Calderdale and Huddersfield NHS
NHS Foundation Trust

Annual Report & Accounts 2010/11

Acute Healthcare Organisation of the Year 2010

Pride • Patients • People • Partnerships

Your Care
Our Concern

Calderdale and Huddersfield NHS Foundation Trust

Annual Report and Accounts
2010/11

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

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Chairman's Statement

Tribute to Sukhdev Sharma

Our chairman Sukhdev Sharma died suddenly in April 2011 and we all miss him.

He had been our chairman for four years joining us from South West Yorkshire Mental Health Trust.

Dev brought with him great experience and deep commitment to healthcare delivery and the staff who deliver it. In all our Board meetings whenever an extra thank-you to staff was earned he always made sure it was done and put on record.

He was a very caring man with a tremendous career working for equality and fairness both in this country and abroad for the European Parliament.

Above all else, his pride in this Trust and all its staff shone through. We, his colleagues and friends, miss him immensely.

His colleagues on the Board of Directors

Our chairman wrote this shortly before his sudden death on April 5, 2011 and we reproduce it in his memory.

It is with immense pride and pleasure that I am writing this opening statement as chairman of the HSJ 2010 Acute Healthcare Organisation of the Year.

The Health Service Journal award is a magnificent achievement – one which all trusts would love to win – and every single member of staff at this Trust has every right to feel very proud.

We are a healthcare team made up of more than 5,000 individuals and the award showed that as a team we are working in the right direction for our patients.

When the judges visited us for the day we knew we had a very strong entry reflecting innovation, dedication and, above all else, results in all areas of patient care.

But when our name was announced on the night as overall winner – against eight other top performing Trusts – it was a moment we could all be proud of. We thought we were worth it – and they did too!

For me it was confirmation that this Trust delivers the best care because it is constantly moving on and adapting to provide the best for its patients.

That will be the case for the year ahead. Potentially the greatest year of change the NHS has ever undergone.

Changes are coming at a pace like never before. In April 2011, for example, a further 500 staff joined the Trust from NHS Calderdale and they will drive forward the quality and standards in the care we deliver in people's homes across Calderdale.

It is a time of change and also one of huge challenge. Key to our efforts is the continuing work of our Membership Council, members, volunteers and League of Friends supporters, who help us make sure our services are right for our patients and help keep us on the right track. Their support during the year – in all weathers – continues to be much appreciated.

So a big thankyou to them, to everyone in our team for the award-winning year gone by and in anticipation of the challenges and successes of the year ahead.

Sukhdev Sharma
Chairman

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

Chief Executive's Statement

I would wish to open this statement on a deeply sad note by paying tribute to our late chairman Dev Sharma. Dev died suddenly in April and we will remember him for the gentle humour and integrity he brought to all his work over the past four years as our chairman, colleague and friend. He will be hugely missed by us all.

My statement last year ended saying that *"we cannot afford to stand still if we wish to stay strong in a tough environment."*

The good news for local people is that we have never "stood still." We continue with our aim to consistently improve our services and thanks to the innovation and dedication of the people who work across this Trust, we often lead the way in the NHS.

This was recognised in November 2010 when we were awarded Acute Healthcare Organisation of the Year at a national ceremony in London. The prestigious award was welcome recognition for all my colleagues here in the Trust and also demonstrated the strength of our local authority and primary care partnerships.

This was one of many great achievements in 2010/11:

- In our drive to make services safer for our patients we continue to make substantial reductions in hospital acquired infections. We have made significant improvements over the years but our aim is to eradicate infections and we continue to work towards this
- The opening of two multi-million pound endoscopy units designed around our patients and their needs
- As part of our commitment to keep services local we have launched a new service for heart patients – percutaneous coronary intervention (angioplasty) - which means patients can be fitted with a stent at Calderdale Royal Hospital instead of travelling to Leeds
- We continue with our ward improvement programme at Huddersfield and a major £2m refurbishment of ward 21 has provided a modern and improved environment for our stroke rehabilitation patients
- Our new joint venture partnership with Henry Boot Developments Ltd will ensure that the best value is gained from the former St Luke's Hospital site in Huddersfield and allow us to move ahead with plans to further develop the Acre Mill site in Huddersfield.

These are achievements all worth celebrating – along with many others detailed in the pages ahead. But we don't always get it right and we recognise that. The national inpatient survey and the local feedback you give us tells us where we need to focus our attention. We take your advice and build it into our Quality Improvement strategy which helps us towards our aim of providing safe, effective and personal care for all our patients.

Looking ahead to 2011/12 we start the year by welcoming new colleagues who have joined us from NHS Calderdale provider services. We look forward to working closely with them to improve patient care both in the hospital and in the community.

We will also be advancing our plans to work with other hospital trusts to see if there are ways we can co-operate to save valuable resources. This is not about merger or takeover but working in partnership for mutual benefit and to improve our services. We are working with East Lancashire Hospitals to form a healthcare group and this will be formally established later in 2011.

It is universally acknowledged that this will be a difficult and challenging year and there are many changes taking place in the NHS that will have a significant impact on this organisation and the services that we provide. Thanks to the solid foundations built by our staff and other partners in the system we are in a stronger position than many to face the challenges to come. I want our hospitals and services to thrive, not just survive through these changes. There is a dedicated and professional workforce across Calderdale and Huddersfield who are doing all they can to ensure that our services remain strong and are there for you and your family when you need them. I thank them and you for your continued support.

Diane Whittingham
Chief Executive

Directors' Report

The best

In November in London, the Trust was announced as the HSJ's Acute Healthcare Organisation of the Year.

This award hosted by the prestigious Health Service Journal magazine is the highest honour in the NHS calendar. There were eight contenders in our category.

It came after judges travelled the country to hear about the work taking place at each of the shortlisted organisations.

We organised a day of presentations for them highlighting all our areas of innovation and success in healthcare delivery for our patients.

Back in November the award was hailed an "early Christmas present" and our Chief Executive Diane Whittingham said it was testament to all the hard work of all staff against extremely strong competition and a "real honour".

Our team at the awards.

History

In 2011 our Trust – formed following the merger of Calderdale Healthcare NHS Trust and Huddersfield Healthcare Services NHS Trust – celebrates its 10th anniversary of providing care for the populations of Halifax and Huddersfield.

It is a very important year as it also marks the year when 500 extra staff joined us from NHS Calderdale and they will help us transform the way many of our service are delivered to local residents.

We became a Foundation Trust in 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.

It also gives us the freedoms to work closely with local people and service users and helps us to respond to the needs of our local communities.

At our Trust, consultants and clinicians lead the management of the organisation making sure quality healthcare is at the heart of all decisions.

"In November in London, the Trust was announced as the HSJ's Acute Healthcare Organisation of the Year."

What we do

Our two main hospitals Calderdale Royal Hospital and Huddersfield Royal Infirmary deliver an evolving and expanding range of healthcare services.

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

Last year more than 117,000 men, women and children were cared for as inpatients (stayed at least one night) or day cases and more than 405,000 people attended our outpatient clinics. Our A&E departments at both hospitals cared for more than 134,000 people.

In future years we shall also be delivering even more healthcare services in a variety of community settings and in people's homes. Around 500 healthcare staff joined with us on April 1, 2011 from NHS Calderdale – the primary care trust which used to provide these services.

Our vision and values

"I have done many different things over the years but I get the most satisfaction from what I do now"

MRI scanner John Mannion was the "Unsung Hero" at the staff awards for 2010 nominated by colleagues and patients for his caring nature and ability to put people at ease.

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

The Trust's strategic direction has been developed through partnerships to gain a clear understanding of the needs of the local population. The Trust membership is consulted with regularly on issues of strategic direction. We have a good working relationship with our local primary care trusts, GPs and local authorities.

Our directors are committed members of the Local Strategic Partnership Board in both Calderdale and Kirklees focusing on the joint delivery of the Comprehensive Area Assessments, and our clinicians engage with GPs to ensure patient flow across organisations is continually improved. In 2010/11 the Trust worked with the local health economy and particularly GPs to improve pathways in areas such as urgent care, care of patients with dementia and long term conditions such as heart failure and chronic obstructive pulmonary disease. We also supported our community teams in the facilitation of early discharge to reduce the amount of time patients spend in hospital.

In 2011 we integrated adult and children services from the provider arm of NHS Calderdale into our divisions of Medicine and Elderly and Children and Women's Services. Work continues to fully integrate all pathways. We also continue to work closely with other local providers of services to ensure fully integrated pathways of care are available to all our patients.

In 2011 we have agreed to form a new joint venture partnership company with Henry Boot Developments Limited. The new company will be created to make sure that the best value is gained from the former St Luke's Hospital site in Crosland Moor and support and enhance the development of local health services for local people. This is the first joint venture partnership for the Trust, which will also help secure funding to develop the Acre Mill site in Huddersfield, opposite the Huddersfield Royal Infirmary.

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Chris Monaco, from the cardiology team, pictured above:

"We are passionate about delivering the best possible healthcare for our patients and this service will benefit local people by bringing complex care closer to home."

We continue to develop specialist services with the support of the Yorkshire and Humber Specialist Commissioning Group. In 2011 the Trust received accreditation from the British Cardiovascular Intervention Society (BCIS) to provide a highly specialised service for patients suffering from heart attacks and angina. Percutaneous Coronary Intervention (PCI), previously called angioplasty, involves opening up a blocked or narrowing artery with a balloon and putting a stent in place to prevent the artery blocking again. The new service started from a refurbished, state-of-the-art facility on the Coronary Care Unit at Calderdale Royal Hospital in the spring.

We have worked in partnership with other local provider services. The Trust continues to work in partnership with both the Bradford and Airedale acute trusts to develop the strategy for vascular surgery across the area which is compliant with guidance, meets the standards of the specialist commissioning group and provides a quality local service to the residents of our health economy.

The Trust, NHS Calderdale and NHS Kirklees was one of only eight sites nationally chosen to taken part in an ambitious three-year programme, funded by the Health Foundation, called Co-Creating Health. Since the programme was launched, in 2007, more than 160 people in Calderdale and Kirklees have had their lives transformed, through developing the knowledge, skills and confidence to help them manage their condition, with the support of a specially trained team of clinicians and voluntary tutors.

As a result of its success, the programme has been extended for a further two years. Clinician training is gaining momentum in primary care, with three Huddersfield practices and one Calderdale practice starting the training. The training replaces Care Planning training and is beneficial for all long-term consultations.

In April 2010 a team from the Trust, NHS Kirklees and Kirklees Council won best team, best strategy and best health economy Nursing Times Leadership Challenge.

Patient Care

"After our loss, she did everything to investigate the cause to ensure it didn't happen again. Her door was always open and she was very honest and clear about her thoughts and findings. I was 20 at the time and felt some professionals view was that I was young and I would be fine in the future. She will go the extra mile to ensure you fully understand all the technical terms so you feel reassured and confident with choices made and is never in a rush to get you out of the door. We went on to have a daughter, Stevie born at 33 weeks and without Miss Bhabra's help she wouldn't be here."

Katrina Cliffe who nominated consultant Kaly Bhabra, see next page, for a Tommys' hero award, which she received at star-studded awards in London.

"Everyone cares at this Trust and we like to show we care - whether it's a hug in the clinic or a hello and a smile on the corridor."

Consultant oncologist Jo Dent.

"I think a smile is very important and that kindness and respect leads to everything else."

Betty Durning.

Betty Durning, team leader in orthotics.

Kaly, standing centre, and team with Katrina, front left.

Former medical director and consultant surgeon Bob Macdonald who performed the opening of HRI's new endoscopy unit pictured with Dr Rob Atkinson.

In 2011 we opened two state of the art endoscopy units.

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

2010 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 2011 we opened two state-of-the-art endoscopy units, one at Huddersfield Royal Infirmary and on at Calderdale Royal Hospital. The two are the most modern anywhere in the country and represent an investment of more than £6 million and were designed and built to provide the very best patient care in this specialist area. The equipment is state-of-the-art and the units also have modern hi-tech camera and sound installations to provide live commentaries by consultants during actual surgery for teaching doctors.

Consultant Ashwin Verma, said:

"Not only will it be a great place to work for everyone but it is also a great place for patients. Endoscopy has developed incredibly in the last 10 to 20 years. We are doing things that we would never have envisaged and this is the way forward."

Ashwin Verma, consultant, centre.

Directors' Report

The Early Discharge team.

Patients at the Trust with long-term lung conditions are now benefiting from special team care delivered in their homes. Nurses and physiotherapists from the Trust now visit patients in their homes in a new programme called Early Supported Discharge (ESD) instead of patients having to spend a long time in hospital away from family and friends. The scheme is part of improving care for patients with chronic obstructive pulmonary disease who used to face long periods of time in hospital for the condition.

The Short Stay team at HRI.

Two new Short Stay wards were opened in January 2011. More short stay wards are now needed as patients are spending less time in hospital. The new wards mean patients have faster access to senior doctors after being referred into hospital by their GP or through A&E. There are a total of 60 beds at both hospitals for patients to stay up to 72 hours.

In the 2010 Care Quality Commission survey for maternity new mums and their families rated the trust amongst the best performing 20 per cent in the country for:

- Having confidence and trust in staff
- Being welcoming
- For not being left alone at a worrying time
- Talking in a way which is easy to understand
- Involving them in the key decisions.

Overall the care during childbirth was rated highly again putting the Trust in the top 20 per cent in the country.

The Trust began a new community rehabilitation service model in 2010. As a result of the change the majority of treatments will be carried out in the patients' own homes.

Visual Hospital.

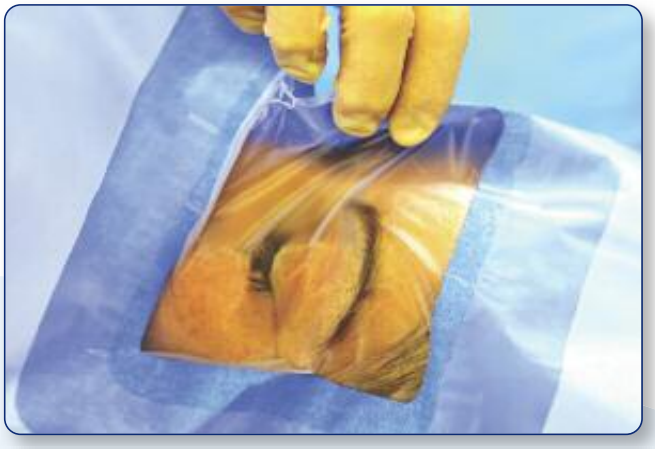
In 2010 we implemented Visual Hospital. This is a system used to support the flow of inpatients through the hospital. It helps staff ensure patients get to the right ward and that any discharge issues are picked up and dealt with as quickly as possible.

Since its implementation in 2010 the average patient length of stay has reduced, improving the individual patient's experience.

"Both hospitals have also scored an excellent rating for the food they offer."

The Acute Stroke team.

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 allows patients to go directly to the acute stroke unit at Calderdale Royal Hospital and receive specialist treatment at the onset of their symptoms. We have established a thrombolysis service 8am to 4pm Monday to Friday and a TIA (Trans Ischaemic Attack) clinic Monday-Friday. We are working in partnership with West Yorkshire Stroke Network to extend these services to cover 24 hours per day, seven days per week.



New theatre for eye surgery.

"The new theatre will be of huge benefit to patients who require eye surgery."

Consultant in ophthalmology Colin Hutchinson on the opening of a new theatre for eye surgery at Huddersfield Royal Infirmary.

A new theatre for eye surgery has opened at Huddersfield Royal Infirmary.

The theatre, costing £150,000, opened in July and will be used mainly for ophthalmology cases such as cataract and eyelid surgery where a local anaesthetic is needed.

Broad Street plan.

The building of the £50m Broad Street development in Halifax is moving ahead well. The services in Laura Mitchell Centre will be transferred to Broad Street in 2012. Laura Mitchell is an old building which is not fit for purpose and staff and patients will have a building which is far better suited to 21st century healthcare services.

Through the Exemplar Ward programme the Trust has continued to focus on providing consistency and standardisation across wards. *(More information in the Quality Report, starting page 21).*

Ward 21.

Calderdale Royal Hospital and Huddersfield Royal Infirmary have both scored well in the 2010 PEAT (Patient Environment Action Teams) national ratings. Both hospitals have scored good for the environment and good for the way they offer privacy and dignity to patients in our care. Privacy and dignity was a new category this year. Both hospitals have also scored an excellent rating for the food they offer.

In the results of the 2009/10 inpatients' survey our patients have put us amongst the top 20 per cent of hospitals in some key areas but also identified areas for improvement.

The survey by the Care Quality Commission revealed there are key areas for improvement and these will be at the centre of our work in the future. These include ensuring things are explained to patients in a way that patients could understand and improving information provided to patients. Areas where we scored highly included the privacy we offer our patients and the availability of hand-gels and hand-washing information. Both doctors and nurses scored highly for washing their hands between patients. Confidence and trust in our nurses and doctors was also high with nurses scoring 88 against a high of 92 and doctors scoring 89 against a high of 96. Patients also rated our admissions system highly with most being admitted on the date they were given without any changes. And they said their discharges out of hospital went smoothly and on time with minimum delays.

Improvements in patient and carer information

"At this Trust our priority is to treat every caller as an individual and put them through to the right extension as quickly as possible."

Switchboard operator John Hartley, above.

The Trust is constantly reviewing and updating its information for patients and carers to make sure it is both current, accurate and available in a variety of sources to make the information as accessible and easily understood as possible.

The most recent developments in this area include:

- The Trust has Patient Information Booklets in every bedside locker detailing the range of services available on each site and informing patients, their relatives and carers of all supportive information to assist them during their stay in hospital.
- Public Information Boards are in each of the main entrances and in our outpatient departments and these have a full range of information covering hospital services on each site.
- Flat-screen TVs in main entrances and outpatient departments 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 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 people who work in the Trust are the unsung heroes which make it tick. As an estates officer I am fortunate enough to go around all areas and wards within the Trust. Most people I meet I treat as friends and no matter how grave the situation may be. I always try to inject a sense of humour into proceedings. After all a little laughter brightens the day."

Estates officer John Ennis.

"All staff are encouraged to address issues as soon as they arise."

"I feel very honoured to serve my local members. I feel very proud of our team."

Midwife Sue Ng who won a top award at the Royal College of Midwives annual awards for being a champion workplace representative.

The Trust has established over time a relationship with recognised staff side representatives based on real partnership working. This is, in part, facilitated through a system of formal working groups which is designed to ensure that employees are involved and consulted about the business of the Trust and, in particular, how services are developed 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 all staff. This framework 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. It also facilitates involvement in matters that impact on an employee's ability to make a significant contribution to the success of the Trust.

In 2010/2011 the Trust agreed 'A Strategy to Save Jobs' with staff side representatives in response to the economic downturn and the resulting impact of the financial challenge facing public sector organisations. The strategy aims to ensure that the Trust retains skilled and experienced employees so that it can deliver higher quality services whilst at the same time identifying opportunities, through partnership working, for efficiency gains that help to protect the jobs of the existing and future workforce. The strategy recognises that keeping people in work and economically active maintains their health and wellbeing. The Trust, as a responsible employer operating in local communities, takes this responsibility very seriously.

The Trust employs more than 5,500 staff working in a variety of roles and settings and engagement with employees takes place through a number of ways at an organisation-wide and more 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.

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

For 2010/2011 the Trust's sickness absence rate was 3.8%.

Health and Safety

The Trust attaches great importance to fulfilling its duty of care in relation to the health, safety and welfare of its staff, patients and visitors who use our services and facilities.

We have the necessary policies in place each detailing key responsibilities and how safe systems of work are implemented, monitored and reviewed. Health and safety training is also key component in the Trust's mandatory training portfolio.

The Trust operates a proactive Health and Safety Committee working in partnership with staff representatives and encourages involvement from the workforce. The committee monitors and reports on non-clinical risks to the organisation ensuring they are managed and dealt with appropriately.

Financial standing and outlook

We are pleased to be able to report strong financial performance in 2010/11. We achieved a surplus, the operating part of which will be spent on improved facilities and equipment to benefit patient care. In addition, we finished the year with a healthy cash position.

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 3, 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 below shows the financial criteria that are used to calculate the Financial Risk Rating and our planned and actual performance in 2010/11.

Criteria	Metric	Planned score	Actual score	Planned rating	Actual rating
Underlying performance	Earnings before Interest, Tax, Depreciation and Amortisation as a % of income	7.7%	7.8%	3	3
Achievement of plan	Earnings before Interest, Tax, Depreciation and Amortisation as a % of plan	100.0%	103.2%	5	5
Financial efficiency	Return on assets	3.4%	4.0%	3	3
	Income and Expenditure Surplus margin	0.2%	0.5%	3	3
Liquidity	Liquidity days	27.6	28.2	3	3
Overall Financial Risk Rating				**3**	**3**

In 2010/11 the Trust received total operating income of £315m (excluding income relating to the reversal of impairment charges which is a technical accounting adjustment and does not impact on the cash position of the Trust). 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 2010/11 showed a 1.87% increase on income received in the previous year (excluding the technical adjustments described above).

Total operating expenditure (excluding impairment charges) in 2010/11 was £299.9m. Of the total amount spent, £202.3m was spent on pay costs and £97.6m on non-pay costs. The Trust achieved efficiency gains of £8.9m; this was achieved through clinical and operational efficiencies across the Trust.

After taking account of other non-operating income and expenditure items (net costs of £13.8m on items such as Public Dividend Capital dividends and interest received on cash balances), the surplus before impairment charges/reversals for 2010/11 was £1.4m; the plan agreed with Monitor at the start of the financial year showed an anticipated surplus before impairment charges of £0.4m. The increased surplus position was primarily due to contract over-performance and lower asset-related costs than planned.

The reversal of impairment charges included in operating income in 2010/11 was £5.6m. This relates to revaluation gains on property assets as a result of the increase in building costs which impacts on the carrying value of the Trust's operational assets.

The impairment charge on property assets included in operating expenditure was £5.1m. This relates primarily to vacation of the St Luke's Hospital site in Huddersfield which has now become non-operational for hospital services.

Private patient income accounted for 0.14% 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 2010/11 was £12.9m. Major schemes undertaken in 2010/11 included:

- New endoscopy units at Calderdale Royal Hospital and Huddersfield Royal Infirmary £4.1m.
- Major refurbishment of Ward 21 at Huddersfield Royal Infirmary £1.7m.
- Improvement of car parking facilities at Calderdale Royal Hospital £0.7m.
- Replacement of the boiler house at Huddersfield Royal Infirmary to a more energy-efficient plant £1.5m – to be completed 2011/12.

Operational and infrastructure schemes £2.7m.

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 other retirement benefits, and details of senior employees remuneration can be found in the notes to the Accounts.

The Trust takes a pro-active 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.

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 the year outside of this code.

This work undertaken outside of the code was in relation to the requirement for all NHS Foundation Trusts to produce quality accounts within their 2009/10 annual reports. This reflected the requirement from Monitor that Boards of Directors needed to engage external auditors to review and report on the arrangements in place to produce the quality report as well as testing some quality indicators. It should be noted that similar work in relation to quality accounts within the 2010/11 annual report is now covered by the Audit Code for NHS Foundation Trusts.

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.


NOT FOR SUPPORT

Quality Account

Chief Executive's Statement

This report is our opportunity to provide information about the quality of the services we deliver to our patients.

Quality simply defined is how good or bad something is. For me quality is about getting it right first time. This means our patients should be treated in the right place at the right time by the right people.

It means they should not suffer unintentional harm, such as falling while they are with us or picking up an infection. They should be treated with dignity and respect and as an individual and their care should be the best possible.

The quality of care for our patients has always been at the very heart of what we do every day. It may not have always been described as "quality improvement" but our work over many years to tackle infections, our involvement with the Safer Patients Initiative and many other programmes of work and campaigns led us naturally to a point where we pulled all these things together to create our Quality Improvement Strategy in 2009.

In addition to this we have ensured that the learning from the Francis report – the independent inquiry into care provided by Mid Staffordshire NHS Foundation Trust – underpins our work in quality improvement.

Two years later and quality improvement is part of everyday practice across our Trust. Wards proudly display charts showing that none of their patients have fallen or had a pressure sore for weeks and months.

Our Board of Directors takes an active leadership role on quality. The quality of our services is an integral part of discussions on business matters and business decisions and the board receives updates every month.

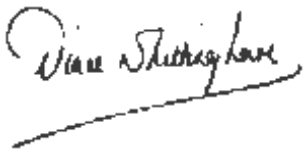
Our membership and staff regularly receive updates about the great work that is taking place through newsletters and meetings within the Trust. We share our Quality Improvement news with local GPs and other partners.

In September we held an event with our membership dedicated to the theme where staff showcased the work taking place, outlined the challenges and the progress to date.

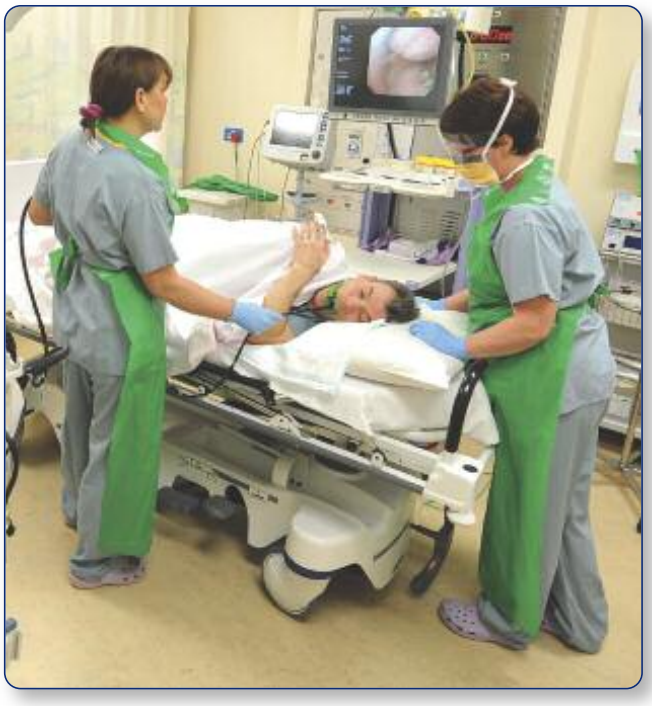
This is a journey and it will continue to develop and change. We still face many uphill struggles and although there is a lot to be proud of, there is still a lot we need to do better.

We can't report back on everything in this document – it will only be a snapshot of what is taking place. But I hope you will understand from the following pages that our drive for quality improvement is work undertaken with a passion – from the board to the ward.

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



Diane Whittingham · Chief Executive
26th May 2011



"Our patients should be treated in the right place at the right time by the right people."

Quality Account

Looking ahead to 2011/12 and how we performed on our priorities in 2010/11

When we were deciding our priorities for the year ahead we:

- Looked at national priorities and the things we have agreed with our commissioners (primary care trusts) as part of Commissioning for Quality and Innovation (CQUIN)
- Drew up a long list of contenders
- Asked our public and staff membership, LINks, our local authority overview and scrutiny committees and provider services what they thought should be our priorities
- Considered the priorities in the current Operating Framework and the future NHS Outcome Framework – both documents which shape our approach

This work helped us identify the following around patient safety, effectiveness and patient experience because they were important to our stakeholders:

Safety

- Reducing the numbers of pressure ulcers (sores)
- Reducing the numbers of Healthcare Associated Infections – MRSA bacteraemias
- Reducing the numbers of Venous Thromboembolism episodes (blood clots)

Effectiveness

- Reducing readmissions
- Developing care bundles* (Chronic Obstructive Pulmonary Disease, heart failure)

Experience

- Improving communication – particularly between doctors and patients
- Improving discharge processes

Care bundles – an explanation

Care bundles are a new approach to delivering safe and reliable care.

Care bundles are:

- A small number of evidence based actions all necessary to make sure staff get the results they need
- All the actions are simple and straightforward with a Yes or No answer
- They are designed to deliver safe reliable care at one point in time eg on discharge, prescribing antibiotics, preventing surgical site infections etc.

We are constantly scrutinising the quality of all our services but these areas were chosen because they were important to our staff and members. Over a number of months we have taken a long list of possible priorities to many different groups and stakeholders and asked the different audiences what is most important to them. The result was the seven priorities listed left.

The two areas which are no longer highlighted in this report as priorities are reducing the length of stay for patients undergoing colorectal surgery and end of life care. But this does not mean that the work is complete – it will continue alongside many other areas identified in our Quality Improvement Strategy.

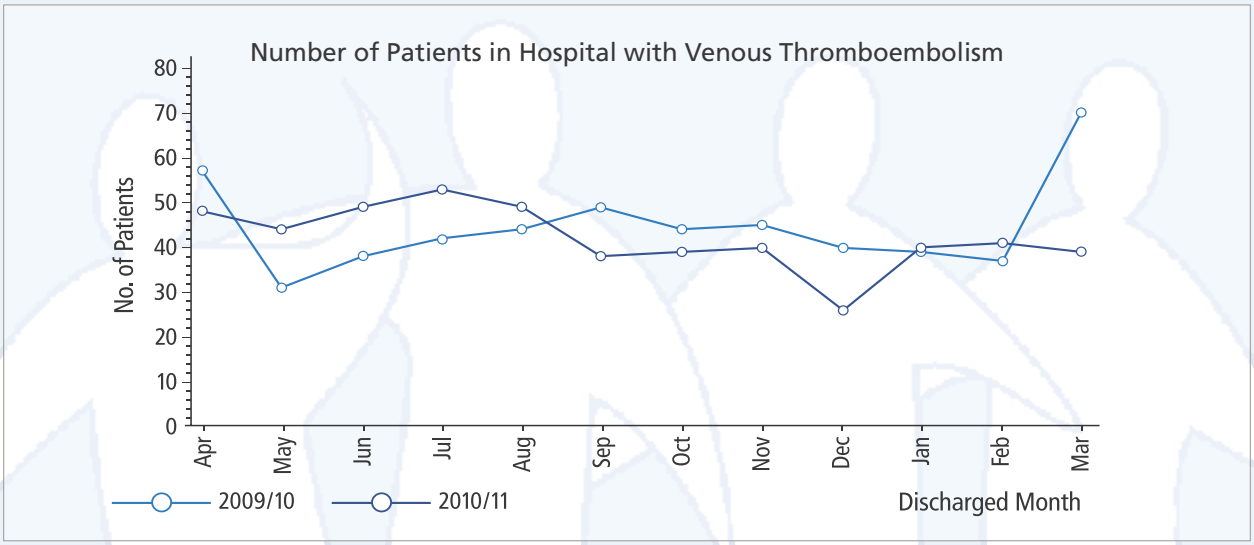
"We are constantly scrutinising the quality of all our services."

How we performed against the six priorities we set for 2010-11

This section tells you how we performed against the priorities we set ourselves for last year (2010/11).

Priority one:
Venous Thromboembolism (VTE or blood clots)

We said we would reduce the numbers of VTE episodes for patients in our care and also reduce the numbers of deaths as a result. It is known that VTE causes a significant amount of harm and in and some cases death. By identifying patients at increased risk and taking certain preventative measures we can reduce the number of VTEs. The number of VTEs is shown below.



There were 534 VTEs in 2009/10 compared to 507 in 2010/11 representing a 5% reduction the number of VTEs.

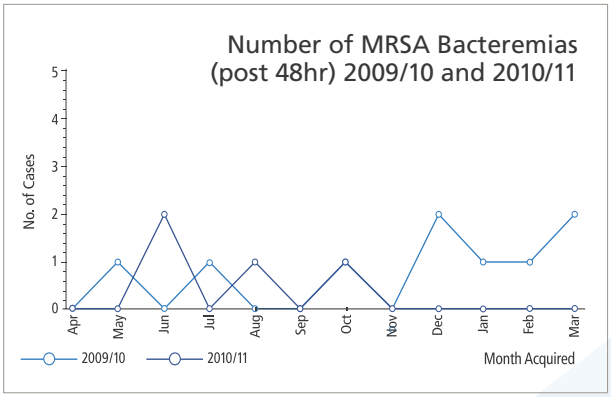
The focus has been on ensuring all our patients have a risk assessment for VTE completed on admission. This is the first stage in the implementation of a care bundle that will help us ensure we risk assess, act on the results and make sure patients are kept well informed about VTE.

- A clerking in document has been designed, tested and introduced for surgical and medical patients. This incorporates the risk assessment tool helping to make the process more reliable
- That the appropriate treatment is then given following risk assessment is being measured and highlighted where it is not yet reliable
- The risk assessment tool itself has been revised helping to ensure it is intuitive and helps the medical staff make the correct decision regarding preventative measures
- This priority has been carried forward to 2011/12.

