Calderdale and Huddersfield NHS
NHS Foundation Trust

annual report & accounts 2009/10




Your Care Our Concern

Pride • Patients • People • Partnerships

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of the National Health Service Act 2006.

Calderdale and Huddersfield NHS Foundation Trust

Annual Report and Accounts
2009/10

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Your Care Our Concern

Chairman's Statement

Every year we talk about the challenges that face the people who work in the NHS, and every year they are different.

One of the greatest strengths of our staff is their ability to deal with whatever faces them - whether it is changing and modernising services to improve patient care, meeting exacting targets or dealing with unexpected pressures.

The emergence of swine flu was one of the first major tests of organisations across the country in 2009/10. Years of planning to deal with a flu epidemic was quickly turned into action as the NHS readied itself for the outbreak.

Teams worked hard to ensure that our hospitals were ready to care for people with swine flu, roll out a vaccination programme for frontline staff and keep our day-to-day services running smoothly.

The hard winter of 2009/10 again saw our staff come to the fore - some walked miles through snow drifts to make sure services kept running for our patients and our A&E teams dealt with the many fractures and breaks that inevitably come with snow and ice. Both our hospitals were extremely busy and every ward and department pulled out all the stops to deal with the pressures of a tough winter.

The coming year will, of course, present new challenges - one of the greatest will be making sure we continue to deliver high quality services in a time of financial recession.

We have a strong financial track record and have once again reported a financial surplus. This money is reinvested for the benefit of our patients and this year work has started at both our hospitals on new endoscopy units, which will be completed later in 2010.

At Huddersfield Royal Infirmary we have carried out major ward refurbishments to make sure the environments meet the latest privacy and dignity guidelines and tough infection control standards.

We are also investing to improve car parking - a source of complaints that we are keen to tackle.

Work is constantly taking place behind the scenes to improve the way we care for patients and the services we provide for them.

Our members and Membership Council have a vital role in helping us make the right changes for local people and I would like to thank them for all their hard work, advice and insight.

We are also keen to ensure that the principles underpinning the NHS Constitution are fully embraced throughout our organisation.

I would like to place on record our thanks to all our volunteers and supporters, such as the League of Friends. Many people give time and effort to the Trust and it is greatly appreciated.

In accordance with my duties under the Monitor 'Code of Governance' I confirm that my commitments have not changed in the last 12 months.

Sukhdev Sharma

"One of the greatest strengths of our staff is their ability to deal with whatever faces them"

Chief Executive's Statement

The annual report is an opportunity for us to look back over the past year and take stock. It is a chance to recognise our achievements and where we need to continue to focus our efforts.

Our services have been recognised as "good" quality by the health and social care regulator the Care Quality Commission but we cannot in any way be complacent.

The quality of the services we provide to our local community is at the heart of everything, which is why we launched our Quality Improvement Strategy in 2009. The key words associated with it are: "Safe, effective and personal" - which is what the care we provide to people should always be.

One of the many areas covered by the strategy is infections. We have seen significant reductions in cases of Clostridium difficile and the numbers of MRSA bacteraemias have remained fairly static over the past two years - but we need to do more.

We also want our patients to tell their friends and family that they have had a good experience at our hospitals. We have invested to improve privacy and dignity with more bathrooms and the virtual elimination of mixed sex accommodation. But our patient surveys have told us there are areas we need to improve on and we are working hard to do just that.

The financial regime we will have to operate within in future years will be tough to say the least and we need to find ways of working within tight budgets without compromising quality.

I have confidence that we can do this. We are co-operating with our partners in primary care to make sure we integrate care wherever possible - avoiding repetition and unnecessary processes to improve the patients' experience and drive out waste.

We will also be looking to work with other hospital trusts to see if there are ways we can co-operate to save valuable resources - for example by working collectively to increase our buying power.

Over the last few years there have been significant developments at both our sites to improve wards and clinical departments and we plan to see this continue.

Acre Mill, opposite Huddersfield Royal Infirmary, is home to some of our non-clinical services, our pharmacy manufacturing unit and some temporary car parking. In 2010 we hope to find ways of financing the further development of this site for the benefit of our patients.

We cannot afford to stand still if we wish to stay strong in a tough environment. Thankfully our staff, members and supporters continue to help us meet the challenges which come our way.

Diane Whittingham

"We cannot afford to stand still if we wish to stay strong in a tough environment."

Highlights 2009/10

Patients

May 2009: Privacy and dignity

Our Trust received £187,000 from the Department of Health to improve privacy and dignity for our patients. Extensive work has taken place at both our hospitals, including the refurbishment of a number of wards, new and improved signage on our wards and the provision of more shower rooms and toilets.

Refurbished: The Surgical Assessment Unit at HRI.

July 2009: New specialist service

A new service was launched at the Huddersfield Royal Infirmary. Children with complex orthopaedic conditions no longer have to travel to Leeds for outpatient and follow-up appointments.

Paediatric orthopaedic consultant Brian Scott (second left) examines two-month old Leo McKenzie Clarke with staff nurse Lynn Harrison, Leo's parents (from left) Gary Clarke and Rachel Calverley and plaster technicians Lorraine Gough and David Sugden.

November 2009: Speedy recovery

Our Trust was one of 14 sites in England chosen to take part in a national programme to help patients recover more quickly after surgery. Enhanced recovery is a new approach to planned surgery which ensures that patients are in the best condition before, during and after their operation.

Enhanced Recovery Team: Consultant anaesthetist Julio Nunez, staff nurse Stephanie Rich, patient Betty Stott, staff Nurse Richard Armitage, colorectal clinical nurse specialist Kerry Matthews.

March 2010: Surgery first for our Trust

Pioneering keyhole bowel surgery was performed for the first time at the Huddersfield Royal Infirmary. Our Trust is one of only a few in the country offering the new laparoscopic ileo-anal pouch procedure for inflammatory bowel disease.

Patient Kevin Firth, of Huddersfield, with staff nurse Maria Singh (front) and (back from left) ward clerk Pam Lewis, Mr Anwar, Sister Shelagh Phillips and healthcare assistant Marcia Coates.

March 2010: Focus on research

Our Trust is taking part in major national and international studies into the treatment of glaucoma. Local patients have been recruited to take part in the pioneering studies. The results will provide valuable information about the treatment of glaucoma.

Consultant ophthalmologist Mr Nitin Anand
Photo courtesy of the Huddersfield Examiner

Highlights 2009/10

People

April 2009: Top awards

Two nurses from our Trust scored a hat-trick of awards at the Nursing Times Leadership Challenge. Matron Jo Middleton and patient flow manager Lydia Holroyd won best team, best strategy and best health economy.

Matron Jo Middleton and patient flow manager Lydia Holroyd.

June 2009: Red carpet night for our staff

Each year we recognise staff innovation that leads to improved care for our patients. The winner was the SWANS (Support for Women and Ante-Natal Services) project. The project is a partnership between our Trust and Kirklees Council, offering advice to women on ante-natal care, parenting skills and housing issues.

Chairman Sukhdev Sharma presents the winners Hayley Wimpenny and Janet Woodhouse with their award.

October 2009: Helping others

John Ennis, an estates officer at Huddersfield Royal Infirmary, travelled to Tanzania with Rotary International to help refurbish a hospital on the island of Ukerewe.

Estates officer John Ennis.

February 2010: Helping survivors in Haiti

Debbie Lau, a senior sister in the A&E Department at our Trust, spent two weeks in disaster-struck Haiti, helping the sick and injured. Debbie went out with a team from UK aid agency, Merlin.

From left: American doctor Janelle Martin, Debbie Lau, American nurse practitioner Kayla Burker.

Your Care Our Concern

Highlights 2009/10

Partnerships

April 2009: Pioneering DVD

Nurses from our Trust worked with the charity Breast Cancer Care to create a pioneering exercise DVD to help women recover after breast cancer surgery.

Oncology physiotherapist Lisa Wright (front) and breast care nurse Susan Booker (back, third left) with patients.

November 2009: Top award

A partnership to improve seatbelt wearing and reduce the number of people killed and injured won an NHS innovation award. The Trust worked with Calderdale Council, police, fire service, local schools and communities on Safer Roads Group Seatbelt on? Campaign.

From left: Sergeant Gary Alderson of West Yorkshire Police, John Bradley of Ryburn Valley High School, Kate Marsh of Calderdale Council, Lee Benson of West Yorkshire Fire Service, and Andrew Lockey, A&E consultant

November 2009: Health Secretary visits Todmorden Health Centre

Health Secretary Andy Burnham visited Todmorden Health Centre to celebrate the centre's first anniversary. We have worked with GPs and NHS Calderdale to provide some hospital services at the health centre.

Health Secretary Andy Burnham with staff at Todmorden Health Centre.

December 2009: David Cameron's visit

Conservative leader David Cameron visited the birth centre and children's ward at Calderdale Royal Hospital.
Mr Cameron spoke to new mums who told him about the excellent care that they had received from our staff.

Conservative leader David Cameron meets with new mum Kathryn Blanchard and baby Freddie.

Pride

April 2009: ICU innovation

Our two intensive care teams became the first in the country to gain a national award recognising high quality and innovative care. Both teams achieved stage one of the Practice Development Unit accreditation from Leeds University.

The ICU team.

Highlights 2009/10

May 2009: Major investment

A new £2m scheme was launched to transform ward 10 at Huddersfield Royal Infirmary along with a further scheme for a new £2.8m state of the art endoscopy scheme at Calderdale Royal Hospital.

Transformed: ward 10, HRI

June 2009: MAU success

Our medical assessment unit (MAU) at Calderdale Royal Hospital retained a prestigious national award. The unit was re-accredited at level two for its medical emergency as a Practice Development Unit by health experts from Leeds University.

The MAU team at CRH.

July 2009: Top status

Our Trust was awarded Associated Teaching Hospital status by the Leeds University Medical School in recognition of its top level tuition for medical students. The award recognises the important work that the Trust does in training medical students and the commitment of our medical staff in teaching the next generation of doctors.

The Medical Education Team at CRH.

January 2010: First for community rehabilitation

Our Trust's community rehabilitation team was the first therapy-only unit in the country to gain a prestigious recognition from the University of Leeds. The team achieved second stage practice development unit accreditation.

The Community Rehabilitation Team.

January 2010: Six years of success

Our stroke and rehabilitation unit at CRH has retained a prestigious award for the sixth year. The unit was rewarded with accreditation as a Practice Development Unit (PDU) by Leeds University. The re-accreditation recognises that high quality care for patients has been maintained.

The Stroke and Rehabilitation Unit team.

March 2010: Building for the future

Work started on a £3.5m building scheme to provide a dedicated, state-of-the-art endoscopy unit at HRI.


NHS

Directors' Report

A bit of history

The Calderdale and Huddersfield NHS Trust was formed in April 2001, following the merger of Calderdale Healthcare NHS Trust and Huddersfield Healthcare Services NHS Trust.

The merger improved our ability to provide modern, high quality healthcare to the communities of Calderdale and Huddersfield.

In 2006 we applied for Foundation Trust status and became an NHS Foundation Trust from August 1, 2006 under the Health and Social Care (Community Health and Standards) Act 2003. As a Foundation Trust we remain part of the NHS family and are subject to the same NHS quality standards, performance ratings and systems of inspection. Foundation Trust status allows us to work much more closely with local people and service users and helps us to respond to the needs of our local communities.

The focus of the Trust is on clinically led services with consultants and clinicians taking the lead role in the management of the organisation.

What we do

We deliver healthcare services from our two main hospitals, Calderdale Royal Hospital and Huddersfield Royal Infirmary, and in a range of community settings such as health centres and GP practices.

We provide health services for more than 435,000 people in the areas served by Calderdale and Kirklees Councils, although patients travel from further afield to access our services. Last year more than 110,000 men, women and children were cared for as inpatients (stayed at least one night) or day cases and almost 380,000 people attended our outpatient clinics. Added to that, our accident and emergency departments at the two hospitals cared for more than 130,000 people.

The majority of our services are based in the two hospitals but we have continued to develop services in the local communities. This reflects the way that the steps in patients' treatment are being redesigned, and also our quest to become known as a provider of both hospital and community services.

Our vision and values

Your Care, Our Concern – this vision is at the heart of everything we do and our success in achieving high quality care for all our patients is driven by four key themes:

Patients: we will continuously transform care and improve the patient experience

People: we will attract, retain and develop the best staff

Partnerships: we will create a sustainable future and develop effective external relationships

Pride: we will be recognised for our achievements and aspirations as a highly successful organisation.

Stakeholder relations

By working with our partner organisations we have been able to gain a clear understanding of the needs of the local population. We have good working relationships with our local primary care trusts, practice based commissioners and local authorities. Our directors are committed members of the Local Strategic Partnership Boards in both Calderdale and Kirklees focusing on the joint delivery of the Comprehensive Area Assessments.

Our clinicians are actively encouraged to engage with the local health community to ensure patients flow seamlessly across organisations where required, and receive care in the most appropriate environment for their needs.

Building upon the success of our outpatient facility at Todmorden, we are working with the primary care trusts to explore and develop opportunities to expand the locations and ranges of services that can be provided to patients closer to their home and provide a choice of convenient location for their appointments and treatment.

The Trust has been working with both Bradford Hospitals NHS Foundation Trust and Airedale NHS Trust to develop a strategy for vascular services across the area which provides a quality local service to the residents of our health economy.

As a forward looking Foundation Trust, we have fully embraced the development of specialist commissioning for services which require specialist knowledge and skills. Through this we have commenced a local service for bariatric surgery and are working with the West Yorkshire Cardiac Network for the transfer of some cardiac procedures which may have previously resulted in patients travelling further afield.

The focus of the Trust is on clinically led services with consultants and clinicians taking the lead role in the management of the organisation.

Directors' Report

Patient Care

The Trust continues to deliver high quality services in an ever changing environment. Our latest Care Quality Commission ratings announced in 2009 - good for the quality of services and excellent for the quality of financial management - demonstrate our ability to provide the best for our patients.

Performance against national and local targets is reported monthly to the Board of Directors and the Trust has delivered excellent work in-year to achieve the key requirements of the Care Quality Commission and has successfully registered under the new statutory requirements.

2009 has been an excellent year for achieving all our performance targets. Working with our partners in primary care, we have enhanced patient pathways and made significant progress in year to ensure all patients receive their first treatment within 18 weeks of their referral.

In January 2010 a new target was implemented to ensure that all patients referred by their GPs with breast symptoms are seen within two weeks. To achieve this we have developed seamless pathways across Calderdale and Huddersfield and increased our clinics to provide sufficient and timely appointments.

We have worked closely with our colleagues across the health community to enhance our services for patients who have experienced a stroke. New pathways have been developed with the Yorkshire Ambulance Service which now allow patients to go directly to the Acute Stroke Unit at Calderdale Royal Hospital and receive specialist treatment at the onset of their symptoms.

In partnership with the South West Yorkshire Partnership NHS Foundation Trust we have developed a joint bid to integrate the provider arm of NHS Calderdale. The main focus of work will be on transforming pathways of care which will ultimately lead to improved patient outcomes; satisfaction and increase efficiencies by reducing hospital attendances; admissions and lengths of stay as well as supporting people closer to home. Work on this will continue throughout 2010.

In 2009 we successfully bid for entry onto the Enhanced Recovery Programme (ERP) for both Colorectal and Gynaecology services. The programme is an evidence-based approach to care designed to prepare patients for, and reduce the total impact of surgery, helping them to recover more quickly. As the programme gets embedded within practice we should start to see improvements in patient experience and clinical outcomes, improved staff experience, reduced lengths of stay and improved waiting times.

We continue to work in partnership with NHS Calderdale and NHS Kirklees as one of eight joint award holders for a national pilot project to support patients with long term conditions. The pilot, funded by The Health Foundation, is called Co-Creating Health. In Calderdale and Huddersfield patients with musculo-skeletal pain and their clinicians are facilitated, through training and service development, to use self-management tools and techniques. Evidence from the pilot is collected by Coventry University to demonstrate benefits for patients and achievable efficiencies in resource use. In 2010 we hope to extend the pilot to a second long-term condition.

The Trust continues to deliver high quality services in an ever changing environment.

Improvements in patient and carer information

Our new Patient Information Booklet was launched in April 2010. It is a bedside information folder which will be kept in every locker by every inpatient bed, detailing the range of services available on each site, and informing patients, their relatives and carers of all the supportive information to assist them during their stay in hospital.

Public Information Boards have been placed in each of the main entrances and in our outpatient departments. These have a full range of information covering hospital services on each site.

Flat screen TVs have also been installed in the main entrances and outpatient departments, and help us to provide information about our services, new developments and other useful advice and updates for visitors and patients.

Handling complaints

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

The importance of using feedback is central to the new NHS Complaints Regulation 2009. This guides all Trusts on handling issues raised by patients and their families and carers.

All staff are encouraged to address issues as soon as they arise with the support of the Patient Advice and Liaison Service (PALS) or the Complaints Department when required.

Our objective is to resolve any concerns as quickly as we can.

Staff Relations

The Trust works in partnership with recognised staff side representatives through formal groups established to ensure that the workforce is involved and consulted about the business of the Trust and how services are designed and managed.

Through these formal mechanisms the Trust ensures that an appropriate framework of terms and conditions of employment and employment policies and procedures exists for staff which supports a positive approach to work, creates opportunities for personal and professional development, allows autonomy and enables decision making as close to the patient as possible and facilitates involvement in matters that impact on an employees ability to make a significant contribution to the work of the Trust.

The Trust employs more than 5,500 staff working in a variety of roles and settings and engagement with employees takes place through a variety of means at a corporate and local level. More details are available in the Staff Survey Report.

Equal opportunities and disabled employees

The Trust has a comprehensive disability equality scheme which operates as the principal mechanism for ensuring that policies and procedures are in place to give full and fair consideration to all applications for employment made by people with a disability.

Equality impact assessments are completed to ensure that what we do in relation to employment matters takes account of the needs of people with disabilities so that they are not disadvantaged.




Our objective is to resolve any concerns as quickly as we can.

The Trust monitors, for equal opportunities purposes, all applications for employment. This enables us to identify the number of people in employment who have declared a disability and provides us with an opportunity to engage with them to improve ways of working and the working environment.

The Trust guarantees, under the 'two tick symbol' scheme sponsored by jobcentreplus, an interview for any applicant with a disability who meets the minimum requirement for the job they have applied for.

The Trust's approach to treating people with disabilities fairly is applied throughout our employment practice and takes account of training and development needs for people with a disability at the point of entry to employment as well as those who during the course of their employment with the Trust become disabled.

The Trust has a widely recognised employability scheme which has been successful in positively encouraging applications for employment from people with a disability and has placed such applicants in volunteer and paid roles.

Sickness absence

The Trust has a sickness absence rate of 4% on average and this is monitored by our Divisions which, with the necessary corporate support, are best placed to manage workforce issues.

Health and Safety

The Trust attaches great importance to fulfilling its duty of care in relation to the health, safety and welfare of its employees, patients, visitors, contractors and any other users of its services and facilities.

We have the necessary policies in place detailing key responsibilities and how safe systems of work are implemented, monitored and reviewed. Health and Safety training continues to be a key component in the Trust's training portfolio.

The Trust operates a proactive Health and Safety Committee working in partnership with staff representatives and involving the workforce. The Committee monitor and report the effectiveness of systems for the safe management of non-clinical risks and receive regular updates on key risks to the organisation giving assurance to the Trust.

Financial standing and outlook

We are pleased to be able to report strong financial performance in 2009/10. We achieved a surplus, which will be spent on improved facilities and equipment to benefit patient care. In addition, we finished the year with a healthy cash position.

It should be noted that 2009/10 is the first year in which the Trust has been required by Monitor to produce its statutory accounts under International Financial Reporting Standards rather than under UK Generally Accepted Accounting Practice. Whilst this has introduced some minor technical changes to accounting policies and disclosures, the main change has been that Calderdale Royal Hospital (provided as part of the Private Finance Initiative) is now shown as part of the Trust's assets.

The financial risk rating is a measure used by Monitor (the independent regulator of NHS Foundation Trusts) to assess financial risk and more specifically to assess the likelihood of a financial breach of the terms of authorisation. The risk rating is on a scale of 1 to 5, with 5 being the strongest rating and 1 being the weakest. The plan agreed with Monitor at the start of the year was for the Trust to achieve a risk rating of 4, which we have achieved. This rating indicates that there are no concerns of a financial breach of our terms of authorisation as an NHS Foundation Trust. The table on the following page shows the financial criteria that are used to calculate the Financial Risk Rating and our planned and actual performance in 2009/10.

We are pleased to be able to report strong financial performance in 2009/10.

Criteria	Metric	Planned score	Actual score	Planned rating	Actual rating
Underlying performance	Earnings before Interest, Tax, Depreciation and Amortisation as a % of income	9.0%	9.0%	4	4
Achievement of plan	Earnings before Interest, Tax, Depreciation and Amortisation as a % of plan	100%	102.5%	5	5
Financial efficiency	Return on assets	4.8%	5.7%	3	4
	Income and Expenditure Surplus margin	1.0%	1.4%	3	3
Liquidity	Liquidity days	27.8	34.6	4	4
Overall Financial Risk Rating				**4**	**4**

In 2009/10 the Trust received total operating income of £309.2m. The vast majority of this income came from our two local primary care trusts (NHS Calderdale and NHS Kirklees) for the delivery of patient care to our local population. Total income in 2009/10 showed a 6.3% increase on income received in the previous year.

Total operating expenditure in 2009/10 was £310.9m, which included an impairment charge of £19.6m relating to a reduction in value of property assets (impairment charges do not impact on the cash position of the Trust). Excluding the impairment charge, the Trust spent £291.3m, comprising £198.0m of pay costs and £93.3m of non-pay costs. The Trust achieved efficiency gains of £7.5m; this was achieved through clinical and operational efficiencies across the Trust and improved contributions relating to service re-design.

After taking account of non-operating income and expenditure items (net costs of £7.1m on items such as Public Dividend Capital dividends and interest received on cash balances), the surplus before impairment charges for 2009/10 was £3.8m; the plan agreed with Monitor at the start of the financial year showed an anticipated surplus before impairment charges of £3.0m. The increased surplus position was primarily due to the receipt of income above plan for the treatment of patients over contracted levels as well as lower capital charges (depreciation and PDC dividend) than originally planned for.

The impairment charge on fixed assets of £19.6m relates to the Trust undertaking a full revaluation of its property assets in 2009/10 in line with accounting policies. This valuation reflected the continued decrease in property assets in 2009/10 (particularly on larger sites) as well as the impact of some blocks at the St. Luke's Hospital site in Huddersfield becoming non-operational.

Private patient income accounted for 0.2% of our total patient-related income. This is within the maximum level of 0.4% that we have been set as part of our terms of authorisation as a Foundation Trust.

Capital expenditure in 2009/10 was £12.9m. Major schemes undertaken in 2009/10 included:

- Major refurbishment of Ward 10 at Huddersfield Royal Infirmary £2m
- Work to improve and enhance the hospital environment to meet privacy and dignity standards £0.4m
- Demolition/site works and creation of a temporary car park on the Acre Mill site at Huddersfield £0.9m
- Operational and infrastructure schemes £3.4m
- Lift replacement at Huddersfield Royal Infirmary £1.1m - to be completed 2010/11
- New endoscopy units at Calderdale Royal Hospital and Huddersfield Royal Infirmary £1.7m - to be completed 2010/11

Directors' Report

Having considered the risks, the Directors of the Trust reasonably expect that there are adequate resources to continue operating for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

For each individual who is a Director at the time the annual report is approved, so far as each Director is aware, there is no relevant audit information of which the auditors are unaware. Each Director has taken all the 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 auditors are aware of that information.

The accounting policies for pensions and retirement benefits, and details of senior employees' remuneration can be found in the notes to the Accounts.

The Trust takes a proactive approach to counter fraud and corruption and has a dedicated Local Counter Fraud Specialist, who is employed by the Trust's Internal Audit provider.

The Trust complies with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

The Accounts of the Trust have been prepared under a direction issued by Monitor, the independent regulator of NHS Foundation Trusts.

Our external auditors

The Trust's external auditors for the period covered by this annual report were the Audit Commission (Trust Practice). As well as performing audit work under Monitor's Audit Code for NHS Foundation Trusts, the Trust has commissioned work from the external auditors during 2009/10 outside of this code. This work was in relation to the restatement of the 2008/09 financial position as part of the transition from UK Generally Accepted Accounting Practice to International Financial Reporting Standards, and reflected the requirement from Monitor that stated that Boards of Directors of Foundation Trusts needed to obtain and consider appropriate independent assurance as to the accuracy of the restatement.

The terms of reference for any non-audit work are reviewed by the Audit Committee to ensure that there is no conflict of interest, to ensure that they are the most suitable person(s) to carry out any such work, and to ensure that the value of the work is not excessive to ensure that the independence of external auditors is properly maintained.

Quality Report

Chief Executive's Statement

I am proud that Calderdale and Huddersfield NHS Foundation Trust has consistently performed well against national and local standards, targets, meeting Monitors' regulatory requirements and achieving unconditional registration with the Care Quality Commission in 2010.

The quality of care for our patients has always been our greatest concern: over many years we have taken part in local and national programmes such as the Safer Patients' Initiative and Co-Creating Health and have encouraged all our staff to seek out and implement best practice to ensure that our patients receive evidence-based high quality care.

In September 2009 we took this approach further with the publication of our three-year Quality Improvement Strategy "Your Care Our Concern - Safe, Effective, Personal." For the first time we set ourselves challenging goals, not only to meet all externally-driven targets and standards but to exceed them.

The strategy extends to all parts of the organisation and covers the three critical domains of safety, effectiveness and patient experience. It puts quality improvement at the heart of the Board of Director's agenda, using patient stories to bring it to life and clear measures that demonstrate how good our care is, whether it's getting better and how close we are to becoming the best in class.

As a Trust we are building our new strategy on firm foundations – strong clinical leadership and engagement, firm board leadership, a proactive Membership Council and a movement of passionate people amongst our staff and our membership.

Our patient voice has not always reflected the care we believe they should expect. We are confident that by implementing safe systems, driving out delays and waste and paying attention to their personal needs, patients will have more confidence in the care that they are receiving and we will live up to our promise to them of making "Your Care our Concern".

Our Quality Report for 2009/10 and our commitment to continue to improve in 2010/11 accurately reflects the large amount of work and energy that staff in Calderdale and Huddersfield NHS Foundation Trust are investing in quality improvement. It has been developed by listening to our staff and members and by taking into account conversations with our local LINks and primary care trusts.

We confidently look forward to meeting our commitments to all our partners and continuing our journey to become one of the safest, most productive Trusts in the country endorsed by our patients, our local community and our staff.

Calderdale and Huddersfield NHS Foundation Trust Board Commitment

The Board of Directors endorse the Trust's second Quality Report which puts improving patient care at the heart of the agenda. We believe that delivering safe care in the most effective way with compassionate and competent staff will give our patients confidence in our care and show that our priority is to meet their individual needs with kindness and respect.

We welcome the involvement of our patients and members in helping us to set our priorities for the year ahead. Our focus as a Board will be strengthened by listening to their stories, by continuing with our ward and departmental visits to celebrate their achievements and hear their views and by regularly monitoring progress through reports that measure the quality of care from frontline to the Board.

The Quality Report has been reviewed by the Board of Directors and to the best of our knowledge, accurately reflects both an overview of the quality of our services over the last year and our priorities for quality improvement in 2010/11.

Diane Whittingham
Chief Executive
27 May 2010

"The quality of care for our patients has always been our greatest concern"

Our new approach to Quality Improvement

The Quality Report aims to improve public accountability for the quality of care provided by Calderdale and Huddersfield NHS Foundation Trust (CHFT) during 2009/10, as required by Monitor as part of the Annual Report and by the Department of Health's Quality Accounts Regulations 2010.

In January 2010 the Board of Directors approved a new Quality Improvement Strategy for the Trust, which sets four strategic goals for the next three years.

- To reduce our Hospital Standardised Mortality Rates (HSMR) to be in the top 20% of comparative trusts
- To reduce 'harm' by 50%
- To be in the top 20% of comparative trusts for Length of Stay and Readmission Rates
- To achieve patient satisfaction in the top 20% of the NHS

These goals encompass the three domains of Quality: Safety, Effectiveness and Patient Experience

HSMR explained . . .

HSMR is a measurement system which compares an organisation's actual number of deaths with its predicted number. If a trust has an HSMR of 100, this means that the number of patients who died is as expected. An HSMR above 100 means that more patients died than expected, and a rate below 100 suggests that fewer patients died than expected. HSMR is a complex comparative indicator, which taken alone, can be misleading. It does however provide one indicator of the safety of patient care we provide, so that our first goal is:

- To reduce our Hospital Standardised Mortality Rates (HSMR) to be in the top 20% of comparative trusts

Harm explained . . .

Every year NHS services are used by millions of people; the vast majority receive care that is safe and effective. However, as in every healthcare system, not all care is as safe as it could be, and some patients are inadvertently harmed. Hospital acquired infections, medication errors, pressure ulcers and falls are all examples of avoidable harm. Measuring the extent of this "harm" gives us a good indication of the reliability and safety of our care. The Trust uses the Institute for Healthcare Improvement's (IHI) Global Trigger Tool (GTT) to provide us with an understanding of incidence of harmful events, which audits 20 randomly selected case notes from discharged patients on a monthly basis. Our second goal over the next three years is:

- To reduce 'harm' by 50%

Length of Stay and Readmission Rates explained . . .

Improving safety and productivity are inextricably linked. Effective care adds value to the patients' outcome and the patient experience. Patients whose care is less than optimal stay in hospital longer and are subjected to a greater risk of harm. As well as a personal cost to the individual, there is a financial cost to the taxpayer and a lost opportunity to treat more patients with the same level of resource. Good care is cost effective care; care that is delivered in the right place with competent, caring staff and delivers the best outcome. The public maybe concerned that patients being discharged earlier is unsafe and checking the rates for those patients readmitted with the same condition is an important balancing measure. Our third goal is:

- To be in the top 20% of comparative trusts for Length of Stay and Readmission Rates

Focusing on the Patients' Experience of Care . . .

Patients' views provide the real test of quality and our aim is for them to feel safe and well cared for and to have every confidence in the services we provide. However well our objective measures of safety and effectiveness may demonstrate improvement, the most important consideration is that the quality of care patients receive is reflected in their personal feedback. Our fourth goal is:

- To achieve patient satisfaction in the top 20% of the NHS

Understanding the collaboratives

A programme of projects has been identified to move us towards these goals. The projects are referred to as collaboratives to emphasise the joint working and learning that is involved and to reinforce the fact that safe, effective and personal care are intimately related.

The diagram below shows all our improvement collaboratives:

Listening to our partners

As a Foundation Trust we have strong relationships with our members and with their elected representatives on the Membership Council. Every year we hold 15 focus groups with members to test out our plans and to listen to their feedback. A key theme that we heard from them was the importance of achieving a consistently high standard of care on the wards.

The "Exemplar Ward" programme explained

The Quality Improvement Strategy collaboratives are built around a programme which we have called the "Exemplar Ward". The Exemplar Ward programme commenced in August 2009 and provides a strategic vision for nursing that promotes consistency and standardisation of care within wards across the Trust, providing a clear framework that brings together quality, safety, service improvement and patient experience.

The Exemplar Ward programme is a framework that introduces a range of nursing quality metrics, outcomes, performance measures and quality improvements which all wards at Calderdale and Huddersfield NHS Foundation Trust will achieve as the baseline standard for assuring safe, effective and personal care over the next three years.

An important part of the programme is the implementation of the Productive Ward - Releasing Time to Care. This is the national initiative developed by the Institute for Innovation and Improvement, which identifies 11 areas of quality improvement for ward management and patient interventions.

