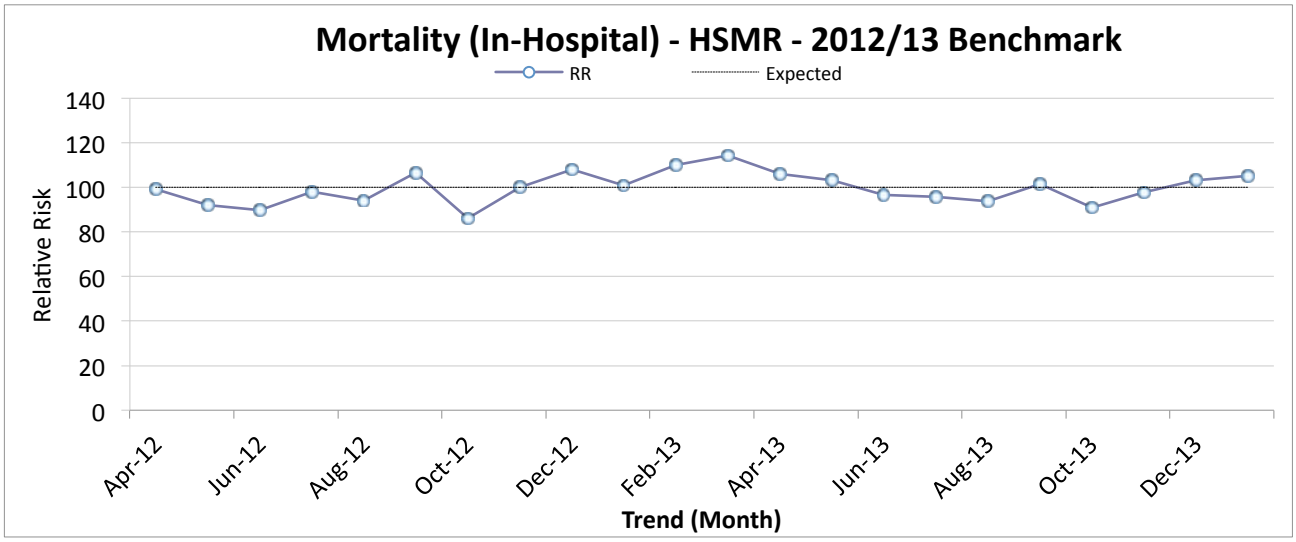
Quality Account: **Part 3**

This section provides an overview of care offered by Calderdale and Huddersfield NHS Foundation Trust based on its performance in 2013/14 against indicators selected by the board in consultation with stakeholders, with an explanation of the underlying reason for selection.

The indicators are as follows:

Patient Safety	Clinical Effectiveness	Patient Experience
Hospital Standardised Mortality Rates (HSMR)	*Cancer Waiting Times*	*Real Time Patient Monitoring*
Falls in Hospital	*Stroke*	*End of Life care*
Healthcare Associated Infections	*Length of Stay in Medicine*	*Patient Experience in accident & emergency*

Hospital Standardised Mortality Rate (HSMR)



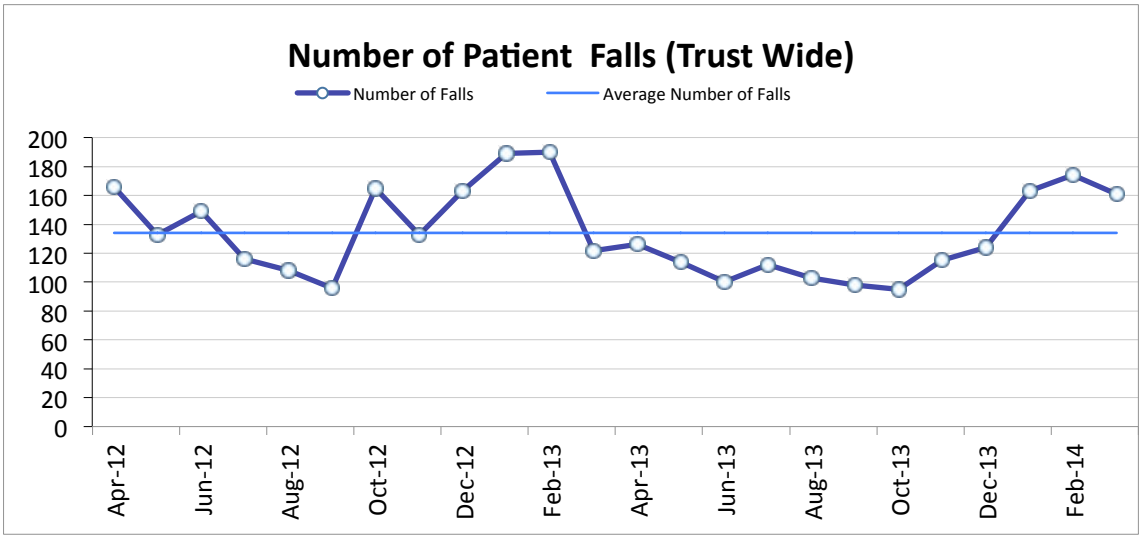
HSMR is a national measure that the trust uses to compare its death rate with that of other English trusts.

On the chart the dotted 100 line indicates the expected rate of overall deaths for the Trust (the relative risk), the Trust aims to maintain its score below this line as this tells us there is a lower than expected rate for our population.

The Trust also monitors HSMR at speciality and condition levels as this can be used as an indicator for the quality of care provided. If alerts are noted the Trust investigates thoroughly and instigates any necessary changes.

HSMR is also used as the Trust's key measure for progress of the 'Care of the acutely ill Patient' programme, selected as a quality priority for 2014/15.

Falls in Hospital
Hospital falls continue to be the highest reported safety incident in the Trust and therefore remain a priority for improvement.



The chart shows the number of falls the Trust's had whilst in hospital, on average this was 148 per month.

Through 2013/14 new falls prevention equipment was allocated to high risk wards including alarms and specialist beds. Another focus of the work has been changes to the way the Trust assesses falls risk and linked to this is the introduction of a falls prevention care bundle.

The work is now more focussed on person centred care as a way of reducing individual risk.

Key ward leaders of inpatient areas have been trained to disseminate to their teams re falls prevention and management; documentation to support these changes will be available from May 2014.

A post falls care bundle is currently being developed.

Healthcare associated infections (HCAIs)
Mandatory indicator 24 sets out the Trust's ongoing plans for further reduction of Clostridium difficile, priority 2 from 2013/14 sets out long term plans for further reduction of MRSA.

Quality Account: **Part 3**

Cancer Waiting Times

Over the last 10 years the NHS has made significant progress in delivering important aspects of cancer services with falling mortality rates and consistent achievement of the Cancer Waiting Times.

Early diagnosis is key to improving survival and it is estimated 10,000 deaths from cancer could be avoided each year if the one year survival rate in England was the same as the best performing countries. Although much has been done to improve awareness and early diagnosis with the introduction of the National Cancer Awareness Campaign, which the Trust has participated in over the last year for Bowel, Lung and Gynaecological Cancer, there is still much work to do. It is recognised that high quality cancer intelligence is critical to improving outcomes for cancer and the Trust is highly committed to supporting the introduction of the new Cancer Outcomes and Services Dataset (COSD).

Delivery of the National Cancer Targets is a key part of cancer care and the Trust's performance around these key targets is a significant indicator of the quality of cancer services delivery.

Chart 1

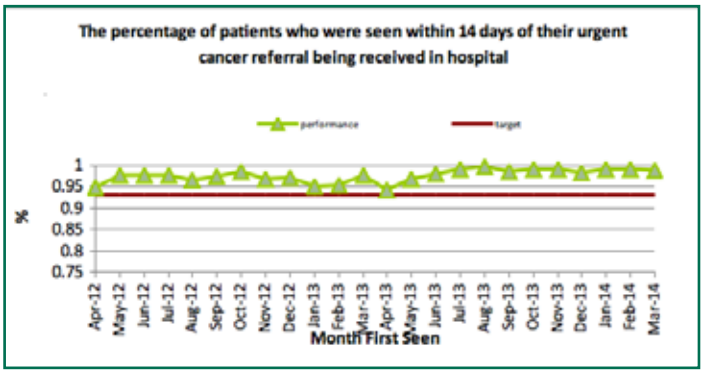


Chart 2

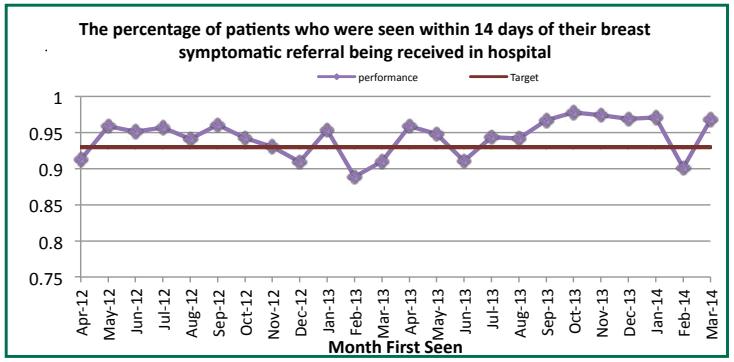


Chart 3

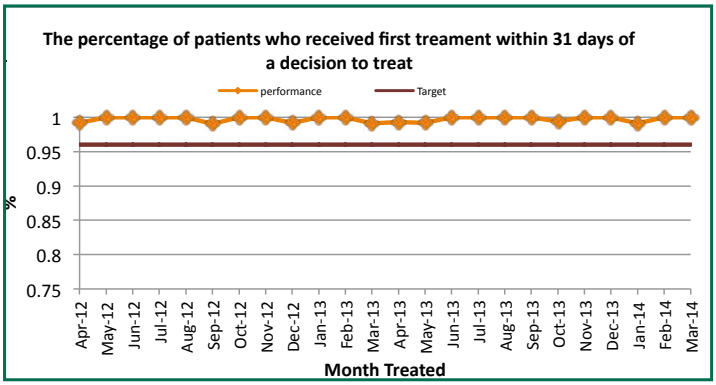


Chart 4

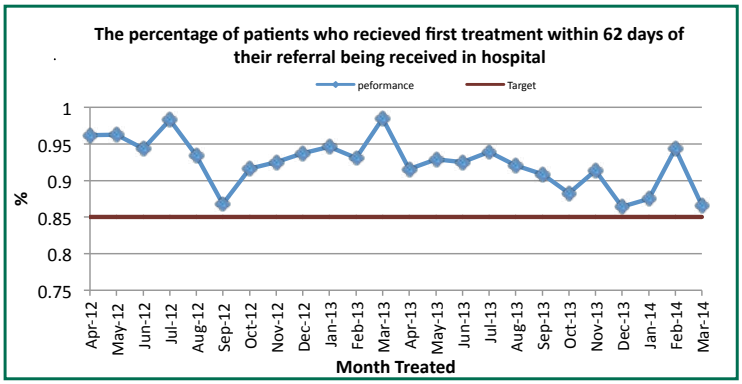


Chart 1 shows the Trusts reporting period April 2012 – January 2014 for patients seen within 14 days for urgent referral.
The performance required for this target is 93% and this has been exceeded for the whole of the year.

The Trust intends to take the following actions to improve this percentage further and so the quality of its service by continued monitoring of the target:

- Patient choice of appointment date and time is a key driver for performance. The Trust continues to work with primary care colleagues to ensure patients are fully aware and informed of the need to attend within 14 days.
- Choose and book will be commencing in late summer 2014 which will allow patients to choose their appointment whilst with their GP.

Chart 2 shows the percentage of patients who were seen within 14 days of their breast symptomatic referral being received in hospital
The chart shows the Trust's reporting period April 2012 – January 2014.

The performance required for this target is 93%. Performance has been variable largely due to patients exercising choice about time and date of appointment.

The Trust has an action plan in place to further improve performance which includes:

- Monitoring and intervention for appointments booked outside of 14 days
- In conjunction with primary care provide more robust information for patients on the need to attend an appointment within 14 days.
- Sharing of data and information on cancellations with GP colleagues.
- Maximise Choose and Book software to support performance, starting summer 2014

Chart 3 shows the percentage of patients who received first treatment within 31 days of a decision to treat
The chart shows the Trust's reporting period April 2012 – January 2014.

The performance required for this target is 96%. Performance has largely been maintained at 100% with slight variations on four occasions; however this has not fallen below 99%.

The Trust intends to continue close monitoring of this target to maintain and improve performance.

Chart 4 shows the percentage of patients who received first treatment within 62 days of their referral being received in hospital
The chart shows the Trust's reporting period April 2012 – January 2014.

The performance required for this target is 85%. Performance has been above the required 85% for all of the year.

The Trust intends to take the following actions to improve performance and so the quality of its service by continuing to undertake pathway work in a number of areas to improve the timeliness of the patient's pathway. This will include:

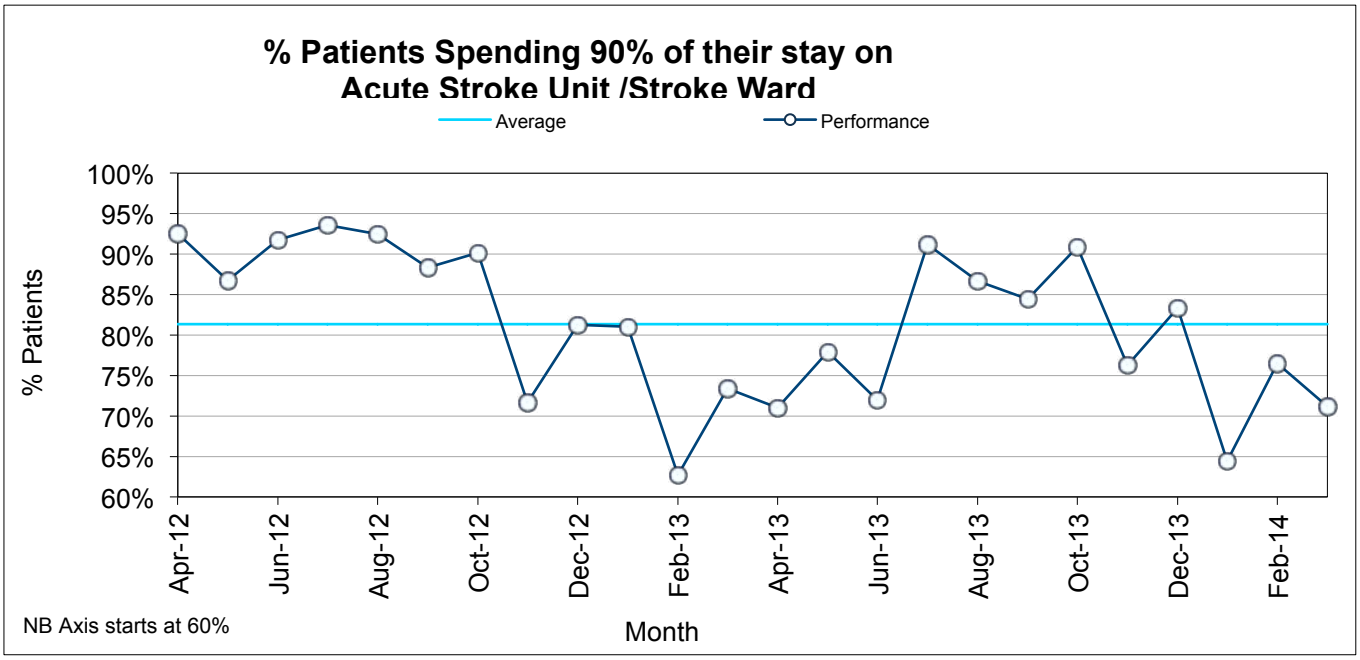
- Meet with all Clinicians to review pathways
- Review of CT scan availability.
- Working with primary care colleagues to review the diagnostic pathway.
- Continue to work with tertiary centres to improve handovers.
- Continue robust tracking of patients.
- Introduce 2 week waits on to Choose and book, summer 2014

Did you know...?
HRI kitchen sends out 900 meals a day for our patients.

Quality Account: **Part 3**

Stroke

As stroke patients occupy around 20% of all hospital beds, it is very important they receive specialist care proven to aid recovery and reduce mortality.



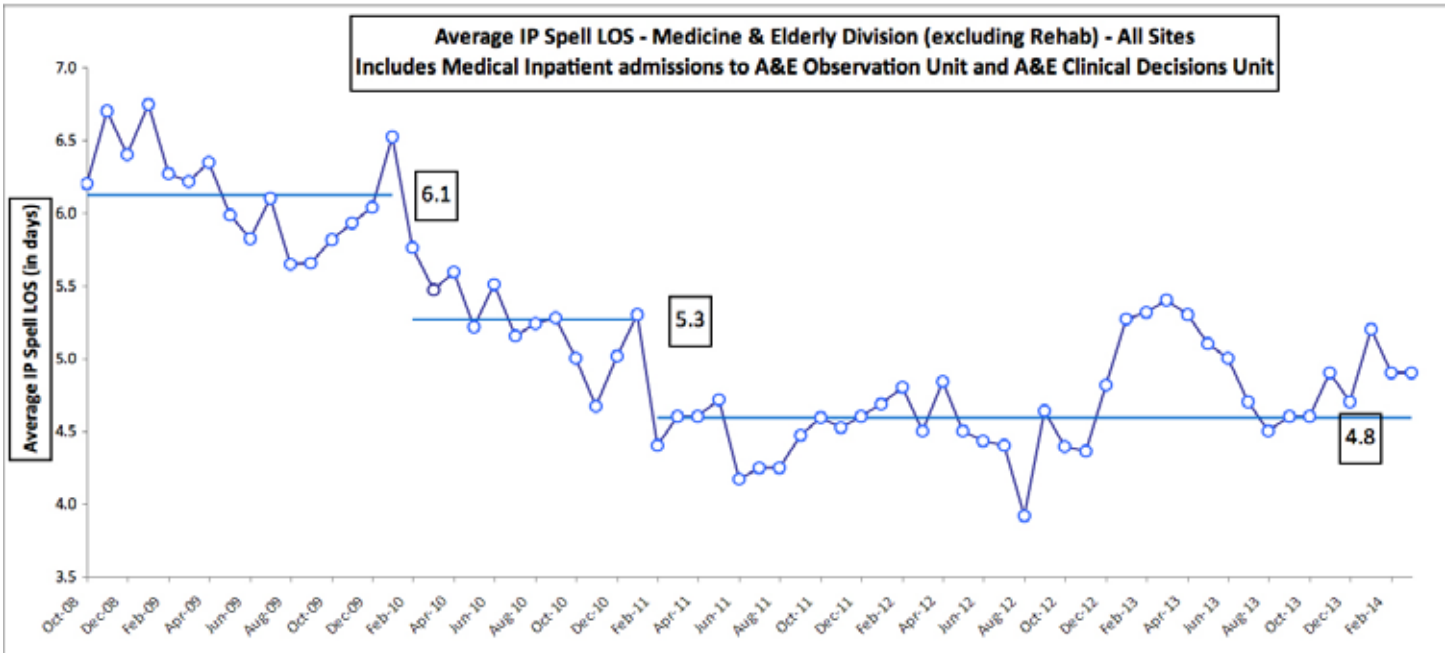
The above chart shows the percentage of patients diagnosed with a stroke that spent more than 90% of their hospital stay on a specialist stroke ward.

The drops in performance relate to bed closures on the specialist wards for infection control reasons. The drop in performance this year in particular was caused when the Acute stroke ward was closed to admissions due to infection control but in addition so was the specialist rehabilitation stroke ward. The Trust does have standard operating procedures for such eventuality but due to multiple ward closures it was not able to accommodate patients as it has done before. The figures are improving with February figures of 76% and aiming to be back up to high 80's in the following months.

There is a quality improvement work stream on Stroke, one of its key interventions is around improving this score. This is tied in with improvements to the management of specialty beds in the Trust as a whole.

Length of stay in medicine

Ensuring that patients have the correct length of stay in hospital reduces the risk of avoidable harm, improves patient experience and also helps ensure the Trust is able to reduce financial pressures and give good value care.



The chart above shows that the length of stay in medicine has been reducing since 2008. However during this year (in particular April 2013 to August 2013) the length of stay rose.

During this time period there was an increase in the complexity of patients on the wards, this can mean that more complex discharge planning is required and therefore patients stay in hospital longer. In addition work was sucessfully carried out to reduce length of stay for less complex patients and this, along with the introduction of the Ambulatory Assessment Unit and the Admission Avoidance team in A&E at Calderdale Royal Hospital are likely to have further skewed the data set.

Cardiology: "I would like to say thank-you to the cardiology department and particularly the anaesthetist my mother saw today. The anaesthetist could not have been more helpful and informative in helping my mother understand the risks of surgery .Thank you for the care and support that we received today."

Quality Account: **Part 3**

Real time patient monitoring

The Trust continues to operate a real time patent monitoring system. Using volunteers to ask patients a set of pre determined questions when they are ready for discharge allows the Trust to relate feedback to specific wards and therefore drive improvement.

There has been a continued focus on improving doctors' communication and continued improvement can be seen in the scores achieved over the last four years for the question used as the main measure

	2010/11	2011/12	2012/13	2013/14
When you have important questions to ask a doctor, do you get answers that you can understand?	8.0	8.3	8.9	9.3

Specific interventions that are in place to support this are:

- Divisional and specialty based champions to lead and support the work
- Roll out of 'Dear Doctor' notes, for patients to capture in advance of a ward round any specific questions they would like to discuss
- A Delivering Excellence in Communication Skills Consultant training day, to help make consultations and ward rounds more effective and give the opportunity to practice challenging communication skills issues using role play

A further area of focus has been to ensure that patients know what is happening to them and for them to be involved in the decision making about their care and treatment. A number of the questions asked in the RTPM measure these elements and show an improved / sustained score

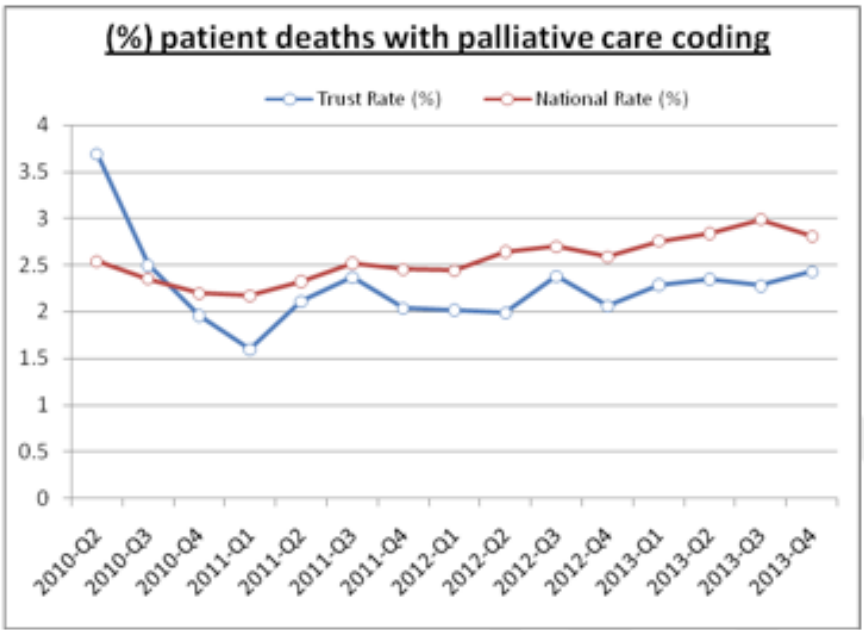
	2010/11	2011/12	2012/13	2013/14
Are you involved as much as you want to be in decisions about your care and treatment?	7.7	8.0	8.5	9.0
How much information about your condition or treatment has been given to you?	8.2	8.2	8.8	8.8
Before your operation or procedure, did a member of staff explain what would be done?	8.8	8.8	9.2	9.4
After the operation or procedure, did a member of staff explain how it had gone in a way you could understand?	7.9	8.2	8.6	8.8
Do you feel involved in decisions about your discharge from hospital?	7.3	8.5	8.8	9.2
Has a member of staff explained the purpose of the medicines you are to take at home in a way you could understand?	7.9	8.7	9.1	9.5
Have the doctors or nurses given your family or someone close to you all the information they need to help care for you?	6.6	7.5	8.2	9.0

Interventions that are supporting these aspects include:

- Bedside handover which helps patients to feel more involved in their care and provides a further opportunity for them to raise questions and for staff to check with patients that they understand what is happening to them on a daily basis.
- Provision of information for patients undergoing 'non consented procedures'. Packs of information for procedures such as MRI, CT and ECGs have been provided for each ward, to share and discuss with patients
- Nurse-led courtesy ward rounds which enable staff to listen to patients, answer questions and allay patient-and-relative concerns. It also gives staff a chance to assess patients' understanding of their plan-of-care and to 'fill-in any gaps'.

End of life care

The Trust continues to work to ensure that when patients die in hospital their death is expected and they receive appropriate end of life care.



The above graph shows the percentage of patients dying who were seen by the palliative care team. The data has been gradually increasing nationally as Trusts improve accuracy of coding to capture this specialist care when provided.

The Leadership alliance for the care of dying people stated: 'we are committed to ensure that everyone who is in the last days and hours of life, and those important to them, receive high quality care tailored to their needs and wishes and delivered with compassion and competence.'

There is work ongoing to improve the documentation and subsequent capture of information for patients receiving palliative care. This is part of a larger piece of work being delivered through the End of Life Workstream all aimed at ensuring quality of care is maintained throughout the period leading to death.

Quality Account: **Part 3**

Patient experience in accident & emergency

For the majority of unplanned patient attendances at hospital A&E is the first experience of care. As this is often a very stressful time it is important that the Trust understands and can improve on the service they received.

	A&E RTM Comparison of Quarterly Results after Offset	National Survey 2008	National Survey 2012	A&E RTM 2010 (Baseline)	A&E RTM 2011 (Overall)	A&E RTM 2012 (Overall)	
	Sample Size:	**345**	**338**	**399**	**614**	**239**	
Patient Experience Questionnaire	Q1 Were you given enough privacy when discussing your condition with the receptionist?	6.5	7.0	7.5	8.1	8.3	*
	Q2 Were you told how long you would have to wait to be examined?	3.1	3.2	3.7	6.2	6.5	*
	Q3 Did the member of staff treating and assessing you introduce themselves?	N/A	N/A	N/A	N/A	7.9	
	Q4 Did you have enough time to discuss your health or medical problem with the doctor or nurse?	8.4	8.1	N/A	N/A	8.6	
	Q5 Did a doctor or nurse explain your condition and treatment in a way you could understand?	7.8	7.7	7.5	8.0	8.1	*
	Q6b Do you think the hospital staff did everything they could to help control the pain?	7.0	6.9	7.7	7.9	7.6	*
	Q7 If you needed attention, were you able to get a member of medical or nursing staff to help you?	8.1	8.0	N/A	N/A	8.6	
	Q8b Did a member of staff explain the results of your tests in a way you could understand?	7.6	8.1	N/A	N/A	7.6	
	Q9 In your opinion, how clean was the A&E Department?	8.0	8.4	7.9	8.1	8.3	*
	Q10 Were you able to get suitable food or drinks when you were in the A&E Department?	N/A	5.7	N/A	N/A	8.9	
	Q11 Overall, did you feel you were treated with respect and dignity while you were in the A&E Department?	8.8	8.8	8.7	9.0	9.2	*
	Average Score (*comparable questions)	**6.9**	**7.0**	**7.2**	**7.9**	**8.0**	
	Q12 If the need arose, would you recommend this hospital to your family and friends? (Yes, definitly)	**N/A**	**N/A**	**78%**	**89%**	**88%**	

A&E RTM questions have changed since last year
From 2011 quality accounts, Q4 201 1 has been added (from 445 to 614 sample size)
In 2012 two sets of dfaa, one collected in Feb 2012 and other over Q1 2012 have been merged (239 sample) - quarterly RTM suspended at this point, no more recent data but suggested that in future will be conducted annually
All Rag rated against 2012 (prev 2008 in last year's QA)
All RTM scores offset by -7

A&E Activity in 2013/14 and for 2014/15.

Questionnaires were collected and reported quarterly in 2013/14, though there are still concerns about variability of data collection and quality. Volunteers are collecting data in both departments although there are more hours available at Huddersfield Royal Infirmary and so staff are collecting data at Calderdale Royal Hospital to supplement questionnaire numbers. There has been a marked difference in patient experience scores across the two sites, both with questionnaire data and in Friends and Family feedback. As a result an action plan has been implemented at Huddersfield Royal Infirmary with many of the actions now complete. There are patient experience groups now meeting on both sites which include patient participation, to discuss areas of concern and to champion change.

The National Picker Survey is due to occur in May 2014 (from March 2014 patients), and will be reported to the Executive Board.