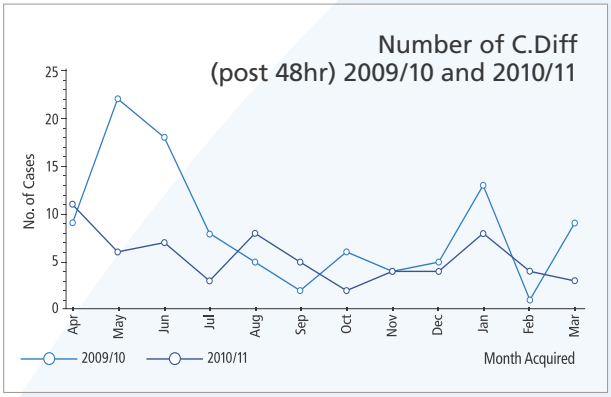
Priority two:
Reducing the numbers of Healthcare Associated Infections (HCAIs)

We said we would achieve a reduction in the number of hospital acquired infections. As a Trust we have made great progress but we believe there are further improvements that can be made to ensure our processes are as reliable as possible, driving down infection rates further. We believe every infection is one too many.

The following two charts show the Trust's performance on MRSA bacteraemia and Clostridium difficile infections.



There were nine MRSA bacteraemias apportioned to the Trust in 2009/10 compared to four in 10/11. This shows a 55% reduction in the number of healthcare associated bacteraemias.



There were 102 Clostridium difficile infections apportioned to the Trust in 2009/10 compared to 66 in 2010/11 representing a 35% reduction.

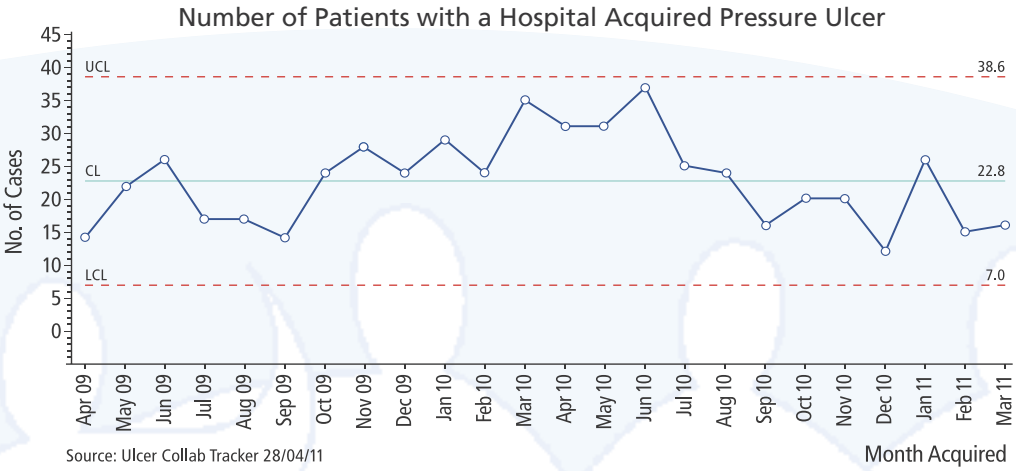
As shown we have seen a sustained reduction in Clostridium difficile and although our rates of MRSA bacteraemia are low we are not seeing the same sustained reduction here. Ongoing improvement work is outlined below:

- To continue to improve hand hygiene a new web based tool is being tested. This also captures the quality of hand hygiene practiced allowing us to further target improvements
- Further improvements to the environment are being implemented such as an improved bed cleaning tool and reductions in the use of commodes on wards. Through the national Showcase Hospitals Programme we have been testing innovative, new equipment to improve the ward environment
- We have been working hard to improve the use of antibiotics, running a campaign to raise awareness among the staff for their safe use and working to develop a care bundle approach to improve the reliability of practice.
- This year has seen continued improvement in our screening performance for MRSA, helping to ensure patients are given suppression treatment as soon as possible reducing the chance of infection developing
- We have also been targeting the use of invasive devices, continuing to focus on central lines and looking at the use of peripheral venous cannulas. Better insertion and ongoing care documentation is being developed along with packs to aid safe insertion
- The work to reduce MRSA bacteraemias has been carried forward as a priority for 2011/12.

"We believe every infection is one too many."

Priority three:
Reducing the number of pressure ulcers

We said we aimed to reduce the incidence of hospital acquired pressure ulcers. Pressure ulcer incidence is an important measure of nursing quality.



In 2009/10 we had 274 pressure ulcers of all grades compared with 277 this year. This represents a 1.09% increase. We believe this is because we have continued to focus in 2010 on improving data quality, including making sure all grades of pressure ulcers were accurately reported. We built on that work with:

- Systematised risk assessment within two hours of admission for all patients
- Appropriate introduction of preventative measures such as repositioning, nutrition, equipment and skin assessments
- Implemented monthly ward audits
- Implemented a nursing procedure module to look at pressure ulcers on a number of wards
- Worked with all our local healthcare partners
- We tested nationally developed initiatives to reduce pressure ulcers on some of our wards, working alongside the Institute for Health Improvement.

We have been building on these firm foundations by:

- Developing an E-learning (website based) education and training package
- Intentional nurse rounding (regular visits to each patient by nurses) is carried out for patients at risk of developing pressure ulcers. We plan to roll this out across our hospital wards
- The implementation of improved combined risk assessment and care planning tools
- A new incident reporting form has been developed across the health economy
- The implementation of improved nutritional screening tool, as nutrition and hydration help prevent pressure ulcers.

Our wards now use safety crosses to record the days between incidents and display this information to staff, patients and visitors.

We have made a successful application to work with the Safer Patient Network to implement the SKIN bundle, which has had a significant impact upon reducing pressure ulcers in a number of trusts in Wales.

The introduction of the new incident reporting form has strengthened ward to board reporting of all grades of pressure ulcers. Root cause analysis (a detailed investigation) is now performed on the pressure ulcers that cause the most harm and the lessons learnt are shared.

The work to reduce the incidence of hospital acquired pressure ulcers has been carried forward as a priority for 2011/12.

Priority four:
Reduction in the length of stay for patients undergoing colorectal surgery

"Enhanced recovery has been hugely beneficial to patients: giving them a better experience and helping them get home sooner."

Anaesthetist Paul Knight, who won the effectiveness of care category at the annual staff awards for the team working to improve our care for colorectal and gynaecological surgery patients.

"I was amazed that I was able to eat on the same day as my operation and was up and walking about the day after."

Betty Stott, of Sowerby Bridge, who had a speedy recovery from bowel surgery thanks to the new, improved approach to treatment and care called enhanced recovery.

We said that by implementing an enhanced recovery programme patients would recover more quickly and be discharged sooner.

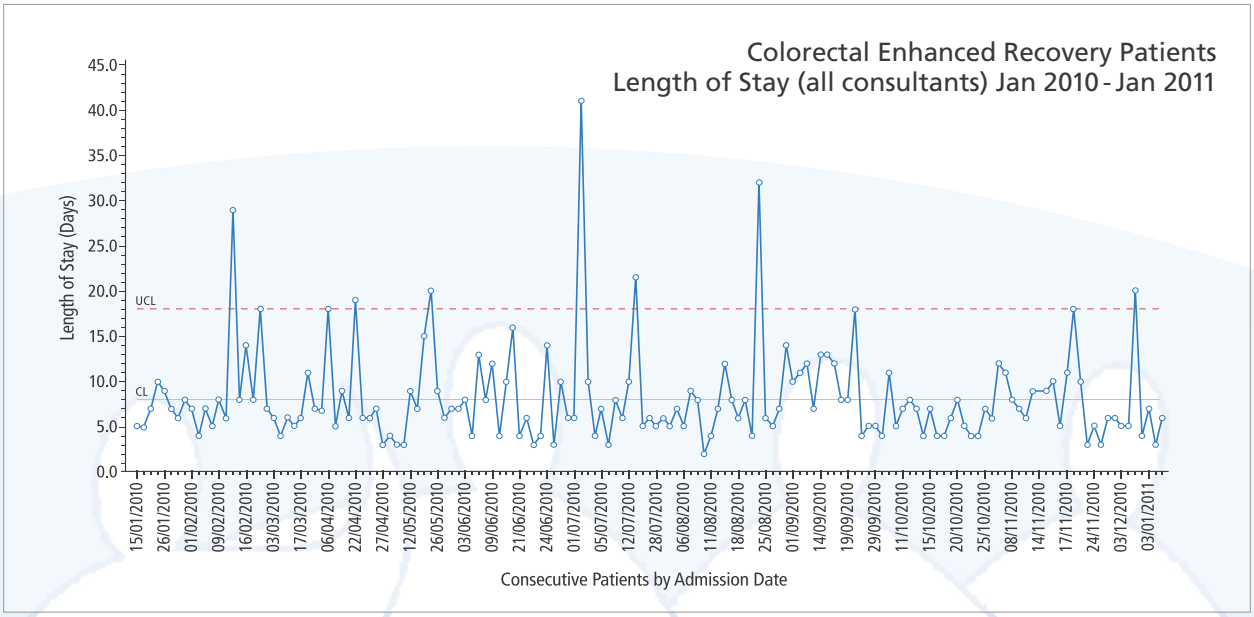
Evidence suggests that if patients undergoing certain colorectal procedures receive a defined list of interventions before, during and after an operation they will recover more quickly, leave hospital sooner, and report a better outcome, being able to return to work or normal activity sooner.

By prioritising this we are following best practice to give a better outcome for patients whilst at the same time reducing length of stay. These principles of enhanced recovery are transferable to other conditions (e.g. gynaecology and orthopaedic), so the work we do in implementing enhanced recovery in colorectal will help us in other areas too.

For all patients undergoing certain colorectal procedures we aimed to see a reduction in average length of stay from 10 days to eight days in one year.

"We are following best practice to give a better outcome for patients whilst at the same time reducing length of stay."

Priority four: *(continued)*
Reduction in the length of stay for patients undergoing colorectal surgery



The chart above shows length of stay for all patients undergoing certain colorectal procedures. Baseline data for the year before gave an average of 10 days. It can be seen from the chart that the average length of stay has reduced to eight days:

- Time has been spent developing the processes and pathways for these patients to follow, to ensure that they receive all the interventions required
- This is being used by a couple of surgeons until the pathway works and we can be sure we have a reliable process to make sure patients receive all the parts of the bundle
- An enhanced recovery pathway is also being tested with certain hysterectomy patients.

The work we have done has given us assurance that patients are reliably receiving clinically effective, evidence based care when they go on the enhanced recovery pathway. There has been a reduction in length of stay for patients and better outcome for patients. We now use patient diaries so that patients know what to expect before, during and after their procedure and can retain some control over what happens to them.

This is not being carried forward as a priority but the work will continue and new initiatives to be implemented in 2011/12 include:

- Rolling out the programme - once we have a process we can rely on, other surgeons will adopt the pathway which should further reduce length of stay
- Patient experience information will be routinely collected for enhanced recovery patients
- We will look at how enhanced recovery can be used in orthopaedic surgery, focussing on hip and knee replacements.

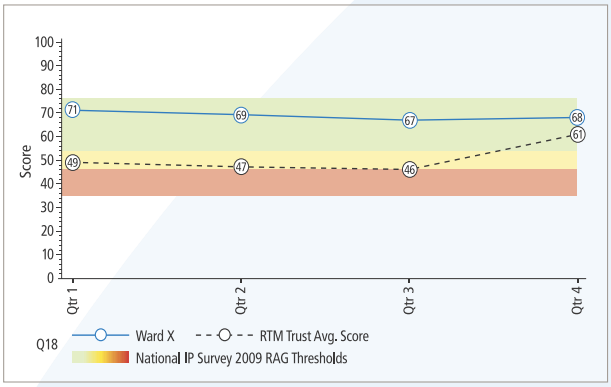
Priority five:
Real Time (Patient) Monitoring (RTM)

We said we would improve patient experience by using real time data across all areas. Real time monitoring is a way of asking patients about the care they receive while they are still in hospital. The Trust's Quality Improvement targets for this indicator are demonstrated in the table below:

	Baseline	Target	Target	RTM (Real Time Monitoring) Q3	RTM Q1	RTM Q2	RTM Q3
Overall, how would you rate the care you received? (threshold for top 20% in 2009 survey = 81 Highest scoring Trust=91)	**40th Score = 79**	84	Top 20%	Baseline percentile position from 2009 National Inpatient survey. Will use Local Inpatient Survey and RTM to track performance.	84	85	82
Would you recommend this hospital to a friend or family member? (Yes, definitely) Target =90%	**81%**	81%	90%	Patients with a response of **"Yes, definitely"**. Baseline from sample of 585 RTM surveys taken Mar-Jul 2010. RTM will track performance.	80%	82%	81%

The table shows the high level results for the Trust in terms of patient experience. This is based on the most recent national inpatient survey results and Real Time Patient Monitoring data. However the survey also focuses on admission, privacy and dignity, infection control, safety, information and involvement, care and treatment and discharge from hospital. Please see example of a ward's report for one question below.

Question: Has a member of staff told you about medication side effects to watch out for when you are at home?



Note: National IP (Inpatient) survey RAG (red, amber, green) thresholds: Red = bottom 20% of trusts and green = top 20% of trusts

- A report structure is in place to disseminate the results of the monitoring. Reports are received monthly at Trust, divisional and directorate level, along with monthly ward level reports
- Reports are also received quarterly from Picker identifying positive findings for the Trust along with areas for improvement (Picker Institute is a not-for-profit organisation dedicated to "making patients' views count in healthcare")
- A recruitment drive continues to enlist a constant flow of volunteers to undertake the surveys, supported by in-house audit staff as required to ensure objectivity
- We are achieving the target of surveying 20 patients per quarter per ward and are also starting the monitoring in outpatient areas
- We continue to undertake a local inpatient survey annually in addition to the statutory annual survey
- The Trust Executive Board report has comparative quantitative and qualitative trends based on national surveys and our own monitoring data, which includes analysis of all comments received
- One of the Quality Improvement collaborative projects involves working with small groups of wards to test and spread interventions that improve patient experience
- Training has been delivered to frontline staff in Experience Based Design to enable them to use it as a tool to better understand the emotional impact that patients may experience throughout their hospital stay
- The communication and discharge processes highlighted in our monitoring will be a priority in 2011/12.

Cardiology sister Sally Lee said the system had been of benefit for obtaining both positive and negative feedback from patients. *"After the monitoring takes place a report is given to us and from that we do an action plan. One thing we have been looking at is giving patients a better explanation of the medication they are given after the questionnaires highlighted some patients did not feel they were given enough information."*

Priority six:
End of life care

We said we wanted to ensure that patients who were at the end of their life had the opportunity to state their preference as to where they died and that this was recorded and communicated to relevant staff.

Our work towards this aim has meant:

- We have developed an Advance Care Plan (ACP) and we are working with patients to test the document to ensure it suits their needs
- We introduced the role of ACP facilitator to work across organisations so that we can assist patients to die in their place of choice and to help professionals use the end of life pathway
- We introduced further training and education in end of life care
- We worked with the hospice to capture patients experience of hospital care
- Our Trust has constantly achieved above the regional average number of patients being cared for on the end of life pathway
- We have worked with clinicians and partner organisations to facilitate patients wishes of their choice of place of death
- While this has not been carried forward as a priority for 2011/12 the work will continue and it is still part of our Quality Improvement Strategy.

The target agreed for patients being cared for on a Liverpool Care Pathway (end of life pathway) was 30%. We managed to achieve this in each quarter and the overall figure for 2010/11 was 36.5%.

"Our mother was admitted to Calderdale Royal Hospital and spent three weeks as a patient. We are writing to express our deep gratitude for the diligent care and compassion she received during her illness and their help and support to our family. The staff, despite their busy schedule, went the extra mile at all times to ensure her death was dignified and comfortable, and above all they were truly kind."

"Nothing has ever been too much trouble and we have all felt confident leaving her in your care, knowing she will be looked after."


NHS
NHS

Looking ahead to 2011/12

Here you can find more detail about the seven priorities for the coming year which were chosen after consulting with many of our different stakeholders. All these priorities will be reported each month to the Trust's Executive Board, the Board of Directors and, quarterly, to the Membership Council.

Safety

Reducing the numbers of pressure ulcers

Why we chose this

This priority has been carried forward to ensure we maintain our focus and pace of improvement to reduce the number of patients who develop avoidable hospital acquired pressure ulcers.

Work is ongoing within the pressure ulcers collaborative to ensure we deliver reliable care on our wards, which is shown to reduce pressure ulcers. This includes risk assessment, care planning and re-evaluation of risk. Intentional nurse rounds - special rounds carried out regularly though the day where the ward staff make sure patients are risked assessed and checked - have also been implemented for patients who are at risk.

Improvement work

- We will continue to work with the Safer Patients Network to implement the SKIN bundle (a series of steps implemented for at risk patients) reliably within the collaborative wards
- Implement intentional nurse rounds across more ward areas
- Ensure all patients receive risk assessments on admission to hospital in line with the Trust policy
- Work with partner organisations to reduce pressure ulcers within community settings

Reporting

We will measure performance using the following indicator – number of patients with a hospital acquired pressure ulcer. During 2011/12 we will include a further six ward areas into the pressure ulcer improvement collaborative. Progress will be reported on a monthly basis to the Exemplar Ward Board, chaired by the Director of Nursing, and this information is then reported to the Quality Improvement Board.

Reducing the numbers of healthcare associated infections - MRSA bacteraemias

Why we chose this

MRSA continues to be a priority for the Trust as we believe we can drive down the rate of infection still further – every infection is one too many.

Improvement work

- We are revisiting our work on hand hygiene to gain a greater understanding around some of the possible quality issues
- There is work ongoing around invasive devices. For central lines we are rolling out a care bundle to all wards, which has already been successfully applied in our intensive care unit. For peripheral venous cannulae we have recently adapted the care plan to include new guidance and are working on an insertion pack that will make it easier to insert them safely. Work is also ongoing to reduce the number of urinary catheter infections again through updating care plans and rolling out training to the nursing teams
- All the work on indwelling devices is being underpinned by a programme of Aseptic Non Touch Technique (ANTT) training to all staff who work with the devices, including all medical and nursing staff
- Work is continuing to improve our ward environments.

Reporting

We will measure performance using the following indicator – number of patients who develop a post 48-hour MRSA bacteraemia. Our target is to continue to ensure staff practice frequent and effective hand hygiene. Performance is closely monitored by our Infection Control Performance Board and fed up to Executive Board.

Safety *(continued)*

Reducing the numbers of Venous Thromboembolism (VTE) episodes

Why we chose this

As explained earlier VTE (blood clots) can cause significant harm to patients and in some cases death. Improvements have been made, particularly around risk assessment, but we know there are a number of other things we can also do and therefore this remains a priority for the Trust.

Improvement work

- Risk assessment of patients is the first stage in implementing the care bundle for reducing VTE. Therefore for the coming year we will be continuing to improve compliance with this element but also working on the other elements namely, ensuring appropriate prophylaxis (preventative measure) is given, review after 24 hours and giving patient information
- We are continuing to test interventions to help medical staff choose the correct prophylaxis and testing has begun on an adapted prescription chart
- A systematic process for 24-hour review is being designed and implemented. This is to ensure that as a patient's condition changes, choice of prophylaxis remains correct
- A patient information leaflet will be given to all patients on admission explaining what VTE is, the purpose of prophylaxis and what actions can be taken to prevent blood clots.

Reporting

We will measure performance using the following indicator – number of hospital acquired VTE episodes. Our target is to maintain 90% risk assessments for all patients. A monthly report for our performance on VTE is produced for the VTE Improvement Collaborative and a summary of this is monitored by the Trust's Quality Improvement Board.

Effectiveness

Reducing hospital readmissions

Why we chose this

Readmissions following an elective (planned) procedure or a previous emergency admission can be distressing for patients and a significant cost to healthcare. Eliminating unnecessary readmissions can free up resources which can be redirected in providing care closer to people's homes or in their homes.

This work includes looking at patient discharges. Patient discharge is most successful when it is well planned by the hospital in partnership with patients, relatives and other agencies, such as social services.

Improvement work

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

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

Reporting

We will measure performance using the following indicators - emergency readmission within 30 days of discharge (for elective admissions) and emergency admissions within 30 days of discharge (following previous emergency admission). Our aim for the year is to do a rigorous analysis to better understand the categories of patients who are at risk of readmission. Progress will be managed and monitored via a readmission steering group, which will ultimately report to the Quality Improvement Board.

"Eliminating unnecessary readmissions can free up resources which can be redirected in providing care closer to people's homes."

Effectiveness *(continued)*

Developing care bundles - Chronic Obstructive Pulmonary Disease (COPD) and heart failure

Why we chose this

We are aiming to reduce the number of deaths of patients with these conditions using care bundles. Through our work with the North West Mortality Collaborative we are working to develop a care bundle approach for COPD and heart failure. Care bundles are a small number of evidence based actions that act as prompts to deliver safe and reliable care and achieve the best outcomes for the patient.

The Trust has used the care bundle approach for some time with success in small areas such as reducing ventilator acquired pneumonias in intensive care.

Improvement work

We are designing and testing care bundles for both COPD and heart failure with the specialist teams. These bundles are beginning to be rolled out in admission areas. Close monitoring will take place on both the reliability of this process and also the impact it has on mortality from these conditions

Links are being made from this collaborative to work on end of life care to help ensure, where needed, transition is as smooth as possible and the best care given

The process for developing and implementing condition specific care bundles once thoroughly tested for COPD and heart failure will be spread to other conditions.

Reporting

We will measure performance using the following indicator – compliance against all elements of the specific care bundles. Our target is to ensure that all relevant patients are commenced on the care bundle and all elements are reliably applied. A monthly dashboard indicating our performance on COPD and heart failure care bundles is produced for the improvement collaborative and a summary of this is monitored by our Quality Improvement Board.

Experience

Real Time Patient Monitoring (RTPM)

These priorities have been carried forward from 2010/11. The recently published results of the National Inpatient Survey 2010 again showed room for improvement and in recognition of this we will focus on two areas:

Improving doctors' communication with patients

Why we chose this

Although most doctors communicate effectively, there is increasing evidence that some patients are unhappy with the amount of information received and the manner of its delivery. Poor communication is one of the most common reasons for complaints and is often the underlying cause of adverse events.

Improvement work

Three consultants are to champion the doctors' communication work, using scheduled training days to maximise their opportunity to deliver key messages and using the 'Expert Patient Programme' to support any training requirements identified.

The following questions from the National Inpatient Survey will be used to measure improvement, the first question via the monthly RTPM report and the second and third questions through the results of the national and local inpatient surveys

Improving doctors' communication:

- When you had important questions to ask a doctor, did you get answers that you could understand?
- Did doctors talk in front of you as if you weren't there?
- If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?

Reporting

We will measure performance using the following indicator – Real Time Patient Monitoring. Our aim is to increase the number of consultants who attend communication training. Reporting on this will be through the Trust's Patient Experience Steering Group, which reports to the Quality Improvement Board

Experience *(continued)*

Improving patient information on discharge

Why we chose this

It is essential to ensure that patients have the correct information when they are discharged and also have a point of contact should they be concerned about their condition in any way. It is important that patients feel confident when going home to ensure that their recovery is as uneventful as possible and as a consequence avoid unnecessary readmissions and any further contact in relation to their treatment.

Improvement work

Each ward is currently reviewing its processes for ensuring patients receive the information they require on discharge and good practice will be shared.

The following questions from the National Inpatient Survey will be used to measure improvement via the monthly RTPM report:

Improving information on discharge:

- Were you told about medication side effects to watch out for when you went home?
- Were you told who to contact if you were worried about your condition after you left hospital?

Reporting

We will measure performance using the following indicator – Real Time Patient Monitoring. Our aim is to identify the remedial actions for specific wards and to introduce a generic discharge sheet. Reporting on this communication issue will be though the Trust's Patient Experience Steering Group, which reports to the Quality Improvement Board.

The information on the next few pages is mandatory text that all NHS Foundation Trusts must include in their Quality Accounts and Reports. Where we have provided an explanation it is in italics.

Review of services

- During 2010/11 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 19 of these services
- The income generated by the NHS services reviewed in 2010/11 represents 36% of the total income generated from the provision of NHS services by CHFT for 2010/11.

Participation in clinical audits

Clinical audit involves improving the quality of patient care by looking at current practice and modifying it where necessary. We take part in regional and national clinical audits. Sometimes there are also national confidential enquiries which investigate an area of healthcare and recommend ways of improving it.

During 2010/11, 39 of the national clinical audits and four national confidential enquiries identified for inclusion in the Quality Accounts covered NHS services that Calderdale and Huddersfield NHS Foundation Trust provides.

During that period Calderdale and Huddersfield NHS Foundation Trust participated in 87% of national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

For more information about these audits please see appendix A.

Participation in clinical research

Irene Firth, of Stainland, Halifax, took part in a pioneering research study, which aims to improve the follow-up care for breast cancer survivors.

"I made a good recovery following surgery, and I don't believe that I would have benefitted from attending a hospital appointment just to tell the doctor that I was feeling well. But it was reassuring to know, that at any time, I could pick up the phone and speak to a clinical nurse specialist if I had any worries."

Clinical research involves gathering information to help us understand the best treatments, medication or procedures for patients. It also enables new treatments and medications to be developed. Research must be approved by an ethics committee.

Consultant oncologist Dr Johnathan Joffe, is leading our oncology research work. He said:

"The Trust is recognised as one of the highest recruiters to clinical trials in the region, excluding specialist cancer centres, with an excellent track record. We have put together an oncology strategy which will make sure that we continue to develop existing research areas, maintaining our principle of, whenever possible, having a study available for every patient referred to us, for each stage of the patient's cancer journey."

"It was reassuring to know, that at any time, I could pick up the phone and speak to a clinical nurse specialist if I had any worries."

Between April 2010 and March 2011 the number of patients receiving NHS services provided or sub-contracted by Calderdale and Huddersfield NHS Foundation Trust that were recruited to participate in research approved by an authorised research ethics committee was 456, as opposed to 1,127 in the previous year. The reduction in numbers recruited was due to the completion of two high recruiting non Clinical Trials of an Investigational Medicinal Product studies.

Seventy-nine clinical staff employed by the Trust participated in this research, drawn from over 20 medical specialties.

This level of participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer and making our contribution to wider health improvement.

Altogether the Trust hosted 150 health related research studies (an increase of 12% over last year) of which 79 were randomised interventional studies and of these 72 were supported by the National Institute of Health Research (NIHR) Clinical Research Networks.

Of the 150 studies the Trust completed 39 studies as designed within the agreed time and to the agreed recruitment targets.

The Trust used national systems to manage the studies in proportion to risk. Of the 50 studies given permission to start:

- 78% were studies adopted into the NIHR clinical research portfolio (25 studies through its Topic Specific Research Networks and 14 through the local specialty groups set up by the local comprehensive research network);
- 71% were given permission by an authorised person less than 30 days from receipt
- 54% were established and managed under national model agreements;
- 28% used the Human Resources 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, five publications have resulted from our involvement in NIHR research, helping to improve patient outcomes and experience across the NHS.

Goals agreed with commissioners

Primary care trusts hold the NHS budget for their area and decide how it is spent on health services for local people, which is known as commissioning. The primary care trusts also set targets based on quality and innovation.

A proportion of Calderdale and Huddersfield NHS Foundation Trust income in 2010/11 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body (e.g. commissioning PCT) it entered into a contract, agreement and arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. The figure for CQUIN received for 2010/11 was £3.4m.

Further details of the agreed goals for 10/11 and for the following 12 month period are available electronically at: http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html

Care Quality Commission registration

The Care Quality Commission regulates and inspects health organisations. If it is satisfied the organisation provides good, safe care it registers it without any conditions.

Calderdale and Huddersfield NHS Foundation Trust is required to register with the Care Quality Commission and has full registration without conditions. The Care Quality Commission has not taken enforcement action against Calderdale and Huddersfield NHS Foundation Trust during April 2010 to March 2011.

Data quality

Good quality information underpins the effective delivery of patient care and is essential if improvements in quality of care are to be made.

Calderdale and Huddersfield NHS Foundation Trust has continued to move forward with measures to improve data quality during 2010/11. These measures include:

- Completion of a project to implement the mandate of the NHS Number in secondary care; this includes making the necessary changes to the in-house Patient Administration System as well as raising awareness within the Trust of the importance of the NHS Number
- Establishment of an Information Quality Assurance Group which will take responsibility for the Trust's data quality improvement plan and for the monitoring and auditing of data quality, thereby freeing the Trust's Information Governance and Records Strategy Committee to focus on strategic issues
- Introduction of procedures to investigate and resolve commissioning assignment queries raised by the Trust's commissioners and by the purchasers of non-commissioned activity.
- Working with the local primary care trusts to improve inclusion of the NHS Number on diagnostic test requests
- Continued roll-out of electronic requesting and reporting for diagnostic tests, both from primary care and within the Trust, with measures to reduce patient duplication and to ensure that full consolidated test result histories are available to clinicians at the points of requesting and reviewing reports
- Extension of the process to automatically update the patient's registered GP in the Trust's Patient Administration System to include patients in the Bradford area in addition to those in the Calderdale and Kirklees areas; this supports the correct delivery of clinical correspondence as well as identifying the correct commissioner.

These actions incorporate:

- Issues identified through the Information Governance Toolkit self assessment process
- Issues agreed for improvement with the Trust's main commissioner as part of the service level agreement
- Issues identified through internal monitoring and external assurance processes

NHS Number and General Medical Practice Code Validity

Calderdale and Huddersfield NHS Foundation Trust submitted records during 2010/2011 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:
99.6% for admitted patient care;
99.9% for out patient care; and
97.4% for accident and emergency care.

Which included the patient's valid General Medical Practice Code was:
100.0% for admitted patient care;
100.0% for out patient care; and
91.9% for accident and emergency care.

Information governance

Information governance is about keeping the information we hold about staff and patients safe.

Calderdale and Huddersfield NHS Foundation Trust Information Governance Toolkit Assessment Report overall score for March 2011 was 71% and was graded unsatisfactory. This was due to five requirements (out of a total of 45 requirements) not meeting the required scoring level of two.

NB: There are only two levels of assessment grading available: satisfactory or unsatisfactory. In previous years the grading was a traffic light approach (red, amber, green), with overall toolkit scores of 70% or over being 'green'.

Data loss

In 2010 we experienced the theft of a portable computer which was part of an electromyography (EMG) machine. The manufacturers/suppliers of the EMG machine, used for testing the electrical activity of muscles, confirmed that the portable computer is not encrypted but we know that the operating system was password protected. The portable computer held personal information relating to 1,569 patients. In all of records referral symptoms, name and date of birth were shown. In 1,051 of these records, the address was also included.