The initiative has been designed to focus on ward teams and their processes and systems. It undertakes a multi-disciplinary approach and works with teams so that they can understand and plan the most effective ways of delivering their ward priorities, and redirects time into patient care at the bedside.

The programme has a phased approach with groups of wards commencing the programme at specified times within the implementation plan. The programme has dedicated internal project leadership and support to ward teams to enable them to implement the modules into working practice on the wards.

A recent national review published by the National Nursing Research Unit, King's College London supports our local implementation approach.

A group of six wards started the programme in June, followed by our paediatric, gastroenterology, cardiology, vascular and head and neck wards in November. In February this year wards from orthopaedics, general surgery, urology, stroke, respiratory, medical and rehabilitation areas also started the programme.

The wards are making good progress and they are starting to see the impact of the results and the time they are releasing back into direct patient care.

Our objectives this year are to support the development of the Exemplar Ward programme aligned to the Trust's Quality Improvement Strategy.

How we have decided our priorities for 2010/11

The whole programme for improvement in the strategy is informed by national and international research on what will make the difference to the quality of care over the next three years. The work has been endorsed by the Board and the Membership Council. Our established series of Safety Walkrounds by the Board of Directors and divisional directors, which started when we joined the second wave of the Safer Patients' Initiative, has been re-titled "Quality Improvement Walkrounds" and refocused around a programme of ward visits aligned to the strategy. These provide a very visible commitment to the organisation of the importance of quality, providing an opportunity for staff and patients to talk about their concerns and for the wards and teams to showcase their progress.

The Membership Council members are linked to the clinical divisions and lead the members and volunteers who have been trained in using the Real Time Patient Feedback Monitoring Tool. At a divisional level they will pay attention to the divisional quality measures and the patient voice and engage with the membership through Focus Groups. In 2010/11 they will host a quality improvement event for both staff and public members to share the work of the collaboratives and ensure everyone feels connected and involved in the programme.

Members' views have been triangulated into the issues that our local LINks have raised and with themes expressed through PALs (Patient Advice and Liaison services) and complaints. Our priorities for the year have been further refined by their relationship with the CQUIN (Commissioning for Quality and Innovation) payment framework and national requirements.

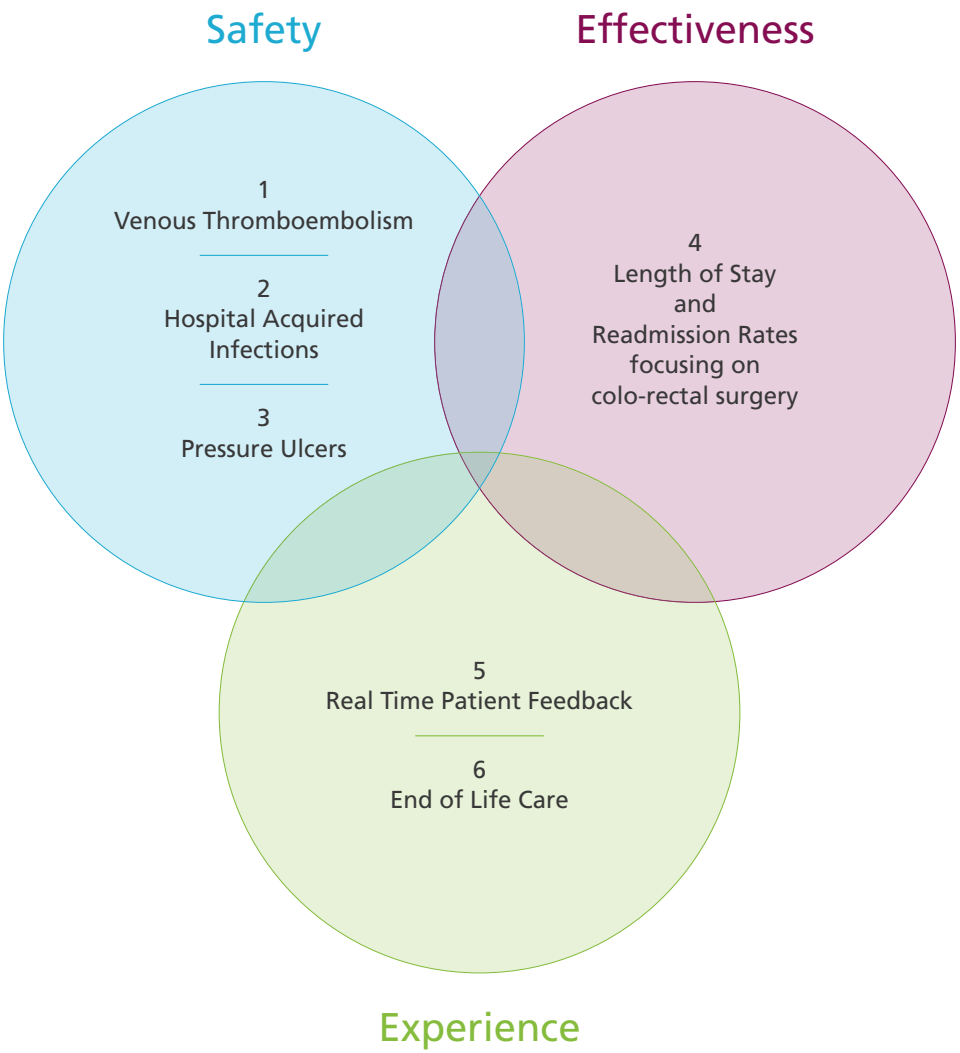
The wards are making good progress and they are starting to see the impact of the results and the time they are releasing back into direct patient care

Our Quality Account: Aligning the priorities for 2010/11

Safety					
CHFT Goal	• To reduce Hospital Standardised Mortality Rates (HSMR) • To reduce Harm				
	CHFT Priority	**Local CQUIN**	**Regional CQUIN**	**National CQUIN**	**Statutory Requirements**
1	To reduce Healthcare Acquired Infection (HCAIs)	-	-	-	Reduce HCAIs
3	To reduce both the incidence of and associated deaths from Venous Thromboembolisms (VTE)	-	-	95% patients risk assessed for VTE	-
3	To reduce the incidence of hospital acquired pressure ulcers	Reduce the incidence of pressures ulcers	Improve pressure ulcer prevention and management	-	-
Effectiveness					
CHFT Goal	• To reduce Length of Stay (LOS) and Readmission Rates				
	CHFT Priority	**Local CQUIN**	**Regional CQUIN**	**National CQUIN**	**Statutory Requirements**
4	To reduce LOS for patients undergoing colo-rectal surgery	-	-	-	• 4 Hour A&E wait • Waiting times • Readmission rates • Cancer targets
Experience					
CHFT Goal	• To improve our satisfaction scores in the national Inpatient Survey				
	CHFT Priority	**Local CQUIN**	**Regional CQUIN**	**National CQUIN**	**Statutory Requirements**
5	To achieve ongoing improvement in patients' experience of care	-	-	Improve responsiveness to personal needs of patients	Patient surveys
6	To improve End of Life Care	Improve End of Life Care	Improve End of Life Care	-	-

Our improvement priorities for 2010/11

Taking into account local and national opinion, these are the six priority areas identified for 2010/11. It is important to recognise that work has started across all the improvement collaboratives in the programme and that incremental progress in line with the three year programme will be expected.



It is important to recognise that work has started across all the improvement collaboratives in the programme

Reviewing our improvement priorities for 2010/11

As a Foundation Trust 2008/09 saw the publication of our first Quality Report. In it we identified three priorities:

Priority 1

To further reduce the incidence of MRSA and Clostridium difficile infections.

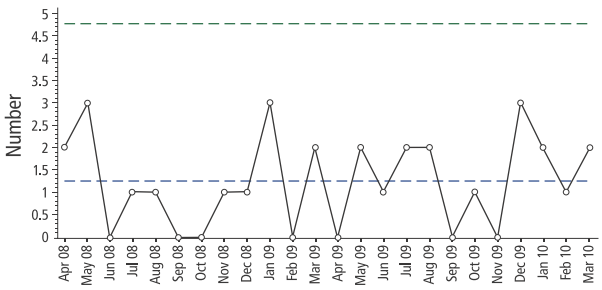
Description of issue and rationale for prioritising

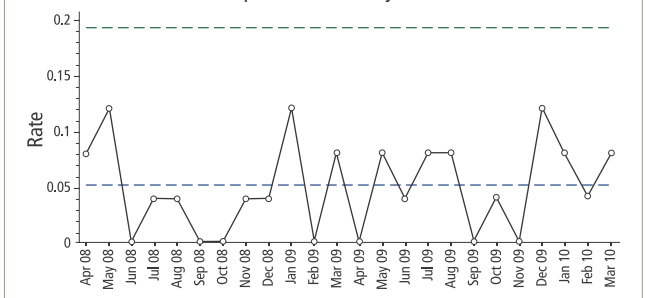
Last year one of our three priorities was to reduce our HCAI rate. Despite our rates being below the national average we chose this priority as we believed we could bring about further improvements.

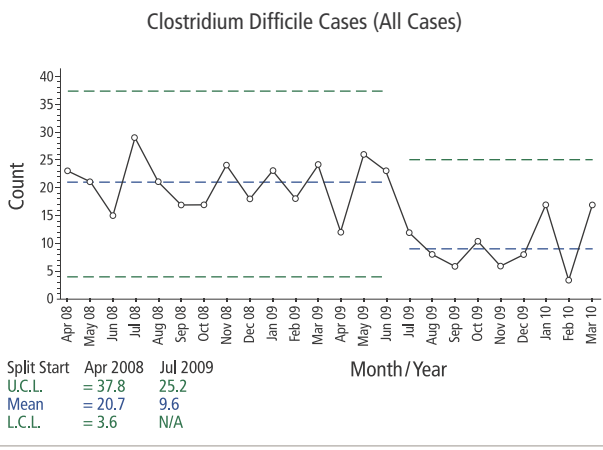
Aim/Goal

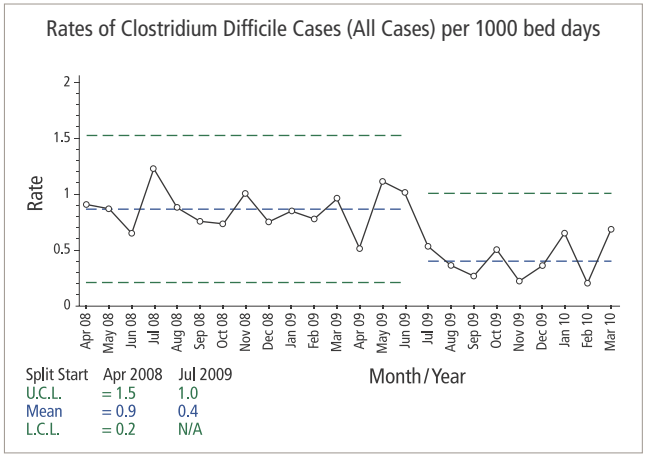
To reduce the incidence of MRSA bacteraemias and Clostridium difficile infections.

Current status









Improvement areas identified in 2008-2009 Quality Report

- Focus on improving hand hygiene compliance and Saving Lives High Impact Interventions
- Improve communication throughout the Trust
- Improved sharing of lessons learnt from root cause analysis
- Antimicrobial prescribing.

Current initiatives in 2009/10

- Ongoing development and support of Link Infection Prevention and Control Practitioners
- Showcase hospital project is still ongoing - trialling and evaluating new innovations and technologies to help reduce HCAIs
- Further development of antibiotic guidelines and close monitoring of adherence to the policy
- A combined environmental audit tool has been developed and is being implemented
- Invasive Devices Clinical Nurse Specialist Team in place and managing all central lines
- Universal screening of patients for MRSA (in line with DoH Guidance), ongoing monitoring of compliance with policy.

Achievements

- Work continued on hand hygiene and saving lives high impact interventions, we continued throughout the year to monitor and achieve compliance of 99.8% in hand hygiene and 97.2% on our saving lives returns.
- Strengthened board to ward reporting, all wards are now aware of their infection rates, this is further strengthened by infection rates being part of nursing indicators dashboards publicly displayed so all staff, visitors and patients can see their scores.
- All MRSA Bacteraemia and Clostridium Difficile infections are investigated using Root Cause analysis and lessons learnt are shared with all staff involved. Common themes are also explored and used to guide improvement work.
- A lot of work has been ongoing in improving antimicrobial prescribing; improvements have been made in adherence to the policy and restricting the use of some antimicrobials.

Priority 2

For patients who have suffered Fractured Neck of Femur (FNoF), to improve the timeliness of surgery, and reduce morbidity, mortality and Length of Stay.

Description of issue and rationale for prioritising

The time to surgery for patients with fractured neck of femur has been exceeding the nationally accepted target range.

Aim/Goal

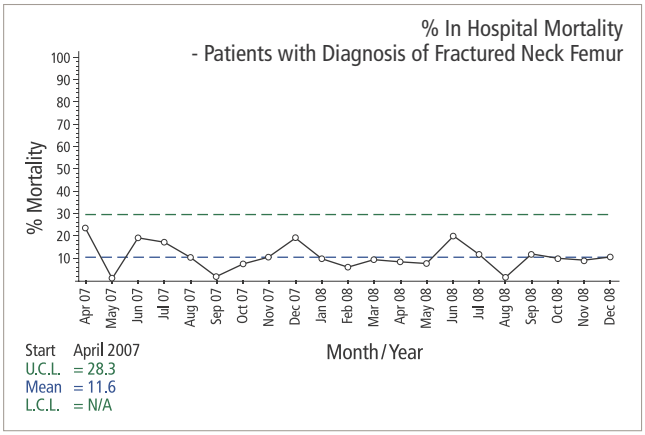
To improve the pathway of patients with fractured neck of femur by ensuring that all medically-fit patients have surgery within 48 hours of admission to hospital.

Improvement areas identified in 2008-2009 Quality Report

- Management of the care pathway from admission to discharge
- Access to Ortho-Geriatrician
- Communication between teams

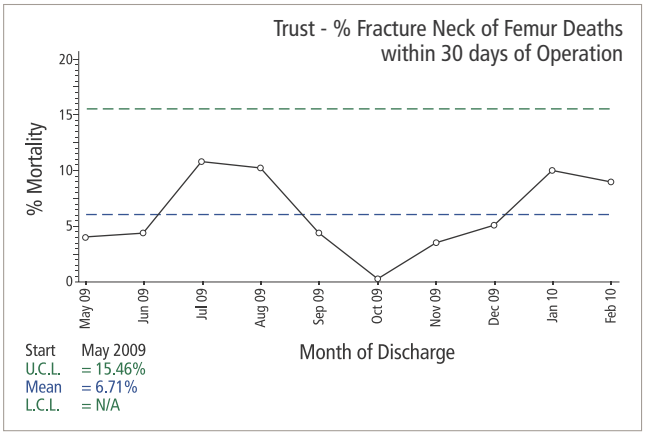
As a Foundation Trust 2008/09 saw the publication of our first Quality Report

Performance 2007/08



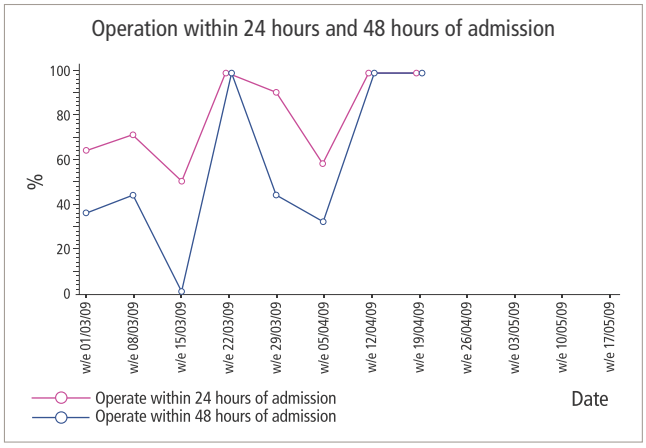
The data above shows deaths in hospital following diagnosis of FNOF at a mean average of 11.6 %.

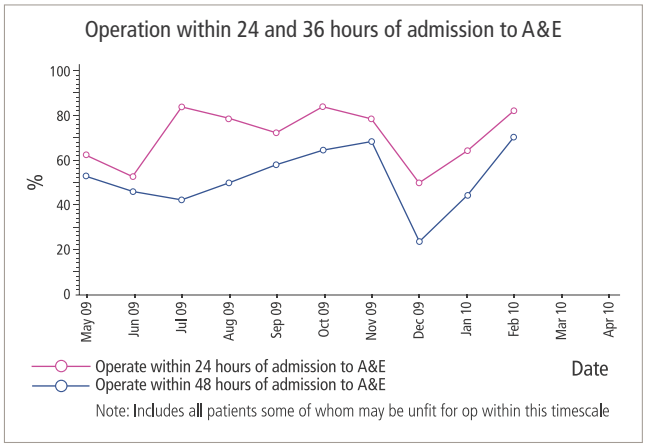
Current status



The mean average of deaths within 30 days following surgery shows a mean average of 6.17% implying an improvement on post operative outcomes.

Providing a direct comparison is difficult as the data collection system was altered to demonstrate FNoF within 30 days of surgery, as this was felt to be a better reflection of post-operative outcomes following early surgical intervention.





The early data was collected weekly and showed a marked improvement in access to theatre within 24 hours; however the data collection was altered to be reported monthly and now represents all patients including those deemed not fit for surgery within 24 hours. It is difficult to benchmark our performance in this area as it is well known that there are different ways of collecting this data and in some trusts those not fit for surgery are not counted from admission but the date they become fit for surgery. Our performance in December was significantly challenged by the sheer volume of cases of FNoF and pressures from other trauma related incidences experienced locally with the long periods of snow and Ice.

Current Initiatives in 2008/09

- Patients with fractured neck of femur are now first on the theatre list
- Discharge planning commenced at time of admission
- Baseline data collection commenced, so that measurement can begin in 2008-09

New initiatives to be implemented in 2009/10

- Daily input to the orthopaedic wards from the ortho-geriatricians
- Introduce dedicated trauma co-ordinator role, to track patients from admission, and ensure improved communication between theatres and ward teams
- Reduce delays in discharge
- Improve communication between multi-disciplinary teams by introduction of a chronological patient record.

Achievements

The pathway for fractured neck of femur (FNoF) was developed and has been monitored as part of the improvement work done in collaboration with the national improvement team in 07/08 with regular reporting to the orthopaedic directorate and divisional board.

Daily input into routine ortho-geriatrician reviews has been more difficult to achieve on a routine basis, and has been reliant on changes to the elderly physicians' job plans and input from a consultant nurse for the elderly who was appointed within our Trust in 2009.

A new business case has been developed by the surgical division and work is ongoing across both the surgical and medical and elderly division to prioritise this requirement during 2010/11 business planning rounds.

A dedicated trauma co-ordinator has been appointed and has been in post for several months. This role has now been separated from the ward manager's portfolio and the co-ordinator provides the links between the wards, the bed teams and the theatre staff. Work is ongoing with the multi disciplinary team to ensure appropriate rehabilitation and discharge co-ordination is managed appropriately and in a timely manner.

Priority 2

To increase the score relating to the rating of overall quality of care provided by patients in the National Patient Survey.

Description of issue and rationale for prioritising

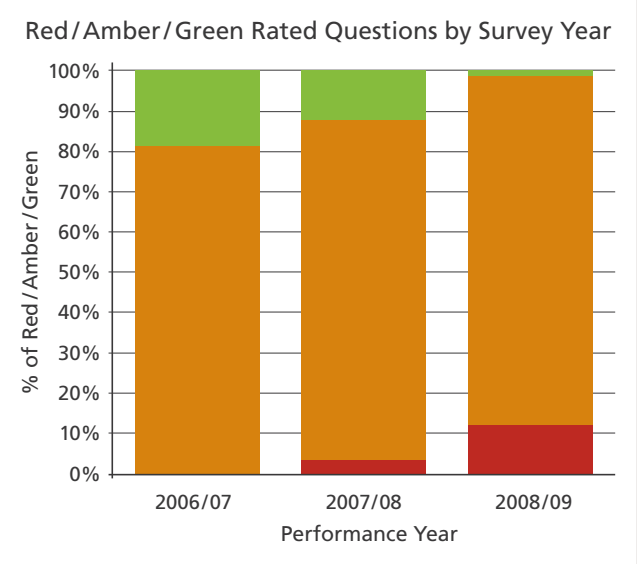
We will continue our mission to continuously transform care and improve the patient experience, so that we consistently meet and exceed patients' expectations.

Aim/Goal

To increase the score relating to the rating of overall quality of care, provided by patients in the National Patient Survey.

Current status

National Inpatient Survey	2006 score	2007 score	2008 score	2009 score
Overall, how would patients rate the care they received	79/100	78/100	76/100	79/100



We will continue our mission to continuously transform care and improve the patient experience

Improvement areas identified in 2008-2009 Quality Report

- Insufficient feedback given to patients and their families throughout the care pathway (information and communication)
- Nurses need more time to provide direct patient care

New initiatives to be implemented during 2009/10

Progress the Patient Experience Programme within the Quality Improvement Strategy

- Full implementation of Real Time Monitoring using data to identify areas for improvement in specific ward areas
- In-house repeat of national survey
- Patient focus groups to 'hear' their stories and identify themes for attention
- Large scale annual 'Patient Experience' event for all staff from ward to Board to demonstrate their commitment
- Communications Strategy creating a campaign of "Seeing the Person in the Patient"

Achievements

- Action plan to eliminate mixed sex accommodation delivered (estates programme, training and monitoring). Compliance statement to commissioners, SHA and published on website
- "Exemplar Ward" programme initiative to be rolled out to wards, with the objective of releasing nurses to give more time to providing direct patient care. Aligned to Quality Improvement Strategy
- Paper to Board mapping Trust performance and providing assurance in respect of privacy and dignity
- Improving the Patient Experience day - September 2009
- Introduction of mechanisms for "real time" patient feedback
- Inpatient surveys being conducted twice yearly (one internal and one statutory) and one outpatient survey
- Introduction of Patient Reported Outcome Measures (PROMS)
- Improving Patient Experience Programme established (as part of the Quality Improvement Strategy), together with associated collaboratives

Our Six Priorities for 2010/11

Safe

Priority 1

Venous Thromboembolism (VTE)

What:

We are aiming to reduce both the numbers of VTE episodes for patients in our care and also to reduce the number of deaths as a result.

Current Status:

VTE is widely recognised by doctors as a largely avoidable risk of harm to both surgical and non-surgical patients.

- Work is ongoing on two test wards to introduce a clerking-in document which contains a VTE Risk Assessment Tool. Early indications have been encouraging, however in some cases it has been found that the DoH tool doesn't help junior doctors to make prescribing decisions.
- Appropriate treatment has been reliably measured on two test wards.

Improvement Work

- Work is beginning on testing a revised VTE Risk Assessment form to see if it assists junior medical staff make a decision when prescribing
- To test how to get patients reliably re-assessed after 48 Hours
- To reliably ensure all patients get information on VTE risk assessment on admission and on discharge

Safe

Priority 2

Reducing the numbers of Hospital Acquired Infections (HCAI)

What:

To achieve a reduction in the number of HCAIs

Current Status:

This priority has been carried forward from the 2008/09 Quality Account to ensure that the significant progress made last year is sustained and improved upon.
The HCAI improvement collaborative continues to focus on all the factors that are known to reduce HCAIs:

- Hand hygiene
- Clean environment
- Speed of turnaround for lab tests
- Best practice care of invasive devices
- Antibiotic use
- Screening
- Involvement in national Showcase Hospitals Programme

Improvement Work

- Hand hygiene quality tool to be rolled out.
- Reliable systems for bed space cleaning between patients to be rolled out.
- Continued improvements to appropriate use and care of all invasive devices.
- Improvement work to stop dates and missed does of antibiotics and adherence to the policy for treatment.
- Further improvements to isolation practices.
- Further improvements to the communication of infection status for patients moving between healthcare settings.

Safe

Priority 3

Reducing the numbers of Pressure Ulcers

What:

To reduce the incidence of hospital-acquired Pressure Ulcers

Current Status:

Pressure ulcer incidence is an important measure of nursing quality and has been identified by the Strategic Health Authority as a CQUIN and the Trust as a Nursing Quality Indicator (NQI). No avoidable pressure ulcers in NHS provided care is also one of the High Impact Actions for Nursing and Midwifery (2009).

Improvement Work

- Introduce programme of education for staff
- Develop good quality information for patients
- Systematise risk assessment within two hours of admission
- Appropriate introduction of preventative measures such as re-positioning, nutrition, equipment and skin assessments
- Develop system for recording good quality accurate information on our patient complaints and incidents database
- Your Skin Matters campaign - High Impact Actions for Nursing and Midwifery
- Implement the monthly Exemplar Ward Nursing Audits
- Implement Productive Ward modules
- Heath Economy wide approach

Effective

Priority 4

Reduction in the Length of Stay for patients undergoing colorectal surgery

What:

By implementing an Enhanced Recovery Programme, which means that all patients receive a bundle of evidence based interventions, patients undergoing specific colo-rectal surgery will recover more quickly and be discharged sooner

Current Status:

Unnecessarily long lengths of stay increase the potential for harm and impact upon the patients' experience. The Enhanced Recovery Programme is one of a range of initiatives targeting this important area.

A number of patients are now going through the Enhanced Recovery Programme and their early recovery is being reflected in a reduced length of stay for individual patients.

Improvement Work

- Two consultants are testing compliance with the bundle on their patients
- Regular patient feedback
- Majority of documentation now formalised and in place.
- Telephone follow up sheet and process under review by team
- Measurement data collection tool implemented 1st April
- Service and informatics support team developing dashboard reporting tool
- Multi-disciplinary team meeting monthly to drive monitor and performance manage process improvement.

Experience

Priority 5

Real Time (Patient) Monitoring (RTM)

What:

To improve patient experience by using RTM data across all areas.

Current Status:

This priority has been carried forward from 2008/09 to ensure that the Trust maintains its focus and improves the pace of improvement. The National Inpatient data provides the Trust with a comparative measure against a range of factors that influence the experience of patients, both over time and compared against other acute trusts. The Trust has scored well in a number of these:

- Length of time patients wait for a bed or ward
- Confidence in nursing staff
- Hand washing of both medical and nursing staff
- Cleanliness of wards

Improvement Work

- Areas of concern identified by the survey have action plans developed and monitored by the Patient Experience Steering Group, which includes Membership Councillors
- The Inpatient Survey is now replicated in June each year to monitor progress
- A large scale event for staff, Board of Directors and Membership Councillors identified priorities for action and demonstrated our shared concern for improving patient experience
- Members and volunteers will monitor 20 patients monthly per ward to track progress and target identified problems
- Patient focus groups with staff to share their experiences
- Campaign drive to emphasise the need to "See the Person in the Patient"

Experience

Priority 6

End of Life Care

What:

To ensure that patients who are at the end of their life have the opportunity to state their preference as to where they die and this is recorded and communicated to relevant staff.

Current Status:

Whilst the hospital aims to provide high quality palliative care to patients who do choose to die in hospital some of these services could also be provided in the patient's home.

An End of Life Care Strategy 2010/15 for Calderdale and Kirklees Health and Social Care Community has been developed.

Audits of current processes have begun to establish a baseline position and an End of Life Care Strategy has been developed with partner organisations.

Improvement Work

- Developing processes for Advance Care Planning
- Patients identified and placed on the Care of the Dying Pathway
- Monitoring compliance with Fast Track to Preferred Place of Death policy
- Training and competency in End of Life Care to be incorporated into all appraisal and revalidation processes for staff
- Initial testing of the improvement work taking place on oncology and respiratory wards

How will quality be monitored?

Progress in the Quality Improvement Strategy is monitored through the newly formed Quality Improvement Board. Its task is to oversee the implementation of the Strategy as a whole ensuring that it meets both process and outcome goals as the work is spread reliably across the organisation. Each programme of work associated with Safety, Effectiveness and Experience and the Exemplar Ward programme has an executive lead and clinical sponsorship.

Enabling mechanisms to support the capacity and capability of the staff in measurement and improvement science are the responsibility of the Quality Improvement programme managers and the quality co-ordinator.

The Board of Directors receives monthly information on progress towards the four strategic goals with exception reports when required. The Board agenda begins with a patient story to ensure that their work is centred around the patient experience.

A range of Nursing Quality Indicators (NQIs), covering quality of care and workforce, provides the Board with an overview of care provided and wards' progress in reducing any unacceptable variation in performance.

Required Information – Please see Appendix A

Overview of quality of services provided

Our Quality Improvement Strategy is intended to build on a sound foundation for success. Our aim is to provide safe, effective care that is well regarded by our patients and which aims to strengthen our reputation as a high performing organisation.

We aim to bring all our services up to the standard of the best and to reduce variation in patient experience and clinical outcomes with an aspirational goal to become one of the most highly regarded trusts in the NHS.

To make this a reality we have described a model known as a driver diagram to help us ensure that all our activities from the role of the Board to the development of individual members of staff work together towards our challenging goal of:

- Reducing HSMR
- Reducing 'harm'
- Reducing length of stay and readmission rates
- Improving patient experience

To achieve this we have:

- Adopted an approach to improvement that works with frontline staff to design 'small tests of change' that can be applied in a consistent and reliable way before being implemented across the Trust as a whole.
- Routinely benchmarked our performance against others.
- Developed our established Leadership Walkrounds in a programme of visits where the Board of Directors and senior clinical leaders demonstrate their commitment to improving quality.
- Developed a training strategy for improvement measurement and methods
- Created a focus for the Membership Council to support the Strategy and a have a leadership role in hearing the patients' voice.
- Worked with the Lean Enterprise Academy to drive down unnecessary waits in the patient journey.
- Created a communication strategy to engage our staff and our local communities to support our goals.
- Joined the North West Mortality Collaborative to work together sharing learning and best practice in reducing our HSMR.
- Continued to participate in local and national programmes, eg the Fractured Neck of Femur Collaborative, the Enhance Recovery Programme for Gynaecology and Colorectal surgery patients and Co-Creating Health to support self-management for patients with chronic pain.
- Strengthened ward management and accountability.
- Reviewed and strengthened our approach to appraisals and personal development reviews.
- Improved the patient environment with a continuing capital programme to continuously improve cleanliness, privacy and dignity.

Quality indicators 2009/10

We have chosen a range of indicators building upon the more limited set included in our 2008/09 Quality Accounts to demonstrate our approach to providing safe, effective and personal care in 2009/10.