Performance against relevant indicators and performance thresholds from the Risk Assessment Framework

Area	Indicator	Threshold	Performance	Achieved?
Access 1	Maximum time of 18 weeks from pint of referral to treatment in aggregate-admitted	90%	92.69%	Yes
Access 2	Maximum time of 18 weeks from pint of referral to treatment in aggregate- non admitted	95%	98.72%	Yes
Access 3	Maximum time of 18 weeks from pint of referral to treatment in aggregate- patients on an incomplete pathway	92%	94.8%	Yes
Access 4	A&E: maximum waiting time of four hours from arrival to admission/ transfer/discharge	95%	95.4%	Yes
Access 5	All cancers: 62-day wait for first treatment from:			
	• Urgent GP referral for suspected cancer	85%	90.72%	Yes
	• NHS Cancer Screening Service referral	90%	98.1%	Yes
Access 6	All cancers: 31-day wait for second or subsequent treatment , comprising:			Yes
	• Surgery	94%	98.27%	Yes
	• Anti-cancer drug treatments	98%	100%	
Access 7	All cancers: 31 day wait from diagnosis to first treatment	96%	99.74%	Yes
Access 8	Cancer: two week wait from referral to date first seen, comprising:			
	• all urgent referrals (cancer suspected)	93%	98.4%	Yes
	• for symptomatic breast patients (cancer not initially suspected)	93%	95.6%	Yes
Outcomes 14	Clostridium difficile – meeting the C. difficile objective	7 per quarter (28)	15 whole year	Yes
Outcome 19	Certification against compliance with requirements regarding access to health care for people with a learning disability	N/A	Remain compliant	Yes
Outcome 20	Data completeness: community services, comprising:			
	• Referral to treatment information	50%	84.66%	Yes
	• Referral information	50%	98.32%	Yes
	• Treatment activity information	50%	98.57%	Yes

Quality Account: **Part 3**

Performance Monitoring

There were two areas of concern raised in the Trust's performance report where actions are not covered elsewhere in this report; the following section expands on work ongoing to address these issues.

Fractured Neck of Femur
Care for patients with a fractured neck of femur is provided by a specialist multi-disciplinary team and nursed on two wards at Huddersfield Royal Infirmary.
It is recognised in the Trust that some improvements must be made to care when measured against the Best Practice Tariff which is based on the guidance around achievement of best clinical outcomes.

CHFT Data against Best Practice Tariff is as follows:

Best Practice Indicator	% Achievement 2013-14
Surgery within 36 hours from arrival or time of diagnosis	**61%**
Admitted under joint care of consultant geriatrician & Orthopaedic surgeon	**89%**
Admitted using an assessment protocol	**76%**
Assessed by a geriatrician in the preoperative period	**67%**
Postoperative geriatrician-directed multi professional rehabilitation team	**58%**
Fracture prevention assessment (falls)	**33%**
Fracture prevention assessment (bone health)	**85%**
Two abbreviated mental tests, first prior to surgery and second post surgery (in same spell) pre-op	**91%**
Two abbreviated mental tests, first prior to surgery and second post surgery (in same spell) post-op	**69%**
Compliance with all elements	**12%**

In addition many other metrics are tracked and reported, data is held on the national hip fracture database which gives opportunity for the Trust to benchmark practice against others.

Improvement Work
Recognising that changes need to be made to performance against key indicators the Trust has a Workstream tasked with understanding and improving the care provided for these patients. Best Practice delivery has moved from 2% to 28%, and is focusing on the following key interventions to lead to improvements:

- Falls component, to prevent re-injury
- Increases to geriatrician time spent on the speciality wards, to improve optimisation and manage co-morbidities associated with age related changes to physiology .
- Work in theatres to improve efficiency, increasing through put and supporting 36 to theatre target.

Delayed transfers of care and patient flow
Courage to put the Patient First – Making Hospitals Work Programme

To ensure the Trust fully understand the issues involved a team of clinical and non-clinical colleagues undertook a 2.5 day patient mapping exercise for an unplanned medical pathway (shortness of breath) across both the Calderdale Royal

Hospital and Huddersfield Royal Infirmary sites. The patient mapping exercise focussed in on all of the steps from initial attendance to A&E all the way through to the point of discharge

The key headlines as a result of this work were as follows:
- Pathway of 9.1 days.
- 5 days of value adding (either intervention or healing time).
- 4 days (44%) are spent waiting.
- At least 6 different electronic systems in place.
- A total of 45 steps in the pathway.

As a result of undertaking this work the team recognised the opportunity to transform the care provided to the Trust's patients and have been working to map out a future state which eliminates the non-value adding steps. The group has developed a strategic narrative which outlines what we are trying to achieve and how we will monitor progress against the plan.

The aims of the work are as follows:
- Ensuring that at least half of the patients stay in the Emergency Department (ED) 75 minutes or less and 80% stay 2 hours or less before discharge or admission.
- For patients who require a bed to ensure that from making the request to a patient arriving on the ward should not take longer than 30 minutes.
- All information will flow therefore alleviating the need to keep asking patients the same questions.
- Whilst in the Trusts care all patients will have a plan developed on admission (plan for every patient) meaning that they get what they need when they need it.
- The only time patients are moved from one ward to another will be for clinical reasons.
- To ensure that discharge planning will commence on admission and that once medically fit our patients will have to wait as little time as possible for arrangements to be made for a safe discharge or transfer.
- With correct planning and preparation to be able to carry out discharges at regular intervals during the day so that patients are discharged when they are ready, also to have a bed available to meet demand just when the next patient needs it.
- Achievement of these goals will positively affect staff morale.

This is a 3 year programme of work. being undertaken by a project team with representatives from ED, MAU, medical wards, pharmacy, radiology, pathology, therapy services, portering and service improvement who come together on a fortnightly basis to report on progress being made.

In addition to this the project team and a wider group of individuals from within each of the service areas meets with the Lean Enterprise Academy consultants on a monthly basis to help ensure the correct applicability of lean principles and methodologies.

Quality Account: **Part 3**

Feedback from commissioners, overview and scrutiny committees and Local Healthwatch

Response from Greater Huddersfield and Calderdale Clinical Commissioning Groups
We were pleased to receive and comment on the Quality Account prepared by Calderdale and Huddersfield NHS Foundation Trust (CHFT). The following statement is presented on behalf of NHS Greater Huddersfield CCG and NHS Calderdale CCG.

The Quality Account is a more comprehensive assessment of the levels of quality than has been received in previous years. It describes progress in many areas and comparisons against other hospitals are included. We recognise improvements have been made in a number of areas such as the reduction of healthcare associated infection rates, and the introduction of discharge coordinators on the medical wards which has supported the significant reduction in the number of readmissions within 30 days.

As commissioners we welcome the on-going work to improve the care of patients with dementia, diabetes and other long term conditions. We support the commitment to partnership working in order to support self-management for these patient groups. In addition, we note the Trust's continued commitment to improve the patient experience by "putting the patient first".

We welcome the inclusion of the section on "goals agreed with commissioners" in terms of the Commissioning for Quality and Innovation (CQUIN) scheme. However, we note that improving management of patients with pneumonia refers to those attending Accident and Emergency; this CQUIN indicator should include all admitted patients, not just those attending Accident and Emergency.

We note that there is no reference to the peer review process in Stroke and Cancer services and feel that this should be included as there are positive outcomes and areas for improvement drawn from the process.
It would be welcomed if the Quality Account could include reference to the support given by the CCGs and the Clinical Quality Board to help the Trust make the improvements described.
We note that there are a number of gaps in the information provided but understand that the Quality Accounts process dictates the timeframe, and that all the information/data was not available at the time of publication for approval.
We welcome the priority areas for 2014/15 and note the significant amount of investment and commitment to reducing the Hospital Standardised Mortality Rate over this coming year.

We look forward to continuing to work closely with the Trust over the coming year in order support the Trust in achieving the quality improvement priorities set out in the account.

Response from Healthwatch Kirklees
Healthwatch Kirklees recognises the progress made by the Trust, as represented by these Quality Accounts. We note the progress made against the Trusts Targets for 2013/14 and the new objectives for the next 12 months.

We enjoy a good working relationship with staff across the Trust who have responded promptly and openly to our requests. We look forward to supporting the Trusts work on improving Hospital Food in the next 12 months.

Response from Healthwatch Calderdale
Thank you for giving Healthwatch Calderdale the opportunity to comment on Calderdale and Huddersfield NHS Foundations Trusts' Quality Account statement for 2013/14.

We welcome the improvements that have been made in the priority areas set for 2013/14. A lot of good work has been done; we also note that the trust acknowledges that further improvements can be made and systems are being put in place to ensure this is happening.

Here are the comments from Healthwatch Calderdale:

Priority One;
Reducing the number of pressure ulcers: We noticed a rise in pressure sores in January 2014, but welcome the fact that the Trust has introduced new systems to monitor this; we also note that the Trust recognises that further improvements can be made to reduce the number of pressure sores.

Priority two;
Reducing the number(s) of healthcare associated infections: It is good to see that the Trust is making progress in reducing the number of healthcare associated infections. Furthermore, that this work will be expanded to include health and social care partners.

Priority three;
Appropriate and safe discharge: Appropriate and safe discharge is vital for the long-term wellbeing of patients. It is therefore reassuring to know that the Trust has introduced discharge co-ordinators on medical wards, to ensure that patients are supported when discharged. It is important that patients have the right type of help and support when discharged to avoid readmission to hospital.

We would to like to see the Trust carry out follow up work in speaking with patients to make sure their care plan needs are being met.

Priority four;
Improving the care of patients with dementia: We welcome the improvements that have been made and the schemes that are in place in the care of patients with dementia. We hope this good work continues. We would like to see the Trust continue to look for and work on the latest and innovative ideas to support patients with dementia.

Priority five;
Helping people to manage their long-term conditions: We welcome the changes that have been made by the Trust, as well as further proposed plans for improvement.

The four priorities for 2014/15
We welcome the four priorities set for 2014/15 and look forward to seeing improvements being made in the areas identified and the relevant targets being met. We welcome the improvement suggestions that have been made and how they will be implemented.

Priority 1; *To improve the quality of the care we provide as measured by the HSMR:*
It is reassuring to know that the Trust is taking action to reduce the Hospital: Standardised Mortality Rate (HSMR) and improving the quality of care provided to acutely ill patients (CAIP).

Priority 2; *To ensure IV antibiotics are given correctly and on time: We would like to see the Trust reduce the number of*

Did you know...?
A roast dinner is our patients' favourite at CRH. (Fish fingers for children)

Quality Account: **Part 3**

unintentional missed doses of IV antibiotics and explore further ways as to how this can be done.

Priority 3; *Improving the care of patients with Diabetes, so they do not develop complications and have to spend longer in hospital: We welcome the improvements proposed by the Trust and add that the trust work with partner organisations on the preventative agenda by promoting healthier lifestyles to meet the desired targets.*

Priority 4; *To help patients with long term pain develop the skills needed to manage their conditions through supported self-management courses: We welcome the self management courses and supporting patients to better care for themselves in managing their conditions. We would like to see patients feeling empowered, but at the same time being supported to enable them to do this.*

Recommendations;

Data Capturing
The data captured by Trust with regard to age profile does not give a clear picture of which age group is at risk or has been affected by issues highlighted in the QA document. Can the data on age profile be broken into categories to give a better picture of the care patients are receiving and what the issues for those patients are?

Fall in hospital
We are concerned about the number of falls patients have had whilst in hospital. Falls prevention work has been going on for a number of years, yet the number of falls remains quite high, with an average of 148 falls per month. We would like the Trust to monitor the cause(s) of falls and put appropriate systems in place to reduce the number of falls.

Stroke Ward
We are concerned the Trust did not have a contingency plan following of the closure of the acute stroke ward and specialist rehabilitation stroke ward, due to infection control. In the likely event this should happen again; we would like to see the Trust have systems in place to ensure that patients are not put at risk and the health care of stroke patients is not comprised.

Non-consent procedures
We welcome the provision of information for patients undergoing 'non consented procedures' and add that patients are informed about the implications of such procedures and how to manage their care following the procedure.

Response from Kirklees Overview and Scrutiny Committee
"The Kirklees Council Well-Being & Communities Scrutiny Panel, as the local health overview and scrutiny committee, has reviewed the Draft Quality Account which included reference to the Department of Health's guidance for Overview and Scrutiny Committees.

The Panel has noted your priorities for 2014/15 and are supportive of the range of areas that they will cover. Although none of these issues have been recently covered by the Panel the fact that the priorities have a clear focus on the quality of patient care is welcomed.

A priority for the Panel during 2013/14 was to take careful note of the issues and recommendations that came from the Francis Inquiry. This resulted in the Panel agreeing to develop a Francis Action Plan which will be used to help support the commissioning and delivery of effective and safe local health services. The Panel noted that although the Quality Account details the work that will take place to improve the quality of care and patient experience there is no explicit reference made to the implications of the Francis Inquiry Report and the specific actions being taken by the Trust.

The Panel would have liked to have seen the 2013/14 priority of reducing the number of pressure ulcers carried forward and included as a 2014/15 priority. Despite an apparent downward trend in the numbers of incidents since February 2013 the Panel noted that, excluding the spike in January 2014, the number of incidents in February 2014 had risen to a similar number reported at the start of the period of improved data. The Panel therefore felt that it would have been prudent to continue to include the issue as a priority for 2014/15 to help ensure that the actions taken to improve the number of incidents were sustainable.

During 2013/14 the Panel has maintained an overview on the developments in models of care across the district that will support the delivery of care either at or closer to people's homes. One benefit of the new model of care will be to provide on-going support to people with long term conditions which should help to avoid hospital re-admission. The Panel acknowledge that causes of readmission can be complex and in order to prevent readmissions there will need to be strong links between the support provided in the hospital setting and that provided at or closer to home. For this reason the Panel feels it would be helpful for there to be a continued focus on hospital readmissions particularly for people aged 65 and over, rather than the broader age range of adults of ages 16 and over which the Panel feels may not accurately represent the levels of readmissions occurring within the older age group.

The Panel felt that the report did highlight the work of the trust to engage with staff, patients and the public. However the Panel felt it would have been helpful to provide more detail on the scale of the work carried out with patients and the public. In addition the Panel would have liked to have seen a greater emphasis in the trust's vision on working with patients and using their feedback to further improve the quality of care and patient experience.

The Panel noted that no reference has been made to the Calderdale and Huddersfield health and social care strategic review which has the potential to have a major impact on health services within the district.

The Panel did not have sight of the quarter 4 data when considering the Quality Account and therefore no comment has been made on this."

Response from Calderdale Overview and Scrutiny Committee

'*Thank you for giving the Scrutiny Panel the opportunity to comment on your Quality Account. My reply focuses on those issues that the Adults Health and Social Care Scrutiny Panel has focused on over the last couple of years.*
I am pleased to see you identifying success against all your Improvement Priorities for 2013/4.

The reduction in the number of patients with Hospital Acquired Pressure Ulcers is steady and I would expect to see a "spike" in the data from time to time. You have identified the increase in January 2014 as due to changes in data validation, so I presume you are satisfied that this is not due to a real increase of more than twenty in one month? Is there any merit in presenting this information (and other information in the Quality Account) with the addition of a moving average, which would smooth out the inevitable month to month variations and give a clear picture of the trends?
There is a positive reduction in healthcare associated infections. Although we should have zero tolerance, the numbers are so small that an increase of one makes the graphs look dramatic!

There seems to be a positive reduction in number of readmissions within thirty days. Might the figures be better presented as a percentage? If the number of admissions changes, this will have an impact on the number of readmissions. Are the rates of delayed discharge still high? Might reducing delayed discharge risk increased readmission. It seems to me that re-admission is one part of the complex system of admission and re-admission to hospital and a change in one part of the system may have an impact on other parts. I anticipate that the RAID service should contribute to further improvements in these figures over the coming year.

As you are aware, dementia is something the Scrutiny Panel has taken a close interest in and I am pleased to see high levels of compliance being achieved. When we undertook our detailed review of dementia in 2011-12 we were concerned

Antenatal: "The sonographer (who performed the scan) I saw this morning for my 20 week scan was very reasurring, especially when my husband fainted! Please pass on my thanks for her kindness and support."

Quality Account: **Part 3**

about the longer stays in hospital for people with dementia than other patients and would be interested to learn of the impact that compliance levels, the Butterfly scheme and the other initiatives you detail are having on lengths of stay for people with dementia.
Again, it is good to see high levels of compliance with the COPD discharge bundle and I am pleased that you have plans to continue to drive improvement.

I have noted your priorities for 2014/15. I am particularly encouraged to see that you have included improving the care of patients with diabetes in your priorities as this is something that the Panel has discussed in detail during the last year and I anticipate will return to. I am sure that you will agree that your Trust has a vital part to play in working in partnership with other agencies to improve diagnosis rates and preventive measures, as well as helping patients with diabetes manage their care.

Hospital Standardised Mortality Rate is clearly a very important indicator and I am pleased that you are giving it close attention. However, I am not sure how it identifies a priority. Surely delivering improvements in the HSMR may require changes across any area of your activity, as suggested in your CAIP programme. This may be a matter of semantics – your priority may be better identified as implementing the CAIP Programme and measuring its success through improvements in the HMSR. Having said that, I note that Dr Foster records a higher HSMR for Calderdale Royal Hospital than that at Huddersfield Royal Infirmary - http://myhospitalguide.drfosterintelligence.co.uk/#/mortality . Particularly if any firm proposals emerge from the Strategic Outline Case, I would be interested to see more site specific information in next year's Quality Account.

I have no comments to make on your other priorities, but I am sure the Scrutiny Panel will be interested to learn of progress when we conduct our mid-year review in November or December.

I only have a couple of comments to make on the more detailed parts of the Quality Account. The information included is valuable and I will make sure that next year's Panel members have access to it before their work planning meeting on 1 July 2014.

I will be interested in the information on the review of services (page 15) when it is available. It is obviously very good that there were no Never Events during the year.
I was interested in the Accident and Emergency data on page 47, but the table is impossible to read, even when blown up to 400% on my screen! Particularly in the context of the Strategic Outline Case I would be interested to receive more information about the difference in patient experience of Accident and Emergency across the two sites.

I appreciate that the Quality Account is intended to focus very much on your own performance, but it does seem very hospital-centric. At the centre of your proposals in the Strategic Outline Case is improving outcomes for patients through more integrated working with general practice and social care services. I would like to see this reflected more in the Quality Account.

Thank you very much for giving me the opportunity to comment on the Quality Account. '

Response from Membership Council (Trust Governors)
The Chair of the Trust's Membership Council had no comments to add on the content of the Quality Account.

Quality Account: **Appendix A**

The national clinical audits and national confidential enquiries that Calderdale and Huddersfield NHS Foundation Trust were eligible to participate in during 2013/14 are as follows:

Women's and Children's Health	
Audit title	**Trust Eligible for Involvement**
Child health programme (CHR-UK)	No
Epilepsy 12 audit (Childhood Epilepsy)	Yes
Maternal, infant and newborn programme (MBRRACE-UK)	Yes
Neonatal intensive and special care (NNAP)	Yes
Paediatric asthma (British Thoracic Society)	Yes
Moderate or severe asthma in children (CEM)	Yes
Paediatric intensive care (PICANet)	No
Paediatric bronchiectasis (British Thoracic Society)	Yes

Acute	
Audit title	**Trust Eligible for Involvement**
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes
Emergency use of oxygen (British Thoracic Society)	Yes
National Joint Registry (NJR)	Yes
Severe trauma (Trauma Audit & Research Network, TARN)	Yes
Paracetamol overdose (CEM)	Yes
Severe sepsis and septic shock (CEM)	Yes
National emergency laparotomy audit (NELA)	Yes
National audit of seizure management (NASH)	Yes

Blood and transplant	
Audit title	**Trust Eligible for Involvement**
Medical Use of Blood (National Comparative Audit of Blood Transfusion) National Comparative Audit of Blood Transfusion - programme includes the following audits, which were previously listed separately in QA:	
a) 2012 National Comparative Audit of Blood Sample Collecting and Labelling	Yes
b) National audit of patient information and consent	Yes
c) National Medical use of Blood audit	Yes
d) 2013 National Comparative Audit of the Use of Anti-D	Yes

Cancer	
Audit title	**Trust Eligible for Involvement**
Bowel cancer (NBOCAP)	Yes
Head and neck oncology (DAHNO)	No
Lung cancer (NLCA)	Yes
Oesophago-gastric cancer (NAOGC)	Yes

Heart	
Audit title	**Trust Eligible for Involvement**
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes
Adult cardiac surgery audit (ACS)	No
Cardiac arrhythmia (HRM)	Yes
Congenital heart disease (Paediatric cardiac surgery) (CHD)	No
Coronary angioplasty	Yes
Heart failure (HF)	Yes
National Cardiac Arrest Audit (NCAA)	Yes
National Vascular Registry (elements include CIA, peripheral vascular surgery, VSGBI Vascular Surgery Database, NVD)	Yes

Long term conditions	
Audit title	**Trust Eligible for Involvement**
COPD (not BTS)	Yes
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Yes
Diabetes (Paediatric) (NPDA)	Yes
Inflammatory bowel disease (IBD)	Yes
Renal replacement therapy (Renal Registry)	No

Mental Health	
Audit title	**Trust Eligible for Involvement**
Prescribing observatory for Mental Health (POMH)	No
National Audit of Schizophrenia (NAS) Prescribing Observatory for Mental Health (POMH)	No

Older People	
Audit title	**Trust Eligible for Involvement**
Falls and fragility fractures audit programme	Yes
Sentinel Stroke (SSNAP)	Yes
Rheumatoid and early inflammatory arthritis (NCAPOP)	Yes

Other	
Audit title	**Trust Eligible for Involvement**
Elective surgery (National PROMs Programme)	Yes
Groin hernia	Yes
Hip replacements	Yes
Knee replacements	Yes
Varicose veins	Yes

National Confidential Enquiries	
Audit title	**Trust Eligible for Involvement**
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Deaths:	Yes
Gastrointestinal Haemorrhage	Yes
Lower limb amputation study	Yes
Tracheostomy study	Yes
Mental Health programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	Yes

The national clinical audits and national confidential enquiries that Calderdale and Huddersfield NHS Foundation Trust participated in during 2013/14 are as follows:

Women's and Children's Health	
Audit title	**Trust Partcipated**
Child health programme (CHR-UK)	NA
Epilepsy 12 audit (Childhood Epilepsy)	Yes
Maternal, infant and newborn programme (MBRRACE-UK)	Yes
Neonatal intensive and special care (NNAP)	Yes
Paediatric asthma (British Thoracic Society)	Yes
Moderate or severe asthma in children (CEM)	Yes
Paediatric intensive care (PICANet)	NA
Paediatric bronchiectasis (British Thoracic Society)	Yes

Acute	
Audit title	**Trust Participated**
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes
Emergency use of oxygen (British Thoracic Society)	Yes
National Joint Registry (NJR)	Yes
Severe trauma (Trauma Audit & Research Network, TARN)	Yes
Paracetamol overdose (CEM)	Yes
Severe sepsis and septic shock (CEM)	Yes
National emergency laparotomy audit (NELA)	Yes
National audit of seizure management (NASH)	Yes

Blood and transplant	
Audit title	**Trust Participated**
Medical Use of Blood (National Comparative Audit of Blood Transfusion) National Comparative Audit of Blood Transfusion - programme includes the following audits, which were previously listed separately in Quality Account:	
a) 2012 National Comparative Audit of Blood Sample Collecting and Labelling	Yes
b) National audit of patient information and consent	Yes
c) National Medical use of Blood audit	Yes
d) 2013 National Comparative Audit of the Use of Anti-D	Yes

Cancer	
Audit title	**Trust Participated**
Bowel cancer (NBOCAP)	Yes
Head and neck oncology (DAHNO)	N/A
Lung cancer (NLCA)	Yes
Oesophago-gastric cancer (NAOGC)	Yes

Heart	
Audit title	**Trust Participated**
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes
Adult cardiac surgery audit (ACS)	N/A
Cardiac arrhythmia (HRM)	Yes
Congenital heart disease (Paediatric cardiac surgery) (CHD)	N/A
Coronary angioplasty	Yes
Heart failure (HF)	Yes
National Cardiac Arrest Audit (NCAA)	Yes
National Vascular Registry (elements include CIA, peripheral vascular surgery, VSGBI Vascular Surgery Database, NVD)	Yes
Pulmonary hypertension (Pulmonary Hypertension Audit)	N/A

Did you know...?

Our A&E teams cared for 139,000 patients in 2013/2-14.

Long term conditions	
Audit title	**Trust Participated**
COPD (not BTS)	Yes
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Yes
Diabetes (Paediatric) (NPDA)	Yes
Inflammatory bowel disease (IBD)	Yes
Renal replacement therapy (Renal Registry)	N/A

Mental Health	
Audit title	**Trust Participated**
Prescribing observatory for Mental Health (POMH)	N/A
National Audit of Schizophrenia (NAS) Prescribing Observatory for Mental Health (POMH)	N/A

Older People	
Audit title	**Trust Participated**
Falls and fragility fractures audit programme	N/A
Sentinel Stroke (SSNAP)	Yes
Rheumatoid & early inflammatory arthritis (NCAPOP)	Yes

Other	
Audit title	**Trust Participated**
Elective surgery (National PROMs Programme)	
Groin hernia	Yes
Hip replacements	Yes
Knee replacements	Yes
Varicose veins	Yes

National Confidential Enquiries	
Audit title	**Trust Participated**
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Deaths:	
Gastrointestinal Haemorrhage	Yes
Lower limb amputation study	Yes
Tracheostomy study	Yes
Mental Health programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	Yes

The national clinical audits and national confidential enquiries that Calderdale and Huddersfield NHS Foundation Trust did not participate in and reasons during 2013/14 are as follows: **There were no audits that were not participated in for 2013/14**

The national clinical audits and national confidential enquiries that Calderdale and Huddersfield NHS Foundation Trust participated in, and for which data collection was completed during 2013/14, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Women's and Children's Health			
Audit title	**Trust Participated**	**Audit Sample**	**% Cases submitted**
Epilepsy 12 audit (Childhood Epilepsy)	Yes	All	Continuous – all cases ongoing
Maternal, infant and newborn programme (MBRRACE-UK)	Yes	100%	100%
Neonatal intensive and special care (NNAP)	Yes	472	100%
Paediatric asthma (British Thoracic Society)	Yes	19	All cases in time period
Moderate or severe asthma in children (CEM)	Yes	50	Ongoing
Paediatric bronchiectasis (British Thoracic Society)	Yes	3	All cases in time period

Acute			
Audit title	**Trust Participated**	**Audit Sample**	**% Cases submitted**
Adult critical care (Case Mix Programme – ICNARC CMP)	Yes	100%	ongoing
Emergency use of oxygen (British Thoracic Society)	Yes	287	All cases in time period
National Joint Registry (NJR)	Yes	1113	ongoing
Severe trauma (Trauma Audit & Research Network, TARN)	Yes	All	100%
Paracetamol overdose (CEM)	Yes	50	ongoing
Severe sepsis and septic shock (CEM)	Yes	50	ongoing
National emergency laparotomy audit (NELA)	Yes	All	100%
National audit of seizure management (NASH)	Yes	30	100%

Blood and transplant			
Audit title	**Trust Participated**	**Audit Sample**	**% Cases submitted**
Medical Use of Blood (National Comparative Audit of Blood Transfusion) National Comparative Audit of Blood Transfusion - programme includes the following audits, which were previously listed separately in QA:			
b) National audit of patient information & consent	Yes	24	ongoing
c) National Medical use of Blood audit	Yes	3138	51% (1592)
d) 2013 National Comparative Audit of the Use of Anti-D	Yes	93	ongoing

Cancer			
Audit title	**Trust Participated**	**Audit Sample**	**% Cases submitted**
Bowel cancer (NBOCAP)	Yes	207	100%
Lung cancer (NLCA)	Yes	244	28% (68)
Oesophago-gastric cancer (NAOGC)	Yes	100%	ongoing

Acute Stroke Unit: "My mum, who is in a home, and a wheelchair, suffered a mild stroke this week and was in for scans. The staff at every point were brilliant. After visiting one department and not being able to find the next, a nurse who I was simply passing in the corridor, insisted on taking us to the right department. If there is a better hospital staff in England, then that is a very good hospital! Outstanding."

Heart			
Audit title	**Trust Participated**	**Audit Sample**	**% Cases submitted**
Acute coronary syndrome or Acute myocardial infarction (MINAP)	Yes	100%	100%
Cardiac arrhythmia (HRM)	Yes	100%	ongoing
Heart failure (HF)	Yes	100%	ongoing
National Cardiac Arrest Audit (NCAA)	Yes	62	100%
National Vascular Registry (elements include CIA, peripheral vascular surgery, VSGBI Vascular Surgery Database, NVD)	Yes	77	95% (73)

Long term conditions			
Audit title	**Trust Participated**	**Audit Sample**	**% Cases submitted**
COPD (not BTS)	Yes	All	All cases in time period
Diabetes (Adult) ND(A), includes National Diabetes Inpatient Audit (NADIA)	Yes	81	100%
Diabetes (Paediatric) (NPDA)	Yes	100%	100%
Inflammatory bowel disease (IBD)	Yes	40	98% (39)

Older people			
Audit title	**Trust Participated**	**Audit Sample**	**% Cases submitted**
Sentinel Stroke (SSNAP)	Yes	All	ongoing
Rheumatoid and early inflammatory arthritis (NCAPOP)	Yes	All	ongoing

Other			
Audit title	**Trust Participated**	**Audit Sample**	**% Cases submitted**
Elective surgery (National PROMs Programme)			
Groin hernia	Yes	All	47%
Hip replacements	Yes	All	88%
Knee replacements	Yes	All	87%
Varicose veins	Yes	All	51%

National Confidential Enquiries			
Audit title	**Trust Participated**	**Audit Sample**	**% Cases submitted**
Medical and Surgical programme: National Confidential Enquiry into Patient Outcome and Deaths:			
Gastrointestinal Haemorrhage	Yes	5	ongoing
Lower limb amputation study	Yes	8	ongoing
Tracheostomy study	Yes	2	100%
Mental Health programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	Yes	0	No cases in 2013/14

The reports of 21 national clinical audits were reviewed by the provider in 2013/14 and the following are examples where Calderdale and Huddersfield NHS Foundation Trust intend to take actions to improve the quality of healthcare provided.