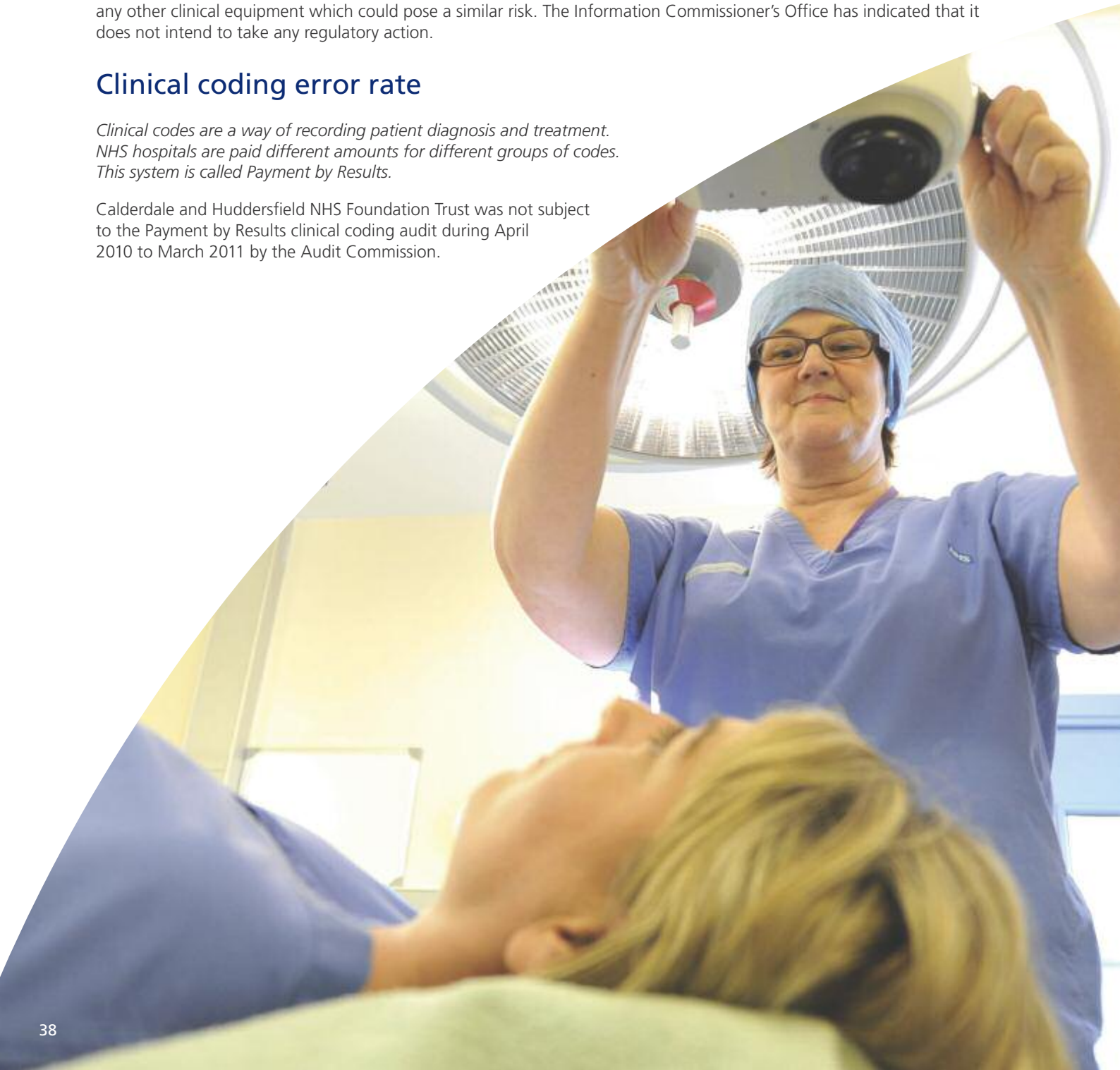
The theft was reported to the police and reported as a serious incident in accordance with Department of Health guidance. All those affected were notified and the incident was reported to the Information Commissioners Office.

Immediate action was taken to improve security, and an action plan put in place to identify and take mitigating actions on any other clinical equipment which could pose a similar risk. The Information Commissioner's Office has indicated that it does not intend to take any regulatory action.

Clinical coding error rate

Clinical codes are a way of recording patient diagnosis and treatment. NHS hospitals are paid different amounts for different groups of codes. This system is called Payment by Results.

Calderdale and Huddersfield NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during April 2010 to March 2011 by the Audit Commission.



How we performed on quality in 2010/11

"My world fell apart following the accident but with the help of Dr Vyas and the self-management programme I learned how to manage my pain. I no longer require medication and regular hospital or GP appointments. My life is back on track."

Peter Stubbs, of Dalton, Huddersfield, who has been involved in a groundbreaking programme to help people manage their pain called Co-creating Health.

Case study:

"Staff don't have time to talk to me about fears or concerns"

This was one comment we had back from real time patient monitoring – a clear demonstration that our staff needed more time to care!

The key to better care is, undoubtedly, that our staff have more time with their patients. We want them to spend as much time as possible with patients during their stay making sure they get the care and support they need.

To this end we have been pursuing the productive ward* toolkit - a series of small changes - aimed at freeing-up nurses' time. And already the results – from ward areas taking part - make exciting reading.

So far the changes, which started in August 2009, have led to a staggering:

16,372 hours per year or 1,364 hours per month freed up to spend with patients.

So how have we done it?

We've been tidying so we spend less time looking for things; we've reworked mealtime deliveries to speed them up; we've introduced a new system to reduce the time spent on medicines rounds.

The work around mealtimes has had a direct impact on both patient and staff experience on the ward – a calmer, unhurried meals round without interruptions has benefited us all.We have now saved 1,427 hours per year or 119 hours per month by implementing new trolleys and ordering food on the same day within the meals module.

In medications a large amount of time was spent delivering them, which has fallen with the implementation of new trolleys and staff started wearing tabards asking not to be disturbed.

This is now running on various wards making a huge saving of 5,055 hours per year and will continue to be implemented across the Trust.

And there's even more to celebrate

Many wards are now achieving longer and longer periods of time between cases of pressure sores and falls which is excellent news. At the time of writing one ward had gone 145 days without a patient getting a pressure ulcer and another 57 days without a patient having a fall.

**A programme devised by the Institute for Innovation and Improvement.*

Case study:

Eliminating mixed sex accommodation

Providing same sex accommodation is a top priority for the Trust to ensure the wards and clinical areas are as pleasant as they can possibly be for our patients and their families.

Same sex accommodation which is both up-to-date and up to standard is now central to the privacy and dignity drive across the Trust.

Extensive work has been carried out remodelling old bathrooms areas and creating new ones to make sure they provide the correct, separate facilities.

Signage is now on all wards helping patients to the correct facilities in their areas. So while some wards have both female and male patients we provide completely separate male and female sleeping areas, bathroom and toilet facilities. Patients should not need to pass through opposite sex accommodation or toilet and washing facilities in order to access their own.

Deputy director of nursing Rob Dearden said:

"For most people being in hospital is a difficult and worrying time and we are doing our utmost to ensure privacy and dignity are respected and individual cultural needs are recognised.

"Providing same sex accommodation is an ongoing piece of work in the past year in order that our quality of care is the very best. Staff are fully aware of the changes so they can help patients when they need assistance."

Work in the last year has included:

- Ward 21 at HRI had a £1.9 million revamp and now has a number of single rooms offering ensuite facilities, two four-bedded bays and a therapy area
- Improvements have been made to the Clinical Decisions Unit at Huddersfield A&E and in the Observation Ward at Calderdale A&E by the provision of screens which allow the areas to be separated.

- New endoscopy units at both our hospitals will make sure our patients are provided with excellent accommodation, which protects their privacy and dignity.

There are some circumstances where sharing sleeping accommodation may be clinically justified and these include where a patient needs very high-tech care, with one-to-one nursing (e.g. ICU, HDU) or needs very specialised care, where one nurse might be caring for a small number of patients and cannot safely leave the room other than for very short periods (e.g. immediately following major surgery) or where our patient needs very urgent care (e.g. Acute Stroke Unit or Coronary Care Unit).

"Providing same sex accommodation is a top priority for the Trust."

Case study:

Equality and diversity

The Trust has taken great strides to ensure that quality care is available to all our patients.

As part of this, we have appointed a matron with special responsibility for patients with learning disabilities to make sure their needs and those of their families are met by our clinical teams.

We have adapted our PAS (Patient Administration System) so complex care matron Amanda McKie receives an alert when a vulnerable patient is admitted. She can then meet with them and their families and assist them throughout their care.

A "hospital VIP passport" has been developed for these patients, which explains everything as clearly as possible.

In the last year, she has cared for 368 inpatients and nearly 700 other patients who are out-patients, on waiting lists or receiving care from us.

Amanda continues to work closely with partner organisations to improve specialised pathways of care for our patients with special needs. Their team effort made them overall winner of our Celebrating Success top award at the staff event.

After winning, she said:

"I am really pleased. The award gives profile and recognition for the work we have been doing and it gets people thinking."

Adding to Amanda's work is nurse consultant for older people, Barbara Schofield, who has been awarded the new Claire Rayner national scholarship to research care in memory of the late agony aunt who championed patient care.

The award is from our partner organisation, University of Huddersfield, and Claire's son Jay attended the ceremony when the scholarship was awarded. Barbara said:

"I am thrilled to have been given this opportunity to look into compassion and its role in nursing. What I am determined to do is make sure that this research is worthwhile and that it can be used to improve patient experience."

The Trust has started a programme of awareness training for staff to help them care for patients who are deaf or hard of hearing. We are also continuing to work closely with the Calderdale Disability Partnership Board to appraise the way we deliver care for all our patients with a disability.

Vice chancellor of Huddersfield University Bob Cryan, nurse consultant for older people Barbara Schofield, Jay Rayner and chief nursing officer Christine Beasley.

Our performance against national targets and regulatory requirements

	Target for the year	April 2010 to March 2011	Achieved?
Clostridium difficile infections	151	66	✓
MRSA bacteraemias	5	4	✓
All cancers: 31-day wait for second subsequent treatment, comprising either: • Surgery • Anti cancer drug treatments • Radiotherapy	 94% 98% 94%	 99% 99.8% N/A	 ✓ ✓
All cancers: 62 day wait for first treatment, comprising either: • From urgent GP referral to treatment • From consultant screening service referral	 85% 90%	 91.7% 99.4%	 ✓ ✓
Maximum time of 18 weeks from point of referral to treatment for admitted patients	90%	90.1%	✓
Maximum time of 18 weeks from point of referral to treatment for non-admitted patients	95%	99.3%	✓
All cancers: 31-day wait from diagnosis to first treatment	96%	99.7%	✓
Cancer: two week wait from referral to date first seen: • All cancers • Symptomatic breast patients (cancer not initially suspected)	 93% 93%	 98.6% 97.3%	 ✓ ✓
Screening all elective (planned) inpatients for MRSA	100%	108.1%	✓
Maximum wait of four hours in A&E from arrival to admission, transfer or discharge	95%	96.7%	✓

**Values are expected at over 100% as occasionally patients may require more than one screening.*

Review of quality performance – how we compare with others

This section is designed to give you more information about the quality of services that we provide by looking at our performance over the last year, and if the data is available how we compare with other trusts.

The ones we have chosen to look at in more detail link into three areas of quality and reflect a different set of indicators from last year. This is because we wanted to demonstrate our performance across a broader range of indicators and also to include some specific measures such as maternity which are only carried out periodically.

Safety	Effectiveness	Experience
Hospital Standardised Mortality Rates (HSMR)	Cancer waiting times	Real Time Patient Monitoring
Falls	Cancelled operations	End of Life care
Infections	Stroke	Maternity survey

In April 2011 NHS Calderdale provider services for adults and children joined our Trust so we have included a review of their quality performance too.

Safety	Effectiveness	Experience
Pressure ulcers	Leg ulcers	Surveys

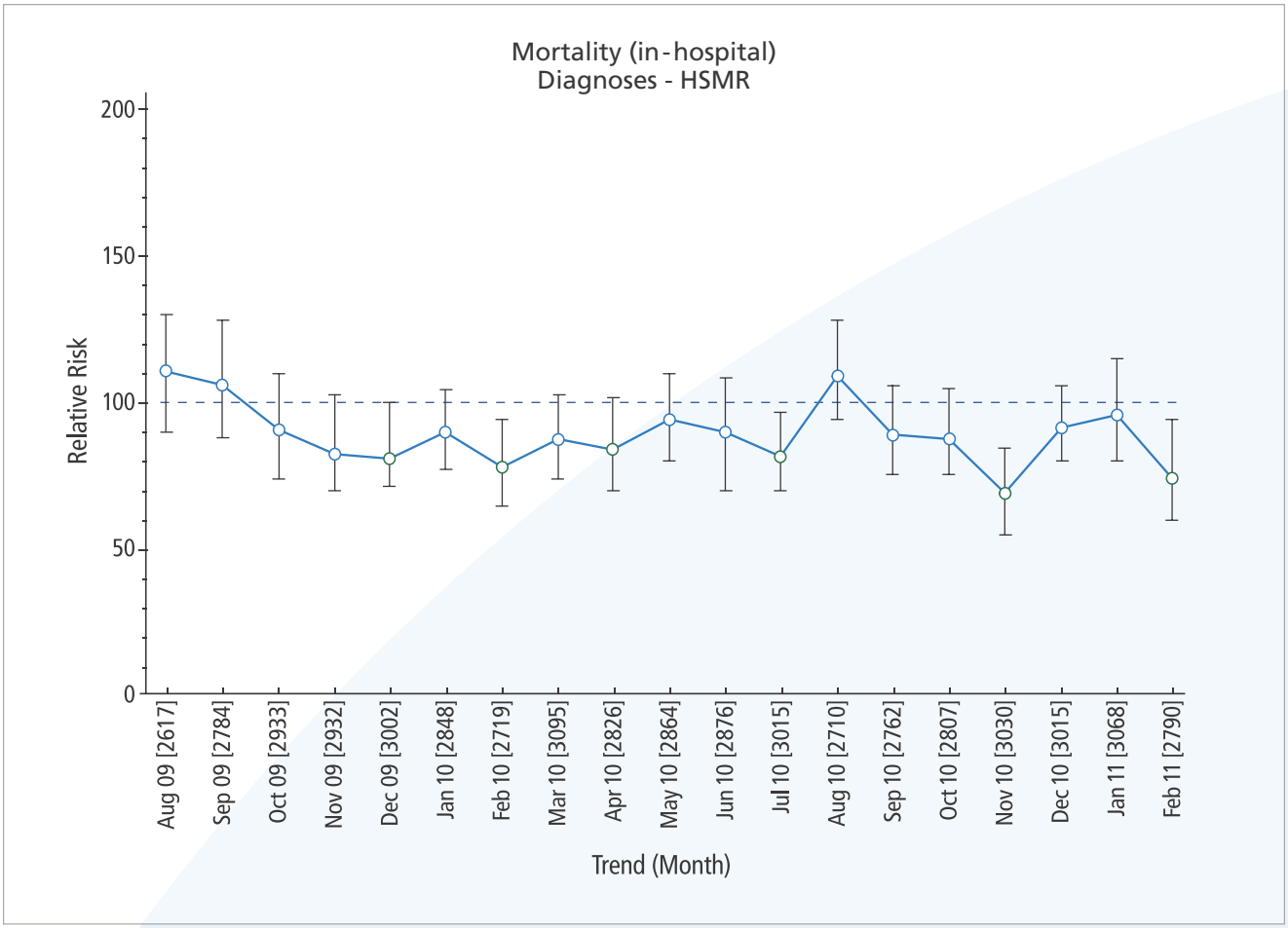
With each indicator we have included why we believe this is important to our patients and public, some charts to show our progress and commentary to provide further explanation of the data.

Safety

Hospital Standardised Mortality Rates

Rationale for choosing this

HSMR is a national measure that looks at all deaths and compares us with other Trusts. It lets us know when we have more or less deaths than expected based on our population so we can look into the cause. It is one of the key indicators for our Quality Improvement Strategy.



Commentary

All the work within our Quality Improvement Strategy is focussed upon reducing our HSMR to be one of the best trusts in England. This chart illustrates the Trust's HSMR. The national expected HSMR is represented by the dotted line at 100. Therefore our aim is be below this line showing we have a mortality rate below that expected for our population.

"All the work within our Quality Improvement Strategy is focussed upon reducing our HSMR to be one of the best trusts in England."

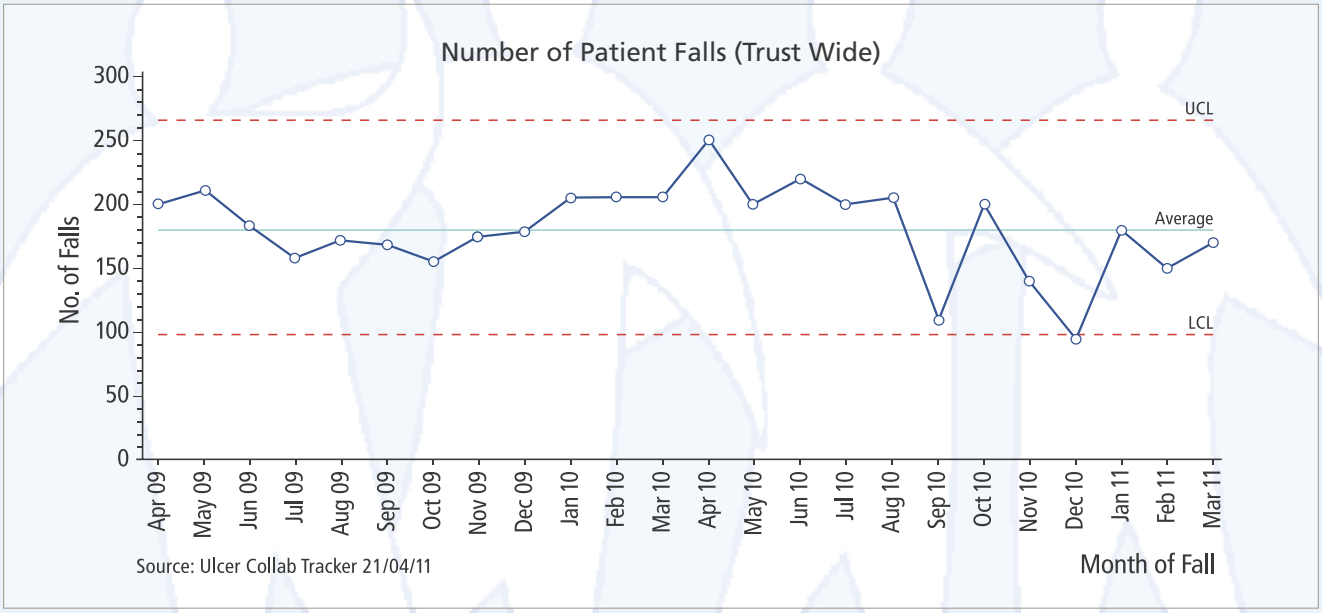
Safety

Falls

Rationale for choosing this

Throughout the UK, approximately 152,000 falls are reported in acute hospitals every year. A significant number result in severe or moderate injury at an estimated cost of £15 million per annum. (National Patient Safety Agency, 2007). Our Trust is committed to delivering safe effective and personal care and falls are one of the highest safety incidents recorded within the Trust. Reducing the number of falls and harm related to inpatient falls is part of our Exemplar Ward* programme.

*Exemplar ward is a local nursing framework that promotes consistency and standardisation of high quality, effective care across all wards. It includes a range of nursing measures that all wards need to achieve. One of its great benefits is that it increases the time spent by nurses at the bedside to improve patient experience – and so help reduce falls and pressure ulcers.



Commentary

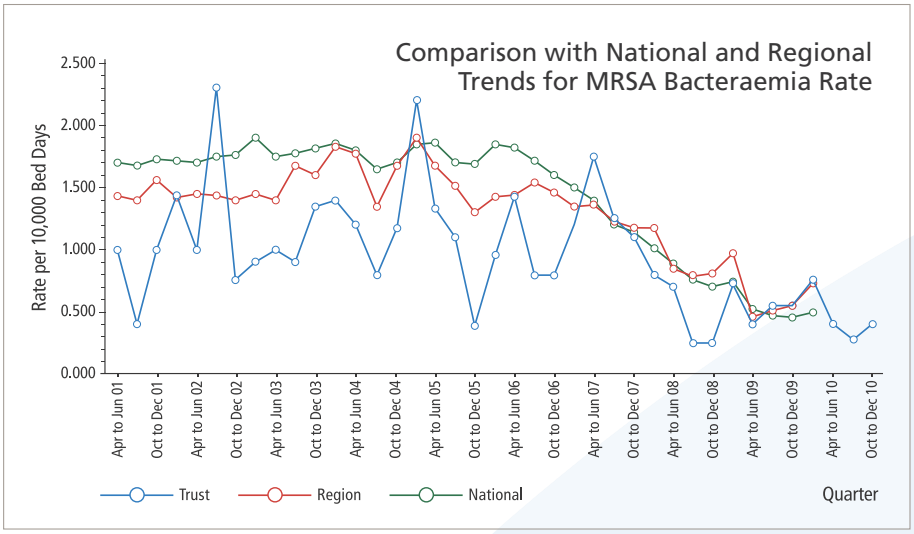
We had a total of 2,240 falls in 2009/10 compared with 2,111 in 2010/11 - this represents a 5.8 % decrease Trustwide. The above graph shows the number of falls each month within the Trust. Throughout the year a number of wards have been testing interventions to reduce the number of inpatient falls that occur on ward areas. These have included placing patients in the most visible areas in individual ward environments, understanding locations on the wards where patient falls were occurring, ensuring risk assessments are completed on all patients, ensuring patients are not left alone in toilets and bathrooms and undertaking two hourly nursing rounds to those patients who are at risk of falling.

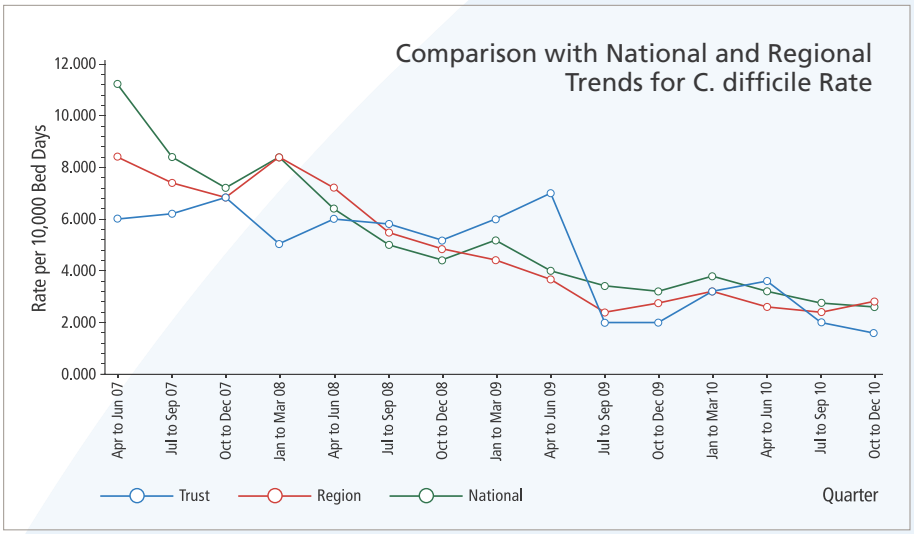
Safety

Healthcare Associated Infections (HCAIs)

Rationale for choosing this

The choice of this indicator was to ensure progress made in previous years towards reducing infections has continued – we know this issue is extremely important to our patients and visitors. The following charts show how we are doing against national and regional trends for MRSA bacteraemias and Clostridium difficile. Using this information we can ensure our progress is in line with other trusts as well as meeting our own improvement targets.





Commentary

We continued to focus on safe hand hygiene, and further improvements to the environment have been implemented such as an improved bed cleaning tool and reductions in the use of commodes on wards. Through the Showcase Hospitals Programme we have been testing innovative new equipment to improve the ward environment

We have been working hard to improve the use of antibiotics, running a campaign to raise awareness among the staff for their safe use and working to develop a Care bundle approach to improve the reliability of practice. This year has seen continued improvement in our screening performance for MRSA, helping to ensure patients are given suppression treatment as soon as possible reducing the chance of infection developing. As outlined earlier we have also been targeting the use of invasive devices, continuing to focus on central lines and looking at the use of Peripheral venous cannula.

"This year has seen continued improvement in our screening performance for MRSA."

Effectiveness

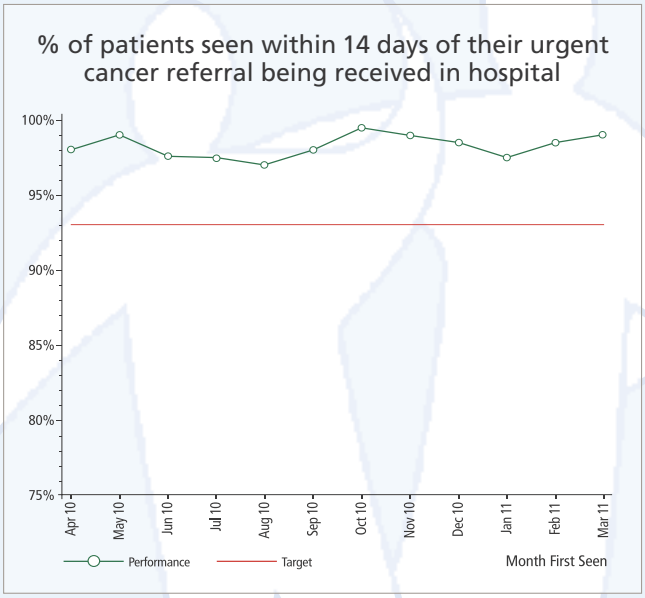
Cancer waiting times

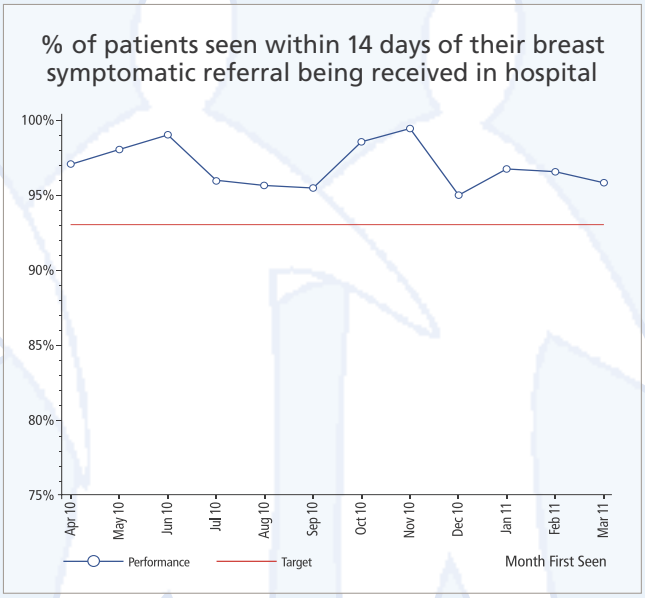
Rationale for choosing this

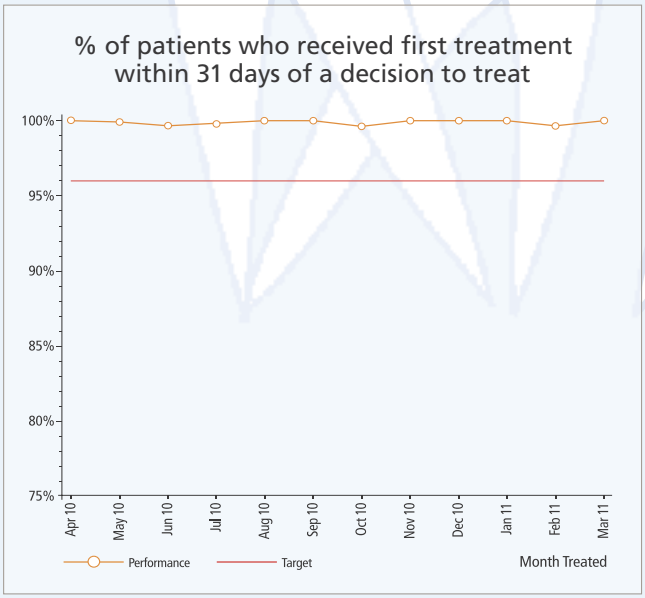
More than a quarter of a million people are diagnosed with cancer in England each year. Currently about 1.8 million people are living with and beyond a cancer diagnosis and surveys show that people fear cancer more than anything else. Patients often are anxious and face uncertainty. Many require several different tests to diagnose their cancer accurately and then a combination of different treatments such as surgery, radiotherapy and chemotherapy. Rapid access to high quality services and good coordination between different parts of the NHS can save lives and improve patients' quality of life.

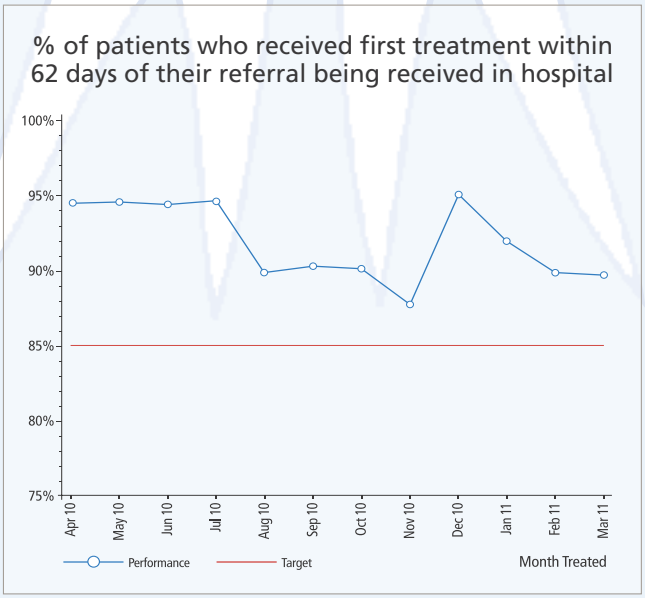
Research shows early diagnosis significantly improves outcomes for cancer patients and to this end there are a number of national targets around cancer waiting times.

Charts









Effectiveness

Cancer waiting times *(continued)*

Comparative data

	YTD YCN	YTD CHFT	YTD National
14 Day	95.3	98.62%	95
31 Day	97.6	99.72%	98.3
62 Day	83.70%	91.67%	86.80%
14 Day Breast	95.50%	97.24%	94.20%

Key:

YTD	Year to date
YCN	Yorkshire Cancer Network
CHFT	Calderdale and Huddersfield NHS Foundation Trust

Commentary

2 Week Target:

The requirement for this target is 93%. The chart shows that performance for the Trust remains strong both against performance locally and nationally. The Trust demonstrates sustained over achievement against the target. Collaborative work across primary (e.g. GPs) and secondary care (e.g. hospitals) has embedded the target into clinical practice.

31 Day Target:

The requirement for this target is 96%. The chart shows that we have sustained performance through 2010/11 which is above both the local and national performance, constantly over achieving.

62 Day Target:

The requirement for this target is 85%. Our performance against the target remains strong, and above both the local and national performance.

14 Day Breast Symptomatic:

This target was introduced in December 2010 with the requirement to achieve 93%. For the year to date performance is at 97% which is higher than the local performance for the Yorkshire Cancer Network and also the national performance.

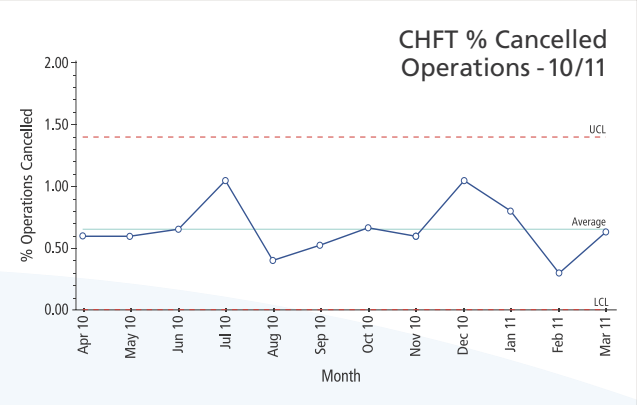
"Performance for the Trust remains strong both against performance locally and nationally."

Safety

Rationale for choosing indicator

Rationale for choosing this

Cancelled operations are inconvenient for patients and can be distressing. They also represent a waste of valuable resources and time. Cancelled operations are reported by trusts as a quality indicator.



Trust	Q1 2009/10	Q2 2009/10	Q3 2009/10	Q4 2009/10	Q1 2010/11	Q2 2010/11	Q3 2010/11	2010/11 YTD Pos	2010/11 YTD Actual
York Hospitals NHS Foundation Trust	1	2	1	9	5	4	2	1	0.58%
Harrogate and District NHS Foundation Trust	6	8	4	2	7	5	1	2	0.59%
Sheffield Teaching Hospitals NHS Foundation Trust	4	6	10	6	8	3	5	3	0.62%
Barnsley Hospital NHS Foundation Trust	9	5	3	3	3	1	7	4	0.63%
Airdale NHS Trust	8	3	2	4	1	2	9	5	0.63%
Sheffield Children's NHS Foundation Trust	2	1	9	1	4	6	3	6	0.66%
Calderdale and Huddersfield NHS Foundation Trust	**3**	**4**	**5**	**7**	**6**	**7**	**4**	**7**	**0.70%**
Hull and East Yorkshire Hospitals NHS Trust	12	11	9	8	2	9	10	8	0.78%
Bradford Teaching Hospitals NHS Foundation Trust	10	9	7	5	9	11	11	9	0.92%
Leeds Teaching Hospitals NHS Trust	15	15	14	13	11	12	8	10	0.95%
Scarborough and North East Yorkshire Health Care NHS Trust	13	7	12	11	14	14	6	11	1.09%
The Rotherham NHS Foundation Trust	5	10	13	13	10	8	12	12	1.14%
Mid Yorkshire Hospitals NHS Trust	14	12	15	14	15	10	13	13	1.32%
North Lincolnshire and Goole Hospitals NHS Foundation Trust	7	13	6	10	13	13	15	14	1.32%
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	11	14	11	15	12	15	14	15	1.37%

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 for non-clinical reasons and shows we have again met the 0.7% quality standard set nationally.