Safety	• Hospital Standardised Mortality rates • Healthcare Acquired Infections • Rate of Caesarean Sections
Effectiveness	• Cancer Waiting Times • 18 Weeks Referral to Treatment Target • Cancelled Operations • Accident & Emergency Target Performance
Experience	• Same Sex Accommodation • Cleanliness - PEAT Inspection (Patient Environment Action Team) • Co Creating Health National Pilot Programme

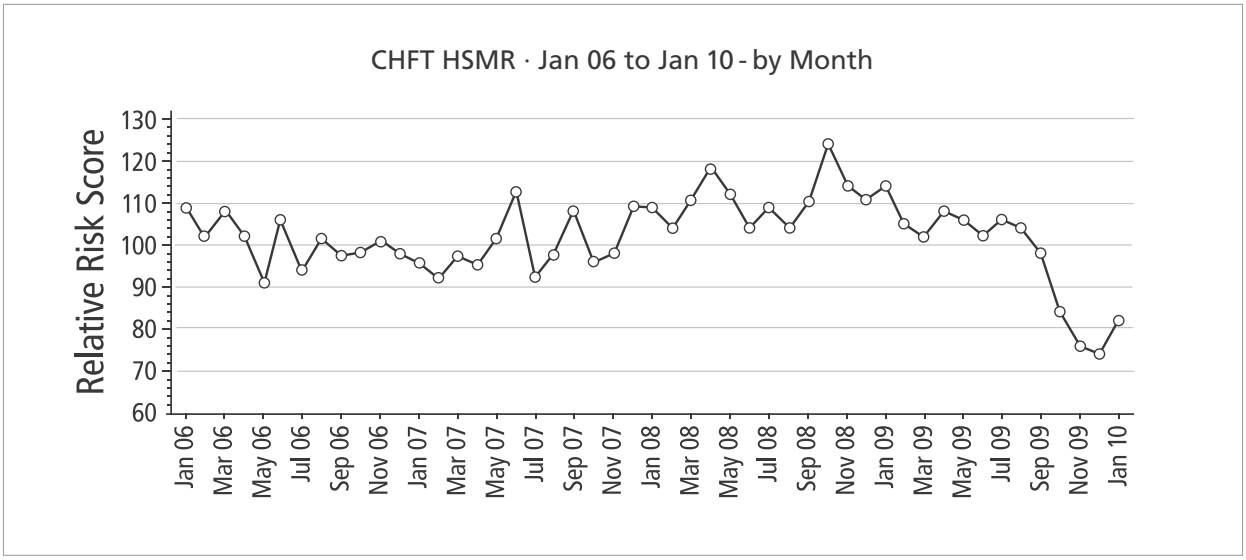
Our aim is to provide safe, effective care that is well regarded by our patients and which aims to strengthen our reputation as a high performing organisation

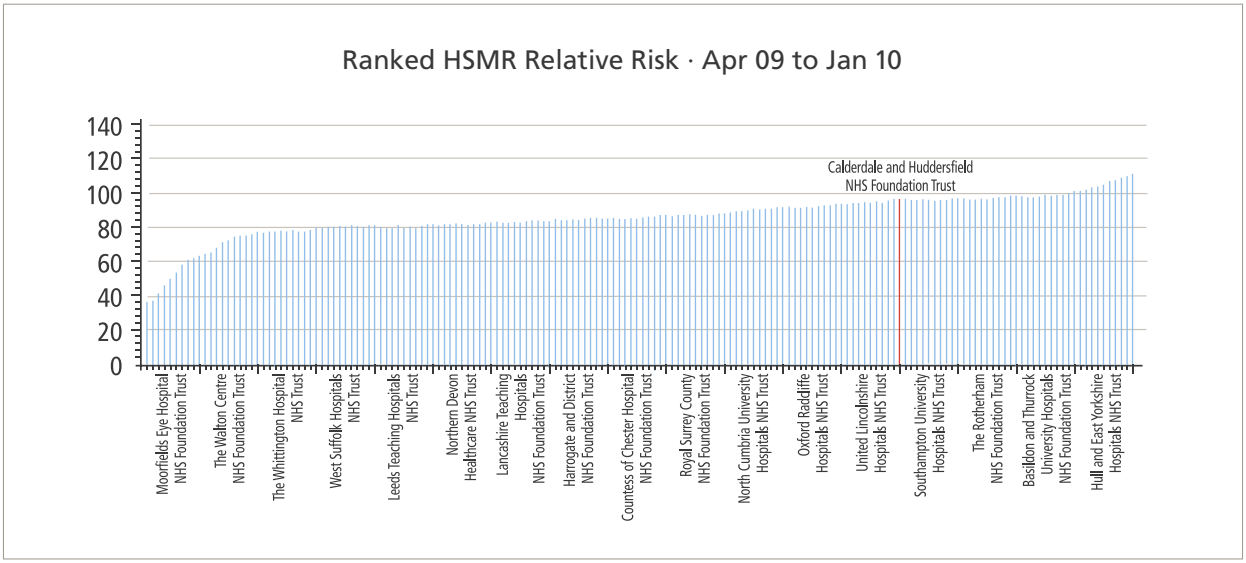
Safety Indicator

Hospital Standardised Mortality Rates (HSMR)

Rationale for choosing indicator:

This is a national indicator used to benchmark trusts for their standardised mortality rates. It is also a key indicator for our Quality Improvement Strategy and forms one of our high level outcome measures.





Commentary:

The first chart shows a marked drop in our HSMR value in the first 3 months of 2010 with values now around the 80 mark. The second chart shows where we are rated against other acute trusts.

The Trust's HSMR is monitored closely and discussed at the Trust's Assurance Board. Work on improving the accuracy of clinical coding and understanding its significance on the HSMR rate has been ongoing throughout the year and has begun to have an impact. In addition we have made improvements to the process for mortality audits making it easier to highlight any issues of concern from care received.

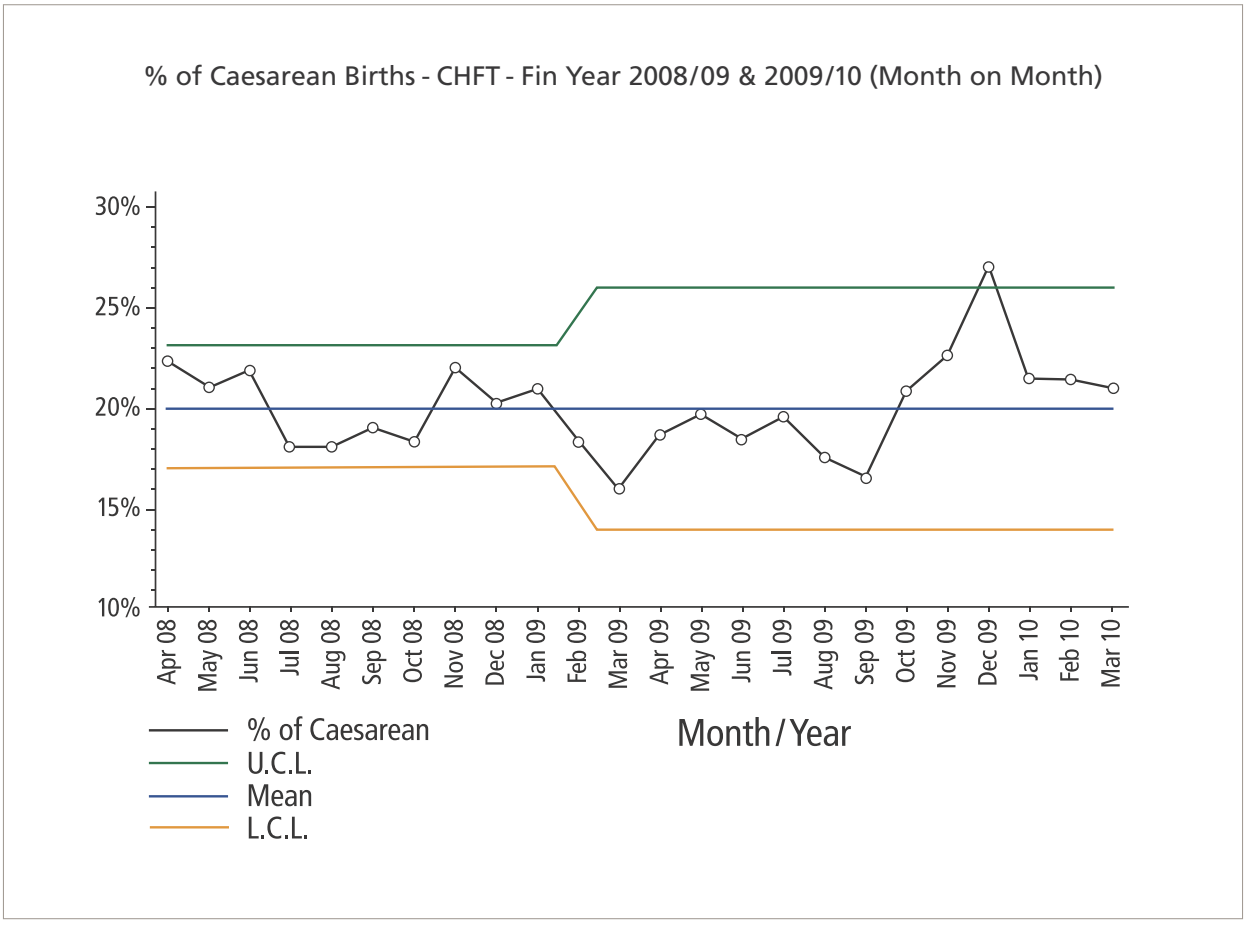
Safety Indicator

Rate of Caesarean Sections

Rationale for choosing indicator:

Concern regarding the alarming rise in caesarean section from around 12% in the 1990s to over 25% by 2000 resulted in the first national audit to determine reasons for the rise in operative delivery in the UK (NCSA 2002). The national sentinel caesarean section audit, showed wide regional differences. Caesarean section rates were highest in Wales (24.2%) and lowest in the north east of England (19.3%) and the south west of England (19.4%).

By 2005-6 the rates for individual services ranged from 16% to well over 30% (NHS Institute 2006). CHFT at this time was around the national average of between 22% and 28%. It became evident that with the rise in caesarean section came a rise in maternal morbidity and an overall dissatisfaction with the predominant interventionist approach to childbirth.



Commentary:

In 2005 CWS appointed their first consultant midwife; with a remit to lead on midwifery led care and promote normal birth in all areas. She also led on the development of the Huddersfield Family Birth Centre building on the success of the existing Calderdale midwifery led unit that had been supporting between 700 - 800 normal births for the previous seven years. As a result of local concern a multidisciplinary team from CWS attended one of the first regional workshops held by the National Institute for Innovation and Improvement [NIII] to learn how to use their tool-kit to focus on normal birth and reduce the caesarean section rate.

From 2008/2009 to 2009/2010 CHFT's Caesarean section rate has reduced to an annual average of approximately 19%.

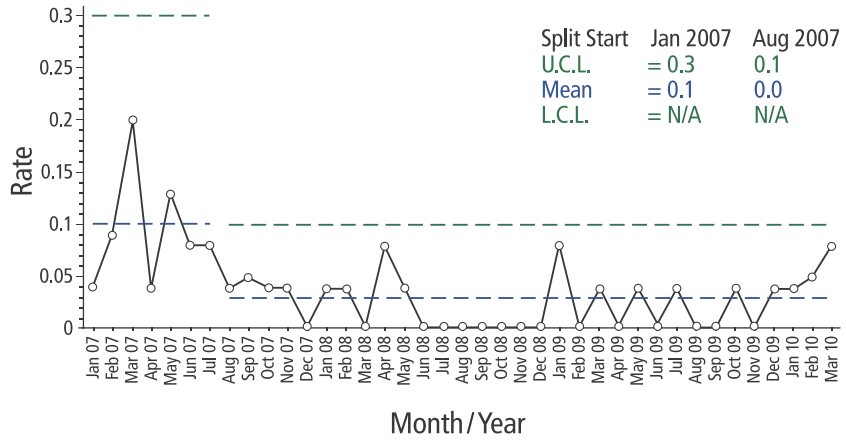
Safety Indicator

Healthcare Acquired Infections

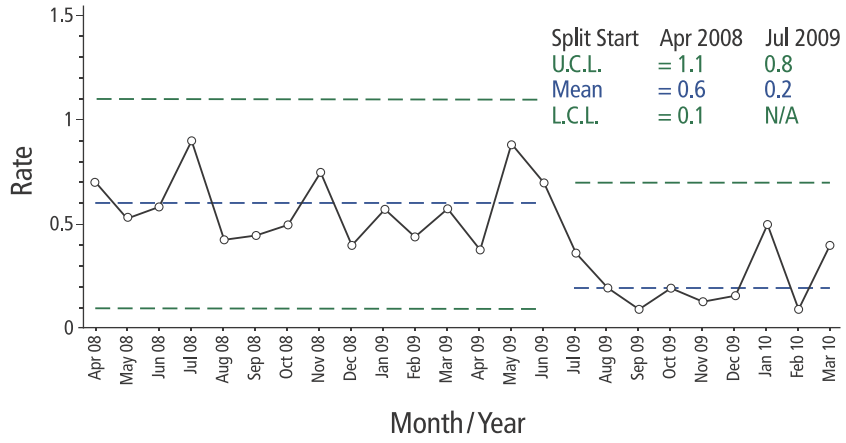
Rationale for choosing indicator:

Healthcare acquired infections were a key improvement area for the Trust in 2009-10. This was both to meet local and national targets for reduction but also because we believed we could bring about further reductions in rates and improving patient safety.

Hospital Acquired MRSA Bloodstream Infections per 1000 Bed Days (General Wards)



Rate of C.Diff Post 48 hours



Commentary:

For 2009-10 the number of post 48 hour reported MRSA Bacteremias was nine against a national target of 19 and Clostridium difficile was 102 against a national target of 166.

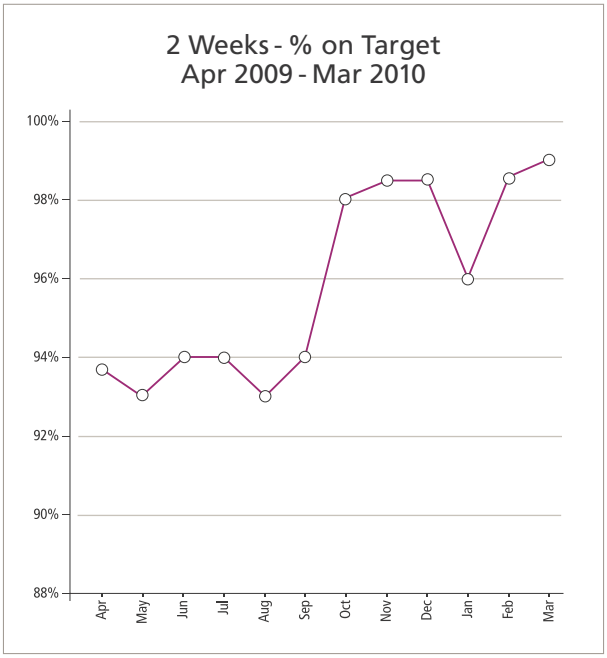
Throughout the year a number of interventions have had a positive effect on driving the rates down including a specialist nursing team managing central lines, continued adherence to hand hygiene practice and the saving lives high impact interventions. Improvements to anti-biotic usage, screening appropriate patients on admission and improvements to the cleanliness of ward environments have also been rigorously addressed.

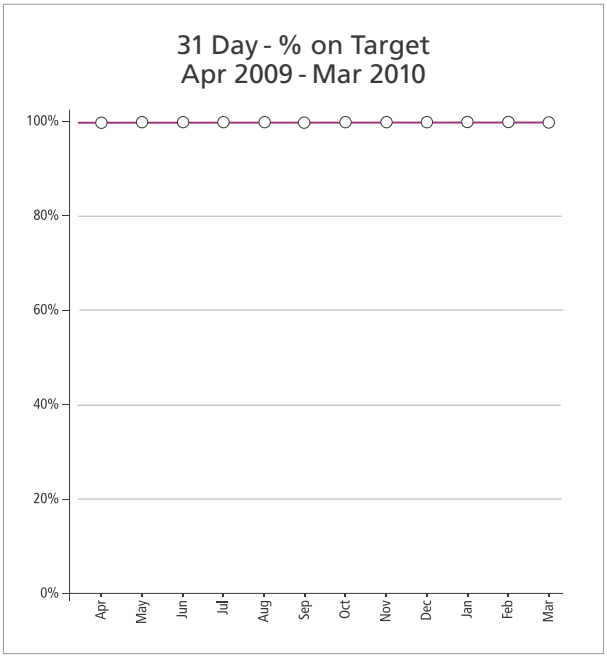
Effectiveness Indicator

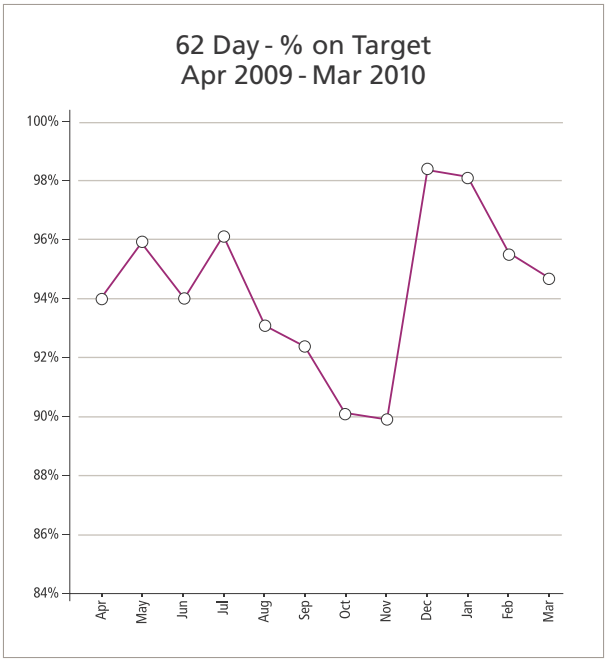
Cancer Waiting Times

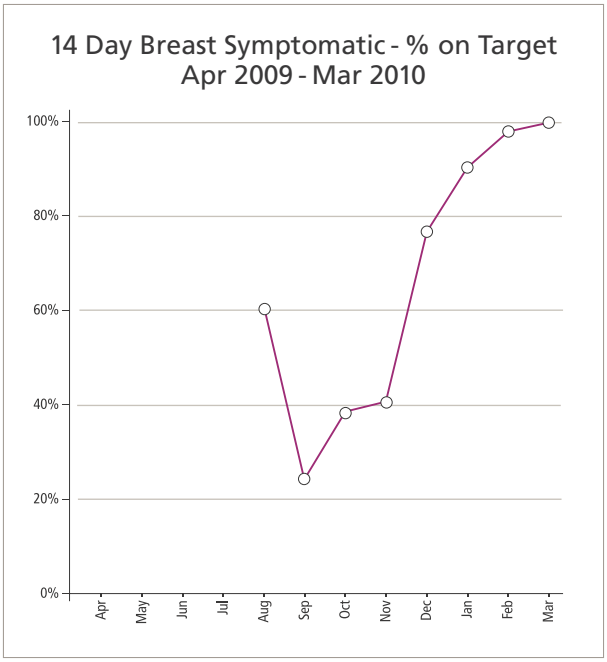
Rationale for choosing indicator:

These are national targets. The 2 weeks target (from receipt of GP referral to first hospital assessment for suspected cancer), 31 days target (from decision to treat to first treatment), and the 62 days target (from GP referral to treatment) have been in operation for a number of years now, but the 14 day breast symptomatic target (women with breast symptoms not thought to be cancer-related have first hospital assessment within 2 weeks) is a new target for Acute Trusts









Effectiveness Indicator

Cancer Waiting Times *continued*

Target	Target	CHFT Q3 2009/2010	Yorkshire Cancer Network 2009/2010	National	CHFT Year End Performance 2009/2010
CRS GP cancer referrals seen within two-weeks	93.0%	98.3%	95.5%	95.6%	95.8%
CRS Cancer: 1 month diagnosis to treatment	96.0%	100.0%	97.9%	98.4%	100.00%
CRS Cancer: 2 month GP urgent referral to treatment	85.0%	92.4%	85.7%	86.5%	94.3%
CRS Cancer: 2 month Consultant upgrade date to treatment	No Target	100.0%	89.0%	94.4%	98.8%
CRS Cancer: 2 month Screening Referral to treatment	90.0%	100.0%	95.1%	94.9%	98.3%
CRS Cancer: 1 Month decision to treat to treatment with subsequent surgery	94.0%	98.0%	95.0%	97.1%	98.9%
CRS Cancer: 1 Month decision to treat to treatment with subsequent anti cancer drugs	98.0%	100.0%	99.7%	99.7%	100.0%
CRS All Breast Symptomatic seen within two-weeks (JAN performance)	93.0%	90.6%	75.6%	88.2%	96.4% (Q4)

Commentary:

2 week target: The requirement for this target is 93%. The chart shows that during 2009/2010 our achievement against the target has increased from approximately 93% to approximately 98% demonstrating sustained overachievement against this target.

31 day target: The requirement for this target is 96%. The chart shows that we have maintained a 100% achievement against this, consistently overachieving.

62 day target: The requirement for this target is 85%. The chart shows again a consistent over achievement throughout the year.

14 day breast symptomatic: From January 2010 we were required to achieve 93% for this target. We have again overachieved during the first quarter of the year.

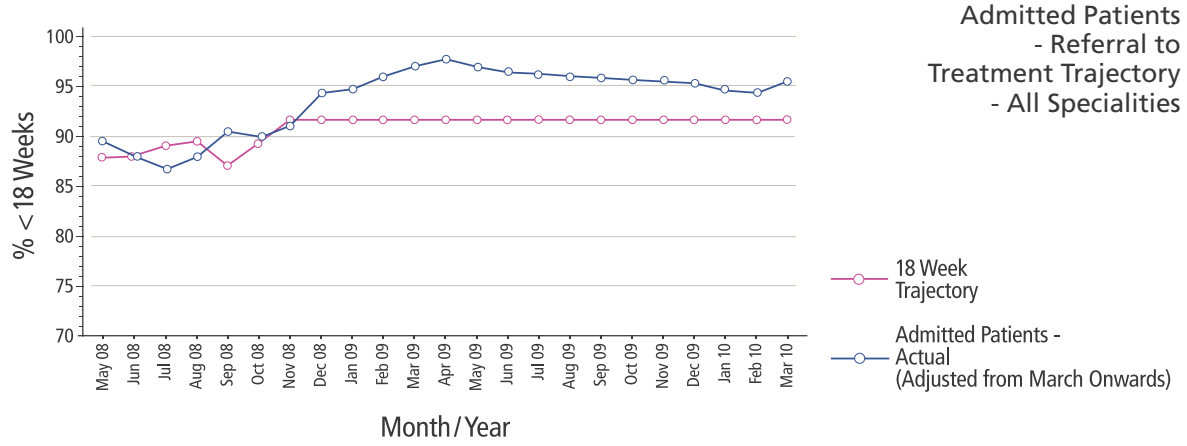
The table above compares our performance for Q3 2009/2010 with local Trusts in the Yorkshire Cancer Network, and also against national performance. It can be seen that we have performed above average both nationally and locally. The end of year performance demonstrates our sustained and strong performance against all the cancer targets.

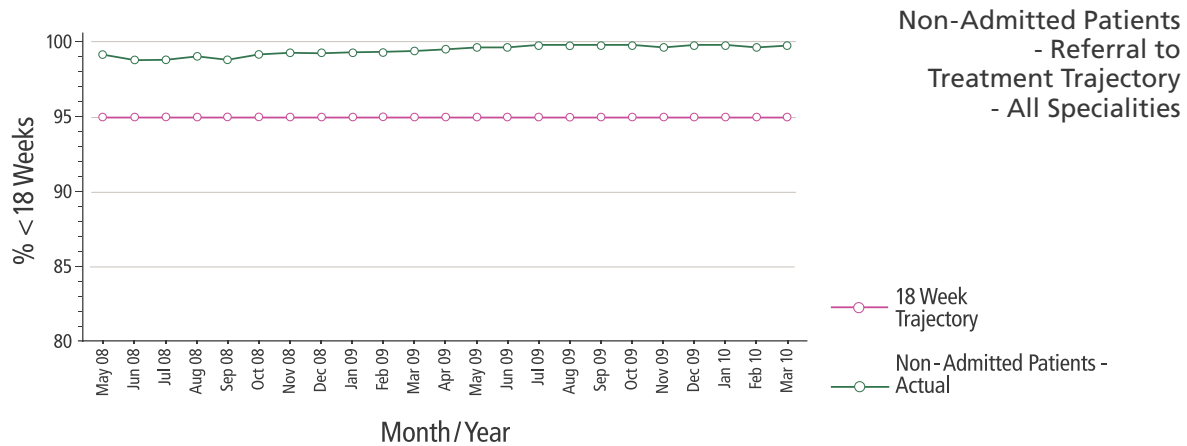
Effectiveness Indicator

18 Weeks Referral to Treatment Target

Rationale for choosing indicator:

This is a national target stipulating a maximum waiting time of 18 weeks from their referral to their treatment, be that as an inpatient, daycase or an outpatient. The target for patients who are admitted is 90% for each speciality (after March 2009), the target for patients who are not admitted is 95% for each speciality. The NHS Constitution now gives the patients the right, if they are on an 18 week pathway, to be treated in 18 weeks unless they choose not to do so or have a complex pathway.





Commentary:

The Trust has consistently overachieved against the targets for both admitted and non admitted patients at aggregate and individual specialty level.

When comparing ourselves to other Trusts within our Strategic Health Authority (SHA) the most recent benchmarking information available from January 2010 shows us to be one of seven out of fifteen Trusts in the SHA who have achieved the 90% standard in all treatment areas for admitted patients, and one of twelve Trusts in the SHA achieving the 95% standard in all treatment areas for non-admitted patients. In fact our performance for non admitted patients was the highest in the SHA.

Effectiveness Indicator

Cancelled Operations

Rationale for choosing indicator:

Cancelled operations are reported by Trusts as a quality indicator. Cancelled operations are a waste of resources and time, and are distressing and inconvenient for patients.

	2008/09				2009/10				
Trust	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Annual Pos**	**YTD Actual**
York Hospitals NHS Foundation Trust	1	2	1	12	1	2	1	**1**	0.32%
Calderdale and Huddersfield NHS Foundation Trust	11	9	2	2	3	4	5	**2**	0.49%
Airedale NHS Trust	4	5	4	3	8	3	2	**3**	0.50%
Sheffield Children's NHS Foundation Trust	3	1	9	1	2	1	8	**4**	0.51%
Barnsley Hospital NHS Foundation Trust	12	7	7	10	9	5	3	**5**	0.56%
Harrogate and District NHS Foundation Trust	2	3	3	8	6	8	4	**6**	0.58%
Sheffield Teaching Hospitals NHS Foundation Trust	8	4	6	11	4	6	10	**7**	0.61%
North Lincolnshire and Goole Hospitals NHS Foundation Trust	5	8	8	5	7	13	6	**8**	0.80%
Bradford Teaching Hospitals NHS Foundation Trust	7	12	12	13	10	9	7	**9**	0.80%
The Rotherham NHS Foundation Trust	6	6	5	6	5	10	13	**10**	0.85%
Hull and East Yorkshire Hospitals NHS Trust	10	13	11	7	12	11	9	**11**	0.86%
Scarborough and North East Yorkshire Health Care NHS Trust	14	14	10	4	13	7	12	**12**	0.90%
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	9	10	13	9	11	14	11	**13**	0.99%
Mid Yorkshire Hospitals NHS Trust	15	15	15	15	14	12	15	**14**	1.11%
Leeds Teaching Hospitals NHS Trust	13	11	14	14	15	15	14	**15**	1.29%

Commentary:

The table above compares us with other Trusts within our Strategic Health Authority (SHA) in terms of the percentage of operations which are cancelled, and shows that we have improved our comparative position in 2009/10 as compared with the previous year. At the end of January 2010 (final quarter figures not available at this time) we have the second lowest rate for cancelled operations in our SHA at 0.49%.

Effectiveness Indicator

Accident and Emergency 4 hour Target Performance

Rationale for choosing indicator:

This is a national target requiring that 98% of patients spend less than 4 hours in A&E. The 2% tolerance allowed is to account for patients who are clinically unfit to leave A&E in this timeframe.

National A&E Performance (England)		
	Q4 2009/10	Full year 2009/10
Number of Trusts below 98%	106	88
Number of Trusts above 98%	44	66
CHFT performance	98.1%	98.24%

NB. The figures above include only performance against what is called Type 1 attendances. These constitute the vast majority but exclude such as attendances at walk-in or minor injuries centres.

Commentary:

The table shows that we have achieved the target during 2009/10 being one of 66 from a total of 154 comparative Trusts who have done so.

We have consistently achieved 98% or above during each Quarter of 2009/10 and despite what is acknowledged to have been a particularly difficult winter period we achieved the target during the final quarter of the year being one of only 44 (from a possible 154) Trusts who also did so.

Length of stay for patients in A&E continues to be a top priority for us over the next three years as part of our Quality Improvement Strategy and a number of pieces of work have already begun in A&E to further improve this.

Experience Indicator

Same Sex Accommodation

Rationale for choosing indicator:

The Trust is committed to delivering privacy & dignity for our patients and is fully supportive of the drive to virtually eliminate mixed sex accommodation. Safe, timely access to high quality care will always be a priority, whilst seeking to maintain privacy & dignity.

Inpatient Survey Data	2008	2009
When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or a bay with patients of the opposite sex?	73	85
After you moved to another ward (or wards), did you ever share a sleeping area, for example a room or a bay with patients of the opposite sex?	Not asked	85
While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?	71	82

Commentary:

The table above shows the results taken from the National Inpatient Survey which demonstrate a marked improvement in response to questions relating to Same Sex Accommodation. There have been a number of initiatives that have supported this achievement which are detailed below:

- A major programme of estates work has taken place over the last 12 months: enhancing sleeping accommodation, provision of additional bathrooms/toilets, signage to bedrooms and bathrooms; and privacy curtains where appropriate. (Frequent reports on progress submitted to PCTs/SHA/DoH).
- An Operational Policy for the Delivery of Same Sex Accommodation was established and ratified by the Trust Board.
- Training sessions held with staff throughout to educate around the new guidance and to ensure compliance with effect from 1 July 2009 as required.
- SHA Leads, Chairs from commissioners & patient representatives, have all been hosted to discuss and observe the Trust's Programme of Improvement in delivering same sex accommodation.
- A breach reporting system has been established which is aligned to the PAS system, which feeds into the quarterly contract reporting structure. This has been in place covering the last 3 quarters of 2009/10.
- Statutory Department of Health Delivering Same Sex Accommodation Patient Experience Surveys have been undertaken on consecutive months between December 2009 and March 2010.
- A Communications Strategy was established which has included updates on the website, trust intranet, Trust News, Foundation News, GP update, articles in the local press, patient leaflets and an inclusion in the Coming into Hospital Book.
- The Trust has made a declaration of compliance in virtually eliminating mixed sex accommodation by 31 March 2010, which has been posted on the Trust website.

Experience Indicator

Cleanliness - PEAT Inspection (Patient Environment Action Team)

Rationale for choosing indicator:

Patient environment is an important measure of patient experience, recognising the environment in which patients receive their care can have a significant impact on their overall experience.

Year	Sites	Results		
2009		Environment	Food	Privacy and Dignity
	CRH	Good	Excellent	Good
	HRI	Good	Excellent	Good

National	Excellent	Good	Acceptable	Poor
Environment	24%	60%	15%	1%
Food	58%	37%	5%	<1%
Privacy and Dignity	44%	50%	6%	<1%

Year	Sites	Results	
2008		Environment	Food
	CRH	Good	Good
	HRI	Good	Excellent

National	Excellent	Good	Acceptable	Poor
Environment	19%	56%	24%	1%
Food	54%	39.55%	5%	0.5%

Year	Sites	Results	
2007		Environment	Food
	CRH	Good	Excellent
	HRI	Good	Excellent

National	Excellent	Good	Acceptable	Poor
Environment	14%	49%	35%	2%
Food	46.5%	48.5%	4.5%	0.5%

Experience Indicator

Cleanliness - PEAT Inspection (Patient Environment Action Team) *continued*

Commentary:

PEAT is self assessed and provides a framework for inspecting standards to demonstrate how well individual healthcare organisations believe they are performing in key areas including:

- food
- cleanliness
- infection control
- patient environment (including bathroom areas, lighting, floors and patient areas)

Assessments are carried out by NHS staff (nurses, matrons, doctors, catering and domestic service managers, executive and non-executive directors, dieticians and estates directors), patients, patient representatives and members of the public are also part of this assessment process).

The table above shows the Trust's position against three areas measured as part of the PEAT inspection: Environment, Food, and Privacy and Dignity.

- **Environment:**
  The Trust has consistently scored 'good' in this category over the last three years, it is noted that 24% of Trusts scored 'excellent' in 2009.
- **Food:**
  with the exception of 2008 CRH (Calderdale Royal Hospital), both sites have scored of 'excellent' over the last three years
- **Privacy and Dignity:**
  this was introduced as a category in 2009 with both sites achieving a 'good' rating. 44% of trusts scored excellent in this category.