National audit of blood Sampling
Errors can occur because a blood sample is miscollected (from the wrong patient) or mislabelled (with one of the four core identifiers missing, incorrectly written or illegible).

Previous national and international audits have shown these errors are common.
Factors contributing to incorrect sample taking include;

- Lack of knowledge / understanding of the process
- Failure to properly identify the patient
- Being distracted while taking and labelling the sample
- Labelling the sample away from the vicinity of the patient

The findings that miscollected samples (Wrong Blood in Tube) are still regularly identified could be considered to strengthen the recommendation, made by the British Committee for Standards in Haematology (BCSH) guidelines on pre-transfusion compatibility procedures, that, where possible, a second "group check" sample should be obtained before group-specific blood is issued.

There would be resource implications to implement the taking of a second "group check" sample as well as a change in practice. The possibility of obtaining a second "group check" sample is being discussed by the hospital transfusion committee.

Staff taking blood samples should recognise that obtaining positive patient identification is central to safer blood sample labelling. An article was drafted and included in the next available edition of Pathology Newsletter.

A protocol has been agreed by the hospital transfusion committee to ensure the sample is labelled correctly and witnessed by the person taking the sample.

The process for pulling reports from Q-Pulse and feeding back to relevant clinical areas has been streamlined.

National College of Emergency Medicine - Fever in children audit
These standards are derived from the NICE guideline "Feverish illness in children: Assessment and initial management in children younger than 5 years", which provides a tool to risk assess feverish children for serious bacterial illness. The Traffic Light System is recommended for use in emergency departments. An adequate 'safety net' is defined as:

a) providing the parent or carer with verbal and/or written advice on warning symptoms and how further care can be accessed or
b) the parent or carer is given follow up at a specific time and place or
c) ensuring direct access for the patient if further assessment is required.

Emergency Departments on both sites showed an improvement in the documentation of vital signs since 2010. Calderdale Royal Hospital managed 71% within 20 minutes of arrival, however, performance at Huddersfield Royal Hospital decreased to 39% within 20 minutes of arrival. Most noticeable was the lack of written discharge advice available for patients/carer.

Results have been used to raise awareness and educate triage nurses to assess more rapidly the vital signs in children to identify the most ill children more quickly.
A 'take home' leaflet has been designed for parents /carers of feverish children. This provides information and a safety net for parents/ carers. It has now been produced and is in use on both sites.

National British Association of Dermatologists audit on management of Psoriasis
Following the publication of NICE CG153 in October 2012, the British Association of Dermatologist (BAD) published audit tools to aid the implementation of the guidelines.

Results measured against NICE CG153 Guidelines recommendations:
- use of the PEST tool nationally was very low (9% in Yorkshire and the Humber region).
- assessment for psoriatic arthritis 61% nationally, (65% in Yorkshire and the Humber region).
- involvement of nails 71% nationally (77% in Y&H region, **but not done routinely at the Trust)**

Locally, the assessment for involvement of nails was also identified as a weak area in the gap analysis of NICE CG152. The Trust has now completely adopted NICE guidance and dermatologists are now assessing for nail involvement with psoriasis. Practice has been changed and, in future, the Trust will use all BAD nationally recognised scoring tools and proformas for new and follow up patients.

Other National Clinical Audits the Trust has participated in during 2013/14:
- Breast cancer clinical outcome measures project - National Audit Symptomatic Breast Cancer
- National Breast Screening Programme
- UK National Bariatric Surgery Registry
- National Institute of Academic Anaesthesia (NAP 5): Accidental Awareness during General Anaesthesia
- Potential Donor
- National Audit of Hip Fractures
- Diabetic Retinopathy Screening (KPI)
- Mid-Urethral Tapes (BAUS)
- Nephrectomy Surgery (BAUS)
- Percutaneous Nephrolithotomy (PCNL) British Association of Urological Surgeons
- National audit of intermediate care
- National clinical audit of sample collection and labelling
- BAD Management of psoriasis
- BAD Safe use of isotretinoin in acne in UK
- BAD excision of non- melanoma skin cancer
- Audit on current practice in preventing early onset neonatal group B strep disease
- Invasive cytology
- British Association for Sexual Health and HIV and British HIV Association – Partner Notification Audit
- National Cardiac Rehab audit
- National review of adult asthma deaths – year 3
- National care of the dying – round 4

The reports of **80** local clinical audits were reviewed by the provider in 2013/14 and Calderdale and Huddersfield NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Audit of Glaucoma Suspect Clinic (GSC)
The introduction of NICE Guidelines in 2009 provided an opportunity for the Orthoptic led glaucoma service to re-evaluate its protocols and support a new pathway for Glaucoma referrals.
The aim of this service is to reduce demand on the Ophthalmology out-patient clinics, to comply with the 18 week pathway and to promote quality and cost effectiveness through the provision of a uniform standard of assessment.

Local agreements are in place for referral refinement by participating optometrists which support NICE quality standards to provide an integrated referral pathway for all patients with suspect chronic open angle glaucoma or ocular hypertension.

Findings showed that the majority of referring optometrists provide correct information according to the refinement protocol. The majority of optometrists referred via non refinement provided relevant information although did not include a copy of the visual field test performed.

It was recommended that collaborative working and further audits between hospital and optometrists is implemented to improve efficiency of Glaucoma pathway in the Calderdale and Kirklees area in line with NICE Quality Standards. Further and ongoing training for orthoptists will be implemented to improve their false positive / discharge rate.

Ocular hypertension scheme leaflets will be provided in new doctor induction packs for February 2014 intake.

Paediatric diabetes Peer review 2013
Children and young people newly diagnosed with Type 1 Diabetes Mellitus in Calderdale and Huddersfield are diagnosed and stabilised in line with the operational policy for Type 1 Diabetes Mellitus. The operational policy incorporates the standards of care expected.

The number of new patients diagnosed over the last four years has remained static. Most children and young people were referred by their GP. Disappointingly, the number of new patients admitted in Diabetic ketoacidosis has increased this year, despite the 4Ts campaign (Thirst, Tiredness, Weight loss, Toilets) and the alert on the pathology order communications system for all requests for glucose in patients under 18.

The Trust will need to target GPs to remind them that all Children and Young People suspected of having diabetes are to be referred straight away rather than wait for investigations with any child or young person where diabetes is suspected. To this end, a flow chart has been designed and distributed to all GPs.
All GPs were notified within 48 hours of discharge and the Trust will continue to complete an electronic discharge summary for all patients. This is also supplemented by a faxed referral from the paediatric diabetes specialist nurse notifying the GP of the diagnosis and medications.

Emergency Trolleys audit
Incident reports at the Trust have highlighted instances where emergency equipment trolleys had failed to meet the standard required. The need to monitor the checking of emergency trolleys in relation to the standard checklist was recognised and an audit proforma was designed.

Following a recent review of the paediatric emergency trolleys, updated checklists and pictures were distributed to all clinical areas providing care to children. In line with the checking procedure for adult emergency trolleys, areas were given adhesive tape to seal the paediatric trolley as per the photographs supplied. The tape requires the professional checking of the trolley to sign and date that all contents are correct. Once the tape is in place and remains visibly intact, staff can choose to recheck the trolley on a maximum monthly basis or the first expiry date of items held within the trolley, whichever is the sooner.

The audit was undertaken to ensure that all areas had been able to manage this transition smoothly or whether there were any issues that required corrective actions.

Adult trolleys:
- Still missing and faulty equipment in the trolleys.
- The checking of dates is not consistent

Paediatric trolleys:
- Similar situation to adults
- Particular problems with laryngoscopes and blades compatibility

120 red folders were purchased and are now in place (one for each trolley) containing:
- new photos of drawers
- minimum acceptable standards
- tiers of responsibility
- list of order codes / stock lists
- procedure for completing and checking forms

The resuscitation officers have also spoken to the relevant persons to ensure the laryngoscopes and blades on the paediatric trolleys are now compatible.

A monthly report is now sent to the patient safety boards with RAG rating system for the wards. Random checks continue with support from the audit department.

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Calderdale and Huddersfield NHS Foundation Trust to perform an independent assurance engagement in respect of Calderdale and Huddersfield NHS Foundation Trust's Quality Report for the year ended 31 March 2014 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2014 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

For acute NHS foundation trusts:

- 62 Day cancer waits – the percentage of patients treated within 62 days of referral from GP; and
- Emergency readmissions within 28 days of discharge from hospital.

We refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*
- the Quality Report is not consistent in all material respects with the sources - specified in the *Detailed Guidance for External Assurance on Quality Reports; and.*
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports.*

We read the Quality Report and consider whether it addresses the content requirements of the *NHS Foundation Trust Annual Reporting Manual,* and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2013 to May 2014;
- Papers relating to Quality reported to the Board over the period April 2013 to May 2014;
- Feedback from the Commissioners dated May 2014;
- Feedback from local Healthwatch organisations dated May 2014;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2013/14;
- The 2013/14 national patient survey*;*
- The 2013/14 national staff survey*;*
- Care Quality Commission quality and risk profiles/intelligent monitoring reports 2013/14; and
- The 2013/14 Head of Internal Audit's annual opinion over the Trust's control environment.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Calderdale and Huddersfield NHS Foundation Trust as a body, to assist the Council of Governors in reporting Calderdale and Huddersfield NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2014, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Calderdale and Huddersfield NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators.
- Making enquiries of management.
- Testing key management controls.
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation.
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report.
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

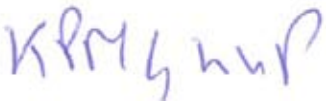
The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual.*

The scope of our assurance work has not included governance over quality or non-mandated indicators which have been determined locally by Calderdale and Huddersfield NHS Foundation

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2014:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual;*
- the Quality Report is not consistent in all material respects with the sources specified above; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual.*



KPMG LLP, Statutory Auditor

Manchester

29 May 2014

Our Governance and organisational arrangements

Our governance and organisational arrangements

Our Board of Directors

The Board of Directors is responsible for managing the business of the Trust and, subject to the Constitution, exercises all the powers of the Trust.

The Board of Directors is a unitary board with overall responsibility for delivering the activities of the Trust and is accountable for the clinical, service quality, financial and governance performance of the Trust as well as the definition and implementation of strategy and policy.

The Board has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in the Reservation of Powers to the Board and Scheme of Delegation. The day-to-day management of the Trust rests with the Chief Executive and Executive Directors who are responsible for taking decisions, particularly with regard to financial and performance issues and day-to-day quality matters, subject to the Trust's Scheme of Delegation and Standing Financial Instructions.

The Board is legally accountable for the services provided by the Trust and its key responsibilities include:

- Formulating strategy
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable.
- Shaping a positive culture for the board and the organisation.
- Working in partnership with patients, service users, carers, members, local health organisations, local government authorities and others to provide safe, accessible, effective and well governed services for patients, service users, and carers;
- Ensuring that the Trust meets its obligations to the population served, its stakeholders and its staff in a way that is wholly consistent with public sector values and probity; and
- Adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner.

The general duty of the board of directors, and of each director individually, is to act with a view to promoting the success of the trust so as to maximise the benefits for the members of the corporation as a whole and for the public.

The Board is of sufficient size that the balance of skills and experience is appropriate for the requirements of the business and the future direction of the Trust. Arrangements are in place that enable appropriate review of the Board's balance, completeness and appropriateness to the requirements of the Trust. The Board of Directors currently comprises a Chairman, six Non-Executive Directors and six Executive Directors. The Board considers each of the Non-Executive Directors to be independent in character and judgement and have identified no relationships or circumstances that are likely to affect or appear to affect their judgement. Our Non-Executive Directors were appointed because of their experience and specific skills and their strong links with the community. Their appointments and termination of tenure are determined by the Membership Council. Our Executive Directors are appointed through open competition in accordance with the Trust's recruitment and selection procedures.

Assessments of the Board are conducted using established Trust appraisal and personal development planning processes. In addition a skills assessment for the board, which was developed in 2007/8, continues to be undertaken and is reviewed each year as to its suitability. The outcomes of Non-Executive Director appraisals are provided to the Council of Governors in a summary format.

During 2013/14 the Trust commissioned independent external advisors to undertake a review of Board performance and the wider governance arrangements. This resulted in an action plan to streamline governance arrangements, improve performance reporting and review the annual business cycle. These actions were monitored through a task and finish group and at Board development workshops.

Register of directors' interests: Any member of the public who would like to view the Register of Directors' Interests should contact the Board Secretary on 01484 355933 or Email: kathy.bray@cht.nhs.uk. Anyone who would like to get in touch with a director should also contact the Board Secretary.

Meet the Board

NON-EXECUTIVE DIRECTORS

Mr Andrew Haigh - Chairman

Andrew was appointed as Chairman of the Trust in July 2011. He trained locally as a chartered accountant with Armitage & Norton and moved to KPMG in Leeds when the two firms merged in 1987. He specialised in IT risk management and audit, particularly within retail financial services and the public sector eventually leading the IT Advisory practice for the KPMG in the UK and the Financial Services practice in the North of England.

He retired from KPMG in 2008 to care for his wife who has a long term degenerative illness and became a Non-Executive Director of the Trust in December 2010. He is also a Non Executive Director at Furness Building Society in Barrow.

Andrew has lived in Huddersfield all his life and for the last 17 years in Almondbury. He has two daughters. When not at the Trust he enjoys music, walking and sport generally. He has been a Huddersfield Town supporter for over 50 years.

"Having personally experienced the good and bad of the NHS over the last few years, I wanted to join the Trust to help develop the good aspects and develop where it needs to and especially to get the whole health system operating in a more seamless way."

Mrs Jan Wilson – Non-Executive Director

Jan lives in the Holme Valley and has a background in strategic planning, commissioning and inspection in health and social care services. She has a management qualification and worked for Kirklees and Calderdale local authorities before moving to the West Midlands and the Mersey region LAs to implement the NHS and Community Care Act and the Children Act.

She was a Non-Executive Director with Calderdale and Kirklees Health Authority, Deputy Chair at South West Yorkshire Mental Health Trust and Senior Independent Director when it became South West Yorkshire Partnership NHS Foundation Trust (SWYPFT).

Current positions include Lay Chair for junior doctor recruitment and training with Yorkshire and the Humber Post Graduate Deanery, Non-Executive Director at Groundwork, Wakefield and its subsidiary companies Jobmatch UK and Whitwood Golf Club, Associate Hospital Manager at SWYPFT and Ambassador for Public Appointments with the Government Equalities Office.

Jan is currently Deputy Chair of the Trust and chairs the Quality Committee and the Health & Safety Committee and is a member of Audit & Risk Committee.

"I joined CHFT to bring experience in community health and social care to the acute hospital, improving integration of services in the local communities served by the Trust."

Dr David Anderson – Non-Executive Director

David is a GP at the Grange Group Practice, Fartown, where he has worked since 1983.

He is past Chairman of both the former Huddersfield Central and NHS Kirklees Professional Executive Committees. He was involved in commissioning hospital services, until he stepped down in June 2011.

David was brought up in West Yorkshire and has lived in Halifax and Huddersfield since 1980. He is married to a health visitor and has three children. He enjoys cycling, running and tennis.
David is committed to developing and delivering services in Calderdale and Huddersfield and recognises the benefits of more integration across hospital, primary care and local authority services.

David is the Senior Independent Director and is a member of the Charitable Funds Committee.

"I believe the future of health service provision locally lies in much closer working between hospital and community services , I hope to be part of making this a reality".

Prof Peter Roberts OBE – Non-Executive Director

Peter is Professor Emeritus of Sustainable Spatial Development at the University Of Leeds, Vice-Chair of the Northern Ireland Housing Executive and Group Chair of the First Ark Group – which includes a housing association and social enterprises.

He lives in Kirkheaton and is married to Jo, a former nurse who worked at Kirkwood Hospice.

Nationally and internationally he is involved in a range of activities linked to regional and urban planning, regeneration, housing and health, economic development and environmental management. Peter has acted as an advisor to the House of Commons Children's, Schools and Families Select Committee and to the Local Government Association and he has also written many books, reports and papers on urban and regional governance, planning, development, regeneration and the role of health in sustainable communities.

Did you know...?

We had 5,822 births last year with 48% girls and 52% boys.

Our governance and organisational arrangements

He has been involved in community regeneration projects in Tyneside, Merseyside, Greater Manchester, West Yorkshire and elsewhere.

He was awarded the OBE in 2004 for services to regeneration and planning. His hobbies include reading, fell-walking, restoring classic cars, opera and supporting Liverpool FC.

Peter is the Chair of the Trust's Audit and Risk Committee.

"I joined the Trust Board in order to help to plan, develop and sustain excellent health and associated care services for everyone who lives in the communities of Calderdale and Huddersfield."

Mr Jeremy Pease – Non-Executive Director

Jeremy has worked for the NHS for over 30 years in Human Resource and Operational Management roles in acute, community and mental health organisations and the ambulance service. Since 2007 he has been self employed and runs his own management consultancy.

Jeremy is married, has two sons and lives in Shepley. He enjoys walking and cycling in his spare time and has been a keen supporter of Barnsley FC for over 50 years.

Jeremy is a member of the Quality Committee and the Efficiency Programme Board.

"I do this job because I am part of a team at the Trust that is committed to meeting the challenges ahead in ensuring the continued provision of excellent, compassionate care for patients and families"

Mr Phil Oldfield – Non-Executive Director

Phil is a Chartered Accountant and MBA and he has a wide range of senior management experience within Retail, Manufacturing, Healthcare and Consultancy. He has over 15 years experience at Board level and has held a number of senior management roles in Logistics, IT and Operations.

Previous Healthcare experience includes Finance and Commercial Director for Nuffield Hospitals, Finance Director for Health and Social Care in Guernsey and a number of consultancy projects across the NHS. Phil has also recently taken up the role of Finance Director for the Sue Ryder Charity.

Phil grew up in the Huddersfield area and has travelled extensively taking two years out of his career to travel spending time in Mexico, Africa, China, USA, Australia, Central Asia, China and Eastern Europe.
Phil is a member of the Trust's Audit and Risk Committee and Charitable Funds Committee.

"I have had many contacts with the Trust especially with the A&E teams in my rugby playing years. I now watch sport which is safer! Through my own experiences I am fully aware of how important quality, local, healthcare is for all."

Dr Linda Patterson OBE – Non-Executive Director

Dr Linda Patterson OBE lives in Hebden Bridge and is a consultant physician in general and geriatric medicine. She worked in clinical practice at the East Lancashire Hospitals Trust.

She has been a clinical director, Trust Medical Director, and was medical director of the first NHS regulator, the Commission for Health Improvement. She has also been a non-executive director for the National Patient Safety Agency. She has recently stood down as the clinical vice-president of the Royal College of Physicians. She is passionate about improving quality of care, particularly using patient experiences to drive up quality. Her hobbies include playing the piano.

Linda is a member of the Quality Committee.

"I joined the Trust Board so I could bring my experience as a clinician to the delivery and improvement of care to patients".

EXECUTIVE DIRECTORS

Mr Owen Williams – Chief Executive

Owen joined Calderdale and Huddersfield NHS Foundation Trust as Chief Executive in May

2012. Working with doctors, nurses, therapists, porters and partners, Owen is keen to ensure that compassionate care is provided for the 458,000 people in the Trust's catchment area and beyond.

Prior to joining Calderdale he was Chief Executive of Rossendale Council and before that he worked in the commercial sector across Financial Services, Telecommunications and Marketing. He has also worked with the Department of Health as part of its original Strategic Health Authority assurance process and was Joint Chair and Local Authority lead on the National Mental Health Strategy Board – No Health without Mental Health.

Mr Williams, 46, was born in Bradford and educated at the

former Buttershaw Comprehensive School in Bradford and completed his MBA at the University of Huddersfield. Married with three children, he is a keen football fan and has resurrected his career as a basketball player – when his body and work permits.

"I want to make a positive difference to the lives of local people through providing compassionate care".

Mr Keith Griffiths – Executive Director of Finance

Keith was appointed Director of Finance in May 2011. He joined the Trust from Wrightington, Wigan and Leigh NHS Foundation Trust in Lancashire where he was Director of Finance and IT.

Keith joined the NHS graduate financial management team after leaving Bradford University in 1986. He qualified in 1991 and was appointed Finance Director of Walton Centre, in Liverpool in 1995 and also Acting Chief Executive there.

During a career break he travelled to South America, New Zealand, Australia, China and North America. When he returned he joined East Cheshire Hospitals in Macclesfield as Finance Director then moved to Wrightington, Wigan and Leigh.

"I am passionate about the values of the NHS. My aim is always to ensure every pound the organisation spends has maximum benefit to clinical outcomes and the patient experience".

Dr Barbara Crosse – Executive Medical Director

Consultant medical oncologist, Barbara Crosse has been at our Trust for 13 years and specialises in lung and gynaecological cancers, working with numerous teams within oncology and the medical and surgical specialties.

She previously worked in Leeds and Bradford as part of her training before joining the Trust. Her career started in infectious diseases and general internal medicine before moving into oncology.

Dr Crosse is married to John, retired deputy chief constable from Humberside police, and has a daughter Frankie. She enjoys music, mountain walking and is a church member

"My focus is on the quality and safety of patient care, the professional development of the medical workforce and contributing to the strategic direction of the Trust in the coming years."

Mrs Julie Dawes – Executive Director of Nursing (commenced 1 April 2014)

Julie joined the Trust as Director of Nursing in April 2014.

Previously Chief Nurse at Portsmouth NHS Trust, Julie brings a wealth of expertise in patient safety, patient experience and quality. Julie is originally from Hebden Bridge and has worked in hospitals in Leeds, Southampton and Portsmouth.

Julie has a clinical and managerial background in cancer and palliative care. She has particular areas of expertise in developing improvement programmes for patient experience and safety. She is an experienced leader who demonstrates an open and honest, but tenacious approach, and has a very high level of personal drive and commitment.

Julie has recently completed the Kings Fund Stretch to the Board programme and has been identified as one of the 100 leaders chosen to attend the Top Leaders Programme being led by the National Leadership Council. Julie is married with 3 children and enjoys walking, badminton and sailing.

I have been a nurse for over 30 years and my motives for becoming a nurse have never changed , I want to care for patients and strive to ensure they receive care that not only meets but exceeds expectations, I am delighted to have joined the trust and to be able to influence the the care patients and their families receive, I want every patient to receive the care I would wish for myself or my family.

Miss Julie Hull – Executive Director of Workforce and Organisational Development

Julie is a Chartered Fellow of the Institute of Personnel and Development and holds a law degree. Julie was the Director of Personnel for Calderdale NHS Trust, a position she held since September 1995, and was then appointed to the merged Calderdale and Huddersfield NHS Trust in May 2001.

Julie has broad NHS experience, having worked in primary, secondary and mental health care organisations. Her principal interest is ensuring that the employment arrangements in the Trust support the delivery of high quality, compassionate and organisational development care for patients and provide the best employment context for the workforce.

Julie is committed to developing workforce strategies that benefit the Trust, the local population and the wider health and social care community. Julie enjoys spending time with her family, reading and music.

"I am passionate about my role in Calderdale and Huddersfield NHS Foundation Trust team and I am fully committed to the values of the NHS."

A&E and Medical Assessment Unit:
"Could you please pass my thanks to A&E and MAU for the care they have given me. I have spent a lot of time at the hospital over the last 18 months and can't thank the staff enough for all they have done for me whilst I have been facing some very difficult illnesses."

Our governance and organisational arrangements

Miss Lesley Hill – Executive Director of Planning, Performance, Estates and Facilities

Lesley has 23 years' experience as both a healthcare practitioner and manager. She entered health service management following a period as a Community Pharmacist and having completed an MBA at Cranfield School of Management. She then worked in a variety of business manager, contracts manager and general manager roles at Northwick Park Hospital in Harrow.

Lesley became Head of Acute Commissioning for Bradford Health Authority in 1998, with a specific remit to help them sort out their waiting list and patient access problems, and deliver modernised services. In 2000 Lesley became the Director of Commissioning and Deputy Chief Executive for North Bradford Primary Care Trust. Lesley was Acting Chief Executive of North Bradford and Airedale Primary Care Trusts before her move to Calderdale and Huddersfield NHS Foundation Trust as Director of Service Development in 2006. In 2012 Lesley moved to her new role as Director of Planning. Performance, Estates and Facilities.

Lesley enjoys the theatre and opera, and participates in a variety of sports. She lives near Ilkley with her daughters.

"I am committed to my role at the team at CHFT and helping to provide quality care in a quality environment for our patients and their families."

Appointment and Board attendance during 2013/14				
Executive Directors				
Name	Responsibilities	Appointment date		Board attendance
		From	To	
Owen Williams	Chief Executive	14.05.12	Present	11/13
Keith Griffiths	Executive Director of Finance	25.07.11	Present	13/13
Barbara Crosse	Executive Medical Director	17.06.13	Present	09/11
*David Wise	Executive Medical Director	03.10.11	14.06.13	02/02
Julie Dawes	Executive Director of Nursing	01.04.14	Present	Not applicable
* Helen Thompson	Executive Director of Nursing	01.04.93	Retired 31.03.14	10/13
Julie Hull	Executive Director of Workforce and Organisational Development	01.09.95	Present	13/13
Lesley Hill	Executive Director of Planning, Performance, estates and Facilities	02.05.06	Present	11/13
Non-Executive Directors				
Name	Responsibilities	Appointment date		Board attendance
		From	To	
Andrew Haigh	Chairman	06.07.11	06.07.14	13/13
Jan Wilson	Non-Executive Director / Vice-Chair	30.11.11	30.11.14	12/13
David Anderson	Non-Executive Director, Senior Independent Director	22.09.11	22.09.14	11/13
Peter Roberts	Non-Executive Director	22.09.11	22.09.14	12/13
Jeremy Pease	Non-Executive Director	01.10.13	30.09.16	06/06
Phil Oldfield	Non-Executive Director	23.09.13	23.09.16	04/07
Linda Patterson	Non-Executive Director	01.10.13	30.09.16	04/06
*Jane Hanson	Non-Executive Director	01.10.08	Resigned 30.09.13	02/07
*Alison Fisher	Non-Executive Director	01.12.05	Term expired 30.09.13	05/07

*Post held in year

In accordance with the Monitor's revised Code of Governance "Non-Executive Directors may in exceptional circumstances serve longer than six years (e.g. two three-year terms following authorisation of the NHS Foundation Trust), but subject to annual re-appointment."

Our Membership Council

Our Membership Council has 28 places, of which 22 represent the public and staff and are elected by our members. The remaining six are appointed by partnership organisations. In 2013/14 these included: the two clinical commissioning groups, NHS Calderdale and NHS Greater Huddersfield; the University of Huddersfield, Calderdale Metropolitan Council; Kirklees Metropolitan Council and South West Yorkshire Partnership NHS Foundation Trust.

The Membership Council meets formally four times per year plus the Annual General Meeting. Ad hoc meetings are called as required. Membership Councillors listen to the views and ideas of the Trust's membership and of the wider public. They are broadly representative of the population that the Trust serves.

The Membership Council is involved in decisions with regard to:

- The appointment/removal of the Chairman and other Non-Executive Directors;
- The approval of the appointment (by the Non-Executive Directors) of the Chief Executive;
- The remuneration and allowances and the other terms and conditions of the Non-Executive Directors;
- The appointment/removal of the Trust's External Auditor;
- Receiving the Annual Accounts, any report of the External Auditor on the Annual Accounts and the Annual Report;
- The provision of views to the Board of Directors with particular regard to the Annual Plan;
- Consultation processes when consulted by the Board of Directors in accordance with the Constitution;
- Undertake such functions as the Board of Directors shall from time to time request; and
- The preparation and review of the Trust's Membership Strategy, its policy for the composition of the Membership Council and of the Non-Executive Directors.

In addition, the Membership Council has established the following Sub-Committees and Groups:

- Remuneration and Terms of Service of Non-Executive Directors Sub-Committee;
- Nominations Sub-Committee for Non-Executive Directors;
- Chairs Information Exchange Sub-Committee;
- Divisional Reference Groups:
  - Children's, Women's and Families Division
  - Diagnostic and Therapeutic Services
  - Surgical and Anaesthetic Services
  - Medical Division
  - Estates and Facilities

The Chair's Information Exchange Sub-Committee receives reports and recommendations from each of the above. In turn, these inform the Membership Council meetings.