Further work is planned for 2011/12 which hopes to build on the results already achieved and make the Trust the best performing in this area in the region.

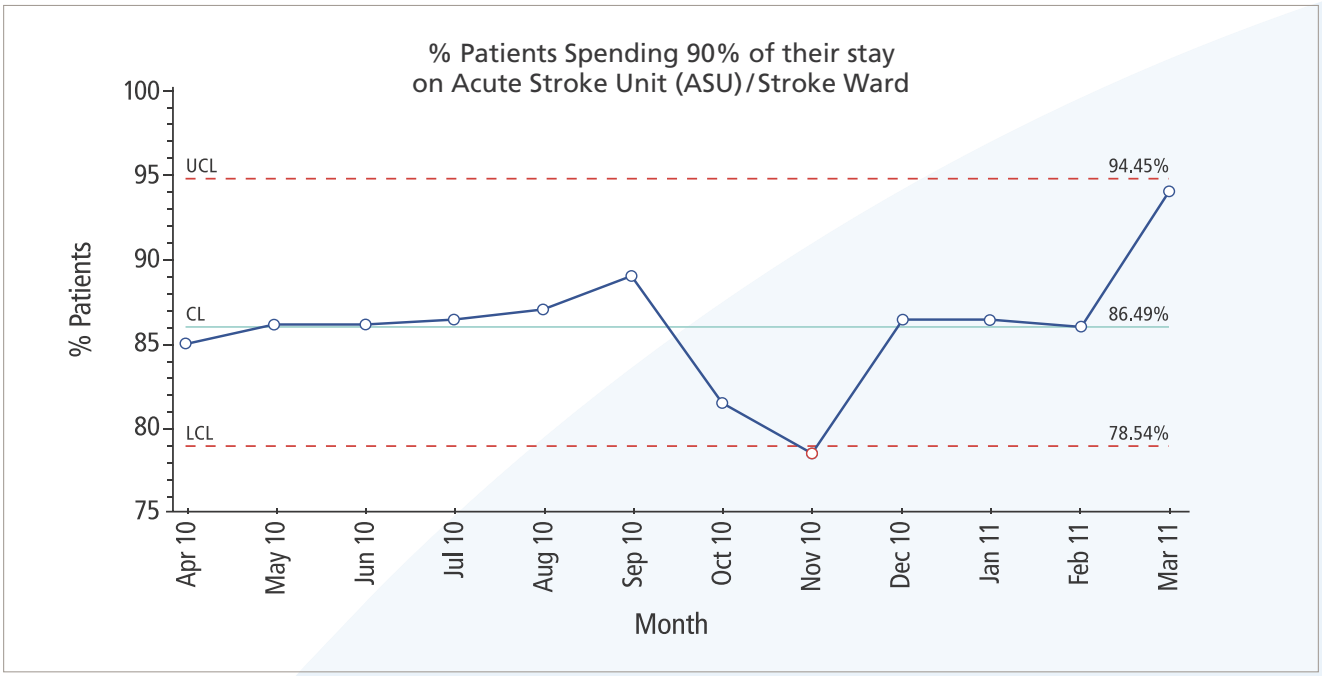
Safety

Stroke

Rationale for choosing this

Stroke is the third biggest cause of death in the UK and the largest single cause of severe disability. Each year more than 110,000 people in England will have a stroke, which costs the NHS over £2.8 billion.

The stroke strategy, launched in December 2007, sets a clear direction for the development of stroke services in England over the next 10 years. Linked to this, in February 2010, the Department of Health committed the NHS to an accelerated programme of improvement in stroke services for 2010/11.



Commentary

The Trust has taken significant steps to meet national standards and guidance on stroke care over the last 12 months. The chart demonstrates a large increase in the number of patients who have had a stroke that spend more than 90% of their time in hospital in a specialist stroke ward. This was achieved following a change in the stroke pathway from February 2010 to ensure that all patients who have a stroke are rapidly assessed and admitted to our acute stroke unit.

Other significant improvements in stroke care over the last 12 months include provision of a thrombolysis service 8am to 4pm, five days per week, reorganising consultant and nursing workforce to deliver this service and the associated dedicated stroke on-call rota. We have also begun an acute daily (Mon-Fri) Transient Ischaemic attack (TIA) clinic from January 2011. Further work is planned over the coming year to further improve the service which builds on the work in 2010/11.

"The Trust has taken significant steps to meet national standards and guidance on stroke care over the last 12 months."

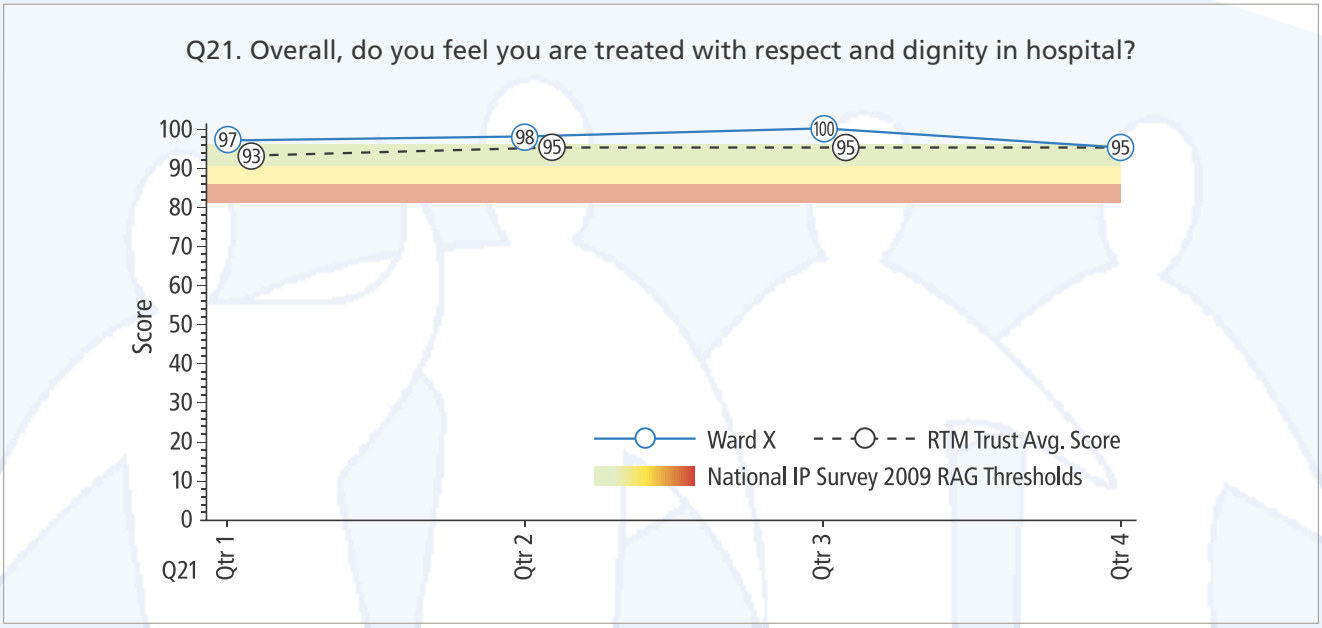
Experience

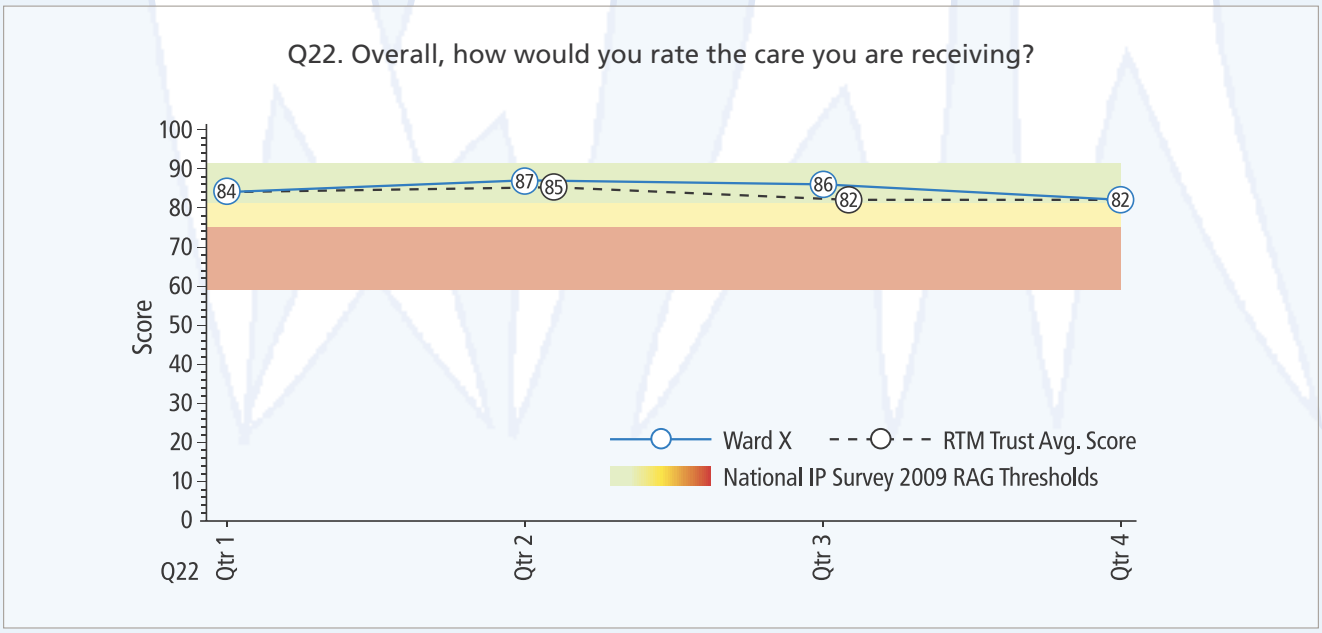
Real time patient monitoring

Rationale for choosing this

The Trust introduced a system of Real Time Patient Monitoring in March 2010, using a set of generic questions from the National Inpatient Survey to ask patients before they left hospital. RTPM provides feedback from patients that can be related to specific wards, providing useful benchmarking data that can be used to identify areas of the service requiring improvements.

Examples of ward reports for two questions





Note: National IP (Inpatient) survey RAG (red, amber, green) thresholds:
Red = bottom 20% of trusts and **Green** = top 20% of trusts

Experience

Real time patient monitoring *(continued)*

IP RTM - Scores by Ward YTD: 01 April to 31 January 2011	Division I															Division II																						DMI	RTM Trust Average
	Directorate 1										Directorate 2			Dir3		Directorate 4										Directorate 5										6	7	
	A	B	C	D	E	F	G	H	I	J	K	L	M	N		O	P	Q	R	S	T	U	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI		
# Surveys Conducted	54	44	64	96	71	90	106	97	82	71	107	80	111	100		65	78	73	71	58	49	65	59	49	30	111	79	108	89	41	71	40	105	78	78	65		2489
From the time that you arrived at the hospital, did you feel you had to wait a long time to get a bed on a ward?	98	87	77	76	71	74	83	82	78	79	81	77	88	83		92	84	77	74	87	84	93	91	88	95	80	76	81	80	74	88	92	88	90	81	91		82
During this stay in hospital, have you ever shared a sleeping area, for example a room or bay, with patients of the opposite sex?	77	37	81	89	96	86	99	98	95	93	90	92	99	98		92	92	92	94	86	64	90	95	91	100	65	73	82	88	92	94	87	-	-	99	100		89
Have you ever used the same bathroom or shower area as patients of the opposite sex?	75	58	90	95	90	72	94	98	96	96	96	97	94	95		100	99	97	85	78	87	100	93	89	100	90	79	79	94	97	99	92	93	83	92	100		91
Are you ever bothered by noise at night by hospital staff?	84	88	68	82	97	75	84	82	79	80	83	76	86	96		84	85	69	86	82	87	90	73	87	83	71	73	85	90	79	80	89	84	89	89	92		83
In your opinion, how clean is the hospital room or ward that you are in?	97	95	93	97	95	97	96	97	96	93	92	94	95	97		95	91	95	87	97	95	94	98	95	97	94	90	92	97	90	93	92	95	96	93	95		94
When you have important questions to ask a doctor, do you get answers that you can understand?	82	87	80	77	77	86	86	86	83	68	74	76	89	85		81	74	75	78	78	84	75	68	79	73	72	80	76	86	79	75	80	88	94	85	84		80
As far as you know, do doctors wash or clean their hands between touching patients?	88	96	96	89	94	95	92	94	90	88	81	94	94	93		97	90	95	92	97	88	93	76	92	84	88	84	88	94	90	88	89	92	97	92	98		91
As far as you know, do nurses wash or clean their hands between touching patients?	89	100	95	97	98	98	96	96	95	94	92	97	95	96		96	92	96	97	98	99	97	99	93	100	91	95	94	96	91	93	94	94	97	93	98		95
Are you involved as much as you want to be in decisions about your care and treatment?	71	88	77	71	80	82	82	83	79	73	74	70	83	84		79	70	75	69	76	78	73	68	75	65	72	77	76	74	77	67	77	76	86	87	93		77
How much information about your condition or treatment has been given to you?	81	86	87	91	91	86	86	86	81	75	72	74	92	91		82	86	83	72	70	81	80	71	88	56	76	77	75	86	78	76	69	94	88	85	90		82
Have you found someone on the hospital staff to talk to about your worries and fears?	57	80	56	67	77	80	81	58	77	64	83	60	89	79		80	48	73	52	78	83	60	83	91	50	52	68	67	67	38	56	80	63	91	68	92		72
Are you given enough privacy when discussing your condition or treatment?	90	84	90	84	88	79	89	88	91	78	85	86	88	95		90	91	89	78	81	90	95	92	92	88	80	89	74	90	79	81	84	90	92	85	88		87
How many minutes after you use the call button does it usually take before you get the help you need?	75	50	78	73	68	72	78	75	83	73	67	74	84	85		68	63	57	76	72	68	57	75	71	77	63	71	77	63	58	77	78	77	93	64	89		73
Beforehand, did a member of staff explain what would be done during the operation or procedure?	83	91	93	90	91	91	86	88	90	93	78	92	89	86		79	79	90	88	100	93	92	79	79	75	92	67	89	82	94	85	90	88	96	87	93		88
After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?	83	92	79	80	76	85	64	81	86	77	69	84	83	70		96	71	90	80	92	85	90	61	83	77	80	56	69	77	78	73	88	89	86	76	84		79
Do you feel you are involved in decisions about your discharge from hospital?	59	97	59	68	77	74	85	68	70	59	61	63	80	70		59	60	61	76	72	78	68	73	73	67	71	76	78	71	68	70	87	63	77	79	94		73
Has a member of staff explained the purpose of the medicines you are to take home in a way you could understand?	71	88	58	73	85	85	94	66	91	62	75	66	94	93		68	60	48	65	82	94	78	88	59	67	75	83	79	86	71	69	68	70	85	86	100		79
Has a member of staff told you about medication side effects to watch out for when you are at home?	45	81	50	55	67	56	64	37	70	28	48	39	69	51		50	41	14	50	38	77	56	44	44	20	28	36	44	45	33	34	25	46	59	81	88		51
Have the doctors or nurses given your family or someone close to you all the information they need to help care for you?	62	83	44	63	66	69	62	57	63	40	57	49	66	73		62	60	57	49	78	87	75	90	89	63	51	63	66	64	46	55	89	73	82	78	75		66
Have hospital staff told you who to contact if you are worried about your condition or treatment when you leave hospital?	78	75	44	50	55	67	75	43	77	33	50	43	70	59		50	65	35	36	56	70	53	91	63	80	43	60	45	60	0	63	43	84	86	82	86		61
Overall, do you feel you are treated with respect and dignity in the hospital?	92	99	95	95	96	94	99	96	98	92	88	95	97	96		94	89	94	89	92	97	90	94	95	100	91	95	95	96	91	94	96	97	99	94	98		95
Overall, how would you rate the care you are receiving?	78	90	84	87	88	90	90	88	87	78	80	85	85	88		77	79	78	78	76	87	74	78	80	84	77	80	81	87	78	82	87	84	89	85	91		83
Would you recommend this hospital to your family and friends?	81	94	92	87	83	88	94	87	88	78	76	87	95	94		89	81	88	83	82	87	82	89	88	93	87	87	92	93	84	95	90	93	94	86	95		88

Key:
- 'Best practice' indicator: a score >5 points higher than the highest score achieved by any Trust in the National Inpatient Survey 2009. The threshold for best practice is to be revised to ensure more statistically robust.
- Score within the thresholds of the top 20% of Trusts in the National Inpatient Survey
- Score within the thresholds of the intermediate 60% of Trusts in the National Inpatient Survey
- Score within the thresholds of the lowest scoring 20% of Trusts in the National Inpatient Survey

Commentary

Each ward receives its individual results on a quarterly basis, with at least 20 surveys carried out on their ward during that period. These reports provide reliable data from which the ward team can identify areas of concern.

Action plans are being progressed to address concerns with areas such as noise at night, information on discharge and doctors' communications being some of the issues raised. Some of the areas highlighted have also been taken forward as priorities for the year ahead.

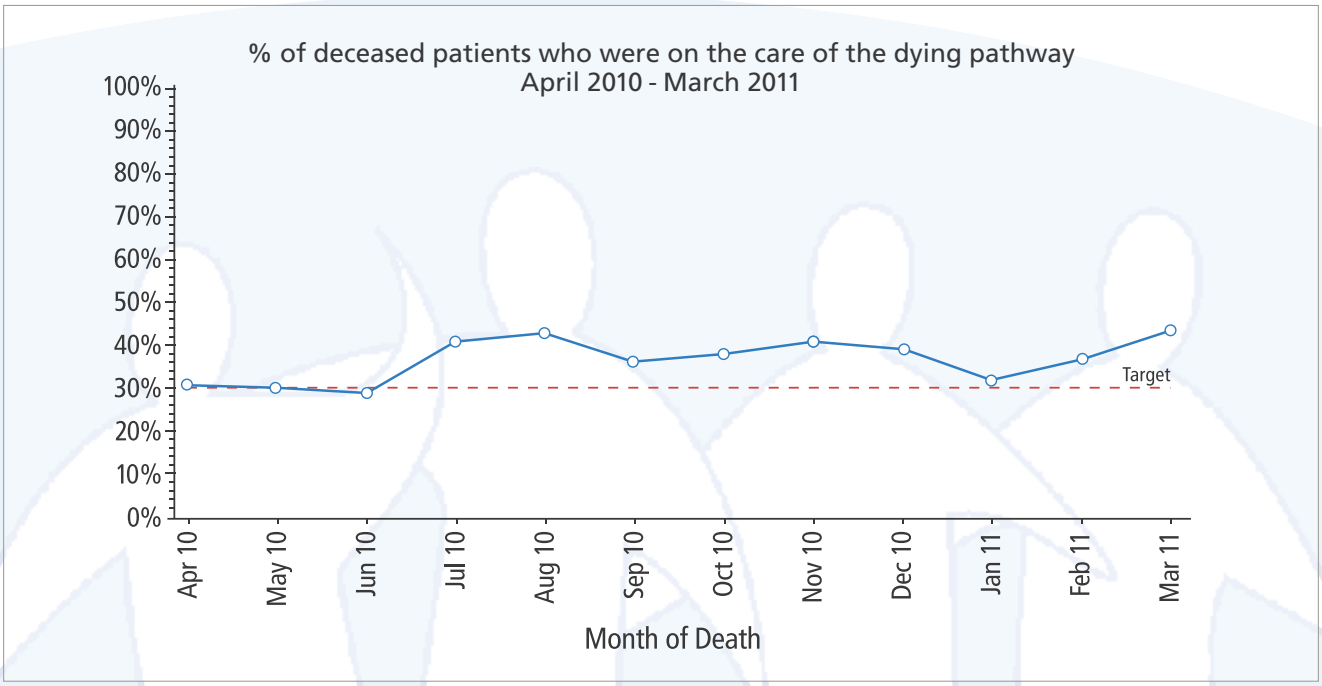
Cumulative data is also been displayed on a 'ward benchmarking map' which enables us to understand the overall picture, by question, across all wards. This is proving to be an invaluable tool for identifying the lower scoring wards and also those with high scores from which we can select areas of good practice to share. Directorate, divisional and Trust level reports are also available monthly.

Experience

End of life care

Rationale for choosing the indicator

End of life continues to focus on the work to date enabling patients to state their preference as to where they wish to die, however if they die in hospital and their death is expected they are nursed using the Care of the Dying Pathway.



Commentary

The above graph shows the percentage of patients who were placed on the Care of the Dying Pathway. We have continued to achieve 30% of patients placed on pathway. During the year we have developed and tested documentation for advance care plans. We have also improved patient and carer involvement and feedback alongside establishing and strengthening user forums with partner organisations including the hospice. A training and education package for nursing staff to be able to provide a good end of life experience has been developed, and these are now being developed as bespoke packages for patients with learning disabilities, dementia and for children.

Experience

Maternity survey

Rationale for choosing the indicator

The Care Quality Commission's (CQC) survey of women's experiences of maternity services in 2010 provides a comprehensive overview of maternity services provided by NHS trusts in England. This enabled trusts to compare the scores achieved for their services with those from across the country. The survey questioned women who had a live birth in February 2010 about care during pregnancy, labour and birth, and in the weeks following the birth of their baby.

	National Maternity Survey Summary 2010	National Survey 2010 Mean Score
Antenatal Care	B5 Were you given a choice of having your baby at home?	75
	B15 Was the reason for this scan clearly explained to you?	89
	B17 Were the reasons for having a screening test for Down's syndrome clearly explained to you?	80
	B19 Was the reason for this scan clearly explained to you?	92
Labour and Birth	C2 During your labour, were you able to move around and choose the position that made you most comfortable?	85
	C4 During your labour and birth, did you feel you got the pain relief you wanted?	82
	C9 If you had an episiotomy (cut) or tear requiring stitches, how long after your baby was born were the stitches done?	54
	C10 Did you have skin to skin contact (baby naked, directly on your chestor tummy) with your baby shortly after the birth?	88
Staff during Labour and Birth	C12 Did you have confidence and trust in the staff caring for you during your labour and birth?	90
	C13 If you had a partner or a companion with you during your labour and delivery, were they made welcome by the staff?	95
	C14 Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you?	85
	C15 Thinking about your care during labour and birth, were you spoken to in a way you could understand?	94
	C16 Thinking about your care during labour and birth, were you involved enough in decisions about your care?	88
	C17 Overall, how would you rate the care received during your labour and birth?	89
Postnatal Care	D2 Looking back, do you feel that the length of your stay in hospital after the birth was….	75
	D3 Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?	77
	D4 Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?	83
Feeding	E4 Did you feel that midwives and other carers gave you consistent advice?	67
	E5 Did you feel that midwives and other carers gave you active support and encouragement?	71

National benchmarking: = top 20% of trusts, = intermediate 60% of trusts, = bottom 20% of trusts

Scores published by CQC, December 2010

Commentary

Overall, the survey results were very good for CHFT, and compared favourably to national benchmarks in many areas, in comparison with other trusts, we were ranked 27th out of 100.

Nineteen questions - focusing on results which can be directly attributed to the acute trust - were benchmarked nationally:

- 12 were rated green (within best performing 20% of trusts)
- Five were rated amber (intermediate 60% of trusts)
- Two were rated red (worst performing 20%).

When comparing the 2010 survey results with those from 2007 (all questions asked in both surveys, including care at home):

- 12 showed a statistically significant improvement in 2010,
- 13 showed no (statistically significant) change, and
- No questions showed a statistically significant decrease in 2010

Performance was particularly strong for "Staff during labour and birth," all six benchmarked questions were rated green and showed significant improvement from previous survey results. Results were also strong for "Feeding the baby during the first few days" (2/2 green).

There are areas still requiring some improvement these are "Antenatal care" (primarily communication related to scanning, where one question was rated red) and some specific aspects of "Labour and birth" (particularly time taken to suture, which was rated red). An action plan to address these areas has been developed.

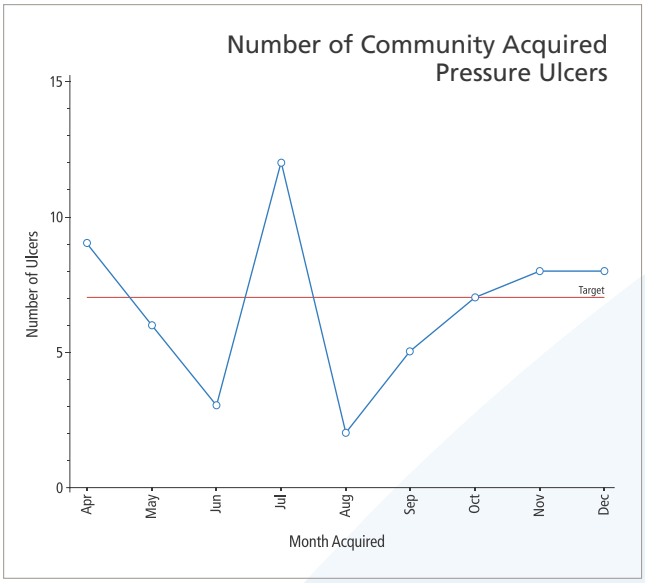
In April 2011 some of the community services provided by NHS Calderdale (primary care trust) were transferred to Calderdale and Huddersfield NHS Foundation Trust. The following information gives you more information about the quality of their services.

Safe

Pressure ulcers

Rationale for choosing this

Pressure ulcer incidence is an important measure of nursing quality. No avoidable pressure ulcers in NHS provided care is also one of the High Impact Actions for Nursing and Midwifery (2009). Our aim is to reduce the incidence of community acquired pressure ulcers.



Month	Grade 2	Grade 3	Grade 4	Total
April	8	1	0	9
May	6	0	0	6
June	3	0	0	3
July	9	2	1	12
August	2	0	0	2
September	5	0	0	5
October	6	1	0	7
November	4	1	3	8
December	8	0	0	8

Commentary

Whilst the data above doesn't show a significant decrease, the work over the year has focused on improvement in the quality and frequency of incident reporting of pressure ulcers, alongside the development and implementation of a new pressure ulcer incident form for district nursing teams across Calderdale. Guidance for identifying pressure ulcers and the vulnerable patient has also been developed, approved and rolled out to community nursing teams and educational information, including information on categorising pressure ulcers and wound care formulary, has been disseminated.

All grade 3 and 4 pressure ulcers (most severe) are investigated using root cause analysis and lessons learnt are shared with all staff involved. Common themes are explored and used to guide improvement work. Further work is planned in 2011/12 to focus improvement on reducing the numbers of pressure ulcers that occur, and build on current initiatives.

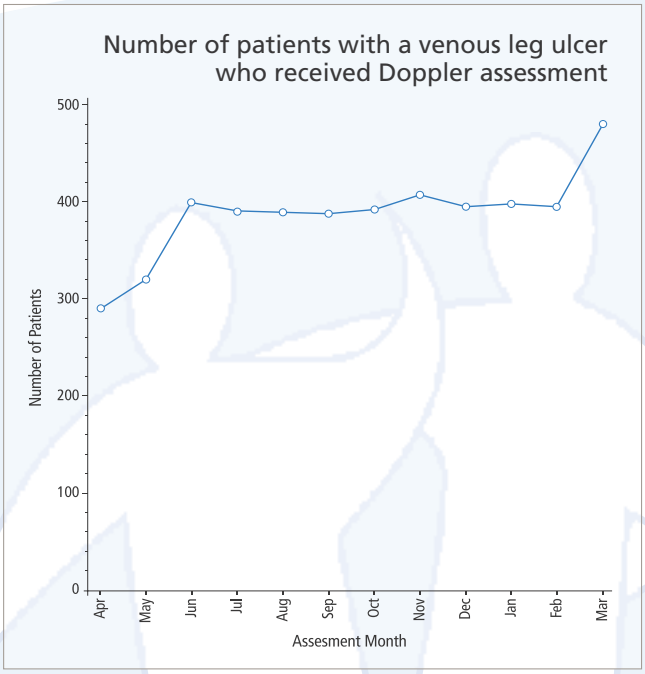
"Common themes are explored and used to guide improvement work."

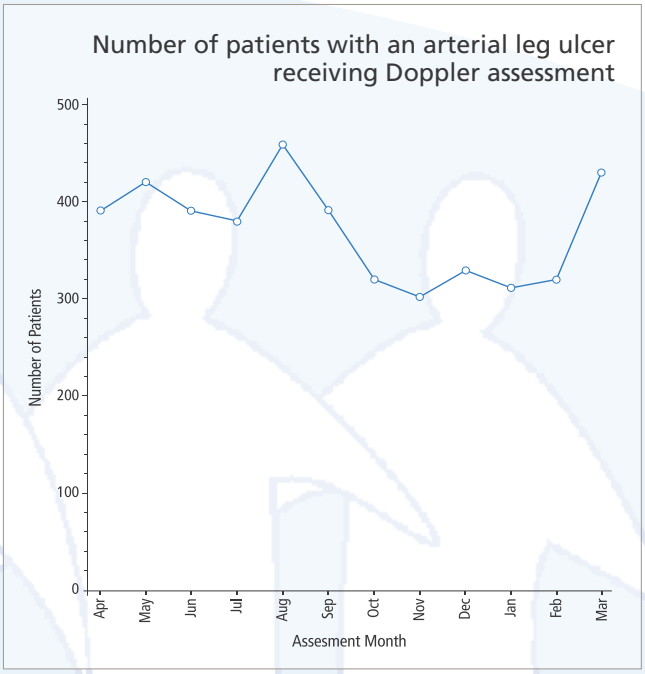
Effectiveness

Leg ulcers

Rationale for choosing this:

Leg ulcer management forms a significant part of core district nursing and improving the overall management of leg ulcers, by reducing healing times and recurrence rates, will provide a positive impact on patient outcomes. We are working towards a more holistic partnership approach between patients and professionals.





Commentary

The graphs above show the number of patients who received Doppler assessments* for both venous and arterial leg ulcers**. Everyone who needed a Doppler assessment received one. During 2010/11 we improved patient access by re-establishing two leg ulcer clinics. The clinical guidelines for leg ulcer management were reviewed and a framework for in-house training established. This work contributed to the successful achievement of Practice Development Unit accreditation (July 2010) and a Foundation of Nursing studies grant approved (July 2010 – July 2012) to support developmental and evaluation work around the leg clinics and overall lower limb care.

* A Doppler test assesses the movement of blood through the blood vessels to determine if the ulcer is caused by venous or arterial insufficiency

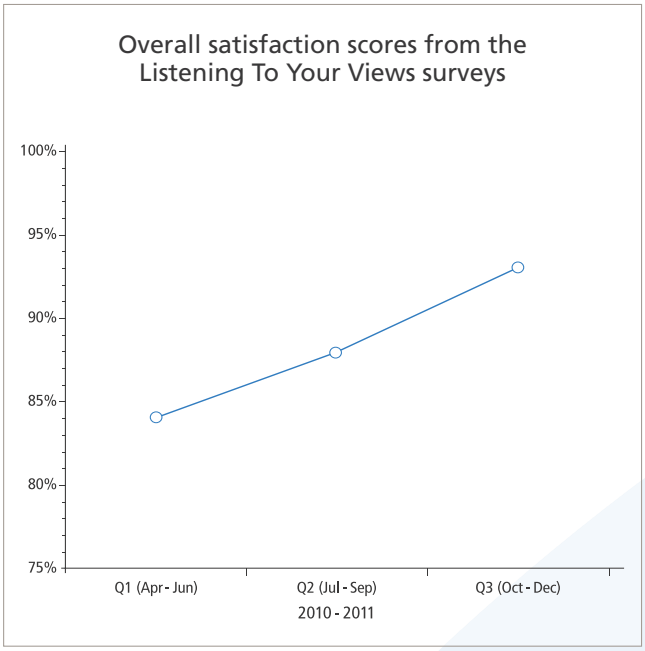
** Venous leg ulcers occur when persistently high blood pressure in the veins of the legs (venous hypertension) causes damage to the skin. Arterial leg ulcers are caused by poor blood circulation in the arteries.