In addition to the annual inspection, the Trust has a number of local initiatives in place that enable ongoing assessment and improvements:

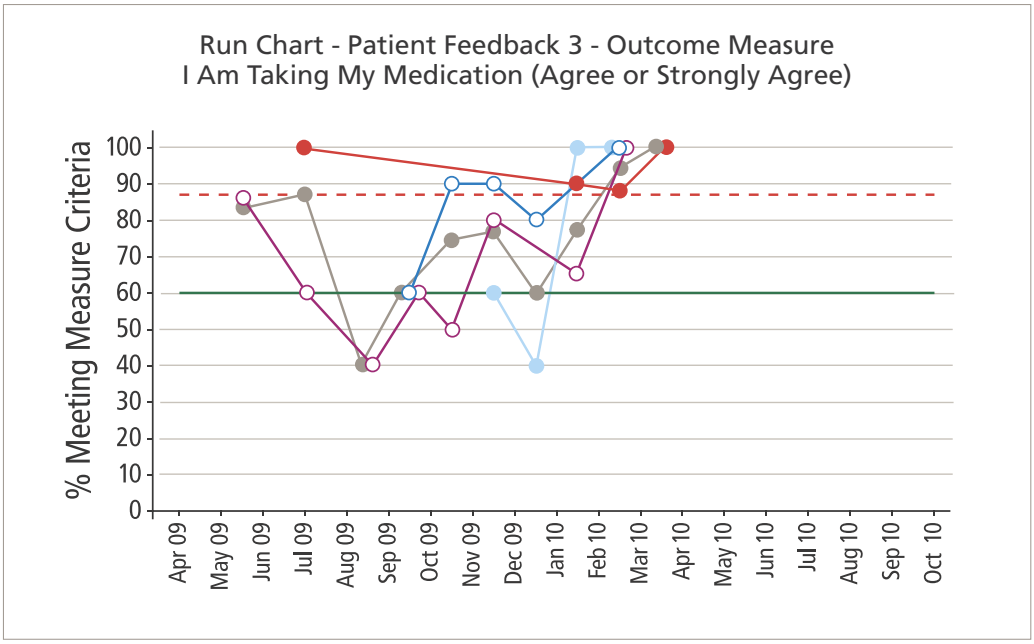
- Food tasting surveys - team reviews of issues such as choice, quantity (portions) and temperatures carried out on specific wards
- Catering satisfaction surveys, undertaken with patients covering issues such as choice, help with eating, availability of drinks & snacks
- An annual schedule of mini-PEAT inspections, recently replaced by a more extensive inspection covering nursing, infection control, estates and cleaning
- Monthly performance reports are reviewed coving results of patient feedback re food, cleanliness audits and patient surveys of cleanliness
- Following any ward upgrades patient feedback is sought (20-30 responses) to resolve issues prior to future upgrades

Experience Indicator

Co-Creating Health National Pilot Programme

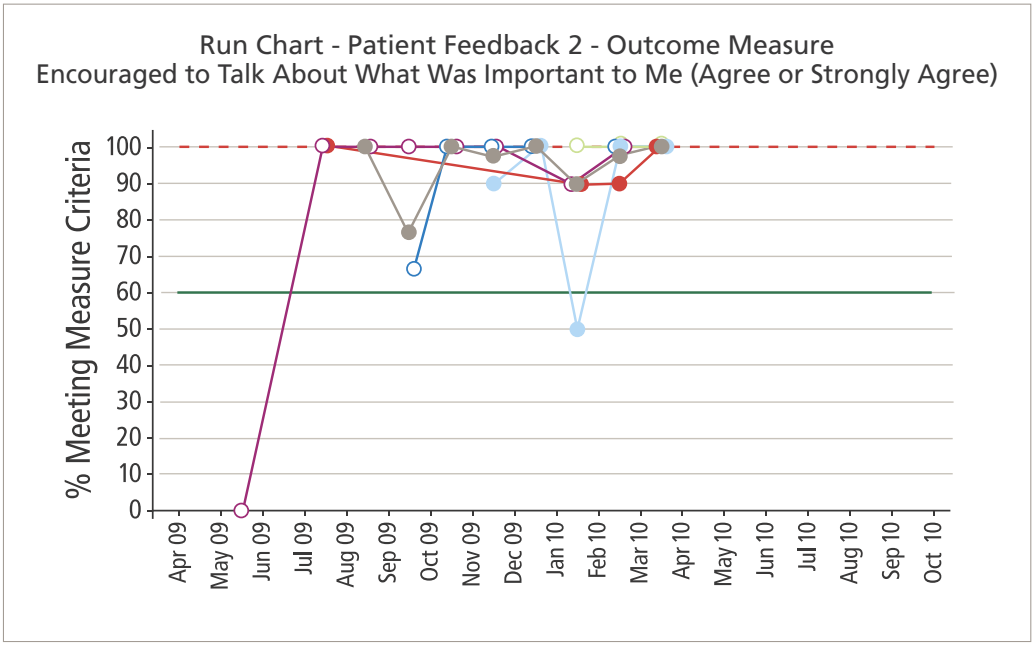
Rationale for choosing indicator:

We are working in partnership with NHS Calderdale and NHS Kirklees as one of eight joint award holders for a national pilot project to support patients with long term conditions. The pilot, funded by The Health Foundation, is called Co-Creating Health. In Calderdale and Huddersfield patients with musculo-skeletal pain and their clinicians are facilitated, through training and service development, to use self management tools and techniques. Evidence from the pilot is collected by Coventry University to demonstrate benefits for patients and achievable efficiencies in resource use. In 2010 we hope to extend the pilot to a second long-term condition.



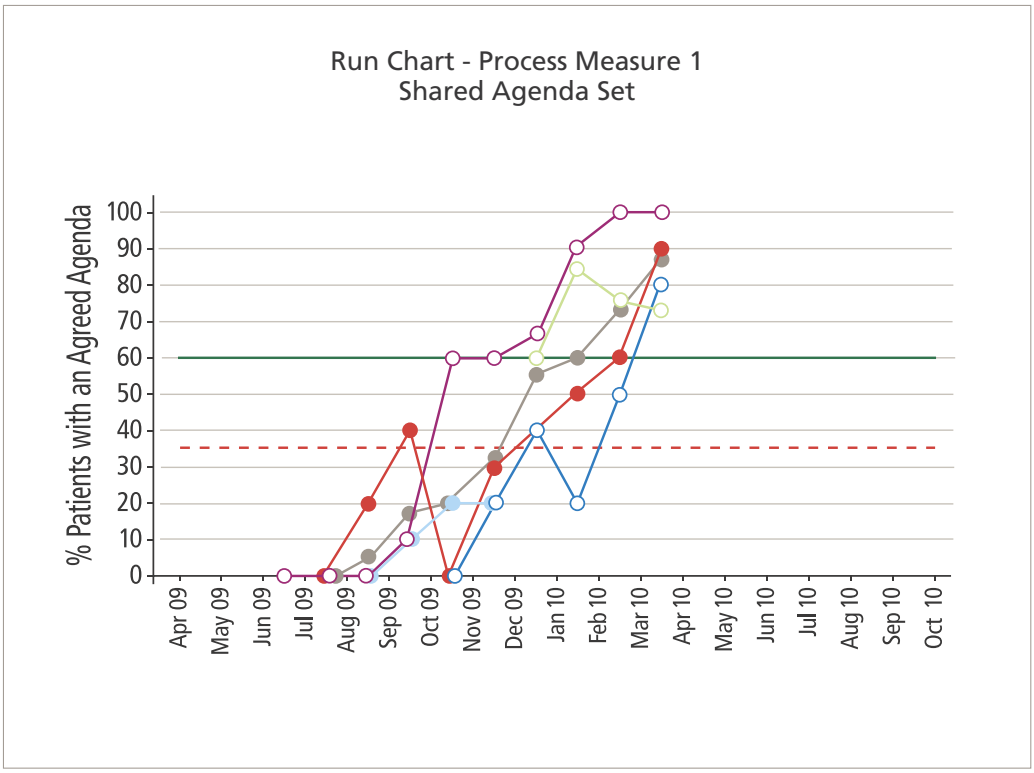
Key:

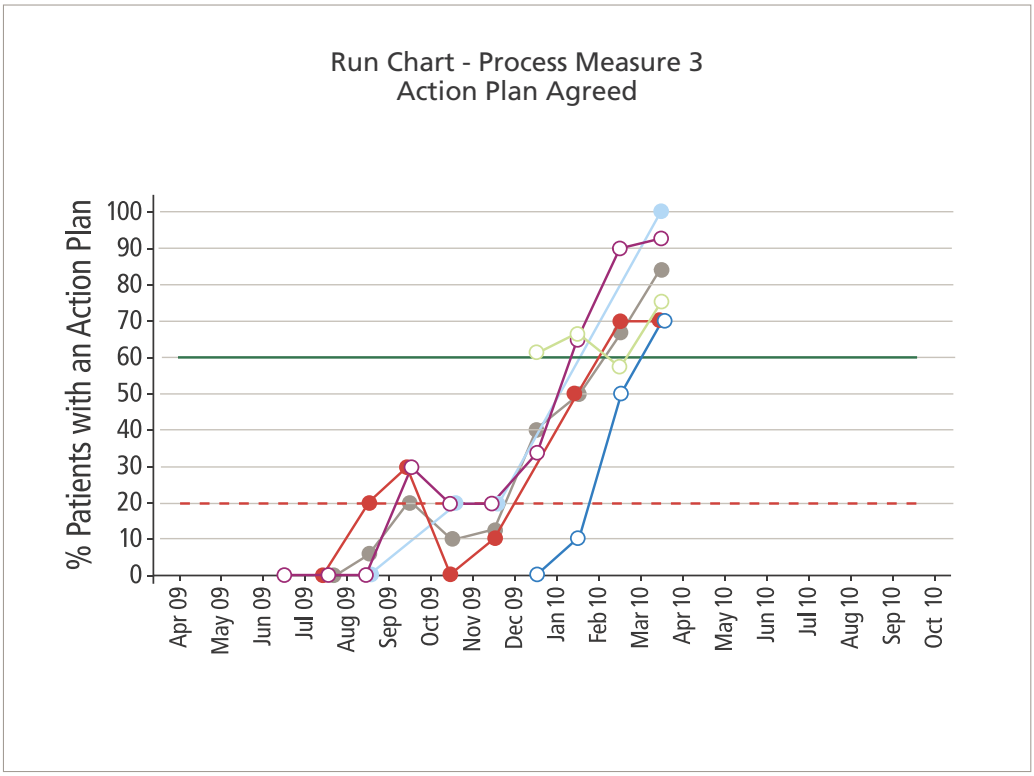
- Target
- SITE
- Median
- Team A
- Team B
- Team C
- Team D
- Team E
- Team F
- Team G
- Team H
- Team I
- Team J
- Team K
- Team L



Experience Indicator

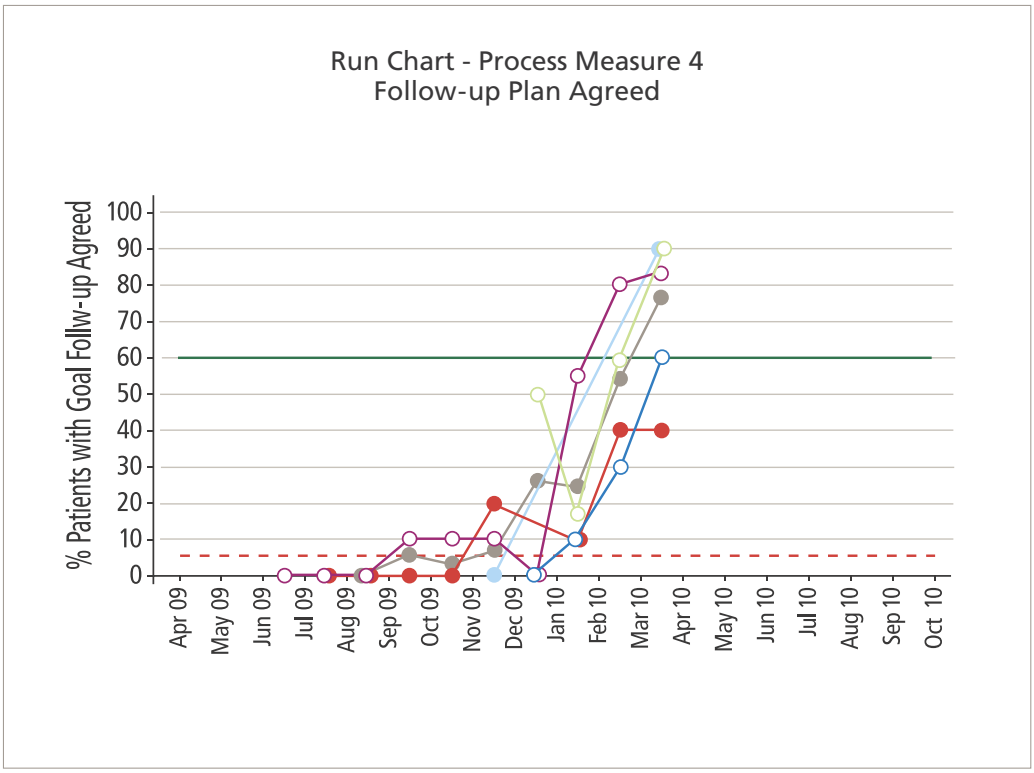
Co-Creating Health National Pilot Programme *continued*





Experience Indicator

Co-Creating Health National Pilot Programme *continued*



Commentary:

The graphs above are collated on a monthly basis for all clinical teams taking part in the service improvement element of the project. Data on agreed process and outcome measures is collected from a random audit of patient records and also directly from patient feedback.

The graphs show that patients are creating agendas, goals and follow up plans in partnership with their clinicians. High levels of satisfaction are reported and an increase in self reported compliance with prescribed medication is demonstrated. Other outcome measures are collated by Coventry University and further evidence of effectiveness is anticipated at the conclusion of this phase of the project. (Autumn 2010).

Performance against National Key Priorities

	Threshold (1)	Weighting	Year End Position
Acute targets - national requirements			
Clostridium difficile year on year reduction (to fit the trajectory for the year as agreed with PCT - assumed a 15% reduction if no level agreed in contract)	166	1.0	102
MRSA - meeting the MRSA objective (2)	19	1.0	13
All cancers: 31-day wait for second or subsequent treatment (3), comprising either: surgery anti cancer drug treatments radiotherapy (from 1 Jan 2011)	 94% 98% 94%	1.0	 98.9% 100% N/A
All cancers: 62 day wait for first treatment (4), comprising either: from urgent GP referral to treatment from consultant screening service referral	 85% 90%	1.0	 94.3% 98.3%
Maximum time of 18 weeks from point of referral to treatment in aggregate and by speciality for admitted patients (5):	90%	1.0 (0.5 for 3 or more specialities)	94.7%
Maximum time of 18 weeks from point of referral to treatment in aggregate and by speciality for non-admitted patients (5):	95%	1.0 (0.5 for 3 or more specialities)	99.3%
Acute targets - minimum standards			
All cancers: 31 day wait from diagnosis to first treatment (6)	96%	0.5	100%
Cancer: two week wait from referral to date first seen (7), comprising either: all cancers for symptomatic breast patients (cancer not initially suspected)	 93% 93%	0.5	 95.8% 96.4%
Screening all elective in-patients for MRSA (8)	100%	0.5	104%
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge (9)	98%	0.5	98.3%
People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack) (10)	68%	0.5	N/A
Mental health indicators			
Care Programme Approach (CPA) patients (11): receiving follow-up contact within seven days of discharge having formal review within 12 months	 95% 95%	 0.5 0.5	 N/A N/A
Minimising delayed transfers of care (12)	<=7.5%	1.0	N/A
Admissions to inpatients services had access to crisis resolution home treatment teams (13)	90%	1.0	N/A

Performance against National Key Priorities *continued*

	Threshold (1)	Weighting	Year End Position
Mental health indicators *continued*			
Meeting commitment to serve new psychosis cases by early intervention teams (14)	95%	0.5	N/A
Data completeness identifiers (15)	99%	0.5	N/A
Data completeness outcomes (16)	tbc%	0.5	N/A
Specific Ambulance targets			
Category A call - emergency response within 8 minutes (17)	75%	1.0	N/A
Category A call - ambulance vehicle arrives within 19 minutes (17)	95%	1.0	N/A
Category B call - a response within 19 minutes (18)	95%	1.0	N/A
All acute and mental health NHS foundation trusts			
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability (19)	N/A	0.5	N/A

Performance against National Core Standards

The Trust declared compliance against all of the 24 Care Quality Commission Core Standards.

Annex

Statement from Kirklees Local Involvement Network (LINk)

This commentary on the Quality Account seeks to discuss areas that the LINk has knowledge and awareness of. We see the Quality Account as a document that sets a baseline for all of us who seek to improve services. We welcome this approach but know that its true effectiveness will only become evident over a period of time.

Kirklees LINk has had a long standing interest in reducing hospital acquired and community acquired pressure ulcers. We believe there should be zero tolerance of the incidence of pressure sores acquired in an inpatient setting. We hope that a reduction of 50% trends very close to this figure of zero.

From the previous work of the Patient Forum's, Kirklees LINk is aware of figures for previous years, in 2004 the Calderdale and Huddersfield NHS Foundation Trust (CHFT) admitted 656 people who had pressure ulcers and in 2005 CHFT admitted 627. Similarly, figures for people who acquired pressure ulcers whilst inpatients were 550 in 2004 and 488 in 2005. Without figures for recent years it is hard to do an adequate comparison.

Kirklees LINk has been lobbying for a whole-systems approach to the management of pressure ulcers for many months. The LINk remains concerned that Pressure Ulcers that originate in Care Homes and private homes are not adequately tracked as to origin and frequency and this makes it difficult to map areas of good and bad practice. If this approach were instituted then CHFT may find itself in a more positive position with regard to admitting people with pressure ulcers.

The LINk is aware that the population of older people is growing and that pressure ulcers may become a larger and more hidden problem. The LINk would like to be reassured that this growing population group is receiving services across all sectors that maximize their safety when in the community and that people don't end up receiving treatment in a District General Hospital.

Kirklees LINk welcomes the development of Exemplar Wards as it seeks to address the problems we identify above. We especially welcome this approach as it is designed to provide more contact time between clinicians, nurses and patients. We look forward to learning how effective the Exemplar Wards will be over the coming years.

In conclusion, Kirklees LINk knows that CHFT is striving for improvement as evidenced above. We know that CHFT provides services that are valued by the communities the Trust serves, whilst also being aware that services can always be improved. Kirklees LINk is interested in supporting all the improvements CHFT plans and looks forward to an improved relationship with CHFT so that this support can be more effective.

Statement from Calderdale Local Involvement Network (LINk)

No official response received.

Statement from Kirklees Overview and Scrutiny Committee (OSC)

The relationship between CHFT and Kirklees Council's Overview and Scrutiny remains a positive one which is further strengthened by quarterly meetings between OSC and the NHS Chairs.

The content of the Trust's quality account reflects priorities driven by central government as well as priorities chosen locally; and whilst these priorities may not directly correlate with the priorities that will be chosen by Scrutiny: Scrutiny will endeavour to receive updates on these priorities through the quarterly meetings with the NHS chairs.

In addition the Trust's chosen priorities will also be considered when the Scrutiny panels discuss and agree their work programme at the start of the municipal year.

Statement from Calderdale Overview and Scrutiny Committee (OSC)

No official response received.

Document assurance by lead commissioning Primary Care Trust (PCT).

Statement from NHS Kirklees

As lead commissioner, NHS Kirklees agrees that the content of the report is accurate.

There is a lot of detail included in the report demonstrating the organisations approach to quality and your achievements to date.

The linkages made between leadership and culture, quality improvement and workforce capability are particularly welcome.

Your priorities are stretching and link well with local CQUINS.

There are gaps in how initiatives will be monitored and future reports need to be clearer.

There is a lot of detail including graphs and tables that as a public facing document make it difficult to read.

NHS Kirklees would like to see more input for patients. The document could be brought to life with some patient quotes on their perception of the quality of care.

It does however, highlight the quality issues that are important to the public and demonstrate an organisation that is focused on quality improvement.





PDI

Sustainability and Climate Change Report

Sustainability and climate change reporting is being developed alongside our Corporate Citizenship work to enhance our capacity to make a positive social, economic and environmental input and to help reduce health inequalities, whilst contributing towards sustainable development.

Our strategy is to initially concentrate on energy and environmental aspects, such as agreeing energy saving and carbon reduction targets, in line with what is proposed in the Saving Carbon, Improving Health / NHS Carbon Reduction Strategy document - i.e. achieving a 10% reduction by 2015 from our 2007 baseline level. We are developing plans in line with this guidance and will include a commitment to continuous improvement in minimising the impact of our activities on the environment.

We have established a Sustainable Development Performance Group (SDPG), chaired by a Non-Executive Director and accountable to the Board of Directors via annual and exception reports.

Summary of performance

The non-financial and financial data for 2008-09 and 2009-10:

Future priorities and targets

We are currently developing sustainable policies and procedures through our Sustainable Development Performance Group. Future priorities and strategies will target the mechanisms to measure progress against set objectives to comply with relevant legislation and guidance and look at areas in addition to the energy and the environmental aspects. Current priorities and targets include:

- The provision of a new £4.79m boiler-house/energy centre at HRI with anticipated carbon benefits of up to 4,000 tonnes of CO^2 per annum
- An updated Green Travel Plan to encourage the use of public transport, walking, cycling and making sure that pollution and CO^2 emissions are minimised
- Replacement lighting programme to new energy efficient fittings saving in the region of 200 tonnes of CO^2 per annum
- Implementation of Plate Heat Exchanges from Calorifers at HRI saving some 1,300 tonnes of CO^2 per annum
- Waste management monitoring to improve recycling and reuse of all waste streams saving approximately 50 tonnes of CO^2 per annum
- HRI window replacement programme to improve thermal qualities.

Area		Non-financial data (applicable metric)	Non-financial data (applicable metric)		Financial data (£k)	Financial data (£k)
		2008/09	2009/10		2008/09	2009/10
Waste minimisation and management	• Absolute values for total amount of waste produced by the trust. • Methods of disposal.	• 699 tonnes Clinical = incineration Non-clinical = Landfill and recycle	• 906 tonnes Clinical = incineration Non-clinical = Landfill and recycle	• Expenditure on waste disposal.	661,682	681,030
		kWh	kWh		£	£
Finite Resources	• Water • Electricity • Gas • Other energy consumption	201,716 22,696,234 24,386,629 32,677,777 (coal)	211,812 22,860,105 25,418,757 33,007,777 (coal)		462,011 2,776,724 513,927 616,324	483,741 2,192,667 642,182 610,641

Equality and Diversity Report

Summary of approach

As a best practice employer we have for many years adopted and implemented broad policies which focus on individual needs, regardless of age, race, faith, culture, gender, sexuality, marital status or disability and support equality of opportunity, flexible practice, investing in people and improving working lives.

The Corporate Social Responsibility agenda has also focused on equality of opportunity and economic regeneration supporting minority groups.

General Human Rights issues are clearly demonstrated via the broad policies outlined above and clinically focused policies such as Consent.

We have a formal approach to engagement with partners in working to reduce health inequalities and improve social inclusion via Local Strategic Partnerships (LSPs) and Local Area Agreement targets.

Trust Executive Board members each take a lead on LSPs and ensure engagement in all areas of health inequalities and narrowing the gap agendas. Local population statistics are used to inform service improvements, such as provision of outreach clinics in areas considered to have significant deprivation.

We are becoming increasingly involved in the Safer and Stronger Communities partnerships and are represented on the Hate Incident Reporting Boards in both Calderdale and Kirklees. Both hospital sites are designated hate incident sign posting centres.

Information from both staff and patient surveys is action planned and where appropriate built into business planning and assurance frameworks.

We are working closely with local authorities and both primary care trusts to ensure a cohesive approach to implementation of legislation and to share learning and data. Consultation exercises by each organisation with representative groups will inform all action plans and impact assessment processes.

Consideration of all of the above enables us to ensure that the patient experience is improved, services are concentrated on the patient and any clinical risks, which may result from diversity or disadvantage, are managed and reduced.

We have built substantial relationships with representative user groups who support consultation on service issues and respond positively to requests from user groups to engage on health issues.

Compliance with data recording in relation to ethnicity of service users is now 100%. Workforce data is collected routinely for every new starter and is available for the whole workforce on the Trust website.

A number of our Membership Councillors have an interest in learning more about the general Corporate Social Responsibility agenda and these individuals meet on a quarterly basis. One of them takes a specific interest in the Equality and Diversity area.

We have published equality schemes in relation to race, disability and gender which have all been approved by the Board of Directors. Progress on implementation of equality, diversity and human rights issues is reported regularly to Board and communicated throughout the organisation via team briefings and document cascade. Leadership of these portfolios lies with the Director of Nursing for all service areas, the Director of Personnel and Development for all employment issues and a Non-Executive Director with a special interest in this area. Issue specific policies, such as equal opportunities, are also approved at Board level.

A Trust-wide steering group, which includes representation from all our divisions and corporate areas, meets on a bi-monthly basis to progress actions and share learning across the organisation.

As a best practice employer we have for many years adopted and implemented broad policies which focus on individual needs

Contact has been made with Disability Rights Network's through the partnership approach and they are aware of the Trust's plans for the future.

A considerable amount of work has been undertaken over recent years by the Acute Hospital Steering Group to improve access and information to patients with learning disabilities. This work includes the appointment of a Matron with specific responsibility for learning disabilities patients with complex needs.

We were represented at the launch of the local lesbian, bisexual, gay and transgender network, whose members have agreed to be a point of contact for future consultation in this area. They have also provided us with information to support individuals under going gender reassignment.

We have developed a comprehensive equality impact assessment (EqIA) framework which is being worked through by all service and corporate areas in relation to both policy and service delivery. Completed impact assessments and action plans will be published and reviewed regularly. The framework process includes review of all existing data and consultation with relevant user groups.

It is our intention to review the existing equality schemes in 2010, replacing them with a Single Equality Scheme based on EqIA action plans.

The Trust Board has adopted the following statement for inclusion in all policies:

> "Calderdale and Huddersfield NHS Foundation 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, race, faith, culture, gender, sexuality, marital status or disability."

All our new staff are required to undertake mandatory induction and risk management training which includes workplace bullying and positive work environment sessions.

A number of our staff have been trained in an Embracing Diversity programme and this programme is now run on a regular basis and available to all staff.

The procurement strategy includes compliance statements relating to race, gender, age and disability for all Trust contractors and the estates strategy includes safe and healthy workplace initiatives including disability adaptations and signage etc.

Comprehensive occupational health services are available to all staff and where necessary reasonable adjustments are made to ensure that staff experiencing difficulties in the workplace can continue in employment.

Through a well established employability scheme, we work closely with local employment agencies to actively support economically inactive individuals into jobs, including those with physical, mental or learning disabilities.

We are also an approved two tick symbol organisation in relation to disability.

Priorities going forward

Key areas of work over the coming year will include embedding the new interpreting service introduced in February 2010. Enhancing the service for this client group and ensuring instant access to 244 languages through quality accredited interpreters in order to reduce clinical risk, improve confidentiality and improve the patient experience.

Following preliminary work on equality impact assessments this will be accelerated in divisions and completion reported to Board through monthly performance monitoring reports. The Equality and Diversity steering group will continue to monitor progress and share learning across the organisation.

Existing schemes will be reviewed and work will commence on ensuring compliance with the new Equality and Human Rights legislative duties.

Occupational health services will continue to build on the work to date in promotion of staff health and well being and the achievement of stage 1 Practice Development Unit accreditation with a view to full accreditation in 2011. This will be the first time the accreditation process, which reflects evidence based practice and stakeholder involvement, will have been applied to occupational health services in the UK.

All our new staff are required to undertake mandatory induction and risk management training

Equality and Diversity Report

	Staff 2008/09	%	Staff 2009/10	%	Membership 2008/09	%	Membership 2009/10	%
Age								
0-16	0		2	0.03%	24	0.25%	27	0%
17-21	62	1.1%	102	1.74%	675	7.25%	961	9.87%
22+	5574	98.9%	5746	98.2%	8607	92.4%	8748	89.8%
Ethnicity								
White	4803	85%	5063	87%	8543	91.8%	8748	89.8%
Mixed	63	1%	67	1%	76	0.81%	115	1.18%
Asian or Asian British	339	6%	372	6%	496	5.32%	620	6.36%
Black or Black British	115	2%	138	2%	156	1.67%	219	2.24%
Other	73	1%	77	1%	35	0.37%	36	0.36%
Not Stated	80	1%	82	1%	0	0%	0	0%
Undefined	163	3%	51	1%	0	0%	0	0%
Gender								
Female	4570	81%	4734	81%	5571	59.8%	6048	62.1%
Male	1066	19%	1116	19%	3735	40.1%	3688	37.8%
Trans-gender	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Recorded Disability	31	0.60%	30	0.50%	N/A	N/A	N/A	N/A

We are committed to improving data quality during 2010. In order to address any issues relating to employee data the Trust is planning to send a personal Audit Report to all employees to allow them the opportunity to confirm or amend their data.

We are committed to improving data quality during 2010

Staff Survey Report

Staff engagement

We recognise that our employees play an important role in designing and delivering services that are of high quality and that meet the diverse needs of the people who use our services.

We believe that employees who are treated fairly, given the opportunity to develop their skills, allowed to take decisions and are involved in decisions about matters that affect them and the environment in which they work, who are well managed and supported by effective leaders are more likely to be motivated and experience higher levels of job satisfaction leading them to want to be involved in the work of the Trust.

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 are working with our staff side partners to better understand the implications on the NHS of the economic downturn and its impact on public sector funding in order to ensure that we safeguard employment and retain our skilled and motivated workforce. This will be an important feature of partnership working in the next few years.

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 have involved the Trust's Chief Executive and other members of the executive team
- Staff have access to the Chief Executive through regular sessions which allow for an exchange of views about what is happening in the Trust and its future direction and provide an opportunity for staff to question the Chief Executive about issues that are important to them.

The Trust has been recognised as an 'Investor in People' for the last 10 years. The Investor in People Standard is a nationally recognised business improvement tool. We follow an internal review strategy using a cohort of staff known as internal reviewers, who engage staff to elicit their views and understanding of how the Trust develops strategies which support their learning and development and how these strategies improve the Trust's performance. This is a continuous process of obtaining feedback to inform the development of new approaches and implementation of best practice.

We regularly seek the views of our staff on a range of matters as a means to ensure we are a successful provider of services and a good employer. This is done on an annual basis through the national NHS Staff Survey.

Summary of performance - results from the NHS Staff Survey

The Trust participated, along with every other Trust in England, in the 2009 NHS staff survey organised by the Care Quality Commission. The survey is the seventh national survey, with annual surveys undertaken since 2003.

We achieved a response rate of 53%.

The survey asked staff 116 questions and the responses were clustered into 40 key findings (36 in 2008).

We regularly seek the views of our staff on a range of matters as a means to ensure we are a successful provider of services and a good employer

Staff Survey Report

	2008/09		2009/10		Trust Improvement/ Deterioration
Response rate	**Trust**	**National Average**	**Trust**	**National Average**	
	55% (above average)	53%	53% (average)	53%	Deterioration Decrease of 2%
Top 4 Ranking Scores	**Trust**	**National Average**	**Trust**	**National Average**	
Staff using flexible working options	73%	71%	75%	70%	Improvement Increase of 2%
Staff experiencing physical violence from staff	3%	2%	1%	2%	Improvement Decrease of 2%
Staff saying hand washing materials are always available	73%	4.69%	74%	69%	Improvement Increase of 1%
Staff experiencing harassment, bullying or abuse from staff	15%	19%	16%	18%	Deterioration Increase of 1%
Bottom 4 Ranking Scores	**Trust**	**National Average**	**Trust**	**National Average**	
Staff receiving health and safety training	54%	76%	63%	78%	Improvement Increase of 9%
Staff working in a well structured team environment	38%	37%	33%	38%	Deterioration Decrease of 5%
Perceptions of effective action from employer towards violence and harassment	3.58%	3.54%	3.47%	3.55%	Deterioration Decrease of 0.11%
Staff appraised in last 12 months	51%	64%	58%	70%	Improvement Increase of 7%

New for 2009, the staff survey used the responses for the following key findings (KF) to calculate an overall measure of staff engagement:

- KF33 - Staff ability to contribute towards improvements at work
- KF36 - Staff recommending the trust as a place to work or receive treatment
- KF37 - Staff motivation at work

Our overall staff engagement score was average when compared with trusts of a similar type.