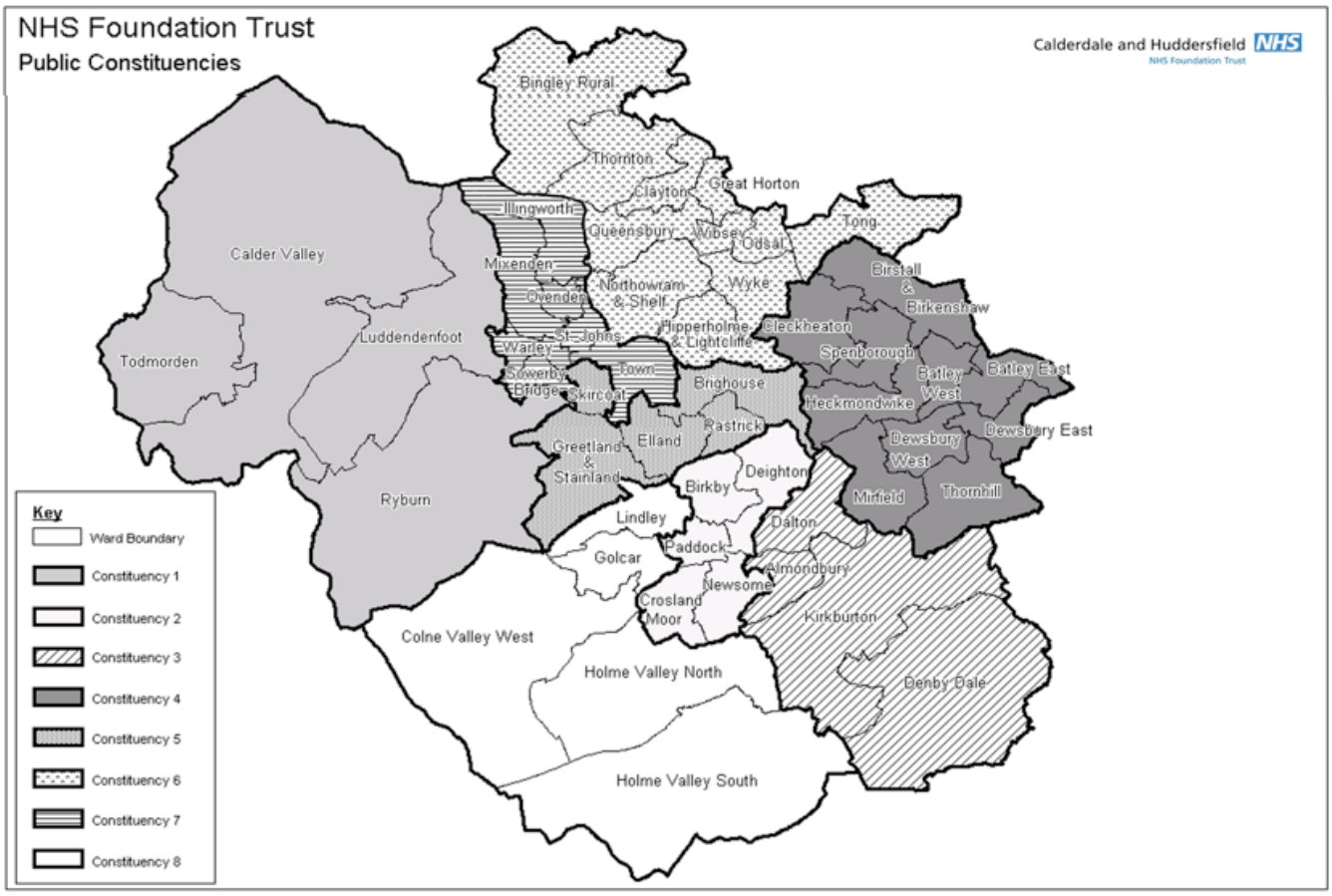
The Membership Council works closely with the Board of Directors. Directors routinely attend meetings of the Membership Council and representatives from the Membership Council attend Board of Director meetings. The Board of Directors and Membership Council also hold a joint workshop twice a year to consider future plans and strategic issues. The Membership Council receives reports at each of its meetings from the Director of Finance and Director of Planning, Performance, Estates and Facilities on current issues of performance. In addition the Membership Council receive minutes and papers of the monthly Board of Director Meeting together with the monthly Integrated Performance Report.

The Constitution clearly sets out how any disagreement between the Board of Directors and the Membership Council would be resolved and the role of the Senior Independent Director and Lead Membership Councillor in this process.

Board of Directors attendance at Membership Council meetings – 2013-14

	2.4.13	3.7.13	19.9.13 (AGM)	6.11.13	20.1.14
Andrew Haigh	✔	✔	✔	✔	✔
David Anderson		✔	✔		
Peter Roberts	✔		✔		
Jan Wilson			✔	✔	✔
Phil Oldfield	n/a		✔		
Linda Patterson	n/a	n/a	n/a		
Jeremy Pease	n/a	n/a	✔		
Alison Fisher		✔		n/a	n/a
Jane Hanson		✔		n/a	n/a
Owen Williams	✔	✔	✔		✔
Helen Thomson			✔		
Julie Hull	✔	✔	✔		✔
Keith Griffiths	✔	✔	✔		
Lesley Hill			✔	✔	✔
Barbara Crosse			✔	✔	

Our governance and organisational arrangements



Membership Council Public Constituencies

Constituency	Wards	Population
1	Todmorden	37,487
	Calder Valley	
	Luddendenfoot	
	Ryburn	
2	Birkby	62,501
	Deighton	
	Paddock	
	Crossland Moor	
	Newsome	
3	Dalton	56,161
	Almondbury	
	Kirkburton	
	Denby Dale	
4	Cleckheaton	144,794
	Birstall and Birkenshaw	
	Spenborough	
	Heckmondwike	
	Batley West	
	Batley East	
	Mirfield	
	Dewsbury West	
	Dewsbury East	
	Thornhill	
5	Skircoat	47,727
	Greetland & Stainland	
	Elland	
	Rastrick	
	Brighouse	

Constituency	Wards	Population
6	Northowram & Shelf	150,326
	Hipperholme & Lightcliffe	
	Bingley Rural	
	Thornton	
	Clayton	
	Queensbury	
	Great Horton	
	Wibsey	
	Odsal	
	Wyke	
	Tong	
7	Illingworth & Mixenden	63,407
	Ovenden	
	Warley	
	Sowerby Bridge	
	St Johns	
	Town	
8	Lindley	73,412
	Golcar	
	Colne Valley West	
	Holme Valley North	
	Holme Valley South	

Our governance and organisational arrangements

Summer elections were held in five public constituencies during 2013 and the results were announced at the Annual Members' Meeting in September 2013.

The elections were held under the independent scrutiny of the Electoral Reform Services.

There have been five formal meetings of the Membership Council during 2013/14 financial year and the attendance of the Membership Council members at these meetings is detailed below.

CONSTITUENCY	NAME	ELECTED UNTIL ANNUAL MEMBERS' MEETING (shading = current serving members as at 31.3.14)	ATTENDANCE AT FORMAL MEMBERSHIP COUNCIL MEETINGS 2013/14
PUBLIC – ELECTED			
1	Mrs Joan Doreen Taylor	2016	2 / 3
1	Mr Martin Urmston	2015	4 / 5
1.	Mr Bernard Pierce Also see Constituency 5 below	2014	1 / 2
2	Mrs Linda Wild	2014	4 / 5
2	Rev Wayne Clarke	2016	3 / 3
2	Mr Harjinder Singh Sandhu	2013	2 / 3
3	Mr Peter John Middleton	2014	3 / 5
3	Ms Dianne Hughes	2016	3 / 5
3	Mrs Wendy Wood	2013	1 / 3
4	Mrs Marlene Chambers	20.9.12	4 / 5
4	Mrs Christine Breare	2014	5 / 5
5	Mr Grenville Horsfall	2016	3 / 3
5 (RESERVE REGISTER)	Mr Bernard Pierce	2014	3 / 3
5	Miss Lisa Francis	2013	0 / 2
6	Mrs Johanna Turner	2015	5 / 5
6 (RESERVE REGISTER)	Mrs Janette Roberts	2014	3 / 3
7	Ms Kate Wileman	2014	2 / 5

7	Mrs Liz Schofield	2014	5 / 5
8	Mr Andrew Sykes	2015	4 / 5
8	Mrs Jennifer Beaumont	2016	2 / 3
8	Mrs Janette Roberts (Deputy Chair) *Also see Constituency 6 above*	2013	2 / 2
STAFF – ELECTED			
9 – Drs/Dentists	Dr Mary Kiely	2014	1 / 5
10 – AHPs/HCS/Pharm's	Miss Avril Henson	2015	3 / 5
11 – Mgmt/Admin/Clerical	Mrs Eileen Hamer	2015	5 / 5
12 – Ancillary	Miss Liz Farnell	2015	4 / 5
13 – Nurses/Midwives	Mrs Chris Bentley	2015	3 / 5
13 – Nurses/Midwives	Mrs Julie Mellor	Resigned 5.11.13	0 / 4
13 – Nurses/Midwives	VACANT POST		
NOMINATED STAKEHOLDER			
University of Huddersfield	Prof John Playle	2015	3 / 5
Calderdale Metropolitan Council	Cllr R Metcalfe	2014	5 / 5
Kirklees Metropolitan Council	VACANT POST		
NHS Kirklees CCG	Mrs Jan Giles	2014	2 / 5
NHS Calderdale CCG	Mrs Sue Cannon	2014	0 / 5
South West Yorkshire Partnership NHS FT	Mrs Dawn Stephenson	2016	4 / 5

Acute Stroke Unit:
"The staff we met were extremely helpful -from directing us to the right department, explaining what was happening and even making me a cup of coffee as I waited for my brother. Everyone we met seemed 'to care'. Thank you."

Our governance and organisational arrangements

The Register of Membership Council members' interests is made known at the start of each Membership Council meeting. Anyone who wants to view the register should contact the Board Secretary on 01484 355933 or email: kathy.bray@cht.nhs.uk.

MEMBERSHIP COUNCIL EXPENSES		
	TOTAL	Date of claim
Wendy Wood	£17.48	24.6.13
Liz Schofield	£17.59	23.7.13
Johanna Turner	£16.10	8.5.13
Johanna Turner	£5.00	8.5.13
Peter Middleton	£125.61	15.5.13
Johanna Turner	£124.40	2.6.13
Liz Schofield	£21.13	11.6.13
Liz Schofield	£12.47	28.10.13
Johanna Turner	£3.70	2.12.13
Johanna Turner	£21.10	2.12.13
Liz Schofield	£24.79	10.12.13
Grenville Horsfall	£18.80	14.12.13
Peter Middleton	£106.54	14.1.14
Grenville Horsfall	£19.32	11.3.14
Liz Schofield	£45.80	11.3.14
TOTAL	**£579.83**	

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 can be categorised as follows:

Training & Development opportunities

- **Membership Council Induction**

All newly elected or appointed Membership Councillors are invited to attend a comprehensive induction process. This consists of presentations, discussion, information and Trust guest speakers. Attended by the chairman, this induction introduces Membership Councillors to the structure, services and strategy of the Trust; and it clarifies their role in terms of governance and accountability. It marks the beginning of the process of Councillors becoming familiar with and engaging in the development of Trust plans and services.

- **Membership Councillor Training Programme**

Following induction, Membership Councillors are invited to attend a series of training offerings. These training offerings are designed to extend Councillors' knowledge of the Trust and the wider NHS in order to help them contribute to discussions on Trust strategy and planning. These interactive and informative sessions are delivered by subject experts and cover such topics as 'Understanding Quality in the NHS', 'An Introduction to NHS Finance', 'Improving The Patient Experience'

- **Membership Council Development Days**

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.

Governance

- **Chairman's One-to-One meetings**

Each newly elected or appointed Membership Councillor is offered the opportunity to meet with the Trust chairman on a one-to-one basis. These meetings help to set expectations, detail the support that is available, and clarify the role of the Membership Council. In addition, the Trust chairman meets quarterly with the deputy chairman of the Membership Council.

- **Membership Council meetings**

The full Membership Council meets formally four times a year, including the AGM. The meetings are attended by board directors as well as Membership Councillors and standing agenda items include business planning, service developments, quality and the Trust's financial position. These meetings include non-executive director observers.

- **Trust Board meetings**

Trust Board meetings are held monthly. To each of these meetings, three Membership Councillors are invited to attend as observers. An opportunity is given to Membership Councillors to share any comments or observations.

- **Membership Council Sub-committees and other Trust groups**

Membership Councillors are invited to sit on various sub-committees and groups across the Trust. These are opportunities for them to contribute to forward planning and strategic decision-making. These groups include the Remuneration & Terms of Service sub-committee; the Nominations sub-committee; the AGM planning sub-group; the Audit & Risk committee; the Charitable Funds committee; the Organ Donation committee; and the Equality & Inclusion group.

- **Quality Accounts**

Each year, members and Membership Councillors are asked to help the Trust to decide upon its priorities for quality improvement. A list of quality indicators is presented and explained. Membership Councillors discuss the priorities and are invited to give their

views on these or to add their own suggestions. Members and Membership Councillors gathered at an event at Huddersfield Royal Infirmary on February 28th this year to hear about the work being done across the hospitals to improve services for patients. They were then invited to vote on the suggested improvement indicators, and progress on these is published in the Trust's Quality Accounts.

Approval of Annual Plan

A draft version of the Trust's annual plan is shared with Membership Councillors. An extraordinary meeting provides an opportunity for Membership Councillors to review and comment upon divisional proposals and the Trust's overall plans. At the meeting, the Membership Councillors are asked to give their agreement to the finalisation of the annual plan.

Membership

Membership is free and aims to give local people and staff a greater influence over how our services are provided and developed. It also helps the Trust to work much more closely with local people and service users.

Our members:

- Have the chance to find out more about the hospitals, the way they are run and the challenges they face
- Help us work with local people to improve the care and experience of patients and their carers
- Elect representatives to the Membership Council.

Public membership is open to people aged 16 or over who:

- Is or has been a patient or carer at Calderdale and Huddersfield NHS Foundation Trust
- Lives within our defined membership area (see map on page 106)
- Works at the Trust

All eligible staff members automatically become foundation trust members unless they choose to opt out. Staff are eligible for membership provided that they fulfil one of the following criteria:

- They hold a permanent contract of employment with us,
- They have been employed by the Trust on a temporary contract of 12 months or longer
- They are employed by the Trust or one of its partners (e.g. local government, other NHS trusts) on a permanent basis or fixed-term contract of 12 months or more.

Membership as at May 2014

Constituency		Total
Overall Membership	All	15987
Public	1	624
	2	1974
	3	1241
	4	504
	5	1240
	6	746
	7	1464
	8	2157
Staff	9 Doctors/dentists	418
	10 AHPs/HCS/Pharmacists	790
	11 Mgmnt/Admin/clerical	1265
	12 Anciliary	1635
	13 Nurses/midwives	1929

Membership Strategy

Our Membership Strategy was reviewed in December 2013 and set out the vision for the Trust's membership and the methods we intend to use to maintain a representative, engaged membership. It also set out the plans for the recruitment and retention of members. The Strategy included six key membership objectives for 2014/15:

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 the 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 engagement activities in an effort to ensure we are communicating and engaging with our members at the optimal level.

5. Deliver on 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 the Membership Office business systems and processes and the Membership Portal and implement any changes necessary to enhance the membership function.

Did you know...?

Sending text reminders is now helping us to cut the number of missed appointments.

Our governance and organisational arrangements

Engagement with members
There are a number of ways in which the Trust engages and communicates with its membership. Some examples are:

- Medicine 4 Members

The Trust holds a programme of events throughout the year called Medicine 4 Members. These provide a behind-the-scenes look at how we deliver healthcare from some of our leading clinicians and are proving increasingly popular. Audience levels are increasing all the time and the light-hearted and informative talks are proving popular amongst people of all ages – including people who are lifelong NHS supporters and want to find out more about it and also from schools and colleges who have 6th forms where student maybe considering careers in medicine. The topics covered included the history of X-rays from their discovery to their modern use in diagnosis, the full range of maternity service and advances in diabetes medicine.

- Foundation News

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

- Recruitment Panels

As part of the Trust's recruitment process, members are invited to sit on interview panels for key appointments. This gives the Trust the opportunity to directly engage with its members and involve them in the decision making.

- Real time patient monitoring

Members have been 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.

Recruitment activity
To maintain a thriving membership, the Trust undertakes an active recruitment campaign throughout the year. A recent review of the membership against the 2011 Census showed that while the membership is broadly representative, there were gaps in representation of men and Asian members. A targeted recruitment campaign will take place during 2014/15 to address these gaps. Membership Councillors are involved in the recruitment and include both face to face as well as information campaigns and use of the Trust's website.

Contacting the Membership Council
If you would like to get in touch with a Membership Council member, or would like to find out more about becoming a member or about the services provided by the Trust please contact the membership office on 01484 347342 or email: membership@cht.nhs.uk or mail: The Membership Office, Calderdale and Huddersfield NHS Foundation Trust, Freepost HF2076, The Royal Infirmary, Lindley, Huddersfield, HD3 3LE.

Committees of the Board of Directors

The Board of Directors has established a number of committees to enable it to discharge its duties effectively. These are:

- Audit and Risk Committee
- Quality Committee
- Health and Safety Committee
- Nominations Committee
- Charitable Funds Committee
- Pennine Property Partnership Board - The Pennine Property Partnership (PPP) was established by the Trust and Henry Boot developments in March 2011, to support the Trust in delivering its Estates strategy. Its short term objectives are, to develop and deliver for Trust occupation, the Acre Mill site, together with securing a commercially viable redevelopment of the St Luke's site at Crossland Moor in Huddersfield.

Audit and Risk Committee Report

The Trust has an Audit and Risk Committee (Committee) whose primary role is to judge and report upon the adequacy and effective operation of the overall control systems of the organisation with specific focus on the framework of risks, controls and related assurances that underpin the delivery of the organisation's objectives.

The Committee has approved Terms of Reference which are reviewed annually and are available on request.

The Committee, which met nine times during 2013/14, consists of non-executive director members (and membership council observers) and their attendance of the Committee for the financial year 2013/14 was:

NAME	ATTENDANCE AT AUDIT COMMITTEE MEETINGS 01/04/2013 – 31/03/2014
Jane Hanson (Chair from 1.2.10 until 24.7.13)	**02 / 03**
Peter Roberts (Chair from 22.10.13 to present)	**02 / 02**
Philip Oldfield	**02 / 02**
Jan Wilson	**05 / 05**
Alison Fisher	**02 / 03**
David Anderson (co-opted)	**01 / 01**
Andrew Sykes (appointed December 2012 as Membership Council Observer on Audit and Risk Committee)	**01 / 05**
Peter Middleton (appointed Dec 2012 as Deputy Membership Council Observer on Audit and Risk Committee)	**02 / 02**

Although not members of the Committee, the Director of Finance, Director of Nursing, Deputy Director of Finance, Associate Director of Risk Management, Trust Company Secretary attend each meeting along with representatives from both internal and external audit functions together with representation from the local counter fraud service.

The Committee is keen to interact with other executives and senior managers and representatives from finance and the wider organisation have attended at the Committee's request.

The principal activities of the Committee over the year were:

Financial Reporting
The primary role of the Committee in relation to financial reporting is to review with both management and the external auditor the appropriateness of the annual financial statements concentrating on:

- the quality and acceptability of accounting policies and practices;
- the clarity of the disclosures and compliance with financial accounting standards and the relevant financial reporting requirements;
- material areas in which significant judgements have been applied or there has been discussion with the external auditor.

To aid the review, the Committee received reports from the Director of Finance and also reports from the external auditor on the outcomes of their interim and year end audit process.

The four key areas of judgement for the 2013/14 financial statements considered by the Committee were:

- the consolidation of the Trust's charitable funds.

Within the year, the Director of Finance confirmed to the Committee that the Trust would prepare consolidated financial statements of the Trust and charitable funds. As part of the interim and final audit reporting process the Committee received assurance from the external auditor that the requirement to consolidate charitable funds was appropriate and consistent and compliant with the relevant accounting standards and the Annual Reporting Manual as issued by Monitor.

- the provision of liabilities;

The Trust has made provision for future liabilities within the financial statements. As part of the year end reporting process the external auditor has reviewed the appropriateness of these provisions and has confirmed to the Committee that they represent a 'cautious' position.

- the impairments of fixed assets;

The Committee has reviewed the impairments of fixed assets that have been recognised in accordance with the relevant accounting policy. As part of the year end reporting process the external auditor has reviewed the District Valuers fixed asset valuation report and confirms the Trust has applied this report in the correct way.

- the evidence to support the Trust's going concern status.

The Committee received a paper from the Director of Finance detailing the evidence to support the Trust's going concern status. The Committee reviewed this paper and confirmed their support for recommending to the Trust Board that the financial statements should be prepared on a going concern basis.

In addition, and on a quarterly basis, the Committee considered the financial statements that formed part of the quarterly reporting submission to the Trust's regulator, Monitor.

Governance and Risk Management
During the course of the year the Committee has continued to ensure the Trusts governance arrangements are reviewed in line with the Code of Governance for Foundation Trusts published by Monitor.

Any changes are reflected within the relevant Trust policies and procedures and reported to the Committee for approval.

In the early part of 2014/15 the Committee approved updates to the following key documents:
- The Standing Orders
- The Standing Financial Instructions
- Scheme of Delegation

The Committee also reviews, on a regular basis, the risks that are described within the Trust's Board Assurance Framework and Trust Risk Register. The Committee has oversight of, and relies on the work of the Risk, Compliance and Assurance Committee to monitor compliance registers and risk registers and performance against national risk and safety standards.

Of particular importance is the review of the disclosure statements that flow from the Trust's assurance processes with internal control weaknesses described within the Annual Governance Statement.

The Committee discussed and agreed upon the disclosed areas of internal control gaps as described within the 2013/14 Annual Governance Statement.

Within the year 2013/14, the Committee has followed the progress of a Trust-wide review of governance and risk management processes from Trust Board to ward level. The review was conducted by independent facilitators and was undertaken to ensure that from Board to ward level, there were robust arrangements in place for governance and risk management processes.

The Committee is specifically focused on the improvement work being undertaken with the Board Assurance Framework and associated risk management processes that exist within the Trust. This work stream, along with the wider programme of work, is expected to be complete by June 2014.

Regulatory Relationships
The Committee is briefed by the executive directors on the Trust's relationship with it's key regulators and any significant changes that affect the Trust's operational environment.

Within 2013/14 the following key items were discussed:
- reports from Monitor following the Trust's quarterly reporting submissions;
- recognition and impact assessment of the changes to Monitor's risk assessment framework;
- changes to Monitor's provider licence conditions;
- site and service inspection reports from the Care Quality Commission (CQC).

Internal Audit and Counter Fraud
The internal audit and counter fraud service is supplied by the West Yorkshire Audit Consortium (WYAC).

The Committee receives regular reports from the Internal Auditor and Local Counter Fraud Specialist.

The Committee agrees a defined work plan and monitors progress against this plan in addition to any specific, pro-active pieces of work that have been identified by management within the year.

The plans as agreed for 2013/14 were completed and culminated in an annual opinion from the Head of Internal Audit (HOIA).

The HOIA opinion is received and discussed by the Committee as part of the year end assurance process.

External Audit
The external audit service is provided by KPMG LLP (KPMG). KPMG was appointed on 1 October 2012 following a market testing exercise in the summer of 2012.

The appointment process followed the guidance issued by Monitor and resulted in the approval of KPMG by the Membership Council at their meeting in September 2012.

A three year contract was awarded to KPMG with options to extend or terminate in accordance with the conditions of the contracts. The three year contract is in line with Monitor's recommendations that NHS Foundation Trusts undertake a market testing exercise at least once every five years.

The Committee recognise that non-audit related services can be provided by KPMG. In order to maintain KPMG's independence, the Committee has been informed of the robust internal procedures that KPMG apply when considering the undertaking of any non-audit services. In addition to this control, any significant non-audit services would require the pre-approval of the Committee.

In the year 2013/14 there were no significant non-audit related services provided by KPMG.

The Committee reviewed and approved the External Audit plan for 2013/14. The auditors explained the programme of work they planned to undertake to ensure that the identified audit risks did not lead to a material misstatement of the financial statements and it is through the monitoring of this audit plan that the Committee gain assurance of the quality and effectiveness of the service received from KPMG.

The key risks they identified for 2013/14 were:
- Restructure of the finance function;
- Achievement of financial targets and cost improvement plan (CIP) delivery; and
- Consolidation of the Trust's charitable funds.

As part of the yearend audit process the auditor confirmed that there are no material misstatements within the financial statements. The auditors also reported the misstatements that they had found in the course of their work and confirmed that there are no materials items remaining unadjusted within the financial statements.

Remuneration Committees

The remuneration and nomination of directors is separated. Executive Director appointment and remuneration is the responsibility of the Board of Directors. Non-Executive Director appointment and remuneration is the responsibility of the Membership Council.

Remuneration Committee – Executive Directors
The Remuneration Committee of the Board of Directors sets the remuneration and contractual arrangements for the Executive Directors.

The Sub-Committee comprises the Chair of the Board of Directors and five Non–Executive Directors (the Non–Executive Director who Chairs the Audit Committee does not sit on the Remuneration Committee).

In the 2013/14 financial year the Sub-Committee met on 19 December 2013.

The business of the Sub-Committee was conducted in accordance with its Terms of Reference. The members of the Sub-Committee were as follows:

Name and Role	Attendance at 19.12.13
Mr Andrew Haigh, Chair	✔
Mr Jeremy Pease, Non-Executive Director	✔
Dr Linda Patterson, Non- Executive Director	✔
Mr Philip Oldfield, Non-Executive Director	✔
Mrs Jan Wilson, Non-Executive Director	✘
Dr David Anderson, Non-Executive Director	✘

The Sub-Committee was quorate with four members present at the meeting and was able to conduct its business. The Sub-Committee's Terms of Reference were reviewed and accepted for the current financial year.

Nominations Committee - Executive Directors
The Nominations Committee for Executive Directors is the Board of Directors. In April 2013 the Board agreed to progress recruitment to the position of Medical Director following the resignation of the incumbent post holder and in August 2013 the Board agreed to progress recruitment to the Director of Nursing post following the retirement of the incumbent post holder.

Our governance and organisational arrangements

Remuneration and Terms of Service – Non-Executive Directors
The Remuneration and Terms of Service Sub-Committee of the Membership Council sets the remuneration and terms of service for the Non-Executive Directors of the Foundation Trust.

In 2013/14 the Sub-Committee met on the 28 January 2014, in accordance with its Terms of Reference.

The Sub-Committee comprises six members of the Membership Council from which the Chair of the Sub-committee is appointed. In the 2013/14 financial year the members were as follows:

Name and Role	Attendance at 28.1.14
Mrs Eileen Hamer, staff elected member and nominated Chair (for this meeting)	✔
Mrs Janette Roberts, publicly elected member	✔
Rev Wayne Clarke, publicly elected member	✔
Mrs Jennifer Beaumont, publicly elected member	✔
Mrs Chris Bentley, staff elected member	✘
Mr Andrew Sykes, publicly elected member	✘

Nominations Committee - Non-Executive Directors
The Nominations Committee for Non-Executive Director appointments is a sub - committee of the full Foundation Trust Membership Council. The standing membership of the sub-committee is:

- The Chair of the Trust (or Vice Chair/Acting Chair in relation to the appointment of the Chair)
- One appointed Membership Council Member
- Three elected Membership Council Members (at least two of whom must be publicly elected)
- The Chief Executive of the Foundation Trust

The quorum necessary for the transaction of business is four members of the Sub-Committee, one of whom must be the Chair (or Vice Chair/Acting Chair).

Attendees for advice and committee support:

- Director of Workforce and Organisational Development
- Board Secretary

The Sub-Committee met on three occasions (16.5.13, 3.7.13, 18.7.13 and 31.7.13) to discuss and appoint to Non-Executive appointments arising in-year. The Sub-Committee made the following decisions:

- The appointments of three Non-Executive Directors for three years: - Mr Philip Oldfield (with effect from 23.9.13), Dr Linda Patterson (with effect from 1.10.13) and Mr Jeremy Pease (with effect from 1.10.13).
- In accordance with best practice, the Nominations Sub-Committee commissioned the services of an external recruitment consultancy (Odgers Berndtson) to assist with the recruitment of the Non-Executive Directors.

Name	Attendance at 16.5.13 Nominations Sub-Committee	Attendance at 3.7.13 Nominations Sub-Committee (Longlisting)	Attendance at 18.7.13 Nominations Sub-Committee (Shortlisting)	Attendance at 31.7.13 Nominations Sub-Committee (Interviews)
Mr Andrew Haigh (Chairman)	✔	✔	✔	✔
Mrs Chris Breare	✔	✔	✔	✔
Mrs Linda Wild	✔	✔	✔	✔
Prof John Playle	✔	✔	✔	✔
Mrs Johanna Turner (from Jan 2014)	N/A	N/A	N/A	N/A
Mr Owen Williams	✔	✔	✔	✔
Mr Keith Griffiths (co-opted as Finance Assessor)			✔	✔

Remuneration Report

I am pleased to present the Remuneration Report for 2013-14. It is important that our remuneration policy enables the Trust to recruit and retain skilled and experienced leaders that are able to drive forward our ambitious plans for delivering compassionate care. At the same time it is important to recognise the broader economic environment and the need to deliver value for money from the public funds with which we are entrusted.

This report outlines the approach adopted by the appointments, remuneration and terms of employment committee when setting the remuneration of the executive directors and the other executives who have authority or responsibility for directing or controlling the major activities of the organisation.

Details on membership of the appointments, remuneration and terms of employment committee and individual attendance can be found on page 115 of this Annual Report.