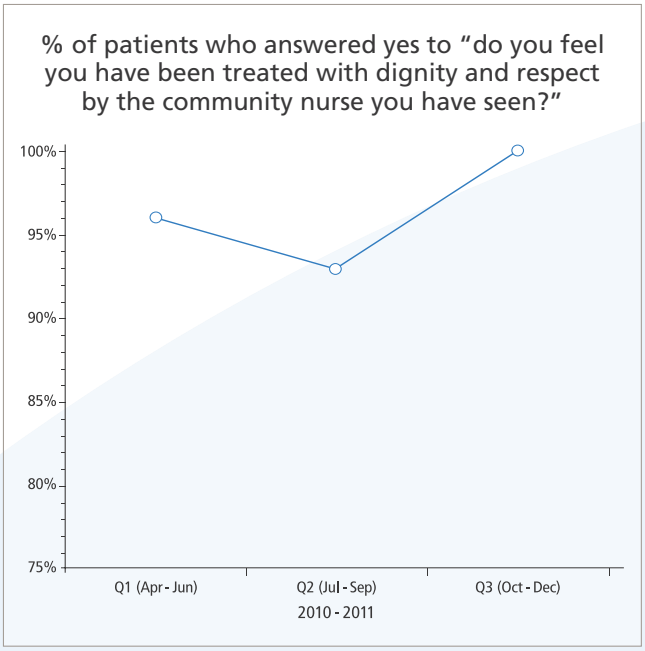
Experience

Patient Experience

Rationale for choosing this:

Patients' views through patient surveys, feedback forms, compliment letters and complaints inform us how we are doing on patient experience and help us make changes that improve the experience for patients.





Commentary

The above graphs both show an increase in scores in Quarter 3 (October to December) of 2010/11. The focus of our work has been to gain a greater understanding of patients and clients' experience of our services through surveys and meeting up with patients to listen to their views. This all helps us learn and improve across many areas.

"Listening to your views" questionnaires, incorporating all our community services, have been used widely. We have been working towards greater understanding of patient experience, dignity and respect so we can further improve our services. We have appointed a "dignity link nurse" to all of our nursing teams and a list of commitments and expectations is now included within the nursing documentation left in patients' homes.

We also plan further development of case management around long term conditions – this means there is one person who co-ordinates all an individual patient's care.

Over 90% of patients reported being treated with dignity and respect as part of the "Listening to Your Views" questionnaires, which indicates our efforts are having an impact, and we plan to continue our efforts to further improve patient experience.

"We have been working towards greater understanding of patient experience, dignity and respect."

Statements from commissioning PCT, LINks, OSCs

Response from NHS Kirklees, Lead Commissioning PCT

NHS Kirklees is pleased to receive and comment of the Quality Account prepared by Calderdale and Huddersfield NHS Foundation Trust (CHFT).

The published account is a comprehensive and detailed assessment of quality in 2010/11, and highlights clearly the priorities for quality improvement in 2011/12.

To the best of our knowledge, through the work of the joint clinical quality board and our contracting processes, the information provided is accurate.

Basing the account on the three pillars of Quality as described by Lord Darzi; Patient safety, patient experience and clinical effectiveness demonstrates the Trust's commitment to continuous quality improvement.

We are pleased to note the progress the Trust has made and the further improvements and initiatives outlined for 2011/12.

We also note that in some areas, whilst there has been improvement, targets have not been met and we will continue to monitor the Trust's achievement in these areas over the next twelve months.

We commend the introduction of real-time monitoring of patient experience and the focus of improving the time spent by clinical staff on direct patient contact.

We note the CQINN achievement and as commissioners are pleased that the 2011/12 will include the SKIN bundle and continue to focus on high quality patient care and clinical effectiveness.

NHS Kirklees is pleased to see the inclusion of patient comments in the document but would like this section to be extended in future reports reflecting patient comments which are both positive and negative on a range of service areas.

There is no evidence of complacency in this report and the Trust recognises areas where it need to improve. NHS Kirklees will continue to work with the trust on this important agenda.

Response from Calderdale Council's Adult Health & Social Care Scrutiny Panel

Please find below a statement from Cllr Ruth Goldthorpe, Chair, Adults Health and Social Care Scrutiny Panel in response to your Quality Account.

"Thank you for sending us your Quality Accounts for the comments of the Adults Health and Social Care Scrutiny Panel. They are a comprehensive and invaluable account of your work over the last year.

During 2010/11 the Adults Health and Social Care Scrutiny Panel considered the following issues that directly relate to the work of your Trust:

- In June 2010 we considered a report on pressure ulcers.
- At the same meeting in June, we also considered a report on "real time patient experience monitoring" and also received an update on same sex accommodation
- In October we considered proposals for changes to vascular services
- Our January meeting considered the visual hospitals programme initiative and the "short stay, fast flow" initiative, including your decision on ward closures on both hospital sites.

Many of our other discussions about council care services and residential ands nursing provision in the independent sector have concerned people who are provided with care in hospital, at home or in other settings in a closely integrated way. Changes to the Fair Access to Care Scheme, for example, will inevitably have some impact on hospital services.

We have noted the seven priorities you have identified for 2011/12 and in our work programme discussions we will consider which of these are of particular interest to the Scrutiny Panel and where our involvement can add value. I hope that we will be able to contribute to next years Quality Audit by our active involvement through the year.

Finally, I would like to thank the Trust for the attending our meetings and keeping Council members informed about developments."

Response from Kirklees Council's Wellbeing & Communities Scrunity Panel

Regrettably, due to the timing of the consultation on the Quality Account for 2010/11, Kirklees Council's Well-Being & Communities Scrutiny Panel has not been able to comment on the content of the draft document. Scrutiny do see this as an important opportunity and it is disappointing that the consultation period runs immediately prior to and directly after the Local Council elections, when scrutiny is not operational and is therefore unable to meet to consider the draft Quality Account. We would be grateful if this concern regarding the consultation period could be communicated by the Trust to the Department of Health.

Response from Kirklees Local Involvement Network

We would like thank the Trust for the opportunity to comment on the many areas of improvement described in the Quality Account. The LINk is aware of the challenging environment being imposed on health and social care and wish to support the Trust as it prioritises Patient Experience during the coming year, with a focus on robust processes for discharge and reductions in re-admission rates.

Kirklees LINk would like to draw attention to the responsiveness of the Trust when working on concerns important to our membership, for example on Pressure Ulcers. This has lead to excellent partnership working leading to a very positive service model across Hospital and Community settings.

The LINk is also pleased to learn of the improved prevention rates and focus on healthcare associated infections at the Calderdale and Huddersfield NHS Foundation Trust.

The LINk would like to state that there has been a much greater and welcome effort to involve members of the public in setting the priorities for the Account, both through membership events and the LINk. We commend the Trust on the organisation of the Membership Events that helped set the priority areas, however we would suggest a more participatory approach to generating possible priority areas in the future.

We are satisfied that no significant area of public concern is missing from the Quality Account and that the priorities identified by the Trust are credible and relevant to the public.

Although we are aware that the format of Quality Account is determined by the Department of Health, Kirklees LINk believes the technical nature of the content of the report needs to be presented in plain English if it is to be relevant to the people and diverse communities across Calderdale and Huddersfield.

There follows a number of detailed comments prompted by particular parts of the Account. They are:

- Kirklees LINk welcomes the introduction of Real Time Monitoring of the service. We see this as a very positive move and expect that it will lead to improved Patient Care.
- The Trust mention several instances of developing local guidance, however excellent NICE guidance is available. We hope that national guidance is being fully implemented, if not the reasons should be available in the Account.
- Kirklees LINk is very heartened to see satisfaction rates of patients improving month on month in the Patient Experience section. Although we understand that a Quality Account seeks to describe positive outcomes we believe quality assurance is also promoted by an awareness of information about complaints management, however this data is not in the Account.

Kirklees LINk recognises that the Calderdale and Huddersfield NHS Foundation Trust is an effective and improving provider of services vital for the people of Calderdale and Huddersfield.

Response from Calderdale Local Involvement Network

Calderdale LINk is pleased to have the opportunity to comment on the Quality Accounts, 2010-2011. The LINk is aware of the challenging environment which health and social care services face in the current climate and Calderdale LINk would wish to support the Trust as it priorities patient experience in the forthcoming year, recognising the continued focus on rigorous processes for patient discharge and re-admission rates.

In part three of the report, Performance against Targets, (figures to the end of February 2011), Calderdale LINk welcomes the positive achievement against targets for the period and is hopeful that this will continue in the coming year.

Improved prevention rates outlined in part two of the report are also welcomed with a reduction in pressure sores, an area previously causing serious concern and one in which Calderdale LINk has been involved.

Improving patient experience is an area of specific interest to Calderdale LINk and it is pleasing to see that this continues to be a priority for the Trust. Efforts have been made to involve the public in setting priorities and building relationships with local LINk organisations and Patient Groups, although this is an area in which continued improvement can be made with continued use of local LINk organisations.

Performance against national priorities has identified continued areas around patient safety, effectiveness and Calderdale LINk is pleased to see that the Trust recognised that the work here is not complete but must continue to improve over the coming year.

Having been invited to attend a public event looking at the Quality Account of the Trust earlier this year, and the document received, there does not appear to be any particular areas of concern missing from the Quality Account.

Priority Five, Real Time Monitoring is welcomed by the LINk and provides a significant opportunity for improvement inpatient care.

Priority Six, End of Life Care is also welcomed in the development of an Advanced Care Plan and the involvement of patients putting this into practice.

In relation to the presentation of the Quality Account, Calderdale LINk placed this on its website for comment. Consideration might be given to the overall presentation and use of language in making this document more accessible and user friendly, thus providing for greater public comment.

Calderdale LINk does however recognise that Calderdale and Huddersfield NHS Foundation Trust is continuing to improve services for patients and work towards greater public involvement.

Statement of directors' responsibilities in respect of the quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- The content of the quality report meets the requirements set out in the NHS

Foundation Trust Annual Reporting Manual 2010-11;

- The content of the Quality Report is not inconsistent with internal and external sources of information including:

Board minutes and papers for the period April 2010 to June 2011

Papers relating to Quality reported to the Board over the period April 2010 to June 2011

Feedback from the commissioners dated 26/5/11

Feedback from the Membership Council dated 18/05/2011

Feedback from LINks dated 26/5/11

The trust's complaints report published under regulation 18 of the Local Authority

Social Services and NHS Complaints Regulations 2009, dated 23/12/2010;

The [latest] national patient survey 21/4/11

The national staff survey 16/3/2011

The Head of Internal Audit's annual opinion over the trust's control environment dated 25/5/2010

CQC quality and risk profiles dated September 2010; October 2010; November 2010; December 2010; February 2011 and March 2011.

- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at: www.monitornhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at: www.monitornhsft.gov.uk/annualreportingmanual)).

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Date: 2nd June 2011

Signed:

Diane Whittingham · Chief Executive

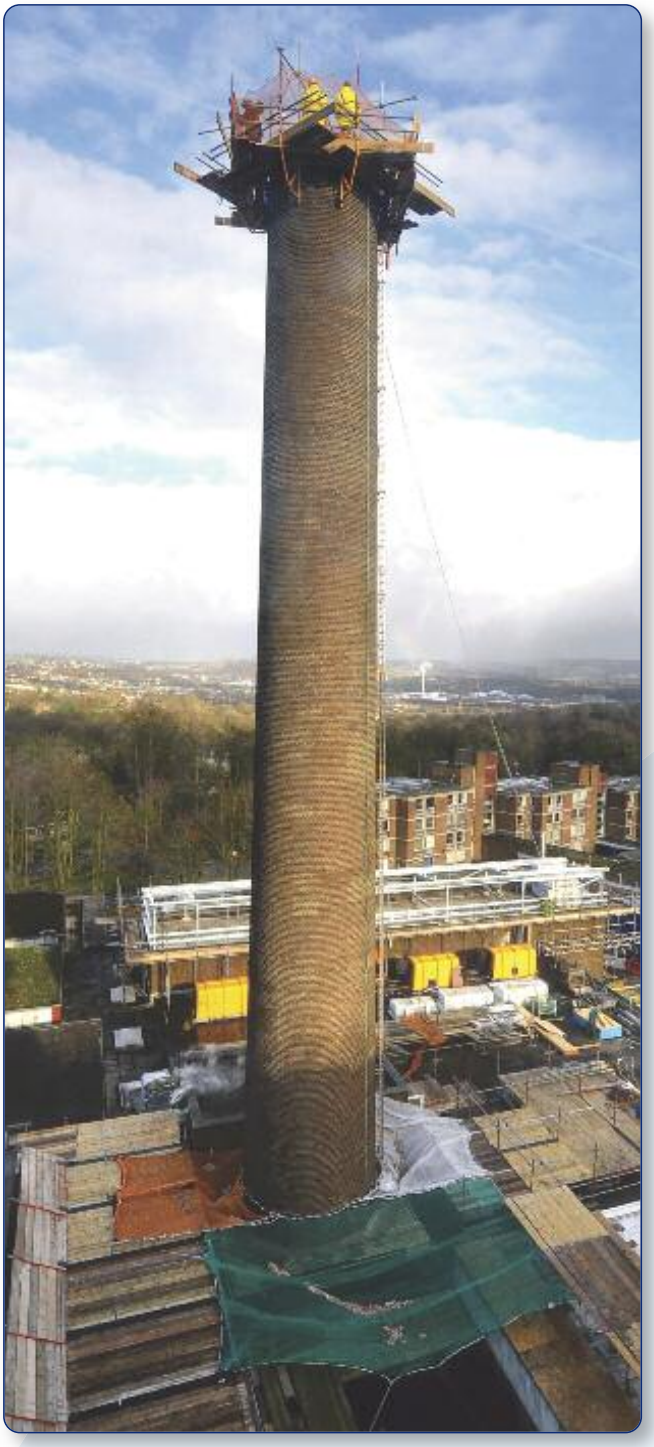
Carol Clark · Acting Chairman

How to provide feedback

We hope you have found the information in this report useful and relevant but we are keen to hear your views and ideas about future content.

If you would like to comment please contact our Board Secretary on **01484 347 186** or via the website **www.cht.nhs.uk**

Sustainability and Climate Change Report



Huddersfield Royal Infirmary has made massive inroads into reducing its carbon emissions with the conversion to a gas-fired state-of-the-art boiler system.

The brick-by-brick demolition of the old 200ft landmark coal chimney marked a move from the old system to the new.

The temporary gas-fired boilers started running in January and already our early figures to the end of February are showing a reduction from an estimated 2903 tonnes when it was coal-fired to just 1251 tonnes – a 57 per cent reduction thanks to the cleaner fuel.

Overall, it means no coal-smoke over Lindley making us better community neighbours and the hospital now has a cleaner and greener, more efficient 21st century heating plant system to take us into the future.

- Other "green" measures include: planting trees, sensor taps to save water, replacement windows to keep the heat in and recycling bins for all purposes across all areas of the hospital.

At Calderdale Royal Hospital new and ongoing measures include:

- A 'one stop shop' approach to food deliveries to site. This has meant a significant reduction to the number of deliveries to the site on a daily basis thus reducing food miles, diesel and cost
- An energy saving measure – OTEX - where cloths and mops are cleaned at reduced temperatures but still to highest cleanliness standards
- New bed pan-washers have been installed which cut the cleaning cycle time from 19 minutes down to four minutes which will significantly reduce the amount of water we use
- The hospital has reduced heating energy by using air handling units which pass the old air through a 'reheat radiator' and it is then circulated around the building.

"Huddersfield Royal Infirmary has made massive inroads into reducing its carbon emissions."

Comparisons of scopes 1 & 2 for years 2009/10 & 2010/11

	CHFT 2009/10				
	Emissions source	**Amount used**	**Units**	**Tonnes of CO^2**	**Cost £**
Scope 1	**Fuel type**				
	Natural gas	25396666	kWh	5231.713	671221.2
	Coal	36426111	kWh	10752.57	610932.1
	Diesel	104467.9	kWh	26.43	2617.405
	Water	211812	M^3	–	454204
	Fleet Vehicles	867859.2229	kWh	219.5771	84069.52
	Business Travel	–	–	–	827268.6
Scope 2	Electricity	22786666	kWh	12236.9	2258851
			Totals	**28467.19**	**4909164**

	CHFT 2010/11				
	Emissions source	**Amount used**	**Units**	**Tonnes of CO^2**	**Cost £**
Scope 1	**Fuel type**				
	Natural gas	24179781	kWh	4439.4	663255
	Coal	22257904.86	kWh	7723.493	419355
	Diesel	577923	kWh	146.22	48412.29
	Water	234985	M^3	–	471481
	Fleet Vehicles	727256.43	kWh	184.0058	81171.9
	Business Travel	–	–	–	1210573
Scope 2	Expediture CRC	–	–	–	121057.1
	Electricity	23340635	kWh	12627.28	1996754
			Totals	**25120.4**	**5012059**

Commentary

Costs & CO^2 output

Whilst costs are slightly higher than the previous year, the CO^2 tonnage has reduced mainly due to the new gas boiler house coming on line during late December 2010. However, if the expenditure of CRC is ignored, the comparative costs are slightly less than 2009/10.

Diesel

Consumption has increased due to commissioning of dual fuel temporary boilers used to replace redundant coal boilers.

Water

Consumption has increased due to increased process loads and ground losses.

Area type non-financial	Information	Financial information
Clinical waste (incineration)	The clinical waste tonnage has been reduced by the Trust over the period of 2010/11 by 40 tonnes. Tonnage for 2010/11 621 tonnes.	Total removal of all waste from the Trust 2010/11
General waste (landfill)	955.31 tonnes recycled	
Cardboard	85.05 tonnes recycled	
Confidential waste	65 tonnes recycled	
WEEE	Unknown quantity	
Batteries	Recycled	
Ink and toner cartridges	Recycled	
Registration of Sites yearly	Calderdale Royal Hospital Huddersfield Royal Infirmary Laura Mitchell Health Centre Princess Royal Health Centre	£30.00 per site

"The Trust has maintained its general approach to equality, diversity and human rights."

Equality and Diversity Report

Our approach

The Trust has maintained its general approach to equality, diversity and human rights as outlined in previous annual reports. Specific activity during the reporting year included:

- Equality impact assessments of policy and practice
- Review of employment policies to assess compliance with the Equality Act enacted in October 2010
- Partnership working with local community groups to inform internal work streams particularly in relation to disability and sexuality. The considerable work done to improve services for patients with learning disabilities and complex needs was recognised through the 2010 Trust's Celebrating Success overall award
- Training and implementation on the new interpreting service contract has ensured that it is now embedded across the whole Trust. This has ensured improved confidentiality, availability and quality assurance in relation to the standard of the interpreted clinical consultation
- Training provision has been enhanced by increasing the number of embracing diversity facilitators and the commissioning of specific training around deaf awareness
- Continuing development of occupational health services has increased the focus on staff health and wellbeing, particularly in relation to stress management. A rapid access physiotherapy service for staff experiencing musculo-skeletal difficulties was introduced in December 2010 with considerable uptake and positive evaluation by staff accessing the service. The occupational health service successfully achieved stage one Practice Development Unit accreditation in June 2010.

Priorities for 2011/2012

During the reporting year 2011/2012 the Trust will focus on compliance with the Equality Act 2010 and the general and specific duties for public sector bodies. There will be a particular focus on improving service provision to those people from groups with protected characteristics to address service inequalities. This work will include :

- Continuing progression of existing work streams, particularly in relation to learning disabilities
- Further consultation with communities of special interest to set Trust and Divisional priorities within the NHS Equality Delivery System
- Specific work streams in relation to visual impairment, hearing impairment, mobility, dementia and sexuality
- Review of internal reporting and accountability, including terms of reference and composition of the Equality and Diversity steering group
- Review of the training strategy to reflect all of the above. Including introduction of specific training on visual impairment
- Review of the Equality Impact Assessment framework
- Staff data audit to improve quality of staff records and the establishment of staff reference groups of those people with protected characteristics
- Further development of occupational health services to achieve full Practice Development Unit accreditation in June 2011.

Staff Survey Report

Appointments manager Kath Fletcher *(far left):*

"This Trust is a great place to work. The Trust not only cares for its patients but its workforce too. I believe that the Trust endeavours to make sure that everybody counts and knows they count – patients and staff alike."

"We are all trained to do the job but sometimes you see some pretty unpleasant things and it's clinically quite demanding."

Anaesthetist Jez Pinnell *(left)* who also is on standby for the Yorkshire Air Ambulance rescue teams, helping to get seriously injured people rapidly into hospital.

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. Our "Saving Jobs Strategy" (mentioned under Staff Relations) is one example of effective working relationships to achieve a common goal. These groups will be an important feature of partnership working over the next few years of economic prudence.

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, which has had a major revamp this year, following a user survey
- 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.

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

"The Trust has been recognised as an 'Investor in People' for the last 10 years."

decisions which affect their health and wellbeing. A part of our strategy is an audit programme across the Trust to identify workload pressures in an attempt to avoid or manage work-related stress. Each survey is followed by a series of staff engagement events, resulting in an agreed action plan.

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.

Staff Survey

Every year we take part in the national NHS staff survey, where our staff have the chance to give us feedback on their job and workplace. We use this feedback to plan where we need to make improvements. Each year we produce a staff feedback and action plan based on "what you said – what we've done and what we're doing". Between October and December 2010 a random sample of 850 members of staff were asked to fill in the survey and 446 responded (53%).

Where we are improving

Following staff feedback from our 2009 survey, we focused on four key areas, with the support of our workforce wellbeing strategy group:

1. Staff being appraised
2. Staff receiving health and safety training
3. Staff working in a well structured team environment
4. Trust taking effective action to deal with violence and harassment

Each division across the Trust is represented on the strategy group and the divisional lead is responsible for ensuring that results are reported to their board, shared with staff and actions to address their concerns set out in an action plan.

The results of the staff survey in 2010 have shown that we have made significant improvements in our staff appraisal figures. We have also improved on our training figures – both health and safety training and equality and diversity training – by introducing new approaches to our training. Our mandatory health and safety training is provided by an innovative DVD production, which has allowed greater accessibility and flexibility for staff to acquire knowledge. This is supplemented with more specialised clinical training. We have provided classroom-based diversity training and equality impact assessment training during 2010 and we will be launching an e-learning product in 2011 to ensure our staff understand their responsibilities under the new Equality Act.

As part of our modernisation agenda, the Trust has developed a new approach to dealing with workplace conflict issues such as grievances, harassment and bullying. This cultural shift will be achieved through a focus on mediation as an alternative to formal processes. A number of key Trust staff have been trained and are now operating as accredited workplace mediators. Plans are in hand to cascade the training down to middle and junior managers to supplement their existing skills in handling workplace conflict.

Summary of Performance

	2009/10		2010/11	
Response rate	CHFT	National average for acute trusts	CHFT	National average for acute trusts
	53%	51%	53%	53%

	2009/10	2010/11	Ranking compared with national average for acute trusts 2010/11
Top 4 Ranking Scores			
Staff feeling valued by work colleagues	77%	80%	76% Highest (best) 20%
Staff appraised in last 12 months	58%	85%	78% Highest (best) 20%
Staff appraised with a personal development plan	51%	74%	66% Highest (best) 20%
Staff using flexible working options	75%	66%	63% Highest (best) 20%
Bottom 4 Ranking Scores			
Staff suffering work-related stress in last 12 months	29%	35%	28% Highest (worst) 20%
Staff motivation at work	3.79	3.73	3.83 (out of 5) Lowest (worst) 20%
Staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	20%	18%	15% Highest (worst) 20%
Quality of job design (clear job content, feedback and staff involvement)	3.32	3.32	3.41 (out of 5) Lowest (worst) 20%

Next Steps

Our survey results will be shared with our workforce wellbeing strategy group and divisional senior management teams, who will look at the results in more detail to understand the actions they need to take to respond to the feedback.

We are fully committed to preventing and managing factors in the workplace which promote safe working practices and safe working environments for our staff and patients. We are already listening to our staff and taking action to address health and well-being issues, particularly around our approach to managing work-related stress.

In 2009 the Trust implemented the Health and Safety Executive Management Standards for work-related stress, which deal with issues such as demands of the job, relationships at work and the support staff get from their manager and work colleagues.

In the period 2010/11 we carried out a number of audits across the Trust, engaged with our staff to identify solutions to their concerns and developed agreed action plans. This work will continue throughout 2011 and beyond.

Regulatory Ratings Report

	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

	Annual Plan 2010/11	Q1 2010/11	Q2 2010/11	Q3 2010/11	Q4 2010/11
Financial risk rating	3	3	3	3	3
Governance risk rating	Green	Green	Green	Green	Green

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

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 2010 to 31 March 2011 was as follows:

Board Member	Position	Tenure Review Date*
Sukhdev Sharma	Chairman	
Carol Clark	Non-Executive Director/Vice-Chair and Senior Independent Director	4 years office expires on 30.11.11
Alison Fisher	Non-Executive Director	3 years office expires on 30.11.12
Jane Hanson	Non-Executive Director	3 years office expires on 30.9.12
Bill Jones	Non-Executive Director	3 years office expires on 30.11.11
Andrew Haigh	Non-Executive Director	30.11.13 (Appointed 1.12.10)
Mohammad Naeem	Non-Executive Director	(Term of office expired on 30.11.10)
		Appointment Date
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 & Development	1.9.95

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

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

The Board of Directors currently 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 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 and is in the process of appointing a sixth Non-Executive Director in line with the recommendations within the Code of Governance. For more information about how the Trust applies the main and supporting principles of the code please see the Annual Statement of Internal Control in the accounts section of this report.

During 2010/11 the Board of Directors met on 12 occasions and attendance at these meetings is given below:

Name	Attendance at Board of Director meetings 1.4.10 - 31.3.10
Sukhdev Sharma	11 / 12
Carol Clark	11 / 12
Alison Fisher	10 / 12
Andrew Haigh	4 / 4
Jane Hanson	9 / 12
Bill Jones	7 / 12
Mohammad Naeem	6 / 8
Diane Whittingham	11 / 12
Helen Thomson	9 / 12
Mark Brearley	12 / 12
Yvette Oade	11 / 12
Lesley Hill	10 / 12
Julie Hull	10 / 12

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 via the website **www.cht.nhs.uk**

Anyone who would like to get in touch with a director should also contact the Board Secretary.

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. .

In addition to her role at Calderdale and Huddersfield, Diane has been acting as interim chief executive in East Lancashire Hospitals Trust. This role completed in April 2011 when the newly appointed Chief Executive took up post.

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.

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. She is a member of the University of Huddersfield Council.

Our Board of Directors

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 is the chair of the Yorkshire and Humber Finance Skills Development Board.

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

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.

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 the first woman medical director at the Trust and continues in her clinical role caring for young patients. Yvette is married and lives in Liversedge. She has one daughter who is studying medicine at Liverpool University.

Lesley Hill · Director of Service Development

Lesley has 23 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.

Sukhdev Sharma · Chairman

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

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 was a member of the European Economic and Social Committee since 1998 and a rapporteur (expert/spokesman) on equality, anti-discrimination, migration and human rights issues for the committee.

He chaired the Migration Policy Group, a Brussels-based think tank. He was 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 & 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 Quality Assurance Board.

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.

Andrew Haigh · Non-Executive Director

Andrew trained as a chartered accountant at Armitage & Norton in Huddersfield and moved to KPMG when the two firms merged in 1987. He specialised in IT risk management, audit and advice working primarily in retail financial services, payment services and the public sector.

He has worked with the majority of Retail Banks, Mortgage Banks and Building Societies, and a large number of General and Life Insurers, as well as local and central government organisations and the Health Service. He ran the IT advisory team in Leeds for 21 years and held a variety of senior positions within the firm including running the retail Financial Services practice in the North of England and latterly the IT Advisory Practice for the UK.

He retired from KPMG in 2008 to care for his wife who has a long term degenerative illness. Andrew was appointed as a non-executive director in December 2010 and has a particular interest in care in the community.

Andrew has lived in Huddersfield all his life and for the last 15 years in Almondbury. He has two daughters. He loves all sport and has been a Huddersfield Town fan for 50 years. He also enjoys music and walking.

Jane Hanson · Non-Executive Director & Chair of the Audit Committee

Jane is a fellow of the Institute of Chartered Accountants. She 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 the 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 the North of England.

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 over 20 years' experience of working at Board level in large and complex organisations Jane now has her own financial sector consulting business delivering audit, enterprise risk and corporate governance services. She is also a magistrate.

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

Our Board of Directors

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.

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 has served as audit chair to date again in a non-executive role.

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 non-executive of the Health Informatics Service.

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. He has recently been appointed as a trustee of Lloyds TSB Foundation Trust for England and Wales and has set up a private business in Halifax specialising in Immigration and Asylum representation work in West Yorkshire.

The Board would like to thank Naeem for all his contributions during his tenure as Non-Executive Director of the Foundation Trust.


NHS

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
Staff 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 2011)

Constituency	No. of Members
1	598
2	2017
3	1273
4	483
5	1284
6	750
7	1508
8	2250

Staff members per constituency (as at 31 March 2011)

Constituency	No. of Members
9	349
10	900
11	1368
12	1687
13	1719

Matron Chris Bentley, right, at a member event.

Our engagement activities in 2010/11

- 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
- 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 have been involved with helping to recruit clinical staff by sitting on service user interview panels. They have also helped us to improve our written information to patients and helped with surveys on particular services.
- The Trust's AGM was held in October 2010. 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 the Membership Council and Trust directors to meet and engage with the wider membership and people from the local community. Staff and the Membership Council worked together to host a high quality and enjoyable event which was attended by around 200 people
- A bi-monthly Medicine for Members event, hosted by our Membership Council and featuring clinicians from the Trust speaking on topics of local and national importance, has proved popular. The programme included presentations on the topics of NHS and our Trust's finances, stroke care, bowel screening and Releasing Time to Care – a programme to improve care on the wards
- 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 reporting on our membership's ongoing involvement in relation to service developments.

Chief executive Diane Whittingham together with deputy chair of the membership council Peter Naylor.

- Our Public and Patient Involvement (PPI) team continues to work closely with our LINks (local involvement network) organisations. We have been able to take their views into consideration when we are improving and developing those services. Our PPI team has always valued their feedback highly in this process. LINks has been involved in developing our Quality Account which sets out our key healthcare priorities
- Members and volunteers have been involved in helping us measure patient experience via real-time monitoring. Patients are interviewed prior to discharge with the information being recorded electronically and analysed and fed-back which enables actions to be taken where needed as soon as possible
- To familiarise the Membership Council with the organisation and services it provides, a number of informal "walkabouts" have taken places in areas such as wards and departments, theatres and catering
- As wards are refurbished and new facilities are opened for patients we invite our members to attend special tours in advance of them opening for patient care
- 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. All staff are now automatically welcomed to the Trust membership unless they "opt out".

Our Membership and Membership Council

Following analysis of our membership database, we identified areas of under-representation. Some of the following activities, between April 2010 and March 2011, were undertaken in an attempt to address this issue.

Action / Recruitment Activity	Target Population	Outcome
Focus groups	For people with physical and sensory disabilities	Increased membership from this community
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 University 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
Shopping Centres	General	Increased membership
Local health conferences	Local population	Increased membership and awareness of Trust

Photos from some of our recruitment events, 2010/11:

Shaping the Future.

Calderdale College Freshers' Day.

Increased membership.

Our Membership Council

Our Membership Council has 28 places, of which 22 represent the public and staff and are elected by our members. The remaining six are appointed by partnership organisations 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
- Chairs Information Exchange Sub-Committee
- Corporate Social Responsibility Group
- Divisional Reference:
  - Children's and Women's Services
  - Diagnostic and Therapeutic Services
  - Surgical and Anaesthetic Services
  - Medicine and Elderly Services
  - Estates and Facilities
  - Corporate Reference Group (from January 2011. (previously Membership Engagement and Recruitment Sub-Committee)

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

The Membership Council works closely with the Board of Directors. Directors routinely attend meetings of the Membership Council and representatives from the Membership Council attend Board of Director meetings. The 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.