Action plans to address areas of concern

Each year we produce a staff feedback and action plan based on "what you said - what we've done and what we're doing". Some of the things we have done are:

Staff receiving health and safety training - We have developed a Workforce Health and Wellbeing Strategy, with one of its key tenets being that every member of staff must be released and make themselves available to attend mandatory training (which includes risk management and health and safety). This will be monitored within divisions through an assurance framework. All new staff receive health and safety training as part of their induction and this is then followed up by annual risk management training. An annual programme for all staff has increased attendance throughout 2009 and 2010. Specific health and safety training is currently one session out of a full day of mandatory training. In addition we are reviewing our approach to delivering this training using e-learning. We have now incorporated elements of health and safety training in other training courses such as a management/ leadership programme, thus increasing awareness levels within the organisation.

Staff working in a well structured team environment - We have a well-developed team briefing structure to ensure staff are regularly updated on developments and are given the opportunity to identify ways to improve the team's effectiveness.

Perceptions of effective action from employer towards violence and harassment - Executive Board members and senior managers make regular visits to wards and departments throughout the year to discuss issues of concern with staff, whose views are considered and actions put in place. The Trust encourages staff to have zero tolerance to any kind of violence. We have a trust-wide violence and aggression group which has police representation and our objective is to discourage violence of any kind. The Trust delivers Conflict Resolution training (as a mandatory requirement) to all frontline staff. We encourage reporting so we can take action, which could includes working with the police and local authorities.

Staff appraised in last 12 months - Appraisal for medical staff is well-embedded and optimum levels are achieved. For non-medical staff, a working group is reviewing both the content and process of appraisal across the Trust.

Future priorities and targets

In 2010 we will focus on implementing the Workforce Health and Wellbeing Strategy and have developed key performance indicators to inform the Executive Board and Board of Directors on a regular basis.

We have an established workforce wellbeing strategy group which monitors the delivery of our wellbeing strategy. The staff survey results inform our wellbeing strategy and divisions will ensure there are systems in place to engage with staff in finding solutions which address their concerns. They will develop action plans which will be monitored at divisional boards.

The Trust will use the staff survey results as an indicator for the work associated with the Quality Improvement Strategy.

Each year we produce a staff feedback and action plan based on "what you said - what we've done and what we're doing"

Regulatory Ratings Report

	Annual Plan 2008/09	Q1 2008/09	Q2 2008/09	Q3 2008/09	Q4 2008/09
Financial risk rating	4	4	4	4	4
Governance risk rating	Amber	Red	Red	Amber	Green
Mandatory services	Green	Green	Green	Green	Green

	Annual Plan 2009/10	Q1 2009/10	Q2 2009/10	Q3 2009/10	Q4 2009/10
Financial risk rating	4	4	4	4	4
Governance risk rating	Green	Green	Green	Green	Green
Mandatory services	Green	Green	Green	Green	Green

In line with Monitor's 'Compliance Framework' all Trusts are assigned a rating for Finance, Governance and Mandatory Services by Monitor on a quarterly basis.

The Trust was assigned a red governance rating for Q1 2008/09 as a result of its failure to meet its MRSA target in 2007/08. Following successfully achieving the Trust's quarterly MRSA target, Monitor assigned a Green rating with effect from Q4 2008/09.

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 has overall responsibility for delivering the activities of the Trust and is accountable for the operational performance of the Trust as well as the definition and implementation of strategy and policy.

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 of Directors for the period 1 April 2009 to 31 March 2010 was as follows:

Board Member	Position	Tenure Review Date
Sukhdev Sharma	Chairman	3.10.10
Carol Clark	Non-Executive Director/Vice-Chair and Senior Independent Director	Final term of office expires on 30.10.10
Alison Fisher	Non-Executive Director	Final term of office expires on 30.11.12
Jane Hanson	Non-Executive Director	30.9.12
Bill Jones	Non-Executive Director	Final term of office expires on 30.11.11
Mohammad Naeem	Non-Executive Director	Final term of office expires on 30.11.10
		Appointed:
Diane Whittingham	Chief Executive	1.4.97
Helen Thomson	Director of Nursing/ Deputy Chief Executive	1.4.93
Mark Brearley	Director of Finance	1.10.05
Yvette Oade	Medical Director	2.7.07
Lesley Hill	Director of Service Development	2.5.06
Julie Hull	Director of Personnel and Development	1.9.95

Non-Executive Director appointments and termination of tenure are determined by the Membership Council.

The Board of Directors comprises a Chairman, five 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. Our Executive Directors are appointed through open competition in accordance with the Trust's recruitment and selection policies and 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 reviewed.

The Board of Directors has monitored its compliance with the NHS Foundation Trust Code of Governance throughout the year and is satisfied that the Trust complies with the provisions of the code. For more information about how the Trust applies the main and supporting principles of the code please see the Statement of Internal Control in the accounts section of this report.

Our Board of Directors

During 2009/10 the Board of Directors met on 13 occasions and attendance at these meetings is given below:

Name	Attendance at Board of Directors Meetings 1.4.09 - 31.3.10
Sukhdev Sharma	12/13
Carol Clark	13/13
Alison Fisher	11/13
Jane Hanson	11/13
Bill Jones	8/13
Mohammad Naeem	9/13
Diane Whittingham	10/13
Helen Thomson	10/13
Mark Brearley	12/13
Yvette Oade	11/13
Lesley Hill	11/13
Julie Hull	11/13

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 347 186** or email: **Kathy.bray@cht.nhs.uk**. Anyone who would like to get in touch with a director should also contact the Board Secretary.

Executive Directors

Diane Whittingham, Chief Executive

Diane holds an MA in Health Service Management from Manchester University and the Diploma of the Institute of Health Service Managers.

Diane was previously chief executive of Huddersfield NHS Trust and was appointed to lead the merged Calderdale and Huddersfield NHS Trust in April 2001. She has more than 30 years experience of health service management and has previously worked in the West Midlands, Manchester and Lancashire.

Diane has a specialist interest in organisational development, plays an active role in health policy issues and is a member of a number of national groups. She is a member of the Huddersfield University Council.

Diane is currently acting as interim Chief Executive in East Lancashire Hospitals Trust in addition to her role at Calderdale and Huddersfield.

Helen Thomson, Director of Nursing

Helen holds an MA in Leading Innovation and Change from York University and a BA (hons) in Management from Leeds University. She is also a registered nurse and midwife and holds the Advanced Diploma in Midwifery and the Midwife Teachers Diploma. She has also undertaken the High Potential Development Programme organised by the Department of Health.

Helen moved to Huddersfield as Head of Midwifery in 1989, from a teaching post at a Leeds hospital. She became the Director of Nursing and Midwifery and Deputy General Manager at Huddersfield Royal Infirmary from 1991.

In 1993, she took the post of Director of Operational Management then became Executive Director of Nursing and Clinical Development in April 1995. In April 2001, she has appointed Executive Director of Nursing for the newly-formed Calderdale and Huddersfield NHS Trust and has also held the post of Deputy Chief Executive since January 2006.

Mark Brearley, Director of Finance

Mark is an associate member of the Chartered Institute of Management Accountants and a Member of the Institute of Healthcare Management. He also has a Post-Graduate Diploma in Business Administration from Warwick Business School (Warwick University).

Mark joined the NHS in 1981, after undertaking his basic training with a FTSE 250 manufacturing company. He has been an NHS board director since 1989 and held the post of Director of Finance at Leicester General Hospital NHS Trust from 1992 to 1997. From 1997 to 2005 he held the post of Director of Finance with Royal Hull Hospitals NHS Trust and from 1 October 1999, the merged Hull and East Yorkshire Hospitals NHS Trust, where latterly he was Deputy Chief Executive.

He has been a member of the Audit Committee of the University of Lincoln (seven years) and a primary school governor (four years). He has been the chair of the Yorkshire and Humber Finance Skills Development Board.

Mark enjoys music and sport. He is married with three children.

Our Board of Directors

Yvette Oade, Medical Director

Dr Yvette Oade was appointed Medical Director in July 2007. Yvette joined the Trust in 1993 as a Consultant Paediatrician. She was a Clinical Director and then Divisional Director of the Trust's Children's and Women's Services Division.

Yvette studied medicine at Leeds University. She is a Fellow of the Royal College of Paediatrics and Child Health. She has worked in the field of paediatric medicine since 1985 and did her higher specialist training in Leeds, Blackburn and Manchester. Her particular area of interest is children with diabetes. She has cared for children with diabetes in Calderdale since 1993.

Yvette is married and lives in Liversedge. She has one daughter who has recently become a medical student.

Lesley Hill, Director of Service Development

Lesley has 22 years experience as both a health care 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.

Lesley enjoys the theatre and opera, and participates in a variety of sports. She is married with two teenage daughters.

Julie Hull, Director of Personnel and 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 healthcare and provide the best employment context for the workforce.

Julie is committed to developing sustainable good corporate citizenship strategies, which will benefit the Trust, the local population and the wider health and social care community.

Julie enjoys spending time with her family, reading and music.

Non-Executive Directors

Sukhdev Sharma, Chairman

Sukhdev was appointed Chairman of Calderdale and Huddersfield NHS Foundation Trust in October 2007.

He lives in Halifax and is married with four children. He was the Chief Executive of the Commission for Racial Equality in London until 1998 and before his appointment to the Trust was Chairman of the South West Yorkshire Mental Health Trust - a position he held since 2002.

He was also a Chairman of the former Calderdale and Kirklees Health Authority. He has been a member of the European Economic and Social Committee since 1998 and has been a rapporteur (expert/spokesman) on equality, anti-discrimination, migration and human rights issues for the Committee.

He currently chairs the Migration Policy Group, a Brussels-based think tank. He is a lay member of the Employment Tribunal, and a board member of the Shaw Trust charity, the largest provider of vocational and job training to disabled and disadvantaged people. He was awarded a CBE in 1998 for services to the community.

Carol Clark, Vice-Chair and Senior Independent Non-Executive Director

Carol has a BA Hons degree in French and a Post-graduate Certificate in Education. She has lived in Almondbury, Huddersfield, since 1981 and was a Parent Governor at the local comprehensive school and chairman of Governors at one of the infant schools.

In 1989 she became a member of Huddersfield Community Health Council and acted as Convenor of the Women and Children's Services Special Interest Group. She was Deputy Chairman for two years and Chairman from 1996-98.

Carol was appointed as a Non-Executive Director of Huddersfield NHS Trust in 1998, and when it merged with Calderdale Trust in 2001 she became a member of the new board.

She has a special interest in public involvement in health service provision and has been the non-executive representative on the Patient Safety Committee.

In her spare time Carol particularly enjoys walking and gardening, as well as being an armchair supporter of rugby league and soccer. She has three grandchildren.

Our Board of Directors

Mohammad Naeem, Non-Executive Director

Mohammad Naeem is a Diversity and Race Relations Professional with extensive experience at executive and consultative level in policy development and implementation within public, private and voluntary sector establishments. He combines an impressive track record in influencing public policy via support and development of third sector organisations, maintaining strong links with the wider community.

He was appointed as a Non-Executive Director in May 2001. Naeem is the former Chief Executive of the Rochdale Centre of Diversity and was Chairman of the Local Strategic Partnership from 2005 to 2009. He has lived in Calderdale for more than 30 years and has previously served as an elected member of Calderdale Council.

Naeem worked in Huddersfield, Calderdale and Bradford for more than 15 years in Community Related work, before taking up the post with the Rochdale Centre of Diversity in 1985, which he held until August 2009. His other public appointments include Independent Chairman of Race and Religious Scrutiny Panel of the Greater Manchester Crown Prosecution Service and he has also Chaired Northwest Network and the infrastructure Alliance in Rochdale, organisations set up to provide infrastructure support to The Third Sector.

Jane Hanson, Non-Executive Director

Jane was appointed as a Non-Executive Director in October 2008. Having obtained a BA Hons degree in Music from York University, Jane joined KPMG and qualified as a Chartered Accountant where she became a director responsible for the delivery of corporate governance, internal audit and risk management advisory services to many private sector organisations specialising in the financial sector.

In 2002 she was appointed Director of Audit at Norwich Union Life and in 2004 was made Risk Director working in York and London, responsible for the risk functions, regulatory compliance and a significant portfolio of change programs.

With 20 years' experience of working at Board level in large and complex organisations Jane now has her own financial sector consulting business delivering audit, risk and corporate governance services. She is also a Magistrate and Vice-Chair of Governors at a local primary school.

Jane took on the role of Audit Chair for the Trust with effect from 1 February 2010.

Jane lives in Huddersfield, is married and has two children. She loves travelling, skiing, gardening and music.

Alison Fisher, Non-Executive Director

Alison was appointed as a Non-Executive Director in December 2005. She is employed, part-time, by the West Yorkshire Probation Board as Diversity Manager and has a particular interest in issues of equality and diversity. She has worked for the Probation Service for 25 years and holds a Certificate of Qualification in Social Work, a Post Qualifying Award in Social Work and a Practice Teaching Award.

She is also an assessor and internal verifier for NVQs in Community Justice. She has an honours degree in theology and religious studies from the University of Leeds and a CMI Executive Diploma in Management (Level 5) from Park Lane College, Leeds.

Alison was a representative parent on the General Teaching Council (England) for its first five years of operation and continues to sit on teacher conduct hearings as a lay representative. She was also previously a representative parent on the Education Scrutiny Panel of Kirklees Council for four years and for more than 10 years was a governor at a local primary school.

Alison lives in Huddersfield and has two daughters. She sings with women's singing group unityvoices, who are involved in various local events.

Bill Jones, Non-Executive Director

Bill holds a BSc (Hons) in Sociology linked to Politics and is an associate of the Chartered Institute of Bankers. During his career in banking he has had responsibility for the audit function of a large commercial bank in the North of England and retired as an Area Director of that bank.

Bill has been involved with the NHS since 1992 firstly as a Non-Executive Director with the Prescription Pricing Authority serving in the role of Audit Chair until 1998, and then in 2002 he joined the board of the Calderdale and Huddersfield NHS Trust and served as Audit Chair until 31 January 2010 again in a Non-Executive role. Bill was appointed Non-Executive Director with specialist responsibility for security issues with effect from 31 January 2010.

In 2005 he was invited to join the Board of the Foundation Trust Financing Committee with the Department of Health in London as a Non-Executive contributor and has since then assumed the role of a permanent member.

In 2008 Bill was appointed independent adviser of the Health Informatics Service.

Our Membership and Membership Council

Our membership and Membership Council are our vital link with the local community. Joining our Trust as a Foundation Trust member is a voluntary role and demonstrates support and interest in our hospitals and their future. In turn our members help us to learn and grow as an organisation and to continuously improve our services.

Our membership - eligibility requirements

Our membership is open to any individual who:

- Is over 16 years of age, and
- Is entitled under our Constitution to be a member of one of the public constituencies or of one of the classes of the staff constituency *(table below):*

Public Constituencies	
1	Calder Valley, Luddendenfoot, Ryburn, Todmorden
2	Birkby, Crosland Moor, Deighton, Newsome, Paddock
3	Almondbury, Dalton, Denby Dale, Kirkburton
4	Batley East, Batley West, Birstall, Birkenshaw, Cleckheaton, Dewsbury East, Dewsbury West, Heckmondwike, Mirfield, Spenborough, Thornhill
5	Brighouse, Elland, Greetland, Stainland, Rastrick, Skircoat
6	Bingley Rural, Clayton, Great Horton, Hipperholme, Lightcliffe, Illingworth, Northowram, Shelf, Odsal, Queensbury, Thornton, Tong, Wibsey, Wyke
7	Mixenden, Ovenden, St John's Sowerby Bridge, Halifax Town, Warley
8	Colne Valley West, Golcar, Holme Valley North, Holme Valley South, Lindley
Public Constituencies	
9	Doctors and Dentists
10	Allied Health Professionals
11	Management, Admin & Clerical
12	Ancilliary
13	Nurses & Midwives

The Board Secretary makes the final decision about the class to which an individual is eligible to be a member.

Membership numbers

Public Members per Constituency (as at 31 March 2010)	
Constituency	**Number of Members**
1	581
2	1974
3	1242
4	429
5	1197
6	719
7	1398
8	2196

Staff Members per Constituency (as at 31 March 2010)	
Constituency	**Number of Members**
9	270
10	844
11	1181
12	1482
13	1563

Membership development

Our engagement activities in 2009/10:

- With effect from February 2010 all staff who did not exercise their right to opt-out of membership became members of the Foundation Trust
- The role of the Membership Council is to ensure that the Trust responds to the needs and preferences of the local community as well as working towards achieving a representative membership to ensure all sections of the community have a voice. Membership Council members have focused on engaging with the membership to hear their views on local services
- The Membership Council members are linked to our clinical divisions and host a range of focus groups. At divisional reference groups they hear about divisional business and share their views and that of the wider membership. Regular feedback is given to members at the focus groups on issues that have been raised at earlier events

Our Membership and Membership Council

- Members with an interest in specific services have been invited to focus groups which are linked to our clinical divisions. These are held twice a year for each of the five divisions and inform both divisional and Trust plans. Members have the opportunity to hear service plans and have their views heard in order to help shape future services
- In addition, members and Membership Council members have been involved with helping to recruit clinical staff; improving written information to patients and surveys on particular services i.e. cardiology and orthopaedic services
- The Trust's AGM was held in October 2009. This was staged as part of a comprehensive health fair which showcased a range of patient services and activities from across the Trust. The event provided a valuable opportunity for Membership Council members and Trust directors to meet and engage with people from the local community. Staff and Membership Council members worked together to host a high quality and enjoyable event which was attended by almost 200 people
- A bi-monthly Medicine for Members event, hosted by Membership Council members and featuring clinicians from the Trust speaking on topics of local and national importance, has proved very popular and consistently attracts around 50 members. The programme included presentations on the topics of Anaesthetics and Pain Management, Demystifying Mental Health, Osteoporosis and Palliative Care. These events continue to evaluate extremely well
- In spring 2009 a survey of the Trust membership was conducted. Survey questions covered both the quality of membership activities and the membership office support. Survey results helped to improve communication and activities
- The Trust continues to write and publish the newsletter Foundation News three times a year informing members about developments at the Trust, membership events and a programme of future membership activities
- For staff members a quarterly event entitled "A Conversation with the Chief Executive" was held. This informal event enables staff to share their views, hear about latest developments and influence strategy
- We continue to work closely with our LINks (local involvement network) organisations. Where issues have been raised by their members in areas such as audiology, breast-feeding, pressure sores and rehabilitation services we have been able to take their views into consideration when we are improving and developing those services. We value their feedback highly in this process.

Following analysis of our membership database, we identified areas of under-representation. Some of the following activities, between April 2009 and March 2010, were undertaken in an attempt to address this issue.

Action / Recruitment Activity	Target Population	Outcome
Ladies annual fun and sports day (Asian women's event)	Asian women	Increased membership in under represented areas
Jobs and Enterprise Fair	Young men and women	Engaged and recruited younger job seekers
Carnivals across both towns	Local population	Popular events, good responses
Local universities' Freshers' Day	Young people	Good response particularly from Health and Social Care students
Careers events at local colleges	Young people	Some recruitment and the beginning of partnership working with schools and colleges
Young men's health fairs	Young men	Increase in number of male members
Local health conferences	Local population	Increased membership and awareness of Trust
Staff events - meet the Chief Executive	Staff	Excellent response to events
All staff automatically enrolled as FT members	Staff	Increase in staff numbers Improved representation

Our Membership and Membership Council

Our Membership Council

"As members of the Membership Council we are able to raise issues on behalf of patients and the public so that in partnership with the Trust it is possible to work to ensure an effective first class service is provided for all."
Janette Roberts

"Although I was elected onto the Membership Council I don't just represent a specific constituency. To me it is important, that alongside my colleagues on the Council, I act on behalf of all the membership. Therefore I try to bridge the gap between the users and provider of local hospital services, by influencing the delivery and quality of care."
Allan Templeton

"Being a staff Membership Council member has meant that issues which are important such as high quality care and the wellbeing of staff are always at the forefront of agendas."
Charge Nurse Chris Burton

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 which include: The two primary care trusts, NHS Calderdale and NHS Kirklees, 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. Ad hoc meetings are called as required.

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
- 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
- Membership Engagement & Recruitment Sub-Committee (MER)
- Corporate Social Responsibility Group
- Divisional Reference and Focus Groups:
- Children's and Women's Services
- Diagnostic and Therapeutic Services
- Surgical and Anaesthetic Services
- Medicine and Elderly Services
- Estates and Facilities

The Membership Council receives reports and recommendations from each of these Sub-Committees/Groups at its 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 Membership Council receives reports at each of its meetings from the Director of Finance and Director of Service Development on current issues of performance. In addition the Membership Council receive summary minutes of the monthly Board of Director Meeting together with the monthly Integrated Performance Report.

"Being a staff Membership Council member has meant that issues which are important such as high quality care and the wellbeing of staff are always at the forefront of agendas."

Elected Council Members

Elections were held in five public constituencies and four staff constituencies during the autumn of 2009 and the results were announced at the Annual Members' Meeting in October 2009. The elections were held under the independent scrutiny of the Electoral Reform Services.

There have been four formal meetings of the Membership Council during 2009/10 financial year and the attendance of the Membership Council members at these meetings is detailed below.

Name	Constituency	Elected Until Annual Members' Meeting (Shaded = current serving members)	Attendance at Formal Membership Council Meetings 2009/10
Public			
Bernard Pierce	1	2010	2 / 4
Frances Macguire	1	2011	2 / 2
Linda Wild	2	2011	3 / 2
Lesley Longbottom	2	2010	3 / 4
Yash Pal Kansal	3	2012	2 / 2
Ann Nicholas	3	2009	2 / 2
Dorothy Conroy	3	2011	0 / 3
Christine Breare	4	2011	3 / 4
Richard Hill	4	2012	2 / 2
George Richardson	5	2010	2 / 3
Allan Templeton	5	2010	3 / 4
Peter Naylor (Deputy Chair)	6	2009/2010 (2nd term)	4 / 4
Christine Mickleborough	6	2011	4 / 4
Dot Rayner	7	2011	4 / 4
Liz Breen	7	2011	3 / 4
Jan Roberts	8	2009	3 / 4
Janette Roberts	8	2010	2 / 4
Staff			
Paul Knight	9	2011	2 / 4
Joanna Birch	10	2012	1 / 2
Sue Scholefield	11	2009	1 / 3
Sue Burton	11	2012	1 / 2
June Richardson	12	2009	2 / 3
Liz Farnell	12	2012	2 / 2
Carole Hallam	13	2009	1 / 3
Chris Bentley	13	2012	2 / 2
Chris Burton	13	2011	4 / 4
Stakeholders			
Sue Bernhauser	University of Huddersfield	2012	1 / 4
Jonathan Phillips	Calderdale Metropolitan Council	2010	0 / 4
Merran McRae	Kirklees Metropolitan Council	2012	0 / 0
Helena Corder	NHS Kirklees	2012	2 / 4
Sue Cannon	NHS Calderdale	2011	1 / 4
Ruth Unwin	South West Yorkshire Mental Health Trust	2012	2 / 4

Our Membership and Membership Council

Attendance of Executive Directors at Membership Council Meetings		
Sukhdev Sharma	Chairman	4 / 4
Diane Whittingham	Chief Executive	4 / 4
Mark Brearley	Director of Finance	4 / 4
Lesley Hill	Director of Service Development	3 / 4
Julie Hull	Director of Personnel and Development	4 / 4
Jan Freer	Director of OD/Membership Director	4 / 4
Yvette Oade	Medical Director	1 / 4
Helen Thomson	Director of Nursing	3 / 4
Two Non-Executive Directors are invited to each meeting on a rotation basis		
Carol Clark	Non-executive director/SINED & Vice-chair	3 / 4
Alison Fisher	Non-executive director	2 / 2
Mohammad Naeem	Non-executive director	1 / 2

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 347 186** or email: **Kathy.bray@cht.nhs.uk**.

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 347 342**
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.**





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Audit Committee

The Trust has an Audit Committee which meets at least nine times a year. The primary role of the Audit Committee is to judge and report upon the adequacy and effective operation of the overall control systems of the organisation.
The committee will focus on the framework of risks, controls and related assurances that underpin the delivery of the organisation's objectives. The Audit Committee has approved Terms of Reference which are available on request and are regularly reviewed.

The Audit Committee also reviews the disclosure statements that flow from the Trust's assurance processes, in particular, the Statement of Internal Control. During the course of the year the Trust has continued to ensure its Governance Arrangements are aligned with the Code of Governance for Foundation Trusts published by Monitor

It should be noted that the Board of Directors extended the invitation to Andrew McConnell (a Chartered Accountant and Director of Finance at the University of Huddersfield) to assist the Audit Committee in discharging its duties.

The Non-Executive Director membership and attendance of the Audit Committee for the period 1.4.09 to 31.3.10 was:

Name	Attendance at Audit Committee Meetings 1.4.09 - 31.3.10
Bill Jones (Chair until 31.1.10)	5/9
Jane Hanson (Chair from 1.2.10)	7/9
Mohammad Naeem	8/9
* Alison Fisher	1/9
* Carol Clark	1/9
Andrew McConnell (appointed 1.11.08 as Independent Member of Audit Committee)	7/9

** Co-opted members*

Executive Directors

The Board of Directors is the Nomination Committee for Executive director appointments. This committee is responsible for appointing the Executive Directors of the Foundation Trust. The Committee complies with the Code of Governance issued by Monitor, the Foundation Trust Regulator. The Chair of the Nomination Committee for Executive Directors is the Chair of the Trust, Mr Sukhdev Sharma.

There were no Executive Director appointments in 2009/2010.

Nomination Committee

Non-Executive Directors

The Nomination 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 Sukhdev Sharma (or Vice Chair/ Acting Chair in relation to the appointment of the Chair)
- One appointed Membership Council member
- Sue Bernhauser, University of Huddersfield, Stakeholder Representative
- Three elected Membership Council members (at least two of which must be publicly elected)
  - George Richardson, publicly elected member
  - Chris Breare, publicly elected member
  - Linda Wild, publicly elected member
- The Chief Executive of the Trust - Diane Whittingham

Attendees

- The Director of Personnel and Development - Julie Hull
- The Board Secretary - Kathy Bray

The sub-committee met on 28 July 2009 to discuss the Non-Executive Director appointments arising in year and after due consideration, offered a further three-year term of office to Mrs Alison Fisher, Non-Executive Director. The appointment was accepted and took effect from 1 October 2009 with an expiry date of 30 September 2012.

Name	Attendance at 28.7.09 Nominations Sub-Committee
Mr Sukhdev Sharma (Chair)	✓
Mr George Richardson	✓
Mrs Linda Wild	✓
Mrs Chris Breare	✓
Prof Sue Bernhauser	✓
Mrs Diane Whittingham	Apologies

Name	Attendance at 22.10.09 Renumeration & Terms of Service Sub-Committee
Mr Peter Naylor (Chair)	✓
Mr Chris Burton	✓
Mrs Janette Roberts	✓
Mrs Lesley Longbottom	✓
Mr Allan Templeton	✓

Renumeration 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 on open, transparent and proportionate pay decisions which are subject to audit scrutiny. All pay decisions are based on market intelligence and 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 of 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 together with Foundation Trust information, Department of Health guidance and independent advisors.

Remuneration of 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 2009/2010 the Sub-Committee met on the 22 October 2009, 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 2009/2010 financial year the members were as follows:

- Mr Peter Naylor, Chair (public elected member)
- Mr Chris Burton, (staff elected member)
- Mrs Janette Roberts (public elected member)
- Mr Allan Templeton (public elected member)
- Mrs Lesley Longbottom (public elected member)
- Vacant seat

The Committee was quorate and able to conduct its business. The Committee reviewed its Terms of Reference and agreed these for the current financial year.

The Committee received professional advice from Julie Hull, Director of Personnel and Development

In 2009/2010 the Sub-Committee reviewed the pay arrangements for the Non-Executive Directors and determined that salaries should be uplifted in line with pay recommendations from the Department of Health for Non-Executive Directors in non Foundation Trusts, Strategic Health Authorities and Primary Care Trusts.

In addition the Chair's pay was reviewed using benchmarking data collected from the Foundation Trust Network. Terms and conditions for the Non-Executive Directors remained the same.

Remuneration of 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 four Non-Executive Directors (the Non-Executive Director who Chairs the Audit Committee does not sit on the Remuneration Committee).

In the 2009/2010 financial year the Sub Committee met on three occasions (26.11.09, 28.1.10 and 25.3.10). The business of the Sub Committee was conducted in accordance with its Terms of Reference. The members of the Sub Committee were as follows:

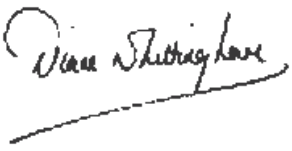
- Mr Sukhdev Sharma, Chair
- Mrs Carol Clark, Non-Executive Director
- Mrs Jane Hanson, Non-Executive Director
- Mrs Alison Fisher, Non-Executive Director
- Mr Mohammad Naeem, Non-Executive Director

The Sub Committee was quorate and able to conduct its business. The Sub Committee's Terms of Reference were reviewed and accepted for the current financial year.

The Sub Committee received professional advice from Julie Hull, Director of Personnel and Development and in addition commissioned and received a report from external remuneration specialists.

The Remuneration Committee, in setting the pay of the Executive Directors, based its decisions on Department of Health guidance for Strategic Health Authorities and Primary Care Trusts, benchmarking data produced by Income Data Services Ltd and Foundation Trust data.

The details of salary and entitlements for Executive Directors are included in the Annual Accounts. 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.



Diane Whittingham
Chief Executive
April 2010

Appendix A

Review of services

- During 2009/10 Calderdale and Huddersfield NHS Foundation Trust (CHFT) provided and/or sub contracted 41 NHS services.
- CHFT has reviewed all the data available to them on the quality of care in 21 of these services.
- The income generated by the NHS services reviewed in 2009/10 represents 38% of the total income generated from the provision of NHS services by CHFT for 2009/10.