Remuneration Policy
The remuneration policy of the Foundation Trust, which applies equally to Non-Executive Directors, Executive Directors and senior below Board level posts is based upon open, transparent and proportionate pay decisions. All pay decisions are based on market intelligence and are designed to be capable of responding flexibly to recruitment imperatives to secure high calibre people. The Trust has well established performance appraisal systems that operate within the Trust's devolved structure

The Sub-Committees of the Membership Council and Board of Directors, which deal with the remuneration, terms of service and contractual arrangements for the Non-Executive Directors and Executive Directors respectively, operate within well understood and regulated frameworks. The Committees receive professional reports in order to inform their decisions and ensure they are evidence-based. The reports use pay information derived from the Annual Reports of all Trusts of a similar size and complexity as Calderdale and Huddersfield NHS Foundation Trust (the annual IDS NHS Boardroom Pay Report), together with Foundation Trust Network information, Department of Health guidance and, in accordance with the Terms of Reference for the Committees, advice from independent advisors. The way in which the Committees operate is subject to audit scrutiny.

Remuneration of Non-Executive Directors
The Remuneration and Terms of Service sub-committee of the Membership Council received a report from the Hay Group which set out in detail all the matters that should be in place to receive assurance about the remuneration of the Non-Executive Directors. The recommendation was to adhere to the NHS pay arrangements for the NHS workforce for 2013/14 and therefore apply a 1% uplift in the pay for Non-Executive Directors for this financial year. The Sub-Committee received professional advice from Julie Hull, Director of Workforce and Organisational Development.

Remuneration of Executive Directors
The Remuneration Committee, in setting the pay of the Executive Directors, based its decisions on Department of Health guidance, Foundation Trust Network pay data, and IDS NHS Boardroom Pay Reports.

In accordance with the Committee's Terms of Reference it was agreed that:

- In line with the 1% pay award for the NHS the Directors pay points would be uplifted by 1% from 1 April 2013
- A job evaluation process would be undertaken for Executive Directors as well as those currently outside the purview of the Remuneration Committee (Director of Commissioning & Partnerships, Director of Operations and Director of Health Informatics Service).
- The Director of Workforce & Organisational Development, in liaison with the Board Secretary would review and amend the Terms of Reference, having regard to the Compendium of Good Practice issued by the Foundation Trust Network.

Further details about the work of the Nominations, Remuneration and Terms of Service Committees can be found within the section about Committees of the Board.

Additional Information
The details of salary and expenses are included in the table below. The contractual arrangements for the Executive Directors are based on standard NHS contracts and best employment practice. There are no liabilities in the event of early termination save for contractual notice and rights accruing under employment legislation. No significant awards have been made in year to Executive Directors or senior managers.

Mr Owen Williams
Chief Executive
May 2014

A&E, MAU, Pain Clinic, Rheumatology: "I had to attend A&E due to intolerable pain. The staff in both A&E and the Medical Assessment Unit were incredibly caring and patient. I am a single parent and attended with my young son. Upon being told I needed to be admitted, the staff went above and beyond to help me locate someone who could look after my son overnight. I had great and fast treatment which reduced my pain quickly and the food was fantastic."

Our governance and organisational arrangements

It is the view of the Board of Directors that the authority and responsibility for directing and controlling the major activities of the trust is retained by the board of directors and is not exercised below this level.

Name and Title	2013 -14					
	Salary (bands of £5,000) £000	Taxable Benefits (bands of £00) £00	Annual Performance Related Bonuses (bands of £5,000) £000	Long Term Performance Related Bonus (bands of £2,500) £000	Pension Related Benefits (bands of £2,500) £000	Pension Entitlement as at 31.03.14 (bands of £5,000) £000
A Haigh ~ Chair	50 - 55	4 - 5	0	0	0	0
A Fisher ~ Non-Executive Director (Note A)	5 - 10	0	0	0	0	0
D Anderson ~ Non-Executive Director	10 - 15	0	0	0	0	0
J Hanson~ Non-Executive Director (Note B)	5 - 10	4 - 5	0	0	0	0
J Pease ~ Non-Executive Director (Note C)	5 - 10	0	0	0	0	0
J Wilson ~ Non-Executive Director	10 - 15	7 - 8	0	0	0	0
L Patterson ~ Non-Executive Director (Note D)	5 - 10	0	0	0	0	0
M Savage ~ Non-Executive Director (Note E)	0	0	0	0	0	0
P Oldfield ~ Non-Executive Director (Note F)	5 - 10	0	0	0	0	0
Prof P Roberts ~ Non-Executive Director (Note G)	10 - 15	1 - 2	0	0	0	0
W Jones ~ Non-Executive Director (Note H)	0	3 - 4	0	0	0	0
B Crosse ~ Medical Director (Note I)	155 - 160	0	0	0	275.0 - 280.0	65 - 70
J Webb ~ Acting Director of Service Development (Note J)	0	0	0	0	0	0
K Griffiths ~ Director of Finance	145 - 150	13 - 14	0	0	7.5 - 10.0	50 - 55
L Hill ~ Director of Planning, Performance and Estates & Facilities (Note K)	130 - 135	6 - 7	0	0	62.5 - 65.0	40 - 45
J Hull ~ Director of Personnel	125 - 130	0	0	0	42.5 - 45.0	45 - 50
D Wise ~ Medical Director (Note L)	40 - 45	0	0	0	(132.5 - 135.0)	55 - 60
H Thomson ~ Director of Nursing	130 - 135	29 - 30	0	0	(160.0 - 162.5)	65 - 70
O Williams ~ Chief Executive (Note M)	185 - 190	19 - 20	0	0	22.5 - 25.0	60 - 65
Additional disclosure						
Band of the highest paid Director's total remuneration	185 - 190					
Median Total (£'000)	26,907					
Remuneration ratio	7					

Name and Title	2012-13					
	Salary (bands of £5,000) £000	Taxable Benefits (bands of £00) £00	Annual Performance Related Bonuses (bands of £5,000) £000	Long Term Performance Related Bonus (bands of £2,500) £000	Pension Related Benefits (bands of £2,500) £000	Pension Entitlement as at 31.03.13 (bands of £5,000) £000
A Haigh ~ Chair	45 - 50	3 - 4	0	0	0	0
A Fisher ~ Non-Executive Director (Note A)	10 - 15	0 - 1	0	0	0	0
D Anderson ~ Non-Executive Director	10 - 15	0	0	0	0	0
J Hanson~ Non-Executive Director (Note B)	20 - 25	0 - 1	0	0	0	0
J Pease ~ Non-Executive Director (Note C)	0	0	0	0	0	0
J Wilson ~ Non-Executive Director	10 - 15	4 - 5	0	0	0	0
L Patterson ~ Non-Executive Director (Note D)	0	0	0	0	0	0
M Savage ~ Non-Executive Director (Note E)	0 - 5	0	0	0	0	0
P Oldfield ~ Non-Executive Director (Note F)	0	0	0	0	0	0
Prof P Roberts ~ Non-Executive Director (Note G)	10 - 15	4 - 5	0	0	0	0
W Jones ~ Non-Executive Director (Note H)	5 - 10	0	0	0	0	0
B Crosse ~ Medical Director (Note I)						
J Webb ~ Acting Director of Service Development (Note J)	65 - 70	2 - 3	0	0	57.5 - 60.0	25 - 30
K Griffiths ~ Director of Finance	145 - 150	1 - 2	0	0	55.0 - 57.5	45 - 50
L Hill ~ Director of Planning, Performance and Estates & Facilities (Note K)	100 - 105	4 - 5	0	0	(35.0 - 37.5)	35 - 40
J Hull ~ Director of Personnel	120 - 125	0	0	0	5.0 - 7.5	40 - 45
D Wise ~ Medical Director (Note L)	220 - 225	0	0	0	95 - 100	80 - 85
H Thomson ~ Director of Nursing	130 - 135	28 - 29	0	0	155.0 - 157.5	70 - 75
O Williams ~ Chief Executive (Note M)	160 - 165	15 - 16	0	0	**	55 - 60
Additional disclosure						
Band of the highest paid Director's total remuneration	220 - 225					
Median Total (£'000) (Note N)	27,625					
Remuneration ratio	8					

Our governance and organisational arrangements

B) Pension Benefits

Name and title	Real Increase / (Decrease) in pension at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2014 (bands of £5000) £000	Cash Equivalent Transfer Value at 1 April 2013 £000	Real Increase / (Decrease) in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2014 £000
B Crosse ~ Medical Director	10.0 - 12.5	65 - 70	1,033	357	1,413
K Griffiths ~ Director of Finance	0.0 - 2.5	50 - 55	839	48	906
L Hill ~ Director of Service Development	2.5 - 5.0	40 - 45	658	82	755
J Hull ~ Director of Personnel	2.5 - 5.0	45 - 50	795	72	885
D Wise ~ Medical Director (Note O)	(5.0 - 7.5)	55 - 60	1,621	(510)	1,147
H Thomson ~ Director of Nursing	(5.0 - 7.5)	65 - 70	1,421	(84)	1,369
O Williams ~ Chief Executive	2.5 - 5.0	60 - 65	577	43	632

O, 12.13 pension figure has been amended to show the full annual pension as opposed to time worked as director

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase/ (Decrease) in CETV

As of 22nd July 2010 all CETV factors are based on Consumer Price Index (CPI)
Non-Executive directors do not receive pensionable remuneration, there will be no entries in respect of pension related benefits for Non-Executive directors.

A, A Fisher resigned 30.09.13
B, J Hanson was Chair of Risk & Audit Committee and resigned 30.09.13
C, J Pease appointed 01.10.13
D, L Patterson appointed 01.10.13
E, M Savage appointed 01.11.12 and resigned 31.03.13
F, P Oldfield appointed 23.09.13
G, Prof P Roberts is the Chair of Risk & Audit Committee
H, W Jones resigned 11.11.12
I, B Crosse appointed as Medical Director on 17.06.13
J, J Webb acted up as Director of Service Development from April to September 2012.
K, L Hill (Director of Service Development) salary reduced due to leave within 2012.13
L, D Wise resigned 15.06.13. 12.13 salary figure has been amended to show the full annual salary and as opposed to time worked as director
M, O Williams - appointed 14.05.12
N, The median value for 12.13 has been amended in line amendment to medical director salary
**, Unable to disclose as started 14.05.12 so no prior year comparator

Additional disclosure

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest-paid director in Calderdale and Huddersfield NHS Foundation Trust in the financial year 2013/14 was £185k - £190k (2012/13 was £220k - £225k). This was 7 times the median remuneration of the workforce, which was £26,907.

Compliance with the NHS Foundation Trust Code Of Governance

The purpose of the code of governance is to assist NHS foundation trust boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance. The code is issued as best practice advice, but requires a number of disclosures to be made within the annual report.

The NHS foundation trust code of governance contains guidance on good corporate governance to NHS foundation trusts to help them deliver effective corporate governance, contribute to better organisational performance and ultimately discharge their duties in the best interests of patients.. Monitor, as the healthcare sector regulator and the code's author, is keen to ensure that NHS foundation trusts have the autonomy and flexibility to ensure their structures and processes work well for their individual organisations, whilst making sure they meet overall requirements. For this reason, the code is designed around a "comply or explain" approach.

Comply or explain
Monitor recognises that departure from the specific provisions of the code may be justified in particular circumstances, and reasons for non-compliance with the code should be explained. This "comply or explain" approach has been in successful operation for many years in the private sector and within the NHS foundation trust sector. Trusts are required to assess their compliance with the Code and explain any departures to Monitor. In providing an explanation for non-compliance, NHS foundation trusts are encouraged to demonstrate how its actual practices are consistent with the principle to which the particular provision relates.

Whilst the majority of disclosures are made on a "comply or explain" basis, there are other disclosures and statements (which we have termed "mandatory disclosures" in this report) that we are required to make, even where we are fully compliant with the provision.

As a licensee, the Trust is required to apply those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. To do this, the Trust has regard to guidance from Monitor, the sector regulator for healthcare, including the NHS Foundation Trust Code of Governance which has recently been updated. All directors and governors have signed a declaration indicating their compliance with the "fit and proper persons" test introduced through condition G4 of the provider licence.

There are a number of key policies and documents that capture the main and supporting principles of the Code:

- Standing Orders, Standing Financial Instructions, Scheme of Delegation and Constitution.
- Standards of Business Conduct and Register of Declarations of Interest
- Integrated Board report

- Board and Committee reports and the supporting minutes
- Annual business cycle of the Board of Directors and its Committees
- Governance Strategy, including the Risk Management Policy and Procedure
- Job description and role description of the Senior Independent Director
- Terms of reference of the committees and sub-committees of the Board of Directors and Membership Council
- The Board of Directors skills and capabilities matrix
- Non-Executive Director candidate information pack and induction programme
- Appraisal policy
- Independent Governance review report
- Membership Council standing orders
- Membership Councillors' Charter
- Membership Strategy and Policy for Engaging Members
- Membership Councillors Recruitment and Induction Pack
- Policy for the expulsion of Membership Councillors
- Patient and Public Involvement Strategy
- Chairs' Information Exchange
- Internal and External Auditor reports

The Board of Directors receives an annual assessment of the Trust's compliance with the Code, which is tested through internal audit. The full assessment against the Code is available on the Trust website in the meeting papers of the Board of Directors.

The Trust has identified one departure from the Code:
B.2.11 the appointment of an executive director

The Code recommends that the Chair, other Non-Executive Directors and the Chief Executive make appointments to executive director posts following nomination of suitable candidates by the Nominations Committee. In the case of the appointment of the Executive Director of Nursing, the appointment to the post was made by a panel comprising the Chair, Chief Executive, Executive Director of Finance and external nursing advisor.

Did you know...?
Acre Mills thrills – looking forward to opening of our new healthcare centre hub in 2015 and welcoming our first patients.

Our governance and organisational arrangements

All provisions required to be shared with the public are included on the Trust's website. The Code requires that Trusts include compliance with a number of provisions to be clearly set out in the Annual Report. The table below demonstrates where these are evidenced within the Annual Report:

Code provision	Requirement	Location in Annual Report
A.1.1	This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	Strategic Report Page 8 Our Membership Council Page 109
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	Our Governance and Organisational Arrangements Board of Directors Page 104
A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	Our Governance and Organisational Arrangements Our Membership Council Page 109
FT ARM	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	Our Governance and Organisational Arrangements Our Membership Council Page 109
B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary	Our Governance and Organisational Arrangements Board of Directors Page 104
B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	Our Governance and Organisational Arrangements Board of Directors Pages 104
FT ARM	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated	Our Governance and Organisational Arrangements Board of Directors Pages 104
B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	Our Governance and Organisational Arrangements Committees of the Board of Directors Page 104
FT ARM	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	Not applicable. Non Executive Directors were recruited through open advertisement.
B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	The Chair has no other significant commitments to disclose
B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Strategic Report Page 8 In 2014, the Trust has published a Strategic Outline Case for a major reconfiguration of services. As part of the engagement and consultation process, Membership Councillors will be engaging with their constituencies to gain insight and feedback on the plans.
FT ARM	If, during the financial year, the Governors have exercised their power under paragraph 10C of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report.	Not applicable. The Membership Council have not exercised this power during this financial year.

Code provision	Requirement	Location in Annual Report
B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	Our Governance and Organisational Arrangements Board of Directors Page 104
B.6.2	Where an external facilitator is used for reviews of governance, they should be identified and a statement made as to whether they have any other connection with the trust.	Our Governance and Organisational Arrangements Board of Directors Page 104
C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	Statement of the Accountable Officer Page 139 Statement of the Auditor Page 140 Annual Governance Statement Page 130
C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	Annual Governance Statement Page 130
C.2.2	A trust should disclose in the annual report: (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	Annual Governance Statement Page 130
C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	Not applicable in this financial year
C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: – the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; – an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and – if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	Our Governance and Organisational Arrangements Committees of the Board of Directors Page 116
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Not applicable. No executive directors have been released to serve as a non-executive elsewhere
E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Strategic Report Page 8 Our Governance and Organisational Arrangements Our Membership Council Page 109
E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Our Governance and Organisational Arrangements Our Membership Council Page 109
FT ARM	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership, including progress towards any recruitment targets for members.	Our Governance and Organisational Arrangements Our Membership Council Page 109
FT ARM	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust.	Our Governance and Organisational Arrangements Board of Directors Page 104

Our governance and organisational arrangements

FT ARM refers to disclosures required by the NHS Foundation Trust Annual Reporting Manual rather than the Code of Governance. The Monitor Code of Governance refers to Council of Governors which we know as our Membership Council.

Other disclosures in the public interest
NHS foundation trusts are public benefit corporations and it is considered to be best practice for the annual report to include "public interest disclosures" on the foundation trust's activities and policies in the areas set out below.

Summary of disclosure	
Actions taken to maintain or develop the provision of information to, and consultation with, employees;	Directors' Report Our Staff – Colleague Engagement
The foundation trust's policies in relation to disabled employees and equal opportunities;	Directors' Report Equality and Diversity
Information on health and safety performance;	Strategic Report Health and Safety
Information on policies and procedures with respect to countering fraud and corruption;	Our Governance and Organisational Arrangements Audit and Risk Committee Report
Statement describing the better payment practice code, or any other policy adopted on payment of suppliers, performance achieved and any interest paid under the Late Payment of Commercial Debts (Interest) Act 1998	Annual Accounts Page 137
Details of any consultations completed in the previous year, consultations in progress at the date of the report, or consultations planned for the coming year;	Not applicable in the financial year.
The number of, and average additional pension liabilities for, individuals who retired early on ill-health grounds during the year.	Annual Accounts Page 137
Detailed disclosures in relation to "other income" where "other income" in the notes to the accounts is significant.	Annual Accounts Page 137
A statement that the NHS foundation trust has complied with the cost allocation and charging guidance issued by HM Treasury	Annual Accounts Page 137
Details of serious incidents involving data loss or confidentiality breach	No incidents.

Voluntary disclosures
The "voluntary disclosures" (as defined by the foundation trust annual reporting manual) have also been covered in this annual report. These can be found as follows:

Summary of disclosure	
Sustainability reporting	Strategic Report Sustainability and Climate Change Page 15
Equality reporting	Directors' Report Equality and Diversity Page 27

CRH Birth Centre: "As it was my first birth I was unsure as to what to expect and was extremely nervous. The support I was given over the phone before coming in was absolutely amazing. Nothing was too much for the team. I can not imagine how I would have got through it without my midwife's kindness and patience. She is a credit to the hospital and an absolute angel."

Annual Governance Statement 2013/14

Scope of responsibility
As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The purpose of the system of internal control
The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Calderdale and Huddersfield NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Calderdale & Huddersfield NHS Foundation Trust for the year ended 31 March 2014 and up to the date of approval of the annual report and accounts.

Capacity to handle risk
As Chief Executive, I recognise that committed leadership in risk management is essential to maintaining the sound systems of internal control required to manage the risks associated with the achievement of organisational objectives and compliance with the Provider Licence.

The Governance Strategy provides a framework for managing risks across the Trust which is consistent with national guidance and best practice. The Strategy sets out the role of the Board and its committees, together with individual responsibilities of the Chief Executive, Executive Directors and all staff in managing risk. The Strategy sets out a clear, systematic approach to risk management that ensures it is an integral part of the clinical, managerial, quality and financial processes within the organisation.

As accounting officer, I have responsibility for risk management within the Trust. Non-Executive Directors play an active role in the Trust's Risk Management and Assurance processes and participate in the following Committees, all of which report to the Board of Directors:

- Quality Committee(previously Quality Assurance Board)
- Audit & Risk Committee
- Health & Safety Committee

The Trust's focus is on clinically led services with clinicians taking the lead role in the management of the organisation. These clinical services are split into four divisions:

- Children Women & Families
- Medicine
- Surgery and Anaesthetics
- Diagnostic and Therapeutic Services

Corporate functions provide the operating frameworks and advice and support to the Clinical Divisions.

Risks are identified, managed and reviewed at a department, directorate and divisional level as appropriate. The Risk Compliance and Assurance Committee is responsible for monitoring risk throughout the Trust and reports this to the Quality Committee. Additional assurance on the effectiveness of the systems for ensuring clinical quality is given to the Board of Directors, by the Quality Committee. Independent assurance on the effectiveness of the system of internal control and overall governance arrangements is provided by the Audit & Risk Committee. The Board of Directors routinely receives the minutes of these Committees alongside the Board Assurance Framework.

The Trust has mechanisms in place to act upon alerts and recommendations from national bodies such as the NHS England and the NHS Litigation Authority.

Learning from good practice, and from untoward incidents, is seen as an important mechanism for continuously improving risk management systems. A report on Learning from Experience is presented to the Board annually. We also rigorously apply national guidance including the recommendations from investigations and enquiries.

Effective training is essential in the management of risk and this is demonstrable at all levels within the organisation.

At an operational level the Trust has well developed programmes of generic and specific risk management training. We have reviewed and refreshed the mandatory training programme to ensure that it continues to meet the needs of all staff which includes risk management processes including infection control, safeguarding adults and children, information governance and manual handling. In addition we have introduced a new health & safety training programme from Board to ward.

The risk and control framework
Risk is unavoidable and Calderdale and Huddersfield NHS Foundation Trust takes action to manage risk to a level which is tolerable. We acknowledge that risk can rarely be totally eradicated and will accept a level of managed residual risk. In addition, we recognise that we cannot influence some risks e.g. civil contingencies and our response to these, is to have tested contingency/ business continuity plans. Risk management requires active participation and commitment from all staff. It is an intrinsic part of the way the business of the Trust is conducted and its

effectiveness is monitored by the Trust's performance management and assurance systems.

The Board of Directors has agreed that an unacceptable risk is one which scores 15 or above on a 5x5 likelihood and consequence matrix, before mitigation.

The key principles of the risk and control framework are that:
– The same process applies to all types of risk.

– All levels and every part of the Trust will carry out a system of self assessment for the identification and quantification of risk.

– Risks with their original risk rating, treatment plan and residual risk rating will be documented in operational risk registers, with risks rated 15 or above escalated to the corporate risk register.

Operational risk registers are maintained in every ward and department, and for time limited projects. Divisional registers consolidate directorate risks scoring 8 or above and any additional business risks to the division. Divisional registers are cross-referenced to the divisional business plan.

Internal assurance as to the effectiveness of this system of control is provided through the operational management system by way of management checks. In addition, the Risk, Compliance and Assurance Committee monitors the Compliance Register and Risk Registers, and performance against national risk and safety standards on my behalf. Assurance is also provided by the governance system which includes the Quality Committee, and Audit & Risk Committee, supported by Internal and External Audit. These assurance processes allow the Board to issue an accurate Corporate Governance Statement, required under NHS foundation trust condition 4(8)(b) of Monitor's provider licence.

Regular reports are received by the Executive Board which performance manages the operational management framework and by the Board of Directors which monitors the governance framework. These reports focus on the quality of service provision and the duty to operate efficiently, effectively and economically, as required by Monitor's NHS provider licence.

In 2013/14 the Board undertook an independent Board governance review process which highlighted a number of strengths of the Board, including its clear commitment to quality and patient safety. The review was conducted by an independent faciliatator. The review was undertaken to ensure that the Board had robust arrangements in place for discharging its duties. One of the areas highlighted for development was to streamline the governance arrangements. As part of this work, expected to be completed by June 2014, the Quality Committee – the sub-committee of the Board that is responsible for assuring the Board of the quality of its services - is re-visiting its terms of reference and membership to ensure it remains fit for purpose.

Annual Governance Statement 2013/14

Information governance is extremely important to us. The Trust uses the Connecting for Health Information governance toolkit framework to assist in the identification of risks and weakness in relation to its information assets, including the systems and media used in processing and storing of information. The existing framework is used for the process of identification, analysis, treatment and evaluation of potential and actual risks, with risks being recorded on the relevant Divisional or Corporate Risk Register. The Trust is committed to further developing knowledge and expertise in the area of information security risk assessment across a network of information asset owners. The Trust's Senior Information Risk Owner (SIRO) supported by information asset owners, is responsible for the information risk programme within the Trust, and works closely with the Caldicott Guardian.

The Trust has implemented a number of measures to mitigate the risk of loss and disclosure of personal identifiable information including a programme of encryption which has ensured that all existing and new supported laptop devices should be encrypted. Additionally, removable media used to transfer confidential information must be encrypted, in line with the Trust's Data Encryption and Protection Policy. A number of policies and supporting staff guidance materials set the parameters and expectations around the safe and secure handling and transfer of confidential information.

Confidentiality and information security awareness training is provided to all staff in the Trust's Induction Programme and through mandatory annual Information Governance training. Progress with Information Governance compliance is measured on a yearly basis through the Trust's self assessment against the Connecting for Health Information Governance Toolkit.

CHFT positively encourages incident reporting. Incidents are reported from all services, by all staff groups. Many of the reported incidents did not result in harm, but had the potential to do so. Information from incidents is analysed, to identify trends and areas for improvement work identified. This data is considered by Risk, Compliance & Assurance Committee, Quality Committee, Board of Directors, and Divisional Safety & Quality Boards in Learning from Experience reports.

During 2013-14 we have moved to a web based incident reporting system so that staff can electronically report incidents as they occur. This means that "real time" information is available to identify any safety issues as they occur.

The Organisation's major risks

The Trust has identified a number of key risks to the achievement of its objectives:

- Lack of robust processes leads to failure to obtain approval for the implementation of the strategic review business case (SOC) and therefore potential safety and sustainability of the Trust.

- Risk to Financial stability, profitability and liquidity due to the planned reductions in public spending. The challenge for the Trust will be to ensure that realistic and deliverable service and financial plans are developed and implemented, with ever increasing levels of efficiency savings required.
- Failure to meet performance targets, such as A&E waits, issues with bed capacity and patient flow and a rising HSMR.
- Changes to the commissioning of specialised services leads to a loss of some services to the Trust.

These risks are set out in the Board Assurance Framework with appropriate controls and mitigations. The Assurance Framework is presented to the Audit and Risk Committee and the Board four times per year.

In addition the Board reviews the Integrated Board Report which sets out the performance targets and indicators (including CQUIN targets). Each is assigned to an executive lead who is accountable for the achievement of the target and ensuring appropriate monitoring is in place.

In August 2013/14 the Trust underwent CQC inspections which resulted in a compliance action with regard to Outcome 10 - Safety and Suitability of Premises. The Trust met all the other standards that were inspected.

The Trust developed an action plan with regard to Outcome 10, which has been implemented. Following a revisit by the CQC to the Trust in early February, assurance has been received from the CQC that it is satisfied that the actions have addressed the shortcomings and the Trust has now been declared to be compliant against all standards.

As an employer with staff entitled to membership of the NHS

Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their age, disability gender reassignment, marriage & civil partnership, pregnancy & maternity, race, religion & belief, sex, sexual orientation.

The Trust has undertaken risk assessments and Carbon Reduction Delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of economy, efficiency and effectiveness of the use of resources

The Trust produces an annual plan that includes an assessment of the resources required to deliver the commissioned level of clinical activity, whilst ensuring that resources are used economically, efficiently and effectively. The plan incorporates the national requirements to continually improve productivity and efficiency, and to manage resources within a national tariff structure that drives the economic use of resources. The Trust has also established Quality Improvement arrangements to ensure that resources are deployed effectively.

The Trust has a successful track record of delivery against savings plans and achieving planned surplus levels or better; this financial year has been no exception.

The Board of Directors receive a monthly performance report which includes key financial information and updates on performance against the Trust's efficiency target. In addition, Directors are able to review performance in more detail at the monthly Finance Briefing meetings. The Trust also provides financial information to Monitor on a quarterly basis inclusive of financial tables and a commentary.

The resources of the Trust are managed through various measures, including the adoption of a robust budgetary control system, the consistent application of internal financial controls and effective procurement and tendering procedures.

The resource and financial governance arrangements are further supported by both internal and external audit to secure economic, efficient and effective use of the resources the Trust has at its disposal.

The Trust is very aware of the impact that the restriction on public finances will have on the NHS and is continuing to develop plans to address this challenging situation. There is a clear direction within the Trust that the way to respond to these challenges is to focus on improving quality and reducing costs at the same time.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

Our Board of Directors takes an active leadership role on quality. The quality of our services is an integral part of our discussions on business matters and business decisions and the Board receives updates regularly.

We have a number of quality improvement programmes underway at any time, lead by senior clinicians, supported by quality improvement specialists and information specialists. We use improvement methodologies developed by organisations such as the LEAN Academy and the Institute for Healthcare Improvement

There has been wide engagement with Stakeholders including staff and members in developing our priorities, and with patients through surveys, and complaints and patient safety incidents.

Quality metrics are monitored by the Quality Assurance Board. We have controls in place to ensure the accuracy of data which include:

- Internal data quality reports.
- External data quality reports from CHKS.
- The Internal Audit programme which increasingly is aligned with the quality programme.
- The External Audit of the data and performance indicators within the quality account.

To further inform it's approach to quality, The Trust's Board of Directors have reviewed the recommendations of the Francis Report and the subsequent reports by Sir Bruce Keogh and Professor Don Berwick.