Elected Council Members

Elections were held in three public constituencies during the autumn of 2010 and the results were announced at the Annual Members' Meeting in October 2010. 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 shading = current serving members	Attendance at formal membership council meetings 2009/10
Public			
Bernard Pierce	1	2013 (2nd term)	2 / 4
Frances Macguire	1	2011	1 / 4
Linda Wild	2	2011	4 / 4
Lesley Longbottom	2	2010	3 / 3
Harjinder Singh Sandhu	2	2013	2 / 2
Yash Pal Kansal	3	2012	4 / 4
Wendy Wood	3	2013	2 / 2
Christine Breare	4	2011	3 / 4
Richard Hill	4	2012	2 / 3
Allan Templeton	5	2010	3 / 3
George Richardson	6	2010	2 / 3
Vera Parojcic	5	2013	1 / 2
Lisa Herron	5	2013	1 / 2
Peter Naylor (Deputy Chair)	6	2012 (2nd term)	4 / 4
Christine Mickleborough	6	2011	3 / 4
Dot Rayner	7	2011	4 / 4
Liz Breen	7	2011	1 / 4
Jan Roberts	8	2009	3 / 4
Janette Roberts	8	2010	4 / 4
Staff			
Paul Knight	9	2011	3 / 4
Joanna Birch	10	2012	4 / 4
Sue Burton	11	2012	3 / 4
Liz Farnell	12	2012	4 / 4
Chris Bentley	13	2012	2 / 4
Chris Burton	13	2011	4 / 4
Stakeholders			
Sue Bernhauser	University of Huddersfield	2012 (2nd term)	2 / 4
Sally McIvor	Kirklees Metropolitan Council	2013	0 / 4
Robert Metcalf	Calderdale Metropolitan	2014	1 / 1
Jonathan Phillips	Calderdale Metropolitan Council	2010	0 / 3
Helena Corder	NHS Kirklees	2012 (2nd term)	2 / 4
Sue Cannon	NHS Calderdale	2011	2 / 4
Dawn Stephenson	South West Yorkshire Mental Health Trust	2013	1 / 4

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 via the website **www.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.**

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 Annual Statement of Internal Control (SIC). During the course of the year the Trust has continued to ensure its Governance Arrangements are reviewed in line 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 1.4.10 to 31.3.11 was:

Name	Attendance at Audit Committee meetings 1.4.10 - 31.3.10
Jane Hanson (Chair from 1.2.10)	6 / 9
Bill Jones (Chair until 31.1.10)	6 / 9
Andrew Haigh	2 / 3 (Appointed 1.12.10)
Mohammad Naeem	4 / 6 (Term of office expired 30.11.10)
Carol Clark	3 / 9
Andrew McConnell (appointed 1.11.08 as Independent Member of Audit Committee)	7 / 9

** = Co-opted members*

Nominations Committee

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 (or Vice Chair/Acting Chair in relation to the appointment of the Chair
- One appointed Membership Council Member
- One appointed Stakeholder
- Three elected Membership Council Members (at least two of whom must be publicly elected)
- The Chief Executive of the Foundation Trust

Attendees:

- Director of Personnel & Development
- Board Secretary

The Sub-Committee met on three occasions (19 May 2010, 1 July 2010, 27 July 2010) to discuss the Non-Executive appointments arising in-year. The Sub-Committee made the following decisions:-

- The offer of a further term of office to the Chair of the Trust to take effect from 5 October 2010 for a period of three years.
- The officer of a further term of office to the Vice Chair of the Trust to take effect from 1 December 2010 for a period of one year.
- The appointment of Mr Andrew Haigh as a Non-Executive Director with effect from 1 December 2010. The Nominations Sub-Committee commissioned the services of an external recruitment consultancy (Odgers Berndtson) to assist with the recruitment of the Non-Executive Director.

Name	Attendance at 19.5.10 Nominations Sub-Committee	Attendance at 1.7.10 Nominations Sub-Committee	Attendance at 27.7.10 Nominations Sub-Committee
Mr Sukhdev Sharma	✓	N/A	✓
Mrs Carol Clark	N/A	✓	N/A
Mr Allan Templeton	✓	✓	✓
Mrs Linda Wild	✓	✓	✓
Mrs Sue Bernhauser	✗	✓	✓
Mrs Chris Breare	✗	✓	✓
Mrs Diane Whittingham	✓	✓	✓

Remuneration 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 2010/2011 the sub-committee met on the 15 July 2010, 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 2010/2011 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 George Richardson (public elected member)
- Mrs Lesley Longbottom (public elected member)
- Vacant seat

The committee was quorate, with three members present, 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 2010/2011 the sub-committee, in accordance with the Code of Governance, agreed to commission an external review of the remuneration of the Non-Executive Directors. An external consultancy (Hewitt Associates LLC) was appointed and their report will be presented to the Remuneration Sub-Committee in the near future.

Name	Attendance at 15.7.10 Remuneration & Terms of Service Sub-Committee for Non-Executive Directors
Mr Peter Naylor (Chair)	✓
Mr Chris Burton	✓
Mrs Janette Roberts	✓
Mrs Lesley Longbottom	✗
Mr George Richardson	✗

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 2010/2011 financial year the sub-committee met on one occasion on 24 February 2011. 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
- Mr Andrew Haigh, Non-Executive Director
- Mrs Alison Fisher, Non-Executive Director
- Mr Bill Jones, Non-Executive Director

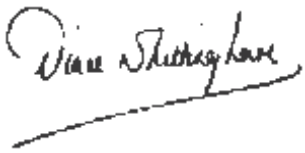
The sub-committee was quorate, with four members present, and able to conduct its business.
The sub-committee's Terms of Reference were reviewed and accepted for the current financial year.

The sub-committee received professional advice from Julie Hull, Director of Personnel and Development. In addition the Internal Auditors reviewed the business of the committee.

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.

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.

Name	Attendance at 24.2.11 Remuneration Committee for Executive Directors
Mr Sukhdev Sharma	✓
Mrs Carol Clark	✓
Mrs Alison Fisher	✓
Mr Andrew Haigh	✓
Mr Bill Jones	✗



Diane Whittingham
Chief Executive
April 2011


NHS

Appendix A

Participation in Clinical Audits

The national clinical audits and national confidential enquiries that Calderdale and Huddersfield NHS Foundation Trust **was eligible to participate in** during 2010/11 are as follows:

Peri- and Neonatal

Audit title	CHFT Eligible for Involvement
Perinatal mortality (CEMACH)	Yes
Neonatal intensive and special care (NNAP)	Yes

Children

Audit title	CHFT Eligible for Involvement
Paediatric pneumonia (British Thoracic Society)	Yes
Paediatric asthma (British Thoracic Society)	Yes
Paediatric fever (College of Emergency Medicine)	Yes
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	Yes
Paediatric intensive care (PICANet)	No
Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	No
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes

Acute Care

Audit title	CHFT Eligible for Involvement
Emergency use of oxygen (British Thoracic Society)	Yes
Adult community acquired pneumonia (British Thoracic Society)	Yes
Non invasive ventilation (NIV) - adults (British Thoracic Society)	Yes
Pleural procedures (British Thoracic Society)	Yes
Cardiac arrest (National Cardiac Arrest Audit)	Yes
Vital signs in majors (College of Emergency Medicine)	Yes
Adult critical care (Case Mix Programme)	Yes
Potential donor audit (NHS Blood & Transplant)	No

Long term conditions

Audit title	CHFT Eligible for Involvement
Diabetes (National Adult Diabetes Audit)	Yes
Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes
Chronic pain (National Pain Audit)	Yes
Ulcerative colitis & Crohn's disease (National IBD Audit)	Yes
Parkinson's disease (National Parkinson's Audit)	Yes
COPD (British Thoracic Society/European Audit)	Yes
Adult asthma (British Thoracic Society)	Yes
Bronchiectasis (British Thoracic Society)	Yes

Elective Procedures

Audit title	CHFT Eligible for Involvement
Hip, knee and ankle replacements (National Joint Registry)	Yes
Elective surgery (National PROMs Programme)	Yes
Cardiothoracic transplantation (NHSBT UK Transplant Registry)	No
Liver transplantation (NHSBT UK Transplant Registry)	No
Coronary angioplasty (NICOR Adult cardiac interventions audit)	No*
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes
Carotid interventions (Carotid Intervention Audit)	Yes
CABG and valvular surgery (Adult cardiac surgery audit)	No

*Local service delivery will begin in 2011, when CHFT will become eligible to participate, and when it is planned to participate.

Cardiovascular disease

Audit title	CHFT Eligible for Involvement
Familial hypercholesterolaemia (National Clinical Audit of Mgt of FH)	Yes
Acute Myocardial Infarction & other ACS (MINAP)	Yes
Heart failure (Heart Failure Audit)	Yes
Pulmonary hypertension (Pulmonary Hypertension Audit)	No
Acute stroke (SINAP)	Yes
Stroke care (National Sentinel Stroke Audit)	Yes

Appendix A

Renal disease

Audit title	CHFT Eligible for Involvement
Renal replacement therapy (Renal Registry)	No
Renal transplantation (NHSBT UK Transplant Registry)	No
Patient transport (National Kidney Care Audit)	Yes
Renal colic (College of Emergency Medicine)	Yes

Cancer

Audit title	CHFT Eligible for Involvement
Lung cancer (National Lung Cancer Audit)	Yes
Bowel cancer (National Bowel Cancer Audit Programme)	Yes
Head & neck cancer (DAHNO)	No

Trauma

Audit title	CHFT Eligible for Involvement
Hip fracture (National Hip Fracture Database)	Yes
Severe trauma (Trauma Audit & Research Network)	Yes
Falls and non-hip fractures (National Falls & Bone Health Audit)	Yes

Psychological conditions

Audit title	CHFT Eligible for Involvement
Depression & anxiety (National Audit of Psychological Therapies)	No
Prescribing in mental health services (POMH)	No
National Audit of Schizophrenia (NAS)	No

Blood transfusion

Audit title	CHFT Eligible for Involvement
O neg blood use (National Comparative Audit of Blood Transfusion)	Yes
Platelet use (National Comparative Audit of Blood Transfusion)	Yes

National Confidential Enquires

Audit title	CHFT Eligible for Involvement
Cardiac Arrest Procedures (NCEPOD)	Yes
Cosmetic Surgery (NCEPOD)	No
Peri-Operative Care (NCEPOD)	Yes
Surgery in Children (NCEPOD)	Yes
Maternal Death Enquiry (CMACE)	Yes

The national clinical audits and national confidential enquiries that Calderdale and Huddersfield NHS Foundation Trust **participated in** during 2010/11 are as follows:

Peri- and Neonatal

Audit title	CHFT Eligible for Involvement
Perinatal mortality (CEMACH)	Yes
Neonatal intensive and special care (NNAP)	Yes

Children

Audit title	CHFT Eligible for Involvement
Paediatric pneumonia (British Thoracic Society)	Yes
Paediatric asthma (British Thoracic Society)	Yes
Paediatric fever (College of Emergency Medicine)	Yes
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	Yes
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes

Acute Care

Audit title	CHFT Eligible for Involvement
Emergency use of oxygen (British Thoracic Society)	Yes
Adult community acquired pneumonia (British Thoracic Society)	Yes
Non invasive ventilation (NIV) - adults (British Thoracic Society)	Yes
Pleural procedures (British Thoracic Society)	No
Cardiac arrest (National Cardiac Arrest Audit)	No
Vital signs in majors (College of Emergency Medicine)	Yes
Adult critical care (Case Mix Programme)	Yes

Appendix A

Long term conditions

Audit title	CHFT Eligible for Involvement
Diabetes (National Adult Diabetes Audit)	Yes
Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes
Chronic pain (National Pain Audit)	Yes
Ulcerative colitis & Crohn's disease (National IBD Audit)	Yes
Parkinson's disease (National Parkinson's Audit)	No
COPD (British Thoracic Society/European Audit)	Yes
Adult asthma (British Thoracic Society)	Yes
Bronchiectasis (British Thoracic Society)	No

Elective Procedures

Audit title	CHFT Eligible for Involvement
Hip, knee and ankle replacements (National Joint Registry)	Yes
Elective surgery (National PROMs Programme)	Yes
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes
Carotid interventions (Carotid Intervention Audit)	Yes

Cardiovascular disease

Audit title	CHFT Eligible for Involvement
Familial hypercholesterolaemia (National Clinical Audit of Mgt of FH)	Yes
Acute Myocardial Infarction & other ACS (MINAP)	Yes
Heart failure (Heart Failure Audit)	Yes
Acute stroke (SINAP)	No
Stroke care (National Sentinel Stroke Audit)	Yes

Renal disease

Audit title	CHFT Eligible for Involvement
Patient transport (National Kidney Care Audit)	No
Renal colic (College of Emergency Medicine)	Yes

Cancer

Audit title	CHFT Eligible for Involvement
Lung cancer (National Lung Cancer Audit)	Yes
Bowel cancer (National Bowel Cancer Audit Programme)	Yes

Trauma

Audit title	CHFT Eligible for Involvement
Hip fracture (National Hip Fracture Database)	Yes
Severe trauma (Trauma Audit & Research Network)	Yes
Falls and non-hip fractures (National Falls & Bone Health Audit)	Yes

Blood transfusion

Audit title	CHFT Eligible for Involvement
O neg blood use (National Comparative Audit of Blood Transfusion)	Yes
Platelet use (National Comparative Audit of Blood Transfusion)	Yes

National Confidential Enquires

Audit title	CHFT Eligible for Involvement
Cardiac Arrest Procedures (NCEPOD)	Yes
Peri-Operative Care (NCEPOD)	Yes
Surgery in Children (NCEPOD)	Yes
Maternal Death Enquiry (CMACE)	Yes

Appendix A

The national clinical audits and national confidential enquiries that Calderdale and Huddersfield NHS Foundation Trust **did not participate in** and reasons during 2010/11 are as follows:

Acute Care

Audit title	CHFT participation	Reason	Projected date of commencement
Pleural procedures (British Thoracic Society)	No	Planned to do in 2010 but missed deadline to submit data to BTS. Now being continued locally.	
Cardiac arrest (National Cardiac Arrest Audit)	No	Participation in this requires payment of fees; this funding has now been approved and CHFT will be participating in future.	March 2011

Long term conditions

Audit title	CHFT participation	Reason	Projected date of commencement
Parkinson's disease (National Parkinson's Audit)	No	CHFT were not directly invited to participate (project organisers reported CHFT not on mailing list, but now on list for 2011)	
Bronchiectasis (British Thoracic Society)	No	Decision not to take part owing to clinicians' lack of time	

Cardiovascular disease

Audit title	CHFT participation	Reason	Projected date of commencement
Acute stroke (SINAP)	No	We decided not to participate this year – it is currently a pilot and it was not viewed as mandatory and was felt to be labour intensive until further developed. We discussed our thoughts with the West Yorkshire Stroke Network: Bradford took part in an early trial and we are watching their progress with interest. No other West Yorkshire hospitals have participated yet. CHFT currently evaluating participation in Clinical Information Management System for Stroke (CIMSS), which should support SINAP.	

The national clinical audits and national confidential enquires that Calderdale and Huddersfield NHS Foundation Trust **participated in, and for which data collection was completed** during 2010/11, 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.

Peri- and Neonatal

Audit title	CHFT participation	Audit sample	% Cases submitted
Perinatal mortality (CEMACH)	Yes	100%	Ongoing
Neonatal intensive and special care (NNAP)	Yes	100%	Ongoing

Children

Audit title	CHFT participation	Audit sample	% Cases submitted
Paediatric pneumonia (British Thoracic Society)	Yes	100%	Ongoing - deadline 31st Mar 2011
Paediatric asthma (British Thoracic Society)	Yes	100%	Ongoing - deadline 31st Jan 2011
Paediatric fever (College of Emergency Medicine)	Yes	100 (50 per site)	100%
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	Yes	100%	Ongoing
Diabetes (RCPH National Paediatric Diabetes Audit)	Yes	100%	100%

Acute Care

Audit title	CHFT participation	Audit sample	% Cases submitted
Emergency use of oxygen (British Thoracic Society)	Yes	Min 10	30%
Adult community acquired pneumonia (British Thoracic Society)	Yes	Min 10	Ongoing - deadline 31st Mar 2011
Non invasive ventilation (NIV) - adults (British Thoracic Society)	Yes	Min 10	Ongoing - deadline 31st May 2011
Vital signs in majors (College of Emergency Medicine)	Yes	99 (50 per site)	99%
Adult critical care (Case Mix Programme)	Yes	100%	Ongoing

Appendix A

Long term conditions

Audit title	CHFT participation	Audit sample	% Cases submitted
Diabetes (National Adult Diabetes Audit)	Yes	Not stated	363 cases submitted
Heavy menstrual bleeding (RCOG National Audit of HMB)	Yes	Not stated - patient postal survey	Ongoing - deadline 31st Jan 2012
Chronic pain (National Pain Audit)	Yes	100%	Ongoing - data collection to start March 2011
Ulcerative colitis & Crohn's disease (National IBD Audit)	Yes	40	Ongoing - deadline August 2011
Parkinson's disease (National Parkinson's Audit)	No	N/A	N/A
COPD (British Thoracic Society/European Audit)	Yes	100%	Ongoing - deadline 1st April 2011
Adult asthma (British Thoracic Society)	Yes	Min 10	100%
Bronchiectasis (British Thoracic Society)	No	N/A	N/A

Elective Procedures

Audit title	CHFT participation	Audit sample	% Cases submitted
Hip, knee and ankle replacements (National Joint Registry)	Yes	100%	Ongoing
Elective surgery (National PROMs Programme)	Yes	100%	Ongoing
Peripheral vascular surgery (VSGBI Vascular Surgery Database)	Yes	100%	Ongoing
Carotid interventions (Carotid Intervention Audit)	Yes	100%	Ongoing

Cardiovascular disease

Audit title	CHFT participation	Audit sample	% Cases submitted
Familial hypercholesterolaemia (National Clinical Audit of Mgt of FH)	Yes	40%	100% (only 18 applicable in audit time frame)
Acute Myocardial Infarction & other ACS (MINAP)	Yes	100%	100%
Heart failure (Heart Failure Audit)	Yes	20 per site, or 100% of cases if less cases present	100%
Stroke care (National Sentinel Stroke Audit)	Yes	60	100%

Renal disease

Audit title	CHFT participation	Audit sample	% Cases submitted
Renal colic (College of Emergency Medicine)	Yes	50 (per site)	100%

Cancer

Audit title	CHFT participation	Audit sample	% Cases submitted
Lung cancer (National Lung Cancer Audit)	Yes	100%	100%
Bowel cancer (National Bowel Cancer Audit Programme)	Yes	100%	98%

Trauma

Audit title	CHFT participation	Audit sample	% Cases submitted
Hip fracture (National Hip Fracture Database)	Yes	100%	Ongoing
Severe trauma (Trauma Audit & Research Network)	Yes	100%	Ongoing
Falls and non-hip fractures (National Falls & Bone Health Audit)	Yes	60	100%

Blood transfusion

Audit title	CHFT participation	Audit sample	% Cases submitted
O neg blood use (National Comparative Audit of Blood Transfusion)	Yes	Up to 40	100%
Platelet use (National Comparative Audit of Blood Transfusion)	Yes	40	100%

National Confidential Enquires

Audit title	CHFT participation	Audit sample	% Cases submitted
Cardiac Arrest Procedures (NCEPOD)	Yes	100%	100%
Peri-Operative Care (NCEPOD)	Yes	Ongoing	Ongoing
Surgery in Children (NCEPOD)	Yes	100%	N/A - No surgical deaths in audit time period
Maternal Death Enquiry (CMACE)	Yes	100%	100%

Appendix A

The reports of 18 national clinical audits published in 2010 were reviewed by the provider in 2010/11 and Calderdale and Huddersfield NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

BTS National Asthma Audit 2009

Following the 2008 BTS National Asthma Audit CHFT introduced a trial of an asthma 'care bundle'* in the form of a sticker with check boxes which could easily be stuck in the patient's notes. Following this initiative the 2009 round of the project showed marked improvements in processes as compared to the 2008 results.

Over 2011 there are plans to further develop the use of the bundle. There is a need to introduce it to the A&E department. The trial will continue with a view to it being incorporated into a larger multi-disciplinary bundle mid-2011. The use of the bundle will be monitored to establish reliable use of the interventions listed in it.

*A "care bundle" is a collection of interventions (usually three to five) that may be applied to the management of a particular condition. The elements in a bundle are best practices based on evidence, and all clinicians should know them. In routine clinical practice, these elements may not always all be done in the same way, making patient care vary. So a bundle aims to tie them together into a cohesive unit that must be adhered to for every patient, every time. All the tasks are necessary and must all occur in a specified period and place. Successfully completing a bundle is clear cut, and compliance is measured in an "all or none" approach, as its proponents argue that better outcomes are achieved when interventions are executed together rather than individually.

National Dementia Audit 2010

CHFT has a Dementia Collaborative which has been established to oversee the development of a dementia care pathway and to monitor quality standards relating to the care of patients with dementia. It has a membership of 4 wards and 4 emergency admissions areas, with dementia 'champions' in these areas who are receiving specialised training. The findings from the national audit are being used to inform the collaborative's action plan and the development of the care pathway. The care pathway includes: delirium and dementia assessment, coding proforma, person-centred care planning, risk assessment, pain assessment, and early discharge planning. As such, it addresses the key findings of the national audit (lack of standard approach to care assessment; care assessments did not contributing to effective care planning; little evidence of risk assessment; poor record keeping; little evidence of user engagement; little evidence of liaison regarding discharge planning).

The collaborative has successfully introduced the 'Butterfly' scheme. This scheme allows staff to identify patients that are suffering from dementia and alerts them to the need to approach a nurse for information on that patient's particular situation and needs, and also that the patient should not be moved unless clinically indicated (i.e. not for reasons of patient flow management) The scheme is recognized as facilitating a significant improvement in the quality of care for patients with dementia.

National Mastectomy & Breast Reconstruction Audit

The audit recommended that clinicians should act to better inform women about both the procedures they decide to undergo and the reconstructive options available. As per the 2009 NICE guidance, clinicians should ensure that women are offered a full range of appropriate reconstructive options, whether or not these are available locally.

In response to this recommendation, an information booklet is in the process of being produced outlining reconstructive options, whether or not these are available locally.

National Neonatal Audit

The Trust is currently discussing early care guidelines which will include early administration of surfactant and early measurement of blood pressure and temperature.

We have also introduced a separate green sheet of paper to record conversations with parents so that we know whether we have talked to parents of our babies within 24 hours of birth.

Other National Clinical Audits CHFT have participated in during 2010/11:

- The Second National Diabetes Inpatient Audit Day (data collection November 2010)
- Heart Rhythm Management (continuous data collection)
- National Audit of Dementia Care (data collection March - July 2010)
- National Audit of Cardiac Rehabilitation (continuous data collection)
- National Cancer Registries (continuous data collection)
- National Clinical Audit Programme for HIV (annual data collection)
- National Audit of Multiple Sclerosis (data collection January - July 2011)
- National Diabetic Retinopathy Audit
- National Thyroid/Parathyroid audit
- Audit of management of the open abdomen to investigate the occurrence of intestinal fistulae
- Implementing NICE Guidance for Health and Work: A National Organisational Audit
- Emergency Laparotomy Audit
- National Audit of Fractured Hips
- National audit of Avascular Necrosis/Bisphosphonate Related Jaw Necrosis (BRONJ)

The reports of 73 local clinical audits were reviewed by the provider in 2010/11 and Calderdale and Huddersfield NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Current practice in Rheumatoid Arthritis Disease Management

In February 2009 NICE clinical guideline 79 was published. This guidance relates to management of rheumatoid arthritis (RA) in adults. The purpose of this audit was to gain an understanding of current practice across CHFT in the management of RA, and assess if we are complying with the guidance and where improvements could be made.

The project resulted in the following recommendations:

- Need to educate patients better about the benefits of combination treatment in order to optimise uptake.
- Need to reduce drug doses once patients achieve satisfactory disease control
- Need to ensure that we check and act upon levels of acute phase proteins and other disease activity measures

Following this, attempts have been made to increase use of combination treatment, but there have been problems with side effects and patient compliance issues. The other two recommendations have been acted upon and the impact of these will be confirmed by a re-audit during 2011/12.

Appendix A

Thromboprophylaxis in Acute Medical Admissions

There are around 25,000 deaths from VTE each year in hospitals in England. Many are avoidable if a patient is assessed for risk of VTE on admission and appropriate prophylaxis is given based on national guidelines.

'High Quality Care For All' (NHS Next Stage Review Final Report (2008) included a commitment to make a proportion of providers' income conditional on quality and innovation, through the Commissioning for Quality and Innovation (CQUIN) payment framework. The CQUIN payment framework will allow all local health communities to develop their own scheme to encourage quality improvement and recognise innovation by making a proportion of income conditional on locally agreed goals. To support CHFT's goal of satisfying the CQUIN requirements relating to VTE, this project had the following aims:

- 90% of all adult inpatients to have VTE risk assessment on admission to hospital
- Hospitals to ensure patients receive appropriate prophylaxis for VTE based on national guidance according to their risk assessment
- Carry out root cause analysis on all confirmed inpatient cases of pulmonary embolism (PE) or deep vein thrombosis (DVT)

The project aimed to improve the reliability with which VTE risk assessments are carried out by modifying the clerking-in document to include a formal, specially designed assessment tool and by educating medical staff in the importance of the assessments. Before this initiative risk assessments were completed at MAU HRI in 50% of cases, but afterwards this figure had risen to 89%. This Improvement work around VTE risk assessment is now being continued and developed in all areas under the Trust's VTE Collaborative.

Management of Osteoporosis in the Fracture Clinic

Aldendronate is recommended by NICE as a treatment option for the secondary prevention of osteoporotic fragility fractures in post menopausal women who are confirmed to have osteoporosis (i.e. T score of -2.5 SD or below). In women aged 75 years or older, a DEXA scan may not be required if the responsible clinician considers it to be clinically inappropriate or unfeasible. Assessment for osteoporosis, should in principle, be an integral part of any orthopaedic fracture service. BOA and NICE recommends it should be picked up in the fracture clinic.

Following the recommendations from this audit a protocol has been developed and is now agreed and disseminated.

Termination of Pregnancy

One of the recommendations from this audit was to introduce a new clinic for Teenage clients to encourage use of Long Acting Reversible Contraception (LARC) methods.

Following this recommendation a teenage clinic started in April 2010. It is funded for 2 clinics a month. 8-10 teenagers attend each clinic. Clients of all age groups expressed their views at the time of termination consultation that they want to come back to the clinic for follow up and contraception.

Re-audit of Prostate Patients Privacy & Dignity

Following the results of this audit the subsequent improvements have been made:

- A cannulation/nurses room is now available within the ultrasound dept where the biopsies take place.
- A specific room in ultrasound is now available for nurses to interview patients prior to procedure.

" 90% of all adult inpatients to have VTE risk assessment on admission to hospital."

Calderdale and Huddersfield NHS
NHS Foundation Trust

Accounts

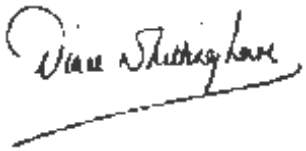
for the 12 month period ended 31st March 2011

Acute Healthcare Organisation of the Year 2010

Accounts

Foreword to the Accounts

These accounts, for the year ended 31 March 2011, have been prepared by the Calderdale & Huddersfield NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006.



Diane Whittingham · Chief Executive
Date: 2nd June 2011

National Health Service Act 2006

Directions by monitor in respect of National Health Service Foundation Trust's annual accounts

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 for an NHS foundation trust in its first operating period since authorisation, the accounts of an NHS foundation trust for the period from authorisation until 31 March; accounts of an NHS foundation trust for the period from authorisation until 31 March;

or

for an NHS foundation trust in its second or subsequent operating period following 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 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. "the NHS foundation trust" means the NHS foundation trust in question.

2. Form of accounts

(1) The accounts submitted under paragraph 25 of Schedule 7 of the 2006 Act shall show, and give a true and fair view of, the NHS foundation trust's gains and losses, cash flows and financial state at the end of the financial period.

(2) The accounts shall meet the accounting requirements of the 'NHS Foundation Trust Annual Reporting Manual' (FT ARM) as agreed with 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

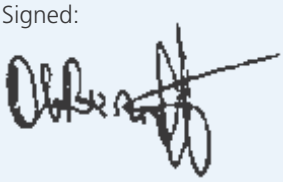
(1) The statement of accounting officer's responsibilities in respect of the accounts shall be signed and dated by the chief executive of the NHS foundation trust.

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: **David Bennett** · Chairman
Date: 28th February 2011

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

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed Calderdale and Huddersfield NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Calderdale and Huddersfield NHS foundation trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

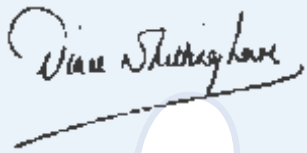
In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

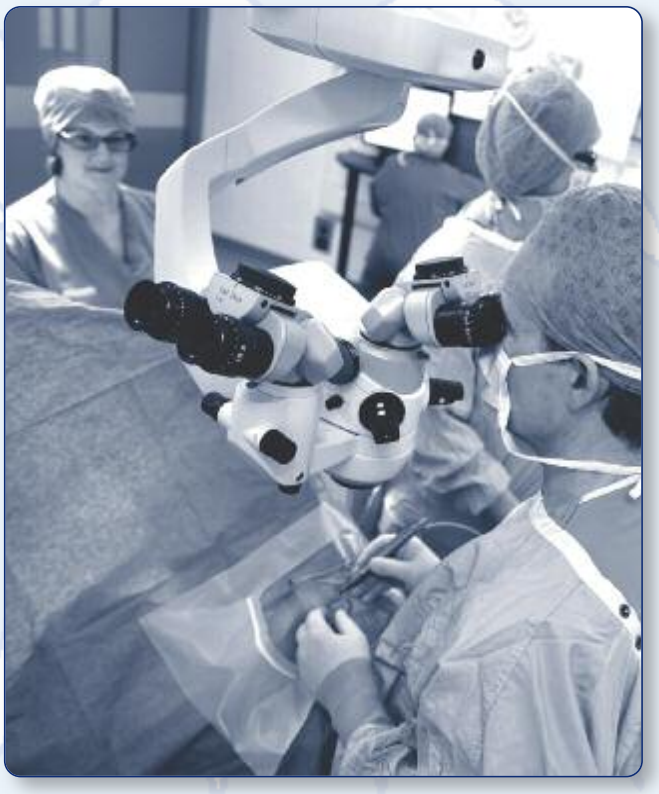
The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

Signed:



Name: **Diane Whittingham** · Chief Executive
Date: 2nd June 2011



Statement on 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 2011 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 Board of Directors:

Quality Assurance Board 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. 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 Quality

"The system of internal control is designed to manage risk to a reasonable level."

Assurance Board by the Risk Compliance and Assurance Committee. This Committee is responsible for monitoring the Compliance Register, Risk Register, 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 Quality Assurance Board, which monitors the assurance framework. 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 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 e.g. 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.

Statement on internal control

(continued)

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. In addition, the Risk, Compliance and Assurance Committee monitors the Compliance Register and Risk Register, and performance against national risk and safety standards on my behalf. Assurance is also provided by the governance system which includes the Quality Assurance Board and Audit Committee, supported by 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 should be 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 in the Trusts Induction Programme and ongoing mandatory risk training programme. Progress with Information Governance compliance is measured on a yearly basis through the Trusts self assessment against the Connecting for Health Information Governance Toolkit.

"Operational risk registers are maintained in every ward and department, and for time limited projects."

The Organisation's major risks

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 Performance 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 Achieved compliance with targets 2011/12 Compliance with targets: MRSA: 4 C.Difficile: 66 2012/13 Compliance with targets
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.	Current 3 year financial plans are based on a cautious but realistic assessment of the economic environment, including tariff changes. Plans seek to protect clinical quality whilst reducing costs. There has been Board, senior manager and clinician involvement in plans from the outset of financial planning, to ensure full engagement.	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 organisation. 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.	Staff and service transferred 1 April 2011

continued overleaf >

The Organisation's major risks *(continued)*

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.

Care Quality Commission registration

The Foundation Trust is fully compliant with the core requirements of registration with the Care Quality Commission.

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 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. The Trust requires an Equality Impact Assessment to be completed in the development of any new/revised policy.

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.

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

The Trust produces an annual plan that includes an assessment of the resources required to deliver the commissioned level of clinical activity, whilst ensuring that resources are used economically, efficiently and effectively. The plan incorporates the national requirements to continually improve productivity and efficiency, and to manage resources within a national tariff structure that drives the economic use of resources. The Trust has also established Quality Improvement arrangements to ensure that resources are deployed effectively.

The Trust has a successful track record of delivery against savings plans and achieving planned surplus levels or better; this financial year has been no exception.

The Board of Directors receive a monthly performance report which includes key financial information and updates on performance against the Trust's efficiency target. In addition, Directors are able to review performance in more detail at the monthly Finance Briefing meetings. The Trust also provides financial information to Monitor on a quarterly basis inclusive of financial tables and a commentary.