Participation in Clinical Audits

- During 2009/10 40 national clinical audits and seven national confidential enquiries covered NHS services that CHFT provides.
- During that period CHFT participated in 90% national clinical audits and 75% national confidential enquiries of the national clinical audits and confidential enquiries it was eligible to participate in.
- The national clinical audits and national confidential enquiries that CHFT participated in during 2009/10 are as follows:

National Clinical Audits Priorities for NCAPOP

Audit title	Method of submission	Audit Coordinator	CHFT participation
Paediatric Intensive Care Audit Network	One off	Universities of Leeds and Leicester	Not eligible
Mastectomy and Breast Reconstruction	One off, all pts	RCS/NCASP	Participated
Oesophago-Gastric (stomach) Cancer	One off, all pts	AUGIS/NCASP	Participated
Continence Care Audit	One off, all pts	RCP	Participated
National Neonatal Audit (NNAP)	Continuous	RCPCH	Not Participated (regional Network decision)
National Diabetes Audit	Continuous	NCASP	Participated
National Diabetes Inpatient Audit 2009	Continuous	NCD/NCASP	Participated
ICNARC CMPD: Adult Critical Care Units	Continuous	CMP	Participated
National Elective Surgery PROMS: Four Operations	Continuous	Dr Foster	Participated
National Joint Registry (NJR)	Continuous	BOA/Northgate	Participated
Renal Registry: Renal Replacement Therapy	Continuous		Not eligible
Head & Neck Cancer Da(HNO)	Continuous	BAHNO/NCASP	Not eligible
National Lung Cancer Audit (NLCA)	Continuous	RCP/NCASP	Participated
Bowel Cancer (NBOCAP)	Continuous	ACP/NCASP	Participated

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National Clinical Audits Priorities for NCAPOP *continued*

Audit title	Method of submission	Audit Coordinator	CHFT participation
NAPTAD: Anxiety & Depression	Continuous		Not eligible
NHS Blood & Transplant: Intra-Thoracic; Liver; Renal Transplants*	Continuous		Not eligible
NHS Blood & Transplant: potential donor audit	Continuous		Not eligible
TARN: Severe Trauma	Continuous	TARN	Participated
Hip Fracture Database	Continuous	NHF	Participated
National Thyroid Audit	Continuous	BAES	Participated
National Kidney Care Audit (2 days)	Intermittent		Participated
National Audit of Dementia	Intermittent	RCP/RCPsy	Participated
National Sentinel Stroke Audit	Intermittent	RCP	Participated
National Falls and Bone Health Audit	Intermittent	RCP	Participated
POMH: prescribing topics in mental health services	Intermittent		Not eligible
National Audit of Pain in Children with Fracture Neck of Femur 2009	Intermittent	CEM	Participated
Adult Cardiac Interventions			
Adult Cardiac Surgery: CABG and Valvular Surgery	Continuous		Not eligible
Myocardial Ischaemia (MINAP) (heart attack)	Continuous	UCLH/NCASP	Participated
National Audit of Cardiac Rehabilitation	Continuous	NCASP/CCAD	Participated
Heart Rhythm Management (pacing/implantable defibrillators)	Continuous	HRUK/NCASP	Participated
Heart Failure	Continuous	BSH/NCASP	Participated
Pulmonary Hypertension	Continuous	NCASP	Not eligible
Congenital Heart Disease: Paediatric Cardiac Surgery	Continuous	NCASP	Not eligible
Sudden Arrhythmia Death Syndrome	Continuous	NCASP	Not participated
Infarct Angioplasty	Continuous	NCASP	Not eligible
National Comparative Audit of Blood Transfusion			
Audit of the Usage of Group O RhD Negative Red Cells in Neonates & Children	Intermittent	NCABT	Registered to participate
Bedside Audit NHS	Intermittent	NCABT	Participated

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National Clinical Audits Priorities for NCAPOP *continued*

Audit title	Method of submission	Audit Coordinator	CHFT participation
BTS Respiratory Diseases			
Adult Community Acquired Pneumonia	Intermittent	BTS	Participated
NIV (Adult)	Intermittent	BTS	Participated
Adult Asthma	Intermittent	BTS	Participated
Emergency Oxygen	Intermittent	BTS	Participated
Paediatric Pneumonia	Intermittent	BTS	Not participated
2009 Pilot Pleural Procedures Audit	Intermittent	BTS	Not participated
National Paediatric Asthma Audit	Intermittent	CEM	Participated
VSSGBI			
Abdominal Aortic Aneurysm	Continuous	VSSGBI VSD	Participated
Infrainguinal Bypass	Continuous	VSSGBI VSD	Participated
Amputation	Continuous	VSSGBI VSD	Participated
Carotid Interventions (UKCIA) (preventing stroke)	Intermittent	RCP/VSSGBI	Participated

Key to Audit Coordinator abbreviations			
ACP	Association of Coloproctology of GB & Ireland	NCD	National Clinical Directors
AUGIS	Association of Upper Gastrointestinal Surgeons	NICE	National Institute for Clinical Excellence
BAHNO	British Association of Head and Neck Oncologists'	NHF	National Hip Fracture Database
BHIVA	British HIV Association	RA	Renal Association
BOA	British Orthopaedic Association	Northgate	Northgate Information Solutions
BSH	British Society for Heart Failure	RCOA	Royal College of Anaesthetists
BTS	British Thoracic Society	RCP	Royal College of Physicians
CEM	College of Emergency Medicine	RCPCH	Royal College of Paediatrics and Child Health
CCAD	Central Cardiac Audit Database	RCPsy	Royal College of Psychiatrists
CMP	Case Mix Programme	RCR	Royal College Radiologists
DOH	Department of Health	RCS	Royal College of Surgeons
Dr Foster	Dr Foster Intelligence	TARN	Trauma Audit & Research Network
HRUK	Heart Rhythm UK	UCLH	University College London Hospitals NHS Foundation Trust
NCABT	National Comparative Audit of Blood Transfusion	VSSGBI	Vascular Surgery Society of Great Britain and Ireland
NCASP	National Clinical Audit Support Programme		

Appendix A

Confidential Enquiries

Audit title	Method of submission	Audit Coordinator	CHFT participation
National Maternal & Perinatal Mortality Surveillance	Continuous	CMACE	Participated
Maternal Death Enquiry	Continuous	CMACE	Participated
Acute Kidney Injury: Adding Insult to Injury	Once	NCEPOD	Partial Participation
Death in acute Hospitals: Caring till the end	Once	NCEPOD	Partial Participation
Emergency & Elective Care in the Elderly	Once	NCEPOD	Participated
Parenteral Nutrition	Once	NCEPOD	Participated
Peri-Operative Care	Once	NCEPOD	Participated
Cosmetic Surgery	Once	NCEPOD	Not eligible
Surgery in Children	Once	NCEPOD	Participated

Key to Audit Enquiry Coordinator abbreviations	
CMACE	Centre for Maternal and Child Enquiries
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCISH	National Confidential Inquiry into Suicide and Homicide

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The national clinical audits and national confidential enquiries that CHFT participated, and for which data collection was completed during 2009/10 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.

Audit title	Running 2009/10	Audit Sample	Sample Submitted
Adult Asthma	BTS	15	100%
Adult Community Acquired Pneumonia	BTS	Min 10	Ongoing
Bowel cancer (NBOCAP)	ACP/NCASP	100%	92%
Carotid Interventions (UKCIA) (preventing stroke)	RCP/VSSGBI	100%	100%
Heart Failure	BSH/NCASP	100%	Ongoing
Heart Rhythm Management (pacing/implantable defibrillators)	HRUK/NCASP	100%	100%
Hip Fracture Database	NHF	100%	Ongoing
ICNARC CMPD: Adult Critical Care Units	CMP	100%	Ongoing
Major Complications of Airway Management in the UK (NAP4)	RCA	100%	100%
Mastectomy and Breast Reconstruction	RCS/NCASP	100%	75%
Myocardial Ischaemia (MINAP) (heart attack)	UCLH/NCASP	100%	100%
National Diabetes Inpatient Audit 2009	NCD/NCASP	100%	100%
National Elective Surgery PROMS: Four Operations	Dr Foster	100%	Ongoing
National Joint Registry (NJR)	BOA/Northgate	100%	Ongoing
National Lung Cancer Audit (NLCA)	RCP/NCASP	100%	100%
NIV (Adult)	BTS	15	Ongoing
Oesophago-Gastric (stomach) Cancer	AUGIS/NCASP	100%	13%
TARN: Severe Trauma	TARN	100%	Ongoing
Abdominal Aortic Aneurysm	VSSGBI VSD	100%	Ongoing
Infrainguinal Bypass	VSSGBI VSD	100%	Ongoing
Amputation	VSSGBI VSD	100%	Ongoing
National Diabetes Audit	NCASP	100%	100%
National Kidney Care Audit (2 days)	NCASP	100%	100%
National Sentinel Stroke Audit	RCP	40-60	Organisational Data
National Audit of Dementia	RCP/RCPsy	40	Ongoing
National Falls and Bone Health Audit (Pt survey)	RCP	60	Ongoing
National Asthma Audit	CEM	50	100%
National Audit: Management of Fracture Neck of Femur 2009	CEM	50	100%
Continence Care Audit	RCP	80	100%
Major Complications of Spinal and Epidural Anaesthesia	RCOA	100%	100%
National Thyroid Audit	BAES	100%	Ongoing
National Audit of Anaesthetic Activity - Hip Fractures	NHS networks	100%	Ongoing
National IBD Audit	NCASP	40	100%

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continued from previous page.

Audit title	Running 2009/10	Audit Sample	Sample Submitted
National Diabetic Retinopathy Screening Audit	ENDRSP	100%	100%
Audit of Management of the Open Abdomen to Investigate the Occurrence of Intestinal Fisutlae	NICE	100%	Ongoing
National Audit of Cardiac Rehabilitation	CCAD/NCASP	100%	Ongoing
National Clinical Audit Programme for HIV	BHIVA	100%	100%
National Audit of the Management of Familial Hypercholesterolaemia	RCP	Registered to participate	Ongoing
National Epilepsy 12	RCPCH	Registered to participate	Ongoing
Renal Services (vascular access; patient transport)	RA/NCASP		
Audit of the Usage of Group O RhD Negative Red Cells in Neonates & Children	NCABT	Registered to participate	Ongoing
Bedside Audit NHS	NCABT	40	100%
Emergency Oxygen	BTS	Min 1 ward	100% (11 wards)
National Liver Biopsy Audit	RCR	50	100%

Confidential Enquiries

Audit title	Running 2009/10	Audit Sample	Sample Submitted
Parenteral Nutrition	NCEPOD	100%	76%
Emergency & Elective Care in the Elderly	NCEPOD	100%	100%
Death in Acute Hospitals: Caring Till the End	NCEPOD	100%	0%
Acute Kidney Injury: Adding Insult to Injury	NCEPOD	100%	0%
Paediatric Surgery	NCEPOD	100%	Ongoing
Peri-Operative Care	NCEPOD	100%	Ongoing
National Maternal & Perinatal Mortality Surveillance	CMACE	100%	100%
Maternal Death Enquiry	CMACE	100%	100%

- A full review of participation in these national audits and confidential enquiries will be undertaken during 2010/11 to ensure that action is taken to strengthen participation.
- The reports of 9 national clinical audits were reviewed by the provider in 2009/10. An action plan is developed for each clinical audit following presentation of the recommendations at clinical governance half days. The action plan is monitored by the Clinical Governance Support Unit and reviewed on a regular basis. Implementation of these action plans will be systematically progressed during 2010/11.
- The reports of 135 local clinical audits were reviewed by the provider in 2009/10. An action plan is developed for each clinical audit following presentation and completion of the final report. The action plan is monitored by the Clinical Governance Support Unit and reviewed on a regular basis until full implementation is achieved.
- The Trust's approach to clinical audit was refreshed in 2009/10 which led to a reduction in the number of projects included in the annual programme. This was necessary to ensure that the programme reflected projects that assessed the patient experience and had the potential to improve both the quality and safety of service provision.

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- The number of patients receiving NHS services provided or sub-contracted by CHFT in 2009/10 that were recruited during that period to participate in research approved by a research ethics committee was 1127 as opposed to 792 in the previous year.
- This increasing level of 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.
- Calderdale and Huddersfield NHS Foundation Trust hosted 134 health related research studies of which 72 were clinical trials and of these 60 were supported by the National Institute for Health Research Clinical Research Networks.
- Of the 134 studies Calderdale and Huddersfield NHS Foundation Trust completed 32% as designed within the agreed time and to the agreed recruitment targets.
- Calderdale and Huddersfield NHS Foundation Trust used national systems to manage the studies in proportion to risk. Of the 48 studies given permission to start between 1st of April 2009 and 31st of March 2010:
  - 48% were studies adopted into the National Institute Health Research clinical research portfolio (13 studies through its Topic Specific Research Networks and 10 through the local specialty groups set up by the local comprehensive research network);
  - 50% were given permission by an authorised person less than 30 days from receipt of a valid application;
  - 44% were established and managed under national model agreements;
  - 12.5% used the HR Good Practice Resource Pack for Research Passports (all required letters of access, honorary contracts or research passports were issued following the HR guidance).
- In the last three years, three publications have resulted from our involvement in NIHR research, helping to improve patient outcomes and experience across the NHS.
- 0.5 % of CHFT's income in 2009/10 was conditional on achieving the improvement and innovation goals through the Commissioning for Quality and Innovation payment framework. All measures were achieved for the local CQINS Scheme through our lead commissioner NHS Kirklees.
- CHFT is required to register with the Care Quality Commission and is registered with agreed conditions (Locations)
- The Care Quality Commission has not taken any enforcement action against CHFT during 2009/10
- CHFT is subject to periodic reviews by the Care Quality Commission and the last review was on 31/03/09. The CQC's assessment of CHFT following that review was Good for Quality of Services and Excellent for Financial Management.
- CHFT intends to take the following action to address the points made in the CQC's assessment. CHFT will improve the quality of maternity HES data.
- CHFT has made the following progress by 31 March 2010 in taking such action. The action is fully completed.
- CHFT has not participated in any special reviews or investigations by the CQC during the reporting period 2009/10.
- CHFT submitted records during 2009/10 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:
  - 99.5% for admitted patient care;
  - 99.8% for out patient care; and
  - 96.3% for accident and emergency care.
- which included the patient's valid General Medical Practice Code was:
  - 100% for admitted patient care;
  - 100% for out patient care; and
  - 93.6% for accident and emergency care.

- CHFT score for 2009/10 for Information Quality and Records Management, assessed using the Information Governance Toolkit was 83%
- CHFT was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were:
  - Primary Diagnosis Overall 10.7%
  - Primary Procedures Overall 16.8%
  - Secondary Diagnosis Overall 15.4%
  - Secondary Procedures Overall 7.3%
- Please note that the results should not be extrapolated further than the actual sample audited. Areas audited: General Medicine, Gastroenterology, Orthopaedics Trauma, Non-transient or cerebrovascular accident, nervous system infections or Encephalopathy.

Calderdale and Huddersfield NHS
NHS Foundation Trust

accounts
for the 12 month period ended 31st march 2010




Your Care Our Concern

Pride • Patients • People • Partnerships

Accounts

National Health Service Act 2006

Monitor, the Independent Regulator of NHS Foundation Trusts, with the approval of HM Treasury, in exercise of powers conferred on it by paragraph 25(1) of Schedule 7 of the National Health Service Act 2006, 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 31March; 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 2009/10' (FT ARM) as agreed with HM Treasury, 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 Statement on Internal Control shall be signed and dated by the chief executive of the NHS foundation trust.

3. Statement of accounting officer's responsibilities

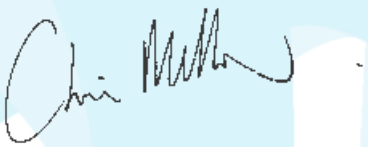
(1) The statement of accounting officer's responsibilities in respect of the accounts shall be signed and dated by the chief executive of the NHS foundation trust.

4. Approval on behalf of HM Treasury

(1) These directions have been approved on behalf of HM Treasury.

Signed by the authority of Monitor, the Independent Regulator of NHS foundation trusts

Signed:



Name: **Chris Mellor** (Acting Chairman)
Date: 7th April 2010

Statement of the Chief Executive's responsibilities as the accounting officer of Calderdale and Huddersfield NHS Foundation Trust

The National Health Service Act 2006 ("the 2006 Act") 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 accounting officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the 2006 Act, Monitor has directed the 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 affairs of Calderdale & Huddersfield NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

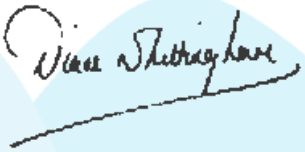
In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- 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
- 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 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:



Name: **Diane Whittingham** (Chief Executive)
Date: 3rd June 2010

Statement of directors' responsibility in respect of internal control

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 2010 and up to the date of approval of the annual report and accounts.

Compliance with NHS Pension Scheme regulations

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.

Capacity to handle risk

As Chief Executive, I recognise that committed leadership in the area of 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 our Terms of Authorisation as a Foundation Trust.

As accounting officer, I have responsibility for risk management within the Trust. I have delegated responsibility for key categories of risk:

Financial risk:
Executive Director of Finance

Clinical risk:
Executive Director of Nursing/Medical Director

Organisational risk:
Executive Director of Nursing

Non-Executive Directors play an active role in the Trust's Risk Management and Assurance processes and participate in the following Committees, both of which report to the Trust Board:

Patient Safety Committee

Audit 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 and Women's services
- Medicine and Elderly
- Surgery and Anaesthetics
- Diagnostic and Therapeutic Services

Corporate functions, including the Risk Management Team, provide the operating frameworks and advice and support to the Clinical Divisions.

This operational management framework is the primary mechanism by which the Trust achieves its business, financial and service objectives and mitigates risks to achieving them.

The Trust's focus is on clinically led services with clinicians taking the lead role in the management of the organisation

Decision-making is devolved to Managers at all levels with clear responsibilities and accountabilities. The Executive Team and Executive Board are responsible for managing performance by a system of management checks and controls, with additional assurance on the effectiveness of the system of internal control being provided to the Executive Board by the Risk Compliance and Assurance Committee. This Committee is responsible for monitoring the Compliance Register, Risk Register, Assurance Framework and performance against national standards.

Additional assurance on the effectiveness of the systems for ensuring clinical quality is given to the Board of Directors by the Patient Safety Committee. Independent assurance on the effectiveness of the system of internal control and overall governance arrangements is provided by the Audit Committee.

In addition to this, I recognise that 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 in place 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.

Learning from good practice, and from untoward incidents, is seen as an important mechanism for continuously improving risk management systems.

The Trust continues to apply the improvement methodologies promoted by the Institute for Healthcare Improvement and the Health Foundation to help us further develop our risk and safety culture.

We also rigorously apply national guidance including the recommendations from Investigations and Enquiries.

Risk is considered to be an integral part of the Trust's Organisational Development and training strategy and is included in key training programmes.

The risk and control framework

Risk Management is an integral part of the Board of Directors' System of Internal Control. The delivery of the Trust's objectives is always surrounded by a degree of uncertainty, which poses threats to both success and opportunities for increasing success. Risk is defined as this uncertainty of outcome. The risk has to be assessed in respect of the likelihood of something happening, and consequence which arises if it does actually happen. Risk management involves identifying and assessing these inherent risks and responding to them.

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 eg: civil contingencies and our response to these, is to have tested contingency/ business continuity plans. Risk management 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.

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. Directorates hold a Risk Register which includes ward/department risks scoring 8 or above, along with any business risks facing the Directorate. Divisional risk registers consolidate directorate risks scoring 8 or above and any additional business risks to the division. Divisional risk 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.

Risk is considered to be an integral part of the Trust's Organisational Development and training strategy

In addition, the Compliance and Assurance Committee monitors the Compliance Register, Risk Register, Assurance Framework and performance against national risk and safety standards on my behalf. Assurance is also provided by the governance system which includes the Patient Safety Committee, Audit Committee, and Internal and External Audit.

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.

The Trust uses the Connecting for Health Information governance toolkit framework to assist in the identification of risk and weakness in relation to information risks of its information assets including the systems and media used in processing and storing of information. The existing risk management framework is used for the process of risk 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) who is also the Director of Health Informatics, supported by information asset owners, is responsible for the information risk programme within the Trust.

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 are encrypted. Additionally, removable media used to transfer confidential information must be encrypted, in line with the Trusts 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.

More widely, the Information Governance Toolkit work programme is led and monitored by the Trusts Information Governance and Records Management Group, chaired by the Caldicott Guardian, who is also the Medical Director. Specific information governance expertise is fed into the group including Confidentiality and information security expertise which is provided at an operational level by The Health Informatics Service.

Confidentiality and information security awareness training is provided to all staff within the organisation via the Trusts Induction Programme and ongoing mandatory training sessions. Learning in relation to incidents and risks are fed into this training.

Progress with Information Governance compliance is measured on a yearly basis through the Trusts self assessment against the Connecting for Health Information Governance Toolkit which in 2009/10 includes acceptance of the Information Governance Assurance Statement which contains additional terms and conditions applicable to all organisations using NHS Connecting for Health services such as N3.

Capacity to handle risk

Risk	Mitigating actions	Outcome measures
HCAIs are a major cause of harm and are of concern both to the Board and to our patients and public. Reducing their incidence is both a national and local priority in delivering our strategic intent of safe, personal and effective care. The Trust has a significantly reduced trajectory for numbers of MRSA and C Difficile in 10/11 as compared to 09/10 making it more difficult to achieve compliance.	The Trust has an Infection Control Board where MRSA and C Difficile levels are monitored and improvement work identified and progress monitored. This accounts to the Board of Directors who review the information monthly to assure themselves that levels are reducing in line with our targets.	2010/11 Compliance with targets MRSA 6 CDiff 151 2011/12 Compliance with targets 2011/13 Compliance with targets

continued from previous page.

Risk	Mitigating actions	Outcome measures
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.	The Trust has undertaken downside scenario planning during the year and has set out to the Board of Directors the available options. These include generating additional efficiency savings, reducing the levels of surplus planned for and additional prioritisation of capital expenditure In addition, the three-year financial plans submitted for 2010/11 onwards are based on a cautious but realistic assessment of the likely financial challenges via national tariff changes. Further scenario analysis has been undertaken to further 'stress-test' the financial projections. There has been Board, senior manager and clinician involvement in plans from the outset of financial planning to ensure full engagement. Plans have been developed as part of the overall Quality Improvement Strategy programme, seeking to protect and improve clinical quality whilst reducing costs. There is robust performance management of the schemes through the monthly Divisional Finance & Performance meetings.	The Foundation Trust maintains financial balance.
Inability to migrate PCT provider services by the March 2011 deadline. Financial risk associated with the transfer of services if they are not adequately resourced.	Overall transformation board with local CEO and executive director membership has been established to produce a shared agenda between organisations. Transforming community services board established with key membership from all local partners to oversee the integration of provider services. Individual work stream established to conduct the transactional elements of work required to deliver the transformation agenda this will include areas such as HR, estates, contracting, finance, due diligence and IM&T.	Transformation board established and key priorities agreed - 2010/11 Transforming community services board established as well as all transactional work streams - 2010/11 Full business case development and approval by board, due diligence exercise completed - 2010/11 Staff and service transfer - 2011/12. Pathway transformation work 2010/11- 2012/13

continued from previous page.

Risk	Mitigating actions	Outcome measures
Quality improvement collaboratives do not deliver change at the pace required to improve quality, and ensure compliance with local and national indicators.	There is a clear action plan for achieving the quality goals, with designated leads and timeframes. There are clear roles and accountabilities in relation to quality governance. Responsibilities are cascaded from Board to ward to Board. Quality performance is discussed in detail by the Quality Assurance Board, a Board sub-committee, so that early warning signs of risks to quality are detected, and mitigating actions introduced	2010/11: All national and local performance indicators are met. Patient satisfaction is improved in accordance with our Quality Strategy. CQC registration is maintained. We deliver what is required under our contract with our Commissioners Ongoing authorisation by Monitor. 2011/12: All national and local performance indicators are met. Patient satisfaction is improved in accordance with our Quality Strategy. CQC registration is maintained. We deliver what is required under our contract with our Commissioners Ongoing authorisation by Monitor 2012/13: All national and local performance indicators are met. Patient satisfaction is improved in accordance with our Quality Strategy. CQC registration is maintained. We deliver what is required under our contract with our Commissioners Ongoing authorisation by Monitor.
Trust services not future proofed to deal with changes in local demographics resulting in inability to cater for the needs of our patients.	Work closely with PCT public health teams to predict growth areas and develop service plans to address areas of concern and health inequalities. Internal business planning to identify areas for future investment so that workforce, staffing and estates are in place to deal with demographic changes. CHFT clinical strategy for the next 10 years developed.	Services which are fit for the future. Clinical services which help address health inequalities. Transformed patient pathways resulting in increased focus on prevention, health and well being agenda.

The Annual Plan which details the risks and mitigating actions is shared with the Membership Council. Individual risk issues and preventative actions e.g. infection are promoted, on the website, in publications for the membership, local media and "Medicine for Members" events.

Core Standards for Better Health

The Foundation Trust is fully compliant with the core Standards for Better Health.

Environment

The Foundation 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.

Equality, diversity and human rights legislation

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 has developed a comprehensive equality impact assessment [EqIA] framework which covers both policy and service delivery. Completed impact assessments and action plans will be published and reviewed regularly.

Review of economy, efficiency and effectiveness of the use of resources

The Trust ensures the economic, efficient and effective use of resources through a variety of measures including the adoption of a robust budgetary control system, the consistent application of internal financial controls and effective procurement and tendering procedures.

The Trust received an 'excellent' rating for 2008/09 for its 'Use of Resources' from the Healthcare Commission (whose functions are now undertaken by the Care Quality Commission). This rating is based on the assessment of financial risk undertaken by Monitor.

As a result of the national Payment by Results tariff uplift for 2009/10, the Trust faced a challenging cash releasing efficiency target. 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 monthly performance report to the Board of Directors includes an update on performance against the efficiency target. In addition Directors are able to review performance in more detail at the monthly Finance Briefing meetings.

Following the successful reconfiguration of services in the Surgical Division and the Children's & Women's Services Division, the Trust has commissioned some external consultancy support to assist the Trust in developing a strategy for service reconfiguration within the Medicine & Elderly Division. In addition, the Medicine & Elderly Division in 2009/10 have implemented action plans designed to reduce average lengths of inpatient stays in line with better clinical practice and bed utilisation.

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.

During the year, the Trust continued the roll-out of Service Line Reporting throughout the organisation, in order to support the drive for efficiency and effectiveness within the Divisions. The Project Board for Service Line Reporting was chaired by the Divisional Director for Surgery and Anaesthetics and has two Executive Directors on the Board.

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, and 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 board, the audit committee and governance sub-committees 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. Underpinning the Assurance Framework, is the Trust Risk Register which includes strategic risks identified by the Executive Team and the most significant operational risks identified by our Clinical and Corporate Divisions.

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 it's 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 Statement on Internal Control.

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 Patient Safety Committee is chaired by the Medical Director and receives regular reports from Divisions, specialist committees e.g. Medicines Management and specialist functions e.g. control of infection. It considers action plans prepared in response to serious incidents and national enquiries, and monitors their implementation.

The Compliance and Assurance Committee, chaired by the Associate Director - Risk Management, receives regular reports from specialist committees and functions e.g. health and safety and considers risk registers and the Trust's compliance with national risk and safety standards.

A Non-Executive Director chairs the Audit 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 Trust 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 Standards for Better Health, clinical governance and corporate governance.

The Compliance and Assurance Committee provides additional assurance to Executive Managers regarding the effectiveness of the system of internal control.

Conclusion

There have been no significant internal control issues identified during the year.

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 of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

In September 2009 we published our Quality Improvement Strategy 'Your Care Our Concern, Safe, Effective, Personal'. We set ourselves challenging goals, not only to meet all externally driven targets and standards but to exceed them. The strategy extends to all parts of the organisation and covers the 3 critical domains of safety, effectiveness and patient experience. It puts quality improvement at the heart of the Board of Director's agenda, using patient stories to bring it to life and clear measures that demonstrate how good our care is, whether it's getting better and how close we are to becoming the best in class.

As a Foundation Trust we are building our new strategy on firm foundations - strong clinical leadership and engagement, firm board leadership, a proactive Membership Council and a movement of passionate people amongst our staff and our membership.

The Quality Improvement Strategy is overseen by a Quality Improvement Board, reporting to the Executive Board, chaired by the Medical Director, supported by the Director of Organisational Development, working as the Quality Co-ordinator and supported by the Associate Medical Director as Quality Improvement Fellow and the leads for the Safety, Effectiveness and Patient Experience programmes.

The Safety, Effectiveness and Patient Experience Programmes have an underpinning project structure taking the form of Improvement Collaboratives. Each strand of the programme has an Executive Sponsor, a Programme Director and a Clinical Champion.

Whilst the lead for improving safety and effectiveness lies with the Medical Director and the responsibility for improving patient experience lies with the Director of Nursing, all members of the Executive Team play key roles in championing Service Improvement, supporting the cost/quality dimension and enabling the workforce capacity and capability. However, the key owners and drivers are the Clinical Divisions, setting priorities and empowering the clinical teams to drive the quality improvement agenda.

The priorities for 2010/11 in the Quality Report were selected by:

- Alignment with the Trust's 4 year Quality Improvement Strategy, which was endorsed by the Board in September 2009.

We set ourselves challenging goals, not only to meet all externally driven targets and standards but to exceed them

- Alignment with National, Regional and Local CQUINs.
- Alignment with known priorities from the local health Quality Board economy, issues raised by PALs and Complaints and by local LINks. These were tested with the Membership Council at a workshop on 16 March 2010 and with the Executive Team and Divisional Managers.

Alignment with the Trust's core business and objectives provides the Board of Directors with assurance that the report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data.

The Trust has an Information Quality Policy which sets the strategic approach to the delivery and assurance of data quality within the Trust. These policies are supported as required by protocols and guidance notes which describe the data collection and validation arrangements for specific aspects of the Trust's activities. All aspects of these policies and protocols may be selected for inclusion in a rolling programme of data quality audits, or be subject to an ad-hoc audit.

We have in place systems and processes which secure the quality of data underpinning the Quality Report as part of its normal business activity. An audit working group comprising divisional information and data quality members of The Health Informatics Service organises and conducts a rolling programme of data quality audits. These audits reflect areas where data quality issues have previously been identified and areas which the clinical divisions identify as being critical to their business and service improvement plans.

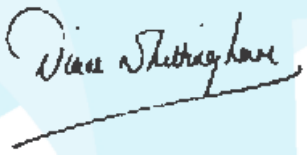
In line with the Trust's management arrangements, the operational responsibility for data quality is devolved to its clinical divisions and directorates. These are supported by a dedicated Data Quality Team within The Health Informatics Service, providing specialist advice and support. Each quality improvement collaborative has analyst support from the Health Informatics Team.

We have in place arrangements that are focused on ensuring that data supporting reported Quality Information is actively used in the decision making process, and is subject to a system of internal control and validation. The Health Informatics Service provides divisional, corporate and clinical information responsibility to maintain They provide information to corporate and divisional clinicians and managers which meet business and service improvement information needs.

Review of effectiveness

The Board of directors has been actively engaged in the development of the Quality Improvement Strategy, which has informed the Quality Report, and the Executive Management team has identified the priorities in the Quality Report. The Quality Improvement Board, provides assurance to the Executive Board that progress is being made against quality indicators, and that data is reliable.

Signed:



Name: **Diane Whittingham** (Chief Executive)
Date: 3rd June 2010

As a Foundation Trust we are building our new strategy on firm foundations

Independent auditor's report to the Membership Council of Calderdale and Huddersfield NHS Foundation Trust

I have audited the financial statements of Calderdale and Huddersfield NHS Foundation Trust for the year ended 31 March 2010 under the National Health Service Act 2006. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. These financial statements have been prepared under the accounting policies set out within them.

I have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers and related narrative notes at Note 4.3 of the financial statements; and
- the table of pension benefits of senior managers and related narrative notes at Note 4.3 of the financial statements.

This report is made solely to the Membership Council of Calderdale and Huddersfield NHS Foundation Trust as a body in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. My work was undertaken so that I might state to the Membership Council those matters I am required to state to it in an auditor's report and for no other purpose. In those circumstances, to the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Foundation Trust as a body, for my audit work, for the audit report or for the opinions I form.

Respective responsibilities of the Accounting Officer and auditor

The Accounting Officer's responsibilities for preparing the financial statements in accordance with directions made by the Independent Regulator of NHS Foundation Trusts (Monitor) are set out in the Statement of Accounting Officer's Responsibilities.

My responsibility is to audit the financial statements in accordance with statute, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland).