Annual Governance Statement 2013/14

The Trust is fully committed to the central themes of:

- A structure of fundamental standards and measures of compliance – the Trust is aware of the Department of Health consultation document on 'Introducing Fundamental Standards', which was published on 23 January 2014. Should this be accepted the Trust will implement the changes to the CQC registration regulations included within the consultation document.
- Openness, transparency and candour throughout the system to develop a common culture of being open and honest with patients and regulators.
- Improved support for compassionate, caring and committed nursing.
- Stronger healthcare leadership.

The Trust will continue to strive towards the provision of excellent service in response to these reports.

The work brought together the 8 ambitions from the Keogh report and the 10 recommendations (9 of which related directly to NHS Trusts) to define a set of 8 key results on which the staff views were sought.

These were:

1. Reduce patient harm and avoidable death
2. Competently use data for quality improvement
3. Involve and listen to patients
4. Confidence in systems of regulation and inspection
5. Participate in professional, academic and management networks
6. Ensure safe staffing levels
7. Involve junior doctor and student nurses
8. Engage all staff

A number of actions were identified and these are being taken forward. An example of this is safe staffing levels. To ensure safe staffing levels, the Trust has now developed a standard operating procedure for nurse and midwifery staffing. This will ensure the right level of staff and skill mix is available to deliver safe, effective patient care and to robustly manage staffing levels as part of the operational management of the organisation. It supports the organisation to understand and manage the potential risk associated with staffing levels.

Staffing on individual wards is also to be displayed for both staff and the public to see, following a pilot on two wards of the Trust. This information will identify the planned staffing levels against actual staffing levels in an open and transparent way.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Quality Assurance Board, the Board, and the Audit & Risk Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Executive Management Team has identified the Trust's principal objectives and the risks to their achievement, along with risk controls and assurance mechanisms. As part of this risk assessment process, gaps in controls and assurances have been highlighted. This information is incorporated in the Trust's Assurance Framework document. This is monitored by the Audit & Risk Committee and the Board of Directors.

These documents and internal and external audits of specific areas of internal control provide the Board of Directors with the information it requires to gain assurance that the Trust is meeting its objectives to protect patients, staff the public and other stakeholders against risks of any kind: which allows the Board to support me in signing this Annual Governance Statement.

Responsibility for the effectiveness of organisational systems rests with the Board of Directors which is informed regarding risk by its Governance sub-committees and the Audit Committee. The Board of Directors receives monthly Performance and Financial Management reports as the primary mechanism for assessing compliance with national and local targets, and the identification of existing and potential risks. The Board also receives and endorses key internal and external reports that specifically demonstrate the adequacy of the internal control function in designated risk areas, alongside generic reviews of the Assurance Framework.

The Quality Committee monitors selected quality metrics, and ensures that the Foundation Trust has robust systems in place to learn from experience. It receives reports from specialist governance committees e.g. Safeguarding: Information Governance; Medicines Management; Risk Compliance Assurance Committee, and assures itself that Divisional Quality Boards are assuring themselves on the quality of their services. The Quality Committee is chaired by a Non-Executive Director and reports to the Board of Directors.

The Risk Compliance and Assurance Committee, receives regular reports from specialist committees and functions and considers

risk registers and the Trust's compliance with national risk and safety standards. It also considers the detail of incidents and complaints to provide assurance that any trends are identified and improvement work identified.

A Non-Executive Director chairs the Audit & Risk Committee. Its role is to review the establishment of an effective system of internal control and risk management and provide an independent assurance to the Board. The Committee takes an overview of the organisation's governance activity supported by the internal auditors who provide opinions on compliance with standards and the systems of internal control. Internal Audit have reviewed elements of the system of internal control including the assurance framework, self assessment of performance against the Essential standards of Quality and Safety, clinical governance and corporate governance.

The Internal Audit reports issued in the year have given significant assurance that there is a generally sound system of internal control. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk. There were nine internal audits which received limited assurance:
- Boiler House replacement
- Portering services
- Agency invoices
- Staff bank and agency booking
- Business continuity
- Payroll
- Greenacres Shop
- Discharge medication
- Medical gases

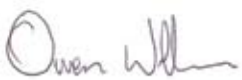
Of these two reports – Staff Bank and Agency booking and payment systems and Business Continuity – required more significant action to address the weakness identified. Progress against these actions has been monitored closely by the Audit and Risk Committee and reported to the Board through the Committee minutes.

Conclusion

The system of internal control has been in place in Calderdale & Huddersfield NHS Foundation Trust for the year ended 31 March 2014 and up to the date of approval of the annual report and accounts.

In summary I am assured that the NHS foundation trust has an overall sound system of internal controls in place, which is designed to manage the key organisational objectives and minimise the NHS foundation trust's exposure to risk. There are however weaknesses in the system which are being addressed. The Board of Directors is committed to continuous improvement and enhancement of the system of internal control.

Signed



Chief Executive
Date: 29 May 2014

Did you know...?

Flower power - the gardens at Calderdale Royal Hospital were winners in Calderdale in Bloom competition in 2013.

Calderdale and Huddersfield NHS

NHS Foundation Trust

Accounts 2013/14

Calderdale & Huddersfield NHS Foundation Trust Accounts
For the 12 month period ended 31st March 2014

Calderdale & Huddersfield NHS Foundation Trust

Foreword to the Accounts

These accounts, for the year ended 31 March 2014, have been prepared by the Calderdale & Huddersfield NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006

Owen Williams (Chief Executive)
29th May 2014

NATIONAL HEALTH SERVICE ACT 2006

DIRECTIONS BY MONITOR IN RESPECT OF NATIONAL HEALTH SERVICE

Foundation Trust's ANNUAL ACCOUNTS

Monitor, with the approval of the Secretary of State, in exercise of powers conferred on it by paragraph 25(1) of Schedule 7 of the National Health Service Act 2006 (the "2006 Act"), hereby gives the following Directions:

1. Application and interpretation
(1) These Directions apply to NHS Foundation Trusts in England.

(2) In these Directions "The Accounts" means:

for an NHS Foundation Trust in its first operating period since authorisation, the accounts of an NHS Foundation Trust for the period from authorisation until 31 March;

or

for an NHS Foundation Trust in its second or subsequent operating period following authorisation, the accounts of an NHS Foundation Trust for the period from 1 April until 31 March.

"the NHS Foundation Trust" means the NHS Foundation Trust in question.

2. Form of accounts
(1) The accounts submitted under paragraph 25 of Schedule 7 of the 2006 Act shall show, and give a true and fair view of, the NHS Foundation Trust's gains and losses, cash flows and financial state at the end of the financial period.

(2) The accounts shall meet the accounting requirements of the 'NHS Foundation Trust Annual Reporting Manual' (FT ARM) as agreed with the Secretary of State, in force for the relevant financial year.

(3) The Statement of Financial Position shall be signed and dated by the chief executive of the NHS Foundation Trust.

(4) The Annual Governance Statement shall be signed and dated by the chief executive of the NHS Foundation Trust.

3. Statement of accounting officer's responsibilities
(1) The statement of accounting officer's responsibilities in respect of the accounts shall be signed and dated by the chief executive of the NHS Foundation Trust.

4. Approval on behalf of HM Treasury
(1) These directions have been approved on behalf of the Secretary of State.

Signed by the authority of Monitor, the Independent Regulator of NHS foundation trusts

Name: David Bennett (Chairman and Chief Executive)

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their
responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by Monitor.

Under the NHS Act 2006, Monitor has directed Calderdale and Huddersfield NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Calderdale and Huddersfield NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

Signed

Owen Williams, Chief Executive

Date: 29th May 2014

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST

We have audited the Group and the Trust financial statements of Calderdale and Huddersfield NHS Foundation Trust for the year ended 31 March 2014 comprising the Consolidated Statement of Comprehensive Income, Consolidated Statement of Financial Position, Consolidated Statement of Changes in Taxpayers Equity, Consolidated Statement of Cash Flows and related notes which have been prepared under applicable law and the NHS Foundation Trust Annual Reporting Manual 2013/14.

This report is made solely to the Council of Governors of Calderdale and Huddersfield NHS Foundation Trust in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the accounting officer and the auditor

As described more fully in the Statement of Accounting Officer's Responsibilities on the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of whether the accounting policies are appropriate to the Group's and the Trust's circumstances and have been consistently applied and adequately disclosed, the reasonableness of significant accounting estimates made by the accounting officer and the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view of the state of the Group's and the Trust's affairs as at 31 March 2014 and of the Group's and the Trust's income and expenditure for the year then ended; and

- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2013/14.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion the information given in the Strategic Report and the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report where under the Audit Code for NHS Foundation Trusts we are required to report to you if, in our opinion, the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2013/14, is misleading or is not consistent with our knowledge of the Group and the Trust and other information of which we are aware from our audit of the financial statements.

We are not required to assess, nor have we assessed, whether all risks and controls have been addressed by the Annual Governance Statement or that risks are satisfactorily addressed by internal controls.

Certificate

We certify that we have completed the audit of the accounts of Calderdale and Huddersfield NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Trevor Rees

Trevor Rees for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
St James Square
Manchester
M2 6DS

29 May 2014

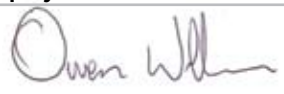
STATEMENT OF COMPREHENSIVE INCOME

		Foundation Trust		Group	
		2013/14	2012/13	**2013/14**	2012/13
	note	**£000**	£000	**£000**	£000
Operating Income from continuing operations	3	**353,274**	351,314	**353,634**	351,588
Operating Expenses of continuing operations	4	**(338,742)**	(339,818)	**(339,236)**	(340,295)
OPERATING SURPLUS / (DEFICIT)		**14,532**	11,496	**14,399**	11,293
FINANCE COSTS					
Finance income	9	**96**	263	**138**	307
Finance expense - financial liabilities	10	**(10,787)**	(10,724)	**(10,787)**	(10,724)
Finance expense - unwinding of discount on provisions		**(76)**	(99)	**(76)**	(99)
PDC Dividends payable		**(3,123)**	(3,224)	**(3,123)**	(3,224)
NET FINANCE COSTS		**(13,890)**	(13,784)	**(13,848)**	(13,740)
Share of Profit / (Loss) of Associates/Joint Ventures accounted for using the equity method		**-**	-	**-**	-
Movement in fair value of investment property and other investments		**-**	-	**12**	823
Corporation tax expense	8	**-**	-	**-**	-
Surplus/(Deficit) from continuing operations		**642**	(2,288)	**563**	(1,624)
Surplus/(deficit) of discontinued operations and the gain/(loss) on disposal of discontinued operations		**-**	-	**-**	-
SURPLUS/(DEFICIT) FOR THE YEAR		**642**	(2,288)	**563**	(1,624)
Other comprehensive income					
Will not be reclassified to income and expenditure:					
Gain/(loss) from transfer by absorption from demising bodies		**-**	-	**-**	-
Impairments		**(2,904)**	(1,520)	**(2,904)**	(1,520)
Revaluations		**9,983**	2,221	**9,983**	2,221
Transfer to retained earnings on disposal of assets		**-**	-	**-**	-
Share of comprehensive income from associates and joint ventures		**-**	-	**-**	-
Other recognised gains and losses		**-**	-	**-**	-
Remeasurements of net defined benefit pension scheme liability / asset		**-**	-	**-**	-
Other reserve movements		**-**	-	**102**	(530)
Fair Value gains/(losses) on Available-for-sale financial investments		**-**	-	**-**	-
Recycling gains/(losses) on Available-for-sale financial investments		**-**	-	**-**	-
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE PERIOD		**7,721**	(1,587)	**7,642**	(923)
Prior period adjustment		**-**	-	**-**	-
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		**7,721**	(1,587)	**7,642**	(923)
Note: Allocation of Profits/(Losses) for the period:		**2013/14**	2012/13	**2013/14**	2012/13
		£000	£000	**£000**	£000
(a) Surplus/(Deficit) for the period attributable to:					
(i) minority interest, and		**-**	-	**-**	-
(ii) owners of the parent.		**642**	(2,288)	**563**	(1,624)
TOTAL		**642**	(2,288)	**563**	(1,624)
(b) total comprehensive income/ (expense) for the period attributable to:					
(i) minority interest, and		**-**	-	**-**	-
(ii) owners of the parent.		**7,721**	(1,587)	**7,745**	(1,453)
TOTAL		**7,721**	(1,587)	**7,642**	(923)

The notes on the following pages form part of these Accounts.
Operating income for 2013/14 and 2012/13 includes an exceptional item relating to the reversal of impairments on property, plant & equipment of £935,000 and £214,000 respectively. Operating expenses for 2013/14 and 2012/13 include exceptional items relating to impairments on property, plant & equipment of £2,983,000 and £6,318,000 respectively.
The surplus positions for 2013/14 and 2012/13, excluding these non-cash exceptional items, are £2,611,000 and £3,816,000 respectively.

STATEMENT OF FINANCIAL POSITION

		Foundation Trust			Group		
		31 March 2014	31 March 2013	01 Apr 2012	**31 March 2014**	31 March 2013	01 Apr 2012
	note	**£000**	£000	£000	**£000**	£000	£000
Non-current assets							
Intangible assets	12	**997**	412	482	**997**	412	482
Property, plant and equipment	13	**209,159**	200,763	206,606	**209,159**	200,763	206,606
Investment Property		**-**	-	-	**-**	-	-
Investments in associates (and joined controlled operations)		**-**	-	-	**-**	-	-
Other investments		**-**	-	-	**2,614**	2,602	1,779
Trade and other receivables	17	**2,080**	1,943	1,956	**2,080**	1,943	1,956
Other Financial assets		**-**	-	-	**-**	-	-
Other assets		**-**	-	-	**-**	-	-
Total non-current assets		**212,236**	203,118	209,044	**214,850**	205,720	210,823
Current assets							
Inventories	16	**5,687**	5,217	5,489	**5,687**	5,217	5,489
Trade and other receivables	17	**14,977**	11,622	10,396	**14,949**	11,596	10,428
Other financial assets		**-**	-	-	**100**	60	644
Non-current assets for sale and assets in disposal groups	15	**-**	939	1,420	**-**	939	1,420
Cash and cash equivalents	18	**22,840**	33,407	20,306	**22,840**	33,408	20,382
Total current assets		**43,504**	51,186	37,611	**43,576**	51,220	38,363
Current liabilities							
Trade and other payables	19	**(34,977)**	(34,210)	(26,508)	**(34,996)**	(34,201)	(26,529)
Borrowings	20	**(1,449)**	(1,908)	(1,771)	**(1,449)**	(1,908)	(1,771)
Other financial liabilities		**-**	-	-	**-**	-	-
Provisions	23	**(3,126)**	(6,222)	(2,036)	**(3,126)**	(6,222)	(2,036)
Other liabilities	22	**(1,150)**	(725)	(1,149)	**(1,150)**	(725)	(1,149)
Total current liabilities		**(40,702)**	(43,065)	(31,464)	**(40,720)**	(43,057)	(31,485)
Total assets less current liabilities		**215,039**	211,239	215,191	**217,706**	213,883	217,701
Non-current liabilities							
Trade and other payables	19	**(281)**	(367)	(457)	**(281)**	(367)	(457)
Borrowings	20	**(81,441)**	(86,908)	(88,758)	**(81,440)**	(86,908)	(88,758)
Other financial liabilities		**-**	-	-	**-**	-	-
Provisions	23	**(2,806)**	(2,903)	(3,190)	**(2,806)**	(2,903)	(3,190)
Other liabilities	22	**(1,546)**	(1,653)	(1,791)	**(1,546)**	(1,653)	(1,791)
Total non-current liabilities		**(86,075)**	(91,831)	(94,196)	**(86,074)**	(91,831)	(94,196)
Total assets employed		**128,964**	119,408	120,995	**131,632**	122,052	123,505
Financed by (taxpayers' equity)							
Financed by (taxpayers' equity)							
Public Dividend Capital		**113,734**	111,899	111,899	**113,734**	111,899	111,899
Revaluation reserve		**35,308**	29,605	29,786	**35,308**	29,605	29,786
Available for sale investments reserve		**-**	-	-	**-**	-	-
Other reserves		**-**	-	-	**-**	-	-
Merger reserve		**-**	-	-	**-**	-	-
Income and expenditure reserve		**(20,078)**	(22,096)	(20,690)	**(20,077)**	(22,096)	(20,690)
Minority Interest		**-**	-	-	**-**	-	-
Charitable fund reserves		**-**	-	-	**2,667**	2,644	2,510
Total taxpayers' equity		**128,964**	119,408	120,995	**131,632**	122,052	123,505

Signed :  Date : 29th May 2014

STATEMENT OF CHANGES IN EQUITY	Total	NHS Charitable Funds Reserves	Public Dividend Capital	Revaluation Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000	£000
Taxpayers' and Others' Equity at 1 April 2013	**122,052**	**2,644**	**111,899**	**29,605**	**(22,095)**
Surplus/(deficit) for the year	564	(79)	-	-	**642**
Transfers by MODIFIED absorption: transfers between reserves	-	-	-	-	-
Transfers by NORMAL absorption: transfers between reserves	-	-	-	-	-
Transfers between reserves	-	-	-	-	-
Impairments	(2,904)	-	-	**(2,904)**	-
Revaluations - property, plant and equipment	9,983	-	-	**9,983**	-
Revaluations - intangible assets	-	-	-	-	-
Revaluations - financial assets	-	-	-	-	-
Revaluations and impairments- charitable funds	-	-	-	-	-
Transfer to retained earnings on disposal of assets	-	-	-	-	-
Share of comprehensive income from associates and joint ventures	-	-	-	-	-
Fair Value gains/(losses) on Available-for-sale financial investments	-	-	-	-	-
Recycling gains/(losses) on Available-for-sale financial investments	-	-	-	-	-
Other recognised gains and losses	-	-	-	-	-
Remeasurements of defined net benefit pension scheme liability / asset	-	-	-	-	-
Public Dividend Capital received	**1,835**	**-**	**1,835**	-	-
Public Dividend Capital repaid	-	-	-	-	-
Public Dividend Capital written off	-	-	-	-	-
Other movements in PDC in year	-	-	-	-	-
Reserves eliminated on dissolution	-	-	-	-	-
Other reserve movements	-	-	-	(1,376)	**1,376**
Other reserve movements - charitable funds consolidation adjustment	**102**	**102**	**-**	**-**	**-**
Taxpayers' and Others' Equity at 31 March 2014	**131,632**	**2,667**	**113,734**	**35,308**	**(20,077)**
	Total	**NHS Charitable Funds Reserves**	**Public Dividend Capital**	**Revaluation Reserve**	**Income and Expenditure Reserve**
	£000	£000	£000	£000	£000
Taxpayers' and Others' Equity at 1 April 2012	**123,505**	**2,510**	**111,899**	**29,786**	**(20,690)**
Surplus/(deficit) for the year	(1,624)	664	-	-	(2,288)
Transfers by absorption: transfers between reserves	-	-	-	-	-
Transfer from reval reserve to I&E reserve for impairments arising from consumption of economic benefits	-	-	-	-	-
Transfers between reserves	-	-	-	-	-
Impairments	(1,520)	-	-	(1,520)	-
Revaluations - property, plant and equipment	2,221	-	-	2,221	-
Revaluations - intangible assets	-	-	-	-	-
Revaluations - financial assets	-	-	-	-	-
Revaluations and impairments- charitable funds	-	-	-	-	-
Transfer to retained earnings on disposal of assets	-	-	-	-	-
Share of comprehensive income from associates and joint ventures	-	-	-	-	-
Fair Value gains/(losses) on Available-for-sale financial investments	-	-	-	-	-
Recycling gains/(losses) on Available-for-sale financial investments	-	-	-	-	-
Other recognised gains and losses	-	-	-	-	-
Remeasurements of defined net benefit pension scheme liability / asset	-	-	-	-	-
Public Dividend Capital received	-	-	-	-	-
Public Dividend Capital repaid	-	-	-	-	-
Public Dividend Capital written off	-	-	-	-	-
Other movements in PDC in year	-	-	-	-	-
Reserves eliminated on dissolution	-	-	-	-	-
Other reserve movements	-	-	-	(882)	882
Other reserve movements - charitable funds consolidation adjustment	(530)	(530)	-	-	-
Taxpayers' and Others' Equity at 31 March 2013	**122,052**	**2,644**	**111,899**	**29,605**	**(22,096)**

STATEMENT OF CASH FLOWS

	Foundation Trust		Group	
	2013/14	2012/13	2013/14	2012/13
	£000	£000	£000	£000
Cash flows from operating activities				
Operating surplus/(deficit) from continuing operations	**14,532**	11,496	**14,399**	11,293
Operating surplus/(deficit) from discontinued operations	**-**	-	**-**	-
Operating surplus/(deficit)	**14,532**	**11,496**	**14,399**	**11,293**
Non-cash income and expense:				
Depreciation and amortisation	**10,592**	9,254	**10,592**	9,254
Impairments	**2,983**	6,318	**2,983**	6,318
Reversals of impairments	**(935)**	(214)	**(935)**	(214)
(Gain)/Loss on disposal	**58**	469	**58**	469
Non-cash donations/grants credited to income	**(101)**	-	**(101)**	-
Interest accrued and not paid	**-**	-	**-**	-
Dividends accrued and not paid or received	**-**	-	**-**	-
Amortisation of PFI credit	**-**	-	**-**	-
On SoFP Pension liability - employer contributions paid less net charge to the SOCI	**-**	-	**-**	-
(Increase)/Decrease in Trade and Other Receivables	**(3,530)**	(1,098)	**(3,527)**	(1,098)
Increase/(Decrease) in Other Assets	**-**	-	**-**	-
(Increase)/Decrease in Inventories	**(470)**	272	**(470)**	272
Increase/(Decrease) in Trade and Other Payables	**1,746**	6,485	**1,742**	6,485
Increase/(Decrease) in Other Liabilities	**318**	(562)	**318**	(562)
Increase/(Decrease) in Provisions	**(3,269)**	3,899	**(3,269)**	3,899
Tax (paid) / received	**(9)**	(164)	**(9)**	(164)
Movements in operating cash flow of discontinued operations	**-**	-	**-**	-
Movements in operating cash flow in respect of Transforming Community Services transaction	**-**	-	**-**	-
NHS Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows	**-**	-	**133**	124
Other movements in operating cash flows	**(25)**	879	**(25)**	879
NET CASH GENERATED FROM/(USED IN) OPERATIONS	**21,890**	**37,034**	**21,890**	**36,955**
Cash flows from investing activities				
Interest received	**96**	263	**96**	263
Purchase of financial assets	**-**	-	**-**	-
Sale of financial assets	**-**	-	**-**	-
Purchase of intangible assets	**(720)**	(55)	**(720)**	(55)
Sales of intangible assets	**-**	-	**-**	-
Purchase of Property, Plant and Equipment	**(16,102)**	(9,249)	**(16,102)**	(9,249)
Sales of Property, Plant and Equipment	**2,198**	954	**2,198**	954
PFI lifecycle prepayments (cash outflow)	**-**	-	**-**	-
Cash flows attributable to investing activities of discontinued operations	**-**	-	**-**	-
Cash from acquisition of business units and subsidiaries	**-**	-	**-**	-
Cash from (disposals) of business units and subsidiaries	**-**	-	**-**	-
NHS Charitable funds - net cash flows from investing activities	**-**	-	**-**	2
Net cash generated from/(used in) investing activities	**(14,528)**	**(8,087)**	**(14,528)**	**(8,085)**
Cash flows from financing activities				
Public dividend capital received	**1,835**	-	**1,835**	-
Public dividend capital repaid	**-**	-	**-**	-
Public dividend capital received (PDC adjustment for modified absorption transfers of payables/ receivables)	**-**	-	**-**	-
Loans received from the Foundation Trust Financing Facility	**-**	-	**-**	-
Loans received from the Department of Health	**-**	-	**-**	-
Other loans received	**1,050**	-	**1,050**	-
Loans repaid to the Foundation Trust Financing Facility	**(5,631)**	(562)	**(5,631)**	(562)
Loans repaid to the Department of Health	**-**	-	**-**	-
Other loans repaid	**-**	-	**-**	-
Capital element of finance lease rental payments	**(1,345)**	(1,209)	**(1,345)**	(1,209)
Other capital receipts	**-**	-	**-**	-
Capital element of Private Finance Initiative Obligations	**-**	-	**-**	-
Interest paid	**(158)**	(270)	**(158)**	(270)
Interest element of finance lease	**-**	-	**-**	-
Interest element of Private Finance Initiative obligations	**(10,745)**	(10,464)	**(10,745)**	(10,464)
PDC Dividend paid	**(2,937)**	(3,340)	**(2,937)**	(3,340)
Cash flows attributable to financing activities of discontinued operations	**-**	-	**-**	-
NHS Charitable funds - net cash flows from financing activities	**-**	-	**-**	-
cash flows from (used in) other financing activities	**-**	-	**-**	-
Net cash generated from/(used in) financing activities	**(17,931)**	**(15,845)**	**(17,930)**	**(15,845)**
Increase/(decrease) in cash and cash equivalents	**(10,568)**	**13,102**	**(10,568)**	**13,025**
Cash and Cash equivalents at 1 April	**33,408**	20,306	**33,408**	20,382
Cash and Cash equivalents at start of period for new FTs	**-**	-	**-**	-
NHS Charitable funds cash and cash equivalents for new FTs	**-**	-	**-**	-
Cash and Cash equivalents changes due to transfers by Modified absorption	**-**	-	**-**	-
Cash and Cash equivalents transferred by Normal absorption	**-**	-	**-**	-
Cash and Cash equivalents changes due to transfers by absorption - transfer of PCT charitable funds	**-**	-	**-**	-
Cash and Cash equivalents at 31 March	**22,840**	33,408	**22,840**	33,408

NOTES TO THE ACCOUNTS

1 Accounting policies and other information

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the Foundation Trust Annual Reporting Manual 2013/14 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Consolidation

Subsidiaries

Subsidiary entities are those over which the trust has the power to exercise control or a dominant influence so as to gain economic or other benefits. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year, except where a subsidiary's financial year end is before 1 January or after 1 July in which case the actual amounts for each month of the trust's financial year are obtained from the subsidiary and consolidated.

Where subsidiaries' accounting policies are not aligned with those of the trust (including where they report under UK GAAP) then amounts are adjusted during consolidation where the differences are material.

Subsidiaries which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

Calderdael & Huddersfield NHS foundation Trust is the corporate trustee to Calderdale & Huddersfield NHS Foundation Trust charitable fund. The foundation trust has assessed it's relationship to the charitable fund and determined it to be a subsidiary because the foundatiuon trust has the power to govern the financial and operating policies of the charitable fund so as to obtain benefits from its activities for itself, its patients or its staff.

Prior to 2013/14, the FT ARM permitted the NHS foundation Trust not to consolidate the charitable fund. From 2013/14, the foundation trust has consolidated the charitable fund and has applied this as a change in accounting policy.

The charitable fund's statutory accounts are prepared to 31 March on accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Generally Accepted Accounting Principles (UK GAAP). On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the accounting policies of Calderdale and Huddersfield NHS Foundation Trust; and
- eliminate intra-group transactions, balances, gains and losses.

Joint Ventures

Joint ventures are separate entities over which the trust has joint control with one or more other parties. The meaning of control is the same as that for subsidiaries.

Joint ventures are accounted for using the equity method.

Joint ventures which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

1.3 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

The value at the start or end of an accounting period of incomplete spells of care is recognised to the extent that treatment services have been provided in that period. The value of incomplete spells of care has been calculated using estimation techniques.

1.4 Expenditure on Employee Benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. Given the low value of annual leave carried forward by employees across periods, and as this value does not change significantly between financial years, the cost of annual leave earned but not taken by employees at the end of the period is not recognised in the financial statements.

Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health.

The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.6 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised where:
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably.

In addition, property, plant and equipment is capitalised if it:
- individually has a cost of at least £5,000; or
- forms a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- forms part of the initial setting-up of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at fair value.

All property assets are revalued using professional valuations in accordance with IAS 16 every five years. A three yearly interim valuation is also carried out.

A full revaluation was undertaken of all property assets as at 31 March 2014.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual.

Specialised operational property is valued using the HM Treasury standard approach of depreciated replacement cost valuations based on modern equivalent assets, and where it would meet the location requirements of the service being provided an alternative site can be valued.

Non-specialised operational owner-occupied property is valued at existing use value, which is the market value subject to the assumption that the property is sold as part of the continuing enterprise in occupation.

Non-operational properties, including surplus land, are valued at market value.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Until 31 March 2009, plant and equipment were carried at net current replacement cost, as assessed by indexation and depreciation. From 1 April 2009 the national equipment indices issued by the Department of Health are no longer available. The carrying value of existing assets at that date is being written off over their remaining useful lives and any new plant and equipment are carried at depreciated historical cost as these are considered to be a reasonable proxy for fair value.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the

extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairemnt arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Derecognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated assets

Donated and grant funded property, plant and equipment assets are capitalised as their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the Trust. The underlying assets are recognised as Property, Plant and Equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

Lifecycle replacement costs are apportioned, using information from the PFI operator's financial model, between costs charged to operating expenses and costs that are capitalised.

Protected assets

Assets that are required for the provision of mandatory goods and services are protected. Assets which are not required for mandatory goods and services are not protected and may be disposed of by the Trust without the approval of Monitor (the Independent Regulator of NHS Foundation Trusts).