The resources of the Trust are managed through various measures, including the adoption of a robust budgetary control system, the consistent application of internal financial controls and effective procurement and tendering procedures.

The resource and financial governance arrangements are further supported by both internal and external audit to secure economic, efficient and effective use of the resources the Trust has at its disposal.

Some external consultancy support was commissioned in 2010/11 to review the efficiency plans being developed and implemented by the Clinical Divisions which provided both an external challenge and the generation of other potential areas where further efficiencies could be sought.

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

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.

Following a competitive tendering process the Trust has agreed to enter into a Property Investment Partnership with Henry Boot Developments Ltd. The joint venture approach provides an innovative and flexible solution that will ensure the good use of public money, provide flexibility of funding arrangements and benefits from utilising the skills and expertise of both the public and private sector. This will ensure the most efficient use of the overall estate to ensure it is fit for purpose to support the delivery of modern health care services.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

Our Board of directors takes an active leadership role on quality. The quality of our services is an integral part of our discussions on business matters and business decisions and the Board receives updates regularly.

We have a Quality Improvement Strategy, which includes a number of work programmes, lead by senior clinicians, supported by quality improvement specialists and information specialists. We use improvement methodologies developed by organisations such at the Institute for Healthcare Improvement which recognise that improvement science has an emphasis on measurement of individual initiatives.

There has been wide engagement with Stakeholders including staff and members in developing our priorities, and with patients through surveys and complaints and patient safety incidents.

Quality improvement metrics are monitored by the Quality Improvement Board. We have controls in place to ensure the accuracy of data which include:

- Internal data quality reports.
- External data quality reports from CHKS.
- The Internal Audit programme which increasingly is being aligned with the quality programme.
- The External Audit of the data and performance indicators within the quality account.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Quality Assurance Board, the Board, and the Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Executive Management Team has identified the Trust's principal objectives and the risks to their achievement, along with risk controls and assurance mechanisms. As part of this risk assessment process, gaps in controls and assurances have been highlighted. This information is incorporated in the Trust's Assurance Framework document. Underpinning the Assurance Framework, is the Trust Risk Register which includes 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 Quality Assurance Board monitors selected quality metrics, and ensures that the Foundation Trust has robust systems in place to learn from experience. It receives reports

from specialist governance committees e.g. Safeguarding: Information Governance; Medicines Management; Risk Compliance Assurance Committee, and assures itself that Divisional Quality Boards are assuring themselves on the quality of their services. The Quality Assurance Board reports to the Board of Directors.

The Risk Compliance and Assurance Committee, 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. It also considers the detail of incidents and complaints to provide assurance that any trends are identified and improvement work identified, and that actions on individual cases are implemented.

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 Board. The Committee takes an overview of the organisation's governance activity supported by the internal auditors who provide opinions on compliance with standards and the systems of internal control. Internal Audit have reviewed elements of the system of internal control including the assurance framework, self assessment of performance against the Essential standards of Quality and Safety, clinical governance and corporate governance.

There has been one significant internal control issue identified during the year. We experienced the theft of a portable computer which was part of an electromyography (EMG) machine. The manufacturers/suppliers of the EMG machine, used for testing the electrical activity of muscles, have confirmed that the portable computer is not encrypted but we know that the operating system, Windows XP was password protected. The portable computer holds personal information relating to 1569 patients. The EMG record on the portable computer does not include the clinical interpretation of the record, as this is processed separately. In all of the 1569 records, referral symptoms, name and date of birth are shown. In 1051 of these records, the address is also included.

The theft was reported to the police and reported as a serious incident in accordance with Department of Health guidance. All those affected were notified and the incident was reported to the Information Commissioners office.

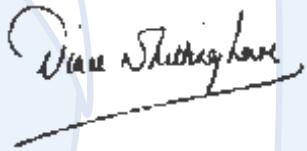
Immediate action was taken to improve security, and an action plan put in place to identify and take mitigating actions on any other clinical equipment which could pose a similar risk. The Information Commissioner's Office has indicated that it does not intend to take any regulatory action.

Conclusion

The system of internal control has been in place in Calderdale & Huddersfield NHS Foundation Trust for the year ended 31 March 2011 and up to the date of approval of the annual report and accounts. Other than the internal control issue referred to within the Review of effectiveness section, no significant internal control issues have been identified.

In summary I am assured that the NHS foundation trust has a sound system of internal controls in place, which is designed to manage the key organisational objectives and minimise the NHS foundation trust's exposure to risk. The Board of Directors is committed to continuous improvement and enhancement of the system of internal control.

Signed:



Name: **Diane Whittingham** · Chief Executive
Date: 2nd June 2011

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 2011 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 in the Statement of Accounting Policies.

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
- the table of pension benefits of senior managers and related narrative notes.

This report is made solely to the Membership Council of Calderdale and Huddersfield NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. My audit work has been 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. 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 this report or for the opinions I have formed.

Respective responsibilities of the Accounting Officer and auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view.

My responsibility is to audit the financial statements in accordance with applicable law, the Audit Code for NHS Foundation Trusts and International Standards on Auditing (UK and Ireland). Those standards require me to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements. I read all the information in the annual report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Opinion on financial statements

In my opinion the financial statements:

- give a true and fair view of the state of affairs of Calderdale and Huddersfield NHS Foundation Trust's as at 31 March 2011 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts.

Opinion on other matters

In my opinion:

- the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which I report by exception

I have nothing to report in respect of the Statement on Internal Control on which I report to you if, in my opinion the Statement on Internal Control does not reflect compliance with Monitor's requirements.

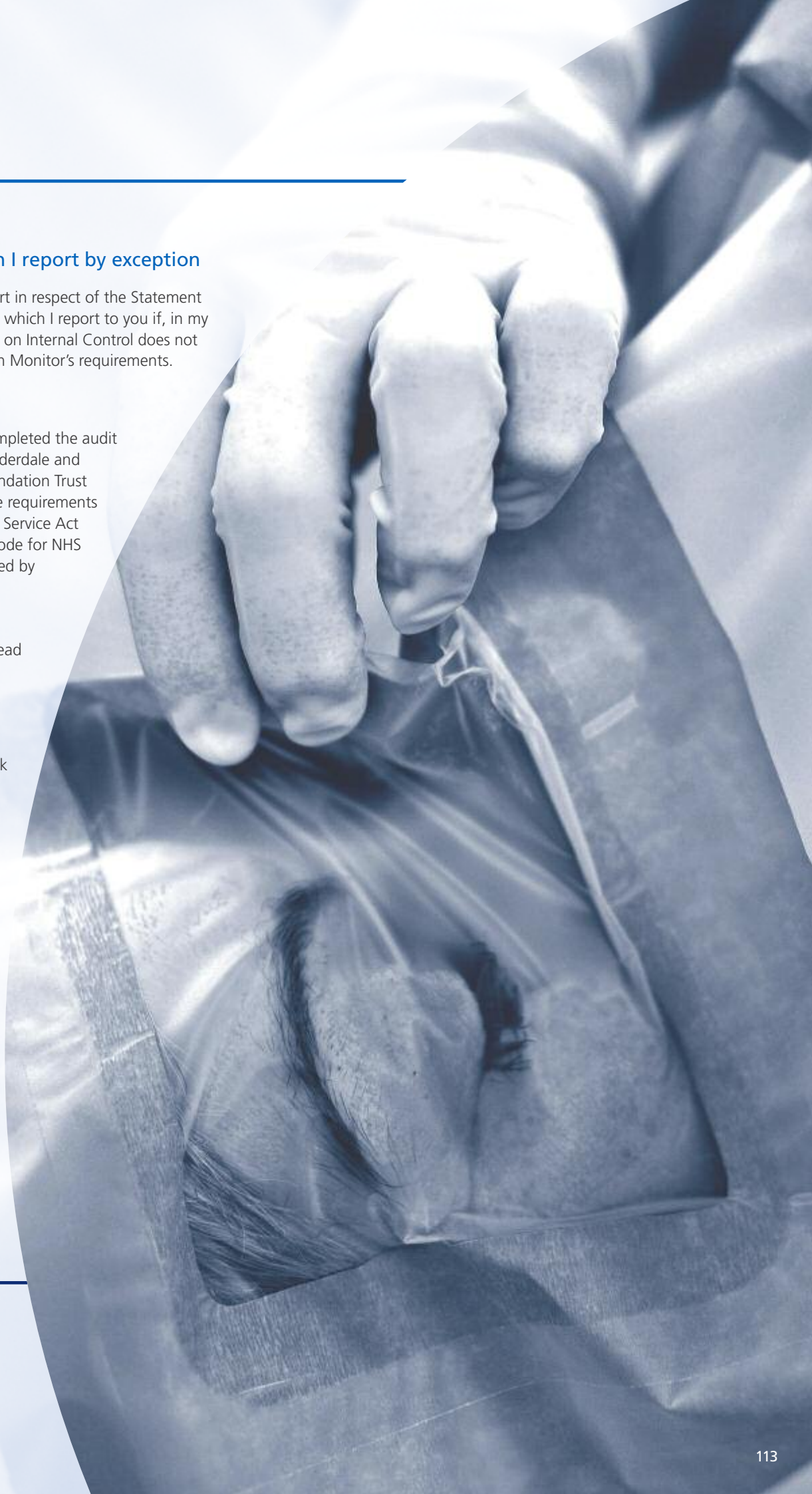
Certificate

I certify that I have completed the audit of the accounts of Calderdale and Huddersfield NHS Foundation Trust 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: 2nd June 2011

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



Statement of comprehensive income

	Note	2010/11	2009/10
		£000	£000
Operating Income from continuing operations	3	320,660	309,228
Operating Expenses of continuing operations	4	(304,995)	(310,920)
OPERATING SURPLUS / (DEFICIT)		15,665	(1,692)
FINANCE COSTS			
Finance income	10	162	188
Finance expense - financial liabilities	11	(10,210)	(9,866)
Finance expense - unwinding of discount on provisions		(59)	(69)
PDC Dividends payable		(3,744)	(4,328)
NET FINANCE COSTS		(13,851)	(14,075)
Share of Profit / (Loss) of Associates / Joint Ventures accounted for using the equity method		-	-
Corporation tax expense	9	-	-
Surplus/(Deficit) from continuing operations		1,814	(15,767)
Surplus / (deficit) of discontinued operations and the gain / (loss) on disposal of discontinued operations	8	-	-
SURPLUS / (DEFICIT) FOR THE YEAR		1,814	(15,767)
Other comprehensive income			
Impairments	36	(19,765)	(34,621)
Revaluations	36	5,043	25,725
Receipt of donated assets		151	244
Asset disposals		-	-
Share of comprehensive income from associates and joint ventures		-	-
Movements arising from classifying non current assets as Assets Held for Sale		-	-
Fair Value gains / (losses) on Available-for-sale financial investments		-	-
Recycling gains / (losses) on Available-for-sale financial investments		-	-
Other recognised gains and losses		-	-
Actuarial gains / (losses) on defined benefit pension schemes		-	-
Other reserve movements	36	(308)	(318)
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE PERIOD		(13,065)	(24,737)
Prior period adjustment		-	-
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		(13,065)	(24,737)
Note: Allocation of Profits / (Losses) for the period:		2010/11	2009/10
		£000	£000
(a) Surplus / (Deficit) for the period attributable to:			
(i) minority interest, and		-	-
(ii) owners of the parent.		1,814	(15,767)
TOTAL		1,814	(15,767)
(b) total comprehensive income / (expense) for the period attributable to:			
(i) minority interest, and		-	-
(ii) owners of the parent.		(13,065)	(24,737)
TOTAL		(13,065)	(24,737)

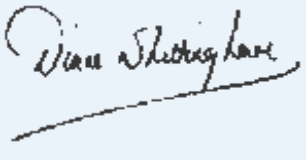
The notes on the following pages form part of these Accounts.

Operating income for 2010/11 includes an exceptional item relating to the reversal of impairments on property, plant & equipment of £5,608,000. Operating expenses for 2010/11 and 2009/10 include exceptional items relating to impairments on property, plant & equipment of £5,146,000 and £19,596,000 respectively.

The surplus positions for 2010/11 and 2009/10, excluding these non-cash exceptional items, are £1,351,000 and £3,829,000 respectively.

Statement of financial position

	Note	2010/11	2009/10
		£000	£000
Non-current assets			
Intangible assets	13	385	281
Property, plant and equipment	14	206,366	217,912
Investment Property		-	-
Investments in associates (and joined controlled operations)		-	-
Other investments		-	-
Trade and other receivables	18	1,736	1,722
Other Financial assets		-	-
Tax receivable		-	-
Other assets		-	-
Total non-current assets		208,487	219,915
Current assets			
Inventories	17	4,727	4,699
Trade and other receivables	18	11,424	13,361
Other financial assets		-	-
Tax receivable		-	-
Non-current assets for sale and assets in disposal groups	16	500	-
Cash and cash equivalents	19	15,025	18,237
Total current assets		31,676	36,297
Current liabilities			
Trade and other payables	20	(16,762)	(19,228)
Borrowings	21	(1,771)	(2,155)
Other financial liabilities		-	-
Provisions	24	(634)	(448)
Tax payable		(4,124)	(4,020)
Other liabilities	23	(3,190)	(1,497)
Liabilities in disposal groups		-	-
Total current liabilities		(26,481)	(27,348)
Total assets less current liabilities		213,682	228,864
Non-current liabilities			
Trade and other payables	20	-	-
Borrowings	21	(90,528)	(92,299)
Other financial liabilities		-	-
Provisions	24	(2,299)	(2,562)
Tax payable		(550)	(633)
Other liabilities	23	(1,933)	(1,933)
Total non-current liabilities		(95,310)	(97,427)
Total assets employed		118,372	131,437
Financed by (taxpayers' equity)			
Minority Interest		-	-
Public Dividend Capital		111,899	111,899
Revaluation reserve		30,883	46,059
Donated Asset Reserve		1,370	1,543
Available for sale investments reserve		-	-
Other reserves		-	-
Merger reserve		-	-
Income and expenditure reserve		(25,780)	(28,064)
Total taxpayers' equity		118,372	131,437

Signed: 

Name: **Diane Whittingham** · Chief Executive
Date: 2nd June 2011

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 2010	**131,437**	**111,899**	**46,059**	**1,543**	**(28,064)**
Surplus / (deficit) for the year	1,814	-	-	-	1,814
Impairments	(19,765)	-	(19,678)	(87)	-
Revaluations	5,043	-	4,972	71	-
Receipt of donated assets	151	-	-	151	-
Asset disposals	-	-	-	-	-
Share of comprehensive income from associates and joint ventures	-	-	-	-	-
Movements arising from classifying non-current assets as Assets Held for Sale	-	-	-	-	-
Fair Value gains / (losses) on Available-for-sale financial investments	-	-	-	-	-
Recycling gains / (losses) on Available-for-sale financial investments	-	-	-	-	-
Other recognised gains and losses	-	-	-	-	-
Actuarial gains / (losses) on defined benefit pension schemes	-	-	-	-	-
Public Dividend Capital received	-	-	-	-	-
Public Dividend Capital repaid	-	-	-	-	-
Public Dividend Capital written off	-	-	-	-	-
Other reserve movements	(308)	-	(470)	(308)	470
Taxpayers' Equity at 31 March 2011	**118,372**	**111,899**	**30,883**	**1,370**	**(25,780)**

	Total	Dividend Capital	Revaluation Reserve	Assets Reserve	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)	-	-	-	(15,767)
Impairments*	(34,621)	-	(34,606)	(15)	-
Revaluations*	25,725	-	25,725	-	-
Receipt of donated assets	244	-	-	244	-
Asset disposals	-	-	(96)	-	96
Share of comprehensive income from associates and joint ventures	-	-	-	-	-
Movements arising from classifying non-current assets as Assets Held for Sale	-	-	-	-	-
Fair Value gains / (losses) on Available-for-sale financial investments	-	-	-	-	-
Recycling gains / (losses) on Available-for-sale financial investments	-	-	-	-	-
Other recognised gains and losses	-	-	-	-	-
Actuarial gains / (losses) on defined benefit pension schemes	-	-	-	-	-
Public Dividend Capital received	-	-	-	-	-
Public Dividend Capital repaid	-	-	-	-	-
Public Dividend Capital written off	-	-	-	-	-
Other reserve movements*	(318)	-	(211)	(318)	211
Taxpayers' Equity at 31 March 2010	**131,437**	**111,899**	**46,059**	**1,543**	**(28,064)**

*See Note 36

Statement of cash flows

	2010/11	2009/10
	£000	£000
Cash flows from operating activities		
Operating surplus / (deficit) from continuing operations	15,665	(1,692)
Operating surplus / (deficit) from discontinued operations	-	-
Operating surplus / (deficit)	15,665	(1,692)
Non-cash income and expense:		
Depreciation and amortisation	9,094	9,616
Impairments	5,146	19,596
Reversals of impairments	(5,608)	-
Transfer from the donated asset reserve	(308)	(318)
Amortisation of government grants	-	-
Amortisation of PFI credit	-	-
(Increase)/ Decrease in Trade and Other Receivables	1,923	(910)
Increase / (Decrease) in Other Assets	-	-
(Increase) / Decrease in Inventories	(28)	(212)
Increase / (Decrease) in Trade and Other Payables	(1,027)	(1,447)
Increase / (Decrease) in Other Liabilities	1,692	214
Increase / (Decrease) in Provisions	(77)	(120)
Tax (paid) / received	21	369
Movements in operating cash flow of discontinued operations	-	-
Other movements in operating cash flows	(167)	295
NET CASH GENERATED FROM / (USED IN) OPERATIONS	26,326	25,391
Cash flows from investing activities		
Interest received	162	188
Purchase of financial assets	-	-
Sale of financial assets	-	-
Purchase of intangible assets	(193)	(99)
Sales of intangible assets	-	-
Purchase of Property, Plant and Equipment	(14,113)	(12,029)
Sales of Property, Plant and Equipment	451	461
Cash flows attributable to investing activities of discontinued operations	-	-
Cash from acquisition of business units and subsidiaries	-	-
Cash from (disposals) of business units and subsidiaries	-	-
Net cash generated from / (used in) investing activities	(13,693)	(11,479)
Cash flows from financing activities		
Public dividend capital received	-	-
Public dividend capital repaid	-	-
Loans received	-	1,200
Loans repaid	(562)	(281)
Capital element of finance lease rental payments	-	-
Capital element of Private Finance Initiative Obligations	(1,593)	(1,468)
Interest paid	(322)	(189)
Interest element of finance lease	-	-
Interest element of Private Finance Initiative obligations	(9,900)	(9,536)
PDC Dividend paid	(3,468)	(4,480)
Cash flows attributable to financing activities of discontinued operations	-	-
cash flows from (used in) other financing activities	-	-
Net cash generated from / (used in) financing activities	(15,845)	(14,754)
Increase / (decrease) in cash and cash equivalents	(3,212)	(842)
Cash and Cash equivalents at 1 April	18,237	19,079
Cash and Cash equivalents at 31 March	15,025	18,237

*In the 2009/10 accounts, there was a balance of £633,000 disclosed as 'Non-current Other Payables' which has now been correctly disclosed as 'Non-current Taxes Payable' (see note 20.1). This impacts on the 2009/10 Statement of Cash Flows; the movement on 'Trade and Other Payables' and 'Tax received' have both been restated. This led to an decrease in cash of £121,000 relating to movements on 'Trade and Other Payables' and an increase in cash relating to 'Tax Received' of £121,000.

Notes to the accounts

1 Accounting policies and other information

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the Foundation Trust Annual Reporting Manual 2010/11 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Consolidation

Subsidiaries

Subsidiary entities are those over which the trust has the power to exercise control or a dominant influence so as to gain economic or other benefits. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to minority interests are included as a separate item in the Statement of Financial Position.

The amounts consolidated are drawn from the published financial statements of the subsidiaries for the year, except where a subsidiary's financial year end is before 1 January or after 1 July in which case the actual amounts for each month of the trust's financial year are obtained from the subsidiary and consolidated.

Where subsidiaries' accounting policies are not aligned with those of the trust (including where they report under UK GAAP) then amounts are adjusted during consolidation where the differences are material.

Subsidiaries which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

Joint Ventures

Joint ventures are separate entities over which the trust has joint control with one or more other parties. The meaning of control is the same as that for subsidiaries.

Joint ventures are accounted for using the equity method.

Joint ventures which are classified as held for sale are measured at the lower of their carrying amount and 'fair value less costs to sell'.

1.3 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

The value at the start or end of an accounting period of incomplete spells of care is recognised to the extent that treatment services have been provided in that period. The value of incomplete spells of care has been calculated using estimation techniques.

1.4 Expenditure on Employee Benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. Given the low value of annual leave carried forward by employees across periods, and as this value does

not change significantly between financial years, the cost of annual leave earned but not taken by employees at the end of the period is not recognised in the financial statements.

Pension costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

The NHS Pension Scheme is subject to a full valuation every four years by the Government Actuary. The latest published valuation relates to the period 1 April 1999 to 31 March 2004 which was published in December 2007 and is available on the NHS Pensions Agency website.

The national deficit of the scheme was £3.3 billion as per the last scheme valuation by the Government Actuary for the period 1 April 1999 to 31 March 2004. The conclusion of the valuation was that the scheme continues to operate on a sound financial basis.

Employer contribution rates are reviewed every four years following the scheme valuation, on advice from the actuary. At the last valuation it was recommended that employer contribution rates should continue at 14% of pensionable pay. From 1 April 2008, employees pay contributions will be on a tiered scale from 5% to 8.5% of their pensionable pay.

1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.6 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably.

In addition, property, plant and equipment is capitalised if it:

- individually has a cost of at least £5,000; or
- forms a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- forms part of the initial setting-up of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at fair value.

All property assets are revalued using professional valuations in accordance with IAS 16 every five years. A three yearly interim valuation is also carried out.

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

In addition, as a result of changes in replacement costs and the property market, an additional interim revaluation was undertaken as at 31 March 2011 on all property assets.

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

Specialised operational property is valued using the HM Treasury standard approach of depreciated replacement cost valuations based on modern equivalent assets, and where it would meet the location requirements of the service being provided an alternative site can be valued.

Non-specialised operational owner-occupied property is valued at existing use value, which is the market value subject to the assumption that the property is sold as part of the continuing enterprise in occupation.

Non-operational properties, including surplus land, are valued at market value.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Until 31 March 2009, plant and equipment were carried at net current replacement cost, as assessed by indexation and depreciation. From 1 April 2009 the national equipment indices issued by the Department of Health are no longer available. The carrying value of existing assets at that date 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

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of Property, Plant and Equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised

in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Derecognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated assets

Donated 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 'on-Statement of Financial Position' by the Trust. The underlying assets are recognised as Property, Plant and Equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income.

Lifecycle replacement costs are apportioned, using information from the PFI operator's financial model, between costs charged to operating expenses and costs that are capitalised.

Protected assets

Assets that are required for the provision of mandatory goods and services are protected. Assets which are not required for mandatory goods and services are not protected and may be disposed of by the Trust without the approval of Monitor (the Independent Regulator of NHS Foundation Trusts).

1.7 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Revaluation gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.8 Government grants

Government grants are grants from Government bodies other than income from 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.

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost valuation is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.10 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets are categorised as 'Loans and receivables'.

Financial liabilities are classified as 'Other Financial liabilities'.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS debtors, accrued income and 'other debtors'.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method.

The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the statement of financial position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

1.11 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.12 Provisions

The NHS foundation trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the HM Treasury's discount rate of 2.2% in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.9% 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 24.

Non-clinical risk pooling

The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 24.4 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 24.4, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.14 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) net cash balances held with the Government Banking Services and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.15 Value Added Tax

Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.16 Corporation Tax

The Trust is potentially within the scope of corporation tax in respect of activities which are not related to, or are ancillary to, the provision of healthcare, and where the profits exceed £50,000 per annum. In the period covered by these accounts the Trust has assessed that it is not liable to pay corporation tax.

1.17 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the statement of financial position date:

- monetary items (other than financial instruments measured at 'fair value through income and expenditure') are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; 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.

1.18 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

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

	2010/11	2009/10
	£000	£000
Income from activities		
Elective income	**52,982**	49,061
Non elective income	**87,685**	88,992
Outpatient income*	**43,594**	29,378
A&E income	**11,963**	10,633
Other NHS clinical income*	**81,124**	89,499
Private patient income	**383**	442
Other non-protected clinical income	**4,055**	3,836
Total income from activities	**281,786**	271,841
Other operating income		
Research and development	**849**	498
Education and training	**7,430**	7,543
Charitable and other contributions to expenditure	**351**	428
Transfer from donated asset reserve in respect of depreciation on donated assets	**309**	319
Non-patient care services to other bodies	**8,531**	9,185
Other	**15,796**	19,414
Reversal of impairments of property, plant and equipment	**5,608**	-
Total other operating income	**38,874**	37,387
TOTAL OPERATING INCOME	**320,660**	309,228

*There has been a movement on income categories for outpatient procedures which were paid for using a local pricing agreement in 2009/10 and classified as 'Other NHS Clinical Income', to a national tariff in 2010/11 and classified as 'Outpatient Income'.

3.2 Private patient income

	2010/11	2009/10	Base Year
	£000	£000	£000
Private patient income	**383**	442	635
Total patient related income	**281,786**	271,841	174,934
Proportion (as percentage)	**0.14%**	0.16%	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 remained compliant in 2010/11.

3.3 Operating lease income

	2010/11	2009/10
	£000	£000
Operating Lease Income		
Rents recognised as income in the period	27	27
Contingent rents recognised as income in the period	7	6
TOTAL	34	33
Future minimum lease payments due		
- not later than one year;	6	27
- later than one year and not later than five years;	16	16
- later than five years.	32	36
TOTAL	54	79

3.4 Operating Income by type

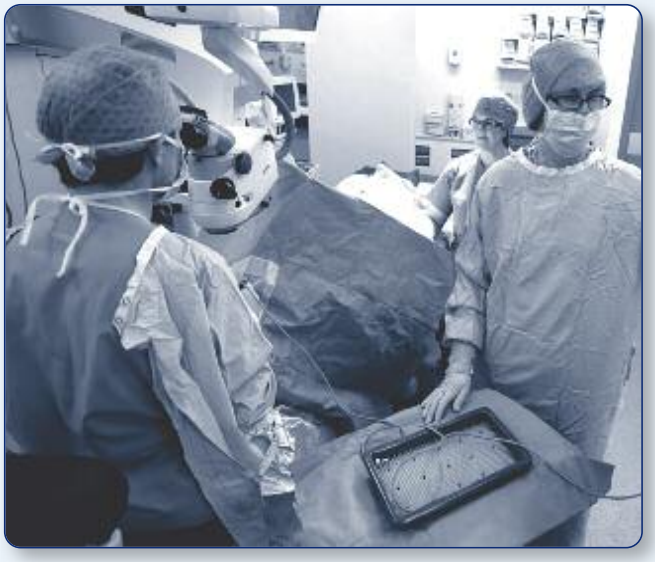
	2010/11	2009/10
	£000	£000
Income from activities		
NHS Foundation Trusts	-	-
NHS Trusts	293	318
Strategic Health Authorities	8	63
Primary Care Trusts	276,934	267,155
Local Authorities	478	453
Department of Health - other	113	27
Non-NHS: Private patients	383	442
Non-NHS: Overseas patients (non-reciprocal)	-	-
NHS injury scheme (was RTA)	1,584	1,391
Non-NHS: Other	1,993	1,992
Total income from activities	281,786	271,841
Other operating income		
Research and development	849	498
Education and training	7,430	7,543
Charitable and other contributions to expenditure	351	428
Transfer from donated asset reserve in respect of depreciation on donated assets	309	319
Non-patient care services to other bodies	8,531	9,185
Other*	15,796	19,414
Reversal of impairments of property, plant and equipment	5,608	-
Total other operating income	38,874	37,387
TOTAL OPERATING INCOME	320,660	309,228
Analysis of Income from activities: Non-NHS Other		
Ministry of Defence	-	-
Other government departments and agencies	-	-
Other	1,993	1,992
Total	1,993	1,992

*Other Operating income includes £5.7m estates recharges, £3.8m pharmacy sales and £1.3m catering income (In 2009/10 the comparative figures were £8.3m estates recharges, £3.4m pharmacy sales & £1.3m catering income).

4 Operating Expenses

	2010/11	2009/10
	£000	£000
Services from NHS Foundation Trusts	138	155
Services from NHS Trusts	1,645	1,511
Services from other NHS Bodies	166	79
Purchase of healthcare from non NHS bodies	1,733	1,142
Employee Expenses - Executive directors	936	874
Employee Expenses - Non-executive directors	152	138
Employee Expenses - Staff	201,269	196,944
Drug costs	20,365	17,343
Supplies and services - clinical (excluding drug costs)	24,601	23,513
Supplies and services - general	4,316	3,687
Establishment	4,188	4,477
Transport	698	2,334
Premises	19,802	20,278
Increase / (decrease) in bad debt provision	579	(129)
Depreciation on property, plant and equipment	9,005	9,546
Amortisation on intangible assets	89	70
Impairments of property, plant and equipment	5,146	19,596
Audit services - statutory audit	52	49
Audit services - other services	12	11
Clinical negligence	6,417	6,152
Loss on disposal of land and buildings	-	60
Loss on disposal of other property, plant and equipment	157	304
Other	3,529	2,786
TOTAL	304,995	310,920

The reduction in transport costs reflects the transfer of responsibility for commissioned 'Patient Transport Services' (from Yorkshire Ambulance Service) from the Trust to the PCT's on 1st April 2010.



5 Salary and Pension entitlements of senior managers

5.1 Remuneration

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

	2010/11				2009/10			
	Salary	Other Remuneration	Golden Hello	Compensation for loss of office	Salary	Other Remuneration	Golden Hello	Compensation for loss of office
Name and Title	(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)	(bands of £5,000) £000
S Sharma Chairman	45 - 50				45 - 50			
C Clark Non-Executive Director	15 - 20				10 - 15			
A Fisher Non-Executive Director	10 - 15				10 - 15			
A Haigh Non-Executive Director (Note A)	0 - 5				N/A			
J Hanson Non-Executive Director	15 - 20				10 - 15			
W Jones Non-Executive Director	10 - 15				15 - 20			
M Naeem Non-Executive Director (Note B)	5 - 10				10 - 15			
M Brearley Director of Finance	140 - 145				135 - 140			
L Hill Director of Service Development	125 - 130				125 - 130			
J Hull Director of Personnel	120 - 125				115 - 120			
Y A Oade Medical Director (Note C)	95 - 100				95 - 100			
H Thomson Director of Nursing	125 - 130				125 - 130			
D Whittingham Chief Executive (Note D)	130 - 135				185 - 190			

A. A Haigh, appointed as Non-Executive Director from 01.12.2010

B. M Naeem in post until 30.11.2010

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

D. The Chief Executive has carried dual accountability for Calderdale & Huddersfield NHS Foundation Trust and East Lancashire Hospitals NHS Trust. The accounts report the proportion of salary costs attributable to Calderdale & Huddersfield NHS Foundation Trust. East Lancashire Hospitals NHS Trust will disclose their proportion of the salary costs. The Remuneration Committees of each Trust agreed the proportionality.

5.2 Pension Benefits

Name and Title	Real increase / (decrease) in pension at age 60 (bands of £2,500) £000	Real increase / (decrease) in related lump sum at age 60 (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2011 (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2011 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2011 £000	Cash Equivalent Transfer Value at 31 March 2010 £000	Real Increase / (decrease) in Cash Equivalent Transfer Value £000
M Brearley Director of Finance	(0.0 - 2.5)	(0.0 - 2.5)	50 - 55	155 - 160	910	983	(113)
L Hill Director of Service Development	0.0 - 2.5	2.5 - 5.0	30 - 35	100 - 105	491	535	(65)
J Hull Director of Personnel	0.0 - 2.5	0.0 - 2.5	35 - 40	115 - 120	600	653	(79)
Y A Oade Medical Director (Note E)	0.0 - 2.5	0.0 - 2.5	25 - 30	80 - 85	482	514	(51)
H Thomson Director of Nursing	(0.0 - 2.5)	(0.0 - 2.5)	55 - 60	170 - 175	1,028	1,098	(113)
D Whittingham Chief Executive (Note F)	12.5 - 15.0	40.0 - 42.5	95 - 100	290 - 295	1,903	1,705	130

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

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

F. The pension change for the Chief Executive is indicative based on the time limited dual accountability arrangements for Calderdale & Huddersfield NHS Foundation Trust and East Lancashire Hospitals NHS Trust, described above. The arrangements in place to calculate NHS pensions (used by the NHS Pensions Agency) provide for the erosion of this increase over time.