I report to you my opinion as to whether the financial statements give a true and fair view in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. I report whether the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. I also report to you whether, in my opinion, the information which comprises the commentary on the financial performance included within the Directors' Report, included in the Annual Report, is consistent with the financial statements.

I review whether the Accounting Officer's Statement on Internal Control reflects compliance with the requirements of Monitor contained in the NHS Foundation Trust Annual Reporting Manual 2009/10. I report if it does not meet the requirements specified by Monitor or if the statement is misleading or inconsistent with other information I am aware of from my audit of the financial statements. I am not required to consider, nor have I considered, whether the Accounting Officer's statement on internal control covers all risks and controls. Neither am I required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures.

I read the other information contained in the Annual Report and consider whether it is consistent with the audited financial statements. This other information comprises the Chair's Statement, the Chief Executive's Statement, Some Highlights, Directors' Report, the sections on Membership and Membership Council, the Board of Directors and the un-audited part of the Remuneration Report. I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with the financial statements. My responsibilities do not extend to any other information.

Basis of audit opinion

I conducted my audit in accordance with the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor, which requires compliance with International Standards on Auditing (United Kingdom and Ireland) issued by the Auditing Practices Board. An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements and the part of the Remuneration Report to be audited. It also includes an assessment of the significant estimates and judgments made by the directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

I planned and performed my audit so as to obtain all the information and explanations which I considered necessary in order to provide me with sufficient evidence to give reasonable assurance that:

- the financial statements are free from material misstatement, whether caused by or other irregularity or error; and
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared.

In forming my opinion I also evaluated the overall adequacy of the presentation of information in the financial statements and the part of the Remuneration Report to be audited.

Opinion

In my opinion:

- the financial statements give a true and fair view of the state of affairs of Calderdale and Huddersfield NHS Foundation Trust as at 31 March 2010 and of its income and expenditure for the year then ended in accordance with the accounting policies adopted by the Trust;
- the financial statements and the part of the Remuneration Report to be audited has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and
- information which comprises the commentary on the financial performance included within the Directors' Report, included in the annual report, is consistent with the financial statements.

Certificate

I certify that I have completed the audit of the accounts in accordance with the requirements of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Name: **John Prentice** (Engagement Lead)
Date: 3rd June 2010

(Officer of the Audit Commission),
3 Leeds City Office Park,
Holbeck,
Leeds,
West Yorkshire,
LS11 5BD.

Statement of comprehensive income for the period ended 31st March 2010

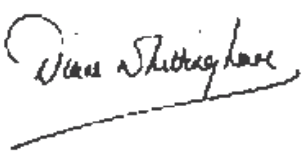
	Note	2009/10	2008/09
		£000	£000
Operating Income	3	309,228	290,922
Operating Expenses	4	(310,920)	(291,604)
OPERATING SURPLUS/(DEFICIT)		(1,692)	(682)
FINANCE COSTS			
Finance income	7	188	887
Finance expense - financial liabilities	8	(9,866)	(9,894)
Finance expense - unwinding of discount on provisions		(69)	(69)
PDC Dividends payable		(4,328)	(5,770)
NET FINANCE COSTS		(14,075)	(14,846)
Share of Profit/(Loss) of Associates/Joint Ventures accounted for using the equity method		0	0
Corporation tax expense		0	0
Surplus/(Deficit) from continuing operations		(15,767)	(15,528)
Surplus/(deficit) of discontinued operations and the gain/(loss) on disposal of discontinued operations	28	0	0
SURPLUS/(DEFICIT) FOR THE YEAR		(15,767)	(15,528)
Other comprehensive income			
Share of comprehensive income from associates and joint ventures		0	0
Revaluation gains/(losses) and impairment losses on intangible assets		0	0
Revaluation gains/(losses) and impairment losses property, plant and equipment		(8,881)	(76,970)
Revaluation gains/(losses) and impairment losses arising from classifying non current assets as Assets Held for Sale		0	0
Fair Value gains/(losses) on Available-for-sale financial investments		0	0
Recycling gains/(losses) on Available-for-sale financial investments		0	0
Increase in the donated asset reserve due to receipt of donated assets		244	437
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets		(333)	(181)
Additions/(reduction) in "Other reserves"		0	0
Other recognised gains and losses		0	0
Actuarial gains/(losses) on defined benefit pension schemes		0	0
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR		(24,737)	(92,242)
Note: Allocation of Profits/(Losses) for the period:		2009/10	2008/09
		£000	£000
(a) Surplus/(Deficit) for the period attributable to:			
(i) minority interest, and		0	0
(ii) owners of the parent.		(15,767)	(15,528)
TOTAL		(15,767)	(15,528)
(b) total comprehensive income/(expense) for the period attributable to:			
(i) minority interest, and		0	0
(ii) owners of the parent.		(24,737)	(92,242)
TOTAL		(24,737)	(92,242)

All income and expenses shown relate to continuing operations.
The notes on the following pages form part of these Accounts.

*Operating expenses for 2009/10 and 2008/09 include exceptional costs relating to fixed asset impairments of £19,596,000 and £16,530,000 respectively. Further details are contained in note 3.1.2. The surplus for 2009/10 excluding these non-cash costs is £3,829,000.

Statement of financial position

	Note	31 Mar 2010	31 Mar 2009	1 Apr 2008
		£000	£000	£000
Non-current assets				
Intangible assets	9.1	281	252	148
Property, plant and equipment	10.1	217,912	243,751	337,893
Investment Property		0	0	0
Investments in associates (and joined controlled operations)		0	0	0
Trade and other receivables	12	1,722	1,150	1,600
Other Financial assets		0	0	0
Other assets		0	0	0
Total non-current assets		219,915	245,153	339,641
Current assets				
Inventories	11	4,699	4,487	4,330
Trade and other receivables	12	13,361	13,023	12,131
Other financial assets		0	0	0
Tax receivable		0	0	0
Non-current assets for sale and assets in disposal groups		0	0	0
Cash and cash equivalents	19	18,237	19,079	11,047
Total current assets		36,297	36,589	27,508
Current liabilities				
Trade and other payables	13	(19,228)	(19,682)	(18,214)
Borrowings	15	(2,155)	(1,715)	(1,356)
Other financial liabilities		0	0	0
Provisions	18	(448)	(490)	(657)
Tax payable		(4,020)	(3,772)	(173)
Other liabilities	13	(1,497)	(1,186)	(1,902)
Liabilities in disposal groups		0	0	0
Total current liabilities		(27,348)	(26,845)	(22,302)
Total assets less current liabilities		228,864	254,897	344,847
Non-current liabilities				
Trade and other payables	13	(633)	(754)	(730)
Borrowings	15	(92,299)	(93,299)	(90,704)
Other financial liabilities		0	0	0
Provisions	18	(2,562)	(2,640)	(2,863)
Tax payable		0	0	0
Other liabilities	14	(1,933)	(2,030)	(2,134)
Total non-current liabilities		(97,427)	(98,723)	(96,431)
Total assets employed		131,437	156,174	248,416
Minority Interest		0	0	0
Public Dividend Capital		111,899	111,899	111,899
Revaluation reserve		46,059	55,247	132,881
Donated Asset Reserve		1,543	1,632	1,376
Available for sale investments reserve		0	0	0
Other reserves		0	0	0
Merger reserve		0	0	0
Income and expenditure reserve		(28,064)	(12,604)	2,260
Total taxpayers' equity		131,437	156,174	248,416

Signed: 

Name: **Diane Whittingham** (Chief Executive)
Date: 3rd June 2010

Statement of changes in taxpayers' equity

	Total	Public Dividend Capital	Revaluation Reserve	Donated Assets Reserve	Income and Expenditure Reserve
	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2009	156,174	111,899	55,247	1,632	(12,604)
Surplus/(deficit) for the year	(15,767)	0	0	0	(15,767)
Revaluation gains/(losses) and impairment losses on intangible assets	0	0	0	0	0
Revaluation gains/(losses) and impairment losses property, plant and equipment	(8,881)	0	(8,881)	0	0
Increase in the donated asset reserve due to receipt of donated assets	244	0	0	244	0
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets	(333)	0	0	(333)	0
Transfers to the income and expenditure account in respect of assets disposed of	0	0	(96)	0	96
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	0	0	(211)	0	211
Public Dividend Capital received	0	0	0	0	0
Public Dividend Capital repaid	0	0	0	0	0
Public Dividend Capital repayable (creditor)	0	0	0	0	0
Public Dividend Capital written off	0	0	0	0	0
Other transfers between reserves	0	0	0	0	0
Movements on other reserves	0	0	0	0	0
Taxpayers' Equity at 31 March 2010	131,437	111,899	46,059	1,543	(28,064)
Taxpayers' Equity at 1 April 2008	248,416	111,899	132,881	1,376	2,260
Surplus/(deficit) for the year	(15,528)	0	0	0	(15,528)
Revaluation gains/(losses) and impairment losses on intangible assets	0	0	0	0	0
Revaluation gains/(losses) and impairment losses property, plant and equipment	(76,970)	0	(76,970)	0	0
Increase in the donated asset reserve due to receipt of donated assets	437	0	0	437	0
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets	(181)	0	0	(181)	0
Transfers to the income and expenditure account in respect of assets disposed of	0	0	0	0	0
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve	0	0	(664)	0	664
Public Dividend Capital received	0	0	0	0	0
Public Dividend Capital repaid	0	0	0	0	0
Public Dividend Capital repayable (creditor)	0	0	0	0	0
Public Dividend Capital written off	0	0	0	0	0
Other transfers between reserves	0	0	0	0	0
Movements on other reserves	0	0	0	0	0
Taxpayers' Equity at 31 March 2009	156,174	111,899	55,247	1,632	(12,604)

Statement of cash flows

	2009/10	2008/09
	£000	£000
Cash flows from operating activities		
Operating surplus/(deficit) from continuing operations	(1,692)	(682)
Operating surplus/(deficit)	(1,692)	(682)
Non-cash income and expense:		
Depreciation and amortisation	9,616	11,960
Impairments	19,596	16,530
Transfer from the donated asset reserve	(318)	(182)
(Increase)/Decrease in Trade and Other Receivables	(910)	(442)
(Increase)/Decrease in Inventories	(212)	(157)
Increase/(Decrease) in Trade and Other Payables	(1,326)	1,790
Increase/(Decrease) in Other Liabilities	214	(823)
Increase/(Decrease) in Provisions	(120)	(390)
Tax (paid)/received	248	3,599
Other movements in operating cash flows	295	70
NET CASH GENERATED FROM/(USED IN) OPERATIONS	25,391	31,273
Cash flows from investing activities		
Interest received	188	887
Purchase of intangible assets	(99)	(145)
Sales of intangible assets	0	0
Purchase of Property, Plant and Equipment	(12,029)	(11,197)
Sales of Property, Plant and Equipment	461	0
Net cash generated from/(used in) investing activities	(11,479)	(10,455)
Cash flows from financing activities		
Public dividend capital received	0	0
Public dividend capital repaid	0	0
Loans received	1,200	4,300
Loans repaid	(281)	0
Capital element of finance lease rental payments	0	0
Capital element of Private Finance Initiative Obligations	(1,468)	(1,353)
Interest paid	(189)	(270)
Interest element of finance lease	0	0
Interest element of Private Finance Initiative obligations	(9,536)	(9,693)
PDC Dividend paid	(4,480)	(5,770)
Net cash generated from/(used in) financing activities	(14,754)	(12,786)
Increase/(decrease) in cash and cash equivalents	(842)	8,032
Cash and Cash equivalents at 1 April	19,079	11,047
Cash and Cash equivalents at 31 March	18,237	19,079

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 2009/10 NHS Foundation Trust Annual Reporting Manual 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.

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 have been calculated using estimation techniques.

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 Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions web site: www.nhsbsa.nhs.uk/pensions

The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2010, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2010 with summary global member and accounting data.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.

c) Scheme provisions

In 2008-09 the NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

Annual Pensions

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and on the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Pensions Indexation

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Lump Sum Allowance

A lump sum is payable on retirement which is normally three times the annual pension payment.

Ill-Health Retirement

Early payment of a pension, with enhancement in certain circumstances, is available to members of the Scheme who are permanently incapable of fulfilling their duties or regular employment effectively through illness or infirmity.

Death Benefits

A death gratuity of twice their final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

Additional Voluntary Contributions (AVCs)

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Transfer between Funds

Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

Preserved Benefits

Where a scheme member ceases NHS employment with more than two years service they can preserve their accrued NHS pension for payment when they reach retirement age.

Compensation for Early Retirement

Where a member of the Scheme is made redundant they may be entitled to early receipt of their pension plus enhancement, at the employer's cost.

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.

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.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual.

An additional interim valuation was undertaken on 31 March 2009 to bring the valuation methodology for specialised operational property in line with HM Treasury requirements and to reflect changes in property values. HM Treasury has adopted a standard approach to 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.
HM Treasury has agreed that NHS Foundation Trusts must apply these new valuation requirements between 1 April 2008 and 1 April 2010. The move to a Modern Equivalent Asset Valuation by the Trust was undertaken on 31 March 2009.

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.

A full revaluation was undertaken of all property assets on 31 March 2010.

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 will be 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

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where a component of an assest 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.

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 are not depreciated until the asset is brought into use.

Equipment is depreciated evenly over its estimated life, as follows:

- Engineering plant and equipment
  5-15 years
- Vehicles
  7 years
- Office equipment, furniture and soft furnishings
  5-10 years
- Medical and other equipment
  5-15 years
- IT equipment
  5-8 years
- Buildings
  15-80 years

Revaluation and impairment

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income.

Decreases in asset values and impairments 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'.

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 and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. 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 fixed assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the income and expenditure account. Similarly, any impairment on donated assets charged to the income and expenditure account is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the Income and Expenditure Reserve.

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 '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 finance cost is calculated using the implicit interest rate for the scheme.

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).

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.

Subsequently intangible assets are measured at fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments 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'.

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.

Government grants

Government grants are grants from Government bodies other than income from 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. Where the grant is used to fund capital expenditure the grant is held as deferred income and released to operating income over the life of the asset in a manner consistent with the depreciation charge for that asset.

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 and weighted average method.

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: current investments, cash and cash equivalents, NHS debtors, accrued income and 'other debtors'.

Loans and receivables are recognised initially at fair value, net of transactions 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.

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 implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

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. Leased land is treated as an operating lease.

Provisions

The NHS Foundation Trust provides for legal or constructive obligations that are of uncertain timing or amount at the statement of financial position date on the basis of the best estimate of the expenditure 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 HM Treasury's discount rate of 2.2% in real terms.

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 22 .

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.

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 26 where an inflow of economic benefits is probable.

- Contingent liabilities are not recognised, but are disclosed in note 26, 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.

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 forecast 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 donated assets and cash held with the Office of the Paymaster General/ Government Banking Service. Average relevant net assets are calculated as a simple means of opening and closing relevant net assets.

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.

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.

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; and
- 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.

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.

2. Segmental Analysis

Segmental analysis of the Accounts is not required for the Trust as the totality of its operations relate to healthcare.

3. Operating income

3.1. Operating income - by classification

	2009/10	2008/09
	£000	£000
Acute Trusts		
Elective income	49,061	43,581
Non elective income	88,992	84,845
Outpatient income*	29,378	37,097
A&E income	10,633	10,700
Other NHS clinical income	89,499	72,402
Private patient income	442	271
Other non-protected clinical income	3,836	4,436
Total income from activities	271,841	253,332
Other operating income		
Research and development	498	471
Education and training	7,543	6,966
Charitable and other contributions to expenditure	428	667
Transfer from donated asset reserve in respect of depreciation on donated assets	319	182
Non-patient care services to other bodies	9,185	9,116
Other	19,414	20,188
Total other operating income	37,387	37,590
TOTAL OPERATING INCOME	309,228	290,922

*The move in Acute Trust Outpatient Income from 2008/09 to 2009/10 includes a move of c£10m from Outpatient income to Other NHS clinical income. This relates to Outpatient Procedures being chargeable under a non-mandatory tariff in 2009/10.

3.2. Private patient income

	2009/10	2009/10	Base Year
	£000	£000	£000
Private patient income	442	271	635
Total patient related income	271,841	253,332	174,934
Proportion (as percentage)	0.16%	0.11%	0.36%

Section 44 of the National Health Service Act 2006 requires that the proportion of private patient income to the total patient related income of NHS Foundation should not exceed its proportion whilst the body was an NHS Trust in 2002/03. The proportion in 2002/03 was 0.4%. The above note shows that the Trust was compliant for 2009/10.

3.3. Operating lease income

	2009/10	2008/09
	£000	£000
Operating Lease Income		
Rents recognised as income in the period	27	27
Contingent rents recognised as income in the period	6	6
TOTAL	33	33
Future minimum lease payments due		
- not later than one year;	27	31
- later than one year and not later than five years;	16	43
- later than five years.	36	39
TOTAL	79	113

3.4. Operating income by type

	2009/10	2008/09
	£000	£000
Income from activities		
NHS Foundation Trusts	0	0
NHS Trusts	318	339
Strategic Health Authorities	63	161
Primary Care Trusts	267,155	236,796
Local Authorities	453	432
Department of Health - other *	27	11,329
Non NHS: Private patients	442	271
Non-NHS: Overseas patients (non-reciprocal)	0	2
NHS injury scheme (was RTA)	1,391	1,577
Non NHS: Other	1,992	2,425
Total income from activities	271,841	253,332
Other operating income		
Research and development	498	471
Education and training	7,543	6,966
Charitable and other contributions to expenditure	428	667
Transfer from donated asset reserve in respect of depreciation on donated assets	319	182
Non-patient care services to other bodies	9,185	9,116
Other **	19,414	20,188
Total other operating income	37,387	37,590
TOTAL OPERATING INCOME	309,228	290,922

*In 2008/09 the Trust received a payment for the Market Forces Factor adjustment directly from the Department of Health. In 2009/10 this payment came from Primary Care Trusts.

**Other Operating income includes £8.3m estates recharges, £3.4m pharmacy sales and £1.3m catering income.

4. Operating expenses

4.1. Operating expenses by type

	2009/10	2008/09
	£000	£000
Services from NHS Foundation Trusts	155	110
Services from NHS Trusts	1,511	1,774
Services from other NHS Bodies	79	57
Purchase of healthcare from non NHS bodies	1,142	1,929
Employee Expenses - Executive directors	874	948
Employee Expenses - Non-executive directors	138	128
Employee Expenses - Staff	196,944	183,858
Drug costs	17,343	15,681
Supplies and services - clinical (excluding drug costs)	23,513	21,891
Supplies and services - general	3,687	3,377
Establishment	4,477	5,144
Transport	2,334	2,386
Premises	20,278	20,378
Increase/(decrease) in bad debt provision	(129)	38
Depreciation on property, plant and equipment	9,546	11,919
Amortisation on intangible assets	70	41
Impairments of property, plant and equipment	19,596	16,530
Audit services - statutory audit	49	48
Audit services - other services	11	8
Clinical negligence	6,152	3,324
Loss on disposal of land and buildings	60	0
Loss on disposal of other property, plant and equipment	304	70
Other	2,786	1,965
TOTAL	310,920	291,604

Any disposals in 2009/10 or 2008/09 relate to assets which are not "protected" (as defined by Monitor's guidance on protected assets).

4.2. Impairments of Property, Plant and Equipment

The Trust undertook a full revaluation of its property assets at 31 March 2010 in line with its accounting policies. This valuation reflected the continued decrease in property assets seen in 2009/10 (particularly on larger sites) as well as the impact of some blocks at the St. Luke's Hospital site in Huddersfield becoming non-operational. The reduction in asset values leads to an impairment charge which is offset against the revaluation reserve to the extent that there are positive reserve balances for that site; any further impairment is charged to the Statement of Comprehensive Income (SoCI). In 2009/10 this charge to the SoCI equated in total to £19,596,000.

The Trust also undertook an interim revaluation of its property assets at 31 March 2009 as a result of the decrease in property prices in 2008/09 which also coincided with a change to the Modern Equivalent Asset valuation methodology. As in 2009/10, some blocks on the St. Luke's Hospital site become non-operational. The charge to the Statement of Comprehensive Income in 2008/09 was £16,530,000.

4.3. Arrangements containing an operating lease

	2009/10	2008/09
	£000	£000
Minimum lease payments	2,020	1,421
Contingent rents	0	0
Less sublease payments received	0	0
TOTAL	2,020	1,421
Future minimum lease payments due:		
- not later than one year;	1,885	1,258
- later than one year and not later than five years;	5,085	3,198
- later than five years.	2,172	2,040
TOTAL	9,142	6,496

5. Salary and Pension entitlements of senior managers

5.1. Remuneration

It is the view of the Board that the authority and responsibility for controlling major activities is retained by the Board and is not exercised below this level.

	2009/10				2008/09			
	Salary	Other Remuneration	Compensation for loss of office	Benefits in kind	Salary	Other Remuneration	Compensation for loss of office	Benefits in kind
Name and Title	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £5,000) £000	(Rounded to the nearest £100)	(bands of £5,000) £000	(bands of £5,000) £000	(bands of £5,000) £000	(Rounded to the nearest £100)
S Sharma ~ Chairman	45 - 50				45 - 50			
W Jones Non-Executive Director	15 - 20				15 - 20			
M Naeem Non-Executive Director	10 - 15				10 - 15			
C Clark Non-Executive Director	10 - 15				10 - 15			
A Fisher Non-Executive Director	10 - 15				10 - 15			
G Caddock Non-Executive Director*					5 - 10			
J Hanson Non-Executive Director	10 - 15				5 - 10			
D Whittingham Chief Executive	185 - 190				180 - 185			
L Hill Director of Service Development	125 - 130				120 - 125			
J Hull Director of Personnel	115 - 120				110 - 115			
Y A Oade Medical Director**	95 - 100				95 - 100			
M Brearley Director of Finance	135 - 140				135 - 140			
H Thomson Director of Nursing	125 - 130				120 - 125			

*G Caddock was in post until 30.09.08 and was replaced by J Hanson on 01.10.08.

**The salary details disclosed for Y Oade are apportioned on an estimate of time spent on management rather than clinical duties.The salary for 2008/09 has been restated based on a corrected estimate of time spent on management duties

5.2. Pension Benefits

Name and Title	Real increase in pension at age 60 (bands of £2,500) £000	Lump sum at age 60 related to real increase in pension (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2010 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2010 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2010 £000	Cash Equivalent Transfer Value at 31 March 2009 £000	Real Increase in Cash Equivalent Transfer Value Employer Funded £000	Real Increase in Cash Equivalent Transfer Value Employee Funded £000
D Whittingham Chief Executive	0 - 0.25	5 - 7.5	80 - 85	240 - 245	1,705	1,509	84	36
L Hill Director of Service Development	0 - 0.25	5 - 7.5	30 - 35	95 - 100	535	448	45	19
J Hull Director of Personnel	0 - 0.25	0 - 2.5	35 - 40	110 - 115	653	563	43	18
Y A Oade Medical Director (*)	0 - 0.25	0 - 2.5	25 - 30	75 - 80	514	457**	24	10
M Brearley Director of Finance	0 - 0.25	0 - 2.5	50 - 55	150 - 155	983	881	41	17
H Thomson Director of Nursing	0 - 0.25	2.5 - 5	55 - 60	165 - 170	1,098	979	49	21

As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.

*The pension benefit details disclosed for Y Oade are apportioned on an estimate of time spent on management rather than clinical duties.

**The CETV value at 31st March 2009 for Y Oade has been restated in line with the assesment of time spent on management rather than clinical duties.

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 in CETV

This reflects the increase in CETV, taking into account the increase in accrued pension due to inflation and contributions paid by the employer during the year. Common market valuation factors are used for the start and end of the period. An apportionment of the real increase between employer and employee contributions is made based on an assessment of their relative percentage contributions to the NHS Pension Scheme.

6. Employee expenses

6.1. Employee expenses breakdown

	2009/10	2008/09
	£000	£000
Salaries and wages	160,007	149,457
Social security costs	11,629	10,973
Pension costs - defined contribution plans Employers contributions to NHS Pensions	19,348	18,041
Agency/contract staff	6,834	6,335
TOTAL	197,818	184,806

All Employer pension contributions in 2009/10 were paid to the NHS Pensions Agency

6.2 Average number of employees (WTE basis)

	2009/10	2008/09
	Total No.	Total No.
Medical and dental	485	476
Administration and estates	1,206	1,003
Healthcare assistants and other support staff	1,052	1,105
Nursing, midwifery and health visiting staff	1,400	1,373
Scientific, therapeutic and technical staff	767	736
Social care staff	0	0
Bank and agency staff	183	176
TOTAL	5,093	4,869

6.3. Employee benefits

The Trust has not paid any Employee benefits in the year.

6.4. Early retirements due to ill health

During 2009/10 there were 15 early retirements from the Trust agreed on the grounds of ill health that incurred additional pension liabilities of £990,000 (borne by the NHS Pensions Agency). There were none in 2008/09.

7. Finance income

	2009/10	2008/09
	£000	£000
Interest on loans and receivables	0	0
Interest on available for sale financial assets	0	0
Interest on held-to-maturity financial assets	0	0
Other*	188	887
TOTAL	188	887

*In the 2008/09 Accounts,£887,000 was disclosed as Interest on loans and receivables this should have been disclosed as Other Finance Income ,and has been amended in comparison figures above.

8. Finance costs - interest expense

	2009/10	2008/09
	£000	£000
Loans from the Foundation Trust Financing Facility	330	201
Commercial loans	0	0
Overdrafts	0	0
Finance leases	0	0
Other	0	0
Finance Costs in PFI obligations		
Main Finance Costs	7,542	7,657
Contingent Finance Costs	1,994	2,036
TOTAL	9,866	9,894

9. Intangible assets

9.1. Intangible assets 2009/10

	Total £000
Gross cost at 1 April 2009	766
Gross cost at start of period for new FT's	0
Impairments charged to revaluation reserve/donated asset reserve	0
Reclassifications	0
Revaluation surpluses	0
Additions - purchased	99
Additions - donated	0
Disposals	0
Gross cost at 31 March 2010	865
Amortisation at 1 April 2009	514
Provided during the year	70
Impairments recognised in the income and expenditure account	0
Reversal of impairments recognised in the income and expenditure account	0
Reclassifications	0
Revaluation surpluses	0
Disposals	0
Amortisation at 31 March 2010	584
Net book value	
NBV - Purchased at 1 April 2009	252
NBV - Donated at 1 April 2009	0
NBV total at 1 April 2009	252
Net book value	
NBV - Purchased at 31 March 2010	281
NBV - Donated at 31 March 2010	0
NBV total at 31 March 2010	281

9.2. Intangible assets 2008/09

	Total £000
Gross cost at 1 April 2008	621
Impairments charged to revaluation reserve/donated asset reserve	0
Reclassifications	0
Revaluation surpluses	0
Additions - purchased	145
Additions - donated	0
Disposals	0
Gross cost at 31 March 2009	766
Amortisation at 1 April 2008	473
Provided during the year	41
Impairments recognised in the income and expenditure account	0
Reversal of impairments recognised in the income and expenditure account	0
Reclassifications	0
Revaluation surpluses	0
Disposals	0
Amortisation at 31 March 2009	514
Net book value	
NBV - Purchased at 1 April 2008	148
NBV - Donated at 1 April 2008	0
NBV total at 1 April 2008	148
Net book value	
NBV - Purchased at 31 March 2009	252
NBV - Donated at 31 March 2009	0
NBV total at 31 March 2009	252

9.3. Economic life of intangible assets

All of the Trusts intangible assets are software licences which have been purchased. 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 purchased is five years.