1.7 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for

internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Revaluation gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.8 Government grants

Government grants are grants from Government bodies other than income from Clinical Commissioning Groups (previously Primary Care Trusts) or NHS Trusts for the provision of services. Grants from the Department of Health are accounted for as Government grants. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The Cost of inventories is measured using the First In, First Out (FIFO) method. The cost valuation is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.10 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets are categorised as 'Loans and receivables'.

Financial liabilities are classified as 'Other Financial liabilities'.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise of cash and cash equivalents, NHS debtors, accrued income and 'other debtors'.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the statement of financial position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

1.11 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.12 Provisions

The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk- adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at Note 23.3.

Non-clinical risk pooling

The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 23.4 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 23.4, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.14 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) liabilities in relation to donated assets(iii) net cash balances held with the Government Banking Services and (iv) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.15 Value Added Tax

Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.16 Corporation Tax

The Trust is potentially within the scope of corporation tax in respect of activities which are not related to, or are ancillary to, the provision of healthcare, and where the profits exceed £50,000 per annum. In the period covered by these accounts the Trust has assessed that it is not liable to pay corporation tax.

1.17 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the statement of financial position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; andl non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the statement of financial position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.18 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

Note 2 Segmental Analysis

Calderdale & Huddersfield Foundation Trust recognises it has two distinct activities: (i) the provision of healthcare and (ii) charitable funding activities, with the majority of the activity relating to the provision of healthcare. The provision of healthcare being an aggregate of all the individual specialty components included therein.

Healthcare
The large majority of the Foundation Trust's income originates with the UK Whole of Government Accounting (WGA) bodies. The majority of expenses incurred are payroll expenditure on staff involved in the production or support of healthcare activities generally across the Trust together with the related supplies and overheads needed to establish this production. The business activities which earn revenue and incur expenses are therefore of one broad combined nature and therefore a segment of 'Healthcare' is deemed appropriate.

The operating results of the Foundation Trust are reviewed monthly or more frequently by the Trust's chief operating decision maker which is the overall Foundation Trust Board and which includes senior professional non-executive directors. The Trust Board review the financial position of the Trust as a whole in their decision making process, rather than individual components included in the totals, in terms of allocating resources. This process again implies a distinct operating segment under IFRS8.

The finance report considered monthly by the Trust Board contains summary figures for the whole Trust together with graphical line and bar charts relating to different total income activity levels, and directorate expense budgets with their cost improvement positions. Similarly only total balance sheet positions and cash flow forecasts are considered for the whole Foundation Trust. The Board as chief operating decision maker therefore only considers this segment of healthcare in its decision-making process.

Charitable Funds
The charitable funds activity of the Foundation Trust are managed through The Calderdale and Huddersfield NHS Foundation Trust Charitable Funds. The day-to-day management of the charity is overseen by the Charitable Funds Committee which then reports to the Foundation Trust Board of Directors in it's role as the Corporate Trustee. The financial position of the charity is reported separately to the Corporate Trustee throughout the year and is subject to separate decision making processes.

The two identified segments of 'the provision of healthcare' and 'charitable funding activities' are consistent with the core principle of IFRS8 which is to enable users of the financial statements to evaluate the nature and financial effects of business activities and economic environments.

	Healthcare		Charitable Fund		Total	
Note 2.1 Segmental Analysis	2013/14	2012/13	2013/14	2012/13	2013/14	2012/13
	£000	£000	£000	£000	£000	£000
Income	**353,274**	351,314	**360**	274	**353,634**	351,588
Surplus / (Deficit)	**642**	(2,288)	**(79)**	664	**563**	(1,624)
Net Assets	**128,964**	119,408	**2,668**	2,644	**131,632**	122,052

Note 3 Operating Income

Note 3.1 Operating Income by classification		
	2013/14	2012/13
	£000	£000
Income from activities		
Elective income	**52,383**	52,260
Non elective income	**85,031**	89,190
Outpatient income	**38,978**	45,650
A & E income	**14,024**	13,260
Other NHS clinical income	**124,954**	111,350
Private patient income	**504**	553
Other non-protected clinical income	**5,144**	5,464
Total income from activities	**321,017**	317,727
Other operating income		
Research and development	**987**	1,119
Education and training	**8,280**	7,967
Received from NHS charities: Receipt of grants/donations for capital acquisitions - Donation (i.e. receipt of donated asset)	**-**	7
Received from NHS charities: Other charitable and other contributions to expenditure	**481**	403
Non-patient care services to other bodies	**10,712**	10,708
Other	**10,796**	13,108
Reversal of impairments of property, plant and equipment	**935**	214
Rental revenue from operating leases - Minimum lease receipts	**62**	59
Rental revenue from operating leases - contingent rent	**4**	2
Total other operating income	**32,256**	33,587
Total operating income	**353,274**	351,314

Note 3.2 Commissioner and non-commissioner requested services		
	2013/14	2012/13
	£000	£000
Commissioner and non-commssioner requested Goods and Services	353,274	351,314

Note 3.3 Operating lease income		
	2013/14	2012/13
	£000	£000
Operating Lease Income		
Rental revenue from operating leases - Minimum lease receipts	**62**	59
Rental revenue from operating leases - contingent rent	**4**	2
Rental revenue from operating leases - Other	**-**	-
TOTAL	**66**	61
Future minimum lease payments due		
- not later than one year;	32	32
- later than one year and not later than five years;	16	16
- later than five years.	24	28
TOTAL	72	76
Future minimum lease payments due all relate to buildings leases.		

Note 3.4 Operating Income by type				
	Foundation Trust		Group	
	2013/14	2012/13	2013/14	2012/13
	£000	£000	£000	£000
Income from activities				
NHS Foundation Trusts	**0**	(247)	**0**	(247)
NHS Trusts	**207**	177	**207**	177
Strategic Health Authorities	**0**	19	**0**	19
CCGs and NHS England	**315,143**	-	**315,143**	-
Primary Care Trusts	**0**	311,579	**0**	311,579
Local Authorities	**127**	332	**127**	332
Department of Health - grants	**0**	-	**0**	-
Department of Health - other	**20**	62	**20**	62
NHS Other	**0**	83	**0**	83
Non NHS: Private patients	**504**	553	**504**	553
Non-NHS: Overseas patients (chargeable to patient)	**64**	86	**64**	86
NHS injury scheme (was RTA)	**2,062**	1,926	**2,062**	1,926
Non NHS: Other *	**2,890**	3,158	**2,890**	3,158
Total income from activities	**321,017**	317,727	**321,017**	317,727
Other Operating Income (See note 3.1 for break down)	**32,256**	33,587	**32,617**	33,861
TOTAL OPERATING INCOME	**353,274**	351,314	**353,634**	351,588
Of Which				
Related to Continuing Operations	**353,274**	351,314	**353,634**	351,588
Related to Discontinued Operations	**-**	-	**-**	-
Analysis of Income from activities: Non-NHS Other				
Ministry of Defence	**-**	-	**-**	-
Other government departments and agencies	**-**	-	**-**	-
Other	**2,890**	3,158	**2,890**	3,158
Total	**2,890**	3,158	**2,890**	3,158

* Other Operating income of £10.8m includes £5.4m sales of manufactured pharmaceutical products and £0.4m property rental income, £0.9m catering income (In 2012/13 the comparative figures were £4.2m sales of manufactured pharmaceutical products and £1.3m property rental income, £0.9m catering income).

Note 4 Operating Expenses				
	Foundation Trust		Group	
	2013/14	2012/13	2013/14	2012/13
	£000	£000	£000	£000
Services from NHS Foundation Trusts	**20**	13	**20**	13
Services from NHS Trusts	**1,908**	1,673	**1,908**	1,673
Services from PCTs	**-**	47	**-**	47
Services from CCGs and NHS England	**38**	-	**38**	-
Services from other NHS Bodies	**-**	29	**-**	29
Purchase of healthcare from non NHS bodies	**1,631**	1,360	**1,631**	1,360
Employee Expenses - Executive directors	**894**	1,025	**894**	1,025
Employee Expenses - Non-executive directors	**147**	155	**147**	155
Employee Expenses - Staff	**217,020**	213,019	**217,020**	213,019
NHS Charitable funds - employee expenses			**-**	-
Supplies and services - clinical (excluding drug costs)	**29,054**	29,078	**29,054**	29,078
Supplies and services - general	**2,781**	3,091	**2,781**	3,091
Establishment	**4,794**	4,959	**4,794**	4,959
Research and Development - (Not Included in employee expenses)	**9**	29	**9**	29
Transport (Business travel only)	**134**	-	**134**	-
Transport (other)	**290**	372	**290**	372
Premises	**26,664**	24,946	**26,664**	24,946
Increase / (decrease) in bad debt provision	**822**	1,276	**822**	1,276
Increase in other provisions	**(1,061)**	4,563	**(1,061)**	4,563
Change in provisions discount rate(s)	**27**	-	**27**	-
Drug costs (non inventory drugs only)	**-**	3,076	**-**	3,076
Inventories consumed (excluding drugs)		-	**-**	-
Drugs Inventories consumed	**25,755**	20,392	**25,755**	20,392
Rentals under operating leases - minimum lease receipts	**4,327**	3,682	**4,327**	3,682
Rentals under operating leases - sublease payments	**(6)**	(6)	**(6)**	(6)
Depreciation on property, plant and equipment	**10,457**	9,129	**10,457**	9,129
Amortisation on intangible assets	**135**	125	**135**	125
NHS Charitable funds: Depreciation and amortisation on charitable fund assets	**-**	-	**-**	-
Impairments of property, plant and equipment	**2,983**	6,318	**2,983**	6,318
NHS Charitable funds: impairments of charitable fund assets	**-**	-	**-**	-
Audit fees				
audit services- statutory audit	**52**	52	**52**	52
audit services -regulatory reporting	**10**	19	**10**	19
other auditor remuneration - analysis in note 6.4	**-**	-	**4**	4
Clinical negligence	**6,915**	7,307	**6,915**	7,307
Loss on disposal of other property, plant and equipment	**58**	469	**58**	469
Consultancy costs	**1,387**	1,829	**1,387**	1,829
Training, courses and conferences	**865**	912	**865**	912
Redundancy - (Included in employee expenses)	**526**	-	**526**	-
Losses, ex gratia & special payments- (Not included in employee expenses)	**84**	-	**84**	-
Other	**25**	879	**25**	879
NHS Charitable funds: Other resources expended			**490**	473
TOTAL	**338,741**	339,818	**339,236**	340,295
of Which				
Related to Continuing Operations	**338,742**	339,818	**339,236**	340,295
Related to Discontinued Operations	**-**	-	**-**	-

Note 5 Employee Expenses				
Note 5.1 Employee Expenses breakdown	**Foundation Trust**		**Group**	
	2013/14	**2012/13**	**2013/14**	**2012/13**
	£000	**£000**	**£000**	**£000**
Salaries and wages	**171,004**	169,718	**171,004**	169,718
Social security costs	**12,881**	12,668	**12,881**	12,668
Pension costs - defined contribution plans				
Employers contributions to NHS Pensions	**21,582**	20,669	**21,582**	20,669
Pension cost - other	**-**	-	**-**	-
Other post employment benefits	**-**	-	**-**	-
Other employment benefits	**-**	-	**-**	-
Termination benefits	**526**	1,714	**526**	1,714
Agency/contract staff	**13,248**	9,275	**13,248**	9,275
NHS Charitable funds staff			**-**	-
TOTAL	**219,241**	214,044	**219,241**	214,044
Costs capitalised as part of assets	**801**	-	**801**	-
included within:				
Analysed into Operating Expenditure				
Employee Expenses - Staff	**217,020**	213,019	**217,020**	213,019
Employee Expenses - Executive directors	**894**	1,025	**894**	1,025
Research & development	**-**	-	**-**	-
Redundancy	**526**	-	**526**	-
Early retirements	**-**	-	**-**	-
Special Payments	**-**	-	**-**	-
NHS Charitable funds: Employee expenses			**-**	-
Total Employee benefits excluding capitalised costs	**218,440**	214,044	**218,440**	214,044
Note 5.1 Average number of employees (Whole Time Equivalent basis)				
	2013/14	**2012/13**	**2013/14**	**2012/13**
	Number	**Number**	**Number**	**Number**
Medical and dental	**529**	514	**529**	514
Administration and estates	**1,213**	1,223	**1,213**	1,223
Healthcare assistants and other support staff	**1,039**	996	**1,039**	996
Nursing, midwifery and health visiting staff	**1,614**	1,585	**1,614**	1,585
Scientific, therapeutic and technical staff	**681**	727	**681**	727
Agency and contract staff	**163**	215	**163**	215
Bank staff	**126**	-	**126**	-
TOTAL	**5,365**	5,260	**5,365**	5,260
Note 5.3 Employee benefits				
The Trust has not paid any Employee benefits in the 2013/14 or 2012/13 financial years.				
Note 5.4 Early retirements due to ill health				
	2013/14	**2012/13**	**2013/14**	**2012/13**
	Number	**Number**	**Number**	**Number**
No of early retirements on the grounds of ill health	**7**	11	**7**	11
	2013/14	2012/13	2013/14	2012/13
	£000	£000	£000	£000
Value of early retirements on the grounds of ill health	355	590	355	590

Note 5.6 Staff exit packages				
Exit package cost band 2013/14:	**Number of compulsary redundancies**	**Total number of exit packages by cost band**	**Number of compulsary redundancies**	**Total number of exit packages by cost band**
£10,000 - £25,000	2	3	2	3
£25,001 - £50,000	2	5	2	5
£50,001 - £100,000	2	2	2	2
£100,001 - £150,000	1	1	1	1
£150,001 - £200,000	-	-	-	-
>£200,001	-	-	-	-
Total number of exit packages by type	**8**	**12**	**8**	**12**
Total resource cost	**387**	**526**	**387**	**526**

Note 5.7 Exit packages: other (non-compulsory) departure payments 2013/14			
	Payments agreed		**Payments agreed**
	Number		**Number**
Voluntary redundancies including early retirement contractual costs	0		0
Mutually agreed resignations (MARS) contractual costs	4		4
Early retirements in the efficiency of the service contractual costs	0		0
Contractual payments in lieu of notice	0		0
Exit payments following Employment Tribunals or court orders	0		0
Non-contractual payments requiring HMT approval*	0		0
Total**	**4**		**4**
of which:			
non-contractual payments made to individuals where the payment value was more than 12 months' of their annual salary			

The Trust has operated the 'Mutually Approved Resignation Scheme' (MARS) for four individuals in 2013/14. The principles of MARS were based on the nationally agreed scheme and applies the principles agreed by the NHS Staff Council for local schemes. The MARS is a scheme under which an individual employee, in agreement with their employer, chooses to leave employment in return for a severance payment. A mutually agreed resignation is not a redundancy or a voluntary redundancy. The scheme was agreed with staff side representatives on the Trust's Staff Management Partnership Forum.

Note 6 Operating expenses - miscellaneous		
Note 6.1 Operating leases		
	2013/14	2012/13
	£000	£000
Minimum lease payments	4,327	3,682
Contingent rents	-	-
Less sublease payments received	(6)	(6)
TOTAL	4,321	3,676
Note 6.2 Arrangements containing an operating lease		
	2013/14	2012/13
	£000	£000
Future minimum lease payments due on buildings:		
- not later than one year;	724	869
- later than one year and not later than five years;	2,218	3,878
- later than five years.	6,065	19,319
TOTAL	9,006	24,066
Future minimum lease payments due on plant & Machinery:		
- not later than one year;	1,888	1,935
- later than one year and not later than five years;	4,185	4,523
- later than five years.	423	435
TOTAL	6,496	6,893
Future minimum lease payments due on other leases:		
- not later than one year;	286	448
- later than one year and not later than five years;	164	555
- later than five years.	17	43
TOTAL	468	1,045
There are no lease payments due on land		
Total of future minimum sublease lease payments to be received as the balance sheet date	44	48
Note 6.3 Late Payment		
There were no amounts included within 'Interest payable' arising from claims made under the Late Payment of Commercial Debts (Interest) Act 1998 or any compensation paid to cover debt recovery costs under this legislation.		
Note 6.4 Audit Remuneration		
	2013/14	2012/13
	£000	£000
Audit services- statutory audit *	**56**	56
Audit services -regulatory reporting	**10**	19
Other auditor remuneration paid to the external auditor is analysed as follows:		
1. The auditing of accounts of any associate of the Trust	**-**	-
2. Audit-related assurance services	**-**	-
3. Taxation compliance services	**-**	-
4. All taxation advisory services not falling within item 3 above;	**-**	-
5. internal audit services (only those payable to the external auditor)	**-**	-
6. All assurance services not falling within items 1 to 5	**-**	-
7. Corporate finance transaction services not falling within items 1 to 6 above	**-**	-
8. All other non-audit services not falling within items 2 to 7 above	**-**	-
TOTAL	**66**	75
* Charitable Funds audit of £4k is included within the Audit services - statutary audit figure		

Note 7 Discontinued operations
The Trust had no discontinued operations to disclose in 2013/14 or 2012/13.
Note 8 Corporation Tax
The Trust has assessed that it is not liable for Corporation tax in 2013/14 or 2012/13.

Note 9 Finance income				
	Foundation Trust		Group	
	2013/14	2012/13	2013/14	2012/13
	£000	£000	£000	£000
PFI revenue	**-**	-	**-**	-
Interest on bank accounts	**96**	263	**96**	263
Interest on loans and receivables	**-**	-	**-**	-
Interest on available for sale financial assets	**-**	-	**-**	-
Interest on held-to-maturity financial assets	**-**	-	**-**	-
NHS Charitable funds: investment income	**42**	44	**42**	44
Other	**-**	-	**-**	-
TOTAL	**138**	307	**138**	307

Note 10 Finance costs - interest expense				
	2013/14	2012/13	2013/14	2012/13
	£000	£000	£000	£000
Loans from the Foundation Trust Financing Facility	**42**	260	**42**	260
Capital loans from the Department of Health	**-**	-	**-**	-
Working capital loans from the Department of Health	**-**	-	**-**	-
Commercial loans	**-**	-	**-**	-
Overdrafts	**-**	-	**-**	-
Finance leases	**-**	-	**-**	-
Interest on late payment of commercial debt	**-**	-	**-**	-
Other	**-**	-	**-**	-
Finance Costs in PFI obligations				
Main Finance Costs	**7,076**	7,178	**7,076**	7,178
Contingent Finance Costs	**3,670**	3,286	**3,670**	3,286
TOTAL	**10,787**	10,724	**10,787**	10,724

Note 11 Impairment of assets				
	2013/14	2012/13	2013/14	2012/13
	£000	£000	£000	£000
Loss or damage from normal operations	**-**	-	**-**	-
Loss as a result of catastrophe	**-**	-	**-**	-
Abandonment of assets in course of construction	**-**	-	**-**	-
Unforeseen obsolescence	**-**	-	**-**	-
Loss as a result of catastrophe	**-**	-	**-**	-
Other	**-**	-	**-**	-
Changes in market price	**2,048**	6,104	**2,048**	6,104
Impairments charged to the revaluation reserve	**2,904**	1,520	**2,904**	1,520
TOTAL	**4,952**	7,624	**4,952**	7,624

Note 12 Intangible assets

Note 12.1 Intangible assets - 2013/14									
	Foundation Trust				Group				
	Total	Software licences (purchased)	Information technology (internally generated)	Intangible Assets Under Construction	Total	Software licences (purchased)	Information technology (internally generated)	Intangible Assets Under Construction	NHS Charitable fund assets
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/Gross Cost at 1 April 2013 - as previously stated	1,320	636	611	73	1,320	636	611	73	-
Additions - purchased / internally generated	720	-	720	-	720	-	720	-	-
Reclassifications	-	-	73	(73)	-	-	73	(73)	-
Gross cost at 31 March 2014	2,040	636	1,404	-	2,040	636	1,404	-	-
Amortisation at 1 April 2013	908	484	424	-	908	484	424	-	-
Provided during the year	135	47	88	-	135	47	88	-	-
Amortisation at 31 March 2014	1,043	531	512	-	1,043	531	512	-	-

Note 12.2 Intangible assets - 2012/13									
	Foundation Trust				Group				
	Total	Software licences (purchased)	Information technology (internally generated)	Intangible Assets Under Construction	Total	Software licences (purchased)	Information technology (internally generated)	Intangible Assets Under Construction	NHS Charitable fund assets
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Gross cost at 1 April 2012	1,265	625	611	29	1,265	625	611	29	-
Additions - purchased	55	11	-	44	55	11	-	44	-
Valuation/Gross cost at 31 March 2013	1,320	636	611	73	1,320	636	611	73	-
Amortisation at 1 April 2012	783	446	337	-	783	446	337	-	-
Provided during the year	125	38	87	-	125	38	87	-	-
Amortisation at 31 March 2013	908	484	424	-	908	484	424	-	-

Note 12.3 Intangible assets financing									
	Foundation Trust				Group				
	Total	Software licences (purchased)	Information technology (internally generated)	Intangible Assets Under Construction	Total	Software licences (purchased)	Information technology (internally generated)	Intangible Assets Under Construction	NHS Charitable fund assets
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value									
NBV - Purchased at 31 March 2014	997	105	892	-	997	105	892	-	-
NBV total at 31 March 2014	997	105	892	-	997	105	892	-	-
Net book value									
NBV - Purchased at 31 March 2013 (restated)	412	152	187	73	412	152	187	73	-
NBV total at 31 March 2013	412	152	187	73	412	152	187	73	-

Note 12.4 Government grants
The Trust has no intangible assets acquired by government grants.

Note 12.5 Economic life of intangible assets									
All of the Trusts intangible assets relate to software. The Trust has no intangible assets for Licenses & trademarks, Patents, Information Technology, Development expenditure, Goodwill or Intangible Assets under construction. The estimated economic useful life of software is five years.									

Note 13 Property, plant and equipment

Note 13.1 Property, plant and equipment

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & Payments on Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	NHS Charitable fund assets
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/Gross cost at 1 April 2013	242,875	41,190	155,929	2,912	433	24,892	70	15,944	1,505	-
Transfers by absorption - MODIFIED	-	-	-	-	-	-	-	-	-	-
Transfers by absorption - NORMAL	-	-	-	-	-	-	-	-	-	-
Additions - purchased	15,038	-	5,849	-	1,685	1,900	-	5,566	38	-
Additions - Leased	-	-	-	-	-	-	-	-	-	-
Additions - donations of physical assets (non-cash)	101	-	5	-	-	71	-	25	-	-
Additions - grants / donations of cash to purchase assets	-	-	-	-	-	-	-	-	-	-
Impairments charged to operating expenses	-	(1,944)	1,969	(25)	-	-	-	-	-	-
Impairments charged to the revaluation reserve	(2,904)	-	(2,904)	-	-	-	-	-	-	-
Reversal of impairments credited to operating income	-	-	-	-	-	-	-	-	-	-
Reversal of impairments credited to the revaluation reserve	-	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	34	-	(150)	5	-	111	-	-
Revaluations	9,983	1,520	8,325	138	-	-	-	-	-	-
Transfers to/from assets held for sale and assets in disposal groups	(1,148)	(725)	-	(423)	-	-	-	-	-	-
Disposals	(1,256)	-	-	-	-	(1,256)	-	-	-	-
Valuation/Gross cost at 31 March 2014	262,689	40,041	169,207	2,602	1,968	25,612	70	21,646	1,543	-
Accumulated depreciation at 1 April 2013	42,112	145	11,310	406	-	18,487	70	10,333	1,361	-
Transfers by absorption - MODIFIED	-	-	-	-	-	-	-	-	-	-
Transfers by absorption - NORMAL	-	-	-	-	-	-	-	-	-	-
Provided during the year	10,457	-	6,931	95	-	1,840	-	1,531	60	-
Impairments charged to operating expenses	2,983	-	2,983	-	-	-	-	-	-	-
Impairments charged to the revaluation reserve	-	-	-	-	-	-	-	-	-	-
Reversal of impairments credited to operating income	(935)	-	(935)	-	-	-	-	-	-	-
Reversal of impairments credited to the revaluation reserve	-	-	-	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-	-	-	-
Transfers to/from assets held for sale and assets in disposal groups	-	-	-	-	-	-	-	-	-	-
Disposals	(1,087)	-	-	-	-	(1,087)	-	-	-	-
Accumulated depreciation at 31 March 2014	53,530	145	20,289	501	-	19,240	70	11,864	1,421	-

Note 13.2 Property, plant and equipment	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & Payments on Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	NHS Charitable fund assets
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/Gross cost at 1 April 2012	237,424	42,385	147,513	3,963	1,174	27,754	106	13,024	1,505	-
Transfers by absorption	-	-	-	-	-	-	-	-	-	-
Additions - purchased	-	-	-	-	-	-	-	-	-	-
Additions - Leased	10,549	35	6,028	-	468	1,308	-	2,710	-	-
Additions - donated	-	-	-	-	-	-	-	-	-	-
Additions - government granted	7	-	-	-	-	7	-	-	-	-
Impairments (through RR)	-	-	-	-	-	-	-	-	-	-
Reversal of impairments (through RR)	(1,520)	(915)	(93)	(512)	-	-	-	-	-	-
Reclassifications	-	-	921	-	(1,209)	-	-	288	-	-
Revaluations	2,221	65	2,136	20	-	-	-	-	-	-
Transfers to/from assets held for sale and assets in disposal groups	(939)	(380)	-	(559)	-	-	-	-	-	-
Disposals	(4,867)	-	(576)	-	-	(4,177)	(36)	(78)	-	-
Valuation/Gross cost at 31 March 2013	242,875	41,190	155,929	2,912	433	24,892	70	15,944	1,505	-
Accumulated depreciation at 1 April 2012	30,818	-	-	-	-	20,269	106	9,142	1,301	-
Transfers by absorption	-	-	-	-	-	-	-	-	-	-
Provided during the year	9,129	-	5,667	106	-	2,030	-	1,266	60	-
Impairments (through I&E)	6,318	145	5,873	300	-	-	-	-	-	-
Reversal of impairments (through I&E)	(214)	-	(214)	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-	-	-	-
Transfers to/from assets held for sale and assets in disposal groups	-	-	-	-	-	-	-	-	-	-
Disposals	(3,939)	-	(16)	-	-	(3,812)	(36)	(75)	-	-
Accumulated depreciation at 31 March 2013	42,112	145	11,310	406	-	18,487	70	10,333	1,361	-

Note 13.3 Property, plant and equipment financing	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & Payments on Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	NHS Charitable fund assets
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value - 31 March 2014										
Owned	126,598	39,161	67,532	2,101	1,893	6,041	-	9,748	122	-
Finance Leased	760	735	-	-	-	25	-	-	-	-
On-balance-sheet PFI contracts and other service concession arrangements	80,736	-	80,661	-	75	-	-	-	-	-
Donated	1,065	-	725	-	-	306	-	34	-	-
NBV total at 31 March 2014	209,159	39,896	148,918	2,101	1,968	6,372	-	9,782	122	-
Net book value - 31 March 2013										
Owned	119,143	40,310	64,467	2,506	209	5,911	-	5,596	144	-
Finance Leased	803	735	-	-	-	68	-	-	-	-
On-balance-sheet PFI contracts and other service concession arrangements	79,473	-	79,451	-	22	-	-	-	-	-
Donated	1,344	-	701	-	202	426	-	15	-	-
NBV total at 31 March 2013	200,763	41,045	144,619	2,506	433	6,405	-	5,611	144	-

Note 13.4 Economic life of property, plant and equipment		
	Min Life	Max Life
	Years	Years
Land	-	-
Buildings excluding dwellings	15	80
Dwellings	15	80
Assets under Construction & POA	-	-
Plant & Machinery	5	15
Transport Equipment	7	7
Information Technology	5	8
Furniture & Fittings	5	10

Note 13.5 Revaluation Reserve Movements						
2013/14	Total Revaluation Reserve	Revaluation Reserve -intangibles	Revaluation Reserve -property, plant and equipment	Revaluation Reserve - financial assets	Revaluation Reserve - assets held for sale	Revaluation reserve - investment property
	£000	£000	£000	£000	£000	£000
Revaluation reserve at 1 April 2013	29,605	-	29,605	-	-	-
Impairments	(2,904)	-	(2,904)	-	-	-
Revaluations	9,983	-	9,983	-	-	-
Other reserve movements	(1,376)	-	(1,376)	-	-	-
Revaluation reserve at 31 March 2014	35,308	0	35,308	0	0	0
2012/13	Total Revaluation Reserve	Revaluation Reserve -intangibles	Revaluation Reserve -property, plant and equipment	Revaluation Reserve - financial assets	Revaluation Reserve - assets held for sale	Revaluation reserve - investment property
	£000	£000	£000	£000	£000	£000
Revaluation reserve at 1 April 2012	29,786	-	29,786	-	-	-
Impairments	(1,520)	-	(1,520)	-	-	-
Revaluations	2,221	-	2,221	-	-	-
Other reserve movements	(882)	-	(882)	-	-	-
Revaluation reserve at 31 March 2013	29,605	0	29,605	0	0	0

Note 14 Additions on consolidation of NHS Charities

Note 14.1 - Reclassification of PPE additions on consolidation of NHS charities	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & Payments on Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
Purchased additions in 2013/14	£000	£000	£000	£000	£000	£000	£000	£000	£000
Additions - purchased by Trust	15,038	-	5,849	-	1,685	1,900	-	5,566	38
Additions - donations of physical assets from charity	-	-	-	-	-	-	-	-	-
Additions - donated of cash by charity to purchase assets	-	-	-	-	-	-	-	-	-
Purchased additions in 2012/13									
Additions - purchased by Trust	10,549	35	6,028	-	468	1,308	-	2,710	-
Additions - donations of physical assets from charity	-	-	-	-	-	-	-	-	-
Additions - donated of cash by charity to purchase assets	-	-	-	-	-	-	-	-	-