Real increase / (decrease in pensions and related lump sums at age 60

The real movements in pensions and related lump sums at age 60 have been calculated by adjusting for the movement on the Consumer Prices Index of 4% for 2010/11.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase / (Decrease) in CETV

This reflects the change in CETV, taking into account changes in accrued pension due to inflation and contributions paid by the employer and employee during the year. Common market valuation factors are used for the start and end of the period.

In the budget of 22nd July 2010 the Chancellor announced that the uprating (annual increase) of public sector pensions would change from the Retail Price Index (RPI) to the Consumer Prices Index (CPI). As a result the Government Actuaries Department undertook a review of all transfer factors. The new CETV factors have been used in the above calculations and are lower than the previous factors, resulting in the value of the CETV for some members having fallen since 1 April 2010.

6 Employee Expenses

6.1 Employee Expenses breakdown

	2010/11	2009/10
	£000	£000
Salaries and wages	162,569	160,007
Social security costs	12,036	11,629
Pension costs - defined contribution plans Employers contributions to NHS Pensions	19,919	19,348
Termination benefits	399	-
Agency / contract staff	7,282	6,834
TOTAL	202,205	197,818

6.2 Average number of employees (Whole Time Equivalent basis)

	2010/11	2009/10
	Number	Number
Medical and dental	489	485
Administration and estates*	1,240	1,250
Healthcare assistants and other support staff	1,035	1,052
Nursing, midwifery and health visiting staff	1,415	1,400
Scientific, therapeutic and technical staff	768	767
Bank and agency staff	163	183
TOTAL	5,110	5,137

*The whole time equivalent staff number for 2009/10 in the 'Administration and estates' category has been restated to include West Yorkshire Audit Consortium staff to ensure comparabilty with the 2010/11 numbers.

6.3 Employee benefits

The Trust has not paid any Employee benefits in the 2010/11 or 2009/10 financial years.

6.4 Early retirements due to ill health

	2010/11	2009/10
	Number	Number
No of early retirements on the grounds of ill health	8	15

	2010/11	2009/10
	Number	Number
Value of early retirements on the grounds of ill health	480	990

6.5 Staff exit packages

	2010/11	2009/10
	Number	Number
Exit package cost band:		
< £10,000	9	-
£10,000 - £25,000	4	-
£25,001 - £50,000	3	-
£50,001 - £100,000	-	-
£100,001 - £150,000	-	-
£150,001 - £200,000	-	-
Total number of exit packages by type	16	0

	2010/11	2009/10
	£000	£000
Total resource cost	205	0

The Trust operated a time-limited 'Mutually Approved Resignation Scheme' (MARS) in 2010/11 which was based on the nationally agreed scheme and applies the principles agreed by the NHS Staff Council for local schemes. The MARS is a scheme under which an individual employee, in agreement with their employer, chooses to leave employment in return for a severance payment. A mutually agreed resignation is not a redundancy or a voluntary redundancy. The scheme was agreed with staff side representatives on the Trust's Staff Management Partnership Forum.

7 Operating expenses - miscellaneous

7.1 Operating leases

	2010/11	2009/10
	£000	£000
Minimum lease payments	2,603	2,020
Contingent rents	-	-
Less sublease payments received	-	-
TOTAL	2,603	2,020

7.2 Arrangements containing an operating lease

	2010/11	2009/10
	£000	£000
Future minimum lease payments due:		
- not later than one year;	2,431	1,885
- later than one year and not later than five years;	6,192	5,085
- later than five years.	3,080	2,172
TOTAL	11,703	9,142
Total of future minimum sublease lease payments to be received as the balance sheet date	52	56

7.3 Late Payment

There were no amounts included within 'Interest payable' arising from claims made under the Late Payment of Commercial Debts (Interest) Act 1998 or any compensation paid to cover debt recovery costs under this legislation.

7.4 Audit Remuneration

	2010/11	2009/10
	£000	£000
Taxation services	-	-
IT services	-	-
Internal audit services	-	-
Valuation and actuarial services	-	-
Litigation services	-	-
Recruitment and remuneration services	-	-
Corporate finance transactions	-	-
Other	12	11
TOTAL	12	11

8 Discontinued operations

The Trust had no discontinued operations to disclose in 2010/11 or 2009/10.

9 Corporation Tax

The Trust has assessed that it is not liable for Corporation tax in 2010/11 or 2009/10.

10 Finance income

	2010/11	2009/10
	£000	£000
Interest on loans and receivables	-	-
Interest on available for sale financial assets	-	-
Interest on held-to-maturity financial assets	-	-
Other	162	188
TOTAL	162	188

11 Finance costs - interest expense

	2010/11	2009/10
	£000	£000
Loans from the Foundation Trust Financing Facility	310	330
Commercial loans	-	-
Overdrafts	-	-
Finance leases	-	-
Other	-	-
Finance Costs in PFI obligations	-	-
Main Finance Costs	7,417	7,542
Contingent Finance Costs	2,483	1,994
TOTAL	10,210	9,866

12 Impairment of assets

	2010/11	2009/10
	£000	£000
Loss or damage from normal operations	-	-
Loss as a result of catastrophe	-	-
Abandonment of assets in course of construction	-	-
Unforeseen obsolescence	-	-
Over specification of assets	-	-
Other	19,447	4,486
Changes in market price	5,464	49,731
Reversal of impairments	(5,608)	-
TOTAL	19,303	54,217

13 Intangible assets

13.1 Intangible assets 2010/11

	Total
	£000
Valuation / Gross cost at 1 April 2010	865
Additions - purchased	193
Additions - donated	-
Impairments	-
Reclassifications	-
Revaluations	-
Disposals	-
Valuation / Gross cost at 31 March 2011	1,058
Amortisation at 1 April 2010	584
Provided during the year	89
Impairments	-
Reclassifications	-
Revaluation surpluses	-
Disposals	-
Amortisation at 31 March 2011	673

13.2 Intangible assets 2009/10

	Total
	£000
Valuation / Gross cost at 1 April 2009	766
Additions - purchased	99
Additions - donated	-
Impairments	-
Reclassifications	-
Revaluations	-
Disposals	-
Valuation / Gross cost at 31 March 2010	865
Amortisation at 1 April 2009	514
Provided during the year	70
Impairments	-
Reclassifications	-
Revaluation surpluses	-
Disposals	-
Amortisation at 31 March 2010	584

13.3 Intangible assets financing

	Total
	£000
Net book value	
NBV - Purchased at 31 March 2011	385
NBV - Finance leases at 31 March 2011	-
NBV - Donated at 31 March 2011	-
NBV total at 31 March 2011	385
Net book value	
NBV - Purchased at 31 March 2010	281
NBV - Finance leases at 31 March 2010	-
NBV - Donated at 31 March 2010	-
NBV total at 31 March 2010	281

13.4 Government grants

The Trust has no intangible assets acquired by government grants.

13.5 Economic life of intangible assets

All of the Trusts intangible assets relate to software. The Trust has no intangible assets for Licenses & trademarks, Patents, Information Technology, Development expenditure, Goodwill or Intangible Assets under construction.

The estimated economic useful life of software is five years.

14 Property, plant and equipment

14.1 Property, plant and equipment 2010/11

	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
Valuation / Gross cost at 1 April 2010	251,973	56,689	134,575	5,029	6,276	36,452	132	11,342	1,478
Additions - purchased	12,676	-	3,521	-	8,291	400	-	452	12
Additions - donated	151	-	101	-	-	23	-	27	-
Impairments	(19,765)	(12,275)	(7,470)	(20)	-	-	-	-	-
Reclassifications	-	100	9,571	(389)	(9,529)	24	-	223	-
Revaluations	71	-	71	-	-	-	-	-	-
Transferred to disposal group as asset held for sale	(500)	(500)	-	-	-	-	-	-	-
Disposals	(4,846)	-	(28)	(7)	-	(4,799)	(12)	-	-
Valuation / Gross cost at 31 March 2011	239,760	44,014	140,341	4,613	5,038	32,100	120	12,044	1,490
Accumulated depreciation at 1 April 2010	34,061	-	-	-	-	25,492	132	7,403	1,034
Provided during the year	9,005	-	5,312	125	-	2,083	-	1,328	157
Impairments	(462)	(155)	(203)	(104)	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-	-	-
Revaluation surpluses	(4,972)	155	(5,107)	(20)	-	-	-	-	-
Disposals	(4,238)	-	(2)	(1)	-	(4,223)	(12)	-	-
Accumulated depreciation at 31 March 2011	33,394	-	-	-	-	23,352	120	8,731	1,191

14.2 Property, plant and equipment 2009/10

	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
Valuation / Gross cost at 1 April 2009 - as previously stated	325,369	62,916	194,160	5,806	12,917	38,337	132	9,864	1,237
Prior year adjustments	(47,925)	(2,162)	(45,319)	(444)	-	-	-	-	-
Valuation/Gross cost at 1 April 2009 - restated	277,444	60,754	148,841	5,362	12,917	38,337	132	9,864	1,237
Additions - purchased	12,780	180	3,604	57	7,299	1,033	-	598	9
Additions - donated	244	-	11	-	-	233	-	-	-
Impairments	(34,621)	(4,245)	(29,986)	(390)	-	-	-	-	-
Reclassifications	-	-	12,176	-	(13,940)	652	-	880	232
Revaluations	-	-	-	-	-	-	-	-	-
Disposals	(3,874)	-	(71)	-	-	(3,803)	-	-	-
Valuation / Gross cost at 31 March 2010	251,973	56,689	134,575	5,029	6,276	36,452	132	11,342	1,478
Accumulated depreciation at 1 April 2009 - as previously stated	81,618	2,162	45,319	444	-	26,499	132	6,161	901
Prior year adjustments	(47,925)	(2,162)	(45,319)	(444)	-	-	-	-	-
Accumulated depreciation at 1 April 2009 - restated	33,693	-	-	-	-	26,499	132	6,161	901
Provided during the year	9,546	-	6,073	128	-	2,031	-	1,181	133
Impairments	19,596	-	20,261	(726)	-	-	-	61	-
Reclassifications	-	-	-	-	-	-	-	-	-
Revaluation surpluses	(25,725)	-	(26,323)	598	-	-	-	-	-
Disposals	(3,049)	-	(11)	-	-	(3,038)	-	-	-
Accumulated depreciation at 31 March 2010	34,061	-	-	-	-	25,492	132	7,403	1,034

In the published 2009/10 accounts, 'Impairments' and 'Revaluation Surpluses' in this note were disclosed as (£8,896,000) and nil respectively. In accordance with Monitor's reporting guidance that states "when assets are revalued, the carrying amount of the asset should be restated at it's revalued amount. NHS Foundation Trusts should follow the approach set out in paragraph 35(b) of IAS 16 and eliminate any accumulated depreciation against the carrying value of the asset", the 2009/10 comparative values have been amended to 'Impairments' of (£34,621,000) and 'Revaluation surpluses' of (£25,725,000), a net movement of (£8,896,000).

In addition, as land, buildings and dwellings were also revalued in 2008/09, accumulated depreciation should have been set to nil in 2008/09 on these asset categories. This was not done in 2008/09, the accumulated balances at 1st April 2009 have been restated in the note above through prior year adjustments.

14.3 Property, plant and equipment financing

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under Construction & Payments on Account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value - 31 March 2011									
Owned	124,616	43,279	60,329	4,613	4,948	7,861	-	3,287	299
Finance Lease*	735	735	-	-	-	-	-	-	-
PFI	79,645	-	79,610	-	35	-	-	-	-
Donated	1,370	-	402	-	55	887	-	26	-
NBV total at 31 March 2011	206,366	44,014	140,341	4,613	5,038	8,748	-	3,313	299
Net book value - 31 March 2010									
Owned	141,466	55,954	60,043	5,029	6,221	9,836	-	3,939	444
Finance Lease	735	735	-	-	-	-	-	-	-
PFI	74,168	-	74,168	-	-	-	-	-	-
Donated	1,543	-	364	-	55	1,124	-	-	-
NBV total at 31 March 2010	217,912	56,689	134,575	5,029	6,276	10,960	-	3,939	444

*In the 2009/10 accounts, £735,000 of long leashold land was classified as 'owned'. This has been corrected and transferred to the 'finance lease' classification in the comparative figures.

14.4 Economic life of property, plant and equipment

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

15 Protected assets

15.1 Analysis of property, plant and equipment 31 March 2011

	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 2011	93,724	3,847	89,877	-	-	-	-	-	-
NBV - Unprotected assets at 31 March 2011	112,642	40,167	50,464	4,613	5,038	8,748	-	3,313	299
Total at 31 March 2011	206,366	44,014	140,341	4,613	5,038	8,748	-	3,313	299

15.2 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	-	-	-	-	-	-
NBV - Unprotected assets at 31 March 2010	131,818	52,842	52,328	5,029	6,276	10,960	-	3,939	444
Total at 31 March 2010	217,912	56,689	134,575	5,029	6,276	10,960	-	3,939	444

16 Assets held for sale

16.1 Non-current assets for sale and assets in disposal groups - 2010/11

	Total	Intangible Assets	Property, Plant & Equipment	Financial Investments	Other
	£000	£000	£000	£000	£000
NBV of non-current assets for sale and assets in disposal groups at 1 April 2010					
Plus assets classified as available for sale in the year	500	-	500	-	-
Less assets sold in year	-	-	-	-	-
Less Impairment of assets held for sale	-	-	-	-	-
Plus Reversal of impairment of assets held for sale	-	-	-	-	-
Less assets no longer classified as held for sale, for reasons other than disposal by sale	-	-	-	-	-
NBV of non-current assets for sale and assets in disposal groups at 31 March 2011	500	-	500	-	-

17 Inventories

17.1 Inventories

	31 Mar 2011	31 Mar 2010
	£000	£000
Materials	4,132	4,016
Work in progress	182	211
Finished goods	413	472
TOTAL Inventories	4,727	4,699

17.2 Inventories recognised in expenses

	2010/11	2009/10
	£000	£000
Inventories recognised in expenses	44,966	40,856
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	44,966	40,856

18 Trade and other receivables

18.1 Trade receivables and other receivables

	Total 31 Mar 2011	Total 31 Mar 2010
	£000	£000
Current		
NHS Receivables	6,552	6,562
Other receivables with related parties	60	0
Provision for impaired receivables	(511)	(155)
Prepayments	2,029	1,716
Accrued income	421	309
Finance Lease Receivables	0	0
PDC receivable	0	152
Other receivables	2,873	4,777
TOTAL CURRENT TRADE AND OTHER RECEIVABLES	11,424	13,361
Non-Current		
NHS Receivables	685	688
Other receivables with related parties	0	0
Provision for impaired receivables	(248)	(90)
Prepayments	0	0
Accrued income	0	0
Finance Lease Receivables	0	0
Other receivables	1,299	1,124
TOTAL NON-CURRENT TRADE AND OTHER RECEIVABLES	1,736	1,722

NHS Receivables falling due within one year includes £2,541,000 for incomplete spells of care provided at 31 March 2011 (£2,497,000 at 31 March 2010).

18.2 Provision for impairment of receivables

	2010/11	2009/10
	£000	£000
At 1 April	245	779
Increase in provision	602	0
Amounts utilised	(65)	(405)
Unused amounts reversed	(23)	(129)
At 31 March	759	245

18.3 Analysis of impaired receivables

	2010/11	2009/10
	£000	£000
Ageing of impaired receivables		
Up to three months	261	14
In three to six months	117	12
Over six months	381	219
Total	759	245
Ageing of non-impaired receivables past their due date		
Up to three months	1,992	1,178
In three to six months	409	277
Over six months	395	414
Total	2,796	1,869

18.4 Finance lease receivables

The Trust had no Finance lease receivables in 2010/11 or 2009/10.

19 Cash and cash equivalents

	2010/11	2009/10
	£000	£000
At 1 April	18,237	19,079
Net change in year	(3,212)	(842)
At 31 March	15,025	18,237
Broken down into:		
Cash at commercial banks and in hand	129	88
Cash with the Government Banking Service	14,896	18,149
Other current investments	-	-
Cash and cash equivalents as in SoFP	15,025	18,237
Bank overdraft	0	0
Cash and cash equivalents as in SoCF	15,025	18,237
Third party assets held by the NHS Foundation Trust	1	3

20 Trade and other payables

20.1 Trade and other payables

	Total 31 Mar 2011	Total 31 Mar 2010
	£000	£000
Current		
Receipts in advance	1	561
NHS payables	5,402	4,601
Amounts due to other related parties	-	-
Trade payables - capital	1,157	2,593
Other trade payables	5,742	5,513
Taxes payable	4,124	4,020
Other payables	1,695	2,212
Accruals	2,641	3,748
PDC payable	124	-
TOTAL CURRENT TRADE AND OTHER PAYABLES	20,886	23,248
Non-current		
Receipts in advance	-	-
NHS payables	-	-
Amounts due to other related parties	-	-
Trade payables - capital	-	-
Other trade payables	-	-
Taxes payable*	550	633
Other payables*	-	-
Accruals	-	-
TOTAL NON CURRENT TRADE AND OTHER PAYABLES	550	633

*In the 2009/10 accounts, VAT repayable of £633,000 under the Lennartz mechanism was disclosed under 'Other payables'. This has been corrected and is now shown under 'Taxes payable'.

20.2 Early retirements detail included in NHS payables above

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

21 Borrowings

	31 Mar 2011	31 Mar 2010
	£000	£000
Current		
Bank overdrafts	-	-
Drawdown of committed facility	-	-
Loans from Foundation Trust Financing Facility	562	562
Other Loans	-	-
Obligations under finance leases	-	-
Obligations under Private Finance Initiative contracts	1,209	1,593
TOTAL CURRENT BORROWINGS	1,771	2,155
Non-current		
Loans from Foundation Trust Financing Facility	6,194	6,756
Other Loans	-	-
Obligations under finance leases	-	-
Obligations under Private Finance Initiative contracts	84,334	85,543
TOTAL OTHER NON-CURRENT LIABILITIES	90,528	92,299

22 Prudential borrowing

22.1 Prudential borrowing limit

	2010/11	2009/10
	£000	£000
Total long term borrowing limit set by Monitor	94,500	96,204
Working capital facility agreed by Monitor	22,800	22,800
TOTAL PRUDENTIAL BORROWING LIMIT	117,300	119,004
Long term borrowing at 1 April	94,455	95,004
Net actual borrowing / (repayment) in year - long term	(2,156)	(549)
Long term borrowing at 31 March	92,299	94,455
Working capital borrowing at 1 April	-	-
Net actual borrowing / (repayment) in year - working capital	-	-
Working capital borrowing at 31 March	-	-

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 £94.5m in 2010/11 (£96.2m in 2009/10) and remained within these limits.

The Trust repaid £562,000 to the Foundation Trust Financing Facility, and repaid £1,593,000 on the PFI Finance Lease Creditor in 2010/11.

The Trust's approved working capital facility limit was £22.8m in 2010/11 (£18.0m from 1 April 2009 to 30 November 2009, and £22.8m from 1 December 2009 to 31 March 2011). The Trust did not use this facility during the 2010/11 or 2009/10. financial years.

22.2 Financial Ratios

	2010/11		2009/10	
	Actual	Approved	Actual	Approved
Financial Ratios				
Minimum dividend cover	3.8x	3.8x	4.2x	3.7x
Minimum interest cover	2.4x	2.3x	2.8x	2.8x
Minimum debt service cover	2.0x	1.9x	2.4x	2.4x
Maximum debt service to revenue	4.0%	4.0%	3.8%	3.9%

23 Other liabilities

	31 Mar 2011	31 Mar 2010
	£000	£000
Current		
Deferred Income	3,190	1,497
TOTAL OTHER CURRENT LIABILITIES	3,190	1,497
Non-current		
Deferred Income	1,933	1,933
TOTAL OTHER NON-CURRENT LIABILITIES	1,933	1,933

24 Provisions and contingent liabilities

24.1 Provisions for liabilities and charges

	Current		Non-current	
	31 Mar 2011	31 Mar 2010	31 Mar 2011	31 Mar 2010
	£000	£000	£000	£000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	251	251	1,275	1,508
Other legal claims	148	156	-	-
Other	235	41	1,024	1,054
Total	634	448	2,299	2,562

24.2 Provisions for liabilities and charges analysis

	Total	Pensions - other staff	Other legal claims	Other
	£000	£000	£000	£000
At 1 April 2010	3,010	1,759	156	1,095
Change in the discount rate	(101)	(13)	-	(88)
Arising during the year	421	7	128	286
Utilised during the year	(409)	(258)	(99)	(52)
Reclassified to liabilities held in disposal groups in year	-	-	-	-
Reversed unused	(47)	(6)	(37)	(4)
Unwinding of discount	59	36	-	23
At 31 March 2011	2,933	1,525	148	1,260
Expected timing of cashflows:				
- not later than one year;	634	251	148	235
- later than one year and not later than five years;	1,170	1,005	-	165
- later than five years.	1,129	269	-	860
TOTAL	2,933	1,525	148	1,260

24.3 Clinical Negligence liabilities

	31 Mar 2011	31 Mar 2010
	£000	£000
Amount included in provisions of the NHSLA in respect of clinical negligence liabilities of Calderdale and Huddersfield NHS Foundation Trust	39,595	33,968

24.4 Contingent (Liabilities) / Assets

There were no contingent liabilities or assets to disclose at 31 March 2011 or 31 March 2010.

25 Related Party Transactions

The Trust has established which entities and individuals are its related parties, in accordance with International Accounting Standard 24. Monitor have directed, through the Annual Reporting Manual 2010/11, that all bodies within the scope of 'Whole of Government Accounts' (WGA) are related parties. Accordingly, the table below details material transactions.

Related party transactions - WGA organisations	2010/11	2009/10
	£000	£000
Income - NHS Calderdale	130,667	127,358
Income - NHS Kirklees	140,949	138,059
Income - NHS Bradford & Airedale	8,173	6,756
Income - NHS Wakefield District	3,394	3,150
Income - South West Yorkshire Partnership NHS Foundation Trust	6,674	6,501
Income - Yorkshire & Humber SHA	9,173	10,377
Income - NHS Pension Scheme	-	-
Income - NHS Litigation Authority	1	41
Income - NHS Purchasing & Supply Agency	-	150
Income - HMRC - Taxes & Duties	-	-
Income - Other WGA	11,325	11,329
Income - Total with WGA organisations	310,356	303,721
Expenditure - NHS Calderdale	753	162
Expenditure - NHS Kirklees	301	149
Expenditure - NHS Bradford & Airedale	74	37
Expenditure - NHS Wakefield District	52	30
Expenditure - South West Yorkshire Partnership NHS Foundation Trust	107	176
Expenditure - Yorkshire & Humber SHA	60	88
Expenditure - NHS Pension Scheme	19,983	19,348
Expenditure - NHS Litigation Authority	6,615	6,156
Expenditure - NHS Purchasing & Supply Agency	8,513	7,480
Expenditure - HMRC - Taxes & Duties	12,036	11,629
Expenditure - Other WGA	7,402	8,824
Expenditure - Total with WGA organisations	55,896	54,079

Related party balances - WGA organisations	31 Mar 2011	31 Mar 2010
	£000	£000
Receivables - NHS Calderdale	1,776	1,985
Receivables - NHS Kirklees	3,155	2,222
Receivables - NHS Bradford & Airedale	319	32
Receivables - NHS Wakefield District	246	198
Receivables - South West Yorkshire Partnership NHS Foundation Trust	493	211
Receivables - Yorkshire & Humber SHA	110	298
Receivables - NHS Pension Scheme	-	-
Receivables - NHS Litigation Authority	1	41
Receivables - NHS Purchasing & Supply Agency	-	-
Receivables - HMRC - Taxes & Duties	-	-
Receivables - Other WGA	1,197	2,146
Receivables - Total with WGA organisations	7,297	7,133
Payables - NHS Calderdale	681	52
Payables - NHS Kirklees	118	132
Payables - NHS Bradford & Airedale	17	11
Payables - NHS Wakefield District	16	-
Payables - South West Yorkshire Partnership NHS Foundation Trust	15	74
Payables - Yorkshire & Humber SHA	1	4
Payables - NHS Pension Scheme	2,549	2,456
Payables - NHS Litigation Authority	-	2
Payables - NHS Purchasing & Supply Agency	1,024	716
Payables - HMRC - Taxes & Duties	4,124	4,020
Payables - Other WGA	981	1,286
Payables - Total with WGA organisations	9,526	8,753

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 less than £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).

The NHS Foundation Trust has also received revenue and capital payments from the Calderdale & Huddersfield NHS Foundation Trust Charitable Fund, for which the NHS Foundation Trust is a corporate trustee. The transactions and balances are shown in the tables below:

Related party transactions Calderdale & Huddersfield NHS Foundation Trust Charitable Fund	2010/11 £000	2009/10 £000
Income	351	428
Expenditure	-	-

Related party balances Calderdale & Huddersfield NHS Foundation Trust Charitable Fund	31 Mar 2011 £000	31 Mar 2010 £000
Receivables	-	-
Payables	-	-

The Trust entered into a joint venture with Henry Boot Development Ltd on 24th March 2011. This newly created partnership is the Pennine Property Partnership LLP and is owned 50/50 by the Trust and Henry Boot Development Ltd. No financial transactions were undertaken in the financial year 2010/11.

During the year, none of the key management personnel (Board of Directors) or their close family members have undertaken any material transaction with the Trust (other than key management personnel remuneration detailed in note 5).

26 Contractual Capital Commitments

	31 Mar 2011 £000	31 Mar 2010 £000
Property, Plant and Equipment	1,547	3,257
Intangible assets	-	-
Total	1,547	3,257

27 PFI (on Statement of Financial Position)

27.1 PFI obligations (on Statement of Financial Position)

	31 Mar 2011	31 Mar 2010
	£000	£000
Gross PFI liabilities of which liabilities are due	251,746	252,025
- not later than one year;	10,830	11,004
- later than one year and not later than five years;	42,734	41,098
- later than five years.	198,182	199,923
Finance charges allocated to future periods	(166,203)	(164,889)
	85,543	87,136
Net PFI obligation		
- not later than one year;	1,209	1,593
- later than one year and not later than five years;	5,439	5,152
- later than five years.	78,895	80,391

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

	31 Mar 2011	31 Mar 2010
	£000	£000
Commitments*		
Within one year	9,542	9,143
2nd to 5th years (inclusive)	38,169	36,570
later than five years.	144,724	147,805
	192,435	193,518

The PFI scheme above 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 accommodation.

*The amount disclosed in the 2009/10 accounts was based on the full payment to Catalyst rather than just the service element and has been restated accordingly.

28 For PFI schemes deemed to be off-Statement of Financial Position

The Trust has no PFI schemes deemed to be off-Statement of Financial Position.

29 Events after the reporting period

It should be noted that from 1 April 2011, the Trust entered into a contract with NHS Calderdale to provide community services (with an associated income stream of c.£14m) which were previously provided by NHS Calderdale. As part of this arrangement, clinical and non-clinical staff transferred from NHS Calderdale to the Trust on the same date. No material assets were transferred.

30 Financial assets and financial liabilities

30.1 Financial assets by category

	Total
	£000
Assets as per Statement of Financial Position	
Trade and other receivables excluding non financial assets (at 31 Mar 2011)	8,373
Cash and cash equivalents (at bank and in hand (at 31 Mar 2011)	15,025
Total at 31 March 2011	23,398
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

All financial assets at 31 March 2011 and 31 March 2010 were classified as loans and receivables. The Trust had no financial assets held at fair value through Income and expenditure, Held to maturity or Available-for-sale.

30.2 Financial liabilities by category

	Total
	£000
Liabilities as per Statement of Financial Position	
Borrowings excluding Finance lease and PFI liabilities (at 31 Mar 2011)	6,756
Obligations under Private Finance Initiative contracts (at 31 Mar 2011)	85,543
Trade and other payables excluding non financial liabilities (at 31 Mar 2011)	16,637
Other financial liabilities (at 31 Mar 2011)	-
Total at 31 March 2011	108,936
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 liabilities (31 Mar 2010)	19,300
Other financial liabilities (31 Mar 2010)	-
Total at 31 March 2010	113,754

All financial liabilities at 31 March 2011 and 31 March 2010 were classed as other financial liabilities. The Trust had no liabilities held at fair value through income and expenditure.

30.3 Fair values of financial assets at 31 March 2011

	Book value	Fair value
	£000	£000
Non current trade and other receivables excluding non financial assets	685	685
Other Investments	-	-
Other	-	-
Total	685	685

30.4 Fair values of financial liabilities at 31 March 2011

	Book value	Fair value
	£000	£000
Non current trade and other payables excluding non financial liabilities	-	-
Provisions under contract	-	-
Loans	6,756	6,756
Other	-	-
Total	6,756	6,756

Management consider that the carrying amounts of financial assets and financial liabilities recorded at amortised cost in the financial statements approximate to their fair value.

30.5 Financial Instruments

Financial risk management

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 listed companies. The Trust neither buys or sells financial instruments. The NHS Foundation Trust has limited powers or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

The Board of Directors has approved a Treasury Management policy which sets out the parameters for investing any surplus operating cash in short-term deposits. This includes the restriction of any such investment to 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. the Trust's treasury management activity is subject to review by the Trust's internal auditors.

Interest rate risk

All of the Trust's financial liabilities carry nil or fixed rates of interest. The Trust therefore has low exposure to interest rate fluctuations.

Liquidity risk

The Trust's operating costs are largely incurred under contracts with local Primary Care Trusts, which are financed from resources voted annually by Parliament. The Trust receives cash each month based on an annually agreed level of contract activity with in-year adjustments to reflect actual levels of income due.

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

In 2010/11 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 Trust is not, therefore, exposed to significant liquidity risk.

Currency risk

The Trust is principally a domestic organisation with negligible transactions, assets and liabilities in foreign currencies. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

31 Pharmacy Manufacturing Unit

The Trust operates a Pharmacy Manufacturing Unit. 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; the value of income in 2010/11 was £3,833,000 (£3,430,557 in 2009/10).

32 West Yorkshire Audit Consortium

The Audit Consortium was set up on 1st April 1993. It provides the internal audit function to a number of NHS organisations 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 Statement of Comprehensive Income; the value of income in 2010/11 was £1,734,000 (£1,845,440 in 2009/10).

33 Health Informatics

The Trust provides information management and technology services to a number of other NHS Organisations from the Health Informatics Service. The income and expenditure of the service are included in the Statement of Comprehensive Income; and the value of income in 2010/11 was £7,495,000 (£7,367,709 in 2009/10).

34 Limitation on Auditors Liability

There is no limit on our external Auditors liability.

35 Losses and special payments

35.1 Losses and special payments

There were 49 cases of losses and special payments totalling £251,000 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.

35.2 Recovered Losses

The Trust has not received any compensation payments from CHCC.

36 Impairments, Revaluations and Other Reserve Movements

In the published 2009/10 accounts, the value of 'Revaluation gains/(losses) and impairment losses on property, plant and equipment' disclosed for 2009/10 in the Statement of Comprehensive Income and Statement of Changes in Taxpayers Equity was (£8,881,000). In addition, the value of impairments on donated assets was (£15,000); this value was not identified separately and was included within a value of (£333,000) described as 'Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets'.

In order to achieve consistency between the published accounts and the annual financial returns submitted to Monitor, the way that the movements on these two Statements are identified have been amended in the published 2010/11 accounts. This note is intended to describe these changes as they relate to the 2009/10 comparative values.

The (£15,000) value of impairments on donated assets in 2009/10 has been reclassified as 'Impairments' and the residual (£318,000) that was previously described as 'Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets' for 2009/10 is now described as 'Other reserve movements'.

This would lead to (£8,896,000) being recognised as 'Revaluation gains/(losses) and impairment losses on property, plant and equipment' for 2009/10. The annual financial returns submitted to Monitor now break this line into two parts: 'Impairments' and 'Revaluations'. The 2009/10 restated comparative figures are (£34,621,000) and £25,725,000 respectively. It should be noted that the £25,725,000 'Revaluations' gain relates to the instruction in Monitor's Annual Reporting Manual for 2010/11 which states that "when assets are re-valued, the carrying amount of the asset should be re-stated at its re-valued amount. NHS foundation trusts should follow the approach set out in paragraph 35(b) of IAS 16 and eliminate any accumulated depreciation against the carrying value of the asset."


NHS

"Our patients should be treated in the right place at the right time by the right people."

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