10. Property, plant and equipment 2009/10

10.1. Property, plant and equipment

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & Payments on Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2009	325,369	62,916	194,160	5,806	12,917	38,337	132	9,864	1,237
Additions - purchased	12,780	180	3,604	57	7,299	1,033	0	598	9
Additions - donated	244	0	11	0	0	233	0	0	0
Impairments charged to revaluation reserve / donated asset reserve	(8,896)	(4,245)	(3,663)	(988)	0	0	0	0	0
Reclassifications	0	0	12,176	0	(13,940)	652	0	880	232
Revaluation surpluses	0	0	0	0	0	0	0	0	0
Disposals	(3,874)	0	(71)	0	0	(3,803)	0	0	0
Cost or valuation at 31 March 2010	325,623	58,851	206,217	4,875	6,276	36,452	132	11,342	1,478
Accumulated depreciation at 1 April 2009	81,618	2,162	45,319	444	0	26,499	132	6,161	901
Provided during the year	9,546	0	6,073	128	0	2,031	0	1,181	133
Acquisition through business combination	0	0	0	0	0	0	0	0	0
Impairments recognised in operating expenses	19,596	0	20,261	(726)	0	0	0	61	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation surpluses	0	0	0	0	0	0	0	0	0
Disposals	(3,049)	0	(11)	0	0	(3,038)	0	0	0
Accumulated depreciation at 31 March 2010	107,711	2,162	71,642	(154)	0	25,492	132	7,403	1,034
Net book value									
NBV - Owned at 1 April 2009	155,751	60,754	62,082	5,362	12,858	10,656	0	3,703	336
NBV - Finance lease at 1 April 2009	86,368	0	86,361	0	7	0	0	0	0
NBV - Donated at 1 April 2009	1,632	0	398	0	52	1,182	0	0	0
NBV total at 1 April 2009	243,751	60,754	148,841	5,362	12,917	11,838	0	3,703	336
Net book value									
NBV - Owned at 31 March 2010	142,201	56,689	60,043	5,029	6,221	9,836	0	3,939	444
NBV - Finance lease at 31 March 2010	74,168	0	74,168	0	0	0	0	0	0
NBV - Donated at 31 March 2010	1,543	0	364	0	55	1,124	0	0	0
NBV total at 31 March 2010	217,912	56,689	134,575	5,029	6,276	10,960	0	3,939	444

10.2. Analysis of property, plant and equipment 31 March 2010

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & Payments on Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value									
NBV - Protected assets at 31 March 2010	86,094	3,847	82,247	0	0	0	0	0	0
NBV - Unprotected assets at 31 March 2010	131,818	52,842	52,328	5,029	6,276	10,960	0	3,939	444
Total at 31 March 2010	217,912	56,689	134,575	5,029	6,276	10,960	0	3,939	444

10.3. Property, plant and equipment 2008/09

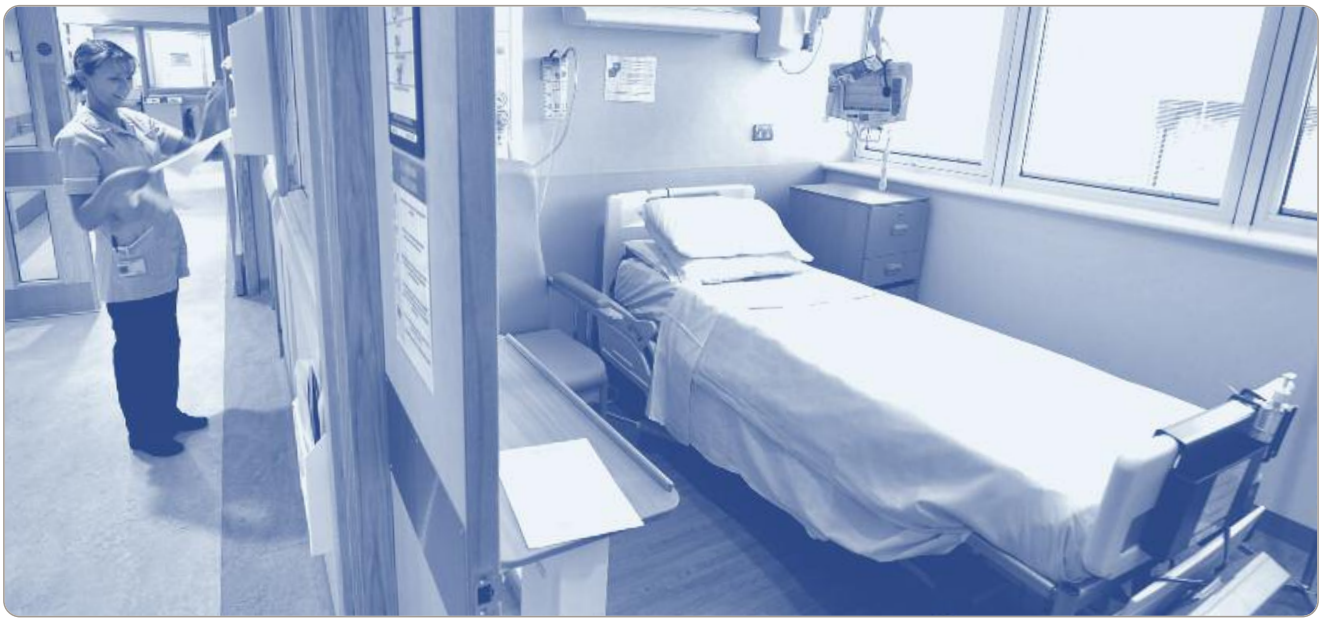
	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & Payments on Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2008	392,125	77,912	250,062	6,475	9,759	37,784	129	8,809	1,195
Additions - purchased	10,909	1	2,068	0	6,925	868	0	1,036	11
Additions - donated	437	0	0	0	0	437	0	0	0
Acquisition through business combination	0	0	0	0	0	0	0	0	0
Impairments charged to revaluation reserve / donated asset reserve	(77,307)	(14,997)	(61,602)	(708)	0	0	0	0	0
Reclassifications	0	0	3,632	39	(3,767)	77	0	19	0
Revaluation surpluses	1,019	0	0	0	0	985	3	0	31
Disposals	(1,814)	0	0	0	0	(1,814)	0	0	0
Cost or valuation at 31 March 2009	325,369	62,916	194,160	5,806	12,917	38,337	132	9,864	1,237
Accumulated depreciation at 1 April 2008	54,232	0	22,672	314	0	25,300	126	5,047	773
Provided during the year	11,919	0	8,279	130	0	2,285	3	1,114	108
Acquisition through business combination	0	0	0	0	0	0	0	0	0
Impairments recognised in operating expenses	16,530	2,162	14,368	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0
Revaluation surpluses	682	0	0	0	0	659	3	0	20
Disposals	(1,745)	0	0	0	0	(1,745)	0	0	0
Accumulated depreciation at 31 March 2009	81,618	2,162	45,319	444	0	26,499	132	6,161	901
Net book value									
NBV - Owned at 1 April 2008	191,193	77,912	81,625	6,161	9,707	11,601	3	3,762	422
NBV - Finance lease at 1 April 2008	145,327	0	145,327	0	0	0	0	0	0
NBV - Donated at 1 April 2008	1,373	0	438	0	52	883	0	0	0
NBV total at 1 April 2008	337,893	77,912	227,390	6,161	9,759	12,484	3	3,762	422
Net book value									
NBV - Purchased at 31 March 2009	155,753	60,754	62,082	5,362	12,858	10,658	0	3,703	336
NBV - Finance lease at 31 March 2009	86,368	0	86,361	0	7	0	0	0	0
NBV - Donated at 31 March 2009	1,630	0	398	0	52	1,180	0	0	0
NBV total at 31 March 2009	243,751	60,754	148,841	5,362	12,917	11,838	0	3,703	336

10.4. Analysis of property, plant and equipment 31 March 2009

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & Payments on Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value									
NBV - Protected assets at 31 March 2009	99,151	7,575	91,576	0	0	0	0	0	0
NBV - Unprotected assets at 31 March 2009	144,600	53,179	57,265	5,362	12,917	11,838	0	3,703	336
Total at 31 March 2009	243,751	60,754	148,841	5,362	12,917	11,838	0	3,703	336

10.5. Economic life of property, plant and equipment

	Min Life	Max Life
	Years	Years
Land	0	0
Buildings excluding dwellings	15	80
Dwellings	15	80
Assets under Construction & POA	0	0
Plant & Machinery	5	15
Transport Equipment	7	7
Information Technology	5	8
Furniture & Fittings	5	10



10.6. Net book value of assets held under finance leases 2009/10

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & Payments on Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	PFI arrangements
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2009	120,869	0	0	0	7	0	0	0	0	120,862
Additions - purchased	365	0	0	0	0	0	0	0	0	365
Additions - donated	0	0	0	0	0	0	0	0	0	0
Acquisition through business combination	0	0	0	0	0	0	0	0	0	0
Impairments charged to revaluation reserve / donated asset reserve	0	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	(7)	0	0	0	0	7
Revaluation surpluses	0	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0	0
Cost or valuation at 31 March 2010	121,234	0	0	0	0	0	0	0	0	121,234
Accumulated depreciation at 1 April 2009	34,501	0	0	0	0	0	0	0	0	34,501
Provided during the year	3,073	0	0	0	0	0	0	0	0	3,073
Acquisition through business combination	0	0	0	0	0	0	0	0	0	0
Impairments recognised in operating expenses	9,492	0	0	0	0	0	0	0	0	9,492
Reversal of impairments	0	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0	0
Revaluation surpluses	0	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0	0
Accumulated depreciation at 31 March 2010	47,066	0	0	0	0	0	0	0	0	47,066
Net book value										
NBV - Purchased at 1 April 2009	86,368	0	0	0	7	0	0	0	0	86,361
NBV - Donated at 1 April 2009	0	0	0	0	0	0	0	0	0	0
NBV total at 1 April 2009	86,368	0	0	0	7	0	0	0	0	86,361
Net book value										
NBV - Purchased at 31 March 2010	74,168	0	0	0	0	0	0	0	0	74,168
NBV - Donated at 31 March 2010	0	0	0	0	0	0	0	0	0	0
NBV total at 31 March 2010	74,168	0	0	0	0	0	0	0	0	74,168

10.7. Net book value of assets held under finance leases 2008/9

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & Payments on Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	PFI arrangements
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2008	161,598	0	0	0	0	0	0	0	0	161,598
Additions - purchased	1,628	0	0	0	7	0	0	0	0	1,621
Additions - donated	0	0	0	0	0	0	0	0	0	0
Acquisition through business combination	0	0	0	0	0	0	0	0	0	0
Impairments charged to revaluation reserve / donated asset reserve	(42,357)	0	0	0	0	0	0	0	0	(42,357)
Reclassifications	0	0	0	0	0	0	0	0	0	0
Revaluation surpluses	0	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0	0
Cost or valuation at 31 March 2009	120,869	0	0	0	7	0	0	0	0	120,862
Accumulated depreciation at 1 April 2008	16,271	0	0	0	0	0	0	0	0	16,271
Provided during the year	4,833	0	0	0	0	0	0	0	0	4,833
Acquisition through business combination	0	0	0	0	0	0	0	0	0	0
Impairments recognised in operating expenses	13,397	0	0	0	0	0	0	0	0	13,397
Reversal of impairments	0	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0	0	0	0	0
Revaluation surpluses	0	0	0	0	0	0	0	0	0	0
Disposals	0	0	0	0	0	0	0	0	0	0
Accumulated depreciation at 31 March 2009	34,501	0	0	0	0	0	0	0	0	34,501
Net book value										
NBV - Purchased at 1 April 2008	145,327	0	0	0	0	0	0	0	0	145,327
NBV - Donated at 1 April 2008	0	0	0	0	0	0	0	0	0	0
NBV total at 1 April 2008	145,327	0	0	0	0	0	0	0	0	145,327
Net book value										
NBV - Purchased at 31 March 2009	86,368	0	0	0	7	0	0	0	0	86,361
NBV - Donated at 31 March 2009	0	0	0	0	0	0	0	0	0	0
NBV total at 31 March 2009	86,368	0	0	0	7	0	0	0	0	86,361

11. Inventories

11.1. Inventories breakdown

	31 March 2010	31 March 2009	1 April 2008
	£000	£000	£000
Materials	4,016	4,018	4,038
Work in progress	211	223	75
Finished goods	472	246	217
TOTAL Inventories	4,699	4,487	4,330

11.2. Inventories recognised in expenses

	2009/10	2008/09
	£000	£000
Inventories recognised in expenses	40,856	37,572
Write-down of inventories recognised as an expense	0	0
Reversal of any write down of inventories resulting in a reduction of recognised expenses	0	0
TOTAL Inventories recognised in expenses	40,856	37,572

12. Trade and other receivables

12.1. Trade receivables and other receivables

	Total	Financial assets	Non - financial assets	Total	Financial assets	Non - financial assets	Total	Financial assets	Non - financial assets
	31 March 2010	31 March 2010	31 March 2010	31 March 2009	31 March 2009	31 March 2009	1 April 2008	1 April 2008	1 April 2008
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Current									
NHS Receivables	6,562	6,562	0	6,025	6,025	0	6,425	6,425	0
Provision for impaired receivables	(155)	(155)	0	(779)	(779)	0	(770)	(770)	0
Prepayments	1,716	0	1,716	2,931	0	2,931	1,613	0	1,613
Accrued income	309	309	0	725	725	0	794	794	0
PDC receivable	152	0	152	0	0	0	0	0	0
Other receivables	4,777	3,491	1,286	4,121	2,199	1,922	4,069	4,069	0
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	13,361	10,207	3,154	13,023	8,170	4,853	12,131	10,518	1,613
Non-Current									
NHS Receivables	688	688	0	758	758	0	771	771	0
Provision for impaired receivables	(90)	0	(90)	0	0	0	0	0	0
Prepayments	0	0	0	0	0	0	0	0	0
Accrued income	0	0	0	0	0	0	0	0	0
Other receivables	1,124	0	1,124	392	0	392	829	829	0
TOTAL NON-CURRENT TRADE AND OTHER RECEIVABLES	1,722	688	1,034	1,150	758	392	1,600	1,600	0

NHS Debtors falling due within one year includes £2,496,942 for incomplete spells of care provided at 31st March 2010.

12.2. Provision for impairment of receivables

	2009/10	2008/09
	£000	£000
At 1 April	779	770
Increase in provision	0	346
Amounts utilised	(405)	(29)
Unused amounts reversed	(129)	(308)
At 31 March	245	779

12.3. Analysis of impaired receivables

	2009/10	2008/09
	£000	£000
Ageing of impaired receivables		
Up to three months	14	172
In three to six months	12	97
Over six months	219	510
Total	245	779
Ageing of non-impaired receivables past their due date		
Up to three months	1,178	1,404
In three to six months	277	322
Over six months	414	216
Total	1,869	1,942

12.4. Finance lease receivables

The trust had no Finance lease receivables in 2009/10 or 2008/09.

13. Trade and other payables (including tax payable)

13.1. Trade and other payables (including tax payable)

	Total	Financial assets	Non - financial assets	Total	Financial assets	Non - financial assets	Total	Financial assets	Non - financial assets
	31 March 2010	31 March 2010	31 March 2010	31 March 2009	31 March 2009	31 March 2009	1 April 2008	1 April 2008	1 April 2008
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Current									
Receipts in advance	561	0	561	1,154	0	1,154	2,030	0	2,030
NHS payables	4,601	4,601	0	3,826	3,826	0	1,310	1310	0
Trade payables - capital	2,593	2,593	0	1,842	1,842	0	2,132	2132	0
Other trade payables	5,513	5,513	0	0	0	0	0	0	0
Taxes payable	4,020	0	4,020	3,772	0	3,772	173	0	173
Other payables	2,212	2,212	0	8,680	8,680	0	4,780	4780	0
Accruals	3,748	3,748	0	4,180	4,180	0	7,962	7962	0
TOTAL CURRENT TRADE AND OTHER PAYABLES	23,248	18,667	4,581	23,454	18,528	4,926	18,387	16,184	2,203
Non-current									
Receipts in advance	0	0	0	0	0	0	0	0	0
NHS payables	0	0	0	0	0	0	0	0	0
Trade payables - capital	0	0	0	0	0	0	0	0	0
Other trade payables	0	0	0	0	0	0	0	0	0
Taxes payable	0	0	0	0	0	0	0	0	0
Other payables	633	633	0	754	754	0	730	730	0
Accruals	0	0	0	0	0	0	0	0	0
TOTAL NON-CURRENT TRADE AND OTHER PAYABLES	633	633	0	754	754	0	730	730	0

Non-Current Payables includes VAT reclaimed under the Lennartz mechanism which is repayable to Her Majesty's Revenue & Customs over an extended time period.

13.2. Early retirements detail included in NHS payables above

The Trust has no early retirement costs included in NHS Payables above.

14. Other liabilities

	31 March 2010	31 March 2009	1 April 2008
	£000	£000	£000
Current			
Deferred Income	1,497	1,186	1,902
TOTAL OTHER CURRENT LIABILITIES	1,497	1,186	1,902
Non-current			
Deferred Income	1,933	2,030	2,134
TOTAL OTHER NON-CURRENT LIABILITIES	1,933	2,030	2,134

Deferred income relates to the PFI scheme at Calderdale Royal Hospital which is being released over the life of the contract.

15. Borrowings

15.1. Borrowings

	31 March 2010	31 March 2009	1 April 2008
	£000	£000	£000
Current			
Bank overdrafts	0	0	0
Drawdown of committed facility	0	0	0
Loans from Foundation Trust Financing Facility	562	247	3
Other Loans	0	0	0
Obligations under finance leases	0	0	0
Obligations under Private Finance Initiative contracts	1,593	1,468	1,353
TOTAL CURRENT BORROWINGS	2,155	1,715	1,356
Non-current			
Bank overdrafts	0	0	0
Drawdown in committed facility	0	0	0
Loans from Foundation Trust Financing Facility	6,756	6,163	2,100
Other Loans	0	0	0
Obligations under finance leases	0	0	0
Obligations under Private Finance Initiative contracts	85,543	87,136	88,604
TOTAL OTHER NON-CURRENT LIABILITIES	92,299	93,299	90,704

16. Prudential Borrowing Limit

The NHS Foundation Trust is required to comply and remain within a Prudential Borrowing Limit.

This is made up of two elements:

- the maximum cumulative amount of long-term borrowing. This is set by reference to the ratio tests set out in Monitor's Prudential Borrowing Code.
- the amount of any working capital facility approved by Monitor.

Further information on the NHS Foundation Trust Prudential Borrowing Code can be found on the website of Monitor, the Independent Regulator of Foundation Trusts.

The Trust has a maximum long term borrowing limit of £96.2m in 2009/10 (£65.9m 2008/09).

It should be noted that the borrowing limit for 2008/09 was based on the financial postion as declared under UK Generally Accepted Accounting Practice.

Importantly, under UK GAAP, the PFI scheme at Calderdale Royal Hospital was considered "Off-balance sheet" and as such there was not a finance lease creditor recorded in the Trust's liabiliites. As such a comparison of performance against the Prudential Borrowing Limit, as it may have been under International Financial Reporting Standards in 2008/09, is not possible.

The Trust borrowed £1.2m in 2009/10 from the Foundation Trust Financing Facility (FTFF), repaid £281,000 to the FTFF, and repaid £1,468,000 on the PFI Finance Lease Creditor.

During 2009/10 the Trust had the following Working Capital Facilities in place:

- £18.0m from 1st April to 30th November 2009.
- £22.8m from 1st December 09 to 31st March 2010.

The Trust has not drawndown against this facility.

16.1. Prudential borrowing limit

	31 March 2010
	£000
Total long term borrowing limit set by Monitor	96,204
Working capital facility agreed by Monitor	22,800
TOTAL PRUDENTIAL BORROWING LIMIT	119,004
Long term borrowing at 1 April 2009	95,004
Long term borrowing at start of period for new FT's	0
Net actual borrowing/(repayment) in year - long term	(549)
Long term borrowing at 31 March 2010	94,455
Working capital borrowing at 1 April 2009	0
Working capital borrowing at start of period for new FT's	0
Net actual borrowing/(repayment) in year - working capital	0
Working capital borrowing at 31 March 2010	0

16.2. Financial Ratios

	2009/10	
	Actual	Planned
Financial Ratios		
Minimum dividend cover	4.2x	3.7x
Minimum interest cover	2.8x	2.8x
Minimum debt service cover	2.4x	2.4x
Maximum debt service to revenue	3.8%	3.9%

17. PFI obligations (on Statement of Financial Position)

	31 March 2010	31 March 2009
	£000	£000
Gross PFI liabilities	252,025	263,028
of which liabilities are due		
- not later than one year;	11,004	11,004
- later than one year and not later than five years;	41,098	41,858
- later than five years	199,923	210,166
Finance charges allocated to future periods	(164,889)	(174,424)
Net PFI liabilities	87,136	88,604
- not later than one year;	1,593	1,468
- later than one year and not later than five years;	5,152	5,322
- later than five years	80,391	81,814

17.2. The trust is committed to make the following payments for on-SoFP PFIs obligations during the next year in which the commitment expires:

	31 March 2010
	£000
Within one year	0
2nd to 5th years (inclusive)	0
6th to 10th years (inclusive)	0
11th to 15th years (inclusive)	0
16th to 20th years (inclusive)	0
21st to 25th years (inclusive)	20,739
26th to 30th years (inclusive)	0
31st to 35th years (inclusive)	0
36th year and beyond	0

The PFI scheme (left) relates to Calderdale Royal Hospital. The PFI contractor is Catalyst Healthcare Ltd. The trust are responsible for the provision of all clinical services, Catalyst Healthcare Ltd provide fully serviced hospital accomodation.

18. Provisions for liabilities and charges

18.1. Provisions for liabilities and charges

	Current			Non-Current		
	31 Mar 2010	31 Mar 2009	1 Apr 2008	31 Mar 2010	31 Mar 2009	1 Apr 2008
Pensions relating to former directors	0	0	0	0	0	0
Pensions relating to other staff	251	320	429	1,508	1,734	1,938
Other legal claims	156	11	171	0	107	0
Other	41	159	57	1,054	799	925
Total	448	490	657	2,562	2,640	2,863

	Total	Pensions - other staff	Other legal claims	Other
	£000	£000	£000	£000
At 1 April 2009	3,130	2,054	118	958
Change in the discount rate	0	0	0	0
Arising during the year	401	0	161	240
Utilised during the year	(402)	(260)	(87)	(55)
Reclassified to liabilities held in disposal groups in year	0	0	0	0
Reversed unused	(188)	(82)	(36)	(70)
Unwinding of discount	69	47	0	22
At 31 March 2010	3,010	1,759	156	1,095
Expected timing of cashflows:				
- not later than one year;	448	251	156	41
- later than one year and not later than five years;	1,170	1,005	0	165
- later than five years	1,392	503	0	889
TOTAL	3,010	1,759	156	1,095

Clinical Negligence liabilities

As at 31 March 2010 is £33,968,000 (£39,127,000 at 31 March 2009) is included in the provisions of the NHS Litigation Authority in respect of the clinical negligence liabilities of Calderdale and Huddersfield NHS Foundation Trust.

19. Cash and cash equivalents

19.1. Cash and cash equivalents

	31 March 2010	31 March 2009
	£000	£000
At 1 April	19,079	11,047
Net change in year	(842)	8,032
At 31 March	18,237	19,079
Broken down into:		
Cash at commercial banks and in hand	88	240
Cash with the Government Banking Service	18,149	18,839
Other current investments	0	0
Cash and cash equivalents as in SoFP	18,237	19,079
Bank overdraft	0	0
Cash and cash equivalents as in SoCF	18,237	19,079
Third party assets held by the NHS Foundation Trust	3	4

20. Contractual Capital Commitments

Commitments under capital expenditure contracts at 31 March 2010 were £3,257,000, (compared to £2,316,000 at 31 March 2009).

21. Events after the reporting period

There are no events after the reporting period

22. Contingent (Liabilities)/Assets

There were no contingent assets or liabilities at 31 March 2010.

23. Related Party Transactions

Calderdale & Huddersfield NHS Foundation Trust is a public interest body authorised by Monitor, the Independent Regulator for NHS Foundation Trusts. It is an independent body not controlled by the Secretary of State.

It is therefore considered that Government departments and agencies of Government departments are not related parties.

During the year none of the Board Members or members of the key management staff, or parties related to them, has undertaken any material transactions with the Calderdale & Huddersfield NHS Foundation Trust.

The Register of Council Member Interests for 2009/10 has been compiled and is available to be viewed by contacting the Board Secretary.

The Trust has also received revenue and capital payments from a number of charitable funds, certain of the Trustees for which are also members of the NHS Foundation Trust Board of Directors.

The Trust's main Commissioner PCT's are Calderdale PCT and Kirklees PCT.

The transactions are detailed below.

	Income 2009/10	Income 2008/09	Expenditure 2009/10	Expenditure 2008/09
	£000	£000	£000	£000
Calderdale PCT	127,358	114,099	162	73
Kirklees PCT	138,059	122,689	149	117
	265,417	236,788	311	190

	Debtors 31 March 2010	Debtors 31 March 2009	Creditors 31 March 2010	Creditors 31 March 2009
	£000	£000	£000	£000
Calderdale PCT	1,985	2,128	52	58
Kirklees PCT	2,222	2,632	132	34
	4,207	4,760	184	92

24. 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.

25. Financial assets and financial liabilities

25.1. Financial assets by category

	Total
	£000
Assets as per Statement of Financial Position	
Trade and other receivables excluding non financial assets (at 31 Mar 2010)	**10,895**
Cash and cash equivalents (at bank and in hand (at 31 Mar 2010))	**18,237**
Total at 31 March 2010	**29,132**
Trade and other receivables excluding non financial assets (at 31 Mar 2009)	8,928
Cash and cash equivalents (at bank and in hand (at 31 Mar 2009))	19,079
Total at 31 March 2009	28,007
Trade and other receivables excluding non financial assets (at 1 Apr 2008)	12,118
Cash and cash equivalents (at bank and in hand (at 1 Apr 2008))	11,047
Total at 1 April 2008	23,165

All financial asests at 31 March 2010, 31 March 2009 and 31 March 2008 were Loans and receivables.
The trust had no financial assets held at fair value through Income and expenditure, Held to maturity or Available-for-sale.

25.2. Financial liabilities by category

	Total
	£000
Liabilities as per Statement of Financial Position	
Borrowings excluding Finance lease and PFI liabilities (at 31 Mar 2010)	**7,318**
Obligations under Private Finance Initiative contracts (31 Mar 2010)	**87,136**
Trade and other payables excluding non financial assets (31 Mar 2010)	**19,300**
Other financial liabilities (31 Mar 2010)	**0**
Total at 31 March 2010	**113,754**
Borrowings excluding Finance lease and PFI liabilities (at 31 Mar 2009)	6,410
Obligations under Private Finance Initiative contracts (31 Mar 2009)	88,604
Trade and other payables excluding non financial assets (31 Mar 2009)	19,282
Other financial liabilities (31 Mar 2009)	0
Total at 31 March 2009	114,296
Borrowings excluding Finance lease and PFI liabilities (at 1 Apr 2008)	2,103
Obligations under Private Finance Initiative contracts (1 Apr 2008)	89,957
Trade and other payables excluding non financial assets (1 Apr 2008)	16,914
Other financial liabilities (1 Apr 2008)	0
Total at 1 April 2008	108,974

All financial liabilities at 31 March 2010, 31 March 2009 and 31 March 2008 were other financial liabilities. The trust had no liabilities held at fair value through income and expenditure.

25.3. Fair values of financial assets at 31 March 2010

	Book value	Fair value	
	£000	£000	
Non-current trade and other receivables excluding non financial assets	688	688	Note A
Other Investments	0	0	
Other	0	0	
Total	688	688	

25.4. Fair values of financial liabilities at 31 March 2010

	Book value	Fair value	
	£000	£000	
Non-current trade and other payables excluding non financial liabilities	633	633	Note B
Provisions under contract	0	0	
Loans	7,318	7,318	Note C
Other	0	0	
Total	7,951	7,951	

Note A:

The Non-current trade and other receivables excluding non financial assets reflects agreements with commissioners to cover receivables over 1 year for provisions under contract, and their related interest charge/unwinding of discount. In line with Notes B & C below, fair value is not significantly different from book value.

Note B:

The Non-current trade and other payables excluding non financial liabilities reflects the long term provision to repay Lennartz VAT over 10 years for Buildings and 5 years for Equipment relating to the Acre Mill Pharmacy Manufacturing Unit. The fair value of this provision is not significantly different from the book value.

Note C:

Fair value is not significantly different from book value since, in the calculation of book value, the expected cash flows have been discounted by the Treasury discount rate of 2.2% in real terms.

25.5. Financial Instruments

Because of the continuing service provider relationship that the NHS Foundation Trust has with local Primary Care Trusts and the way those Primary Care Trusts 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 the listed companies. The Trust neither buys nor sells financial instruments. Financial assets 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.

Interest rate risk

42% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. Calderdale and Huddersfield NHS Foundation Trust is not exposed to significant interest-rate risk.

Currency Risk

The Trust has negligible foreign currency income or expenditure.

Liquidity risk

The Trust's net operating costs are incurred under three year service contracts with local Primary Care Trusts, which are financed from resources voted annually by Parliament. The Trust receives such contract income in accordance with Payment by Results (PBR), which is intended to match the income received in year to the activity delivered in that year by reference to the National Tariff procedure cost. The Trust receives cash each month based on an annually agreed level of contract activity and there are corrections made to adjust for the actual income due under PBR.

The Trust has put in place an £22.8m working capital facility which to date it has not had to use.

In 2009/10 the Trust has financed it's capital expenditure from internally generated funds or from Public Dividend Capital previously made available by the Government. The Trust has the ability to borrow funds to fund capital expenditure within the limits set by it's Prudential Borrowing Limit.

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 specific 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 Committee and the Board of Directors.

It is therefore felt that the Trust is not exposed to significant liquidity risk.

26. Losses and special payments

There were 68 cases of losses and special payments totalling £61,384 during the period covered by these accounts.

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.

The total cases in this note are on a cash basis.

27. Recovered Losses

The Trust has not received any compensation payments from CHCC.

28. Discontinued operations

The Trust has no discontinued operations.

29. Corporation Tax

The Trust has assed that it is not liable for Corporation tax in 2009/10.

30. Pharmacy Manufacturing Unit

The Trust operates a Pharmacy Manufacturing Unit as part of its Pharmacy department. The unit purchases raw materials for the manufacture of pharmaceutical products which are used within the Trust, and sold to other NHS and non NHS bodies. The income and expenditure of the unit are included in the Statement of Comprehensive Income; and the value of income in 2009/10 was £3,430,557.

31. West Riding Audit Consortium

The Audit Consortium was set up on 1st April 1993. It provides the internal audit function to a number of NHS Trusts and other public bodies, and is a non-profit making organisation. The Consortium is managed by a Board consisting of the Directors of Finance of its major customers. Calderdale and Huddersfield NHS Foundation Trust provides accounting services to the Consortium and its income and expenditure is included in the Trust's accounts.

The income of the Consortium for the period covered by these accounts was £1,845,440; these amounts are recorded in the Statement of Comprehensive Income.

32. Health Informatics

The Trust provides information management and technology services to a number of other NHS Organisations from the Health Informatics Service. The income recorded in the Income and Expenditure Account relating to the service is £7,367,709.

33. Limitation on Auditors Liability

There is no limit on our external Auditors liability.

34. Woodstock Management company

Under International Accounting Standard 27, the Trust is viewed as having 'control' over Woodstock Management Company (Huddersfield) Limited. The Trust owns five of the nine properties in a shared residential development in Huddersfield and in conjunction with the other owners, established a company through which shared estates and grounds work is undertaken.

It should be noted that the Woodstock Management Company does not hold any title to any of the Woodstock properties. It has a net asset balance of nil and the value of transactions anticipated in a year is normally c.£1,000 (which involves costs being incurred which are then recouped from shareholders). The Trust owns five of the nine shares of the Company and two of the three Woodstock Management Company directors are Directors of the Trust (and were appointed as such by the Board of Directors of the trust).

35. Transition to IFRS (IAS1)

As 2009/10 is the first year in which the Trust's Accounts have been produced using International Financial Reporting Standards,

the information below details the movements to explain how the transition from UK Generally Accepted Accounting

Practice (previously used) has impacted on the reported financial position, financial performance and cash flows.

Note A: Reconciliation of UK GAAP Taxpayers' Equity to IFRS Taxpayers Equity

Reconciliation of UK GAAP Taxpayers' Equity to IFRS Taxpayers Equity as at 1 April 2008 (date of transition to IFRS)

Taxpayers' equity	UK GAAP 31/03/08	Effect of transition to IFRS	IFRS 01/04/08
Taxpayers' equity			
Public Dividend Capital	111,899		111,899
Revaluation Reserve	80,960	51,921	132,881
Donated asset reserve	1,376		1,376
Income and expenditure reserve	8,969	(6,709)	2,260
Total taxpayers' equity at 31 March 2008	203,204	45,212	248,416

Reconciliation of UK GAAP Taxpayers' Equity to IFRS Taxpayers Equity as at 31 March 2009 (end of the previous balance sheet period in relation to the first full IFRS accounts)

Taxpayers' equity	UK GAAP 31/03/08	Effect of transition to IFRS	IFRS 01/04/08
Taxpayers' equity			
Public Dividend Capital	111,899		111,899
Revaluation Reserve	48,030	7,217	55,247
Donated asset reserve	1,632		1,632
Income and expenditure reserve	12,102	(24,706)	(12,604)
Total taxpayers' equity at 31 March 2009	173,663	(17,489)	156,174

Note B: Transition to IFRS

	Retained earnings	Revaluation reserve	Donated asset reserve
	£000	£000	£000
Taxpayers' equity at 31 March 2009 under UK GAAP:	12,102	48,030	1,632
Adjustments for IFRS changes:			
Private finance initiative	(24,706)	7,217	0
Leases	0	0	0
Others (specify)	0	0	0
Adjustments for:			
Impairments recognised on transition	0	0	0
UK GAAP errors	0	0	0
Taxpayers' equity at 1 April 2009 under IFRS:	(12,604)	55,247	1,632

	£000
Surplus/(deficit) for 2008/09 under UK GAAP	2,469
Adjustments for:	
Private finance initiative	(17,997)
Leases	0
Others (specify)	0
Surplus/(deficit) for 2008/09 under IFRS	(15,528)

Note C: Reconciliation to Statement of Cash flows

	UK GAAP 2008/09	Effect of transition to IFRS (PFI) adjustment	IFRS 2008/09
NET CASH GENERATED FROM/(USED IN) OPERATIONS	19,159	12,114	31,273
Cash flows from investing activities			
Interest received	887	0	887
Purchase of intangible assets	(145)	0	(145)
Purchase of Property, Plant and Equipment	(10,129)	(1,068)	(11,197)
Net cash generated from/(used in) investing activities	**(9,387)**	**(1,068)**	**(10,455)**
Cash flows from financing activities			
Loans received	4,300	0	4,300
Capital element of Private Finance Initiative Obligations	0	(1,353)	(1,353)
Interest paid	(270)	0	(270)
Interest element of Private Finance Initiative obligations	0	(9,693)	(9,693)
PDC Dividend paid	(5,770)	0	(5,770)
Net cash generated from/(used in) financing activities	**(1,740)**	**(11,046)**	**(12,786)**
Increase/(decrease) in cash and cash equivalents	8,032	0	8,032
Cash and Cash equivalents at 1 April 2008	11,047		11,047
Cash and Cash equivalents at 31 March 2009	19,079		19,079


Toilets &
Shower /
Bathroom

Calderdale Royal Hospital

Huddersfield Road
Salterhebble
Halifax
West Yorkshire
HX3 0PW

Tel: 01422 357 171
or
08448 110 101

www.cht.nhs.uk

Huddersfield Royal Infirmary

Acre Street
Lindley
Huddersfield
West Yorkshire
HD3 3EA

Tel: 01484 342 000
or
08448 110 101

www.cht.nhs.uk