Note 14.2 - Reclassification of Intangible additions on consolidation of NHS charities	Total	Software licences (purchased)	Licences & trademarks Licences & trademarks	Patents (purchased)	Information technology (internally generated)	Development expenditure (internally generated)	Other (purchased)	Other (internally generated	Goodwill	Intangible Assets Under Construction
Purchased additions in 2013/14	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Additions - purchased by Trust	720	-	-	-	720	-	-	-	-	-
Additions - donations of physical assets from charity	-	-	-	-	-	-	-	-	-	-
Additions - donated of cash by charity to purchase assets	-	-	-	-	-	-	-	-	-	-
Purchased additions in 2012/13										
Additions - purchased by Trust	11	11	-	-	-	-	-	-	-	44
Additions - donations of physical assets from charity	-	-	-	-	-	-	-	-	-	-
Additions - donated of cash by charity to purchase assets	-	-	-	-	-	-	-	-	-	-

Note 14.3 Investments - 2013/14					
	Investment Property*	Investments in associates (and joined controlled operations)	Other Investments**	NHS Charitable funds: Investment property	NHS Charitable funds: Other investments
	£000	£000	£000	£000	£000
Carrying value at 01 April 2013	-	-	-	-	2,602
Prior Period Adjustment	-	-	-	-	-
Merger adjustments	-	-	-	-	-
Carrying value at 01 April 2013 (restated)	-	-	-	-	2,602
Fair value losses (impairment)	-	-	-	-	12
Carrying value at 31 March 2014	0	0	0	0	2,614

Note 14.3 Investments - 2012/13					
	Investment Property*	Investments in associates (and joined controlled operations)	Other Investments**	NHS Charitable funds: Investment property	NHS Charitable funds: Other investments
	£000	£000	£000	£000	£000
Carrying value at 01 April 2012	-	-	-	-	-
Prior Period Adjustment	-	-	-	-	1,779
Merger adjustments	-	-	-	-	-
Carrying value at 01 April 2012 (restated)	-	-	-	-	1,779
Movement in fair value (revaluation or impairment)	-	-	-	-	823
Carrying value at 31 March 2013	-	-	-	-	2,602

Note 15 Assets held for sale

Note 15.1 Non-current assets for sale and assets in disposal groups - 2013/14							
	Foundation Trust Total	Group Total	Intangible assets	Property, Plant and Equipment - Land	PPE: Dwellings	Financial Investments	NHS Charitable fund assets held for sale
	£000	£000	£000	£000	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April 2013	939.00	939.00	-	380.00	559.00	-	-
Plus assets classified as available for sale in the year	1,148.00	1,148.00	-	725.00	423.00	-	-
Less assets sold in year	(2,087)	(2,087)	-	(1,105)	(982)	-	-
Less Impairment of assets held for sale	-	-	-	-	-	-	-
Plus Reversal of impairment of assets held for sale	-	-	-	-	-	-	-
Less assets no longer classified as held for sale, for reasons other than disposal by sale	-	-	-	-	-	-	-
NBV of non-current assets for sale and assets in disposal groups at 31 March 2014	-	-	-	-	-	-	-

Note 15.2 Non-current assets for sale and assets in disposal groups 2012/13							
	Foundation Trust Total	Group Total	Intangible assets	Property, Plant and Equipment - Land	PPE: Dwellings	Financial Investments	NHS Charitable fund assets held for sale
	£000		£000	£000	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April 12	1,420.00	1,420.00	-	880.00	540.00	-	-
Plus assets classified as available for sale in the year	939.00	939.00	-	380.00	559.00	-	-
Less assets sold in year	-	-	-	-	-	-	-
Less Impairment of assets held for sale	(1,420)	(1,420)	-	(880)	(540)	-	-
Plus Reversal of impairment of assets held for sale	-	-	-	-	-	-	-
Less assets no longer classified as held for sale, for reasons other than disposal by sale	-	-	-	-	-	-	-
NBV of non-current assets for sale and assets in disposal groups at 31 March 2013	939.00	939.00	-	380.00	559.00	-	-

Note 16 Inventories

Note 16.1 Inventories		
	Foundation Trust	
	31 March 2014	31 March 2013
	£000	£000
Drugs	**1,709**	1,795
Work in progress	**293**	196
Consumables	**3,685**	3,226
TOTAL Inventories	**5,687**	5,217

Note 16.2 Breakdown of inventories recognised in expenses	
	31 March 2014
	£000
Total inventories consumed	**54,877**
Charged to:	
Drugs inventories consumed	**25,755**
Supplies and services - clinical	**26,079**
Supplies and services - non clinical	**2,754**
Transport (other)	**289**
TOTAL	**54,877**

Note 17 Trade and other receivables

Note 17.1 Trade receivables and other receivables				
	Foundation Trust		Group	
	Total		Total	
	31 March 2014	31 March 2013	31 March 2014	31 March 2013
	£000	£000	£000	£000
Current				
NHS Receivables - Revenue	8,310	5,932	8,310	5,932
Provision for impaired receivables	(1,897)	(1,123)	(1,897)	(1,123)
Prepayments (Non-PFI)	2,216	1,947	2,216	1,947
Accrued income	1,426	803	1,426	803
Interest Receivable	-	38	-	38
PDC dividend receivable	117	303	117	303
VAT receivable	1,225	972	1,225	972
Other receivables - Revenue	3,581	2,750	3,532	2,705
NHS Charitable funds: Trade and other receivables			20	19
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	**14,977**	**11,622**	**14,949**	**11,596**
Non-Current				
Provision for impaired receivables	(392)	(354)	(392)	(354)
Other receivables - Revenue	1,547	1,372	1,547	1,372
Other receivables - Capital	925	925	925	925
TOTAL NON CURRENT TRADE AND OTHER RECEIVABLES	**2,080**	**1,943**	**2,080**	**1,943**

NHS Receivables falling due within one year includes £2,656,225 for incomplete spells of care provided at 31 March 2014 (£2,654,460 at 31 March 2013).

Note 17.2 Provision for impairment of receivables		
	2013/14	2012/13
	£000	£000
At 1 April as previously stated	**1,477**	604
Increase in provision	**1,422**	1,458
Amounts utilised	**(10)**	(403)
Unused amounts reversed	**(600)**	(182)
At 31 Mar / 31 Mar	**2,289**	1,477

Note 17.3 Analysis of impaired receivables		
	2013/14	2012/13
	£000	£000
Ageing of impaired receivables		
0 - 30 days	**223**	274
30-60 Days	**14**	502
60-90 days	**39**	32
90- 180 days (was "In three to six months")	**664**	199
180-360 days (was "Over six months")	**1,349**	470
Total	**2,289**	1,477
Ageing of non-impaired receivables past their due date		
0 - 30 days	**1,768**	1,900
30-60 Days	**454**	419
60-90 days	**438**	29
90- 180 days (was "In three to six months")	**1,217**	26
180-360 days (was "Over six months")	**2,171**	2
Total	**6,048**	2,376

Note 18.4 Finance lease receivables
The Trust had no Finance lease receivables in 2013/14 or 2012/13.

Note 18 Cash and cash equivalents				
	Foundation Trust		Group	
	2013/14	2012/13	2013/14	2012/13
	£000	£000	£000	£000
At 1 April	**33,408**	20,306	**33,408**	20,382
Net change in year	**(10,568)**	13,102	**(10,568)**	13,025
At 31 March	**22,840**	33,408	**22,840**	33,408
Broken down into:				
Cash at commercial banks and in hand	**80**	106	**80**	106
Cash with the Government Banking Service	**22,760**	33,302	**22,760**	33,302
Cash and cash equivalents as in SoFP	**22,840**	33,408	**22,840**	33,408
Bank overdraft - Government Banking Service	**-**	-	**-**	-
Bank overdraft - Commercial banks	**-**	-	**-**	-
Cash and cash equivalents as in SoCF	**22,840**	33,408	**22,840**	33,408

Note 18.1 Third party assets held by the NHS Foundation Trust				
	2013/14	2013/14	2012/13	2012/13
	Bank Balances	Money on Deposit	Bank Balances	Money on Deposit
	£000	£000	£000	£000
At 31 March	3	-	2	-

Note 19 Trade and other payables

Note 19.1 Trade and other payables	Foundation Trust		Group	
	Total	Total	Total	Total
	Monday, 31 March 2014	Sunday, 31 March 2013	Monday, 31 March 2014	Sunday, 31 March 2013
	£000	£000	£000	£000
NHS payables - revenue	**1,125**	374	**1,125**	374
Other trade payables - capital	**3,062**	4,126	**3,062**	4,126
Other trade payables - revenue	**14,316**	10,585	**14,316**	10,585
Other taxes payable	**4,162**	4,171	**4,162**	4,171
Other payables	**2,722**	1,216	**2,722**	1,216
Accruals	**9,543**	13,694	**9,543**	13,694
NHS Charitable funds: Trade and other payables			**67**	37
TOTAL CURRENT TRADE AND OTHER PAYABLES	**34,929**	34,165	**34,996**	34,201
Non-current				
Other payables	**281**	367	**281**	367
TOTAL NON CURRENT TRADE AND OTHER PAYABLES	**281**	367	**281**	367

Note 19.2 Early retirements detail included in NHS payables above
The Trust has no early retirement costs included in NHS Payables above.

Note 20 Borrowings

	Foundation Trust		Group	
	31-Mar-14	31-Mar-13	31-Mar-14	31-Mar-13
	£000	£000	£000	£000
Current				
Loans from Independent Trust Financing Facility	**-**	562	**-**	562
Obligations under finance leases	**25**	34	**25**	34
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	**1,424**	1,312	**1,424**	1,312
NHS Charitable funds: other current borrowings			**-**	-
TOTAL CURRENT BORROWINGS	**1,449**	1,908	**1,449**	1,908
Non-current				
Loans from Independent Trust Financing Facility	**-**	5,069	**-**	5,069
Capital loans from Department of Health	**1,050**	-	**1,050**	-
Obligations under finance leases	**-**	25	**-**	25
Obligations under PFI, LIFT or other service concession contracts	**80,390**	81,814	**80,390**	81,814
NHS Charitable funds: non-current borrowings			**-**	-
TOTAL OTHER NON CURRENT LIABILITIES	**81,440**	86,908	**81,440**	86,908

Note 21 Prudential borrowing

The prudential borrowing code requirements in section 41 of the NHS Act 2006 have been replaced with effect from 1 April 2013 by the Health and Social Care Act 2012. The financial statements disclosures that were provided previously are no longer required.

Note 22 Other liabilities

	Foundation Trust		Group	
	Monday, 31 March 2014	Sunday, 31 March 2013	Monday, 31 March 2014	Sunday, 31 March 2013
	£000	£000	£000	£000
Current				
Deferred income - goods and services	1,053	628	1,053	628
Other deferred income	97	97	97	97
TOTAL OTHER CURRENT LIABILITIES	1,150	725	1,150	725
Non-current				
Deferred income - goods and services	-	10	-	10
Other deferred income	1,546	1,643	1,546	1,643
NHS Charitable funds: other liabilities	-	-	-	-
TOTAL OTHER NON CURRENT LIABILITIES	1,546	1,653	1,546	1,653

Note 22.1 Other Financial Liabilities

	Monday, 31 March 2014	Sunday, 31 March 2013	Monday, 31 March 2014	Sunday, 31 March 2013
	£'000	£'000	£'000	£'000
Non-current				
Derivative and embedded derivatives held at 'fair value through income and expenditure'	-	-	-	-
Other financial liabilities	-	-	-	-
NHS Charitable funds: other financial liabilities			-	-
Total	-	-	-	-
Current				
Derivative and embedded derivatives held at 'fair value through income and expenditure'	-	-	-	-
Other financial liabilities	-	-	-	-
NHS Charitable funds: other charitable funds			-	-
Total	-	-	-	-

Note 23 Provisions and contingent liabilities

Note 23.1 Provisions for liabilities and charges									
	Foundation Trust					Group			
	Current		Non-current			Current		Non-current	
	Monday, 31 March 2014	Sunday, 31 March 2013	Monday, 31 March 2014	Sunday, 31 March 2013		Monday, 31 March 2014	Sunday, 31 March 2013	Monday, 31 March 2014	Sunday, 31 March 2013
	£000	£000	£000	£000		£000	£000	£000	£000
Pensions relating to other staff	**249**	262	**1,641**	1,849		**249**	262	**1,641**	1,849
Other legal claims	**63**	86	**(0)**	0		**63**	86	**(0)**	0
Restructurings	**1,663**	2,516	**-**	-		**1,663**	2,516	**-**	-
Redundancy	**-**	414	**-**	-		**-**	414	**-**	-
Other	**1,151**	2,944	**1,166**	1,054		**1,151**	2,944	**1,166**	1,054
NHS Charitable fund provisions	**-**	-	**-**	-		**-**	-	**-**	-
Total	**3,126**	6,222	**2,806**	2,903		**3,126**	6,222	**2,806**	2,903

Note 23.2 Provisions for liabilities and charges analysis	Foundation Trust Total	Group Total	Pensions - former directors	Pensions - other staff	Other legal claims	Re-structurings	Redundancy	Other *	NHS charitable fund provisions
	£000	£000	£000	£000	£000	£001	£000	£000	£000
At 1 April 2013	**9,125**	2,111	-	2,111	86	2,516	414	3,998	-
Change in the discount rate	**27**	-	-	-	-	-	-	27	-
Arising during the year	**2,998**	-	-	-	-	1,001	-	1,997	-
Utilised during the year - accruals	**(2,235)**	(271)	-	(271)	(23)	(445)	-	(1,496)	-
Reversed unused	**(4,059)**	-	-	-	-	(1,409)	(414)	(2,236)	-
Unwinding of discount	**76**	50	-	50	-	-	-	26	-
NHS charitable funds: movement in provisions	**-**	-	-	-	-	-	-	-	-
At March 2014	**5,932**	1,890	-	1,890	63	1,663	-	2,316	-
Expected timing of cashflows:									
- not later than one year;	**3,126**	3,126	-	249	63	1,663	-	1,151	-
- later than one year and not later than five years;	**1,480**	1,480	-	916	-	-	-	564	-
- later than five years.	**1,327**	1,327	-	725	-	-	-	602	-
TOTAL	**5,932**	5,932	-	1,890	63	1,663	-	2,316	-

*The significant values within Other Provisions of £2.316m relate to provisions of £1.1m for Injury Benefit payments for previous employees of the Trust payable to NHS Pensions Agency. All other provisions are individually less than £1m.

Note 23.3 Clinical Negligence liabilities	Monday, 31 March 2014	Sunday, 31 March 2013
	£000	£000
Amount included in provisions of the NHSLA in respect of clinical negligence liabilities of Calderdale and Huddersfield NHS Foundation Trust.	**73,234**	56,836

Note 24 Related Party Transactions

The Trust has established which entities and individuals are its related parties, in accordance with International Accounting Standard 24.

Monitor have directed, through the Annual Reporting Manual 2013/14, that all bodies within the scope of 'Whole of Government Accounts' (WGA) are related parties. Accordingly, the table below details material transactions.

Related party transactions - WGA organisations	2013/14	2012/13
	£000	£000
Income - NHS Calderdale CCG	**137,677**	
Income - NHS Greater Huddersfield CCG	**126,801**	
Income - NHS North Kirklees CCG	**5,223**	
Income - NHS Bradford Districts CCG	**6,939**	
Income - NHS Wakefield CCG	**936**	
Income - NHS Calderdale		153,894
Income - NHS Kirklees		146,645
Income - NHS Bradford & Airedale		8,672
Income - NHS Wakefield District		2,557
Income - Leeds Teaching Hospitals NHS Trust	**1,897**	1,658
Income - South West Yorkshire Partnership NHS Foundation Trust	**4,906**	4,765
Income - Yorkshire & Humber SHA		9,481
Income - South Yorkshire and Bassetlaw Area Team	**17,184**	
Income - Health Education England	**8,603**	
Income - NHS Litigation Authority	**1,247**	
Income - NHS England - Core	**4,398**	
Income - Calderdale Metropolitan Borough Council	**3,040**	1,153
Income - Kirklees Metropolitan Council	**1,239**	283
Income - Other WGA	**23,719**	12,993
Income - Total with WGA organisations	**343,811**	342,101
Expenditure - Bradford Teaching Hospitals NHS Foundation Trust	**1,076**	537
Expenditure - Leeds Teaching Hospitals NHS Trust	**1,526**	1,400
Expenditure - NHS Pension Scheme	**21,518**	20,669
Expenditure - NHS Litigation Authority	**6,915**	7,513
Expenditure - Calderdale Metropolitan Borough Council	**1,108**	1,169
Expenditure - National Insurance Fund	**13,795**	12,668
Expenditure - Other WGA	**4,817**	5,980
Expenditure - Total with WGA organisations	**50,755**	49,936
Related party balances - WGA organisations	**31 March 2012**	31 March 2012
	£000	£000
Receivables - NHS Calderdale CCG	**2,629**	
Receivables - NHS Greater Huddersfield CCG	**1,214**	
Receivables - NHS Calderdale		2,473
Receivables - NHS Kirklees		1,438
Receivables - NHS England	**1,613**	
Receivables - HM Revenue & Customs - VAT	**1,225**	952
Receivables - Other WGA	**4,449**	2,903
Receivables - Total with WGA organisations	**11,129**	7,766
Payables - NHS Pension Scheme	**2,989**	2,743
Payables - HMRC - Taxes & Duties	**2,124**	2,180
Payables - National Insurance Fund	**2,038**	1,991
Payables - Other WGA	**2,289**	1,288
Payables - Total with WGA organisations	**9,439**	8,202

During the year, two of the Board Members or members of the key management staff or parties related to them have undertaken transactions with Calderdale & Huddersfield NHS Foundation Trust.

David Anderson, Non Executive Director is partner in Grange Group Practice, Fartown and his spouse is employed by Locala.

Helen Thompson, Director of Nursing is a governor at the University of Huddersfield.

The trust realises these as imaterial transactions.

Note 25.1 Joint Venture

The Trust entered into a joint venture with Henry Boot Development Ltd on 24th March 2011. This partnership is the Pennine Property Partnership LLP and is owned 50/50 by the Trust and Henry Boot Development Ltd.
It will develop a new 56,000 sq ft healthcare facility following the exchange of a pre-let agreement, with the Trust to operate the building.

The development will involve the substantial reconstruction and refurbishment of an existing derelict stone mill, known as Acre Mill, and will provide a range of modern outpatient facilities.
The Pennine Property Partnership LLP's principal place of business is within the UK.

The Trust has used the equity accounting method.

There are no contingent liabilities of the JV for which the Trust is jointly and contingently liable.

The JV has no capital commitments.

Disclosure of aggregate amounts for assets and liabilities of jointly controlled operations	Monday, 31 March 2014	Sunday, 31 March 2013
	£000	£000
Current assets	**876**	50
Non current assets	**3,041**	1,249
Total assets	**3,917**	1,299
Current liabilities	**(4,085)**	(1,310)
Non current liabilities	**168**	11
Total liabilities	**(3,917)**	(1,299)
Operating income	**-**	-
Operating expenses	**(40)**	(21)
Surplus /(deficit) for the year	**(40)**	(21)

* The 2012/13 figure has been restated in line with audited accounts from the Joint Venture

The trust has not equity accounted for the joint venture which becomes operational in 2014/15. When the JV isa operational the trust will follow equity accounting in line with the accounting policies described in note 1.2 consoolidation.

Note 26 Contractual Capital Commitments

	Monday, 31 March 2014	Sunday, 31 March 2013
	£000	£000
Property, Plant and Equipment	**589**	438
Intangible assets	**-**	-
Total	**589**	438

Note 26.1 Other Financial Commitments

The Trust is not committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangements).

Note 26.2 Finance lease obligations

	Monday, 31 March 2014	Sunday, 31 March 2013
Gross lease liabilities	25	59
of which liabilities are due		
- not later than one year;	25	34
- later than one year and not later than five years;	-	25
- later than five years.	-	-
Finance charges allocated to future periods	-	-
Net lease liabilities	25	59
- not later than one year;	25	34
- later than one year and not later than five years;	-	25
- later than five years.	-	-

All Finance Lease obligations are for Plant & Machinery.

Note 27 PFI (on Statement of Financial Position)

Note 27.1 PFI obligations (on Statement of Financial Position)		
	Monday, 31 March 2014	Sunday, 31 March 2013
	£000	£000
Gross PFI liabilities	**306,164**	312,216
of which liabilities are due		
- not later than one year;	**12,382**	11,907
- later than one year and not later than five years;	**50,596**	49,111
- later than five years.	**243,186**	251,198
Finance charges allocated to future periods	**(224,350)**	(229,090)
Net PFI obligation	**81,814**	83,126
- not later than one year;	**1,424**	1,312
- later than one year and not later than five years;	**5,992**	5,806
- later than five years.	**74,398**	76,008

Note 27.2 On-SoFP PFI commitments in respect of the service element of the PFI		
	Monday, 31 March 2014	Sunday, 31 March 2013
	£000	£000
Commitments		
Within one year	**11,022**	10,541
2nd to 5th years (inclusive)	**46,338**	44,317
later than five years.	**165,789**	173,368
	223,149	228,226

The PFI scheme above relates to Calderdale Royal Hospital. The PFI contractor is Calderdale Hospitals SPC Ltd (formerly Catalyst Healthcare Ltd). The Trust are responsible for the provision of all clinical services, Calderdale Hospitals SPC Ltd provide fully serviced hospital accommodation.

Note 28 For PFI schemes deemed to be off-Statement of Financial Position

The Trust has no PFI Schemes deemed to be off-Statement of Financial Position.

Note 29 Financial assets and financial liabilities

Note 29.1 Financial assets by category		
	Foundation Trust	Group
	Total	Total
	£000	£000
Assets as per Statement of Financial Position		
Trade and other receivables excluding non financial assets (at 31 March 2014)	**9,655**	**9,655**
Other Investments (at 31 March 2014)	**-**	**-**
Other Financial Assets (at 31 March 2014)	**-**	**-**
Non current assets held for sale and assets held in disposal group excluding non financial assets (at 31 March 2014)	**-**	**-**
Cash and cash equivalents at bank and in hand (at 31 March 2014)	**22,840**	**22,840**
NHS Charitable funds: financial assets (at 31 March 2014)		**-**
Total at 31 March 2014	**32,495**	**32,495**
Trade and other receivables excluding non financial assets (at 31 March 2013)	7,090	7,090
Other Investments (at 31 March 2013)	-	-
Other Financial Assets (at 31 March 2013)	-	-
Non current assets held for sale and assets held in disposal group excluding non financial assets (at 31 March 2013)	-	-
Cash and cash equivalents (at bank and in hand (at 31 March 2013)	33,407	33,407
NHS Charitable funds: financial assets (at 31 March 2013)		-
Total at 31 March 2012	40,497	40,497

All financial assets at 31 March 2013 and 31 March 2012 were classified as loans and receivables. The Trust had no financial assets held at fair value through Income and expenditure, Held to maturity or Available-for-sale.

Note 29.2 Financial liabilities by category	Total	Total
	£000	£000
Liabilities as per Statement of Financial Position		
Borrowings excluding Finance lease and PFI liabilities (at 31 March 2014)	**1,050**	**1,050**
Obligations under finance leases (at 31 March 2014)	**25**	**25**
Obligations under PFI, LIFT and other service concession contracts (at 31 March 2014)	**81,814**	**81,814**
Trade and other payables excluding non financial liabilities (at 31 March 2014)	**30,767**	**30,767**
Other financial liabilities (at 31 March 2014)	**-**	**-**
Provisions under contract (at 31 March 2014)	**-**	**-**
NHS Charitable funds: financial liabilities (at 31 March 2014)		**-**
Total at 31 March 2014	**113,656**	**113,656**
Borrowings excluding Finance lease and PFI liabilities (at 31 March 2013)	5,632	5,632
Obligations under finance leases (31 March 2013)	59	59
Obligations under PFI, LIFT and other service concession contracts (31 March 2013)	83,126	83,126
Trade and other payables excluding non financial liabilities (31 March 2013)	30,041	30,041
Other financial liabilities (31 March 2013)	-	-
Provisions under contract (at 31 March 2013)	-	-
NHS Charitable funds: financial liabilities (at 31 March 2013)		-
Total at 31 March 2013	118,858	118,858

All financial liabilities at 31 March 2014 and 31 March 2013 were classed as other financial liabilities. The Trust had no liabilities held at fair value through income and expenditure.

Note 29.3 Maturity of Financial liabilities	31 March 2014	31 March 2013
	£000	£000
In one year or less	**32,215**	31,950
In more than one year but not more than two years	**1,996**	2,010
In more than two years but not more than five years	**5,046**	6,071
In more than five years	**74,399**	78,827
Total	**113,656**	118,858

Note 29.4 Fair values of financial assets at 31 March 2014	Foundation Trust		Group	
	Book Value	Fair value	Book Value	Fair value
	£000	£000	£000	£000
Non current trade and other receivables excluding non financial assets	-	-	-	-
Other Investments	-	-	-	-
Other	-	-	-	-
NHS Charitable funds: non-current financial assets			-	-
Total	-	-	-	-

Note 29.5 Fair values of financial liabilities at 31 March 2013	Book Value	Fair value	Book Value	Fair value
	£000	£000	£000	£000
Non current trade and other payables excluding non financial liabilities	-	-	-	-
Provisions under contract	-	-	-	-
Loans **	1,050	1,050	1,050	1,050
Other	-	-	-	-
NHS Charitable funds: non-current financial liabilities			-	-
Total	1,050	1,050	1,050	1,050

Management consider that the carrying amounts of financial assets and financial liabilities recorded at amortised cost in the financial statements approximate to their fair value.

Note 29.6 Financial Instruments

Financial risk management
Because of the continuing service provider relationship that the NHS Foundation Trust has with local Clinical Commisioning Groups (formerly) Primary Care Trusts and the way those Clinical Commissioning Groups are financed, the NHS Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies. The Trust neither buys or sells financial instruments. The NHS Foundation Trust has limited powers or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

The Board of Directors has approved a Treasury Management policy which sets out the parameters for investing any surplus operating cash in short-term deposits. This includes the restriction of any such investment to permitted institutions with appropriate credit ratings; these ratings are in line with the guidance issued by Monitor 'Managing Operating Cash in NHS Foundation Trusts'. In addition the policy sets out the maximum limits for any such investments. The policy, and its implementation are reviewed by the Audit & Risk Committee and the Board of Directors. The Trust's treasury management activity is subject to review by the Trust's internal auditors.

Interest rate risk
All of the Trust's financial liabilities carry nil or fixed rates of interest. The Trust therefore has low exposure to interest rate fluctuations.

Liquidity risk
The Trust's operating costs are largely incurred under contracts with local Clinical Commisioning Groups, which are financed from resources voted annually by Parliament. The Trust receives cash each month based on an annually agreed level of contract activity with in-year adjustments to reflect actual levels of income due.

The Trust has withdrawn it's working capital facility, which the Trust never utilised, based on a change in guidance from Monitor.

In 2013/14 the Trust has financed it's capital expenditure from internally generated funds. If the Trust were to require external borrowing, the Trust would have to meet the relevant borrowing criteria from the lender.

The Trust is not, therefore, exposed to significant liquidity risk.

Currency risk
The Trust is principally a domestic organisation with negligible transactions, assets and liabilities in foreign currencies. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Note 30 Health Informatics
The Trust provides information management and technology services to a number of other NHS Organisations from the Health Informatics Service. The income and expenditure of the service are included in the Statement of Comprehensive Income; and the value of income in 2013/14 was £6,771,000 (£7,763,000 in 2012/13).

Note 31 Limitation on Auditors Liability
There is £1m limit on our external Auditors liability.

Note 32 Losses and special payments

Note 32.1 Losses and special payments

There were 115 cases of losses and special payments totalling £109,000 during the period covered by these accounts (71 cases totalling £184,000 in 2012/13).

There were no clinical negligence cases where the net payment exceeded £100,000.

There were no fraud cases where the net payment exceeded £100,000.

There were no personal injury cases where the net payment exceeded £100,000.

There were no compensation under legal obligation cases where the net payment exceeded £100,000.

There were no fruitless payment cases where the net payment exceeded £100,000.

Note 32.2 Recovered Losses
The Trust has not received any compensation payments from CHCC.

Note 33 Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2013-14. The application of the Standards as revised would not have a material impact on the accounts for 2013-14, were they applied in that year:

IFRS 9 Financial Instruments
IFRS 10 Consolidated Financial Statements
IFRS 11 Joint Arrangements
IFRS 12 Disclosure of Interests in Other Entities
IFRS 13 Fair Value Measurement
IAS 27 Separate Financial Statements
IAS 28 Associates and joint ventures.
IAS 32 Financial Instruments: Presentation - amendment Offsetting financial assets and liabilities
IFRS 7 Financial Instruments: Disclosures – amendment Offsetting financial assets and liabilities

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Calderdale and Huddersfield NHS

NHS Foundation Trust